

**Product Information as approved by the CHMP on 22 April 2022, pending endorsement by the  
European Commission**

## **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**

Rubraca 200 mg film-coated tablets  
Rubraca 250 mg film-coated tablets  
Rubraca 300 mg film-coated tablets

## **2. QUALITATIVE AND QUANTITATIVE COMPOSITION**

### Rubraca 200 mg film-coated tablets

Each tablet contains rucaparib camsylate corresponding to 200 mg rucaparib.

### Rubraca 250 mg film-coated tablets

Each tablet contains rucaparib camsylate corresponding to 250 mg rucaparib.

### Rubraca 300 mg film-coated tablets

Each tablet contains rucaparib camsylate corresponding to 300 mg rucaparib.

For the full list of excipients, see section 6.1.

## **3. PHARMACEUTICAL FORM**

Film-coated tablet.

### Rubraca 200 mg film-coated tablet

Blue, 11 mm, round film-coated tablet, debossed with “C2”.

### Rubraca 250 mg film-coated tablet

White, 11 x 15 mm, diamond-shaped film-coated tablet, debossed with “C25”.

### Rubraca 300 mg film-coated tablet

Yellow, 8 x 16 mm, oval film-coated tablet, debossed with “C3”.

## **4. CLINICAL PARTICULARS**

### **4.1 Therapeutic indications**

Rubraca is indicated as monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to platinum-based chemotherapy.

Rubraca is indicated as monotherapy treatment of adult patients with platinum sensitive, relapsed or progressive, BRCA mutated (germline and/or somatic), high-grade epithelial ovarian, fallopian tube,

or primary peritoneal cancer, who have been treated with two or more prior lines of platinum based chemotherapy, and who are unable to tolerate further platinum based chemotherapy.

## 4.2 Posology and method of administration

Treatment with rucaparib should be initiated and supervised by a physician experienced in the use of anticancer medicinal products.

### Detection of BRCA mutation

There is no requirement for BRCA testing prior to using Rubraca for the maintenance treatment of adult patients with relapsed high-grade epithelial ovarian cancer (EOC), fallopian tube cancer (FTC), or primary peritoneal cancer (PPC) who are in a complete or partial response to platinum-based chemotherapy.

Before taking Rubraca as treatment for relapsed or progressive EOC, FTC, or PPC, patients must have confirmation of deleterious germline or somatic mutations in the breast cancer 1 (BRCA1) or breast cancer 2 (BRCA2) gene using a validated test.

### Posology

The recommended dose is 600 mg rucaparib taken twice daily, equivalent to a total daily dose of 1,200 mg, until disease progression or unacceptable toxicity.

For the maintenance treatment, patients should start the maintenance treatment with Rubraca no later than 8 weeks after completion of their final dose of the platinum containing regimen.

If a patient vomits after taking Rubraca, the patient should not retake the dose and should take the next scheduled dose.

### *Missed doses*

If a dose is missed, the patient should resume taking Rubraca with the next scheduled dose.

### *Dose adjustments for adverse reactions*

Adverse reactions may be managed through dose interruptions and/or dose reductions for moderate to severe reactions (i.e. CTCAE Grade 3 or 4) such as neutropenia, anaemia and thrombocytopenia.

Liver transaminase elevations (aspartate aminotransferase (AST) and/or alanine aminotransferase (ALT)) occur early in treatment and are generally transient. Grade 1-3 elevations in AST/ALT can be managed without change to the rucaparib dose, or with treatment modification (interruption and/or dose reduction). Grade 4 reactions require treatment modification (see Table 2).

Other moderate to severe non-haematological adverse reactions such as nausea and vomiting, can be managed through dose interruption and/or reductions, if not adequately controlled by appropriate symptomatic management.

**Table 1. Recommended dose adjustments**

| Dose reduction        | Dose                                                |
|-----------------------|-----------------------------------------------------|
| Starting dose         | 600 mg twice daily (two 300 mg tablets twice daily) |
| First dose reduction  | 500 mg twice daily (two 250 mg tablets twice daily) |
| Second dose reduction | 400 mg twice daily (two 200 mg tablets twice daily) |
| Third dose reduction  | 300 mg twice daily (one 300 mg tablet twice daily)  |

**Table 2. Management of Treatment-emergent AST/ ALT Elevations**

| Grade of AST/ALT Elevation                       | Management                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Grade 3 without other signs of liver dysfunction | Monitor LFTs weekly until resolution to Grade $\leq 2$<br>Continue rucaparib provided bilirubin is $< \text{ULN}$ and alkaline phosphatase is $< 3 \times \text{ULN}$<br>Interrupt treatment if AST/ALT levels do not decline within 2 weeks until Grade $\leq 2$ , then resume rucaparib at the same or at a reduced dose |
| Grade 4                                          | Interrupt rucaparib until values return to Grade $\leq 2$ ; then resume rucaparib with a dose reduction and monitor LFTs weekly for 3 weeks                                                                                                                                                                                |

### Special populations

#### *Elderly*

No adjustment is recommended to the starting dose for elderly patients ( $\geq 65$  years of age) (see sections 4.8 and 5.2). Greater sensitivity of some elderly patients ( $\geq 65$  years of age) to adverse events cannot be ruled out. There are limited clinical data in patients aged 75 or over.

#### *Hepatic impairment*

No starting dose adjustment is required in patients with mild or moderate hepatic impairment (see section 5.2). Patients with moderate hepatic impairment should be carefully monitored for hepatic function and adverse reactions. There are no clinical data in patients with severe hepatic impairment (ie, total bilirubin  $> 3$  times ULN), therefore rucaparib is not recommended for use in patients with severe hepatic impairment.

#### *Renal impairment*

No starting dose adjustment is required in patients with mild or moderate renal impairment (see section 5.2). There are no clinical data in patients with severe renal impairment (CL<sub>cr</sub> less than 30 mL/min), therefore rucaparib is not recommended for use in patients with severe renal impairment. Rucaparib may only be used in patients with severe renal impairment if the potential benefit outweighs the risk. Patients with moderate or severe renal impairment should be carefully monitored for renal function and adverse reactions.

#### *Paediatric population*

The safety and efficacy of Rubraca in children or adolescents aged less than 18 years have not been established. No data are available.

### Method of administration

Rubraca is for oral use and can be taken with or without food. The doses should be taken approximately 12 hours apart. See section 5.2.

## **4.3 Contraindications**

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.  
Breast-feeding (see section 4.6).

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

Efficacy of Rubraca as treatment for relapsed or progressive EOC, FTC, or PPC has not been investigated in patients who have received prior treatment with a PARP inhibitor. Therefore, use in this patient population is not recommended.

### Haematological toxicity

During treatment with rucaparib, events of myelosuppression (anaemia, neutropenia, thrombocytopenia) may be observed and are typically first observed after 8-10 weeks of treatment with rucaparib. These reactions are manageable with routine medical treatment and/or dose adjustment for more severe cases. Complete blood count testing prior to starting treatment with Rubraca, and monthly thereafter, is advised. Patients should not start Rubraca treatment until they have recovered from haematological toxicities caused by previous chemotherapy ( $\leq$  CTCAE Grade 1).

Supportive care and institutional guidelines should be implemented for the management of low blood counts for the treatment of anaemia and neutropenia. Rubraca should be interrupted or dose reduced according to Table 1 (see section 4.2) and blood counts monitored weekly until recovery. If the levels have not recovered to CTCAE Grade 1 or better after 4 weeks, the patient should be referred to a haematologist for further investigations.

#### Myelodysplastic syndrome/acute myeloid leukaemia

Myelodysplastic syndrome/acute myeloid leukaemia (MDS/AML), including cases with fatal outcome, have been reported in patients who received rucaparib. The duration of therapy with rucaparib in patients who developed MDS/AML varied from less than 1 month to approximately 28 months.

If MDS/AML is suspected, the patient should be referred to a haematologist for further investigations, including bone marrow analysis and blood sampling for cytogenetics. If, following investigation for prolonged haematological toxicity, MDS/AML is confirmed, Rubraca should be discontinued.

#### Photosensitivity

Photosensitivity has been observed in patients treated with rucaparib. Patients should avoid spending time in direct sunlight because they may burn more easily during rucaparib treatment; when outdoors, patients should wear a hat and protective clothing, and use sunscreen and lip balm with sun protection factor (SPF) of 50 or greater.

#### Gastrointestinal toxicities

Gastrointestinal toxicities (nausea and vomiting) are frequently reported with rucaparib, are generally low grade (CTCAE Grade 1 or 2), and may be managed with dose reduction (refer to Table 1) or interruption. Antiemetics, such as 5-HT<sub>3</sub> antagonists, dexamethasone, aprepitant and fosaprepitant, can be used as treatment for nausea/vomiting and may also be considered for prophylactic (i.e., preventative) use prior to starting Rubraca. It is important to proactively manage these events to avoid prolonged or more severe events of nausea/vomiting which have the potential to lead to complications such as dehydration or hospitalisation.

#### Embryofetal toxicity

Rubraca can cause fetal harm when administered to a pregnant woman based on its mechanism of action and findings from animal studies. In an animal reproduction study, administration of rucaparib to pregnant rats during the period of organogenesis resulted in embryo-fetal toxicity at exposures below those in patients receiving the recommended human dose of 600 mg twice daily (see section 5.3).

