A Non-Taxane Chemotherapy Monotherapy Treatment for Anthracycline, Taxane, and Capecitabine Resistant Metastatic Breast Cancer
Breast Cancer: Scope of Disease in the US

- It is estimated that 226,870 women will be diagnosed with and 39,510 women will die of breast cancer in 2012.
  - Median age at diagnosis is 61 years, based on data from 2005 to 2009.
  - Median age at death is 68 years, based on data from 2005 to 2009.
- Based on rates from 2007–2009, the lifetime risk of a woman developing breast cancer is 1 in 8.
- Approximately 5% of women with breast cancer are diagnosed in the metastatic setting.

IXEMPRA (ixabepilone): Indications and Usage

- IXEMPRA (ixabepilone) is indicated as monotherapy for the treatment of metastatic or locally advanced breast cancer in patients whose tumors are resistant or refractory to anthracyclines, taxanes, and capecitabine.

- IXEMPRA is indicated in combination with capecitabine for the treatment of patients with metastatic or locally advanced breast cancer resistant to treatment with an anthracycline and a taxane, or whose cancer is taxane resistant and for whom further anthracycline therapy is contraindicated.
  - Anthracycline resistance is defined as progression while on therapy or within 6 months in the adjuvant setting or 3 months in the metastatic setting.
  - Taxane resistance is defined as progression while on therapy or within 12 months in the adjuvant setting or 4 months in the metastatic setting.

Please see Important Safety Information, including Boxed WARNING, within this slide deck and accompanying Full Prescribing Information.
IXEMPRA (ixabepilone): Boxed WARNING and Contraindications

Toxicity in hepatic impairment

- IXEMPRA (ixabepilone) in combination with capecitabine is contraindicated in patients with AST or ALT >2.5 x ULN or bilirubin >1 x ULN due to increased risk of toxicity and neutropenia-related death.

- In combination with capecitabine, the overall frequency of grade 3/4 adverse reactions, febrile neutropenia, serious adverse reactions, and toxicity-related deaths was greater in patients with hepatic impairment.

- Caution should be used when using IXEMPRA as monotherapy in patients with AST or ALT >5 x ULN.

- Use of IXEMPRA in patients with AST or ALT >10 x ULN or bilirubin >3 x ULN is not recommended.

- With monotherapy, grade 4 neutropenia, febrile neutropenia, and serious adverse reactions were more frequent in patients with hepatic impairment.

Contraindications

IXEMPRA is contraindicated in patients:

- with a known history of a severe (CTC grade 3/4) hypersensitivity reaction to agents containing Cremophor® EL or its derivatives such as polyoxyethylated castor oil.

- who have a baseline neutrophil count <1500 cells/mm³ or a platelet count <100,000 cells/mm³.

Cremophor is a registered trademark of DAOT AG.

AST = aspartate aminotransferase; ALT = alanine aminotransferase; ULN = upper limit of normal. CTC = common terminology criteria.

Please see Important Safety Information, including Boxed WARNING, within this slide deck and accompanying Full Prescribing Information.
The objective of Study 081 was to evaluate the efficacy and safety of IXEMPRA (ixabepilone) monotherapy in patients with metastatic breast cancer (MBC) who progressed on an anthracycline, a taxane, and capecitabine.

Notes

- Study 081 was a multicenter, single-arm trial that evaluated IXEMPRA (ixabepilone) monotherapy in 126 women with metastatic or locally advanced breast cancer\(^1\).\(^2\)
- The study enrolled patients whose tumors had recurred or had progressed following \(\geq 2\) chemotherapy regimens including an anthracycline, a taxane, and capcitabine. For anthracyclines, patients who received a minimum cumulative dose of 240 mg/m\(^2\) of doxorubicin or 360 mg/m\(^2\) of epirubicin were also eligible\(^1\).\(^2\)
- Key exclusion criteria included prior treatment with an epothilone, concurrent chemotherapy, current or previous brain metastases, or grade \(\geq 2\) neuropathy (National Cancer Institute, Common Toxicity Criteria [NCI-CTC]) at study entry. Patients suitable and eligible for trastuzumab or hormonal therapy based on HER2+ or ER+ status were excluded\(^1\).
- Patients with serum bilirubin \(>1.5\) x ULN, ALT \(\geq 2.5\) x ULN (\(5\) x ULN if documented hepatic metastases are present) were excluded\(^3\).
- Patients were treated with IXEMPRA monotherapy administered as a 3-hour intravenous infusion of 40 mg/m\(^2\) on Day 1 of a 21-day cycle. Treatment continued for \(\leq 18\) cycles or until disease progression or unacceptable toxicity\(^1\).\(^2\).
- The primary end point of this study was objective tumor response rate (ORR), using the Response Evaluation Criteria in Solid Tumors (RECIST), as assessed by independent radiologic review (IRR). ORR was also assessed by the investigator\(^1\).\(^2\).
- Secondary efficacy end points included duration of response and time to response. These analyses were based on IRR data\(^1\).
- Of note, patients received their first assessment at 6 weeks\(^1\).

\(^1\) Patients who received a minimum cumulative dose of 240 mg/m\(^2\) of doxorubicin or 360 mg/m\(^2\) of epirubicin were also eligible.
\(^2\) As determined by Independent Radiologic Review (IRR).

2. IXEMPRA\(^\circledR\) (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
Baseline disease characteristics were representative of a population with metastatic breast cancer resistant to anthracyclines, taxanes, and capecitabine.1

- The median age of patients was 51 years (range, 30–78 years)1,2
- Patients had metastases at multiple sites, including extensive visceral disease:
  - 86% had visceral disease in the liver and/or lung2
  - 64% presented with 3 or more metastatic disease sites1
- About one-third of patients had ER-, PR-, HER2- tumors1,2

2. IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
Baseline Characteristics (cont)

<table>
<thead>
<tr>
<th>Prior Treatment</th>
<th>Patients, no. (%) (N=126)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior neoadjuvant/adjuvant chemotherapy</td>
<td>95 (75)</td>
</tr>
<tr>
<td>No. of prior chemotherapy regimens for metastatic disease* †</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>15 (12)</td>
</tr>
<tr>
<td>2</td>
<td>51 (40)</td>
</tr>
<tr>
<td>3</td>
<td>60 (48)</td>
</tr>
<tr>
<td>No. of prior taxane-containing regimens</td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>126 (100)</td>
</tr>
<tr>
<td>1</td>
<td>88 (70)</td>
</tr>
<tr>
<td>2</td>
<td>31 (26)</td>
</tr>
<tr>
<td>≥3</td>
<td>7 (6)</td>
</tr>
<tr>
<td>Progressive disease as best response to prior taxane</td>
<td>47 (37)</td>
</tr>
<tr>
<td>No. of patients who received all 3 (A, T, C) regimens</td>
<td>128 (100)</td>
</tr>
</tbody>
</table>

A = anthracyclines; T = taxanes; C = capecitabine.
* Approximately 30% of patients had received ≥2 taxane-containing regimens. In addition to anthracyclines, taxanes, and capecitabine, patients had received prior treatment with other chemotherapies, including vinorelbine (39%) and gemcitabine (15%).
† Patients may have received chemotherapy in more than one setting.

Notes

- Seventy-five percent of patients had prior chemotherapy in the neoadjuvant/adjuvant setting.
- The majority of patients had received multiple prior regimens. Eighty-eight percent had received ≥2 lines of chemotherapy in the metastatic setting, including 48% who had received 3 lines of chemotherapy.
- Approximately 30% of patients had received ≥2 taxane-containing regimens. In addition to anthracyclines, taxanes, and capecitabine, many patients had received other commonly used agents in the metastatic breast cancer setting, including vinorelbine (25%) and gemcitabine (13%).
- As per protocol, all patients had received prior therapy with a taxane, an anthracycline, and capecitabine.

Notes

- IXEMPRA (ixabepilone) demonstrated efficacy as monotherapy in patients who have progressed on an anthracycline, a taxane, and capecitabine
  
- Objective tumor response is defined as those patients who achieved either a complete or partial response
  
- The objective tumor response among response-evaluable patients, as assessed by the IRR, was 12.4% (95% CI, 6.9–19.9). All responses were partial
  
- The objective tumor response was 18.3% (95% CI, 11.9–26.1) based on investigator assessment
  
- The median time to response was calculated for patients who achieved an objective tumor response
    
    - The median time to response was 6.1 weeks (95% CI, 5–54.4)

1. IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
The median duration of response was calculated for patients who achieved an objective tumor response

- The median duration of response was 6.0 months (95% CI, 5.0–7.6)

IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
Notes

- Prior therapy with neurotoxic chemotherapy agents did not predict the development of neuropathy. Neuropathy was the most frequent cause of treatment discontinuation due to drug toxicity.
- Peripheral neuropathy is a common nonhematologic adverse reaction with IXEMPRA (ixabepilone), occurring in 63% of patients treated with IXEMPRA monotherapy.
- 14% of patients had grade 3/4 peripheral neuropathy.
- The median number of cycles to onset of grade 3/4 neuropathy was 4, and the median time to improvement of grade 3/4 neuropathy to baseline or to grade 1 was 4.6 weeks.
- In clinical studies, management of peripheral neuropathy included: dose reductions, dose delays, and treatment discontinuation.
  - In Study 081, the majority of patients (87%) had improvement or no worsening of their neuropathy following dose reduction. Of the patients with grade 3/4 neuropathy, 79% had documented improvement to baseline or grade 1 twelve weeks after onset.
- Patients treated with IXEMPRA should be monitored for symptoms of neuropathy, such as burning sensation, hyperesthesia, hypoesthesia, paresthesia, discomfort, or neuropathic pain.

Dose modification guidelines for IXEMPRA for certain toxicities will be covered later in this slide deck.

IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
Notes

- IXEMPRA (ixabepilone) must not be administered to patients with a neutrophil count less than 1500 cells/mm³ or a platelet count less than 100,000 cells/mm³.
- Myelosuppression is dose-dependent and primarily manifested as neutropenia.
- Drug-associated hematologic abnormalities (>40%) include neutropenia, leukopenia, anemia, and thrombocytopenia.
- Patients should be monitored for myelosuppression; frequent peripheral blood cell counts are recommended for all patients receiving IXEMPRA.
- Patients who experience severe neutropenia or thrombocytopenia should have their dose reduced.
- Neutropenia-related deaths occurred in 0.4% of 240 patients treated with IXEMPRA as monotherapy.
- Grade 3/4 neutropenia was observed in 54% of patients. The rate of grade 3 febrile neutropenia, which was classified as a nonhematologic adverse event, was 3% with IXEMPRA monotherapy. There were no reports of grade 4 febrile neutropenia.
- Grades 3/4 leukopenia occurred in 49% of patients.
- Seventeen percent of patients received growth factor support in this study.
- In clinical trials, febrile neutropenia was categorized as a nonhematologic adverse event.
- Infection with neutropenia was reported in 5% of patients treated with IXEMPRA.

IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
Nonhematologic Drug-Related Adverse Reactions (≥5%)

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>Patients, % (N=125)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Nervous System Disorder</td>
<td></td>
</tr>
<tr>
<td>Peripheral neuropathy</td>
<td>82</td>
</tr>
<tr>
<td>Sensory neuropathy(\d)</td>
<td>10</td>
</tr>
<tr>
<td>Motor neuropathy(\d)</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>11</td>
</tr>
<tr>
<td>Taste disorder(\d)</td>
<td>6</td>
</tr>
<tr>
<td>Dizziness</td>
<td>7</td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
</tr>
<tr>
<td>Insomnia(\d)</td>
<td>5</td>
</tr>
</tbody>
</table>

* System organ class presented as outlined in Guidelines for Preparing Oeea Clinical Safety Information on Drugs by the Council for International Organizations of Medical Sciences (CIOMS).

\(\d\) A composite of multiple MedDRA Preferred Terms. \(\d\) Peripheral sensory neuropathy (graded with the NCICTC scale) was defined as the occurrence of any of the following: areflexia, burning sensation, dysesthesia, hypesthesia, hyposthesia, hypesthesia, hypoesthesia, neuropathy, neuritis, neuritis, neuritis, neuropathy, peripheral neuropathy, neuropathy, painful response to normal stimuli, paraesthesia, paresthesia, peripheral sensory neuropathy, polyneuropathy, polyneuropathy toxic and sensorimotor disorder. Peripheral motor neuropathy was defined as the occurrence of any of the following: multifocal motor neuropathy, neuromuscular toxicity, peripheral motor neuropathy, and peripheral sensorimotor neuropathy. \(\d\) No grade 4 reports.

Notes
- Drug-related adverse reactions occurring in ≥5% of patients are reported on the following 4 slides
- Drug-related adverse reactions occurring in ≥20% of patients are highlighted on each of the slides
- This slide lists nervous system and psychiatric disorders
- Peripheral neuropathy is the most common nonhematologic adverse event

IXEMPRA\(\textsuperscript{(ixabepilone)}\) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
### Nonhematologic Drug-Related Adverse Reactions (≥5%) (cont)

<table>
<thead>
<tr>
<th>Adverse Event*</th>
<th>Patients, % (N=126)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Disorders and Administrative Site Conditions</strong></td>
<td>Total</td>
<td>Grade 3/4</td>
</tr>
<tr>
<td>Fatigue/asthenia(^1)</td>
<td>56</td>
<td>13</td>
</tr>
<tr>
<td>Edema(^1)</td>
<td>9</td>
<td>1(^2)</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>8</td>
<td>1(^2)</td>
</tr>
<tr>
<td>Pain(^1)</td>
<td>8</td>
<td>3(^2)</td>
</tr>
<tr>
<td>Chest pain(^1)</td>
<td>5</td>
<td>1(^2)</td>
</tr>
<tr>
<td><strong>Vascular Disorders</strong></td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td><strong>Immune System Disorders</strong></td>
<td>5</td>
<td>1(^3)</td>
</tr>
<tr>
<td>Hypersensitivity(^1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Musculoskeletal, Connective Tissue, and Bone Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myalgia/arthritis(^1)</td>
<td>49</td>
<td>6(^2)</td>
</tr>
<tr>
<td>Musculoskeletal pain(^1)</td>
<td>20</td>
<td>3(^2)</td>
</tr>
</tbody>
</table>

* System organ class presented as outlined in Guidelines for Preparing Core Clinical Safety Information on Drugs for the Council for International Organizations of Medical Sciences (CIOMS) 1 A composite of multiple MedDRA Preferred Terms 2 No grade 4 reports

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**Notes**

- Drug-related adverse reactions occurring in ≥20% of patients included fatigue/asthenia, myalgia/arthritis, and musculoskeletal pain
- This slide includes general disorders and administrative site conditions; blood and lymphatic system; vascular; immune system; musculoskeletal, connective tissue, and bone disorders

IXEMPRA\(^\circ\) (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
### Nonhematologic Drug-Related Adverse Reactions (≥5%) (cont)

<table>
<thead>
<tr>
<th>Adverse Event*</th>
<th>Patients, % (N=126)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>42</td>
<td>2²</td>
</tr>
<tr>
<td>Vomiting¹</td>
<td>29</td>
<td>1²</td>
</tr>
<tr>
<td>Stomatitis/mucositis³</td>
<td>29</td>
<td>6</td>
</tr>
<tr>
<td>Diarrhea²</td>
<td>22</td>
<td>1³</td>
</tr>
<tr>
<td>Constipation</td>
<td>16</td>
<td>2⁴</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>13</td>
<td>2³</td>
</tr>
<tr>
<td>Gastroesophageal reflux disease²</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td><strong>Metabolism and Nutrition Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anorexia³</td>
<td>19</td>
<td>2³</td>
</tr>
<tr>
<td><strong>Infections and Infestations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper respiratory tract infection³</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Weight decreased</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

* System organ class presented as outlined in Guidelines for Preparing Core Clinical Safety Information on Drugs by the Council for International Organizations of Medical Sciences (CIOMS). * A compendium of multiple MedDRA Preferred Terms. * No grade 4 reports.

**Notes**

- This slide shows drug-related adverse events for gastrointestinal disorders, metabolic and nutrition disorders, infections and infestations, and weight decrease.
- Drug-related adverse reactions occurring in ≥20% of patients included gastrointestinal disorders, such as nausea, vomiting, stomatitis/mucositis, and diarrhea.

**IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.**
### Nonhematologic Drug-Related Adverse Reactions (≥5%) (cont)

<table>
<thead>
<tr>
<th>Adverse Event*</th>
<th>Patients, % (N=126)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Grade 3/4</td>
<td></td>
</tr>
<tr>
<td><strong>Skin and Subcutaneous Tissue Disorders</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alopecia¹</td>
<td>48</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Skin rash¹</td>
<td>9</td>
<td>2²</td>
<td></td>
</tr>
<tr>
<td>Nail disorder¹</td>
<td>9</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Palmar-plantar erythrodynasthesia syndrome¹</td>
<td>0</td>
<td>2¹</td>
<td></td>
</tr>
<tr>
<td>Pruritus</td>
<td>6</td>
<td>1¹</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory, Thoracic, and Mediastinal Disorders</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspnea¹</td>
<td>9</td>
<td>1²</td>
<td></td>
</tr>
</tbody>
</table>

* System organ class presented as defined in U.S. Department of Health and Human Services. 

Notes

- Here, associated drug-related adverse events included skin, eye disorders, and respiratory problems.
- Alopecia occurred at a rate of ≥20% in patients treated with IXEMPRA (ixabepilone) monotherapy.

IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
Notes

- Patients should be evaluated during treatment by periodic clinical observation and laboratory tests including complete blood cell counts. If toxicities are present, treatment should be delayed to allow recovery.
- Dosing adjustment guidelines for certain non-hematologic and hematologic toxicities are shown on the slide. If toxicities recur, an additional 20% dose reduction may be made.
- Dose adjustments may allow patients to recover from toxicities.
- Retreatment criteria
  - Dose adjustments at the start of a cycle should be based on nonhematologic toxicity or blood counts from the preceding cycle.
  - Patients should not begin a new cycle of treatment unless the neutrophil count is at least 1500 cells/mm³, the platelet count is at least 100,000 cells/mm³, and nonhematologic toxicities have improved to grade 1 (mild) or resolved.
- Depending on the type and severity of the toxicity, patients may require treatment discontinuation or no dose adjustment. If toxicities are present, treatment should be delayed to allow for recovery.

IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
**Notes**

- The recommended dose of IXEMPRA (ixabepilone) is 40 mg/m² IV over 3 hours every 3 weeks
- Doses for patients with body surface area greater than 2.2 m² should be based on 2.2 m²
- For certain grade 2 and 3 nonhematologic toxicities, and for certain hematologic toxicities, reduce the dose by 20%, if tolerable
- If toxicities recur, an additional 20% dose reduction may be made
- Depending on the type and severity of the toxicity, patients may require treatment discontinuation or no dose adjustment. If toxicities are present, treatment should be delayed to allow for recovery

IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
**Notes**

- Patients with baseline AST or ALT >2.5 x ULN or bilirubin >1.5 x ULN experienced greater toxicity than patients with baseline AST or ALT ≤2.5 x ULN or bilirubin ≤1.5 x ULN when treated with IXEMPRA (ixabepilone) in combination with capecitabine or as monotherapy.
- Patients with hepatic impairment should be dosed with IXEMPRA based on the table on the slide.
- Limited data are available for patients with baseline AST or ALT >5 x ULN. Caution should be used when treating these patients when using IXEMPRA as monotherapy. Use of IXEMPRA in patients with AST or ALT >10 x ULN or bilirubin >3 x ULN is not recommended.

IXEMPRA® (ixabepilone) Prescribing Information. Bristol-Myers Squibb: Princeton, NJ.
Important Safety Information
**Important Safety Information**

**Toxicity in hepatic impairment**
- IXEMPRA (ixabepilone) in combination with capecitabine is contraindicated in patients with AST or ALT $>2.5 \times$ ULN or bilirubin $>1 \times$ ULN due to increased risk of toxicity and neutropenia-related death.
- In combination with capecitabine, the overall frequency of grade 3/4 adverse reactions, febrile neutropenia, serious adverse reactions, and toxicity-related deaths was greater in patients with hepatic impairment.
- Caution should be used when using IXEMPRA as monotherapy in patients with AST or ALT $>5 \times$ ULN. Use of IXEMPRA in patients with AST or ALT $>10 \times$ ULN or bilirubin $>3 \times$ ULN is not recommended.
- With monotherapy, grade 4 neutropenia, febrile neutropenia, and serious adverse reactions were more frequent in patients with hepatic impairment.

