ANNEX I SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Bosulif 100 mg film-coated tablets Bosulif 400 mg film-coated tablets Bosulif 500 mg film-coated tablets

Bosulif 50 mg hard capsules Bosulif 100 mg hard capsules

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Bosulif 100 mg film-coated tablets

Each film-coated tablet contains 100 mg bosutinib (as monohydrate).

Bosulif 400 mg film-coated tablets

Each film-coated tablet contains 400 mg bosutinib (as monohydrate).

Bosulif 500 mg film-coated tablets

Each film-coated tablet contains 500 mg bosutinib (as monohydrate).

Bosulif 50 mg hard capsules

Each hard capsule contains 50 mg bosutinib (as monohydrate).

Bosulif 100 mg hard capsules

Each hard capsule contains 100 mg bosutinib (as monohydrate).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet.

Bosulif 100 mg film-coated tablets

Yellow oval (width: 5.6 mm; length: 10.7 mm) biconvex, film-coated tablet debossed with "Pfizer" on one side and "100" on the other side.

Bosulif 400 mg film-coated tablets

Orange oval (width: 8.8 mm; length: 16.9 mm) biconvex, film-coated tablet debossed with "Pfizer" on one side and "400" on the other side.

Bosulif 500 mg film-coated tablets

Red oval (width: 9.5 mm; length: 18.3 mm) biconvex, film-coated tablet debossed with "Pfizer" on one side and "500" on the other side.

Hard capsule.

Bosulif 50 mg hard capsules

White body/orange cap (approximate length: 18 mm) with "BOS 50" printed on the body and "Pfizer" printed on the cap in black ink.

Bosulif 100 mg hard capsules

White body/brownish-red cap (approximate length: 22 mm) with "BOS 100" printed on the body and "Pfizer" printed on the cap in black ink.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Bosulif is indicated for the treatment of:

- Adult and paediatric patients aged 6 years and older with newly-diagnosed (ND) chronic phase (CP) Philadelphia chromosome-positive chronic myelogenous leukaemia (Ph+ CML).
- Adult and paediatric patients aged 6 years and older with CP Ph+ CML previously treated with one or more tyrosine kinase inhibitor(s) [TKI(s)] and for whom imatinib, nilotinib and dasatinib are not considered appropriate treatment options.
- Adult patients with accelerated phase (AP), and blast phase (BP) Ph+ CML previously treated with one or more tyrosine kinase inhibitor(s) [TKI(s)] and for whom imatinib, nilotinib and dasatinib are not considered appropriate treatment options.

4.2 Posology and method of administration

Posology

Adult patients with newly-diagnosed CP Ph+ CML

The recommended dose is 400 mg bosutinib once daily.

Adult patients with CP, AP, or BP Ph+ CML with resistance or intolerance to prior therapy. The recommended dose is 500 mg bosutinib once daily.

In clinical studies for both indications, treatment with bosutinib continued until disease progression or intolerance to therapy.

<u>Paediatric patients with newly-diagnosed CP Ph+ CML or with CP Ph+ CML with resistance or intolerance to prior therapy</u>

The recommended dosage of bosutinib for newly-diagnosed paediatric patients is 300 mg/m² body surface area (BSA) orally once daily and the recommended dosage for paediatric patients resistant or intolerant (R/I) to prior therapies is 400 mg/m² BSA orally once daily; dose recommendations are provided in Table 1. As appropriate, the desired dose can be attained by combining different strengths of bosutinib film-coated tablets and/or hard capsules.

Table 1 – Dosing of bosutinib for paediatric patients with newly-diagnosed CP Ph+ CML or with CP Ph+ CML with resistance or intolerance to prior therapy

BSA ND Recommended Dose		R/I Recommended Dose	
$0.55 - < 0.63 \text{ m}^2$	200 mg	250 mg	
$0.63 - < 0.75 \text{ m}^2$	200 mg	300 mg	
$0.75 - < 0.9 \text{ m}^2$	250 mg	350 mg	

$0.9 - < 1.1 \text{ m}^2$	300 mg	400 mg
$\geq 1.1 \text{ m}^2$	$400~\mathrm{mg}^*$	500 mg*

^{*} maximum starting dose (corresponding to maximum starting dose in adult indication)
Abbreviations: AP=accelerated phase; BP=blast phase; BSA=body surface area; CML=chronic myeloid leukaemia; CP=chronic phase; ND=newly-diagnosed; Ph+=Philadelphia chromosome-positive; R/I=resistant or intolerant.

Dose adjustments

In adult patients with CML who are resistant or intolerant to prior therapy, doses can be escalated to 600 mg in those with unsatisfactory response or with signs of progression and in the absence of any Grade 3 or 4 or persistent Grade 2 adverse events.

In adult patients with newly-diagnosed CP CML, doses can be escalated by 100 mg increments to a maximum of 600 mg once daily if patients fail to demonstrate breakpoint cluster region Abelson (BCR-ABL) transcripts \leq 10% at months 3 and do not have a grade 3 or 4 adverse reaction at the time of escalation and all Grade 2 non-haematological toxicities are resolved to at least Grade 1.

In paediatric patients with BSA < $1.1~\text{m}^2$ and an insufficient response after 3 months consider increasing dose by 50 mg increments up to maximum of 100 mg above BSA-adjusted recommended dose. In paediatric patients with BSA $\geq 1.1~\text{m}^2$ and an insufficient response after 3 months consider increasing dose similarly to adult recommendations in 100 mg increments. If there is inadequate clinical response and further dose escalation cannot be performed in paediatric patients, treatment will be stopped.

The maximum dose in paediatric patients is 600 mg once daily in previously treated CML and 500 mg once daily in newly-diagnosed CML.

Doses greater than 600 mg/day have not been studied and, therefore, should not be given.

Dose adjustments for adverse reactions

If clinically significant moderate or severe non-haematological toxicity develops, bosutinib should be interrupted, and may be resumed at a dose reduced by 100 mg taken once daily after the toxicity has resolved. If clinically appropriate, re-escalation to the dose prior to the dose reduction taken once daily should be considered (see section 4.4). Doses less than 300 mg/day have been used in patients; however, efficacy has not been established.

Elevated liver transaminases

If elevations in liver transaminases $> 5 \times$ institutional upper limit of normal (ULN) occur, bosutinib should be interrupted until recovery to $\le 2.5 \times$ ULN and may be resumed at 400 mg once daily thereafter. If recovery takes longer than 4 weeks, discontinuation of bosutinib should be considered. If transaminase elevations $\ge 3 \times$ ULN occur concurrently with bilirubin elevations $> 2 \times$ ULN and alkaline phosphatase $< 2 \times$ ULN, bosutinib should be discontinued (see section 4.4).

Diarrhoea

For NCI Common Terminology Criteria for Adverse Events (CTCAE) Grade 3-4 diarrhoea, bosutinib should be interrupted and may be resumed at 400 mg once daily upon recovery to grade ≤ 1 (see section 4.4).

In paediatric patients, dose adjustments for non-haematologic toxicities can be conducted similarly to adults, however the dose reduction increments may differ. For paediatric patients with BSA $< 1.1 \text{ m}^2$, consider dose reduction by 50 mg initially followed by additional 50 mg reductions if the adverse drug reaction (ADR) persists, in line with recommendations from Table 2. For paediatric patients with BSA $\ge 1.1 \text{ m}^2$ reduce dose similarly to adults.

Haematological adverse reactions

Dose reductions are recommended for severe or persistent neutropenia and thrombocytopenia as described in Table 2:

Table 2 – Dose adjustments for neutropenia and thrombocytopenia in adult and paediatric patients

$ANC^{a} < 1.0 \times 10^{9}/L$	Hold bosutinib until ANC $\geq 1.0 \times 10^9/L$ and platelets $\geq 50 \times 10^9/L$.	
and/or		
Platelets $< 50 \times 10^9/L$	Resume treatment with bosutinib at the same dose if recovery occurs within 2 weeks. If blood counts remain low for > 2 weeks, upon recovery reduce dose by 100 mg in adult patients and paediatric patients with BSA ≥ 1.1 m ² or by 50 mg in paediatric patients with BSA < 1.1 m ² and resume treatment.	
	If cytopoenia recurs, reduce dose by an additional 100 mg in adult patients and paediatric patients with BSA \geq 1.1 m ² upon recovery, or by an additional 50 mg in paediatric patients with BSA $<$ 1.1 m ² and resume treatment.	
	Doses less than 300 mg/day have been used in adult patients and paediatric patients with BSA ≥ 1.1 m ² ; however, efficacy has not been established. Doses less than 300 mg/m ² have been used in paediatric patients however efficacy has not been established.	

^a ANC=absolute neutrophil count; BSA=body surface area

Missed dose

If a dose is missed by more than 12 hours, the patient should not be given an additional dose. The patient should take the usual prescribed dose on the following day.

Special populations

Elderly patients (≥ 65 years)

No specific dose recommendation is necessary in the elderly. Since there is limited information in the elderly, caution should be exercised in these patients.

Renal impairment

Patients with serum creatinine > 1.5×ULN were excluded from CML studies. Increasing exposure (area under curve [AUC]) in patients with moderate and severe renal impairment during studies was observed.

Newly-diagnosed CP Ph+ CML

In adult patients with moderate renal impairment (creatinine clearance [CL_{Cr}] 30 to 50 mL/min, estimated by the Cockcroft-Gault formula), the recommended dose of bosutinib is 300 mg daily with food (see sections 4.4 and 5.2).

In adult patients with severe renal impairment ($CL_{Cr} \le 30$ mL/min, estimated by the Cockcroft-Gault formula), the recommended dose of bosutinib is 200 mg daily with food (see sections 4.4 and 5.2).

Dose escalation to 400 mg once daily with food for adult patients with moderate renal impairment or to 300 mg once daily for patients with severe renal impairment may be considered if they do not experience severe or persistent moderate adverse reactions and if they do not achieve an adequate haematological, cytogenetic, or molecular response.

CP, AP, or BP Ph+ CML with resistance or intolerance to prior therapy In adult patients with moderate renal impairment (CL_{Cr} 30 to 50 mL/min, calculated by the Cockcroft-Gault formula), the recommended dose of bosutinib is 400 mg daily (see sections 4.4 and 5.2).

In patients with severe renal impairment ($CL_{Cr} < 30 \text{ mL/min}$, calculated by the Cockcroft-Gault formula), the recommended dose of bosutinib is 300 mg daily (see sections 4.4 and 5.2).

Dose escalation to 500 mg once daily for adult patients with moderate renal impairment or to 400 mg once daily in patients with severe renal impairment may be considered in those who did not experience severe or persistent moderate adverse reactions, and if they do not achieve an adequate haematological, cytogenetic, or molecular response.

Cardiac disorders

In clinical studies, patients with uncontrolled or significant cardiac disease (e.g., recent myocardial infarction, congestive heart failure or unstable angina) were excluded. Caution should be exercised in patients with relevant cardiac disorders (see section 4.4).

Recent or ongoing clinically significant gastrointestinal disorder

In clinical studies, patients with recent or ongoing clinically significant gastrointestinal disorder (e.g., severe vomiting and/or diarrhoea) were excluded. Caution should be exercised in patients with recent or ongoing clinically significant gastrointestinal disorder (see section 4.4).

Paediatric population

The safety and efficacy of bosutinib in paediatric patients below the age of 1 year with newly-diagnosed, or resistant or intolerant Ph+ CML in CP have not been established. No data are available. The information from paediatric patients below the age of 6 years are too limited so that no dose recommendations can be made (see section 5.1).

Method of administration

Bosulif should be taken orally once daily with food (see section 5.2).

The film-coated tablets should be swallowed whole. Do not cut, crush, break or chew the film-coated tablets.

The hard capsules may be swallowed whole. For patients who are unable to swallow a whole hard capsule(s), each hard capsule can be opened and the contents mixed with applesauce or yogurt. Mixing the hard capsule contents with applesauce or yogurt is no substitute of a proper meal, the dose should be taken with food to increase gastrointestinal tolerability.

If mixing with applesauce or yogurt, patients should immediately consume the full mixture in its entirety, without chewing. The mixture should not be stored for later use. If the entire preparation is not swallowed, an additional dose should not be administered, and it is advised to wait until the next day to resume dosing. In order to facilitate the administration, the recommended volume of applesauce or yogurt is provided in Table 3.

Table 3 – Bosutinib dose using hard capsules and soft food volumes

Dose	Volume of Applesauce or Yogurt	
200 mg	20 mL (4 teaspoons)	
250 mg	25 mL (5 teaspoons)	
300 mg	30 mL (6 teaspoons)	
350 mg	30 mL (6 teaspoons)	
400 mg	35 mL (7 teaspoons)	

500 mg	45 mL (9 teaspoons)
500 mg	15 IIIL (5 teuspoons)

4.3 Contraindications

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

Hepatic impairment (see sections 5.1 and 5.2).

4.4 Special warnings and precautions for use

Liver function abnormalities

Treatment with bosutinib in adult and paediatric patients is associated with elevations in serum transaminases (alanine aminotransferase [ALT], aspartate aminotransferase [AST]).

Transaminase elevations generally occurred early in the course of treatment (of the patients who experienced transaminase elevations of any grade, > 80% experienced their first event within the first 3 months). Patients receiving bosutinib should have liver function tests prior to treatment initiation and monthly for the first 3 months of treatment, and as clinically indicated.

Patients with transaminase elevations should be managed by withholding bosutinib temporarily (with consideration given to dose reduction after recovery to Grade 1 or baseline), and/or discontinuation of bosutinib. Elevations of transaminases, particularly in the setting of concomitant increases in bilirubin, may be an early indication of drug-induced liver injury and these patients should be managed appropriately (see sections 4.2 and 4.8).

Diarrhoea and vomiting

Treatment with bosutinib in adult and paediatric patients is associated with diarrhoea and vomiting; therefore, patients with recent or ongoing clinically significant gastrointestinal disorder should use this medicinal product with caution and only after a careful benefit-risk assessment as respective patients were excluded from the clinical studies. Patients with diarrhoea and vomiting should be managed using standard-of-care treatment, including an anti-diarrhoeal or antiemetic medicinal product and/or fluid replacement. In addition, diarrhoea and vomiting can also be managed by withholding bosutinib temporarily, dose reduction, and/or discontinuation of bosutinib (see sections 4.2 and 4.8). The antiemetic agent, domperidone, has the potential to increase QT interval (QTc) prolongation and to induce "torsade de pointes"- arrhythmias; therefore, co-administration with domperidone should be avoided. It should only be used, if other medicinal products are not efficacious. In these situations an individual benefit-risk assessment is mandatory and patients should be monitored for occurrence of QTc prolongation.

Myelosuppression

Treatment with bosutinib in adult and paediatric patients is associated with myelosuppression, defined as anaemia, neutropenia, and thrombocytopenia. Complete blood counts should be performed weekly for the first month and then monthly thereafter, or as clinically indicated. Myelosuppression should/can be managed by withholding bosutinib temporarily, dose reduction, and/or discontinuation of bosutinib (see sections 4.2 and 4.8).

Fluid retention

Treatment with bosutinib in adult patients may be associated with fluid retention including pericardial effusion, pleural effusion, pulmonary oedema and/or peripheral oedema. Treatment with bosutinib in paediatric patients may be associated with low-grade pericardial effusion and peripheral oedema.

Patients should be monitored and managed using standard-of-care treatment.

In addition, fluid retention can also be managed by withholding bosutinib temporarily, dose reduction, and/or discontinuation of bosutinib (see sections 4.2 and 4.8).

Serum lipase

Elevation in serum lipase has been observed. Caution is recommended in patients with previous history of pancreatitis. In case lipase elevations are accompanied by abdominal symptoms, bosutinib should be interrupted and appropriate diagnostic measures considered to exclude pancreatitis (see section 4.2).

Infections

Bosutinib may predispose patients to bacterial, fungal, viral, or protozoan infections.

Cardiovascular toxicity

Bosulif can cause cardiovascular toxicity including cardiac failure and cardiac ischaemic events. Cardiac failure events occurred more frequently in previously treated patients than in patients with newly-diagnosed CML and were more frequent in patients with advanced age or risk factors, including previous medical history of cardiac failure. Cardiac ischaemic events occurred in both previously treated patients and in patients with newly-diagnosed CML and were more common in patients with coronary artery disease risk factors, including history of diabetes, body mass index greater than 30, hypertension and vascular disorders.

Patients should be monitored for signs and symptoms consistent with cardiac failure and cardiac ischaemia and treated as clinically indicated. Cardiovascular toxicity can also be managed by dose interruption, dose reduction and/or discontinuation of bosutinib.

Proarrhythmic potential

Automated machine-read QTc prolongation without accompanying arrhythmia has been observed. Bosutinib should be administered with caution to patients who have a history of or predisposition for QTc prolongation, who have uncontrolled or significant cardiac disease including recent myocardial infarction, congestive heart failure, unstable angina or clinically significant bradycardia, or who are taking medicinal products that are known to prolong the QTc (e.g., anti-arrhythmic medicinal products and other substances that may prolong QTc [see section 4.5]). The presence of hypokalaemia and hypomagnesaemia may further enhance this effect.

Monitoring for an effect on the QTc is advisable and a baseline electrocardiogram (ECG) is recommended prior to initiating therapy with bosutinib and as clinically indicated. Hypokalaemia or hypomagnesaemia must be corrected prior to bosutinib administration and should be monitored periodically during therapy.

Renal impairment

Treatment with bosutinib may result in a clinically significant decline in renal function in CML adult and paediatric patients. A decline over time in estimated glomerular filtration rate (eGFR) has been observed in patients treated with bosutinib in clinical studies (see section 4.8).

It is important that renal function is assessed prior to treatment initiation and closely monitored during therapy with bosutinib, with particular attention in those patients who have preexisting renal compromise or in those patients exhibiting risk factors for renal dysfunction, including concomitant use of medicinal products with potential for nephrotoxicity, such as diuretics, angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers, and nonsteroidal anti-inflammatory drugs (NSAIDs).

In a renal impairment study, bosutinib exposures were increased in subjects with moderately and severely impaired renal function. Dose reduction is recommended for patients with moderate or severe renal impairment (see sections 4.2 and 5.2).

Patients with serum creatinine $> 1.5 \times \text{ULN}$ were excluded from the CML studies (see sections 4.2 and 5.2).

Clinical data are very limited (n=3) for CML patients with moderate renal impairment receiving an escalated dose of 600 mg bosutinib.

Asian race

According to population pharmacokinetic analyses, Asians had a lower clearance resulting in increased exposure. Therefore, these patients should be closely monitored for adverse reactions especially in case of dose escalation.

Severe skin reactions

Bosutinib can induce severe skin reactions such as Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis. Bosutinib should be permanently discontinued in patients who experience a severe skin reaction during treatment.

Tumour lysis syndrome

Due to the possible occurrence of tumour lysis syndrome (TLS), correction of clinically significant dehydration and treatment of high uric acid levels are recommended prior to initiation of bosutinib (see section 4.8).

Hepatitis B reactivation

Reactivation of hepatitis B (HBV) in patients who are chronic carriers of this virus has occurred after these patients received BCR-ABL TKIs. Some cases resulted in acute hepatic failure or fulminant hepatitis leading to liver transplantation or a fatal outcome.

Patients should be tested for HBV infection before initiating treatment with bosutinib. Experts in liver disease and in the treatment of HBV should be consulted before treatment is initiated in patients with positive HBV serology (including those with active disease) and for patients who test positive for HBV infection during treatment. Carriers of HBV who require treatment with bosutinib should be closely monitored for signs and symptoms of active HBV infection throughout therapy and for several months following termination of therapy (see section 4.8).

Photosensitivity

Exposure to direct sunlight or ultraviolet (UV) radiation should be avoided or minimised due to the risk of photosensitivity associated with bosutinib treatment. Patients should be instructed to use measures such as protective clothing and sunscreen with high sun protection factor (SPF).

Cytochrome P-450 (CYP)3A inhibitors

The concomitant use of bosutinib with strong or moderate CYP3A inhibitors should be avoided, as an increase in bosutinib plasma concentration will occur (see section 4.5).

Selection of an alternate concomitant medicinal product with no or minimal CYP3A inhibition potential, if possible, is recommended.

If a strong or moderate CYP3A inhibitor must be administered during bosutinib treatment, an interruption of bosutinib therapy or a dose reduction in bosutinib should be considered.

CYP3A inducers

The concomitant use of bosutinib with strong or moderate CYP3A inducers should be avoided as a decrease in bosutinib plasma concentration will occur (see section 4.5).

Food effect

Grapefruit products, including grapefruit juice and other foods that are known to inhibit CYP3A should be avoided (see section 4.5).

Sodium

This medicinal product contains less than 1 mmol sodium (23 mg) per 100 mg, 400 mg, or 500 mg film-coated tablet and per 50 mg or 100 mg hard capsules. Patients on low sodium diets should be informed that this product is essentially 'sodium-free'.

4.5 Interaction with other medicinal products and other forms of interaction

Effects of other medicinal products on bosutinib

CYP3A inhibitors

The concomitant use of bosutinib with strong CYP3A inhibitors (including, but not limited to itraconazole, ketoconazole, posaconazole, voriconazole, clarithromycin, telithromycin, nefazodone, mibefradil, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, boceprevir, telaprevir, grapefruit products including grapefruit juice) or moderate CYP3A inhibitors (including, but not limited to fluconazole, ciprofloxacin, erythromycin, diltiazem, verapamil, amprenavir, atazanavir, darunavir/ritonavir, fosamprenavir, aprepitant, crizotinib, imatinib) should be avoided, as an increase in bosutinib plasma concentration will occur.

