ANNEX I

SUMMARY OF PRODUCT CHARACTERISTICS

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

1. NAME OF THE MEDICINAL PRODUCT

Tecentriq 1,200 mg concentrate for solution for infusion.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each 20 mL vial of concentrate contains 1,200 mg atezolizumab*.

After dilution (see section 6.6), one mL of solution contains approximately 4.4 mg of atezolizumab.

*Atezolizumab is an Fc-engineered, humanised IgG1 anti-programmed death-ligand 1 (PD-L1) monoclonal antibody produced in Chinese hamster ovary cells by recombinant DNA technology.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Concentrate for solution for infusion.

Clear, colourless to slightly yellowish liquid.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Tecentriq as monotherapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial carcinoma (UC):

- after prior platinum-containing chemotherapy, or
- who are considered cisplatin ineligible, and whose tumours have a PD-L1 expression ≥ 5% (see section 5.1).

Tecentriq as monotherapy is indicated for the treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) after prior chemotherapy. Patients with EGFR activating mutations or ALK-positive tumour mutations should also have received targeted therapy before receiving Tecentriq (see section 5.1).

4.2 Posology and method of administration

Tecentriq must be initiated and supervised by physicians experienced in the treatment of cancer.

PD-L1 testing for patients with UC
Patients with previously untreated UC should be selected for treatment based on the tumour expression of PD-L1 confirmed by a validated test (see section 5.1).

Posology

The recommended dose of Tecentriq is 1,200 mg administered intravenously every three weeks.

Duration of treatment
It is recommended that patients are treated with Tecentriq until loss of clinical benefit (see section 5.1) or unmanageable toxicity.

Delayed or missed doses
If a planned dose of Tecentriq is missed, it should be administered as soon as possible; it is recommended not to wait until the next planned dose. The schedule of administration must be adjusted to maintain a 3-week interval between doses.

Dose modifications during treatment
Dose reductions of Tecentriq are not recommended.

Dose delay or discontinuation (see also sections 4.4 and 4.8)

Table 1: Dose modification advice for Tecentriq

Immune related adverse reaction	**Severity**	**Treatment modification**
Pneumonitis	Grade 2	Withhold Tecentriq Treatment may be resumed when the event improves to Grade 0 or Grade 1 within 12 weeks, and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day
	Grade 3 or 4	Permanently discontinue Tecentriq
Hepatitis	Grade 2: (ALT or AST > 3 to 5 x upper limit of normal [ULN] *or* blood bilirubin > 1.5 to 3 x ULN)	Withhold Tecentriq Treatment may be resumed when the event improves to Grade 0 or Grade 1 within 12 weeks and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day
	Grade 3 or 4: (ALT or AST > 5 x ULN *or* blood bilirubin > 3 x ULN)	Permanently discontinue Tecentriq
Colitis	Grade 2 or 3 Diarrhoea (increase of ≥ 4 stools/day over baseline) *or* Symptomatic Colitis	Withhold Tecentriq Treatment may be resumed when the event improves to Grade 0 or Grade 1 within 12 weeks and corticosteroids have been reduced to ≤ 10 mg prednisone equivalent per day
	Grade 4 Diarrhoea or Colitis (life threatening; urgent intervention indicated)	Permanently discontinue Tecentriq

Immune related adverse reaction	Severity	Treatment modification
Hypothyroidism or hyperthyroidism	Symptomatic	Withhold Tecentriq *Hypothyroidism:* Treatment may be resumed when symptoms are controlled by thyroid replacement therapy and TSH levels are decreasing *Hyperthyroidism:* Treatment may be resumed when symptoms are controlled by antithyroid medicinal product and thyroid function is improving
Adrenal insufficiency	Symptomatic	Withhold Tecentriq Treatment may be resumed when the symptoms improve to Grade 0 or Grade 1 within 12 weeks and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day and patient is stable on replacement therapy
Hypophysitis	Grade 2 or 3	Withhold Tecentriq Treatment may be resumed when the symptoms improve to Grade 0 or Grade 1 within 12 weeks and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day and patient is stable on replacement therapy
	Grade 4	Permanently discontinue Tecentriq
Type 1 diabetes mellitus	Grade 3 or 4 hyperglycaemia (fasting glucose > 250 mg/dL or 13.9 mmol/L)	Withhold Tecentriq Treatment may be resumed when metabolic control is achieved on insulin replacement therapy
Infusion-related reactions	Grade 1 or 2	Reduce infusion rate or interrupt. Treatment may be resumed when the event is resolved
	Grade 3 or 4	Permanently discontinue Tecentriq
Rash	Grade 3	Withhold Tecentriq Treatment may be resumed when rash is resolved and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day
	Grade 4	Permanently discontinue Tecentriq

Immune related adverse reaction	Severity	Treatment modification
Myasthenic syndrome/myasthenia gravis, Guillain-Barré syndrome and Meningoencephalitis	All Grades	Permanently discontinue Tecentriq
Pancreatitis	Grade 3 or 4 serum amylase or lipase levels increased (> 2 x ULN) or Grade 2 or 3 pancreatitis	Withhold Tecentriq Treatment may be resumed when serum amylase and lipase levels improve to Grade 0 or Grade 1 within 12 weeks, or symptoms of pancreatitis have resolved, and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day
	Grade 4 or any grade of recurrent pancreatitis	Permanently discontinue Tecentriq
Myocarditis	Grade 2	Withhold Tecentriq Treatment may be resumed when the symptoms improve to Grade 0 or Grade 1 within 12 weeks and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day
	Grade 3 and 4	Permanently discontinue Tecentriq
Other immune-related adverse reactions	Grade 2 or Grade 3	Withhold until adverse reactions recovers to Grade 0-1 within 12 weeks, and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day.
	Grade 4 or recurrent Grade 3	Permanently discontinue Tecentriq (except endocrinopathies controlled with replacement hormones)

Note: Toxicity grades are in accordance with National Cancer Institute Common Terminology Criteria for Adverse Event Version 4.0 (NCI-CTCAE v.4.).

Patients treated with Tecentriq must be given the Patient Alert Card and be informed about the risks of Tecentriq (see also package leaflet).

Special populations

Paediatric population
The safety and efficacy of Tecentriq in children and adolescents aged below 18 years have not been established. No data are available.

Elderly
Based on a population pharmacokinetic analysis, no dose adjustment of Tecentriq is required in patients ≥ 65 years of age.

Renal impairment
Based on a population pharmacokinetic analysis, no dose adjustment is required in patients with mild or moderate renal impairment (see section 5.2). Data from patients with severe renal impairment are too limited to draw conclusions on this population.

Hepatic impairment
Based on a population pharmacokinetic analysis, no dose adjustment is required for patients with mild hepatic impairment. Tecentriq has not been studied in patients with moderate or severe hepatic impairment (see section 5.2).

Eastern Cooperative Oncology Group (ECOG) performance status ≥ 2
Patients with ECOG performance status ≥ 2 were excluded from the clinical trials in NSCLC and 2nd line UC (see sections 4.4 and 5.1).

Method of administration

Tecentriq is for intravenous use. The infusions must not be administered as an intravenous push or bolus.

The initial dose of Tecentriq must be administered over 60 minutes. If the first infusion is well tolerated, all subsequent infusions may be administered over 30 minutes.

For instructions on dilution and handling of the medicinal product before administration, see section 6.6.

4.3 Contraindications

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

4.4 Special warnings and precautions for use

In order to improve the traceability of biological medicinal products, the trade name and the batch number of the administered product should be clearly recorded (or stated) in the patient file.

Most immune-related adverse reactions occurring during treatment with atezolizumab were reversible with interruptions of atezolizumab and initiation of corticosteroids and/or supportive care. Immune-related adverse reactions affecting more than one body system have been observed. Immune-related adverse reactions with atezolizumab may occur after the last dose of atezolizumab.

For suspected immune-related adverse reactions, thorough evaluation to confirm aetiology or exclude other causes should be performed. Based on the severity of the adverse reaction, atezolizumab should be withheld and corticosteroids administered. Upon improvement to Grade ≤ 1, corticosteroid should be tapered over ≥ 1 month. Based on limited data from clinical studies in patients whose immune-related adverse reactions could not be controlled with systemic corticosteroid use, administration of other systemic immunosuppressants may be considered.

Atezolizumab must be permanently discontinued for any Grade 3 immune-related adverse reaction that recurs and for any Grade 4 immune-related adverse reactions, except for endocrinopathies that are controlled with replacement hormones (see sections 4.2 and 4.8).

Immune-related pneumonitis

Cases of pneumonitis, including fatal cases, have been observed in clinical trials with atezolizumab (see section 4.8). Patients should be monitored for signs and symptoms of pneumonitis.

Treatment with atezolizumab should be withheld for Grade 2 pneumonitis, and 1 to 2 mg/kg/day prednisone or equivalent should be started. If symptoms improve to ≤ Grade 1, corticosteroids should be tapered over ≥ 1 month. Treatment with atezolizumab may be resumed if the event improves to ≤ Grade 1 within 12 weeks, and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day. Treatment with atezolizumab must be permanently discontinued for Grade 3 or 4 pneumonitis.

Immune-related hepatitis

Cases of hepatitis, some leading to fatal outcomes have been observed in clinical trials with atezolizumab (see section 4.8). Patients should be monitored for signs and symptoms of hepatitis.

Aspartate aminotransferase (AST), alanine aminotransferase (ALT) and bilirubin should be monitored prior to initiation of treatment, periodically during treatment with atezolizumab and as indicated based on clinical evaluation.

Treatment with atezolizumab should be withheld if Grade 2 event (ALT or AST > 3 to 5 x ULN or blood bilirubin > 1.5 to 3 x ULN) persists for more than 5 to 7 days, and 1 to 2 mg/kg/day of prednisone or equivalent should be started. If the event improves to ≤ Grade 1, corticosteroids should be tapered over ≥ 1 month.

Treatment with atezolizumab may be resumed if the event improves to ≤ Grade 1 within 12 weeks and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day. Treatment with atezolizumab must be permanently discontinued for Grade 3 or Grade 4 events (ALT or AST > 5.0 x ULN or blood bilirubin > 3 x ULN).

Immune-related colitis

Cases of diarrhoea or colitis have been observed in clinical trials with atezolizumab (see section 4.8). Patients should be monitored for signs and symptoms of colitis.

Treatment with atezolizumab should be withheld for Grade 2 or 3 diarrhoea (increase of ≥ 4 stools/day over baseline) or colitis (symptomatic). For Grade 2 diarrhoea or colitis, if symptoms persist > 5 days or recur, treatment with 1 to 2 mg/kg/day prednisone or equivalent should be started. For Grade 3 diarrhoea or colitis, treatment with intravenous corticosteroids (1 to 2 mg/kg/day methylprednisolone or equivalent) should be started. Once symptoms improve, treatment with 1 to 2 mg/kg/day of prednisone or equivalent should be started. If symptoms improve to ≤ Grade 1, corticosteroids should be tapered over ≥ 1 month. Treatment with atezolizumab may be resumed if the event improves to ≤ Grade 1 within 12 weeks and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day. Treatment with atezolizumab must be permanently discontinued for Grade 4 (life threatening; urgent intervention indicated) diarrhoea or colitis.

