

Regulatory Affairs

**FEMARA<sup>®</sup>**

**(letrozole)**

2.5 mg film-coated tablets

**Summary of Product Characteristics (SmPC)**

## **Femara®**

Non-steroidal aromatase inhibitor (inhibitor of estrogen biosynthesis); antineoplastic agent.

### **DESCRIPTION AND COMPOSITION**

#### **Pharmaceutical form**

Film-coated tablets.

Coated tablet, dark yellow, round, slightly biconvex with bevelled edges. One side bears the imprint "FV", the other "CG".

#### **Active substance**

4,4'-[(1H-1,2,4-triazol-1-yl)-methylene]bis-benzonitrile (INN/USAN= letrozole).

Each film-coated tablet contains 2.5 mg letrozole.

#### **Excipients**

Colloidal anhydrous silica, microcrystalline cellulose, lactose monohydrate, magnesium stearate, maize starch, sodium starch glycolate, hydroxypropyl methylcellulose, polyethylene glycol 8000, talc, titanium dioxide (E 171), iron oxide yellow (E 172).

Pharmaceutical formulations may vary between countries.

### **INDICATIONS**

Letrozole is not indicated in hormone receptor negative disease.

Letrozole is indicated in:

- Adjuvant treatment of postmenopausal women with hormone receptor positive invasive early breast cancer.
- Extended adjuvant treatment of invasive early breast cancer in post menopausal women who have received prior standard adjuvant tamoxifen therapy for five years.
- First-line treatment in postmenopausal women with hormone-dependent advanced breast cancer.
- Advanced breast cancer after relapse or disease progression, in women with natural or artificially induced postmenopausal endocrine status, who have previously been treated with anti-estrogens.
- Neo-adjuvant treatment of postmenopausal women with hormone receptor positive, HER-2 negative breast cancer where chemotherapy is not suitable and immediate surgery not indicated.

## **DOSAGE REGIMEN AND ADMINISTRATION**

### **Dosage regimen**

#### **General target population**

##### **Adults**

The recommended dose of Femara is 2.5 mg once daily. In the adjuvant and extended adjuvant setting, treatment with Femara should continue for 5 years or until disease relapse/recurrence occurs, whichever comes first. In the large pivotal study of letrozole versus tamoxifen in the adjuvant setting, no benefit in efficacy or safety was obtained by sequential administration of these treatments compared with letrozole administered continuously for 5 years. In patients with metastatic disease, treatment with Femara should continue until tumor progression is evident. In the neoadjuvant (pre-operative) setting, treatment with Femara should be continued for 4 to 8 months in order to establish optimal tumor reduction. If the response is not adequate, treatment with Femara should be discontinued, surgery scheduled and/or further treatment options discussed with the patient.

##### **Special populations**

###### **Hepatic impairment**

No dose adjustment of Femara is required for patients with mild to moderate hepatic insufficiency (Child-Pugh score A or B). Insufficient data are available for patients with severe hepatic impairment, but patients with severe hepatic impairment (Child-Pugh score C) should be kept under close supervision (see sections WARNINGS AND PRECAUTIONS and CLINICAL PHARMACOLOGY - Pharmacokinetics).

###### **Renal impairment**

No dosage adjustment of Femara is required for patients with renal insufficiency with creatinine clearance (CL<sub>cr</sub>) ≥10 mL/min. Insufficient data are available in cases of renal insufficiency with CL<sub>cr</sub> <10 mL/min (see sections WARNINGS AND PRECAUTIONS and CLINICAL PHARMACOLOGY - Pharmacokinetics).

###### **Pediatric patients**

Femara is not recommended for use in children and adolescents. The safety and efficacy of Femara in children and adolescents aged up to 17 years have not been established. Limited data are available and no recommendation on a posology can be made.

###### **Geriatric patients (65 years of age or older)**

No dose adjustment is required for elderly patients.

### **Method of administration**

Femara should be taken orally and can be taken with or without food because food has no effect on the extent of absorption.

### **Missed dose**

The missed dose should be taken as soon as the patient remembers. However, if it is almost time for the next dose, the missed dose should be skipped, and the patient should go back to her regular dosage schedule. Doses should not be doubled because with daily doses over the 2.5 mg recommended dose, over-proportionality in systemic exposure was observed (see section CLINICAL PHARMACOLOGY).

### **CONTRAINDICATIONS**

- Known hypersensitivity to the active substance or to any of the excipients.
- Premenopausal endocrine status; pregnancy, lactation (see sections PREGNANCY, LACTATION, FEMALES AND MALES OF REPRODUCTIVE POTENTIAL).

### **WARNINGS AND PRECAUTIONS**

#### **Renal impairment**

Femara has not been investigated in patients with creatinine clearance <10 mL/min. The potential risk/benefit to such patients should be carefully considered before administration of Femara.

#### **Hepatic impairment**

In patients with severe hepatic impairment (Child-Pugh score C), systemic exposure and terminal half-life were approximately doubled compared to healthy volunteers. Such patients should therefore be kept under close supervision (see section CLINICAL PHARMACOLOGY - Pharmacokinetics).

#### **Bone effects**

Osteoporosis and/or bone fractures have been reported with the use of Femara. Therefore monitoring of overall bone health is recommended during treatment (see sections ADVERSE DRUG REACTIONS and CLINICAL PHARMACOLOGY - Pharmacodynamics).

#### **Menopausal status**

In patients whose menopausal status is unclear, luteinising hormone (LH), follicle-stimulating hormone (FSH) and/or estradiol levels should be measured before initiating treatment with Femara. Only women of confirmed postmenopausal endocrine status should receive Femara.

## Fertility

The pharmacological action of letrozole is to reduce estrogen production by aromatase inhibition. In premenopausal women, the inhibition of estrogen synthesis leads to feedback increases in gonadotropin (LH, FSH) levels. Increased FSH levels in turn stimulate follicular growth, and can induce ovulation.