Caution should be exercised if mild CYP3A inhibitors are used concomitantly with bosutinib.

Selection of an alternate concomitant medicinal product with no or minimal CYP3A enzyme inhibition potential, if possible, is recommended.

If a strong or moderate CYP3A inhibitor must be administered during bosutinib treatment, an interruption of bosutinib therapy or a dose reduction in bosutinib should be considered.

In a study of 24 healthy subjects in whom 5 daily doses of 400 mg ketoconazole (a strong CYP3A inhibitor) were co-administered with a single dose of 100 mg bosutinib under fasting conditions, ketoconazole increased bosutinib C_{max} by 5.2-fold, and bosutinib AUC in plasma by 8.6-fold, as compared with administration of bosutinib alone.

In a study of 20 healthy subjects, in whom a single dose of 125 mg aprepitant (a moderate CYP3A inhibitor) was co-administered with a single dose of 500 mg bosutinib under fed conditions, aprepitant

increased bosutinib C_{max} by 1.5-fold, and bosutinib AUC in plasma by 2.0-fold, as compared with administration of bosutinib alone.

CYP3A inducers

The concomitant use of bosutinib with strong CYP3A inducers (including, but not limited to carbamazepine, phenytoin, rifampicin, St. John's Wort), or moderate CYP3A inducers (including, but not limited to bosentan, efavirenz, etravirine, modafinil, nafcillin) should be avoided, as a decrease in bosutinib plasma concentration will occur.

Based on the large reduction in bosutinib exposure that occurred when bosutinib was co-administered with rifampicin, increasing the dose of bosutinib when co-administering with strong or moderate CYP3A inducers is unlikely to sufficiently compensate for the loss of exposure.

Caution is warranted if mild CYP3A inducers are used concomitantly with bosutinib.

Following concomitant administration of a single dose bosutinib with 6 daily doses of 600 mg rifampicin, in 24 healthy subjects in fed state bosutinib exposure (C_{max} and AUC in plasma) decreased to 14% and 6%, respectively, of the values when bosutinib 500 mg was administered alone.

Proton pump inhibitors (PPIs)

Caution should be exercised when administering bosutinib concomitantly with PPIs. Short-acting antacids should be considered as an alternative to PPIs and administration times of bosutinib and antacids should be separated (i.e. take bosutinib in the morning and antacids in the evening) whenever possible. Bosutinib displays pH-dependent aqueous solubility *in vitro*. When a single oral dose of bosutinib (400 mg) was co-administered with multiple-oral doses of lansoprazole (60 mg) in a study of 24 healthy fasting subjects, bosutinib C_{max} and AUC decreased to 54% and 74%, respectively, of the values seen when bosutinib (400 mg) was given alone.

Effects of bosutinib on other medicinal products

In a study of 27 healthy subjects, in whom a single dose of 500 mg bosutinib was co-administered with a single dose of 150 mg dabigatran etexilate mesylate (a P-glycoprotein [P-gp] substrate) under fed conditions, bosutinib did not increase C_{max} or AUC of dabigatran in plasma, as compared with administration of dabigatran etexilate mesylate alone. The study results indicate that bosutinib does not exhibit clinically relevant P-gp inhibitory effects.

An *in vitro* study indicates that drug-drug interactions are unlikely to occur at therapeutic doses as a result of induction by bosutinib on the metabolism of medicinal products that are substrates for CYP1A2, CYP2B6, CYP2C9, CYP2C19, and CYP3A4.

In vitro studies indicate that clinical drug-drug interactions are unlikely to occur at therapeutic doses as a result of inhibition by bosutinib on the metabolism of medicinal products that are substrates for CYP1A2, CYP2A6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, or CYP3A4/5.

In vitro studies indicate that bosutinib has a low potential to inhibit breast cancer resistance protein (BCRP, systemically), organic anion transporting polypeptide (OATP)1B1, OATP1B3, organic anion transporter (OAT)1, OAT3, organic cation transporter (OCT)2 at clinically relevant concentrations, but may have the potential to inhibit BCRP in the gastrointestinal tract and OCT1.

Anti-arrhythmic medicinal products and other substances that may prolong OT

Bosutinib should be used with caution in patients who have or may develop prolongation of QT, including those patients taking anti-arrhythmic medicinal products such as amiodarone, disopyramide, procainamide, quinidine and sotalol or other medicinal products that may lead to QT prolongation such as chloroquine, halofantrine, clarithromycin, domperidone, haloperidol, methadone, and moxifloxacin (see section 4.4).

4.6 Fertility, pregnancy and lactation

Women of childbearing potential/contraception

Women of childbearing potential should be advised to use effective contraception during treatment with bosutinib and for at least 1 month after the last dose and to avoid becoming pregnant while receiving bosutinib. In addition, the patient should be advised that vomiting or diarrhoea may reduce the efficacy of oral contraceptives by preventing full absorption.

Pregnancy

There are limited amount of data in pregnant women from the use of bosutinib. Studies in animals have shown reproductive toxicity (see section 5.3). Bosutinib is not recommended for use during pregnancy, or in women of childbearing potential not using contraception. If bosutinib is used during pregnancy, or the patient becomes pregnant while taking bosutinib, she should be apprised of the potential hazard to the foetus.

Breast-feeding

It is unknown whether bosutinib and its metabolites are excreted in human milk. A study of [\frac{14C}] radiolabelled bosutinib in rats demonstrated excretion of bosutinib-derived radioactivity in breast milk (see section 5.3). A potential risk to the breast-feeding infant cannot be excluded. Breast-feeding should be discontinued during treatment with bosutinib.

Fertility

Based on non-clinical findings, bosutinib has the potential to impair reproductive function and fertility in humans (see section 5.3). Men being treated with bosutinib are advised to seek advice on conservation of sperm prior to treatment because of the possibility of decreased fertility due to therapy with bosutinib.

4.7 Effects on ability to drive and use machines

Bosutinib has no or negligible influence on the ability to drive and use machines. However, if a patient taking bosutinib experiences dizziness, fatigue, visual impairment or other undesirable effects with a potential impact on the ability to drive or use machines safely, the patient should refrain from these activities for as long as the undesirable effects persist.

4.8 Undesirable effects

Summary of safety profile

A total of 1 372 leukaemia adult patients received at least 1 dose of single-agent bosutinib. The median duration of therapy was 26.30 months (range: 0.03 to 170.49 months). These patients were either newly-diagnosed, with CP CML or were resistant or intolerant to prior therapy with chronic, accelerated, or blast phase CML or Ph+ acute lymphoblastic leukaemia (ALL). The safety analyses included data from a completed extension study.

At least 1 adverse reaction of any toxicity grade was reported for 1,349 (98.3%) patients. The most frequent adverse reactions reported for \geq 20% of patients were diarrhoea (80.4%), nausea (41.5%), abdominal pain (35.6%), thrombocytopenia (34.4%), vomiting (33.7%), rash (32.8%), ALT increased (28.0%), anaemia (27.2%), pyrexia (23.4%), AST increased (22.5%), fatigue (32.0%), and headache (20.3%). At least 1 Grade 3 or Grade 4 adverse reaction was reported for 943 (68.7%) patients. The Grade 3 or Grade 4 adverse reactions reported for \geq 5% of patients were thrombocytopenia (19.7%), ALT increased (14.6%), neutropenia (10.6%), diarrhoea (10.6%), anaemia (10.3%), lipase increased (10.1%), AST increased (6.7%), and rash (5.0%).

Tabulated list of adverse reactions

These adverse reactions are presented by system organ class and frequency. Frequency categories are defined as: very common ($\geq 1/10$), common ($\geq 1/100$ to < 1/10), uncommon ($\geq 1/1000$), rare ($\geq 1/1000$), very rare (< 1/1000), not known (cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

Table 4 – Adverse reactions for bosutinib

Infections and in	festations		
Very common	Nasopharyngitis		
, j	Respiratory tract infection ^a		
Common	Influenza ^b		
	Pneumonia ^c		
	Bronchitis		
Neoplasms benig	n, malignant and unspecified (incl cysts and polyps)		
Uncommon	Tumour lysis syndrome**		
Blood and lymph	atic system disorders		
Very common	Thrombocytopenia ^d		
	Anaemiae		
	Neutropenia ^f		
Common	Leukopenia ^g		
Uncommon	Febrile neutropenia		
	Granulocytopenia		
Immune system o	lisorders		
Common	Drug hypersensitivity		
Uncommon	Anaphylactic shock		
Metabolism and	nutrition disorders		
Very common	Decreased appetite		
Common	Hypophosphataemia ^h		
	Dehydration		
	Hyperkalaemia ⁱ		
Nervous system d	lisorders		
Very common	Headache		
	Dizziness		
Common	Dysgeusia		
Ear and labyrint	h disorders		
Common	Tinnitus		
Cardiac disorder	S		
Common	Pericardial effusion, Cardiac failure ^j , Cardiac ischaemic ^k		
Uncommon	Pericarditis		
Vascular disorde	Vascular disorders		
Common	Hypertension ¹		
	racic and mediastinal disorders		
Very common	Cough		
	Dyspnoea		
	Pleural effusion		
Common	Pulmonary hypertension ^m		
Uncommon	Respiratory failure		
	Acute pulmonary oedema ⁿ		
Not known	Interstitial lung disease		

Gastrointestinal	disorders
Very common	Diarrhoea
	Nausea
	Abdominal pain ^o
	Vomiting
Common	Gastritis
	Gastrointestinal haemorrhage ^p
	Pancreatitis acute ^q
Hepatobiliary dis	sorders
Common	Hepatic function abnormal ^r
	Hepatotoxicity ^s
Uncommon	Liver injury ^t
Skin and subcuta	neous tissue disorders
Very common	Rash ^u
Common	Pruritus
	Acne
	Urticaria
	Photosensitivity reaction ^v
Uncommon	Drug eruption
	Exfoliative rash
	Erythema multiforme
Not known	Stevens-Johnson Syndrome**, Toxic epidermal necrolysis**
Musculoskeletal	and connective tissue disorders
Very common	Arthralgia, Back pain
Common	Myalgia
Renal and urinar	y disorders
Common	Acute kidney injury
	Renal failure
	Renal impairment
General disorder	s and administration site conditions
Very common	Fatigue ^w
	Pyrexia
	Oedema ^x
Common	Chest pain ^y
	Pain
Investigations	
Very common	Alanine aminotransferase increased ^z
	Aspartate aminotransferase increased
	Lipase increased ^{aa}
	Blood creatinine increased
Common	Amylase increased ^{bb}
	Blood creatine phosphokinase increased
	Blood bilirubin increased ^{cc}
	Gamma-glutamyltransferase increased
	Electrocardiogram QT prolonged ^{dd}

- a Respiratory tract infection includes Lower respiratory tract infection, Respiratory tract infection, Respiratory tract infection viral, Upper respiratory tract infection, Viral upper respiratory tract infection
- b Influenza includes H1N1 influenza, Influenza
- c Pneumonia includes Atypical pneumonia, Pneumonia, Pneumonia bacterial, Pneumonia fungal, Pneumonia necrotising, Pneumonia streptococcal
- d Thrombocytopenia includes Platelet count decreased, Thrombocytopenia
- e Anaemia includes Anaemia, Haemoglobin decreased, Red blood cell count decreased
- f Neutropenia includes Neutropenia, Neutrophil count decreased
- g Leukopenia includes Leukopenia, White blood cell count decreased
- h Hypophosphataemia includes Blood phosphorus decreased, Hypophosphataemia

- i Hyperkalaemia includes Blood potassium increased, Hyperkalaemia
- j Cardiac failure includes Cardiac failure, Cardiac failure acute, Cardiac failure chronic, Cardiac failure congestive, Cardiogenic shock, Cardiorenal syndrome, Ejection fraction decreased, Left ventricular failure
- k Cardiac ischaemic includes Acute coronary syndrome, Acute myocardial infarction, Angina pectoris, Angina unstable, Arteriosclerosis coronary artery, Coronary artery disease, Coronary artery occlusion, Coronary artery stenosis, Myocardial infarction, Myocardial ischaemia, Troponin increased
- 1 Hypertension includes the Blood pressure increased, Blood pressure systolic increased, Essential hypertension, Hypertension, Hypertensive crisis
- m Pulmonary hypertension includes Pulmonary arterial hypertension, Pulmonary arterial pressure increased, Pulmonary hypertension
- n Acute pulmonary oedema includes Acute pulmonary oedema, Pulmonary oedema
- o Abdominal pain includes Abdominal discomfort, Abdominal pain, Abdominal pain lower, Abdominal pain upper, Abdominal tenderness, Gastrointestinal pain
- p Gastrointestinal haemorrhage includes Anal haemorrhage, Gastrointestinal haemorrhage, Intestinal haemorrhage, Lower gastrointestinal haemorrhage, Rectal haemorrhage, Upper gastrointestinal haemorrhage
- q Pancreatitis acute includes Pancreatitis, Pancreatitis acute
- r Hepatic function abnormal includes Hepatic enzyme increased, Hepatic function abnormal, Liver function test abnormal, Liver function test increased, Transaminases increased
- s Hepatotoxicity includes Hepatitis, Hepatitis toxic, Hepatotoxicity, Liver disorder
- t Liver injury includes Drug-induced liver injury, Hepatocellular injury, Liver injury
- u Rash includes Rash, Rash macular, Rash maculo-papular, Rash papular, Rash pruritic
- v Photosensitivity reaction includes Photosensitivity reaction, Polymorphic light eruption
- w Fatigue includes Asthenia, Fatigue, Malaise
- x Oedema includes Eyelid oedema, Face oedema, Generalised oedema, Localised oedema, Oedema, Oedema peripheral, Periorbital oedema, Periorbital swelling, Peripheral swelling, Swelling, Swelling of eyelid
- y Chest pain includes Chest discomfort, Chest pain
- z Alanine aminotransferase increased includes Alanine aminotransferase abnormal, Alanine aminotransferase increased
- aa Lipase increased includes Hyperlipasaemia, Lipase increased
- bb Amylase increased includes Amylase increased, Hyperamylasaemia
- cc Blood bilirubin increased includes Bilirubin conjugated increased, Blood bilirubin increased, Blood bilirubin unconjugated increased, Hyperbilirubinaemia
- dd Electrocardiogram QT prolonged includes Electrocardiogram QT prolonged, Long QT syndrome

Paediatric populations

A total of 55 paediatric patients \geq 1 year of age received at least 1 dose of bosutinib in the Phase I/II, multicentre, international, single-arm, open-label BCHILD study. The median duration of treatment was 13.5 months (range: 0.2 to 60.9 months). These patients were either newly-diagnosed CP Ph+CML or resistant or intolerant Ph+CML-CP and CML-AP.

At least 1 adverse reaction of any toxicity grade was reported for 54 (98.2%) paediatric patients. The most frequent adverse reactions reported were diarrhoea (82%), abdominal pain (65%), vomiting (56%), nausea (51%), rash (36%), fatigue (35%), thrombocytopenia (35%), headache (33%), pyrexia (33%), ALT increased (29%), and decreased appetite (24%).

The most frequent Grade 3 or Grade 4 adverse reactions reported were thrombocytopenia (18%), ALT increased (15%) and diarrhoea (13%).

Blood and lymphatic system disorders

Blood and lymphatic events in 55 paediatric patients in the BCHILD study include thrombocytopenia in 19 (34.5%) patients, anaemia in 10 patients (18.2%), and neutropenia in 7 patients (12.7%). One

^{**}Adverse reaction identified post marketing in adults.

patient discontinued treatment due to Grade 4 neutropenia. Among patients with blood and lymphatic events, 37.5% were managed with treatment interruption and 16.7% required dose reduction. Among patients with dose interruptions, none had a positive rechallenge when bosutinib was restarted. The median time to first event was 13 days (range: 1 to 757 days) and the median cumulative duration of grade 3/4 events was 16.0 (range: 4 to 47) days.

Hepatobiliary disorders

Of the 55 participants, the incidence based on laboratory data of ALT and AST increased was 67.3% and 63.6%, respectively and 43 (78.2% participants experienced an increase in either ALT or AST). Most cases of transaminase elevation occurred early in treatment; of participants who experienced transaminase elevations of any grade, 83.7% experienced their first event within 3 months. The median time to onset of ALT and AST increased was 22.0 days (range: 9 to 847 days) and 18.5 days (range: 9 to 169 days), respectively. The median duration of Grade 3/4 events was 18.0 days (range: 2 to 132 days) and 12 days (range: 5 to 19 days) for ALT and AST increased, respectively.

Gastrointestinal disorders

Gastrointestinal disorders of diarrhoea, vomiting and nausea occurred in 81.8%, 56.4%, and 50.9% of the 55 paediatric patients treated with bosutinib in the BCHILD study, respectively. Three (5.5%) patients discontinued bosutinib treatment due to diarrhoea (n=3), abdominal pain (n=2), nausea (n=1) and/or vomiting (n=1). Among paediatric patients with gastrointestinal disorders, 9 (19%) were managed with treatment interruption and 4 (8.3%) required dose reduction. Among the 9 patients who required a treatment interruption, 8 (88.9%) were rechallenged. Of these, 55.6% were successfully rechallenged. The median time to onset for diarrhoea was 2 days and the median duration of any grade diarrhoea was 2 days.

Renal disorders

In the paediatric study, 45 (82%) of the total 55 patients had normal eGFR (\geq 90 mL/min/1.73 m² estimated by Bedside Schwartz Equation) at baseline. Among these 45 patients, 19 (34.5%) experienced a decline in eGFR to Grade 1 (60 < 90 mL/min/1.73 m²) and 1 (1.8%) patient to Grade 2 (30 < 60 mL/min/1.73 m²) at 13.47 months. No participant had a post-baseline eGFR < 45 mL/min/1.73 m² regardless of baseline values.

Description of selected adverse reactions

Blood and lymphatic system disorders

Of the 372 (27.1%) adult patients with reports of adverse reactions of anaemia, 6 patients discontinued bosutinib due to anaemia. Maximum toxicity of Grade 1 occurred in 95 (25.5%) patients, Grade 2 in 135 (36.3%) patients, Grade 3 in 113 patients (30.4%), and Grade 4 in 29 (7.8%) patients. Among these patients, the median time to first event was 29 days (range: 1 to 3 999 days) and the median duration per event was 22 days (range: 1 to 3 682 days).

Of the 209 (15.2%) adult patients with reports of adverse reactions of neutropenia, 19 patients discontinued bosutinib due to neutropenia. Maximum toxicity of Grade 1 occurred in 19 patients (9.1%), Grade 2 in 45 (21.5%) patients, Grade 3 in 95 (45.5%) patients, and Grade 4 in 50 (23.9%) patients. Among these patients, the median time to first event was 56 days (range: 1 to 1 769 days), and the median duration per event was 15 days (range: 1 to 913 days).

Of the 472 (34.4%) adult patients with reports of adverse reactions of thrombocytopenia, 42 patients discontinued bosutinib due to thrombocytopenia. Maximum toxicity of Grade 1 occurred in 114 (24.2%) patients, Grade 2 in 88 (18.6%) patients, Grade 3 in 172 (36.4%) patients, and Grade 4 in 98 (20.8%) patients. Among these patients, the median time to first event was 28 days (range: 1 to 1 688 days), and median duration per event was 15 days (range: 1 to 3 921 days).

Hepatobiliary disorders

Among adult patients with reports of adverse reactions of elevations in either ALT or AST (all grades), the median time of onset observed was 29 days with a range of onset 1 to 3 995 days for ALT

and AST. The median duration of an event was 17 days (range: 1 to 1 148 days), and 15 days (range: 1 to 803 days) for ALT and AST, respectively.

Two cases consistent with drug-induced liver injury (defined as concurrent elevations in ALT or AST \geq 3 × ULN with total bilirubin > 2 × ULN and with alkaline phosphatase < 2 × ULN) without alternative causes have occurred in 2/1 711 (0.1%) adult subjects treated with bosutinib.

Hepatitis B reactivation

Hepatitis B reactivation has been reported in association with BCR-ABL TKIs. Some cases resulted in acute hepatic failure or fulminant hepatitis leading to liver transplantation or a fatal outcome (see section 4.4).

Gastrointestinal disorders

Of the 1 103 (80.4%) patients that experienced diarrhoea, 14 patients discontinued bosutinib due to this event. Concomitant medicinal products were given to treat diarrhoea in 756 (68.5%) patients. Maximum toxicity of Grade 1 occurred in 575 (52.1%) patients, Grade 2 in 383 (34.7%) patients, Grade 3 in 144 (13.1%) patients; 1 patient (0.1%) experienced a Grade 4 event. Among patients with diarrhoea, the median time to first event was 2 days (range: 1 to 2 702 days) and the median duration of any grade of diarrhoea was 2 days (range: 1 to 4 247 days).

Among the 1 103 patients with diarrhoea, 218 patients (19.8%) were managed with treatment interruption and of these 208 (95.4%) were rechallenged with bosutinib. Of those who were rechallenged, 201 (96.6%) did not have a subsequent event or did not discontinue bosutinib due to a subsequent event of diarrhoea.

Cardiac disorders

Among 1372 patients, cardiac failure occurred in 50 (3.6%) patients and cardiac ischaemic events in 57 (4.2%) patients.

