

## SUMMARY OF PRODUCT CHARACTERISTICS

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See Section 4.8 for how to report adverse reactions.

### 1 NAME OF THE MEDICINAL PRODUCT

Lonsurf 15 mg/6.14 mg film-coated tablets

Lonsurf 20 mg/8.19 mg film-coated tablets

### 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Lonsurf 15 mg/6.14 mg film-coated tablets

Each film-coated tablet contains 15 mg trifluridine and 6.14 mg tipiracil (as hydrochloride).

Excipient with known effect

Each film-coated tablet contains 90.735 mg of lactose monohydrate.

Lonsurf 20 mg/8.19 mg film-coated tablets

Each film-coated tablet contains 20 mg trifluridine and 8.19 mg tipiracil (as hydrochloride).

Excipient with known effect

Each film-coated tablet contains 120.980 mg of lactose monohydrate.

For the full list of excipients, see section 6.1.

### 3 PHARMACEUTICAL FORM

Film-coated tablet (tablet).

Lonsurf 15 mg/6.14 mg film-coated tablets

The tablet is a white, biconvex, round, film-coated tablet, with a diameter of 7.1 mm and a thickness of 2.7 mm, imprinted with '15' on one side, and '102' and '15 mg' on the other side, in grey ink.

Lonsurf 20 mg/8.19 mg film-coated tablets

The tablet is a pale red, biconvex, round, film-coated tablet, with a diameter of 7.6 mm and a thickness of 3.2 mm, imprinted with '20' on one side, and '102' and '20 mg' on the other side, in grey ink.

### 4 CLINICAL PARTICULARS

#### 4.1 Therapeutic indications

Lonsurf is indicated for the treatment of adult patients with metastatic colorectal cancer (CRC) who have been previously treated with, or are not considered candidates for, available

therapies including fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapies, anti-VEGF agents, and anti-EGFR agents.

## 4.2 Posology and method of administration

Lonsurf should be prescribed by physicians experienced in the administration of anticancer therapy.

### Posology

The recommended starting dose of Lonsurf in adults is 35 mg/m<sup>2</sup>/dose administered orally twice daily on Days 1 to 5 and Days 8 to 12 of each 28-day cycle as long as benefit is observed or until unacceptable toxicity occurs (see section 4.4).

The dosage is calculated according to body surface area (BSA) (see Table 1). The dosage must be rounded to the nearest 5 mg increment. The dosage must not exceed 80 mg/dose.

If doses were missed or held, the patient must not make up for missed doses.

**Table 1 - Starting dose calculation according to body surface area (BSA)**

| Starting dose        | BSA (m <sup>2</sup> ) | Dose in mg (2x daily) | Tablets per dose |       | Total daily dose (mg) |
|----------------------|-----------------------|-----------------------|------------------|-------|-----------------------|
|                      |                       |                       | 15 mg            | 20 mg |                       |
| 35 mg/m <sup>2</sup> | < 1.07                | 35                    | 1                | 1     | 70                    |
|                      | 1.07 - 1.22           | 40                    | 0                | 2     | 80                    |
|                      | 1.23 - 1.37           | 45                    | 3                | 0     | 90                    |
|                      | 1.38 - 1.52           | 50                    | 2                | 1     | 100                   |
|                      | 1.53 - 1.68           | 55                    | 1                | 2     | 110                   |
|                      | 1.69 - 1.83           | 60                    | 0                | 3     | 120                   |
|                      | 1.84 - 1.98           | 65                    | 3                | 1     | 130                   |
|                      | 1.99 - 2.14           | 70                    | 2                | 2     | 140                   |
|                      | 2.15 - 2.29           | 75                    | 1                | 3     | 150                   |
|                      | ≥ 2.30                | 80                    | 0                | 4     | 160                   |

### *Recommended dose adjustments*

Dosing adjustments may be required based on individual safety and tolerability.

A maximum of 3 dose reductions are permitted to a minimum dose of 20 mg/m<sup>2</sup> twice daily. Dose escalation is not permitted after it has been reduced.

In the event of haematological and/or non-haematological toxicities patients should follow the dose interruption, resumption and reduction criteria stated in Table 2, Table 3 and Table 4.

**Table 2 - Dose interruption and resumption criteria for haematological toxicities related to myelosuppression**

| <b>Parameter</b> | <b>Interruption criteria</b> | <b>Resumption criteria<sup>a</sup></b> |
|------------------|------------------------------|--|
| Neutrophils      | $< 0.5 \times 10^9/L$        | $\geq 1.5 \times 10^9/L$               |
| Platelets        | $< 50 \times 10^9/L$         | $\geq 75 \times 10^9/L$                |

<sup>a</sup> Resumption criteria applied to the start of the next cycle for all patients regardless of whether or not the interruption criteria were met.

**Table 3 - Recommended dose modifications for Lonsurf in case of haematological and non-haematological adverse reactions**

| <b>Adverse reaction</b>  | <b>Recommended dose modifications</b>   |
|--|---|
| <ul style="list-style-type: none"> <li>• Febrile neutropenia</li> <li>• CTCAE* Grade 4 neutropenia (<math>&lt; 0.5 \times 10^9/L</math>) or thrombocytopenia (<math>&lt; 25 \times 10^9/L</math>) that results in more than 1 week's delay in start of next cycle</li> <li>• CTCAE* non-haematologic Grade 3 or Grade 4 adverse reaction; except for Grade 3 nausea and/or vomiting controlled by antiemetic therapy or diarrhoea responsive to antidiarrhoeal medicinal products</li> </ul> | <ul style="list-style-type: none"> <li>• Interrupt dosing until toxicity resolves to Grade 1 or baseline.</li> <li>• When resuming dosing, decrease the dose level by 5 mg/m<sup>2</sup>/dose from the previous dose level (Table 4).</li> <li>• Dose reductions are permitted to a minimum dose of 20 mg/m<sup>2</sup>/dose twice daily.</li> <li>• Do not increase dose after it has been reduced.</li> </ul> |

