

## VTTACK

---

### 1. Product Name

---

VTTACK 50 mg and 200 mg film coated tablets.

---

### 2. Qualitative and Quantitative Composition

---

Each film coated tablet contains 50 mg or 200 mg of voriconazole.

VTTACK contains lactose. For the full list of excipients, see section 6.1.

---

### 3. Pharmaceutical Form

---

VTTACK 50 mg is a white to off-white, film coated, oval, biconvex tablet debossed with 'V26' on one side of the tablet and blank on the other side.

VTTACK 200 mg is a white to off-white, film coated, capsule shaped, biconvex tablet debossed with 'M164' on one side of the tablet and blank on the other side.

**VTTACK is NOT available as an intravenous infusion nor as an oral suspension of voriconazole. Clinical data relating to intravenous infusions and oral suspensions of voriconazole are included in this data sheet as an aid to the prescriber and this is not an implication that the tablet may be substituted for the intravenous infusion or oral suspension unless specifically stated.**

---

### 4. Clinical Particulars

---

#### 4.1 Therapeutic indications

VTTACK is indicated for treatment of the following fungal infections:

- Invasive aspergillosis.
- Serious *Candida* infections (including *C. krusei*), including oesophageal and systemic *Candida* infections (hepatosplenic candidiasis, disseminated candidiasis, candidaemia).
- Serious fungal infections caused by *Scedosporium* spp. and *Fusarium* spp.
- Other serious fungal infections, in patients intolerant of, or refractory to, other therapy.

#### 4.2 Dose and method of administration

##### Dose

##### Use in adults

Therapy must be initiated with the specified loading dose regimen of VTTACK to achieve plasma concentrations on Day 1 that are close to steady state. On the basis of the high oral bioavailability (96%; see section 5.2), switching between intravenous and oral administration is appropriate when clinically indicated.

Intravenous administration is not recommended for the treatment of oesophageal candidiasis; dosage recommendations for oesophageal candidiasis are provided in the following table:

---

	Oral	
	Patients 40 kg or above	Patients less than 40 kg
<b>Serious invasive <i>Candida</i> infections</b>		
Loading dose regimen (first 24 hours)	400 mg every 12 hours (for the first 24 hours)	200 mg every 12 hours (for the first 24 hours)
Maintenance dose (after first 24 hours)	200 mg twice daily	100 mg twice daily
<b>Oesophageal Candidiasis</b>		
Loading dose regimen (first 24 hours)	400 mg every 12 hours (for the first 24 hours)	200 mg every 12 hours (for the first 24 hours)
Maintenance dose (after first 24 hours)	200 mg twice daily	100 mg twice daily
<b>Invasive aspergillosis/ <i>Scedosporium</i> and <i>Fusarium</i> infections/ other serious fungal infections</b>		
Loading dose regimen (first 24 hours)	400 mg every 12 hours (for the first 24 hours)	200 mg every 12 hours (for the first 24 hours)
Maintenance dose (after first 24 hours)	200 mg twice daily	100 mg twice daily

### **Dosage adjustment**

If patient response is inadequate, the maintenance dose may be increased to 300 mg twice daily. For patients less than 40 kg the dose may be increased to 150 mg twice daily. If patients are unable to tolerate treatment at these higher doses reduce the oral dose by 50 mg steps to a minimum 200 mg twice daily (or 100 mg twice daily for patients less than 40 kg) maintenance dose.

Phenytoin may be co-administered with voriconazole if the maintenance dose of voriconazole is increased from 200 mg to 400 mg twice daily orally (100 mg to 200 mg twice daily orally in patients less than 40 kg). The loading dose regimen remains unchanged (see sections 4.4 and 4.5).

When voriconazole is co-administered with efavirenz, the voriconazole maintenance dose should be increased to 400 mg every 12 hours and the efavirenz dose should be decreased to 300 mg every 24 hours (see sections 4.3 and 4.5).

Treatment duration depends upon patients' clinical and mycological response.

### **Special populations**

#### **Use in the elderly**

No dose adjustment is necessary for elderly patients.

#### **Use in patients with renal impairment**

The pharmacokinetics of orally administered voriconazole are not affected by renal impairment. Therefore, no adjustment is necessary for oral dosing for patients with mild to severe renal impairment.

In patients with moderate to severe renal dysfunction (creatinine clearance < 50 ml/min), including dialysis patients, accumulation of the intravenous vehicle, SBECD, occurs. Oral voriconazole should be administered to these patients, unless an assessment of the risk-benefit to the patient justifies the use of intravenous voriconazole. Serum creatinine levels should be closely monitored in these patients and, if increases occur, consideration should be given to changing to oral voriconazole therapy (see section 5.2).

## Use in patients with hepatic impairment

No dose adjustment is necessary in patients with acute hepatic injury, manifested by elevated liver function tests (ALT, AST) (but continued monitoring of liver function tests for further elevations is recommended).

It is recommended that the standard loading dose regimens be used but that the maintenance dose be halved in patients with mild to moderate hepatic cirrhosis (Child-Pugh A and B) receiving voriconazole.

Voriconazole has not been studied in patients with severe chronic hepatic cirrhosis (Child- Pugh C). Voriconazole has been associated with elevations in liver function tests and clinical signs of liver damage such as jaundice, and must only be used in patients with severe hepatic impairment if the benefit outweighs the potential risk. Patients with severe hepatic impairment must be carefully monitored for drug toxicity (see section 4.8).

## Use in children

Safety and efficacy in paediatric subjects below the age of 2 years has not been established (see section 5.2). Therefore, voriconazole is not recommended for children less than 2 years of age. The recommended dose forms for paediatric patients 2 to < 12 years are either intravenous infusion or oral suspension.

Adolescents (12 -16 years of age) should be dosed as adults.

## Method of administration

VTTACK tablets are to be taken at least one hour before or one hour following a meal.

### 4.3 Contraindications

VTTACK is contraindicated in patients with known hypersensitivity to voriconazole or to any of the excipients (see section 6.1).

Co-administration of the CYP3A4 substrates pimozide, quinidine or ivabradine with voriconazole is contraindicated since increased plasma concentrations of these medicinal products can lead to QTc prolongation and rare occurrences of *torsade de pointes* (see section 4.5).

Co-administration of voriconazole with rifabutin, rifampicin, carbamazepine, long-acting barbiturates (e.g. phenobarbital) and St John's Wort is contraindicated since these medicinal products are likely to decrease plasma voriconazole concentrations significantly (see section 4.5).

Co-administration of standard doses of voriconazole with patients receiving efavirenz doses of 400 mg once daily or higher is contraindicated because efavirenz significantly decreases plasma voriconazole concentrations in healthy subjects at these doses. Voriconazole also significantly increases efavirenz plasma concentrations (see section 4.5). For information pertaining to lower doses of efavirenz see sections 4.5 and 4.2.

Co-administration of voriconazole with patients receiving high doses of ritonavir (400 mg and higher twice daily) is contraindicated because ritonavir significantly decreases plasma voriconazole concentrations in healthy subjects at these doses (see section 4.5). For information pertaining to lower doses of ritonavir see section 4.4.

Co-administration of ergot alkaloids (ergotamine, dihydroergotamine), which are CYP3A4 substrates, is contraindicated since increased plasma concentrations of these medicinal products can lead to ergotism (see section 4.5).

Co-administration of voriconazole and sirolimus is contraindicated, since voriconazole is likely to increase plasma concentrations of sirolimus significantly (see section 4.5).

Co-administration of voriconazole with naloxegol is contraindicated because voriconazole may significantly increase plasma concentrations of naloxegol which may precipitate opioid withdrawal symptoms (see Section 4.5).

Co-administration of voriconazole with tolvaptan is contraindicated because voriconazole may significantly increase plasma concentrations of tolvaptan (see Section 4.5).

Co-administration of voriconazole with venetoclax is contraindicated at initiation and during the venetoclax dose titration phase since voriconazole is likely to significantly increase plasma concentrations of venetoclax and increase risk of tumour lysis syndrome (see Section 4.5).

Co-administration of voriconazole with lurasidone is contraindicated since it may result in significant increases in lurasidone exposure and the potential for serious adverse reactions (see Section 4.5).

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

### **Hypersensitivity**

Caution should be used in prescribing voriconazole to patients with hypersensitivity to other azoles.

### **Cardiovascular**

Some azoles, including voriconazole have been associated with QT interval prolongation. There have been rare cases of *torsade de pointes* in patients taking voriconazole who had risk factors, such as history of cardiotoxic chemotherapy, cardiomyopathy, hypokalaemia and concomitant medications that may have been contributory. Voriconazole should be administered with caution to patients with these potentially proarrhythmic conditions, such as:

- Congenital or acquired QT-prolongation
- Cardiomyopathy, in particular when heart failure is present
- Sinus bradycardia
- Existing symptomatic arrhythmias
- Concomitant medicinal product that is known to prolong QT interval (see section 4.5).

Electrolyte disturbances such as hypokalaemia, hypomagnesaemia and hypocalcaemia should be monitored and corrected, if necessary, prior to initiation of and during voriconazole therapy (see section 4.2).

### **Hepatic**

In clinical trials, there have been cases of serious hepatic reactions during treatment with voriconazole (including clinical hepatitis, cholestasis and fulminant hepatic failure including fatalities). Instances of hepatic reactions were noted to occur primarily in patients with serious underlying medical conditions (predominantly haematological malignancy). Transient hepatic reactions, including hepatitis and jaundice, have occurred among patients with no other identifiable risk factors. Liver dysfunction has usually been reversible on discontinuation of therapy.

Patients receiving voriconazole must be carefully monitored for hepatic toxicity. Clinical management should include laboratory evaluation of hepatic function (specifically AST and ALT) at the initiation of treatment with voriconazole and at least weekly for the first month of treatment. If treatment is continued, monitoring frequency can be reduced to monthly if there are no changes in the liver function tests.

If the liver function tests become markedly elevated, voriconazole should be discontinued, unless the medical judgment of the risk-benefit of the treatment for the patient justifies continued use (see section 4.2).

### **Renal**

The pharmacokinetic parameters of orally administered voriconazole are not affected by renal impairment. However, acute renal failure has been observed in severely ill patients undergoing

treatment with voriconazole. Patients being treated with voriconazole are likely to be treated concomitantly with nephrotoxic medications and have concurrent conditions that may result in decreased renal function.