Seven patients (0.5%) experienced QTcF prolongation (greater than 500 ms). Eleven (0.8%) patients experienced QTcF increase > 60 ms from baseline. Patients with uncontrolled or significant cardiovascular disease including QTc prolongation, at baseline, were not included in clinical studies (see sections 5.1 and 5.3).

Renal disorders

In patients with newly-diagnosed- CP CML treated with 400 mg, the median decline from baseline in eGFR (estimated by MDRD Equation) was 11.1 mL/min/1.73 m² at 1 year and 14.1 mL/min/1.73 m² at 5 years for patients on treatment. Treatment-naïve CML patients treated with 500 mg showed a median eGFR decline of 9.2 mL/min/1.73 m² at 1 year, 12.0 mL/min/1.73 m² at 5 years and 16.6 mL/min/1.73 m² at 10 years for patients on-treatment. In pre-treated patients with CP and advanced stage CML treated with 500 mg the median eGFR decline was 7.6 mL/min/1.73 m² at 1 year, 12.3 mL/min/1.73 m² at 5 years and 15.9 mL/min/1.73 m² at 10 years for patients on-treatment. In patients with Ph+ CML previously treated with 1 or more TKI(s) treated with 500 mg, the median eGFR decline from baseline was 9.2 mL/min/1.73 m² at 1 year and 14.5 mL/min/1.73 m² at 4 years for patients on-treatment.

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 national reporting system listed in Appendix V.

4.9 Overdose

Experience with bosutinib overdose in clinical studies was limited to isolated cases. Patients who take an overdose of bosutinib should be observed and given appropriate supportive treatment.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antineoplastic agents, protein kinase inhibitors, ATC code: L01EA04.

Mechanism of action

Bosutinib belongs to a pharmacological class of medicinal products known as kinase inhibitors. Bosutinib inhibits the abnormal BCR-ABL kinase that promotes CML. Modelling studies indicate that bosutinib binds the kinase domain of BCR-ABL. Bosutinib is also an inhibitor of Src family kinases including Src, Lyn and Hck. Bosutinib minimally inhibits platelet-derived growth factor (PDGF) receptor and c-Kit.

In *in vitro* studies, bosutinib inhibits proliferation and survival of established CML cell lines, Ph+ ALL cell lines, and patient-derived primary primitive CML cells. Bosutinib inhibited 16 of 18 imatinib-resistant forms of BCR-ABL expressed in murine myeloid cell lines. Bosutinib treatment reduced the size of CML tumours growing in nude mice and inhibited growth of murine myeloid tumours expressing imatinib-resistant forms of BCR-ABL. Bosutinib also inhibits receptor tyrosine kinases c-Fms, EphA and B receptors, Trk family kinases, Axl family kinases, Tec family kinases, some members of the ErbB family, the non-receptor tyrosine kinase Csk, serine/threonine kinases of the Ste20 family, and 2 calmodulin-dependent protein kinases.

Pharmacodynamic effects

The effect of bosutinib 500 mg administration on corrected QTc was evaluated in a randomised, single-dose, double-blind (with respect to bosutinib), crossover, placebo- and open-label moxifloxacin-controlled study in healthy subjects.

The data from this study indicate that bosutinib does not prolong the QTc in healthy subjects at the dose of 500 mg daily with food, and under conditions that give rise to supratherapeutic plasma concentrations. Following administration of a single oral dose of bosutinib 500 mg (therapeutic dose) and bosutinib 500 mg with ketoconazole 400 mg (to achieve supratherapeutic concentrations of bosutinib) in healthy subjects, the upper bound of the 1-sided 95% confidence interval (CI) around the mean change in QTc was less than 10 ms at all post-dose time points, and no adverse events suggestive of QTc prolongation were observed.

In a study in liver impaired subjects, an increasing frequency of QTc prolongation > 450 ms with declining hepatic function was observed. In the Phase 1/2 clinical study in patients with previously treated Ph+ leukaemias treated with bosutinib 500 mg, QTcF increase > 60 ms from baseline was observed in 9 (1.6%) of 570 patients. In the Phase 3 clinical study in patients with newly-diagnosed CP CML treated with bosutinib 400 mg, there were no patients in the bosutinib treatment group (N=268) with a QTcF increase of > 60 ms from baseline. In the Phase 3 clinical study in patients with newly-diagnosed Ph+ CP CML treated with bosutinib 500 mg, QTcF increase > 60 ms from baseline was observed in 2 (0.8%) of 248 patients receiving bosutinib. In the Phase 4 clinical study in patients with Ph+ CML previously treated with 1 or more TKI(s) treated with bosutinib 500 mg (N=163), there

were no patients with a QTcF increase > 60 ms from baseline. A proarrhythmic potential of bosutinib cannot be ruled out.

Clinical efficacy

Clinical study in CP previously untreated CML in adult patients

Bosutinib 400 mg study

A 2-arm, Phase 3, open-label, multicentre superiority trial was conducted to investigate the efficacy and safety of bosutinib 400 mg once daily alone compared with imatinib 400 mg once daily alone in adult patients with newly-diagnosed Ph+ CP CML. The trial randomised 536 patients (268 in each treatment group) with Ph+ or Ph- newly-diagnosed CP CML (intent-to-treat population [ITT]) including 487 patients with Ph+ CML harbouring b2a2 and/or b3a2 transcripts and baseline BCR-ABL copies > 0 (modified intent-to-treat [mITT] population).

The primary efficacy endpoint was the proportion demonstrating a major molecular response (MMR) at 12 months (48 weeks) in the bosutinib treatment group compared with that in the imatinib treatment group in the mITT population. MMR was defined as $\leq 0.1\%$ BCR-ABL/ABL ratio by international scale (corresponding to \geq 3 log reduction from standardised baseline) with a minimum of 3 000 ABL transcripts as assessed by the central laboratory.

Key secondary endpoints included complete cytogenetic response (CCyR) by 12 months, duration of CCyR, duration of MMR, event-free survival (EFS), and overall survival (OS). CCyR by Month 12, was defined as the absence of Ph+ metaphases in chromosome banding analysis of ≥ 20 metaphases derived from bone marrow aspirate or MMR if an adequate cytogenetic assessment was unavailable. The p-values for endpoints other than MMR at 12 months and CCyR by 12 months have not been adjusted for multiple comparisons.

Baseline characteristics for the mITT population were well balanced between the 2 treatment groups with respect to age (median age was 52 years for the bosutinib group and 53 years for the imatinib group with 19.5% and 17.4% of patients 65 years of age or older, respectively); gender (women 42.3% and 44.0%, respectively); race (Caucasian 78.0% and 77.6%, Asian 12.2% and 12.4%, Black or African American 4.1% and 4.1%, and Other 5.7% and 5.4%, respectively, and 1 unknown in the imatinib group); and Sokal risk score (low risk 35.0% and 39.4%, intermediate risk 43.5% and 38.2%, high risk 21.5% and 22.4%, respectively).

After 60 months of follow-up in the mITT population, 60.2% of patients treated with bosutinib (N=246) and 59.8% of patients treated with imatinib (N=239) were still receiving first-line treatment.

After 60 months of follow-up in the mITT population, discontinuations due to disease progression to AP or BP CML for bosutinib-treated patients were 0.8% compared to 1.7% for imatinib-treated patients. Six (2.4%) bosutinib patients and 7 (2.9%) imatinib patients transformed to AP CML or BP CML. Discontinuations due to suboptimal response or treatment failure as assessed by the investigator occurred for 5.3% of patients in the bosutinib-treated group compared to 15.5% of patients in the imatinib-treated group. Twelve (4.9%) patients on bosutinib and 14 (5.8%) patients on imatinib died while on study. No additional transformations occurred in the ITT population, there were 2 additional deaths in the bosutinib arm in the ITT population.

The efficacy results of MMR and CCyR are summarised in Table 5.

Table 5 - Summary of MMR at Months 12 and 18 and CCyR by Month 12, by treatment group in the mITT population

Response	Bosutinib (N=246)	Imatinib (N=241)	Odds ratio (95% CI) ^a
Major molecular response			
MMR at Month 12, n (%)	116 (47.2) ^b	89 (36.9)	1.55 (1.07,2.23)
(95% CI)	(40.9,53.4)	(30.8,43.0)	
1-sided p-value		0.0100 ^b	
MMR at Month 18, n (%)	140 (56.9)	115 (47.7)	1.45 (1.02,2.07)
(95% CI)	(50.7,63.1)	(41.4,54.0)	
1-sided p-value		0.0208°	
Complete cytogenetic response			
CCyR by Month 12, n (%)	190 (77.2) ^b	160 (66.4)	1.74 (1.16,2.61)
(95% CI)	(72.0,82.5)	(60.4,72.4)	
1-sided p-value		0.0037 ^b	

Note: MMR was defined as \leq 0.1% BCR-ABL/ABL ratio by international scale (corresponding to \geq 3 log reduction from standardised baseline) with a minimum of 3 000 ABL transcripts assessed by the central laboratory. Complete cytogenetic response was defined as the absence of Ph+ metaphases in chromosome banding analysis of \geq 20 metaphases derived from bone marrow aspirate or MMR if an adequate cytogenetic assessment was unavailable.

Abbreviations: BCR-ABL=breakpoint cluster region-Abelson; CI=confidence interval;

CMH=Cochran-Mantel-Haenszel; CCyR=complete cytogenetic response; mITT=modified intent-to-treat; MMR=major molecular response; N/n=number of patients; Ph+=Philadelphia chromosome-positive.

At Month 12, the MR⁴ rate (defined as \leq 0.01% BCR-ABL [corresponding to \geq 4 log reduction from standardised baseline] with a minimum of 9,800 ABL transcripts) was higher in the bosutinib treatment group compared to the imatinib treatment group in the mITT population (20.7% [95% CI: 15.7%, 25.8%] versus 12.0% [95% CI: 7.9%, 16.1%], respectively, odds ratio (OR) 1.88 [95% CI: 1.15, 3.08], 1-sided p-value=0.0052).

^a Adjusted for geographical region and Sokal score at randomisation.

^b Statistically significant comparison at the pre-specified significance level; based on CMH test stratified by geographical region and Sokal score at randomisation.

^c Based on CMH test stratified by geographical region and Sokal score at randomisation.

At Months 3, 6, and 9, the proportion of patients with MMR was higher in the bosutinib treatment group compared to the imatinib treatment group (Table 6).

Table 6 - Comparison of MMR at Months 3, 6, and 9 by treatment in the mITT population

	Number (%) of subjects with MMR		
Time	Bosutinib	Imatinib	Odds ratio
	(N=246)	(N=241)	(95% CI) ^a
Month 3	10 (4.1)	4 (1.7)	2.48 (0.77,7.98)
(95% CI)	(1.6,6.5)	(0.0,3.3)	
1-sided p-value ^b		0.0578	1
Month 6	86 (35.0)	44 (18.3)	2.42 (1.59,3.69)
(95% CI)	(29.0,40.9)	(13.4,23.1)	
1-sided p-value ^b		< 0.0001	
Month 9	104 (42.3)	71 (29.5)	1.78 (1.22,2.60)
(95% CI)	(36.1,48.4)	(23.7,35.2)	
1-sided p-value ^b		0.0015	1

Note: Percentages were based on number of patients in each treatment group. MMR was defined as $\leq 0.1\%$ BCR-ABL/ABL ratio on international scale (corresponding to ≥ 3 log reduction from standardised baseline) with a minimum of 3 000 ABL transcripts assessed by the central laboratory.

Abbreviations: BCR-ABL=breakpoint cluster region-Abelson; CI=confidence interval;

CMH=Cochran-Mantel-Haenszel; mITT=modified intent-to-treat; MMR=major molecular response; N=number of patients.

By Month 60 in the mITT population, the proportion of patients with MMR, MR⁴ and MR^{4.5} was higher in the bosutinib group compared to the imatinib group (Table 7). MMR rates by Month 60 across Sokal risk subgroups are summarised in Table 8.

Table 7 - Summary of molecular response by Month 60 in the mITT population

Response	Bosutinib (N=246)	Imatinib (N=241)	Odds ratio (95% CI) ^a
Molecular response by Month 60, n (%) (95% CI)			
MMR	182 (74.0) (68.5,79.5)	158 (65.6) (59.6,71.6)	1.52 (1.02,2.25)
MR ⁴	145 (58.9) (52.8,65.1)	120 (49.8) (43.5,56.1)	1.46 (1.02,2.09)
MR ^{4.5}	119 (48.4) (42.1,54.6)	93 (38.6) (32.4,44.7)	1.50 (1.05,2.16)

Note: MMR/MR^{4/M}R^{4.5} were defined as $\leq 0.1/0.01/0.0032\%$ BCR-ABL/ABL ratio on international scale (corresponding to $\geq 3/4/4.5$ log reduction from standardised baseline) with a minimum of 3 000/9 800/30 990 ABL transcripts assessed by the central laboratory.

Abbreviations: BCR-ABL=breakpoint cluster region-Abelson; CI=confidence interval; mITT=modified intent-to-treat; MMR=major molecular response; MR=molecular response; N/n=number of patients.

^a Adjusted for geographical region and Sokal score at randomisation.

^b Based on CMH test stratified by geographical region and Sokal score at randomisation.

^a Adjusted for geographical region and Sokal score at randomisation.

Table 8 - Summary of MMR by Month 60 by Sokal risk score in the mITT population

Response	Bosutinib	Imatinib	Odds ratio (95% CI)
Low Sokal risk	N=86	N=95	1.40 (0.71,2.76)
MMR, n (%)	67 (77.9)	68 (71.6)	
(95% CI)	(69.1,86.7)	(62.5,80.6)	
Intermediate Sokal risk	N=107	N=92	1.37 (0.74,2.52)
MMR, n (%)	79 (73.8)	62 (67.4)	
(95% CI)	(65.5,82.2)	(57.8,77.0)	
High Sokal risk	N=53	N=54	1.97 (0.90,4.32)
MMR, n (%)	36 (67.9)	28 (51.9)	
(95% CI)	(55.4,80.5)	(38.5,65.2)	

Note: Percentages were based on number of patients in each treatment group. MMR was defined as $\leq 0.1\%$ BCR-ABL/ABL ratio on international scale (corresponding to ≥ 3 log reduction from standardised baseline) with a minimum of 3 000 ABL transcripts assessed by the central laboratory.

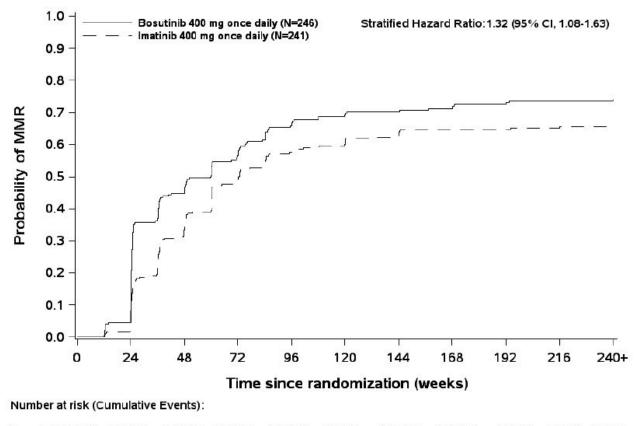
Abbreviations: BCR-ABL=breakpoint cluster region-Abelson; CI=confidence interval; mITT=modified intent-to-treat; MMR=major molecular response; N/n=number of patients.

The cumulative incidence of CCyR adjusted for the competing risk of treatment discontinuation without CCyR was higher in the bosutinib treatment group compared to the imatinib treatment group in the mITT population (83.3% [95% CI: 78.1%, 87.4%] versus 76.8% [95% CI: 70.9%, 81.6%] at Month 60; hazard ratio [HR] from a stratified proportional sub distributional hazards model: 1.35, [95% CI: 1.11, 1.64]). The median time to CCyR (responders only) was 24.0 weeks (range: 11.4 to 120.7) in the bosutinib group compared to the 24.3 weeks (range: 11.4 to 96.6) in the imatinib group.

The median time to MMR, MR⁴ and MR^{4.5} (responders only) was 36.1 weeks (range: 11.9 to 241.9), 83.7 weeks (range: 12.4 to 244.3), and 108.0 weeks (range: 24.1 to 242.1), respectively, for the bosutinib treatment group versus 47.7 weeks (range: 12.1 to 216.1), 84.4 weeks (range: 23.6 to 241.9), and 120.4 weeks (range: 24.6 to 240.7), respectively, for the imatinib treatment group in the mITT population.

The cumulative incidence of MMR, MR⁴ and MR^{4.5} adjusted for the competing risk of treatment discontinuation without the event was higher with bosutinib compared to imatinib as shown in Figures 1 to 3.

Figure 1 - Cumulative incidence of MMR (mITT population)



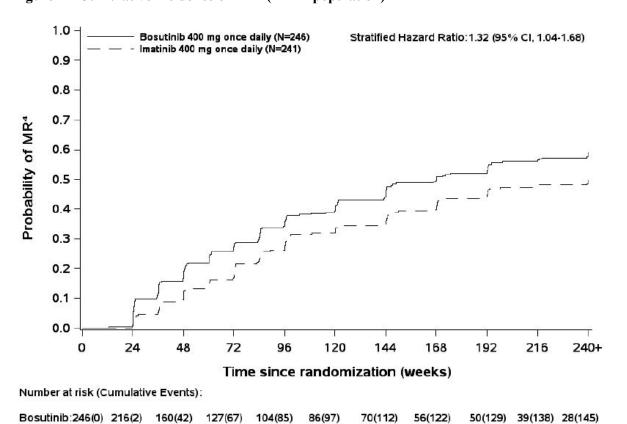
Bosutinib:246(0) 206(20) 58(139) 30(162) 19(170) 12(173) 10(175) 6(179) 4(181) 3(182) Imatinib: 241(0) 204(11) 116(81) 62(116) 29(139) 23(145) 16(153) 10(156) 10(156) 8(157) 5(158)

Figure 2 - Cumulative incidence of MR⁴ (mITT population)

Imatinib: 241(0) 209(3)

172(25)

133(41)



86(77)

78(85)

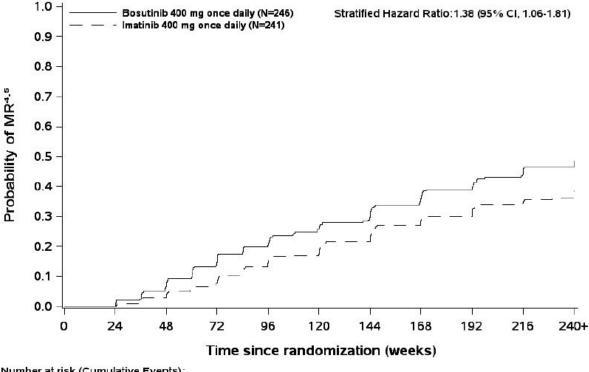
61(96)

49(107)

39(115) 28(120)

101(65)

Figure 3 - Cumulative incidence of MR^{4.5} (mITT population)



Number at risk (Cumulative Events):

Bosutinib:246(0) 218(0) 159(36) 89(88) 76(98) 65(108) 50(119) 185(16) 138(50) 116(64) 103(76) Imatinib: 241(0) 210(0) 188(8) 155(19) 128(35) 118(42) 107(54) 86(69) 79(73) 67(83) 47(93)

In the mITT population, among patients who achieved CCyR, the Kaplan-Meier estimate of maintaining a response at Year 4 was 97.4% (95% CI: 93.9%, 98.9%) and 93.7% (95% CI: 88.9%, 96.5%) in the bosutinib and imatinib groups (HR 0.39 [95% CI: 0.14, 1.13]), respectively. Among patients who achieved MMR, the Kaplan-Meier estimate of maintaining a response at Year 4 was 92.2% (95% CI: 86.8%, 95.4%) and 92.0% (95% CI: 85.9%, 95.5%) in the bosutinib and imatinib groups (HR 1.09 [95% CI: 0.49, 2.44]), respectively.

By Month 60, 43.9% (95% CI: 37.7%, 50.1%) and 38.6% (95% CI: 32.4%, 44.7%) of bosutinib- and imatinib-treated patients (OR 1.24 [95% CI: 0.87, 1.78]) in the mITT population, respectively, had sustained MR⁴ defined by the following criteria: treatment for at least 3 years with at least MR⁴ at all assessments during a 1-year period.

The cumulative incidence of on-treatment EFS events at Month 60 in the mITT population was 6.9% (95% CI: 4.2%, 10.5%) in the bosutinib arm and 10.4% (95% CI: 6.9%, 14.6%) in the imatinib arm (HR 0.64, 95% CI: 0.35, 1.17).

The Kaplan-Meier estimates of OS at Month 60 for bosutinib and imatinib patients in the mITT population were 94.9% (95% CI: 91.1%, 97.0%) and 94.0% (95% CI: 90.1%, 96.4%), respectively (HR 0.80, 95% CI: 0.37, 1.73).

In a retrospective analysis, among evaluable patients in the ITT population, more patients in the bosutinib arm 200/248 (80.6%) achieved early molecular response (BCR-ABL transcripts ≤ 10% at 3 months) compared to patients in the imatinib arm 153/253 (60.5%), OR 2.72 (95% CI: 1.82, 4.08). MMR and EFS at Month 60 in bosutinib patients with and without early molecular response are summarised in Table 9.