#### Pregnancy/contraception

Pregnant women should be informed of the potential risk to a foetus. Women of reproductive potential should be advised to use effective contraception during treatment and for 6 months following the last dose of Rubraca (see section 4.6). A pregnancy test before initiating treatment is recommended in women of reproductive potential.

## Excipients

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

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

### Effect of other medicinal products on rucaparib

Enzymes responsible for rucaparib metabolism have not been identified. Based on *in vitro* data, CYP2D6, and to a lesser extent CYP1A2 and CYP3A4, were able to metabolize rucaparib. Although *in vitro* rucaparib metabolism mediated by CYP3A4 was slow, a significant contribution of CYP3A4 *in vivo* cannot be excluded. Caution should be used for concomitant use of strong CYP3A4 inhibitors or inducers.

*In vitro*, rucaparib was shown to be a substrate of P-gp and BCRP. Effect of P-gp and BCRP inhibitors on rucaparib PK cannot be ruled out. Caution is recommended when rucaparib is co-administered with medicinal products that are strong inhibitors of P-gp.

### Effects of rucaparib on other medicinal products

In medicinal product interaction studies in cancer patients, the effects of steady-state rucaparib at 600 mg twice daily on CYP1A2, CYP2C9, CYP2C19, CYP3A, BCRP and P-gp were evaluated with single oral doses of sensitive probes (caffeine, S-warfarin, omeprazole, midazolam, rosuvastatin, and digoxin, respectively). The effect of rucaparib on the pharmacokinetics of the combined oral contraceptive (ethinylestradiol and levonorgestrel) was also evaluated. Data suggest that rucaparib is a moderate inhibitor of CYP1A2, and a mild inhibitor of CYP2C9, CYP2C19, and CYP3A. Rucaparib also marginally inhibits P-gp and weakly inhibits BCRP in the gut.

#### *CYP1A2 substrates*

Rucaparib showed no effect on  $C_{max}$  of caffeine while moderately increasing  $AUC_{inf}$  of caffeine by 2.55 fold (90% CI: 2.12, 3.08). When co-administering medicinal products metabolized by CYP1A2, particularly medicines which have a narrow therapeutic index (e.g., tizanidine, theophylline), dose adjustments may be considered based on appropriate clinical monitoring.

#### *CYP2C9 substrates*

Rucaparib increased S-warfarin  $C_{max}$  by 1.05 fold (90% CI: 0.99 to 1.12) and  $AUC_{0-96h}$  by 1.49 fold (90% CI: 1.40 to 1.58), respectively. When co-administering medicinal products that are CYP2C9 substrates with a narrow therapeutic index (e.g., warfarin, phenytoin), dose adjustments may be considered, if clinically indicated. Caution should be exercised and additional International Normalised Ratio (INR) monitoring with co-administration of warfarin and therapeutic drug level monitoring of phenytoin should be considered, if used concomitantly with rucaparib.

#### *CYP2C19 substrates*

Rucaparib increased omeprazole  $C_{max}$  by 1.09 fold (90% CI: 0.93 to 1.27) and  $AUC_{inf}$  by 1.55 fold (90% CI: 1.32 to 1.83). The risk for a clinically relevant effect of concomitant administration of proton pump inhibitors (PPIs) is likely small (see section 5.2). No dose adjustment is considered necessary for co-administered medicinal products that are CYP2C19 substrates.

#### *CYP3A substrates*

Rucaparib increased midazolam  $C_{max}$  by 1.13 fold (90% CI: 0.95 to 1.36) and  $AUC_{inf}$  by 1.38 fold (90% CI: 1.13 to 1.69). Caution is advised when co-administering medicinal products that are CYP3A substrates with a narrow therapeutic index (e.g., alfentanil, astemizole, cisapride, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, tacrolimus, terfenadine). Dose adjustments may be considered, if clinically indicated based on observed adverse reactions.

#### *Oral contraceptives*

Rucaparib increased ethinylestradiol  $C_{\max}$  by 1.09 fold (90% CI: 0.94 to 1.27) and  $AUC_{\text{last}}$  by 1.43 fold (90% CI: 1.15 to 1.77). Rucaparib increased levonorgestrel  $C_{\max}$  by 1.19 fold (90% CI: 1.00 to 1.42) and  $AUC_{\text{last}}$  by 1.56 fold (90% CI: 1.33 to 1.83). No dose adjustment is recommended for co-administered oral contraceptives.

#### *BCRP substrates*

Rucaparib increased rosuvastatin  $C_{\max}$  by 1.29 fold (90% CI: 1.07 to 1.55) and  $AUC_{\text{inf}}$  by 1.35 fold (90% CI: 1.17 to 1.57). No dose adjustment is recommended for co-administered medicinal products that are BCRP substrates.

#### *P-gp substrates*

Rucaparib showed no effect on  $C_{\max}$  of digoxin while marginally increasing  $AUC_{0-72h}$  by 1.20 fold (90% CI: 1.12 to 1.29). No dose adjustment is recommended for co-administered medicinal products that are P-gp substrates.

Interaction of rucaparib with other enzymes and transporter was evaluated *in vitro*. Rucaparib is a weak inhibitor of CYP2C8, CYP2D6, and UGT1A1. Rucaparib down regulated CYP2B6 in human hepatocytes at clinically relevant exposures. Rucaparib is a potent inhibitor of MATE1 and MATE2-K, a moderate inhibitor of OCT1, and a weak inhibitor of OCT2. As inhibition of these transporters could decrease metformin renal elimination and decrease liver uptake of metformin, caution is advised when metformin is co-administered with rucaparib. The clinical relevance of UGT1A1 inhibition by rucaparib is not clear. Caution should be used when rucaparib is co-administered with UGT1A1 substrates (i.e. irinotecan) to patients with UGT1A1\*28 (poor metabolizer) due to a possible increase in the exposure of SN-38 (the active metabolite of irinotecan) and associated toxicities.

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

### Women of childbearing potential/contraception in females

Women of childbearing potential should be advised to avoid becoming pregnant while receiving rucaparib. Patients should be advised to use effective contraception during treatment and for 6 months following the last dose of rucaparib (see section 4.5).

### Pregnancy

There are no or limited data from the use of rucaparib in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3). Based on its mechanism of action and preclinical data, rucaparib may cause fetal harm when administered to a pregnant woman. Rubraca should not be used during pregnancy unless the clinical condition of the woman requires treatment with rucaparib. A pregnancy test before initiating treatment is recommended in women of reproductive potential.

### Breast-feeding

There are no animal studies on the excretion of rucaparib in breast milk. It is unknown whether rucaparib/or its metabolites are excreted in human milk. A risk to the newborns/infants cannot be excluded. Rubraca must not be used during breast-feeding.

Because of the potential for serious adverse reactions in breast-fed infants from rucaparib, breast-feeding is contraindicated during treatment with Rubraca and for 2 weeks after the final dose (see section 4.3).

### Fertility

There are no data on the effect of rucaparib on human fertility. Based on the animal studies, impact on fertility associated with the use of rucaparib cannot be ruled out (see section 5.3). Moreover, according to its mechanism of action, rucaparib may impact human fertility.

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

Rubraca has minor influence on the ability to drive and use machines. Caution when driving or using machines is advised for patients who report fatigue, nausea, or dizziness during treatment with Rubraca (see section 4.8).

#### 4.8 Undesirable effects

##### Summary of the safety profile

The overall safety profile of rucaparib is based on data from 937 patients in clinical trials in ovarian cancer treated with rucaparib monotherapy.

Adverse reactions occurring in  $\geq 20\%$  of patients receiving rucaparib were nausea, fatigue/asthenia, vomiting, anaemia, abdominal pain, dysgeusia, ALT elevations, AST elevations, decreased appetite, diarrhoea, thrombocytopenia and creatinine elevations. The majority of adverse reactions were mild to moderate (Grade 1 or 2).

The  $\geq$  Grade 3 adverse reactions occurring in  $> 5\%$  of patients were anaemia (23%), ALT elevations (10%), fatigue/asthenia (10%), neutropenia (8%), thrombocytopenia (6%), and nausea (5%). The only serious adverse reaction occurring in  $> 2\%$  of patients was anaemia (5%).

Adverse reactions that most commonly led to dose reduction or interruption were anaemia (20%), fatigue/asthenia (18%), nausea (16%), thrombocytopenia (15%), and AST/ALT elevations (10%). Adverse reactions leading to permanent discontinuation occurred in 10% of patients, with thrombocytopenia, nausea, anaemia, and fatigue/asthenia being the most frequent adverse reactions leading to permanent discontinuation.

##### Tabulated list of adverse reactions

The adverse reaction frequency is listed by MedDRA System Organ Class (SOC) at the preferred term level. Frequencies of occurrence of adverse reactions are defined as: very common ( $\geq 1/10$ ); common ( $\geq 1/100$  to  $< 1/10$ ); uncommon ( $\geq 1/1,000$  to  $< 1/100$ ); rare ( $\geq 1/10,000$  to  $< 1/1,000$ ); very rare ( $< 1/10,000$ ), not known (cannot be estimated from the available data).

