

NEW ZEALAND DATA SHEET

1 PRODUCT NAME

Jakavi tablets: 5 mg, 10 mg, 15 mg and 20 mg

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

- **5 mg:** Each tablet contains 5 mg of ruxolitinib as the phosphate salt.
- **10 mg:** Each tablet contains 10 mg of ruxolitinib as the phosphate salt
- **15 mg:** Each tablet contains 15 mg of ruxolitinib as the phosphate salt.
- **20 mg:** Each tablet contains 20 mg of ruxolitinib as the phosphate salt.

Excipient with known effect: these tablets contain sugars as lactose monohydrate.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

5mg tablet: Round curved white to almost white tablets of approximately 7.5 mm in diameter with “NVR” debossed on one side and “L5” debossed on the other side.

10mg tablet: Round curved white to almost white tablets of approximately 9.3 mm in diameter with “NVR” debossed on one side and “L10” debossed on the other side.

15 mg tablet: Ovaloid curved white to almost white tablets of approximately 15.0 x 7.0 mm with “NVR” debossed on one side and “L15” debossed on the other side.

20 mg tablet: Elongated curved white to almost white tablets of approximately 16.5 x 7.4 mm with “NVR” debossed on one side and “L20” debossed on the other side.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

- Jakavi is indicated for the treatment of disease-related splenomegaly or symptoms in patients with primary myelofibrosis, post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis.
- Jakavi is indicated for the treatment of adult patients with polycythemia vera who are resistant to or intolerant of hydroxyurea.
- Jakavi is indicated for the treatment of patients aged 12 years and older with acute graft-versus-host disease who have inadequate response to corticosteroids.
- Jakavi is indicated for the treatment of patients aged 12 years and older with chronic graft-versus-host disease who have inadequate response to corticosteroids.

4.2 Dose and method of administration

Doses should be individualised based on safety and efficacy. Starting doses per indication are noted below.

Monitoring instructions

Blood cell counts: a blood cell count must be performed before initiating therapy with Jakavi. Complete blood counts should be monitored every 2 to 4 weeks until doses are stabilized, and then as clinically indicated (see section 4.4 Special warnings and precautions for use).

Dose

Myelofibrosis (MF)

Starting dose

The recommended starting dose of Jakavi in MF is based on platelet count (see Table 1). Jakavi can be taken with or without food.

Table 1: Recommended Jakavi Starting Dose in MF

Platelet Count	Starting Dose
50 x 10 ⁹ /L to less than 100 x 10 ⁹ /L	10 mg orally twice daily
100 x 10 ⁹ /L to 200 x 10 ⁹ /L	15 mg orally twice daily
More than 200 x 10 ⁹ /L	20 mg orally twice daily

Dose modifications

Doses may be titrated based on efficacy and safety.

If efficacy is considered insufficient and blood counts are adequate, doses may be increased in 5 mg twice daily increments to a maximum dose of 25 mg twice daily. Doses should not be increased during the first 4 weeks of therapy and not more frequently than every 2 weeks.

Based on limited clinical data, long-term maintenance at a 5 mg twice daily dose has not shown responses and continued use at this dose should be limited to patients in whom the benefits outweigh the potential risks. Discontinue treatment after 6 months if there is no spleen size reduction or symptom improvement since initiation of therapy with Jakavi.

Dose Reduction, treatment interruption and restart

The Jakavi dose should be reduced if the platelet counts decrease during treatment as outlined in Table 2, with the goal of avoiding dose interruptions for thrombocytopenia.

Table 2: Dosing Recommendations for Thrombocytopenia in MF

Platelet Count	Dose at Time of Platelet Decline				
	25 mg twice daily	20 mg twice daily	15 mg twice daily	10 mg twice daily	5 mg twice daily
	New Dose	New Dose	New Dose	New Dose	New Dose
100 to less than 125 x 10 ⁹ /L	20 mg twice daily	15 mg twice daily	No Change	No Change	No Change
75 to less than 100 x 10 ⁹ /L	10 mg twice daily	10 mg twice daily	10 mg twice daily	No Change	No Change
50 to less than 75 x 10 ⁹ /L	5 mg twice daily	5 mg twice daily	5 mg twice daily	5 mg twice daily	No Change
Less than 50 x 10 ⁹ /L	Hold	Hold	Hold	Hold	Hold

Polycythemia vera (PV)

Starting dose

The recommended starting dose of Jakavi in PV is 10 mg given orally twice daily with or without food.

Dose modifications

Doses may be titrated based on efficacy and safety.

If efficacy is considered insufficient and blood counts are adequate, doses may be increased in 5 mg twice daily increments to a maximum dose of 25 mg twice daily. Doses should not be increased during the first 4 weeks of therapy and not more frequently than every 2 weeks.

Dose Reduction, treatment interruption and restart

In PV, dose reduction should also be considered if haemoglobin decreases below 120 g/L and is recommended if haemoglobin decreases below 100 g/L. Treatment should be interrupted if the platelet count decreases below $50 \times 10^9/L$ or the absolute neutrophil count decreases below $0.5 \times 10^9/L$. Treatment should also be interrupted when haemoglobin is below 80 g/L.

After recovery of blood counts above these levels, Jakavi may be restarted at 5 mg twice daily and gradually increased based on careful monitoring of blood cell counts.

Acute Graft-versus-host disease

The recommended starting dose of Jakavi in acute GvHD is 5 to 10 mg given orally twice daily with or without food.

Chronic Graft-versus-host disease

The recommended starting dose of Jakavi in chronic GvHD is 10 mg given orally twice daily with or without food.

Dose modifications for acute and chronic GvHD

Dose reductions and temporary interruptions of treatment may be needed in GvHD patients with thrombocytopenia, neutropenia, or elevated total bilirubin after standard supportive therapy including growth-factors, anti-infective therapies and transfusions. One dose level reduction step is recommended (10 mg twice daily to 5 mg twice daily or 5 mg twice daily to 5 mg once daily). In patients who are unable to tolerate Jakavi at a dose of 5 mg once daily, treatment should be interrupted. Detailed dosing recommendations are provided in Table 3.

Table 3: Dosing recommendations for patients with thrombocytopenia, neutropenia, or elevated total bilirubin in patients with graft-versus- host disease

Laboratory Parameter	Dosing Recommendation
Platelet count $<20 \times 10^9/L$	Reduce Jakavi by one dose level. If platelet count $\geq 20 \times 10^9/L$ within seven days, dose may be increased to initial dose level, otherwise maintain reduced dose.
Platelet count $<15 \times 10^9/L$	Hold Jakavi until platelet count $\geq 20 \times 10^9/L$, then resume at one lower dose level.

Laboratory Parameter	Dosing Recommendation
Absolute neutrophil count (ANC) ≥0.5 x 10 ⁹ /L to <0.75 x 10 ⁹ /L	Reduce Jakavi by one dose level. Resume at initial dose level if ANC >1 x 10 ⁹ /L.
Absolute neutrophil count <0.5 x 10 ⁹ /L	Hold Jakavi until ANC >0.5 x 10 ⁹ /L, then resume at one lower dose level. If ANC >1 x 10 ⁹ /L, dosing may resume at initial dose level.
Total bilirubin elevation, no liver GvHD	3.0 to 5.0 x ULN: Continue Jakavi at one lower dose level until ≤3.0 x ULN.
	>5.0 to 10.0 x ULN: Hold Jakavi up to 14 days until total bilirubin ≤3.0 x ULN. If total bilirubin ≤3.0 x ULN dosing may resume at current dose. If not ≤3.0 x ULN after 14 days, resume at one lower dose level.
	>10.0 x ULN: Hold Jakavi until total bilirubin ≤3.0 x ULN, then resume at one lower dose level.
Total bilirubin elevation, liver GvHD	>3.0 x ULN: Continue Jakavi at one lower dose level until total bilirubin ≤3.0 x ULN.
Other adverse reactions: Grade 3	Continue Jakavi at 1 dose level lower until recovery.
Other adverse reactions: Grade 4	Discontinue Jakavi.

In GvHD, tapering of Jakavi may be considered in patients with a response and after having discontinued corticosteroids. A 50% dose reduction of Jakavi every two months is recommended. If signs or symptoms of GvHD reoccur during or after the taper of Jakavi, re-escalation of treatment should be considered.

Administration instruction

If a dose is missed, the patient should not take an additional dose, but should take the next usual prescribed dose.

Treatment may be continued as long as the benefit- risk ratio remains positive.

Dose adjustment with concomitant CYP3A4 Inhibitors or dual moderate inhibitors of CYP2C9 and CYP3A4:

When Jakavi is administered with strong CYP3A4 inhibitors in MF and PV patients or dual moderate inhibitors of CYP2C9 and CYP3A4 enzymes (e.g. fluconazole) in MF, PV or GvHD patients, the total daily dose of Jakavi should be modified according to Table 4. The concomitant use of Jakavi with fluconazole doses of greater than 200 mg daily should be avoided (see section 4.5 Interaction with other medicinal products and other forms of interaction).

More frequent monitoring of haematology parameters and clinical signs and symptoms of Jakavi related adverse drug reactions is recommended upon initiation of a strong CYP3A4 inhibitor or dual moderate inhibitors of CYP2C9 and CYP3A4 enzymes.

Table 4: Dose modifications for concomitant use with CYP3A4 inhibitors or dual inhibitors of CYP2C9 and CYP3A4

Concomitant use with	Recommended Jakavi dose modification
<p>MF patients – starting dose based on platelet count Strong CYP3A4 inhibitors, or dual moderate inhibitors of CYP2C9 and CYP3A4 enzymes (e.g., fluconazole ≤ 200 mg daily)</p> <ul style="list-style-type: none"> • Greater than or equal to 100 x 10⁹/L • 50 x 10⁹/L to less than 100 x 10⁹/L 	<ul style="list-style-type: none"> • 10 mg twice daily • 5 mg once daily
<p>PV patients – starting dose Strong CYP3A4 inhibitors, or dual moderate inhibitors of CYP2C9 and CYP3A4 enzymes (e.g., fluconazole ≤ 200 mg daily).</p>	<ul style="list-style-type: none"> • 5 mg twice daily
<p>MF & PV patients on a stable dose Strong CYP3A4 inhibitors, or dual moderate inhibitors of CYP2C9 and CYP3A4 enzymes (e.g., fluconazole ≤ 200 mg daily)</p> <ul style="list-style-type: none"> • Greater than or equal to 10 mg twice daily • 5 mg twice daily • 5 mg once daily 	<ul style="list-style-type: none"> • Decrease dose by 50% (round up to the closest available tablet strength) • 5 mg once daily • Avoid strong CYP3A4 inhibitor or fluconazole treatment, or interrupt Jakavi treatment for the duration of strong CYP3A4 inhibitor or fluconazole use
<p>Acute GvHD Dual moderate inhibitors of CYP2C9 and CYP3A4 enzymes (e.g., fluconazole ≤ 200 mg daily)</p> <ul style="list-style-type: none"> • Starting dose 5 mg twice daily • Starting dose 10 mg twice daily 	<ul style="list-style-type: none"> • 5 mg once daily • 5 mg twice daily
<p>Chronic GvHD Dual moderate inhibitors of CYP2C9 and CYP3A4 enzymes (e.g., fluconazole ≤ 200 mg daily)</p>	<ul style="list-style-type: none"> • 5 mg twice daily

Patients with Renal Impairment

In patients with moderate to severe renal impairment (creatinine clearance (Cl_{cr}) less than 60mL/min) the recommended starting dose based on platelet count should be reduced by approximately 50%. The recommended starting dose for PV patients with severe renal impairment is 5 mg twice daily. Patients diagnosed with moderate to severe renal impairment

while receiving Jakavi should be carefully monitored and may need to have their doses reduced to avoid adverse drug reactions.