## Interactions

Co-administration of Femara with tamoxifen, other anti-estrogens or estrogen-containing therapies should be avoided as these substances may diminish the pharmacological action of letrozole. The mechanism of this interaction is unknown (see section INTERACTIONS).

## Driving and using machines

Since fatigue and dizziness have been observed with the use of Femara and somnolence has been reported uncommonly, caution is advised when driving or using machines.

## ADVERSE DRUG REACTIONS

### Summary of the safety profile

Femara was generally well tolerated across all studies as first-line and second-line treatment for advanced breast cancer, as adjuvant treatment of early breast cancer and as extended adjuvant treatment in women who have received prior standard adjuvant therapy with tamoxifen. Approximately one third of the patients treated with Femara in the metastatic and neoadjuvant settings, approximately 81% of the patients in the adjuvant setting (in both Femara and tamoxifen arms), at a median treatment duration of 60 months, and approximately 80% of the patients in the extended adjuvant setting (both Femara and placebo arms, at a median treatment duration of 60 months) experienced adverse reactions. Generally, the observed adverse reactions are mild or moderate in nature, and many are associated with estrogen deprivation.

The most frequently reported adverse reactions in the clinical studies were hot flushes, arthralgia, nausea and fatigue. Many adverse reactions can be attributed to the normal pharmacological consequences of estrogen deprivation (e.g. hot flushes, alopecia and vaginal bleeding). The following adverse drug reactions, listed in Table 1, were reported from clinical studies and from post marketing experience with Femara.

**Table 1**                    **Tabulated summary of adverse drug reactions from clinical trials and from post marketing experience with Femara**

Adverse reactions are ranked under headings of frequency, the most frequent first, using the following convention: very common  $\geq 10\%$ , common  $\geq 1\%$  to  $< 10\%$ , uncommon  $\geq 0.1\%$  to  $< 1\%$ , rare  $\geq 0.01\%$  to  $< 0.1\%$ , very rare  $< 0.01\%$ , not known (cannot be estimated from the available data).

**Table 1 Adverse drug reactions**

<b>Infections and infestations</b>	
Uncommon	Urinary tract infection
<b>Neoplasms benign, malignant and unspecified (including cysts and polyps)</b>	
Uncommon	Tumor pain <sup>1</sup>
<b>Blood and the lymphatic system disorders</b>	
Uncommon	Leukopenia
<b>Immune system disorders</b>	
Not known	Anaphylactic reaction
<b>Metabolism and nutrition disorders</b>	
Very common	Hypercholesterolemia
Common	Decreased appetite, increased appetite
<b>Psychiatric disorders</b>	
Common	Depression
Uncommon	Anxiety (including nervousness), irritability
<b>Nervous system disorders</b>	
Common	Headache, dizziness, vertigo
Uncommon	Somnolence, insomnia, memory impairment, dysaesthesia (including paraesthesia, hypoaesthesia), dysgeusia, cerebrovascular accident, carpal tunnel syndrome
<b>Eye disorders</b>	
Uncommon	Cataract, eye irritation, blurred vision
<b>Cardiac disorders</b>	
Common	Palpitations
Uncommon	, Tachycardia, ischemic cardiac events (including new or worsening angina, angina requiring surgery, myocardial infarction and myocardial ischemia)
<b>Vascular disorders</b>	
Very common	Hot flush
Common	Hypertension
Uncommon	Thrombophlebitis (including superficial and deep vein thrombophlebitis)
Rare	Pulmonary embolism, arterial thrombosis, cerebral infarction
<b>Respiratory, thoracic and mediastinal disorders</b>	
Uncommon	Dyspnoea, cough
<b>Gastrointestinal disorders</b>	
Common	Nausea, vomiting, dyspepsia, constipation, diarrhoea, abdominal pain
Uncommon	Stomatitis, dry mouth
<b>Hepatobiliary disorders</b>	
Uncommon	Increased hepatic enzymes, hyperbilirubinaemia, jaundice
Very rare	Hepatitis
<b>Skin and subcutaneous tissue disorders</b>	
Very common	Hyperhidrosis

Common	Alopecia, dry skin, rash (including erythematous, maculopapular, psoriaform, and vesicular rash)
Uncommon	Pruritus, urticaria
Not known	Angioedema, toxic epidermal necrolysis, erythema multiforme
<b>Musculoskeletal and connective tissue disorders</b>	
Very common	Arthralgia
Common	Myalgia, bone pain, osteoporosis, bone fractures, arthritis, back pain
Not known	Trigger finger
<b>Renal and urinary disorders</b>	
Uncommon	Pollakiuria
<b>Reproductive system and breast disorders</b>	
Common	Vaginal haemorrhage
Uncommon	Vaginal discharge, vulvovaginal dryness, breast pain
<b>General disorders and administration site conditions</b>	
Very common	Fatigue (including asthenia, malaise)
Common	Peripheral oedema, chest pain
Uncommon	General oedema, pyrexia, mucosal dryness, thirst
<b>Investigations</b>	
Common	Weight increased
Uncommon	Weight decreased
<b>Injury, poisoning and procedural complications</b>	
Common <sup>2</sup>	Fall <sup>3</sup>

<sup>1</sup> Adverse drug reactions reported only in the metastatic setting

<sup>2</sup> Frequency determined based on FACE Study data

<sup>3</sup> In some cases fall was reported as a consequence of other adverse events such as dizziness and vertigo

## Description of selected adverse drug reactions

### *Cardiac adverse reactions*

In the adjuvant setting, in addition to the data presented in Table 6, the following adverse events were reported for Femara and tamoxifen, respectively (median treatment duration of 5 years): angina requiring surgery (1.0% vs. 1.0%); cardiac failure (1.1% vs. 0.6%); hypertension (5.6% vs. 5.7%); cerebrovascular accident/transient ischaemic attack (2.1% vs. 1.9%).