In patients with moderate to severe renal dysfunction (creatinine clearance <50 ml/min), including dialysis patients, accumulation of the intravenous vehicle SBEDC occurs. Oral voriconazole should be administered to these patients, unless an assessment of the risk to the patient justifies the use of intravenous voriconazole.

Patients should be monitored for the development of abnormal renal function. This should include laboratory evaluation, particularly serum creatinine.

### **Monitoring of pancreatic function**

Adults and children with risk factors for acute pancreatitis (e.g. recent chemotherapy, haematopoietic stem cell transplantation (HSCT)) should be monitored closely during voriconazole treatment. Monitoring of serum amylase or lipase may be considered in this clinical situation.

### **Dermatological adverse events**

Severe cutaneous adverse reactions (SCARs), such as Stevens-Johnson syndrome, toxic epidermal necrolysis (TEN) and drug reaction with eosinophilia and systemic symptoms (DRESS), which can be life-threatening or fatal, have been reported with the use of voriconazole. If a patient develops a suspected SCAR voriconazole should be discontinued immediately and an alternative treatment should be considered.

In addition, voriconazole has been associated with photosensitivity skin reaction. It is recommended that patients, including children, avoid exposure to direct sunlight during voriconazole treatment and use measures such as protective clothing and sunscreen with high sun protection factor (SPF) (see Squamous Cell Carcinoma).

The frequency of phototoxicity reactions is higher in the paediatric population. As an evolution towards squamous cell carcinoma (SCC) has been reported, stringent measures for the photo-protection are warranted in this population of patients. In children experiencing photo-aging injuries such as lentiginos or ephelides, sun avoidance and dermatologic follow-up are recommended even after treatment discontinuation.

### **Adrenal events**

Reversible cases of adrenal insufficiency have been reported in patients receiving azoles, including voriconazole. Adrenal insufficiency has been reported in patients receiving azoles with or without concomitant corticosteroids. (e.g. ketoconazole). In patients receiving azoles without corticosteroids, adrenal insufficiency is related to direct inhibition of steroidogenesis by azoles. In patients taking corticosteroids, voriconazole associated CYP3A4 inhibition of their metabolism may lead to corticosteroid excess and adrenal suppression (see Section 4.5). Cushing's syndrome with and without subsequent adrenal insufficiency has also been reported in patients receiving voriconazole concomitantly with corticosteroids.

Patients on long-term treatment with voriconazole and corticosteroids (including inhaled corticosteroids e.g. budesonide) should be carefully monitored for adrenal cortex dysfunction both during treatment and when voriconazole is discontinued (see Section 4.5). Patients should be instructed to seek immediate medical care if they develop signs and symptoms of Cushing's syndrome or renal insufficiency.

### **Long-term treatment**

The following severe adverse events have been reported in relation with long-term voriconazole treatment.

**Squamous Cell Carcinoma (SCC):** In patients with photosensitivity skin reactions and additional risk factors (including immunosuppression), squamous cell carcinoma of the skin (including

cutaneous SCC *in situ*, or Bowen's disease) and melanoma have been reported during long-term therapy. If phototoxic reactions occur, multidisciplinary advice should be sought and the patient should be referred to a dermatologist. Voriconazole discontinuation should be considered. Dermatologic evaluation should be performed on a systematic and regular basis, whenever voriconazole is continued despite the occurrence of phototoxicity-related lesions, to allow early detection and management of premalignant lesions. If a patient develops a skin lesion consistent with premalignant skin lesions, squamous cell carcinoma or melanoma, voriconazole discontinuation should be considered.

**Non-infectious periostitis:** Periostitis has been reported in transplant patients during long-term voriconazole therapy. If a patient develops skeletal pain and radiologic findings compatible with periostitis, voriconazole should be discontinued.

### **Visual adverse events**

There have been post-marketing reports of prolonged visual adverse events, including optic neuritis and papilloedema. These events occurred primarily in severely ill patients who had underlying conditions and/or concomitant medications which may have caused or contributed to these events (see section 4.8 and section 4.7).

### **Methadone (CYP3A4 substrate)**

Increased plasma concentrations of methadone have been associated with toxicity including QT prolongation. Frequent monitoring for adverse events and toxicity related to methadone is recommended during co-administration. Dose reduction of methadone may be needed (see section 4.5).

### **Short acting opiates (CYP3A4 substrate)**

Reduction in the dose of alfentanil, fentanyl and other short acting opiates similar in structure to alfentanil and metabolised by CYP3A4 (e.g. sufentanil) should be considered when co-administered with voriconazole (see section 4.5). As the half-life of alfentanil is prolonged in a 4-fold manner when alfentanil is co-administered with voriconazole and in an independent published study, concomitant use of voriconazole with fentanyl resulted in an increase in the mean  $AUC_{0-\infty}$  of fentanyl by 1.4-fold, frequent monitoring for opiate-associated adverse events (including a longer respiratory monitoring period) may be necessary.

### **Long acting opiates (CYP3A4 substrate)**

Reduction in the dose of oxycodone and other long-acting opiates metabolised by CYP3A4 (e.g. hydrocodone) should be considered when co-administered with voriconazole. Frequent monitoring for opiate-associated adverse events may be necessary (see section 4.5).

### **Everolimus (CYP3A4 substrate, P-gp substrate)**

Co-administration of voriconazole with everolimus is not recommended because voriconazole is expected to significantly increase everolimus concentrations. Currently there are insufficient data to allow dosing recommendations in this situation (see section 4.5).

### **Fluconazole (CYP2C9, CYP2C19 and CYP3A4 inhibitor)**

Co-administration of oral voriconazole and oral fluconazole resulted in significant increase in  $C_{max}$  and  $AUC_{\tau}$  of voriconazole in healthy subjects. The reduced dose and/or frequency of voriconazole and fluconazole that would reduce this effect have not been established. Monitoring for voriconazole associated adverse events is recommended if voriconazole is used sequentially after fluconazole (see section 4.5).

### **Glasdegib (CYP3A4 substrate)**

Co-administration of voriconazole is expected to increase glasdegib plasma concentrations and increase the risk of QTc prolongation (see Section 4.5). If concomitant use cannot be avoided, frequent ECG monitoring is recommended.

### **Tyrosine kinase inhibitors (CYP3A4 substrate)**

Co-administration of voriconazole with tyrosine kinase inhibitors metabolised by CYP3A4 is expected to increase tyrosine kinase inhibitor plasma concentrations and the risk of adverse reactions. If concomitant use cannot be avoided, dose reduction of the tyrosine kinase inhibitor and close clinical monitoring is recommended (see Section 4.5).

### **Phenytoin (CYP2C9 substrate and potent CYP450 inducer)**

Careful monitoring of phenytoin levels is recommended when phenytoin is co-administered with voriconazole. Concomitant use of voriconazole and phenytoin should be avoided unless the benefit outweighs the risk (see section 4.5).

### **Ritonavir (potent CYP450 inducer; CYP3A4 inhibitor and substrate)**

Co-administration of voriconazole and low dose ritonavir (100 mg twice daily) should be avoided unless an assessment of the benefit/risk justifies the use of voriconazole (see section 4.5). Co-administration of voriconazole and ritonavir 400 mg and higher twice daily is contraindicated (see section 4.3).

### **Advice about lactose**

VTTACK tablets contain lactose and should not be given to patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption.

### **Paediatric use**

**The information relating to paediatric use has been generated using only oral suspension and intravenous dose forms of voriconazole and these presentations are not available in this product range.**

Safety and efficacy in paediatric subjects below the age of two years has not been established (see section 5.2). A higher frequency of liver enzyme elevations was observed in the paediatric population (see section 4.8). Hepatic function and pancreatic function should be monitored. Oral bioavailability may be limited in paediatric patients 2 to 12 years with malabsorption and very low body weight for age. In that case, intravenous voriconazole administration is recommended.

## **4.5 Interaction with other medicines and other forms of interaction**

Unless otherwise specified, drug interaction studies have been performed in healthy male subjects, using multiple dosing to steady state with oral voriconazole at 200 mg twice daily. These results are relevant to other populations and routes of administration.

This section addresses the effects of other medicinal products on voriconazole, the effects of voriconazole on other medicinal products and two-way interactions. The interactions for the first two sections are presented in the following order: contraindications, those requiring dosage adjustment, those requiring careful clinical and/or biochemical monitoring and finally those that have no significant pharmacokinetic interaction but may be of clinical interest in this therapeutic field.

### **1. Effects of other medicinal products on voriconazole**

Voriconazole is metabolised by cytochrome P450 isoenzymes, CYP2C19, CYP2C9 and CYP3A4. Inhibitors or inducers of these isoenzymes may increase or decrease voriconazole plasma concentrations, respectively.

***The exposure to voriconazole is significantly reduced by the concomitant administration of the following agents:***

#### **Rifampicin (CYP450 inducer)**

Rifampicin (600 mg once daily) decreased the  $C_{max}$  (maximum plasma concentration) and  $AUC_{\tau}$  (area under the plasma concentration time curve within a dose interval) of voriconazole by 93% and

96%, respectively. Co-administration of voriconazole and rifampicin is contraindicated (see section 4.3).

#### **Rifabutin (potent CYP450 inducer)**

Rifabutin (300 mg once daily) decreased the  $C_{max}$  and  $AUC_{\tau}$  of voriconazole at 200 mg twice daily by 69% and 78%, respectively. During co-administration with rifabutin, the  $C_{max}$  and  $AUC_{\tau}$  of voriconazole at 350 mg twice daily were 96% and 68% of the levels when administered alone at 200 mg twice daily. At a voriconazole dose of 400 mg twice daily  $C_{max}$  and  $AUC_{\tau}$  were 104% and 87% higher, respectively, compared with voriconazole alone at 200 mg twice daily. Voriconazole at 400 mg twice daily increased  $C_{max}$  and  $AUC_{\tau}$  of rifabutin by 195% and 331%, respectively. Co-administration of voriconazole with rifabutin is contraindicated (see section 4.3).