Immune-related endocrinopathies

Hypothyroidism, hyperthyroidism, adrenal insufficiency, hypophysitis and type 1 diabetes mellitus, including diabetic ketoacidosis have been observed in clinical trials with atezolizumab (see section 4.8).

Patients should be monitored for clinical signs and symptoms of endocrinopathies. Thyroid function should be monitored prior to and periodically during treatment with atezolizumab. Appropriate management of patients with abnormal thyroid function tests at baseline should be considered.

Asymptomatic patients with abnormal thyroid function tests can receive atezolizumab. For symptomatic hypothyroidism, atezolizumab should be withheld and thyroid hormone replacement should be initiated as needed. Isolated hypothyroidism may be managed with replacement therapy and without corticosteroids. For symptomatic hyperthyroidism, atezolizumab should be withheld and an antithyroid medicinal product should be initiated as needed. Treatment with atezolizumab may be resumed when symptoms are controlled and thyroid function is improving.

For symptomatic adrenal insufficiency, atezolizumab should be withheld and treatment with intravenous corticosteroids (1 to 2 mg/kg/day methylprednisolone or equivalent) should be started. Once symptoms improve, treatment with 1 to 2 mg/kg/day of prednisone or equivalent should follow. If symptoms improve to ≤ Grade 1, corticosteroids should be tapered over ≥ 1 month. Treatment may be resumed if the event improves to ≤ Grade 1 within 12 weeks and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day and the patient is stable on replacement therapy (if required).

For Grade 2 or Grade 3 hypophysitis, atezolizumab should be withheld and treatment with intravenous corticosteroids (1 to 2 mg/kg/day methylprednisolone or equivalent) should be started, and hormone replacement should be initiated as needed. Once symptoms improve, treatment with 1 to 2 mg/kg/day of prednisone or equivalent should follow. If symptoms improve to ≤ Grade 1, corticosteroids should be tapered over ≥ 1 month. Treatment may be resumed if the event improves to ≤ Grade 1 within 12 weeks and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day and the patient is stable on replacement therapy (if required). Treatment with atezolizumab should be permanently discontinued for Grade 4 hypophysitis.

Treatment with insulin should be initiated for type 1 diabetes mellitus. For ≥ Grade 3 hyperglycaemia (fasting glucose > 250 mg/dL or 13.9 mmol/L), atezolizumab should be withheld. Treatment with atezolizumab may be resumed if metabolic control is achieved on insulin replacement therapy.

Immune-related meningoencephalitis

Meningoencephalitis has been observed in clinical trials with atezolizumab (see section 4.8). Patients should be monitored for clinical signs and symptoms of meningitis or encephalitis.

Treatment with atezolizumab must be permanently discontinued for any grade of meningitis or encephalitis. Treatment with intravenous corticosteroids (1 to 2 mg/kg/day methylprednisolone or equivalent) should be started. Once symptoms improve, treatment with 1 to 2 mg/kg/day of prednisone or equivalent should follow.

Immune-related neuropathies

Myasthenic syndrome/myasthenia gravis or Guillain-Barré syndrome, which may be life threatening, were observed in patients receiving atezolizumab. Patients should be monitored for symptoms of motor and sensory neuropathy.

Treatment with atezolizumab must be permanently discontinued for any grade of myasthenic syndrome / myasthenia gravis or Guillain-Barré syndrome. Initiation of systemic corticosteroids (at a dose of 1 to 2mg/kg/day of prednisone or equivalent) should be considered.

Immune-related pancreatitis

Pancreatitis, including increases in serum amylase and lipase levels, have been observed in clinical trials with atezolizumab (see section 4.8). Patients should be closely monitored for signs and symptoms that are suggestive of acute pancreatitis.

Treatment with atezolizumab should be withheld for ≥ Grade 3 serum amylase or lipase levels increased (> 2 x ULN), or Grade 2 or 3 pancreatitis, and treatment with intravenous corticosteroids

(1 to 2 mg/kg/day methylprednisolone or equivalent) should be started. Once symptoms improve, treatment with 1 to 2 mg/kg/day of prednisone or equivalent should follow. Treatment with atezolizumab may be resumed when serum amylase and lipase levels improve to ≤ Grade 1 within 12 weeks, or symptoms of pancreatitis have resolved, and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day. Treatment with atezolizumab should be permanently discontinued for Grade 4, or any grade of recurrent pancreatitis.

Immune-related myocarditis

Myocarditis has been observed in clinical trials with atezolizumab (see section 4.8). Patients should be monitored for signs and symptoms of myocarditis.

Treatment with atezolizumab should be withheld for Grade 2 myocarditis, and treatment with systemic corticosteroids at a dose of 1 to 2mg/kg/day of prednisone or equivalent should be started. Treatment with atezolizumab may be resumed if the event improves to ≤ Grade 1 within 12 weeks, and corticosteroids have been reduced to ≤ 10 mg prednisone or equivalent per day Treatment with atezolizumab must be permanently discontinued for Grade 3 or 4 myocarditis.

Infusion-related reactions

Infusion related reactions have been observed in clinical trials with atezolizumab (see section 4.8). The rate of infusion should be reduced or treatment should be interrupted in patients with Grade 1 or 2 infusion related reactions. Atezolizumab should be permanently discontinued in patients with Grade 3 or 4 infusion related reactions. Patients with Grade 1 or 2 infusion-related reactions may continue to receive atezolizumab with close monitoring; premedication with antipyretic and antihistamines may be considered.

Patients excluded from clinical trials

Patients with the following conditions were excluded from clinical trials: a history of autoimmune disease, history of pneumonitis, active brain metastasis, HIV, hepatitis B or hepatitis C infection. Patients who were administered a live, attenuated vaccine within 28 days prior to enrolment; systemic immunostimulatory agents within 4 weeks or systemic immunosuppressive medicinal products within 2 weeks prior to study entry were excluded from clinical trials.

Patients with a baseline performance status ≥ 2 were excluded (apart from Study GO29293 [IMvigor210] Cohort 1 that enrolled patients with cisplatin ineligible urothelial carcinoma and allowed a baseline performance status ≥ 2) (see section 5.1).

In the absence of data, atezolizumab should be used with caution in these populations after careful evaluation of the balance of benefits and risks for the patient.

Use of atezolizumab in urothelial carcinoma for previously untreated patients who are considered cisplatin ineligible

The baseline and prognostic disease characteristics of the IMvigor210 Cohort 1 study population were overall comparable to patients in the clinic who would be considered cisplatin ineligible but would be eligible for a carboplatin-based combination chemotherapy. There are insufficient data for the subgroup of patients that would be unfit for any chemotherapy; therefore atezolizumab should be used with caution in these patients, after careful consideration of the potential balance of risks and benefits on an individual basis.

Patient Alert Card

All prescribers of Tecentriq must be familiar with the Physician Information and Management Guidelines. The prescriber must discuss the risks of Tecentriq therapy with the patient. The patient will be provided with the Patient Alert Card and instructed to carry the card at all times.

4.5 Interaction with other medicinal products and other forms of interaction

No formal pharmacokinetic drug interaction studies have been conducted with atezolizumab. Since atezolizumab is cleared from the circulation through catabolism, no metabolic drug-drug interactions are expected.

The use of systemic corticosteroids or immunosuppressants before starting atezolizumab should be avoided because of their potential interference with the pharmacodynamic activity and efficacy of atezolizumab. However, systemic corticosteroids or other immunosuppressants can be used to treat immune-related adverse reactions after starting atezolizumab (see section 4.4).

4.6 Fertility, pregnancy and lactation

Women of childbearing potential

Women of childbearing potential have to use effective contraception during and for 5 months after treatment with atezolizumab.

Pregnancy

There are no data from the use of atezolizumab in pregnant women. No developmental and reproductive studies were conducted with atezolizumab. Animal studies have demonstrated that inhibition of the PD-L1/PD-1 pathway in murine pregnancy models can lead to immune-related rejection of the developing foetus resulting in foetal death (see section 5.3). These results indicate a potential risk, based on its mechanism of action, that administration of atezolizumab during pregnancy could cause foetal harm, including increased rates of abortion or stillbirth.

Human immunoglobulins G1 (IgG1) are known to cross the placental barrier and atezolizumab is an IgG1; therefore, atezolizumab has the potential to be transmitted from the mother to the developing foetus.

Atezolizumab should not be used during pregnancy unless the clinical condition of the woman requires treatment with atezolizumab.

Breast-feeding

It is unknown whether atezolizumab is excreted in human milk. Atezolizumab is a monoclonal antibody and is expected to be present in the first milk and at low levels afterwards. A risk to the newborns/infants cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue Tecentriq therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman.

Fertility

No clinical data are available on the possible effects of atezolizumab on fertility. No reproductive and development toxicity studies have been conducted with atezolizumab; however, based on the 26-week repeat dose toxicity study, atezolizumab had an effect on menstrual cycles at an estimated AUC approximately 6 times the AUC in patients receiving the recommended dose and was reversible (see section 5.3). There were no effects on the male reproductive organs.

4.7 Effects on ability to drive and use machines

Tecentriq has minor influence on the ability to drive and use machines. Patients experiencing fatigue should be advised not to drive and use machines until symptoms abate (see section 4.8).

4.8 Undesirable effects

Summary of the safety profile

The safety of Tecentriq is based on pooled data in 2,160 patients with metastatic UC and NSCLC. The most common adverse reactions were fatigue (35.4%), decreased appetite (25.5%), nausea (22.9%), dyspnoea (21.8%), diarrhoea (18.6%), rash (18.6%), pyrexia (18.3%), vomiting (15.0%), arthralgia (14.2%), asthenia (13.8%) and pruritus (11.3%).

Tabulated list of adverse reactions

The Adverse Drug Reactions (ADRs) are listed below by MedDRA system organ class (SOC) and categories of frequency. The following categories of frequency have been used: very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100), rare (≥ 1/10,000 to < 1/1,000), very rare (< 1/10,000). Within each frequency grouping, adverse reactions are presented in the order of decreasing seriousness.

