

SUMMARY OF PRODUCT CHARACTERISTICS

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting systems. See section 4.8 for how to report adverse reactions.

1. NAME OF THE MEDICINAL PRODUCT

OXFET 90 mg film-coated tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Active substance

Deferasirox 90 mg

Excipients

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet

Light blue-whitish colored, biconvex, oval film coated tablets.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

OXFET is indicated for the treatment of chronic iron overload (transfusional hemosiderosis) due to blood transfusions in patients aged 6 years and older. This film coated tablets should not be preferred for 2-5 years old patients, if dispersible tablet and parenterally iron chelating agents can be used.

OXFET is also indicated for the treatment of chronic iron overload (liver iron concentration ≥ 5 mg/g dry weight or serum ferritin consistently >800 $\mu\text{g/l}$) non-transfusion-dependent thalassaemia syndromes (α -thalassaemia intermedia, β -thalassaemia intermedia, $\delta\beta$ -thalassaemia/ $\gamma\beta$ -thalassaemia / $\delta\gamma\beta$ -thalassaemia with mild to moderate clinical findings) aged 10 years and older. Once liver iron concentration <3 mg/g dry weight or serum ferritin <300 $\mu\text{g/l}$ has been achieved, treatment should be stopped.

4.2 Posology and method of administration

Posology/administration frequency and time

Treatment with Deferasirox should be initiated and maintained by physicians experienced in the treatment of chronic iron overload.

Transfusional iron overload

It is recommended that OXFET treatment be started after the transfusion of approximately 20 units (about 100 ml/kg) of packed red blood cells (PRBC) or when there is evidence from clinical monitoring that chronic iron overload is present (when serum ferritin $>1,000$ $\mu\text{g/l}$). Doses (in mg/kg) must be calculated and rounded to the nearest whole tablet size.

The goals of iron chelation therapy are to remove the amount of iron administered in transfusions and, as required, to reduce the existing iron burden. Decision to remove the amount of iron administered in transfusions should be given individually by considering risk and benefits expected with the chelation therapy.

Deferasirox film-coated tablets demonstrate higher bioavailability compared to the deferasirox dispersible tablet formulation (see section 5.2). In case of switching from dispersible tablets to film-coated tablets, the dose of the film-coated tablets should be 30% lower than the dose of the dispersible tablets, rounded to the nearest whole tablet.

The corresponding doses for the different formulations are shown in the table below.

Table 1 Recommended doses for transfusional iron overload

	Film-coated tablets	Dispersible tablets	Transfusions		Serum ferritin
Starting dose	14 mg/kg/day	20 mg/kg/day	After 20 units (about 100 ml/kg) of PRBC	or	>1,000 µg/l
Alternative starting doses	21 mg/kg/day	30 mg/kg/day	>14 ml/kg/month of PRBC (approx. >4 units/month for an adult)		
	7 mg/kg/day	10 mg/kg/day	<7 ml/kg/month of PRBC (approx. <2 units/month for an adult)		
For patients well managed on deferoxamine	One third of deferoxamine dose	Half of deferoxamine dose			
Monitoring					Monthly
Target range					500-1,000 µg/l
Adjustment steps (every 3-6 months)	Increase				>2,500 µg/l
	3.5 - 7 mg/kg/day Up to 28 mg/kg/day	5-10 mg/kg/day Up to 40 mg/kg/day			
	Decrease				
	3.5 - 7 mg/kg/day	5-10 mg/kg/day			<2,500 µg/l
	In patients treated with doses >21 mg/kg/day	In patients treated with doses >30 mg/kg/day			
	- When target is reached				500-1,000 µg/l
Maximum dose	28 mg/kg/day	40 mg/kg/day			
Consider interruption					<500 µg/l

Starting dose

The recommended initial daily dose of OXFET film-coated tablets is 14 mg/kg body weight.

An initial daily dose of 21 mg/kg OXFET may be considered for patients who require reduction of elevated body iron levels and who are also receiving more than 14 ml/kg/month for an adult of packed red blood cells (approximately >4 units/month).

An initial daily dose of 7 mg/kg OXFET may be considered for patients who do not require reduction of body iron levels and who are also receiving less than 7 ml/kg/month for an adult of packed red blood cells (approximately <2 units/month). The patient's response must be monitored and a dose increase should be considered if sufficient efficacy is not obtained (see section 5.1).

For patients already well managed on treatment with deferoxamine, a starting dose of OXFET film-coated tablets that is numerically one third that of the deferoxamine dose could be considered (e.g. a patient receiving 40 mg/kg/day of deferoxamine for 5 days per week (or equivalent) could be transferred to a starting daily dose of 14 mg/kg/day of OXFET film-coated tablets). When this results in a daily dose less than 14 mg/kg body weight, the patient's response must be monitored and a dose increase should be considered if sufficient efficacy is not obtained (see section 5.1).

Dose adjustment

It is recommended that serum ferritin be monitored every month and that the dose of OXFET be adjusted, if necessary, every 3 to 6 months based on the trends in serum ferritin. Dose adjustments may be made in steps of 3.5 to 7 mg/kg and are to be tailored to the individual patient's response and therapeutic goals (maintenance or reduction of iron burden). In patients not adequately controlled with doses of 21 mg/kg (e.g. serum ferritin levels persistently above 2,500 µg/l and not showing a decreasing trend over time), doses of up to 28 mg/kg may be considered. The availability of long-term efficacy and safety data from clinical studies conducted with Deferasirox dispersible tablets used at doses above 30 mg/kg is currently limited (264 patients followed for an average of 1 year after dose escalation). If only very poor haemosiderosis control is achieved at doses up to 21 mg/kg, a further increase (to a maximum of 28 mg/kg) may not achieve satisfactory control, and alternative treatment options may be considered. If no satisfactory control is achieved at doses above 21 mg/kg, treatment at such doses should not be maintained and alternative treatment options should be considered whenever possible. Doses above 28 mg/kg are not recommended because there is only limited experience with doses above this level.

In patients treated with doses greater than 21 mg/kg, dose reductions in steps of 3.5 to 7 mg/kg should be considered when control has been achieved (e.g. serum ferritin levels persistently below 2,500 µg/l and showing a decreasing trend over time). In patients whose serum ferritin level has reached the target (usually between 500 and 1,000 µg/l), dose reductions in steps of 3.5 to 7 mg/kg should be considered to maintain serum ferritin levels within the target range. If serum ferritin falls consistently below 500 µg/l, an interruption of treatment should be considered (see section 4.4).

