

**CENTER FOR DRUG EVALUATION AND  
RESEARCH**

*APPLICATION NUMBER:*

**761025Orig1s000**

**SUMMARY REVIEW**

## Summary Review for Regulatory Action

<b>Date</b>	(electronic stamp)
<b>From</b>	Edvardas Kaminskas, M.D.
<b>Subject</b>	Deputy Division Director Summary Review
<b>BLA #</b>	761025
<b>Applicant Name</b>	Boehringer Ingelheim Pharmaceuticals
<b>Date of Submission</b>	02/19/2015
<b>PDUFA Goal Date</b>	10/19/2015
<b>Proprietary Name / Established (USAN) Name</b>	Praxbind Idarucizumab
<b>Dosage Forms / Strength</b>	Solution for injection/infusion 2.5 g idarucizumab/50 mL
<b>Proposed Indications</b>	Reversal of the anticoagulant activity of dabigatran for (1) emergency surgery/urgent procedures, and (2) life-threatening or uncontrolled bleeding
<b>Recommended Action for NME:</b>	<i>Accelerated Approval</i>

<b>Material Reviewed/Consulted</b>	
OND Action Package, including:	
Medical Officer Review	Andrew Dmyrijuk, M.D./Kathy M. Robie Suh, Ph.D., M.D.
Pharmacology Toxicology Review	Emily Place, Ph.D., M.P.H./Christopher Sheth, Ph.D.
OPQ/OBP/Division of Biotechnology and Research Review	Tura Camilli, Ph.D./Lixin Xu, M.D., Ph.D./Frederick Mills, Ph.D./Chana Fuchs, Ph.D.
OPQ/OBP/Division of Microbiology Assessment Review	Reyes Candau-Chacon, Ph.D./Candace Gomez-Broughton, Ph.D./Patria Hughes, Ph.D.
OPQ/OBP/Division of Inspectional Assessment Review	Wayne Seifert/Donald Oberhuber/Steven Fong, Ph.D.
Clinical Pharmacology Review	Martina Sahre, Ph.D./Dinko Rekić, Ph.D./Rajanikanth Madabigatranushi, Ph.D./Jeffrey Florian, Ph.D.
OSIS/DGDBE	Gajendiran Mahadevan, Ph.D./Kara A. Schreiber, Ph.D./Xiaohan Cai, Ph.D./Sam F. Skelly, Ph.D.
CDTL Review	Kathy M. Robie Suh, Ph.D., M.D.
OMEPRM/DMEPA	Teresa McMillan, Pharm.D./Yelena Maslov, Pharm.D.
OPDP	James Dvorsky, Pharm.D.
OSE/DRISK	Carolyn L. Yancey, M.D./Naomi Redd, Pharm.D./Cynthia LaCivita, Pharm.D.
OPE/OSE/DEPI-1	Kate Gelperin, M.D., M.P.H./Steve Bird, Pharm.D./Ph.D., M.S./Cunlin Wang, M.D., Ph.D.

OND=Office of New Drugs  
OPE=Office of Pharmacovigilance and Epidemiology  
OSE= Office of Surveillance and Epidemiology

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OPQ=Office of Pharmaceutical Quality  
OBP=Office of Biotechnology Products  
OPDP=Office of Prescription Drug Promotion  
CDTL=Cross-Discipline Team Leader  
OSIS=Office of Study Integrity and Surveillance  
DNDBE=Division of New Drug Bioequivalence Evaluation  
OMEPRM=Office of Medication Error Prevention and Risk Management  
DRISK=Division of Risk Management  
DMEPA=Division of Medication Error Prevention and Analysis  
DEPI-1=Division of Epidemiology 1