Table 2: Summary of adverse reactions occurring in patients treated with Tecentriq in clinical trials

Blood and lymphatic system disorders	
Common	thrombocytopenia
Immune system disorders	
Common	hypersensitivity
Endocrine disorders	
Common	hypothyroidism[a], hyperthyroidism[b]
Uncommon	diabetes mellitus[c], adrenal insufficiency[d]
Rare	hypophysitis
Metabolism and nutrition disorders	
Very common	decreased appetite
Common	hypokalaemia, hyponatremia
Nervous system disorders	
Uncommon	Guillain-Barré syndrome[e], noninfective meningitis[f]
Rare	noninfective encephalitis[g], myasthenic syndrome[h]
Cardiac disorders	
Rare	myocarditis[h]
Vascular disorders	
Common	hypotension
Respiratory, thoracic, and mediastinal disorders	
Very Common	dyspnoea
Common	pneumonitis[i], hypoxia, nasal congestion,

Gastrointestinal disorders	
Very common	nausea, vomiting, diarrhoea
Common	abdominal pain, colitis[j], dysphagia,
Uncommon	pancreatitis[k], lipase increased,
Rare	amylase increase
Hepatobiliary disorders	
Common	AST increased, ALT increased
Uncommon	hepatitis[l]
Skin and subcutaneous tissue disorders	
Very Common	rash[m], pruritus
Musculoskeletal and connective tissue disorders	
Very common	arthralgia
Common	musculoskeletal pain
General disorders and administration site conditions	
Very Common	pyrexia, fatigue, asthenia
Common	infusion related reaction, influenza like illness, chills

[a] Includes reports of hypothyroidism, blood thyroid stimulating hormone increased, thyroiditis, blood thyroid stimulating hormone decreased, myxoedema, thyroid function test abnormal, thyroiditis acute, thyroxine decreased.
[b] Includes reports of hyperthyroidism, blood thyroid stimulating hormone increased, thyroiditis, blood thyroid stimulating hormone decreased, endocrine ophthalmopathy, exophthalmus, thyroid function test abnormal, thyroiditis acute, thyroxine decreased.
[c] Includes reports of diabetes mellitus and type 1 diabetes mellitus.
[d] Includes reports of adrenal insufficiency, primary adrenal insufficiency, and Addison's disease.
[e] Includes reports of Guillain-Barré syndrome and demyelinating polyneuropathy.
[f] Includes reports of meningitis.
[g] Includes reports of encephalitis.
[h] Reported in studies other than those in metastatic UC and NSCLC patients. The frequency is based on the exposure in 8,000 patients across all atezolizumab clinical trials.
[i] Includes reports of pneumonitis, lung infiltration, bronchiolitis, interstitial lung disease, radiation pneumonitis.
[j] Includes reports of colitis, autoimmune colitis, colitis ischaemic, colitis microscopic.
[k] Includes reports of pancreatitis and pancreatitis acute.
[l] Includes reports of autoimmune hepatitis, hepatitis, hepatitis acute.
[m] Includes reports of acne, eczema, erythema, erythema of eyelid, erythema multiforme, exfoliative rash, eyelid rash, folliculitis, furuncle, dermatitis, dermatitis acneiform, dermatitis allergic, dermatitis bullous, dermatitis exfoliative, drug eruption, palmar-plantar erythrodysaesthesia syndrome, rash, rash erythematous, rash generalised, rash macular, rash maculo-papular, rash papular, rash papulosquamous, rash pruritic, rash pustular, seborrhoeic dermatitis, skin exfoliation, skin toxicity, skin ulcer, toxic skin eruption.

Description of selected adverse reactions

The data below reflect exposure to atezolizumab for clinically significant adverse reactions in clinical studies (see section 5.1). The management guidelines for these adverse reactions are described in sections 4.2 and 4.4.

Immune-related pneumonitis
Pneumonitis occurred in 3.1% (68/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. Of the 68 patients, one experienced a fatal event. The median time to onset was 3.5 months (range 3 days to 20.5 months). The median duration was 1.5 months (range 0 days to 15.1+ months; + denotes a censored value). Pneumonitis led to discontinuation of atezolizumab in 10 (0.5 %) patients. Pneumonitis requiring the use of corticosteroids occurred in 1.6% (34/2,160) of patients receiving atezolizumab.

Immune-related hepatitis
Hepatitis occurred in 0.3% (7/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The median time to onset was 1.1 months (range 9 days to 7.9 months). The median duration was 1 month (range 9 days to 1.9+ months; + denotes a censored value). Hepatitis led to discontinuation of atezolizumab in 2 (< 0.1%) patients. Hepatitis requiring the use of corticosteroids occurred in 0.2% (5/2,160) of patients receiving atezolizumab.

Immune-related colitis
Colitis occurred in 1.1% (23/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The median time to onset was 4 months (range 15 days to 15.2 months). The median duration was 1.4 months (range 3 days to 17.8+ months; + denotes a censored value). Colitis led to discontinuation of atezolizumab in 5 (0.2%) patients. Colitis requiring the use of corticosteroids occurred in 0.5% (10/2,160) of patients receiving atezolizumab.

Immune-related endocrinopathies
Hypothyroidism occurred in 4.7% (101/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The median time to onset was 5.5 months (range 15 days to 31.3 months). Hyperthyroidism occurred in 1.7% (36/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The median time to onset was 3.5 months (range 21 days to 31.3 months).

Adrenal insufficiency occurred in 0.3% (7/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The median time to onset was 5.7 months (range: 3 days to 19 months). Adrenal insufficiency requiring the use of corticosteroids occurred in 0.3% (6/2,160) of patients receiving atezolizumab.

Hypophysitis occurred in < 0.1% (1/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The time to onset for this patient was 13.7 months.

Diabetes mellitus occurred in 0.3% (6/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The time to onset ranged from 3 days to 6.5 months. Diabetes mellitus led to the discontinuation of atezolizumab in 1 (< 0.1%) patient.

Immune-related meningoencephalitis
Meningitis occurred in 0.1% (3/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The time to onset ranged from 15 to 16 days. All three patients required the use of corticosteroids and discontinued atezolizumab.

Encephalitis occurred in < 0.1% (2/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The time to onset was 14 and 16 days. Encephalitis led to discontinuation of atezolizumab in 1 (< 0.1%) patient. Encephalitis requiring the use of corticosteroids occurred in < 0.1% (1/2,160) of patients receiving atezolizumab.

Immune-related neuropathies
Guillain-Barré syndrome and demyelinating polyneuropathy occurred in 0.2% (5/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The median time to onset was 7 months (range: 18 days to 8.1 months). The median duration was 4.6 months (0+ day to 8.3+ months; + denotes a censored value). Guillain-Barré syndrome led to discontinuation of atezolizumab in 1 patient (< 0.1%). Guillain-Barré syndrome requiring the use of corticosteroids occurred in < 0.1% (2/2,160) of patients receiving atezolizumab.

Myasthenic syndrome
Myasthenia gravis occurred in < 0.1% (4/6,000) of patients across all atezolizumab clinical trials in multiple tumour types. The time to onset ranged from 20 days to 4 months. All four patients discontinued atezolizumab. Myasthenic syndrome/myasthenia gravis requiring the use of corticosteroids occurred in < 0.1% (3/6,000) of patients receiving atezolizumab.

Immune-related pancreatitis
Pancreatitis, including amylase increased and lipase increased, occurred in 0.5% (10/2,160) of patients who received atezolizumab for metastatic UC and NSCLC. The median time to onset was 5.5 months (range: 9 days to 16.9 months). The median duration was 19 days (range 3 days to 11.2+ months; + denotes a censored value). Pancreatitis requiring the use of corticosteroids occurred in < 0.1% (2/2,160) of patients receiving atezolizumab.

Immune-related myocarditis
Myocarditis occurred in < 0.1% (2/8,000) of patients across all atezolizumab clinical trials in multiple tumour types. The time to onset was 18 and 33 days. Both patients required corticosteroids and discontinued atezolizumab.

Immunogenicity
In study IMvigor210, 43.9% of patients tested positive for anti-atezolizumab antibodies (ATAs) at one or more post-dose time points. In study OAK (GO28915), the treatment-emergent ATA rate was 30.4%. Overall, ATA positivity appeared to have no clinically relevant impact on pharmacokinetics, efficacy or safety.

No data are available to allow conclusions to be drawn on any possible effect of neutralising antibodies.

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 the national reporting system listed in Appendix V.

4.9 Overdose

There is no information on overdose with atezolizumab.

In case of overdose, patients should be closely monitored for signs or symptoms of adverse reactions, and appropriate symptomatic treatment instituted.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antineoplastic agents, monoclonal antibodies. ATC code: not yet assigned

Mechanism of action

Programmed death-ligand 1 (PD-L1) may be expressed on tumour cells and/or tumour-infiltrating immune cells, and can contribute to the inhibition of the antitumour immune response in the tumour microenvironment. Binding of PD-L1 to the PD-1 and B7.1 receptors found on T-cells and antigen presenting cells suppresses cytotoxic T-cell activity, T-cell proliferation and cytokine production.

Atezolizumab is an Fc-engineered, humanised immunoglobulin G1 (IgG1) monoclonal antibody that directly binds to PD-L1 and provides a dual blockade of the PD-1 and B7.1 receptors, releasing PD-L1/PD-1 mediated inhibition of the immune response, including reactivating the antitumour immune response without inducing antibody-dependent cellular cytotoxicity. Atezolizumab spares the PD-L2/PD-1 interaction allowing PD-L2/PD-1 mediated inhibitory signals to persist.

Clinical efficacy and safety

Duration of treatment

For previously untreated patients, treatment with Tecentriq was permitted until disease progression. For previously treated patients in the pivotal studies treatment with Tecentriq was permitted until loss of clinical benefit as defined by the following criteria:

- Absence of symptoms and signs (including worsening of laboratory values [e.g., new or worsening hypercalcaemia]) indicating unequivocal progression of disease
- No decline in ECOG performance status
- Absence of tumour progression at critical anatomical sites (e.g., leptomeningeal disease) that cannot be readily managed and stabilised by protocol-allowed medical interventions prior to repeat dosing
- Evidence of clinical benefit as assessed by the investigator

Urothelial carcinoma

IMvigor211 (GO29294): Randomised trial in locally advanced or metastatic UC patients previously treated with chemotherapy

A phase III, open-label, multi-center, international, randomised study, (IMvigor211), was conducted to evaluate the efficacy and safety of atezolizumab compared with chemotherapy (investigator's choice of vinflunine, docetaxel, or paclitaxel) in patients with locally advanced or metastatic UC who progressed during or following a platinum-containing regimen. This study excluded patients who had a history of autoimmune disease; active or corticosteroid-dependent brain metastases; administration of a live, attenuated vaccine within 28 days prior to enrolment; and administration of systemic immunostimulatory agents within 4 weeks or systemic immunosuppressive medicinal product within 2 weeks prior to enrolment. Tumour assessments were conducted every 9 weeks for the first 54 weeks, and every 12 weeks thereafter. Tumour specimens were evaluated prospectively for PD-L1 expression on tumour-infiltrating immune cells (IC) and the results were used to define the PD-L1 expression subgroups for the analyses described below.

