

PONATINIB

Iclusig[®]

15 mg & 45 mg Film-coated tablet

Anti-neoplastic/ Anti-cancer

FORMULATION:

Each film-coated tablet contains 15 mg or 45 mg of ponatinib (as hydrochloride).

PRODUCT DESCRIPTION:

15 mg: White, biconvex, round film-coated tablet that is approximately 6 mm in diameter, with "A5" debossed on one side.

45 mg: White, biconvex, round film-coated tablet that is approximately 9 mm in diameter, with "AP4" debossed on one side.

INDICATIONS:

Ponatinib (Iclusig[®]) is indicated in adult patients with

- chronic phase, accelerated phase, or blast phase chronic myeloid leukaemia (CML) who are resistant to dasatinib or nilotinib; who are intolerant to dasatinib or nilotinib and for whom subsequent treatment with imatinib is not clinically appropriate; or who have the T315I mutation
- Philadelphia chromosome positive acute lymphoblastic leukaemia (Ph+ ALL) who are resistant to dasatinib; who are intolerant to dasatinib and for whom subsequent treatment with imatinib is not clinically appropriate; or who have the T315I mutation.

See Precautions Regarding Administration for the assessment of cardiovascular status prior to start of therapy and Special Warnings and Precautions for Use for situations where an alternative treatment may be considered.

DOSAGE AND ADMINISTRATION:

The recommended starting dose is 45 mg of ponatinib once daily. For the standard dose of 45 mg once daily, a 45 mg film-coated tablet is available. Treatment should be continued as long as the patient does not show evidence of disease progression or unacceptable toxicity.

Patients should be monitored for response according to standard clinical guidelines.

Discontinuing ponatinib should be considered if a complete haematologic response has not occurred by 3 months (90 days).

Method of administration

Ponatinib (Iclusig) is for oral use. The tablets should be swallowed whole. Patients should not crush or dissolve the tablets. Ponatinib (Iclusig[®]) may be taken with or without food.

Patients should be advised not to swallow the desiccant canister found in the bottle.

PRECAUTIONS REGARDING ADMINISTRATION:

Therapy should be initiated by a physician experienced in the diagnosis and treatment of patients with leukaemia. Haematologic support such as platelet transfusion and haematopoietic growth factors can be used during treatment if clinically indicated.

Before starting treatment with ponatinib, the cardiovascular status of the patient should be assessed, including history and physical examination, and cardiovascular risk factors should be actively managed. Cardiovascular status should continue to be monitored and medical and supportive therapy for conditions that contribute to cardiovascular risk should be optimised during treatment with ponatinib.

The risk of arterial occlusive events is likely to be dose-related. Reducing the dose of Ponatinib (Iclusig[®]) to 15 mg should be considered for CP-CML patients who have achieved a major cytogenetic response taking the following factors into account in the individual patient assessment: cardiovascular risk, side effects of ponatinib therapy, time to cytogenetic response, and BCR-ABL transcript levels (*see Special Warnings and Precautions for Use and Pharmacology*). If dose reduction is undertaken, close monitoring of response is recommended.

MANAGEMENT OF TOXICITIES:

Dose modifications or interruption of dosing should be considered for the management of haematological and non-haematological toxicities. In the case of severe adverse reactions, treatment should be withheld.

For patients whose adverse reactions are resolved or attenuated in severity, Ponatinib (Iclusig[®]) may be restarted and escalation of the dose back to the daily dose used prior to the adverse reaction may be considered, if clinically appropriate.

For a dose of 30 mg or 15 mg once daily, 15 mg film-coated tablets are available.

Myelosuppression

Dose modifications for neutropenia (ANC* < 1.0 x 10⁹/L) and thrombocytopenia (platelet < 50 x 10⁹/L) that are unrelated to leukaemia are summarized in Table 1.

Table 1 Dose modifications for myelosuppression

ANC* < 1.0 x 10 ⁹ /L or platelet < 50 x 10 ⁹ /L	First occurrence: <ul style="list-style-type: none">• Ponatinib (Iclusig[®]) should be withheld and resumed at the same dose after recovery to ANC ≥ 1.5 x 10⁹/L and platelet ≥ 75 x 10⁹/L
	Recurrence at 45 mg: <ul style="list-style-type: none">• Ponatinib (Iclusig[®]) should be withheld and resumed at 30 mg after recovery to ANC ≥ 1.5 x 10⁹/L and platelet ≥ 75 x 10⁹/L
	Recurrence at 30 mg: <ul style="list-style-type: none">• Ponatinib (Iclusig[®]) should be withheld and resumed at 15 mg after recovery to ANC ≥ 1.5 x 10⁹/L and platelet ≥ 75 x 10⁹/L
*ANC = absolute neutrophil count	

Arterial occlusion and venous thromboembolism

In a patient suspected of developing an arterial occlusive event or a venous thromboembolism, Ponatinib (Iclusig[®]) should be immediately interrupted. A benefit-risk consideration should guide a decision to restart Ponatinib (Iclusig[®]) therapy (*see Special Warnings and Precautions for Use and Adverse Reactions*) after the event is resolved.

Hypertension may contribute to risk of arterial occlusive events. Ponatinib (Iclusig[®]) treatment should be temporarily interrupted if hypertension is not medically controlled.

Pancreatitis

Recommended modifications for pancreatic adverse reactions are summarized in Table 2.

Table 2 Dose modifications for pancreatitis and elevation of lipase/amylase

Grade 2 pancreatitis and/or asymptomatic elevation of lipase/amylase	Ponatinib (Iclusig [®]) should be continued at the same dose
Grade 3 or 4 asymptomatic elevation of lipase/amylase (> 2.0 x IULN*) only	<p>Occurrence at 45 mg:</p> <ul style="list-style-type: none"> • Ponatinib (Iclusig[®]) should be withheld and resumed at 30 mg after recovery to ≤ Grade 1 (< 1.5 x IULN) <p>Occurrence at 30 mg:</p> <ul style="list-style-type: none"> • Ponatinib (Iclusig[®]) should be withheld and resumed at 15 mg after recovery to ≤ Grade 1 (< 1.5 x IULN) <p>Occurrence at 15 mg:</p> <ul style="list-style-type: none"> • Ponatinib (Iclusig[®]) discontinuation should be considered
Grade 3 pancreatitis	<p>Occurrence at 45 mg:</p> <ul style="list-style-type: none"> • Ponatinib (Iclusig[®]) should be withheld and resumed at 30 mg after recovery to < Grade 2 <p>Occurrence at 30 mg:</p> <ul style="list-style-type: none"> • Ponatinib (Iclusig[®]) should be withheld and resumed at 15 mg after recovery to < Grade 2 <p>Occurrence at 15 mg:</p> <ul style="list-style-type: none"> • Ponatinib (Iclusig[®]) discontinuation should be considered
Grade 4 pancreatitis	Ponatinib (Iclusig [®]) should be discontinued
*IULN = institution upper limit of normal	

Hepatic toxicity

Dose interruption or discontinuation may be required as described in Table 3.

Table 3 Recommended dose modifications for hepatic toxicity

<p>Elevation of liver transaminase > 3 × ULN*</p> <p>Persistent grade 2 (longer than 7 days)</p> <p>Grade 3 or higher</p>	<p>Occurrence at 45 mg:</p> <ul style="list-style-type: none"> • Ponatinib (Iclusig[®]) should be interrupted and hepatic function should be monitored • Ponatinib (Iclusig[®]) should be resumed at 30 mg after recovery to ≤ Grade 1 (< 3 × ULN), or recovery to pre-treatment grade <p>Occurrence at 30 mg:</p> <ul style="list-style-type: none"> • Ponatinib (Iclusig[®]) should be interrupted and resumed at 15 mg after recovery to ≤ Grade 1, or recovery to pre-treatment grade <p>Occurrence at 15 mg:</p> <ul style="list-style-type: none"> • Ponatinib (Iclusig[®]) should be discontinued
Elevation of AST or ALT ≥ 3 × ULN concurrent with an elevation of bilirubin > 2 × ULN and alkaline phosphatase < 2 × ULN	Ponatinib (Iclusig [®]) should be discontinued

*ULN = Upper Limit of Normal for the lab

Elderly patients

Of the 449 patients in the clinical study of Ponatinib (Iclusig[®]), 155 (35%) were ≥ 65 years of age. Compared to patients <65 years, older patients are more likely to experience adverse reactions.

Hepatic impairment

Patients with hepatic impairment may receive the recommended starting dose. Caution is recommended when administering Ponatinib (Iclusig[®]) to patients with hepatic impairment (see *Special Warnings and Precautions for Use* and *Pharmacokinetics*).

Renal impairment

Renal excretion is not a major route of ponatinib elimination. Ponatinib (Iclusig[®]) has not been studied in patients with renal impairment. Patients with estimated creatinine clearance of ≥ 50 mL/min should be able to safely receive Ponatinib (Iclusig[®]) with no dosage adjustment. Caution is recommended when administering Ponatinib (Iclusig[®]) to patients with estimated creatinine clearance of < 50 mL/min, or end-stage renal disease.

Paediatric population

The safety and efficacy of Ponatinib (Iclusig[®]) in patients less than 18 years of age have not been established. No data are available.

CONTRAINDICATIONS:

Hypersensitivity to the active substance or to any of the excipients.

SPECIAL WARNINGS AND PRECAUTIONS FOR USE:

Important adverse reactions

Myelosuppression

Ponatinib (Iclusig[®]) is associated with severe (National Cancer Institute Common Terminology Criteria for Adverse Events grade 3 or 4) thrombocytopenia, neutropenia, and anaemia. Most of the patients with grade 3 or 4 platelet count decreased, anaemia or neutropenia, developed it within the first 3 months of treatment. The frequency of these events is greater in patients with accelerated phase CML (AP-CML) or blast phase CML (BP-CML)/Ph+ ALL than in chronic phase CML (CP-CML). A complete blood count should be performed every 2 weeks for the first 3 months and then monthly or as clinically indicated. Myelosuppression was generally reversible and usually managed by withholding Ponatinib (Iclusig[®]) temporarily or reducing the dose (see *Management of Toxicities*).