\* Common terminology criteria for adverse events

**Table 4 - Dose reductions according to body surface area (BSA)**

| Reduced dose   | BSA (m <sup>2</sup> )  | Dose in mg (2x daily) | Tablets per dose (2x daily) |                | Total daily dose (mg) |
|--|--|-----------------------|-----------------------------|----------------|-----------------------|
|  |  |                       | 15 mg                       | 20 mg          |                       |
| <b>Level 1 dose reduction: From 35 mg/m<sup>2</sup> to 30 mg/m<sup>2</sup></b> |  |                       |                             |                |                       |
| <b>30 mg/m<sup>2</sup></b>   | < 1.09   | 30                    | 2                           | 0              | 60                    |
|  | 1.09 - 1.24  | 35                    | 1                           | 1              | 70                    |
|  | 1.25 - 1.39  | 40                    | 0                           | 2              | 80                    |
|  | 1.40 - 1.54  | 45                    | 3                           | 0              | 90                    |
|  | 1.55 - 1.69  | 50                    | 2                           | 1              | 100                   |
|  | 1.70 - 1.94  | 55                    | 1                           | 2              | 110                   |
|  | 1.95 - 2.09  | 60                    | 0                           | 3              | 120                   |
|  | 2.10 - 2.28  | 65                    | 3                           | 1              | 130                   |
|  | ≥ 2.29   | 70                    | 2                           | 2              | 140                   |
| <b>Level 2 dose reduction: From 30 mg/m<sup>2</sup> to 25 mg/m<sup>2</sup></b> |  |                       |                             |                |                       |
| <b>25 mg/m<sup>2</sup></b>   | < 1.10   | 25 <sup>a</sup>       | 2 <sup>a</sup>              | 1 <sup>a</sup> | 50 <sup>a</sup>       |
|  | 1.10 - 1.29  | 30                    | 2                           | 0              | 60                    |
|  | 1.30 - 1.49  | 35                    | 1                           | 1              | 70                    |
|  | 1.50 - 1.69  | 40                    | 0                           | 2              | 80                    |
|  | 1.70 - 1.89  | 45                    | 3                           | 0              | 90                    |
|  | 1.90 - 2.09  | 50                    | 2                           | 1              | 100                   |
|  | 2.10 - 2.29  | 55                    | 1                           | 2              | 110                   |
|  | ≥ 2.30   | 60                    | 0                           | 3              | 120                   |
|  | <b>Level 3 dose reduction: From 25 mg/m<sup>2</sup> to 20 mg/m<sup>2</sup></b> |                       |                             |                |                       |
| <b>20 mg/m<sup>2</sup></b>   | < 1.14   | 20                    | 0                           | 1              | 40                    |
|  | 1.14 – 1.34  | 25 <sup>a</sup>       | 2 <sup>a</sup>              | 1 <sup>a</sup> | 50 <sup>a</sup>       |
|  | 1.35 – 1.59  | 30                    | 2                           | 0              | 60                    |
|  | 1.60 – 1.94  | 35                    | 1                           | 1              | 70                    |
|  | 1.95 – 2.09  | 40                    | 0                           | 2              | 80                    |
|  | 2.10 – 2.34  | 45                    | 3                           | 0              | 90                    |
|  | ≥ 2.35   | 50                    | 2                           | 1              | 100                   |

<sup>a</sup> At a total daily dose of 50 mg, patients should take 1 x 20 mg tablet in the morning and 2 x 15 mg tablets in the evening.

### Special populations

#### *Renal impairment*

- *Mild renal impairment (CrCl 60 to 89 mL/min) or moderate renal impairment (CrCl 30 to 59 mL/min)*

No adjustment of the starting dose is recommended in patients with mild or moderate renal impairment (see sections 4.4 and 5.2).

- *Severe renal impairment (CrCl below 30 mL/min) or end stage renal disease*  
Administration is not recommended in patients with severe renal impairment or end stage renal disease as there are no data available for these patients (see section 4.4).

#### *Hepatic impairment*

- *Mild hepatic impairment*  
No adjustment of the starting dose is recommended in patients with mild hepatic impairment.
- *Moderate or severe hepatic impairment*  
Administration is not recommended in patients with moderate or severe hepatic impairment as there are no data available for these patients (see sections 4.4 and 5.2).

#### *Elderly*

No adjustment of the starting dose is required in patients  $\geq 65$  years old (see sections 4.8, 5.1 and 5.2).  
Efficacy and safety data in patients over 75 years old is limited.

#### *Paediatric population*

There is no relevant use of Lonsurf in the paediatric population for the indication of metastatic colorectal cancer.

#### *Race*

No adjustment of the starting dose is required on the basis of patient's race (see sections 5.1 and 5.2). There is limited data on Lonsurf in Black/African American patients but there is no biological rationale to expect any difference between this subgroup and the overall population.

#### Method of administration

Lonsurf is for oral use. The tablets must be taken with a glass of water within 1 hour after completion of the morning and evening meals.

### **4.3 Contraindications**

Hypersensitivity to the active substances or to any of the excipients listed in section 6.1.

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

#### Bone marrow suppression

Lonsurf caused an increase in the incidence of myelosuppression including anaemia, neutropenia, leucopenia, and thrombocytopenia.

Complete blood cell counts must be obtained prior to initiation of therapy and as needed to monitor toxicity, but at a minimum, prior to each treatment cycle.

Treatment must not be started if the absolute neutrophil count is  $< 1.5 \times 10^9/L$ , if the platelet counts are  $< 75 \times 10^9/L$ , or if the patient has an unresolved Grade 3 or 4 non-haematological clinically relevant toxicity from prior therapies.

Serious infections have been reported following treatment with Lonsurf (see section 4.8). Given that the majority were reported in the context of bone marrow suppression, the patient's condition should be monitored closely, and appropriate measures, such as antimicrobial agents and granulocyte-colony stimulating factor (G-CSF), should be administered as clinically indicated. In the RECURSE study, 9.4% of patients in the Lonsurf group received G-CSF mainly for therapeutic use.

#### Gastrointestinal toxicity

Lonsurf caused an increase in the incidence of gastrointestinal toxicities including nausea, vomiting and diarrhoea.

Patients with nausea, vomiting, diarrhoea and other gastrointestinal toxicities should be carefully monitored, and anti-emetic, anti-diarrhoeal and other measures, such as fluid/electrolyte replacement therapy, should be administered as clinically indicated. Dose modifications (delay and/or reduction) should be applied as necessary (see section 4.2).

#### Renal impairment

Lonsurf is not recommended for use in patients with severe renal impairment or end-stage renal disease (creatinine clearance [CrCl] < 30 mL/min or requiring dialysis, respectively), as Lonsurf has not been studied in these patients (see section 5.2).

