Prescribing Information as of December 2005

℞ only

TAXOTERE®
(docetaxel)

Injection Concentrate

WARNING

TAXOTERE® (docetaxel) Injection Concentrate should be administered under the supervision of a qualified physician experienced in the use of antineoplastic agents. Appropriate management of complications is possible only when adequate diagnostic and treatment facilities are readily available.

The incidence of treatment-related mortality associated with TAXOTERE therapy is increased in patients with abnormal liver function, in patients receiving higher doses, and in patients with non-small cell lung carcinoma and a history of prior treatment with platinum-based chemotherapy who receive TAXOTERE as a single agent at a dose of 100 mg/m^2 (see **WARNINGS**).

TAXOTERE should generally not be given to patients with bilirubin > upper limit of normal (ULN), or to patients with SGOT and/or SGPT >1.5 x ULN concomitant with alkaline phosphatase > 2.5 x ULN. Patients with elevations of bilirubin or abnormalities of transaminase concurrent with alkaline phosphatase are at increased risk for the development of grade 4 neutropenia, febrile neutropenia, infections, severe thrombocytopenia, severe stomatitis, severe skin toxicity, and toxic death. Patients with isolated elevations of transaminase > 1.5 x ULN also had a higher rate of febrile neutropenia grade 4 but did not have an increased incidence of toxic death. Bilirubin, SGOT or SGPT, and alkaline phosphatase values should be obtained prior to each cycle of TAXOTERE therapy and reviewed by the treating physician.

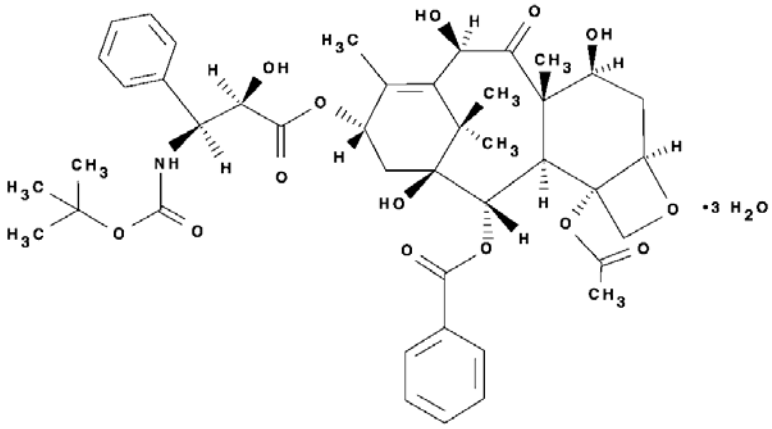
TAXOTERE therapy should not be given to patients with neutrophil counts of < 1500 cells/mm^3. In order to monitor the occurrence of neutropenia, which may be severe and result in infection, frequent blood cell counts should be performed on all patients receiving TAXOTERE.

Severe hypersensitivity reactions characterized by generalized rash/erythema, hypotension and/or bronchospasm, or very rarely fatal anaphylaxis, have been reported in patients who received the recommended 3-day dexamethasone premedication. Hypersensitivity reactions require immediate discontinuation of the TAXOTERE infusion and administration of appropriate therapy. TAXOTERE must not be given to patients who have a history of severe hypersensitivity reactions to TAXOTERE or to other drugs formulated with polysorbate 80 (see **WARNINGS**).

Severe fluid retention occurred in 6.5% (6/92) of patients despite use of a 3-day dexamethasone premedication regimen. It was characterized by one or more of the following events: poorly tolerated peripheral edema, generalized edema, pleural effusion requiring urgent drainage, dyspnea at rest, cardiac tamponade, or pronounced abdominal distention (due to ascites) (see **PRECAUTIONS**).

DESCRIPTION

Docetaxel is an antineoplastic agent belonging to the taxoid family. It is prepared by semisynthesis beginning with a precursor extracted from the renewable needle biomass of yew plants. The chemical name for docetaxel is (2R,3S)-N-carboxy-3-phenylisoserine,N-*tert*-butyl ester, 13-ester with 5β-20-epoxy-1,2α,4,7β,10β,13α-hexahydroxytax-11-en-9-one 4-acetate 2-benzoate, trihydrate. Docetaxel has the following structural formula:



Docetaxel is a white to almost-white powder with an empirical formula of $C_{43}H_{53}NO_{14}\bullet 3H_2O$, and a molecular weight of 861.9. It is highly lipophilic and practically insoluble in water. TAXOTERE (docetaxel) Injection Concentrate is a clear yellow to brownish-yellow viscous solution. TAXOTERE is sterile, non-pyrogenic, and is available in single-dose vials containing 20 mg (0.5 mL) or 80 mg (2 mL) docetaxel (anhydrous). Each mL contains 40 mg docetaxel (anhydrous) and 1040 mg polysorbate 80.

TAXOTERE Injection Concentrate requires dilution prior to use. A sterile, non-pyrogenic, single-dose diluent is supplied for that purpose. The diluent for TAXOTERE contains 13% ethanol in water for injection, and is supplied in vials.

CLINICAL PHARMACOLOGY

Docetaxel is an antineoplastic agent that acts by disrupting the microtubular network in cells that is essential for mitotic and interphase cellular functions. Docetaxel binds to free tubulin and promotes the assembly of tubulin into stable microtubules while simultaneously inhibiting their disassembly. This leads to the production of microtubule bundles without normal function and to the stabilization of microtubules, which results in the inhibition of mitosis in cells. Docetaxel's binding to microtubules does not alter the number of protofilaments in the bound microtubules, a feature which differs from most spindle poisons currently in clinical use.

HUMAN PHARMACOKINETICS

The pharmacokinetics of docetaxel have been evaluated in cancer patients after administration of 20-115 mg/m^2 in phase I studies. The area under the curve (AUC) was dose proportional following doses of 70-115 mg/m^2 with infusion times of 1 to 2 hours. Docetaxel's pharmacokinetic profile is consistent with a three-compartment pharmacokinetic model, with

half-lives for the α, β, and γ phases of 4 min, 36 min, and 11.1 hr, respectively. The initial rapid decline represents distribution to the peripheral compartments and the late (terminal) phase is due, in part, to a relatively slow efflux of docetaxel from the peripheral compartment. Mean values for total body clearance and steady state volume of distribution were 21 L/h/m^2 and 113 L, respectively. Mean total body clearance for Japanese patients dosed at the range of 10-90 mg/m^2 was similar to that of European/American populations dosed at 100 mg/m^2, suggesting no significant difference in the elimination of docetaxel in the two populations.

A study of ^{14}C-docetaxel was conducted in three cancer patients. Docetaxel was eliminated in both the urine and feces following oxidative metabolism of the *tert*-butyl ester group, but fecal excretion was the main elimination route. Within 7 days, urinary and fecal excretion accounted for approximately 6% and 75% of the administered radioactivity, respectively. About 80% of the radioactivity recovered in feces is excreted during the first 48 hours as 1 major and 3 minor metabolites with very small amounts (less than 8%) of unchanged drug.

A population pharmacokinetic analysis was carried out after TAXOTERE treatment of 535 patients dosed at 100 mg/m^2. Pharmacokinetic parameters estimated by this analysis were very close to those estimated from phase I studies. The pharmacokinetics of docetaxel were not influenced by age or gender and docetaxel total body clearance was not modified by pretreatment with dexamethasone. In patients with clinical chemistry data suggestive of mild to moderate liver function impairment (SGOT and/or SGPT >1.5 times the upper limit of normal [ULN] concomitant with alkaline phosphatase >2.5 times ULN), total body clearance was lowered by an average of 27%, resulting in a 38% increase in systemic exposure (AUC). This average, however, includes a substantial range and there is, at present, no measurement that would allow recommendation for dose adjustment in such patients. Patients with combined abnormalities of transaminase and alkaline phosphatase should, in general, not be treated with TAXOTERE.

Clearance of docetaxel in combination therapy with cisplatin was similar to that previously observed following monotherapy with docetaxel. The pharmacokinetic profile of cisplatin in combination therapy with docetaxel was similar to that observed with cisplatin alone.

A population pharmacokinetic analysis of plasma data from 40 patients with hormone-refractory metastatic prostate cancer indicated that docetaxel systemic clearance in combination with prednisone is similar to that observed following administration of docetaxel alone.

A study was conducted in 30 patients with advanced breast cancer to determine the potential for drug-drug-interactions between docetaxel (75 mg/m²), doxorubicin (50 mg/m²), and cyclophosphamide (500 mg/m²) when administered in combination. The coadministration of docetaxel had no effect on the pharmacokinetics of doxorubicin and cyclophosphamide when the three drugs were given in combination compared to coadministration of doxorubicin and cyclophosphamide only. In addition, doxorubicin and cyclophosphamide had no effect on docetaxel plasma clearance when the three drugs were given in combination compared to historical data for docetaxel monotherapy.

In vitro studies showed that docetaxel is about 94% protein bound, mainly to α_1-acid glycoprotein, albumin, and lipoproteins. In three cancer patients, the *in vitro* binding to plasma proteins was found to be approximately 97%. Dexamethasone does not affect the protein binding of docetaxel.

In vitro drug interaction studies revealed that docetaxel is metabolized by the CYP3A4 isoenzyme, and its metabolism can be inhibited by CYP3A4 inhibitors, such as ketoconazole, erythromycin, troleandomycin, and nifedipine. Based on *in vitro* findings, it is likely that

CYP3A4 inhibitors and/or substrates may lead to substantial increases in docetaxel blood concentrations. No clinical studies have been performed to evaluate this finding (see **PRECAUTIONS**).

CLINICAL STUDIES

Breast Cancer

The efficacy and safety of TAXOTERE have been evaluated in locally advanced or metastatic breast cancer after failure of previous chemotherapy (alkylating agent-containing regimens or anthracycline-containing regimens).

Randomized Trials

In one randomized trial, patients with a history of prior treatment with an anthracycline-containing regimen were assigned to treatment with TAXOTERE (100 mg/m^2 every 3 weeks) or the combination of mitomycin (12 mg/m^2 every 6 weeks) and vinblastine (6 mg/m^2 every 3 weeks). 203 patients were randomized to TAXOTERE and 189 to the comparator arm. Most patients had received prior chemotherapy for metastatic disease; only 27 patients on the TAXOTERE arm and 33 patients on the comparator arm entered the study following relapse after adjuvant therapy. Three-quarters of patients had measurable, visceral metastases. The primary endpoint was time to progression. The following table summarizes the study results:

Efficacy of TAXOTERE in the Treatment of Breast Cancer Patients Previously Treated with an Anthracycline-Containing Regimen (Intent-to-Treat Analysis)

Efficacy Parameter	**Docetaxel (n=203)**	**Mitomycin/ Vinblastine (n=189)**	**p-value**
Median Survival	11.4 months	8.7 months	
Risk Ratio*, Mortality (Docetaxel: Control)	0.73		p=0.01 Log Rank
95% CI (Risk Ratio)	0.58-0.93		
Median Time to Progression	4.3 months	2.5 months	
Risk Ratio*, Progression (Docetaxel: Control)	0.75		p=0.01 Log Rank
95% CI (Risk Ratio)	0.61-0.94		
Overall Response Rate	28.1%	9.5%	p<0.0001
Complete Response Rate	3.4%	1.6%	Chi Square

*For the risk ratio, a value less than 1.00 favors docetaxel.

In a second randomized trial, patients previously treated with an alkylating-containing regimen were assigned to treatment with TAXOTERE (100 mg/m^2) or doxorubicin (75 mg/m^2) every 3 weeks. 161 patients were randomized to TAXOTERE and 165 patients to doxorubicin.