A total of 931 patients were enrolled. Patients were randomised (1:1) to receive either atezolizumab or chemotherapy. Randomisation was stratified by chemotherapy (vinflunine vs taxane), PD-L1 expression status on IC (< 5% vs ≥ 5%), number of prognostic risk factors (0 vs. 1-3), and liver metastases (yes vs. no). Prognostic risk factors included time from prior chemotherapy of < 3 months, ECOG performance status > 0 and hemoglobin < 10 g/dL.

Atezolizumab was administered as a fixed dose of 1,200 mg by intravenous infusion every 3 weeks. No dose reduction of atezolizumab was allowed. Patients were treated until loss of clinical benefit as assessed by the investigator or unacceptable toxicity. Vinflunine was administered 320 mg/m^2 by intravenous infusion on day 1 of each 3-week cycle until disease progression or unacceptable toxicity. Paclitaxel was administered 175 mg/m^2 by intravenous infusion over 3 hours on day 1 of each 3-week cycle until disease progression or unacceptable toxicity. Docetaxel was administered 75 mg/m^2 by intravenous infusion on day 1 of each 3-week cycle until disease progression or unacceptable toxicity. For all treated patients, the median duration of treatment was 2.8 months for the atezolizumab arm, 2.1 months for the vinflunine and paclitaxel arms and 1.6 months for the docetaxel arm.

The demographic and baseline disease characteristics of the primary analysis population were well balanced between the treatment arms. The median age was 67 years (range: 31 to 88), and 77.1% of patients were male. The majority of patients were white (72.1%), 53.9% of patients within the chemotherapy arm received vinflunine, 71.4% of patients had at least one poor prognostic risk factor and 28.8% had liver metastases at baseline. Baseline ECOG performance status was 0 (45.6%) or 1 (54.4%). Bladder was the primary tumour site for 71.1% of patients and 25.4% of patients had upper tract urothelial carcinoma. There were 24.2% of patients who received only prior platinum-containing adjuvant or neoadjuvant therapy and progressed within 12 months.

The primary efficacy endpoint for IMvigor211 is overall survival (OS). Secondary efficacy endpoints evaluated per investigator-assessed Response Evaluation Criteria in Solid Tumors (RECIST) v1.1 are objective response rate (ORR), progression-free survival (PFS), and duration of response (DOR). Comparisons with respect to OS between the treatment arm and control arm within the IC2/3, IC1/2/3, and ITT (Intention-to-treat, i.e. all comers) populations were tested using a hierarchical fixed-sequence procedure based on a stratified log-rank test at two-sided level of 5% as follows: step 1) IC2/3 population; step 2) IC1/2/3 population; step 3) all comers population. OS results for each of steps 2 and 3 could be formally tested for statistical significance only if the result in the preceding step was statistically significant.

The median survival follow-up is 17 months. The primary analysis of study IMvigor211 did not meet its primary endpoint of OS. Atezolizumab did not demonstrate a statistically significant survival benefit compared to chemotherapy in patients with previously treated, locally advanced or metastatic urothelial carcinoma. Per the pre-specified hierarchical testing order, the IC2/3 population was tested first, with an OS HR of 0.87 (95% CI: 0.63, 1.21; median OS of 11.1 vs. 10.6 months for atezolizumab and chemotherapy respectively). The stratified log-rank p-value was 0.41 and therefore the results are considered not statistically significant in this population. As a consequence, no formal tests of statistical significance could be performed for OS in the IC1/2/3 or all comer populations, and results of those analyses would be considered exploratory. The key results in the all comer population are summarised in Table 3. The Kaplan-Meier curve for OS in the all comer population is presented in Figure 1.

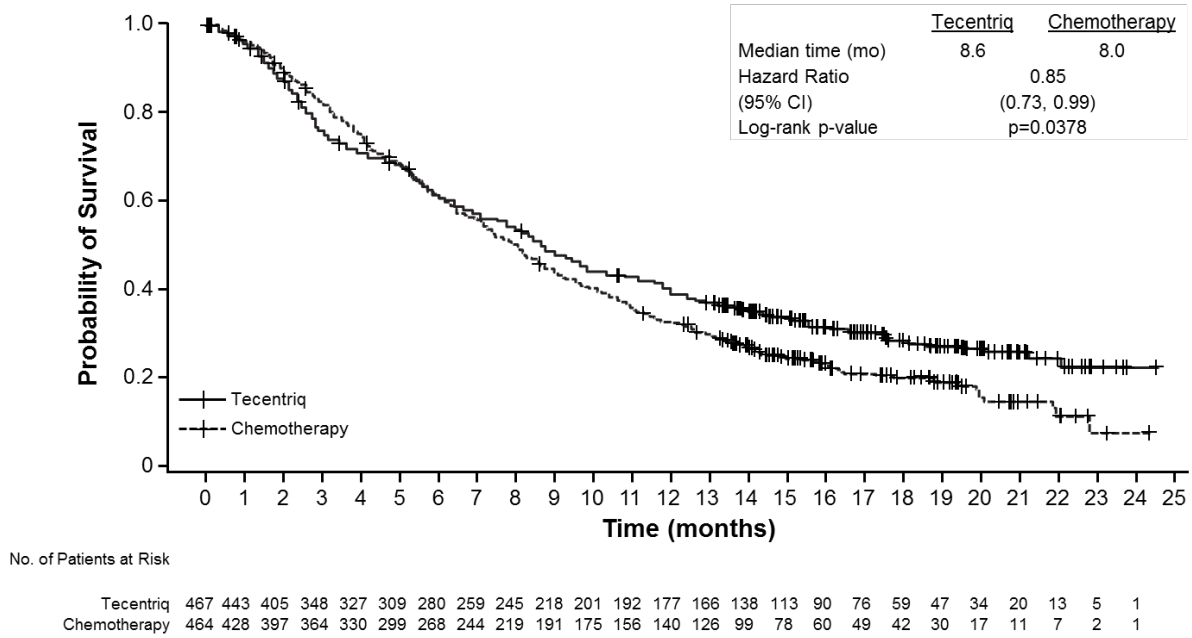
Table 3: Summary of efficacy in all comers (IMvigor211)

Efficacy endpoint	Atezolizumab (n = 467)	Chemotherapy (n = 464)
Primary efficacy endpoint		
OS		
No. of deaths (%)	324 (69.4%)	350 (75.4%)
Median time to events (months)	8.6	8.0
95% CI	7.8, 9.6	7.2, 8.6
Stratified‡ hazard ratio (95% CI)	0.85 (0.73, 0.99)	
p-value**	0.0378	
12-month OS (%)*	39.2%	32.4%
Secondary and exploratory endpoints		
Investigator-assessed PFS (RECIST v1.1)		
No. of events (%)	407 (87.2%)	410 (88.4%)
Median duration of PFS (months)	2.1	4.0
95% CI	2.1, 2.2	3.4, 4.2
Stratified hazard ratio (95% CI)	1.10 (0.95, 1.26)	
Investigator-assessed ORR (RECIST v1.1)	n = 462	n = 461
No. of confirmed responders (%)	62 (13.4%)	62 (13.4%)
95% CI	10.45, 16.87	10.47, 16.91
No. of complete response (%)	16 (3.5%)	16 (3.5%)
No. of partial response (%)	46 (10.0%)	46 (10.0%)
No. of stable disease (%)	92 (19.9%)	162 (35.1%)
Investigator-assessed DOR (RECIST v1.1)	n = 62	n = 62
Median in months ***	21.7	7.4
95% CI	13.0, 21.7	6.1, 10.3

CI=confidence interval; DOR=duration of response; ORR=objective response rate; OS=overall survival; PFS=progression-free survival; RECIST=Response Evaluation Criteria in Solid Tumours v1.1.
* Based on Kaplan-Meier estimate

‡ Stratified by chemotherapy (vinflunine vs taxane), status on IC (<5% vs. ≥ 5%), number of prognostic risk factors (0 vs. 1-3), and liver metastases (yes vs. no).
** Based on the stratified log-rank test; provided for descriptive purposes only; according to the pre-specified analysis hierarchy, the p-value for the OS analysis in the all comer population cannot be considered statistically significant.
*** Responses were ongoing in 63% of responders in the atezolizumab arm and in 21% of responders in the chemotherapy arm.

Figure 1: Kaplan-Meier curve for overall survival (IMvigor211)



No. of Patients at Risk

Tecentriq	467	443	405	348	327	309	280	259	245	218	201	192	177	166	138	113	90	76	59	47	34	20	13	5	1
Chemotherapy	464	428	397	364	330	299	268	244	219	191	175	156	140	126	99	78	60	49	42	30	17	11	7	2	1

IMvigor210 (GO29293): Single-arm trial in previously untreated urothelial carcinoma patients who are ineligible for cisplatin therapy and in urothelial carcinoma patients previously treated with chemotherapy

A phase II, multi-centre, international, two-cohort, single-arm clinical trial, IMvigor210, was conducted in patients with locally advanced or metastatic UC (also known as urothelial bladder cancer).

The study enrolled a total of 438 patients and had two patient cohorts. Cohort 1 included previously untreated patients with locally advanced or metastatic UC who were ineligible or unfit for cisplatin-based chemotherapy or had disease progression at least 12 months after treatment with a platinum-containing neoadjuvant or adjuvant chemotherapy regimen. Cohort 2 included patients who received at least one platinum-based chemotherapy regimen for locally advanced or metastatic UC or had disease progression within 12 months of treatment with a platinum-containing neoadjuvant or adjuvant chemotherapy regimen.

In Cohort 1, 119 patients were treated with atezolizumab 1,200 mg by intravenous infusion every 3 weeks until disease progression. The median age was 73 years. Most patients were male (81%), and the majority of patients were White (91%).

Cohort 1 included 45 patients (38%) with ECOG performance status of 0, 50 patients (42%) with ECOG performance status of 1 and 24 patients (20%) with ECOG performance status of 2, 35 patients (29%) with no Bajorin risk factors (ECOG performance status ≥ 2 and visceral metastasis), 66 patients (56%) with one Bajorin risk factor and 18 patients (15 %) with two Bajorin risk factors, 84 patients (71%) with impaired renal function (glomerular filtration rate [GFR] < 60 mL/min), and 25 patients (21%) with liver metastasis.

The primary efficacy endpoint for Cohort 1 was confirmed objective response rate (ORR) as assessed by an independent review facility (IRF) using RECIST v1.1.