Non-transfusion-dependent thalassaemia syndromes

Chelation therapy should only be initiated when there is evidence of iron overload (liver iron concentration [LIC] ≥ 5 mg Fe/g dry weight [dw] or serum ferritin consistently >800 µg/l). For patient that LIC is not evaluated, caution should be taken during chelation therapy to minimise the risk of overchelation.

Deferasirox film-coated tablets demonstrate higher bioavailability compared to the deferasirox dispersible tablet formulation (see section 5.2). In case of switching from dispersible tablets to film-coated tablets, the dose of the film-coated tablets should be 30% lower than the dose of the dispersible tablets, rounded to the nearest whole tablet.

The corresponding doses for the different formulations are shown in the table below.

Table 2 Recommended doses for non-transfusion-dependent thalassaemia syndromes

	Film-coated tablets	Dispersible tablets	Liver iron concentration (LIC)*		Serum ferritin
Starting dose	7 mg/kg/day	10 mg/kg/day	≥5 mg Fe/g dw	or	>800 µg/l
Monitoring					Monthly
Adjustment steps (every 3-6 months)	Increase		≥7 mg Fe/g dw	or	>2,000 µg/l
	3.5 - 7 mg/kg/day	5-10 mg/kg/day			
	Decrease		<7 mg Fe/g dw	or	≤2,000 µg/l
	3.5 - 7 mg/kg/day	5-10 mg/kg/day			
Maximum dose	14 mg/kg/day	20 mg/kg/day			
	7 mg/kg/day	10 mg/kg/day			
	For adults		not assessed	and	≤2,000 µg/l
For paediatric patients					
Interruption			<3 mg Fe/g dw	or	<300 µg/l
Retreatment			Not recommended		

*LIC is the preferred method of iron overload determination.

Starting dose

The recommended initial daily dose of OXFET film-coated tablets in patients with non-transfusion-dependent thalassaemia syndromes is 7 mg/kg body weight.

Dose adjustment

It is recommended that serum ferritin be monitored every month. After every 3 to 6 months of treatment, a dose increase in increments of 3.5 to 7 mg/kg should be considered if the patient's LIC is ≥ 7 mg Fe/g dw, or if serum ferritin is consistently $>2,000$ $\mu\text{g/l}$ and not showing a downward trend, and the patient is tolerating the medicinal product well. Doses above 14 mg/kg are not recommended because there is no experience with doses above this level in patients with non-transfusion-dependent thalassaemia syndromes.

In patients in whom LIC was not assessed and serum ferritin is $\leq 2,000$ $\mu\text{g/l}$, dosing should not exceed 7 mg/kg.

For patients in whom the dose was increased to >7 mg/kg, dose reduction to 7 mg/kg or less is recommended when LIC is < 7 mg Fe/g dw or serum ferritin is $\leq 2,000$ $\mu\text{g/l}$.

Treatment cessation

Once a satisfactory body iron level has been achieved (LIC < 3 mg Fe/g dw or serum ferritin < 300 $\mu\text{g/l}$), treatment should be stopped. (There are no data available on the retreatment of patients who reaccumulate iron after having achieved a satisfactory body iron level and therefore retreatment cannot be recommended.)

Method of administration

For oral use.

The film-coated tablets should be swallowed whole with some water. For patients who are unable to swallow whole tablets, the film-coated tablets may be crushed and administered by sprinkling the full dose onto soft food, e.g. yogurt or apple sauce (pureed apple).

The film-coated tablets should be taken once a day, preferably at the same time each day, and may be taken on an empty stomach or with a light meal (see sections 4.5 and 5.2).

Additional information for special populations

Patients with renal impairment

OXFET has not been studied in patients with renal impairment and is contraindicated in patients with estimated creatinine clearance <60 ml/min (see sections 4.3 and 4.4).

Patients with hepatic impairment

OXFET is not recommended in patients with severe hepatic impairment (Child-Pugh Class C) (see sections 4.4 and 5.2). In patients with moderate hepatic impairment (Child-Pugh Class B), the dose should be considerably reduced followed by progressive increase up to a limit of 50%, and OXFET must be used with caution in such patients. Hepatic function in all patients should be monitored before treatment, every 2 weeks during the first month and then every month (see section 4.4).

Paediatric population

Transfusional iron overload:

The dosing recommendations for paediatric patients aged 2 to 17 years with transfusional iron overload are the same as for adult patients. Changes in weight of paediatric patients over time must be taken into account when calculating the dose.

This film coated tablets should not be preferred for 2-5 years old patients, if dispersible tablet and parenterally iron chelating agents can be used.

In children with transfusional iron overload aged between 2 and 5 years, exposure is lower than in adults (see section 5.2). This age group may therefore require higher doses than are necessary in adults. However, the initial dose should be the same as in adults, followed by individual titration.

Non-transfusion-dependent thalassaemia syndromes:

In paediatric patients with non-transfusion-dependent thalassaemia syndromes, dosing should not exceed 7 mg/kg. In these patients, closer monitoring of LIC and serum ferritin is essential to avoid overchelation. In addition to monthly serum ferritin assessments, LIC should be monitored every three months when serum ferritin is ≤ 800 $\mu\text{g/l}$.

Children from birth to 23 months:

The safety and efficacy of OXFET in children from birth to 23 months of age have not been established. No data are available.

Geriatric population

The dosing recommendations for elderly patients are the same as described above. In clinical studies, elderly patients experienced a higher frequency of adverse reactions than younger patients (in particular, diarrhoea) and should be monitored closely for adverse reactions that may require a dose adjustment.

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients.
- Combination with other iron chelator therapies as the safety of such combinations has not been established (see section 4.5).
- Patients with estimated creatinine clearance <60 ml/min.

4.4 Special warnings and precautions for use

Renal function

Deferasirox has been studied only in patients with baseline serum creatinine within the age-appropriate normal range.

During clinical studies, increases in serum creatinine of >33% on ≥ 2 consecutive occasions, sometimes above the upper limit of the normal range, occurred in about 36% of patients. These were dose-dependent.