#### **Ritonavir (potent CYP450 inducer; CYP3A4 inhibitor and substrate)**

The effect of the co-administration of oral voriconazole (200 mg twice daily) and high dose (400 mg) and low dose (100 mg) oral ritonavir was investigated in two separate studies in healthy volunteers. High doses of ritonavir (400 mg twice daily) decreased the steady state  $C_{max}$  and  $AUC_{\tau}$  of oral voriconazole by an average of 66% and 82% respectively, whereas low doses of ritonavir (100 mg twice daily) decreased the  $C_{max}$  and  $AUC_{\tau}$  of oral voriconazole by an average of 24% and 39% respectively. Administration of voriconazole did not have a significant effect on mean  $C_{max}$  and  $AUC_{\tau}$  of ritonavir in the high dose study, although a minor decrease in steady state  $C_{max}$  and  $AUC_{\tau}$  of ritonavir with an average of 25% and 13% respectively was observed in the low dose ritonavir interaction study. One outlier subject with raised voriconazole levels was identified in each of the ritonavir interaction studies. Co-administration of voriconazole and high doses ritonavir (400 mg and above twice daily) is contraindicated (see section 4.3). Co-administration of voriconazole and low dose ritonavir (100 mg twice daily) should be avoided unless an assessment of the benefit/risk to the patient justifies the use of voriconazole (see section 4.4)

#### **Carbamazepine and long acting barbiturates (potent CYP450 inducers e.g., phenobarbital)**

Although not studied, carbamazepine or phenobarbital are likely to significantly decrease plasma voriconazole levels. Co-administration of voriconazole with carbamazepine and long acting barbiturates are contraindicated (see section 4.3).

#### **Letermovir (CYP2C9 and CYP2C19 inducer)**

Letermovir decreased the  $C_{max}$ ,  $AUC_{0-12}$  and  $C_{12}$  of voriconazole by 39%, 44% and 51%, respectively. If concomitant administration of voriconazole with letermovir cannot be avoided, monitor for loss of voriconazole effectiveness.

#### ***Significant drug interactions that may require voriconazole dosage adjustment, or frequent monitoring of voriconazole related adverse events/toxicity:***

##### **Fluconazole (CYP2C9, CYP2C19 and CYP3A4 inhibitor)**

Co-administration of oral voriconazole and oral fluconazole resulted in significant increase in  $C_{max}$  and  $AUC_{\tau}$  of voriconazole in healthy subjects. The clinical significance of this drug interaction has not been established and the co-administration of voriconazole and oral fluconazole is not recommended. Monitoring for voriconazole associated adverse events is recommended if voriconazole is used sequentially after fluconazole.

#### ***Minor or no significant pharmacokinetic interactions that require no dosage adjustment:***

##### **Cimetidine (non-specific CYP450 inhibitor and increases gastric pH)**

Cimetidine (400 mg twice daily) increased voriconazole  $C_{max}$  and  $AUC_{\tau}$  by 18% and 23%, respectively. No dosage adjustment of voriconazole is recommended.

##### **Ranitidine (increases gastric pH)**

Ranitidine (150 mg twice daily) had no significant effect on voriconazole  $C_{max}$  and  $AUC_{\tau}$ .



## Macrolide antibiotics

Erythromycin (CYP3A4 inhibitor; 1 g twice daily) and azithromycin (500 mg once daily) had no significant effect on voriconazole  $C_{max}$  and  $AUC_{\tau}$ .

## 2. Effects of voriconazole on other medicinal products

Voriconazole inhibits the activity of cytochrome P450 isoenzymes, CYP2C19, CYP2C9 and CYP3A4. Therefore, there is potential for voriconazole to increase the plasma levels of drugs metabolised by these CYP450 isoenzymes, in particular for substances metabolised by CYP3A4 since voriconazole is a strong CYP3A4 inhibitor though the increase in AUC is substrate dependent.

Voriconazole should be administered with caution in patients receiving concomitant medication that is known to prolong QT interval. When there is also a potential for voriconazole to increase the plasma levels of substances metabolised by CYP3A4 isoenzymes (certain antihistamines, quinidine, pimozide and ivabradine) co-administration is contraindicated (see below and section 4.3).

### **Concomitant use of the following agents with voriconazole is contraindicated:**

#### **Pimozide, quinidine and ivabradine (CYP3A4 substrates)**

Although not studied, co-administration of voriconazole with pimozide, quinidine or ivabradine is contraindicated, since increased plasma concentrations of these drugs can lead to QTc prolongation and rare occurrences of *torsade de pointes* (see section 4.3).

#### **Sirolimus (CYP3A4 substrate)**

Voriconazole increased sirolimus (2 mg single dose)  $C_{max}$  and  $AUC_{\tau}$  by 556% and 1014%, respectively. Co-administration of voriconazole and sirolimus is contraindicated (see section 4.3).

#### **Ergot alkaloids (CYP3A4 substrates)**

Although not studied, voriconazole may increase the plasma concentrations of ergot alkaloids (ergotamine and dihydroergotamine) and lead to ergotism. Co-administration of voriconazole with ergot alkaloids is contraindicated (see section 4.3).

#### **Lurasidone (CYP3A4 substrate)**

Although not studied, voriconazole is likely to significantly increase the plasma concentrations of lurasidone. Co-administration of voriconazole with lurasidone is contraindicated (see Section 4.3).

#### **Naloxegol (CYP3A4 substrate)**

Although not studied, voriconazole is likely to significantly increase the plasma concentrations of naloxegol. Co-administration of voriconazole with naloxegol is contraindicated (see Section 4.3).

#### **St John's Wort (CYP450 inducer; P-gp inducer)**

In a clinical study in healthy volunteers, St John's Wort exhibited a short initial inhibitory effect followed by induction of voriconazole metabolism. After 15 days of treatment with St John's Wort (300 mg three times daily), plasma exposure following a single 400 mg dose of voriconazole decreased by 40-60%. Therefore, concomitant use of voriconazole with St John's Wort is contraindicated (see section 4.3).

#### **Tolvaptan (CYP3A substrate)**

Although not studied, voriconazole is likely to significantly increase the plasma concentrations of tolvaptan. Co-administration of voriconazole with tolvaptan is contraindicated (see Section 4.3).

#### **Venetoclax (CYP3A substrate)**

Although not studied, voriconazole is likely to significantly increase the plasma concentrations of venetoclax. Concomitant administration of voriconazole is contraindicated at initiation and during venetoclax dose titration phase (see section 4.3). Dose reduction of venetoclax is required as

instructed in venetoclax prescribing information during steady daily dosing; close monitoring for signs of toxicity is recommended.

***Interaction of voriconazole with the following agents may result in increased exposure to these drugs. Careful monitoring and/or dosage adjustment should be considered:***

#### **Ciclosporin (CYP3A4 substrate)**

In stable, renal transplant recipients, voriconazole increased cyclosporin  $C_{max}$  and  $AUC_{\tau}$  by at least 13% and 70% respectively. When initiating voriconazole in patients already receiving cyclosporin, it is recommended that the cyclosporin dose be halved and cyclosporin level carefully monitored. Increased cyclosporin levels have been associated with nephrotoxicity. When voriconazole is discontinued, cyclosporin levels must be carefully monitored and the dose increased as necessary.

#### **Tacrolimus (CYP3A4 substrate)**

Voriconazole increased tacrolimus (0.1 mg/kg single dose)  $C_{max}$  and  $AUC_{\tau}$  by 117% and 221%, respectively. When initiating voriconazole in patients already receiving tacrolimus, it is recommended that the tacrolimus dose be reduced to a third of the original dose and tacrolimus levels carefully monitored. Increased tacrolimus levels have been associated with nephrotoxicity. When voriconazole is discontinued, tacrolimus levels must be carefully monitored and the dose increased as necessary.

#### **Methadone (CYP3A4 substrate)**

Repeat dose administration of oral voriconazole (400 mg every 12 hours for 1 day, then 200 mg every 12 hours for 4 days) increased the  $C_{max}$  and  $AUC_{\tau}$  of pharmacologically active R-methadone by 31% (90% CI: 22%, 40%) and 47% (90% CI: 38%, 57%) respectively in subjects receiving a methadone maintenance dose (30-100 mg daily) (see section 4.4).

#### **Short acting opiates (CYP3A4 substrate)**

In an independent publication, steady-state administration of oral voriconazole increased the  $AUC_{\infty}$  of a single dose of alfentanil by 6-fold. Reduction in the dose of alfentanil and other short acting opiates similar in structure to alfentanil and metabolised by CYP3A4 (e.g. sufentanil) should be considered when co-administered with voriconazole (see section 4.4).

#### **Fentanyl (CYP3A4 substrate)**

In an independent published study, concomitant use of voriconazole (400 mg every 12 hours on Day 1, then 200 mg every 12 hours on Day 2) with a single intravenous dose of fentanyl (5 µg/kg) resulted in an increase in the mean  $AUC_{0-\infty}$  of fentanyl by 1.4-fold (range 1.12 - 1.60-fold). When voriconazole is co-administered with fentanyl, extended and frequent monitoring of patients for respiratory depression and other fentanyl-associated adverse events is recommended, and the fentanyl dose should be reduced if warranted.

#### **Oxycodone (CYP3A4 substrate)**

In an independent publication, co-administration of multiple doses of oral voriconazole (400 mg every 12 hours on Day 1 followed by five doses of 200 mg every 12 hours on Days 2 to 4) with a single 10 mg oral dose of oxycodone on Day 3 resulted in an increase in the mean  $C_{max}$  and  $AUC_{0-\infty}$  of oxycodone by 1.7-fold (range 1.4- to 2.2-fold) and 3.6-fold (range 2.7- to 5.6-fold) respectively. The mean elimination half-life of oxycodone was also increased by 2.0-fold (range 1.4- to 2.5-fold). A reduction in oxycodone dosage may be needed during voriconazole treatment to avoid opioid related adverse effects. Extended and frequent monitoring for adverse effects associated with oxycodone and other long-acting opiates metabolised by CYP3A4 is recommended.

#### **Everolimus (CYP3A4 substrate, P-gp substrate)**

Although not studied, voriconazole is likely to significantly increase the plasma concentrations of everolimus. Co-administration of voriconazole and everolimus is not recommended because voriconazole is expected to significantly increase everolimus concentrations (see section 4.4).

### **Lemborexant (CYP3A4 substrate)**

Although not studied, voriconazole is likely to increase the plasma concentrations of lemborexant. Concomitant use of voriconazole and lemborexant should be avoided.

### **Warfarin (CYP2C9 substrate)**

Co-administration of voriconazole (300 mg twice daily) with warfarin (30 mg single dose) increased maximum prothrombin time by 93%. Close monitoring of prothrombin time is recommended if warfarin and voriconazole are co-administered.