In the extended adjuvant setting for Femara (median duration of treatment 5 years) and placebo (median duration of treatment 3 years), respectively: angina requiring surgery (0.8% vs. 0.6%); new or worsening angina (1.4% vs. 1.0%); myocardial infarction (1.0% vs. 0.7%); thromboembolic event\* (0.9% vs. 0.3%); stroke/transient ischaemic attack\* (1.5% vs. 0.8%) were reported.

Events marked \* were statistically significantly different in the two treatment arms.

### ***Skeletal adverse reactions***

For skeletal safety data from the adjuvant setting, please refer to Table 6.

In the extended adjuvant setting, significantly more patients treated with Femara experienced bone fractures or osteoporosis (bone fractures, 10.4% and osteoporosis, 12.2%) than patients in the placebo arm (5.8% and 6.4%, respectively). Median duration of treatment was 5 years for Femara, compared with 3 years for placebo.

## **INTERACTIONS**

Letrozole is mainly metabolized in the liver and the cytochrome P450 enzymes CYP3A4 and CYP2A6 mediate the metabolic clearance of letrozole. Therefore, the systemic elimination of letrozole may be influenced by drugs known to affect the CYP3A4 and CYP2A6. The metabolism of letrozole appears to have a low affinity for CYP3A4 because the enzyme could not be saturated at concentrations more than 150 fold higher than those observed in plasma for letrozole at steady-state in the typical clinical situation.

### **Drugs that may increase Letrozole serum concentrations**

Inhibitors of CYP3A4 and CYP2A6 activities could decrease the metabolism of letrozole and thereby increase plasma concentrations of letrozole. The concomitant administration of medications that strongly inhibit these enzymes (strong CYP3A4 inhibitors: including but not limited to ketoconazole, itraconazole, voriconazole, ritonavir, clarithromycin, and telithromycin; CYP2A6 (e.g. methoxsalen) may increase exposure to letrozole. Therefore caution is recommended in patients for whom strong CYP3A4 and CYP2A6 inhibitors are administered.

### **Drugs that may decrease Letrozole serum concentrations**

Inducers of CYP3A4 activity could increase the metabolism of letrozole and thereby decrease plasma concentrations of letrozole. The concomitant administration of medications that induce CYP3A4 (e.g. phenytoin, rifampicin, carbamazepine, phenobarbital, and St. John's Wort) may reduce exposure to letrozole. Therefore caution is recommended in patients for whom strong CYP3A4 inducers are administered. No drug inducer is known for CYP2A6.

Co-administration of Femara (2.5mg) and tamoxifen 20 mg daily resulted in a reduction of letrozole plasma levels by 38% on average. Clinical experience in the second-line breast cancer trials indicates that neither the therapeutic effect of Femara therapy nor the occurrence of adverse reactions is increased if Femara is administered immediately after tamoxifen. The mechanism of this interaction is unknown.

### **Drugs that may have their systemic serum concentrations altered by Letrozole**

*In vitro*, letrozole inhibits the cytochrome P450 isoenzymes CYP2A6 and, moderately, CYP2C19, but the clinical relevance is unknown. Caution is therefore indicated when giving letrozole concomitantly with medicinal products whose elimination is mainly dependent on CYP2C19 and whose therapeutic index is narrow (e.g. phenytoin, clopidogrel). No substrate with a narrow therapeutic index is known for CYP2A6.



Clinical interaction studies with cimetidine (a known non-specific inhibitor of CYP2C19 and CYP3A4 and warfarin (sensitive substrate for CYP2C9 with a narrow therapeutic window and commonly used as co-medication in the target population of letrozole) indicated that the coadministration of Femara with these drugs does not result in clinically significant drug interactions.

A review of the clinical trial database indicated no evidence of other clinically relevant interaction with other commonly prescribed drugs.

## **Pregnancy, lactation, females and males of reproductive potential**

### **Pregnancy**

Femara is contraindicated during pregnancy (see section CONTRAINDICATIONS). There are post-marketing reports of spontaneous abortions and congenital anomalies in infants of mothers who took Femara (see section WARNINGS AND PRECAUTIONS) during pregnancy.

Isolated cases of birth defects (labial fusion, ambiguous genitalia) have been reported in infants born to pregnant women exposed to off label use (infertility treatment, ovulation induction) of Femara .

### **Lactation**

Femara is contraindicated during lactation (see section CONTRAINDICATIONS).

### **Females and males of reproductive potential**

The physician needs to discuss the necessity of adequate contraception with women who have the potential to become pregnant including women who are perimenopausal or who recently became postmenopausal, until their postmenopausal status is fully established.

## **OVERDOSAGE**

Isolated cases of overdosage with Femara have been reported.

No specific treatment for overdosage is known; treatment should be symptomatic and supportive.

## **CLINICAL PHARMACOLOGY**

### **Mechanism of action (MOA)**

The elimination of estrogen-mediated stimulatory effects is a prerequisite for tumor response in cases where the growth of tumor tissue depends on the presence of estrogens. In postmenopausal women, estrogens are mainly derived from the action of the aromatase enzyme, which converts adrenal androgens - primarily androstenedione and testosterone - to

estrone (E1) and estradiol (E2). The suppression of estrogen biosynthesis in peripheral tissues and the cancer tissue itself can therefore be achieved by specifically inhibiting the aromatase enzyme.

Letrozole is a non-steroidal aromatase inhibitor. It inhibits the aromatase enzyme by competitively binding to the hem of the cytochrome P<sub>450</sub> subunit of the enzyme, resulting in a reduction of estrogen biosynthesis in all tissues.

## Pharmacodynamics

In healthy postmenopausal women, single doses of 0.1 mg, 0.5 mg and 2.5 mg letrozole suppress serum estrone and estradiol by 75 to 78% and 78% from baseline, respectively. Maximum suppression is achieved in 48 to 78 hours.

