

#### 4.8 Overdose

In cases of suspected overdose symptomatic and supportive therapy should be given as appropriate, which should include ECG and blood potassium monitoring.

### 5. PHARMACOLOGICAL PROPERTIES

#### 5.1 Pharmacodynamics properties

Pharmacotherapeutic group: antimalarials, blood schizonticide.

ATC code: P01 BF01.

Pharmacodynamic effects

BGMAL comprises a fixed ratio of 1:6 parts of artemether and lumefantrine, respectively.

The site of

antiparasitic action of both components is the food vacuole of the malarial parasite, where they are

thought to interfere with the conversion of haem, a toxic intermediate produced during haemoglobin

breakdown, to the nontoxic haemozoin, malaria pigment. Lumefantrine is thought to interfere with.

the polymerisation process, while artemether generates reactive metabolites as a result of the interaction between its peroxide bridge and haem iron. Both artemether and lumefantrine have a secondary action involving inhibition of nucleic acid- and protein synthesis within the malarial parasite.

Treatment of Acute Uncomplicated *P. falciparum* Malaria

The efficacy of BGMAL Tablets was evaluated for the treatment of acute, uncomplicated malaria (defined as symptomatic *P. falciparum* malaria without signs and symptoms of severe malaria or evidence of vital organ dysfunction) in five 6-dose regimen studies and one study comparing the 6-

dose regimen with the 4-dose regimen. Baseline parasite density ranged from 500/ $\mu$ L - 200,000/ $\mu$ L

(0.01% to 4% parasitemia) in the majority of patients. Studies were conducted in otherwise healthy,

partially immune or non-immune adults and children ( $\geq$ 5kg body weight) with uncomplicated malaria in Thailand, sub-Saharan Africa, Europe, and South America.

Efficacy endpoints consisted of:

- 28-day cure rate, proportion of patients with clearance of asexual parasites within 7 days without recrudescence by day 28

- parasite clearance time (PCT), defined as time from first dose until first total and continued disappearance of asexual parasite which continues for a further 48 hours

- fever clearance time (FCT), defined as time from first dose until the first time body temperature

fell below 37.5°C and remained below 37.5°C for at least a further 48 hours (only for patients with

temperature  $>37.5^\circ\text{C}$  at baseline)

The modified intent to treat (mITT) population includes all patients with malaria diagnosis confirmation who received at least one dose of study drug. Evaluable patients generally are all patients who had a day 7 and a day 28 parasitological assessment or experienced treatment failure by

day 28. The results are presented in the table below:

**Table 2 Clinical efficacy results**

Study No.	Age	Polymerase chain reaction (PCR)-corrected 28-day cure rate <sup>1</sup> n/N (%) in evaluable patients	Median FCT <sup>2</sup> [25 <sup>th</sup> , 75 <sup>th</sup> percentile]	Median PCT <sup>2</sup> [25 <sup>th</sup> , 75 <sup>th</sup> percentile]	Year/ Study location
A025 <sup>4</sup>	3-62 years	93/96 (96.9)	n <sup>3</sup> =59 35 hours [20, 46]	n=118 44 hours [22, 47]	1996-97 Thailand
A026	2-63 years	130/133 (97.7)	n <sup>3</sup> =87 22 hours [19, 44]	NA	1997-98 Thailand
A028	12-71 years	148/154 (96.1)	n <sup>3</sup> =76 29 hours [8, 51]	n=164 29 hours [18, 40]	1998-99 Thailand
A2401	16-66 years	119/124 (96.0)	n <sup>3</sup> =100 37 hours [18, 44]	n=162 42 hours [34, 63]	2001-05 Europe, Columbia
A2403	2 months-9 years	289/299 (96.7)	n <sup>3</sup> =309 8 hours [8, 24]	n=310 24 hours [24, 36]	2002-03 3 countries in Africa
B2303 <sup>CT</sup>	3 months-12 years	403/419 (96.2)	n <sup>3</sup> =323 8 hours [8, 23]	n=452 35 hours [24, 36]	2006-07 5 countries in Africa
B2303 <sup>DT</sup>	3 months-12 years	394/416 (94.7)	n <sup>3</sup> =311 8 hours [8, 24]	n=446 34 hours [24, 36]	2006-07 5 countries in Africa