### **Other Oral Anticoagulants (CYP2C9, CYP3A4 substrates)**

Although not studied, voriconazole may increase the plasma concentrations of coumarins and therefore may cause an increase in prothrombin time. If patients receiving coumarin preparations are treated simultaneously with voriconazole, the prothrombin time should be monitored at close intervals and the dosage of anticoagulants adjusted accordingly.

### **Ivacaftor (CYP3A4 substrate)**

Although not studied, voriconazole is likely to increase the plasma concentrations of ivacaftor with risk of increased adverse effects. Dose reduction of ivacaftor is recommended.

### **Glasdegib (CYP3A4 substrate)**

Although not studied, voriconazole is likely to increase the plasma concentrations of glasdegib and increase risk of QTc prolongation. If concomitant use cannot be avoided, frequent ECG monitoring is recommended.

### **Tyrosine kinase inhibitors (CYP3A4 substrates) (including but not limited to: axitinib, bosutinib, cabozantinib, ceritinib, cobimetinib, dabrafenib, dasatinib, nilotinib, sunitinib, ibrutinib, ribociclib)**

Although not studied, voriconazole may increase plasma concentrations of tyrosine kinase inhibitors metabolized by CYP3A4. If concomitant use cannot be avoided, dose reduction of the tyrosine kinase inhibitor and close clinical monitoring is recommended.

### **Eszopiclone (CYP3A4 substrate)**

Although not studied, voriconazole is likely to increase the plasma concentrations and sedative effect of eszopiclone. Dose reduction of eszopiclone is recommended.

### **Tretinoin (CYP3A4 substrate)**

Although not studied, voriconazole may increase tretinoin concentrations and increase risk of adverse reactions (pseudotumor cerebri, hypercalcaemia). Dose adjustment of tretinoin is recommended during treatment with voriconazole and after its discontinuation.

### **Sulphonylureas (CYP2C9 substrates)**

Although not studied, voriconazole may increase the plasma levels of sulphonylureas, (including but not limited to: tolbutamide, glipizide, and glibenclamide) and therefore cause hypoglycaemia. Careful monitoring of blood glucose is recommended during co-administration.

### **Statins (CYP3A4 substrates)**

Although not studied, voriconazole has been shown to inhibit lovastatin metabolism *in vitro* (human liver microsomes). Therefore, voriconazole is likely to increase plasma levels of statins that are metabolised by CYP3A4. Increased statin levels have been associated with rhabdomyolysis. If concomitant administration of voriconazole with statins metabolised by CYP3A4 cannot be avoided, dose reduction of the statin should be considered.

### **Benzodiazepines (CYP3A4 substrates)**

*Midazolam (0.05 mg/kg IV single dose):* In an independent published study, Midazolam AUC<sub>0-∞</sub> increased (↑) 3.6-fold.

*Midazolam (7.5 mg oral single dose):* In an independent published study, Midazolam C<sub>max</sub> increased (↑) 3.8-fold, Midazolam AUC<sub>0-∞</sub> increased (↑) 10.3-fold.

*Other benzodiazepines (e.g., triazolam, alprazolam):* Although not studied, voriconazole is likely to increase the plasma levels of other benzodiazepines that are metabolised by CYP3A4 (e.g. triazolam and alprazolam) and lead to a prolonged sedative effect.

It is recommended that dose reduction of the benzodiazepine be considered during co-administration.

### **Vinca alkaloids (CYP3A4 substrates)**

Although not studied, voriconazole may increase the plasma levels of the vinca alkaloids (including but not limited to vincristine and vinblastine) and lead to neurotoxicity. It is therefore recommended that dose adjustment of the vinca alkaloid be considered.

### **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)**

Voriconazole increased C<sub>max</sub> and AUC of ibuprofen (400 mg single dose) by 20% and 100% respectively. Voriconazole increased C<sub>max</sub> and AUC of diclofenac (50 mg single dose) by 114% and 78% respectively. Frequent monitoring for adverse events and toxicity relating to NSAIDs is recommended. Adjustment of dosage of NSAIDs may be needed.

***No significant pharmacokinetic interactions were observed when voriconazole was co-administered with the following agents. No dosage adjustment for these agents is recommended:***

#### **Corticosteroids**

##### **Prednisolone (CYP3A4 substrate)**

Voriconazole increased C<sub>max</sub> and AUC<sub>τ</sub> of prednisolone (60 mg single dose) by 11% and 34%, respectively. No dosage adjustment is recommended.

Patients on long-term treatment with voriconazole and corticosteroids (including inhaled corticosteroids e.g., budesonide) should be carefully monitored for adrenal cortex dysfunction both during treatment and when voriconazole is discontinued (see Section 4.4).

##### **Digoxin (P-glycoprotein mediated transport)**

Voriconazole had no significant effect on C<sub>max</sub> and AUC<sub>τ</sub> of digoxin (0.25 mg once daily).

##### **Mycophenolic acid (UDP-glucuronyl transferase substrate)**

Voriconazole had no effect on the C<sub>max</sub> and AUC<sub>τ</sub> of mycophenolic acid (1 g single dose).

## **3. Two-way interactions**

### **Phenytoin (CYP2C9 substrates and potent CYP450 inducer)**

Concomitant use of voriconazole and phenytoin should be avoided unless the benefit outweighs the risk. Phenytoin (300 mg once daily) decreased the C<sub>max</sub> and AUC<sub>τ</sub> of voriconazole by 49% and 69%, respectively. Voriconazole (400 mg twice daily) increased C<sub>max</sub> and AUC<sub>τ</sub> of phenytoin (300 mg once daily) by 67% and 81%, respectively.

Phenytoin may be co-administered with voriconazole if the maintenance dose of voriconazole is increased to 5 mg/kg intravenously twice daily or from 200 mg to 400 mg orally, twice daily (100 mg to 200 mg orally, twice daily in patients less than 40 kg). Careful monitoring of phenytoin plasma levels is recommended when phenytoin is co-administered with voriconazole.

### **Omeprazole (CYP2C19 inhibitor; CYP2C19 and CYP3A4 substrate)**

Omeprazole (40 mg once daily) increased voriconazole  $C_{max}$  and  $AUC_{\tau}$  by 15% and 41%, respectively. No dosage adjustment of voriconazole is recommended. Voriconazole increased omeprazole  $C_{max}$  and  $AUC_{\tau}$  by 116% and 280%, respectively. When initiating voriconazole in patients already receiving omeprazole, it is recommended that the omeprazole dose be halved. The metabolism of other proton pump inhibitors which are CYP2C19 substrates may also be inhibited by voriconazole.

### **Fluconazole (CYP2C9, CYP2C19 and CYP3A4 inhibitor)**

Fluconazole (200 mg once daily) increased the  $C_{max}$  and  $AUC_{\tau}$  of voriconazole by 57% and 79%, respectively. The  $C_{max}$  and  $AUC_{\tau}$  of fluconazole were not determined. The reduced dose and/or frequency of voriconazole and fluconazole that would eliminate this effect have not been established. Monitoring for voriconazole-associated adverse events is recommended if voriconazole is used sequentially after fluconazole.

### **Oral Contraceptives (CYP3A4 substrate)**

Co-administration of voriconazole and an oral contraceptive (norethisterone 1 mg and ethinylestradiol 0.035 mg once daily) in healthy female subjects resulted in increases in the  $C_{max}$  and  $AUC_{\tau}$  of ethinylestradiol (36% and 61% respectively) and norethisterone (15% and 53% respectively). Voriconazole  $C_{max}$  and  $AUC_{\tau}$  increased by 14% and 46% respectively. Oral contraceptives containing doses other than norethisterone 1 mg and ethinylestradiol 0.035 mg have not been studied. As the ratio between norethisterone and ethinylestradiol remained similar during interaction with voriconazole, their contraceptive activity would probably not be affected. Monitoring for adverse events related to oral contraceptives is recommended during co-administration.

### **Indinavir (CYP3A4 inhibitor and substrate)**

Indinavir (800 mg three times daily) had no significant effect on voriconazole  $C_{max}$  and  $AUC_{\tau}$ . Voriconazole did not have a significant effect on  $C_{max}$ ,  $C_{min}$  and  $AUC_{\tau}$  of indinavir.

### **Other HIV protease inhibitors (CYP3A4 substrates and inhibitors)**

*In vitro* studies suggest that voriconazole may inhibit the metabolism of HIV protease inhibitors (including but not limited to saquinavir, amprenavir and nelfinavir). *In vitro* studies also show that the metabolism of voriconazole may be inhibited by HIV protease inhibitors. Patients should be carefully monitored for drug toxicity during the co-administration of voriconazole and HIV protease inhibitors.

### **Efavirenz (a non-nucleoside reverse transcriptase inhibitor [CYP450 inducer; CYP3A4 inhibitor and substrate])**

Use of standard doses of voriconazole with efavirenz doses of 400 mg once daily or higher is contraindicated (see section 4.3).

In healthy subjects, steady state efavirenz (400 mg oral once daily) decreased the steady state  $C_{max}$  and  $AUC_{\tau}$  of voriconazole by an average of 61% and 77%, respectively. In the same study, voriconazole at steady state (400 mg orally every 12 hours for 1 day, then 200 mg orally every 12 hours for 8 days) increased the steady state  $C_{max}$  and  $AUC_{\tau}$  of efavirenz by an average of 38% and 44% respectively, in the same subjects.

In a separate study in healthy subjects, voriconazole dose of 300 mg twice daily in combination with low dose efavirenz (300 mg once daily) did not lead to sufficient voriconazole exposure.

Following co-administration of voriconazole 400 mg twice daily with efavirenz 300 mg orally once daily in healthy subjects, the  $AUC_{\tau}$  of voriconazole was decreased by 7%, and  $C_{max}$  was increased by 23%, compared to voriconazole 200 mg twice daily alone. The  $AUC_{\tau}$  of efavirenz was increased by 17% and  $C_{max}$  was equivalent compared to efavirenz 600 mg once daily alone. These differences were not considered to be clinically significant.



## Pregnancy

### *Pregnancy category B3*

There are no adequate studies in pregnant women. Studies in rats have shown reproductive toxicity, including teratogenicity (cleft palates) at oral doses of  $\geq 10$  mg/kg/day and disturbance of parturition (dystocia) at oral doses of  $\geq 3$  mg/kg/day, with exposures similar to or below those expected in humans at maintenance dosing. Voriconazole was not teratogenic in rabbits at oral doses of up to 100 mg/kg/day, but produced an increase in post-implantation loss and a decrease in foetal body weight, with exposures approximately 4 times the expected human exposure. Voriconazole must not be used during pregnancy except in patients with severe or potentially life-threatening fungal infections in whom voriconazole may be used if the benefit to the mother clearly outweighs the potential risk to the foetus.