The primary analysis was performed when all patients had at least 24 weeks of follow-up. Median duration of treatment was 15.0 weeks and median duration of survival follow-up was 8.5 months in all comers. Clinically relevant IRF-assessed ORRs per RECIST v1.1 were shown; however, when compared to a pre-specified historical control response rate of 10%, statistical significance was not reached for the primary endpoint. The confirmed ORRs per IRF-RECIST v1.1 were 21.9% (95% CI:

9.3, 40.0) in patients with PD-L1 expression ≥ 5%, 18.8% (95% CI: 10.9, 29.0) in patients with PD-L1 expression ≥ 1%, and 19.3% (95% CI: 12.7, 27.6) in all comers. The median duration of response (DOR) was not reached in any PD-L1 expression subgroup or in all comers. OS was not mature with an event patient ratio of approximately 40%. Median OS for all patient subgroups (PD-L1 expression ≥ 5 % and ≥ 1 %) and in all comers was 10.6 months.

An updated analysis was performed with a median duration of survival follow-up of 17.2 months for Cohort 1 and is summarised in Table 4. The median DOR was not reached in any PD-L1 expression subgroup or in all comers.

Table 4: Summary of updated efficacy (IMvigor210 Cohort 1)

Efficacy endpoint	**PD-L1 expression of ≥ 5% in IC**	**PD-L1 expression of ≥ 1% in IC**	**All Comers**
ORR (IRF-assessed; RECIST v1.1)	n = 32	n = 80	n = 119
No. of Responders (%)	9 (28.1%)	19 (23.8%)	27 (22.7%)
95% CI	13.8, 46.8	15.0, 34.6	15.5, 31.3
No. of complete response (%)	4 (12.5%)	8 (10.0%)	11 (9.2%)
95% CI	(3.5, 29.0)	(4.4, 18.8)	(4.7, 15.9)
No. of partial response (%)	5 (15.6%)	11 (13.8%)	16 (13.4%)
95% CI	(5.3, 32.8)	(7.1, 23.3)	(7.9, 20.9)
DOR (IRF-assessed; RECIST v1.1)	n = 9	n = 19	n = 27
Patients with event (%)	3 (33.3%)	5 (26.3%)	8 (29.6%)
Median (months) (95% CI)	NE (11.1, NE)	NE (NE)	NE (14.1, NE)
PFS (IRF-assessed; RECIST v1.1)	n = 32	n = 80	n = 119
Patients with event (%)	24 (75.0%)	59 (73.8%)	88 (73.9%)
Median (months) (95% CI)	4.1 (2.3, 11.8)	2.9 (2.1, 5.4)	2.7 (2.1, 4.2)
OS	n = 32	n = 80	n = 119
Patients with event (%)	18 (56.3%)	42 (52.5%)	59 (49.6%)
Median (months) (95% CI)	12.3 (6.0, NE)	14.1 (9.2, NE)	15.9 (10.4, NE)
1-year OS rate (%)	52.4%	54.8%	57.2%

CI=confidence interval; DOR=duration of response; IC= tumour-infiltrating immune cells; IRF= independent review facility; NE=not estimable; ORR=objective response rate; OS=overall survival; PFS=progression-free survival; RECIST=Response Evaluation Criteria in Solid Tumours v1.1.

In Cohort 2, the co-primary efficacy endpoints were confirmed ORR as assessed by an IRF using RECIST v1.1 and investigator-assessed ORR according to Modified RECIST (mRECIST) criteria. There were 310 patients treated with atezolizumab 1,200 mg by intravenous infusion every 3 weeks until loss of clinical benefit. The primary analysis of Cohort 2 was performed when all patients had at least 24 weeks of follow-up. The study met its co-primary endpoints in Cohort 2, demonstrating statistically significant ORRs per IRF-assessed RECIST v1.1 and investigator-assessed mRECIST compared to a pre-specified historical control response rate of 10%.

An analysis was also performed with a median duration of survival follow-up of 21.1 months for Cohort 2. The confirmed ORRs per IRF-RECIST v1.1 were 28.0% (95% CI: 19.5, 37.9) in patients with PD-L1 expression ≥ 5%, 19.3% (95% CI: 14.2, 25.4) in patients with PD-L1 expression ≥ 1%, and 15.8% (95% CI: 11.9, 20.4) in all comers. The confirmed ORR per investigator-assessed mRECIST was 29.0% (95% CI: 20.4, 38.9) in patients with PD-L1 expression ≥ 5%, 23.7% (95% CI: 18.1, 30.1) in patients with PD-L1 expression ≥ 1%, and 19.7% (95% CI: 15.4, 24.6) in all comers. The rate of complete response per IRF-RECIST v1.1 in the all comer population was 6.1% (95% CI: 3.7, 9.4). For Cohort 2, median DOR was not reached in any PD-L1 expression subgroup or in all

comers, however was reached in patients with PD-L1 expression < 1% (13.3 months; 95% CI 4.2, NE). The OS rate at 12 month was 37% in all comers.

IMvigor130 (WO30070): Phase III multi-center, randomized, placebo-controlled study of atezolizumab as monotherapy and in combination with platinum-based chemotherapy in patients with untreated locally advanced or metastatic urothelial carcinoma

Based on an independent Data Monitoring Committee (iDMC) recommendation following an early review of survival data, accrual of patients on the atezolizumab monotherapy treatment arm whose tumours have a low PD-L1 expression (less than 5% of immune cells staining positive for PD-L1 by immunohistochemistry) was stopped after observing decreased overall survival for this subgroup. The iDMC did not recommend any change of therapy for patients who had already been randomized to and were receiving treatment in the monotherapy arm. No other changes were recommended.

Non-small cell lung cancer

OAK (GO28915): Randomised phase III trial in locally advanced or metastatic NSCLC patients previously treated with chemotherapy

A phase III, open-label, multi-center, international, randomised study, OAK, was conducted to evaluate the efficacy and safety of atezolizumab compared with docetaxel in patients with locally advanced or metastatic NSCLC who progressed during or following a platinum-containing regimen. This study excluded patients who had a history of autoimmune disease, active or corticosteroid-dependent brain metastases, administration of a live, attenuated vaccine within 28 days prior to enrolment, administration of systemic immunostimulatory agents within 4 weeks or systemic immunosuppressive medicinal product within 2 weeks prior to enrolment. Tumour assessments were conducted every 6 weeks for the first 36 weeks, and every 9 weeks thereafter. Tumour specimens were evaluated prospectively for PD-L1 expression on tumour cells (TC) and tumour-infiltrating immune cells (IC).

A total of 1225 patients were enrolled and per the analysis plan the first 850 randomised patients were included in the primary efficacy analysis. Randomisation was stratified by PD-L1 expression status on IC, by the number of prior chemotherapy regimens, and by histology. Patients were randomised (1:1) to receive either atezolizumab or docetaxel.

Atezolizumab was administered as a fixed dose of 1,200 mg by intravenous infusion every 3 weeks. No dose reduction was allowed. Patients were treated until loss of clinical benefit as assessed by the investigator. Docetaxel was administered 75 mg/m^2 by intravenous infusion on day 1 of each 3-week cycle until disease progression. For all treated patients, the median duration of treatment was 2.1 months for the docetaxel arm and 3.4 months for the atezolizumab arm.

The demographic and baseline disease characteristics of the primary analysis population were well balanced between the treatment arms. The median age was 64 years (range: 33 to 85), and 61% of patients were male. The majority of patients were white (70%). Approximately three-quarters of patients had non-squamous histology (74%), 10% had known EGFR mutation, 0.2% had known ALK rearrangements, 10% had CNS metastases at baseline, and most patients were current or previous smokers (82%). Baseline ECOG performance status was 0 (37%) or 1 (63%). Seventy five percent of patients received only one prior platinum-based therapeutic regimen.

The primary efficacy endpoint was OS. The key results of this study with a median survival follow-up of 21 months are summarised in Table 5. Kaplan-Meier curves for OS in the ITT population are presented in Figure 2. Figure 3 summarises the results of OS in the ITT and PD-L1 subgroups, demonstrating OS benefit with atezolizumab in all subgroups, including those with PD-L1 expression < 1% in TC and IC.

Table 5: Summary of efficacy in the primary analysis population (all comers)* (OAK)

Efficacy endpoint	Atezolizumab (n = 425)	Docetaxel (n = 425)
Primary efficacy endpoint		
OS		
No. of deaths (%)	271 (64%)	298 (70%)
Median time to events (months)	13.8	9.6
95% CI	(11.8, 15.7)	(8.6, 11.2)
Stratified‡ hazard ratio (95% CI)	0.73 (0.62, 0.87)	
p-value**	0.0003	
12-month OS (%)***	218 (55%)	151 (41%)
18-month OS (%)***	157 (40%)	98 (27%)
Secondary endpoints		
Investigator-assessed PFS (RECIST v1.1)		
No. of events (%)	380 (89%)	375 (88%)
Median duration of PFS (months)	2.8	4.0
95% CI	(2.6, 3.0)	(3.3, 4.2)
Stratified hazard ratio (95% CI)	0.95 (0.82, 1.10)	
Investigator-assessed ORR (RECIST v1.1)		
No. of responders (%)	58 (14%)	57 (13%)
95% CI	(10.5, 17.3)	(10.3, 17.0)
Investigator-assessed DOR (RECIST v1.1)	n = 58	n = 57
Median in months	16.3	6.2
95% CI	(10.0, NE)	(4.9, 7.6)

CI=confidence interval; DOR=duration of response; NE=not estimable; ORR=objective response rate; OS=overall survival; PFS=progression-free survival; RECIST=Response Evaluation Criteria in Solid Tumours v1.1.

*The primary analysis population consists of the first 850 randomised patients

‡Stratified by PD-L1 expression in tumour infiltrating immune cells, the number of prior chemotherapy regimens, and histology

** Based on the stratified log-rank test

*** Based on Kaplan-Meier estimates

Figure 2: Kaplan-Meier curve for overall survival in the primary analysis population (all comers) (OAK)