About two-thirds of the patients showing serum creatinine increase returned below the 33% level without dose adjustment. In the remaining third the serum creatinine increase did not always respond to a dose reduction or a dose interruption. In some cases, only a stabilisation of the serum creatinine values has been observed after dose reduction. Cases of acute renal failure have been reported following post-marketing use of deferasirox (see section 4.8). In some post-marketing cases, renal function deterioration has led to renal failure requiring temporary or permanent dialysis.

The causes of the rises in serum creatinine have not been elucidated. Particular attention should therefore be paid to monitoring of serum creatinine in patients who are concomitantly receiving medicinal products that depress renal function, and in patients who are receiving high doses of deferasirox and/or low rates of transfusion (<7 ml/kg/month of packed red blood cells or <2 units/month for an adult). While no increase in renal adverse events was observed after dose escalation of deferasirox dispersible tablets to doses above 30 mg/kg in clinical studies, an increased risk of renal adverse events with film-coated tablet doses above 21 mg/kg cannot be excluded.

It is recommended that serum creatinine be assessed in duplicate before initiating therapy. **Serum creatinine, creatinine clearance** (estimated with the Cockcroft-Gault or MDRD formula in adults and with the Schwartz formula in children) and/or plasma cystatin C levels **should be monitored prior to therapy, weekly in the first month after initiation or modification of therapy with deferasirox (including switch of formulation), and monthly thereafter**. Patients with pre-existing renal conditions and patients who are receiving medicinal products that depress renal function may be more at risk of complications. Care should be taken to maintain adequate hydration in patients who develop diarrhoea or vomiting.

There have been post-marketing reports of metabolic acidosis occurring during treatment with deferasirox. The majority of these patients had renal impairment, renal tubulopathy (Fanconi syndrome) or diarrhoea, or conditions where acid-base imbalance is a known complication. Acid-base balance should be monitored as clinically indicated in these populations. Interruption of deferasirox therapy should be considered in patients who develop metabolic acidosis.

Post-marketing cases of severe forms of renal tubulopathy (such as Fanconi syndrome) and renal failure associated with changes in consciousness in the context of hyperammonaemic encephalopathy have been reported in patients treated with deferasirox, mainly in children. It is recommended that hyperammonaemic encephalopathy be considered and ammonia levels measured in patients who develop unexplained changes in mental status while on OXFET therapy.

Table 3 Dose adjustment and interruption of treatment for renal monitoring

	Serum creatinine		Creatinine clearance
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Before initiation of therapy	Twice (2x)	and	Once (1x)
Contraindicated			<60 ml/min
Monitoring			
- First month after start of therapy or dose modification (including switch of formulation)	Weekly	and	Weekly
- Thereafter	Monthly	and	Monthly
Reduction of daily dose by 7 mg/kg/day (film-coated tablet formulation), if following renal parameters are observed at two consecutive visits and cannot be attributed to other causes			
Adult patients	>33% above pre-treatment average	and	Decreases <LLN* (<90 ml/min)
Paediatric patients	> age appropriate ULN**	and/or	Decreases <LLN* (<90 ml/min)
After dose reduction, interrupt treatment, if			
Adult and paediatric	Remains >33% above pre-treatment average	and/or	Decreases <LLN* (<90 ml/min)
*LLN: lower limit of the normal range **ULN: upper limit of the normal range			

Treatment may be reinitiated depending on the individual clinical circumstances.

Dose reduction or interruption may be also considered if abnormalities occur in levels of markers of renal tubular function and/or as clinically indicated:

- Proteinuria (test should be performed prior to therapy and monthly thereafter)
- Glycosuria in non-diabetics and low levels of serum potassium, phosphate, magnesium or urate, phosphaturia, aminoaciduria (monitor as needed).

Renal tubulopathy has been mainly reported in children and adolescents with beta-thalassaemia treated with OXFET.

Patients should be referred to a renal specialist, and further specialised investigations (such as renal biopsy) may be considered if the following occur despite dose reduction and interruption:

- Serum creatinine remains significantly elevated and
- Persistent abnormality in another marker of renal function (e.g. proteinuria, Fanconi Syndrome).

Hepatic function

Liver function test elevations have been observed in patients treated with deferasirox. Post-marketing cases of hepatic failure, some of which were fatal, have been reported. Severe forms associated with changes in consciousness in the context of hyperammonaemic encephalopathy, may occur in patients treated with deferasirox, particularly in children. It is recommended that hyperammonaemic encephalopathy be considered and ammonia levels measured in patients who develop unexplained changes in mental status while on OXFET therapy. Care should be taken to maintain adequate hydration in patients who experience volume-depleting events (such as diarrhoea or vomiting), particularly in children with acute illness. Most reports of hepatic failure involved patients with significant comorbidities including pre-existing chronic liver conditions (including cirrhosis and hepatitis C) and multi-organ failure. The role of deferasirox as a contributing or aggravating factor cannot be excluded (see section 4.8).

It is recommended that serum transaminases, bilirubin and alkaline phosphatase be checked before the initiation of treatment, every 2 weeks during the first month and monthly thereafter. If there is a persistent and progressive increase in serum transaminase levels that cannot be attributed to other

causes, OXFET should be interrupted.

Once the cause of the liver function test abnormalities has been clarified or after return to normal levels, cautious re-initiation of treatment at a lower dose followed by gradual dose escalation may be considered.

OXFET is not recommended in patients with severe hepatic impairment (Child-Pugh Class C) (see section 5.2).

Table 4 Summary of safety monitoring recommendations

Test	Frequency
Serum creatinine	In duplicate prior to therapy. Weekly during first month of therapy or after dose modification (including switch of formulation). Monthly thereafter.
Creatinine clearance and/or plasma cystatin C	Prior to therapy. Weekly during first month of therapy or after dose modification (including switch of formulation). Monthly thereafter.
Proteinuria	Prior to therapy. Monthly thereafter.
Other markers of renal tubular function (such as glycosuria in non-diabetics and low levels of serum potassium, phosphate, magnesium or urate, phosphaturia, aminoaciduria)	As needed.
Serum transaminases, bilirubin, alkaline phosphatase	Prior to therapy. Every 2 weeks during first month of therapy. Monthly thereafter.
Auditory and ophthalmic testing	Prior to therapy. Annually thereafter.
Body weight, height and sexual development	Prior to therapy. Annually in paediatric patients.