**Contraindications**
- IXEMPRA is contraindicated in patients:
  - with a known history of a severe (CTC grade 3/4) hypersensitivity reaction to agents containing Cremophor EL or its derivatives such as polyoxylated castor oil
  - who have a baseline neutrophil count $<1500$ cells/mm$^3$ or a platelet count $<100,000$ cells/mm$^3$

Cremophor is a registered trademark of DSM AG.
AST = aspartate aminotransferase; ALT = alanine aminotransferase; ULN = upper limit of normal; CTC = common terminology criteria.

*Please see Important Safety Information, including Boxed WARNING, within this slide deck and accompanying Full Prescribing Information.*
Important Safety Information (cont)

Peripheral neuropathy
- Peripheral neuropathy was common. Patients treated with Ixempra (ixabepilone) should be monitored for symptoms of neuropathy, such as burning sensation, hyperesthesia, hypoesthesia, paresthesia, discomfort, or neuropathic pain.
- Neuropathy occurred early during treatment; ~75% of new onset or worsening neuropathy occurred during the first 3 cycles. Patients experiencing new or worsening peripheral neuropathy may require changes in the dose or discontinuation of Ixempra.
- Neuropathy was the most frequent cause of treatment discontinuation due to drug toxicity. Caution should be used when treating patients with diabetes mellitus or preexisting peripheral neuropathy.

Myelosuppression
- Myelosuppression is dose-dependent and primarily manifested as neutropenia.
- Patients should be monitored for myelosuppression; frequent peripheral blood cell counts are recommended for all patients receiving Ixempra.
- Patients who experience severe neutropenia or thrombocytopenia should have their dose reduced. Neutropenia-related deaths occurred in 1.9% of 414 patients with normal hepatic function or mild hepatic impairment treated with Ixempra in combination with capecitabine. Neutropenia-related death occurred in 0.4% of 240 patients with Ixempra as monotherapy.

Please see Important Safety Information, including Brand WARNING, within this slide deck and accompanying full prescribing information.
Important Safety Information (cont)

Hypersensitivity reaction
- Premedicate with an H$_1$ and an H$_2$ antagonist approximately 1 hour before IXEMPRA (irinotecan) infusion and observe for hypersensitivity reactions (eg, flushing, rash, dyspnea, and bronchospasm).
- In case of severe hypersensitivity reactions, infusion of IXEMPRA should be stopped and aggressive supportive treatment (eg, epinephrine, corticosteroids) started.
- Patients who experience a hypersensitivity reaction in one cycle of IXEMPRA must be premedicated in subsequent cycles with a corticosteroid in addition to the H$_1$ and H$_2$ antagonists, and extension of the infusion time should be considered.

Pregnancy
- Women should be advised not to become pregnant when taking IXEMPRA. If this drug is used during pregnancy or the patient becomes pregnant, the patient should be apprised of the potential hazard to the fetus.
Important Safety Information (cont)

Cardiac adverse reactions
- Caution should be exercised in patients with a history of cardiac disease. Discontinuation of IXEMPRA (ixabepilone) should be considered in patients who develop cardiac ischemia or impaired cardiac function due to reports of cardiovascular adverse reactions (e.g., myocardial ischemia, supraventricular arrhythmia, and ventricular dysfunction). The frequency of cardiac adverse reactions (myocardial ischemia and ventricular dysfunction) was higher in the IXEMPRA in combination with capecitabine (1.9%) than in the capecitabine alone (0.3%) treatment group.

Potential for cognitive impairment from excipients
- IXEMPRA contains dehydrated alcohol USP. Consideration should be given to the possibility of central nervous system and other effects of alcohol.

Adverse reactions: Monotherapy
- The most common adverse reactions (≥20%) reported by patients receiving IXEMPRA monotherapy were peripheral sensory neuropathy, 62% (grade 3/4: 14%); fatigue/asthenia, 56% (grade 3/4: 13%); myalgia/arthralgia, 49% (grade 3/4: 8%); alopecia, 48% (grade 3/4: 0%); nausea, 42% (grade 3/4: 2%); stomatitis/mucositis, 29% (grade 3/4: 8%); vomiting, 29% (grade 3/4: 1%); diarrhea, 22% (grade 3/4: 1%); and musculoskeletal pain, 20% (grade 3/4: 3%). Drug-associated hematologic abnormalities (>10%) included neutropenia, leukopenia, anemia, and thrombocytopenia. Grade 3/4 hematologic adverse reactions included neutropenia, 54%; leukopenia, 49%; anemia, 8%; and thrombocytopenia, 7%

Please see Important Safety Information, including Brand WARNING, within this slide deck and accompanying Full Prescribing Information.
Important Safety Information (cont)

Adverse reactions: Combination with capecitabine

- The most common adverse reactions (≥20%) reported by patients receiving IXEMPRA (ixabepilone) in combination with capecitabine compared to capecitabine alone, respectively, were peripheral sensory neuropathy, 65% vs 16% (grade 3/4: 21% vs 0%); palmar-plantar erythrodysesthesia (hand-foot) syndrome, 64% vs 63% (grade 3/4: 18% vs 17%); fatigue/asthenia, 80% vs 26% (grade 3/4: 16% vs 4%); nausea, 53% vs 40% (grade 3/4: 3% vs 2%); diarrhea, 44% vs 39% (grade 3/4: 6% vs 9%); vomiting, 39% vs 24% (grade 3/4: 4% vs 2%); myalgia/arthritis, 39% vs 5% (grade 3/4: 8% vs <1%); anorexia, 34% vs 15% (grade 3/4: 3% vs 1%); stomatitis/mucositis, 31% vs 20% (grade 3/4: 4% vs 3%); alopecia, 31% vs 3% (grade 3/4: 0% vs 0%); abdominal pain, 24% vs 14% (grade 3/4: 2% vs 1%); nail disorder, 24% vs 10% (grade 3/4: 2% vs <1%); musculoskeletal pain, 23% vs 5% (grade 3/4: 2% vs 0%); and constipation, 22% vs 0% (grade 3/4: 0% vs <1%). Drug-associated hematologic abnormalities (>40%) with IXEMpra in combination with capecitabine and capecitabine alone, respectively, included neutropenia, leukopenia, anemia, and thrombocytopenia. Grade 3/4 hematologic adverse reactions included neutropenia, 68% vs 11%; leukopenia, 57% vs 6%; anemia, 16% vs 8%; and thrombocytopenia, 8% vs 4%.
Study 081: Summary of Monotherapy IXEMPRA (ixabepilone)

- Study enrolled patients whose tumors had recurred or progressed following ≥2 chemotherapy regimens, including an anthracycline, a taxane, and capecitabine

- Objective tumor response rate was 12.4% [95% CI, 6.9–19.9] based on IRR (n=113) and 18.3% [95% CI, 11.9–26.1] based on investigator assessment (N=126)
  - The median duration of response (n=14) was 6 months [95% CI, 5.0–7.6]
  - The median time to response (n=14) was 6.1 weeks (range, 5–54.4)
**WARNING:** Toxicity in hepatic impairment

- IXEMPRA in combination with capecitabine is contraindicated in patients with AST or ALT >2.5 x ULN or bilirubin >1 x ULN due to increased risk of toxicity and neutropenia-related death

- IXEMPRA is contraindicated in patients:
  - with a known history of a severe (CTC grade 3/4) hypersensitivity reaction to agents containing Cremophor® EL or its derivatives such as polyoxyethylated castor oil
  - who have a baseline neutrophil count <1500 cells/mm³ or a platelet count <100,000 cells/mm³

**Adverse reactions: Monotherapy**

- The most common adverse reactions (≥20%) reported by patients receiving IXEMPRA monotherapy were peripheral sensory neuropathy, 62% (grade 3/4: 14%); fatigue/asthenia, 50% (grade 3/4: 13%); myalgia/arthritis, 48% (grade 3/4: 0%); alopecia 48%, (grade 3/4: 0%); nausea 42%, (grade 3/4: 2%); stomatitis/mucositis, 20% (grade 3/4: 6%); vomiting, 20% (grade 3/4: 1%); diarrhea, 22% (grade 3/4: 1%); and musculoskeletal pain, 20% (grade 3/4: 5%). Drug-associated hematologic abnormalities (>40%) included neutropenia, leukopenia, anemia, and thrombocytopenia. Grade 3/4 hematologic adverse reactions included neutropenia, 54%; leukopenia, 49%; anemia, 8%; and thrombocytopenia, 7%.

Cremophor® is a registered trademark of BASF AG.

AST = aspartate aminotransferase; ALT = alanine aminotransferase; ULN = upper limit of normal; CTC = common terminology criteria.

Please see accompanying Full Prescribing Information, including Boxed WARNING regarding hepatic impairment.
HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use IXEMPRA® safely and effectively. See full prescribing information for IXEMPRA®.

IXEMPRA® Kit (ixabepilone) for Injection, for intravenous infusion only
Initial U.S. Approval: 2007

WARNING: TOXICITY IN HEPATIC IMPAIRMENT

See full prescribing information for complete boxed warning.

IXEMPRA® in combination with capecitabine must not be given to patients with AST or ALT >2.5 x ULN or bilirubin >1 x ULN due to increased risk of toxicity and neutropenia-related death. (4, 5.3)

--- INDICATIONS AND USAGE ---

- IXEMPRA, a microtubule inhibitor, in combination with capecitabine is indicated for the treatment of metastatic or locally advanced breast cancer in patients after failure of an anthracycline and a taxane (1).
- IXEMPRA as monotherapy is indicated for the treatment of metastatic or locally advanced breast cancer in patients after failure of an anthracycline, a taxane, and capcitabine (1).

--- DOSAGE AND ADMINISTRATION ---

- The recommended dose of IXEMPRA is 40 mg/m² infused intravenously over 3 hours every 3 weeks (2.1).
- Dose reduction is required in certain patients with elevated AST, ALT, or bilirubin (2.2, 8.6).