Patients with moderate renal impairment (CrCl = 30 to 59 mL/min) had a higher incidence (defined as a difference of at least 5%) of  $\geq$  Grade 3 adverse events (AEs), serious AEs, and dose delays and reductions compared to the patients with normal (CrCl  $\geq$  90 mL/min) or mild renal impairment (CrCl = 60 to 89 mL/min). In addition, a higher exposure of trifluridine and tipiracil was observed in patients with moderate renal impairment, compared with patients with normal renal function or patients with mild renal impairment (see section 5.2). Patients with moderate renal impairment should be more frequently monitored for haematological toxicities.

#### Hepatic impairment

Lonsurf is not recommended for use in patients with moderate or severe hepatic impairment (National Cancer Institute [NCI] Criteria Group C and D) as Lonsurf has not been studied in these patients (see section 5.2).

#### Proteinuria

Monitoring of proteinuria by dipstick urinalysis is recommended prior to starting and during therapy (see section 4.8).

#### Lactose intolerance

Lonsurf contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

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

*In vitro* studies indicated that trifluridine, tipiracil hydrochloride and 5-[trifluoromethyl]uracil (FTY) did not inhibit the activity of human cytochrome P450 (CYP) isoforms. *In vitro* evaluation indicated that trifluridine and FTY had no inductive effect on human CYP isoforms (see section 5.2).

Inductive effect of tipiracil on human CYP isoforms cannot be excluded.

*In vitro* studies indicated that trifluridine is a substrate for the nucleoside transporters CNT1, ENT1 and ENT2. Therefore, caution is required when using medicinal products that interact with these transporters. Tipiracil hydrochloride was a substrate for OCT2 and MATE1, therefore, the concentration might be increased when Lonsurf is administered concomitantly with inhibitors of OCT2 or MATE1.

Caution is required when using medicinal products that are human thymidine kinase substrates, e.g., zidovudine. Such medicinal products, if used concomitantly with Lonsurf, may compete with the effector, trifluridine, for activation via thymidine kinases. Therefore, when using antiviral medicinal products that are human thymidine kinase substrates, monitor for possible decreased efficacy of the antiviral medicinal product, and consider switching to an alternative antiviral medicinal product that is not a human thymidine kinase substrate, such as lamivudine, zalcitabine, didanosine and abacavir (see section 5.1).

It is unknown whether Lonsurf may reduce the effectiveness of hormonal contraceptives. Therefore, women using hormonal contraceptive must also use a barrier contraceptive method.

#### **4.6 Fertility, pregnancy and lactation**

##### Women of childbearing potential / Contraception in males and females

Based on findings in animals, trifluridine may cause foetal harm when administered to pregnant women. Women should avoid becoming pregnant while taking Lonsurf and for up to 6 months after ending treatment. Therefore, women of child-bearing potential must use highly effective contraceptive measures while taking Lonsurf and for 6 months after stopping treatment. It is currently unknown whether Lonsurf may reduce the effectiveness of hormonal contraceptives, and therefore women using hormonal contraceptives should add a barrier contraceptive method.

Men with a partner of child-bearing potential must use effective contraception during treatment and for up to 6 months after discontinuation of treatment.

##### Pregnancy

There are no available data from the use of Lonsurf in pregnant women. Based on the mechanism of action, trifluridine is suspected to cause congenital malformations when administered during pregnancy. Studies in animals have shown reproductive toxicity (see section 5.3). Lonsurf should not be used during pregnancy unless the clinical condition of the woman requires treatment with Lonsurf.

##### Breast-feeding

It is unknown whether Lonsurf or its metabolites are excreted in human milk. Studies in animals have shown excretion of trifluridine, tipiracil hydrochloride and/or their metabolites in milk (see section 5.3). A risk to the suckling child cannot be excluded. Breast-feeding should be discontinued during treatment with Lonsurf.

##### Fertility

There are no data available on the effects of Lonsurf on human fertility. Results of animal studies did not indicate an effect of Lonsurf on male or female fertility (see section 5.3).

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

Lonsurf has minor influence on the ability to drive and use machines. Fatigue, dizziness or malaise may occur during treatment (see section 4.8).

#### 4.8 Undesirable effects

##### Summary of safety profile

The most serious observed adverse drug reactions in patients receiving Lonsurf are bone marrow suppression and gastrointestinal toxicity (see section 4.4).

The most frequently observed adverse drug reactions ( $\geq 30\%$ ) in patients receiving Lonsurf are neutropenia (54% [35%  $\geq$  Grade 3]), nausea (39% [1%  $\geq$  Grade 3]), fatigue (35% [4%  $\geq$  Grade 3]), anaemia (32% [13%  $\geq$  Grade 3]) and leucopenia (31% [12%  $\geq$  Grade 3]).

The most common adverse drug reactions in patients receiving Lonsurf that resulted in treatment discontinuation, dose reduction, dose delay, or dose interruption were neutropenia, general deterioration of health, anaemia, febrile neutropenia, fatigue, diarrhoea and dyspnoea.

##### Tabulated list of adverse drug reactions

The adverse drug reactions observed from the 533 patients with metastatic colorectal cancer, treated with a starting dose of 35 mg/m<sup>2</sup>/dose of Lonsurf, in the placebo-controlled Phase III (RECOURSE) clinical trial, are shown in Table 5. They are classified according to System Organ Class (SOC) and the appropriate Medical Dictionary for Regulatory (MedDRA) term is used to describe a certain drug reaction and its synonyms and related conditions.

Adverse drug reactions are grouped according to their frequencies. Frequency groups are defined by the following convention: very common ( $\geq 1/10$ ); common ( $\geq 1/100$  to  $< 1/10$ ); and uncommon ( $\geq 1/1,000$  to  $< 1/100$ ).

Within each frequency group, adverse drug reactions are presented in order of decreasing seriousness.