In patients with a short life expectancy (e.g. high-risk myelodysplastic syndromes), especially when co-morbidities could increase the risk of adverse events, the benefit of OXFET might be limited and may be inferior to risks. As a consequence, treatment with OXFET is not recommended in these patients.

Caution should be used in elderly patients due to a higher frequency of adverse reactions (in particular, diarrhoea).

Data in children with non-transfusion-dependent thalassaemia are very limited (see section 5.1). As a consequence, OXFET therapy should be closely monitored to detect adverse reactions and to follow iron burden in the paediatric population. In addition, before treating heavily iron-overloaded children with non-transfusion-dependent thalassaemia with OXFET, the physician should be aware that the consequences of long-term exposure in such patients are currently not known.

Gastrointestinal disorders

Upper gastrointestinal ulceration and haemorrhage have been reported in patients, including children and adolescents, receiving deferasirox. Multiple ulcers have been observed in some patients (see section 4.8). There have been reports of ulcers complicated with digestive perforation. Also, there have been reports of fatal gastrointestinal haemorrhages, especially in elderly patients who had haematological malignancies and/or low platelet counts. Physicians and

patients should remain alert for signs and symptoms of gastrointestinal ulceration and haemorrhage during OXFET therapy and in case of gastrointestinal adverse event doubt, immediately additional evaluation and treatment must be promptly initiated. Caution should be exercised in patients who are taking OXFET in combination with substances that have known ulcerogenic potential, such as NSAIDs, corticosteroids, or oral bisphosphonates, in patients receiving anticoagulants and in patients with platelet counts below 50,000/mm³ (50 x 10⁹/l) (see section 4.5).

Skin disorders

Skin rashes may appear during OXFET treatment. The rashes resolve spontaneously in most cases. When interruption of treatment may be necessary, treatment may be reintroduced after resolution of the rash, at a lower dose followed by gradual dose escalation. In severe cases this reintroduction could be conducted in combination with a short period of oral steroid administration. Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) have been reported at postmarketing. Severe cutaneous adverse reactions (SCARs) including DRESS (drug reaction with eosinophilia and systemic symptoms) should not be ignored. If any SJS or other severe cutaneous adverse reaction is suspected, OXFET should be discontinued immediately and should not be reintroduced.

Hypersensitivity reactions

Cases of serious hypersensitivity reactions (such as anaphylaxis and angioedema) have been reported in patients receiving deferasirox, with the onset of the reaction occurring in the majority of cases within the first month of treatment (see section 4.8). If such reactions occur, OXFET should be discontinued and appropriate medical intervention instituted. Deferasirox should not be reintroduced in patients who have experienced a hypersensitivity reaction due to the risk of anaphylactic shock (see section 4.3).

Vision and hearing

Auditory (decreased hearing) and ocular (lens opacities) disturbances have been reported (see section 4.8). Auditory and ophthalmic testing (including fundoscopy) is recommended before the start of treatment and at regular intervals thereafter (every 12 months). If disturbances are noted during the treatment, dose reduction or interruption may be considered.

Blood disorders

There have been post-marketing reports of leukopenia, thrombocytopenia or pancytopenia (or aggravation of these cytopenias) and of aggravated anaemia in patients treated with deferasirox. Most of these patients had pre-existing haematological disorders that are frequently associated with bone marrow failure. However, a contributory or aggravating role cannot be excluded. Interruption of treatment should be considered in patients who develop unexplained cytopenia.

Other considerations

Monthly monitoring of serum ferritin is recommended in order to assess the patient's response to therapy and to avoid overchelation (see section 4.2). If serum ferritin falls consistently below 500 µg/l (in transfusional iron overload) or below 300 µg/l (in non-transfusion-dependent thalassaemia syndromes), an interruption of treatment should be considered.

The results of the tests for serum creatinine, serum ferritin and serum transaminases should be recorded and regularly assessed for trends.

In two clinical studies, growth and sexual development of paediatric patients treated with deferasirox for up to 5 years were not affected (see section 4.8). However, as a general precautionary measure in the management of paediatric patients with transfusional iron overload, body weight, height and sexual development should be monitored prior to therapy and at regular intervals (every 12 months).

Cardiac dysfunction is a known complication of severe iron overload. Cardiac function should be monitored in patients with severe iron overload during long-term treatment with OXFET.

4.5 Interaction with other medicinal products and other forms of interaction

The safety of deferasirox in combination with other iron chelators has not been established. Therefore, it must not be combined with other iron chelator therapies (see section 4.3).

Interaction with food

The $C_{\max}$ of deferasirox film-coated tablets was increased (by 29%) when taken with a high-fat meal. OXFET film-coated tablets may be taken either on an empty stomach or with a light meal, preferably at the same time each day (see sections 4.2 and 5.2).

Agents that may decrease OXFET systemic exposure

Deferasirox metabolism depends on UGT enzymes. In a healthy volunteer study, the concomitant administration of deferasirox (single dose of 30 mg/kg, dispersible tablet formulation) and the potent UGT inducer, rifampicin, (repeated dose of 600 mg/day) resulted in a decrease of deferasirox exposure by 44% (90% CI: 37% - 51%). Therefore, the concomitant use of OXFET with potent UGT inducers (e.g. rifampicin, carbamazepine, phenytoin, phenobarbital, ritonavir) may result in a decrease in OXFET efficacy. The patient's serum ferritin should be monitored during and after the combination, and the dose of OXFET adjusted if necessary.

Cholestyramine significantly reduced the deferasirox exposure in a mechanistic study to determine the degree of enterohepatic recycling (see section 5.2).

Interaction with midazolam and other agents metabolised by CYP3A4

In a healthy volunteer study, the concomitant administration of deferasirox dispersible tablets and midazolam (a CYP3A4 probe substrate) resulted in a decrease of midazolam exposure by 17% (90% CI: 8% - 26%). In the clinical setting, this effect may be more pronounced. Therefore, due to a possible decrease in efficacy, caution should be exercised when deferasirox is combined with substances metabolised through CYP3A4 (e.g. ciclosporin, simvastatin, hormonal contraceptive agents, bepridil, ergotamine).