IXEMPRA (ixabepilone) for injection must be constituted with supplied DILUENT. The ixabepilone concentration in constituted solution is 2 mg/mL. Constituted solution must be diluted with one of the specified fluids, to a final ixabepilone concentration of 0.2 mg/mL to 0.6 mg/mL. The final solution must be used within 6 hours of preparation (2.4).

--- DOSAGE FORMS AND STRENGTHS ---

- IXEMPRA for injection, 15 mg supplied with DILUENT for IXEMPRA, 8 mL (3)
- IXEMPRA for injection, 45 mg supplied with DILUENT for IXEMPRA, 23.5 mL (3)

--- CONTRAINDICATIONS ---

- Hypersensitivity to drugs formulated with Cremophor® EL (4).
- Baseline neutrophil count <1500 cells/mm³ or a platelet count <100,000 cells/mm³ (4).
- Patients with AST or ALT >2.5 x ULN or bilirubin >1 x ULN must not be treated with IXEMPRA (ixabepilone) in combination with capecitabine (4).

--- WARNINGS AND PRECAUTIONS ---

- Peripheral Neuropathy: Monitor for symptoms of neuropathy, primarily sensory. Neuropathy is cumulative, generally reversible, and should be managed by dose adjustment and delays (2.2, 5.1).
- Myelosuppression: Primarily neutropenia. Monitor with peripheral blood cell counts and adjust dose as appropriate (2.2, 5.2).
- Hypersensitivity reaction: Must premedicate all patients with an H₁ antagonist and an H₂ antagonist before treatment (2.3, 5.4).
- Fetal harm can occur when administered to a pregnant woman. Women should be advised not to become pregnant when taking IXEMPRA (5.5, 8.1).

--- ADVERSE REACTIONS ---

- The most common adverse reactions (≥20%) are peripheral sensory neuropathy, fatigue/asthenia, myalgia/arthritis, alopecia, nausea, vomiting, stomatitis/mucositis, diarrhea, and musculoskeletal pain. Additional reactions occurred in ≥20% in combination treatment: palmar-plantar erythrodysesthesia syndrome, anorexia, abdominal pain, nail disorder, and constipation (6).
- Drug-associated hematologic abnormalities (≥40%) include neutropenia, leukopenia, anemia, and thrombocytopenia (6).

To report SUSPECTED ADVERSE REACTIONS, contact Bristol-Myers Squibb at 1-800-721-5072 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

--- DRUG INTERACTIONS ---

- Inhibitors of CYP3A4 may increase plasma concentrations of ixabepilone; dose of IXEMPRA must be reduced with strong CYP3A4 inhibitors (7.1).
- Inducers of CYP3A4 may decrease plasma concentrations of ixabepilone; alternative therapeutic agents with low enzyme induction potential should be considered (7.1).

See 17 for PATIENT COUNSELING INFORMATION and FDA-Approved Patient Labeling

Revised: 10/2011

--- PATIENT COUNSELING INFORMATION ---

- Peripheral Neuropathy: Monitor for symptoms of neuropathy, primarily sensory. Neuropathy is cumulative, generally reversible, and should be managed by dose adjustment and delays (2.2, 5.1).
- Myelosuppression: Primarily neutropenia. Monitor with peripheral blood cell counts and adjust dose as appropriate (2.2, 5.2).
- Hypersensitivity reaction: Must premedicate all patients with an H₁ antagonist and an H₂ antagonist before treatment (2.3, 5.4).
- Fetal harm can occur when administered to a pregnant woman. Women should be advised not to become pregnant when taking IXEMPRA (5.5, 8.1).

--- ADVERSE REACTIONS ---

- The most common adverse reactions (≥20%) are peripheral sensory neuropathy, fatigue/asthenia, myalgia/arthritis, alopecia, nausea, vomiting, stomatitis/mucositis, diarrhea, and musculoskeletal pain. Additional reactions occurred in ≥20% in combination treatment: palmar-plantar erythrodysesthesia syndrome, anorexia, abdominal pain, nail disorder, and constipation (6).
- Drug-associated hematologic abnormalities (≥40%) include neutropenia, leukopenia, anemia, and thrombocytopenia (6).

To report SUSPECTED ADVERSE REACTIONS, contact Bristol-Myers Squibb at 1-800-721-5072 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

--- DRUG INTERACTIONS ---

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- Inducers of CYP3A4 may decrease plasma concentrations of ixabepilone; alternative therapeutic agents with low enzyme induction potential should be considered (7.1).

See 17 for PATIENT COUNSELING INFORMATION and FDA-Approved Patient Labeling

Revised: 10/2011
Monotherapy: Patients with hepatic impairment should be dosed with IXEMPRA based on the guidelines in Table 2. Patients with moderate hepatic impairment should be started at 20 mg/m², the dosage in subsequent cycles may be escalated up to, but not exceeding, 30 mg/m² if tolerated. Use in patients with AST or ALT >10 x ULN or bilirubin >3 x ULN is not recommended. Limited data are available for patients with baseline AST or ALT >5 x ULN. Caution should be used when treating these patients [see Warnings and Precautions (5.3) and Use in Specific Populations (8.6)].

### Table 2: Dose Adjustments for IXEMPRA as Monotherapy in Patients with Hepatic Impairment

<table>
<thead>
<tr>
<th>Transaminase Levels</th>
<th>Bilirubin Levels</th>
<th>IXEMPRA (mg/m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid AST and ALT ≤2.5 x ULN and ≤1 x ULN</td>
<td>≤1 x ULN</td>
<td>40</td>
</tr>
<tr>
<td>Mid AST and ALT ≤2 x ULN and ≤1 x ULN</td>
<td>≤1 x ULN</td>
<td>32</td>
</tr>
<tr>
<td>Moderate AST and ALT &gt;10 x ULN and &gt;1.5 x ULN</td>
<td>≤3 x ULN</td>
<td>20 - 30</td>
</tr>
</tbody>
</table>

Excluding patients whose total bilirubin is elevated due to Gilbert’s disease.

#### Strong CYP3A4 Inhibitors

The use of concomitant strong CYP3A4 inhibitors should be avoided (eg, ketoconazole, itraconazole, clarithromycin, atazanavir, saquinavir, telithromycin, delavirdine, or voriconazole). Grapefruit juice may also increase plasma concentrations of IXEMPRA and should be avoided. Based on pharmacokinetic studies, if a strong CYP3A4 inhibitor must be concomitantly administered, a reduced dose of 20 mg/m² is predicted to adjust the ixabepilone AUC to the range observed without inhibitors and should be considered. If the strong inhibitor is discontinued, a washout period of approximately 1 week should be allowed before the IXEMPRA dose is adjusted upward to the indicated dose [see Drug Interactions (7.1)].

#### Strong CYP3A4 Inducers

The use of concomitant strong CYP3A4 inducers should be avoided (eg, phenytoin, carbamazepine, rifampin, rifabutin, dexamethasone, and phenobarbital). Selection of an alternative concomitant medication with no or minimal enzyme induction potential should be considered. Based on extrapolation from drug interaction study with rifampin, the following guidance may be considered for dosing in patients requiring coadministration of a strong CYP3A4 inducer, if no alternatives are feasible. Once patients have been maintained on a strong CYP3A4 inducer, the dose of IXEMPRA may be gradually increased from 40 mg/m² to 60 mg/m² depending on tolerance. If the dose is increased, IXEMPRA should be given as a 4-hour intravenous infusion. This 60 mg/m² dose given intravenously over 4 hours is predicted to adjust the AUC to the range observed without inhibitors. However, there are no clinical data with this dose adjustment in patients receiving strong CYP3A4 inducers. Patients whose dose is increased above 40 mg/m² should be monitored carefully for toxicities associated with IXEMPRA. If the strong inducer is discontinued, the IXEMPRA dose should be returned to the dose used prior to initiation of the strong CYP3A4 inducer [see Drug Interactions (7.1)].

#### 2.3 Premedication

To minimize the chance of occurrence of a hypersensitivity reaction, all patients must be premedicated approximately 1 hour before the infusion of IXEMPRA with:

- An H₂ antagonist (eg, diphenhydramine 50 mg orally or equivalent) and
- An H₁ antagonist (eg, ranitidine 150 - 300 mg orally or equivalent).

Patients who experienced a hypersensitivity reaction to IXEMPRA require premedication with corticosteroids (eg, dexamethasone 20 mg intravenously, 30 minutes before infusion or orally, 60 minutes before infusion) in addition to pretreatment with H₁ and H₂ antagonists.

#### 2.4 Instructions for Preparation and IV Administration

IXEMPRA Kit contains two vials, a vial labeled IXEMPRA (ixabepilone) for injection which contains ixabepilone powder and a vial containing DILUENT for IXEMPRA. Only supplied DILUENT must be used for constituting IXEMPRA (ixabepilone) for injection. IXEMPRA Kit must be stored in a refrigerator at 2°C - 8°C (36°F - 46°F) in the original package to protect from light. Prior to constituting IXEMPRA for injection, the Kit should be removed from the refrigerator and allowed to stand at room temperature for approximately 30 minutes. When the vials are first removed from the refrigerator, a white precipitate may be observed in the DILUENT vial. This precipitate will dissolve to form a clear solution once the DILUENT warms to room temperature. To allow for withdrawal losses, the vial labeled as 15 mg IXEMPRA for injection contains 16 mg of ixabepilone and the vial labeled as 45 mg IXEMPRA for injection contains 47 mg of ixabepilone. The 15-mg IXEMPRA Kit is supplied with a vial providing 8 mL of the DILUENT and the 45-mg IXEMPRA Kit is supplied with a vial providing 23.5 mL of the DILUENT. After constituting with the DILUENT, the concentration of ixabepilone is 2 mg/mL.

Please refer to Preparation and Handling Precautions [see Dosage and Administration (2.5)] before preparation.

### A. To constitute:

1. With a suitable syringe, aseptically withdraw the DILUENT and slowly inject it into the IXEMPRA for injection vial. The 15-mg IXEMPRA is constituted with 8 mL of DILUENT and the 45-mg IXEMPRA is constituted with 23.5 mL of DILUENT.

2. Gently swirl and invert the vial until the powder in IXEMPRA is completely dissolved.
**IXEMPRA® (ixabepilone)**

**B. To dilute:**

Before administration, the constituted solution must be further diluted with one of the specified infusion fluids listed below. The IXEMPRA infusion must be prepared in a DEHP [di-(2-ethylhexyl) pthalate] free bag.