**Table 3. Tabulated list of adverse reactions by MedDRA system organ class**

|                                                                                 | <b>Adverse reactions</b>                                                                                                                                                                           |                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>MedDRA system organ class</b>                                                | <b>Frequency of all CTCAE grades</b>                                                                                                                                                               | <b>Frequency of CTCAE grade 3 and above</b>                                                                                                                                                                           |
| <b>Neoplasms benign, malignant and unspecified (including cysts and polyps)</b> | <b>Common</b><br>Myelodysplastic syndrome / Acute myeloid leukaemia <sup>a</sup>                                                                                                                   | <b>Common</b><br>Myelodysplastic syndrome / Acute myeloid leukaemia <sup>a</sup>                                                                                                                                      |
| <b>Blood and lymphatic system disorders</b>                                     | <b>Very common</b><br>Anaemia <sup>b</sup> , Thrombocytopenia <sup>b</sup> , Neutropenia <sup>b</sup><br><b>Common</b><br>Leukopenia <sup>b</sup> , Lymphopenia <sup>b</sup> , Febrile neutropenia | <b>Very common</b><br>Anaemia <sup>b</sup><br><b>Common</b><br>Thrombocytopenia <sup>b</sup> , Neutropenia <sup>b</sup> , Febrile neutropenia, Leukopenia <sup>b</sup><br><b>Uncommon</b><br>Lymphopenia <sup>b</sup> |
| <b>Immune system disorders</b>                                                  | <b>Common</b><br>Hypersensitivity <sup>c</sup>                                                                                                                                                     | <b>Uncommon</b><br>Hypersensitivity <sup>c</sup>                                                                                                                                                                      |
| <b>Metabolism and nutrition disorders</b>                                       | <b>Very common</b><br>Decreased appetite, Increased blood creatinine <sup>b</sup>                                                                                                                  | <b>Common</b><br>Decreased appetite, Dehydration<br><b>Uncommon</b>                                                                                                                                                   |

|                                                             |                                                                                                                                                               |                                                                                                                                                            |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                             | <b>Common</b><br>Hypercholesterolaemia <sup>b</sup> ,<br>Dehydration                                                                                          | Increased blood creatinine <sup>b</sup> ,<br>Hypercholesterolaemia <sup>b</sup>                                                                            |
| <b>Nervous system disorders</b>                             | <b>Very common</b><br>Dysgeusia, Dizziness                                                                                                                    | <b>Uncommon</b><br>Dysgeusia, Dizziness                                                                                                                    |
| <b>Respiratory, thoracic and mediastinal disorders</b>      | <b>Common</b><br>Dyspnoea                                                                                                                                     | <b>Uncommon</b><br>Dyspnoea                                                                                                                                |
| <b>Gastrointestinal disorders</b>                           | <b>Very common</b><br>Nausea, Vomiting, Diarrhoea,<br>Dyspepsia, Abdominal pain                                                                               | <b>Common</b><br>Nausea, Vomiting, Diarrhoea,<br>Abdominal pain<br><b>Uncommon</b><br>Dyspepsia                                                            |
| <b>Hepatobiliary disorders</b>                              | <b>Very common</b><br>Increased alanine<br>aminotransferase, Increased<br>aspartate aminotransferase<br><b>Common</b><br>Increased transaminases <sup>b</sup> | <b>Common</b><br>Increased alanine<br>aminotransferase, Increased<br>aspartate aminotransferase<br><b>Uncommon</b><br>Increased transaminases <sup>b</sup> |
| <b>Skin and subcutaneous tissue disorders</b>               | <b>Very common</b><br>Photosensitivity reaction, Rash<br><b>Common</b><br>Rash maculo-papular, Palmar-<br>plantar erythrodysesthesia<br>syndrome, Erythema    | <b>Uncommon</b><br>Photosensitivity reaction, Rash,<br>Rash maculo-papular, Palmar-<br>plantar erythrodysesthesia<br>syndrome                              |
| <b>General disorders and administration site conditions</b> | <b>Very common</b><br>Fatigue <sup>d</sup> , Pyrexia                                                                                                          | <b>Common</b><br>Fatigue <sup>d</sup><br><b>Uncommon</b><br>Pyrexia                                                                                        |

a MDS/AML rate is based on overall total patient population of 1321 who have received one dose of oral rucaparib.

b Includes laboratory findings

c Most commonly observed events include hypersensitivity, drug hypersensitivity and swelling/oedema of the face and eyes.

d Includes fatigue, asthenia and lethargy

### Description of selected adverse reactions

#### *Haematological toxicity*

Haematological adverse reactions of all CTCAE Grades of anaemia, thrombocytopenia and neutropenia were reported in 42%, 26% and 16% of patients respectively. Thrombocytopenia and anaemia led to discontinuation in 1.8% and 2.1% of patients. Adverse reactions CTCAE Grade 3 or higher occurred in 23% (anaemia), 8% (neutropenia) and 6% (thrombocytopenia) of patients. The time of onset for adverse reactions of myelosuppression Grade 3 or higher was generally later in treatment (after 2 or more months). For risk mitigation and management, see section 4.4.

#### *Myelodysplastic syndrome/Acute myeloid leukaemia*

MDS/AML are serious adverse reactions that occur uncommonly (0.5%) in patients on treatment and during the 28 day safety follow up, and commonly (1.3%) for all patients including during the long term safety follow up (rate is calculated based on overall safety population of 1321 patients exposed to at least one dose of oral rucaparib in all clinical studies). In the pivotal Phase 3 study (ARIEL3), the incidence of MDS/AML during therapy in patients who received rucaparib was 0.8%. Although no cases were reported during therapy in patients who received placebo, one case has been reported in a placebo - treated patient during the long term safety follow up. All patients had potential contributing factors for the development of MDS/AML; in all cases, patients had received previous platinum-containing chemotherapy regimens and/or other DNA damaging agents. For risk mitigation and management, see section 4.4.

### *Gastrointestinal toxicities*

Vomiting and nausea were reported in 42% and 77% of patients, respectively and were generally low grade (CTCAE Grade 1 to 3). Abdominal pain (combined terms abdominal pain, abdominal pain lower, abdominal pain upper) was reported in 40.1% of rucaparib treated patients, but was also very common (33%) in placebo patients, most likely associated with underlying disease. For risk mitigation and management, see section 4.4.

### *Photosensitivity*

Photosensitivity was reported in 13% of patients as low grade skin reactions (CTCAE Grade 1 or 2), and by 2 (0.2%) patients as  $\geq$  CTCAE Grade 3 reaction. For risk mitigation and management, see section 4.4.

### *Increases in serum aminotransferases (AST/ALT)*

Events related to increases in alanine aminotransferase (ALT) and aspartate aminotransferase (AST) were observed in 38% (all grades) and 11% ( $\geq$  CTCAE Grade 3) of patients. These events occurred within the first few weeks of treatment with rucaparib, were reversible, and were rarely associated with increases in bilirubin. Increased ALT was observed in 34.8% (all grades) and 9.9% ( $\geq$  CTCAE Grade 3) of patients, increased AST in 31.4% (all grades) and 2.8% ( $\geq$  CTCAE Grade 3) of patients and increased ALT and AST in 28.6% (all grades) and 2.1% ( $\geq$  CTCAE Grade 3) of patients. No events met Hy's Law criteria for drug-induced liver injury. AST/ALT elevations may need to be managed with treatment interruption and/or dose reduction as described in Table 2 (see section 4.2). Most patients could continue rucaparib with or without treatment modification without recurrence of Grade  $\geq$  3 LFT abnormalities.

### *Elevations in serum creatinine*

Increases in serum creatinine, predominantly mild to moderate (CTCAE Grade 1 or 2), were observed in 20% of patients within the first few weeks of treatment with rucaparib. Four (0.4%) patients reported a CTCAE Grade 3 reaction. Elevations in creatinine with rucaparib treatment may be due to inhibition of the renal transporters MATE1 and MATE2-K (see section 4.5). These increases in serum creatinine were clinically asymptomatic.

### *Elderly*

In patients  $\geq$  75 years old, frequencies of some adverse reactions increased: increased blood creatinine (32%), dizziness (20%), pruritus (15%), and memory impairment (4%) were higher than in patients < 75 years old (18%, 15%, 9% and 1% respectively).

### *Patients with Renal Impairment*

In patients with moderate renal impairment (CL<sub>cr</sub> of 30-59 mL/min), frequencies of some adverse reactions increased: Grade 3 or 4 anaemia (31%), Grade 3 or 4 thrombocytopenia (12%), and Grade 3 fatigue/asthenia (15%) were higher than in patients with mild renal impairment (CL<sub>cr</sub> > 59-80 mL/min) or normal renal function (CL<sub>cr</sub> > 80 mL/min) (21%, 5%, and 8%).

### Paediatric population

No studies have been conducted to investigate the pharmacokinetics of rucaparib in paediatric patients.

### 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**

There is no specific treatment in the event of Rubraca overdose, and symptoms of overdose are not established. In the event of suspected overdose, physicians should follow general supportive measures

and should treat symptomatically.

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other antineoplastic agents, ATC code: L01XK03

#### Mechanism of action and pharmacodynamics effects

Rucaparib is an inhibitor of poly(ADP-ribose) polymerase (PARP) enzymes, including PARP-1, PARP-2, and PARP-3, which play a role in DNA repair. *In vitro* studies have shown that rucaparib-induced cytotoxicity involves inhibition of PARP enzymatic activity and the trapping of PARP-DNA complexes resulting in increased DNA damage, apoptosis, and cell death.