Approximately one-half of patients had received prior chemotherapy for metastatic disease, and one-half entered the study following relapse after adjuvant therapy. Three-quarters of patients had measurable, visceral metastases. The primary endpoint was time to progression. The study results are summarized below:

Efficacy of TAXOTERE in the Treatment of Breast Cancer Patients Previously Treated with an Alkylating-Containing Regimen (Intent-to-Treat Analysis)

Efficacy Parameter	**Docetaxel (n=161)**	**Doxorubicin (n=165)**	**p-value**
Median Survival	14.7 months	14.3 months	
Risk Ratio*, Mortality (Docetaxel: Control)	0.89		p=0.39 Log Rank
95% CI (Risk Ratio)	0.68-1.16		
Median Time to Progression	6.5 months	5.3 months	
Risk Ratio*, Progression (Docetaxel: Control)	0.93		p=0.45 Log Rank
95% CI (Risk Ratio)	0.71-1.16		
Overall Response Rate	45.3%	29.7%	p=0.004 Chi Square
Complete Response Rate	6.8%	4.2%	

*For the risk ratio, a value less than 1.00 favors docetaxel.

In another multicenter open-label, randomized trial (TAX313), in the treatment of patients with advanced breast cancer who progressed or relapsed after one prior chemotherapy regimen, 527 patients were randomized to receive TAXOTERE monotherapy 60 mg/m^2 (n=151), 75 mg/m^2 (n=188) or 100 mg/m^2 (n=188). In this trial, 94% of patients had metastatic disease and 79% had received prior anthracycline therapy. Response rate was the primary endpoint. Response rates increased with TAXOTERE dose: 19.9% for the 60 mg/m^2 group compared to 22.3% for the 75 mg/m^2 and 29.8% for the 100 mg/m^2 group; pair-wise comparison between the 60 mg/m^2 and 100 mg/m^2 groups was statistically significant, (p=0.037).

Single Arm Studies

TAXOTERE at a dose of 100 mg/m^2 was studied in six single arm studies involving a total of 309 patients with metastatic breast cancer in whom previous chemotherapy had failed. Among these, 190 patients had anthracycline-resistant breast cancer, defined as progression during an anthracycline-containing chemotherapy regimen for metastatic disease, or relapse during an anthracycline-containing adjuvant regimen. In anthracycline-resistant patients, the overall response rate was 37.9% (72/190; 95% C.I.: 31.0-44.8) and the complete response rate was 2.1%.

TAXOTERE was also studied in three single arm Japanese studies at a dose of 60 mg/m^2, in 174 patients who had received prior chemotherapy for locally advanced or metastatic breast cancer. Among 26 patients whose best response to an anthracycline had been progression, the response rate was 34.6% (95% C.I.: 17.2-55.7), similar to the response rate in single arm studies of 100 mg/m^2.

Adjuvant Treatment of Breast Cancer

A multicenter, open-label, randomized trial (TAX316) evaluated the efficacy and safety of TAXOTERE for the adjuvant treatment of patients with axillary-node-positive breast cancer and no evidence of distant metastatic disease. After stratification according to the number of positive lymph nodes (1-3, 4+), 1491 patients were randomized to receive either TAXOTERE 75 mg/m^2 administered 1-hour after doxorubicin 50 mg/m^2 and cyclophosphamide 500 mg/m^2 (TAC arm), or doxorubicin 50 mg/m^2 followed by fluorouracil 500 mg/m^2 and cyclosphosphamide 500 mg/m^2 (FAC arm). Both regimens were administered every 3 weeks for 6 cycles. TAXOTERE was administered as a 1-hour infusion; all other drugs were given as IV bolus on day 1. In both arms, after the last cycle of chemotherapy, patients with positive estrogen and/or progesterone receptors received tamoxifen 20 mg daily for up to 5 years. Adjuvant radiation therapy was prescribed according to guidelines in place at participating institutions and was given to 69% of patients who received TAC and 72% of patients who received FAC.

Results from a second interim analysis (median follow-up 55 months) are as follows: In study TAX 316, the docetaxel-containing combination regimen TAC showed significantly longer disease-free survival (DFS) than FAC (hazard ratio=0.74; 2-sided 95% CI=0.60, 0.92, stratified log rank p=0.0047). The primary endpoint, disease-free survival, included local and distant recurrences, contralateral breast cancer and deaths from any cause. The overall reduction in risk of relapse was 25.7% for TAC-treated patients. (See Figure 1).

At the time of this interim analysis, based on 219 deaths, overall survival was longer for TAC than FAC (hazard ratio=0.69, 2-sided 95% CI=0.53, 0.90). (See Figure 2). There will be further analysis at the time survival data mature.

Figure 1-TAX 316 Disease Free Survival K-M curve

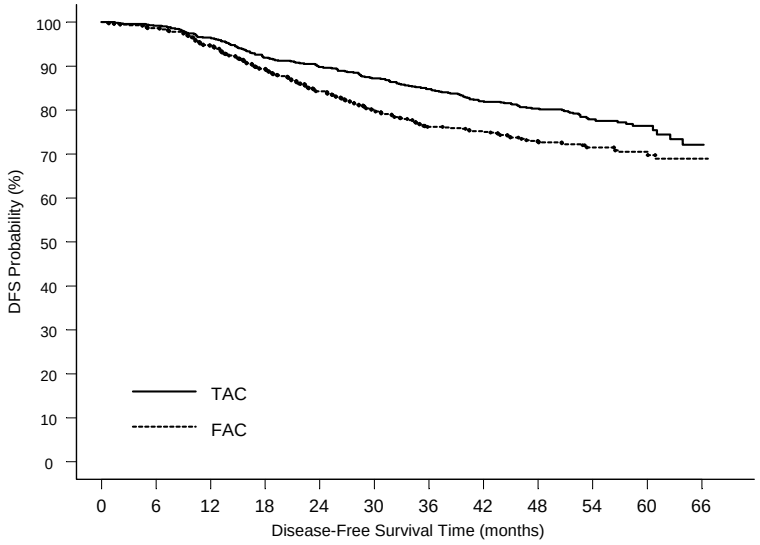
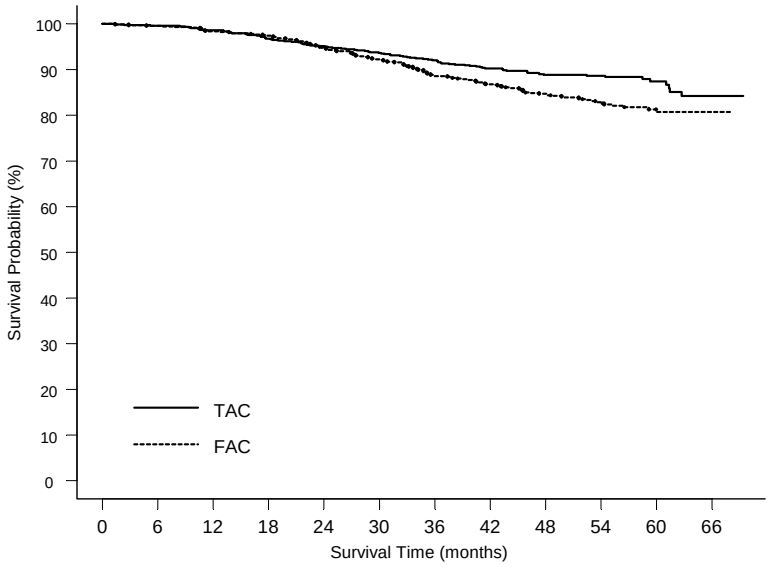


Figure 2-TAX 316 Overall Survival K-M Curve



The following table describes the results of subgroup analyses for DFS and OS.

Subset Analyses-Adjuvant Breast Cancer Study

		Disease Free Survival		Overall Survival	
Patient subset	**Number of patients**	**Hazard ratio***	**95% CI**	**Hazard ratio***	**95% CI**
No. of positive nodes					
Overall	744	0.74	(0.60, 0.92)	0.69	(0.53, 0.90)
1-3	467	0.64	(0.47, 0.87)	0.45	(0.29, 0.70)
4+	277	0.84	(0.63, 1.12)	0.93	(0.66, 1.32)
Receptor status					
Positive	566	0.76	(0.59, 0.98)	0.69	(0.48, 0.99)
Negative	178	0.68	(0.48, 0.97)	0.66	(0.44, 0.98)

*****a hazard ratio of less than 1 indicates that TAC is associated with a longer disease free survival or overall survival compared to FAC.

Non-Small Cell Lung Cancer (NSCLC)

The efficacy and safety of TAXOTERE has been evaluated in patients with unresectable, locally advanced or metastatic non-small cell lung cancer whose disease has failed prior platinum-based chemotherapy or in patients who are chemotherapy-naïve.

Monotherapy with TAXOTERE for NSCLC Previously Treated with Platinum-Based Chemotherapy

Two randomized, controlled trials established that a TAXOTERE dose of 75 mg/m^2 was tolerable and yielded a favorable outcome in patients previously treated with platinum-based chemotherapy (see below). TAXOTERE at a dose of 100 mg/m^2, however, was associated with unacceptable hematologic toxicity, infections, and treatment-related mortality and this dose

should not be used (see **BOXED WARNING, WARNINGS**, and **DOSAGE AND ADMINISTRATION** sections).

One trial (TAX317), randomized patients with locally advanced or metastatic non-small cell lung cancer, a history of prior platinum-based chemotherapy, no history of taxane exposure, and an ECOG performance status ≤2 to TAXOTERE or best supportive care. The primary endpoint of the study was survival. Patients were initially randomized to TAXOTERE 100 mg/m^2 or best supportive care, but early toxic deaths at this dose led to a dose reduction to TAXOTERE 75 mg/m^2. A total of 104 patients were randomized in this amended study to either TAXOTERE 75 mg/m^2 or best supportive care.

In a second randomized trial (TAX320), 373 patients with locally advanced or metastatic non-small cell lung cancer, a history of prior platinum-based chemotherapy, and an ECOG performance status ≤2 were randomized to TAXOTERE 75 mg/m^2, TAXOTERE 100 mg/m^2 and a treatment in which the investigator chose either vinorelbine 30 mg/m^2 days 1, 8, and 15 repeated every 3 weeks **or** ifosfamide 2 g/m^2 days 1-3 repeated every 3 weeks. Forty percent of the patients in this study had a history of prior paclitaxel exposure. The primary endpoint was survival in both trials. The efficacy data for the TAXOTERE 75 mg/m^2 arm and the comparator arms are summarized in the table below and in figures 3 and 4 showing the survival curves for the two studies.

Efficacy of TAXOTERE in the Treatment of Non-Small Cell Lung Cancer Patients Previously Treated with a Platinum-Based Chemotherapy Regimen (Intent-to-Treat Analysis)

	TAX317		**TAX320**	
	Docetaxel 75 mg/m^2 n=55	**Best Supportive Care/75 n=49**	**Docetaxel 75 mg/m^2 n=125**	**Control (V/I) n=123**
Overall Survival Log-rank Test	p=0.01		p=0.13	
Risk Ratio††, Mortality (Docetaxel: Control) 95% CI (Risk Ratio)	0.56 (0.35, 0.88)		0.82 (0.63, 1.06)	
Median Survival 95% CI	7.5 months* (5.5, 12.8)	4.6 months (3.7, 6.1)	5.7 months (5.1, 7.1)	5.6 months (4.4, 7.9)
% 1-year Survival 95% CI	37%*† (24, 50)	12% (2, 23)	30%*† (22, 39)	20% (13, 27)
Time to Progression 95% CI	12.3 weeks* (9.0, 18.3)	7.0 weeks (6.0, 9.3)	8.3 weeks (7.0, 11.7)	7.6 weeks (6.7, 10.1)
Response Rate 95% CI	5.5% (1.1, 15.1)	Not Applicable	5.7% (2.3, 11.3)	0.8% (0.0, 4.5)

* p≤0.05; † uncorrected for multiple comparisons; †† a value less than 1.00 favors docetaxel.