Interaction with repaglinide and other agents metabolised by CYP2C8

In a healthy volunteer study, the concomitant administration of deferasirox as a moderate CYP2C8 inhibitor (30 mg/kg daily, dispersible tablet formulation), with repaglinide, a CYP2C8 substrate, given as a single dose of 0.5 mg, increased repaglinide AUC and $C_{\max}$ about 2.3-fold (90% CI [2.03-2.63]) and 1.6-fold (90% CI [1.42-1.84]), respectively. Since the interaction has not been established with dosages higher than 0.5 mg for repaglinide, the concomitant use of deferasirox with repaglinide should be avoided. If the combination appears necessary, careful clinical and blood glucose monitoring should be performed (see section 4.4). An interaction between deferasirox and other CYP2C8 substrates like paclitaxel cannot be excluded.

Interaction with theophylline and other agents metabolised by CYP1A2

In a healthy volunteer study, the concomitant administration of deferasirox as a CYP1A2 inhibitor (repeated dose of 30 mg/kg/day, dispersible tablet formulation) and the CYP1A2 substrate theophylline (single dose of 120 mg) resulted in an increase of theophylline AUC by

84% (90% CI: 73% to 95%). The single dose $C_{\max}$ was not affected, but an increase of theophylline $C_{\max}$ is expected to occur with chronic dosing. Therefore, the concomitant use of deferasirox with theophylline is not recommended. If deferasirox and theophylline are used concomitantly, monitoring of theophylline concentration and theophylline dose reduction should be considered. An interaction between deferasirox and other CYP1A2 substrates cannot be excluded. For substances that are predominantly metabolised by CYP1A2 and that have a narrow therapeutic index (e.g. clozapine, tizanidine), the same recommendations apply as for theophylline.

Other information

The concomitant administration of deferasirox and aluminium-containing antacid preparations has not been formally studied. Although deferasirox has a lower affinity for aluminium than for iron, it is not recommended to take deferasirox tablets with aluminium-containing antacid preparations.

The concomitant administration of deferasirox with substances that have known ulcerogenic potential, such as NSAIDs (including acetylsalicylic acid at high dosage), corticosteroids or oral bisphosphonates may increase the risk of gastrointestinal toxicity (see section 4.4). The concomitant administration of deferasirox with anticoagulants may also increase the risk of gastrointestinal haemorrhage. Close clinical monitoring is required when deferasirox is combined with these substances.

Concomitant administration of deferasirox and busulfan resulted in an increase of busulfan exposure (AUC), but the mechanism of the interaction remains unclear. If possible, evaluation of the pharmacokinetics (AUC, clearance) of a busulfan test dose should be performed to allow dose adjustment.

Additional information for special populations

No data available for interactions at special populations.

Additional information for paediatric populations

No data available for interactions at paediatric populations.

4.6 Pregnancy and lactation

General advice:

Pregnancy category C.

Women of childbearing potential/ birth control (Contraception)

OXFET may decrease the efficacy of hormonal contraceptives (see section 4.5). Women of childbearing potential are recommended to use additional or alternative non-hormonal methods of contraception when using OXFET

Pregnancy

As a precaution, it is recommended that OXFET is not used during pregnancy unless clearly necessary. No clinical data on exposed pregnancies are available for deferasirox.

Studies in animals have shown some reproductive toxicity at maternally toxic doses (see section 5.3). The potential risk for humans is unknown.

Lactation

It is not known if deferasirox is secreted into human milk. In animal studies, deferasirox was found to be rapidly and extensively secreted into maternal milk. Whether ending breast feeding or ending OXFET treatment/ not recommending, benefit for the infant and OXFET treatment for the mother should be considered. Breast-feeding while taking OXFET is not recommended.

Reproduction/ Fertility

No fertility data is available for humans. In animals, no adverse effects on male or female fertility were found.

Reproduction toxicity potential have been observed for rats and rabbits. Deferasirox had not shown teratogenic effect, but increased variation frequency for skeleton structure and stillborn counts at pregnant rats. Deferasirox, have no additional effect on fertility or reproduction (see 5.3 Preclinical data)

4.7 Effects on ability to drive and use machines

OXFET has minor influence on the ability to drive and use machines. Patients experiencing the uncommon adverse reaction of dizziness should exercise caution when driving or operating machines (see section 4.8).

4.8 Undesirable effects

The most frequent reactions reported during Clinical studies performed with transfusional iron overload patients, gastrointestinal disturbances mainly nausea, vomiting, diarrhoea or abdominal pain occurred 26% of the patients, skin rash observed approximately 7% of the patients, for long term deferasirox therapy, both adult and paediatric patients. Diarrhoea is reported more commonly in paediatric patients aged 2 to 5 years and in the elderly. These reactions are dose-dependent, mostly mild to moderate, generally transient and mostly resolve even if treatment is continued. During clinical studies dose-dependent increases in serum creatinine occurred in about 36% of patients, though most remained within the normal range. These reactions are dose-dependent, , generally transient and mostly resolve even if treatment is continued. (see section 4.4 Special warnings and precautions for use).

In a retrospective meta-analysis of 2,102 adult and paediatric beta-thalassaemia patients with transfusional iron overload treated with deferasirox dispersible tablets in two randomised and four open label studies of up to five years' duration, a mean creatinine clearance decrease of 13.2% in adult patients (95% CI: -14.4% to -12.1%; n=935) and 9.9% (95% CI: -11.1% to -8.6%; n=1,142) in paediatric patients was observed during the first year of treatment. In 250 patients who were followed for up to five years, no further decrease in mean creatinine clearance levels was observed.

Clinical study in patients with non-transfusion-dependent thalassaemia syndromes In a 1-year study in patients with non-transfusion-dependent thalassaemia syndromes and iron overload (dispersible tablets at a dose of 10 mg/kg/day), diarrhoea (9.1%), rash (9.1%), and nausea (7.3%) were the most frequent study drug-related adverse events. Abnormal serum creatinine and creatinine clearance values were reported in 5.5% and 1.8% of patients, respectively. Elevations of liver transaminases greater than 2 times the baseline and 5 times the upper limit of normal were reported in 1.8% of patients.

Below listed adverse reactions are reported during clinical studies.

