

## HIGHLIGHTS OF PRESCRIBING INFORMATION

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

### SYMBICORT® 80/4.5

(budesonide 80 mcg and formoterol fumarate dihydrate 4.5 mcg) Inhalation Aerosol

### SYMBICORT® 160/4.5

(budesonide 160 mcg and formoterol fumarate dihydrate 4.5 mcg)

Inhalation Aerosol

FOR ORAL INHALATION

Initial US Approval: 2006

#### WARNING: ASTHMA-RELATED DEATH

(See full prescribing information for complete boxed warning.)

- Long-acting beta<sub>2</sub>-adrenergic agonists (LABA), such as formoterol one of the active ingredients in SYMBICORT, increase the risk of asthma-related death. A placebo-controlled study with another LABA (salmeterol) showed an increase in asthma-related deaths in patients receiving salmeterol. This finding with salmeterol is considered a class effect of LABA, including formoterol. Currently available data are inadequate to determine whether concurrent use of inhaled corticosteroids or other long-term asthma control drugs mitigates the increased risk of asthma-related death from LABA. Available data from controlled clinical trials suggest that LABA increase the risk of asthma-related hospitalization in pediatric and adolescent patients. (5.1)
- When treating patients with asthma, prescribe SYMBICORT only for patients not adequately controlled on a long-term asthma-control medication, such as an inhaled corticosteroid or whose disease severity clearly warrants initiation of treatment with both an inhaled corticosteroid and LABA. Once asthma control is achieved and maintained, assess the patient at regular intervals and step down therapy (e.g. discontinue SYMBICORT) if possible without loss of asthma control, and maintain the patient on a long-term asthma control medication, such as an inhaled corticosteroid. Do not use SYMBICORT for patients whose asthma is adequately controlled on low or medium dose inhaled corticosteroids. (1.1, 5.1)

#### -----RECENT MAJOR CHANGES-----

Boxed Warning	May	2010
Indications and Usage, Treatment of Asthma (1.1)	May	2010
Dosage and Administration, Asthma (2.1)	May	2010
Warnings and Precautions, Asthma-Related Death (5.1)	May	2010

#### -----INDICATIONS AND USAGE-----

SYMBICORT is a combination product containing a corticosteroid and a long-acting beta<sub>2</sub>-adrenergic agonist indicated for:

- Treatment of asthma in patients 12 years of age and older. (1.1)
- Maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema. (1.2)

Important limitations:

- Not indicated for the relief of acute bronchospasm. (1.1, 1.2)

#### -----DOSAGE AND ADMINISTRATION-----

For oral inhalation only.

- Treatment of asthma in patients >12 years: 2 inhalations twice daily of SYMBICORT 80/4.5 or 160/4.5. Starting dosage is based on asthma severity. (2.1)
- Maintenance treatment of airflow obstruction in COPD: 2 inhalations of SYMBICORT 160/4.5 twice daily (2.2)

#### -----DOSAGE FORMS AND STRENGTHS-----

Metered-dose inhaler containing a combination of budesonide (80 or 160 mcg) and formoterol (4.5 mcg) as an inhalation aerosol (3)

#### -----CONTRAINDICATIONS-----

- Primary treatment of status asthmaticus or acute episodes of asthma or COPD requiring intensive measures. (4)
- Hypersensitivity to any of the ingredients in SYMBICORT (4)

#### -----WARNINGS AND PRECAUTIONS-----

- Asthma-related death: Long-acting beta<sub>2</sub>-adrenergic agonists increase the risk. Prescribe only for recommended patient populations. (5.1)