### **Women of childbearing potential**

Women of childbearing potential must always use effective contraception during treatment.

### **Breast-feeding**

It is not known whether voriconazole is excreted in the milk of laboratory animals or in human breast milk. Breast-feeding must be stopped on initiation of treatment with voriconazole.

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

Voriconazole may cause changes to vision, including blurring, altered/enhanced visual perception and/or photophobia. Patients must avoid potentially hazardous tasks, such as driving or operating machinery whilst experiencing these symptoms. Patients should be advised not to drive at night while taking voriconazole.

### **4.8 Undesirable effects**

#### **Clinical trial data**

The safety of voriconazole in adults is based on an integrated safety database of more than 2000 subjects (1603 patients in therapeutic studies). This represents a heterogeneous population, containing patients with haematological malignancy, HIV infected patients with oesophageal candidiasis and refractory fungal infections, non-neutropenic patients with candidaemia or aspergillosis and healthy volunteers.

The table below includes all causality adverse reactions in 1603 adults from pooled therapeutic studies. The most commonly reported adverse events were visual impairment, liver function test abnormal, pyrexia, rash, vomiting, nausea, diarrhoea, headache, peripheral oedema and abdominal pain. The severity of the adverse events was generally mild to moderate. No clinically significant differences were seen when the safety data were analysed by age, race, or gender.

#### **All cause adverse reactions from pooled therapeutic studies**

<b>MedDRA system organ class frequency*</b>	<b>Adverse drug reactions</b>
<b>Infections and infestations</b>	
Common	Sinusitis
Uncommon	Pseudomembraneous colitis
<b>Blood and lymphatic system disorders</b>	
Common	Agranulocytosis <sup>a</sup> , pancytopenia, thrombocytopenia <sup>b</sup> , leukopenia, anaemia
Uncommon	Bone marrow failure, lymphadenopathy, eosinophilia
Rare	Disseminated intravascular coagulation
<b>Immune system disorders</b>	
Uncommon	Hypersensitivity

Rare	Anaphylactoid reaction
<b>Endocrine disorders</b>	
Uncommon	Adrenal insufficiency, hypothyroidism
Rare	Hyperthyroidism
<b>Metabolism and nutrition disorders</b>	
Very common	Oedema peripheral
Common	Hypoglycaemia, hypokalaemia, hyponatraemia
<b>Psychiatric disorders</b>	
Common	Depression, hallucination, anxiety, insomnia, agitation, confusional state
<b>Nervous system disorders</b>	
Very common	Headache
Common	Syncope, tremor, hypertonia <sup>c</sup> , paraesthesia, somnolence, dizziness
Uncommon	Brain oedema, encephalopathy <sup>d</sup> , extrapyramidal disorder <sup>e</sup> , neuropathy peripheral, ataxia, hypoaesthesia, dysgeusia
Rare	Hepatic encephalopathy, Guillain-Barre syndrome, seizure, nystagmus
<b>Eye disorders</b>	
Very Common	Visual impairment <sup>f</sup>
Common	Retinal haemorrhage
Uncommon	Papilloedema <sup>g</sup> , oculogyric crisis, diplopia, scleritis, blepharitis
Rare	Optic atrophy, optic nerve disorder <sup>h</sup> , corneal opacity
<b>Ear and labyrinth disorders</b>	
Uncommon	Hypoacusis , vertigo, tinnitus
<b>Cardiac disorders</b>	
Common	Arrhythmia supraventricular, tachycardia, bradycardia
Uncommon	Ventricular fibrillation, ventricular extrasystoles, ventricular tachycardia, electrocardiogram QT prolonged, supraventricular tachycardia
Rare	Atrioventricular (AV) complete block, bundle branch block, nodal rhythm, <i>torsade de pointes</i>
<b>Vascular disorders</b>	
Common	Hypotension, phlebitis
Uncommon	Thrombophlebitis, lymphangitis
<b>Respiratory, thoracic and mediastinal disorders</b>	
Common	Acute respiratory distress syndrome, pulmonary oedema
<b>Gastrointestinal disorders</b>	
Very common	Diarrhoea, vomiting, nausea
Common	Cheilitis, dyspepsia, abdominal pain, constipation, gingivitis
Uncommon	Peritonitis, pancreatitis, swollen tongue, duodenitis, gastroenteritis, glossitis
<b>Hepatobiliary disorders</b>	
Very common	Liver function test abnormal
Common	Jaundice, jaundice cholestatic
Uncommon	Hepatic failure, hepatitis <sup>i</sup> , hepatomegaly, cholecystitis, cholelithiasis
<b>Skin and subcutaneous tissue disorders</b>	
Very common	Rash
Common	Dermatitis exfoliative, alopecia, purpura, rash maculopapular, pruritus
Uncommon	Stevens-Johnson syndrome <sup>g</sup> , photosensitivity reaction, urticaria
Rare	Toxic epidermal necrolysis <sup>g</sup> , drug reaction with eosinophilia and systemic symptoms (DRESS) <sup>g</sup> , angioedema,



	pseudoporphyria, erythema multiforme, psoriasis, drug eruption, eczema
<b>Musculoskeletal, connective tissue and bone disorders</b>	
Common	Back pain
Uncommon	Arthritis
<b>Renal and urinary disorders</b>	
Common	Renal failure acute, haematuria
Uncommon	Renal tubular necrosis, proteinuria, nephritis
<b>General disorders</b>	
Very common	Pyrexia
Common	Chest pain, face oedema <sup>l</sup> , asthenia, chills
Uncommon	Influenza-like illness
<b>Investigations</b>	
Common	Blood creatinine increased
Uncommon	Blood urea increased, blood cholesterol increased

\*Frequencies are categorised as follows: very common  $\geq 10\%$ ; common from  $\geq 1\%$  to  $< 10\%$ ; uncommon from  $\geq 0.1\%$  to  $< 1\%$ ; rare from  $0.01\%$  to  $< 0.1\%$

<sup>a</sup> Includes febrile neutropenia and neutropenia

<sup>b</sup> Includes immune thrombocytopenic purpura

<sup>c</sup> Includes nuchal rigidity and tetany

<sup>d</sup> Includes hypoxic-ischaemic encephalopathy and metabolic encephalopathy

<sup>e</sup> Includes akathisia and parkinsonism

<sup>f</sup> See section 4.4 and "Visual Impairment" in section 4.8

<sup>g</sup> See section 4.4

<sup>h</sup> Prolonged optic neuritis has been reported post-marketing. See section 4.4

<sup>l</sup> Includes drug-induced liver injury, hepatitis toxic, hepatocellular injury and hepatotoxicity

<sup>j</sup> Includes periorbital oedema, lip oedema and oedema mouth

### Adverse events reported in comparative therapeutic studies at a rate of $\geq 1\%$ possibly related to therapy or causality unknown

	Voriconazole vs Fluconazole (oral therapy)		Voriconazole vs Conventional Amphotericin B (IV/oral therapy)	
	Voriconazole N = 200 N (%)	Fluconazole N = 191 N (%)	Voriconazole N = 196 N (%)	Amphotericin B* N = 185 N (%)
<b>Blood and Lymphatic System Disorders</b>				
Thrombocytopenia	-	-	2 (1.0)	2 (1.1)
Anaemia	-	-	-	5 (2.7)
<b>Metabolism and Nutrition Disorders</b>				
Hypokalaemia	-	-	-	36 (19.5)
Hypomagnesaemia	-	-	2 (1.0)	10 (5.4)
<b>Psychiatric Disorders</b>				
Hallucinations	-	-	10 (5.1)	-
<b>Nervous System Disorders</b>				
Dizziness	-	2 (1.0)	5 (2.6)	-
<b>Eye Disorders</b>				
Abnormal vision	31 (15.5)	8 (4.2)	55 (28.1)	1 (0.5)
Photophobia	5 (2.5)	2 (1.0)	7 (3.6)	-
Chromatopsia	2 (1.0)	-	2 (1.0)	-
<b>Cardiac Disorders</b>				
Tachycardia	-	-	5 (2.6)	5 (2.7)
<b>Vascular Disorders</b>				
Hypertension	-	-	-	2 (1.1)
Hypotension	-	-	-	3 (1.6)
Vasodilatation	-	-	2 (1.0)	2 (1.1)

<b>Gastrointestinal Disorders</b>				
Abdominal pain	-	-	5 (2.6)	6 (3.2)
Nausea	2 (1.0)	3 (1.6)	14 (7.1)	29 (15.7)
Vomiting	2 (1.0)	-	11 (5.6)	18 (9.7)
Diarrhoea	-	-	3 (1.5)	6 (3.2)
Dry mouth	-	-	3 (1.5)	-
<b>Hepatobiliary Disorders</b>				
Cholestatic jaundice	3 (1.5)	-	4 (2.0)	-
Bilirubinaemia	-	-	-	3 (1.6)
<b>Skin and Subcutaneous tissue disorders</b>				
Headache	-	-	7 (3.6)	8 (4.3)
Rash	3 (1.5)	1 (0.5)	13 (6.6)	7 (3.8)
Pruritus	-	-	2 (1.0)	2 (1.1)
Maculopapular rash	3 (1.5)	-	-	-
<b>Renal and Urinary Disorders</b>				
Kidney function abnormal	-	-	4 (2.0)	40 (21.6)
Acute kidney failure	-	-	-	11 (5.9)
<b>General Disorders and Administration Site Conditions</b>				
Peripheral oedema	-	-	7 (3.6)	9 (4.9)
Pyrexia	-	-	7 (3.6)	25 (13.5)
Chills	-	-	-	36 (19.5)
Chest pain	-	-	4 (2.0)	2 (1.1)
<b>Investigations</b>				
Liver function tests abnormal	6 (3.0)	2 (1.0)	9 (4.6)	4 (2.2)
Alkaline phosphatase increased	10 (5.0)	3 (1.6)	6 (3.1)	4 (2.2)
Hepatic enzymes increased	3 (1.5)	-	7 (3.6)	5 (2.7)
AST (SGOT) increased	8 (4.0)	2 (1.0)	-	-
Creatinine increased	-	-	-	59 (31.9)
ALT (SGPT) increased	6 (3.0)	2 (1.0)	3 (1.5)	-

\*Amphotericin B followed by other licensed antifungal therapy

## Description of selected adverse reactions

### Visual impairment

In clinical trials, visual impairments (including blurred vision, photophobia, chloropsia, chromatopsia, colour blindness, cyanopsia, eye disorder, halo vision, night blindness, oscillopsia, photopsia, scintillating scotoma, visual acuity reduced, visual brightness, visual field defect, vitreous floaters and xanthopsia) with voriconazole were very common. These visual impairments were transient and fully reversible, with the majority spontaneously resolving within 60 minutes. There was evidence of attenuation with repeated doses of voriconazole. The visual impairments were generally mild, rarely resulted in discontinuation and were not associated with long-term sequelae. Visual impairments may be associated with higher plasma concentrations and/or doses.