In postmenopausal patients with advanced breast cancer, daily doses of 0.1 to 5 mg suppress plasma concentration of estradiol, estrone, and estrone sulphate by 75 to 95% from baseline in all patients treated. With doses of 0.5 mg and higher, many values of estrone and estrone sulphate are below the limit of detection in the assays, indicating that higher estrogen suppression is achieved with these doses. Estrogen suppression was maintained throughout treatment in all these patients.

Letrozole is highly specific in inhibiting aromatase activity. Impairment of adrenal steroidogenesis has not been observed. No clinically relevant changes were found in the plasma concentrations of cortisol, aldosterone, 11-deoxycortisol, 17-hydroxy-progesterone, and ACTH, or in plasma renin activity among postmenopausal patients treated with a daily dose of letrozole 0.1 to 5 mg. The ACTH stimulation test performed after 6 and 12 weeks of treatment with daily doses of 0.1 mg, 0.25 mg, 0.5 mg, 1 mg, 2.5 mg, and 5 mg did not indicate any attenuation of aldosterone or cortisol production. Thus, glucocorticoid and mineralocorticoid supplementation is not necessary.

No changes were noted in plasma concentrations of androgens (androstenedione and testosterone) among healthy postmenopausal women after 0.1 mg, 0.5 mg, and 2.5 mg single doses of letrozole or in plasma concentrations of androstenedione among postmenopausal patients treated with daily doses of 0.1 to 5 mg, indicating that the blockade of estrogen biosynthesis does not lead to accumulation of androgenic precursors. Plasma levels of LH and FSH are not affected by letrozole in patients, nor is thyroid function as evaluated by TSH, T4 and T3 uptake.

## Pharmacokinetics

### Absorption

Letrozole is rapidly and completely absorbed from the gastrointestinal tract (mean absolute bioavailability: 99.9%). Food slightly decreases the rate of absorption (median  $t_{max}$ : 1 hour fasted versus 2 hours fed; and mean  $C_{max}$ :  $129 \pm 20.3$  nmol/L fasted versus  $98.7 \pm 18.6$  nmol/L fed), but the extent of absorption (AUC) is not changed. The minor effect on the absorption rate is not considered to be of clinical relevance, and therefore letrozole may be taken without regard to meal times.

## Distribution

Plasma protein binding of letrozole is approximately 60%, mainly to albumin (55%). The concentration of letrozole in erythrocytes is about 80% of that in plasma. After administration of 2.5 mg <sup>14</sup>C-labelled letrozole, approximately 82% of the radioactivity in plasma was unchanged compound. Systemic exposure to metabolites is therefore low. Letrozole is rapidly and extensively distributed to tissues. Its apparent volume of distribution at steady state is about  $1.87 \pm 0.47$  L/kg.

## Biotransformation/metabolism

Metabolic clearance to a pharmacologically inactive carbinol metabolite is the major elimination pathway of letrozole ( $CL_m = 2.1$  L/h), but is relatively slow when compared to hepatic blood flow (about 90 L/h). The cytochrome P<sub>450</sub> isoenzymes 3A4 and 2A6 were found to be capable of converting letrozole to this metabolite. Formation of minor unidentified metabolites, and direct renal and faecal excretion play only a minor role in the overall elimination of letrozole. Within 2 weeks after administration of 2.5 mg <sup>14</sup>C-labelled letrozole to healthy postmenopausal volunteers,  $88.2 \pm 7.6\%$  of the radioactivity was recovered in urine and  $3.8 \pm 0.9\%$  in faeces. At least 75% of the radioactivity recovered in urine up to 216 hours ( $84.7 \pm 7.8\%$  of the dose) was attributed to the glucuronide of the carbinol metabolite, about 9% to two unidentified metabolites, and 6% to unchanged letrozole.

## Elimination

The apparent terminal elimination half-life in plasma is between about 2 to 4 days. After daily administration of 2.5 mg, steady-state levels are reached within 2 to 6 weeks. Plasma concentrations at steady state are approximately 7 times higher than concentrations measured after a single dose of 2.5 mg, while they are 1.5 to 2 times higher than the steady-state values predicted from the concentrations measured after a single dose, indicating a slight non-linearity in the pharmacokinetics of letrozole upon daily administration of 2.5 mg. Since steady-state levels are maintained over time, it can be concluded that no continuous accumulation of letrozole occurs.

## Linearity/non-linearity

The pharmacokinetics of letrozole were dose proportional after single oral doses up to 10 mg (dose range: 0.01 to 30 mg) and after daily doses up to 1.0 mg (dose range: 0.1 to 5mg). After a 30 mg single oral dose there was a slightly dose over-proportional increase in AUC value. With daily doses of 2.5 and 5 mg the AUC values increased about 3.8 and 12 fold instead of 2.5 and 5 fold, respectively, when compared to the 1.0 mg/day dose. The recommended dose of 2.5 mg/day may thus be a borderline dose at which an onset of over-proportionality becomes apparent, whereas at 5 mg/day the over-proportionality is more pronounced. The dose over-proportionality is likely to be the result of a saturation of metabolic elimination processes. Steady levels were reached after 1 to 2 months at all dosage regimens tested (0.1- 5.0 mg daily).

## Special populations

### Elderly

Age had no effect on the pharmacokinetics of letrozole.

### Renal Impairment

In a study involving 16 postmenopausal volunteers with varying degrees of renal function (24-hour creatinine clearance 9 to 116 mL/min), no effect on the pharmacokinetics systemic exposure of letrozole was found after a single dose of 2.5 mg. In addition to the above study assessing the influence of renal impairment on letrozole, a covariate analysis was performed on the data of two pivotal studies (Study AR/BC2 and Study AR/BC3). Calculated creatinine clearance (CL<sub>cr</sub>) [Study AR/BC2 range: 19 to 187 mL/min; Study AR/BC3 range: 10 to 180 mL/min] showed no statistically significant association between letrozole plasma trough levels at steady-state (C<sub>min</sub>). Furthermore, data of Study AR/BC2 and Study AR/BC3 in second-line metastatic breast cancer showed no evidence of an adverse effect of letrozole on CL<sub>cr</sub> or an impairment of renal function.