- Deterioration of disease and acute episodes: Do not initiate in acutely deteriorating asthma or to treat acute symptoms. (5.2)
- Use with additional long-acting beta<sub>2</sub>-agonist: Do not use in combination because of risk of overdose. (5.3)
- Localized infections: *Candida albicans* infection of the mouth and throat may occur. Monitor patients periodically for signs of adverse effects on the oral cavity. Advise patients to rinse the mouth following inhalation. (5.4)
- Pneumonia: Increased risk in patients with COPD. Monitor patients for signs and symptoms of pneumonia and other potential lung infections. (5.5)
- Immunosuppression: Potential worsening of infections (e.g., existing tuberculosis, fungal, bacterial, viral, or parasitic infection; or ocular herpes simplex). Use with caution in patients with these infections. More serious or even fatal course of chickenpox or measles can occur in susceptible patients. (5.6)
- Transferring patients from systemic corticosteroids: Risk of impaired adrenal function when transferring from oral steroids. Taper patients slowly from systemic corticosteroids if transferring to SYMBICORT. (5.7)
- Hypercorticism and adrenal suppression: May occur with very high dosages or at the regular dosage in susceptible individuals. If such changes occur, discontinue SYMBICORT slowly. (5.8)
- Strong cytochrome P450 3A4 inhibitors (e.g., ritonavir): Risk of increased systemic corticosteroid effects. Exercise caution when used with SYMBICORT. (5.9)
- Paradoxical bronchospasm: Discontinue SYMBICORT and institute alternative therapy if paradoxical bronchospasm occurs. (5.10)
- Patients with cardiovascular or central nervous system disorders: Use with caution because of beta-adrenergic stimulation. (5.12)
- Decreases in bone mineral density: Assess bone mineral density initially and periodically thereafter. (5.13)
- Effects on growth: Monitor growth of pediatric patients. (5.14)
- Glaucoma and cataracts: Close monitoring is warranted. (5.15)
- Metabolic effects: Be alert to eosinophilic conditions, hypokalemia, and hyperglycemia. (5.16, 5.18)
- Coexisting conditions: Use with caution in patients with convulsive disorders, thyrotoxicosis, diabetes mellitus, and ketoacidosis. (5.17)

#### -----ADVERSE REACTIONS-----

Most common adverse reactions (incidence ≥ 3%) are:

- Asthma: nasopharyngitis, headache, upper respiratory tract infection, pharyngolaryngeal pain, sinusitis, influenza, back pain, nasal congestion, stomach discomfort, vomiting, and oral candidiasis. (6.1)
- COPD: nasopharyngitis, oral candidiasis, bronchitis, sinusitis, upper respiratory tract infections. (6.2)

**To report SUSPECTED ADVERSE REACTIONS, contact AstraZeneca at 1-800-236-9933 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

#### -----DRUG INTERACTIONS-----

- Strong cytochrome P450 3A4 inhibitors (e.g., ritonavir): Use with caution. May cause increased systemic corticosteroid effects.
- Monoamine oxidase inhibitors and tricyclic antidepressants: Use with extreme caution. May potentiate effect of formoterol on vascular system. (7.2)
- Beta-blockers: Use with caution. May block bronchodilatory effects of beta-agonists and produce severe bronchospasm. (7.3)
- Diuretics: Use with caution. Electrocardiographic changes and/or hypokalemia associated with nonpotassium-sparing diuretics may worsen with concomitant beta-agonists. (7.4)

#### -----USE IN SPECIFIC POPULATIONS-----

Hepatic impairment: Monitor patients for signs of increased drug exposure. (8)

#### -----SEE 17 FOR PATIENT COUNSELING INFORMATION AND MEDICATION GUIDE-----

Revised JUNE 2010

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## FULL PRESCRIBING INFORMATION