There are limited data to determine the best dosing options for patients with end-stage renal disease (ESRD) on dialysis. Available data in this population suggest that MF patients on dialysis should be started on an initial single dose of 15 mg or 20 mg (or two doses of 10mg given 12 hours apart) based on platelet counts with subsequent single doses only after each dialysis session, and with careful monitoring of safety and efficacy. The recommended starting dose for PV patients with ESRD on haemodialysis is a single dose of 10 mg or two doses of 5 mg given 12 hours apart, to be administered post-dialysis and only on the day of haemodialysis and with careful monitoring of safety and efficacy (see section 5.1 Pharmacodynamic Properties). There are no data for patients undergoing peritoneal dialysis or continuous venovenous haemofiltration. Jakavi should be avoided in patients with end stage renal disease (CrCl less than 15 mL/min) not undergoing dialysis and in patients with moderate to severe renal impairment with platelet counts less than $100 \times 10^9/L$.

Table 5: GvHD Dose modifications for patients with renal impairment

Renal Impairment Status	Recommended starting dose
Severe	5 mg twice daily
ESRD on dialysis	10 mg once after dialysis

Patients with Hepatic Impairment

In MF patients with any hepatic impairment the recommended starting dose based on platelet count should be reduced by approximately 50%. The recommended starting dose is 5 mg twice daily for PV patients. Patients diagnosed with hepatic impairment while receiving Jakavi should be carefully monitored and may need to have their dose reduced to avoid adverse drug reactions.

Jakavi should be avoided in patients with hepatic impairment with platelet counts less than $100 \times 10^9/L$.

Table 6: GvHD Dose modifications for patients with hepatic impairment

Hepatic Impairment Status	Recommended starting dose
Mild, moderate, or severe based on Child-Pugh, including liver GvHD	No dose modification
Mild, moderate, or severe based on Child-Pugh without liver involvement	5 mg twice daily
GvHD with liver involvement and an increase of total bilirubin to $>3 \times ULN$	Monitor blood counts more frequently for toxicity and a dose reduction by one dose level may be considered

(see section 5.2 Pharmacokinetic properties)

Elderly Patients

No additional dose adjustments are recommended for elderly patients.

4.3 Contraindications

Hypersensitivity to the active substance or any of the excipients (see section 6.1 List of excipients).

4.4 Special warnings and precautions for use

Decrease in blood cell count

Treatment with Jakavi can cause haematological adverse reactions, including thrombocytopenia, anaemia and neutropenia. A complete blood count must be performed before initiating therapy with Jakavi (for monitoring frequency see section 4.2 Dose and method of administration section).

It has been observed that MF patients with low platelet counts ($<200 \times 10^9/L$) at the start of therapy are more likely to develop thrombocytopenia during treatment.

Thrombocytopenia was generally reversible and was usually managed by reducing the dose or temporarily withholding Jakavi. However, platelet transfusions may be required as clinically indicated (see sections 4.2 Dose and method of administration and 4.8 Undesirable Effects sections).

Patients developing anaemia may require blood transfusions. Dose modifications or interruptions for patients developing anaemia may also be considered.

Neutropenia (Absolute Neutrophil Count (ANC) $<0.5 \times 10^9/L$) was generally reversible and was managed by temporarily withholding Jakavi (see sections 4.2 Dose and method of administration and 4.8 Undesirable Effects sections).

Complete blood counts should be monitored as clinically indicated and dose adjusted as required (see sections 4.2 Dose and method of administration and 4.8 Undesirable Effects sections).

Infections

Serious bacterial, mycobacterial, fungal, viral and other opportunistic infections have occurred in patients treated with Jakavi. Patients should be assessed for the risk of developing serious infections. Physicians should carefully observe patients receiving Jakavi for signs and symptoms of infections and appropriate treatment should be initiated promptly. Jakavi therapy should not be started until active serious infections have resolved.

Tuberculosis has been reported in patients receiving Jakavi. Before starting treatment, patients should be evaluated for active and inactive (“latent”) tuberculosis.

Hepatitis B viral load (HBV-DNA titre) increases, with and without associated elevations in alanine aminotransferase (ALT) and aspartate aminotransferase (AST), have been reported in patients with chronic HBV infections taking Jakavi. The effect of Jakavi on viral replication in patients with chronic HBV infection is unknown. Patients with chronic HBV infection should be treated and monitored according to clinical guidelines.

Herpes Zoster

Physicians should educate patients about early signs and symptoms of herpes zoster, advising that treatment should be sought as early as possible.

Progressive Multifocal Leukoencephalopathy

Progressive Multifocal Leukoencephalopathy (PML) has been reported with ruxolitinib treatment. Physicians should be alert for neuropsychiatric symptoms suggestive of PML. If PML is suspected, further dosing must be suspended until PML has been excluded.

Non-Melanoma Skin Cancer

Non-melanoma skin cancers (NMSCs), including basal cell, squamous cell, and Merkel cell carcinoma have been reported in patients treated with Jakavi. Most of these patients had histories of extended treatment with hydroxyurea and prior NMSC or pre-malignant skin lesions. A causal relationship to ruxolitinib has not been established. Periodic skin examination is recommended for patients who are at increased risk for skin cancer.

Lipid Abnormalities/Elevations

Treatment with Jakavi has been associated with increases in lipid parameters including total cholesterol, high-density lipoprotein (HDL) cholesterol, low-density lipoprotein (LDL) cholesterol, and triglycerides. Lipid monitoring and treatment of dyslipidemia according to clinical guidelines is recommended.

Withdrawal Effects

Following interruption or discontinuation of ruxolitinib, symptoms of myelofibrosis may return over a period of approximately 1 week. There have been cases of patients discontinuing ruxolitinib who sustained more severe events, particularly in the presence of acute intercurrent illness. It has not been established whether abrupt discontinuation of ruxolitinib contributed to these events. Unless abrupt discontinuation is required, gradual tapering of the dose of ruxolitinib may be considered, although the utility of the tapering is unproven.

Use in hepatic impairment

Dose modifications are required, depending on the level of severity of hepatic impairment and the condition treated (see section 4.2 Dose and method of administration).

Use in renal impairment

Dose modifications are needed in patients with renal impairment (see sections 4.2 Dose and method of administration and 5.2 Pharmacokinetic properties, special populations).

Paediatric Use

MF and PV: The safety and efficacy of Jakavi in paediatric patients have not been established.

GvHD: In paediatric patients 12 years of age and older with GvHD, the safety and efficacy of Jakavi are supported by evidence from the randomised phase 3 studies REACH2 and REACH3. The safety and efficacy of Jakavi have not been established in patients less than 12 years of age (see sections 4.2 Dose and Method of Administration and 5.1 Pharmacodynamic Properties, Clinical trials).

In studies using juvenile rats, ruxolitinib adversely affected bone development. See section 5.3 Preclinical safety data.

Use in the Elderly

There are no additional safety or efficacy concerns recommended for elderly patients.

4.5 Interaction with other medicines and other forms of interaction

Agents that may alter plasma concentration of ruxolitinib

At clinically relevant concentrations, ruxolitinib does not inhibit CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6 or CYP3A4 and is not a potent inducer of CYP1A2, CYP2B6

or CYP3A4 based on in vitro studies.

In vitro, ruxolitinib was not an inhibitor of the OATP1B1, OATP1B3, OCT1, OCT2, OAT1 or OAT3 transporters at clinically-relevant concentration. Ruxolitinib is not a substrate for the P-glycoprotein transporter but was shown to be a weak inhibitor of this transporter. The effect of ruxolitinib on medicines which are substrates of P-glycoprotein are unknown.

Ruxolitinib is eliminated through metabolism catalysed by CYP3A4 and CYP2C9. Thus, medicinal products inhibiting these enzymes can give rise to increased ruxolitinib exposure.

Strong CYP3A4 inhibitors (such as, but not limited to, boceprevir, clarithromycin, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, ritonavir, nelfinavir, posaconazole, saquinavir, telaprevir, telithromycin, voriconazole): in healthy subjects receiving ketoconazole, a strong CYP3A4 inhibitor, at 200 mg twice daily for four days, the AUC of ruxolitinib increased by 91% and the half-life was prolonged from 3.7 to 6.0 hours.

When administering Jakavi with strong CYP3A4 inhibitors the total daily dose of Jakavi should be reduced by approximately 50% except in GvHD patients. The effect of strong CYP3A4 inhibitors in patients with GvHD was not found to have a significant impact on any parameter in the Population PK model.

Patients should be closely monitored for cytopenias and dose titrated based on safety and efficacy (see section 4.2 Dose and method of administration section).

Grapefruit, grapefruit juice, and other foods that are known to be strong inhibitors of cytochrome P450 3A4 may increase ruxolitinib exposures and should be avoided during treatment.

Mild or moderate CYP3A4 inhibitors (such as, but not limited to, ciprofloxacin, erythromycin, amprenavir, atazanavir, diltiazem, cimetidine): in healthy subjects receiving erythromycin, a moderate CYP3A4 inhibitor, at 500 mg twice daily for four days, there was a 27% increase in the AUC of ruxolitinib.

No dose adjustment is recommended when Jakavi is co administered with mild or moderate CYP3A4 inhibitors (e.g. erythromycin). Patients should be closely monitored for cytopenias when initiating therapy with a moderate CYP3A4 inhibitor.

Dual moderate CYP2C9 and CYP3A4 inhibitors (e.g. fluconazole): in healthy subjects receiving fluconazole, a dual CYP2C9 and CYP3A4 inhibitor, as a single 400 mg dose followed by 200 mg once daily for seven days, there was a 232% increase in the AUC of ruxolitinib. A 50% dose reduction should be considered when using medicinal products which are dual inhibitors of CYP2C9 and CYP3A4 enzymes. The concomitant use of Jakavi with fluconazole doses of greater than 200 mg daily should be avoided.

CYP3A4 inducers (such as, but not limited to, dexamethasone, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampin (rifampicin), rifapentine, St. John's wort (*Hypericum perforatum*)): Upon initiation of a CYP3A4 inducer, no dose adjustment is recommended. Patients should be closely monitored and the dose titrated based on safety and efficacy.

In healthy subjects receiving rifampin, a potent CYP3A4 inducer, at 600 mg once daily for ten days, the AUC of ruxolitinib following a single dose decreased by 71% and the half-life decreased from 3.3 to 1.7 hours. The relative amount of active metabolites increased in relation to parent compound.