Arterial occlusion

Arterial occlusions, including fatal myocardial infarction, stroke, retinal arterial occlusions associated in some cases with permanent visual impairment or vision loss, stenosis of large arterial vessels of the brain, severe peripheral vascular disease, renal artery stenosis (associated with worsening, labile or treatment-resistant hypertension), and the need for urgent revascularization procedures have occurred in Ponatinib (Iclusig[®])-treated patients. Patients with and without cardiovascular risk factors, including patients age 50 years or younger, experienced these events. Arterial occlusion adverse events were more frequent with increasing age and in patients with history of ischaemia, hypertension, diabetes, or hyperlipidaemia.

The risk of arterial occlusive events is likely to be dose-related (see *Precautions Regarding Administration and Pharmacology*).

In the phase 2 trial (with a minimum of 64 months follow-up), arterial occlusive adverse reactions have occurred in 25% of patients (treatment-emergent frequencies). Some patients experienced more than 1 type of event. Arterial cardiovascular, cerebrovascular, and peripheral vascular occlusive adverse reactions (treatment-emergent frequencies) occurred in 13%, 9%, and 11% of Ponatinib (Iclusig[®])-treated patients, respectively.

In the phase 2 trial, serious arterial occlusive adverse reactions occurred in 20% of patients (treatment-emergent frequencies). Serious arterial cardiovascular, cerebrovascular, and peripheral vascular occlusive adverse reactions (treatment-emergent frequencies) occurred in 10%, 7%, and 9% of Ponatinib (Iclusig[®])-treated patients, respectively. (see *Adverse Reactions*).

The median time to onset of the first cardiovascular, cerebrovascular, and peripheral vascular arterial occlusive events was 351, 611, and 605 days, respectively.

Ponatinib (Iclusig[®]) should not be used in patients with a history of myocardial infarction, prior revascularization or stroke, unless the potential benefit of treatment outweighs the potential risk (see *Precautions Regarding Administration* and *Adverse Reactions*). In these patients, alternative treatment options should also be considered before starting treatment with ponatinib.

Before starting treatment with ponatinib, the cardiovascular status of the patient should be assessed, including history and physical examination, and cardiovascular risk factors should be actively managed. Cardiovascular status should continue to be monitored and medical and supportive therapy for conditions that contribute to cardiovascular risk should be optimised during treatment with ponatinib.

Monitoring for evidence of arterial occlusion should be performed and if decreased vision or blurred vision occurs, an ophthalmic examination (including fundoscopy) should be performed. Ponatinib (Iclusig[®]) should be interrupted immediately in case of arterial occlusion. A benefit -risk consideration should guide a decision to restart Ponatinib (Iclusig[®]) therapy (see *Precautions Regarding Administration* and *Adverse Reactions*).

Venous thromboembolism

In the phase 2 trial (with a minimum of 64 months follow-up), venous thromboembolic adverse reactions have occurred in 6% of patients (treatment-emergent frequencies). Serious venous thromboembolic adverse reactions occurred in 5% of patients (treatment-emergent frequencies) (see *Adverse Reactions*).

Monitoring for evidence of thromboembolism should be performed. Ponatinib (Iclusig[®]) should be interrupted immediately in case of thromboembolism. A benefit -risk consideration should guide a decision to restart Ponatinib (Iclusig[®]) therapy (see *Precautions Regarding Administration* and *Adverse Reactions*).

Retinal venous occlusions associated in some cases with permanent visual impairment or vision loss have occurred in Ponatinib (Iclusig[®])-treated patients. If decreased vision or blurred vision occurs, an ophthalmic examination (including fundoscopy) should be performed.

Hypertension

Hypertension may contribute to risk of arterial thrombotic events, including renal artery stenosis. During Ponatinib (Iclusig[®]) treatment, blood pressure should be monitored and managed at each clinic visit and hypertension should be treated to normal. Ponatinib (Iclusig[®]) treatment should be temporarily interrupted if hypertension is not medically controlled (see *Precautions Regarding Administration*).

In the event of significant worsening, labile or treatment-resistant hypertension, treatment should be interrupted and evaluation for renal artery stenosis should be considered.

Treatment-emergent hypertension (including hypertensive crisis) occurred in Ponatinib (Iclusig[®])-treated patients. Patients may require urgent clinical intervention for hypertension associated with confusion, headache, chest pain, or shortness of breath.

Aneurysms and artery dissections

The use of VEGF pathway inhibitors in patients with or without hypertension may promote the formation of aneurysms and/or artery dissections. Before initiating Ponatinib (Iclusig[®]), this risk should be carefully considered in patients with risk factors such as hypertension or history of aneurysm.

Congestive heart failure

Fatal and serious heart failure or left ventricular dysfunction occurred in Ponatinib (Iclusig[®])-treated patients, including events related to prior vascular occlusive events. Patients should be monitored for signs or symptoms consistent with heart failure and they should be treated as clinically indicated,

including interruption of Ponatinib (Iclusig®). Discontinuation of ponatinib should be considered in patients who develop serious heart failure (see *Precautions Regarding Administration and Adverse Reactions*).

Pancreatitis and serum lipase

Ponatinib (Iclusig®) is associated with pancreatitis. The frequency of pancreatitis is greater in the first 2 months of use. Check serum lipase every 2 weeks for the first 2 months and then periodically thereafter. Dose interruption or reduction may be required. If lipase elevations are accompanied by abdominal symptoms, Ponatinib (Iclusig®) should be withheld and patients evaluated for evidence of pancreatitis (see *Precautions Regarding Administration*). Caution is recommended in patients with a history of pancreatitis or alcohol abuse. Patients with severe or very severe hypertriglyceridemia should be appropriately managed to reduce the risk of pancreatitis.

Hepatotoxicity

Ponatinib (Iclusig®) may result in elevation in ALT, AST, bilirubin, and alkaline phosphatase. Most patients who had an event of hepatotoxicity had their first event during the first year of treatment. Hepatic failure (including fatal outcome) has been observed. Liver function tests should be performed prior to treatment initiation and monitored periodically, as clinically indicated.

Haemorrhage

Severe haemorrhage, including fatalities, occurred in Ponatinib (Iclusig®)-treated patients. The incidence of severe bleeding events was higher in patients with AP-CML, BP-CML and Ph+ ALL. Gastrointestinal haemorrhage and subdural hematoma were the most commonly reported grade 3/4 bleeding events. Most haemorrhagic events, but not all, occurred in patients with grade 3/4 thrombocytopenia. Ponatinib (Iclusig®) should be interrupted and patients evaluated for serious or severe haemorrhage.

Hepatitis B reactivation

Reactivation of hepatitis B in patients who are chronic carriers of this virus has occurred after these patients received BCR-ABL tyrosine kinase inhibitors. Some cases resulted in acute hepatic failure or fulminant hepatitis leading to liver transplantation or a fatal outcome. Patients should be tested for HBV infection before initiating treatment with Ponatinib (Iclusig®). Experts in liver disease and in the treatment of hepatitis B should be consulted before treatment is initiated in patients with positive hepatitis B serology (including those with active disease) and for patients who test positive for HBV infection during treatment. Carriers of HBV who require treatment with Ponatinib (Iclusig®) should be closely monitored for signs and symptoms of active HBV infection throughout therapy and for several months following termination of therapy (see *Adverse Reactions*).

Posterior Reversible Encephalopathy Syndrome

Post-marketing cases of Posterior Reversible Encephalopathy Syndrome (PRES) have been reported in Ponatinib (Iclusig®)-treated patients.

PRES is a neurological disorder that can present with signs and symptoms such as seizure, headache, decreased alertness, altered mental functioning, vision loss, and other visual and neurological disturbances.

If diagnosed, interrupt Ponatinib (Iclusig®) treatment and resume treatment only once the event is resolved and if the benefit of continued treatment outweighs the risk of PRES.

Medicinal product interactions

Caution should be exercised with concurrent use of Ponatinib (Iclusig®) and moderate and strong CYP3A inhibitors and moderate and strong CYP3A inducers (see *Drug Interactions*).

Concomitant use of ponatinib with anti-clotting agents should be approached with caution in patients who may be at risk of bleeding events (see “Myelosuppression” and “Haemorrhage”). Formal studies of ponatinib with anti-clotting medicinal products have not been conducted.

QT prolongation

The QT interval prolongation potential of Ponatinib (Iclusig®) was assessed in 39 leukaemia patients and no clinically significant QT prolongation was observed (see *Pharmacology*). However, a thorough QT study has not been performed; therefore a clinically significant effect on QT cannot be excluded.

Special populations

Hepatic impairment

Patients with hepatic impairment may receive the recommended starting dose. Caution is recommended when administering Ponatinib (Iclusig[®]) to patients with hepatic impairment (see *Precautions Regarding Administration and Pharmacology*).

Renal impairment

Caution is recommended in when administering Ponatinib (Iclusig[®]) to patients with estimated creatinine clearance of < 50 mL/min or end-stage renal disease (see *Precautions Regarding Administration*).

Lactose

This medicinal product contains lactose monohydrate. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

DRUG INTERACTIONS:

Substances that may increase ponatinib serum concentrations

CYP3A inhibitors

Ponatinib is metabolized by CYP3A4.

Co-administration of a single 15 mg oral dose of Ponatinib (Iclusig[®]) in the presence of ketoconazole (400 mg daily), a strong CYP3A inhibitor, resulted in modest increases in ponatinib systemic exposure, with ponatinib AUC_{0-∞} and C_{max} values that were 78% and 47% higher, respectively, than those seen when ponatinib was administered alone.

Caution should be exercised and a reduction of the starting dose of Ponatinib (Iclusig[®]) to 30 mg should be considered with concurrent use of strong CYP3A inhibitors such as clarithromycin, indinavir, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, troleanomycin, voriconazole, and grapefruit juice.

Substances that may decrease ponatinib serum concentrations

CYP3A inducers

Co-administration of a single 45 mg dose of Ponatinib (Iclusig[®]) in the presence of rifampin (600 mg daily), a strong CYP3A inducer, to 19 healthy volunteers, decreased the AUC_{0-∞} and C_{max} of ponatinib by 62% and 42%, respectively, when compared to administration of ponatinib alone.

Co-administration of strong CYP3A4 inducers such as carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, and St. John's Wort with ponatinib should be avoided, and alternatives to the CYP3A4 inducer should be sought, unless the benefit outweighs the possible risk of ponatinib underexposure.