### **WARNING: ASTHMA-RELATED DEATH**

Long-acting beta<sub>2</sub>-adrenergic agonists (LABA), such as formoterol one of the active ingredients in SYMBICORT, increase the risk of asthma-related death. Data from a large placebo-controlled U.S. study that compared the safety of another long-acting beta<sub>2</sub>-adrenergic agonist (salmeterol) or placebo added to usual asthma therapy showed an increase in asthma-related deaths in patients receiving salmeterol. This finding with salmeterol is considered a class effect of the LABA, including formoterol. Currently available data are inadequate to determine whether concurrent use of inhaled corticosteroids or other long-term asthma control drugs mitigates the increased risk of asthma-related death from LABA. Available data from controlled clinical trials suggest that LABA increase the risk of asthma-related hospitalization in pediatric and adolescent patients. Therefore, when treating patients with asthma, SYMBICORT should only be used for patients not adequately controlled on a long-term asthma control medication, such as an inhaled corticosteroid or whose disease severity clearly warrants initiation of treatment with both an inhaled corticosteroid and LABA. Once asthma control is achieved and maintained, assess the patient at regular intervals and step down therapy (e.g., discontinue SYMBICORT) if possible without loss of asthma control and maintain the patient on a long-term asthma control medication, such as an inhaled corticosteroid. Do not use SYMBICORT for patients whose asthma is adequately controlled on low or medium dose inhaled corticosteroids [*see Warnings and Precautions (5.1)*].

## **1 INDICATIONS AND USAGE**

### **1.1 Treatment of Asthma**

SYMBICORT is indicated for the treatment of asthma in patients 12 years of age and older.

Long-acting beta<sub>2</sub>-adrenergic agonists, such as formoterol one of the active ingredients in SYMBICORT, increase the risk of asthma-related death. Available data from controlled clinical trials suggest that LABA increase the risk of asthma-related hospitalization in pediatric and adolescent patients [*see Warnings and Precautions (5.1)*]. Therefore, when treating

patients with asthma, SYMBICORT should only be used for patients not adequately controlled on a long-term asthma-control medication such as an inhaled corticosteroid or whose disease severity clearly warrants initiation of treatment with both an inhaled corticosteroid and LABA. Once asthma control is achieved and maintained, assess the patient at regular intervals and step down therapy (e.g. discontinue SYMBICORT) if possible without loss of asthma control, and maintain the patient on a long-term asthma control medication, such as inhaled corticosteroid. Do not use SYMBICORT for patients whose asthma is adequately controlled on low or medium dose inhaled corticosteroids.

Important Limitations of Use:

- SYMBICORT is NOT indicated for the relief of acute bronchospasm.

## 1.2 Maintenance Treatment of Chronic Obstructive Pulmonary Disease (COPD)

SYMBICORT 160/4.5 is indicated for the twice daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema. SYMBICORT 160/4.5 is the only approved dosage for the treatment of airflow obstruction in COPD.

Important Limitations of Use: SYMBICORT is not indicated for the relief of acute bronchospasm.

## 2 DOSAGE AND ADMINISTRATION

SYMBICORT should be administered twice daily every day by the orally inhaled route only. After inhalation, the patient should rinse the mouth with water without swallowing. [*see Patient Counseling Information (17.4)*]

Prime SYMBICORT before using for the first time by releasing two test sprays into the air away from the face, shaking well for 5 seconds before each spray. In cases where the inhaler has not been used for more than 7 days or when it has been dropped, prime the inhaler again by shaking well before each spray and releasing two test sprays into the air away from the face.

More frequent administration or a higher number of inhalations (more than 2 inhalations twice daily) of the prescribed strength of SYMBICORT is not recommended as some patients are more likely to experience adverse effects with higher doses of formoterol. Patients using SYMBICORT should not use additional long-acting beta<sub>2</sub>-agonists for any reason. [*See Warnings and Precautions (5.3, 5.12)*]

## 2.1 Asthma

If asthma symptoms arise in the period between doses, an inhaled, short-acting beta<sub>2</sub>-agonist should be taken for immediate relief.

Adult and Adolescent Patients 12 Years of Age and Older: For patients 12 years of age and older, the dosage is 2 inhalations twice daily (morning and evening, approximately 12 hours apart).

The recommended starting dosages for SYMBICORT for patients 12 years of age and older are based upon patients' asthma severity.

The maximum recommended dosage is SYMBICORT 160/4.5 mcg twice daily.