<sup>1</sup> Efficacy cure rate based on blood smear microscopy

<sup>2</sup> mITT population

<sup>3</sup> For patients who had a body temperature >37.5°C at baseline only

<sup>4</sup> Only the 6-dose regimen over 60 hours group data is presented

<sup>CT</sup> –Benart tablets administered as crushed tablets

<sup>DT</sup> –Benart Dispersible tablets

BGMAL is not indicated for, and has not been evaluated in, the treatment of malaria due to *P. vivax*, *P. malariae* or *P. ovale*, although some patients in clinical studies had co-infection with *P. falciparum* and *P. vivax* at baseline. BGMAL is active against blood stages of *Plasmodium vivax*, but is not active against hypnozoites.

Paediatric population

Two studies have been conducted

Study A2403 was conducted in Africa in 310 infants and children aged 2 months to 9 years, weighing 5 kg to 25 kg, with an axillary temperature  $\geq 37.5^\circ\text{C}$ . Results of 28-day cure rate (PCRcorrected), median parasite clearance time (PCT), and fever clearance time (FCT) are reported in table 3 below.

Study B2303 was conducted in Africa in 452 infants and children, aged 3 months to 12 years,

weighing 5 kg to <35 kg, with fever ( $\geq 37.5^{\circ}\text{C}$  axillary or  $\geq 38^{\circ}\text{C}$  rectally) or history of fever in the preceding 24 hours. This study compared crushed tablets and dispersible tablets. Results of 28-day cure rate (PCR-corrected), median parasite clearance time (PCT), and fever clearance time (FCT) for crushed tablets are reported in table 3 below.

**Table 3 Clinical efficacy by weight for pediatric studies**

Study No. Weight category	Median PCT <sup>1</sup> [25 <sup>th</sup> , 75 <sup>th</sup> percentile]	PCR-corrected 28-day cure rate <sup>2</sup> n/N (%) in evaluable patients
Study A2403		
5 - <10 kg	24 hours [24, 36]	145/149 (97.3)
10 - <15 kg	35 hours [24, 36]	103/107 (96.3)
15 -25 kg	24 hours [24, 36]	41/43 (95.3)
Study B2303 <sup>CT</sup>		
5 - <10 kg	36 hours [24, 36]	65/69 (94.2)
10 - <15 kg	35 hours [24, 36]	174/179 (97.2)
15 -<25 kg	35 hours [24, 36]	134/140 (95.7)
25-35 kg	26 hours [24, 36]	30/31 (96.8)

<sup>1</sup> mITT population

<sup>2</sup> Efficacy cure rate based on blood smear microscopy

<sup>CT</sup> BGMAL tablets administered as crushed tablets

#### **QT/QTc Prolongation:**

Adults and children with malaria

For information on the risk of QT/QTc prolongation in patients see section 4.4

Healthy adults

In a healthy adult volunteer parallel group study including a placebo and moxifloxacin control group (n=42 per group), the administration of the six dose regimen of BGMAL was associated with prolongation of QTcF. The mean changes from baseline at 68, 72, 96, and 108 hours post first dose were 7.45, 7.29, 6.12 and 6.84 msec, respectively. At 156 and 168 hours after first dose, the changes from baseline for QTcF had no difference from zero. No subject had a >30 msec increase from baseline nor an absolute increase to >500 msec. Moxifloxacin control was associated with a QTcF increase as compared to placebo for 12 hours after the single dose with a maximal change at 1 hour after dose of 14.1 msec.

In the adult/adolescent population included in clinical trials, 8 patients (0.8%) receiving BGMAL experienced a QTcB >500 msec and 3 patients (0.4%) a QTcF >500 msec. Prolongation of QTcF interval >30 msec was observed in 36% of patients.

In clinical trials conducted in children with the 6-dose regimen, no patient had post-baseline QTcF >500 msec whereas 29.4% had QTcF increase from baseline >30 msec and 5.1% >60 msec. In clinical trials conducted in adults and adolescents with the 6-dose regimen, post-baseline QTcF prolongation of >500 msec was reported in 0.2% of patients, whereas QTcF increase from baseline >30 msec was reported in 33.9% and >60 msec in 6.2% of patients.