## Signatory Authority Review Template

### 1. Introduction

Idarucizumab is a humanized murine monoclonal antibody fragment (Fab) that binds with high affinity to the direct thrombin inhibitor dabigatran. It was developed in order to provide rapid reversal of the anticoagulant effect of dabigatran, one of the novel oral anticoagulants (NOACs) that have been approved in the U.S. for multiple thromboembolic treatment and prevention indications. Dabigatran was approved in 2010 to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation, for the treatment of deep venous thrombosis (DVT) and pulmonary embolism (PE), and to reduce the risk of DVT and PE in patients who have been previously treated. Dabigatran and the other approved NOACs (factor Xa inhibitors rivaroxaban, apixaban, and edoxaban) have been at least as effective, safer, and simpler to use than warfarin, the standard of care for patients with atrial fibrillation and venous thromboembolism. NOAC dosing regimens are simpler, they produce more rapid anticoagulation, they have fewer drug-drug interactions, their effect is not influenced by diet, and they have not required monitoring by coagulation tests. These advantages are offset by the lack of standardized tests that measure the extent of anticoagulation, and the absence of antidotes to reverse anticoagulation when that is highly desirable in cases of emergency surgery, severe bleeding, or trauma. Idarucizumab was developed to meet the need for a reversal agent to dabigatran.

### 2. Background

The Applicant addressed the need for a reversal agent to dabigatran by developing a humanized monoclonal antibody with a high affinity for dabigatran, a classic approach pioneered by the developers of an antidote to digoxin (presently marketed as Digibind). The IND was accepted by the Division of Hematology Products on 12/23/2013. Breakthrough therapy designation was granted on 06/16/2014. Proprietary name was granted on 11/17/2014. The BLA was filed on 02/19/2015. Priority review was granted.

Two “think tank” meetings, sponsored by the Cardiac Safety Research Consortium, a partnership between academicians, industry representatives, and FDA developed according to FDA’s Critical Path Initiative, addressed the safety of NOACs and the development of anticoagulant reversal agents, including idarucizumab (Praxbind). The first was held on 04/22/2014 and was entitled “Novel Oral Anticoagulants and Reversal Agents: Considerations for Clinical Development”. The second was held on 02/03/2015 and was entitled “NOAC Monitoring, Reversal Agents, and Post-approval Safety and Effectiveness Evaluation”. These “think tank” meetings provided an opportunity for information sharing, discussion and formation of recommendations.

Idarucizumab has not been approved for marketing in any jurisdiction. The Applicant has a licensing application pending at the European Medicines Agency. Committee for Medicinal Products for Human Use (CHMP) of the EMA at its September 21 -24, 2015 meeting recommended granting a marketing authorization, under accelerated assessment, for Praxbind (idarucizumab) as a specific antidote to the anticoagulant medicine Pradaxa (dabigatran etexilate), when rapid reversal of its effect is required. Praxbind is to be used when a patient taking Pradaxa needs to undergo an emergency surgery or when life-threatening or uncontrolled bleeding occurs.

### **3. CMC/Device**

The Office of Pharmaceutical Quality, CDER, recommends approval of BLA 761025 for Praxbind (idarucizumab) manufactured by Boehringer Ingelheim Pharmaceuticals, Inc. The data submitted in this application are adequate to support the conclusion that the manufacture of Proxbind (idarucizumab) is well controlled and leads to a product that is pure and potent. It is recommended that this product be approved for human use under conditions specified in the package insert. No Phase 4 (Post-Marketing) Commitments, Agreements, and/or Risk Management Steps are recommended from OPQ perspective.

*I concur with the conclusions reached by the chemistry reviewers regarding the acceptability of the manufacturing of the drug product and drug substance. Manufacturing site inspections were acceptable. Stability testing supports an expiry of 30 months at 2 °C to 8° C. There are no outstanding issues.*

### **4. Nonclinical Pharmacology/Toxicology**

Idarucizumab binds to dabigatran with higher affinity (~300 times higher) than the binding of dabigatran to thrombin. Idarucizumab forms a stable complex with dabigatran to neutralize the anticoagulant effects of dabigatran. There is no endogenous target for idarucizumab. The pharmacologic class assigned to idarucizumab is “humanized monoclonal antibody fragment (Fab). Idarucizumab did not affect the activity of factor Xa inhibitors (rivaroxaban, epixaban, edoxaban), direct thrombin inhibitors hirudin and argatroban, vitamin K antagonist warfarin, or heparin.