The following infusion fluids have been qualified for use in the dilution of IXEMPRA:

- Lactated Ringer's Injection, USP
- 0.9% Sodium Chloride Injection, USP (pH adjusted with Sodium Bicarbonate Injection, USP)
- When using a 250 mL or a 500 mL bag of 0.9% Sodium Chloride Injection to prepare the infusion, the pH must be adjusted to a pH between 6.0 and 9.0 by adding 2 mEq (ie, 2 mL of an 8.4% w/v solution or 4 mL of a 4.2% w/v solution) of Sodium Bicarbonate Injection, prior to the addition of the constituted IXEMPRA solution.

**PLASMA-LYTE A Injection pH 7.4®**

For most doses, a 250 mL bag of infusion fluid is sufficient. However, it is necessary to check the final IXEMPRA infusion concentration of each dose based on the volume of infusion fluid to be used.

The final concentration for infusion must be between 0.2 mg/mL and 0.6 mg/mL. To calculate the final infusion concentration, use the following formulas:

**Total Infusion Volume = mL of Constituted Solution + mL of infusion fluid**

**Final Infusion Concentration = Dose of IXEMPRA (mg)/Total Infusion Volume (mL)**

1. Aseptically, withdraw the appropriate volume of constituted solution containing 2 mg of ixabepilone per mL.

2. Aseptically, transfer to an intravenous (IV) bag containing an appropriate volume of infusion fluid to achieve the final desired concentration of IXEMPRA.

3. Thoroughly mix the infusion bag by manual rotation.

The infusion solution must be administered through an appropriate in-line filter with a microporous membrane of 0.2 to 1.2 microns. DEHP-free infusion containers and administration sets must be used. Any remaining solution should be discarded according to institutional procedures for antineoplastics.

**Stability**

After constituting IXEMPRA, the constituted solution should be further diluted with infusion fluid as soon as possible, but may be stored in the vial (not the syringe) for a maximum of 1 hour at room temperature and room light. Once diluted with infusion fluid, the solution is stable at room temperature and room light for a maximum of 6 hours. Administration of diluted IXEMPRA must be completed within this 6-hour period. The infusion fluids previously mentioned are specified because their pH is in the range of 6.0 to 9.0, which is required to maintain IXEMPRA stability. Other infusion fluids should not be used with IXEMPRA.

2.5 Preparation and Handling Precautions

Procedures for proper handling and disposal of antineoplastic drugs [see References (15)] should be followed. To minimize the risk of dermal exposure, impervious gloves should be worn when handling vials containing IXEMPRA, regardless of the setting, including unpacking and inspection, transport within a facility, and dose preparation and administration.

3 DOSAGE FORMS AND STRENGTHS

**IXEMPRA for injection, 15 mg supplied with DILUENT for IXEMPRA, 8 mL.**

**IXEMPRA for injection, 45 mg supplied with DILUENT for IXEMPRA, 23.5 mL.**

4 CONTRAINDICATIONS

**IXEMPRA is contraindicated in patients with a history of a severe (CTC grade 3/4) hypersensitivity reaction to agents containing Cremophor® EL or its derivatives (eg, polyoxyethylated castor oil) [see Warnings and Precautions (5.4)].**

**IXEMPRA is contraindicated in patients who have a neutrophil count <100,000 cells/mm³ [see Warnings and Precautions (5.2)].**

**IXEMPRA in combination with capecitabine is contraindicated in patients with AST or ALT >2.5 x ULN or bilirubin >1 x ULN [see Boxed Warning, Contraindications (4), and Warnings and Precautions (5.3)].**

5 WARNINGS AND PRECAUTIONS

5.1 Peripheral Neuropathy

Peripheral neuropathy was common (see Table 3). Patients treated with IXEMPRA should be monitored for symptoms of neuropathy, such as burning sensation, hyperesthesia, hypoesthesia, paresthesia, discomfort, or neuropathic pain.

Neuropathy occurred early during treatment; ~75% of new onset or worsening neuropathy occurred during the first 3 cycles. Patients experiencing new or worsening symptoms may require a reduction or delay in the dose of IXEMPRA [see Dosage and Administration (2.2)]. In clinical studies, peripheral neuropathy was managed through dose reductions, dose delays, and treatment discontinuation. Neuropathy was the most frequent cause of treatment discontinuation due to drug toxicity.

In Studies 046 and 081, 80% and 87%, respectively, of patients with peripheral neuropathy who received IXEMPRA had improvement or no worsening of their neuropathy following dose reduction. For patients with grade 3/4 neuropathy in Studies 046 and 081, 76% and 79%, respectively, had documented improvement to baseline or grade 1, twelve weeks after onset.

**Table 3: Treatment-related Peripheral Neuropathy**

<table>
<thead>
<tr>
<th>IXEMPRA with capcitabine</th>
<th>IXEMPRA as monotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral neuropathy (all grades) a</td>
<td>67%</td>
</tr>
<tr>
<td>Peripheral neuropathy (grades 3/4) b</td>
<td>23%</td>
</tr>
<tr>
<td>Discontinuation due to neuropathy</td>
<td>21%</td>
</tr>
<tr>
<td>Median number of cycles to onset of grade 3/4 neuropathy</td>
<td>4</td>
</tr>
<tr>
<td>Median time to improvement of grade 3/4 neuropathy to baseline or to grade 1</td>
<td>6.0 weeks</td>
</tr>
</tbody>
</table>

a Sensory and motor neuropathy combined.

b 24% and 27% of patients in 046 and 081, respectively, had preexisting neuropathy (grade 1).

A pooled analysis of 1540 cancer patients treated with IXEMPRA indicated that patients with diabetes mellitus or preexisting peripheral neuropathy may be at increased risk of severe neuropathy. Prior therapy with neurotoxic chemotherapy agents did not predict the development of neuropathy. Patients with moderate to severe neuropathy (grade 2 or greater) were excluded from studies with IXEMPRA. Caution should be used when treating patients with diabetes mellitus or preexisting peripheral neuropathy.

5.2 Myelosuppression

Myelosuppression is dose-dependent and primarily manifested as neutropenia. In clinical studies, grade 4 neutropenia (<500 cells/mm³) occurred in 36% of patients treated with IXEMPRA in combination with capcitabine and 23% of patients treated with IXEMPRA monotherapy. Febrile neutropenia and infection with neutropenia were reported in 5% and 6% of patients treated with IXEMPRA in combination with capcitabine, respectively, and 3% and 5% of patients treated with IXEMPRA as monotherapy, respectively. Neutropenia-related death occurred in 1% of 414 patients with normal hepatic function or mild hepatic impairment treated with IXEMPRA in combination with capcitabine. The rate of neutropenia-related deaths with IXEMPRA monotherapy was lower (29%, 5 out of 17) than with AST or ALT >2.5 x ULN or bilirubin >1.5 x ULN [see Boxed Warning, Contraindications (4), and Warnings and Precautions (5.3)]. Neutropenia-related death occurred in 0.4% of 240 patients treated with IXEMPRA as monotherapy. No neutropenia-related deaths were reported in 24 patients with AST or ALT >2.5 x ULN or bilirubin >1.5 x ULN treated with IXEMPRA monotherapy. IXEMPRA must not be administered to patients with a neutrophil count <1500 cells/mm³. To monitor for myelosuppression, frequent peripheral blood cell counts are recommended for all patients receiving IXEMPRA. Patients who experience severe neutropenia or thrombocytopenia should have their dose reduced [see Dosage and Administration (2.2)].

5.3 Hepatic Impairment

Patients with baseline AST or ALT >2.5 x ULN or bilirubin >1 x ULN experienced greater toxicity than patients with baseline AST or ALT ≤2.5 x ULN or bilirubin ≤1 x ULN when treated with IXEMPRA at 40 mg/m² in combination with capcitabine or as monotherapy in breast cancer studies. In combination with capcitabine, the overall frequency of grade 3/4 adverse reactions, febrile neutropenia, serious adverse reactions, and toxicity-related deaths was greater [see Warnings and Precautions (5.2)]. With monotherapy, grade 4 neutropenia, febrile neutropenia, and serious adverse reactions were more frequent. The safety and pharmacokinetics of IXEMPRA as monotherapy were evaluated in a dose escalation study in 56 patients with varying degrees of hepatic impairment. Exposure was increased in patients with elevated AST or bilirubin [see Use in Specific Populations (8.6)].

IXEMPRA in combination with capcitabine is contraindicated in patients with AST or ALT >2.5 x ULN or bilirubin >1 x ULN due to increased risk of toxicity- and neutropenia-related death [see Boxed Warning, Contraindications (4), and Warnings and Precautions (5.2)]. Patients who are treated with IXEMPRA as monotherapy should receive a reduced dose depending on the degree of hepatic impairment [see Dosage and Administration (2.2)]. Use in patients with AST or ALT >10 x ULN or bilirubin >3 x ULN is not recommended. Limited data are available for patients with AST or ALT >5 x ULN. Caution should be used when treating these patients [see Dosage and Administration (2.2)].

5.4 Hypersensitivity Reactions

Patients with a history of a severe hypersensitivity reaction to agents containing Cremophor® EL or its derivatives (eg, polyoxyethylated castor oil) should not be treated with IXEMPRA. All patients should be premedicated with an H1 and an H2 antagonist approximately 1 hour before IXEMPRA infusion and be observed for hypersensitivity reactions (eg, flushing, rash, dyspnea, and bronchospasm). In case of severe hypersensitivity reactions, infusion of IXEMPRA should be stopped and aggressive supportive treatment (eg, epinephrine, corticosteroids) started. Of the 1323 patients treated with IXEMPRA in clinical studies, 9 patients (1%) had experienced severe hypersensitivity reactions (including anaphylaxis). Three of the 9 patients were able to be retreated. Patients who experience a hypersensitivity reaction in one cycle of IXEMPRA should be premedicated in subsequent cycles with a corticosteroid in addition to the H1 and H2 antagonists, and extension of the infusion time should be considered [see Dosage and Administration (2.3) and Contraindications (4)].

5.5 Pregnancy

Pregnancy Category D.