Therefore, no dose adjustment is required for patients with renal impairment (CL<sub>cr</sub> ≥10 mL/min). Little information is available in patients with severe impairment of renal function (CL<sub>cr</sub> <10 mL/min).

### Hepatic Impairment

In a similar study involving subjects with varying degrees of hepatic function, the mean AUC values of the volunteers with moderate hepatic impairment (Child-Pugh score B) was 37% higher than in normal subjects, but still within the range seen in subjects without impaired function. In a study comparing the pharmacokinetics of letrozole after a single oral dose in eight subjects with liver cirrhosis and severe hepatic impairment (Child-Pugh score C) to those in healthy volunteers (n=8), AUC and t<sub>1/2</sub> increased by 95 and 187%, respectively. Breast-cancer patients with severe hepatic impairment are thus expected to be exposed to higher levels of letrozole than patients without severe hepatic dysfunction. However, since in patients dosed at 5 or 10 mg/day no increase in toxicity was observed, a dose reduction in patients with severe hepatic impairment appears not to be warranted, although such patients should be kept under close supervision. In addition, in two well-controlled studies involving 359 patients with advanced breast cancer, no effect of renal impairment (calculated creatinine clearance: 20 to 50 mL/min) or hepatic dysfunction was found on the letrozole concentration.

## CLINICAL STUDIES

### Adjuvant treatment

#### *Study BIG 1-98 (CFEM345 0019)*

BIG 1-98 was a multicenter, double-blind study in which over 8,000 postmenopausal women with hormone receptor-positive early breast cancer were randomized to one of the following

treatments: A. tamoxifen for 5 years; B. Femara for 5 years; C. tamoxifen for 2 years followed by Femara for 3 years; D. Femara for 2 years followed by tamoxifen for 3 years.

The primary endpoint was disease-free survival (DFS); secondary efficacy endpoints were time to distant metastasis (TDM), distant disease-free survival (DDFS), overall survival (OS), systemic disease-free survival (SDFS), invasive contralateral breast cancer and time to breast cancer recurrence.

### ***Efficacy results at a median follow-up of 26 and 60 months***

Data in Table 2 reflect the results of the Primary Core Analysis based on data from the monotherapy arms (A and B) and from the two switching arms (C and D) at a median treatment duration of 24 months and a median follow-up of 26 months and at a median treatment duration of 32 months and a median follow-up of 60 months.

The 5-year DFS rates were 84% for Femara and 81.4% for tamoxifen.

**Table 2**      **Primary Core Analysis: Disease-free and overall survival, at a median follow-up of 26 months and at median follow-up of 60 months (ITT population)**

	Primary Core Analysis					
	Median follow-up 26 months			Median follow-up 60 months		
	Femara N=4003	Tamoxifen N=4007	HR <sup>1</sup> (95% CI) <i>p</i>	Femara N=4003	Tamoxifen N=4007	HR <sup>1</sup> (95% CI) <i>p</i>
Disease-free survival events <sup>2</sup>	351	428	0.81 (0.70, 0.93) 0.003	585	664	0.86 (0.77, 0.96) 0.008
Overall survival <sup>3</sup>	166	192	0.86 (0.70, 1.06)	330	374	0.87 (0.75, 1.01)

HR = Hazard ratio; CI = Confidence interval

<sup>1</sup> Log rank test, stratified by randomisation option and use of chemotherapy (yes/no)

<sup>2</sup> DFS events: loco-regional recurrence, distant metastasis, invasive contralateral breast cancer, second (non-breast) primary malignancy, death from any cause without a prior cancer event.

<sup>3</sup> Number of deaths

### ***Results at a median follow-up of 96 months (monotherapy arms only)***

The Monotherapy Arms Analysis long-term update of the efficacy of Femara monotherapy compared to tamoxifen monotherapy (median duration of adjuvant treatment: 5 years) is presented in Table 3.

**Table 3**      **Monotherapy Arms Analysis: Disease-free and overall survival at a median follow-up of 96 months (ITT population)**

	Femara N=2463	Tamoxifen N=2459	Hazard Ratio <sup>1</sup> (95% CI)	P Value
Disease-free survival events <sup>2</sup>	626	698	0.87 (0.78, 0.97)	0.01
Time to distant metastasis	301	342	0.86 (0.74, 1.01)	0.06
Overall survival <sup>3</sup>	393	436	0.89 (0.77, 1.02)	0.08
Censored analysis of DFS <sup>4</sup>	626	649	0.83 (0.74, 0.92)	
Censored analysis of OS <sup>4</sup>	393	419	0.81 (0.70, 0.93)	

<sup>1</sup> Log rank test, stratified by randomization option and use of chemotherapy (yes/no)

<sup>2</sup> DFS events: loco-regional recurrence, distant metastasis, invasive contralateral breast cancer, second (non-breast) primary malignancy, death from any cause without a prior cancer event.

<sup>3</sup> Number of deaths<sup>4</sup>      Observations in the tamoxifen arm censored at the date of selectively switching to letrozole after tamoxifen arm was unblinded

### Sequential Treatments Analysis

The Sequential Treatments Analysis (STA) addresses the second primary question of BIG 1-98, namely whether sequencing of tamoxifen and letrozole would be superior to monotherapy. There were no significant differences in DFS, OS, SDFS, or DDFS from switch with respect to monotherapy (Table 4).