Rucaparib has been shown to have *in vitro* and *in vivo* anti-tumour activity in BRCA mutant cell lines through a mechanism known as synthetic lethality, whereby the loss of two DNA repair pathways is required for cell death. Increased rucaparib-induced cytotoxicity and anti-tumour activity was observed in tumour cell lines with deficiencies in BRCA1/2 and other DNA repair genes. Rucaparib has been shown to decrease tumour growth in mouse xenograft models of human cancer with or without deficiencies in BRCA.

#### Clinical efficacy

##### Maintenance treatment of recurrent ovarian cancer

The efficacy of rucaparib was investigated in ARIEL3, a double-blind, multicentre clinical trial in which 564 patients with recurrent EOC, FTC or PPC who were in response to platinum-based chemotherapy were randomized (2:1) to receive Rubraca tablets 600 mg orally twice daily (n=375) or placebo (n=189). Treatment was continued until disease progression or unacceptable toxicity. All patients had achieved a response (complete or partial) to their most recent platinum-based chemotherapy and their cancer antigen 125 (CA-125) was below the upper limit of normal (ULN). Patients were randomised within 8 weeks of completion of platinum chemotherapy and no intervening maintenance treatment was permitted. Patients could not have received prior rucaparib or other PARP inhibitor therapy. Randomisation was stratified by best response to last platinum therapy (complete or partial), time to progression following the penultimate platinum therapy (6 to ≤ 12 months and > 12 months), and tumour biomarker status (tBRCA, non-BRCA homologous recombination deficiency [nbHRD] and biomarker negative).

The primary efficacy outcome was investigator-assessed progression-free survival (invPFS) evaluated according to Response Evaluation Criteria in Solid Tumors (RECIST), version 1.1 (v1.1). PFS assessed by blinded independent radiology review (BIR) was a key secondary efficacy outcome.

The mean age was 61 years (range: 36 to 85); most of the patients were white (80%); and all had an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1. The primary tumour in most patients was ovarian (84%); most patients (95%) had serous histology and 4% of patients reported endometrioid histology. All patients had received at least two prior platinum-based chemotherapies (range: 2 to 6) and 28% of patients had received at least three prior platinum-based chemotherapies. A total of 32% of patients were in complete response (CR) to their most recent therapy. The progression-free interval to penultimate platinum therapy was 6-12 months in 39% of patients and > 12 months in 61%. Prior bevacizumab therapy was reported for 22% of patients who received rucaparib and 23% of patients who received placebo. Demographics, baseline disease characteristics, and prior treatment history were generally well balanced between the rucaparib and placebo arms.

None of the patients had received prior treatment with a PARP inhibitor. As such, efficacy of Rubraca in patients who have received prior treatment with a PARP inhibitor in the maintenance setting, has

not been investigated and cannot be extrapolated from the available data.

Tumour tissue samples for all of the patients (N=564) were tested centrally to determine HRD positive status (as defined by the presence of a deleterious tumour BRCA [tBRCA] mutation or high genomic loss of heterozygosity). Blood samples for 94% (186/196) of the tBRCA patients were evaluated using a central blood germline BRCA (gBRCA) test. Based on these results, 70% (130/186) of the tBRCA patients had a gBRCA mutation and 30% (56/186) had a somatic BRCA mutation.

ARIEL3 demonstrated a statistically significant improvement in PFS for patients randomised to rucaparib as compared with placebo in the ITT population and in the HRD and tBRCA subgroups. IRR- assessment for the ITT population supported the primary endpoint. At the time of the analysis of PFS, OS data were not mature (with 22% of events). Efficacy results are summarised in Table 4 and Figure 1.

**Table 4. ARIEL3 Efficacy Results**

| Parameter                      | Investigator Assessment |                | IRR                |                |
|--------------------------------|-------------------------|----------------|--------------------|----------------|
|                                | Rucaparib               | Placebo        | Rucaparib          | Placebo        |
| ITT population <sup>a</sup>    |                         |                |                    |                |
| Patients, n                    | 375                     | 189            | 375                | 189            |
| PFS events, n (%)              | 234 (62%)               | 167 (88%)      | 165 (44%)          | 133 (70%)      |
| PFS, median in months (95% CI) | 10.8 (8.3, 11.4)        | 5.4 (5.3-5.5)  | 13.7 (11.0, 19.1)  | 5.4 (5.1, 5.5) |
| HR (95% CI)                    | 0.36 (0.30, 0.45)       |                | 0.35 (0.28, 0.45)  |                |
| p-value <sup>b</sup>           | < 0.0001                |                | < 0.0001           |                |
| HRD Group <sup>c</sup>         |                         |                |                    |                |
| Patients, n                    | 236                     | 118            | 236                | 118            |
| PFS events, n (%)              | 134 (57%)               | 101 (86%)      | 90 (38%)           | 74 (63%)       |
| PFS, median in months (95% CI) | 13.6 (10.9, 16.2)       | 5.4 (5.1, 5.6) | 22.9 (16.2, NA)    | 5.5 (5.1, 7.4) |
| HR (95% CI)                    | 0.32 (0.24, 0.42)       |                | 0.34 (0.24, 0.47)  |                |
| p-value <sup>b</sup>           | < 0.0001                |                | < 0.0001           |                |
| tBRCA Group <sup>d</sup>       |                         |                |                    |                |
| Patients, n                    | 130                     | 66             | 130                | 66             |
| PFS events, n (%)              | 67 (52%)                | 56 (85%)       | 42 (32%)           | 42 (64%)       |
| PFS, median in months (95% CI) | 16.6 (13.4, 22.9)       | 5.4 (3.4, 6.7) | 26.8 (19.2, NA)    | 5.4 (4.9, 8.1) |
| HR (95% CI)                    | 0.23 (0.16, 0.34)       |                | 0.20 (0.13, 0.32)  |                |
| p-value <sup>b</sup>           | < 0.0001                |                | < 0.0001           |                |
| nonBRCA LOH+ Group             |                         |                |                    |                |
| Patients, n                    | 106                     | 52             | 106                | 52             |
| PFS events, n (%)              | 67 (63%)                | 45 (87%)       | 48 (45%)           | 32 (62%)       |
| PFS, median in months (95% CI) | 9.7 (7.9, 13.1)         | 5.4 (4.1, 5.7) | 11.1 (8.2, NA)     | 5.6 (2.9, 8.2) |
| HR (95% CI)                    | 0.44 (0.29, 0.66)       |                | 0.554 (0.35, 0.89) |                |
| p-value <sup>b</sup>           | < 0.0001                |                | 0.0135             |                |
| nonBRCA LOH- Group             |                         |                |                    |                |
| Patients, n                    | 107                     | 54             | 107                | 54             |
| PFS events, n (%)              | 81 (73%)                | 50 (93%)       | 63 (59%)           | 46 (85%)       |
| PFS, median in months (95% CI) | 6.7 (5.4, 9.1)          | 5.4 (5.3, 7.4) | 8.2 (5.6, 10.1)    | 5.3 (2.8, 5.5) |
| HR (95% CI)                    | 0.58 (0.40, 0.85)       |                | 0.47 (0.31, 0.71)  |                |
| p-value <sup>b</sup>           | 0.0049                  |                | 0.0003             |                |

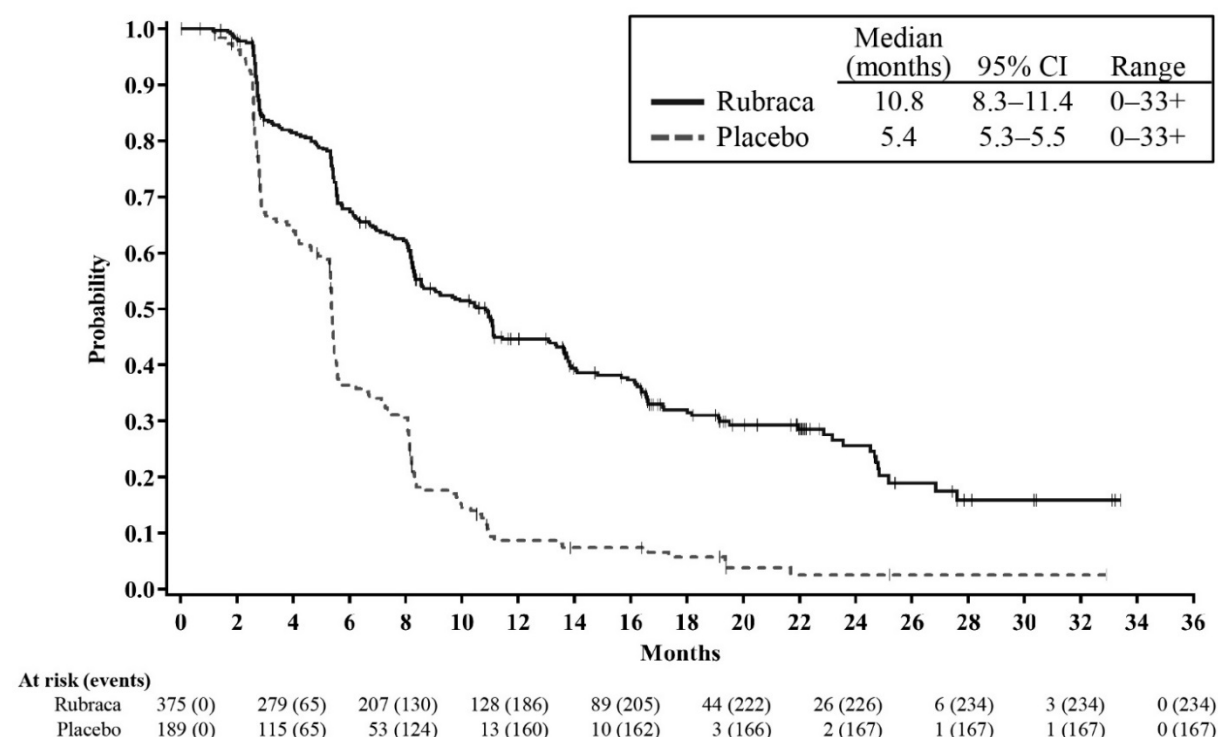
a. All randomised patients.

b. Two-sided p-value

c. HRD includes all patients with a deleterious germline or somatic BRCA mutation or non-tBRCA with high genomic loss of heterozygosity, as determined by the clinical trial assay (CTA).

d. tBRCA includes all patients with a deleterious germline or somatic BRCA mutation, as determined by the CTA.