Substances metabolised by CYP3A4: It cannot be excluded that ruxolitinib inhibits CYP3A4 in the intestine. Increased systemic exposure may be obtained for substances which are metabolised by CYP3A4, and particularly those that undergo extensive intestinal metabolism. Some sensitive CYP3A substrates include lovastatin, aprepitant, budesonide, conivaptan, darifenacin, darunavir, everolimus, sirolimus, and midazolam. Safety monitoring of orally administered CYP3A4 metabolised substances is advised when combined with ruxolitinib. The interaction is likely to be minimised if the time between co-administrations is kept as long as possible.

Substances transported by P-glycoprotein or other transporters: Ruxolitinib may inhibit P-glycoprotein and breast cancer resistance protein (BCRP) in the intestine. This may result in increased systemic exposure of substrates of these transporters, such as dabigatran etexilate, cyclosporin, rosuvastatin and potentially digoxin. Therapeutic drug monitoring (TDM) or clinical monitoring of the affected substance is advised.

Drugs that inhibit P-glycoprotein include tacrolimus, cyclosporine, diltiazem, amiodarone, carvedilol, nifedipine, verapamil, ketoconazole, itraconazole, quinidine, ritonavir, saquinavir, nelfinavir, ranolazine valsopodar and isradipine. It is possible that the potential inhibition of P-gp and BCRP in the intestine can be minimised if the time between administrations is kept apart as long as possible.

No dose adjustment is recommended when Jakavi is co-administered with substances that interact with P-gp and other transporters.

Cytoreductive therapies: The concomitant use of cytoreductive therapies and Jakavi has not been studied. Some cytoreductive therapies include hydroxyurea, mercaptopurine, melphalan, chlorambucil and cytarabine. The safety and efficacy of this co-administration is not known.

4.6 Fertility, pregnancy and lactation

Fertility

There are no human data on the effect of ruxolitinib on fertility. In an animal study, ruxolitinib was administered to male rats prior to and throughout mating and to female rats prior to mating and up to the implantation day. Ruxolitinib had no effect on fertility or reproductive function in male or female rats at doses up to 60 mg/kg/day. However, in female rats, doses of greater than or equal to 30 mg/kg/day resulted in increased post-implantation loss. The exposure (free AUC) at the dose of 30 mg/kg/day is approximately equivalent to the clinical exposure at the maximum recommended dose of 25 mg twice daily.

Females and males of reproductive potential

Females of reproductive potential should be advised that animal studies have been performed showing ruxolitinib to be harmful to the developing fetus. Sexually active females of reproductive potential should use effective contraception (methods that result in <1% pregnancy rates) during treatment with Jakavi.

Pregnancy (Category C)

There are no adequate and well-controlled studies of Jakavi in pregnant women. Ruxolitinib and/or its metabolites crossed the placental barrier in pregnant rats. JAK2 is required for definitive erythropoiesis during embryogenesis. When administered during the period of organogenesis, ruxolitinib was embryolethal and fetotoxic in both rats and rabbits (increases in

postimplantation loss and reduced fetal weights). Exposures (AUC) at the no effect level were subclinical. There was no evidence of teratogenicity.

The use of Jakavi during pregnancy is not recommended. The patient should be advised of the risk to a fetus if Jakavi is used during pregnancy or if the patient becomes pregnant while taking this medicinal product.

Animal Data

Ruxolitinib was administered orally to pregnant rats or rabbits during the period of organogenesis, at doses of 15, 30 or 60 mg/kg/day in rats and 10, 30 or 60 mg/kg/day in rabbits. There was no evidence of teratogenicity. However, decreases of approximately 9% in fetal weights were noted in rats at the highest and maternally toxic dose of 60 mg/kg/day. This dose results in an exposure (AUC) that is approximately 2 times the clinical exposure at the maximum recommended dose of 25 mg twice daily. In rabbits, lower fetal weights of approximately 8% and increased late resorptions were noted at the highest and maternally toxic dose of 60 mg/kg/day. This dose is approximately 0.07 times the clinical exposure at the maximum recommended dose.

In a pre- and post-natal development study in rats, pregnant animals were dosed with ruxolitinib from implantation through lactation at doses up to 30 mg/kg/day. There were no drug-related adverse findings in pups for fertility indices or for maternal or embryo-fetal survival, growth and development parameters at the highest dose evaluated (0.3 times the clinical exposure at the maximum recommended dose of 25 mg twice daily).

Lactation

It is not known if ruxolitinib is transferred to human milk. There are no data on the effects of ruxolitinib on the breast-fed child or the effects of ruxolitinib on milk production. Ruxolitinib and/or its metabolites readily passed into the milk of lactating rats. Because of the potential for serious adverse drug reactions in nursing infants from Jakavi, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. It is recommended that women should not breast-feed during treatment with Jakavi.

Animal Data: In a study in which pregnant rats were dosed with ruxolitinib from implantation through lactation at oral doses up to 30 mg/kg/day, there were no adverse effects on postnatal survival, pup development or pup reproductive function. Maternal exposure (AUC) at the highest dose level was subclinical

4.7 Effects on ability to drive and use machines

Jakavi has no or negligible sedating effect. However, patients who experience dizziness after the intake of Jakavi should refrain from driving or using machines.

4.8 Undesirable effects

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/>

Summary of the safety profile

Myelofibrosis

The safety of Jakavi in MF patients was evaluated using long term follow-up data from the two phase 3 studies COMFORT-I and COMFORT-II including data from patients initially randomised to Jakavi (n=301) and patients who received Jakavi after crossing over from control treatments (n=156). The median exposure upon which the ADR frequency categories for MF patients are based was 30.5 months (range 0.3 to 68.1 months).

The most frequently reported adverse drug reactions (ADRs) were anaemia (83.8% and thrombocytopenia (80.5%).

Haematological ADRs (any CTCAE grade; Common Terminology Criteria for Adverse Events) included anaemia (83.8%), thrombocytopenia (80.5%) and neutropenia (20.8%).

Anaemia, thrombocytopenia and neutropenia are dose related effects.

The most frequent non-haematological ADRs were bruising (33.3%), dizziness (21.9%) and urinary tract infections (21.4%). The most frequent non-haematological laboratory abnormalities identified as ADRs were increased ALT (40.7%), increased AST (31.5%) and hypertriglyceridaemia (25.2%). However, no CTCAE grade 3 or 4 hypertriglyceridemia and increased AST or grade 4 increased ALT were observed.

Discontinuation due to AEs regardless of causality was observed in 30.0% of patients treated with Jakavi.

Polycythemia vera

The safety of Jakavi in PV patients was evaluated using long-term follow-up data from the two phase 3 studies RESPONSE and RESPONSE 2 including data from patients initially randomised to Jakavi (n=184) and patients who received Jakavi after crossing over from control treatments (n=156). The median exposure upon which the ADR frequency categories for PV patients are based was 41.7 months (range 0.03 to 59.7 months).

The most frequently reported ADRs were anaemia (61.8%) and increased ALT (45.3%).

Haematological ADRs (any CTCAE grade) included anaemia (61.8%), thrombocytopenia (25.0%) and neutropenia (5.3%). Anaemia or thrombocytopenia grade 3 and 4 were reported in 2.9% and 2.6% of the patients, respectively.

The most frequent non-haematologic ADRs were weight gain (20.3%), dizziness (19.4%) and headache (17.9%).

The most frequent non-haematological laboratory abnormalities (Any CTCAE grade) identified as ADRs were increased ALT (45.3%), increased AST (42.6%) and hypercholesterolemia (34.7%). The majority were grade 1 to 2 with one CTCAE grade 4 'increased AST'.

Discontinuation due to AEs, regardless of causality, was observed in 19.4% of patients treated with Jakavi.

Acute GvHD

The safety of Jakavi in acute GvHD patients was evaluated in the phase 3 study REACH2, including data from patients initially randomised to Jakavi (n=152) and patients who received Jakavi after crossing over from control treatment (n=49). The median exposure upon which the ADR frequency categories were based was 8.9 weeks (range 0.3 to 66.1 weeks).

The most frequently reported overall ADRs were thrombocytopenia (85.2%), anaemia (75.0%) and neutropenia (65.1%).

Haematological laboratory abnormalities identified as ADRs included thrombocytopenia (85.2%), anaemia (75.0%) and neutropenia (65.1%). Grade 3 anaemia was reported in 47.7% of patients (Grade 4 not applicable per CTCAE v4.03). Grade 3 and 4 thrombocytopenia were reported in 31.3% and 47.7% of patients, respectively.

The most frequent non-haematological ADRs were cytomegalovirus (CMV) infection (32.3%), sepsis (25.4%) and UTI (17.9%).

The most frequent non-haematological laboratory abnormalities identified as ADRs were increased ALT (54.9%), increased AST (52.3%) and hypercholesterolaemia (49.2%). The majority were of grade 1 and 2.

Discontinuation due to AEs, regardless of causality, was observed in 29.4% of patients treated with Jakavi.

Chronic GvHD

The safety of Jakavi in chronic GvHD patients was evaluated in the phase 3 study REACH3, including data from patients initially randomised to Jakavi (n=165) and patients who received Jakavi after crossing over from best available treatment (BAT) [n=61]. The median exposure upon which the ADR frequency categories were based was 41.4 weeks (range 0.7 to 127.3 weeks).

The most frequently reported overall ADRs were anaemia (68.6%), hypercholesterolaemia (52.3%) and increased AST (52.2%).

Haematological laboratory abnormalities identified as ADRs included anaemia (68.6%), thrombocytopenia (34.4%) and neutropenia (36.2%). Grade 3 anaemia was reported in 14.8% of patients (Grade 4 not applicable per CTCAE v4.03). Grade 3 and 4 neutropenia were reported in 9.5% and 6.7% of patients, respectively.

The most frequent non-haematological ADRs were hypertension (15.0%), headache (10.2%) and UTI (9.3%).

The most frequent non-haematological laboratory abnormalities identified as ADRs were hypercholesterolaemia (52.3%), increased AST (52.2%) and increased ALT (43.1%). The majority were Grade 1 and 2.

Discontinuation due to AEs, regardless of causality, was observed in 18.1% of patients treated with Jakavi.

Tabulated summary of adverse drug reactions from clinical trials

ADRs from clinical trials in MF and PV are listed in Table 7. ADRs from clinical trials in acute and chronic GvHD are listed in Table 8. All ADRs are listed by MedDRA system organ class (SOC). Within each SOC, the ADRs are ranked by frequency, with the most frequent reactions first. In addition, the corresponding frequency category for each ADR is based on the following convention (CIOMS III): very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$); very rare ($< 1/10,000$).

In the clinical studies program the severity of ADRs was assessed based on the CTCAE defining grade 1=mild, grade 2= moderate, Grade 3=severe and grade 4=life-threatening or disabling, Grade 5=death.