Pharmacology, safety pharmacology, and toxicology studies were conducted in *in vitro* and *in vivo* models. *In vitro* studies showed that idarucizumab forms complexes with dabigatran and dabigatran acylglucuronide metabolites. Three animal models (a mouse intracranial hemorrhage model, a rat tail cut bleeding model, and a pig blunt liver trauma model) were used to show that idrucizumab administration results in reversal of the anticoagulant effects of dabigatran and significant reduction of blood loss. Additional data demonstrated that the effects of idarucizumab are in part mediated by increasing fibrin coverage and fibrin masses around damaged subendothelium.

No major target organs of toxicity were identified in rats or monkeys. Since idarucizumab is only intended to be administered in acute situations, in accordance with the ICH S6 and S9 Guidances and conditions of use, genetic toxicology, reproductive and developmental, and carcinogenicity studies were not needed. The Applicant's proposed Pregnancy Category <sup>(b)</sup><sub>(4)</sub> for idarucizumab is acceptable. From a nonclinical perspective, PRAXBIND may be approved for the proposed indications. No additional nonclinical studies are needed.

*I concur with the conclusions reached by the pharmacology/toxicology reviewer that there are no outstanding pharmacology/toxicology issues that preclude approval.*

## **5. Clinical Pharmacology/Biopharmaceutics**

The Applicant submitted two randomized, placebo-controlled, double-blind Phase 1 studies in healthy volunteers (n=283) that define the pharmacokinetics of idarucizumab and the effects of idarucizumab on dabigatran pharmacokinetics and clinical coagulation markers. In addition, preliminary clinical data were also available from an ongoing open-label observational Phase 3 study (n=123). These studies demonstrated that there was a dose-dependent reversal of anticoagulant effect of dabigatran in study subjects who received intravenous single or split doses of idarucizumab ranging from 20 mg to 8 g administered over periods up to 1 hour or two 2.5 g infusions over 5 minutes up to 1 hour apart following dabigatran administration. The reversal of anticoagulant effect was measured using dilute thrombin time, thrombin time, ecarin clotting time, and activated thromboplastin time (aPTT). The results show that administration of two doses of idarucizumab 2.5 g intravenously 15 minutes apart can rapidly reverse and sustain the reversal of the anticoagulant effect of dabigatran for at least 24 hours. Pharmacokinetics, metabolism, effects of age, sex, and race, the effect of renal impairment, and drug distribution were also defined. There was no difference in the anticoagulation reversal between males and females (limited data, since only 19 of 283 subjects were females), between younger (45 – 64 years of age) and older (65 – 80 years) subjects, and between Caucasian and Japanese subjects, and in subjects with mild or moderate renal impairment and in subjects with normal renal function (limited data, since only 20 subjects had renal impairment).

Idarucizumab has no intrinsic pro-thrombotic effect. Re-initiation of dabigatran treatment 24 hours after treatment with idarucizumab resulted in comparable unbound dabigatran concentrations and anticoagulant activity before and after idarucizumab treatment.

Pre-existing antibodies with cross-reactivity to idarucizumab were detected in 13% of subjects. These antibodies were non-specific, with low titers, binding to the C-terminus of the molecule and having no impact on reversal of dabigatran-induced prolongation of coagulation parameters dTT and ECT.

The reviewers concluded that there is sufficient clinical pharmacology information provided in the BLA to support approval of idarucizumab for the rapid reversal of the anticoagulant activity of dabigatran in emergency surgery/urgent procedures and life-threatening or uncontrolled bleeding. Labeling recommendations were made. No phase 4 study commitments were recommended.

*I concur with the conclusions reached by the clinical pharmacology/biopharmaceutics reviewer that there are no outstanding clinical pharmacology issues that preclude approval.*

## 6. Clinical Microbiology

N/A.