IXEMPRA may cause fetal harm when administered to pregnant women. There are no adequate and well-controlled studies with IXEMPRA in pregnant women. Women should be advised not to become pregnant while taking IXEMPRA. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.
IXEMPRA® (ixabepilone)

Ixabepilone was studied for effects on embryo-fetal development in pregnant rats and rabbits given IV doses of 0.02, 0.08, and 0.3 mg/kg/day and 0.01, 0.03, 0.11, and 0.3 mg/kg/day, respectively. There were no teratogenic effects. In rats, an increase in resorptions and post-implantation loss and a decrease in the number of live fetuses and fetal weight was observed at the maternally toxic dose of 0.3 mg/kg/day (approximately one-tenth the human clinical exposure based on AUC). Abnormalities included a reduced ossification of caudal vertebrae, sternebrae, and metacarpals. In rabbits, ixabepilone caused maternal toxicity (death) and embryo-fetal toxicity (resorptions) at 0.3 mg/kg/day (approximately one-tenth the human clinical dose based on body surface area). No fetuses were available at this dose for evaluation.

5.6 Cardiac Adverse Reactions

The frequency of cardiac adverse reactions (myocardial ischemia and ventricular dysfunction) was higher in the IXEMPRA in combination with capcitabine (1.9%) than in the capcitabine alone (0.5%) treatment group. Supraventricular arrhythmias were observed in the combination arm (0.5%) and not in the capcitabine alone arm. Caution should be exercised in patients with a history of cardiac disease. Discontinuation of IXEMPRA should be considered in patients who develop cardiac ischemia or impaired cardiac function.

5.7 Potential for Cognitive Impairment from Excipients

Since IXEMPRA contains dehydrated alcohol USP, consideration should be given to the possibility of central nervous system and other effects of alcohol [see Description (11)].

6 ADVERSE REACTIONS

The following adverse reactions are discussed in greater detail in other sections.

- Peripheral neuropathy [see Warnings and Precautions (5.1)]
- Myelosuppression [see Warnings and Precautions (5.2)]
- Hypersensitivity reactions [see Warnings and Precautions (5.4)]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, the adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in other clinical trials and may not reflect the rates observed in clinical practice. Unless otherwise specified, assessment of adverse reactions is based on one randomized study (Study 046) and one single-arm study (Study 081). In Study 046, 369 patients with metastatic breast cancer were treated with IXEMPRA 40 mg/m² administered intravenously over 3 hours every 21 days, combined with capcitabine (ixabepilone).

6.2 Drug-related Adverse Reactions

Hematologic abnormalities are presented separately in Table 5. Table 4 presents nonhematologic adverse reactions reported in 5% or more of patients. Table 4: Nonhematologic Drug-related Adverse Reactions Occurring in at Least 5% of Patients with Metastatic or Locally Advanced Breast Cancer Treated with IXEMPRA

<table>
<thead>
<tr>
<th>System Organ Class/ Preferred Term</th>
<th>Study 046</th>
<th>Study 081</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infecations and Infestations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Blood and Lymphatic System Disorders</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Febrile neutropenia</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Immune System Disorders</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Metabolism and Nutrition Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anorexia</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Dehydration</td>
<td>5</td>
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<td>Psychiatric Disorders</td>
<td>9</td>
<td>9</td>
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<tr>
<td>Nervous System Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripheral neuropathy</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>Sensory neuropathy</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Motor neuropathy</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Headache</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Taste disorder</td>
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IXEMPRA with capecitabine n=369

IXEMPRA with capcitabine n=368

IXEMPRA monotherapy n=126

IXEMPRA with Capecitabine

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<th>System Organ Class/ Preferred Term</th>
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<tr>
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IXEMPRA with Iroximycin n=203

IXEMPRA with Iroximycin n=126

IXEMPRA with Monotherapy

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<tr>
<td>Skin and Subcutaneous Tissue Disorders</td>
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<td>Musculoskeletal, Connective Tissue, and Bone Disorders</td>
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IXEMPRA with Ethylhexol n=31

IXEMPRA with Ethylhexol n=126

IXEMPRA with Monotherapy

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<td>Chest pain</td>
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<td>Investigations</td>
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IXEMPRA with Ethylhexol n=31

IXEMPRA with Ethylhexol n=126

IXEMPRA with Monotherapy

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<th>System Organ Class/ Preferred Term</th>
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<tr>
<td>Hematologic Abnormalities in Patients with Metastatic or Locally Advanced Breast Cancer Treated with IXEMPRA</td>
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<tr>
<td>Neutropenia</td>
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<td>Anemia (Hgb)</td>
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<td>Thrombocytopenia</td>
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IXEMPRA with Ethylhexol n=31

IXEMPRA with Ethylhexol n=126

IXEMPRA with Monotherapy

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IXEMPRA with Ethylhexol n=31

IXEMPRA with Ethylhexol n=126

IXEMPRA with Monotherapy

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<th>System Organ Class/ Preferred Term</th>
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<td>Grade 4</td>
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IXEMPRA with Ethylhexol n=31

IXEMPRA with Ethylhexol n=126

IXEMPRA with Monotherapy

IXEMPRA with Monotherapy

G-CSF (granulocyte colony stimulating factor) or GM-CSF (granulocyte macrophage colony stimulating factor) was used in 20% and 17% of patients who received IXEMPRA in Study 046 and Study 081, respectively.
Ixempra® (ixabepilone)

The following serious adverse reactions were also reported in 1323 patients treated with Ixempra as monotherapy or in combination with other therapies in Phase 2 and 3 studies.

Infections and Infestations: sepsis, pneumonia, infection, neutropenic infection, urinary tract infection, bacterial infection, enterocolitis, laryngitis, lower respiratory tract infection

Blood and Lymphatic System Disorders: coagulopathy, lymphopenia

Metabolism and Nutrition Disorders: hypernatremia, metabolic acidosis, hypokalemia, hypovolemia

Nervous System Disorders: cognitive disorder, syncope, cerebral hemorrhage, abnormal coordination, lethargy

Cardiac Disorders: myocardial infarction, supraventricular arrhythmia, left ventricular dysfunction, angina pectoris, atrial flutter, cardiomyopathy, myocardial ischemia

Vascular Disorders: hypotension, thrombosis, embolism, hemorrhage, hypovolemic shock, vasculitis

Respiratory, Thoracic, and Mediastinal Disorders: pneumonitis, hypoxia, respiratory failure, acute pulmonary edema, dysphonia, pharyngolaryngeal pain

Gastrointestinal Disorders: ileus, colitis, impaired gastric emptying, esophagitis, dysphagia, gastritis, gastrointestinal hemorrhage

Hepatobiliary Disorders: acute hepatic failure, jaundice

Skin and Subcutaneous Tissue Disorders: erythema multiforme

Musculoskeletal, Connective Tissue, and Bone Disorders: muscular weakness, muscle spasms, trismus

Renal and Urinary Disorders: nephrothiasis, renal failure

General Disorders and Administration Site Conditions: chills

Investigations: increased transaminases, increased blood alkaline phosphatase, increased gamma-glutamyltransferase

6.2 Postmarketing Experience

Radiation recall has been reported during postmarketing use of Ixempra. Because this reaction was reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate the frequency or establish a causal relationship to drug exposure.

7. DRUG INTERACTIONS

7.1 Effect of Other Drugs on Ixabepilone

Drugs That May Increase Ixabepilone Plasma Concentrations

CYP3A4 Inhibitors: Co-administration of Ixabepilone with ketoconazole, a potent CYP3A4 inhibitor, increased ibexepilone AUC by 79% compared to ibexepilone treatment alone. If alternative treatment cannot be administered, a dose adjustment should be considered. The effect of mild or moderate inhibitors (eg, erythromycin, fluconazole, or verapamil) on exposure to ibexepilone has not been studied. Therefore, caution should be used when administering mild or moderate CYP3A4 inhibitors during treatment with Ixabepilone, and alternative therapeutic agents that do not inhibit CYP3A4 should be considered. Patients receiving CYP3A4 inhibitors during treatment with Ixabepilone should be monitored closely for adverse effects (eg, frequent monitoring of peripheral blood counts between cycles of Ixabepilone [8.2]).

Drugs That May Decrease Ixabepilone Plasma Concentrations

CYP3A4 Inducers: Ixabepilone is a CYP3A4 substrate. Co-administration of Ixabepilone with rifampin, a potent CYP3A4 inducer, decreased ibexepilone AUC by 43% compared to ibexepilone treatment alone. Other strong CYP3A4 inducers (eg, dexamethasone, phenytoin, carbamazepine, rifabutin, and phenobarbital) may also decrease ibaxepilone concentrations leading to subtherapeutic levels. Therefore, therapeutic agents with low enzyme induction potential should be considered for coadministration with Ixabepilone. Ixabepilone does not inhibit CYP enzymes at relevant clinical concentrations and is not expected to alter the plasma concentrations of other drugs [see Clinical Pharmacology (12.3)].

7.2 Effect of Ixabepilone on Other Drugs

Ixabepilone does not inhibit CYP enzymes at relevant clinical concentrations and is not expected to alter the plasma concentrations of other drugs [see Clinical Pharmacology (12.3)].

7.3 Capecitabine

In patients with cancer who received ibaxepilone (40 mg/m²) in combination with capecitabine (1000 mg/m²), ibaxepilone C10H decreased by 19%, capecitabine C10H decreased by 27%, and 5-fluorouracil AUC increased by 14%, as compared to ibexepilone or capecitabine administered separately. The interaction is not clinically significant given that the combination treatment is supported by efficacy data.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category D [see Warnings and Precautions (5.5)].

8.3 Nursing Mothers

It is not known whether Ixabepilone is excreted into human milk. Following intravenous administration of radiolabeled Ixabepilone to rats on days 7 to 9 postpartum, concentrations of radioactivity in milk were comparable with those in plasma and declined in parallel with the plasma concentrations. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from Ixabepilone, a decision must be made whether to discontinue nursing or to discontinue Ixabepilone taking into account the importance of the drug to the mother.