Only one of the two trials (TAX317) showed a clear effect on survival, the primary endpoint; that trial also showed an increased rate of survival to one year. In the second study (TAX320) the rate of survival at one year favored TAXOTERE 75 mg/m^2.

Figure 3: TAX317 Survival K-M Curves - TAXOTERE 75 mg/m^2 vs. Best Supportive Care

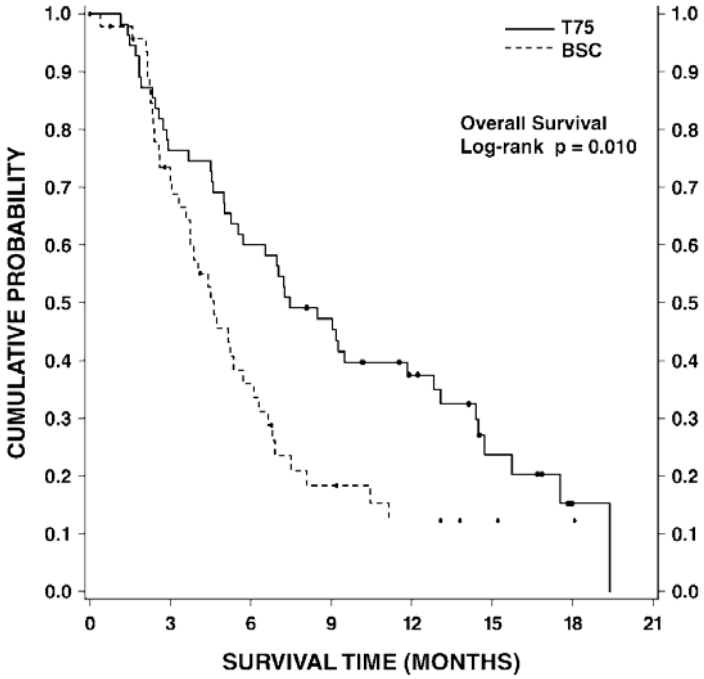
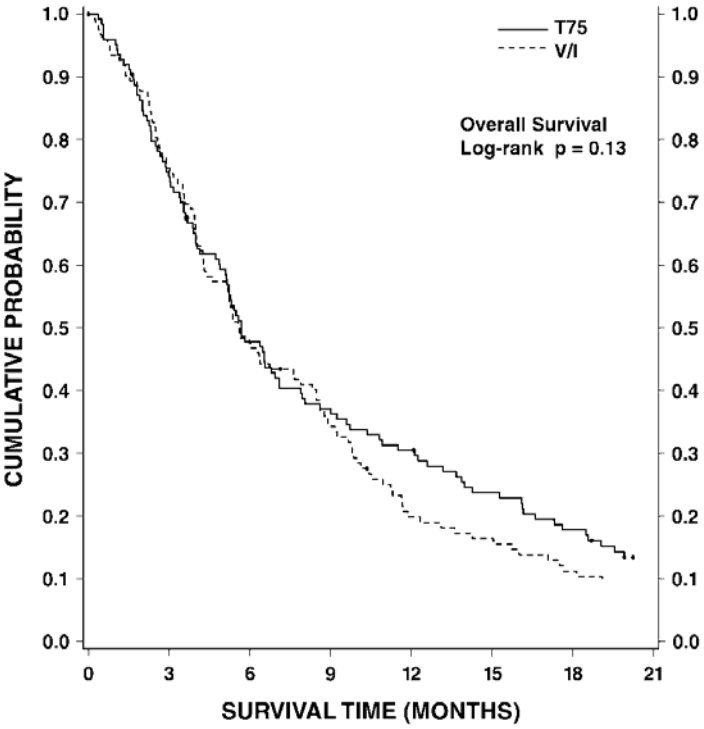


Figure 4: TAX320 Survival K-M Curves - TAXOTERE 75 mg/m^2 vs. Vinorelbine or Ifosfamide Control



Patients treated with TAXOTERE at a dose of 75 mg/m^2 experienced no deterioration in performance status and body weight relative to the comparator arms used in these trials.

Combination Therapy with TAXOTERE for Chemotherapy-Naïve NSCLC

In a randomized controlled trial (TAX326), 1218 patients with unresectable stage IIIB or IV NSCLC and no prior chemotherapy were randomized to receive one of three treatments: TAXOTERE 75 mg/m^2 as a 1 hour infusion immediately followed by cisplatin 75 mg/m^2 over 30-60 minutes every 3 weeks; vinorelbine 25 mg/m^2 administered over 6-10 minutes on days 1, 8, 15, 22 followed by cisplatin 100 mg/m^2 administered on day 1 of cycles repeated every 4 weeks; or a combination of TAXOTERE and carboplatin.

The primary efficacy endpoint was overall survival. Treatment with TAXOTERE+cisplatin did not result in a statistically significantly superior survival compared to vinorelbine+cisplatin (see table below). The 95% confidence interval of the hazard ratio (adjusted for interim analysis and multiple comparisons) shows that the addition of TAXOTERE to cisplatin results in an outcome ranging from a 6% inferior to a 26% superior survival compared to the addition of vinorelbine to cisplatin. The results of a further statistical analysis showed that at least (the lower bound of the 95% confidence interval) 62% of the known survival effect of vinorelbine when added to cisplatin (about a 2-month increase in median survival; Wozniak et al. JCO, 1998) was maintained. The efficacy data for the TAXOTERE+cisplatin arm and the comparator arm are summarized in the table below.

Survival Analysis of TAXOTERE in Combination Therapy for Chemotherapy-Naïve NSCLC

Comparison	Taxotere+Cisplatin n=408	Vinorelbine+Cisplatin n=405
Kaplan-Meier Estimate of Median Survival	10.9 months	10.0 months
p-value[a]	0.122	
Estimated Hazard Ratio[b]	0.88	
Adjusted 95% CI[c]	(0.74, 1.06)	

[a] From the superiority test (stratified log rank) comparing TAXOTERE+cisplatin to vinorelbine+cisplatin

[b]Hazard ratio of TAXOTERE+cisplatin vs. vinorelbine+cisplatin. A hazard ratio of less than 1 indicates that TAXOTERE+cisplatin is associated with a longer survival.

[c]Adjusted for interim analysis and multiple comparisons.

The second comparison in the study, vinorelbine+cisplatin versus TAXOTERE+carboplatin,did not demonstrate superior survival associated with the TAXOTERE arm (Kaplan-Meier estimate of median survival was 9.1 months for TAXOTERE+carboplatin compared to 10.0 months on the vinorelbine+cisplatin arm) and the TAXOTERE+carboplatin arm did not demonstrate preservation of at least 50% of the survival effect of vinorelbine added to cisplatin. Secondary endpoints evaluated in the trial included objective response and time to progression. There was no statistically significant difference between TAXOTERE+cisplatin and vinorelbine+cisplatin with respect to objective response and time to progression (see table below).

Response and TTP Analysis of TAXOTERE in Combination Therapy for Chemotherapy-Naïve NSCLC

Endpoint	TAXOTERE+Cisplatin	Vinorelbine+Cisplatin	p-value
Objective Response Rate (95% CI)[a]	31.6% (26.5%, 36.8%)	24.4% (19.8%, 29.2%)	Not Significant
Median Time to Progression[b] (95% CI)[a]	21.4 weeks (19.3, 24.6)	22.1 weeks (18.1, 25.6)	Not Significant

[a]Adjusted for multiple comparisons.

[b]Kaplan-Meier estimates.

Prostate Cancer

The safety and efficacy of TAXOTERE in combination with prednisone in patients with androgen independent (hormone refractory) metastatic prostate cancer were evaluated in a randomized multicenter active control trial. A total of 1006 patients with Karnofsky Performance Status (KPS) ≥60 were randomized to the following treatment groups:

- TAXOTERE 75 mg/m^2 every 3 weeks for 10 cycles.
- TAXOTERE 30 mg/m^2 administered weekly for the first 5 weeks in a 6-week cycle for 5 cycles.
- Mitoxantrone 12 mg/m^2 every 3 weeks for 10 cycles.

All 3 regimens were administered in combination with prednisone 5 mg twice daily, continuously.

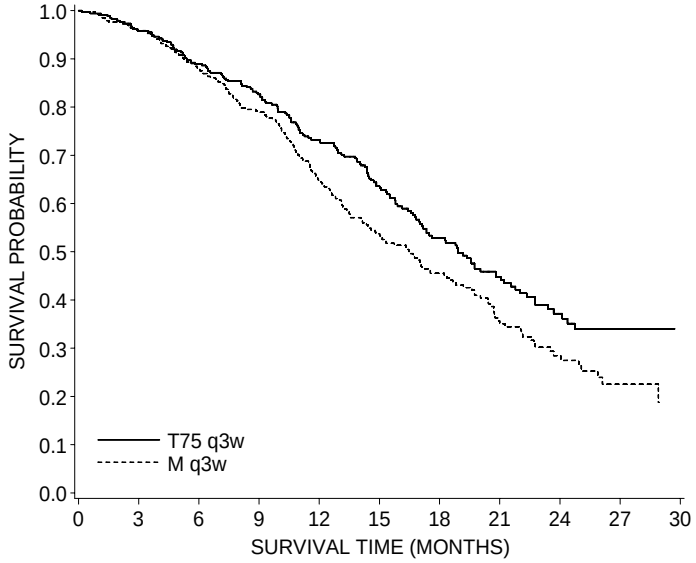
In the TAXOTERE every three week arm, a statistically significant overall survival advantage was demonstrated compared to mitoxantrone. In the TAXOTERE weekly arm, no overall survival advantage was demonstrated compared to the mitoxantrone control arm. Efficacy results for the TAXOTERE every 3 week arm versus the control arm are summarized in the following table and figure 5:

Efficacy of TAXOTERE in the Treatment of Patients with Androgen Independent (Hormone Refractory) Metastatic Prostate Cancer (Intent-to-Treat Analysis)

	TAXOTERE every 3 weeks	**Mitoxantrone every 3 weeks**
Number of patients	335	337
Median survival (months)	18.9	16.5
95% CI	(17.0-21.2)	(14.4-18.6)
Hazard ratio	0.761	--
95% CI	(0.619-0.936)	--
p-value*	0.0094	--

*Stratified log rank test. Threshold for statistical significance = 0.0175 because of 3 arms.

Figure 5 - TAX327 Survival K-M Curves



INDICATIONS AND USAGE

Breast Cancer

TAXOTERE is indicated for the treatment of patients with locally advanced or metastatic breast cancer after failure of prior chemotherapy.

TAXOTERE in combination with doxorubicin and cyclophosphamide is indicated for the adjuvant treatment of patients with operable node-positive breast cancer.

Non-Small Cell Lung Cancer

TAXOTERE as a single agent is indicated for the treatment of patients with locally advanced or metastatic non-small cell lung cancer after failure of prior platinum-based chemotherapy.

TAXOTERE in combination with cisplatin is indicated for the treatment of patients with unresectable, locally advanced or metastatic non-small cell lung cancer who have not previously received chemotherapy for this condition.

Prostate Cancer

TAXOTERE in combination with prednisone is indicated for the treatment of patients with androgen independent (hormone refractory) metastatic prostate cancer.

CONTRAINDICATIONS

TAXOTERE is contraindicated in patients who have a history of severe hypersensitivity reactions to docetaxel or to other drugs formulated with polysorbate 80.