Improvement in asthma control following inhaled administration of SYMBICORT can occur within 15 minutes of beginning treatment, although maximum benefit may not be achieved for 2 weeks or longer after beginning treatment. Individual patients will experience a variable time to onset and degree of symptom relief.

For patients who do not respond adequately to the starting dose after 1-2 weeks of therapy with SYMBICORT 80/4.5, replacement with SYMBICORT 160/4.5 may provide additional asthma control.

If a previously effective dosage regimen of SYMBICORT fails to provide adequate control of asthma, the therapeutic regimen should be re-evaluated and additional therapeutic options, (e.g., replacing the lower strength of SYMBICORT with the higher strength, adding additional inhaled corticosteroid, or initiating oral corticosteroids) should be considered.

## 2.2 Chronic Obstructive Pulmonary Disease (COPD)

For patients with COPD the recommended dose is SYMBICORT 160/4.5, two inhalations twice daily.

If shortness of breath occurs in the period between doses, an inhaled, short-acting beta<sub>2</sub>-agonist should be taken for immediate relief.

## 3 DOSAGE FORMS AND STRENGTHS

SYMBICORT is available as a metered-dose inhaler containing a combination of budesonide (80 or 160 mcg) and

formoterol (4.5 mcg) as an inhalation aerosol in the following two strengths: 80/4.5 and 160/4.5. Each dosage strength contains 60 or 120 actuations per/canister. Each strength of SYMBICORT is supplied with a red plastic actuator with a gray dust cap.

## 4 CONTRAINDICATIONS

The use of SYMBICORT is contraindicated in the following conditions:

- Primary treatment of status asthmaticus or other acute episodes of asthma or COPD where intensive measures are required.
- Hypersensitivity to any of the ingredients in SYMBICORT.

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Asthma-Related Death

**Long-acting beta<sub>2</sub>-adrenergic agonists, such as formoterol, one of the active ingredients in SYMBICORT, increase the risk of asthma-related death. Currently available data are inadequate to determine whether concurrent use of inhaled corticosteroids or other long-term asthma control drugs mitigates the increased risk of asthma-related death from LABA. Available data from controlled clinical trials suggest that LABA increase the risk of asthma-related hospitalization in pediatric and adolescent patients. Therefore, when treating patients with asthma, SYMBICORT should only be used for patients not adequately controlled on a long-term asthma-control medication, such as an inhaled corticosteroid or whose disease severity clearly warrants initiation of treatment with both an inhaled corticosteroid and LABA. Once asthma control is achieved and maintained, assess the patient at regular intervals and step down therapy (e.g. discontinue SYMBICORT) if possible without loss of asthma control, and maintain the patient on a long-term asthma control medication, such as an inhaled corticosteroid. Do not use SYMBICORT for patients whose asthma is adequately controlled on low or medium dose inhaled corticosteroids.**

A 28-week, placebo controlled US study comparing the safety of salmeterol with placebo, each added to usual asthma therapy, showed an increase in asthma-related deaths in patients receiving salmeterol (13/13,176 in patients treated with salmeterol vs 3/13,179 in patients treated with placebo; RR 4.37, 95% CI 1.25, 15.34). This finding with salmeterol is considered a class effect of the LABA, including formoterol, one of the active ingredients in SYMBICORT. No study

adequate to determine whether the rate of asthma-related death is increased with SYMBICORT has been conducted.

Clinical studies with formoterol suggested a higher incidence of serious asthma exacerbations in patients who received formoterol than in those who received placebo. The sizes of these studies were not adequate to precisely quantify the differences in serious asthma exacerbation rates between treatment groups.

## **5.2 Deterioration of Disease and Acute Episodes**

SYMBICORT should not be initiated in patients during rapidly deteriorating or potentially life-threatening episodes of asthma or COPD. SYMBICORT has not been studied in patients with acutely deteriorating asthma or COPD. The initiation of SYMBICORT in this setting is not appropriate.