**Figure 1. Kaplan-Meier Curves of Progression-Free Survival in ARIEL3 as Assessed by Investigator: ITT population**



In the ITT population, 38% of patients (141/375) in the rucaparib group and 35% of patients (66/189) in the placebo group had measurable disease at baseline. In an exploratory analysis in this subgroup, a response was noted in 18% (95% CI 12% – 26%) of patients (n=26) on rucaparib compared to 8% (95% CI 3% – 17%) of patients (n=5) on placebo (2-sided p-value = 0.0069), including 10 patients (7%) in the rucaparib group who achieved a complete remission.

In the tBRCA population, 31% of patients (40/130) in the rucaparib group and 35% of patients (23/66) in the placebo group had measurable disease at baseline. In an exploratory analysis, a response was noted in 38% (95% CI 23% – 54%) of patients (n=15) on rucaparib compared to 9% (95% CI 1% – 28%) of patients (n=2) on placebo (2-sided p-value = 0.0055), including 7 (18%) patients in the rucaparib group who achieved a complete remission.

#### Treatment of BRCA-mutated ovarian cancer after 2 or more chemotherapies

The efficacy of rucaparib was investigated in 106 patients in 2 multicentre, single-arm, open-label clinical studies, Study 10 and ARIEL2, in patients with advanced BRCA-mutant epithelial ovarian, fallopian tube or primary peritoneal cancer who had progressed after 2 or more prior chemotherapies (the primary efficacy population). The tumour histology was high grade serous in 91.5% of patients, endometrioid in 2.8% and mixed histology in 4.7%. None of the patients had received prior treatment with a PARP inhibitor. BRCA status based on a local test was known for some patients at the time of enrollment. Central BRCA testing was performed retrospectively after patients were enrolled. All 106 patients received rucaparib 600 mg twice daily. Patients who had been hospitalised for bowel obstruction in the last 3 months were excluded.

The primary efficacy outcome measure of both studies was objective response rate (ORR) as assessed by the investigator according to RECIST version 1.1. An analysis of progression-free survival (PFS) was also performed.

Study 10 population characteristics in 42 patients were: median age 57 years (range 42 to 84), white (83%), ECOG performance status 0 (62%) or 1 (38%), high grade ovarian cancer (100%), 3 or more prior lines of chemotherapy (36%), median time since ovarian cancer diagnosis 43 months [range: 6 - 178], median progression-free interval from the last platinum treatment 8.0 months [range: 6.0 - 116.4].

ARIEL2 population characteristics in 64 patients were: median age 60 years (range 33 to 80), white (75%), ECOG performance status 0 (61%) or 1 (39%), high grade ovarian cancer (100%), 3 or more prior lines of chemotherapy (78%), median time since ovarian cancer diagnosis 53 months [range: 22-197], median progression-free interval from the last platinum treatment 7.6 months [range: 0.7-26.5].

Most of the primary efficacy population were platinum-sensitive (n=79, 74.5%); the remaining patients were platinum-resistant (n=20, 18.9%) or platinum-refractory (n=7, 6.6%). Patients with germline (g)BRCA (n=88, 83.0%) or somatic (s)BRCA (n=18, 17.0%) mutations were included.

In the subset of 79 platinum-sensitive patients, progression free interval after last platinum dose was  $\geq 6$  – 12 months for 55 (69.6%) patients and  $> 12$  months for 24 (30.4%) patients. Platinum-sensitive patients had received 2 (n=47, 59.5%), 3 (n=28, 35.4%), or  $> 3$  (n=4, 5.1%) prior lines of platinum-based chemotherapy. The proportion of platinum-sensitive patients with gBRCA and sBRCA mutations was comparable to the primary efficacy population at n=66 (83.5%) and n=13 (16.5%) respectively.

Efficacy results from all patients treated are summarized in Table 5.

**Table 5. Summary of primary efficacy findings for patients with BRCA-mutant ovarian cancer who received rucaparib 600 mg twice daily and two or more prior chemotherapy regimens based on investigator assessment of response**

|                                                             | <b>Primary Efficacy<br/>N=106</b> | <b>Platinum Sensitive<br/>N=79</b> |
|-------------------------------------------------------------|-----------------------------------|------------------------------------|
| Objective response rate (ORR) N<br>%<br>(95% CI)            | 58<br>54.7<br>(44.8, 64.4)        | 51<br>64.6<br>(53.0, 75.0)         |
| Complete response %                                         | 8.5                               | 10.1                               |
| Partial response %                                          | 46.2                              | 54.4                               |
| Median duration of response <sup>a</sup> - days<br>(95% CI) | 288<br>(202-392)                  | 294<br>(224-393)                   |
| Median progression-free survival - days<br>(95% CI)         | 289<br>(226-337)                  | 332<br>(255-391)                   |
| Censoring N (%)                                             | 23 (21.7)                         | 19 (24.1)                          |
| Median overall survival - months (95%<br>CI)                | NA (21.7-NA)                      | NA (NA-NA)                         |
| Censoring N (%)                                             | 82 (77.4)                         | 68 (86.1)                          |

a The median duration of response is determined from the patients who had an objective tumour response according to RECIST guidelines, following treatment with rucaparib.

NA: Not Achieved

CI: Confidence interval

Four (5.1%) of 79 platinum sensitive patients overall had progressive disease as best response. ORR was similar for patients with germline BRCA-mutant ovarian cancer or somatic BRCA-mutant ovarian cancer and for patients with a BRCA1 gene mutation or BRCA2 gene mutation.

The ORR, by independent radiology review for the platinum-sensitive population, was 42/79, 53.2% (95% CI [41.6-64.5]).

For the platinum-resistant population (N=20), ORR by investigator review was 35.0% (95% CI [15.4, 59.2]), with a complete response rate of 5.0%, and a partial response rate of 30.0%. The median duration of response was 196 days (95% CI [113 – NA]). The median progression-free survival was

282 days (95% CI [218-335]), and the median overall survival was 18.8 months (95% CI [12.9-NA]).

For the platinum-refractory population (N=7), there were no responders. The median progression-free survival was 162 days (95% CI [51-223]). Median overall survival was not achieved in this population.

### Cardiac electrophysiology

Concentration-QTcF prolongation analysis was conducted using data from 54 patients with a solid tumour administered continuous rucaparib at doses ranging from 40 mg once daily to 840 mg twice daily (1.4 times the approved recommended dose). At the predicted median steady-state  $C_{max}$  following 600 mg rucaparib twice daily, the projected QTcF increase from baseline was 11.5 msec (90% CI: 8.77 to 14.2 msec). Thus, the risk for clinically significant QTcF increase from baseline (i.e. > 20 msec) is low.

### Paediatric population

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

This medicinal product has been authorised under a so-called ‘conditional approval’ scheme. This means that further evidence on this medicinal product is awaited. The European Medicines Agency will review new information on this medicinal product at least every year and this SmPC will be updated as necessary.

## **5.2 Pharmacokinetic properties**

Plasma exposures of rucaparib, as measured by  $C_{max}$  and AUC, were approximately dose proportional at evaluated doses (40 to 500 mg daily, 240 to 840 mg twice a day). Steady state was achieved after 1 week of dosing. Following repeated twice daily dosing, the accumulation based on AUC ranged from 3.5 to 6.2 fold.

### Absorption

In patients with cancer following rucaparib 600 mg taken twice daily, the mean steady-state  $C_{max}$  was 1940 ng/mL and  $AUC_{0-12h}$  was 16900 h·ng/mL with  $T_{max}$  of 1.9 hours. The mean absolute oral bioavailability following a single oral dose of 12 to 120 mg rucaparib was 36%. The absolute oral bioavailability at 600 mg has not been determined. In patients with cancer following a high-fat meal, the  $C_{max}$  increased by 20%, the  $AUC_{0-24h}$  increased by 38%, and the  $T_{max}$  was delayed by 2.5 hours, as compared with dosing under fasted conditions. The food effect on PK was not considered clinically significant. Rubraca can be administered with or without food.

### Distribution

The *in vitro* protein binding of rucaparib is 70.2% in human plasma at therapeutic concentration levels. Rucaparib preferentially distributed to red blood cells with a blood-to-plasma concentration ratio of 1.83. In patients with cancer, rucaparib had a steady-state volume of distribution of 113 L to 262 L following a single intravenous dose of 12 mg to 40 mg rucaparib.