In the infant/children population included in clinical trials, 3 patients (0.2%) experienced a QTcB >500 msec. No patient had QTcF >500 msec. Prolongation of QTcF intervals >30 msec was observed in 34% of children weighing 5-10 kg, 31% of children weighing 10-15 kg and 24% of children weighing 15-25 kg, and 32% of children weighing 25-35 kg.

## **5.2 Pharmacokinetic properties**

Pharmacokinetic characterisation of BGMAL is limited by the lack of an intravenous formulation, and the very high inter-and intra-subject variability of artemether and lumefantrine plasma concentrations and derived pharmacokinetic parameters (AUC, C<sub>max</sub>).

Absorption

Artemether is absorbed fairly rapidly and dihydroartemisinin, the active metabolite of artemether, appears rapidly in the systemic circulation with peak plasma concentrations of both compounds reached about 2 hours after dosing. Mean C<sub>max</sub> and AUC values of artemether ranged between 60.0-104 ng/mL and 146-338 ng·h/mL, respectively, in fed healthy adults after a single dose of BGMAL, 80 mg artemether/480 mg lumefantrine. Mean C<sub>max</sub> and AUC values of dihydroartemisinin ranged between 49.7-104 ng/mL and 169-308 ng·h/mL, respectively. Absorption of lumefantrine, a highly lipophilic compound, starts after a lag-time of up to 2 hours, with peak plasma concentration (mean between 5.10-9.80 µg/mL) about 6-8 hours after dosing. Mean AUC values of lumefantrine ranged between 108 and 243 µg·h/mL. Food enhances the absorption of both artemether and lumefantrine: in healthy volunteers the relative bioavailability of artemether was increased more than two-fold, and that of lumefantrine sixteen-fold compared with fasted conditions when BGMAL was taken after a high-fat meal.

Food has also been shown to increase the absorption of lumefantrine in patients with malaria, although to a lesser extent (approximately two-fold), most probably due to the lower fat content of the food ingested by acutely ill patients. The food interaction data indicate that absorption of lumefantrine under fasted conditions is very poor (assuming 100% absorption after a high-fat meal, the amount absorbed under fasted conditions would be <10% of the dose). Patients should therefore be encouraged to take the medication with a normal diet as soon as food can be tolerated.

#### Distribution

Artemether and lumefantrine are both highly bound to human serum proteins *in vitro* (95.4% and 99.7%, respectively). Dihydroartemisinin is also bound to human serum proteins (47-76%).

#### Biotransformation

Artemether is rapidly and extensively metabolised (substantial first-pass metabolism) both *in vitro* and in humans. Human liver microsomes metabolise artemether to the biologically active main metabolite dihydroartemisinin (demethylation), predominantly through the isoenzyme CYP3A4/5. This metabolite has also been detected in humans *in vivo*.

Dihydroartemisinin is further converted to inactive metabolites.

The pharmacokinetics of artemether in adults is time-dependent. During repeated administration of BGMAL, plasma artemether levels decreased significantly, while levels of the active metabolite (dihydroartemisinin) increased, although not to a statistically significant degree. The ratio of day 3/day 1 AUC for artemether was between 0.19 and 0.44, and was between 1.06 and 2.50 for dihydroartemisinin. This suggests that there was induction of the enzyme responsible for the metabolism of artemether. Artemether and dihydroartemisinin were reported to have a mild inducing effect on CYP3A4 activity. The clinical evidence of induction is consistent with the *in vitro* data described in section 4.5

Lumefantrine is N-debutylated, mainly by CYP3A4, in human liver microsomes. *In vivo* in animals (dogs and rats), glucuronidation of lumefantrine takes place directly and after oxidative biotransformation. In humans, the exposure to lumefantrine increases with repeated administration of BGMAL over the 3-day treatment period, consistent with the slow elimination of the compound (see section 5.2 Elimination). Systemic exposure to the metabolite desbutyl-lumefantrine, for which the *in vitro* antiparasitic effect is 5 to 8 fold higher than that for lumefantrine, was less than 1% of the exposure to the parent drug. Desbutyl-lumefantrine data is not available specifically for an African population. *In vitro*, lumefantrine significantly inhibits the activity of CYP2D6 at therapeutic plasma concentrations (see sections 4.3 and 4.5).