Substances that may have their serum concentrations altered by ponatinib

Transporter substrates

In vitro, ponatinib is an inhibitor of P-gp and BCRP. Therefore, ponatinib may have the potential to increase plasma concentrations of co-administered substrates of P-gp (e.g., digoxin, dabigatran, colchicine, pravastatin) or BCRP (e.g., methotrexate, rosuvastatin, sulfasalazine) and may increase their therapeutic effect and adverse reactions. Close clinical surveillance is recommended when ponatinib is administered with these medicinal products.

Paediatric population

Interaction studies have only been performed in adults.

FERTILITY, PREGNANCY AND LACTATION:

Women of childbearing potential/Contraception in males and females

Women of childbearing age being treated with Ponatinib (Iclusig[®]) should be advised not to become pregnant and men being treated with Ponatinib (Iclusig[®]) should be advised not to father a child during treatment. An effective method of contraception should be used during treatment. It is unknown whether ponatinib affects the effectiveness of systemic hormonal contraceptives. An alternative or additional method of contraception should be used.

Pregnancy

There are no adequate data from the use of Ponatinib (Iclusig[®]) in pregnant women. Studies in animals have shown reproductive toxicity (see *Preclinical safety data*). The potential risk for humans is unknown. Ponatinib (Iclusig[®]) should be used during pregnancy only when clearly necessary. If it is used during pregnancy, the patient must be informed of the potential risk to the fetus.

Breast-feeding

It is unknown whether Ponatinib (Iclusig[®]) is excreted in human milk. Available pharmacodynamic and toxicological data cannot exclude potential excretion in human milk. Breast-feeding should be stopped during treatment with Ponatinib (Iclusig[®]).

Fertility

No human data on the effect of ponatinib on fertility are available. In rats, treatment with ponatinib has shown effects on female fertility and male fertility was not affected (see *Preclinical safety data*). The clinical relevance of these findings to human fertility is unknown.

EFFECTS ON ABILITY TO DRIVE AND USE MACHINES:

Ponatinib (Iclusig[®]) has minor influence on the ability to drive and use machines. Adverse reactions such as lethargy, dizziness, and vision blurred have been associated with Ponatinib (Iclusig[®]). Therefore, caution should be recommended when driving or operating machines.

ADVERSE REACTIONS:

The adverse reactions described in this section were identified in a single-arm, open-label, international, multicenter trial in 449 CML and Ph+ ALL patients who were resistant or intolerant to prior TKI therapy including those with a BCR-ABL T315I mutation. All patients received 45 mg Ponatinib (Iclusig[®]) once daily. Dose adjustments to 30 mg once daily or 15 mg once daily were allowed for the management of treatment toxicity. Additionally, after approximately 2 years of follow-up, all patients who were still taking a 45 mg daily dose were recommended to undergo a dose reduction, even in the absence of adverse events, in response to the continued occurrence of vascular occlusive events in the clinical trial. At the time of reporting, all ongoing patients had a minimum follow-up of 64 months. The median duration of treatment with Ponatinib (Iclusig[®]) was 32.2 months in CP-CML patients, 19.4 months in AP-CML patients, and 2.9 months in BP-CML/Ph+ ALL patients. The median dose intensity was 28 mg/day in CP-CML patients or, 63% of the expected 45 mg dose; median dose intensity was greater in advanced disease states (32 mg/day in the AP-CML patients and 44 mg/day in the BP CML/Ph+ ALL patients).

The most common serious adverse reactions >2% (treatment-emergent frequencies) were pneumonia (7.3%), pancreatitis (5.8%), abdominal pain (4.7%), atrial fibrillation (4.5%), pyrexia (4.5%), myocardial infarction (4.0%), peripheral arterial occlusive disease (3.8%), anaemia (3.8%), angina pectoris (3.3%), platelet count decreased (3.1%), febrile neutropenia (2.9%), hypertension (2.9%), coronary artery disease (2.7%), cardiac failure congestive (2.4%), cerebrovascular accident (2.4%), sepsis (2.4%), cellulitis (2.2%), acute kidney injury (2.0%), urinary tract infection (2.0%) and lipase increased (2.0%).

Serious arterial cardiovascular, cerebrovascular, and peripheral vascular occlusive adverse reactions (treatment-emergent frequencies) occurred in 10%, 7%, and 9% of Ponatinib (Iclusig[®]) treated patients, respectively. Serious venous occlusive reactions (treatment-emergent frequencies) occurred in 5% of patients.

Arterial cardiovascular, cerebrovascular, and peripheral vascular occlusive adverse reactions (treatment-emergent frequencies) occurred in 13%, 9%, and 11% of Ponatinib (Iclusig[®])-treated patients, respectively. Overall arterial occlusive adverse reactions have occurred in 25% of Ponatinib (Iclusig[®])-treated patients from the phase 2 trial, with serious adverse reactions occurring in 20% of patients. Some patients experienced more than one type of event.

Venous thromboembolic reactions (treatment-emergent frequencies) occurred in 6% of patients. The incidence of thromboembolic events is higher in patients with Ph+ ALL or BP-CML than those with AP-CML or CP-CML. No venous occlusive events were fatal.

After a minimum follow-up of 64 months, the rates of adverse reactions resulting in discontinuation were 20% in CP-CML, 11% in AP-CML, 15% in BP-CML and 9% in Ph+ ALL.

Tabulated list of adverse reactions

Adverse reactions reported in all CML and Ph+ ALL patients are presented in Table 4. Frequency categories are very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$) and uncommon ($\geq 1/1,000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1,000$), very rare ($< 1/10,000$), and not known (cannot be estimated from the available data). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

Table 4 Adverse reactions observed in CML and Ph+ ALL patients – frequency reported by incidence of treatment emergent events

System organ class	Frequency	Adverse reactions
Infections and infestations	Very common	upper respiratory tract infection
	Common	pneumonia, sepsis, folliculitis, cellulitis
Blood and lymphatic system disorders	Very common	anaemia, platelet count decreased, neutrophil count decreased,
	Common	pancytopenia, febrile neutropenia, white blood cell count decreased, lymphocyte count decreased
Endocrine disorders	Common	Hypothyroidism
Metabolism and nutrition disorders	Very common	decreased appetite
	Common	dehydration, fluid retention, hypocalcaemia, hyperglycaemia, hyperuricaemia, hypophosphataemia, hypertriglyceridaemia, hypokalaemia, weight decreased, hyponatraemia
	Uncommon	tumour lysis syndrome
Psychiatric disorders	Very common	Insomnia
Nervous system disorders	Very common	headache, dizziness
	Common	cerebrovascular accident, cerebral infarction, neuropathy peripheral, lethargy, migraine, hyperaesthesia, hypoaesthesia, paraesthesia, transient ischaemic attack
	Uncommon	cerebral artery stenosis, cerebral haemorrhage, haemorrhage intracranial, posterior reversible encephalopathy syndrome *
Eye disorders	Common	vision blurred, dry eye, periorbital oedema, eyelid oedema, conjunctivitis, visual impairment
	Uncommon	retinal vein thrombosis, retinal vein occlusion, retinal artery occlusion

System organ class	Frequency	Adverse reactions
Cardiac disorders	Common	cardiac failure, myocardial infarction, cardiac failure congestive, coronary artery disease, angina pectoris, pericardial effusion, atrial fibrillation, ejection fraction decreased, acute coronary syndrome, atrial flutter
	Uncommon	myocardial ischemia, cardiac discomfort, ischemic cardiomyopathy, arteriospasm coronary, left ventricular dysfunction
Vascular disorders	Very common	hypertension
	Common	peripheral arterial occlusive disease, peripheral ischaemia, peripheral artery stenosis, intermittent claudication, deep vein thrombosis, hot flush, flushing
	Uncommon	poor peripheral circulation, splenic infarction, embolism venous, venous thrombosis, hypertensive crisis, renal artery stenosis
	Not known	aneurysms and artery dissections
Respiratory, thoracic and mediastinal disorders	Very common	dyspnoea, cough
	Common	pulmonary embolism, pleural effusion, epistaxis, dysphonia, pulmonary hypertension
Gastrointestinal disorders	Very common	abdominal pain, diarrhoea, vomiting, constipation, nausea, lipase increased
	Common	pancreatitis, blood amylase increased, gastroesophageal reflux disease, stomatitis, dyspepsia, abdominal distension, abdominal discomfort, dry mouth, gastric haemorrhage
Hepatobiliary disorders	Very common	alanine aminotransferase increased, aspartate aminotransferase increased
	Common	blood bilirubin increased, blood alkaline phosphatase increased, gamma-glutamyltransferase increased
	Uncommon	hepatotoxicity, hepatic failure, jaundice
Skin and subcutaneous tissue disorders	Very common	rash, dry skin, pruritus
	Common	rash pruritic, exfoliative rash, erythema, alopecia, skin exfoliation, night sweats, hyperhidrosis, petechia, ecchymosis, pain of skin, dermatitis exfoliative, hyperkeratosis, skin hyperpigmentation
Musculoskeletal and connective tissue disorders	Very common	bone pain, arthralgia, myalgia, pain in extremity, back pain, muscle spasms
	Common	musculoskeletal pain, neck pain, musculoskeletal chest pain
Reproductive system and breast disorders	Common	erectile dysfunction
General disorders and administrative site conditions	Very common	fatigue, asthenia, oedema peripheral, pyrexia, pain
	Common	chills, influenza like illness, non-cardiac chest pain, mass, face oedema

* Spontaneous reports from post-marketing experience

DESCRIPTION OF SELECTED ADVERSE REACTIONS:

Vascular occlusion (see Precautions Regarding Administration and Special Warnings and Precautions for Use).

Serious vascular occlusion has occurred in patients treated with Ponatinib (Iclusig[®]), including cardiovascular, cerebrovascular and peripheral vascular events, and venous thrombotic events. Patients with and without cardiovascular risk factors, including patients age 50 years or younger, experienced these events. Arterial occlusive adverse events were more frequent with increasing age and in patients with history of ischaemia, hypertension, diabetes, or hyperlipidaemia.