**Table 4**      **Sequential treatments analysis of disease-free survival with letrozole as initial endocrine agent (STA switch population)**

	N	Number of events <sup>1</sup>	Hazard ratio <sup>2</sup>	(97.5% confidence interval)	Cox model P-value
[Letrozole→]Tamoxifen	1,460	254	1.03	(0.84, 1.26)	0.72
Letrozole	1,463	249			

<sup>1</sup> Protocol definition, including second non-breast primary malignancies, after switch / beyond two years

<sup>2</sup> Adjusted by chemotherapy use

There were no significant differences in DFS, OS, SDFS or DDFS in any of the STA from randomization pairwise comparisons (Table 5).

**Table 5 Sequential Treatments Analyses from randomization (STA-R) of disease-free survival (ITT STA-R population)**

	Letrozole → Tamoxifen	Letrozole
Number of patients	1,540	1,546
Number of patients with DFS events (protocol definition)	330	319
Hazard ratio <sup>1</sup> (99% CI)	1.04 (0.85, 1.27)	
	Letrozole → Tamoxifen	Tamoxifen <sup>2</sup>
Number of patients	1,540	1,548
Number of patients with DFS events (protocol definition)	330	353
Hazard ratio <sup>1</sup> (99% CI)	0.92 (0.75, 1.12)	

<sup>1</sup> Adjusted by chemotherapy use (yes/no)

<sup>2</sup> 626 (40%) patients selectively crossed to letrozole after tamoxifen arm unblinded in 2005

The following tables 6 and table 7 provide information on significant differences in Femara versus tamoxifen monotherapy and in the Femara-tamoxifen sequential treatment therapy:

**Table 6 Adjuvant Femara monotherapy versus tamoxifen monotherapy – adverse events with significant differences**

	Femara N=2448		Tamoxifen N=2447	
	During treatment (median 5 years)	Any time after randomization (median 96 months)	During treatment (median 5 years)	Any time after randomization (median 96 months)
Bone fracture	10.2%	14.7%	7.2%	11.4%
Osteoporosis	5.1%	5.1%	2.7%	2.7%
Thromboembolic events	2.1%	3.2%	3.6%	4.6%
Myocardial infarction	1.0%	1.7%	0.5%	1.1%
Endometrial hyperplasia / endometrial cancer	0.2%	0.4%	2.3%	2.9%

*Note: Median duration of treatment 60 months. Reporting period includes treatment period plus 30 days after stopping treatment.*

*"Any time after randomization" includes the follow-up period after completion or cessation of study treatment*

**Table 7**            **Sequential treatment versus Femara monotherapy – adverse events with significant differences**

	<b>Femara monotherapy 5 years</b>	<b>Femara &gt;Tamoxifen 2 years + 3 years</b>	<b>Tamoxifen &gt;Femara 2 years + 3 years</b>
	<b>N=1535</b>	<b>N=1527</b>	<b>N=1541</b>
Bone fractures	10.0%	7.7%*	9.7%
Endometrial proliferative disorders	0.7%	3.4%**	1.7%**
Hypercholesterolemia	52.5%	44.2%*	40.8%*
Hot flushes	37.6%	41.7%**	43.9%**
Vaginal bleeding	6.3%	9.6%**	12.7%**
* Significantly less than with Femara monotherapy			
**Significantly more than with Femara monotherapy			
Note : Reporting period is during treatment or within 30 days of stopping treatment			

**Study CFEM345D2407**

Study D2407 was an open-label, randomized, multicentre post-authorization safety study designed to compare the effects of adjuvant treatment with letrozole and tamoxifen on bone mineral density (BMD) and serum lipid profiles. In total, 263 patients were assigned either letrozole for 5 years (133 postmenopausal women) or tamoxifen for 2 years followed by letrozole for 3 years (130 patients). All evaluations of BMD and of serum lipids were conducted treatment-blinded in specialist central laboratories. The primary analysis of BMD and serum lipids was at 2 years.

There was a statistically significant difference between treatments at 2 years in the primary endpoint, lumbar spine (L2-L4) BMD with a median decrease of 4.1% in the letrozole arm compared to a median increase of 0.3% in the tamoxifen arm. The results for total hip BMD were similar to those for lumbar spine but less pronounced.

No patient with a normal BMD at baseline became osteoporotic during 5 years of treatment. One patient with osteopenia at baseline (T-score of -1.9) developed osteoporosis during the treatment period (assessment by central review).

Although treatment differences at the end of 5 years were attenuated such that there was no statistically significant difference between treatments in the protocol-defined clinically relevant BMD-related changes overall, there remained substantial differences in the effects of the two treatments on BMD and skeletal events. In patients with a normal T-score at baseline, significantly more patients in the letrozole arm than in the sequential treatment arm had reductions of at least 6% in lumbar spine BMD within 1 year or cumulative reductions of at least 8% over the entire treatment period. Although there was no significant difference overall between treatment arms in clinical fractures, three-quarters of the fractures in the sequential treatment arm occurred after the switch to letrozole. Both clinical fractures and impending fractures, however, tended to occur in patients whose skeletal status was compromised – i.e. patients with lower BMD T-scores at baseline, and patients with a history of fractures.



Total cholesterol levels (fasting) decreased by a median 16% in the tamoxifen arm at 6 months, and remained so for the duration of tamoxifen therapy. In the letrozole arm, total cholesterol levels were relatively stable throughout treatment. LDL cholesterol levels decreased in the tamoxifen arm but remained stable in the letrozole arm. Consequently, there were statistically significant differences in favour of tamoxifen in total cholesterol, LDL cholesterol and HDL:LDL ratio over the first 2 years of the study. There were no significant differences between treatments in triglycerides.

## **Extended adjuvant treatment**

### **Study MA-17 (CFEM345MA17)**

In a multicenter, double-blind, randomized, placebo-controlled study (MA-17), over 5,100 postmenopausal women with receptor-positive or unknown primary breast cancer who had completed adjuvant treatment with tamoxifen (4.5 to 6 years) were randomized to either Femara or placebo for 5 years.