### Biotransformation

*In vitro*, rucaparib is metabolised primarily by CYP2D6, and to a lesser extent by CYP1A2, and CYP3A4. In a population PK analysis, no clinically relevant PK differences were observed among patients with different CYP2D6 phenotypes (including poor metabolizers, n=9; intermediate metabolizers, n=71; normal metabolizers, n=76; and ultra-rapid metabolizers, n=4) or patients with different CYP1A2 phenotypes (including normal metabolizers, n=28; hyperinducers, n=136). The

results should be interpreted with caution due to the limited representation of some subgroup phenotypes.

Following administration of a single oral dose of [ $^{14}\text{C}$ ]-rucaparib to patients with solid tumours, unchanged rucaparib accounted for 64.0% of the radioactivity in plasma. Oxidation, N-demethylation, N-methylation, glucuronidation, and N-formylation were the major metabolic pathways for rucaparib. The most abundant metabolite was M324, an oxidative deamination product of rucaparib, accounting for 18.6% of the radioactivity in plasma. *In vitro*, M324 was at least 30 fold less potent than rucaparib against PARP-1, PARP-2, and PARP-3. Other minor metabolites accounted for 13.8% of the radioactivity in plasma. Rucaparib accounted for 44.9% and 94.9% of radioactivity in urine and faeces, respectively; while M324 accounted for 50.0% and 5.1% of radioactivity in urine and faeces, respectively.

### Elimination

The clearance ranged from 13.9 to 18.4 L/hour, following a single intravenous dose of rucaparib 12 mg to 40 mg. Following administration of a single oral dose of [ $^{14}\text{C}$ ]-rucaparib 600 mg to patients, the overall mean recovery of radioactivity was 89.3%, with a mean recovery of 71.9% in faeces and 17.4% in urine by 288 hours post dose. Ninety percent of the observed faecal recovery was achieved within 168 hours postdose. The mean half-life ( $t_{1/2}$ ) of rucaparib was 25.9 hours.

### Medicinal product interactions

*In vitro*, rucaparib was shown to be a substrate of P-gp and BCRP, but not a substrate of renal uptake transporters OAT1, OAT3, and OCT2, or hepatic transporters OAPT1B1 and OATP1B3. Effect of P-gp and BCRP inhibitors on rucaparib PK cannot be ruled out.

*In vitro*, rucaparib reversibly inhibited CYP1A2, CYP2C19, CYP2C9, and CYP3A, and to a lesser extent CYP2C8, CYP2D6, and UGT1A1. Rucaparib induced CYP1A2, and down regulated CYP2B6 and CYP3A4 in human hepatocytes at clinically relevant exposures.

*In vitro*, rucaparib is a potent inhibitor of MATE1 and MATE2-K, a moderate inhibitor of OCT1, and a weak inhibitor of OCT2. At clinical exposures, rucaparib did not inhibit bile salt export pump (BSEP), OATP1B1, OATP1B3, OAT1 and OAT3. Inhibition of MRP4 by rucaparib cannot be fully ruled out at clinical exposures. No interaction with MRP2 or MRP3 was observed *in vitro* at the clinical exposure of rucaparib, however, mild bi-phasic activation and inhibition of MRP2 and concentration dependent inhibition of MRP3 were observed at concentrations higher than the observed plasma  $C_{\text{max}}$  of rucaparib. The clinical relevance of MRP2 and MRP3 interaction in the gut is not known. *In vitro*, rucaparib is an inhibitor of the BCRP and P-gp efflux transporters. No significant P-gp inhibition was observed *in vivo* (section 4.5).

Population PK analysis suggested that concomitant use of PPIs is unlikely to have clinically meaningful impact on rucaparib PK. A firm conclusion cannot be made regarding the effect of co-administration of rucaparib and PPIs because dose level and time of administration have not been documented in detail for the PPIs.

### Pharmacokinetics in specific populations

#### *Age, race, and body weight*

Based on population PK analysis, no clinically significant relationships were identified between predicted steady-state exposure and patient's age, race, and body weight. Patients included in the population PK study were aged 21 to 86 years (58% < 65 years, 31% 65-74 years, and 11% > 75 years), 82% were Caucasian, and had body weights between 41 and 171 kg (73% had body weight > 60 kg).

#### *Hepatic impairment*

A population PK analysis was performed to evaluate the effect of hepatic impairment on the clearance

of rucaparib in patients receiving rucaparib 600 mg twice daily. No clinically important differences were observed between 34 patients with mild hepatic impairment (total bilirubin  $\leq$  ULN and AST  $>$  ULN or total bilirubin  $>$  1.0 to 1.5 times ULN and any AST) and 337 patients with normal hepatic function. In a study evaluating the pharmacokinetics of rucaparib in patients with hepatic impairment, patients with moderate hepatic impairment (N=8, National Cancer Institute - Organ Dysfunction Working Group criteria; total bilirubin  $>$  1.5 -  $\leq$  3 times ULN) had a 45% higher AUC of rucaparib following a single dose of 600 mg compared to patients with normal hepatic function (N=8).  $C_{\max}$  or  $T_{\max}$  were similar between the groups. No data are available for patients with severe hepatic impairment (see section 4.2).

#### *Renal impairment*

No formal studies of rucaparib in patients with renal impairment have been conducted. A population PK analysis was performed to evaluate the effect of renal impairment on the clearance of rucaparib in patients receiving rucaparib 600 mg twice daily. Patients with mild renal impairment (N=149; CLcr between 60 and 89 mL/min, as estimated by the Cockcroft-Gault method) and those with moderate renal impairment (N=76; CLcr between 30 and 59 mL/min) showed approximately 15% and 33% higher steady-state AUC, respectively, compared to patients with normal renal function (N=147; CLcr greater than or equal to 90 mL/min). The pharmacokinetic characteristics of rucaparib in patients with CLcr less than 30 mL/min or patients on dialysis are unknown (see section 4.2).

### **5.3 Preclinical safety data**

#### General toxicology

The findings in non-clinical toxicology studies performed with oral rucaparib were generally consistent with the adverse events observed in clinical studies. In repeat-dose toxicity studies of up to 3 months duration in rats and dogs, the target organs were the gastrointestinal, haematopoietic, and lymphopoietic systems. These findings occurred at exposures below those observed in patients treated at the recommended dose, and were largely reversible within 4 weeks of cessation of dosing. *In vitro*, the  $IC_{50}$  of rucaparib against the human ether-à-go-go related gene (hERG) was 22.6  $\mu$ M, which is approximately 13-fold higher than the  $C_{\max}$  in patients at the recommended dose.

Intravenous administration of rucaparib in the rat and dog induced cardiac effects at a high  $C_{\max}$  (5.4 to 7.3-fold higher than patients), but not at a lower  $C_{\max}$  (1.3 to 3.8-fold higher than patients). No cardiac effects were observed with oral dosing of rucaparib in repeat-dose toxicology studies at a rucaparib  $C_{\max}$  comparable to that observed in patients. Although no cardiac effects were observed following oral dosing, based on the findings in the intravenous studies and safety margins, cardiac effects in patients cannot be excluded when rucaparib is given orally.

#### Carcinogenicity

Carcinogenicity studies have not been performed with rucaparib.

#### Genotoxicity

Rucaparib was not mutagenic in a bacterial reverse mutation (Ames) assay. Rucaparib induced structural chromosomal aberrations in the *in vitro* human lymphocyte chromosomal aberration assay.

#### Reproductive toxicology

In an embryo-foetal development study in rats, rucaparib was associated with post-implantation loss at exposures of approximately 0.04 times the human AUC at the recommended dose.

Fertility studies have not been conducted with rucaparib. No effects on male and female fertility were observed in 3-month general toxicology studies in rats and dogs at exposures of 0.09 to 0.3 times the human AUC at the recommended dose. A potential risk cannot be ruled out based on the safety margin observed. In addition, according to its mechanism of action rucaparib may have the potential to impair

fertility in humans.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

#### Tablet core

Microcrystalline cellulose  
Sodium starch glycolate (Type A)  
Colloidal anhydrous silica  
Magnesium stearate

#### Rubraca 200 mg film-coated tablets

##### *Tablet coating*

Polyvinyl alcohol (E1203)  
Titanium dioxide (E171)  
Macrogol 4000 (E1521)  
Talc (E553b)  
Brilliant blue FCF aluminium lake (E133)  
Indigo carmine aluminium lake (E132)

#### Rubraca 250 mg film-coated tablets

##### *Tablet coating*

Polyvinyl alcohol (E1203)  
Titanium dioxide (E171)  
Macrogol 4000 (E1521)  
Talc (E553b)

#### Rubraca 300 mg film-coated tablets

##### *Tablet coating*

Polyvinyl alcohol (E1203)  
Titanium dioxide (E171)  
Macrogol 4000 (E1521)  
Talc (E553b)  
Iron oxide yellow (E172)

### **6.2 Incompatibilities**

Not applicable.

### **6.3 Shelf life**

4 years.

### **6.4 Special precautions for storage**

This medicinal product does not require any special storage conditions.

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

HDPE bottle, with a polypropylene (PP) induction seal closure, containing 60 tablets. Each carton

contains one bottle.