**Table 5 - Adverse drug reactions reported in patients with metastatic colorectal cancer treated with Lonsurf in the Phase III (RECOURSE) clinical trial**

| System Organ Class (MedDRA) <sup>a</sup> | Very common | Common   | Uncommon  |
|--|-------------|--|---|
| Infections and infestations              |             | Lower respiratory tract infection<br>Upper respiratory tract infection | Septic shock <sup>b</sup><br>Enteritis infectious<br>Lung infection<br>Biliary tract infection<br>Influenza<br>Urinary tract infection<br>Gingival infection<br>Herpes zoster<br>Tinea pedis<br>Candidiasis<br>Bacterial infection<br>Infection |



| <b>System Organ Class (MedDRA)<sup>a</sup></b>                       | <b>Very common</b>                                       | <b>Common</b>   | <b>Uncommon</b>   |
|--|--|---|---|
| Neoplasms benign, malignant and unspecified (incl. cysts and polyps) |  |   | Cancer pain   |
| Blood and lymphatic system disorders                                 | Neutropenia<br>Leukopenia<br>Anaemia<br>Thrombocytopenia | Febrile neutropenia<br>Lymphopenia<br>Monocytosis           | Pancytopenia<br>Granulocytopenia<br>Monocytopenia<br>Erythropenia<br>Leukocytosis   |
| Metabolism and nutrition disorders                                   | Decreased appetite                                       | Hypoalbuminaemia  | Dehydration<br>Hyperglycaemia<br>Hyperkalaemia<br>Hypokalaemia<br>Hypophosphataemia<br>Hypernatraemia<br>Hyponatraemia<br>Hypocalcaemia<br>Gout |
| Psychiatric disorders  |  | Insomnia  | Anxiety   |
| Nervous system disorders   |  | Dysgeusia<br>Neuropathy peripheral<br>Dizziness<br>Headache | Neurotoxicity<br>Dysaesthesia<br>Hyperaesthesia<br>Hypoaesthesia<br>Syncope<br>Paraesthesia<br>Burning sensation<br>Lethargy                    |
| Eye disorders  |  |   | Visual acuity reduced<br>Vision blurred<br>Diplopia<br>Cataract<br>Conjunctivitis<br>Dry eye  |
| Ear and labyrinth disorders  |  |   | Vertigo<br>Ear discomfort   |
| Cardiac disorders  |  |   | Angina pectoris<br>Arrhythmia<br>Palpitations   |
| Vascular disorders   |  | Flushing  | Embolism<br>Hypertension<br>Hypotension   |
| Respiratory, thoracic and mediastinal disorders                      |  | Dyspnoea<br>Cough   | Pulmonary embolism<br>Pleural effusion<br>Rhinorrhoea<br>Dysphonia<br>Oropharyngeal pain<br>Epistaxis   |

| <b>System Organ Class (MedDRA)<sup>a</sup></b>  | <b>Very common</b>              | <b>Common</b>   | <b>Uncommon</b>  |
|---|---------------------------------|---|--|
| Gastrointestinal disorders                      | Diarrhoea<br>Nausea<br>Vomiting | Abdominal pain<br>Constipation<br>Stomatitis<br>Oral disorder                                       | Enterocolitis haemorrhagic<br>Gastrointestinal haemorrhage<br>Pancreatitis acute<br>Ascites<br>Ileus<br>Subileus<br>Colitis<br>Gastritis<br>Reflux gastritis<br>Oesophagitis<br>Impaired gastric emptying<br>Abdominal distension<br>Anal inflammation<br>Mouth ulceration<br>Dyspepsia<br>Gastrooesophageal reflux disease<br>Proctalgia<br>Buccal polyp<br>Gingival bleeding<br>Glossitis<br>Periodontal disease<br>Tooth disorder<br>Retching<br>Flatulence<br>Breath odour |
| Hepatobiliary disorders                         |                                 | Hyperbilirubinaemia   | Hepatotoxicity<br>Biliary dilatation   |
| Skin and subcutaneous tissue disorders          |                                 | Palmar-plantar erythrodysesthesia syndrome <sup>c</sup><br>Rash<br>Alopecia<br>Pruritus<br>Dry skin | Skin exfoliation<br>Urticaria<br>Photosensitivity reaction<br>Erythema<br>Acne<br>Hyperhidrosis<br>Blister<br>Nail Disorder  |
| Musculoskeletal and connective tissue disorders |                                 |   | Joint swelling<br>Arthralgia<br>Bone pain<br>Myalgia<br>Musculoskeletal pain<br>Muscular weakness<br>Muscle spasms<br>Pain in extremity<br>Sensation of heaviness  |
| Renal and urinary disorders                     |                                 | Proteinuria   | Renal failure<br>Cystitis noninfective<br>Micturition disorder<br>Haematuria<br>Leukocyturia   |
| Reproductive system and breast disorders        |                                 |   | Menstrual disorder   |

| System Organ Class (MedDRA) <sup>a</sup>             | Very common | Common   | Uncommon   |
|--|-------------|--|--|
| General disorders and administration site conditions | Fatigue     | Pyrexia<br>Oedema<br>Mucosal inflammation<br>Malaise                                 | General physical health deterioration<br>Pain<br>Feeling of body temperature change<br>Xerosis   |
| Investigations                                       |             | Hepatic enzyme increased<br>Blood alkaline phosphatase increased<br>Weight decreased | Blood creatinine increased<br>Electrocardiogram QT prolonged<br>International normalised ratio increased<br>Activated partial thromboplastin time prolonged<br>Blood urea increased<br>Blood lactate dehydrogenase increased<br>Protein total decreased<br>C-reactive protein increased<br>Haematocrit decreased |

- Different MedDRA preferred terms that were considered clinically similar have been grouped into a single term.
- Fatal cases have been reported.
- Hand-foot skin reaction.

### Elderly

Patients 65 years of age or older who received Lonsurf had a higher incidence of the following events compared to patients younger than 65 years: Grade 3 or 4 neutropenia (48% vs 30%), Grade 3 anaemia (26% vs 12%), Grade 3 or 4 leucopenia (26% vs 18%) and Grade 3 or 4 thrombocytopenia (9% vs 2%).

### Infections

In the Phase III (RECOURSE) clinical trial, treatment-related infections occurred more frequently in Lonsurf-treated patients (5.6%) compared to those receiving placebo (1.9%).

### Proteinuria

In the RECOURSE clinical trial, treatment-related proteinuria occurred more frequently in Lonsurf-treated patients (2.8%) compared to those receiving placebo (1.5%), all of which were Grade 1 or 2 in severity (see section 4.4).