Table 7 Adverse drug reactions reported in the phase 3 studies in MF and PV

ADRs and CTCAE grade ³	Frequency category for MF patients	Frequency category for PV patients
	Long-term follow-up data Week 256: COMFORT-I Week 256: COMFORT-II	Long-term follow-up data Week 256: RESPONSE Week 156: RESPONSE-2
Infections and infestations		
Urinary Tract infections	Very common	Very common
Herpes zoster	Very common	Very common
Pneumonia	Very common	Common
Tuberculosis	Uncommon	-
Blood and lymphatic system disorders		
Anaemia ¹		
CTCAE grade 4 ($< 6.5\text{g/dL}$)	Very common	Uncommon
CTCAE grade 3 ($< 8.0 - 6.5\text{g/dL}$)	Very common	Common
Any CTCAE grade	Very common	Very common
Thrombocytopenia ¹		
CTCAE grade 4 ($< 25,000/\text{mm}^3$)	Common	Uncommon
CTCAE grade 3 ($50,000 - 25,000/\text{mm}^3$)	Very common	Common
Any CTCAE grade	Very common	Very common
Neutropenia ¹		
CTCAE grade 4 ($< 500/\text{mm}^3$)	Common	Uncommon
CTCAE grade 3 ($< 1000 - 500/\text{mm}^3$)	Common	Uncommon
Any CTCAE grade	Very common	Common
Pancytopenia ²	Common	Common
Metabolism and nutrition disorders		
Hypercholesterolemia ¹ Any CTCAE grade	Very common	Very common
Hypertriglyceridemia ¹ CTCAE grade 1	Very common	Very common
Weight gain ¹	Very common	Very common

ADRs and CTCAE grade ³	Frequency category for MF patients	Frequency category for PV patients
	Long-term follow-up data Week 256: COMFORT-I Week 256: COMFORT-II	Long-term follow-up data Week 256: RESPONSE Week 156: RESPONSE-2
Nervous system disorders		
Dizziness	Very common	Very common
Headache	Very common	Very common
Gastrointestinal disorders		
Constipation	Very common	Very common
Flatulence	Common	Common-
Skin and subcutaneous tissue disorders		
Bruising	Very common	Very common
Hepatobiliary disorders		
Increased ALT ¹		
CTCAE grade 3 (> 5x – 20 x ULN)	Common	Common
Any CTCAE grade	Very common	Very common
Increased AST ¹		
Any CTCAE grade	Very common	Very common
Vascular disorders		
Hypertension	Very common	Very common
¹ Frequency is based on new or worsened laboratory abnormalities compared to baseline. ³ Pancytopenia is defined as haemoglobin level < 100 g/L, platelet count <100 x 10 ⁹ /L, and neutrophils count <1.5 x 10 ⁹ /L (or low WBC count of grade 2 if neutrophil count is missing), simultaneously in the same laboratory assessment ³ CTCAE Version 3.0		

Upon discontinuation MF patients may experience a return of myelofibrosis symptoms such as fatigue, bone pain, fever, pruritus, night sweats, symptomatic splenomegaly and weight loss. In MF clinical studies the total symptom score for myelofibrosis symptoms gradually returned to baseline values within 7 days after dose discontinuation.

Table 8: ADRs reported in the phase 3 studies in GvHD

ADR	Acute GvHD (REACH2) (N=201)			Chronic GvHD (REACH3) (N=226)		
	Frequency category	All grades (%)	CTCAE ³ Grade 3 / 4 (%)	Frequency category	All grades (%)	CTCAE ³ Grade 3 / 4 (%)
Infections and infestations						
CMV infections	Very common	32.3	10.9 / 0.5	-	-	- / -
Sepsis	Very common	25.4	4.0 / 17.9 ⁴	-	-	- / -
Urinary tract infections	Very common	17.9	6.0 / 0.5	Common	9.3	1.3 / 0
BK virus infections	-	-	- / -	Common	4.9	0.4 / 0
Blood and lymphatic system disorders						
Thrombocytopenia ¹	Very common	85.2	31.3 / 47.7	Very common	34.4	5.9 / 10.7
Anaemia ¹	Very common	75.0	47.7 / NA	Very common	68.6	14.8 / NA
Neutropenia ¹	Very common	65.1	17.9 / 20.6	Very common	36.2	9.5 / 6.7
Pancytopenia ^{1,2}	Very common	32.8	NA	-	-	- / -
Metabolism and nutrition disorders						
Hypercholesterolaemia ¹	Very common	49.2	3.3 / 5.9	Very common	52.3	5.5 / 0.5

ADR	Acute GvHD (REACH2) (N=201)			Chronic GvHD (REACH3) (N=226)		
	Frequency category	All grades (%)	CTCAE ³ Grade 3 / 4 (%)	Frequency category	All grades (%)	CTCAE ³ Grade 3 / 4 (%)
Weight gain	-	-	-	Common	3.5	0 / 0
Nervous system disorders						
Headache	Common	8.5	0.5 / 0	Very common	10.2	1.3 / 0
Vascular disorders						
Hypertension	Very common	13.4	5.5 / 0	Very common	15.0	5.3 / 0
Gastrointestinal disorders						
Increased lipase ¹	-	-	-	Very common	35.9	9.5 / 0.4
Increased amylase ¹	-	-	-	Very common	32.4	4.2 / 2.7
Nausea	Very common	16.4	0.5 / 0	-	-	- / -
Constipation	-	-	-	Common	6.6	0 / 0
Hepatobiliary disorders						
Increased ALT ¹	Very common	54.9	17.6 / 1.5	Very common	43.1	4.7 / 0.9
Increased AST ¹	Very common	52.3	7.8 / 0	Very common	52.2	3.1 / 0.9
Musculoskeletal and connective tissue disorders						
Increased blood CPK ¹	-	-	-	Very common	31.1	1.0 / 1.4
Renal and urinary disorders						
Increased blood creatinine ¹	-	-	-	Very common	38.4	1.3 / 0

¹ Frequency is based on new or worsened laboratory abnormalities compared to baseline.

² Pancytopenia is defined as haemoglobin level <100 g/L, platelet count <100 x 10⁹/L, and neutrophils count <1.5 x 10⁹/L (or low WBC of grade 2 if neutrophil count is missing), simultaneously in the same laboratory assessment. No CTCAE grades defined.

³ CTCAE Version 4.03.

⁴ Grade 4 sepsis includes 16 (8%) Grade 4 events and 20 (10%) Grade 5 events.

Post-marketing experience

Tuberculosis has been observed post-marketing with Jakavi in PV patients via spontaneous case reports and in the literature.

Because cases were reported voluntarily from a population of uncertain size, it is not possible to reliably estimate the frequency, which is therefore characterized as ‘not known’.

Description of selected adverse drug reactions

Anaemia

In phase 3 MF clinical studies, median time to onset of first CTCAE Grade 2 or higher anaemia was 1.5 months. One patient (0.3%) discontinued treatment because of anaemia.

In patients receiving Jakavi mean decreases in haemoglobin reached a nadir of approximately 15 to 20 g/L below baseline after 8 to 12 weeks of therapy and then gradually recovered to reach a new steady state that was approximately 10 g/L below baseline. This pattern was observed in patients regardless of whether they had received transfusion during therapy.

In the randomized, placebo controlled study COMFORT-I, 59.4% of Jakavi treated patients and 37.1% of patients receiving placebo received red blood cell transfusions during randomized

treatment. In the COMFORT-II study, the rate of packed red blood cell transfusions was 51.4% in the Jakavi arm and 38.4% in the best available therapy arm (BAT).

Over the randomized period in the RESPONSE and RESPONSE-2 studies, anaemia was less frequent in the PV patients (40.8%) versus 82.4% in MF patients. The frequency of the CTCAE grade 3 and 4 events was 1.1% in PV patients, while in the MF patients, the frequency was of 42.5%.

In the phase 3 acute and chronic GvHD studies, anaemia CTCAE Grade 3 was reported in 47.7% and 14.8% of patients, respectively.

Thrombocytopenia

In the Phase 3 MF clinical studies, in patients who developed Grade 3 or 4 thrombocytopenia, the median time to onset was approximately 8 weeks. Thrombocytopenia was generally reversible with dose reduction or dose interruption. The median time to recovery of platelet counts above $50 \times 10^9/L$ was 14 days. During the randomized period, platelet transfusions were administered to 4.5% of patients receiving Jakavi and to 5.8% of patients receiving control regimens. Discontinuation of treatment because of thrombocytopenia occurred in 0.7% of patients receiving Jakavi and 0.9% of patients receiving control regimens. Patients with a platelet count of $100 \times 10^9/L$ to $200 \times 10^9/L$ before starting Jakavi had a higher frequency of grade 3 or 4 thrombocytopenia compared to patients with platelet count $>200 \times 10^9/L$ (64.2% versus 35.4%).

Over the randomized period in the RESPONSE and RESPONSE-2 studies, the rate of patients experiencing thrombocytopenia was lower in PV (16.8%) compared to MF (69.8%) patients. The frequency of severe (i.e. of CTCAE grade 3 and 4) thrombocytopenia was lower in PV (3.3%) than in MF (11.6%) patients.

In the phase 3 acute GvHD study, Grade 3 and 4 thrombocytopenia was observed in 31.3% and 47.7% of patients, respectively. In the phase 3 chronic GvHD study Grade 3 and 4 thrombocytopenia was lower (5.9% and 10.7%) than in acute GvHD.

Neutropenia

In the phase 3 clinical studies in MF, in patients who developed Grade 3 or 4 neutropenia, the median time of onset was 12 weeks. During the randomized period of the studies dose holding or reductions due to neutropenia were reported in 1.3% of patients and 0.3% of patients discontinued treatment because of neutropenia.

Over the randomized period in the RESPONSE and RESPONSE-2 study, in PV patients, neutropenia was observed in 3 patients (1.6%) of which one patient developed CTCAE Grade 4 neutropenia. During the long-term follow-up, 2 patients reported CTCAE Grade 4 neutropenia.

In the phase 3 acute GvHD study, Grade 3 and 4 neutropenia was observed in 17.9% and 20.6% of patients, respectively. In the phase 3 chronic GvHD study, Grade 3 and 4 neutropenia was lower (9.5% and 6.7%) than in acute GvHD.

Infections

In the randomised period of the phase 3 MF clinical studies Grade 3 or 4 urinary tract infection was reported for 1.0% of patients. Urosepsis was reported in 1.0% of patients and kidney infection in one patient. The rate of herpes zoster was 4.0%. During long-term follow up, urinary tract infection and herpes zoster of any Grade were observed in 21.4% and 19.7% of patients, respectively.

In the randomized period in the phase 3 PV clinical study, one (0.5%) grade 3 to 4 urinary tract infections was observed. The rate of herpes zoster was 4.3% including one report of grade 3 and 4 post herpetic neuralgia. During long-term follow up, urinary tract infection and herpes zoster of any Grade were observed in 11.8% and 14.7% of patients, respectively.

In the phase 3 acute GvHD study, Grade 3 and 4 CMV infections were reported in 10.9% and 0.5% of patients, respectively. CMV infection with organ involvement was seen in very few patients; CMV colitis, CMV enteritis and CMV gastrointestinal infection of any Grade were reported in four, two and one patients, respectively.