Table 9 - Outcomes at Month 60 in bosutinib patients with BCR-ABL \leq 10% vs > 10% at Month 3 in the ITT population

Bosutinib (N=248)	Patients with BCR-ABL ≤ 10% at 3 Months (N=200)	Patients with BCR-ABL > 10% at 3 Months (N=48)	Hazard Ratio (95% CI) ^a
Cumulative incidence of MMR, % (95% CI)	84.0 (78.1,88.4)	56.5 (41.1,69.4)	2.67 (1.90,3.75)
Cumulative incidence of EFS events, % (95% CI)	5.5 (2.9,9.3)	12.5 (5.1,23.4)	0.40 (0.14,1.17)

Abbreviations: BCR-ABL=breakpoint cluster region-Abelson; CI=confidence interval; ITT=intent-to-treat; MMR=major molecular response; EFS=event free survival; N=number of patients with ≥ 3 000 ABL copies at Month 3.

Fewer patients in the bosutinib arm [6 (2.4%) bosutinib and 12 (5.0%) imatinib] had newly detectable mutations at 60 months in the mITT population.

Phase 1/2 Clinical study in imatinib-resistant or intolerant CML in CP, AP, and BP A single-arm, Phase 1/2 open-label, multicentre trial was conducted to evaluate the efficacy and safety of bosutinib 500 mg once daily in patients with imatinib-resistant or -intolerant CML with separate cohorts for chronic, accelerated, and blast phase disease previously treated with 1 prior TKI (imatinib) or more than 1 TKI (imatinib followed by dasatinib and/or nilotinib).

There were 570 patients treated with bosutinib in this trial including CP CML patients previously treated with only 1 prior TKI (imatinib), CP CML patients previously treated with imatinib and at least 1 additional TKI (dasatinib and/or nilotinib), CML patients in accelerated or blast phase previously treated with at least 1 TKI (imatinib) and patients with Ph+ ALL previously treated with at least 1 TKI (imatinib).

The primary efficacy endpoint of the study was the major cytogenetic response (MCyR) rate at Week 24 in patients with imatinib-resistant CP CML previously treated with only 1 prior TKI (imatinib). Other efficacy endpoints include the cumulative cytogenetic and molecular response rates, time to and duration of cytogenetic and molecular responses, response in baseline mutations, transformation to AP/BP, progression free survival and OS for all cohorts.

Patients who were still receiving bosutinib at the end of the Phase 1/2 study and were benefiting from bosutinib treatment as judged by the investigator, as well as those patients who had already discontinued bosutinib as part of the Phase 1/2 study and were in long-term follow-up for survival or had completed the Phase 1/2 study, were eligible for enrollment into the extension study. Each patient remained in the extension study, either on bosutinib treatment or in long-term survival follow-up, until the last patient reached 10 years of follow-up, as calculated from the date of his/her first dose of bosutinib administered in the Phase 1/2 study.

Extension study efficacy endpoints included duration of cytogenetic and molecular responses, transformation to AP/BP, progression free survival, and OS.

The efficacy analyses included data from this completed extension study. *CP CML patients*

The efficacy results for Ph+ CP CML patients previously treated with imatinib and at least 1 additional TKI (minimum follow-up 120 months, median treatment duration of 9 months (range: 0.23 to 164.28 months) and 20.2% and 7.6% still on-treatment at 60 and 120 months, respectively) and the results for Ph+ CP CML patients previously treated with only imatinib (minimum follow-up

^a Adjusted for geographical region and Sokal score at randomisation.

120 months, median treatment duration of 26 months (range: 0.16 to 170.49 months) and 40.5% and 19.4% still on-treatment at 60 and 120 months, respectively) are presented in Table 9.

AP and BP CML patients

The efficacy results for AP (minimum follow-up 120 months, median treatment duration of 10 months (range: 0.10 to 156.15 months) and 12.7% and 7.6% still on-treatment at 60 and 120 months, respectively) and BP (minimum follow-up 120 months, median treatment duration of 2.8 months (range: 0.03 to 71.38 months) and 3.1% and 0% still on-treatment at 60 and 120 months, respectively) Ph+ CML patients are present in Table 10.

Table 10 - Efficacy results in previously treated patients with chronic and advanced phase CML*

	Ph+ CP CML	Ph+ CP CML	Accelerated	Blast phase
	with prior	with prior	phase with	with prior
	imatinib	treatment	prior	treatment of
	treatment	with imatinib	treatment of	at least
	only	and dasatinib	at least	imatinib
		or nilotinib	imatinib	
Cumulative cytogenetic	N=262	N=112	N=72	N=54
response ^a	59.9	42.0	40.3	37.0
MCyR, % (95% CI)	(53.7,65.9)	(32.7,51.7)	(28.9,52.5)	(24.3,51.3)
CCyR, % (95% CI)	49.6	32.1	30.6	27.8
	(43.4,55.8)	(23.6,41.6)	(20.2,42.5)	(16.5,41.6)
Cumulative molecular	N=197	N=107	N=54	N=48
response ^a	42.1	17.8	16.7 (7.9,29.3)	10.4 (3.5,22.7)
MMR, % (95% CI)	(35.1,49.4)	(11.0,26.3)	13.0 (5.4,24.9)	10.4 (3.5,22.7)
MR ⁴ , % (95% CI)	37.1	15.0 (8.8,23.1)		
	(30.3,44.2)			
Time to MCyR for	12.3	12.3	12.0	8.2 (3.9,25.1)
responders onlyb, median	(4.0,346.0)	(3.9,550.6)	(3.9,144.7)	, , ,
(range), weeks		,		
Duration of MCyR ^b	N=157	N=47	N=29	N=20
K-M at year 5, % (95% CI)	70.7	66.6	40.8	21.2 (0.1,42.3)
K-M at year 10, % (95%	(63.1,78.3)	(51.5,81.7)	(20.9,60.7)	N/E
CI)	65.3	55.3	40.8	29.1
Median, weeks (95% CI)	(56.6,74.0)	(36.3,74.4)	(20.9,60.7)	(11.9,38.3)
	N/R	N/R	84.0 (24.0,N/E)	
Time to CCyR for	24.0	24.0	23.8	8.4 (3.9,25.1)
responders only ^b , median	(7.7,240.6)	(11.6,216.0)	(4.1,120.0)	
(range), weeks				
Duration of CCyR ^b	N=130	N=36	N=22	N=15
K-M at year 5, % (95% CI)	69.7	54.4	40.0	24.9 (0.9,48.9)
K-M at year 10, % (95%	(61.3,78.2)	(36.7,72.1)	(18.5,61.5)	N/E
CI)	63.4	40.8	40.0	20.0 (9.1,29.6)
Median, weeks (95% CI)	(54.0,72.8)	(22.0,59.6)	(18.5,61.5)	
	N/R	252.0	72.0 (36.1,N/E)	
		(24.0,N/E)		
Time to MMR for responders	35.6	12.4	36.1	4.7 (3.9,168.9)
only ^b , median (range), weeks	(3.1,367.1)	(4.0,171.7)	(12.1,144.1)	
Duration of MMR ^b	N=83	N=19	N=9	N=5
K-M at year 5, % (95% CI)	74.1	70.0	66.7	60.0
K-M at year 10, % (95%	(64.2,83.9)	(47.5,92.5)	(35.9,97.5)	(17.1,100.0)
CI)		70.0	66.7	N/E
Median, weeks (95% CI)		(47.5,92.5)	(35.9,97.5)	N/R

	63.4	N/R	N/R	
	(50.2,76.6)	1 1/10	17713	
	N/R			
Time to MR ⁴ for responders	28.0	23.8	24.1	4.7 (3.9,284.9)
only ^b , median (range), weeks	(3.1,583.1)	(4.0,240.1)	(22.9,96.0)	, (0.3,20.13)
Duration of MR ^{4b,e}	N=73	N/A	N/A	N/A
K-M at year 5, % (95% CI)	74.7			
K-M at year 10, % (95%	(64.2,85.2)			
CI)	60.8			
Median, weeks (95% CI)	(46.1,75.4)			
	N/R			
Transformation to AP/ BP ^c	N=284	N=119	N=79	N/A
On-treatment	15	5	3	
transformation, n				
Progression-free survival ^c	N=284	N=119	N=79	N=64
CumInc at year 5, % (95%	19.7	24.4	41.8	67.2
CI) ^d	(15.6,24.9)	(17.8, 33.4)	(32.2,54.2)	(56.6,79.7)
CumInc at year 10, % (95%	23.9	26.9	41.8	N/E
CI) ^d	(19.5,29.5)	(20.0,36.2)	(32.2,54.2)	
,				
Overall survival ^c	N=284	N=119	N=79	N=64
K-M at year 5, % (95% CI)	83.5	74.1	58.5	22.5 (7.1,37.9)
K-M at year 10, % (95%	(78.7,88.3)	(64.8,83.4)	(46.9,70.2)	22.5 (7.1,37.9)
CI)	71.5	60.4	50.7	10.9 (8.7,19.7)
Median, months (95% CI)	(64.4, 78.7)	(47.2,73.7)	(36.5,65.0)	, , ,
	N/R	N/R	N/R	
C			·	

Snapshot date: Phase 1/2 Study 02Oct2015, Extension Study 02Sep2020.

Cytogenetic Response criteria: MCyR included Complete [0% Ph+ metaphases from bone marrow or < 1% positive cells from fluorescent *in situ* hybridisation (FISH)] or partial (1%-35%) cytogenetic responses. Cytogenetic responses were based on the percentage of Ph+ metaphases among \geq 20 metaphase cells in each bone marrow sample. FISH analysis (\geq 200 cells) could be used for post-baseline cytogenetic assessments if

 \geq 20 metaphases were not available. In the extension study, CCyR was imputed from MMR if a valid cytogenetic assessment was not available on a specific date.

Molecular response criteria: In the Phase 1/2 Study, MMR/MR⁴ was defined as $\leq 0.1/0.01\%$ BCR-ABL transcripts as assessed by a central laboratory (not on the international scale). In the extension study, responders had MMR/MR⁴ denoted on the case report form as assessed by a local laboratory.

Abbreviations: AP=accelerated phase; BP=blast phase; Ph+=Philadelphia chromosome-positive; CP=chronic phase; CML=chronic myelogenous leukaemia; K-M=Kaplan-Meier; N/n=number of patients; N/A=not applicable; N/R=not reached as of minimum follow-up; N/E=not estimable; CI=confidence interval; MCyR=major cytogenetic response; CCyR=complete cytogenetic response; CumInc=cumulative incidence; MMR=major molecular response; BCR-ABL=breakpoint cluster region-Abelson.

^a Includes patients (N) with a valid baseline assessment for cytogenetic and patients not from China, South Africa, India, or Russia for molecular as samples could not be exported for molecular assessment in those countries. The analyses allow baseline responders who maintained response post-baseline to be responders. Minimum follow-up time (time from last patient first dose to data snapshot date) of 120 months.

^b Includes patients (N) who attained or maintained response.

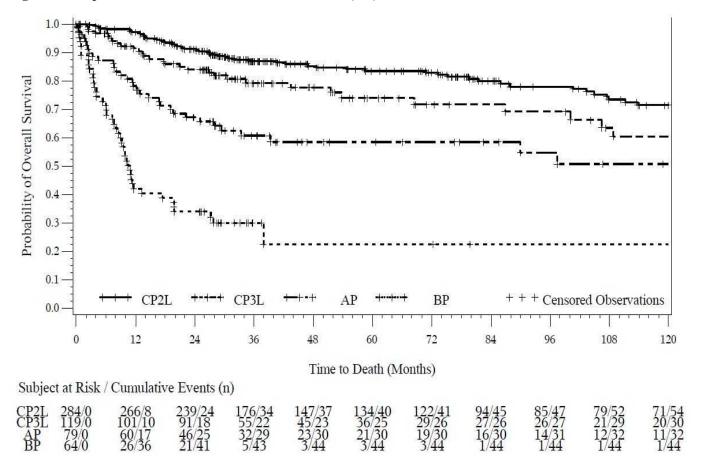
^c Including patients (N) who received at least 1 dose of bosutinib.

^d Cumulative incidence analysis adjusting for the competing risk of treatment discontinuation without the event.

^e Not analysed for groups with limited numbers.

The Overall Survival in the CP, AP and BP cohorts is displayed graphically in Figure 4.

Figure 4 - Kaplan-Meier Estimate of Overall Survival (OS) in CP2L, CP3L, AP, and BP



Based on the limited clinical information from the Phase 1/2 study, some evidence of clinical activity was observed in patients with BCR-ABL mutations (see Table 11).

Table 11 - Response by baseline BCR-ABL mutation status in CP CML evaluable population: prior imatinib and dasatinib and/or nilotinib (third-line)

BCR-ABL mutation status at baseline	Incidence at baseline n (%) ^a	MCyR attained or maintained Resp/Eval ^b (%) N=112
Mutation assessed	98 (100.0)	36/92 (39.1)
No mutation	59 (60.2)	23/55 (41.8)
At least 1 mutation	39 (39.8)	13/37 (35.1)
Dasatinib resistant mutations	10 (10.2)	1/9 (11.1)
E255K/V	2 (2.0)	0/2
F317L	8 (8.2)	1/7 (14.3)
Nilotinib resistant mutations ^c	13 (13.3)	8/13 (61.5)
Y253H	6 (6.1)	5/6 (83.3)
E255K/V	2 (2.0)	0/2
F359C/I/V	7 (7.1)	5/7 (71.4)

Snapshot date: Phase 1/2 Study 02Oct2015, Extension Study 02Sep2020

Note: Baseline mutations were identified before the patient's first dose of study drug.

Abbreviations: BCR-ABL=breakpoint cluster region-Abelson; CP=chronic phase; CML=chronic myelogenous leukaemia; MCyR=major cytogenetic response; N/n=number of patients; Resp=responders; Eval=evaluable.

^a The percentage is based on number of patients with baseline mutation assessment.

One patient with the E255V mutation previously treated with nilotinib achieved CHR as best response.

In vitro testing indicated that bosutinib had limited activity against the T315I or the V299L mutation. Therefore, clinical activity in patients with these mutations is not expected.

Phase 4 Clinical study in Ph+ CML previously treated with 1 or more TKI(s)
A single-arm, Phase 4 open-label, non-randomised, multi-centre study was conducted to evaluate the efficacy and safety of bosutinib 500 mg once daily in patients with TKI-resistant or TKI-intolerant CML with separate cohorts for CP, AP or BP disease previously treated with 1 or more prior TKIs.

There were 163 patients treated with bosutinib in this trial including 46 patients with CP Ph+ CML and treated previously with 1 prior TKI (imatinib or dasatinib or nilotinib), 61 CP Ph+ CML patients previously treated with 2 prior TKIs (imatinib and/or dasatinib and/or nilotinib), 49 CP Ph+ CML patients treated with 3 prior TKIs (imatinib and dasatinib and nilotinib), 4 patients with AP Ph+ CML previously treated with at least 1 TKI (2 patients treated with 2 prior TKIs and 2 patients treated with 3 prior TKIs) and 3 patients with Ph- CML treated with at least 1 prior TKI.

The primary efficacy endpoint was cumulative confirmed MCyR by 1 year (Week 52) in patients with CP Ph+ CML previously treated with 1 or 2 prior TKIs and patients with CP Ph+ CML previously treated with 3 prior TKIs. For patients with AP and BP Ph+ CML with any prior TKI therapy, the primary efficacy endpoint was cumulative confirmed overall haematological response (OHR) by 1 year (Week 52). Other efficacy endpoints in Ph+ CP CML patients include cumulative cytogenetic and molecular response, the duration of cytogenetic and molecular responses, response in baseline mutations, transformation to AP/BP, PFS, and OS. Additional endpoints in the Ph+ AP/BP cohort include cumulative cytogenetic and molecular responses rates, PFS and OS.

CP CML patients

The primary endpoint of cumulative confirmed MCyR (95% CI) rate by 1 year (52 weeks) was 76.5% (66.9, 84.5) in patients treated with 1 or 2 prior TKIs and 62.2% (46.5, 76.2) in patients treated with 3 prior TKIs.

Additional efficacy results at study closure, after a minimum follow-up of 3 years, in Ph+ CP CML patients treated with 1 (median treatment duration 47.5 months (range: 0.9 to 50.1 months) and 60.9% still on-treatment), 2 (median treatment duration 41.9 months (range: 0.4 to 48.9 months) and 45.9% still on-treatment) and 3 (median treatment duration 20.0 months (range: 0.2 to 48.9 months) and 38.8% still on-treatment) prior TKIs are presented in Table 12.

^b The evaluable population includes patients who had a valid baseline disease assessment.

^c 2 patients had more than 1 mutation in this category.

Table 12 – Efficacy results in previously treated patients with chronic phase Ph+ CML

	Ph+ CP CML treated with 1 prior TKI	Ph+ CP CML treated with 2 prior TKIs	Ph+ CP CML treated with 3 prior TKIs	Total Ph+ CP CML cohort
Cumulative confirmed	N=43	N=55	N=45	N=143
MCyR ^a by 1 year, % (95% CI)	83.7 (69.3,93.2)	70.9 (57.1,82.4)	62.2 (46.5,76.2)	72.0 (63.9,79.2)
Cumulative cytogenetic response ^{a,b}	N=43	N=55	N=45	N=143
MCyR, % (95% CI)	88.4 (74.9,96.1)	85.5 (73.3,93.5)	77.8 (62.9,88.8)	83.9 (76.9,89.5)
CCyR, % (95% CI)	86.0 (72.1,94.7)	83.6 (71.2,92.2)	73.3 (58.1,85.4)	81.1 (73.7,87.2)
Cumulative molecular response ^{a,b}	N=46	N=55	N=48	N=149
MMR, % (95% CI)	82.6 (68.6,92.2)	76.4 (63.0,86.8)	56.3 (41.2,70.5)	71.8 (63.9,78.9)
MR ⁴ , % (95% CI)	73.9 (58.9,85.7)	63.6 (49.6,76.2)	41.7 (27.6,56.8)	59.7 (51.4,67.7)
MR ^{4.5} , % (95% CI)	58.7 (43.2,73.0)	50.9 (37.1,64.6)	35.4 (22.2,50.5)	48.3 (40.1,56.6)
Time to cytogenetic response for responders only ^b , median (range), months				
MCyR	3.0 (1.0,11.8)	2.9 (0.3,6.4)	3.0 (1.8,8.8)	3.0 (0.3,11.8)
CCyR	3.0 (1.0,17.6)	2.9 (0.3,6.4)	3.0 (1.8,8.8)	3.0 (0.3,17.6)
Duration of cytogenetic response ^b				
MCyR, K-M at year 3, % (95% CI)	96.6 (77.9,99.5)	94.4 (79.2,98.6)	96.9 (79.8,99.6)	95.6 (88.7,98.4)
CCyR, K-M at year 3, % (95% CI)	96.4 (77.2,99.5)	94.4 (79.2,98.6)	100.0 (100.0,100.0)	96.5 (89.5,98.9)
Time to molecular response for responders only, median (range), months				
MMR	3.0 (2.8,23.3)	3.0 (1.0,35.9)	3.1 (1.8,9.3)	3.0 (1.0,35.9)
MR ⁴	6.0 (2.8,47.4)	3.1 (1.0,36.1)	3.2 (1.8,47.9)	5.5 (1.0,47.9)
MR ^{4.5}	9.2 (2.8,47.6)	6.0 (2.8,36.2)	5.8 (1.8,18.0)	6.0 (1.8,47.6)

Duration of molecular response ^b				
MMR, K-M at year 3, % (95% CI)	90.7 (73.9,96.9)	81.5 (63.2,91.3)	90.2 (65.9,97.5)	87.2 (78.0,92.7)
MR ⁴ , K-M at year 3, % (95% CI)	89.5 (70.9,96.5)	68.7 (48.0,82.5)	85.2 (51.9,96.2)	80.7 (69.4,88.1)

Snapshot date: 23Nov2020.

Abbreviations: Ph+=Philadelphia chromosome-positive; CP=chronic phase; CML=chronic myelogenous leukaemia; K-M=Kaplan-Meier; N=number of patients; CI=confidence interval; MCyR=major cytogenetic response; CCyR=complete cytogenetic response; MMR=major molecular response; MR⁴=≥ 4 log-reduction in BCR-ABL transcripts from standardised baseline; MR^{4.5}=≥ 4.5 log-reduction in BCR-ABL transcripts from standardised baseline.

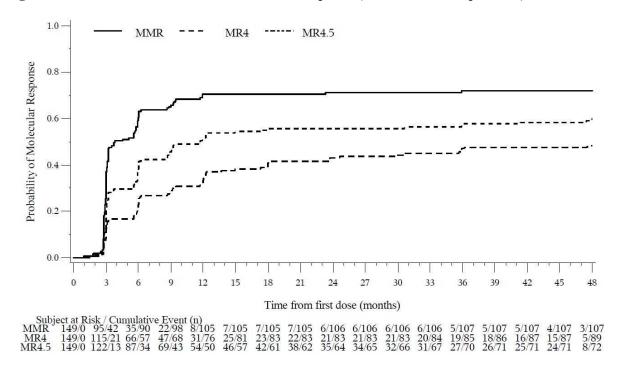
Cumulative Confirmed MCyR criteria: Response is confirmed with 2 consecutive evaluations at least 28 days apart. To be considered a responder, the patient must have maintained a baseline response for at least 52 weeks or improved from baseline. Patients with partial cytogenetic response (PCyR) at baseline must attain CCyR on-treatment to be counted as a cytogenetic responder. Patients with at least MMR and a deeper molecular response than baseline are counted as confirmed CCyR.