The primary endpoint was disease-free survival, defined as the interval between randomization and the earliest occurrence of loco-regional recurrence, distant metastasis, or contralateral breast cancer.

The first planned interim analysis at a median follow-up of around 28 months (25% of patients being followed up for at least 38 months), showed that Femara significantly reduced the risk of breast cancer recurrence by 42% compared with placebo (HR 0.58; 95% CI 0.45, 0.76;  $P=0.00003$ ). The benefit in favor of letrozole was observed regardless of nodal status. There was no significant difference in overall survival: (Femara 51 deaths; placebo 62; HR 0.82; 95% CI 0.56, 1.19).

Consequently, after first interim analysis the study was unblinded and continued in an open-label fashion; patients in the placebo arm were allowed to switch to Femara for up to 5 years. Patients who opted not to switch were followed by observation only. Over 60% of eligible patients (disease-free at unblinding) opted to switch to Femara. The final analysis included 1,551 women who switched from placebo to Femara at a median of 31 months (range 12 to 106 months) after completion of tamoxifen adjuvant therapy. Median duration of Femara after switch was 40 months.

The final analysis conducted at a median follow-up of 62 months confirmed the significant reduction in the risk of breast cancer recurrence with Femara.

**Table 8 Disease-free and overall survival (Modified ITT population)**

	Median follow-up 28 months			Median follow-up 62 months		
	Letrozole N=2582	Placebo N=2586	HR (95% CI) <sup>2</sup> P value	Letrozole N=2582	Placebo N=2586	HR (95% CI) <sup>2</sup> P value
<b>Disease-free survival<sup>3</sup></b>						
Events	92 (3.6%)	155 (6.0%)	0.58 (0.45, 0.76) 0.00003	209 (8.1%)	286 (11.1%)	0.75 (0.63, 0.89)
4-year DFS rate	94.4%	89.8%		94.4%	91.4%	
<b>Disease-free survival<sup>3</sup>, including deaths from any cause</b>						
Events	122 (4.7%)	193 (7.5%)	0.62 (0.49, 0.78)	344 (13.3%)	402 (15.5%)	0.89 (0.77, 1.03)
5 year DFS rate	90.5%	80.8%		88.8%	86.7%	
<b>Distant metastases</b>						
Events	57 (2.2%)	93 (3.6%)	0.61 (0.44, 0.84)	142 (5.5%)	169 (6.5%)	0.88 (0.70, 1.10)
<b>Overall survival</b>						
Deaths	51 (2.0%)	62 (2.4%)	0.82 (0.56, 1.19)	236 (9.1%)	232 (9.0%)	1.13 (0.95, 1.36)
Deaths <sup>4</sup>	--	--	--	236 <sup>5</sup> (9.1%)	170 <sup>6</sup> (6.6%)	0.78 (0.64, 0.96)

HR = Hazard ratio; CI = Confidence Interval

<sup>1</sup> When the study was unblinded in 2003, 1,551 patients in the randomized placebo arm (60% of those eligible to switch – i.e. who were disease-free) switched to letrozole at a median 31 months after randomization. The analyses presented here ignore the selective crossover.

<sup>2</sup> Stratified by receptor status, nodal status and prior adjuvant chemotherapy.

<sup>3</sup> Protocol definition of disease-free survival events: loco-regional recurrence, distant metastasis or contralateral breast cancer.

<sup>4</sup> Exploratory analysis, censoring follow-up times at the date of switch (if it occurred) in the placebo arm.

<sup>5</sup> Median follow-up 62 months.

<sup>6</sup> Median follow-up until switch (if it occurred) 37 months.

In the MA-17 bone substudy in which concomitant calcium and vitamin D were given, greater decreases in BMD compared to baseline occurred with Femara compared with placebo. The only statistically significant difference occurred at 2 years and was in total hip BMD (letrozole median decrease of 3.8% vs placebo median decrease of 2.0%).

In the MA-17 lipid substudy there were no significant differences between letrozole and placebo in total cholesterol or in any lipid fraction.

In the updated quality of life substudy there were no significant differences between treatments in physical component summary score or mental component summary score, or in any domain score in the SF-36 scale. In the MENQOL scale, significantly more women in the Femara arm than in the placebo arm were most bothered (generally in the first year of treatment) by those symptoms deriving from estrogen deprivation – hot flushes and vaginal dryness. The symptom that bothered most patients in both treatment arms was aching muscles, with a statistically significant difference in favor of placebo.

## **Neoadjuvant treatment**

### ***Study CFEM345E P024***

A double blind trial (P024) was conducted in 337 postmenopausal breast cancer patients randomly allocated either Femara 2.5 mg for 4 months or tamoxifen for 4 months. At baseline all patients had tumors stage T2-T4c, N0-2, M0, ER and/or PgR positive and none of the patients would have qualified for breast-conserving surgery. Based on clinical assessment there were 55% objective responses in the Femara arm versus 36% for the tamoxifen arm ( $P<0.001$ ). This finding was consistently confirmed by ultrasound (Femara 35% vs tamoxifen 25%,  $P=0.04$ ) and mammography (Femara 34% vs tamoxifen 16%,  $P<0.001$ ). In total 45% of patients in the Femara group versus 35% of patients in the tamoxifen group ( $P=0.02$ ) underwent breast-conserving therapy). During the 4-month pre-operative treatment period, 12% of patients treated with Femara and 17% of patients treated with tamoxifen had disease progression on clinical assessment.

## **First-line treatment**

### ***Study CFEM345C P025***

One controlled double-blind trial was conducted comparing Femara (letrozole) 2.5 mg to tamoxifen 20 mg as first-line therapy in postmenopausal women with advanced breast cancer. In 907 women, letrozole was superior to tamoxifen in time to progression (primary endpoint) and in overall objective response, time to treatment failure and clinical benefit.