8.4 Pediatric Use

The effectiveness of Ixabepilone in pediatric patients has not been established. Ixabepilone was evaluated in one Phase 1 and one Phase 2 trial. The pediatric patients had a safety profile consistent with that seen in adults, and no new safety signals were identified.
IXEMPRA® (ixabepilone)

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IXEMPRA® (ixabepilone) for injection is intended for intravenous infusion only after constitution with the supplied DILUENT and after further dilution with a specified infusion fluid [see Instructions for Preparation and IV Administration (2.4)]. IXEMPRA (ixabepilone) for injection is supplied as a sterile, non-pyrogenic, single-use vial providing 15 mg or 45 mg ixabepilone as a lyophilized white powder. The DILUENT for IXEMPRA is a sterile, non-pyrogenic, solution of 52.8% (w/v) purified polyethoxylated castor oil and 39.8% (w/v) dehydrated alcohol, USP. The IXEMPRA (ixabepilone) for injection and the DILUENT for IXEMPRA are copackaged and supplied as IXEMPRA Kit.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Ixabepilone is a semi-synthetic analog of epothilone B. Ixabepilone binds directly to β-tubulin subunits on microtubules, leading to suppression of microtubule dynamics. Ixabepilone suppresses the dynamic instability of β-tubulin and causes microtubule bundles. Ixabepilone possesses low in vitro susceptibility to multiple tumor resistance mechanisms including efflux transporters, such as MRP-1 and P-glycoprotein (P-gp). Ixabepilone blocks cells in the mitotic phase of the cell division cycle, leading to cell death.

12.2 Pharmacodynamics

In cancer patients, ixabepilone has a plasma concentration-dependent effect on tubulin dynamics in peripheral blood mononuclear cells that is observed as the formation of microtubule bundles. Ixabepilone has antitumor activity in vivo against human tumor xenografts, including drug-resistant types that overexpress P-gp, MRP-1, and /or tubulin isomorphs, or harbor tubulin mutations. Ixabepilone is active in xenografts that are resistant to multiple agents including taxanes, anthracyclines, and vinca alkaloids. Ixabepilone demonstrates antitumor activity in combination with other chemotherapeutics in vivo. In addition to direct antitumor activity, ixabepilone has antangiogenic activity.

12.3 Pharmacokinetics

Absorption

Following administration of a single 40 mg/m² dose of IXEMPRA in patients with cancer, the maximum Cmax was 252 ng/mL (coefficient of variation, CV 56%) and the mean AUC was 2143 ng-hr/mL (CV 48%). Typically Cmax occurred at the end of the 3-hour infusion. In cancer patients, the pharmacokinetics of ixabepilone were linear at doses of 15 to 57 mg/m².

Distribution

The mean volume of distribution of 40 mg/m² ixabepilone at steady-state was in excess of 1000 L. In vitro, the binding of ixabepilone to human serum proteins ranged from 67 to 77%, and the blood-to-plasma concentration ratios in human blood ranged from 0.65 to 0.85 over a concentration range of 50 to 5000 ng/mL.

Metabolism

Ixabepilone is extensively metabolized in the liver. In vitro studies indicated that the main route of oxidative metabolism of ixabepilone is via CYP3A4. More than 30 metabolites of ixabepilone are excreted into human urine and feces. No single metabolite accounted for more than 6% of the administered dose. The biotransformation products generated from ixabepilone by human liver microsomes were not active when tested for in vitro cytotoxicity against a human tumor cell line. In vitro studies using human liver microsomes indicate that clinically relevant concentrations of ixabepilone do not inhibit CYP3A4, CYP1A2, CYP26, CYP2B6, CYP2C9, CYP2C19, or CYP2D6. Ixabepilone does not induce the activity or the corresponding mRNA levels of CYP1A2, CYP2A6, or CYP3A4 in human hepatocytes at clinically relevant concentrations. Therefore, it is unlikely that ixabepilone will affect the plasma levels of drugs that are substrates of CYP enzymes.

Elimination

Ixabepilone is eliminated primarily as metabolized drug. After an intravenous (IV) ixabepilone dose to patients, approximately 86% of the dose was eliminated within 7 days in feces (65% of the dose) and in urine (21% of the dose). Unchanged ixabepilone accounted for approximately 1.6% and 5.6% of the dose in feces and urine, respectively. Ixabepilone has a terminal elimination half-life of approximately 52 hours. No accumulation in plasma is expected for ixabepilone administered every 3 weeks.

Drug Transport Systems

Ixabepilone is a substrate and a weak inhibitor for the drug efflux transporter P-glycoprotein (P-gp) in vitro. Ixabepilone is not a substrate for the breast cancer resistance protein (BCRP) in vitro.

Effects of Age, Gender, and Race

Based upon a population pharmacokinetic analysis in 676 cancer patients, gender, race, and age do not have meaningful effects on the pharmacokinetics of ixabepilone.

12.4 Effect of Ixabepilone on QT/QTc Interval

The QT prolongation potential of ixabepilone was assessed as part of an uncontrolled, open-label single-dose study in advanced cancer patients. Fourteen patients received a single dose of IXEMPRA 40 mg/m² intravenously over 3 hours and serial ECGs were collected over 24 hours. The maximum mean QTcF was observed 1 hour after the end of infusion and was 8 ms (upper 95th CI: 12 ms). No patients had a QTcF interval >450 ms or QTcF >30 ms after IXEMPRA administration. However, small increases in QTc interval with the use of ixabepilone cannot be excluded due to study design limitations.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenicity studies with ixabepilone have not been conducted. Ixabepilone did not induce mutations in the microbial mutagenesis (Ames) assay and was not clastogenic in an in vitro chromosomal aberration assay using primary human lymphocytes. Ixabepilone was clastogenic (induction of micronuclei) in the in vivo rat micronucleus assay at doses ≥0.625 mg/kg/day.

There were no effects on male or female rat mating or fertility at doses up to 0.2 mg/kg/day in both males and females (approximately one-fifteenth the expected human clinical exposure based on AUC). The effect of ixabepilone on human fertility is unknown. However, when rats were given an IV infusion of ixabepilone during breeding and through the first 7 days of gestation, a significant increase in resorptions and pre- and post-partum loss and a decrease in the number of corpora lutea was observed at 0.2 mg/kg/day. Testicular atrophy or degeneration was observed in 6-month rat and 9-month dog studies when ixabepilone was given every 21 days at intravenous doses of 6.7 mg/m² (40 mg/m² in rats) above the expected clinical exposure based on AUC and 0.5 and 0.75 mg/kg (10 and 15 mg/kg) in dogs (approximately 0.2 and 0.4 times the expected clinical exposure based on AUC).

13.2 Animal Toxicology

Overtol

In rats, single intravenous doses of ixabepilone from 60 to 180 mg/m² (mean AUC values 360±100 mg·h/mL) were associated with mortality occurring between 5 and 14 days after dosing, and toxicity was principally manifested in the gastrointestinal, hematopoietic (bone-marrow), lymphatic, peripheral-nervous, and male-reproductive systems. In dogs, a single intravenous dose of 100 mg/m² (mean AUC value of 6925 ng·h/mL) was markedly toxic, inducing severe gastrointestinal toxicity and death 3 days after dosing.

14 CLINICAL STUDIES

Combination Therapy

In an open-label, multicenter, multinational, randomized trial of 752 patients with metastatic or locally advanced breast cancer, the efficacy and safety of IXEMPRA (40 mg/m² every 3 weeks) in combination with capecitabine at (1000 mg/m² twice daily for 2 weeks followed by 1 week rest) were assessed in comparison with capecitabine as monotherapy (at 1250 mg/m² twice daily for 2 weeks followed by 1 week rest). Patients were previously treated with anthracycline- and taxane- containing regimens. Patients were required to have demonstrated tumor progression or resistance to taxanes and anthracyclines as follows:

- tumor progression within 3 months of the last anthracycline dose in the metastatic setting or recurrence within 6 months in the adjuvant or neoadjuvant setting, and
- tumor progression within 4 months of the last taxane dose in the metastatic setting or recurrence within 12 months in the adjuvant or neoadjuvant setting.

For anthracyclines, patients who received a minimum cumulative dose of 240 mg/m² of doxorubicin or 360 mg/m² of epirubicin were also eligible. Sixty-seven percent of patients were White, 23% were Asian, and 3% were Black. Arms were evenly matched with regards to race, age (median 53 years), baseline performance status (Karnofsky 70-100%), and receipt of prior adjuvant or neo-adjuvant chemotherapy (75%). Tumors were ER-positive in 47% of patients, ER-negative in 43%, HER2-positive in 15%, HER2-negative in 61%, and ER-negative, PR-negative, HER2-negative in 25%.

The primary endpoint of the study was progression-free survival (PFS) defined as time from randomization to disease progression or death from any cause. The results of the study are presented in Table 6.

Table 6: Baseline Disease Characteristics and Previous Therapies

For IXEMPRA plus capecitabine versus capecitabine only, prior treatment in the metastatic setting included cyclophosphamide (25% vs. 23%), fluorouracil (22% vs. 16%), vinorelbine (11% vs. 12%), gemcitabine (9% each arm), carboplatin (9% vs. 7%), liposomal doxorubicin (3% each arm), and cisplatin (2% vs. 3%).

Tumor progression within 3 months in the metastatic setting or recurrence within 6 months in the adjuvant or neoadjuvant setting.

24% and 21% of patients had received 2 or more taxane-containing regimens in the combination and single agent treatment groups, respectively.

The patients in the combination treatment group received a median of 5 cycles of treatment and patients in the capecitabine monotherapy treatment group received a median of 4 cycles of treatment.

The primary endpoint of the study was progression-free survival (PFS) defined as time from randomization to radiologic progression as determined by Independent Radiologic Review (IRR), clinical progression of measurable skin lesions or death from any cause.

Other study endpoints included objective tumor response based on Response Evaluation Criteria in Solid Tumors (RECIST), time to response, response duration, and overall survival.