There have been post-marketing reports of prolonged visual adverse events (see section 4.4).

The mechanism of action is unknown, although the site of action is most likely to be within the retina.

In a study in healthy volunteers investigating the impact of voriconazole on retinal function, voriconazole caused a decrease in the electroretinogram (ERG) waveform amplitude. The ERG measures electrical currents in the retina. The ERG changes did not progress over 29 days of treatment and were fully reversible on withdrawal of voriconazole.

The long-term effect of voriconazole (median 169 days; range 5-353 days) on visual function was evaluated in subjects with paracoccidioidomycosis. Voriconazole had no clinically relevant effect on visual function as assessed by testing visual acuity, visual fields, colour vision and contrast sensitivity. There were no signs of retinal toxicity. 17/35 voriconazole subjects experienced visual

adverse events. These events did not lead to discontinuation, were generally mild, occurred in the first week of therapy and resolved during continued voriconazole therapy.

## **Dermatological reactions**

Dermatological reactions were very common in patients treated with voriconazole. In clinical trials, rashes were reported by 19% (278/1493) of voriconazole treated patients, but these patients had serious underlying diseases and were receiving multiple concomitant medications. The majority of rashes were of mild to moderate severity. Patients have developed serious cutaneous reactions, including Stevens-Johnson syndrome (uncommon), toxic epidermal necrolysis (rare) and erythema multiforme (rare) during treatment with voriconazole (see section 4.4).

If patients develop a rash they should be monitored closely and voriconazole discontinued if lesions progress. Photosensitivity reactions have been reported, especially during long-term therapy (see section 4.4).

Dermatological adverse reactions potentially related to phototoxicity (pseudoporphyria, cheilitis, and cutaneous lupus erythematosus) are also reported with voriconazole. Sun avoidance and photoprotection are recommended for all patients. If phototoxicity occurs, voriconazole discontinuation and dermatological evaluation should be considered (see section 4.4).

There have been post-marketing reports of cutaneous lupus erythematosus and squamous cell carcinoma (SCC including cutaneous SCC *in situ*, or Bowen's disease) (see section 4.4).

## **Liver function tests**

The overall incidence of clinically significant transaminase abnormalities in the voriconazole clinical program was 13.4% (200/1493) of subjects treated with voriconazole. Liver function test abnormalities may be associated with higher plasma concentrations and/or doses. The majority of abnormal liver function tests either resolved during treatment without dose adjustment or following dose adjustment, including discontinuation of therapy.

Voriconazole has been associated with cases of serious hepatic toxicity, in patients with other serious underlying conditions. This includes cases of jaundice, and cases of hepatitis and hepatic failure leading to death (see section 4.4).

## **Paediatric use**

**The information relating to paediatric use has been generated using only oral suspension and intravenous dose forms of voriconazole and these presentations are not available in this product range.**

The safety of voriconazole was investigated in 245 paediatric patients aged 2 to <12 years who were treated with voriconazole in pharmacokinetic studies (87 paediatric patients) and in compassionate use programs (158 paediatric patients). The adverse event profile of these 245 paediatrics was similar to adults. A higher frequency of liver enzyme elevations reported as adverse events was observed in paediatric patients as compared to adults.

Post-marketing data suggest that there might be a higher occurrence of skin reactions in the paediatric population compared to adults.

There have been post-marketing reports of pancreatitis in paediatric patients.

## **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

Clinical data on overdose with this agent is scant.

In clinical trials there were three cases of accidental overdose. All occurred in paediatric patients, who received up to five times the recommended intravenous dose of voriconazole. A single adverse event of photophobia of 10 minutes duration was reported.

There is no known antidote to voriconazole. It is recommended that treatment of overdose is symptomatic and supportive.

Monitor potassium, full blood count and liver function following an overdose.

Consider administration of activated charcoal in the event of a potentially toxic ingestion. Activated charcoal is most effective when administered within **one hour** of ingestion. In patients who are not fully conscious or have impaired gag reflex, consideration should be given to administering activated charcoal via nasogastric tube once the airway is protected.

Voriconazole is haemodialysed with a clearance of 121 ml/min. The intravenous vehicle, SBECD, is haemodialysed with a clearance of 55 ml/min. In an overdose, haemodialysis may assist in the removal of voriconazole and SBECD from the body.

For further advice on management of overdose please contact the National Poisons Information Centre (0800 POISON or 0800 764 766).

---

## 5. Pharmacological Properties

---

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antimycotics for systemic use, ATC code: J02AC03

#### Mechanism of action

Voriconazole is a triazole antifungal agent. Voriconazole's primary mode of action is the inhibition of fungal cytochrome P-450-mediated 14 $\alpha$ -lanosterol demethylation, an essential step in ergosterol biosynthesis. Voriconazole is more selective than some other azole drugs for fungal as opposed to various mammalian cytochrome P-450 enzyme systems. The subsequent loss of normal sterols correlates with the accumulation of 14 $\alpha$ -methyl sterols in fungi and may be responsible for its fungistatic/fungicidal activity.

*In vitro*, voriconazole displays broad-spectrum antifungal activity with high antifungal potency against *Candida* species (including fluconazole resistant *C. krusei* and resistant strains of *C. glabrata* and *C. albicans*) and fungicidal activity against all *Aspergillus* species tested. In addition, voriconazole shows *in vitro* activity against emerging fungal pathogens, such as *Scedosporium* or *Fusarium*, some isolates of which have limited susceptibility to existing antifungal agents. In addition, voriconazole exhibits *in vitro* fungicidal activity against some strains within these species.

In animal studies there is a correlation between Minimum Inhibitory Concentration (MIC) values and efficacy against experimental mycoses. Furthermore, there appears to be a correlation between minimum inhibitory concentration values and clinical outcome for *Candida* species.

#### Microbiology

Clinical efficacy (with partial or complete response, see section 5.2) has been demonstrated for *Aspergillus* spp. including *A. flavus*, *A. fumigatus*, *A. terreus*, *A. niger*, *A. nidulans*, *Candida* spp. , including *C. albicans*, *C. dubliniensis*, *C. glabrata*, *C. inconspicua*, *C. krusei*, *C. parapsilosis*, *C. tropicalis* and *C. guilliermondii*, *Scedosporium* spp., including *S. apiospermum*, *S. prolificans* and *Fusarium* spp.

Other treated fungal infections (with often partial or complete response) included isolated cases of *Alternaria* spp., *Blastomyces dermatitidis*, *Blastoschizomyces capitatus*, *Cladosporium* spp., *Coccidioides immitis*, *Conidiobolus coronatus*, *Cryptococcus neoformans*, *Exserohilum rostratum*, *Exophiala spinifera*, *Fonsecaea pedrosoi*, *Madurella mycetomatis*, *Paecilomyces lilacinus*, *Penicillium* spp including *P. marneffeii*, *Phialophora richardsiae*, *Scopulariopsis brevicaulis* and *Trichosporon* spp including *T. beigellii* infections.

*In vitro* activity against clinical isolates has been observed for *Acremonium* spp., *Alternaria* spp., *Bipolaris* spp., *Cladophialophora* spp, *Histoplasma capsulatum*, with most strains being inhibited by concentrations of voriconazole in the range 0.05 to 2 micrograms/mL.

*In vitro* activity against the following pathogens has been shown, but the clinical significance is unknown: *Curvularia* spp. and *Sporothrix* spp.

Specimens for fungal culture and other relevant laboratory studies (serology, histopathology) should be obtained to isolate and identify causative organisms prior to therapy. Therapy may be instituted before the results of the cultures and other laboratory studies are known; however, once these results become available, anti-infective therapy should be adjusted accordingly.

Clinical isolates with decreased susceptibility to voriconazole have been identified. However, elevated MIC did not always correlate with clinical failure and clinical success has been observed in patients infected with organisms resistant to other azoles. Correlation of *in vitro* activity with clinical outcome is difficult owing to the complexity of the patients studied in clinical trials; breakpoints for voriconazole remain to be established.

## **Clinical trials**

### ***Duration of treatment***

In clinical trials, 561 patients received voriconazole therapy for greater than 12 weeks, with 136 subjects receiving voriconazole for over 6 months.

### ***Clinical experience***

Successful outcome in this section is defined as complete or partial response.

### **Invasive aspergillosis**

The efficacy and survival benefit of voriconazole compared to conventional amphotericin B in the primary treatment of acute invasive aspergillosis was demonstrated in an open, randomised, multicentre study. The total duration of treatment was 12 weeks. Patients could be switched to Other Licensed Antifungal Therapy (OLAT) during the 12 week study period, either due to lack of efficacy of the initial randomised treatment (IRT) or for safety/tolerability reasons. Efficacy was assessed at 12 weeks (primary endpoint) and at the end of initial randomised therapy (IRT) by a Data Review Committee. Voriconazole was administered intravenously with a loading dose of 6 mg/kg every 12 hours for the first 24 hours followed by a maintenance dose of 4 mg/kg every 12 hours for a minimum of seven days, after which the oral formulation at a dose of 200 mg twice a day could be used. Patients in the comparator group received conventional amphotericin B as a slow infusion at a daily dose of 1.0-1.5 mg/kg/day.

In this study, 277 immunocompromised patients with invasive aspergillosis (modified intent to treat population) were evaluated. At week 12, a satisfactory global response (complete or partial resolution of all attributable symptoms, signs, radiographic/bronchoscopic abnormalities present at baseline) was seen in 53% of patients in the voriconazole group compared to 31% of patients in the comparator group. At the end of IRT, a satisfactory global response was seen in 53.5% of voriconazole treated patients compared to 21.8% of conventional amphotericin B treated patients. Subjects in the voriconazole group were treated longer than subjects in the amphotericin B group before switching to OLAT (median duration of IRT was 73 vs 12 days respectively). OLAT included liposomal amphotericin B formulations, itraconazole and flucytosine. Survival in the voriconazole group (71%) was greater than in the comparator group (58%) at week 12.