TAXOTERE should not be used in patients with neutrophil counts of <1500 cells/mm^3.

WARNINGS

TAXOTERE should be administered under the supervision of a qualified physician experienced in the use of antineoplastic agents. Appropriate management of complications is possible only when adequate diagnostic and treatment facilities are readily available.

Toxic Deaths

Breast Cancer

TAXOTERE administered at 100 mg/m^2 was associated with deaths considered possibly or probably related to treatment in 2.0% (19/965) of metastatic breast cancer patients, both previously treated and untreated, with normal baseline liver function and in 11.5% (7/61) of patients with various tumor types who had abnormal baseline liver function (SGOT and/or SGPT > 1.5 times ULN together with AP > 2.5 times ULN). Among patients dosed at 60 mg/m^2, mortality related to treatment occurred in 0.6% (3/481) of patients with normal liver function, and in 3 of 7 patients with abnormal liver function. Approximately half of these deaths occurred during the first cycle. Sepsis accounted for the majority of the deaths.

Non-Small Cell Lung Cancer

TAXOTERE administered at a dose of 100 mg/m^2 in patients with locally advanced or metastatic non-small cell lung cancer who had a history of prior platinum-based chemotherapy was associated with increased treatment-related mortality (14% and 5% in two randomized, controlled studies). There were 2.8% treatment-related deaths among the 176 patients treated at the 75 mg/m^2 dose in the randomized trials. Among patients who experienced treatment-related mortality at the 75 mg/m^2 dose level, 3 of 5 patients had a PS of 2 at study entry (see **BOXED WARNING, CLINICAL STUDIES**, and **DOSAGE AND ADMINISTRATION** sections).

Premedication Regimen

All patients should be premedicated with oral corticosteroids (see below for prostate cancer) such as dexamethasone 16 mg per day (*e.g.*, 8 mg BID) for 3 days starting 1 day prior to TAXOTERE to reduce the severity of fluid retention and hypersensitivity reactions (see **DOSAGE AND ADMINISTRATION** section). This regimen was evaluated in 92 patients with metastatic breast cancer previously treated with chemotherapy given TAXOTERE at a dose of 100 mg/m^2 every 3 weeks.

The pretreatment regimen for hormone-refractory metastatic prostate cancer is oral dexamethasone 8 mg, at 12 hours, 3 hours and 1 hour before the TAXOTERE infusion (see **DOSAGE AND ADMINISTRATION** section).

Hypersensitivity Reactions

Patients should be observed closely for hypersensitivity reactions, especially during the first and second infusions. Severe hypersensitivity reactions characterized by generalized rash/erythema, hypotension and/or bronchospasm, or very rarely fatal anaphylaxis, have been reported in patients premedicated with 3 days of corticosteroids. Hypersensitivity reactions require immediate discontinuation of the TAXOTERE infusion. Patients with a history of severe hypersensitivity reactions should not be rechallenged with TAXOTERE.

Hematologic Effects

Neutropenia (< 2000 neutrophils/mm^3) occurs in virtually all patients given 60-100 mg/m^2 of TAXOTERE and grade 4 neutropenia (< 500 cells/mm^3) occurs in 85% of patients given 100

mg/m^2 and 75% of patients given 60 mg/m^2. Frequent monitoring of blood counts is, therefore, essential so that dose can be adjusted. TAXOTERE should not be administered to patients with neutrophils < 1500 cells/mm^3.

Febrile neutropenia occurred in about 12% of patients given 100 mg/m^2 but was very uncommon in patients given 60 mg/m^2. Hematologic responses, febrile reactions and infections, and rates of septic death for different regimens are dose related and are described in **CLINICAL STUDIES**.

Three breast cancer patients with severe liver impairment (bilirubin > 1.7 times ULN) developed fatal gastrointestinal bleeding associated with severe drug-induced thrombocytopenia.

Hepatic Impairment

(see **BOXED WARNING)**.

Fluid Retention

(see **BOXED WARNING)**.

Acute Myeloid Leukemia

Treatment-related acute myeloid leukemia (AML) has occurred in patients given anthracyclines and/or cyclophosphamide, including use in adjuvant therapy for breast cancer. In the adjuvant breast cancer trial (TAX316, see CLINICAL STUDIES) AML occurred in 3 of 744 patients who received TAXOTERE, doxorubicin and cyclophosphamide and in 1 of 736 patients who received fluorouracil, doxorubicin and cyclophosphamide (see ADVERSE REACTIONS).

Pregnancy

TAXOTERE can cause fetal harm when administered to pregnant women. Studies in both rats and rabbits at doses ≥ 0.3 and 0.03 mg/kg/day, respectively (about 1/50 and 1/300 the daily maximum recommended human dose on a mg/m^2 basis), administered during the period of organogenesis, have shown that TAXOTERE is embryotoxic and fetotoxic (characterized by intrauterine mortality, increased resorption, reduced fetal weight, and fetal ossification delay). The doses indicated above also caused maternal toxicity.

There are no adequate and well-controlled studies in pregnant women using TAXOTERE. If TAXOTERE is used during pregnancy, or if the patient becomes pregnant while receiving this drug, the patient should be apprised of the potential hazard to the fetus or potential risk for loss of the pregnancy. Women of childbearing potential should be advised to avoid becoming pregnant during therapy with TAXOTERE.

PRECAUTIONS

General

Responding patients may not experience an improvement in performance status on therapy and may experience worsening. The relationship between changes in performance status, response to therapy, and treatment-related side effects has not been established.

Hematologic Effects

In order to monitor the occurrence of myelotoxicity, it is recommended that frequent peripheral blood cell counts be performed on all patients receiving TAXOTERE. Patients should not be retreated with subsequent cycles of TAXOTERE until neutrophils recover to a level > 1500 cells/mm^3 and platelets recover to a level > 100,000 cells/mm^3.

A 25% reduction in the dose of TAXOTERE is recommended during subsequent cycles following severe neutropenia (< 500 cells/mm^3) lasting 7 days or more, febrile neutropenia, or a grade 4 infection in a TAXOTERE cycle (see **DOSAGE AND ADMINISTRATION** section).

Hypersensitivity Reactions

Hypersensitivity reactions may occur within a few minutes following initiation of a TAXOTERE infusion. If minor reactions such as flushing or localized skin reactions occur, interruption of therapy is not required. More severe reactions, however, require the immediate discontinuation of TAXOTERE and aggressive therapy. All patients should be premedicated with an oral corticosteroid prior to the initiation of the infusion of TAXOTERE (see **BOXED WARNING** and **WARNINGS**: **Premedication Regimen and Hypersensitivity Reactions**).

Cutaneous

Localized erythema of the extremities with edema followed by desquamation has been observed. In case of severe skin toxicity, an adjustment in dosage is recommended (see **DOSAGE AND ADMINISTRATION** section). The discontinuation rate due to skin toxicity was 1.6% (15/965) for metastatic breast cancer patients. Among 92 breast cancer patients premedicated with 3-day corticosteroids, there were no cases of severe skin toxicity reported and no patient discontinued TAXOTERE due to skin toxicity.

Fluid Retention

Severe fluid retention has been reported following TAXOTERE therapy (see **BOXED WARNING** and **WARNINGS**: **Premedication Regimen**). Patients should be premedicated with oral corticosteroids prior to each TAXOTERE administration to reduce the incidence and severity of fluid retention (see **DOSAGE AND ADMINISTRATION** section). Patients with pre-existing effusions should be closely monitored from the first dose for the possible exacerbation of the effusions.

When fluid retention occurs, peripheral edema usually starts in the lower extremities and may become generalized with a median weight gain of 2 kg.

Among 92 breast cancer patients premedicated with 3-day corticosteroids, moderate fluid retention occurred in 27.2% and severe fluid retention in 6.5%. The median cumulative dose to onset of moderate or severe fluid retention was 819 mg/m^2. 9.8% (9/92) of patients discontinued treatment due to fluid retention: 4 patients discontinued with severe fluid retention; the remaining 5 had mild or moderate fluid retention. The median cumulative dose to treatment discontinuation due to fluid retention was 1021 mg/m^2. Fluid retention was completely, but sometimes slowly, reversible with a median of 16 weeks from the last infusion of TAXOTERE to resolution (range: 0 to 42+ weeks). Patients developing peripheral edema may be treated with standard measures, *e.g.*, salt restriction, oral diuretic(s).

Neurologic

Severe neurosensory symptoms (paresthesia, dysesthesia, pain) were observed in 5.5% (53/965) of metastatic breast cancer patients, and resulted in treatment discontinuation in 6.1%. When these symptoms occur, dosage must be adjusted. If symptoms persist, treatment should be discontinued (see **DOSAGE AND ADMINISTRATION** section). Patients who experienced neurotoxicity in clinical trials and for whom follow-up information on the complete resolution of the event was available had spontaneous reversal of symptoms with a median of 9 weeks from onset (range: 0 to 106 weeks). Severe peripheral motor neuropathy mainly manifested as distal extremity weakness occurred in 4.4% (42/965).

Asthenia

Severe asthenia has been reported in 14.9% (144/965) of metastatic breast cancer patients but has led to treatment discontinuation in only 1.8%. Symptoms of fatigue and weakness may last a few days up to several weeks and may be associated with deterioration of performance status in patients with progressive disease.

Information for Patients

For additional information, see the accompanying Patient Information Leaflet.

Drug Interactions

There have been no formal clinical studies to evaluate the drug interactions of TAXOTERE with other medications. *In vitro* studies have shown that the metabolism of docetaxel may be modified by the concomitant administration of compounds that induce, inhibit, or are metabolized by cytochrome P450 3A4, such as cyclosporine, terfenadine, ketoconazole, erythromycin, and troleandomycin. Caution should be exercised with these drugs when treating patients receiving TAXOTERE as there is a potential for a significant interaction.

Carcinogenicity, Mutagenicity, Impairment of Fertility

No studies have been conducted to assess the carcinogenic potential of TAXOTERE. TAXOTERE has been shown to be clastogenic in the *in vitro* chromosome aberration test in CHO-K_1 cells and in the *in vivo* micronucleus test in the mouse, but it did not induce mutagenicity in the Ames test or the CHO/HGPRT gene mutation assays. TAXOTERE produced no impairment of fertility in rats when administered in multiple IV doses of up to 0.3 mg/kg (about 1/50 the recommended human dose on a mg/m^2 basis), but decreased testicular weights were reported. This correlates with findings of a 10-cycle toxicity study (dosing once every 21 days for 6 months) in rats and dogs in which testicular atrophy or degeneration was observed at IV doses of 5 mg/kg in rats and 0.375 mg/kg in dogs (about 1/3 and 1/15 the recommended human dose on a mg/m^2 basis, respectively). An increased frequency of dosing in rats produced similar effects at lower dose levels.

Pregnancy

Pregnancy Category D (see **WARNINGS** section).

Nursing Mothers

It is not known whether TAXOTERE is excreted in human milk. Because many drugs are excreted in human milk, and because of the potential for serious adverse reactions in nursing infants from TAXOTERE, mothers should discontinue nursing prior to taking the drug.

Pediatric Use

The safety and effectiveness of TAXOTERE in pediatric patients have not been established.