Cumulative Cytogenetic Response criteria: Major Cytogenetic Response included Complete [0% Ph+ metaphases from bone marrow or < 1% positive cells from fluorescent *in situ* hybridisation (FISH)] or partial (1%-35%) cytogenetic responses. Cytogenetic responses were based on the percentage of Ph+ metaphases among ≥ 20 metaphase cells in each bone marrow sample. FISH analysis (≥ 200 cells) could be used to assess CCyR if ≥ 20 metaphases were not available. Patients without a valid bone marrow or FISH assessment and with at least MMR are counted as CCyR.

Cumulative Molecular Response criteria: MMR, MR⁴, and MR^{4.5} were defined as \leq 0.1%, \leq 0.01%, and \leq 0.0032% BCR-ABL/ABL ratio on international scale, respectively (corresponding to \geq 3, \geq 4, and \geq 4.5 log-reduction from standardised baseline) with a minimum of 10 000, 10 000, and 32 000 ABL transcripts assessed by the central laboratory, respectively.

The cumulative incidence of MMR, MR⁴ and MR^{4.5} adjusted for the competing risk of treatment discontinuation without the event are shown in Figure 5.

Figure 5 - Cumulative Incidence of Molecular Response (CP Evaluable Population)



^a Includes patients (N) with a valid baseline assessment. Minimum follow-up time (time from last patient first dose to data snapshot date) of 36 months.

^b Includes patients (N) who attained or maintained response.

Achieved molecular responses by line of treatment are shown in Table 13.

Table 13 – Achieved molecular responses

	Ph+ CP CML treated with 1 prior TKI	Ph+ CP CML treated with 2 prior TKIs	Ph+ CP CML treated with 3 prior TKIs	Total Ph+ CP CML cohort
Patients without MMR at baseline ^a	N=25	N=28	N=26	N=79
MMR, % (95% CI)	76.0 (54.9,90.6)	64.3 (44.1,81.4)	38.5 (20.2,59.4)	59.5 (47.9,70.4)
Patients without MR ⁴ at baseline ^a	N=37	N=38	N=37	N=112
MR ⁴ , % (95% CI)	70.3 (53.0,84.1)	55.3 (38.3,71.4)	32.4 (18.0,49.8)	52.7 (43.0,62.2)
Patients without MR ^{4.5} at baseline ^a	N=42	N=46	N=43	N=131
MR ^{4.5} , % (95% CI)	54.8 (38.7,70.2)	43.5 (28.9,58.9)	30.2 (17.2,46.1)	42.7 (34.1,51.7)
Patients with MMR at baseline ^a	N=21	N=27	N=22	N=70
Deeper MR, % (95% CI)	85.7 (63.7,97.0)	66.7 (46.0,83.5)	63.6 (40.7,82.8)	71.4 (59.4,81.6)

Snapshot date: 23Nov2020.

Abbreviations: Ph+=Philadelphia chromosome-positive; CP=chronic phase; CML=chronic myelogenous leukaemia; N=number of patients; CI=confidence interval; MMR=major molecular response; MR=molecular response; MR⁴=≥ 4 log-reduction in BCR-ABL transcripts from standardised baseline; MR^{4.5}=≥ 4.5 log-reduction in BCR-ABL transcripts from standardised baseline.

In CP patients, there were no on-treatment progressions to AP or BP CML.

AP CML patients

In patients with Ph+ AP CML, the median duration of treatment was 22.1 months (range: 1.6 to 50.1 months), the cumulative confirmed OHR by 1 year (52 weeks) was 75.0% (95% CI: 19.4, 99.4), as was the cumulative CCyR rate, all 3 patients maintained their CCyR on-treatment.

Response by BCR-ABL Mutations at baseline

Ten patients in the CP cohort had mutations at baseline (A365V, E453K, E255V, Q252H, L298V [n=1 each], Y253F and G250E [n=2 each]). One patient in the CP cohort had a F359I mutation identified on study day 8. One patient in the AP cohort had 2 mutations (F311L and L387F) at baseline. In the CP cohort, among patients with mutations, molecular responses were observed in 4/11 (36.4%) patients, 1 patient with a E255V mutation achieved MMR and 3 patients with F359I, Y253F and A365V respectively achieved MR^{4.5}. The patient with mutations in the AP cohort did not achieve any response.

Paediatric population

The efficacy of Bosulif in paediatric patients was evaluated in the BCHILD trial "A Phase I/II study of bosutinib in paediatric patients with newly-diagnosed chronic phase or resistant/intolerant Ph+ CML".

^a Includes patients (N) with a valid baseline assessment. To be considered a responder, patients must have achieved an improved response from baseline. Molecular Response criteria: MMR, MR⁴, and MR^{4.5} were defined as $\leq 0.1\%$, $\leq 0.01\%$, and $\leq 0.0032\%$ BCR-ABL/ABL ratio on international scale, respectively (corresponding to $\geq 3, \geq 4$, and ≥ 4.5 log-reduction from standardised baseline) with a minimum of 10 000, 10 000, and 32 000 ABL transcripts assessed by the central laboratory, respectively.

The BCHILD trial is a Phase I/II, multicentre, international, single-arm, open-label study conducted to identify a recommended dose of bosutinib administered orally once daily in paediatric patients (aged 1 to < 18 years) with newly-diagnosed chronic phase Ph+ CML (ND CML) or Ph+ CML who have received at least one prior TKI therapy (R/I CML) and to assess preliminary estimate the safety tolerability and efficacy, and to evaluate the Pharmacokinetics of bosutinib in this patient population.

Paediatric patients with newly-diagnosed CP Ph+ CML

The efficacy of Bosulif in paediatric patients with newly-diagnosed CP Ph+ CML (CP1L) was evaluated as part of the BCHILD trial. In the Phase II dose expansion portion 30 patients with ND CML received bosutinib at a dose of 300 mg/m² once daily. The median duration of follow-up for overall survival in the total cohort (N=30) was 21.91 (1.08, 45.11) months in ND CML patients, and the median treatment duration was 13.68 (0.20, 43,70). A summary of cumulative cytogenetic and molecular responses at any time in patients with ND CML is shown in Table 15. Among responders, one patient lost CCyR and MCyR.

Among evaluable ND patients (ABL copies \geq 10 000), 81.08% (95% CI: 64.2, 97.7) had a BCR-ABL ratio \leq 10% at 3 months, and 62.5% (95% CI: 38.8, 86.2) had a BCR-ABL ratio \leq 1% at 6 months.

There were no deaths in the ND cohort and no progressions to AP or BP.

Paediatric patients with imatinib-resistant or intolerant Ph+ CP, CML

The efficacy of Bosulif in paediatric patients with resistant or intolerant Ph+ CML was evaluated as part of the BCHILD trial.

In the Phase I dose escalation portion, 28 patients with R/I CML received bosutinib at doses ranging from 300 to 400 mg/m² once daily. 6 patients were enrolled in the Phase II portion (400 mg/m²).

Table 14 – Demographic characteristics of CML patients

	Phase 1 (300 mg/m ²)	Phase 1 (350 mg/m ²)	Phase 1 (400 mg/m ²)	Phase 2 CP1L (300 mg/m ²)	Phase 2 R/I (400 mg/m ²)
	(N=6)	(N=11)	(N=11)	(N=30)	(N=6)
Age					
(Years), n					
(%)					
≥1-<6	2 (33.3)	2 (18.2)	0	2 (6.7)	0
≥6-<12	3 (50.0)	4 (36.4)	3 (27.3)	10 (33.3)	1 (16.7)
≥12-<18	1 (16.7)	5 (45.5)	8 (72.7)	18 (60.0)	5 (83.3)
Median (range)	8.50 (1, 17)	11.00 (4, 17)	15.00 (6, 17)	12.50 (5,17)	14.50 (11, 16)
Gender, n					
(%)					
Male	5 (83.3)	4 (36.4)	7 (63.6)	18 (60.0)	4 (66.7)
Female	1 (16.7)	7 (63.6)	4 (36.4)	12 (40.0)	2 (33.3)
Race, n (%)					
White	0	5 (45.5)	7 (63.6)	22 (73.3)	4 (66.7)
Black or	0	1 (9.1)	1 (9.1)	5 (16.7)	1 (16.7)
African					
American					
Asian	0	1 (9.1)	3 (27.3)	1 (3.3)	1 (16.7)

American Indian or Alaska Native	0	0	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0	2 (6.7)	0
Unknown	6 (100.0)	4 (36.4)	0	0	0
Ethnicity, n (%)					
Hispanic or Latino	0	0	2 (18.2)	7 (23.3)	0
Not Hispanic or Latino	0	8 (72.7)	9 (81.8)	23 (76.7)	6 (100.0)
Unknown	6 (100.0)	3 (27.3)	0	0	0

The median duration of follow-up for overall survival in the total phase 1 portion (N=28) was 29.27 months (15.21, 85.88) and in the phase 2 portion (N=6) was 9.66 (2.00, 15.54). The median treatment duration in the phase 1 portion was 17.26 months (range 0.30 to 60.85) and 9.64 months (1.97, 15.54) in the phase 2 portion.

A summary of cumulative cytogenetic and molecular responses at any time in patients with CML is shown in Table 15. In Phase I, among responders, three patients lost CCyR and 2 patients lost MCyR. In the phase 1 portion, the probability of maintaining MMR at 18 months was 92.3% (95% CI: 56.6, 98.8).

There were no progressions to AP or BP.

Table 15 - Efficacy results in paediatric patients with resistant or intolerant Ph+ CML

	Phase 1 Total (R/I) (N=28)	Phase 2 CP1L (300mg/m²) (N=30)	Phase 2 R/I (400mg/m²) (N=6)
Cumulative MCyR,			
n% (95% CI)	24 (85.7)	26 (86.7)	6 (100.0)
	(67.3, 96.0)	(69.3, 96.2)	(54.1, 100.0)
Cumulative CCyR, n%			
(95% CI)	23 (82.1)	25 (83.3)	6 (100.0)
	(63.1, 93.9)	(65.3, 94.4)	(54.1, 100.0)
Patients without	4	N/A	1
MCyR at baseline, N			
MCyR, n% (95% CI)	3 (75.0) (19.4, 99.4)	N/A	1 (100.0) (2.5, 100.0)
Patients without CCyR at baseline, N	9	N/A	2
CCyR n% (95% CI)			
	7 (77.8) (40.0, 97.2)	N/A	2 (100.0) (15.8, 100.0)
Cumulative MMR, n%			
(95% CI)	16 (57.1) (37.2, 75.5)	13 (43.3) (25.5, 62.6)	4 (66.7) (22.3, 95.7)

Cumulative MR4, n% (95% CI)	6 (21.4)	5 (16.7)	1 (16.7)
	(8.3, 41.0)	(5.6, 34.7)	(0.4, 64.1)
Cumulative MR4.5,	5 (17.9)	0 (0.0)	0 (0.0)
n% (95% CI)	(6.1, 36.9)	(0.0, 11.6)	(0.0, 45.9)

Abbreviations: CCyR=complete cytogenetic response; CI=confidence interval; CML=chronic myelogenous leukaemia; CP=chronic phase; MCyR=major cytogenetic response; MMR=major molecular response; MR=molecular response; N=number of patients; n=number of events; Ph=Philadelphia chromosome-positive; R/I=resistant or intolerant.

5.2 Pharmacokinetic properties

Bosutinib pharmacokinetics were assessed following oral dosing with food in adult patients with CML and were presented as geometric mean (CV%), unless otherwise specified.

Absorption

Following administration of a single dose of bosutinib (500 mg) with food in healthy subjects, the absolute bioavailability was 34%. Absorption was relatively slow, with a median time-to-peak concentration (t_{max}) reached after 6 hours. Bosutinib exhibits dose-proportional increases of AUC over the dose range of 100 to 600 mg. The bosutinib PK parameters for adults were derived from a population PK analysis using pooled data across studies. Bosutinib steady state C_{max} was 127 ng/mL (31%), C_{trough} was 68 ng/mL (39%) and AUC was 2 370 ng•h/mL (34%) following multiple oral doses of Bosulif 400 mg; Bosutinib steady state C_{max} was 171 ng/mL (38%), C_{trough} was 91 ng/mL (42%) and AUC was 3 150 ng•h/mL (38%) following multiple oral doses of Bosulif 500 mg.

No clinically significant differences in the pharmacokinetics of bosutinib were observed following administration of either the tablet or intact hard capsule dosage forms of bosutinib at the same dose, under fed conditions. Bosutinib hard capsule contents mixed with applesauce or yogurt exhibited comparable PK to the bosutinib intact hard capsule under fed condition in healthy adult participants.

The solubility of bosutinib is pH-dependent and absorption is reduced when gastric pH is increased (see section 4.5).

Effect of food

Bosutinib C_{max} increased 1.8-fold and AUC increased 1.7-fold when bosutinib tablets were given with a high-fat meal to healthy subjects compared to administration under fasted condition. In a separate study, bosutinib hard capsule administration under the fed condition resulted in exposures approximately 1.5-1.6-fold higher than administration under fasted conditions.

Distribution

Following administration of a single intravenous dose of 120 mg bosutinib to healthy subjects, bosutinib had a mean (% coefficient of variation [CV]) volume of distribution of 2,331 (32) L, suggesting that bosutinib is extensively distributed to extra vascular tissue.

Bosutinib was highly bound to human plasma proteins *in vitro* (94%) and *ex vivo* in healthy subjects (96%), and binding was not concentration-dependent.

Biotransformation

In vitro and *in vivo* studies indicated that bosutinib (parent compound) undergoes predominantly hepatic metabolism in humans. Following administration of single or multiple doses of bosutinib (400 or 500 mg) to humans, the major circulating metabolites appeared to be oxydechlorinated (M2)

and N-desmethylated (M5) bosutinib, with bosutinib N-oxide (M6) as a minor circulating metabolite. The systemic exposure of N-desmethylated metabolite was 25% of the parent compound, while the oxydechlorinated metabolite was 19% of the parent compound. All 3 metabolites exhibited activity that was $\leq 5\%$ that of bosutinib in a Src-transformed fibroblast anchorage-independent proliferation assay. In faeces, bosutinib and N-desmethyl bosutinib were the major drug-related components. *In vitro* studies with human liver microsomes indicated that the major cytochrome P450 isozyme involved in the metabolism of bosutinib is CYP3A4 and drug interaction studies have shown that ketoconazole and rifampicin had marked effect on the pharmacokinetics of bosutinib (see section 4.5). No metabolism of bosutinib was observed with CYPs 1A2, 2A6, 2B6, 2C8, 2C9, 2C19, 2D6, 2E1, or 3A5.

Elimination

In healthy subjects given a single intravenous dose of 120 mg bosutinib, the mean (%CV) terminal elimination half-life was 35.5 (24) hours, and the mean (%CV) clearance was 61.9 (26) L/h. In a mass-balance study with oral bosutinib, an average of 94.6% of the total dose was recovered in 9 days; faeces (91.3%) was the major route of excretion, with 3.29% of the dose recovered in urine. Seventy-five percent of the dose was recovered within 96 hours. Excretion of unchanged bosutinib in urine was low with approximately 1% of the dose in both healthy subjects and those with advanced malignant solid tumours.

Special populations

Hepatic impairment

A 200 mg dose of bosutinib administered with food was evaluated in a cohort of 18 hepatically impaired subjects (Child-Pugh classes A, B, and C) and 9 matched healthy subjects. C_{max} of bosutinib in plasma increased 2.4-fold, 2-fold, and 1.5-fold, respectively, in Child-Pugh classes A, B, and C; and bosutinib AUC in plasma increased 2.3-fold, 2-fold, and 1.9-fold, respectively. The $t_{1/2}$ of bosutinib increased in hepatic impaired patients as compared to the healthy subjects.

Renal impairment

In a renal impairment study, a single dose of 200 mg bosutinib was administered with food to 26 subjects with mild, moderate, or severe renal impairment and to 8 matching healthy volunteers. Renal impairment was based on CL_{Cr} (calculated by the Cockcroft-Gault formula) of < 30 mL/min (severe renal impairment), $30 \le CL_{Cr} \le 50$ mL/min (moderate renal impairment), or $50 < CL_{Cr} \le 80$ mL/min (mild renal impairment). Subjects with moderate and severe renal impairment had an increase in AUC over healthy volunteers of 35% and 60%, respectively. Maximal exposure C_{max} increased by 28% and 34% in the moderate and severe groups, respectively. Bosutinib exposure was not increased in subjects with mild renal impairment. The elimination half-life of bosutinib in subjects with renal impairment was similar to that in healthy subjects.

Dose adjustments for renal impairment were based on the results of this study, and the known linear pharmacokinetics of bosutinib in the dose range of 200 to 600 mg.

Age, gender and race

No formal studies have been performed to assess the effects of these demographic factors. Population pharmacokinetic analyses in patients with Ph+ leukaemia or malignant solid tumour and in healthy subjects indicate that there are no clinically relevant effects of age, gender or body weight. Population pharmacokinetic analyses revealed that Asians had a 18% lower clearance corresponding to an approximately 25% increase in bosutinib exposure (AUC).

Paediatric population

The pharmacokinetics of bosutinib in 41 newly-diagnosed or resistant/intolerant paediatric patients 1 to < 18 years of age were evaluated over the dose range of 300 mg/m² to 400 mg/m² administered orally once daily with food. In paediatric patients, median T_{max} occurred at approximately 3 hours post-dose (range 1 to 8 hours post-dose). Exposures increased in a dose proportional manner between

100-600 mg. The geometric mean AUC_{tau} in the 300 mg/m² to 400 mg/m² cohorts was within the range (+/- 20%) of geometric mean AUC_{tau} for the adult dose level in the respective newly-diagnosed and resistant or intolerant Ph+ CML indications, however C_{max} and clearance were higher and C_{min} was lower in paediatric patients than in adults.

5.3 Preclinical safety data

Bosutinib has been evaluated in safety pharmacology, repeated dose toxicity, genotoxicity, reproductive toxicity, and phototoxicity studies.

Safety pharmacology

Bosutinib did not have effects on respiratory functions. In a study of the central nervous system (CNS), bosutinib treated rats displayed decreased pupil size and impaired gait. A no observed effect level (NOEL) for pupil size was not established, but the NOEL for impaired gait occurred at exposures approximately 11-times the human exposure resulting from the clinical dose of 400 mg and 8-times the human exposure resulting from the clinical dose of 500 mg (based on unbound C_{max} in the respective species). Bosutinib activity in vitro in hERG assays suggested a potential for prolongation of cardiac ventricular repolarisation (QTc). In an oral study of bosutinib in dogs, bosutinib did not produce changes in blood pressure, abnormal atrial or ventricular arrhythmias, or prolongation of the PR, QRS, or QTc of the ECG at exposures up to 3-times the human exposure resulting from the clinical dose of 400 mg and 2-times the human exposure resulting from the clinical dose of 500 mg (based on unbound C_{max} in the respective species). A delayed increase in heart rate was observed. In an intravenous study in dogs, transient increases in heart rate and decreases in blood pressure and minimal prolongation of the QTc (< 10 msec) were observed at exposures ranging from approximately 6-times to 20-times the human exposure resulting from the clinical dose of 400 mg and 4-times to 15-times the human exposure resulting from the clinical dose of 500 mg (based on unbound C_{max} in the respective species). The relationship between the observed effects and medicinal product treatment were inconclusive.

Repeated-dose toxicity

Repeated-dose toxicity studies in rats of up to 6 months in duration and in dogs up to 9 months in duration revealed the gastrointestinal system to be the primary target organ of toxicity of bosutinib. Clinical signs of toxicity included foecal changes and were associated with decreased food consumption and body weight loss which occasionally led to death or elective euthanasia.

Histopathologically, luminal dilation, goblet cell hyperplasia, haemorrhage, erosion, and oedema of the intestinal tract, and sinus erythrocytosis and haemorrhage in the mesenteric lymph nodes, were observed. The liver was also identified as a target organ in rats. Toxicities were characterised by an increase in liver weights in correlation with hepatocellular hypertrophy which occurred in the absence of elevated liver enzymes or microscopic signs of hepatocellular cytotoxicity, and is of unknown relevance to humans. The exposure comparison across species indicates that exposures that did not elicit adverse events in the 6- and 9-month toxicity studies in rats and dogs, respectively, were similar to the human exposure resulting from a clinical dose of 400 mg or 500 mg (based on unbound AUC in the respective species).

Genotoxicity

Genotoxicity studies in bacterial *in vitro* systems and in mammalian *in vitro* and *in vivo* systems with and without metabolic activation did not reveal any evidence for a mutagenic potential of bosutinib.

Reproductive toxicity and development toxicity

In a rat fertility study, fertility was slightly decreased in males. Females were observed with increased embryonic resorptions, and decreases in implantations and viable embryos. The dose at which no

adverse reproductive effects were observed in males (30 mg/kg/day) and females (3 mg/kg/day) resulted in exposures equal to 0.6-times and 0.3-times, respectively, the human exposure resulting from the clinical dose of 400 mg, and 0.5-times and 0.2-times, respectively, the human exposure resulting from the clinical dose of 500 mg (based on unbound AUC in the respective species). An effect on male fertility cannot be excluded (see section 4.6).