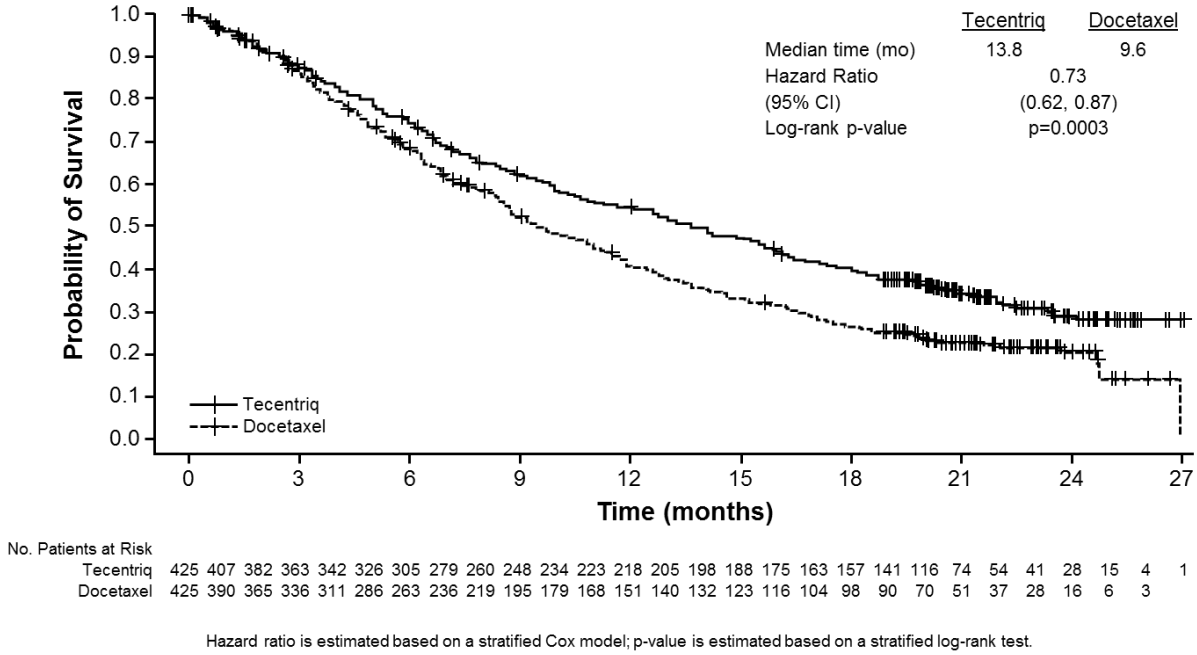
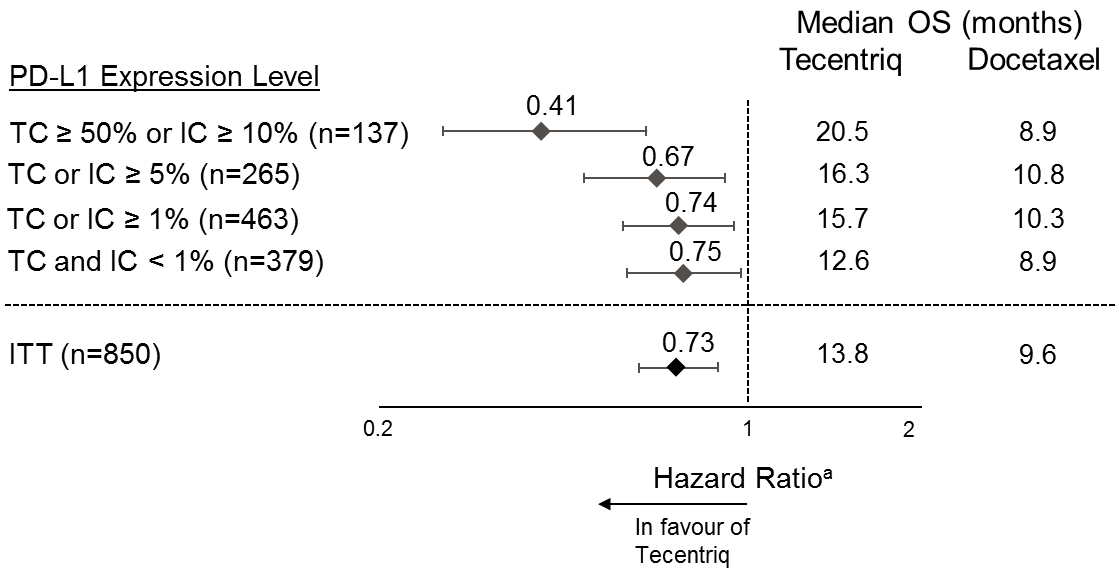


Figure 3: Forest plot of overall survival by PD-L1 expression in the primary analysis population (OAK)



[a]Stratified HR for ITT and TC or IC ≥ 1%. Unstratified HR for other exploratory subgroups.

An improvement in OS was observed with atezolizumab compared to docetaxel in both non-squamous NSCLC patients (hazard ratio [HR] of 0.73, 95% CI: 0.60, 0.89; median OS of 15.6 vs. 11.2 months for atezolizumab and docetaxel, respectively) and squamous NSCLC patients (HR of 0.73, 95% CI: 0.54, 0.98; median OS of 8.9 vs. 7.7 months for atezolizumab and docetaxel, respectively). The observed OS improvement was consistently demonstrated across subgroups of patients including those with brain metastases at baseline (HR of 0.54, 95% CI: 0.31, 0.94; median OS of 20.1 vs. 11.9 months for atezolizumab and docetaxel respectively) and patients who were never smokers (HR of 0.71, 95% CI: 0.47, 1.08; median OS of 16.3 vs. 12.6 months for atezolizumab and docetaxel, respectively). However, patients with EGFR mutations did not show improved OS with atezolizumab

compared to docetaxel (HR of 1.24, 95% CI: 0.71, 2.18; median OS of 10.5 vs. 16.2 months for atezolizumab and docetaxel, respectively).

Prolonged time to deterioration of patient-reported pain in chest as measured by the EORTC QLQ-LC13 was observed with atezolizumab compared to docetaxel (HR of 0.71, 95% CI: 0.49, 1.05; median not reached in either arm). The time to deterioration in other lung cancer symptoms (i.e. cough, dyspnoea, and arm/shoulder pain) as measured by the EORTC QLQ-LC13 was similar between atezolizumab and docetaxel. These results should be interpreted with caution due to the open-label design of the study.

POPLAR (GO28753): Randomised phase II trial in locally advanced or metastatic NSCLC patients previously treated with chemotherapy

A phase II, multi-centre, international, randomised, open-label, controlled study, POPLAR, was conducted in patients with locally advanced or metastatic NSCLC who progressed during or following a platinum-containing regimen, regardless of PD-L1 expression. The primary efficacy outcome was overall survival. A total of 287 patients were randomised 1:1 to receive either atezolizumab (1,200 mg by intravenous infusion every 3 weeks until loss of clinical benefit) or docetaxel (75 mg/m^2 by intravenous infusion on day 1 of each 3-week cycle until disease progression). Randomisation was stratified by PD-L1 expression status on IC, by the number of prior chemotherapy regimens and by histology. An updated analysis with a total of 200 deaths observed and a median survival follow-up of 22 months showed a median OS of 12.6 months in patients treated with atezolizumab, vs. 9.7 months in patients treated with docetaxel (HR of 0.69, 95% CI: 0.52, 0.92). ORR was 15.3% vs. 14.7% and median DOR was 18.6 months vs. 7.2 months for atezolizumab vs. docetaxel, respectively.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with Tecentriq in all subsets of the paediatric population in the treatment of malignant neoplasms (except central nervous system tumours, haematopoietic and lymphoid tissue neoplasms) (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Exposure to atezolizumab increased dose proportionally over the dose range 1 mg/kg to 20 mg/kg including the fixed dose 1,200 mg administered every 3 weeks. A population analysis that included 472 patients described atezolizumab pharmacokinetics for the dose range: 1 to 20 mg/kg with a linear two-compartment disposition model with first-order elimination. A population pharmacokinetic analysis suggests that steady-state is obtained after 6 to 9 weeks (2 to 3 cycles) of repeated dosing. The systemic accumulation in area under the curve, maximum concentration and trough concentration was 1.91, 1.46 and 2.75-fold, respectively.

Absorption

Atezolizumab is administered as an intravenous infusion. There have been no studies performed with other routes of administration.

Distribution

A population pharmacokinetic analysis indicates that central compartment volume of distribution is 3.28 L and volume at steady-state is 6.91 L in the typical patient.

Biotransformation

The metabolism of atezolizumab has not been directly studied. Antibodies are cleared principally by catabolism.

Elimination

A population pharmacokinetic analysis indicates that the clearance of atezolizumab is 0.200 L/day and the typical terminal elimination half-life is 27 days.

Special populations

Based on population PK and exposure-response analyses age (21-89 years), region, ethnicity, renal impairment, mild hepatic impairment, level of PD-L1 expression, or ECOG performance status have no effect on atezolizumab pharmacokinetics. Body weight, gender, positive ATA status, albumin levels and tumour burden have a statistically significant, but not clinically relevant effect on atezolizumab pharmacokinetics. No dose adjustments are recommended.

Elderly

No dedicated studies of atezolizumab have been conducted in elderly patients. The effect of age on the pharmacokinetics of atezolizumab was assessed in a population pharmacokinetic analysis. Age was not identified as a significant covariate influencing atezolizumab pharmacokinetics based on patients of age range of 21-89 years (n=472), and median of 62 years of age. No clinically important difference was observed in the pharmacokinetics of atezolizumab among patients < 65 years (n=274), patients between 65–75 years (n=152) and patients > 75 years (n=46) (see section 4.2).

Paediatric population

No studies have been conducted to investigate the pharmacokinetics of atezolizumab in children or adolescents.

Renal impairment

No dedicated studies of atezolizumab have been conducted in patients with renal impairment. In the population pharmacokinetic analysis, no clinically important differences in the clearance of atezolizumab were found in patients with mild (estimated glomerular filtration rate [eGFR] 60 to 89 mL/min/1.73 m^2; n=208) or, moderate (eGFR 30 to 59 mL/min/1.73 m^2; n=116) renal impairment compared to patients with normal (eGFR greater than or equal to 90 mL/min/1.73 m^2; n=140) renal function. Only a few patients had severe renal impairment (eGFR 15 to 29 mL/min/1.73 m^2; n=8) (see section 4.2). The effect of severe renal impairment on the pharmacokinetics of atezolizumab is unknown.

Hepatic impairment

No dedicated studies of atezolizumab have been conducted in patients with hepatic impairment. In the population pharmacokinetic analysis, there were no clinically important differences in the clearance of atezolizumab between patients with mild hepatic impairment (bilirubin ≤ ULN and AST > ULN or bilirubin > 1.0 × to 1.5 × ULN and any AST, n= 71) and normal hepatic function (bilirubin and AST ≤ ULN, n= 401). No data are available in patients with either moderate or severe hepatic impairment. Hepatic impairment was defined by the National Cancer Institute (NCI) criteria of hepatic dysfunction (see section 4.2). The effect of moderate or severe hepatic impairment (bilirubin > 1.5 × to 3 × ULN and any AST or bilirubin > 3 × ULN and any AST) on the pharmacokinetics of atezolizumab is unknown.

5.3 Preclinical safety data

Carcinogenicity

Carcinogenicity studies have not been performed to establish the carcinogenic potential of atezolizumab.

Mutagenicity

Mutagenicity studies have not been performed to establish the mutagenic potential of atezolizumab. However, monoclonal antibodies are not expected to alter DNA or chromosomes.

Fertility

No fertility studies have been conducted with atezolizumab; however assessment of the cynomolgus monkey male and female reproductive organs was included in the chronic toxicity study. Weekly administration of atezolizumab to female monkeys at an estimated AUC approximately 6 times the AUC in patients receiving the recommended dose caused an irregular menstrual cycle pattern and a lack of newly formed corpora lutea in the ovaries which were reversible. There was no effect on the male reproductive organs.