Sepsis events including septic shock of any Grade were reported in 25.4% of patients.

In the phase 3 chronic GvHD study, Grade 3 urinary tract infections and BK virus infections were reported in 1.3% and 0.4% of patients, respectively.

Increased systolic blood pressure

In the phase 3 pivotal clinical studies an increase in systolic blood pressure of 20 mmHg or more from baseline was recorded in 31.5% of patients on at least one visit compared with 19.5% of the control-treated patients. In COMFORT-I the mean increase from baseline in systolic BP was 0-2 mmHg on Jakavi versus a decrease of 2-5 mmHg in the placebo arm. In COMFORT-II mean values showed little difference between the ruxolitinib-treated and the control-treated patients.

In the randomised period of the pivotal study in PV patients, the mean systolic blood pressure increased by 0.65 mmHg in the Jakavi arm versus a decrease of 2 mmHg in the BAT arm.

4.9 Overdose

There is no known antidote for overdoses with ruxolitinib. Single doses up to 200 mg have been given with acceptable acute tolerability. Higher than recommended repeat doses are associated with increased myelosuppression including leucopenia, anaemia and thrombocytopenia. Appropriate supportive treatment should be given.

Haemodialysis is not expected to enhance the elimination of Jakavi.

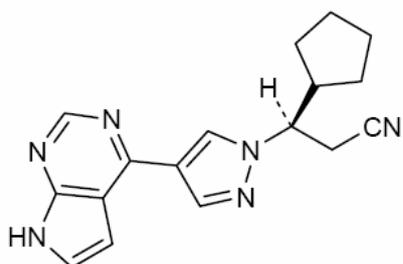
For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

The active ingredient of Jakavi is ruxolitinib (as the phosphate salt) or (*R*)-3-(4-(7*H*-Pyrrolo[2,3-*d*]pyrimidin-4-yl)-1*H*-pyrazol-1-yl)-3-cyclopentylpropanenitrile phosphate.

Structural formula:



INN: ruxolitinib

CAS name .: 1H-Pyrazole-1-propanenitrile, β -cyclopentyl-4-(7H-pyrrolo[2,3-d]pyrimidin-4-yl)-, (β R)-, phosphate (1:1); 941678-49-5

CAS Number.: 1092939-17-7

Molecular formula: C₁₇H₁₈N₆

Molecular weight of the phosphate salt: 404.36

Molecular weight of the free base: 306.37 Ruxolitinib phosphate is a white to almost white powder. It is highly soluble in water, most soluble at low pH (pH 3.3) at 37°C. The pK_a is 4.3 and 11.8. The BCS is Class 1.

Pharmaco-therapeutic group (ATC Code): Protein kinase inhibitors. (L01XE18)

Mechanism of action

Ruxolitinib is an inhibitor of the Janus Associated Kinases (JAKs) JAK1 and JAK2 with nanomolar potency. JAKs mediate the signaling of a number of cytokines and growth factors that are important for haematopoiesis and immune function. JAK signalling involves recruitment of STATs (signal transducers and activators of transcription) to cytokine receptors, activation, and subsequent localization of STATs to the nucleus leading to modulation of gene expression. Dysregulation of the JAK/STAT pathway has been associated with several cancers and increased proliferation and survival of malignant cells.

Myelofibrosis (MF) and Polycythemia vera (PV) are myeloproliferative neoplasm (MPN) known to be associated with dysregulated JAK1 and JAK2 signalling. The basis for the dysregulation is believed to include high levels of circulating cytokines that activate the JAK-STAT pathway, gain of function mutations such as JAK2V617F, and silencing of negative regulatory mechanisms. MF patients exhibit dysregulated JAK signalling regardless of JAK2V617F mutation status. Activating mutations in JAK2 (V617F or exon 12) are found in >95% of PV patients.

Ruxolitinib inhibits JAK-STAT signalling and cell proliferation of cytokine-dependent cellular models of haematological malignancies. In an acute mouse model of JAK2V617F-positive MPN, oral administration of ruxolitinib prevented splenomegaly, decreased circulating inflammatory cytokines (e.g.: TNF- α , IL-6) and resulted in significantly prolonged survival.

JAK-STAT signalling pathways play a role in regulating the development, proliferation, and activation of several immune cell types important for GvHD pathogenesis. In a mouse model of acute GvHD, oral administration of ruxolitinib was associated with decreased expression of inflammatory cytokines in colon homogenates and reduced immune-cell infiltration in the colon.

Pharmacodynamic properties

Ruxolitinib inhibits cytokine induced STAT3 phosphorylation in whole blood from healthy subjects and MF and PV patients. Ruxolitinib resulted in maximal inhibition of STAT3 phosphorylation 2 hours after dosing which returned to near baseline by 8 hours in both healthy subjects and myelofibrosis patients, indicating no accumulation of either parent or active metabolites.

Baseline elevations in inflammatory markers associated with constitutional symptoms such as TNFalpha, IL-6, and CRP in patients with MF were decreased following treatment with ruxolitinib. Patients with myelofibrosis did not become refractory to the pharmacodynamic effects of ruxolitinib treatment over time. Similarly, patients with polycythemia vera also presented with baseline elevations in inflammatory markers and these markers were decreased following treatment with ruxolitinib.

In a thorough QT study in healthy subjects, there was no indication of a QT/QTc prolonging effect of ruxolitinib in single doses up to a supratherapeutic dose of 200 mg indicating that ruxolitinib has no effect on cardiac repolarization.

Clinical efficacy and safety

Myelofibrosis

Two randomized Phase 3 studies (COMFORT-I and COMFORT-II) were conducted in patients with myelofibrosis (Primary Myelofibrosis (PMF), Post-Polycythemia Vera Myelofibrosis (PPV-MF) or Post-Essential Thrombocythemia-Myelofibrosis (PET-MF)) In both studies, patients had palpable splenomegaly at least 5 cm below the costal margin and risk category of intermediate 2 (2 prognostic factors) or high risk (3 or more prognostic factors) based on the International Working Group Consensus Criteria (IWG). The prognostic factors that comprise the IWG criteria consist of age >65 years, presence of constitutional symptoms (weight loss, fever, night sweats) anaemia (haemoglobin <10 g/dL), leukocytosis (history of WBC >25 X 10⁹/L) and circulating blasts ≥1%. The starting dose of Jakavi was based on platelet count. A baseline platelet count > 100 x10⁹/L was required for trial entry. Patients with a platelet count between 100 and 200 x10⁹/L were started on Jakavi 15 mg twice daily and patients with a platelet count >200 x10⁹/L were started on Jakavi 20 mg twice daily. Of the 301 patients, 111 (36.9%) had a baseline platelet count between 100 and 200 x10⁹/L, and 190 (63.1%) had a baseline platelet count >200 x10⁹/L. Maximum safe starting dose (MSSD) for patients with baseline platelet counts ≥50 and <100 x10⁹/L was confirmed as 10 mg twice daily in EXPAND, a Phase Ib, open label, dose-finding study in patients with PMF, PPV-MF or PET-MF. In COMFORT studies, doses were then individualized based upon tolerability and efficacy with maximum doses of 20 mg twice daily for patients with platelet counts between

100 to $\leq 125 \times 10^9/L$, of 10 mg twice daily for patients with platelet counts between 75 to $\leq 100 \times 10^9/L$, and of 5 mg twice daily for patients with platelet counts between 50 to $\leq 75 \times 10^9/L$.

COMFORT-I was a double-blind, randomized, placebo-controlled study in 309 patients who were refractory to or were not candidates for available therapy. Patients were dosed with Jakavi or matching placebo. The primary efficacy endpoint was proportion of subjects achieving $\geq 35\%$ reduction from baseline in spleen volume at Week 24 as measured by MRI or CT.

Secondary endpoints included duration of maintenance of a $\geq 35\%$ reduction from baseline in spleen volume, proportion of patients who had $\geq 50\%$ reduction in total symptom score from baseline to Week 24 as measured by the modified Myelofibrosis Symptom Assessment Form (MFSAF) v2.0 diary, change in total symptom score from baseline to Week 24 as measured by the modified MFSAF v2.0 diary and overall survival.

COMFORT-II was an open-label, randomized study in 219 patients. Patients were randomized 2:1 to Jakavi versus best available therapy (BAT). BAT was selected by the investigator on a patient-by-patient basis. In the BAT arm, 47% of patients received hydroxyurea and 16% of patients received glucocorticoids. The primary efficacy endpoint was proportion of patients achieving $\geq 35\%$ reduction from baseline in spleen volume at Week 48 as measured by MRI or CT.

A secondary endpoint in COMFORT-II was the proportion of patients achieving a $\geq 35\%$ reduction of spleen volume measured by MRI or CT from baseline to Week 24. Duration of maintenance of a $\geq 35\%$ reduction from baseline in responding patients was also a secondary endpoint.

In COMFORT-I, patient baseline demographics and disease characteristics were comparable between the treatment arms. The median age was 68 years with 61% of patients older than 65 years and 54% male. Fifty percent (50%) of patients had primary MF, 31% had PMF and 18% had PET-MF .

Twenty-one percent (21%) of patients had red blood transfusions within 8 weeks of enrolment in the study. The median platelet count was $251 \times 10^9/L$. Seventy-six percent (76%) of patients had the mutation encoding the V617F substitution present in the JAK protein. Patients had a median palpable spleen length of 16 cm. At baseline 37.4% of the patients in the Jakavi arm had Grade 1 anaemia , 31.6% Grade 2 and 4.5% Grade 3, while in the placebo arm 35.8% had Grade 1, 35.1% Grade 2, 4.6% Grade 3, and 0.7% Grade 4. Grade 1 thrombocytopenia was found in 12.9 % of patients in the Jakavi arm and 13.2% in the placebo arm.

In COMFORT-II, patient baseline demographics and disease characteristics were comparable between the treatment arms. The median age was 66 years with 52% of patients older than 65 years and 57% male. Fifty-three percent (53%) of the patients had PMF, 31% had PPV-MF, and 16% had PET-MF. Nineteen percent (19%) of patients were considered transfusion dependent at baseline. Patients had a median palpable spleen length of 15 cm.

At baseline 34.2% of the patients in the Jakavi arm had Grade 1 anaemia , 28.8% Grade 2, and 7.5% Grade 3, while in the BAT arm 37% had Grade 1, 27.4% Grade 2, 13.7% Grade 3, and 1.4% Grade 4 . Thrombocytopenia of Grade 1 was found in 8.2% of patients in the Jakavi arm, and 9.6% in the BAT arm.

Efficacy analyses of the primary endpoint in COMFORT-I and COMFORT-II are presented in Table 9 below. A significantly larger proportion of patients in the Jakavi group achieved a $\geq 35\%$ reduction in spleen volume from baseline in both studies compared to placebo in COMFORT-I and BAT in COMFORT-II.