## Efficacy of voriconazole in the primary treatment of acute invasive aspergillosis

	<b>Satisfactory Global response</b>	<b>Survival at Week 12<sup>b</sup></b>	<b>Discontinuations due to AEs<sup>c</sup></b>
Voriconazole	76/144 (53%) <sup>e</sup>	102/144 (71%)	40/196 (20%)
Comparator	42/133 (31%) <sup>d,e</sup>	77/133 (58%)	103/185 (56%)
	P <0.0001	P = 0.02	--

<sup>a</sup> MITT (modified intent to treat) population assessed by independent Data Review Committee

<sup>b</sup> MITT population proportion of subjects alive

<sup>c</sup> Safety population discontinuations from initial randomised treatment due to adverse events/laboratory abnormalities (all causality)

<sup>d</sup> Amphotericin B

<sup>e</sup> Response rate stratified by protocol

The results of this comparative trial confirmed the results of an earlier trial in the primary treatment of patients with acute invasive aspergillosis. In this earlier study, an overall success rate of 54% was seen in patients treated with voriconazole.

Voriconazole successfully treated cerebral, sinus, pulmonary and disseminated aspergillosis in patients with bone marrow and solid organ transplants, haematological malignancies, cancer and AIDS.

### Serious candida infections

#### Systemic candida infections

The efficacy of voriconazole compared to the regimen of (conventional) amphotericin B followed by fluconazole in the primary treatment of candidaemia was demonstrated in an open comparative study. Three hundred and seventy (370) non-neutropenic patients with documented candidaemia (positive blood culture and clinical signs of infection) were included in the study, of which 248 were treated with voriconazole. The patient population was seriously ill, with approximately 50% of subjects in the intensive care unit and 40% mechanically ventilated at baseline. The median treatment duration was 15 days in both treatment arms. A successful response (resolution/improvement in all clinical signs and symptoms of infection, blood cultures negative for *Candida*, infected deep tissue sites negative for *Candida*) was seen in 41% of patients in both treatment arms 12 weeks after the End of Therapy (EOT). In this analysis, patients who did not have an assessment 12 weeks after EOT were set to failure. According to a secondary analysis, which compared response rates at the latest time point most relevant to the evaluation of the patient (EOT, or 2, 6, or 12 weeks after EOT, which is more appropriate for this type of study), voriconazole and the regimen of amphotericin B followed by fluconazole had response rates of 65% and 71%, respectively. Forty-seven percent of isolated pathogens in the voriconazole treatment group were from non-*albicans* species, including *C.glabrata* and *C.krusei*, although *C.albicans* was the most commonly isolated species in the small subgroup of patients (n = 14) with confirmed deep tissue infections. When considering response at 12 weeks after EOT by pathogen, the success rates were comparable between voriconazole (43%) and amphotericin B followed by fluconazole (46%) for baseline *Candida albicans* infections. Success rates were more favourable with voriconazole (38.6%) than with amphotericin followed by fluconazole (32.3%) for baseline non-*albicans* infections.

#### Refractory candida infections

A further study (the combined results of 2 open-label, non-comparative trials) assessed voriconazole in the treatment of fungal infections in patients refractory to, or intolerant of, other antifungal medications. Of the 301 patients assessed for efficacy, 87 patients had serious candidiasis: 38 had oesophageal candidiasis and 47 had invasive candidiasis, of which 26 patients had deep tissue *Candida* infections. The median duration of IV therapy was 11 days (range 1-138 days) and of oral therapy was 81 days (range 1-326 days). Overall 25/47 (53.2%) invasive candidiasis subjects had a successful response, with 16/47 (34.0%) having a complete response and 9/47 (19.1%) having a

partial response; 6/47 (12.8%) were assessed as stable. Of the subjects with deep tissue *Candida* infection, 14/26 (53.8%) had a successful response, with 8/26 (30.8%) having a complete response, 6/26 (23.1%) having a partial response and 5/26 (19.2%) assessed as stable.

### Oesophageal candidiasis

Another study was a randomised, double-blind, comparative study versus oral fluconazole in immunocompromised patients with endoscopically-proven oesophageal candidiasis. 200 patients were randomised to receive voriconazole (200 mg twice daily) and 191 to receive fluconazole (400 mg once daily on day 1 followed by 200 mg once daily from day 2 onwards). Over half of the patients in each group had advanced AIDS with CD4 cell counts < 50 cells/microlitres. Outcome was assessed by repeat endoscopy at day 43 or the end of therapy. Voriconazole and fluconazole showed equivalent efficacy against oesophageal candidiasis as per protocol and intention to treat analysis.

### **Efficacy of voriconazole in the treatment of oesophageal candidiasis**

Treatment	Success/Total (%)	
	PP	ITT
<b>Voriconazole</b>	113/115 (98%)	175/200 (88%)
<b>Fluconazole</b>	134/141 (95%)	171/191 (90%)

### **Other serious fungal pathogens**

The efficacy, safety and tolerability of voriconazole in the treatment of systemic and invasive fungal infections in patients failing, or intolerant to other therapy, or for invasive fungal infections due to pathogens for which there is no licensed therapy was assessed in two, open, non-comparative studies. A total of 301 patients were evaluated for efficacy, of whom 72 cases had invasive infections due to fungal pathogens other than *Aspergillus* spp. or *Candida* spp.

Patients received an initial intravenous loading dose of 6 mg/kg every 12 hours or an oral loading dose of 400 mg for the first 24 hours, followed by maintenance dosing with 4 mg/kg every 12 hours or 200 mg twice a day, respectively, for up to 12 weeks. The primary endpoint was satisfactory global response at End of Therapy, defined as 'complete' or 'partial' global response.

Overall 39/72 (54.2%) subjects with other (non-*Aspergillus*, non-*Candida*) serious fungal infections had a satisfactory global outcome at end of voriconazole therapy.

In pooled analyses of patients enrolled across the development program, including those from the combined studies, voriconazole was shown to be effective against the following additional fungal pathogens:

*Scedosporium* spp.- Successful response to voriconazole therapy was seen in 16 of 28 patients with *S. apiospermum* and in 2 of 7 patients with *S. prolificans* infection. In addition, a successful response was seen in 1 of 3 patients with mixed organism infections.

*Fusarium* spp.- Seven of 17 patients were successfully treated with voriconazole. Of these 7 patients, 3 had eye, 1 had sinus, and 3 had disseminated infection. Four additional patients with fusariosis had an infection caused by several organisms; 2 of them had a successful outcome.

The majority of patients receiving voriconazole treatment for rare fungal infections were intolerant of, or refractory to, prior antifungal therapy.

Other successfully treated fungal infections included isolated cases of: *Alternaria* spp., *Blastomyces dermatitidis*, *Blastoschizomyces capitatus*, *Cladosporium* spp., *Coccidioides immitis*, *Conidiobolus coronatus*, *Cryptococcus neoformans*, *Exserohilum rostratum*, *Exophiala spinifera*, *Fonsecaea*

*pedrosoi*, *Madurella mycetomatis*, *Paecilomyces lilacinus*, *Penicillium* spp including *P. marneffeii*, *Phialophora richardsiae*, *Scopulariopsis brevicaulis*, and *Trichosporon* spp. including *T. beigelii* infections.

### **Paediatric use**

**The information relating to paediatric use has been generated using only oral suspension and intravenous dose forms of voriconazole and these presentations are not available in this product range.**

Fifty-three paediatric patients aged 2 to <18 years were treated with voriconazole in two prospective, open-label, non-comparative, multi-centre clinical trials. One study enrolled 31 patients with possible proven or probable invasive aspergillosis (IA), of whom 14 patients had proven or probable IA and were included in the MITT efficacy analyses. The second study enrolled 22 patients with invasive candidiasis including candidaemia (ICC), or oesophageal candidiasis (EC) requiring either primary or salvage therapy, of whom 17 patients were included in the MITT efficacy analyses. Of the total of 31 patients included in the MITT analyses, 14 patients were 2 to <12 years old (5 patients with IA, and 9 patients with ICC or EC) and 17 patients were 12 to <18 years old (9 patients with IA, and 8 patients with ICC or EC). The overall rates of global response were 64.3% (9/14) at 6 weeks for patients with IA 85.7% (6/7) at EOT for patients with ICC, and 70% (7/10) at EOT for patients with EC. In subjects with IA, the success rate was 40% (2/5) for patients 2 to <12 years and 77.8% (7/9) for patients 12 to <18 years of age.

### **Clinical studies examining QT interval**

A placebo-controlled, randomised, single-dose, crossover study to evaluate the effect on the QT interval of healthy volunteers was conducted with three oral doses of voriconazole and ketoconazole. The placebo-adjusted mean maximum increases in QTc from baseline after 800, 1200 and 1600 mg of voriconazole were 5.1, 4.8, and 8.2 msec respectively and 7.0 msec for ketoconazole 800 mg. No subject in any group had an increase in QTc of  $\geq 60$  msec from baseline. No subject experienced an interval exceeding the potentially clinically relevant threshold of 500 msec. Subjects who were CYP2C19 genotype poor metabolisers were excluded from this study however the dose of 1600 mg voriconazole achieved plasma concentrations of approximately 5,400 to 16,900 nanograms/mL which covered the exposure seen in 95% of patients in Phase 2/3 trials where poor metabolisers were not excluded.

## **5.2 Pharmacokinetic properties**

### **General pharmacokinetic characteristics**

The pharmacokinetics of voriconazole have been characterised in healthy subjects, special populations and patients. During oral administration of 200 mg or 300 mg twice daily for 14 days in patients at risk of aspergillosis (mainly patients with malignant neoplasms of lymphatic or haematopoietic tissue), the observed pharmacokinetic characteristics of rapid and consistent absorption, accumulation and non-linear pharmacokinetics were in agreement with those observed in healthy subjects.

The pharmacokinetics of voriconazole are non-linear due to saturation of its metabolism. Greater than proportional increase in exposure is observed with increasing dose. It is estimated that, on average, increasing the oral dose from 200 mg twice daily to 300 mg twice daily leads to a 2.5-fold increase in exposure ( $AUC_{\tau}$ ) (area under the plasma concentration time curve over the 12-hour dosing interval) while increasing the intravenous dose from 3 mg/kg twice daily to 4 mg/kg twice daily produces a 2.3-fold increase in exposure. When the recommended intravenous or oral loading dose regimens are administered, plasma concentrations close to steady state are achieved within the first 24 hours of dosing. Without the loading dose, accumulation occurs during twice daily multiple dosing with steady-state plasma voriconazole concentrations being achieved by day 6 in the majority of subjects.