Myelosuppression

Myelosuppression was commonly reported in all patient populations. The frequency of Grade 3 or 4 thrombocytopenia, neutropenia, and anaemia was higher in patients with AP-CML and BP-CML/Ph+ ALL than in patients with CP-CML (see Table 5). Myelosuppression was reported in patients with normal baseline laboratory values as well as in patients with pre-existing laboratory abnormalities.

Discontinuation due to myelosuppression was infrequent (thrombocytopenia 4%, neutropenia and anaemia <1% each).

Hepatitis B reactivation

Hepatitis B reactivation has been reported in association with BCR-ABL TKIs. Some cases resulted in acute hepatic failure or fulminant hepatitis leading to liver transplantation or a fatal outcome (see *Special Warnings and Precautions for Use*).

Severe Cutaneous Adverse Reactions (SCARs)

Severe skin reactions (such as Stevens-Johnson Syndrome) have been reported with some BCR-ABL Tyrosine Kinase Inhibitors. Patients should be warned to immediately report suspected skin reactions, especially if associated with blistering, peeling, mucosal involvement or systemic symptoms.

Table 5 Incidence of clinically relevant grade 3/4* laboratory abnormalities in ≥2% of patients in any disease group from the Phase 2 Trial (N=449): minimum follow-up of 64 month for all ongoing patients

Laboratory Test	All Patients (N=449) (%)	CP-CML (N=270) (%)	AP-CML (N=85) (%)	BP-CML/Ph+ ALL (N=94) (%)
Haematology				
Thrombocytopenia (platelet count decreased)	40	35	49	46
Neutropenia (ANC decreased)	34	23	52	52
Leukopenia (WBC decreased)	25	12	37	53
Anaemia (Hgb decreased)	20	8	31	46
Lymphopenia	17	10	25	28
Biochemistry				
Lipase increased	14	14	13	14
Phosphorus decreased	10	10	13	9
Glucose increased	7	8	13	1
ALT increased	6	4	8	7
Sodium decreased	5	6	6	2
AST increased	4	3	5	3
Amylase increased	4	4	4	3
Potassium decreased	2	<1	6	2
Potassium increased	2	2	1	3
Alkaline phosphatase increased	2	2	4	2
Bilirubin	1	<1	2	1
Calcium decreased	1	<1	2	1
ALT=alanine aminotransferase, ANC=absolute neutrophil count, AST=aspartate aminotransferase, Hgb=haemoglobin, WBC=white blood cell count. *Reported using National Cancer Institute Common Terminology Criteria for Adverse Events version 4.0.				

OVERDOSAGE:

Isolated reports of unintentional overdose with Ponatinib (Iclusig[®]) were reported in clinical trials. Single doses of 165 mg and an estimated 540 mg in two patients did not result in any clinically significant adverse reactions. Multiple doses of 90 mg per day for 12 days in a patient resulted in pneumonia, systemic inflammatory response, atrial fibrillation, and asymptomatic, moderate pericardial effusion. Treatment was interrupted, the events resolved, and Ponatinib (Iclusig[®]) was restarted at 45 mg, once daily. In the event of an overdose of Ponatinib (Iclusig[®]), the patient should be observed and appropriate supportive treatment given.

PHARMACOLOGY:

PHARMACODYNAMICS

Pharmacotherapeutic group: antineoplastic agents, protein kinase inhibitors

Ponatinib is a potent pan BCR-ABL inhibitor with structural elements, including a carbon-carbon triple-bond, that enable high affinity binding to native BCR-ABL and mutant forms of the ABL kinase. Ponatinib inhibits the tyrosine kinase activity of ABL and T315I mutant ABL with IC₅₀ values of 0.4 and 2.0 nM, respectively. In cellular assays, ponatinib was able to overcome imatinib, dasatinib, and nilotinib resistance mediated by BCR-ABL kinase domain mutations. In preclinical mutagenesis studies, 40 nM was determined as the concentration of ponatinib sufficient to inhibit viability of cells expressing all tested BCR-ABL mutants by >50% (including T315I) and suppress the emergence of mutant clones. In a cell-based accelerated mutagenesis assay, no mutation in BCR-ABL was detected that could confer resistance to 40 nM ponatinib.

Ponatinib elicited tumour shrinkage and prolonged survival in mice bearing tumours expressing native or T315I mutant BCR-ABL.

At doses of 30 mg or greater plasma steady state trough concentrations of ponatinib typically exceed 21 ng/mL (40 nM). At doses of 15 mg or greater, 32 of 34 patients (94%) demonstrated a $\geq 50\%$ reduction of CRK-like (CRKL) phosphorylation, a biomarker of BCR-ABL inhibition, in peripheral blood mononuclear cells.

Ponatinib inhibits the activity of other clinically relevant kinases with IC_{50} values below 20 nM and has demonstrated cellular activity against RET, FLT3, and KIT and members of the FGFR, PDGFR, and VEGFR families of kinases.

Clinical efficacy and safety

The safety and efficacy of Ponatinib (Iclusig[®]) in CML and Ph+ ALL patients who were resistant or intolerant to prior tyrosine kinase inhibitor (TKI) therapy were evaluated in a single-arm, open-label, international, multicenter trial. All patients were administered 45 mg of Ponatinib (Iclusig[®]) once-daily with the possibility of dose de-escalations and dose interruptions followed by dose resumption and re-escalation. Patients were assigned to one of six cohorts based on disease phase (CP-CML; AP-CML; or BP-CML/Ph+ ALL), resistance or intolerance (R/I) to dasatinib or nilotinib, and the presence of the T315I mutation. The trial is ongoing.

Resistance in CP-CML was defined as failure to achieve either a complete haematological response (by 3 months), a minor cytogenetic response (by 6 months), or a major cytogenetic response (by 12 months) while on dasatinib or nilotinib. CP-CML patients who experienced a loss of response or development of a kinase domain mutation in the absence of a complete cytogenetic response or progression to AP-CML or BP-CML at any time on dasatinib or nilotinib were also considered resistant. Resistance in AP-CML and BP-CML/Ph+ ALL was defined as failure to achieve either a major haematological response (AP-CML by 3 months, BP-CML/Ph+ ALL by 1 month), loss of major haematological response (at any time), or development of kinase domain mutation in the absence of a major haematological response while on dasatinib or nilotinib.

Intolerance was defined as the discontinuation of dasatinib or nilotinib due to toxicities despite optimal management in the absence of a complete cytogenetic response for CP CML patients or major haematological response for AP CML, BP CML, or Ph+ ALL patients.

The primary efficacy endpoint in CP-CML was major cytogenetic response (MCyR), which included complete and partial cytogenetic responses (CCyR and PCyR). The secondary efficacy endpoints in CP-CML were complete haematological response (CHR) and major molecular response (MMR).

The primary efficacy endpoint in AP-CML and BP-CML/Ph+ ALL was major haematological response (MaHR), defined as either a complete haematological response (CHR) or no evidence of leukaemia (NEL). The secondary efficacy endpoints in AP-CML and BP-CML/Ph+ ALL were MCyR and MMR.

For all patients, additional secondary efficacy endpoints included: confirmed MCyR, time to response, duration of response, progression free survival, and overall survival. Also, post-hoc analyses to assess the relationship of shorter-term cytogenetic (MCyR) and molecular (MMR) response outcomes with longer-term outcomes of PFS and OS, maintenance of response (MCyR and MMR) after dose reductions, and PFS and OS by Arterial Occlusive Event status were conducted.

The trial enrolled 449 patients of which 444 were eligible for analysis: 267 CP-CML patients (R/I Cohort: n=203, T315I Cohort: n=64), 83 AP-CML patients (R/I Cohort: n=65, T315I Cohort: n=18), 62 BP-CML (R/I Cohort: n=38, T315I Cohort: n=24), and 32 Ph+ ALL patients (R/I Cohort: n=10, T315I Cohort: n=22). A prior MCyR or better (MCyR, MMR, or CMR) to dasatinib or nilotinib was only achieved in 26% patients with CP-CML and a prior MaHR or better (MaHR, MCyR, MMR, or CMR) was only achieved in 21%, and 24% of AP-CML, and BP-CML/Ph+ALL patients, respectively. Baseline demographic characteristics are described in Table 6 below.

Table 6 Demographics and disease characteristics

Patient characteristics at entry	Total safety population N=449
Age	
Median, years (range)	59 (18 - 94)
Gender, n (%)	
Male	238 (53%)
Race, n (%)	
Asian	59 (13%)
Black/African American	25 (6%)
White	352 (78%)
Other	13 (3%)
ECOG Performance Status, n (%)	
ECOG=0 or 1	414 (92%)
Disease history	
Median time from diagnosis to first dose, years (range)	6.09 (0.33 - 28.47)
Resistant to Prior TKI Therapy ^{a *} , n (%)	374 (88%)
Prior TKI therapy– number of regimens, n (%)	
1	32 (7%)
2	155 (35%)
≥3	262 (58%)
BCR-ABL mutation detected at entry, n (%)^b	
None	198 (44%)
1	192 (43%)
≥2	54 (12%)
^{a*} of 427 patients reporting prior TKI therapy with dasatinib or nilotinib	
^b Of the patients with one or more BCR-ABL kinase domain mutations detected at entry, 37 unique mutations were detected.	

Overall, 55% of patients had one or more BCR-ABL kinase domain mutation at entry with the most frequent being: T315I (29%), F317L (8%), E255K (4%) and E359V (4%). In 67% of CP-CML patients in the R/I cohort, no mutations were detected at study entry.

Efficacy results are summarized in Table 7, Table 8 and Table 9.