## 7. Clinical/Statistical-Efficacy

The Clinical review team reviewed the results of the Clinical Pharmacology trials and the preliminary results of the Phase 3 trial entitled “A Phase III, Case Series Clinical Study of the Reversal of the Anticoagulant Effects of Dabigatran by Intravenous Administration of 5.0 g of Idarucizumab in Patients Treated with Dabigatran Etxilate Who Have Uncontrolled Bleeding or Require Emergency Surgery or Procedures, the REVERSE-AD Trial”. The trial is an open label, multicenter, safety and efficacy trial with projected enrollment of up to 300 adult patients. The protocol was amended on October 8, 2015 to include approximately (b) (4) adult patients. The key enrollment criteria are bleeding that requires a reversal agent in the opinion of the physician, or urgent requirement for surgery or an invasive procedure in patients who must be taking dabigatran. The dose of idarucizumab is fixed at 5.0 g administered as two 2.5 g doses 15 minutes apart. The maximum reversal of dilute thrombin time (dTT) or ecarin clotting time (ECT) in the 4 hours after idarucizumab administration is the primary efficacy endpoint.

Of the 123 patients in this interim analysis, 66 were bleeding and 57 required urgent surgery. The median age was 77 years (range 48 – 93 years), 40% of patients had moderate or severe renal insufficiency, the median time from last dabigatran dose was 16 hours (range, 1 – 94 hours), indication for dabigatran treatment was atrial fibrillation in 95% of patients. In the serious bleeding group, 41% of patients presented with gastrointestinal bleeding and 36%, with intracranial bleeding. The most common conditions requiring urgent surgery were bone fractures (23%).

A maximal reversal (100%) of dTT was achieved in 98% of bleeding patients and 93% of patients needing urgent surgery. A maximal reversal of ECT was achieved in 89% of bleeding patients and 88% of patients needing urgent surgery. Both dTT and ECT decreased to normal levels within 10 – 30 minutes after idarucizumab administration and were sustained for a period of 24 hours. Reversal of elevated coagulation tests is considered a surrogate for clinical efficacy.

Two 2.5 gm doses (for a total of 5.0 gm) were administered to all patients. Two patients received an additional 5.0 gm dose within 24 hours due to elevation of coagulation parameters and re-bleeding, and one received a total of three 5.0 gm doses for the same reasons.

In bleeding patients, time to bleeding cessation was estimated in 73% of patients; in others bleeding site could not be identified. Bleeding stopped within 72 hours in 44 of 48 patients; the

median time when bleeding stopped was 9.8 hours. Among patients requiring urgent surgery intra-operative bleeding status was assessed in 52 patients. Most patients (48/52) had normal hemostasis, 3 had mildly abnormal and 1 had moderately abnormal (controllable) hemostasis. Assessments of hemostasis and of bleeding cessation were subjective; however, these data are useful in considerations of efficacy of the reversal agent. Usage of blood products (packed rbc and fresh frozen plasma) was more frequent in bleeding patients than in urgent surgery patients (in 68% vs. 40%). Use of prothrombin complex concentrates was infrequent (in 4% of patients). Dabigatran was re-started after idarucizumab treatment in 26% of patients who presented with bleeding and in 60% of patients requiring urgent surgery.

## 8. Safety

The safety data base included the healthy volunteer studies (n=283) and the preliminary report on patients with severe bleeding and patients requiring urgent surgery treated with the pre-specified 5 g dose of idarucizumab in the on-going open label, safety and efficacy trial in which up to (b) (4) patients will be enrolled (n=123). The percentage of healthy volunteers with AEs was the same in the idarucizumab groups and the placebo groups (~25%). Headache, skin irritation and dizziness were more frequent in the idarucizumab group than in the placebo group. Minor bleeding events, such as epistaxis, were more common in the dabigatran pre-treatment group (~2%) than in idarucizumab treatment group (0.4%). All AEs were assessed as mild.

The patients in the clinical study had conditions requiring anticoagulation as well as numerous comorbidities. All patients can be characterized as having serious medical conditions. In the severe bleeding group, 41% of patients presented with gastrointestinal bleeding, 36% with intracranial bleeding, the remaining had bleeding due to trauma, or intramuscular, retroperitoneal, intra-pericardial, and intra-ocular bleeding; bleeding location could not be identified in one patient. In urgent surgery group, 23% of patients had bone fractures, 12% gall bladder disease requiring cholecystectomy, 7% had joint wound infection, and 5% had acute appendicitis, small bowel obstruction or bowel perforation.