Very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$); very rare ($< 1/10,000$); not known (cannot be estimated from the available data).

Blood and lymphatic system disorders

Not known: Pancytopenia¹, thrombocytopenia¹, anaemia aggravated¹, neutropenia¹

Immune system disorders

Not known: Hypersensitivity reactions (including anaphylactic reactions and angioedema)¹

Metabolism and nutrition disorders

Not known: Metabolic acidosis¹

Psychiatric disorders

Uncommon: Anxiety, sleep disorder

Nervous system disorders

Common: Headache

Uncommon: Dizziness

Eye disorders

Uncommon: Cataract, maculopathy

Rare: Optic neuritis

Ear and labyrinth disorders

Uncommon: Deafness

Respiratory, thoracic and mediastinal disorders

Uncommon: Pharyngolaryngeal pain

Gastrointestinal disorders

Common: Diarrhoea, constipation, vomiting, nausea, abdominal pain, abdominal distension, dyspepsia

Uncommon: Gastrointestinal haemorrhage, gastric ulcer (including multiple ulcers), duodenal ulcer, gastritis

Rare: Oesophagitis

Not known: Gastrointestinal perforation¹, acute pancreatitis

Hepatobiliary disorders

Common: Transaminases increased

Uncommon: Hepatitis, cholelithiasis

Not known: Hepatic failure¹

Skin and subcutaneous tissue disorders

Common: Rash, pruritus

Uncommon: Pigmentation disorder

Not known: Stevens-Johnson syndrome¹, hypersensitivity vasculitis¹, urticaria¹, erythema multiforme¹, alopecia¹, toxic epidermal necrolysis (TEN)¹

Renal and urinary disorders

Very common: Blood creatinine increased

Common: Proteinuria

Uncommon: Renal tubular disorder² (acquired Fanconi syndrome), glycosuria

Not known: Acute renal failure¹, tubulointerstitial nephritis¹, nephrolithiasis¹, renal tubular necrosis¹

General disorders and administration site conditions

Uncommon: Pyrexia, oedema, fatigue

¹ Adverse reactions reported during post-marketing experience. These are derived from spontaneous reports for which it is not always possible to reliably establish frequency or a causal relationship to exposure to the medicinal product.

² Severe forms associated with changes in consciousness in the context of hyperammonaemic encephalopathy have been reported.

Description of selected adverse reactions

Gallstones and related biliary disorders were reported in about 2% of patients. Elevations of liver transaminases were reported as an adverse reaction in 2% of patients. Elevations of transaminases greater than 10 times the upper limit of the normal range, suggestive of hepatitis, were uncommon (0.3%). During post-marketing experience, hepatic failure, sometimes fatal, has been reported with deferasirox (see section 4.4 Special warnings and precautions for use). There have been post-marketing reports of metabolic acidosis. The majority of these patients had renal impairment, renal tubulopathy (Fanconi syndrome) or diarrhoea, or conditions where acid-base imbalance is a known complication (see section 4.4 Special warnings and precautions for use). Cases of serious acute pancreatitis were observed without documented underlying biliary conditions. As with other iron chelator treatment, high-frequency hearing loss and lenticular opacities (early cataracts) have been uncommonly observed in patients treated with deferasirox (see section 4.4 Special warnings and precautions for use).

Creatinine clearance in transfusional iron overload

In a retrospective meta-analysis of 2,102 adult and paediatric beta-thalassaemia patients with transfusional iron overload treated with deferasirox dispersible tablets in two randomised and four open label studies of up to five years' duration, a mean creatinine clearance decrease of 13.2% in adult patients (95% CI: -14.4% to -12.1%; n=935) and 9.9% (95% CI: -11.1% to -8.6%; n=1,142) in paediatric patients was observed during the first year of treatment. In 250 patients who were followed for up to five years, no further decrease in mean creatinine clearance levels was observed.

Clinical study in patients with non-transfusion-dependent thalassaemia syndromes

In a 1-year study in patients with non-transfusion-dependent thalassaemia syndromes and iron overload (dispersible tablets at a dose of 10 mg/kg/day), diarrhoea (9.1%), rash (9.1%), and nausea (7.3%) were the most frequent study drug-related adverse events. Abnormal serum creatinine and creatinine clearance values were reported in 5.5% and 1.8% of patients, respectively. Elevations of liver transaminases greater than 2 times the baseline and 5 times the upper limit of normal were reported in 1.8% of patients.

Additional information for special populations:

Paediatric population:

In two clinical studies, growth and sexual development of paediatric patients treated with deferasirox for up to 5 years were not affected (see section 4.4).

Diarrhoea is reported more commonly in paediatric patients aged 2 to 5 years than in older patients.

Renal tubulopathy has been mainly reported in children and adolescents with beta-thalassaemia treated with deferasirox. In post-marketing reports, a high proportion of cases of metabolic acidosis occurred in children in the context of Fanconi syndrome.

Acute pancreatitis has been reported, particularly in children and adolescents.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting systems.

4.9 Overdose

Acute overdose (2-3 times of the prescribed amount for copules of weeks) cases have been reported. One of the cases is subclinical hepatitis, which is recovered after ending the overdose,

without long term results. High iron loaded thalassaemic patients, deferasirox dispersible tablet formulations with 80 mg/kg daily single dose is well tolerated, and caused only mild nausea and diarrhoea

Nausea, diarrhoea, headache and vomiting may be symptoms of overdose. For management of overdose patient can be vomited or gastric lavage and symptomatic treatment can be applied.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Iron chelating agents,

ATC code: V03AC03

Mechanism of action

Deferasirox is an orally active chelator that is highly selective for iron (III). It is a tridentate ligand that binds iron with high affinity in a 2:1 ratio. Deferasirox promotes excretion of iron, primarily in the faeces. Deferasirox has low affinity for zinc and copper, and does not cause constant low serum levels of these metals.

Pharmacodynamic effects

In an iron-balance metabolic study in iron-overloaded adult thalassaemic patients, deferasirox at daily doses of 10, 20 and 40 mg/kg (dispersible tablet formulation) induced the mean net excretion of 0.119, 0.329 and 0.445 mg Fe/kg body weight/day, respectively.

Clinical efficacy and safety

Clinical efficacy studies were conducted with deferasirox dispersible tablets.