Foetal exposure to bosutinib-derived radioactivity during pregnancy was demonstrated in a placental transfer study in gravid Sprague-Dawley rats. In a rat pre- and postnatal development study, there were reduced number of pups born at ≥ 30 mg/kg/day, and increased incidence of total litter loss and decreased growth of offspring after birth occurred at 70 mg/kg/day. The dose at which no adverse development effects were observed (10 mg/kg/day) resulted in exposures equal to 1.3-times and 1.0-times human exposure resulting from the clinical dose of 400 mg and 500 mg, respectively (based on unbound AUC in the respective species). In a rabbit developmental toxicity study at the maternally toxic dose, there were foetal anomalies observed (fused sternebrae, and 2 foetuses had various visceral observations), and a slight decrease in foetal body weight. The exposure at the highest dose tested in rabbits (10 mg/kg/day) that did not result in adverse foetal effects was 0.9-times and 0.7-times the human exposure resulting from the clinical dose of 400 mg or 500 mg, respectively (based on unbound AUC in the respective species).

Following a single oral (10 mg/kg) administration of [¹⁴C] radiolabelled bosutinib to lactating Sprague-Dawley rats, radioactivity was readily excreted into breast milk as early as 0.5 hr after dosing. Concentration of radioactivity in milk was up to 8-fold higher than in plasma. This allowed measurable concentrations of radioactivity to appear in the plasma of nursing pups.

Carcinogenicity

Bosutinib was not carcinogenic in the 2-year rat and 6-month rasH2 mouse carcinogenicity studies.

Phototoxicity

Bosutinib has demonstrated the ability to absorb light in the UV-B and UV-A range and is distributed into the skin and uveal tract of pigmented rats. However, bosutinib did not demonstrate a potential for phototoxicity of the skin or eyes in pigmented rats exposed to bosutinib in the presence of UV radiation at bosutinib exposures up to 3-times and 2-times the human exposure resulting from the clinical dose of 400 or 500 mg, respectively (based on unbound C_{max} in the respective species).

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Microcrystalline cellulose (E460) Croscarmellose sodium (E468) Poloxamers 188 Povidone (E1201) Magnesium stearate (E470b)

Film coating

Bosulif 100 mg film-coated tablets Polyvinyl alcohol Titanium dioxide (E171) Macrogol 3350 Talc (E553b) Iron oxide yellow (E172) Bosulif 400 mg film-coated tablets Polyvinyl alcohol Titanium dioxide (E171) Macrogol 3350 Talc (E553b) Iron oxide yellow (E172) Iron oxide red (E172)

Bosulif 500 mg film-coated tablets
Polyvinyl alcohol
Titanium dioxide (E171)
Macrogol 3350
Talc (E553b)
Iron oxide red (E172)

Bosulif hard capsules
Mannitol (E421)
Microcrystalline cellulose (E460)
Croscarmellose sodium (E468)
Poloxamers 188
Povidone (E1201)
Magnesium stearate (E470b)

Bosulif hard capsule shells Gelatin Titanium dioxide (E171) Yellow iron oxide (E172) Red iron oxide (E172)

Printing ink hard capsules
Shellac (E904)
Propylene glycol (E1520)
Ammonia solution, concentrated (E527)
Black iron oxide (E172)
Potassium hydroxide (E525)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

Film-coated tablets

4 years.

Hard capsules

3 years.

6.4 Special precautions for storage

Film-coated tablets

This medicinal product does not require any special storage conditions.

Hard capsules

Do not store above 30 °C. Store in the original package in order to protect from light.

6.5 Nature and contents of container

Film-coated tablets

White opaque 3-ply PVC/Polychlorotrifluoroethene/PVC blister sealed with push-through foil backing containing either 14 or 15 tablets.

Bosulif 100 mg film-coated tablets

Each carton contains 28, 30 or 112 tablets.

Bosulif 400 mg film-coated tablets

Each carton contains 28 or 30 tablets.

Bosulif 500 mg film-coated tablets

Each carton contains 28 or 30 tablets.

Hard capsules

High-density polyethylene (HDPE) bottle and polypropylene (PP) closure with heat induction seal (HIS).

Bosulif 50 mg hard capsules

Cartons of one bottle containing 30 hard capsules.

Bosulif 100 mg hard capsules

Cartons of one bottle containing 150 hard capsules.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

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

7. MARKETING AUTHORISATION HOLDER

Pfizer Europe MA EEIG Boulevard de la Plaine 17 1050 Bruxelles Belgium

8. MARKETING AUTHORISATION NUMBER(S)

Bosulif 100 mg film-coated tablets

EU/1/13/818/001 EU/1/13/818/002 EU/1/13/818/005

Bosulif 400 mg film-coated tablets

EU/1/13/818/006 EU/1/13/818/007 Bosulif 500 mg film-coated tablets EU/1/13/818/003 EU/1/13/818/004

Bosulif 50 mg hard capsules EU/1/13/818/008

Bosulif 100 mg hard capsules EU/1/13/818/009

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 27 March 2013 Date of latest renewal: 31 March 2022

10. DATE OF REVISION OF THE TEXT

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

ANNEX II

- A. MANUFACTURER(S) RESPONSIBLE FOR BATCH RELEASE
- B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE
- C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION
- D. CONDITIONS OR RESTRICTIONS WITH REGARD TO THE SAFE AND EFFECTIVE USE OF THE MEDICINAL PRODUCT

A. MANUFACTURER(S) RESPONSIBLE FOR BATCH RELEASE

Name and address of the manufacturer(s) responsible for batch release

Pfizer Manufacturing Deutschland GmbH Mooswaldallee 1 79108 Freiburg Im Breisgau Germany

B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE

Medicinal product subject to restricted medical prescription (see Annex I: Summary of Product Characteristics, section 4.2).

C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION

• Periodic safety update reports (PSURs)

The requirements for submission of PSURs for this medicinal product are set out in the list of Union reference dates (EURD list) provided for under Article 107c(7) of Directive 2001/83/EC and any subsequent updates published on the European medicines web-portal.

D. CONDITIONS OR RESTRICTIONS WITH REGARD TO THE SAFE AND EFFECTIVE USE OF THE MEDICINAL PRODUCT

Risk management plan (RMP)

The marketing authorisation holder (MAH) shall perform the required pharmacovigilance activities and interventions detailed in the agreed RMP presented in Module 1.8.2 of the marketing authorisation and any agreed subsequent updates of the RMP.

An updated RMP should be submitted:

- At the request of the European Medicines Agency;
- Whenever the risk management system is modified, especially as the result of new information being received that may lead to a significant change to the benefit/risk profile or as the result of an important (pharmacovigilance or risk minimisation) milestone being reached.

ANNEX III LABELLING AND PACKAGE LEAFLET

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING
CARTON
1. NAME OF THE MEDICINAL PRODUCT
Bosulif 100 mg film-coated tablets bosutinib
2. STATEMENT OF ACTIVE SUBSTANCE(S)
Each film-coated tablet contains 100 mg bosutinib (as monohydrate).
3. LIST OF EXCIPIENTS
4. PHARMACEUTICAL FORM AND CONTENTS
28 film-coated tablets. 30 film-coated tablets. 112 film-coated tablets.
5. METHOD AND ROUTE(S) OF ADMINISTRATION
Read the package leaflet before use. Oral use.
6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN
Keep out of the sight and reach of children.
7. OTHER SPECIAL WARNING(S), IF NECESSARY
8. EXPIRY DATE
EXP
9. SPECIAL STORAGE CONDITIONS

10.	SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS
	OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF
	APPROPRIATE

Dispose unused medicinal product in accordance with local requirements.

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

Pfizer Europe MA EEIG Boulevard de la Plaine 17 1050 Bruxelles Belgium

12.	MARKETING	AUTHORISATION NUMBER(S)	
------------	-----------	-------------------------	--

EU/1/13/818/001	(28 film-coated tablets)
EU/1/13/818/002	(30 film-coated tablets)
EU/1/13/818/005	(112 film-coated tablets)

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Bosulif 100 mg

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

PC

SN

NN

MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS		
BLISTER		
1. NAME OF THE MEDICINAL PRODUCT		
Bosulif 100 mg film-coated tablets bosutinib		
2. NAME OF THE MARKETING AUTHORISATION HOLDER		
Pfizer		
3. EXPIRY DATE		
EXP		
4. BATCH NUMBER		
Lot		
5. OTHER		

PARTICULARS TO APPEAR ON THE OUTER PACKAGING
CARTON
1. NAME OF THE MEDICINAL PRODUCT
Bosulif 400 mg film-coated tablets bosutinib
2. STATEMENT OF ACTIVE SUBSTANCE(S)
Each film-coated tablet contains 400 mg bosutinib (as monohydrate).
3. LIST OF EXCIPIENTS
4. PHARMACEUTICAL FORM AND CONTENTS
28 film-coated tablets. 30 film-coated tablets.
5. METHOD AND ROUTE(S) OF ADMINISTRATION
Read the package leaflet before use. Oral use.
6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN
Keep out of the sight and reach of children.
7. OTHER SPECIAL WARNING(S), IF NECESSARY
8. EXPIRY DATE
EXP
9. SPECIAL STORAGE CONDITIONS

10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE
Dispose unused medicinal product in accordance with local requirements.
11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER
Pfizer Europe MA EEIG Boulevard de la Plaine 17 1050 Bruxelles Belgium
12. MARKETING AUTHORISATION NUMBER(S)
EU/1/13/818/006 (28 film-coated tablets) EU/1/13/818/007 (30 film-coated tablets)
13. BATCH NUMBER
Lot
14. GENERAL CLASSIFICATION FOR SUPPLY
15. INSTRUCTIONS ON USE
16. INFORMATION IN BRAILLE
Bosulif 400 mg
17. UNIQUE IDENTIFIER – 2D BARCODE
2D barcode carrying the unique identifier included.

UNIQUE IDENTIFIER - HUMAN READABLE DATA

18.

PC SN NN

MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS		
BLISTER		
1. NAME OF THE MEDICINAL PRODUCT		
Bosulif 400 mg film-coated tablets bosutinib		
2. NAME OF THE MARKETING AUTHORISATION HOLDER		
Pfizer		
3. EXPIRY DATE		
EXP		
4. BATCH NUMBER		
Lot		
5 OTHER		

PARTICULARS TO APPEAR ON THE OUTER PACKAGING	
CARTON	
1. NAME OF THE MEDICINAL PRODUCT	
Bosulif 500 mg film-coated tablets bosutinib	
2. STATEMENT OF ACTIVE SUBSTANCE(S)	
Each film-coated tablet contains 500 mg bosutinib (as monohydrate).	
3. LIST OF EXCIPIENTS	
4. PHARMACEUTICAL FORM AND CONTENTS	
28 Film-coated tablets. 30 Film-coated tablets.	
5. METHOD AND ROUTE(S) OF ADMINISTRATION	
Read the package leaflet before use. Oral use.	
6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN	
Keep out of the sight and reach of children.	
7. OTHER SPECIAL WARNING(S), IF NECESSARY	
8. EXPIRY DATE	
EXP	
9. SPECIAL STORAGE CONDITIONS	

10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE
Dispose unused medicinal product in accordance with local requirements.
11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER
Pfizer Europe MA EEIG Boulevard de la Plaine 17 1050 Bruxelles Belgium
12. MARKETING AUTHORISATION NUMBER(S)
EU/1/13/818/003 28 film-coated tablets EU/1/13/818/004 30 film-coated tablets
13. BATCH NUMBER
Lot
14. GENERAL CLASSIFICATION FOR SUPPLY
15. INSTRUCTIONS ON USE

Bosulif 500 mg

16. INFORMATION IN BRAILLE

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

UNIQUE IDENTIFIER - HUMAN READABLE DATA

SN

18.

NN

MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS		
BLISTER		
1. NAME OF THE MEDICINAL PRODUCT		
Bosulif 500 mg film-coated tablets bosutinib		
2. NAME OF THE MARKETING AUTHORISATION HOLDER		
Pfizer		
3. EXPIRY DATE		
EXP		
4. BATCH NUMBER		
Lot		
5. OTHER		

PARTICULARS TO APPEAR ON THE OUTER PACKAGING
CARTON FOR BOTTLE
1. NAME OF THE MEDICINAL PRODUCT
Bosulif 50 mg hard capsules bosutinib
2. STATEMENT OF ACTIVE SUBSTANCE(S)
Each hard capsule contains 50 mg bosutinib (as monohydrate).
3. LIST OF EXCIPIENTS
4. PHARMACEUTICAL FORM AND CONTENTS
30 hard capsules.
5. METHOD AND ROUTE(S) OF ADMINISTRATION
Read the package leaflet before use. Oral use.
6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN
Keep out of the sight and reach of children.
7. OTHER SPECIAL WARNING(S), IF NECESSARY
8. EXPIRY DATE
EXP
9. SPECIAL STORAGE CONDITIONS
Do not store above 30 °C. Store in the original package in order to protect from light.

Dispose according to local requirements.

APPROPRIATE

10.

SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS

OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF

Pfizer Europe MA EEIG Boulevard de la Plaine 17		
1050 Bruxelles Belgium		
12.	MARKETING AUTHORISATION NUMBER(S)	
EU/1/13/818/008		
13.	BATCH NUMBER	
Lot		
14.	GENERAL CLASSIFICATION FOR SUPPLY	
15.	INSTRUCTIONS ON USE	
16.	INFORMATION IN BRAILLE	
Bosu	alif 50 mg	
17.	UNIQUE IDENTIFIER – 2D BARCODE	
2D barcode carrying the unique identifier included.		
18.	UNIQUE IDENTIFIER - HUMAN READABLE DATA	
PC SN NN		

NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

11.

PARTICULARS TO APPEAR ON THE IMMEDIATE PACKAGING		
BOTTLE LABEL		
1. NAME OF THE MEDICINAL PRODUCT		
Bosulif 50 mg hard capsules bosutinib		
2. STATEMENT OF ACTIVE SUBSTANCE(S)		
Each hard capsule contains 50 mg bosutinib (as monohydrate).		
3. LIST OF EXCIPIENTS		
4. PHARMACEUTICAL FORM AND CONTENTS		
30 hard capsules.		
5. METHOD AND ROUTE(S) OF ADMINISTRATION		
Read the package leaflet before use. Oral use.		
6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN		
Keep out of the sight and reach of children.		
7. OTHER SPECIAL WARNING(S), IF NECESSARY		
8. EXPIRY DATE		
EXP		
9. SPECIAL STORAGE CONDITIONS		
Do not store above 30 °C. Store in the original package in order to protect from light.		

	OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE		
Dispo	se according to local requirements.		
11.	. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER		
Boule	Europe MA EEIG vard de la Plaine 17 Bruxelles um		
12.	MARKETING AUTHORISATION NUMBER(S)		
EU/1/	/13/818/008		
13.	BATCH NUMBER		
Lot			
14.	GENERAL CLASSIFICATION FOR SUPPLY		
15.	INSTRUCTIONS ON USE		
16.	INFORMATION IN BRAILLE		
Bosul	if 50 mg		
17.	UNIQUE IDENTIFIER – 2D BARCODE		
18.	UNIQUE IDENTIFIER - HUMAN READABLE DATA		

SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS

PARTICULARS TO APPEAR ON THE OUTER PACKAGING	
CARTON FOR BOTTLE	
1. NAME OF THE MEDICINAL PRODUCT	
Bosulif 100 mg hard capsules bosutinib	
2. STATEMENT OF ACTIVE SUBSTANCE(S)	
Each hard capsule contains 100 mg bosutinib (as monohydrate).	
3. LIST OF EXCIPIENTS	
4. PHARMACEUTICAL FORM AND CONTENTS	
150 hard capsules.	
5. METHOD AND ROUTE(S) OF ADMINISTRATION	
Read the package leaflet before use. Oral use.	
6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN	
Keep out of the sight and reach of children.	
7. OTHER SPECIAL WARNING(S), IF NECESSARY	
8. EXPIRY DATE	
EXP	
9. SPECIAL STORAGE CONDITIONS	
Do not store above 30 °C. Store in the original package in order to protect from light.	

10.	SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE		
Dispo	Dispose according to local requirements.		
11.	NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER		
Boule	r Europe MA EEIG evard de la Plaine 17 Bruxelles um		
12.	MARKETING AUTHORISATION NUMBER(S)		
EU/1	/13/818/009		
13.	BATCH NUMBER		
Lot			
14.	GENERAL CLASSIFICATION FOR SUPPLY		
15.	INSTRUCTIONS ON USE		
16.	INFORMATION IN BRAILLE		
Bosulif 100 mg			
17.	UNIQUE IDENTIFIER – 2D BARCODE		
2D barcode carrying the unique identifier included.			
18.	UNIQUE IDENTIFIER - HUMAN READABLE DATA		
PC SN			
NN			

PARTICULARS TO APPEAR ON THE IMMEDIATE PACKAGING	
BOTTLE LABEL	
1. NAME OF THE MEDICINAL PRODUCT	
Bosulif 100 mg hard capsules bosutinib	
2. STATEMENT OF ACTIVE SUBSTANCE(S)	
Each hard capsule contains 100 mg bosutinib (as monohydrate).	
3. LIST OF EXCIPIENTS	
4. PHARMACEUTICAL FORM AND CONTENTS	
150 hard capsules.	
5. METHOD AND ROUTE(S) OF ADMINISTRATION	
Read the package leaflet before use. Oral use.	
6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN	
Keep out of the sight and reach of children.	
7. OTHER SPECIAL WARNING(S), IF NECESSARY	
8. EXPIRY DATE	
EXP	
9. SPECIAL STORAGE CONDITIONS	
Do not store above 30 °C. Store in the original package in order to protect from light.	

Dispose according to local requirements.

APPROPRIATE

10.

SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS

OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF

Pfizer Europe MA EEIG		
Boulevard de la Plaine 17		
1050 Bruxelles Belgium		
Delgium		
12. MARKETING AUTHORISATION NUMBER(S)		
EU/1/13/818/009		
13. BATCH NUMBER		
Lot		
14. GENERAL CLASSIFICATION FOR SUPPLY		
15. INSTRUCTIONS ON USE		
16. INFORMATION IN BRAILLE		
Bosulif 100 mg		
17. UNIQUE IDENTIFIER – 2D BARCODE		
18. UNIQUE IDENTIFIER - HUMAN READABLE DATA		

NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

11.

B. PACKAGE LEAFLET

Package leaflet: Information for the user

Bosulif 100 mg film-coated tablets Bosulif 400 mg film-coated tablets Bosulif 500 mg film-coated tablets bosutinib

Read all of this leaflet carefully before you start taking this medicine because it contains important information for you and your carer.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet

- 1. What Bosulif is and what it is used for
- 2. What you need to know before you take Bosulif
- 3. How to take Bosulif
- 4. Possible side effects
- 5. How to store Bosulif
- 6. Content of the pack and other information

1. What Bosulif is and what it is used for

Bosulif contains the active substance bosutinib. Bosulif is used to treat adult and paediatric patients aged 6 years and older who have a type of leukaemia called chronic phase (CP) Philadelphia chromosome-positive (Ph-positive) Chronic Myeloid Leukaemia (CML) and are newly-diagnosed or for whom previous medicines to treat CML have either not worked or are not suitable. It is also used to treat adult patients with accelerated phase (AP) and blast phase (BP) Ph+ CML for whom previous medicines to treat CML have not worked or are not suitable.

In patients with Ph-positive CML a change in DNA (genetic material) triggers a signal that tells the body to produce too many of a specific type of white blood cell called granulocytes. Bosulif blocks this signal and therefore stops the production of these cells.

If you have any questions about how Bosulif works or why this medicine has been prescribed for you, ask your doctor.

2. What do you need to know before you take Bosulif

Do not take Bosulif

- if you are allergic to bosutinib or any of the other ingredients of this medicine (listed in section 6).
- if your doctor has told you that your liver has been damaged and is not working normally.

Warnings and precautions

Talk to your doctor, pharmacist or nurse before taking Bosulif:

if you have, or have had in the past, liver problems. Tell your doctor if you have a history of liver problems including hepatitis (liver infection or inflammation) of any kind, or a history of any of signs and symptoms of liver problems (see section 4 "Possible side effects") because Bosulif may affect your liver function. Your doctor should do blood tests to check your liver

function prior to your starting treatment with Bosulif and for the first 3 months of treatment with Bosulif, and as clinically indicated.