There were 26 deaths among the 123 patients. Eleven patients died within 1 day of idarucizumab administration. Deaths were due to cardiovascular events (5), intracranial hemorrhage progression (2), septic shock (2), peritonitis, and respiratory failure. An additional 7 patients died between 1 and 30 days of idarucizumab administration. Causes of death were cardiovascular events (4), intracranial hemorrhage progression, cerebral infarction, and multi-organ failure. An additional 8 patients died between 31 and 106 days of idarucizumab administration. Causes of deaths were progression of malignant disease (3), pneumonia (2), gastrointestinal hemorrhage, Parkinson's disease and general health deterioration. None of the deaths could be related to idarucizumab administration.

Among serious adverse events were deep vein thrombosis in 2% of patients and pulmonary embolism in 2% of patients; none were on antithrombotic therapy at the time of event. A total of 84% of patients reported AEs. AEs in >5% of patients were hypokalemia, delirium,

constipation, pyrexia, and pneumonia. Laboratory abnormalities included elevated aPTT and serum creatinine; these were expected as patients had received dabigatran and renal dysfunction was common in this population. Elevated liver function tests were seen in 3 patients (cholelithiasis and cholecystectomy (1), renal and hepatic failure (1), sepsis with multi-organ failure (1)).

Immunogenicity data were available in 47 patients. Two patients had baseline, nonspecific anti-drug antibodies. One patient had a treatment-emergent ADA of mixed specificity.

## **9. Advisory Committee Meeting**

This BLA was not presented at an Advisory Committee because the application did not raise significant safety or efficacy issues that were unexpected for a biologic of this class.

## **10. Pediatrics**

The Applicant has received Orphan Drug designation for this indication on 05/28/2015. The Applicant is exempt from the Pediatric Research Equity Act (PREA) requirements.

## **11. Other Relevant Regulatory Issues**

### Proprietary name review:

The proposed proprietary name, Praxbind, was reviewed by DMEPA/OMEPRM/OSE. The proposed name was acceptable from a promotional and safety perspective.

### OSE/OPE Division of Epidemiology I consultation:

- OSE/OPE provided comments and recommendations for a postmarketing clinical safety study for idarucizumab. The review noted that “Although no cases of serious hypersensitivity reactions have been identified to date in patients exposed to idarucizumab, the limited clinical experience thus far is not sufficient to rule out potential issues with immunogenicity, or other adverse drug reactions, postmarketing...DEPI recommends issuing a PMR for a clinical safety study to provide additional assurance that serious adverse drug reactions, such as serious hypersensitivity reactions, do not occur commonly with idarucizumab. A target sample size of 1000 exposed patients could provide assurance that serious adverse drug reactions not observed during the study are unlikely to occur in more than three per thousand patients treated with idarucizumab”. The second recommendation is for “the sponsor [to] conduct an evaluation to compare mortality rates among dabigatran exposed patients who have a major hemorrhage/emergency surgery who receive idarucizumab (this trial) versus dabigatran exposed patients who have a major hemorrhage/emergency surgery and do not receive idarucizumab (from historical dabigatran trials).”

Regarding the first recommendation, the Division does not see any utility of expanding the presently ongoing study to 1000 patients. First, absence of a hypersensitivity

reaction will not result in a labeling claim, whether it is based on 123 patients or on 1000 patients. It would be extraordinary for a one-time injection, without prior sensitization, to cause a hypersensitivity reaction. Second, the Division has approved many monoclonal antibodies of various types that cause a high incidence of hypersensitivity reactions and require premedication to alleviate these reactions. Hypersensitivity reactions are not a contra-indication to use, they only require appropriate care in administering the drugs. Third, the Division is not familiar with a requirement to assess the probability of a hypersensitivity reaction in approval of drugs or biologics, if none are noted in 123 patients and 283 normal human volunteers. With regard to serious adverse drug reactions, they are impossible to attribute in trauma settings or other emergency situations. A perusal of narratives submitted in the BLA is instructive but causal relationships cannot be drawn.