#### Elimination

Artemether and dihydroartemisinin are rapidly cleared from plasma with a terminal half-life of about 2 hours. Lumefantrine is eliminated very slowly with an elimination half-life of 2 to 6 days.

Demographic characteristics such as sex and weight appear to have no clinically relevant effects on the pharmacokinetics of BGMAL.

Limited urinary excretion data are available for humans. In 16 healthy volunteers, neither lumefantrine nor artemether was found in urine after administration of BGMAL, and only traces of dihydroartemisinin were detected (urinary excretion of dihydroartemisinin amounted to less than 0.01% of the artemether dose).

In animals (rats and dogs), no unchanged artemether was detected in faeces and urine due to its rapid and extensive first-pass metabolism, but numerous metabolites (partly identified) have been detected in faeces, bile and urine. Lumefantrine was excreted unchanged in faeces and with traces only in urine. Metabolites of lumefantrine were eliminated in bile/faeces.

#### Dose proportionality

No specific dose proportionality studies were performed. Limited data suggest a dose-proportional increase of systemic exposure to lumefantrine when doubling the BGMAL dose. No conclusive data is available for artemether.

**Bioavailability/bioequivalence studies** Systemic exposure to lumefantrine, artemether and dihydroartemisinin was similar following administration of BGMAL as dispersible tablets and crushed tablets in healthy adults.

Systemic exposure to lumefantrine was similar following administration of BGMAL dispersible tablets and intact tablets in healthy adults. However, exposure to artemether and dihydroartemisinin was significantly lower (by 20-35%) for the dispersible than for the intact tablet. These findings are not considered to be clinically relevant for the use of the dispersible tablets in the paediatric population since adequate efficacy of BGMAL dispersible tablets was demonstrated in this population. The dispersible tablet is not recommended for use in adults.

#### Older people

No specific pharmacokinetic studies have been performed in elderly patients. However, there is no information suggesting that the dosage in patients over 65 years of age should be different than in younger adults.

#### Paediatric population

In paediatric malaria patients, mean C<sub>max</sub> (CV%) of artemether (observed after first dose of BGMAL) were 223 (139%), 198 (90%) and 174 ng/mL (83%) for body weight groups 5-<15, 15-<25 and 25-<35 kg, respectively, compared to 186 ng/mL (67%) in adult malaria patients. The associated mean C<sub>max</sub> of DHA were 54.7 (108%), 79.8 (101%) and 65.3 ng/mL (36%), respectively compared to 101 ng/mL (57%) in adult malaria patients. AUC of lumefantrine (population mean, covering the six doses of BGMAL) were 577, 699 and 1150 µg•h/mL for paediatric malaria patients in body weight groups 5-<15, 15-<25 and 25-<35 kg, respectively, compared to a mean AUC of 758 µg•h/mL (87%) in adult malaria patients. The elimination half-lives of artemether and lumefantrine in children are unknown.

#### Hepatic and Renal impairment

No specific pharmacokinetic studies have been performed either in patients with hepatic or renal insufficiency or elderly patients. The primary clearance mechanism of both artemether and lumefantrine may be affected in patients with hepatic impairment. In patients with severe hepatic impairment, a clinically significant increase of exposure to artemether and lumefantrine and/or their metabolites cannot be ruled out. Therefore caution should be exercised in dosing patients with severe hepatic impairment. Based on the pharmacokinetic data in 16 healthy subjects showing no or insignificant renal excretion of lumefantrine, artemether and dihydroartemisinin, no dose adjustment for the use of BGMAL in patients with renal impairment is advised.

### 5.3 Pre-clinical Safety:

#### General toxicity

The main changes observed in repeat-dose toxicity studies were associated with the expected pharmacological action on erythrocytes, accompanied by responsive secondary haematopoiesis.