Table 7 Efficacy of Ponatinib (Iclusig®) in resistant or intolerant chronic phase CML patients

	Overall (N=267)	Resistant or Intolerant	
		R/I Cohort (N=203)	T315I Cohort (N=64)
Cytogenetic Response			
Major (MCyR) ^a % (95% CI)	55% (49-62)	51% (44-58)	70% (58-81)
Complete (CCyR) % (95% CI)	46% (40-52)	40% (33-47)	66% (53-77)
Major Molecular Response^b % (95% CI)	40% (35-47)	35% (28-42)	58% (45-70)
<p>^a Primary endpoint for CP-CML Cohorts was MCyR, which combines both complete (No detectable Ph+ cells) and partial (1% to 35% Ph+ cells) cytogenetic responses.</p> <p>^b Measured in peripheral blood. Defined as a $\leq 0.1\%$ ratio of BCR-ABL to ABL transcripts on the International Scale (IS) (ie, $\leq 0.1\%$ BCR-ABL^{IS}; patients must have the b2a2/b3a2 (p210) transcript), in peripheral blood measured by quantitative reverse transcriptase polymerase chain reaction (qRT PCR).</p> <p>Database cutoff date 06 February 2017.</p>			

CP-CML patients who received fewer prior TKIs attained higher cytogenetic, haematological, and molecular responses. Of the CP-CML patients previously treated with one, two, three or four prior TKIs, 75% (12/16), 68% (66/97), 44% (63/142), and 58% (7/12) achieved a MCyR while on Ponatinib (Iclusig®), respectively.

Of the CP-CML patients with no mutation detected at entry, 49% (66/136) achieved a MCyR.

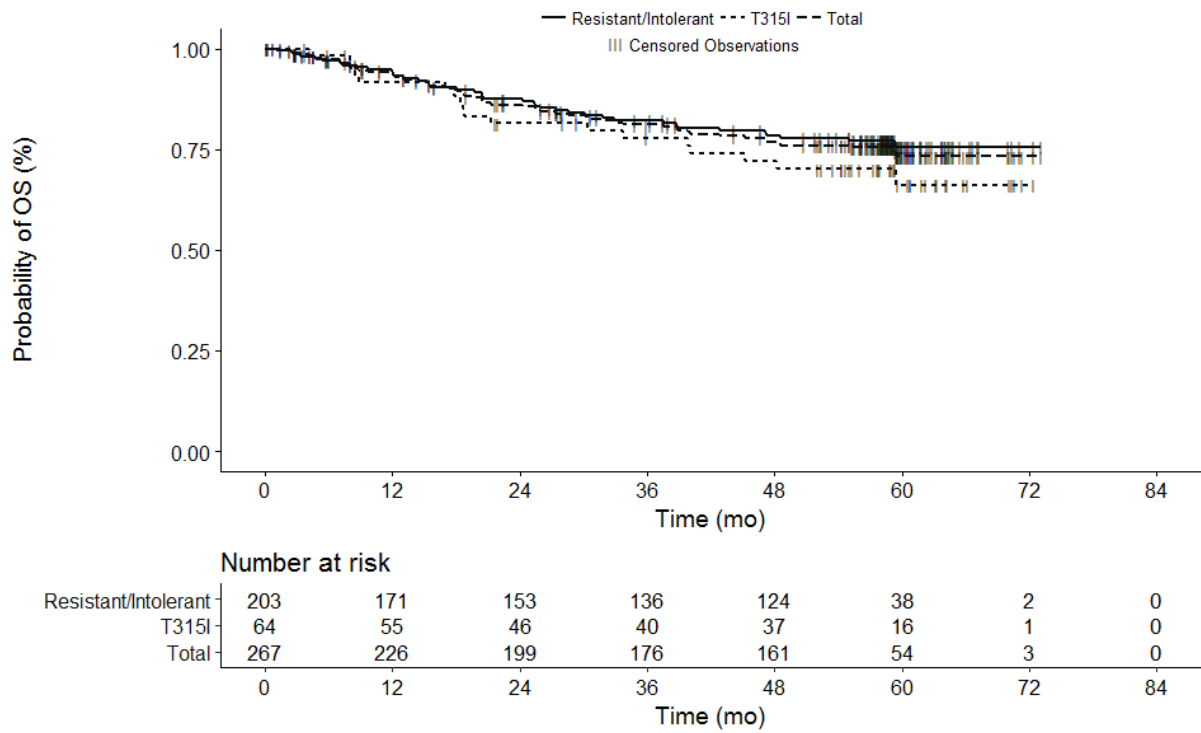
For every BCR-ABL mutation detected in more than one CP-CML patient at entry, a MCyR was achieved following treatment with Ponatinib (Iclusig®).

In CP-CML patients who achieved MCyR, the median time to MCyR was 2.8 months (range: 1.6 to 11.3 months) and in patients who achieved MMR, the median time to MMR was 5.5 months (range: 1.8 to 55.5 months). At the time of updated reporting with minimum follow-up for all ongoing patients of 64 months, the median durations of MCyR and MMR had not yet been reached. Based on the Kaplan-Meier estimates, 82% (95% CI: [74%–88%]) of CP-CML (median duration of treatment: 32.2 months) patients who achieved a MCyR are projected to maintain that response at 48 months and 61% (95% CI: [51%- 70%]) of CP-CML patients who achieved a MMR are projected to maintain that response at 36 months. The probability of all patients with CP CML maintaining MCyR and MMR did not change further when the analysis was extended out to 5 years.

With a minimum follow-up of 64 months, 3.4% (9/267) of CP-CML patients experienced transformation of their disease to AP-CML or BP-CML.

For CP-CML patients overall (N=267), as well as for CP-CML R/I Cohort A patients (N=203) and T315I Cohort B patients (N=64), the median OS has not yet been reached. For the overall CP-CML disease group, the probability of survival at 2, 3, 4, and 5 years is estimated as 86.0%, 81.2%, 76.9%, and 73.3%, respectively, as shown in Figure 1.

Figure 1- Kaplan-Meier estimates for overall survival in the CP-CML population (Treated Population)



CP -CML patients who achieved MCyR or MMR response within the first year of treatment had statistically significantly improved progression-free (PFS) and overall survival (OS) compared to those patients who did not meet the treatment milestones. A MCyR at the 3-month landmark correlated strongly and statistically significantly with PFS and OS ($p < 0.0001$ and $p = 0.0006$, respectively). Statistical significance was achieved in the correlation of PFS and OS with a MCyR at the 12-month landmark ($p < 0.0001$ and $p = 0.0012$, respectively).

Table 8 Efficacy of Ponatinib (Iclusig®) in resistant or intolerant advanced phase CML patients

	Accelerated Phase CML			Blast Phase CML		
	Overall (N=83)	Resistant or Intolerant		Overall (N=62)	Resistant or Intolerant	
		R/I Cohort (N=65)	T315I Cohort (N=18)		R/I Cohort (N=38)	T315I Cohort (N=24)
Haematological Response Rate						
Major ^a (MaHR) % (95% CI)	57% (45-68)	57% (44-69)	56% (31-79)	31% (20-44)	32% (18-49)	29% (13-51)
Complete ^b (CHR) % (95% CI)	51% (39-62)	49% (37-62)	56% (31-79)	21% (12-33)	24% (11-40)	17% (5-37)
Major Cytogenetic Response^c % (95% CI)	39% (28-50)	34% (23-47)	56% (31-79)	23% (13-35)	18% (8-34)	29% (13-51)
^a Primary endpoint for AP-CML and BP-CML/Ph+ ALL Cohorts was MaHR, which combines complete haematological responses and no evidence of leukaemia. ^b CHR: WBC ≤ institutional ULN, ANC ≥ 1,000/mm ³ , platelets ≥ 100,000/mm ³ , no blasts or promyelocytes in peripheral blood, bone marrow blasts ≤ 5%, < 5% myelocytes plus metamyelocytes in peripheral blood, basophils < 5% in peripheral blood, No extramedullary involvement (including no hepatomegaly or splenomegaly). ^c MCyR combines both complete (No detectable Ph+ cells) and partial (1% to 35% Ph+ cells) cytogenetic responses. Database cutoff date 06 February 2017						

Table 9 Efficacy of Ponatinib (Iclusig®) in resistant or intolerant Ph+ ALL patients

	Overall (N=32)	Resistant or Intolerant	
		R/I Cohort (N=10)	T315I Cohort (N=22)
Haematological Response Rate			
Major ^a (MaHR) % (95% CI)	41% (24-59)	50% (19-81)	36% (17-59)
Complete ^b (CHR) % (95% CI)	34% (19-53)	40% (12-74)	32% (14-55)
Major Cytogenetic Response^c % (95% CI)	47% (29-65)	60% (26-88)	41% (21-64)
^a Primary endpoint for AP-CML and BP-CML/Ph+ ALL Cohorts was MaHR, which combines complete haematological responses and no evidence of leukaemia. ^b CHR: WBC ≤ institutional ULN, ANC ≥ 1,000/mm ³ , platelets ≥ 100,000/mm ³ , no blasts or promyelocytes in peripheral blood, bone marrow blasts ≤ 5%, < 5% myelocytes plus metamyelocytes in peripheral blood, basophils < 5% in peripheral blood, No extramedullary involvement (including no hepatomegaly or splenomegaly). ^c MCyR combines both complete (No detectable Ph+ cells) and partial (1% to 35% Ph+ cells) cytogenetic responses. Database cutoff date 06 February 2017			

The median time to MaHR in patients with AP-CML, BP-CML, and Ph+ ALL was 0.7 months (range: 0.4 to 5.8 months), 1.0 months (range: 0.4 to 3.7 months), and 0.7 months (range: 0.4 to 5.5 months), respectively. At the time of updated reporting with minimum follow-up for all ongoing patients of

64 months, the median duration of MaHR for AP-CML (median duration of treatment: 19.4 months) BP-CML (median duration of treatment: 2.9 months), and Ph+ ALL (median duration of treatment: 2.7 months) patients was estimated as 12.9 months (range: 1.2 to 68.4 months), 6.0 months (range: 1.8 to 59.6 months), and 3.2 months (range: 1.8 to 12.8 months), respectively.

For all patients in the phase 2 trial, the dose intensity-safety relationship indicated that there are significant increases in grade ≥ 3 adverse events (cardiac failure, arterial thrombosis, hypertension, thrombocytopenia, pancreatitis, neutropenia, rash, ALT increase, AST increase, lipase increase, myelosuppression, arthralgia) over the dose range of 15 to 45 mg once-daily.

The analysis of the dose intensity-safety relationship in the phase 2 trial concluded that after adjusting for covariates, the overall dose intensity is significantly associated with an increased risk of vascular occlusion, with an odds ratio of approximately 1.6 for each 15 mg increase. In addition, results from logistic regression analyses of data from patients in the phase 1 trial, suggest a relationship between systemic exposure (AUC) and occurrence of arterial thrombotic events. A reduction in dose is therefore expected to reduce the risk of vascular occlusive events, however, the analysis suggested that there may be a ‘carry over’ effect of higher doses such that it might take up to several months before a dose reduction manifests in risk reduction. Other covariates that show a statistically significant association with the occurrence of vascular occlusive events in this analysis are medical history of ischemia and age.