### Radiotherapy

There was a slightly higher incidence of overall haematological and myelosuppression-related adverse reactions for patients who received prior radiotherapy compared to patients without prior radiotherapy in RECOURSE (54.6% versus 49.2%, respectively), of note febrile neutropenia was higher in Lonsurf-treated patients who received prior radiotherapy vs. those that did not.

## Post-marketing experience in patients with unresectable advanced or recurrent colorectal cancer

There have been reports of interstitial lung disease in patients receiving Lonsurf post approval used in Japan.

### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the Yellow Card Scheme Website: [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard)

## **4.9 Overdose**

The highest dose of Lonsurf administered in clinical trials was 180 mg/m<sup>2</sup> per day.

The adverse drug reactions reported in association with overdoses were consistent with the established safety profile.

The primary anticipated complication of an overdose is bone marrow suppression.

There is no known antidote for an overdose of Lonsurf.

Medical management of an overdose should include customary therapeutic and supportive medical intervention aimed at correcting the presenting clinical manifestations and preventing their possible complications.

## **5 PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: antineoplastic agents, antimetabolites, ATC code: L01BC59

#### Mechanism of action

Lonsurf is comprised of an antineoplastic thymidine-based nucleoside analogue, trifluridine, and the thymidine phosphorylase (TPase) inhibitor, tipiracil hydrochloride, at a molar ratio 1:0.5 (weight ratio, 1:0.471).

Following uptake into cancer cells, trifluridine, is phosphorylated by thymidine kinase, further metabolised in cells to a deoxyribonucleic acid DNA substrate, and incorporated directly into DNA, thereby interfering with DNA function to prevent cell proliferation.

However, trifluridine is rapidly degraded by TPase and readily metabolised by a first-pass effect following oral administration, hence the inclusion of the TPase inhibitor, tipiracil hydrochloride.

In nonclinical studies, trifluridine/tipiracil hydrochloride demonstrated antitumour activity against both 5-fluorouracil (5-FU) sensitive and resistant colorectal cancer cell lines.

The cytotoxic activity of trifluridine/tipiracil hydrochloride against several human tumour xenografts correlated highly with the amount of trifluridine incorporated into DNA, suggesting this as the primary mechanism of action.

#### Pharmacodynamic effects

Lonsurf had no clinically relevant effect on QT/QTc prolongation compared with placebo in an open label study in patients with advanced solid tumours.

#### Clinical efficacy and safety

The clinical efficacy and safety of Lonsurf were evaluated in an international, randomised, double-blind, placebo-controlled Phase III study (RECOURSE) in patients with previously treated metastatic colorectal cancer. The primary efficacy endpoint was overall survival (OS), and supportive efficacy endpoints were progression-free survival (PFS), overall response rate (ORR) and disease control rate (DCR).

In total, 800 patients were randomised 2:1 to receive Lonsurf (N = 534) plus best supportive care (BSC) or matching placebo (N = 266) plus BSC. Lonsurf dosing was based on BSA with a starting dose of 35 mg/m<sup>2</sup>/dose. Study treatment was administered orally twice daily after morning and evening meals for 5 days a week with 2 days rest for 2 weeks, followed by 14 days rest, repeated every 4 weeks. Patients continued therapy until disease progression or unacceptable toxicity (see section 4.2).

Of the 800 randomised patients, the median age was 63 years, 61% were male, 58% were Caucasian/White, 35% were Asian/Oriental, and 1% were Black/African American, and all patients had baseline Eastern Cooperative Oncology Group (ECOG) Performance Status (PS) of 0 or 1. The primary site of disease was colon (62%) or rectum (38%). KRAS status was wild (49%) or mutant (51%) at study entry. The median number of prior lines of therapy for metastatic disease was 3. All patients received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy. All but 1 patient received bevacizumab, and all but 2 patients with KRAS wild type tumours received panitumumab or cetuximab. The 2 treatment groups were comparable with respect to demographic and baseline disease characteristics.

An OS analysis of the study, carried out as planned at 72% (N = 574) of events, demonstrated a clinically meaningful and statistically significant survival benefit of Lonsurf plus BSC compared to placebo plus BSC (hazard ratio: 0.68; 95% confidence interval [CI] [0.58 to 0.81]; p < 0.0001) and a median OS of 7.1 months vs 5.3 months, respectively; with 1-year survival rates of 26.6% and 17.6%, respectively. PFS was significantly improved in patients receiving Lonsurf plus BSC (hazard ratio: 0.48; 95% CI [0.41 to 0.57]; p < 0.0001 (see Table 6, Figure 1 and Figure 2).

**Table 6 - Efficacy results from the Phase III (RECOURSE) clinical trial**

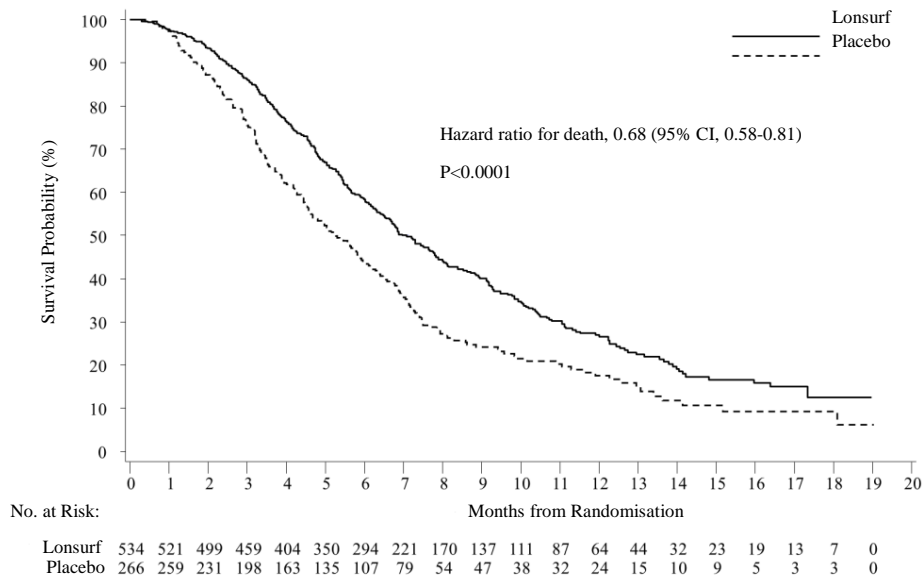
|  | <b>Lonsurf plus BSC<br/>(N=534)</b> | <b>Placebo plus BSC<br/>(N=266)</b> |
|--|-------------------------------------|-------------------------------------|
| <b>Overall Survival</b>                                |                                     |                                     |
| Number of deaths, N (%)                                | 364 (68.2)                          | 210 (78.9)                          |
| Median OS (months) <sup>a</sup> [95% CI] <sup>b</sup>  | 7.1 [6.5, 7.8]                      | 5.3 [4.6, 6.0]                      |
| Hazard ratio [95% CI]                                  | 0.68 [0.58, 0.81]                   |                                     |
| P-value <sup>c</sup>                                   | < 0.0001 (1-sided and 2-sided)      |                                     |
| <b>Progression-Free Survival</b>                       |                                     |                                     |
| Number of Progression or Death, N (%)                  | 472 (88.4)                          | 251 (94.4)                          |
| Median PFS (months) <sup>a</sup> [95% CI] <sup>b</sup> | 2.0 [1.9, 2.1]                      | 1.7 [1.7, 1.8]                      |
| Hazard ratio [95% CI]                                  | 0.48 [0.41, 0.57]                   |                                     |
| P-value <sup>c</sup>                                   | <0.0001 (1-sided and 2-sided)       |                                     |