Table 9: Percent of Patients with $\geq 35\%$ Reduction from Baseline in Spleen Volume at Week 24 in COMFORT-I and at Week 48 in COMFORT-II (ITT)

	Jakavi (N=155)	Placebo (N=153)	Jakavi (N=144)	Best Available Therapy (N=72)
Time Points	Week 24		Week 48	
Number (%) of Subjects with Spleen Volume Reduced by $\geq 35\%$	65 (41.9)	1 (0.7)	41 (28.5)	0
% difference between treatments (95% CI ^a)	41.3 (32.8, 48.7)		28.5 (19.6, 35.2)	
P-value	< 0.0001		< 0.0001	

a: by Agresti-Caffo method (Agresti and Caffo; *The American Statistician*, 2000)

In COMFORT-I, 41.9% of patients in the Jakavi arm achieved a $\geq 35\%$ reduction in spleen volume from baseline compared with 0.7% in the placebo arm at Week 24. A similar proportion of patients in the Jakavi arm achieved a $\geq 50\%$ reduction in the exploratory efficacy endpoint of palpable spleen length.

In COMFORT-II, 28.5% of patients in the Jakavi arm achieved a $\geq 35\%$ reduction in spleen volume from baseline compared with none (0%) in the BAT arm at Week 48. A secondary endpoint was the proportion of patients achieving a $\geq 35\%$ reduction of spleen volume at Week 24. A significantly larger proportion of patients in the Jakavi arm, 46 (31.9%), achieved a $\geq 35\%$ reduction in spleen volume from baseline compared to no (0%) patients in the BAT arm (p-value <0.0001).

An exploratory subgroup analysis showed a significantly higher proportion of patients in the Jakavi arm achieved $\geq 35\%$ reduction from baseline in spleen volume regardless of the presence or absence of the JAK2V617F mutation or the disease subtype (PMF, PPV-MF, PET-MF).

Figure 1 shows a waterfall plot of the percent change from baseline in spleen volume at Week 24 in COMFORT-I. Among the 139 patients in the Jakavi arm who had both baseline spleen volume at Week 24, with a median reduction of 33%. Among the 106 patients in the placebo arm who had both baseline and Week 24 spleen volume evaluations, there was a median increase of 8.5%.

Figure 1 Waterfall Plot of Percent Change From Baseline in Spleen Volume at Week 24 (Observed Cases) COMFORT- I

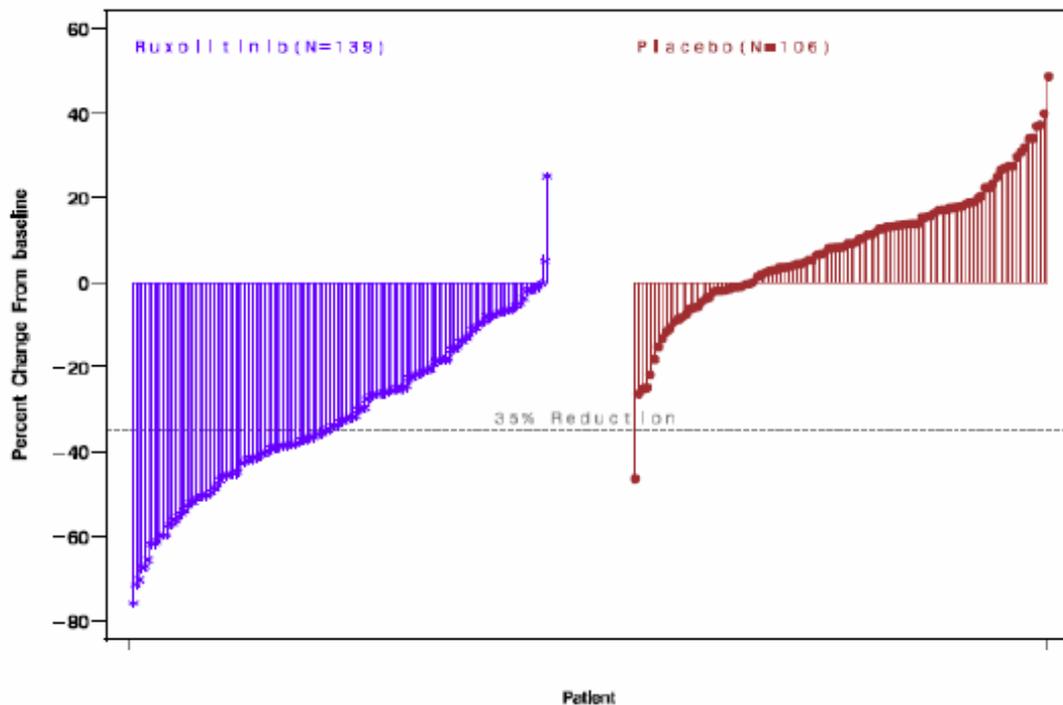
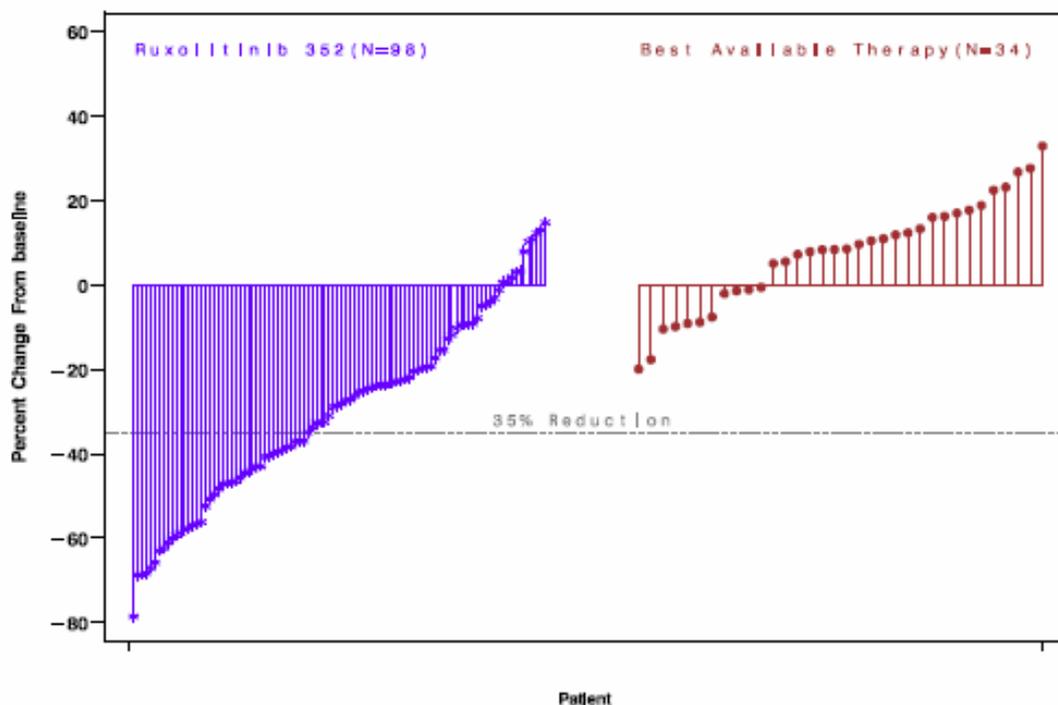


Figure 2 shows a waterfall plot of the percent change from baseline in spleen volume at Week 48 in COMFORT-II. Among the 98 patients in the Jakavi arm who had both baseline and Week 48 spleen volume evaluations, the median reduction in spleen volume at Week 48 was 28%. Among the 34 patients in the BAT arm who had both baseline and Week 48 spleen volume evaluations, there was a median increase of 8.5%.

Figure 2 Waterfall Plot of Percent Change from Baseline in Spleen Volume at Week 48 in COMFORT-II



The probability of duration from 1st $\geq 35\%$ reduction of spleen volume to 25% increase from nadir and loss of response in COMFORT-I and COMFORT-II is shown in Table 10 below.

Table 10: Kaplan-Meier Analysis of Duration from 1st $\geq 35\%$ Reduction of Spleen Volume to 25% Increase from Nadir and Loss of Response in Jakavi Patients (COMFORT-I and - II)

Statistics	Jakavi (COMFORT-I)	Jakavi (COMFORT-II)
Probability of >12 weeks of duration (95% CI)	0.98 (0.89, 1.00)	0.92 (0.82, 0.97)
Probability of >24 weeks of duration (95% CI)	0.89 (0.75, 0.95)	0.87 (0.76, 0.93)
Probability of >36 weeks of duration (95% CI)	0.71 (0.41, 0.88)	0.77 (0.63, 0.87)
Probability of >48 weeks of duration (95% CI)	not applicable	0.52 (0.18, 0.78)

Among the 80 patients that showed a $\geq 35\%$ reduction at any time point in COMFORT-I and of the 69 patients in COMFORT-II, the probability that a patient would maintain a response on Jakavi for at least 24 weeks was 89% and 87% in COMFORT-I and COMFORT-II respectively and the probability of maintaining a response for at least 48 weeks was 52% in COMFORT - II.

Overall survival (OS) was a secondary endpoint on both COMFORT studies. Median OS times had not been reached for either treatment arm in both studies. OS data from COMFORT-I

demonstrate a risk of death reduced with Jakavi treatment by 50% (median follow-up: 51 weeks, HR:0.499, 95% CI, 0.254, 0.980; p=0.04), 13 out of 155 patients (8.4%) died in the Jakavi arm and 24 out of 154 patients (15.6%) died in the placebo arm with OS time censored for 142 (91.6%) and 130 (84.4%) in ruxolitinib and placebo arms, respectively. With 61.1 weeks of follow up COMFORT II OS did not demonstrate a difference between the Jakavi and BAT arm (median follow-up:61.1 weeks; HR:1.01, 95% CI, 0.32, 3.24; p=0.95) with 11 (7.5%) deaths in the Jakavi and 4 (5.5%) in the placebo arm, OS time was censored for 135 (92.5%) and 69 (94.5%) patients in Jakavi and BAT arms, respectively.

In COMFORT-I, after a median follow-up of 34.3 months, the death rate in patients randomized to the Jakavi arm was 27.1% (42 of 155 patients) versus 35.1% (54 of 154) in patients randomized to placebo. There was a 31.3% reduction in the risk of death in the Jakavi arm as compared to placebo (HR 0.687; 95%CI 0.459-1.029; p= 0.0668). At final analysis, after a median follow up of 61.7 months, the reduction in risk of death was maintained at 30.7% (HR 0.693; 95% CI: 0.503, 0.956, p=0.025).

In COMFORT-II, after a median follow-up of 34.7 months, the death rate in patients randomized to Jakavi was 19.9% (29 of 146 patients) versus 30.1% (22 of 73 patients) in patients randomized to BAT. There was a 52% reduction in risk of death in the Jakavi arm compared to BAT arm (HR 0.48; 95% CI 0.28-0.85; p= 0.009). At final analysis, after a median follow up of 55.9 months, the reduction in risk of death was consistent with COMFORT-I (HR 0.67, 95% CI 0.44-1.02, p=0.062).