Dose reduction in CP-CML patients

In the phase 2 trial, dose reductions were recommended following adverse events; in addition in October 2013 new recommendations for prospective dose reduction in all CP-CML patients in the absence of adverse events were introduced in this trial with the aim of reducing the risk of vascular occlusive events.

With a minimum follow-up of 48 months, and approximately 2 years after the recommendation for prospective dose reduction, there were 110 CP-CML patients ongoing. A majority of these ongoing patients (82/110 patients; 75%) were reported to be receiving 15 mg at the last dose, while 24/110 patients (22%) were receiving 30 mg, and 4/110 (4%) were receiving 45 mg. At the time of study closure initiation (minimum follow-up of 64 months, and more than 3 years after the recommendation for prospective dose reduction), 99 CP-CML patients were ongoing and 77 (78%) of these patients received 15 mg as their last dose on study.

Safety

In the phase 2 trial, 86 CP-CML patients achieved MCyR at a dose of 45 mg, 45 CP-CML patients achieved MCyR after a dose reduction to 30 mg, mostly for adverse events.

Vascular occlusive events occurred in 44 of these 131 patients. Most of these events occurred at the dose at which the patient achieved MCyR; fewer events occurred after dose reduction.

Table 10 Vascular occlusive first adverse events in CP-CML patients who achieved MCyR at 45 mg or 30 mg (data extraction 7 April 2014)

	Most recent dose at onset of first vascular occlusive event		
	45 mg	30 mg	15 mg
Achieved MCyR at 45 mg (N=86)	19	6	0
Achieved MCyR at 30 mg (N=45)	1	13	5

The median time to onset of the first cardiovascular, cerebrovascular, and peripheral vascular arterial occlusive events was 351, 611, and 605 days, respectively. When adjusted for exposure, the incidence of first arterial occlusive events was greatest in the first two years of follow-up and declined with decreasing daily dose intensity (following recommendation for prospective dose reduction). Factors other than dose may also contribute to this risk of arterial occlusion.

Efficacy

Data from the phase 2 trial are available on the maintenance of response (MCyR and MMR) in all CP-CML patients who underwent dose reduction for any reason. Table 11 shows these data for patients who achieved MCyR and MMR at 45 mg; similar data are available for patients who achieved MCyR and MMR at 30 mg.

The majority of patients who underwent dose reduction maintained response (MCyR and MMR) for the duration of currently available follow-up. A proportion of patients did not undergo any dose reduction, based on an individual benefit-risk assessment.

Table 11 Maintenance of response in CP-CML patients who achieved MCyR or MMR at 45 mg dose (data extraction 6 February 2017)

	Achieved MCyR at 45 mg (N=86)		Achieved MMR at 45 mg (N=63)	
	Number of Patients	Maintained MCyR	Number of Patients	Maintained MMR
No Dose Reduction	19	13 (68%)	18	11 (61%)
Dose reduction to 30 mg only	15	13 (87%)	5	3 (60%)
≥ 3 month reduction at 30 mg	12	10 (83%)	3	2 (67%)
≥ 6 month reduction at 30 mg	11	9 (82%)	3	2 (67%)
≥ 12 month reduction at 30 mg	8	7 (88%)	3	2 (67%)
≥ 18 month reduction at 30 mg	7	6 (86%)	2	2 (100%)
≥ 24 month reduction at 30 mg	6	6 (100%)	2	2 (100%)
≥ 36 month reduction at 30 mg	1	1 (100%)	--	--
Any dose reduction to 15 mg	52	51 (98%)	40	36 (90%)
≥ 3 month reduction at 15 mg	49	49 (100%)	39	36 (92%)
≥ 6 month reduction at 15 mg	47	47 (100%)	37	35 (95%)
≥ 12 month reduction at 15 mg	44	44 (100%)	34	33 (97%)
≥ 18 month reduction at 15 mg	38	38 (100%)	29	29 (100%)
≥ 24 month reduction at 15 mg	32	32 (100%)	23	23 (100%)
≥ 36 month reduction at 15 mg	8	8 (100%)	4	4 (100%)

The anti-leukaemic activity of Ponatinib (Iclusig[®]) was also evaluated in a phase 1 dose escalation study that included 65 CML and Ph+ ALL patients; the study is completed. Of 43 CP-CML patients, 31 CP-CML patients achieved a MCyR with a median duration of follow-up of 55.5 months (range: 1.7 to 91.4 months). At the time of reporting, 25 CP-CML patients were in MCyR (median duration of MCyR had not been reached).

Cardiac electrophysiology

The QT interval prolongation potential of Ponatinib (Iclusig[®]) was assessed in 39 leukaemia patients who received 30 mg, 45 mg, or 60 mg Ponatinib (Iclusig[®]) once daily. Serial ECGs in triplicate were collected at baseline and at steady state to evaluate the effect of ponatinib on QT intervals. No clinically significant changes in the mean QTc interval (i.e., > 20 ms) from baseline were detected in the study. In addition, the pharmacokinetic-pharmacodynamic models show no exposure-effect relationship, with an estimated QTcF mean change of -6.4 ms (upper confidence interval -0.9 ms) at C_{max} for the 60 mg group.

Pediatric population

The European Medicines Agency has waived the obligation to submit the results of studies with Ponatinib (Iclusig[®]) in children from birth to less than 1 year in CML and Ph+ ALL. The European Medicines Agency has deferred the obligation to submit the results of studies with Ponatinib (Iclusig[®]) in pediatric patients from 1 year to less than 18 years in CML and Ph+ ALL (see *Precautions Regarding Administration* for information on pediatric use).

PHARMACOKINETICS:

Absorption

Peak concentrations of ponatinib are observed approximately 4 hours after oral administration. Within the range of clinically relevant doses evaluated in patients (15 mg to 60 mg), ponatinib exhibited dose proportional increases in both C_{max} and AUC. The geometric mean (CV%) C_{max} and $AUC_{(0-\tau)}$ exposures achieved for ponatinib 45 mg daily at steady state were 77 ng/mL (50%) and 1296 ng•hr/mL (48%), respectively. Following either a high-fat and low-fat meal, plasma ponatinib exposures (C_{max} and AUC) were not different versus fasting conditions. Ponatinib (Iclusig[®]) may be administered with or without food. Co-administration of Ponatinib (Iclusig[®]) with a potent inhibitor of gastric acid secretion resulted in a minor reduction in ponatinib C_{max} without a reduction in $AUC_{0-\infty}$.

Distribution

Ponatinib is highly bound (>99%) to plasma proteins *in vitro*. The blood/plasma ratio of ponatinib is 0.96. Ponatinib is not displaced by concomitant administration of ibuprofen, nifedipine, propranolol, salicylic acid, or warfarin. At daily doses of 45 mg, the geometric mean (CV%) apparent steady state volume of distribution is 1101 L (94%) suggesting that ponatinib is extensively distributed in the extravascular space. *In vitro* studies suggested that ponatinib is either not a substrate or is a weak substrate for both P-gp and breast cancer resistance protein BCRP. Ponatinib is not a substrate for the human organic anion transporting polypeptides OATP1B1, OATP1B3 and the organic cation transporter OCT-1.

Biotransformation

Ponatinib is metabolized to an inactive carboxylic acid by esterases and/or amidases, and metabolized by CYP3A4 to an N-desmethyl metabolite that is 4 times less active than ponatinib. The carboxylic acid and the N-desmethyl metabolite comprise 58% and 2% of the circulating levels of ponatinib, respectively.

At therapeutic serum concentrations, ponatinib did not inhibit OATP1B1 or OATP1B3, OCT1 or OCT2, organic anion transporters OAT1 or OAT3, or bile salt export pump (BSEP) *in vitro*. Therefore, clinical medicinal product interactions are unlikely to occur as a result of ponatinib-mediated inhibition of substrates for these transporters. *In vitro* studies indicate that clinical medicinal product interactions are unlikely to occur as a result of ponatinib-mediated inhibition of the metabolism of substrates for CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP3A or CYP2D6.

An *in vitro* study in human hepatocytes indicated that clinical medicinal product interactions are also unlikely to occur as a result of ponatinib-mediated induction of the metabolism of substrates for CYP1A2, CYP2B6, or CYP3A.

Elimination

Following single and multiple 45 mg doses of Ponatinib (Iclusig[®]), the terminal elimination half-life of ponatinib was 22 hours, and steady state conditions are typically achieved within 1 week of continuous dosing. With once-daily dosing, plasma exposures of ponatinib are increased by approximately 1.5-fold between first dose and steady state conditions. Although plasma ponatinib exposures increased to steady-state levels with continuous dosing, a population pharmacokinetic analysis predicts a limited increase in apparent oral clearance within the first two weeks of continuous dosing, which is not considered clinically relevant. Ponatinib is mainly eliminated via faeces. Following a single oral dose of [¹⁴C]-labeled ponatinib, approximately 87% of the radioactive dose is recovered in the faeces and approximately 5% in the urine. Unchanged ponatinib accounted for 24% and <1% of the administered dose in faeces and urine, respectively, with the remainder of the dose comprising metabolites.

Renal impairment

Ponatinib (Iclusig[®]) has not been studied in patients with renal impairment. Although renal excretion is not a major route of ponatinib elimination, the potential for moderate or severe renal impairment to affect hepatic elimination has not been determined (see *Precautions Regarding Administration*).

Hepatic impairment

A single dose of 30 mg ponatinib was administered to patients with mild, moderate, or severe hepatic impairment and to healthy volunteers with normal hepatic function. Ponatinib C_{max} was comparable in patients with mild hepatic impairment and healthy volunteers with normal hepatic function. In patients with moderate or severe hepatic impairment, ponatinib C_{max} and AUC_{0-∞} were lower and ponatinib plasma elimination half-life was longer in patients with mild, moderate, and severe hepatic impairment but not clinically significantly different than in healthy volunteers with normal hepatic function.