The results are summarized in Table 9:

**Table 9 Results at a median follow-up of 32 months**

Variable	Statistic	Femara N=453	Tamoxifen N=454
<b>Time to progression</b>	<b>Median</b>	<b>9.4 months</b>	<b>6.0 months</b>
	(95% CI for median)	(8.9, 11.6 months)	(5.4, 6.3 months)
	Hazard ratio (HR)		0.72
	(95% CI for HR)		(0.62, 0.83)
			<i>P</i> <0.0001
<b>Objective response rate (ORR)</b>	<b>CR+PR</b>	<b>145 (32%)</b>	<b>95 (21%)</b>
	(95% CI for rate)	(28, 36%)	(17, 25%)
	Odds ratio		1.78
	(95% CI for odds ratio)		(1.32, 2.40)

Time to progression was significantly longer, and response rate significantly higher for letrozole irrespective of whether adjuvant anti-estrogen therapy had been given or not. Time to progression was significantly longer for letrozole irrespective of dominant site of disease. Median time to progression was 12.1 months for Femara and 6.4 months for tamoxifen in patients with soft tissue disease only and median 8.3 months for Femara and 4.6 months for tamoxifen in patients with visceral metastases.

Study design allowed patients to cross over upon progression to the other therapy or discontinue from the study. Approximately 50% of patients crossed over to the opposite treatment arm and crossover was virtually completed by 36 months. The median time to crossover was 17 months (Femara to tamoxifen) and 13 months (tamoxifen to Femara).

Femara treatment in the first-line therapy of advanced breast cancer resulted in a median overall survival of 34 months compared with 30 months for tamoxifen (logrank test *P*=0.53, not significant). The absence of an advantage for Femara on overall survival could be explained by the crossover design of the study.

## Second-line treatment

Two well-controlled clinical trials were conducted comparing two letrozole doses (0.5 mg and 2.5 mg) to megestrol acetate and to aminoglutethimide, respectively, in postmenopausal women with advanced breast cancer previously treated with anti-estrogens.

### Study AR/BC2

Statistically significant differences were observed in favour of letrozole 2.5 mg compared to megestrol acetate in overall objective tumor response rate (24% vs 16%, *P*=0.04), and in time to treatment failure (*P*=0.04). Overall survival and time to progression was not significantly different between the 2 arms (*P*=0.2 and *P*=0.07, respectively).

### **Study AR/BC3**

Letrozole 2.5 mg was statistically superior to aminoglutethimide 250 mg bd for time to progression ( $P=0.008$ ), time to treatment failure ( $P=0.003$ ) and overall survival ( $P=0.002$ ). In this study, the response rate was not significantly different between letrozole 2.5 mg and aminoglutethimide ( $P=0.06$ ).

### **Male breast cancer**

Use of Femara in men with breast cancer has not been studied.

### **NON-CLINICAL SAFETY DATA**

In a variety of preclinical safety studies conducted in standard animal species, there was no evidence of systemic or target organ toxicity.

Letrozole showed a low degree of acute toxicity in rodents exposed to up to 2,000 mg/kg. In dogs, letrozole caused signs of moderate toxicity at 100 mg/kg.

In repeated-dose toxicity studies in rats and dogs up to 12 months, the main findings observed can be attributed to the pharmacological action of the compound. The no-adverse effect level was 0.3 mg/kg in both species.

Oral administration of letrozole to female rats resulted in decreases in mating and pregnancy ratios and increases in pre-implantation loss.

The pharmacological effects of letrozole resulted in skeletal, neuroendocrine and reproductive findings in a juvenile rat study. Bone growth and maturation were decreased from the lowest dose (0.003 mg/kg/day) in males and increased from the lowest dose (0.003 mg/kg) in females. Bone Mineral Density (BMD) was also decreased at that dose in females. In the same study, decreased fertility at all doses was accompanied by hypertrophy of the hypophysis, testicular changes which included a degeneration of the seminiferous tubular epithelium and atrophy of the female reproductive tract. With the exception of bone size in females and morphological changes in the testes, all effects were at least partially reversible.

Both *in vitro* and *in vivo* investigations on letrozole's mutagenic potential revealed no indications of any genotoxicity.

In a 104-week rat carcinogenicity study, no treatment-related tumors were noted in male rats. In female rats, a reduced incidence of benign and malignant mammary tumors at all the doses of letrozole was found.

In a 104-week mouse carcinogenicity study, no treatment-related tumors were noted in male mice. In female mice, a generally dose-related increase in the incidence of benign ovarian granulosa theca cell tumors was observed at all doses of letrozole tested. These tumors were considered to be related to the pharmacological inhibition of estrogen synthesis and may be due to increased LH resulting from the decrease in circulating estrogen.

Oral administration of letrozole to gravid Sprague-Dawley rats resulted in a slight increase in the incidence of fetal malformation (domed head and fused centrum/vertebrae) among the animals treated. Similar malformations were not seen in New Zealand White rabbits.

However, it was not possible to show whether this was an indirect consequence of the pharmacological properties (inhibition of estrogen biosynthesis), or a direct effect of letrozole in its own right (see sections CONTRAINDICATIONS and PREGNANCY, LACTATION, FEMALES AND MALES OF REPRODUCTIVE POTENTIAL).

Preclinical observations were confined to those associated with the recognized pharmacological action, which is the only safety concern for human use derived from animal studies.

## **INCOMPATIBILITIES**

Not applicable.

## **STORAGE**

See folding box.

Femara should not be used after the date marked "EXP" on the pack.

Femara must be kept out of the reach and sight of children.

## **INSTRUCTIONS FOR USE AND HANDLING**

No specific instructions for use/handling.

### **Manufacturers:**

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Schaffhauserstrasse,  
4332 Stein, Switzerland

### **Marketing Authorization Number:**

Femara 2.5mg Film-coated Tablet: NAFDAC Reg. No.: A4-3436

### **Marketing Authorization Holder**

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