Geriatric Use

In a study conducted in chemotherapy-naïve patients with NSCLC (TAX326), 148 patients (36%) in the TAXOTERE+cisplatin group were 65 years of age or greater. There were 128 patients (32%) in the vinorelbine+cisplatin group 65 years of age or greater. In the TAXOTERE+cisplatin group, patients less than 65 years of age had a median survival of 10.3 months (95% CI : 9.1 months, 11.8 months) and patients 65 years or older had a median survival of 12.1 months (95% CI : 9.3 months, 14 months). In patients 65 years of age or greater treated with TAXOTERE+cisplatin, diarrhea (55%), peripheral edema (39%) and stomatitis (28%) were observed more frequently than in the vinorelbine+cisplatin group (diarrhea 24%, peripheral edema 20%, stomatitis 20%). Patients treated with TAXOTERE+cisplatin who were 65 years of

age or greater were more likely to experience diarrhea (55%), infections (42%), peripheral edema (39%) and stomatitis (28%) compared to patients less than the age of 65 administered the same treatment (43%, 31%, 31% and 21%, respectively).
When TAXOTERE was combined with carboplatin for the treatment of chemotherapy-naïve, advanced non-small cell lung carcinoma, patients 65 years of age or greater (28%) experienced higher frequency of infection compared to similar patients treated with TAXOTERE+cisplatin, and a higher frequency of diarrhea, infection and peripheral edema than elderly patients treated with vinorelbine+cisplatin.
Of the 333 patients treated with TAXOTERE every three weeks plus prednisone in the prostate cancer study (TAX327), 209 patients were 65 years of age or greater and 68 patients were older than 75 years. In patients treated with TAXOTERE every three weeks, the following TEAEs occurred at rates ≥ 10% higher in patients 65 years of age or greater compared to younger patients: anemia (71% vs. 59%), infection (37% vs. 24%), nail changes (34% vs. 23%), anorexia (21% vs. 10%), weight loss (15% vs. 5%) respectively.
In the adjuvant breast cancer trial (TAX316), TAXOTERE in combination with doxorubicin and cyclophosphamide was administered to 744 patients of whom 48 (6%) were 65 years of age or greater. The number of elderly patients who received this regimen was not sufficient to determine whether there were differences in safety and efficacy between elderly and younger patients.

ADVERSE REACTIONS

Adverse reactions are described for TAXOTERE according to indication:
-in the treatment of breast cancer, at the maximum dose of 100 mg/m^2
-in the treatment of advanced breast cancer at doses of 60, 75 and 100 mg/m^2
-in the adjuvant therapy of breast cancer at a dose of 75 mg/m^2, in combination with doxorubicin and cyclophosphamide
-in the treatment of advanced non-small cell lung cancer after prior platinum-based chemotherapy, at a dose of 75 mg/m^2
-in the treatment of non-small cell lung cancer in patients who have not previously received chemotherapy for this condition, at a dose of 75 mg/m^2, in combination with cisplatin
-in the treatment of androgen independent (hormone refractory) metastatic prostate cancer, at a dose of 75 mg/m^2 every three weeks in combination with prednisone

Monotherapy with TAXOTERE for Locally Advanced or Metastatic Breast Cancer After Failure of Prior Chemotherapy

TAXOTERE 100 mg/m^2: Adverse drug reactions occurring in at least 5% of patients are compared for three populations who received TAXOTERE administered at 100 mg/m^2 as a 1-hour infusion every 3 weeks: 2045 patients with various tumor types and normal baseline liver function tests; the subset of 965 patients with locally advanced or metastatic breast cancer, both previously treated and untreated with chemotherapy, who had normal baseline liver function tests; and an additional 61 patients with various tumor types who had abnormal liver function tests at baseline. These reactions were described using COSTART terms and were considered possibly or probably related to TAXOTERE. At least 95% of these patients did not receive hematopoietic support. The safety profile is generally similar in patients receiving TAXOTERE for the treatment of breast cancer and in patients with other tumor types.

Summary of Adverse Events in Patients Receiving TAXOTERE at 100 mg/m^2

Adverse Event	All Tumor Types Normal LFTs* n=2045 %	All Tumor Types Elevated LFTs** n=61 %	Breast Cancer Normal LFTs* n=965 %
Hematologic			
Neutropenia			
<2000 cells/mm^3	95.5	96.4	98.5
<500 cells/mm^3	75.4	87.5	85.9
Leukopenia			
<4000 cells/mm^3	95.6	98.3	98.6
<1000 cells/mm^3	31.6	46.6	43.7
Thrombocytopenia			
<100,000 cells/mm^3	8.0	24.6	9.2
Anemia			
<11 g/dL	90.4	91.8	93.6
<8 g/dL	8.8	31.1	7.7
Febrile Neutropenia***	11.0	26.2	12.3
Septic Death	1.6	4.9	1.4
Non-Septic Death	0.6	6.6	0.6
Infections			
Any	21.6	32.8	22.2
Severe	6.1	16.4	6.4
Fever in Absence of Infection			
Any	31.2	41.0	35.1
Severe	2.1	8.2	2.2
Hypersensitivity Reactions			
Regardless of Premedication			
Any	21.0	19.7	17.6
Severe	4.2	9.8	2.6
With 3-day Premedication	n=92	n=3	n=92
Any	15.2	33.3	15.2
Severe	2.2	0	2.2

Fluid Retention			
Regardless of Premedication			
Any	47.0	39.3	59.7
Severe	6.9	8.2	8.9
With 3-day Premedication	n=92	n=3	n=92
Any	64.1	66.7	64.1
Severe	6.5	33.3	6.5
Neurosensory			
Any	49.3	34.4	58.3
Severe	4.3	0	5.5
Cutaneous			
Any	47.6	54.1	47.0
Severe	4.8	9.8	5.2
Nail Changes			
Any	30.6	23.0	40.5
Severe	2.5	4.9	3.7
Gastrointestinal			
Nausea	38.8	37.7	42.1
Vomiting	22.3	23.0	23.4
Diarrhea	38.7	32.8	42.6
Severe	4.7	4.9	5.5
Stomatitis			
Any	41.7	49.2	51.7
Severe	5.5	13.0	7.4
Alopecia	75.8	62.3	74.2
Asthenia			
Any	61.8	52.5	66.3
Severe	12.8	24.6	14.9
Myalgia			
Any	18.9	16.4	21.1
Severe	1.5	1.6	1.8
Arthralgia	9.2	6.6	8.2
Infusion Site Reactions	4.4	3.3	4.0

***Normal Baseline LFTs: Transaminases ≤ 1.5 times ULN or alkaline phosphatase ≤ 2.5 times ULN or isolated elevations of transaminases or alkaline phosphatase up to 5 times ULN**

****Elevated Baseline LFTs: SGOT and/or SGPT > 1.5 times ULN concurrent with alkaline phosphatase > 2.5 times ULN**

*****Febrile Neutropenia: ANC grade 4 with fever > 38°C with IV antibiotics and/or hospitalization**

Hematologic: **(**see **WARNINGS)**.

Reversible marrow suppression was the major dose-limiting toxicity of TAXOTERE. The median time to nadir was 7 days, while the median duration of severe neutropenia (<500 cells/mm^3) was 7 days. Among 2045 patients with solid tumors and normal baseline LFTs, severe neutropenia occurred in 75.4% and lasted for more than 7 days in 2.9% of cycles.

Febrile neutropenia (<500 cells/mm^3 with fever > 38°C with IV antibiotics and/or hospitalization) occurred in 11% of patients with solid tumors, in 12.3% of patients with metastatic breast cancer, and in 9.8% of 92 breast cancer patients premedicated with 3-day corticosteroids.

Severe infectious episodes occurred in 6.1% of patients with solid tumors, in 6.4% of patients with metastatic breast cancer, and in 5.4% of 92 breast cancer patients premedicated with 3-day corticosteroids.

Thrombocytopenia (<100,000 cells/mm^3) associated with fatal gastrointestinal hemorrhage has been reported.

Hypersensitivity Reactions

Severe hypersensitivity reactions are discussed in the **BOXED WARNING, WARNINGS,** and **PRECAUTIONS** sections. Minor events, including flushing, rash with or without pruritus, chest tightness, back pain, dyspnea, drug fever, or chills, have been reported and resolved after discontinuing the infusion and appropriate therapy.

Fluid Retention: (see **BOXED WARNING**, **WARNINGS: Premedication Regimen**, and **PRECAUTIONS** sections).

Cutaneous

Severe skin toxicity is discussed in **PRECAUTIONS**. Reversible cutaneous reactions characterized by a rash including localized eruptions, mainly on the feet and/or hands, but also on the arms, face, or thorax, usually associated with pruritus, have been observed. Eruptions generally occurred within 1 week after TAXOTERE infusion, recovered before the next infusion, and were not disabling.

Severe nail disorders were characterized by hypo- or hyperpigmentation, and occasionally by onycholysis (in 0.8% of patients with solid tumors) and pain.

Neurologic: **(**see **PRECAUTIONS)**.

Gastrointestinal

Gastrointestinal reactions (nausea and/or vomiting and/or diarrhea) were generally mild to moderate. Severe reactions occurred in 3-5% of patients with solid tumors and to a similar extent among metastatic breast cancer patients. The incidence of severe reactions was 1% or less for the 92 breast cancer patients premedicated with 3-day corticosteroids.

Severe stomatitis occurred in 5.5% of patients with solid tumors, in 7.4% of patients with metastatic breast cancer, and in 1.1% of the 92 breast cancer patients premedicated with 3-day corticosteroids.

Cardiovascular

Hypotension occurred in 2.8% of patients with solid tumors; 1.2% required treatment. Clinically meaningful events such as heart failure, sinus tachycardia, atrial flutter, dysrhythmia, unstable angina, pulmonary edema, and hypertension occurred rarely. 8.1% (7/86) of metastatic breast cancer patients receiving TAXOTERE 100 mg/m^2 in a randomized trial and who had serial left ventricular ejection fractions assessed developed deterioration of LVEF by ≥ 10% associated with a drop below the institutional lower limit of normal.

Infusion Site Reactions

Infusion site reactions were generally mild and consisted of hyperpigmentation, inflammation, redness or dryness of the skin, phlebitis, extravasation, or swelling of the vein.

Hepatic

In patients with normal LFTs at baseline, bilirubin values greater than the ULN occurred in 8.9% of patients. Increases in SGOT or SGPT > 1.5 times the ULN, or alkaline phosphatase > 2.5 times ULN, were observed in 18.9% and 7.3% of patients, respectively. While on TAXOTERE, increases in SGOT and/or SGPT > 1.5 times ULN concomitant with alkaline phosphatase > 2.5 times ULN occurred in 4.3% of patients with normal LFTs at baseline. (Whether these changes were related to the drug or underlying disease has not been established.)

Hematologic and Other Toxicity: Relation to dose and baseline liver chemistry abnormalities.

Hematologic and other toxicity is increased at higher doses and in patients with elevated baseline liver function tests (LFTs). In the following tables, adverse drug reactions are compared for three populations: 730 patients with normal LFTs given TAXOTERE at 100 mg/m^2 in the randomized and single arm studies of metastatic breast cancer after failure of previous chemotherapy; 18 patients in these studies who had abnormal baseline LFTs (defined as SGOT and/or SGPT > 1.5 times ULN concurrent with alkaline phosphatase > 2.5 times ULN); and 174 patients in Japanese studies given TAXOTERE at 60 mg/m^2 who had normal LFTs.