Deferasirox has been investigated in 411 adult (age ≥ 16 years) and 292 paediatric patients (aged 2 to <16 years) with chronic iron overload due to blood transfusions. Of the paediatric patients 52 were aged 2 to 5 years. The underlying conditions requiring transfusion included beta-thalassaemia, sickle cell disease and other congenital and acquired anaemias (myelodysplastic syndromes [MDS], Diamond-Blackfan syndrome, aplastic anaemia and other very rare anaemias).

Daily treatment with the deferasirox dispersible tablet formulation at doses of 20 and 30 mg/kg for one year in frequently transfused adult and paediatric patients with beta-thalassaemia led to reductions in indicators of total body iron; liver iron concentration was reduced by about -0.4 and -8.9 mg Fe/g liver (biopsy dry weight (dw)) on average, respectively, and serum ferritin was reduced by about -36 and -926 $\mu\text{g/l}$ on average, respectively. At these same doses the ratios of iron excretion: iron intake were 1.02 (indicating net iron balance) and 1.67 (indicating net iron removal), respectively. Deferasirox induced similar responses in iron-overloaded patients with other anaemias. Daily doses of 10 mg/kg (dispersible tablet formulation) for one year could maintain liver iron and serum ferritin levels and induce net iron balance in patients receiving infrequent transfusions or exchange transfusions. Serum ferritin assessed by monthly monitoring reflected changes in liver iron concentration indicating that trends in serum ferritin can be used to monitor response to therapy. Limited clinical data (29 patients with normal cardiac function at baseline) using MRI indicate that treatment with deferasirox 10-30 mg/kg/day (dispersible tablet formulation) for 1 year may also reduce levels of iron in the heart (on average, MRI T2* increased from 18.3 to 23.0 milliseconds).

The principal analysis of the pivotal comparative study in 586 patients suffering from beta-thalassaemia and transfusional iron overload did not demonstrate non-inferiority of deferasirox dispersible tablets to deferoxamine in the analysis of the total patient population. It appeared from a post-hoc analysis of this study that, in the subgroup of patients with liver iron

concentration ≥ 7 mg Fe/g dw treated with deferasirox dispersible tablets (20 and 30 mg/kg) or deferoxamine (35 to ≥ 50 mg/kg), the non-inferiority criteria were achieved. However, in patients with liver iron concentration < 7 mg Fe/g dw treated with deferasirox dispersible tablets (5 and 10 mg/kg) or deferoxamine (20 to 35 mg/kg), non-inferiority was not established due to imbalance in the dosing of the two chelators. This imbalance occurred because patients on deferoxamine were allowed to remain on their pre-study dose even if it was higher than the protocol specified dose. 56 patients under the age of 6 years participated in this pivotal study, 28 of them receiving deferasirox dispersible tablets.

It appeared from preclinical and clinical studies that deferasirox dispersible tablets could be as active as deferoxamine when used in a dose ratio of 2:1 (i.e. a dose of deferasirox dispersible tablets that is numerically half of the deferoxamine dose). For deferasirox film-coated tablets, a dose ratio of 3:1 can be considered (i.e. a dose of deferasirox film-coated tablets that is numerically one third of the deferoxamine dose). However, this dosing recommendation was not prospectively assessed in the clinical studies.

In addition, in patients with liver iron concentration ≥ 7 mg Fe/g dw with various rare anaemias or sickle cell disease, deferasirox may disperse body total iron. On average, liver iron concentration decreased by 3.80 mg Fe/g dw in patients treated with deferasirox dispersible tablets (starting dose 10 mg/kg/day) and increased by 0.38 mg Fe/g dw in patients treated with placebo ($p < 0.001$). On average, serum ferritin decreased by 222.0 $\mu\text{g/l}$ in patients treated with deferasirox dispersible tablets (starting dose 10 mg/kg/day) and increased by 115 $\mu\text{g/l}$ in patients treated with placebo ($p < 0.001$).

In a 5-year observational study in which 267 children aged 2 to < 6 years (at enrollment) with transfusional haemosiderosis received deferasirox, there were no clinically meaningful differences in the safety and tolerability profile of deferasirox in paediatric patients aged 2 to < 6 years compared to the overall adult and older paediatric population, including increases in serum creatinine of $> 33\%$ and above the upper limit of normal on ≥ 2 consecutive occasions (3.1%), and elevation of alanine aminotransferase (ALT) greater than 5 times the upper limit of normal (4.3%). Single events of increase in ALT and aspartate aminotransferase were reported in 20.0% and 8.3%, respectively, of the 145 patients who completed the study.

In a study to assess the safety of deferasirox film-coated and dispersible tablets, 173 adult and paediatric patients with transfusion dependent thalassaemia or myelodysplastic syndrome were treated for 24 weeks. A comparable safety profile for film-coated and dispersible tablets was observed.

In patients with non-transfusion-dependent thalassaemia syndromes and iron overload, treatment with deferasirox dispersible tablets was assessed in a 1-year, randomised, double-blind, placebo-controlled study. The study compared the efficacy of two different deferasirox dispersible tablet regimens (starting doses of 5 and 10 mg/kg/day, 55 patients in each arm) and of matching placebo (56 patients). The study enrolled 145 adult and 21 paediatric patients. The primary efficacy parameter was the change in liver iron concentration (LIC) from baseline after 12 months of treatment. One of the secondary efficacy parameters was the change in serum ferritin between baseline and fourth quarter. At a starting dose of 10 mg/kg/day, deferasirox dispersible tablets led to reductions in indicators of total body iron. On average, liver iron concentration decreased by 3.80 mg Fe/g dw in patients treated with deferasirox dispersible tablets (starting dose 10 mg/kg/day) and increased by 0.38 mg Fe/g dw in patients treated with placebo ($p < 0.001$). On average, serum ferritin decreased by 222.0 $\mu\text{g/l}$ in patients treated with deferasirox dispersible tablets (starting dose 10 mg/kg/day) and increased by 115 $\mu\text{g/l}$ in patients treated with placebo ($p < 0.001$).