#### Neurotoxicity

Studies in dogs and rats have shown that intramuscular injections of artemether resulted in brain lesions. Changes observed mainly in brainstem nuclei included chromatolysis, eosinophilic cytoplasmic granulation, spheroids, apoptosis and dark neurons. Lesions were observed in rats dosed for at least 7 days and dogs for at least 8 days, but lesions were not observed after shorter intramuscular treatment courses or after oral dosing. The estimated artemether 24 h AUC after 7 days of dosing at the no observed effect level is approximately 7-fold greater or more than the estimated artemether 24 h AUC in humans. The hearing threshold was affected at 20 dB by oral

artemether administration to dogs at a dose of about 29 times the highest artemether clinical dose (160 mg/day) based on body surface area comparisons. Most nervous system disorder adverse events in the studies of the 6-dose regimen were mild in intensity and resolved by the end of the study.

#### Mutagenicity

Artemether and lumefantrine were not genotoxic/clastogenic based on *in vitro* and *in vivo* testing.

#### Carcinogenicity

Carcinogenicity studies were not conducted.

#### Reproductive toxicity studies

Embryotoxicity was observed in rat and rabbit reproductive toxicity studies conducted with artemether, a derivative of artemisinin. Artemisinins are known to be embryotoxic. Lumefantrine alone caused no sign of reproductive or development toxicity at doses up to 1,000 mg/kg/day in rats and rabbits, doses which are at least 10 times higher than the daily human dose based on body surface area comparisons.

Reproductive toxicity studies performed with the artemether:lumefantrine combination caused maternal toxicity and increased post-implantation loss in rats and rabbits.

Artemether caused increases in post-implantation loss and teratogenicity (characterised as a low incidence of cardiovascular and skeletal malformations) in rats and rabbits. The embryotoxic artemether dose in the rat yields artemether and dihydroartemisinin exposures similar to those achieved in humans based on AUC.

#### Fertility

Artemether-lumefantrine administration yielded altered sperm motility, abnormal sperm, reduced epididymal sperm count, increased testes weight, and embryotoxicity; other reproductive effects (decreased implants and viable embryos, increased preimplantation loss) were also observed. The no adverse effect level for fertility was 300 mg/kg/day. The relevance to this finding in humans is unknown.

#### Juvenile toxicity studies

A study investigated the neurotoxicity of oral artemether in juvenile rats. Mortality, clinical signs and reductions in body weight parameters occurred most notably in younger rats. Despite the systemic toxicity noted, there were no effects of artemether on any of the functional tests performed and there was no evidence of a direct neurotoxic effect in juvenile rats.

Very young animals are more sensitive to the toxic effect of artemether than adult animals. There is no difference in sensitivity in slightly older animals compared to adult animals. Clinical studies have established the safety of artemether and lumefantrine administration in patients weighing 5 kg and above.

#### Cardiovascular Safety Pharmacology

In toxicity studies in dogs at doses  $\geq 600$  mg/kg/day, there was some evidence of prolongation of the QTc interval (safety margin of 1.3-fold to 2.2-fold for artemether using calculated free C<sub>max</sub>), at higher doses than intended for use in man. *In vitro* hERG assays showed a safety margin of  $>100$  for artemether and dihydroartemisinin. The hERG IC<sub>50</sub> was 8.1  $\mu$ M for lumefantrine and 5.5  $\mu$ M for its desbutyl metabolite. Based on the available non-clinical data, a potential for QTc prolongation in the human cannot be

discounted. For effects in the human see sections 4.3, 4.4 and 5.1.

## 6. PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

Polysorbate 80, Kyron T-134, PVP K 30, microcrystalline cellulose, Colloidal Silicon Dioxide and magnesium stearate.

### 6.2 Incompatibilities

Not Applicable

**6.3 Shelflife**

36 months from the date of manufacturing

**6.4 Special precautions for storage**

Store below 30° C.

Store in the original package to protect from moisture.

**6.5 Nature and contents of container <and special equipment for use, administration or implantation>**

Alu- Golden PVC Blister of 1 X 24 Tablets

**6.6 Special precautions for disposal <and other handling>**

No special requirements

**7. <APPLICANT/MANUFACTURER>**

BG PHARMA AND HEALTHCARE LIMITED

859 Gudu District, Opp Apo Legislative quarters, Abuja Nigeria