Teratogenicity

No reproductive or teratogenicity studies in animals have been conducted with atezolizumab. Animal studies have demonstrated that inhibition of the PD-L1/PD-1 pathway can lead to immune-related rejection of the developing foetus resulting in foetal death. Administration of atezolizumab could cause foetal harm, including embryo-foetal lethality.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

L-histidine
Glacial acetic acid
Sucrose
Polysorbate 20
Water for injections

6.2 Incompatibilities

This medicinal product must not be mixed with other medicinal products except those mentioned in section 6.6.

6.3 Shelf life

Unopened vial

3 years.

Diluted solution

Chemical and physical in-use stability has been demonstrated for no more than 24 hours at 2 °C to 8 °C or 24 hours at ≤ 30 °C from the time of preparation.

From a microbiological point of view, the prepared solution for infusion should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2 °C to 8 °C or 8 hours at ambient temperature (≤ 25 °C).

6.4 Special precautions for storage

Store in a refrigerator (2 °C – 8 °C).

Do not freeze.

Keep the vial in the outer carton in order to protect from light.

For storage conditions after dilution of the medicinal product, see section 6.3.

6.5 Nature and contents of container

Type I glass-vial with a butyl rubber stopper containing 20 mL of solution.

Pack of one vial.

6.6 Special precautions for disposal and other handling

Tecentriq does not contain any antimicrobial preservative and should be prepared by a healthcare professional using aseptic technique.

Do not shake.

Instructions for dilution

Twenty mL of Tecentriq concentrate should be withdrawn from the vial and diluted into a 250 mL PVC, polyethylene (PE) or polyolefin infusion bag containing sodium chloride 9 mg/mL (0.9%) solution for injection. After dilution, one mL of solution should contain approximately 4.4 mg of Tecentriq (1,200 mg/270 mL). The bag should be gently inverted to mix the solution in order to avoid foaming. Once the infusion is prepared it should be administered immediately (see section 6.3).

Parenteral medicinal products should be inspected visually for particulates and discolouration prior to administration. If particulates or discoloration are observed, the solution should not be used.

No incompatibilities have been observed between Tecentriq and intravenous bags with product-contacting surfaces of polyvinyl chloride (PVC), polyethylene (PE) or polyolefin (PO). In addition, no incompatibilities have been observed with in-line filter membranes composed of polyethersulfone or polysulfone, and infusion sets and other infusion aids composed of PVC, PE, polybutadiene, or polyetherurethane. The use of in-line filter membranes is optional.

Disposal

The release of Tecentriq in the environment should be minimised. Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MARKETING AUTHORISATION HOLDER

Roche Registration GmbH
Emil-Barell-Strasse 1
79639 Grenzach-Wyhlen
Germany

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/17/1220/001

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 21 September 2017

10. DATE OF REVISION OF THE TEXT

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

ANNEX II

A. MANUFACTURER OF THE BIOLOGICAL ACTIVE SUBSTANCE AND MANUFACTURER 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 OF THE BIOLOGICAL ACTIVE SUBSTANCE AND MANUFACTURER RESPONSIBLE FOR BATCH RELEASE

Name and address of the manufacturer of the biological active substance

F. Hoffmann-La Roche AG
Grenzacherstrasse 124
4070 Basel
SWITZERLAND

Name and address of the manufacturer responsible for batch release

Roche Pharma AG
Emil-Barell-Strasse 1
79639 Grenzach-Whylen
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

The requirements for submission of periodic safety update reports 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.

The marketing authorisation holder shall submit the first periodic safety update report for this product within 6 months following authorisation.

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

- **Risk Management Plan (RMP)**

The 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.

- **Additional risk minimisation measures**

Prior to launch of Tecentriq in each Member State the marketing authorisation holder (MAH) must agree about the content and format of the educational programme, including communication media,

distribution modalities, and any other aspects of the programme, with the National Competent Authority.

The educational programme is aimed at increasing awareness and providing information concerning the signs and symptoms of certain important identified risks of atezolizumab, including immune-related pneumonitis, hepatitis, colitis, hypothyroidism, hyperthyroidism, adrenal insufficiency, hypophysitis, type 1 diabetes mellitus, neuropathies, meningoencephalitis, pancreatitis, and infusion related reactions, and how to manage them.

The MAH shall ensure that in each Member State where Tecentriq is marketed, all healthcare professionals and patients/carers who are expected to prescribe and use Tecentriq have access to/are provided with the following educational package:

- Physician educational material
- Patient Alert Card

The physician educational material should contain:

- The Summary of Product Characteristics
- Guide for healthcare professionals

- **The Guide for healthcare professionals** shall contain the following key elements:
  - Relevant information (e.g. seriousness, severity, frequency, time to onset, reversibility as applicable) of the following safety concerns associated with the use of Tecentriq:
    - Immune-Related Hepatitis
    - Immune-Related Pneumonitis
    - Immune-Related Colitis
    - Immune-Related Pancreatitis
    - Immune-Related Endocrinopathies (Type 1 Diabetes Mellitus, Hypothyroidism, Hyperthyroidism, Adrenal Insufficiency and Hypophysitis)
    - Immune-Related Neuropathies (Guillain-Barre Syndrome, Myasthenic Syndrome / Myasthenia Gravis)
    - Immune-Related Meningoencephalitis
    - Immune-Related Myocarditis
    - Infusion-Related Reactions
  - Description of the signs and symptoms of immune-related adverse reactions.
  - Details on how to minimise the safety concerns through appropriate monitoring and management.
  - Reminder to distribute the patient alert card to all patients receiving treatment with Tecentriq and to advise them to show it to any healthcare professional who may treat them.
  - Reminder to educate patients/caregivers about the symptoms of immune-related adverse reactions and of the need to report them immediately to the physician.

The patient alert card shall contain the following key messages:

- Brief introduction to atezolizumab (indication and purpose of this tool)
- Information that atezolizumab can cause serious side effects during or after treatment, that need to be treated right away
- Description of the main signs and symptoms of the following safety concerns and reminder of the importance of notifying their treating physician immediately if symptoms occur, persist or worsen:
  - Immune-Related Hepatitis
  - Immune-Related Pneumonitis
  - Immune-Related Colitis
  - Immune-Related Pancreatitis
  - Immune-Related Endocrinopathies (Type 1 Diabetes Mellitus, Hypothyroidism, Hyperthyroidism, Adrenal Insufficiency and Hypophysitis)
  - Immune-Related Neuropathies (Guillain-Barre Syndrome, Myasthenic Syndrome / Myasthenia Gravis)

- Immune-Related Meningoencephalitis
- Immune-Related Myocarditis
- Infusion-Related Reactions

- Warning message for patients on the importance of consulting their doctor immediately in case they develop any of the listed signs and symptoms and on the important not attempting to treat themselves.
- Reminder to carry the Patient Alert Card at all times and to show it to all healthcare professionals that may treat them.
- The card should also prompt to enter contact details of the physician and include a warning message for healthcare professionals treating the patient at any time, including in conditions of emergency, that the patient is using Tecentriq.

- **Obligation to conduct post-authorisation measures**

The MAH shall complete, within the stated timeframe, the below measures:

Description	**Due date**
Post-authorisation efficacy study (PAES): In order to further evaluate the efficacy of atezolizumab for the treatment of patients with locally advanced or metastatic urothelial cancer, the MAH should submit the final OS results of study IMvigor210.	Submission of study results: 30 June 2019
Post-authorisation efficacy study (PAES): In order to further evaluate the efficacy of atezolizumab compared with chemotherapy for the second/third line treatment of patients with locally advanced or metastatic urothelial cancer, the MAH should submit the final CSR of study IMvigor211.	Submission of study results: 31 May 2019
Post-authorisation efficacy study (PAES): In order to evaluate the efficacy of atezolizumab monotherapy versus atezolizumab plus carboplatin/gemcitabine versus placebo plus cisplatin/gemcitabine in patients with locally advanced or metastatic urothelial cancer who are platinum –ineligible and –eligible patients, the MAH should submit the final CSR of study IMvigor130.	Submission of study results: 31 July 2021

ANNEX III

LABELLING AND PACKAGE LEAFLET

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

OUTER CARTON

1. NAME OF THE MEDICINAL PRODUCT

Tecentriq 1,200 mg concentrate for solution for infusion
atezolizumab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each 20 mL vial of concentrate contains 1,200 mg atezolizumab
After dilution, 1 mL of solution contains approximately 4.4 mg of atezolizumab

3. LIST OF EXCIPIENTS

Excipients: L-histidine, glacial acetic acid, sucrose, polysorbate 20, water for injections

4. PHARMACEUTICAL FORM AND CONTENTS

Concentrate for solution for infusion
1,200 mg/20 mL
1 vial

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Read the package leaflet before use.
For intravenous use after dilution.

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

Do not shake the vial

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

Store in a refrigerator.
Do not freeze.
Keep the vial in the outer carton 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

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

Roche Registration GmbH
Emil-Barell-Strasse 1
79639 Grenzach-Wyhlen
Germany

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/17/1220/001

13. BATCH NUMBER

Batch

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Justification for not including Braille accepted

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying unique identifier included.

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

PC:
SN:
NN:

MINIMUM PARTICULARS TO APPEAR ON SMALL IMMEDIATE PACKAGING UNITS

VIAL

1. NAME OF THE MEDICINAL PRODUCT AND ROUTE(S) OF ADMINISTRATION

Tecentriq 1,200 mg concentrate for solution for infusion
atezolizumab
Intravenous use

2. METHOD OF ADMINISTRATION

For intravenous use after dilution.

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT

1,200 mg/20 mL

6. OTHER

B. PACKAGE LEAFLET

Package leaflet: Information for the patient

Tecentriq 1,200 mg concentrate for solution for infusion
atezolizumab

▼This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get. See the end of section 4 for how to report side effects.

Read all of this leaflet carefully before you are given this medicine because it contains important information for you.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or nurse.
- If you get any side effects, talk to your doctor or nurse. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet

1. What Tecentriq is and what it is used for

What Tecentriq is

Tecentriq is an anti-cancer medicine that contains the active substance atezolizumab. It belongs to a group of medicines called monoclonal antibodies. A monoclonal antibody is a type of protein designed to recognise and attach to a specific target in the body.

What Tecentriq is used for

Tecentriq is used to treat adults with:

- a cancer that affects the bladder and the urinary system, called urothelial carcinoma. It is used when this cancer has:
  - spread to other parts of the body
  - come back after previous treatment
  - or, if you cannot receive cisplatin treatment, and your doctor has tested your cancer and found high levels of a specific protein in your body called programmed death-ligand 1 (PD-L1).

- a cancer that affects the lungs, called non-small cell lung cancer. It is used when this cancer has:
  - spread to other parts of the body
  - come back after previous treatment.