<sup>a</sup> Kaplan-Meier estimates

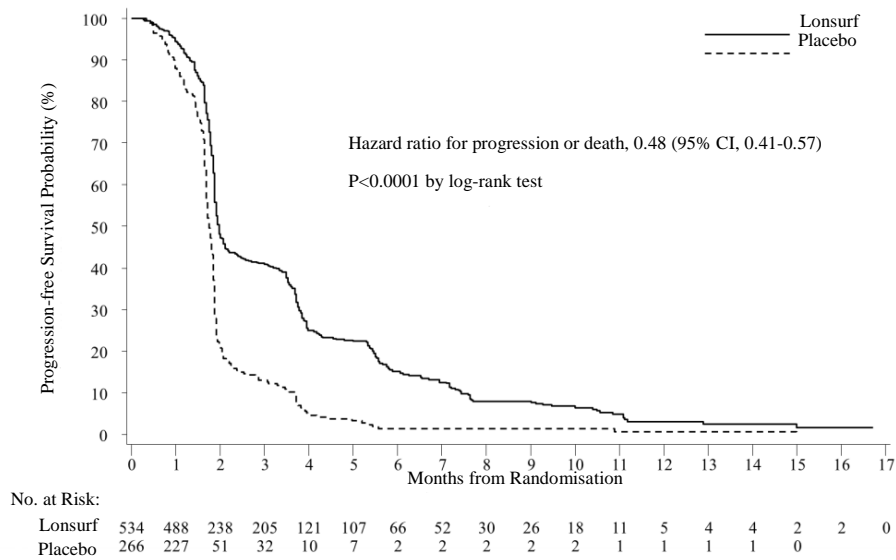
<sup>b</sup> Methodology of Brookmeyer and Crowley

<sup>c</sup> Stratified log-rank test (strata: KRAS status, time since diagnosis of first metastasis, region)

**Figure 1- Kaplan-Meier curves of overall survival**



**Figure 2 - Kaplan-Meier curves of progression-free survival**



An updated OS analysis, carried out at 89% (N = 712) of events, confirmed the clinically meaningful and statistically significant survival benefit of Lonsurf plus BSC compared to placebo plus BSC (hazard ratio: 0.69; 95% CI [0.59 to 0.81]; p < 0.0001) and a median OS of 7.2 months vs 5.2 months; with 1-year survival rates of 27.1% and 16.6%, respectively.

The OS and PFS benefit was observed consistently, in all relevant pre-specified subgroups, including race, geographic region, age (< 65; ≥ 65), sex, ECOG PS, KRAS status, time since diagnosis of first metastasis, number of metastatic sites, and primary tumour site. The Lonsurf survival benefit was maintained after adjusting for all significant prognostic factors, namely, time since diagnosis of first metastasis, ECOG PS and number of metastatic sites (hazard ratio: 0.69; 95% CI [0.58 to 0.81]).

Sixty one percent (61%, N = 485) of all randomised patients received a fluoropyrimidine as part of their last treatment regimen prior to randomisation, of which 455 (94%) were refractory to the fluoropyrimidine at that time. Among these patients, the OS benefit with Lonsurf was maintained (hazard ratio: 0.75, 95% CI [0.59 to 0.94]).

Eighteen percent (18%, N = 144) of all randomised patients received regorafenib prior to randomisation. Among these patients, the OS benefit with Lonsurf was maintained (hazard ratio: 0.69, 95% CI [0.45 to 1.05]). The effect was also maintained in regorafenib-naive patients (hazard ratio: 0.69, 95% CI [0.57 to 0.83]).

The DCR (complete response or partial response or stable disease) was significantly higher in patients treated with Lonsurf (44% vs 16%, p < 0.0001).

Treatment with Lonsurf plus BSC resulted in a statistically significant prolongation of PS < 2 in comparison to placebo plus BSC. The median time to PS ≥ 2 for the Lonsurf group and placebo group was 5.7 months and 4.0 months, respectively, with a hazard ratio of 0.66 (95% CI: [0.56, 0.78]), p < 0.0001.

## Paediatric population

The European Medicines Agency has waived the obligation to submit the results of studies with Lonsurf in all subsets of the paediatric population in refractory metastatic colorectal cancer (see section 4.2 for information on paediatric use).

## Elderly

There is limited data in patients between 75-84 years old (N=60). There were no patients 85 years or older in the RECOURSE study and the Japanese phase 2 study. The effect of Lonsurf on overall survival was similar in patients <65 years and ≥65 years of age.

## **5.2 Pharmacokinetic properties**

### Absorption

After oral administration of Lonsurf with [<sup>14</sup>C]-trifluridine, at least 57% of the administered trifluridine was absorbed and only 3% of the dose was excreted into faeces. After oral administration of Lonsurf with [<sup>14</sup>C]-tipiracil hydrochloride, at least 27% of the administered tipiracil hydrochloride was absorbed and 50% of the total radioactivity dose measured into faeces, suggestive of moderate gastrointestinal absorption of tipiracil hydrochloride. Following a single dose of Lonsurf (35 mg/m<sup>2</sup>) in patients with advanced solid tumours, the mean times to peak plasma concentrations (t<sub>max</sub>) of trifluridine and tipiracil hydrochloride were around 2 hours and 3 hours, respectively.