The impact of Jakavi on MF-associated symptoms was assessed in COMFORT-I only. In COMFORT-I symptoms of MF (night sweats, itchiness, abdominal discomfort, pain under the ribs, early satiety, bone or muscle pain) were captured using the modified MFSAF diary v2.0 as an electronic diary, which subjects completed daily. The change from Baseline in the Week 24 total score was a secondary endpoint in this study. A significantly larger proportion of patients in the Jakavi group achieved a $\geq 50\%$ improvement from Baseline in the Week 24 total symptom score compared with the placebo arm (45.9% and 5.3%, respectively, p <0.0001 using the Chi-Squared test).

An improvement in overall quality of life was measured by the exploratory efficacy endpoint, EORTC QLQ-C30, in both COMFORT-I and COMFORT-II. COMFORT-I compared Jakavi to placebo at 24 weeks and COMFORT-II compared Jakavi to BAT at 48 weeks. At baseline for both studies, EORTC QLQ-C30 individual subscale scores for the Jakavi and comparator arms were similar. At Week 24 in COMFORT-I, the Jakavi arm showed significant improvement in the global health status/quality of life of the EORTC QLQ-C30 compared with the placebo arm (mean change of +12.3 and -3.4 for Jakavi and placebo, respectively, p <0.0001). At week 24 and week 48, the Jakavi arm in COMFORT-II showed a trend towards greater improvement of global health status/QoL compared to BAT (week 24: 8.4 (Jakavi) vs 5.2 (BAT); week 48: 9.1 (Jakavi) vs 3.4 (BAT), an exploratory endpoint, consistent with the COMFORT-I findings.

Polycythemia vera

A randomized, open-label, active-controlled Phase 3 study (RESPONSE) was conducted in 222 patients with PV who were resistant to or intolerant of hydroxyurea. A total of 110 patients were randomized to the Jakavi arm and 112 patients to the BAT arm. Cross-over could occur at Week 32 if BAT patients failed to meet the primary endpoint response, or after 32 weeks if

they had a phlebotomy eligibility or spleen size progression. The starting dose of Jakavi was 10 mg twice daily. Doses were then adjusted in individual patients based on tolerability and efficacy with a maximum dose of 25 mg twice daily. BAT was selected by the investigator on a patient-by-patient basis and included hydroxyurea (59.5%), interferon/pegylated interferon (11.7%), anagrelide (7.2%), pipobroman (1.8%) and observation (15.3%).

Baseline demographics and disease characteristics were comparable between the two treatments arms. The median age was 60 years (range 33 to 90 years). Patients in the Jakavi arm had PV diagnosis for a median of 8.2 years and had previously received hydroxyurea for a median of approximately 3 years. Most patients (> 80%) had received at least two phlebotomies in the last 24 weeks prior to screening.

The primary composite endpoint was the proportion of patients achieving both the absence of phlebotomy eligibility (HCT control) and $\geq 35\%$ reduction in spleen volume from baseline at Week 32. Phlebotomy eligibility was defined as a confirmed HCT > 45% that is at least 3 percentage points higher than the HCT obtained at baseline or a confirmed HCT > 48%, whichever is lower. Key secondary endpoints included the proportion of patients who achieved the primary endpoint and who remained free from progression at Week 48, and the proportion of patients achieving complete haematological remission at Week 32.

The study met its primary objective and a higher proportion of patients in the Jakavi arm achieved the primary composite endpoint and each of its individual components. Significantly more patients on Jakavi (22.7%) compared to BAT (0.9%) achieved a primary response ($p < 0.0001$; 95% CI: 15.3, 31.7 vs 0.0, 4.9). Haematocrit control was achieved in 60% of patients in the Jakavi arm compared to 19.6% in the BAT arm and $\geq 35\%$ reduction in spleen volume was achieved in 40% of patients in the Jakavi arm compared to 0.9% in the BAT arm.

Both key secondary endpoints were also met: The proportion of patients achieving a complete haematologic remission was 23.6% on Jakavi compared to 8.9% on BAT ($p = 0.0028$), and the proportion of patients achieving a durable primary response at week 48 was 20% on Jakavi and 0.9% on BAT ($p < 0.0001$).

Symptom burden was assessed using the MPN- Symptoms Assessment Form (SAF) total symptom score (TSS) electronic patient diary consisting of 14 questions. At Week 32, 49% and 64% of evaluable patients treated with Jakavi achieved a $\geq 50\%$ reduction in TSS-14 and TSS-5, respectively, compared to only 5% and 11% of evaluable patients on BAT.

Treatment benefit perception was measured by the Patient Global Impression of Change (PGIC) questionnaire. 66 % of Jakavi-treated patients compared to 19% in BAT reported an improvement as early as 4 weeks after the start of treatment. Improvement in perception of treatment benefit was also higher in Jakavi-treated patients at Week 32 (78% versus 33%).

Additional analyses from the RESPONSE study to assess durability of response were conducted at Week 80 and week 256 following randomisation. Out of 25 patients who had achieved primary response at week 32, three patients had progressed by week 80 and 6 patients by week 256. The probability to have maintained a response from week 32 up to week 80 and week 256 was 92% and 74%, respectively (see table 11).

Table 11 Durability of Primary response in the RESPONSE study up to week 256

	Week 32	Week 80	Week 256
Primary response achieved at week 32*, n/N (%)	25/110 (23%)	n/a	n/a
Patients maintaining primary response	n/a	22/25	19/25
Probability of maintaining primary response	n/a	92%	74%

**According to the primary response composite endpoint criteria: absence of phlebotomy eligibility (HCT control) and a $\geq 35\%$ reduction in spleen volume from baseline.*

n/a: not applicable

A second randomised, open label, active-controlled phase IIIb study (RESPONSE-2) was conducted in 149 PV patients who were resistant to or intolerant of hydroxyurea but without palpable splenomegaly. Seventy-four patients were randomised to the Jakavi arm and 75 patients to the BAT arm. The starting dose and dose adjustments of Jakavi and investigator-selected BAT were similar to the RESPONSE study. Baseline demographics and disease characteristics were comparable between the two treatment arms and similar to the patient population of the RESPONSE study. The primary endpoint was the proportion of patients achieving HCT control (absence of phlebotomy eligibility) at Week 28. The key secondary endpoint was the proportion of patients achieving complete haematological remission at Week 28.

RESPONSE-2 met its primary objective with a higher proportion of patients in the Jakavi arm (62.2%) compared to the BAT arm (18.7%) achieving the primary endpoint ($p < 0.0001$). The key secondary endpoint was also met with significantly more patients achieving a complete haematologic remission in the Jakavi arm (23.0%) compared to the BAT arm (5.3%; $p = 0.0019$). At week 28, the proportion of patients achieving a $\geq 50\%$ reduction in symptom burden as measured by the MPN-SAF total symptom score was 45.3% in the Jakavi arm and 22.7% in the BAT arm.

Acute Graft versus Host Disease

The clinical efficacy of Jakavi in patients 12 years of age and older with GvHD has been investigated in REACH1, a phase 2 open-label, single-arm, multicentre study of Jakavi for treatment of patients with steroid-refractory aGVHD Grades 2 to 4 (Mount Sinai Acute GVHD International Consortium (MAGIC) criteria) occurring after allogeneic haematopoietic stem cell transplantation. Jakavi was administered at 5 mg twice daily, and the dose could be increased to 10 mg twice daily after 3 days in the absence of toxicity.

Seventy-one patients were enrolled in the study. These patients had a median age of 58 years (range 18-73 years), 49.3% were male and the majority of participants were White/Caucasian (93.0%)

In REACH1, the primary endpoint was the overall response rate (ORR) on Day 28, defined as the proportion of patients in each arm with a complete response (CR), Very good Partial Response (VGPR) or a partial response (PR) (as per the CIBMTR modifications to the IBMTR response index).

The key secondary endpoint was six-month duration of response (DOR), defined as the time from first response until GvHD progression or death assessed when all participants who are still on study complete the Day 180 visit.

The REACH 1 study achieved the predetermined threshold for a positive study outcome (lower limit of the 95% CI for Day 28 ORR \geq 40%). Forty participants (56.3% [95% CI: 44.0, 68.1]) demonstrated a response at Day 28, including 19 participants (26.8%) who achieved a CR, 6 participants who achieved a VGPR (8.5%) and 15 participants who achieved a PR (21.1%).

Chronic Graft versus Host Disease

In REACH3, 329 patients with moderate or severe corticosteroid-refractory, chronic GvHD were randomised 1:1 to Jakavi 10 mg twice daily (n=165) or BAT (n=164). Patients were stratified by severity of chronic GvHD at the time of randomisation. Corticosteroid refractoriness was determined when patients had lack of response or disease progression after 7 days, or had disease persistence for 4 weeks or failed corticosteroid taper twice.

BAT was selected by the investigator on a patient-by-patient basis and included extracorporeal photopheresis (ECP), low dose methotrexate (MTX), mycophenolate mofetil (MMF), mTOR inhibitors (everolimus or sirolimus), infliximab, rituximab, pentostatin, imatinib, or ibrutinib.

In addition to Jakavi or BAT, patients could have received standard allogeneic stem cell transplantation supportive care including anti-infective medications and transfusion support as well as standard chronic GvHD prophylaxis and treatment medications initiated before randomisation including systemic corticosteroids and CNIs (cyclosporine or tacrolimus). Topical or inhaled corticosteroid therapy was allowed to be continued per institutional guidelines.

Patients randomised to the BAT arm were allowed to cross over to the Jakavi arm after the Cycle 7 Day 1 visit (week 24). Tapering of Jakavi was allowed after the Cycle 7 Day 1 visit.

Baseline demographics and disease characteristics were balanced between the two treatment arms. The median age was 49 years (range 12 to 76 years). The study included 3.6% adolescent, 61.1% male and 75.4% white patients. The majority of enrolled patients had malignant underlying disease.

The severity at diagnosis of corticosteroid-refractory chronic GvHD was balanced between the two treatment arms, with 41% and 45% moderate, and 59% and 55% severe, in the Jakavi and the BAT arms, respectively.

Patients' insufficient response to corticosteroids in the Jakavi and BAT arm were characterised by i) a lack of response or disease progression after corticosteroid treatment for at least 7 days at 1mg/kg/day of prednisone equivalents (37.6% and 44.5%, respectively), ii) disease persistence after 4 weeks at 0.5 mg/kg/day (35.2% and 25.6%), or iii) corticosteroid dependency (27.3% and 29.9%, respectively).

Among all patients, 73% and 45% had skin and lung involvement in the Jakavi arm, compared to 69% and 41% in the BAT arm.

The most frequently used prior systemic chronic GvHD therapies were corticosteroids only (43% in the Jakavi arm and 49% in the BAT arm) and corticosteroids+CNIs (41% patients in the Jakavi arm and 42% in the BAT arm).

The primary endpoint was the ORR on Day 1 of Cycle 7, defined as the proportion of patients in each arm with a CR or a PR without the requirement of additional systemic therapies for an

earlier progression, mixed response or non-response based on investigator assessment per NIH criteria.

REACH3 met its primary objective. ORR at week 24 was higher in the Jakavi arm (49.7%) compared to the BAT arm (25.6%). There was a statistically significant difference between the treatment arms (stratified Cochrane-Mantel-Haenszel test $p < 0.0001$, one-sided, OR: 2.99; 95% CI: 1.86, 4.80). Results are presented in Table 12.