## Absorption

Voriconazole is rapidly and almost completely absorbed following oral administration, with maximum plasma concentrations ( $C_{max}$ ) achieved 1 to 2 hours after dosing. The oral bioavailability of voriconazole is estimated to be 96%.

When multiple doses of voriconazole are administered with high fat meals,  $C_{max}$  and  $AUC_{\tau}$  of the tablets are reduced by 34% and 24%, respectively, and  $C_{max}$  and  $AUC_{\tau}$  of the suspension are reduced by 58% and 37%, respectively.

The absorption of voriconazole is not affected by changes in gastric pH.

## Distribution

The volume of distribution at steady state for voriconazole is estimated to be 4.6 L/kg, suggesting extensive distribution into tissues. Plasma protein binding is estimated to be 58%.

Cerebrospinal fluid samples from eight patients in a compassionate programme showed detectable voriconazole concentrations in all patients.

## Biotransformation

*In vitro* studies showed that voriconazole is metabolised by the hepatic cytochrome P450 isoenzymes, CYP2C19, CYP2C9 and CYP3A4.

The inter-individual variability of voriconazole pharmacokinetics is high.

*In vivo* studies indicated that CYP2C19 is significantly involved in the metabolism of voriconazole. This enzyme exhibits genetic polymorphism. For example, 15-20% of Asian populations may be expected to be poor metabolisers. For Caucasians and Blacks the prevalence of poor metabolisers is 3-5%. Studies conducted in Caucasian and Japanese healthy subjects have shown that poor metabolisers have, on average, 4-fold higher voriconazole exposure ( $AUC_{\tau}$ ) than their homozygous extensive metaboliser counterparts. Subjects who are heterozygous extensive metabolisers have on average 2-fold higher voriconazole exposure than their homozygous extensive metaboliser counterparts.

The major metabolite of voriconazole is the N-oxide, which accounts for 72% of the circulating radiolabelled metabolites in plasma. This metabolite has minimal antifungal activity and does not contribute to the overall efficacy of voriconazole.

## Elimination

Voriconazole is eliminated via hepatic metabolism with less than 2% of the dose excreted unchanged in the urine.

After administration of a radiolabelled dose of voriconazole, approximately 80% of the radioactivity is recovered in the urine after multiple intravenous dosing and 83% in the urine after multiple oral dosing. The majority (>94%) of the total radioactivity is excreted in the first 96 hours after oral dosing.

The terminal half-life of voriconazole depends on dose and is approximately 6 hours at 200 mg (orally). Because of non-linear pharmacokinetics, the terminal half-life is not useful in the prediction of the accumulation or elimination of voriconazole.

## Pharmacokinetic/pharmacodynamic (PK/PD) relationships

In 10 therapeutic studies, the median for the average and maximum plasma concentrations in individual subjects across the studies was 2425 ng/mL (inter-quartile range 1193 to 4380 nanograms/mL) and 3742 nanograms/mL (inter-quartile range 2027 to 6302 nanograms/mL), respectively. A positive association between mean, maximum or minimum plasma voriconazole concentration and efficacy in therapeutic studies was not found.

Pharmacokinetic/pharmacodynamic (PK/PD) analyses of clinical trial data identified positive associations between plasma voriconazole concentrations and both LFT abnormalities and visual disturbances.

## **Pharmacokinetics in special patient groups**

### **Gender**

In an oral multiple dose study,  $C_{max}$  and  $AUC_{\tau}$  for healthy young females were 83% and 113% higher, respectively, than in healthy young males (18-45 years). In the same study, no significant differences in  $C_{max}$  and  $AUC_{\tau}$  were observed between healthy elderly males and healthy elderly females ( $\geq 65$  years).

In the clinical program, no dosage adjustment was made on the basis of gender. The safety profile and plasma concentrations observed in male and female patients were similar. Therefore, no dosage adjustment based on gender is necessary.

### **Elderly**

In an oral multiple dose study  $C_{max}$  and  $AUC_{\tau}$  in healthy elderly males ( $\geq 65$  years) were 61% and 86% higher, respectively, than in healthy young males (18-45 years). No significant differences in  $C_{max}$  and  $AUC_{\tau}$  were observed between healthy elderly females ( $\geq 65$  years) and healthy young females (18-45 years).

In the therapeutic studies no dosage adjustment was made on the basis of age. A relationship between plasma concentrations and age was observed. The safety profile of voriconazole in young and elderly patients was similar and, therefore, no dosage adjustment is necessary for the elderly.

### **Paediatrics**

***The information relating to paediatric use has been generated using only oral suspension and intravenous dose forms of voriconazole and these presentations are not available in this product range.***

The recommended oral dose in paediatrics is based on a population pharmacokinetic analysis data obtained from 47 immunocompromised paediatric patients aged 2 to  $<12$  years old who were evaluated in a pharmacokinetic study examining multiple oral suspension doses of 4 to 6 mg/kg twice daily. A comparison of the paediatric and adult population pharmacokinetic data indicated that in order to obtain comparable exposures to those obtained in adults following a maintenance dose of 200 mg twice daily, the same dose of 200 mg of oral solution twice daily is required in paediatric patients, independent of body weight. In paediatric patients there is a general trend towards low bioavailability at lower body weights and high bioavailability at higher body weights (towards the extent demonstrated in adults). Based on the population pharmacokinetic analysis, no dosage adjustment according to age or weight is warranted in patients aged 2 to  $<12$  years old at the 200 mg twice daily oral solution dosing regimen. A loading dose is not indicated in paediatric patients. Oral bioavailability may however be limited in paediatric patients with malabsorption and very low body weight for their age. In that case, intravenous voriconazole administration is recommended.

### **Renal impairment**

In a single oral dose (200 mg) study in subjects with normal renal function and mild (creatinine clearance 41 - 60 mL/min) to severe (creatinine clearance  $< 20$  mL/min) renal impairment, the pharmacokinetics of voriconazole were not significantly affected by renal impairment. The plasma protein binding of voriconazole was similar in subjects with different degrees of renal impairment.

In patients with moderate to severe renal dysfunction (creatinine clearance  $< 50$  mL/min), accumulation of the intravenous vehicle, SBECD, occurs. Oral voriconazole should be administered to patients with moderate to severe renal dysfunction including dialysis patients, unless an assessment of the benefit risk to the patient justifies the use of intravenous voriconazole. Serum creatinine levels should be closely monitored in these patients, and if increases occur, consideration should be given to changing to oral voriconazole therapy (see section 4.2).

A pharmacokinetic study in subjects with renal failure undergoing haemodialysis showed that voriconazole is dialysed with clearance of 121 mL/min. Exposure to voriconazole was lower in the dialysis subjects.

### **Hepatic impairment**

After a single oral dose (200 mg), AUC was 233% higher in subjects with mild to moderate hepatic cirrhosis (Child-Pugh A and B) compared with subjects with normal hepatic function. Protein binding of voriconazole was not affected by impaired hepatic function.

In a multiple oral dose study, AUC<sub>τ</sub> was similar in subjects with moderate hepatic cirrhosis (Child-Pugh B) given maintenance doses of 100 mg twice daily and subjects with normal hepatic function given 200 mg twice daily. No pharmacokinetic data are available for patients with severe hepatic cirrhosis (Child-Pugh C) (see section 4.2).

## **5.3 Preclinical safety data**

### **Carcinogenicity and mutagenicity**

Carcinogenic potential was studied in mice and rats at oral doses of up to 100 mg/kg/day and 50 mg/kg/day for 24 months, respectively. Hepatocellular adenoma appeared in male and female mice at 100 mg/kg/day and in female rats at 50 mg/kg/day. There was also an increased incidence of hepatocellular carcinoma in mice at 100 mg/kg/day. Although mean plasma drug concentrations indicated there is no safety margin in humans in terms of exposure, adenoma and carcinoma (as well as non-neoplastic changes) are known to occur in rodents after chronic administration of compounds that are hepatic enzyme inducers.

Voriconazole showed no mutagenic potential in gene-mutation assays in bacterial (*Salmonella typhimurium*) and mammalian (Chinese hamster ovary) cells. While *in vitro* exposure of human lymphocytes to voriconazole produced equivocal effects on chromosomes, *in vivo* treatment of male and female mice at doses up to, and including the maximum tolerated dose produced no evidence of chromosome damage as determined by the micronucleus assay.

---

## **6. Pharmaceutical Particulars**

---

### **6.1 List of excipients**

VTTACK also contains:

- lactose,
- pregelatinised starch
- croscarmellose sodium
- povidone
- magnesium stearate

The tablet coating contains:

- hypromellose
- titanium dioxide
- lactose
- triacetin.

### **6.2 Incompatibilities**

Not applicable.

### **6.3 Shelf life**

2 years.

## 6.4 *Special precautions for storage*

Store at or below 25°C.

## 6.5 *Nature and contents of container*

Blister packs of 10, 14, 20, 28, 30, 50, 56 and 100 tablets.

Not all pack sizes may be marketed.

## 6.6 *Special precautions for disposal*

Not applicable.

---

## 7. Medicines Schedule

---

Prescription Medicine

---

## 8. Sponsor Details

---

Viatris Ltd  
PO Box 11183  
Ellerslie  
AUCKLAND  
[www.viatris.co.nz](http://www.viatris.co.nz)  
Telephone 0800 168 169

---

## 9. Date of First Approval

---

4 September 2014

---

## 10. Date of Revision of the Text

---

02 August 2022

Section changed	Summary of new information
4.3	Changed 'phenobarbitone' to the commonly used AAN 'phenobarbital'.
4.4	Information added regarding: <ul style="list-style-type: none"><li>• Examples of squamous cell carcinoma</li><li>• tyrosine kinase inhibitors</li></ul>
4.5	Changed 'phenobarbitone' to the commonly used AAN 'phenobarbital'.  Changed 'glyburide' to the commonly used AAN 'glibenclamide'  Information on lemborexant included  Inclusion of precaution to monitor if concomitant use with tyrosine kinase inhibitors.

4.8	Types of squamous cell carcinoma added in line with change to Section 4.4 above
10	Date of revision updated.