In the pharmacokinetic (PK) analyses of the multiple dose administration of Lonsurf (35 mg/m<sup>2</sup>/dose, twice daily for 5 days a week with 2 days rest for 2 weeks followed by a 14-day rest, repeated every 4 weeks), trifluridine area under the concentration-time curve from time 0 to the last measurable concentration (AUC<sub>0-last</sub>) was approximately 3-fold higher and maximum concentration (C<sub>max</sub>) was approximately 2-fold higher after multiple dose administration (Day 12 of Cycle 1) of Lonsurf than after single-dose (Day 1 of Cycle 1).

However, there was no accumulation for tipiracil hydrochloride, and no further accumulation of trifluridine with successive cycles (Day 12 of Cycles 2 and 3) of administration of Lonsurf. Following multiple doses of Lonsurf (35 mg/m<sup>2</sup>/dose twice daily) in patients with advanced solid tumours, the mean times to peak plasma concentrations (t<sub>max</sub>) of trifluridine and tipiracil hydrochloride were around 2 hours and 3 hours, respectively.

### *Contribution of tipiracil hydrochloride*

Single-dose administration of Lonsurf (35 mg/m<sup>2</sup>/dose) increased the mean AUC<sub>0-last</sub> of trifluridine by 37-fold and C<sub>max</sub> by 22-fold with reduced variability compared to trifluridine alone (35 mg/m<sup>2</sup>/dose).

### *Effect of food*

When Lonsurf at a single dose of 35 mg/m<sup>2</sup> was administered to 14 patients with solid tumours after a standardised high-fat, high-calorie meal, trifluridine area under the concentration-time curve (AUC) did not change, but trifluridine C<sub>max</sub>, tipiracil hydrochloride C<sub>max</sub> and AUC decreased by approximately 40% compared to those in a fasting state. In clinical studies Lonsurf was administered within 1 hour after completion of the morning and evening meals (see section 4.2).



### Distribution

The protein binding of trifluridine in human plasma was over 96% and trifluridine bound mainly to human serum albumin. Plasma protein binding of tipiracil hydrochloride was below 8%. Following a single dose of Lonsurf (35 mg/m<sup>2</sup>) in patients with advanced solid tumours, the apparent volume of distribution (Vd/F) for trifluridine and tipiracil hydrochloride was 21 L and 333 L, respectively.

### Biotransformation

Trifluridine was mainly eliminated by metabolism via TPase to form an inactive metabolite, FTY. The absorbed trifluridine was metabolised, and excreted into urine as FTY and trifluridine glucuronide isomers. Other minor metabolites, 5-carboxyuracil and 5-carboxy-2'-deoxyuridine, were detected, but those levels in plasma and urine were at low or trace levels.

Tipiracil hydrochloride was not metabolised in human liver S9 or in cryopreserved human hepatocytes. Tipiracil hydrochloride was the major component and 6-hydroxymethyluracil was the major metabolite consistently in human plasma, urine, and faeces.

### Elimination

Following the multiple-dose administration of Lonsurf at the recommended dose and regimen, the mean elimination half-life (t<sub>1/2</sub>) for trifluridine on Day 1 of Cycle 1 and on Day 12 of Cycle 1 were 1.4 hours and 2.1 hours, respectively. The mean t<sub>1/2</sub> values for tipiracil hydrochloride on Day 1 of Cycle 1 and on Day 12 of Cycle 1 were 2.1 hours and 2.4 hours, respectively.

Following a single dose of Lonsurf (35 mg/m<sup>2</sup>) in patients with advanced solid tumours, the oral clearance (CL/F) for trifluridine and tipiracil hydrochloride were 10.5 L/hr and 109 L/hr, respectively.

After single oral administration of Lonsurf with [<sup>14</sup>C]-trifluridine, the total cumulative excretion of radioactivity was 60% of the administered dose. The majority of recovered radioactivity was eliminated into urine (55% of the dose) within 24 hours, and the excretion into faeces and expired air was less than 3% for both. After single oral administration of Lonsurf with [<sup>14</sup>C]-tipiracil hydrochloride, recovered radioactivity was 77% of the dose, which consisted of 27% urinary excretion and 50% faecal excretion.

### Linearity/non-linearity

In a dose finding study (15 to 35 mg/m<sup>2</sup> twice daily), the AUC from time 0 to 10 hours (AUC<sub>0-10</sub>) of trifluridine tended to increase more than expected based on the increase in dose; however, oral clearance (CL/F) and apparent volume of distribution (Vd/F) of trifluridine were generally constant at the dose range of 20 to 35mg/m<sup>2</sup>. As for the other exposure parameters of trifluridine and tipiracil hydrochloride, those appeared to be dose proportional.

### Pharmacokinetics in special populations

#### *Age, gender and race*

Based on the population PK analysis, there is no clinically relevant effect of age, gender or race on the PK of trifluridine or tipiracil hydrochloride.

### *Renal impairment*

Of the 533 patients in the RECURSE study who received Lonsurf, 306 (57%) patients had normal renal function (CrCl  $\geq$  90 mL/min), 178 (33%) patients had mild renal impairment (CrCl 60 to 89 mL/min), and 47 (9%) had moderate renal impairment (CrCl 30 to 59 mL/min), with data missing for 2 patients. Patients with severe renal impairment were not enrolled in the study.

Based on a population PK analysis, the exposure of Lonsurf in patients with mild renal impairment (CrCl = 60 to 89 mL/min) was similar to those in patients with normal renal function (CrCl  $\geq$  90 mL/min). A higher exposure of Lonsurf was observed in moderate renal impairment (CrCl = 30 to 59 mL/min). Estimated (CrCl) was a significant covariate for CL/F in both final models of trifluridine and tipiracil hydrochloride. The mean relative ratio of AUC in patients with mild (n=38) and moderate (n=16) renal impairment compared to patients with normal renal function (n=84) were 1.31 and 1.43 for trifluridine, respectively, and 1.34 and 1.65 for tipiracil hydrochloride, respectively. The PK of trifluridine and tipiracil hydrochloride have not been studied in patients with severe renal impairment or end-stage renal disease (see section 4.4).