- if you have diarrhoea and vomiting. Tell your doctor if you develop any signs and symptoms of stomach or intestinal problems (see section 4 "Possible Side Effects"). Your doctor may provide an anti-diarrhoeal or antiemetic product and/or fluids in order to reduce the symptoms. Your doctor may also withhold temporarily, dose reduce, or discontinue Bosulif (see section 3 "How to take Bosulif"). You should ask your doctor if use of your treatment for nausea or vomiting medicines together with Bosulif may result in a greater risk of heart arrhythmias.
- **if you suffer from bleeding problems.** Tell your doctor if you develop any signs and symptoms of blood problem (see section 4 "Possible Side Effects"), because Bosulif reduces the capability of your body to stop bleeding. During the first month, your doctor will perform weekly and then monthly complete blood counts for you. Your doctor may also withhold temporarily, dose reduce or discontinue Bosulif (see section 3 "How to take Bosulif").
- **if you have an infection.** Tell your doctor if you develop any of the following signs and symptoms such as fever, problems with urine such as burning on urination, a new cough, or a new sore throat because Bosulif reduces the capability of your body to defend from infections.
- **if you have fluid retention.** Tell your doctor if you develop any of the following signs and symptoms of fluid retention during Bosulif treatment such as swelling of the ankles, feet or legs; difficulty breathing chest pain or a cough (these may be signs of fluid retention in the lungs or chest). Your doctor will monitor you for fluid retention and will manage your symptoms.
- **if you have heart problems.** Tell your doctor if you have a heart disorder, such as heart failure and decreased blood flow to the heart which can lead to heart attack. Get medical help right away if you get shortness of breath, weight gain, chest pain, or swelling in your hands, ankles or feet.
- **if you have been told you have abnormal heart rhythm**. Tell your doctor if you have arrhythmias or an abnormal electrical signal called "prolongation of the QT interval". This is always important, but especially if you are experiencing frequent or prolonged diarrhoea as described above. If you faint (loss of consciousness) or have an irregular heartbeat while taking Bosulif, tell your doctor immediately, as this may be a sign of a serious heart condition (see section 2 "What do you need to know before you take Bosulif"). Your doctor will perform an electrocardiogram (ECG) before you start therapy. Your doctor will do a blood test prior to and during therapy and if you have low potassium or magnesium, your doctor will provide a treatment to correct the low blood levels.
- **if you have been told that you have problems with your kidneys.** Tell your doctor if you are urinating more frequently and producing larger amounts of urine with a pale colour or if you are urinating less frequently and producing smaller amounts of urine with a dark colour. Also tell your doctor if you are losing weight or have experienced swelling of your feet, ankles, legs, hands or face. Your doctor will assess how your kidneys are functioning before treatment and will closely monitor how your kidneys are functioning during the course of treatment with bosutinib.
- **if you have ever had or might now have a hepatitis B infection.** This is because Bosulif could cause hepatitis B to become active again, which can be fatal in some cases. Your doctor will test you for this infection before starting treatment. If you have this infection, your doctor will monitor you closely for signs and symptoms of the infection throughout therapy and several months after you have stopped therapy.
- **if you have or have had pancreas problems.** Tell your doctor if you develop abdominal pain or discomfort. If you have abdominal pain and your blood tests show high levels of lipase, an

enzyme that helps your body break down fats in food, then your doctor may interrupt your treatment and perform tests to rule out problems with your pancreas.

- **if you have any of these symptoms: serious skin rashes.** Tell your doctor if you develop any of the following signs and symptoms of painful red or purplish rash that spreads and blisters and/or other lesions begin to appear in the mucous membrane (e.g., mouth and lips). If you develop a severe skin reaction during treatment, your doctor will permanently discontinue treatment.
- **if you notice any of these symptoms: pain in your side, blood in your urine or reduced amount of urine.** When your disease is very severe, your body may not be able to clear all the waste products from the dying cancer cells. This is called tumour lysis syndrome and can cause kidney failure and heart problems within 48 hours of the first dose of Bosulif. Your doctor will be aware of this and may ensure you are adequately hydrated and give you other medicines to help prevent it. Your doctor will perform a blood test to check for high uric acid levels and your doctor will provide a treatment to correct the high levels prior to starting therapy.

Sun/UV protection

You may become more sensitive to the sun or UV rays while taking bosutinib. It is important to cover sunlight-exposed areas of skin and use sunscreen with high sun protection factor (SPF).

Patients of Asian origin

If you are of Asian origin, you may have an increased risk of side effects with Bosulif. Your doctor will closely monitor you for serious side effects especially when increasing the dose.

Children and adolescents

Bosulif is not recommended for people whose age is under 6 years. This medicine has not been studied in children below the age of 1 year.

Other medicines and Bosulif

Tell your doctor or pharmacist if you are taking, have recently taken or might take any other medicines, including medicines obtained without a prescription, vitamins, and herbal medicines. Some medicines can affect the levels of Bosulif in your body. You should inform your doctor if you are taking medicines containing active substances such as those listed below:

The following active substances may increase the risk of side effects with Bosulif:

- ketoconazole, itraconazole, voriconazole, posaconazole and fluconazole, used to treat fungal infections.
- clarithromycin, telithromycin, erythromycin, and ciprofloxacin, used to treat bacterial infections.
- nefazodone, used to treat depression.
- mibefradil, diltiazem and verapamil, used to lower blood pressure in people with high blood pressure.
- ritonavir, lopinavir/ritonavir, indinavir, nelfinavir, saquinavir, atazanavir, amprenavir, fosamprenavir and darunavir, used to treat human immunodeficiency virus (HIV)/AIDS.
- boceprevir and telaprevir, used to treat hepatitis C.
- aprepitant, used to prevent and control nausea (feeling sick) and vomiting.
- imatinib, used to treat a type of leukaemia.
- crizotinib, used to treat a type of lung cancer called non-small cell lung cancer.

The following active substances may reduce the effectiveness of Bosulif:

- rifampicin, used to treat tuberculosis.
- phenytoin and carbamazepine, used to treat epilepsy.
- bosentan, used to lower high blood pressure in the lungs (pulmonary artery hypertension).
- nafcillin, an antibiotic used to treat bacterial infections.
- St. John's Wort (a herbal preparation obtained without a prescription), used to treat depression.
- efavirenz and etravirine, used to treat HIV infections/AIDS.
- modafinil, used to treat certain types of sleep disorders.

These medicines should be avoided during your treatment with Bosulif. If you are taking any of them, tell your doctor. Your doctor may change the dose of these medicines, change the dose of Bosulif, or switch you to a different medicine.

The following active substances may affect the heart rhythm:

- amiodarone, disopyramide, procainamide, quinidine and sotalol used to treat heart disorder.
- chloroquine, halofantrine used to treat malaria.
- clarithromycin and moxifloxacin antibiotics used to treat bacterial infections.
- haloperidol, used to treat psychotic disease such as schizophrenia.
- domperidone, used to treat nausea and vomiting or to stimulate breast milk production.
- methadone, used to treat pain.

These medicines should be taken with caution during your treatment with Bosulif. If you are taking any of them, tell your doctor.

Acid reducing agents

Proton pump inhibitors (PPIs) should be taken with caution during your treatment with Bosulif as they may reduce the effectiveness of Bosulif. Your doctor may consider short-acting antacids as an alternative to PPIs and administration times of Bosulif and antacids should be separated (i.e. take Bosulif in the morning and antacids in the evening) whenever possible.

The medicines listed here may not be the only ones that could interact with Bosulif, if you are not sure if the above applies to you or your child, ask your doctor.

Bosulif with food and drink

Do not take Bosulif with grapefruit or grapefruit juice, as it may increase the risk of side effects.

Pregnancy, breast-feeding and fertility

Bosulif is not to be used during pregnancy, unless clearly necessary, because Bosulif could harm an unborn baby. Ask your doctor for advice before taking Bosulif if you are pregnant or might become pregnant.

Women taking Bosulif will be advised to use effective contraception during treatment and for at least 1 month after the last dose. Vomiting or diarrhoea may reduce the effectiveness of oral contraceptives.

There is a risk that treatment with Bosulif will lead to decreased fertility and you may wish to seek advice about sperm storage before the treatment starts.

If you are breast-feeding, tell your doctor. Do not breast-feed during treatment with Bosulif as it could harm your baby.

Driving and using machines

If you experience dizziness, have blurred vision or feel unusually tired, do not drive or operate machines until these side effects have gone away.

Bosulif contains sodium

This medicine contains less than 1 mmol sodium (23 mg) per 100 mg, 400 mg, or 500 mg film-coated tablet, that is to say essentially 'sodium-free'.

3. How to take Bosulif

Always take this medicine exactly as your doctor has told you. Check with your doctor or pharmacist if you are not sure.

Bosulif will only be prescribed to you by a doctor with experience in medicines to treat leukaemia.

Dose and method of administration

Adults

The recommended dose is 400 mg once daily for patients with newly-diagnosed CML. The recommended dose is 500 mg once daily for patients whose previous medicines to treat CML have either not worked or are not suitable. In the event you are not able to tolerate the recommended dose or are not responding to Bosulif correctly, your doctor may adjust your dose further.

Children and adolescents (6 years of age and older)

The recommended dose is 300 mg/m² body surface area once daily for newly-diagnosed paediatric patients. The recommended dose is 400 mg/m² body surface area once daily for resistant or intolerant paediatric patients.

Dose recommendations are provided in the following table. As appropriate, for the recommended dose you may combine different strengths of bosutinib film-coated tablets and/or hard capsules (see Package Leaflet for hard capsules).

Dosing of bosutinib for newly-diagnosed (ND) and for resistant or intolerant (R/I) paediatric patients

Body surface area	ND recommended dose	R/I recommended dose
0.55-<0.63 m ²	200 mg	250 mg
0.63-<0.75 m ²	200 mg	300 mg
0.75–<0.9 m ²	250 mg	350 mg
0.9–<1.1 m ²	300 mg	400 mg
$\geq 1.1 \text{ m}^2$	400 mg*	500 mg*

^{*} maximum starting dose (corresponding to maximum starting dose in adult indication)

In the event you are not able to tolerate the recommended dose or are not responding to Bosulif correctly, your doctor may adjust your dose further.

Take the tablets(s) once a day with food. Swallow the tablet(s) whole with water. For patients who are unable to swallow a tablet, a hard capsule formulation is available.

If you take more Bosulif than you should

If you accidentally take too many Bosulif tablets or a higher dose than you need, contact a doctor for advice right away. If possible, show the doctor the pack, or this leaflet. You may require medical attention.

If you forget to take Bosulif

If dose is missed by less than 12 hours, take your recommended dose. If a dose is missed by more than 12 hours, take your next dose at your regular time on the following day.

Do not take a double dose to make up for the forgotten tablets.

If you stop taking Bosulif

Do not stop taking Bosulif unless your doctor tells you to do so. If you are not able to take the medicine as your doctor prescribed or you feel you do not need it anymore, contact your doctor right away.

If you have any further questions on the use of this medicine ask your doctor or pharmacist.

4. Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them.

Serious side effects

You must immediately contact your doctor if you experience any of those serious side effects (see also section 2 "What you need to know before you take Bosulif"):

Very common (may affect more than 1 in 10 people):

- reduction in the number of platelets (thrombocytopenia), red blood cells (anaemia) and/or neutrophils (type of white blood cells) (neutropenia) which may cause you to have abnormal bleeding, fever, or easy bruising without having an injury (you might have blood or lymphatic system disorder) see section 2 "What do you need to know before you take Bosulif").
- fluid around the lungs (pleural effusion).

Common (may affect up to 1 in 10 people):

- low white blood cells count (leukopenia).
- bleeding from the stomach or intestine (gastrointestinal haemorrhage) which may include blood in your vomit, stools (bowel movements) or urine, or have black stools (tarry black bowel movements) (see section 2 "What do you need to know before you take Bosulif").
- chest pain.
- toxic damage to the liver (hepatotoxicity), abnormal hepatic function including liver disorder (hepatic function abnormal) which may be accompanied with itching, yellow eyes or skin, dark urine, and pain or discomfort in the right upper stomach area or fever (see section 2 "What do you need to know before you take Bosulif").
- when the heart does not pump blood as well as it should (heart failure).
- when there is decreased blood flow to the heart (cardiac ischaemia).
- infection of the lung (pneumonia).
- defect in cardiac rhythm (electrocardiogram QT prolonged) that predisposes to fainting, dizziness and palpitation.
- increase in blood pressure (hypertension).
- high level of potassium in the blood (hyperkalaemia).
- acute kidney failure, kidney failure (renal failure), kidney impairment (renal impairment).
- fluid around the heart (pericardial effusion).
- allergic reaction (drug hypersensitivity).
- abnormally high blood pressure in the arteries of the lungs (pulmonary hypertension).
- acute inflammation of the pancreas (pancreatitis acute).

Uncommon (may affect up to 1 in 100 people):

- fever associated with low white blood cell count (febrile neutropenia).
- damage to the liver (liver injury).
- life-threatening allergic reaction (anaphylactic shock).
- abnormal build-up of fluid in the lungs (acute pulmonary oedema).
- skin eruption (drug eruption).
- scaly, peeling rash (exfoliative rash).
- inflammation of the sac-like covering of the heart (pericarditis).
- a marked decrease in the number of granulocytes (a type of white blood cells, granulocytopenia).
- severe skin disorder (erythema multiforme).
- nausea, shortness of breath, irregular heartbeat, muscular cramps, seizure, clouding of urine and tiredness associated with abnormal laboratory test results (high potassium, uric acid and phosphorous levels and low calcium levels in the blood) that can lead to changes in kidney function and acute renal failure (tumour lysis syndrome (TLS)).
- respiratory failure.

Not known (frequency cannot be estimated from the available data):

severe skin disorder (Stevens-Johnson syndrome, toxic epidermal necrolysis) that may include painful red or purplish rash that spreads and blisters and/or other lesions that begin to appear in the mucous membrane (e.g., mouth and lips) due to an allergic reaction.

- interstitial lung disease (disorders causing scarring in the lungs): signs include cough, difficulty breathing, painful breathing.
- recurrence (reactivation) of hepatitis B infection when you have had hepatitis B in the past (a liver infection).

Other side effects with Bosulif may include:

Very common (may affect more than 1 in 10 people):

- diarrhoea, vomiting, stomach pain (abdominal pain), nausea.
- fever (pyrexia), swelling of hands, feet or face (oedema), fatigue, weakness.
- respiratory tract infection.
- nasopharyngitis.
- changes in blood test to determine if Bosulif is affecting your liver (alanine aminotransferase (ALT) increased, aspartate aminotransferase (AST) increased) and/or pancreas (lipase increased), kidneys (blood creatinine increased).
- decrease of appetite.
- joint pain (arthralgia), back pain.
- headache.
- skin rash, which may be itchy and/or generalised (rash).
- cough.
- shortness of breath (dyspnoea).
- feeling of instability (dizziness).

Common (may affect up to 1 in 10 people):

- stomach irritation (gastritis).
- pain.
- influenza, bronchitis.
- changes in blood test to determine if Bosulif is affecting your heart (blood creatine phosphokinase increased), liver (blood bilirubin increased, gamma-glutamyltransferase (GGT) increased), and/or pancreas (amylase increased).
- low level of phosphorus in the blood (hypophosphataemia), excessive loss of body fluid (dehydration).
- pain in the muscles (myalgia).
- alteration of the sense of taste (dysgeusia).
- ringing in the ears (tinnitus).
- hives (urticaria), acne.
- sensitivity to UV rays from the sun and other light sources (photosensitivity reaction).
- itching (pruritus).

Reporting of side effects

If you get any side effects, talk to your doctor or pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via the national reporting system listed in <u>Appendix V</u>. By reporting side effects you can help provide more information on the safety of this medicine.

5. How to store Bosulif

- Keep this medicine out of the sight and reach of children.
- Do not use this medicine after the expiry date which is stated on the blister foil and carton after "EXP". The expiry date refers to the last day of that month.
- This medicine does not require any special storage conditions.
- Do not use this medicine if you notice that the pack is damaged or shows signs of tampering.
- Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. Content of the pack and other information

What Bosulif contains

- The active substance is bosutinib. Bosulif film-coated tablets come in different strengths. Bosulif 100 mg: each film-coated tablet contains 100 mg bosutinib (as monohydrate). Bosulif 400 mg: each film-coated tablet contains 400 mg bosutinib (as monohydrate). Bosulif 500 mg: each film-coated tablet contains 500 mg bosutinib (as monohydrate).
- The other ingredients are: microcrystalline cellulose (E460), croscarmellose sodium (E468), poloxamers 188, povidone (E1201) and magnesium stearate (E470b). The tablet film-coating contains polyvinyl alcohol, titanium dioxide (E171), macrogol 3350, talc (E553b) and iron oxide yellow (E172, for Bosulif 100 mg and 400 mg) or iron oxide red (E172, for Bosulif 400 mg and 500 mg) (see section 2 "Bosulif contains sodium").

What Bosulif looks like and contents of the pack

Bosulif 100 mg film-coated tablets are yellow, oval biconvex, debossed with "Pfizer" on one side and "100" on the other side.

Bosulif 100 mg is available in blisters containing either 14 or 15 film-coated tablets. Each carton contains 28, 30 or 112 film-coated tablets.

Bosulif 400 mg film-coated tablets are orange, oval biconvex, debossed with "Pfizer" on one side and "400" on the other side.

Bosulif 400 mg is available in blisters containing either 14 or 15 film-coated tablets. Each carton contains 28 or 30 film-coated tablets.

Bosulif 500 mg film-coated tablets are red, oval biconvex, debossed with "Pfizer" on one side and "500" on the other side.

Bosulif 500 mg is available in blisters containing either 14 or 15 film-coated tablets. Each carton contains 28 or 30 film-coated tablets.

Not all pack sizes may be marketed.

Marketing Authorisation Holder

Pfizer Europe MA EEIG Boulevard de la Plaine 17 1050 Bruxelles Belgium

Manufacturer

Pfizer Manufacturing Deutschland GmbH Mooswaldallee 1 79108 Freiburg Im Breisgau Germany

For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:

België / Belgique / Belgien Luxembourg/Luxemburg Pfizer NV/SA

Tél/Tel: +32 (0)2 554 62 11

България

Пфайзер Люксембург САРЛ, Клон България

Тел.: +359 2 970 4333

Lietuva

Pfizer Luxembourg SARL filialas Lietuvoje Tel. + 370 52 51 4000 Česká republika

Pfizer, spol. s r.o. Tel: +420 283 004 111

Danmark

Pfizer ApS

Tlf: +45 44 20 11 00

Deutschland

PFIZER PHARMA GmbH Tel: +49 (0)30 550055 51000

Eesti

Pfizer Luxembourg SARL Eesti filiaal

Tel: +372 666 7500

Ελλάδα

Pfizer Ελλάς Α.Ε. Τηλ: +30 210 6785 800

España

Pfizer, S.L.

Tél: +34 91 490 99 00

France

Pfizer

Tél: +33 (0)1 58 07 34 40

Hrvatska

Pfizer Croatia d.o.o. Tel: + 385 1 3908 777

Ireland

Pfizer Healthcare Ireland Unlimited Company

Tel: 1800 633 363 (toll free)

+44 (0)1304 616161

Ísland

Icepharma hf.

Sími: +354 540 8000

Italia

Pfizer S.r.l.

Tel: +39 06 33 18 21

Κύπρος

Pfizer Ελλάς A.E. (Cyprus Branch)

Τηλ+357 22 817690

Latvija

Pfizer Luxembourg SARL filiāle Latvijā

Tel.: + 371 670 35 775

Magyarország

Pfizer Kft.

Tel.: +36-1-488-37-00

Malta

Vivian Corporation Ltd.

Tel: +356 21344610

Nederland

Pfizer BV

Tel: +31 (0)10 406 43 01

Norge

Pfizer AS

Tlf: +47 67 52 61 00

Österreich

Pfizer Corporation Austria Ges.m.b.H.

Tel: +43 (0)1 521 15-0

Polska

Pfizer Polska Sp. z o.o.

Tel:+48 22 335 61 00

Portugal

Laboratórios Pfizer, Lda.

Tel: +351 21 423 5500

România

Pfizer Romania S.R.L.

Tel: +40 (0) 21 207 28 00

Slovenija

Pfizer Luxembourg SARL

Pfizer, podružnica za svetovanje s področja

farmacevtske dejavnosti, Ljubljana

Tel.: + 386 (0)1 52 11 400

Slovenská republika

Pfizer Luxembourg SARL, organizačná zložka

Tel.: + 421 2 3355 5500

Suomi/Finland

Pfizer Oy

Puh./Tel: +358 (0)9 43 00 40

Sverige

Pfizer AB

Tel: +46 (0)8 550 520 00

This leaflet was last revised in

Detailed information on this medicine is available on the European Medicines Agency web site: https://www.ema.europa.eu.

Package leaflet: Information for the user

Bosulif 50 mg hard capsules Bosulif 100 mg hard capsules bosutinib

Read all of this leaflet carefully before you start taking this medicine because it contains important information for you and your carer.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet

- 1. What Bosulif is and what it is used for
- 2. What you need to know before you take Bosulif
- 3. How to take Bosulif
- 4. Possible side effects
- 6. How to store Bosulif
- 6. Content of the pack and other information

1. What Bosulif is and what it is used for

Bosulif contains the active substance bosutinib. Bosulif is used to treat adult and paediatric patients aged 6 years and older who have a type of leukaemia called chronic phase (CP) Philadelphia chromosome-positive (Ph-positive) Chronic Myeloid Leukaemia (CML) and are newly-diagnosed or for whom previous medicines to treat CML have either not worked or are not suitable. It is also used to treat adult patients with accelerated phase (AP) and blast phase (BP) Ph+ CML for whom previous medicines to treat CML have not worked or are not suitable.

In patients with Ph-positive CML a change in DNA (genetic material) triggers a signal that tells the body to produce too many of a specific type of white blood cell called granulocytes. Bosulif blocks this signal and therefore stops the production of these cells.

If you have any questions about how Bosulif works or why this medicine has been prescribed for you, ask your doctor.

2. What do you need to know before you take Bosulif

Do not take Bosulif

- if you are allergic to bosutinib or any of the other ingredients of this medicine (listed in section 6).
- if your doctor has told you that your liver has been damaged and is not working normally.

Warnings and precautions

Talk to your doctor, pharmacist or nurse before taking Bosulif:

if you have, or have had in the past, liver problems. Tell your doctor if you have a history of liver problems including hepatitis (liver infection or inflammation) of any kind, or a history of any of signs and symptoms of liver problems (see section 4 "Possible Side Effects") because Bosulif may affect your liver function. Your doctor should do blood tests to check your liver

function prior to your starting treatment with Bosulif and for the first 3 months of treatment with Bosulif, and as clinically indicated.