5.2 Pharmacokinetic properties

Deferasirox film-coated tablets demonstrate higher bioavailability compared to the deferasirox dispersible tablet formulation. After adjustment of the strength, the film-coated tablet formulation (360 mg strength) was equivalent to Deferasirox dispersible tablets (500 mg strength) with respect to the mean area under the plasma concentration time curve (AUC) under fasting conditions. The C_{max} was increased by 30% (90% CI: 20.3% - 40.0%); however a clinical exposure/response analysis revealed no evidence of clinically relevant effects of such an increase.

Absorption

Deferasirox (dispersible tablet formulation) is absorbed following oral administration with a median time to maximum plasma concentration (t_{max}) of about 1.5 to 4 hours. The absolute bioavailability (AUC) of deferasirox (dispersible tablet formulation) is about 70% compared to an intravenous dose. The absolute bioavailability of the film-coated tablet formulation has not been determined. Bioavailability of deferasirox film-coated tablets was 36% greater than that with dispersible tablets.

A food-effect study involving administration of the film-coated tablets to healthy volunteers under fasting conditions and with a low-fat (fat content <10% of calories) or high-fat (fat content >50% of calories) meal indicated that the AUC and C_{max} were slightly decreased after a low-fat meal (by 11% and 16%, respectively). After a high-fat meal, AUC and C_{max} were increased (by 18% and 29%, respectively). The increases in C_{max} due to the change in formulation and due to the effect of a high-fat meal may be additive and therefore, it is recommended that the film-coated tablets should be taken either on an empty stomach or with a light meal.

Distribution

Deferasirox is highly (99%) protein bound to plasma proteins, almost exclusively serum albumin, and has a small volume of distribution of approximately 14 litres in adults.

Biotransformation

Glucuronidation is the main metabolic pathway for deferasirox, with subsequent biliary excretion. Deconjugation of glucuronides in the intestine and subsequent reabsorption (enterohepatic recycling) is likely to occur. Deferasirox is mainly glucuronidated by UGT1A1 and to a lesser extent UGT1A3. CYP450-catalysed (oxidative) metabolism of deferasirox appears to be minor in humans (about 8%). No inhibition of deferasirox metabolism by hydroxyurea was observed in vitro. Deferasirox enter to enterohepatic recycling. In a healthy volunteer study, the administration of cholestyramine after a single dose of deferasirox resulted in a 45% decrease in deferasirox exposure (AUC).

Elimination

Deferasirox and its metabolites are primarily excreted in the faeces (84% of the dose). Renal excretion of deferasirox and its metabolites is minimal (8% of the dose). The mean elimination half-life (t_{1/2}) ranged from 8 to 16 hours. The transporters MRP2 and MXR (BCRP) are involved in the biliary excretion of deferasirox.

Linearity / non-linearity

The C_{max} and AUC_{0-24h} of deferasirox increase approximately linearly with dose under steady-state conditions. Upon multiple dosing exposure increased by an accumulation factor of 1.3 to 2.3.

Characteristics in patients

Paediatric patients

The overall exposure of adolescents (12 to ≤ 17 years) and children (2 to < 12 years) to deferasirox after single and multiple doses was lower than that in adult patients. In children younger than 6 years old exposure was about 50% lower than in adults. Since dosing is individually adjusted according to response this is not expected to have clinical consequences.

Gender

Females have a 17.5% lower apparent clearance for deferasirox compared to males. Since dosing is individually adjusted according to response this is not expected to have clinical consequences.

Elderly patients

The pharmacokinetics of deferasirox have not been studied in elderly patients (aged 65 or older).

Renal or hepatic impairment

The pharmacokinetics of deferasirox have not been studied in patients with renal impairment.

In a clinical study using single doses of 20 mg/kg deferasirox dispersible tablets, the average exposure was increased by 16% in subjects with mild hepatic impairment (Child-Pugh Class A) and by 76% in subjects with moderate hepatic impairment (Child-Pugh Class B) compared to subjects with normal hepatic function. The average C_{max} of deferasirox in subjects with mild or moderate hepatic impairment was increased by 22%. Exposure was increased 2.8-fold in one subject with severe hepatic impairment (Child-Pugh Class C) (see sections 4.2 and 4.4).

The pharmacokinetics of deferasirox were not influenced by liver transaminase levels up to 5 times the upper limit of the normal range.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity or carcinogenic potential. The main findings were kidney toxicity and lens opacity (cataracts). Similar findings were observed in neonatal and juvenile animals. The kidney toxicity is considered mainly due to iron deprivation in animals that were not previously overloaded with iron.

Tests of genotoxicity in vitro were negative (Ames test, chromosomal aberration test) while deferasirox caused formation of micronuclei in vivo in the bone marrow, but not liver, of non-iron-loaded rats at lethal doses. No such effects were observed in iron-preloaded rats. Deferasirox was not carcinogenic when administered to rats in a 2-year study and transgenic p53^{+/-} heterozygous mice in a 6-month study.

The potential for toxicity to reproduction was assessed in rats and rabbits. Deferasirox was not teratogenic, but caused increased frequency of skeletal variations and stillborn pups in rats at high doses that were severely toxic to the non-iron-overloaded mother. Deferasirox did not cause other effects on fertility or reproduction.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Microcrystalline Cellulose 101

Microcrystalline Cellulose 102

Povidone K30

Crospovidone XL 10

Poloxamer 188

Colloidal silicon dioxide

Magnesium Stearate
Hydroxypropyl methylcellulose
Titanium Dioxide
Macrogol/PEG
Talc
FD&C Blue # 2/Indigo Carmine Aluminum Lacquer

6.2 Incompatibilities

It is not recommended to dissolve it in carbonated drinks and milk, as it will cause foaming or slow meeting.

6.3 Shelf life

24 months

6.4 Special precautions for storage

Store below 25°C.

6.5 Nature and contents of container

Transparent PVC/PE/PVDC/Al Foil blisters.

6.6 Special precautions for disposal

Should be disposed in compliance with regulations.

7. MARKETING AUTHORISATION HOLDER

Santa Farma İlaç San. A.Ş.
Okmeydanı, Boruçiçeği Sok. No:16
34382 Şişli – İstanbul TURKEY
0212 220 64 00
0212 222 57 59

8. MARKETING AUTHORISATION NUMBER(S)

2019/111

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 29.05.2019

Date of latest renewal: -

10. DATE OF REVISION OF THE TEXT