Hematologic Adverse Events in Breast Cancer Patients Previously Treated with Chemotherapy Treated at TAXOTERE 100 mg/m^2 with Normal or Elevated Liver Function Tests or 60 mg/m^2 with Normal Liver Function Tests

	TAXOTERE 100 mg/m^2		**TAXOTERE 60 mg/m^2**
Adverse Event	**Normal LFTs* n=730 %**	**Elevated LFTs** n=18 %**	**Normal LFTs* n=174 %**
Neutropenia			
Any <2000 cells/mm^3	98.4	100	95.4
Grade 4 <500 cells/mm^3	84.4	93.8	74.9
Thrombocytopenia			
Any <100,000 cells/mm^3	10.8	44.4	14.4
Grade 4 <20,000 cells/mm^3	0.6	16.7	1.1
Anemia <11 g/dL	94.6	94.4	64.9
Infection* **			
Any	22.5	38.9	1.1
Grade 3 and 4	7.1	33.3	0
Febrile Neutropenia**			

By Patient	11.8	33.3	0
By Course	2.4	8.6	0
Septic Death	1.5	5.6	1.1
Non-Septic Death	1.1	11.1	0

***Normal Baseline LFTs: Transaminases ≤ 1.5 times ULN or alkaline phosphatase ≤ 2.5 times ULN or isolated elevations of transaminases or alkaline phosphatase up to 5 times ULN**

****Elevated Baseline LFTs: SGOT and/or SGPT >1.5 times ULN concurrent with alkaline phosphatase >2.5 times ULN**

*****Incidence of infection requiring hospitalization and/or intravenous antibiotics was 8.5% (n=62) among the 730 patients with normal LFTs at baseline; 7 patients had concurrent grade 3 neutropenia, and 46 patients had grade 4 neutropenia.**

******Febrile Neutropenia: For 100 mg/m^2, ANC grade 4 and fever > 38°C with IV antibiotics and/or hospitalization; for 60 mg/m^2, ANC grade 3/4 and fever > 38.1°C**

Non-Hematologic Adverse Events in Breast Cancer Patients Previously Treated with Chemotherapy Treated at TAXOTERE 100 mg/m^2 with Normal or Elevated Liver Function Tests or 60 mg/m^2 with Normal Liver Function Tests

	TAXOTERE 100 mg/m^2		**TAXOTERE 60 mg/m^2**
Adverse Event	**Normal LFTs* n=730 %**	**Elevated LFTs** n=18 %**	**Normal LFTs* n=174 %**
Acute Hypersensitivity Reaction Regardless of Premedication			
Any	13.0	5.6	0.6
Severe	1.2	0	0
Fluid Retention* Regardless of Premedication**			
Any	56.2	61.1	12.6
Severe	7.9	16.7	0
Neurosensory			
Any	56.8	50	19.5
Severe	5.8	0	0
Myalgia	22.7	33.3	3.4
Cutaneous			
Any	44.8	61.1	30.5
Severe	4.8	16.7	0

Asthenia			
Any	65.2	44.4	65.5
Severe	16.6	22.2	0
Diarrhea			
Any	42.2	27.8	NA
Severe	6.3	11.1	
Stomatitis			
Any	53.3	66.7	19.0
Severe	7.8	38.9	0.6

***Normal Baseline LFTs: Transaminases ≤ 1.5 times ULN or alkaline phosphatase ≤ 2.5 times ULN or isolated elevations of transaminases or alkaline phosphatase up to 5 times ULN**

**** Elevated Baseline Liver Function: SGOT and/or SGPT >1.5 times ULN concurrent with alkaline phosphatase >2.5 times ULN**

*****Fluid Retention includes (by COSTART): edema (peripheral, localized, generalized, lymphedema, pulmonary edema, and edema otherwise not specified) and effusion (pleural, pericardial, and ascites); no premedication given with the 60 mg/m^2 dose**

NA = not available

In the three-arm monotherapy trial, TAX313, which compared TAXOTERE 60, 75 and 100 mg/m^2 in advanced breast cancer, the overall safety profile was consistent with the safety profile observed in previous TAXOTERE trials. Grade 3/4 or severe adverse events occurred in 49.0% of patients treated with TAXOTERE 60 mg/m^2 compared to 55.3% and 65.9% treated with 75 and 100 mg/m^2 respectively. Discontinuation due to adverse events was reported in 5.3% of patients treated with 60 mg/m^2 vs. 6.9% and 16.5% for patients treated at 75 and 100 mg/m^2 respectively. Deaths within 30 days of last treatment occurred in 4.0% of patients treated with 60 mg/m^2 compared to 5.3% and 1.6% for patients treated at 75 and 100 mg/m^2 respectively.

The following adverse events were associated with increasing docetaxel doses: fluid retention (26%, 38%, and 46% at 60, 75, and 100 mg/m^2 respectively), thrombocytopenia (7%, 11% and 12 % respectively), neutropenia (92%, 94%, and 97% respectively), febrile neutropenia (5%, 7%, and 14% respectively), treatment-related grade 3/ 4 infection (2%, 3%, and 7% respectively) and anemia (87%, 94%, and 97% respectively).

Combination Therapy with TAXOTERE in the Adjuvant Treatment of Breast Cancer

The following table presents treatment emergent adverse events (TEAEs) observed in 744 patients, who were treated with TAXOTERE 75 mg/m² every 3 weeks in combination with doxorubicin and cyclophosphamide.

Clinically Important Treatment Emergent Adverse Events Regardless of Causal Relationship in Patients Receiving TAXOTERE in Combination with Doxorubicin and Cyclophosphamide (TAX 316).

	TAXOTERE 75 mg/m^2+ Doxorubicin 50 mg/m^2+ Cyclophosphamide 500 mg/m^2 (TAC) n=744 %		Fluorouracil 500 mg/m^2+ Doxorubicin 50 mg/m^2+ Cyclophosphamide 500 mg/m^2 (FAC) n=736 %	
Adverse Event	**Any**	**G 3/4**	**Any**	**G 3/4**
Anemia	91.5	4.3	71.7	1.6
Neutropenia	71.4	65.5	82.0	49.3
Fever in absence of infection	46.5	1.3	17.1	0.0
Infection	39.4	3.9	36.3	2.2
Thrombocytopenia	39.4	2.0	27.7	1.2
Febrile neutropenia	24.7	N/A	2.5	N/A
Neutropenic infection	12.1	N/A	6.3	N/A
Hypersensitivity reactions	13.4	1.3	3.7	0.1
Lymphedema	4.4	0.0	1.2	0.0
Fluid Retention*	35.1	0.9	14.7	0.1
Peripheral edema	26.9	0.4	7.3	0.0
Weight gain	12.9	0.3	8.6	0.3
Neuropathy sensory	25.5	0.0	10.2	0.0
Neuro-cortical	5.1	0.5	6.4	0.7
Neuropathy motor	3.8	0.1	2.2	0.0
Neuro-cerebellar	2.4	0.1	2.0	0.0
Syncope	1.6	0.5	1.2	0.3
Alopecia	97.8	N/A	97.1	N/A
Skin toxicity	26.5	0.8	17.7	0.4
Nail disorders	18.5	0.4	14.4	0.1
Nausea	80.5	5.1	88.0	9.5
Stomatitis	69.4	7.1	52.9	2.0
Vomiting	44.5	4.3	59.2	7.3
Diarrhea	35.2	3.8	27.9	1.8
Constipation	33.9	1.1	31.8	1.4
Taste perversion	27.8	0.7	15.1	0.0
Anorexia	21.6	2.2	17.7	1.2
Abdominal Pain	10.9	0.7	5.3	0.0
Amenorrhea	61.7	N/A	52.4	N/A
Cough	13.7	0.0	9.8	0.1
Cardiac dysrhythmias	7.9	0.3	6.0	0.3

Vasodilatation	27.0	1.1	21.2	0.5
Hypotension	2.6	0.0	1.1	0.1
Phlebitis	1.2	0.0	0.8	0.0
Asthenia	80.8	11.2	71.2	5.6
Myalgia	26.7	0.8	9.9	0.0
Arthralgia	19.4	0.5	9.0	0.3
Lacrimation disorder	11.3	0.1	7.1	0.0
Conjunctivitis	5.1	0.3	6.9	0.1

*** COSTART term and grading system for events related to treatment.**

Of the 744 patients treated with TAC, 36.3% experienced severe TEAEs compared to 26.6 % of the 736 patients treated with FAC. Dose reductions due to hematologic toxicity occurred in 1% of cycles in the TAC arm versus 0.1% of cycles in the FAC arm. Six percent of patients treated with TAC discontinued treatment due to adverse events, compared to 1.1% treated with FAC; fever in the absence of infection and allergy being the most common reasons for withdrawal among TAC-treated patients. Two patients died in each arm within 30 days of their last study treatment; 1 death per arm was attributed to study drugs.

Fever and Infection

Fever in the absence of infection was seen in 46.5% of TAC-treated patients and in 17.1% of FAC-treated patients. Grade 3/4 fever in the absence of infection was seen in 1.3% and 0% of TAC- and FAC-treated patients respectively. Infection was seen in 39.4% of TAC-treated patients compared to 36.3% of FAC-treated patients. Grade 3/4 infection was seen in 3.9% and 2.2% of TAC-treated and FAC-treated patients respectively. There were no septic deaths in either treatment arm.

Gastrointestinal events

In addition to gastrointestinal events reflected in the table above, 7 patients in the TAC arm were reported to have colitis/enteritis/large intestine perforation vs. one patient in the FAC arm. Five of the 7 TAC-treated patients required treatment discontinuation; no deaths due to these events occurred.

Cardiovascular events

More cardiovascular events were reported in the TAC arm vs. the FAC arm; dysrhythmias, all grades (7.9% vs. 6.0%), hypotension, all grades (2.6% vs. 1.1%) and CHF (1.6% vs. 0.5%). One patient in each arm died due to heart failure.

Acute Myeloid Leukemia

Treatment-related acute myeloid leukemia (AML) is known to occur in patients treated with anthracyclines and/or cyclophosphamide, including use in adjuvant therapy for breast cancer. AML occurs at a higher frequency when these agents are given in combination with radiation therapy. AML occurred in the adjuvant breast cancer trial (TAX316). The cumulative risk of developing treatment-related AML at 5 years in TAX316 was 0.4% for TAC-treated patients and 0.1% for FAC-treated patients. This risk of AML is comparable to the risk observed for other anthracyclines/cyclophosphamide containing adjuvant breast chemotherapy regimens.

Monotherapy with TAXOTERE for Unresectable, Locally Advanced or Metastatic NSCLC Previously Treated with Platinum-Based Chemotherapy

TAXOTERE 75 mg/m^2: Treatment emergent adverse drug reactions are shown below. Included in this table are safety data for a total of 176 patients with non-small cell lung carcinoma and a

history of prior treatment with platinum-based chemotherapy who were treated in two randomized, controlled trials. These reactions were described using NCI Common Toxicity Criteria regardless of relationship to study treatment, except for the hematologic toxicities or otherwise noted.