- if you have diarrhoea and vomiting. Tell your doctor if you develop any signs and symptoms of stomach or intestinal problems (see section 4 "Possible Side Effects"). Your doctor may provide an anti-diarrhoeal or antiemetic product and/or fluids in order to reduce the symptoms. Your doctor may also withhold temporarily, dose reduce, or discontinue Bosulif (see section 3 "How to take Bosulif"). You should ask your doctor if use of your treatment for nausea or vomiting medicines together with Bosulif may result in a greater risk of heart arrhythmias.
- **if you suffer from bleeding problems.** Tell your doctor if you develop any signs and symptoms of blood problem (see section 4 "Possible Side Effects"), because Bosulif reduces the capability of your body to stop bleeding. During the first month, your doctor will perform weekly and then monthly complete blood counts for you. Your doctor may also withhold temporarily, dose reduce or discontinue Bosulif (see section 3 "How to take Bosulif").
- **if you have an infection.** Tell your doctor if you develop any of the following signs and symptoms such as fever, problems with urine such as burning on urination, a new cough, or a new sore throat because Bosulif reduces the capability of your body to defend from infections.
- **if you have fluid retention.** Tell your doctor if you develop any of the following signs and symptoms of fluid retention during Bosulif treatment such as swelling of the ankles, feet or legs; difficulty breathing chest pain or a cough (these may be signs of fluid retention in the lungs or chest). Your doctor will monitor you for fluid retention and will manage your symptoms.
- **if you have heart problems.** Tell your doctor if you have a heart disorder, such as heart failure and decreased blood flow to the heart which can lead to heart attack. Get medical help right away if you get shortness of breath, weight gain, chest pain, or swelling in your hands, ankles or feet.
- **if you have been told you have abnormal heart rhythm**. Tell your doctor if you have arrhythmias or an abnormal electrical signal called "prolongation of the QT interval". This is always important, but especially if you are experiencing frequent or prolonged diarrhoea as described above. If you faint (loss of consciousness) or have an irregular heartbeat while taking Bosulif, tell your doctor immediately, as this may be a sign of a serious heart condition (see section 2 "What do you need to know before you take Bosulif"). Your doctor will perform an electrocardiogram (ECG) before you start therapy. Your doctor will do a blood test prior to and during therapy and if you have low potassium or magnesium, your doctor will provide a treatment to correct the low blood levels.
- **if you have been told that you have problems with your kidneys.** Tell your doctor if you are urinating more frequently and producing larger amounts of urine with a pale colour or if you are urinating less frequently and producing smaller amounts of urine with a dark colour. Also tell your doctor if you are losing weight or have experienced swelling of your feet, ankles, legs, hands or face. Your doctor will assess how your kidneys are functioning before treatment and will closely monitor how your kidneys are functioning during the course of treatment with bosutinib.
- **if you have ever had or might now have a hepatitis B infection.** This is because Bosulif could cause hepatitis B to become active again, which can be fatal in some cases. Your doctor will test you for this infection before starting treatment. If you have this infection, your doctor will monitor you closely for signs and symptoms of the infection throughout therapy and several months after you have stopped therapy.
- **if you have or have had pancreas problems.** Tell your doctor if you develop abdominal pain or discomfort. If you have abdominal pain and your blood tests show high levels of lipase, an

enzyme that helps your body break down fats in food, then your doctor may interrupt your treatment and perform tests to rule out problems with your pancreas.

- **if you have any of these symptoms: serious skin rashes.** Tell your doctor if you develop any of the following signs and symptoms of painful red or purplish rash that spreads and blisters and/or other lesions begin to appear in the mucous membrane (e.g., mouth and lips). If you develop a severe skin reaction during treatment, your doctor will permanently discontinue treatment.
- **if you notice any of these symptoms: pain in your side, blood in your urine or reduced amount of urine.** When your disease is very severe, your body may not be able to clear all the waste products from the dying cancer cells. This is called tumour lysis syndrome and can cause kidney failure and heart problems within 48 hours of the first dose of Bosulif. Your doctor will be aware of this and may ensure you are adequately hydrated and give you other medicines to help prevent it. Your doctor will perform a blood test to check for high uric acid levels and your doctor will provide a treatment to correct the high levels prior to starting therapy.

Sun/UV protection

You may become more sensitive to the sun or UV rays while taking bosutinib. It is important to cover sunlight-exposed areas of skin and use sunscreen with high sun protection factor (SPF).

Patients of Asian origin

If you are of Asian origin, you may have an increased risk of side effects with Bosulif. Your doctor will closely monitor you for serious side effects especially when increasing the dose.

Children and adolescents

Bosulif is not recommended for people whose age is under 6 years of age. This medicine has not been studied in children below the age of 1 year.

Other medicines and Bosulif

Tell your doctor or pharmacist if you are taking, have recently taken or might take any other medicines, including medicines obtained without a prescription, vitamins, and herbal medicines. Some medicines can affect the levels of Bosulif in your body. You should inform your doctor if you are taking medicines containing active substances such as those listed below:

The following active substances may increase the risk of side effects with Bosulif:

- ketoconazole, itraconazole, voriconazole, posaconazole and fluconazole, used to treat fungal infections.
- clarithromycin, telithromycin, erythromycin, and ciprofloxacin, used to treat bacterial infections.
- nefazodone, used to treat depression.
- mibefradil, diltiazem and verapamil, used to lower blood pressure in people with high blood pressure.
- ritonavir, lopinavir/ritonavir, indinavir, nelfinavir, saquinavir, atazanavir, amprenavir, fosamprenavir and darunavir, used to treat human immunodeficiency virus (HIV)/AIDS.
- boceprevir and telaprevir, used to treat hepatitis C.
- aprepitant, used to prevent and control nausea (feeling sick) and vomiting.
- imatinib, used to treat a type of leukaemia.
- crizotinib, used to treat a type of lung cancer called non-small cell lung cancer.

The following active substances may reduce the effectiveness of Bosulif:

- rifampicin, used to treat tuberculosis.
- phenytoin and carbamazepine, used to treat epilepsy.
- bosentan, used to lower high blood pressure in the lungs (pulmonary artery hypertension).
- nafcillin, an antibiotic used to treat bacterial infections.
- St. John's Wort (a herbal preparation obtained without a prescription), used to treat depression.
- efavirenz and etravirine, used to treat HIV infections/AIDS.
- modafinil, used to treat certain types of sleep disorders.

These medicines should be avoided during your treatment with Bosulif. If you are taking any of them, tell your doctor. Your doctor may change the dose of these medicines, change the dose of Bosulif, or switch you to a different medicine.

The following active substances may affect the heart rhythm:

- amiodarone, disopyramide, procainamide, quinidine and sotalol used to treat heart disorder.
- chloroquine, halofantrine used to treat malaria.
- clarithromycin and moxifloxacin antibiotics used to treat bacterial infections.
- haloperidol, used to treat psychotic disease such as schizophrenia.
- domperidone, used to treat nausea and vomiting or to stimulate breast milk production.
- methadone, used to treat pain.

These medicines should be taken with caution during your treatment with Bosulif. If you are taking any of them, tell your doctor.

Acid reducing agents

Proton pump inhibitors (PPIs) should be taken with caution during your treatment with Bosulif as they may reduce the effectiveness of Bosulif. Your doctor may consider short-acting antacids as an alternative to PPIs and administration times of Bosulif and antacids should be separated (i.e. take Bosulif in the morning and antacids in the evening) whenever possible.

The medicines listed here may not be the only ones that could interact with Bosulif, if you are not sure if the above applies to you or your child, ask your doctor.

Bosulif with food and drink

Do not take Bosulif with grapefruit or grapefruit juice, as it may increase the risk of side effects.

Pregnancy, breast-feeding and fertility

Bosulif is not to be used during pregnancy, unless clearly necessary, because Bosulif could harm an unborn baby. Ask your doctor for advice before taking Bosulif if you are pregnant or might become pregnant.

Women taking Bosulif will be advised to use effective contraception during treatment and for at least 1 month after the last dose. Vomiting or diarrhoea may reduce the effectiveness of oral contraceptives.

There is a risk that treatment with Bosulif will lead to decreased fertility and you may wish to seek advice about sperm storage before the treatment starts.

If you are breast-feeding, tell your doctor. Do not breast-feed during treatment with Bosulif as it could harm your baby.

Driving and using machines

If you experience dizziness, have blurred vision or feel unusually tired, do not drive or operate machines until these side effects have gone away.

Bosulif contains sodium

This medicine contains less than 1 mmol sodium (23 mg) per 50 mg or 100 mg hard capsule, that is to say essentially 'sodium-free'.

3. How to take Bosulif

Always take this medicine exactly as your doctor has told you. Check with your doctor or pharmacist if you are not sure.

Bosulif will only be prescribed to you by a doctor with experience in medicines to treat leukaemia.

Dose and method of administration

Adults

The recommended dose is 400 mg once daily for patients with newly-diagnosed CML. The recommended dose is 500 mg once daily for patients whose previous medicines to treat CML have either not worked or are not suitable. In the event you are not able to tolerate the recommended dose or are not responding to Bosulif correctly, your doctor may adjust your dose further.

Children and Adolescents (6 years of age and older)

The recommended dose is 300 mg/m² body surface area (BSA) once daily for newly-diagnosed paediatric patients. The recommended dose is 400 mg/m² BSA once daily for resistant or intolerant paediatric patients.

Dose recommendations are provided in the following table. As appropriate, for the recommended dose you may combine different strengths of bosutinib film-coated tablets and/or hard capsules (see Package Leaflet for film-coated tablets).

Dosing of bosutinib for newly-diagnosed (ND) and for resistant or intolerant (R/I) paediatric patients

Body Surface	ND recommended dose	R/I recommended dose
Area		
$0.55 - < 0.63 \text{ m}^2$	200 mg	250 mg
$0.63 - < 0.75 \text{ m}^2$	200 mg	300 mg
$0.75 - < 0.9 \text{ m}^2$	250 mg	350 mg
$0.9 - < 1.1 \text{ m}^2$	300 mg	400 mg
$\geq 1.1 \text{ m}^2$	400 mg*	500 mg*

^{*} maximum starting dose (corresponding to maximum starting dose in adult indication)

In the event you are not able to tolerate the recommended dose or are not responding to Bosulif correctly, your doctor may adjust your dose further.

Take the capsule(s) once a day with food. The hard capsule is to be swallowed whole.

Instructions for dose preparation in patients unable to swallow

For patients who are unable to swallow a whole hard capsule(s), each hard capsule can be opened and the contents mixed with applesauce or yogurt. Mixing the hard capsule contents with applesauce or yogurt is no substitute of a proper meal, the dose should be taken with food to improve how well you digest the medicine.

Remove the required number of hard capsules from the container to prepare the dose as instructed and pour the amount of either room temperature applesauce or yogurt in a clean container as detailed in the table below. Carefully open each hard capsule, add the entire capsule content of each hard capsule into the applesauce or yogurt, then mix the entire dose into the applesauce or yogurt. You should immediately consume the full mixture in its entirety, without chewing. Do not store the mixture for later use. If the entire preparation is not swallowed do not take an additional dose. Wait until the next day to resume dosing. In order to facilitate the administration the recommended volume of applesauce or yogurt is provided in the table below.

Bosulif dose using hard capsules and soft food volumes

Dose	Volume of Applesauce or Yogurt
200 mg	20 mL (4 teaspoons)
250 mg	25 mL (5 teaspoons)
300 mg	30 mL (6 teaspoons)

350 mg	30 mL (6 teaspoons)
400 mg	35 mL (7 teaspoons)
500 mg	45 mL (9 teaspoons)

If you take more Bosulif than you should

If you accidentally take too many Bosulif capsules or a higher dose than you need, contact a doctor for advice right away. If possible, show the doctor the pack, or this leaflet. You may require medical attention.

If you forget to take Bosulif

If dose is missed by less than 12 hours, take your recommended dose. If a dose is missed by more than 12 hours, take your next dose at your regular time on the following day.

Do not take a double dose to make up for the forgotten capsules.

If you stop taking Bosulif

Do not stop taking Bosulif unless your doctor tells you to do so. If you are not able to take the medicine as your doctor prescribed or you feel you do not need it anymore, contact your doctor right away.

If you have any further questions on the use of this medicine ask your doctor or pharmacist.

4. Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them.

Serious side effects

You must immediately contact your doctor if you experience any of those serious side effects (see also section 2 "What you need to know before you take Bosulif"):

Very common (may affect more than 1 in 10 people):

- reduction in the number of platelets (thrombocytopenia), red blood cells (anaemia) and/or neutrophils (type of white blood cells) (neutropenia) which may cause you to have abnormal bleeding, fever, or easy bruising without having an injury (you might have blood or lymphatic system disorder) (see section 2 "What do you need to know before you take Bosulif").
- fluid around the lungs (pleural effusion).

Common (may affect up to 1 in 10 people):

- low white blood cells count (leukopenia).
- bleeding from the stomach or intestine (gastrointestinal haemorrhage) which may include blood in your vomit, stools (bowel movements) or urine, or have black stools (tarry black bowel movements) (see section 2 What do you need to know before you take Bosulif).
- chest pain.
- toxic damage to the liver (hepatotoxicity), abnormal hepatic function including liver disorder (hepatic function abnormal) which may be accompanied with itching, yellow eyes or skin, dark urine, and pain or discomfort in the right upper stomach area or fever (see section 2 What do you need to know before you take Bosulif).
- when the heart does not pump blood as well as it should (heart failure).
- when there is decreased blood flow to the heart (cardiac ischaemia).
- infection of the lung (pneumonia).
- defect in cardiac rhythm (electrocardiogram QT prolonged) that predisposes to fainting, dizziness and palpitation.
- increase in blood pressure (hypertension).
- high level of potassium in the blood (hyperkalaemia).
- acute kidney failure, kidney failure (renal failure), kidney impairment (renal impairment).

- fluid around the heart (pericardial effusion).
- allergic reaction (drug hypersensitivity).
- abnormally high blood pressure in the arteries of the lungs (pulmonary hypertension).
- acute inflammation of the pancreas (pancreatitis acute).

Uncommon (may affect up to 1 in 100 people):

- fever associated with low white blood cell count (febrile neutropenia).
- damage to the liver (liver injury).
- life-threatening allergic reaction (anaphylactic shock).
- abnormal build-up of fluid in the lungs (acute pulmonary oedema).
- skin eruption (drug eruption).
- scaly, peeling rash (exfoliative rash).
- inflammation of the sac-like covering of the heart (pericarditis).
- a marked decrease in the number of granulocytes (a type of white blood cells, granulocytopenia).
- severe skin disorder (erythema multiforme).
- nausea, shortness of breath, irregular heartbeat, muscular cramps, seizure, clouding of urine and tiredness associated with abnormal laboratory test results (high potassium, uric acid and phosphorous levels and low calcium levels in the blood) that can lead to changes in kidney function and acute renal failure (tumour lysis syndrome (TLS)).
- respiratory failure.

Not known (frequency cannot be estimated from the available data):

- severe skin disorder (Stevens-Johnson syndrome, toxic epidermal necrolysis) that may include painful red or purplish rash that spreads and blisters and/or other lesions that begin to appear in the mucous membrane (e.g., mouth and lips) due to an allergic reaction.
- interstitial lung disease (disorders causing scarring in the lungs): signs include cough, difficulty breathing, painful breathing.
- recurrence (reactivation) of hepatitis B infection when you have had hepatitis B in the past (a liver infection).

Other side effects with Bosulif may include:

Very common (may affect more than 1 in 10 people):

- diarrhoea, vomiting, stomach pain (abdominal pain), nausea.
- fever (pyrexia), swelling of hands, feet or face (oedema), fatigue, weakness.
- respiratory tract infection.
- nasopharyngitis.
- changes in blood test to determine if Bosulif is affecting your liver (alanine aminotransferase (ALT) increased, aspartate aminotransferase (AST) increased) and/or pancreas (lipase increased), kidneys (blood creatinine increased).
- decrease of appetite.
- joint pain (arthralgia), back pain.
- headache.
- skin rash, which may be itchy and/or generalised (rash).
- cough.
- shortness of breath (dyspnoea).
- feeling of instability (dizziness).

Common (may affect up to 1 in 10 people):

- stomach irritation (gastritis).
- pain.
- influenza, bronchitis.
- changes in blood test to determine if Bosulif is affecting your heart (blood creatine phosphokinase increased), liver (blood bilirubin increased, gamma-glutamyltransferase (GGT) increased), and/or pancreas (amylase increased).

- low level of phosphorus in the blood (hypophosphataemia), excessive loss of body fluid (dehydration).
- pain in the muscles (myalgia).
- alteration of the sense of taste (dysgeusia).
- ringing in the ears (tinnitus).
- hives (urticaria), acne.
- sensitivity to UV rays from the sun and other light sources (photosensitivity reaction).
- itching (pruritus).

Reporting of side effects

If you get any side effects, talk to your doctor or pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via the national reporting system listed in <u>Appendix V</u>. By reporting side effects you can help provide more information on the safety of this medicine.

5. How to store Bosulif

- Keep this medicine out of the sight and reach of children.
- Do not use this medicine after the expiry date which is stated on the bottle and carton after "EXP". The expiry date refers to the last day of that month.
- Do not store above 30 °C. Store in the original package in order to protect from light.
- Do not use this medicine if you notice that the pack is damaged or shows signs of tampering.
- Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. Content of the pack and other information

What Bosulif contains

The active substance is bosutinib. Bosulif hard capsules come in different strengths. Bosulif 50 mg: each hard capsule contains 50 mg bosutinib (as monohydrate). Bosulif 100 mg: each hard capsule contains 100 mg bosutinib (as monohydrate).

The other ingredients are: mannitol (E421), microcrystalline cellulose (E460), croscarmellose sodium (E468), poloxamers 188, povidone (E1201), and magnesium stearate (E470b). The hard capsule shells contain gelatin, titanium dioxide (E171), yellow iron oxide (E172), and red iron oxide (E172). The printing ink contains shellac (E904), propylene glycol (E1520), ammonia solution, concentrated (E527), black iron oxide (E172), potassium hydroxide (E525) (see section 2 Bosulif contains sodium).

What Bosulif looks like and contents of the pack

Bosulif 50 mg hard capsules are white body/orange cap with "BOS 50" printed on the body and "Pfizer" printed on the cap in black ink. Bosulif 50 mg hard capsules are available in bottles containing 30 hard capsules.

Bosulif 100 mg hard capsules are white body/brownish-red cap with "BOS 100" printed on the body and "Pfizer" printed on the cap in black ink. Bosulif 100 mg hard capsules are available in bottles containing 150 hard capsules.

Not all pack sizes may be marketed.

Marketing Authorisation Holder

Pfizer Europe MA EEIG Boulevard de la Plaine 17 1050 Bruxelles Belgium

Manufacturer

Pfizer Manufacturing Deutschland GmbH Mooswaldallee 1 79108 Freiburg Im Breisgau Germany

For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:

België/Belgique/Belgien Luxembourg/Luxemburg

Pfizer NV/SA

Tél/Tel: +32 (0)2 554 62 11

България

Пфайзер Люксембург САРЛ, Клон България

Тел.: +359 2 970 4333

Česká republika

Pfizer, spol. s r.o. Tel: +420 283 004 111

Danmark

Pfizer ApS

Tlf: +45 44 20 11 00

Deutschland

PFIZER PHARMA GmbH Tel: +49 (0)30 550055 51000

Eesti

Pfizer Luxembourg SARL Eesti filiaal

Tel: +372 666 7500

Ελλάδα

Pfizer Ελλάς Α.Ε. Τηλ: +30 210 6785 800

España

Pfizer, S.L.

Tél: +34 91 490 99 00

France

Pfizer

Tél: +33 (0)1 58 07 34 40

Hrvatska

Pfizer Croatia d.o.o. Tel: + 385 1 3908 777

Lietuva

Pfizer Luxembourg SARL filialas Lietuvoje Tel. + 370 52 51 4000

Magyarország

Pfizer Kft.

Tel.: +36-1-488-37-00

Malta

Vivian Corporation Ltd. Tel: +356 21344610

Nederland

Pfizer BV

Tel: +31 (0)10 406 43 01

Norge

Pfizer AS

Tlf: +47 67 52 61 00

Österreich

Pfizer Corporation Austria Ges.m.b.H.

Tel: +43 (0)1 521 15-0

Polska

Pfizer Polska Sp. z o.o. Tel:+48 22 335 61 00

Portugal

Laboratórios Pfizer, Lda. Tel: +351 21 423 5500

România

Pfizer Romania S.R.L. Tel: +40 (0) 21 207 28 00

Ireland

Pfizer Healthcare Ireland Unlimited Company

Tel: 1800 633 363 (toll free)

+44 (0)1304 616161

Ísland

Icepharma hf.

Sími: +354 540 8000

Italia

Pfizer S.r.l.

Tel: +39 06 33 18 21

Κύπρος

Pfizer Ελλάς Α.Ε. (Cyprus Branch)

Τηλ+357 22 817690

Latvija

Pfizer Luxembourg SARL filiāle Latvijā

Tel.: + 371 670 35 775

Slovenija

Pfizer Luxembourg SARL

Pfizer, podružnica za svetovanje s področja farmacevtske dejavnosti, Ljubljana

Tel.: + 386 (0)1 52 11 400

Slovenská republika

Pfizer Luxembourg SARL, organizačná zložka

Tel.: + 421 2 3355 5500

Suomi/Finland

Pfizer Oy

Puh./Tel: +358 (0)9 43 00 40

Sverige

Pfizer AB

Tel: +46 (0)8 550 520 00

This leaflet was last revised in

Detailed information on this medicine is available on the European Medicines Agency web site: https://www.ema.europa.eu.