How Tecentriq works

Tecentriq works by attaching to a specific protein in your body called programmed death-ligand 1 (PD-L1). This protein suppresses the body's immune (defense) system, thereby protecting cancer cells from being attacked by the immune cells. By attaching to the protein, Tecentriq helps your immune system to fight your cancer.

2. What you need to know before you are given Tecentriq

You must not be given Tecentriq if:

- you are allergic to atezolizumab or any of the other ingredients of this medicine (listed in section 6).

If you are not sure, talk to your doctor or nurse before you are given Tecentriq.

Warnings and precautions

Talk to your doctor or nurse before you are given Tecentriq if you:
- have an auto-immune disease (a condition where the body attacks its own cells)
- have been told that your cancer has spread to your brain
- have any history of inflammation of your lungs (called pneumonitis)
- have or have had chronic viral infection of the liver, including hepatitis B (HBV) or hepatitis C (HCV)
- have human immunodeficiency virus (HIV) infection or acquired immune deficiency syndrome (AIDS)
- have had serious side effects because of other antibody therapies that help your immune system to fight cancer
- have been given medicines to stimulate your immune system
- have been given medicines to suppress your immune system
- have been given a live, attenuated vaccine

If any of the above applies to you (or you are not sure), talk to your doctor or nurse before you are given Tecentriq.

Tecentriq may cause some side effects that you must tell your doctor about straight away. They may happen weeks or months after your last dose. Tell your doctor straight away if you notice any of the symptoms below:
- inflammation of the lung (pneumonitis): symptoms may include new or worsening cough, shortness of breath, and chest pain
- inflammation of the liver (hepatitis): symptoms may include yellowing of skin or eyes, nausea, vomiting, bleeding or bruising, dark urine, and stomach pain
- inflammation of the intestines (colitis): symptoms may include diarrhoea (watery, loose or soft stools), blood in stools, and stomach pain
- inflammation of the thyroid, adrenal glands and the pituitary gland (hypothyroidism, hyperthyroidism, adrenal insufficiency or hypophysitis): symptoms may include tiredness, weight loss, weight gain, change in mood, hair loss, constipation, dizziness, headaches, increased thirst, increased urination and changes in vision.
- type 1 diabetes, including acid in the blood produced from diabetes (diabetic ketoacidosis): symptoms may include feeling more hungry or thirsty than usual, need to urinate more often, weight loss, and feeling tired
- inflammation of the brain (encephalitis) or inflammation of the membrane around the spinal cord and brain (meningitis): symptoms may include neck stiffness, headache, fever, chills, vomiting, eye sensitivity to light, confusion and sleepiness
- inflammation or problems of the nerves (neuropathy): symptoms may include muscle weakness and numbness, tingling in hands and feet
- inflammation of the pancreas (pancreatitis): symptoms may include abdominal pain, nausea and vomiting
- inflammation of the heart muscle (myocarditis): symptoms may include shortness of breath, decreased exercise tolerance, feeling tired, chest pain, swelling of the ankles or legs, irregular heart beat, and fainting

- severe reactions associated with infusion (events occurring during the infusion or within one day of the infusion): may include fever, chills, shortness of breath and flushing.

If you notice any of the symptoms above, tell your doctor straight away.

Do not try to treat yourself with other medicines. Your doctor may:
- Give you other medicines to prevent complications and reduce symptoms.
- Delay giving your next dose of Tecentriq.
- Stop your treatment with Tecentriq.

Tests and checks

Before your treatment, your doctor will check your general health. You will also have blood tests during your treatment.

Children and adolescents

This medicine should not be given to children or adolescents below 18 years of age. This is because the effects of Tecentriq in this age group are not known.

Other medicines and Tecentriq

Tell your doctor or nurse if you are taking, have recently taken or might take any other medicines. This includes medicines obtained without a prescription, including herbal medicines.

Pregnancy and contraception

- Tell your doctor if you are pregnant, think you might be pregnant or are planning to become pregnant.
- You will not be given Tecentriq if you are pregnant unless your doctor considers it necessary. This is because the effect of Tecentriq in pregnant women is not known - it is possible that it could harm your unborn baby.
- If you could become pregnant, you must use effective contraception;
  - while you are being treated with Tecentriq and
  - for 5 months after the last dose.
- If you become pregnant while you are being treated with Tecentriq tell your doctor.

Breast-feeding

It is not known if Tecentriq gets into breast milk. Ask your doctor if you should stop breast-feeding or if you should stop treatment with Tecentriq.

Driving and using machines

Tecentriq has minor influence on your ability to drive and use machines. If you feel tired, do not drive or use machines until you feel better.

3. How Tecentriq is given

You will be given Tecentriq by a doctor experienced in cancer treatment in a hospital or clinic.

How much Tecentriq is given

The recommended dose is 1,200 milligrams (mg) every three weeks.

How Tecentriq is given

Tecentriq is given as a drip into a vein (an intravenous infusion).

Your first infusion will be given over 60 minutes.
- Your doctor will monitor you carefully during the first infusion.
- If you do not have an infusion reaction during the first infusion, the next infusions will be given to you over a period of 30 minutes.

How long treatment lasts

Your doctor will keep giving you Tecentriq until you no longer benefit from it. However, it may be stopped if the side effects become too much of a problem.

If you miss a dose of Tecentriq

If you miss an appointment, make another one straight away. For the treatment to be fully effective, it is very important to keep having the infusions.

If you stop receiving Tecentriq

Do not stop treatment with Tecentriq unless you have discussed this with your doctor. This is because stopping treatment may stop the effect of the medicine.

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

4. Possible side effects

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

Tell your doctor straight away if you notice any of the side effects below or if they get worse. They may happen weeks or months after your last dose. Do not try to treat yourself with other medicines: The following side effects have been reported in clinical trials with Tecentriq:

Very common: may affect more than 1 in 10 people
- fever
- nausea
- vomiting
- feeling very tired with no energy (fatigue)
- lack of energy
- itching of the skin
- diarrhoea
- joint pain
- rash
- loss of appetite
- shortness of breath

Common: may affect up to 1 in 10 people
- inflammation of the lungs
- low oxygen levels which may cause shortness of breath as a consequence of inflamed lungs (pneumonitis)
- stomach pain
- elevated liver enzymes (shown in tests) - may be a sign of an inflamed liver
- difficulty swallowing
- blood tests showing low levels of potassium (hypokalaemia) or sodium (hyponatremia)

- low blood pressure (hypotension)
- underactive thyroid gland (hypothyroidism)
- allergic reaction (infusion-related reaction or hypersensitivity)
- flu-like illness
- pain in the muscles and bones.
- chills
- overactive thyroid gland (hyperthyroidism)
- inflammation of the intestines
- low platelet count, which may make you more likely to bruise or bleed
- blocked nose (nasal congestion)

Uncommon: may affect up to 1 in 100 people
- inflammation of the liver
- inflammation of the pancreas
- numbness or paralysis - these may be signs of Guillain-Barré syndrome
- inflammation of the membrane around the spinal cord and brain
- low levels of adrenal hormones
- type 1 diabetes
- high levels of lipase - may be a sign of an inflamed pancreas (shown in blood tests)

Rare: may affect up to 1 in 1,000 people
- inflammation of the heart muscle
- inflammation of the brain
- myasthenia gravis - an illness that can cause muscle weakness
- inflammation of the pituitary gland situated at the base of the brain
- high levels of amylase - may be a sign of an inflamed pancreas (shown in blood tests)

If you notice any of the side effects above or if they get worse, tell your doctor straight away.

Reporting of side effects

If you get any side effects, talk to your doctor 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 Appendix V. By reporting side effects you can help provide more information on the safety of this medicine.

5. How to store Tecentriq

Tecentriq will be stored by the healthcare professionals at the hospital or clinic. The storage details are as follows:
- 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 carton and the vial label after EXP. The expiry date refers to the last day of that month.
- Store in a refrigerator (2 °C - 8 °C). Do not freeze.
- Keep the vial in the outer carton in order to protect from light.
- The diluted solution should not be kept more than 24 hours at 2 °C to 8 °C or 8 hours at ambient temperature.
- Do not use if this medicine is cloudy, discoloured or contains particles

Do not throw away any medicines via wastewater or household waste. Your healthcare professional will throw away any medicines that are no longer being used. These measures will help to protect the environment.

6. Contents of the pack and other information

What Tecentriq contains

- The active substance is atezolizumab. Each mL contains 60 mg of atezolizumab. Each vial contains 1,200 mg of atezolizumab (in 20 mL).
- The other ingredients are L-histidine, glacial acetic acid, sucrose, polysorbate 20 and water for injections.

What Tecentriq looks like and contents of the pack

Tecentriq is a concentrate for solution for infusion. It is a clear, colourless to slightly yellowish liquid.

Tecentriq is available in a pack containing 1 glass vial.

Marketing Authorisation Holder

Roche Registration GmbH
Emil-Barell-Strasse 1
79639 Grenzach-Wyhlen
Germany

Manufacturer

Roche Pharma AG
Emil-Barell-Strasse 1
D-79639
Grenzach-Wyhlen
Germany

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

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Slovenská republika
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Suomi/Finland
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United Kingdom
Roche Products Ltd.
Tel: +44 (0) 1707 366000

This leaflet was last revised in {MM/YYYY}.

Other sources of information

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

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The following information is intended for healthcare professionals only:

Instructions for dilution

Twenty mL of Tecentriq concentrate should be withdrawn from the vial and diluted into a 250 mL PVC, polyethylene (PE) or polyolefin infusion bag containing sodium chloride 9 mg/mL (0.9%) solution for injection. After dilution, one mL of solution should contain approximately 4.4 mg of Tecentriq (1,200 mg/270 mL). The bag should be gently inverted to mix the solution in order to avoid foaming. Once the infusion is prepared it should be administered immediately.

Parenteral medicinal products should be inspected visually for particulates and discolouration prior to administration. If particulates or discoloration are observed, the solution should not be used.

No incompatibilities have been observed between Tecentriq and intravenous bags with product-contacting surfaces of polyvinyl chloride (PVC), polyethylene (PE) or polyolefin (PO). In addition, no incompatibilities have been observed with in-line filter membranes composed of polyethersulfone or polysulfone, and infusion sets and other infusion aids composed of PVC, PE, polybutadiene, or polyetherurethane. The use of in-line filter membranes is optional.

Diluted solution

Chemical and physical in-use stability has been demonstrated for no more than 24 hours at 2 °C to 8 °C or 24 hours at ≤ 30 °C from the time of preparation.

From a microbiological point of view, the prepared solution for infusion should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2 °C to 8 °C or 8 hours at ambient temperature (≤ 25 °C)

Method of administration

Tecentriq is for intravenous use. Tecentriq infusions must not be administered as an intravenous push or bolus.

The initial dose of Tecentriq must be administered over 60 minutes. If the first infusion is tolerated all subsequent infusions may be administered over 30 minutes.

Disposal

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