Treatment Emergent Adverse Events Regardless of Relationship to Treatment in Patients Receiving TAXOTERE as Monotherapy for Non-Small Cell Lung Cancer Previously Treated with Platinum-Based Chemotherapy*

Adverse Event	TAXOTERE 75 mg/m^2 n=176 %	Best Supportive Care n=49 %	Vinorelbine/ Ifosfamide n=119 %
Neutropenia			
Any	84.1	14.3	83.2
Grade ¾	65.3	12.2	57.1
Leukopenia			
Any	83.5	6.1	89.1
Grade ¾	49.4	0	42.9
Thrombocytopenia			
Any	8.0	0	7.6
Grade ¾	2.8	0	1.7
Anemia			
Any	91.0	55.1	90.8
Grade ¾	9.1	12.2	14.3
Febrile Neutropenia**	6.3	NA†	0.8
Infection			
Any	33.5	28.6	30.3
Grade ¾	10.2	6.1	9.2
Treatment Related Mortality	2.8	NA†	3.4
Hypersensitivity Reactions			
Any	5.7	0	0.8
Grade ¾	2.8	0	0
Fluid Retention			
Any	33.5	ND††	22.7
Severe	2.8		3.4
Neurosensory			
Any	23.3	14.3	28.6
Grade ¾	1.7	6.1	5.0

Neuromotor			
Any	15.9	8.2	10.1
Grade ¾	4.5	6.1	3.4
Skin			
Any	19.9	6.1	16.8
Grade ¾	0.6	2.0	0.8
Gastrointestinal			
Nausea			
Any	33.5	30.6	31.1
Grade 3/4	5.1	4.1	7.6
Vomiting			
Any	21.6	26.5	21.8
Grade 3/4	2.8	2.0	5.9
Diarrhea			
Any	22.7	6.1	11.8
Grade 3/4	2.8	0	4.2
Alopecia	56.3	34.7	49.6
Asthenia			
Any	52.8	57.1	53.8
Severe***	18.2	38.8	22.7
Stomatitis			
Any	26.1	6.1	7.6
Grade 3/4	1.7	0	0.8
Pulmonary			
Any	40.9	49.0	45.4
Grade 3/4	21.0	28.6	18.5
Nail Disorder			
Any	11.4	0	1.7
Severe***	1.1	0	0
Myalgia			
Any	6.3	0	2.5
Severe***	0	0	0
Arthralgia			
Any	3.4	2.0	1.7
Severe***	0	0	0.8
Taste Perversion			
Any	5.7	0	0
Severe***	0.6	0	0

***Normal Baseline LFTs: Transaminases ≤ 1.5 times ULN or alkaline phosphatase ≤ 2.5 times ULN or isolated elevations of transaminases or alkaline phosphatase up to 5 times ULN**

****Febrile Neutropenia: ANC grade 4 with fever > 38°C with IV antibiotics and/or hospitalization**

*****COSTART term and grading system**

[†]Not Applicable; [††] Not Done

Combination Therapy with TAXOTERE in Chemotherapy-Naïve Advanced Unresectable or Metastatic NSCLC

The table below presents safety data from two arms of an open label, randomized controlled trial (TAX326) that enrolled patients with unresectable stage IIIB or IV non-small cell lung cancer and no history of prior chemotherapy. Adverse reactions were described using the NCI Common Toxicity Criteria except where otherwise noted.

Adverse Events Regardless of Relationship to Treatment in Chemotherapy-Naïve Advanced Non-Small Cell Lung Cancer Patients Receiving TAXOTERE in Combination with Cisplatin

Adverse Event	TAXOTERE 75 mg/m^2 + Cisplatin 75 mg/m^2 n=406 %	Vinorelbine 25 mg/m^2 + Cisplatin 100 mg/m^2 n=396 %
Neutropenia		
Any	91	90
Grade 3/4	74	78
Febrile Neutropenia	5	5
Thrombocytopenia		
Any	15	15
Grade 3/4	3	4
Anemia		
Any	89	94
Grade 3/4	7	25
Infection		
Any	35	37
Grade 3/4	8	8
Fever in absence of infection		
Any	33	29
Grade 3/4	< 1	1
Hypersensitivity Reaction*		
Any	12	4
Grade 3/4	3	< 1

Fluid Retention**		
Any	54	42
All severe or life-threatening events	2	2
Pleural effusion		
Any	23	22
All severe or life-threatening events	2	2
Peripheral edema		
Any	34	18
All severe or life-threatening events	<1	<1
Weight gain		
Any	15	9
All severe or life-threatening events	<1	<1
Neurosensory		
Any	47	42
Grade 3/4	4	4
Neuromotor		
Any	19	17
Grade 3/4	3	6
Skin		
Any	16	14
Grade 3/4	<1	1
Nausea		
Any	72	76
Grade 3/4	10	17
Vomiting		
Any	55	61
Grade 3/4	8	16
Diarrhea		
Any	47	25
Grade 3/4	7	3
Anorexia**		
Any	42	40
All severe or life-threatening events	5	5
Stomatitis		
Any	24	21
Grade 3/4	2	1
Alopecia		
Any	75	42
Grade 3	<1	0

Asthenia**		
Any	74	75
All severe or life-threatening events	12	14
Nail Disorder**		
Any	14	<1
All severe events	<1	0
Myalgia**		
Any	18	12
All severe events	<1	<1

*** Replaces NCI term "Allergy"**

**** COSTART term and grading system**

Deaths within 30 days of last study treatment occurred in 31 patients (7.6%) in the docetaxel+cisplatin arm and 37 patients (9.3%) in the vinorelbine+cisplatin arm. Deaths within 30 days of last study treatment attributed to study drug occurred in 9 patients (2.2%) in the docetaxel+cisplatin arm and 8 patients (2.0%) in the vinorelbine+cisplatin arm.

The second comparison in the study, vinorelbine+cisplatin versus TAXOTERE+carboplatin (which did not demonstrate a superior survival associated with TAXOTERE, see **CLINICAL STUDIES** section) demonstrated a higher incidence of thrombocytopenia, diarrhea, fluid retention, hypersensitivity reactions, skin toxicity, alopecia and nail changes on the TAXOTERE+carboplatin arm, while a higher incidence of anemia, neurosensory toxicity, nausea, vomiting, anorexia and asthenia was observed on the vinorelbine+cisplatin arm.

Combination Therapy with TAXOTERE in Patients with Prostate Cancer

The following data are based on the experience of 332 patients, who were treated with TAXOTERE 75 mg/m² every 3 weeks in combination with prednisone 5 mg orally twice daily.

Clinically Important Treatment Emergent Adverse Events (Regardless of Relationship) in Patients with Prostate Cancer who Received TAXOTERE in Combination with Prednisone (TAX 327)

	TAXOTERE 75 mg/m^2 every 3 weeks + prednisone 5 mg twice daily n=332 %		**Mitoxantrone 12 mg/m^2 every 3 weeks + prednisone 5 mg twice daily n=335 %**	
Adverse Event	**Any**	**G 3/4**	**Any**	**G 3/4**
Anemia	66.5	4.9	57.8	1.8
Neutropenia	40.9	32.0	48.2	21.7
Thrombocytopenia	3.4	0.6	7.8	1.2
Febrile neutropenia	2.7	N/A	1.8	N/A
Infection	32.2	5.7	20.3	4.2
Epistaxis	5.7	0.3	1.8	0.0

Allergic Reactions	8.4	0.6	0.6	0.0
Fluid Retention*	24.4	0.6	4.5	0.3
Weight Gain*	7.5	0.3	3.0	0.0
Peripheral Edema*	18.1	0.3	1.5	0.0
Neuropathy Sensory	30.4	1.8	7.2	0.3
Neuropathy Motor	7.2	1.5	3.0	0.9
Rash/Desquamation	6.0	0.3	3.3	0.6
Alopecia	65.1	N/A	12.8	N/A
Nail Changes	29.5	0.0	7.5	0.0
Nausea	41.0	2.7	35.5	1.5
Diarrhea	31.6	2.1	9.6	1.2
Stomatitis/Pharyngitis	19.6	0.9	8.4	0.0
Taste Disturbance	18.4	0.0	6.6	0.0
Vomiting	16.9	1.5	14.0	1.5
Anorexia	16.6	1.2	14.3	0.3
Cough	12.3	0.0	7.8	0.0
Dyspnea	15.1	2.7	8.7	0.9
Cardiac left ventricular function	9.6	0.3	22.1	1.2
Fatigue	53.3	4.5	34.6	5.1
Myalgia	14.5	0.3	12.8	0.9
Tearing	9.9	0.6	1.5	0.0
Arthralgia	8.1	0.6	5.1	1.2

***Related to treatment**

Post-marketing Experiences

The following adverse events have been identified from clinical trials and/or post-marketing surveillance. Because they are reported from a population of unknown size, precise estimates of frequency cannot be made.

Body as a whole: diffuse pain, chest pain, radiation recall phenomenon

Cardiovascular: atrial fibrillation, deep vein thrombosis, ECG abnormalities, thrombophlebitis, pulmonary embolism, syncope, tachycardia, myocardial infarction

Cutaneous: very rare cases of cutaneous lupus erythematosus and rare cases of bullous eruptions such as erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis. In some cases multiple factors may have contributed to the development of these effects. Severe hand and foot syndrome has been reported.

Gastrointestinal: abdominal pain, anorexia, constipation, duodenal ulcer, esophagitis, gastrointestinal hemorrhage, gastrointestinal perforation, ischemic colitis, colitis, intestinal obstruction, ileus, neutropenic enterocolitis and dehydration as a consequence to gastrointestinal events have been reported.

Hematologic: bleeding episodes

Hypersensitivity: rare cases of anaphylactic shock have been reported. Very rarely these cases resulted in a fatal outcome in patients who received premedication.
Hepatic: rare cases of hepatitis, sometimes fatal primarily in patients with pre-existing liver disorders, have been reported.
Neurologic: confusion, rare cases of seizures or transient loss of consciousness have been observed, sometimes appearing during the infusion of the drug.
Ophthalmologic: conjunctivitis, lacrimation or lacrimation with or without conjunctivitis. Excessive tearing which may be attributable to lacrimal duct obstruction has been reported. Rare cases of transient visual disturbances (flashes, flashing lights, scotomata) typically occurring during drug infusion and in association with hypersensitivity reactions have been reported. These were reversible upon discontinuation of the infusion.
Hearing: rare cases of ototoxicity, hearing disorders and/or hearing loss have been reported, including cases associated with other ototoxic drugs.
Respiratory: dyspnea, acute pulmonary edema, acute respiratory distress syndrome, interstitial pneumonia. Pulmonary fibrosis has been rarely reported. Rare cases of radiation pneumonitis have been reported in patients receiving concomitant radiotherapy.
Urogenital: renal insufficiency

OVERDOSAGE

There is no known antidote for TAXOTERE overdosage. In case of overdosage, the patient should be kept in a specialized unit where vital functions can be closely monitored. Anticipated complications of overdosage include: bone marrow suppression, peripheral neurotoxicity, and mucositis. Patients should receive therapeutic G-CSF as soon as possible after discovery of overdose. Other appropriate symptomatic measures should be taken, as needed.

In two reports of overdose, one patient received 150 mg/m^2 and the other received 200 mg/m^2 as 1-hour infusions. Both patients experienced severe neutropenia, mild asthenia, cutaneous reactions, and mild paresthesia, and recovered without incident.

In mice, lethality was observed following single IV doses that were ≥154 mg/kg (about 4.5 times the recommended human dose on a mg/m^2 basis); neurotoxicity associated with paralysis, non-extension of hind limbs, and myelin degeneration was observed in mice at 48 mg/kg (about 1.5 times the recommended human dose on a mg/m^2 basis). In male and female rats, lethality was observed at a dose of 20 mg/kg (comparable to the recommended human dose on a mg/m^2 basis) and was associated with abnormal mitosis and necrosis of multiple organs.

DOSAGE AND ADMINISTRATION

Breast Cancer

The recommended dose of TAXOTERE is 60-100 mg/m^2 administered intravenously over 1 hour every 3 weeks.

In the adjuvant treatment of operable node-positive breast cancer, the recommended TAXOTERE dose is 75 mg/m^2 administered 1-hour after doxorubicin 50 mg/m^2 and cyclophosphamide 500 mg/m^2 every 3 weeks for 6 courses. Prophylactic G-CSF may be used to mitigate the risk of hematological toxicities (see also **Dosage Adjustments**).

Non-Small Cell Lung Cancer

For treatment after failure of prior platinum-based chemotherapy, TAXOTERE was evaluated as monotherapy, and the recommended dose is 75 mg/m^2 administered intravenously over 1 hour every 3 weeks. A dose of 100 mg/m^2 in patients previously treated with chemotherapy was associated with increased hematologic toxicity, infection, and treatment-related mortality in randomized, controlled trials (see **BOXED WARNING, WARNINGS** and **CLINICAL STUDIES** sections).