In vitro data showed no difference in plasma protein binding in plasma samples of healthy subjects and hepatically impaired (mild, moderate and severe) subjects. Compared to healthy volunteers with normal liver function, no major differences in ponatinib PK were observed in patients with varying degrees of hepatic impairment. A reduction of the starting dose of Ponatinib (Iclusig[®]) in patients with hepatic impairment is not necessary (see *Precautions Regarding Administration* and *Special Warnings and Precautions for Use*).

Caution is recommended when administering Ponatinib (Iclusig[®]) to patients with hepatic impairment (see *Precautions Regarding Administration* and *Special Warnings and Precautions for Use*).

Ponatinib (Iclusig[®]) has not been studied at doses above 30 mg in patients with hepatic impairment (Childs-Pugh Classes A, B & C).

Intrinsic factors affecting ponatinib pharmacokinetics

No specific studies have been performed to evaluate the effects of gender, age, race, and body weight on ponatinib pharmacokinetics. An integrated population pharmacokinetic analysis completed for ponatinib suggests that age may be predictive of variability for ponatinib apparent oral clearance (CL/F). Gender, race and body weight were not predictive in explaining ponatinib pharmacokinetic intersubject variability.

PRECLINICAL SAFETY DATA:

Ponatinib (Iclusig[®]) has been evaluated in safety pharmacology, repeat-dose toxicity, genotoxicity, reproductive toxicity, phototoxicity and carcinogenicity studies.

Ponatinib did not exhibit genotoxic properties when evaluated in the standard *in vitro* and *in vivo* systems.

Adverse reactions not observed in clinical studies, but seen in animals at exposure levels similar to clinical exposure levels and with possible relevance to clinical use are described below.

Depletion of lymphoid organs was observed in repeat-dose toxicity studies in rats and cynomolgus monkeys. The effects were shown to be reversible after withdrawal of the treatment.

Hyper-/hypoplastic changes of the chondrocytes in the physis were noted in repeat-dose toxicity studies in rats.

In rats, inflammatory changes accompanied by increases in neutrophils, monocytes, eosinophils, and fibrinogen levels were found in the preputial and clitoral glands following chronic dosing.

Skin changes in the form of crusts, hyperkeratosis, or erythema were observed in toxicity studies in cynomolgus monkeys. Dry flaky skin was observed in toxicity studies in rats.

In a study in rats, diffuse corneal edema with neutrophilic cell infiltration, and hyperplastic changes in the lenticular epithelium suggestive of a mild phototoxic reaction were observed in animals treated with 5 and 10 mg/kg ponatinib

In cynomolgus monkeys, systolic heart murmurs with no macroscopic or microscopic correlates were noted in individual animals treated with 5 and 45 mg/kg in the single dose toxicity study and at 1, 2.5 and 5 mg/kg in the 4-week repeat-dose toxicity study. The clinical relevance of this finding is unknown.

In cynomolgus monkeys, thyroid gland follicular atrophy mostly accompanied by a reduction in T3 levels and a tendency toward increased TSH levels were observed in the 4-week repeat-dose toxicity study in cynomolgus monkeys.

Ponatinib-related microscopic findings in the ovaries (increased follicular atresia) and testes (minimal germ cell degeneration) in animals treated with 5 mg/kg ponatinib were noted in repeat-dose toxicity studies in cynomolgus monkeys.

Ponatinib at doses of 3, 10, and 30 mg/kg produced increases in urine output and electrolyte excretions and caused a decrease in gastric emptying in safety pharmacology studies in rats.

In rats, embryo-foetal toxicity in the form of post-implantation loss, reduced foetal body weight, and multiple soft tissue and skeletal alterations were observed at maternal toxic dosages. Multiple foetal soft tissue and skeletal alterations were also observed at maternal nontoxic dosages.

In a fertility study in male and female rats, female fertility parameters were reduced at dose levels corresponding to human clinical exposures. Evidence for pre- and post-implantation loss of embryos was reported in female rats and ponatinib may therefore impair female fertility. There were no effects on male rat fertility parameters. The clinical relevance of these findings on human fertility is unknown.

In juvenile rats, mortality related to inflammatory effects was observed in animals treated with 3 mg/kg/day, and reductions in body weight gain were observed at doses of 0.75, 1.5 and 3 mg/kg/day during the pre-weaning and early post-weaning treatment phases. Ponatinib did not adversely affect important developmental parameters in the juvenile toxicity study.

In a two-year carcinogenicity study in male and female rats, oral administration of ponatinib at 0.05, 0.1 and 0.2 mg/kg/day in males and at 0.2 and 0.4 mg/kg/day in females did not result in any tumorigenic effects. The 0.8 mg/kg/day dose in females resulted in a plasma exposure level generally lower or equivalent to the human exposure at the range of dose from 15 mg to 45 mg daily. A statistically significant increased incidence of squamous cell carcinoma of the clitoral gland was observed at that dose. The clinical relevance of this finding for humans is not known.

List of excipients:

Lactose monohydrate, Microcrystalline cellulose, Sodium starch glycolate, Colloidal silicon dioxide, Magnesium stearate, Talc, Polyethylene glycol, Polyvinyl alcohol, Titanium dioxide.

Storage:

Store at temperatures not exceeding 30°C.

The bottle contains one sealed canister containing a molecular sieve desiccant. Keep the canister in the bottle.

Packaging:

High density polyethylene (HDPE) bottles with screw-top closures, containing 30 film-coated tablets, together with one plastic canister containing a molecular sieve desiccant.

Special precautions handling

Patients should be advised not to swallow the desiccant canister found in the bottle.

DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation:

DATE OF REVISION OF THE TEXT

February 2020

CAUTION:

Foods, Drugs, Devices and Cosmetics Act prohibits dispensing without prescription.

For suspected adverse drug reaction, report to the FDA: www.fda.gov.ph

FDA Reg. No:

Manufactured by:

**Patheon Inc.
2100 Syntex Court Mississauga, ON, Canada L5N 7K9**

Imported by:



**Otsuka (Philippines) Pharmaceutical, Inc.
3/F King's Court II Bldg.,
2129 Chino Roces Avenue, Makati City**

Under license from Otsuka Pharmaceutical Co., Ltd., Japan

Package leaflet: Information for the patient

Ponatinib (Iclusig[®]) 15 mg film-coated tablets Ponatinib (Iclusig[®]) 45 mg film-coated tablets

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

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

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet

1. What Ponatinib (Iclusig[®]) is and what it is used for
2. What you need to know before you take Ponatinib (Iclusig[®])
3. How to take Ponatinib (Iclusig[®])
4. Possible side effects
5. How to store Ponatinib (Iclusig[®])
6. Contents of the pack and other information

1. What Ponatinib (Iclusig[®]) is and what it is used for

Ponatinib (Iclusig[®]) is **used to treat** adults with the following **leukaemia** types who are no longer benefiting from treatment with other medicines, or have a certain genetic difference known as a T315I mutation:

- chronic myeloid leukaemia (CML): a blood cancer involving too many abnormal white blood cells in the blood and the bone marrow (where blood cells are formed).
- Philadelphia-chromosome positive acute lymphoblastic leukaemia (Ph+ ALL): a type of leukaemia involving too many immature white blood cells in the blood and blood forming bone marrow. In this kind of leukaemia, some of the DNA (genetic material) has become rearranged to form an abnormal chromosome, the Philadelphia chromosome.

Ponatinib (Iclusig[®]) belongs to a group of medicines called tyrosine kinase inhibitors. In patients with CML and Ph+ ALL, changes in the DNA trigger a signal that tells the body to produce abnormal white blood cells. Ponatinib (Iclusig[®]) blocks this signal, thereby stopping the production of these cells.

2. What you need to know before you take Ponatinib (Iclusig[®])

Do not take Ponatinib (Iclusig[®])

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

Warnings and precautions

Talk to your doctor or pharmacist before taking Ponatinib (Iclusig[®]) if you have:

- a liver or pancreas disorder or reduced kidney function. Your doctor may want to take additional precautions.
- a history of alcohol abuse
- had a prior heart attack or stroke

- a history of blood clots in your blood vessels
- a history of renal artery stenosis (narrowing of the blood vessels to one or both kidneys)
- heart problems, including heart failure, irregular heartbeats, and QT prolongation
- high blood pressure
- or had an aneurysm (enlargement and weakening of a blood vessel wall) or a tear in a blood vessel wall
- a history of bleeding issues
- ever had or might now have a hepatitis B infection. This is because Ponatinib (Iclusig[®]) could cause hepatitis B to become active again, which can be fatal in some cases. Patients will be carefully checked by their doctor for signs of this infection before treatment is started.

Your doctor will perform:

- evaluations of your heart function and the condition of your arteries and veins
- a complete blood count
This will be repeated every 2 weeks for the first 3 months after starting the therapy. Afterwards it is performed monthly or as indicated by the doctor.
- checks of the serum protein known as lipase
A serum protein called lipase will be checked every 2 weeks for the first 2 months, then periodically. A break in treatment or a decrease in dose may be required when lipase is increased.
- liver tests
Liver function tests will be performed periodically, as indicated by your doctor.

A brain condition called posterior reversible encephalopathy syndrome (PRES) has been reported in patients treated with ponatinib. Symptoms may include sudden onset of severe headache, confusion, seizures, and vision changes. Tell your doctor straight away if you experience any of these symptoms during your treatment with ponatinib, because it could be serious.

Children and adolescents

Do not give this medicine to children under 18 years because no data are available in children.

Other medicines and Ponatinib (Iclusig[®])

Tell your doctor or pharmacist if you are taking, have recently taken or might take any other medicines. The following medicines can affect or be affected by Ponatinib (Iclusig[®]):

- **ketoconazole, itraconazole, voriconazole:** medicines to treat fungal infections.
- **indinavir, nelfinavir, ritonavir, saquinavir:** medicines to treat HIV infection.
- **clarithromycin, telithromycin, troleandomycin:** medicines to treat bacterial infections.
- **nefazodone:** a medicine to treat depression.
- **St. John's wort:** a herbal product used to treat depression.
- **carbamazepine:** a medicine to treat epilepsy, euphoric/depressive stages and certain pain conditions.
- **phenobarbital, phenytoin:** medicines to treat epilepsy.
- **rifabutin, rifampicin:** medicines to treat tuberculosis or certain other infections.
- **digoxin:** a medicine to treat heart weakness.
- **dabigatran:** a medicine to prevent the formation of blood clots.
- **colchicine:** a medicine to treat gout attacks.
- **pravastatin, rosuvastatin:** medicines to lower elevated cholesterol levels.
- **methotrexate:** a medicine to treat severe joint inflammation (rheumatoid arthritis), cancer and the skin disease psoriasis.
- **sulfasalazine:** a medicine to treat severe bowel and rheumatic joint inflammation.