### *Hepatic impairment*

Based on the population PK analysis, liver function parameters including alkaline phosphatase (ALP, 36-2322 U/L), aspartate aminotransferase (AST, 11-197 U/L), alanine aminotransferase (ALT, 5-182 U/L), and total bilirubin (0.17-3.20 mg/dL) were not significant covariates for PK parameters of either trifluridine or tipiracil hydrochloride. The PK of trifluridine and tipiracil hydrochloride have not been studied in patients with moderate or severe hepatic impairment (NCI Criteria Group C and D) (see section 4.4). Serum albumin was found to significantly affect trifluridine clearance, with a negative correlation. For low albumin values ranging from 2.2 to 3.5 g/dL, the corresponding clearance values range from 4.2 to 3.1 L/h.

### *Gastrectomy*

The influence of gastrectomy on PK parameters was not able to be examined in the population PK analysis because there were few patients who had undergone gastrectomy (1% of overall).

### In vitro interaction studies

Trifluridine is a substrate of TPase, but is not metabolised by cytochrome P450 (CYP). Tipiracil hydrochloride is not metabolised in either human liver S9 or cryopreserved hepatocytes.

*In vitro* studies indicated that trifluridine, tipiracil hydrochloride and FTY (inactive metabolite of trifluridine) did not inhibit the CYP isoforms tested (CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP2E1 and CYP3A4/5). *In vitro* evaluation indicated that trifluridine and FTY had no inductive effect on human CYP1A2, CYP2B6 or CYP3A4/5. Thus trifluridine is not expected to cause or be subject to a significant medicinal product interaction mediated by CYP. Inductive effect of tipiracil on human CYP isoforms cannot be excluded.

*In vitro* evaluation of trifluridine and tipiracil hydrochloride was conducted using human uptake and efflux transporters (trifluridine with MDR1, OATP1B1, OATP1B3 and BCRP; tipiracil hydrochloride with OAT1, OAT3, OCT2, MATE1, MDR1 and BCRP).

Neither trifluridine nor tipiracil hydrochloride was an inhibitor of or substrate for human uptake and efflux transporters based on *in vitro* studies, except for OCT2 and MATE1. Tipiracil hydrochloride was an inhibitor of OCT2 and MATE1 *in vitro*, but at concentrations substantially higher than human plasma  $C_{max}$  at steady state. Thus it is unlikely to cause an interaction with other medicinal products, at recommended doses, due to inhibition of OCT2 and MATE1. Transport of tipiracil hydrochloride by OCT2 and MATE1 might be affected when Lonsurf is administered concomitantly with inhibitors of OCT2 and MATE1.

#### Pharmacokinetic/pharmacodynamic relationship

The efficacy and safety of Lonsurf was compared between a high-exposure group (>median) and a low-exposure group ( $\leq$ median) based on the median AUC value of trifluridine. OS appeared more favourable in the high AUC group compared to the low AUC group (median OS of 9.3 vs. 8.1 months, respectively). All AUC groups performed better than placebo throughout the follow-up period. The incidences of Grade  $\geq 3$  neutropenia were higher in the high-trifluridine AUC group (47.8%) compared with the low-trifluridine AUC group (30.4%).

### **5.3 Preclinical safety data**

#### Repeat-dose toxicity

Toxicology assessment of trifluridine/tipiracil hydrochloride was performed in rats, dogs and monkeys. The target organs identified were the lymphatic and haematopoietic systems and the gastrointestinal tract. All changes, i.e., leucopenia, anaemia, bone marrow hypoplasia, atrophic changes in the lymphatic and haematopoietic tissues and the gastrointestinal tract, were reversible within 9 weeks of drug withdrawal. Whitening, breakage, and malocclusion were observed in teeth of rats treated with trifluridine/tipiracil hydrochloride, which are considered rodent specific and not relevant for human.

#### Carcinogenesis and mutagenesis

No long term studies evaluating the carcinogenic potential of trifluridine/tipiracil hydrochloride in animals have been performed. Trifluridine was shown to be genotoxic in a reverse mutation test in bacteria, a chromosomal aberration test in mammal-cultured cells, and a micronucleus test in mice. Therefore, Lonsurf should be treated as a potential carcinogen.

#### Reproductive toxicity

Results of animal studies did not indicate an effect of trifluridine and tipiracil hydrochloride on male and female fertility in rats. The increases in the corpus luteum count and implanting embryo count observed in female rats at high doses were not considered adverse (see section 4.6). Lonsurf has been shown to cause embryo-foetal lethality and embryo-foetal toxicity in pregnant rats when given at dose levels lower than the clinical exposure. No peri/post-natal developmental toxicity studies have been performed.

## 6 PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

#### Tablet core

Lactose monohydrate  
Starch, Pregelatinised (Maize)  
Stearic acid

#### Film coating

##### *Lonsurf 15 mg/6.14 mg film-coated tablets*

Hypromellose  
Macrogol (8000)  
Titanium dioxide (E171)  
Magnesium stearate

##### *Lonsurf 20 mg/8.19 mg film-coated tablets*

Hypromellose  
Macrogol (8000)  
Titanium dioxide (E171)  
Iron oxide red (E172)  
Magnesium stearate

#### Printing ink

Shellac  
Iron oxide red (E172)  
Iron oxide yellow (E172)  
Titanium dioxide (E171)  
Indigo carmine aluminium lake (E132)  
Carnauba wax  
Talc

### 6.2 Incompatibilities

Not applicable.

### 6.3 Shelf life

30 months.

### 6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

### **6.5 Nature and contents of container**

Aluminium/Aluminium blister with laminated desiccant (Calcium oxide) containing 10 tablets.

Each pack contains 20, 40 or 60 film-coated tablets.

Not all pack sizes may be marketed.

### **6.6 Special precautions for disposal**

Hands should be washed after handling the tablets.

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

## **7 MARKETING AUTHORISATION HOLDER**

Les Laboratoires Servier  
50 rue Carnot  
92284 Suresnes Cedex  
France

## **8 MARKETING AUTHORISATION NUMBER(S)**

EU/1/16/1096/001-006

## **9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

04/2016

## **10 DATE OF REVISION OF THE TEXT**

04/2016

Detailed information on this medicinal product is available on the website of the European Medicines Agency <http://www.ema.europa.eu>.