Table 12: Overall response rate at Cycle 7 Day 1 in REACH3

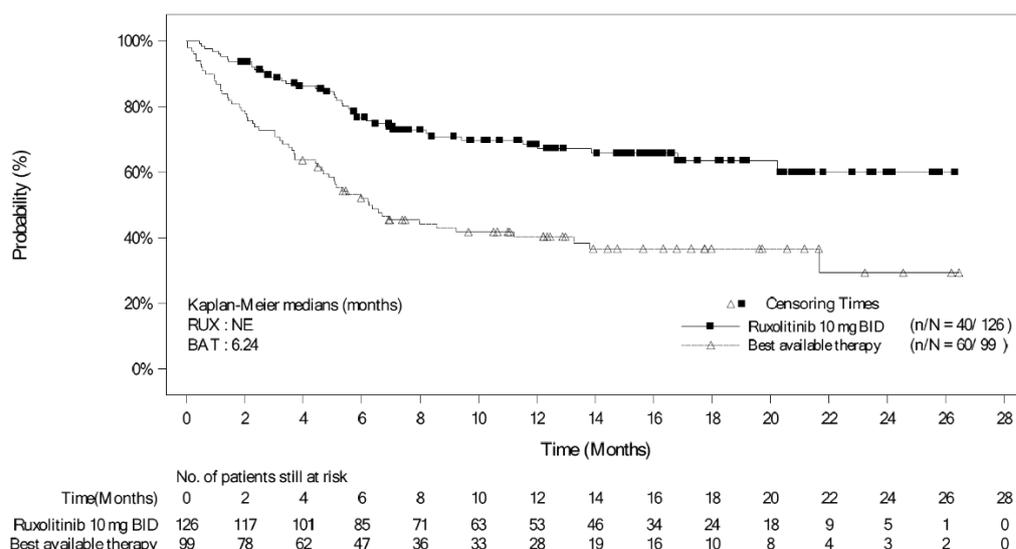
	Jakavi N = 165		BAT N = 164	
	n (%)	95% CI	n (%)	95% CI
Overall Response	82 (49.7)	41.8, 57.6	42 (25.6)	19.1, 33.0
OR (95% CI)	2.99 (1.86, 4.80)			
p-value	p < 0.0001			
Complete Response	11 (6.7)		5 (3.0)	
Partial Response	71 (43.0)		37 (22.6)	

Best overall response (BOR) is defined as the proportion of patients who achieved ORR (CR+PR) at any time point up to Cycle 7 Day 1. The BOR up to Cycle 7 Day 1 was higher in the Jakavi arm (76.4%) than in the BAT arm (60.4%).

The estimated probability of maintaining BOR at 12 months was higher in the Jakavi arm compared to the BAT arm (64.5% [95% CI: 58.9, 76.3] vs 40.3% [95% CI: 30.3, 50.2]).

Duration of response was evaluated in patients who achieved a complete or partial response at or before Cycle 7 Day 1 (BOR). DOR was defined as “time from first response until cGVHD progression, death, or systemic therapies for cGVHD”. The Median duration of response was not reached in Jakavi arm and was 6.2 months (95% CI: 4.7 to 13.3) in the BAT arm. The estimated probability of maintaining BOR with 95% CIs was higher in the Jakavi arm (76.58%; 95% CI: 67.87, 88.22) compared to the BAT arm (52.11%; 95% CI: 41.78, 61.45) at 6 months. Similar trends in probability were observed at 12 months and 18 months.

Figure 1 Kaplan Meier estimate of Duration of Response



5.2 Pharmacokinetic properties

Absorption:

Ruxolitinib is a Class 1 molecule under the Biopharmaceutical Classification System, with high permeability, high solubility and rapid dissolution characteristics. In clinical studies, ruxolitinib is rapidly absorbed after oral administration with maximal plasma concentration (C_{max}) achieved approximately 1 hour post-dose. Based on a mass balance study in humans, oral absorption of ruxolitinib was 95% or greater. Mean ruxolitinib C_{max} and total exposure (AUC) increased proportionally over a single dose range of 5 to 200 mg. There was no clinically relevant change in the pharmacokinetics of ruxolitinib upon administration with a high-fat meal. The mean C_{max} was moderately decreased (24%) while the mean AUC was nearly unchanged (4% increase) upon dosing with a high-fat meal.

Distribution:

The mean volume of distribution at steady-state is 72 L in myelofibrosis patients with an inter-subject variability of 29.4% and 75 L in polycythemia vera patients with an associated inter-subject variability of 22.6%. At clinically relevant concentrations of ruxolitinib, binding to plasma proteins in vitro is approximately 97%, mostly to albumin.

Metabolism:

In vitro studies indicate that CYP3A4 and CYP2C9 are the major enzymes responsible for metabolism of ruxolitinib. Parent compound is the predominant entity in humans representing approximately 60% of the drug-related material in circulation. Two major and active metabolites were identified in plasma of healthy subjects representing 25% and 11% of parent AUC. These metabolites have one half to one fifth of the parent JAK-related pharmacological activity. The sum total of all active metabolites contribute to 18% of the overall pharmacodynamics of ruxolitinib.

Excretion:

Following a single oral dose of [14C]-labelled ruxolitinib in healthy adult subjects, elimination was predominately through metabolism with 74% of radioactivity excreted in urine and 22% excretion via faeces. Unchanged drug accounted for less than 1% of the excreted total radioactivity. The mean elimination half-life of ruxolitinib is approximately 3 hours.

Pharmacokinetics in special patient groups

Effects of age, gender, or race

Based on studies in healthy subjects, no relevant differences in ruxolitinib pharmacokinetics were observed with regard to gender and race. In a population pharmacokinetic evaluation in myelofibrosis patients, no relationship was apparent between oral clearance and patient age or race. Clearance was 17.7 L/h in women and 22.1 L/h in men, with 39% inter-subject variability in MF patients. Clearance was 12.7 L/h in PV patients, with a 42% inter-subject variability, and no relationship was apparent between oral clearance and gender, patient age or race in this patient population.

Paediatric

The safety and effectiveness of Jakavi in paediatric patients with MF or PV have not been established.

The safety, efficacy and PK profile observed in adolescent patients with acute or chronic GvHD was comparable to the overall patient population (see section 5.1 Pharmacodynamic Properties, Clinical trials).

Renal impairment

Following a single ruxolitinib dose of 25 mg, the pharmacokinetics were similar in subjects with various degrees of renal impairment and in those with normal renal function. However, plasma AUC values of ruxolitinib metabolites tended to increase with increasing severity of renal impairment, and most markedly in the subjects with end stage renal disease requiring haemodialysis. Ruxolitinib is not removed by dialysis. A dose modification is recommended for patients with moderate to severe renal impairment (Cl_{cr} less than 60 mL/min). For patients with end stage renal disease a modification of the dosing schedule is recommended. Jakavi should be avoided in patients with end stage renal disease (Cl_{cr} less than 15 mL/min) not undergoing dialysis and in patients with moderate to severe renal impairment with platelet counts less than 100 x10⁹/L (see section 4.2 Dose and method of administration section).

Hepatic impairment

Following a single ruxolitinib dose of 25 mg in patients with varying degrees of hepatic impairment, the pharmacokinetics and pharmacodynamics of ruxolitinib were assessed. The mean AUC for ruxolitinib was increased in patients with mild, moderate and severe hepatic impairment by 87%, 28% and 65%, respectively, compared to patients with normal hepatic function and indicating no clear relationship to the degree of hepatic impairment based on Child-Pugh scores. The terminal elimination half-life was prolonged in patients with hepatic impairment compared to healthy controls (4.1-5.0 hours versus 2.8 hours). A dose reduction is recommended for patients with hepatic impairment (see section 4.2 Dose and method of administration section).

Mild, moderate or severe hepatic impairment in patients with GvHD was not found to have a significant impact on any parameter in the Population PK model.

5.3 Preclinical safety data

Administration of ruxolitinib to juvenile rats resulted in effects on growth and bone measures. Ruxolitinib was administered daily by oral gavage at doses from 1.5 to 75 mg/kg/day from days 7 (the human equivalent of a newborn) to 63 post-partum (pp), 15 mg/kg/day from days 14 (the human equivalent of 1 year of age) to 63 pp and 5, 15 and 60 mg/kg/day from days 21 (the human equivalent of 2 to 3 years of age) to 63 pp. Doses ≥ 30 mg/kg/day (1,200 ng*h/mL based on unbound AUC) resulted in fractures and early termination of the groups when treatment started on day 7 pp. Reduced bone growth was observed at doses ≥ 5 mg/kg/day (≥ 150 ng*h/mL based on unbound AUC) when treatment started on day 7 pp and at ≥ 15 mg/kg/day (≥ 150 ng*h/mL based on unbound AUC) when treatment started on day 14 pp or day 21 pp. Based on unbound AUC, fractures and reduced bone growth occurred at exposures 13- and 1.5- fold the exposure in adult patients at the maximum recommended dose of 25 mg BID, respectively. The effects were generally more severe when administration was initiated earlier in the postnatal period. Other than the effects on bone development, the toxicity profile in juvenile rats was comparable to that observed in adult rats.

Genotoxicity

Ruxolitinib was not mutagenic in a bacterial mutagenicity assay (Ames test) or clastogenic in an *in vitro* chromosomal aberration assay (cultural human peripheral blood lymphocytes) or an *in vivo* rat bone marrow micronucleus assay.

Carcinogenicity

No evidence of carcinogenicity was observed in a 6 month study in the Tg.rasH2 transgenic mouse model at oral doses of ruxolitinib up to 125 mg/kg/day, resulting in approximately 9 times the human exposure (AUC) at the maximum recommended dose of 25 mg twice daily.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

cellulose, microcrystalline

magnesium stearate

silica, colloidal anhydrous

sodium starch glycollate type A

hydroxypropylcellulose

povidone

lactose monohydrate

6.2 Incompatibilities

Not applicable

6.3 Shelf life

Blister pack: 24 months

6.4 Special precautions for storage

Do not store above 30°C

Keep out of the reach and sight of children.

6.5 Nature and contents of container

Jakavi 5 mg, 10 mg, 15 mg and 20 mg tablets: PVC/PCTFE(Aclar)/Al blisters packaged in a cardboard carton containing 14, 28, 56, 112, 168, 224 tablets

Pack sizes: Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

No special requirements.

7 MEDICINE SCHEDULE

Prescription medicine

8 SPONSOR

Novartis New Zealand Limited

PO Box 99102

Newmarket

Auckland 1149

New Zealand

Telephone: 0800 354 335

9 DATE OF FIRST APPROVAL

9 December 2014

10 DATE OF REVISION OF THE TEXT

17 November 2022

SUMMARY TABLE OF CHANGES

Section	Summary of changes
4.1, 4.2, 4.4 4.5, 4.8, 5.1	Addition of acute and chronic GvHD indications, dosage, paediatric use, interactions, undesirable effects and clinical trial information.
All	Revision of sub-headings and cross-references, spelling corrections.

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