#### **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**

Clovis Oncology Ireland Ltd.  
Regus Dublin Airport  
Skybridge House - Dublin Airport  
Swords  
County Dublin  
K67 P6K2  
Ireland

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

EU/1/17/1250/001  
EU/1/17/1250/002  
EU/1/17/1250/003

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

Date of first authorisation: 24 May 2018  
Date of latest renewal: 04 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 <http://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**
- E. SPECIFIC OBLIGATION TO COMPLETE POST-AUTHORISATION MEASURES FOR THE CONDITIONAL MARKETING AUTHORISATION**

## **A. MANUFACTURER(S) RESPONSIBLE FOR BATCH RELEASE**

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

Almac Pharma Services Ltd  
Seagoe Industrial Estate  
Craigavon  
County Armagh  
BT63 5UA  
United Kingdom

Almac Pharma Services (Ireland) Ltd  
Finnabair Industrial Estate  
Dundalk  
County Louth  
A91 P9KD  
Ireland

The printed package leaflet of the medicinal product must state the name and address of the manufacturer responsible for the release of the concerned batch.

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

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

| <b>Description</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Due date</b>  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| PAES: In order to further investigate the efficacy of rucaparib maintenance treatment in patients with relapsed high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to platinum-based chemotherapy, the MAH should submit the final analysis of OS and updated analyses of PFS2, chemotherapy-free interval and time to start of subsequent anti-cancer treatment of the phase 3, randomised, double-blind study CO-338-014 | 31 December 2022 |

- **Temporary Measures**

No new treatment with Rubraca should be initiated in adult patients with platinum sensitive, relapsed or progressive, BRCA mutated (germline and/or somatic), high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer, who have been treated with two or more prior lines of platinum based chemotherapy, and who are unable to tolerate further platinum based chemotherapy.

#### **E. SPECIFIC OBLIGATION TO COMPLETE POST-AUTHORISATION MEASURES FOR THE CONDITIONAL MARKETING AUTHORISATION**

This being a conditional marketing authorisation and pursuant to Article 14(7) of Regulation (EC) No 726/2004, the MAH shall complete, within the stated timeframe, the following measures:

| <b>Description</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Due date</b>   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| In order to further confirm the safety and efficacy of rucaparib in the treatment of platinum sensitive, relapsed or progressive, BRCA mutated (germline and/ or somatic), high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer, the MAH should submit the results of study CO-338-043 (ARIEL4), a phase 3, multicentre, open-label, randomised study evaluating the efficacy and safety of rucaparib versus chemotherapy for treatment of relapsed ovarian cancer. | Due date: Q2 2023 |

**ANNEX III**  
**LABELLING AND PACKAGE LEAFLET**

## **A. LABELLING**

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING****CARTON****1. NAME OF THE MEDICINAL PRODUCT**

Rubraca 200 mg film-coated tablets  
rucaparib

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each tablet contains rucaparib camsylate corresponding to 200 mg rucaparib.

**3. LIST OF EXCIPIENTS****4. PHARMACEUTICAL FORM AND CONTENTS**

60 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****11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

Clovis Oncology Ireland Ltd.

Regus Dublin Airport  
Skybridge House - Dublin Airport  
Swords  
County Dublin  
K67 P6K2  
Ireland

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|----------------------------------------------|
| <b>12. MARKETING AUTHORISATION NUMBER(S)</b> |
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EU/1/17/1250/001

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| <b>13. BATCH NUMBER</b> |
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Lot

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| <b>14. GENERAL CLASSIFICATION FOR SUPPLY</b> |
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| <b>15. INSTRUCTIONS ON USE</b> |
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| <b>16. INFORMATION IN BRAILLE</b> |
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Rubraca 200 mg

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| <b>17. UNIQUE IDENTIFIER – 2D BARCODE</b> |
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2D barcode carrying the unique identifier included.

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| <b>18. UNIQUE IDENTIFIER - HUMAN READABLE DATA</b> |
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PC  
SN  
NN

**PARTICULARS TO APPEAR ON THE IMMEDIATE PACKAGING****BOTTLE LABEL****1. NAME OF THE MEDICINAL PRODUCT**

Rubraca 200 mg tablets  
rucaparib

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each tablet contains rucaparib camsylate corresponding to 200 mg rucaparib.

**3. LIST OF EXCIPIENTS****4. PHARMACEUTICAL FORM AND CONTENTS**

60 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**

|                                                                   |
|-------------------------------------------------------------------|
| <b>11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER</b> |
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| <b>14. GENERAL CLASSIFICATION FOR SUPPLY</b> |
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| <b>15. INSTRUCTIONS ON USE</b> |
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| <b>16. INFORMATION IN BRAILLE</b> |
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| <b>17. UNIQUE IDENTIFIER – 2D BARCODE</b> |
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| <b>18. UNIQUE IDENTIFIER - HUMAN READABLE DATA</b> |
|----------------------------------------------------|

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING****CARTON****1. NAME OF THE MEDICINAL PRODUCT**

Rubraca 250 mg film-coated tablets  
rucaparib

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each tablet contains rucaparib camsylate corresponding to 250 mg rucaparib.

**3. LIST OF EXCIPIENTS****4. PHARMACEUTICAL FORM AND CONTENTS**

60 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**

**11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

Clovis Oncology Ireland Ltd.  
Regus Dublin Airport  
Skybridge House - Dublin Airport  
Swords  
County Dublin  
K67 P6K2  
Ireland

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

EU/1/17/1250/002

**13. BATCH NUMBER**

Lot

**14. GENERAL CLASSIFICATION FOR SUPPLY****15. INSTRUCTIONS ON USE****16. INFORMATION IN BRAILLE**

Rubraca 250 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**

Rubraca 250 mg tablets  
rucaparib

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each tablet contains rucaparib camsylate corresponding to 250 mg rucaparib.

**3. LIST OF EXCIPIENTS****4. PHARMACEUTICAL FORM AND CONTENTS**

60 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**

|                                                                   |
|-------------------------------------------------------------------|
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| <b>13. BATCH NUMBER</b> |
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Lot

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| <b>14. GENERAL CLASSIFICATION FOR SUPPLY</b> |
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| <b>15. INSTRUCTIONS ON USE</b> |
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| <b>16. INFORMATION IN BRAILLE</b> |
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| <b>17. UNIQUE IDENTIFIER – 2D BARCODE</b> |
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| <b>18. UNIQUE IDENTIFIER - HUMAN READABLE DATA</b> |
|----------------------------------------------------|

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING****CARTON****1. NAME OF THE MEDICINAL PRODUCT**

Rubraca 300 mg film-coated tablets  
rucaparib

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each tablet contains rucaparib camsylate corresponding to 300 mg rucaparib.

**3. LIST OF EXCIPIENTS****4. PHARMACEUTICAL FORM AND CONTENTS**

60 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**

**11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

Clovis Oncology Ireland Ltd.  
Regus Dublin Airport  
Skybridge House - Dublin Airport  
Swords  
County Dublin  
K67 P6K2  
Ireland

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

EU/1/17/1250/003

**13. BATCH NUMBER**

Lot

**14. GENERAL CLASSIFICATION FOR SUPPLY****15. INSTRUCTIONS ON USE****16. INFORMATION IN BRAILLE**

Rubraca 300 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**

Rubraca 300 mg tablets  
rucaparib

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each tablet contains rucaparib camsylate corresponding to 300 mg rucaparib.

**3. LIST OF EXCIPIENTS****4. PHARMACEUTICAL FORM AND CONTENTS**

60 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**

|                                                                   |
|-------------------------------------------------------------------|
| <b>11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER</b> |
|-------------------------------------------------------------------|

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|                                              |
|----------------------------------------------|
| <b>12. MARKETING AUTHORISATION NUMBER(S)</b> |
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EU/1/17/1250/003

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| <b>13. BATCH NUMBER</b> |
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| <b>14. GENERAL CLASSIFICATION FOR SUPPLY</b> |
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| <b>15. INSTRUCTIONS ON USE</b> |
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| <b>16. INFORMATION IN BRAILLE</b> |
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| <b>17. UNIQUE IDENTIFIER – 2D BARCODE</b> |
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| <b>18. UNIQUE IDENTIFIER - HUMAN READABLE DATA</b> |
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## **B. PACKAGE LEAFLET**

## **Package leaflet: Information for the patient**

**Rubraca 200 mg film-coated tablets**  
**Rubraca 250 mg film-coated tablets**  
**Rubraca 300 mg film-coated tablets**  
rucaparib

▼ 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 start taking 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, pharmacist or nurse.
- 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, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. See section 4.

### **What is in this leaflet**

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

### **1. What Rubraca is and what it is used for**

#### **What Rubraca is and how it works**

Rubraca contains the active substance rucaparib. Rubraca is an anti-cancer medicine, also known as a 'PARP (poly adenosine diphosphate-ribose polymerase) inhibitor'.

Patients with changes (mutations) in genes called BRCA are at risk of developing a number of types of cancer. Rubraca blocks an enzyme that repairs damaged DNA in the cancer cells, resulting in their death.

#### **What Rubraca is used for**

Rubraca is used to treat a type of cancer of the ovary. It is used after the cancer has responded to previous chemotherapy treatments.

Rubraca can be used as maintenance therapy immediately after a course of chemotherapy that has caused the tumour to shrink.

Rubraca can also be used if your cancer has progressed after chemotherapy has been used and you have an abnormality of the BRCA gene.