Increasing use of inhaled, short-acting beta<sub>2</sub>-agonists is a marker of deteriorating asthma. In this situation, the patient requires immediate re-evaluation with reassessment of the treatment regimen, giving special consideration to the possible need for replacing the current strength of SYMBICORT with a higher strength, adding additional inhaled corticosteroid, or initiating systemic corticosteroids. Patients should not use more than 2 inhalations twice daily (morning and evening) of SYMBICORT.

SYMBICORT should not be used for the relief of acute symptoms, i.e., as rescue therapy for the treatment of acute episodes of bronchospasm. An inhaled, short-acting beta<sub>2</sub>-agonist, not SYMBICORT, should be used to relieve acute symptoms such as shortness of breath. When prescribing SYMBICORT, the physician must also provide the patient with an inhaled, short-acting beta<sub>2</sub>-agonist (e.g., albuterol) for treatment of acute symptoms, despite regular twice-daily (morning and evening) use of SYMBICORT.

When beginning treatment with SYMBICORT, patients who have been taking oral or inhaled, short-acting beta<sub>2</sub>-agonists on a regular basis (e.g., 4 times a day) should be instructed to discontinue the regular use of these drugs.

## **5.3 Excessive Use of SYMBICORT and Use with Other Long-Acting Beta<sub>2</sub>-Agonists**

As with other inhaled drugs containing beta<sub>2</sub>-adrenergic agents, SYMBICORT should not be used more often than recommended, at higher doses than recommended, or in conjunction with other medications containing long-acting beta<sub>2</sub>-agonists, as an overdose may result. Clinically significant cardiovascular effects and fatalities have been

reported in association with excessive use of inhaled sympathomimetic drugs. Patients using SYMBICORT should not use an additional long-acting beta<sub>2</sub>-agonist (e.g., salmeterol, formoterol fumarate, arformoterol tartrate) for any reason, including prevention of exercise-induced bronchospasm (EIB) or the treatment of asthma or COPD.

#### **5.4 Local Effects**

In clinical studies, the development of localized infections of the mouth and pharynx with *Candida albicans* has occurred in patients treated with SYMBICORT. When such an infection develops, it should be treated with appropriate local or systemic (i.e., oral antifungal) therapy while treatment with SYMBICORT continues, but at times therapy with SYMBICORT may need to be interrupted. Patients should rinse the mouth after inhalation of SYMBICORT.

#### **5.5 Pneumonia and Other Lower Respiratory Tract infections**

Physicians should remain vigilant for the possible development of pneumonia in patients with COPD as the clinical features of pneumonia and exacerbations frequently overlap. Lower respiratory tract infections, including pneumonia, have been reported following the inhaled administration of corticosteroids.

In a 6 month study of 1,704 patients with COPD, there was a higher incidence of lung infections other than pneumonia (e.g., bronchitis, viral lower respiratory tract infections, etc.) in patients receiving SYMBICORT 160/4.5 (7.6%) than in those receiving SYMBICORT 80/4.5 (3.2%), formoterol 4.5 mcg (4.6%) or placebo (3.3%). Pneumonia did not occur with greater incidence in the SYMBICORT 160/4.5 group (1.1 %) compared with placebo (1.3%). In a 12-month study of 1,964 patients with COPD, there was also a higher incidence of lung infections other than pneumonia in patients receiving SYMBICORT 160/4.5 (8.1%) than in those receiving SYMBICORT 80/4.5 (6.9%), formoterol 4.5 mcg (7.1%) or placebo (6.2%). Similar to the 6 month study, pneumonia did not occur with greater incidence in the SYMBICORT 160/4.5 group (4.0%) compared with placebo (5.0%).

#### **5.6 Immunosuppression**

Patients who are on drugs that suppress the immune system are more susceptible to infection than healthy individuals. Chicken pox and measles, for example, can have a more serious or even fatal course in susceptible children or adults using corticosteroids. In such children or adults who have not had these diseases or been properly immunized, particular care should be taken to avoid exposure. How the dose, route, and



duration of corticosteroid administration affects the risk of developing a disseminated infection is not known. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed, therapy with varicella zoster immune globulin (VZIG) or pooled intravenous immunoglobulin (IVIG), as appropriate, may be indicated. If exposed to measles, prophylaxis with pooled intramuscular immunoglobulin (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chicken pox develops, treatment with antiviral agents may be considered. The immune responsiveness to varicella vaccine was evaluated in pediatric patients with asthma ages 12 months to 8 years with budesonide inhalation suspension.