Regarding the second recommendation, a review of deaths reported in Study 1321.3 does not suggest reversal of anticoagulation as causal in any of them. A comparison of total numbers of deaths between the on-going trial and the “historical” trials would suffer from multiple deficiencies, including that of different populations studied. In the so-called “historical” dabigatran trials the patients who had a major hemorrhage or required emergency surgery would have been withdrawn from the study. Criteria for inclusion in the on-going study were criteria for exclusion in the “historical” studies. The Division fails to see the utility of such a study, which certainly would not result in labeling.

Risk Evaluation and Mitigation Strategy (REMS) Review:

OMEPRM/OSE concluded as follows: “At this time, based on the risks of 1) thrombotic events (of a patient’s underlying disease) when dabigatran therapy is discontinued and idrucizumab anticoagulant reversal is initiated and 2) potential hypersensitivity reactions to idarucizumab, the DRISK and the DHP concurred that a REMS is not needed to ensure that the benefits of idrucizumab outweigh the risks for this therapeutic biologic formulation. The DHP and the DRISK agreed that prescribers are informed on the serious risks associated with discontinuation of dabigatran treatment when initiating an antidote for reversal of the anticoagulant effect of dabigatran. The DHP and DRISK concurred that the reported adverse events/reactions do not appear to be causally attributed to idarucizumab.”

Office of Study Integrity and Surveillance Review:

- The bioanalytical portions of healthy volunteer studies were inspected regarding method validation for anti-dug antibodies. Non-reproducibility of confirmatory assay was detected. The recommendation was made that the analytical data for ADA in these studies be accepted, if the non-reproducibility and specificity of the confirmatory assay did not impact the study outcome.
- Inspection of the clinical portions of healthy volunteer studies revealed that repeat analysis of coagulation tests in 501 samples for 22 subjects was required because the pre-dose clotting time was higher than the acceptable upper limit of normal. No significant issues were observed and no Form 483 was issued. A recommendation was made to accept the clinical data.

- On-site inspections of two clinical sites were not performed, because these sites had been recently inspected. One site received a No Action Indicated outcome, the other had an outcome of Voluntary Action Indicated. The reviewer recommended accepting data without an on-site inspection.

Office of Prescription Drug Marketing and Promotion (OPDP):

OPDP has reviewed and provided comments on the Applicant's proposed promotional materials for product launch.

*There are no other unresolved relevant regulatory issues.*

## 12. Labeling

The entire review team and reviewers from DMEPA reviewed prescribing information, container labels, (b) (4). All issues were resolved.

## 13. Decision/Action/Risk Benefit Assessment

- Regulatory Action recommended: Accelerated Approval.
- Risk Benefit Assessment: I concur with the detailed analysis of risk/benefit by the clinical reviewer. Patients treated with dabigatran are at increased risk for bleeding, as are patients treated with all other anticoagulants. Idarucizumab reverses the anticoagulant effect of dabigatran; this reversal is an important clinical benefit to patients who require emergency surgery or other invasive procedure or who present with life-threatening or uncontrolled bleeding. There are no other effective reversal agents. Although the safety database is limited, there have been no adverse reactions that could be causally related to idarucizumab. Effective reversal of anticoagulant effect of dabigatran in absence of serious safety concerns supports the conclusion that benefit greatly outweighs the risks.
- Recommendation for Postmarketing Risk Management Activities  
None.
- Recommendation for other Postmarketing Study Commitments

PMR 2977-1 Completion of Trial 1321.3 titled, "*A Phase III, Case Series Clinical Study of the Reversal of the Anticoagulant Effects of Dabigatran by Intravenous Administration of 5.0 g Idarucizumab in Patients Treated with Dabigatran Etxilate Who Have Uncontrolled Bleeding or Require Emergency Surgery or Procedures, the REVERSE – AD trial.*"

Final Protocol Submission: 10/2015  
Trial Completion: 10/2017  
Final Report Submission: 10/2018

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**This is a representation of an electronic record that was signed electronically and this page is the manifestation of the electronic signature.**  
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/s/  
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EDVARDAS KAMINSKAS  
10/16/2015