For chemotherapy-naïve patients, TAXOTERE was evaluated in combination with cisplatin. The recommended dose of TAXOTERE is 75 mg/m^2 administered intravenously over 1 hour immediately followed by cisplatin 75 mg/m^2 over 30-60 minutes every 3 weeks.

Prostate cancer

For hormone-refractory metastatic prostate cancer, the recommended dose of TAXOTERE is 75 mg/m^2 every 3 weeks as a 1 hour infusion. Prednisone 5 mg orally twice daily is administered continuously.

Premedication Regimen

All patients should be premedicated with oral corticosteroids (see below for prostate cancer) such as dexamethasone 16 mg per day (*e.g.*, 8 mg BID) for 3 days starting 1 day prior to TAXOTERE administration in order to reduce the incidence and severity of fluid retention as well as the severity of hypersensitivity reactions (see **BOXED WARNING**, **WARNINGS,** and **PRECAUTIONS** sections).

For hormone-refractory metastatic prostate cancer, given the concurrent use of prednisone, the recommended premedication regimen is oral dexamethasone 8 mg, at 12 hours, 3 hours and 1 hour before the TAXOTERE infusion (see **WARNINGS**, and **PRECAUTIONS** sections).

Dosage Adjustments During Treatment

Breast Cancer

Patients who are dosed initially at 100 mg/m^2 and who experience either febrile neutropenia, neutrophils < 500 cells/mm^3 for more than 1 week, or severe or cumulative cutaneous reactions during TAXOTERE therapy should have the dosage adjusted from 100 mg/m^2 to 75 mg/m^2. If the patient continues to experience these reactions, the dosage should either be decreased from 75 mg/m^2 to 55 mg/m^2 or the treatment should be discontinued. Conversely, patients who are dosed initially at 60 mg/m^2 and who do not experience febrile neutropenia, neutrophils <500 cells/mm^3 for more than 1 week, severe or cumulative cutaneous reactions, or severe peripheral neuropathy during TAXOTERE therapy may tolerate higher doses. Patients who develop ≥ grade 3 peripheral neuropathy should have TAXOTERE treatment discontinued entirely.

Combination Therapy with TAXOTERE in the Adjuvant Treatment of Breast Cancer

TAXOTERE in combination with doxorubicin and cyclophosphamide should be administered when the neutrophil count is ≥ 1,500 cells/mm^3. Patients who experience febrile neutropenia should receive G-CSF in all subsequent cycles. Patients who continue to experience this reaction should remain on G-CSF and have their TAXOTERE dose reduced to 60 mg/m². Patients who experience Grade 3 or 4 stomatitis should have their TAXOTERE dose decreased to 60 mg/m². Patients who experience severe or cumulative cutaneous reactions or moderate neurosensory signs and/or symptoms during TAXOTERE therapy should have their dosage of TAXOTERE reduced from 75 to 60 mg/m². If the patient continues to experience these reactions at 60 mg/m², treatment should be discontinued.

Non-Small Cell Lung Cancer

Monotherapy with TAXOTERE for NSCLC Treatment After Failure of Prior Platinum-Based Chemotherapy

Patients who are dosed initially at 75 mg/m^2 and who experience either febrile neutropenia, neutrophils <500 cells/mm^3 for more than one week, severe or cumulative cutaneous reactions, or other grade 3/4 non-hematological toxicities during TAXOTERE treatment should have treatment withheld until resolution of the toxicity and then resumed at 55 mg/m^2. Patients who develop ≥ grade 3 peripheral neuropathy should have TAXOTERE treatment discontinued entirely.

Combination Therapy with TAXOTERE for Chemotherapy-Naïve NSCLC

For patients who are dosed initially at TAXOTERE 75 mg/m^2 in combination with cisplatin, and whose nadir of platelet count during the previous course of therapy is <25,000 cells/mm^3 , in patients who experience febrile neutropenia, and in patients with serious non-hematologic toxicities, the TAXOTERE dosage in subsequent cycles should be reduced to 65 mg/m^2. In patients who require a further dose reduction, a dose of 50 mg/m^2 is recommended. For cisplatin dosage adjustments, see manufacturers' prescribing information.

Combination Therapy with TAXOTERE for Hormone-Refractory Metastatic Prostate Cancer

TAXOTERE should be administered when the neutrophil count is ≥ 1,500 cells/mm^3. Patients who experience either febrile neutropenia, neutrophils < 500 cells/mm^3 for more than one week, severe or cumulative cutaneous reactions or moderate neurosensory signs and/or symptoms during TAXOTERE therapy should have the dosage of TAXOTERE reduced from 75 to 60 mg/m². If the patient continues to experience these reactions at 60 mg/m², the treatment should be discontinued.

Special Populations

Hepatic Impairment: Patients with bilirubin > ULN should generally not receive TAXOTERE. Also, patients with SGOT and/or SGPT > 1.5 x ULN concomitant with alkaline phosphatase > 2.5 x ULN should generally not receive TAXOTERE.

Children: The safety and effectiveness of docetaxel in pediatric patients below the age of 16 years have not been established.

Elderly: See **Precautions, Geriatric Use**. In general, dose selection for an elderly patient should be cautious, reflecting the greater frequency of decreased hepatic, renal, or cardiac function and of concomitant disease or other drug therapy in elderly patients.

PREPARATION AND ADMINISTRATION

Administration Precautions

TAXOTERE is a cytotoxic anticancer drug and, as with other potentially toxic compounds, caution should be exercised when handling and preparing TAXOTERE solutions. The use of gloves is recommended. Please refer to **Handling and Disposal** section.

If TAXOTERE Injection Concentrate, initial diluted solution, or final dilution for infusion should come into contact with the skin, immediately and thoroughly wash with soap and water. If TAXOTERE Injection Concentrate, initial diluted solution, or final dilution for infusion should come into contact with mucosa, immediately and thoroughly wash with water.

Contact of the TAXOTERE concentrate with plasticized PVC equipment or devices used to prepare solutions for infusion is not recommended. In order to minimize patient exposure to the

plasticizer DEHP (di-2-ethylhexyl phthalate), which may be leached from PVC infusion bags or sets, the final TAXOTERE dilution for infusion should be stored in bottles (glass, polypropylene) or plastic bags (polypropylene, polyolefin) and administered through polyethylene-lined administration sets.

TAXOTERE Injection Concentrate requires two dilutions prior to administration. Please follow the preparation instructions provided below. **Note:** Both the TAXOTERE Injection Concentrate and the diluent vials contain an overfill to compensate for liquid loss during preparation. This overfill ensures that after dilution with the **entire** contents of the accompanying diluent, there is an initial diluted solution containing 10 mg/mL docetaxel.

The table below provides the fill range of the diluent, the approximate extractable volume of diluent when the entire contents of the diluent vial are withdrawn, and the concentration of the initial diluted solution for TAXOTERE 20 mg and TAXOTERE 80 mg.

Product	Diluent 13% (w/w) ethanol in water for injection Fill Range (mL)	Approximate extractable volume of diluent when entire contents are withdrawn (mL)	Concentration of the initial diluted solution (mg/mL docetaxel)
Taxotere® 20 mg/0.5 mL	1.88 – 2.08 mL	1.8 mL	10 mg/mL
Taxotere® 80 mg/2 mL	6.96 – 7.70 mL	7.1 mL	10 mg/mL

Preparation and Administration

A. Initial Diluted Solution

1. TAXOTERE vials should be stored between 2 and 25°C (36 and 77°F). If the vials are stored under refrigeration, allow the appropriate number of vials of TAXOTERE Injection Concentrate and diluent (13% ethanol in water for injection) vials to stand at room temperature for approximately 5 minutes.
2. Aseptically withdraw the **entire** contents of the appropriate diluent vial (approximately 1.8 mL for TAXOTERE 20 mg and approximately 7.1 mL for TAXOTERE 80 mg) into a syringe by partially inverting the vial, and transfer it to the appropriate vial of TAXOTERE Injection Concentrate. **If the procedure is followed as described, an initial diluted solution of 10mg docetaxel/mL will result.**
3. Mix the initial diluted solution by repeated inversions for at least 45 seconds to assure full mixture of the concentrate and diluent. Do not shake.
4. The initial diluted TAXOTERE solution (10 mg docetaxel/mL) should be clear; however, there may be some foam on top of the solution due to the polysorbate 80. Allow the solution to stand for a few minutes to allow any foam to dissipate. It is not required that all foam dissipate prior to continuing the preparation process.

   The initial diluted solution may be used immediately or stored either in the refrigerator or at room temperature for a maximum of 8 hours.

B. Final Dilution for Infusion

1. Aseptically withdraw the required amount of initial diluted TAXOTERE solution (10 mg docetaxel/mL) with a calibrated syringe and inject into a 250 mL infusion bag or bottle of either 0.9% Sodium Chloride solution or 5% Dextrose solution to produce a final concentration of 0.3 to 0.74 mg/mL.

If a dose greater than 200 mg of TAXOTERE is required, use a larger volume of the infusion vehicle so that a concentration of 0.74 mg/mL TAXOTERE is not exceeded.

2.Thoroughly mix the infusion by manual rotation.

3.As with all parenteral products, TAXOTERE should be inspected visually for particulate matter or discoloration prior to administration whenever the solution and container permit. If the TAXOTERE initial diluted solution or final dilution for infusion is not clear or appears to have precipitation, these should be discarded.

The final TAXOTERE dilution for infusion should be administered intravenously as a 1-hour infusion under ambient room temperature and lighting conditions.

Stability

TAXOTERE infusion solution, if stored between 2 and 25°C (36 and 77°F) is stable for 4 hours. Fully prepared TAXOTERE infusion solution (in either 0.9% Sodium Chloride solution or 5% Dextrose solution) should be used within 4 hours (including the 1 hour i.v. administration).

HOW SUPPLIED

TAXOTERE Injection Concentrate is supplied in a single-dose vial as a sterile, pyrogen-free, non-aqueous, viscous solution with an accompanying sterile, non-pyrogenic, Diluent (13% ethanol in water for injection) vial. The following strengths are available:

TAXOTERE 80 mg/2 ML (NDC 0075-8001-80)

TAXOTERE (docetaxel) Injection Concentrate 80 mg/2 mL: 80 mg docetaxel in 2 mL polysorbate 80 and Diluent for TAXOTERE 80 mg (13% (w/w) ethanol in water for injection). Both items are in a blister pack in one carton.

TAXOTERE 20 mg/0.5 ML (NDC 0075-8001-20)

TAXOTERE (docetaxel) Injection Concentrate 20 mg/0.5 mL: 20 mg docetaxel in 0.5 mL polysorbate 80 and diluent for TAXOTERE 20 mg (13% (w/w) ethanol in water for injection). Both items are in a blister pack in one carton.

Storage

Store between 2 and 25°C (36 and 77°F). Retain in the original package to protect from bright light. Freezing does not adversely affect the product.

Handling and Disposal

Procedures for proper handling and disposal of anticancer drugs should be considered. Several guidelines on this subject have been published[1-7]. There is no general agreement that all of the procedures recommended in the guidelines are necessary or appropriate.

REFERENCES

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5.National Study Commission on Cytotoxic Exposure - Recommendations for Handling Cytotoxic Agents. Available from Louis P. Jeffry, Chairman, National Study Commission on Cytotoxic Exposure. Massachusetts College of Pharmacy and Allied Health Sciences, 179 Longwood Avenue, Boston, MA 02115.

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7.Jones, RB, et al. Safe Handling of Chemotherapeutic Agents: A Report from the Mt. Sinai Medical Center. *CA-A Cancer Journal for Clinicians.* 1983; Sept/Oct: 258-263.

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