Ponatinib (Iclusig[®]) with food and drink

Avoid grapefruit products such as grapefruit juice.

Pregnancy and breast-feeding

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

- **Contraceptive advice for men and women**
Women of childbearing age being treated with Ponatinib (Iclusig[®]) should avoid becoming pregnant. **Men** receiving treatment with Ponatinib (Iclusig[®]) are advised not to father a child during treatment. Effective contraception must be used during treatment.
Only use Ponatinib (Iclusig[®]) during pregnancy **if your doctor tells you it is absolutely necessary**, as potential risks exist for the unborn child.
- **Breast-feeding**
Stop breast-feeding during treatment with Ponatinib (Iclusig[®]). It is not known if Ponatinib (Iclusig[®]) passes into breast milk.

Driving and using machines

You should take special care when driving and using machines as patients taking Ponatinib (Iclusig[®]) may experience visual disturbance, dizziness, sleepiness, and tiredness.

Ponatinib (Iclusig[®]) contains lactose

If you have been told by your doctor that you have an intolerance to some sugars, contact your doctor before taking this medicine.

3. How to take Ponatinib (Iclusig[®])

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

Ponatinib (Iclusig[®]) therapy should be prescribed by a doctor experienced in leukaemia treatment.

Ponatinib (Iclusig[®]) is available as:

- a 45 mg film-coated tablet for the recommended dose.
- a 15 mg film-coated tablet to allow for dose adjustments.

The recommended starting dose is one 45 mg film-coated tablet once daily.

Your doctor may reduce your dose or tell you to temporarily stop taking Ponatinib (Iclusig[®]) if:

- an appropriate response to the treatment is reached.
- the number of white blood cells called neutrophils is reduced.
- the number of blood platelets is reduced.
- a severe side effect occurs, not affecting the blood
 - pancreas inflammation.
 - increased levels of the serum proteins lipase or amylase.
- you develop heart or blood vessel problems.
- you have a liver disorder.

Ponatinib (Iclusig[®]) use may be resumed at the same, or a reduced dose, after the event is resolved or controlled. Your doctor may evaluate your response to the treatment at regular intervals.

Method of use

Swallow the tablets whole, with a glass of water. The tablets can be taken with or without food. Do not crush or dissolve the tablets.

Do not swallow the desiccant canister contained in the bottle.

Duration of use

Make sure you take Ponatinib (Iclusig[®]) daily for as long as it is prescribed. This is a long-term treatment.

If you take more Ponatinib (Iclusig[®]) than you should

Talk to your doctor immediately if this occurs.

If you forget to take Ponatinib (Iclusig[®])

Do not take a double dose to make up for a forgotten dose. Take your next dose at your regular time.

If you stop taking Ponatinib (Iclusig[®])

Do not stop taking Ponatinib (Iclusig[®]) without your doctor's permission.

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

4. Possible side effects

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

Patients aged 65 and over are more likely to be affected by side effects.

Seek medical attention immediately if you experience any of the **following serious** side effects.

If abnormal results from blood tests are received, a doctor should be contacted immediately.

Serious side effects (common: may affect up to 1 in 10 people):

- lung infection (may cause breathing difficulty)
- pancreas inflammation. Inform your doctor immediately if pancreas inflammation occurs. Symptoms are severe pain in the stomach and back.
- fever, often with other signs of infection due to decreased number of white blood cells
- heart attack (symptoms include: sudden feeling of increased heart rate, chest pain, breathlessness)
- changes in blood levels:
 - decreased number of red blood cells (symptoms include: weakness, dizziness, fatigue)
 - decreased number of blood platelets (symptoms include: increased tendency to bleed or bruise)
 - decreased number of white blood cells called neutrophils (symptoms include: increase tendency of infection)
 - increased level of the serum protein known as lipase
- a heart rhythm disorder, abnormal pulse
- heart failure (symptoms include: weakness, fatigue, swollen legs)
- uncomfortable pressure, fullness, squeezing or pain in the centre of the chest (Angina pectoris) and chest pain not in connection with the heart
- high blood pressure
- narrowing of the arteries in the brain
- problems of the blood vessels in the heart muscle
- blood infection
- swollen, or red area of skin that feels hot and tender (cellulitis)
- dehydration
- breathing difficulties
- fluid in the thorax (may cause breathing difficulty)
- diarrhoea

- blood clot in a deep vein, sudden vein obstruction, blood clot in a blood vessel of the lung (symptoms include: hot flush, flushing, redness of the face, breathing difficulty)
- stroke (symptoms include: difficulty to speak or move, sleepiness, migraine, abnormal sensations)
- blood circulation problems (symptoms include: pain in the legs or arms, coldness of the extremities of the limbs)
- blood clot in the main arteries carrying blood to the head or neck (carotid artery)
- constipation
- sodium decrease in the blood
- increased tendency to bleed or bruise

Other possible side effects that may occur with the following frequencies are:

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

- upper airway infection (may cause breathing difficulty)
- decreased appetite
- insomnia
- headache, dizziness
- cough
- diarrhoea, vomiting, nausea
- increased blood levels of several liver enzymes called:
 - alanine aminotransferase
 - aspartate aminotransferase
- rash, dry skin, itching
- pain in bones, joints, pain in muscles, back, arms or legs, muscle spasms
- fatigue, accumulation of fluid in arms and/or legs, fever, pain

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

- inflammation of hair follicles, swollen, red area of skin or underneath skin that feels hot and tender
- decreased activity of thyroid gland
- fluid retention
- low calcium, phosphate or potassium levels in the blood
- increased blood sugar or uric acid levels in the blood, high blood fat values of triglycerides
- weight loss
- mini stroke
- nerve disorder in the arms and/or legs (often causes numbness and pain in the hands and feet)
- lethargy, migraine
- increased or reduced sense of touch or sensation, abnormal sensation such as prickling, tingling and itchiness
- blurred vision, dry eye, infection in the eye, visual disturbance
- tissue swelling in eyelid or around the eyes, caused by excess fluid
- palpitation
- pain in one or both legs when walking or exercising, which disappears after some minutes of rest
- hot flush, flushing
- nosebleed, difficulty producing voice sounds, hypertension in the lungs
- increased blood levels of liver and pancreatic enzymes:
 - amylase
 - alkaline phosphatase
 - gamma-glutamyltransferase
- heartburn caused by reflux of stomach juices, inflammation in the mouth, abdominal swelling or discomfort or indigestion, dry mouth
- stomach bleeding (symptoms include: stomach pain, vomiting blood)
- increased blood level of bilirubin - the yellow breakdown substance of the blood pigment (symptoms include: dark amber urine)
- pain in skeletal system or neck
- skin rash, peeling of the skin, abnormal thickening of the skin, redness, bruising, skin pain, changes in skin colour, hair loss

- tissue swelling in face caused by excess fluid
- night sweats, increased sweating
- inability to develop or maintain an erection
- chills, flu-like illness

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

- metabolic disorders caused by the break-down products of dying cancer cells
- bleeding in the brain
- obstruction of the blood vessels in the eye
- heart problems, left sided chest pain, dysfunction of the left heart chamber
- narrowing of the blood vessels, poor blood circulation, sudden increase in blood pressure
- Renal artery stenosis (narrowing of the blood vessels to one or both kidneys)
- circulatory problems in the spleen
- liver damage, jaundice (symptoms include: yellowing of the skin and eyes)
- headache, confusion, seizures, and loss of vision, which may be symptoms of a brain condition known as posterior reversible encephalopathy syndrome (PRES).

Not known (frequency cannot be estimated from the available data):

- recurrence (reactivation) of Hepatitis B infection when you have had hepatitis B in the past (a liver infection)
- troubling skin rashes involving blisters or peeling and spread across the body, and involving tiredness. Inform your doctor immediately if you experience these symptoms.
- an enlargement and weakening of a blood vessel wall or a tear in a blood vessel wall (aneurysms and artery dissections).

Reporting of side effects

If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. By reporting side effects, you can help provide more information on the safety of this medicine.

5. How to store Ponatinib (Iclusig®)

Keep this medicine out of the sight and reach of children.

Do not use this medicine after the expiry date which is stated on the bottle label and carton after EXP. The expiry date refers to the last day of that month.

Store at temperatures not exceeding 30°C.

The bottle contains one sealed plastic canister containing a molecular sieve desiccant. Keep the canister in the bottle. Do not swallow the desiccant canister.

Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. Contents of the pack and other information

What Ponatinib (Iclusig®) contains

- The active substance is ponatinib.
Each 15 mg film-coated tablet contains 15 mg ponatinib (as ponatinib hydrochloride).
Each 45 mg film-coated tablet contains 45 mg ponatinib (as ponatinib hydrochloride).
- The other ingredients are lactose monohydrate, microcrystalline cellulose, sodium starch glycolate, colloidal silicon dioxide, magnesium stearate, talc, polyethylene glycol, polyvinyl alcohol, titanium dioxide. See section 2 “Iclusig contains lactose.”

What Ponatinib (Iclusig®) looks like and contents of the pack

Ponatinib (Iclusig®) film-coated tablets are white, round and rounded on the upper and lower side.

Ponatinib (Iclusig®) 15 mg film-coated tablets are approximately 6 mm in diameter with "A5" on one side.

Ponatinib (Iclusig®) 45 mg film-coated tablets are approximately 9 mm in diameter with "AP4" on one side.

Ponatinib (Iclusig®) is available in plastic bottles, each containing one canister of a molecular sieve desiccant. Bottles are packed within a cardboard box.

Bottles of Ponatinib (Iclusig®) 15 mg contain 30 film-coated tablets.

Bottles of Ponatinib (Iclusig®) 45 mg contain 30 film-coated tablets.