If you take Rubraca because your cancer has progressed you will need to have a clinical test to identify an abnormality in the BRCA gene.

### **2. What you need to know before you take Rubraca**

#### **Do not take Rubraca**

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

If you are not sure, talk to your doctor, pharmacist or nurse before taking Rubraca.

### **Warnings and precautions**

Talk to your doctor, pharmacist or nurse before or during taking Rubraca.

#### **Blood tests**

Your doctor or nurse will perform blood tests to check your blood cell-counts:

- before treatment with Rubraca
- every month during treatment with Rubraca

This is because Rubraca can cause low blood counts of:

- red blood-cells, white blood-cells, or platelets. See section 4 for more information. The signs and symptoms of low blood cell counts include fever, infection, bruising or bleeding.
- a low blood-cell count may be a sign of a serious bone marrow problem - such as 'myelodysplastic syndrome' (MDS) or 'acute myeloid leukaemia' (AML). Your doctor may test your bone marrow to check for any problems.

Your doctor may also do weekly tests, if you have low blood cell counts for a long time. They may stop treatment with Rubraca until your blood cell counts improve.

#### **Take care in direct sunlight**

You may get sunburn more easily during treatment with Rubraca. This means you should:

- keep out of direct sunlight and not use sunbeds while you are taking Rubraca
- wear clothing that covers your head, arms and legs
- use a sunscreen and lip balm with a sun protection factor (SPF) of 50 or higher.

#### **Symptoms you should be aware of**

Talk to your doctor if you feel sick (nauseous), have been sick (vomiting) or you have had diarrhoea. These may be signs and symptoms that Rubraca is affecting your stomach.

#### **Children and adolescents**

Children under 18 years of age should not be given Rubraca, This medicine has not been studied in this age group.

#### **Other medicines and Rubraca**

Tell your doctor, pharmacist or nurse if you are taking, have recently taken, or might take any other medicines. This is because Rubraca can affect the way some other medicines work. Also some other medicines can affect the way Rubraca works.

Tell your doctor, pharmacist or nurse if you are taking any of the following medicines:

- anticoagulant medicines which helps the blood flow freely, such as warfarin
- anticonvulsant medicines used to treat fits (seizures) and epilepsy - such as phenytoin
- medicines to lower blood cholesterol levels- such as rosuvastatin
- medicines to treat stomach problems - such as cisapride, omeprazole
- medicines which suppress the immune system - such as ciclosporin, sirolimus or tacrolimus
- medicines to treat migraines and headaches - such as dihydroergotamine or ergotamine
- medicines to treat severe pain - such as alfentanil or fentanyl
- medicines used to treat uncontrolled movement or mental disorders - such as pimozide
- medicines to lower blood sugar levels and treat diabetes - such as metformin
- medicines to treat irregular heartbeats - such as digoxin or quinidine
- medicines to treat allergic reactions - such as astemizole or terfenadine
- medicines used to cause sleepiness or drowsiness - such as midazolam

- medicines used to relax muscles - such as tizanidine
- medicines used to treat asthma - such as theophylline

### **Pregnancy, breast-feeding and contraception**

If you are pregnant or breast-feeding, think you may be pregnant or are planning to have a baby, ask your doctor, nurse or pharmacist for advice before taking this medicine.

#### Pregnancy

- Rubraca is not recommended during pregnancy. This is because it may harm your unborn baby.
- For women who are able to become pregnant, a pregnancy test is recommended before starting treatment with Rubraca.

#### Breast-feeding

- Do not breast-feed during treatment with Rubraca, and for two weeks after taking the last dose. This is because it is not known if rucaparib passes into breast milk.

#### Contraception

- Women who are able to become pregnant must use effective birth control (contraception):
  - during treatment with Rubraca and
  - for 6 months after taking the last dose of Rubraca.

This is because rucaparib may affect the unborn baby.

- Talk to your doctor or pharmacist about the most effective methods of contraception.

### **Driving and using machines**

Rubraca may affect your ability to drive or use tools or machines. Take care if you feel tired or feel sick (nauseous).

### **Information on other ingredients in this medicine**

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

## **3. How to take Rubraca**

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

### **How much to take**

- The usual recommended dose is 600 mg twice a day. This means you take a total of 1,200 mg each day. If you have certain side effects your doctor may recommend a lower dose, or temporarily stop your treatment.
- Rubraca is available as either 200 mg, 250 mg or 300 mg tablets.

### **Taking this medicine**

- Take the tablets once in the morning and once in the evening, approximately 12 hours apart.
- You can take the tablets with or without food.
- If you are sick (vomit) after taking Rubraca, do not take an extra dose. Take your next dose at your regular time.

### **If you take more Rubraca than you should**

If you take more tablets than you should, tell your doctor, pharmacist or nurse straight away. You may need medical help.

### **If you forget to take Rubraca**

- If you forget to take a dose, skip the missed dose. Then take your next dose at the usual time.

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

#### **If you stop taking Rubraca**

- It is important to keep taking Rubraca every day – as long as your doctor prescribes it for you.
- Do not stop taking this medicine without talking to your doctor first.

If you have any further questions on the use of this medicine, ask your doctor, pharmacist 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 following side effects – you may need urgent medical treatment:**

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

- being short of breath, feeling tired, having pale skin, or fast heart beat - these may be signs of a low red blood cell count (anaemia)
- bleeding or bruising for longer than usual if you hurt yourself - these may be signs of a low blood platelet count (thrombocytopenia)
- fever or infection – these may be signs of a low white blood cell count (neutropenia)

Other side effects include:

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

- feeling sick (nausea)
- feeling tired
- being sick (vomiting)
- pain in the stomach
- changes in the way food tastes
- abnormal blood tests - increase in levels of liver enzymes
- loss of appetite
- diarrhoea
- abnormal blood tests - increase in blood creatinine levels
- difficulty breathing
- feeling dizzy
- sunburn
- heartburn
- rash

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

- high cholesterol levels
- indigestion
- dehydration
- itching
- allergic reaction (e.g. swelling of the face and eyes)

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

- redness, swelling, and pain on the palms of the hands and, or the soles of the feet
- red patches on the skin

#### **Reporting of side effects**

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

## 5. How to store Rubraca

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 the 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 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. Contents of the pack and other information

### What Rubraca contains

- The active substance is rucaparib.

Rubraca 200 mg film-coated tablets: Each film-coated tablet contains rucaparib camsylate corresponding to 200 mg of rucaparib.

Rubraca 250 mg film-coated tablets: Each film-coated tablet contains rucaparib camsylate corresponding to 250 mg of rucaparib.

Rubraca 300 mg film-coated tablets: Each film-coated tablet contains rucaparib camsylate corresponding to 300 mg of rucaparib.

- The other ingredients are:
  - Tablet content: Microcrystalline cellulose, sodium starch glycolate (Type A), colloidal anhydrous silica and magnesium stearate.
  - Tablet coating:
    - Rubraca 200 mg film-coated tablets  
Polyvinyl alcohol (E1203), titanium dioxide (E171), macrogol 4000 (E1521), talc (E553b), brilliant blue FCF aluminium lake (E133) and indigo carmine aluminium lake (E132).
    - Rubraca 250 mg film-coated tablets  
Polyvinyl alcohol (E1203), titanium dioxide (E171), macrogol 4000 (E1521), and talc (E553b).
    - Rubraca 300 mg film-coated tablets  
Polyvinyl alcohol (E1203), titanium dioxide (E171), macrogol 4000 (E1521), talc (E553b), and iron oxide yellow (E172).

### What Rubraca looks like and contents of the pack

- Rubraca 200 mg film-coated tablets are blue, round, film-coated tablets with “C2” marked on one side.
- Rubraca 250 mg film-coated tablets are white, diamond-shaped, film-coated tablets with “C25” marked on one side.
- Rubraca 300 mg film-coated tablets are yellow, oval, film-coated tablets with “C3” marked on one side.

Rubraca is supplied in plastic bottles. Each bottle contains 60 film-coated tablets.

**Marketing Authorisation Holder**

Clovis Oncology Ireland Ltd.  
Regus Dublin Airport  
Skybridge House - Dublin Airport  
Swords  
County Dublin  
K67 P6K2, Ireland

**Manufacturer**

Almac Pharma Services Limited  
Seagoe Industrial Estate,  
Portadown,  
Craigavon,  
BT63 5UA  
United Kingdom

or

Almac Pharma Services (Ireland) Ltd  
Finnabair Industrial Estate  
Dundalk  
County Louth  
A91 P9KD  
Ireland

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

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**France**

Clovis Oncology France SAS  
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**United Kingdom (Northern Ireland)**

Clovis Oncology Ireland Limited  
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**Ireland**

Clovis Oncology Ireland Limited  
Tel: +353 1800804285

**България, Česká republika, Danmark, Eesti, Ελλάδα, Hrvatska, Ísland, Κύπρος, Latvija, Lietuva, Luxembourg/Luxemburg, Magyarország, Malta, Norge, Polska, Portugal, România, Slovenija, Slovenská republika, Suomi/Finland, Sverige:**

Clovis Oncology Ireland Limited  
Tel: +353 16950030

**This leaflet was last revised in**

This medicine has been given ‘conditional approval’. This means that there is more evidence to come about this medicine. The European Medicines Agency will review new information on this medicine at least every year and this leaflet will be updated as necessary.

**Other sources of information**

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