IXEMPRA in combination with capecitabine resulted in a statistically significant improvement in PFS compared to capecitabine. The results of the study are presented in Table 7 and Figure 1.
Table 7: Efficacy of IXEMPRA in Combination with Capecitabine vs Capecitabine Alone – Intent-to-Treat Analysis

<table>
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<tr>
<th>Efficacy Parameter</th>
<th>IXEMPRA with capecitabine</th>
<th>Capecitabine Alone</th>
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<tbody>
<tr>
<td>PFS</td>
<td>242</td>
<td>256</td>
</tr>
<tr>
<td>Median</td>
<td>5.7 months</td>
<td>4.1 months</td>
</tr>
<tr>
<td>(95% CI)</td>
<td>(4.8 - 6.7)</td>
<td>(3.1 - 4.3)</td>
</tr>
<tr>
<td>Hazard Ratio&lt;sup&gt;b&lt;/sup&gt; (95% CI)</td>
<td>0.69 (0.58 - 0.83)</td>
<td></td>
</tr>
<tr>
<td>p-value&lt;sup&gt;c&lt;/sup&gt; (Log rank)</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>Objective Tumor Response Rate (95% CI)</td>
<td>34.7% (29.9 - 39.7)</td>
<td>14.3% (10.9 - 18.3)</td>
</tr>
<tr>
<td>p-value&lt;sup&gt;c&lt;/sup&gt; (CMH)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>Duration of Response, Median (95% CI)</td>
<td>6.4 months (5.6 - 7.1)</td>
<td>5.6 months (4.2 - 7.5)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Patients were censored for PFS at the last date of tumor assessment prior to the start of subsequent therapy. In patients where independent review was not available PFS was censored at the randomization date.

<sup>b</sup> For the hazard ratio, a value less than 1.00 favors combination treatment.

<sup>c</sup> Stratified by visceral metastasis in liver/lung, prior chemotherapy in metastatic setting, and anthracycline resistance.

<sup>d</sup> Cochran-Mantel-Haenszel test.

Figure 1: Progression-free Survival Kaplan Meier Curves

There was no statistically significant difference in overall survival between treatment arms in this study, as well as in a second similar study. In the study described above, the median overall survivals were 12.9 months (95% CI: 11.5, 14.2) in the combination therapy arm and 11.1 months (95% CI: 10.0, 12.6) in the capecitabine alone arm [Hazard Ratio 0.90 (95% CI: 0.77, 1.05), p-value=0.19].

In the second trial, comparing IXEMPRA in combination with capecitabine versus capecitabine alone, conducted in 1221 patients pretreated with an anthracycline and a taxane, the median overall survivals were 16.4 months (95% CI: 15.0, 17.9) in the combination therapy arm and 15.6 months (95% CI: 13.9, 17.0), in the capecitabine alone arm [Hazard Ratio 0.90 (95% CI: 0.78, 1.03), p-value=0.12].

Monotherapy

IXEMPRA was evaluated as a single agent in a multicenter single-arm study in 126 women with metastatic or locally advanced breast cancer. The study enrolled patients whose tumors had recurred or had progressed following two or more chemotherapy regimens including an anthracycline, a taxane, and capecitabine. Patients who had received a minimum cumulative dose of 240 mg/m² of doxorubicin or 360 mg/m² of epirubicin were also eligible. Tumor progression or recurrence were prospectively defined as follows:

- Disease progression while on therapy in the metastatic setting (defined as progression while on treatment or within 8 weeks of last dose),
- Recurrence within 6 months of the last dose in the adjuvant or neoadjuvant setting (only for anthracyline and taxane),
- HER2-positive patients must also have progressed during or after discontinuation of trastuzumab.

In this study, the median age was 51 years (range, 30-78), and 79% were White, 5% Black, and 2% Asian. Karnofsky performance status was 70-100%, 88% had received two or more prior chemotherapy regimens for metastatic disease, and 86% had liver and/or lung metastases. Tumors were ER-positive in 48% of patients, ER-negative in 44%, HER2-positive in 7%, HER2-negative in 72%, and ER-negative, PR-negative, HER2-negative in 33%.

IXEMPRA was administered at a dose of 40 mg/m² intravenously over 3 hours every 3 weeks. Patients received a median of 4 cycles (range 1 to 18) of IXEMPRA therapy.

IXEMPRA® (ixabepilone)
FDA-Approved Patient Labeling

Patient Information

IXEMPRA® Kit (pronounced as ɪk-ˈsɛm-prə) (ixabepilone)
for injection, for intravenous infusion only

Read the Patient Information that comes with IXEMPRA before you start receiving it and before each injection. There may be new information. This leaflet does not take the place of talking with your healthcare provider about your medical condition or your treatment.

What is the most important information I should know about IXEMPRA?

Your healthcare provider should do blood tests to check your liver function:
• before you begin receiving IXEMPRA
• as needed while you are receiving IXEMPRA
If blood tests show that you have liver problems, do not receive injections of IXEMPRA along with the medicine capcitabine. Taking these two medicines together if you have liver problems increases your chance of serious problems. These include: serious infection and death due to a very low white blood cell count (neutropenia).

What is IXEMPRA?

IXEMPRA is a cancer medicine. IXEMPRA is used alone or with another cancer medicine called capecitabine. IXEMPRA is used to treat breast cancer, when other medicines have not worked or no longer work.

Who should not receive IXEMPRA?

Do not receive injections of IXEMPRA if you:
• are allergic to a medicine, such as TAXOL®, that contains Cremophor® EL or polyoxethylated castor oil.
• have low white blood cell or platelet counts. Your healthcare provider will check your blood counts.
• are also taking a cancer medicine called capcitabine and you have liver problems. See “What is the most important information I should know about IXEMPRA?”

What should I tell my healthcare provider before receiving IXEMPRA?

IXEMPRA may not be right for you. Before you receive IXEMPRA, tell your healthcare provider about all of your medical conditions, including if you:
• have liver problems
• have heart problems or a history of heart problems
• have had an allergic reaction to IXEMPRA. You will receive medicines before each injection of IXEMPRA to decrease the chance of an allergic reaction. See “How will I receive IXEMPRA?”
• are pregnant or plan to become pregnant. You should not receive IXEMPRA during pregnancy because it may harm your unborn baby. Talk with your healthcare provider about how to prevent pregnancy while receiving IXEMPRA. Tell your healthcare provider right away if you become pregnant or think you are pregnant while receiving IXEMPRA.
• are breast-feeding. It is not known if IXEMPRA passes into breast milk. You and your healthcare provider should decide if you will receive IXEMPRA or breast-feed. You should not do both.

Tell your healthcare provider about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements.

IXEMPRA and certain other medicines may affect each other causing side effects. IXEMPRA may affect the way other medicines work, and other medicines may affect how IXEMPRA works. Know the medicines you take. Keep a list of your medicines with you to show your healthcare provider.

How will I receive IXEMPRA?

IXEMPRA is given by an injection directly into your vein (intravenous infusion). IXEMPRA is usually given once every three weeks. Each treatment with IXEMPRA will take about 3 hours.
Your healthcare provider will decide how much IXEMPRA you will receive and how often you will receive it.
To lower the chance of allergic reaction, you will receive other medicines about 1 hour before each treatment with IXEMPRA. See “What are the possible side effects of IXEMPRA?”
If you have an allergic reaction to IXEMPRA, you will receive a steroid medicine before future doses of IXEMPRA. You may also need to receive your doses of IXEMPRA more slowly.

What should I avoid while receiving IXEMPRA?

IXEMPRA contains alcohol. If you are dizzy or drowsy, avoid activities that may be dangerous, such as driving or operating machinery.
Do not drink grapefruit juice while receiving IXEMPRA. Drinking grapefruit juice may cause you to have too much IXEMPRA in your blood and lead to side effects.

What are the possible side effects of IXEMPRA?

IXEMPRA may cause serious side effects including:
• Numbness, tingling, or burning in the hands or feet can occur while receiving IXEMPRA (neuropathy). These symptoms may be new or get worse while you are receiving IXEMPRA. These symptoms often occur early during treatment with IXEMPRA. Tell your healthcare provider if you have any of these symptoms. Your dose of IXEMPRA may need to be decreased, stopped until your symptoms get better, or totally stopped.

• Low white blood cell count (neutropenia). White blood cells help protect the body from infections caused by bacteria. If you get a fever or infection when your white blood cells are very low, you can become seriously ill and die. You may need treatment in the hospital with antibiotic medicines. Your healthcare provider will monitor your white blood cell count often with blood tests. Tell your healthcare provider right away or go to the nearest hospital emergency room if you have a fever (temperature above 100.5°F) or other sign of infection, such as chills, cough, burning or pain when you urinate, any time between treatments with IXEMPRA.

• Allergic Reactions. Severe allergic reactions can occur with IXEMPRA and may cause death in rare cases. Allergic reactions are most likely to occur while IXEMPRA is being injected into your veins. Tell your healthcare provider right away if you get any of the following signs and symptoms of an allergic reaction:
  • itching, hives (raised itchy welts), rash
  • flushed face
  • sudden swelling of face, throat or tongue
  • chest tightness, trouble breathing
  • feel dizzy or faint
  • feel your heart beating (palpitations)

• Harm to an unborn child. See “What should I tell my healthcare provider before receiving IXEMPRA?”

• Heart problems. IXEMPRA might cause decreased blood flow to the heart, problems with heart function, and abnormal heart beat. This is seen more often in patients who also take capecitabine. Tell your healthcare provider right away if you have any of the following symptoms:
  • chest pain,
  • difficulty breathing,
  • feel your heart beating (palpitations), or
  • unusual weight gain.

The most common side effects with IXEMPRA used alone or with capecitabine may include:
• tiredness
• loss of appetite
• disorders of toenails and fingernails
• hair loss
• fever
• decreased red blood cells (anemia)
• joint and muscle pain
• headache
• decreased platelets (thrombocytopenia)
• nausea, vomiting, diarrhea, constipation, and abdominal pain
• sores on the lip, in the mouth and esophagus
• tender, red palms and soles of feet (hand-foot syndrome) that looks like a sunburn; the skin may become dry and peel. There may also be numbness and tingling.

Tell your healthcare provider about any side effect that bothers you or that does not go away. These are not all of the side effects of IXEMPRA. Ask your healthcare provider or pharmacist for more information if you have questions or concerns.

General information about IXEMPRA

This patient information leaflet summarizes the most important information about IXEMPRA. Medicines are sometimes prescribed for purposes other than those listed in a Patient Information Leaflet. If you would like more information about IXEMPRA, talk with your healthcare provider. You can ask your healthcare provider or pharmacist for information about IXEMPRA that is written for health professionals. For more information about IXEMPRA, call 1-888-IXEMPRA.

IXEMPRA® (ixabepilone) for injection Manufactured by: Baxter Oncology GmbH, 33790 Halle/Westfalen, Germany
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