An open-label, nonrandomized clinical study examined the immune responsiveness to varicella vaccine in 243 asthma patients 12 months to 8 years of age who were treated with budesonide inhalation suspension 0.25 mg to 1 mg daily (n=151) or noncorticosteroid asthma therapy (n=92) (i.e., beta<sub>2</sub>-agonists, leukotriene receptor antagonists, cromones). The percentage of patients developing a seroprotective antibody titer of  $\geq 5.0$  (gpELISA value) in response to the vaccination was similar in patients treated with budesonide inhalation suspension (85%), compared to patients treated with noncorticosteroid asthma therapy (90%). No patient treated with budesonide inhalation suspension developed chicken pox as a result of vaccination.

Inhaled corticosteroids should be used with caution, if at all, in patients with active or quiescent tuberculosis infections of the respiratory tract; untreated systemic fungal, bacterial, viral, or parasitic infections; or ocular herpes simplex.

## **5.7 Transferring Patients From Systemic Corticosteroid Therapy**

Particular care is needed for patients who have been transferred from systemically active corticosteroids to inhaled corticosteroids because deaths due to adrenal insufficiency have occurred in patients with asthma during and after transfer from systemic corticosteroids to less systemically available inhaled corticosteroids. After withdrawal from systemic corticosteroids, a number of months are required for recovery of hypothalamic-pituitary-adrenal (HPA) function.

Patients who have been previously maintained on 20 mg or more per day of prednisone (or its equivalent) may be most susceptible, particularly when their systemic corticosteroids have been almost completely withdrawn. During this period of

HPA suppression, patients may exhibit signs and symptoms of adrenal insufficiency when exposed to trauma, surgery, or infection (particularly gastroenteritis) or other conditions associated with severe electrolyte loss. Although SYMBICORT may provide control of asthma symptoms during these episodes, in recommended doses it supplies less than normal physiological amounts of glucocorticoid systemically and does NOT provide the mineralocorticoid activity that is necessary for coping with these emergencies.

During periods of stress or a severe asthma attack, patients who have been withdrawn from systemic corticosteroids should be instructed to resume oral corticosteroids (in large doses) immediately and to contact their physicians for further instruction. These patients should also be instructed to carry a warning card indicating that they may need supplementary systemic corticosteroids during periods of stress or a severe asthma attack.

Patients requiring oral corticosteroids should be weaned slowly from systemic corticosteroid use after transferring to SYMBICORT. Prednisone reduction can be accomplished by reducing the daily prednisone dose by 2.5 mg on a weekly basis during therapy with SYMBICORT. Lung function (mean forced expiratory volume in 1 second [FEV<sub>1</sub>] or morning peak expiratory flow [PEF], beta-agonist use, and asthma symptoms should be carefully monitored during withdrawal of oral corticosteroids. In addition to monitoring asthma signs and symptoms, patients should be observed for signs and symptoms of adrenal insufficiency, such as fatigue, lassitude, weakness, nausea and vomiting, and hypotension.

Transfer of patients from systemic corticosteroid therapy to inhaled corticosteroids or SYMBICORT may unmask conditions previously suppressed by the systemic corticosteroid therapy (e.g., rhinitis, conjunctivitis, eczema, arthritis, eosinophilic conditions). Some patients may experience symptoms of systemically active corticosteroid withdrawal (e.g., joint and/or muscular pain, lassitude, depression) despite maintenance or even improvement of respiratory function.

## **5.8 Hypercorticism and Adrenal Suppression**

Budesonide, a component of SYMBICORT, will often help control asthma symptoms with less suppression of HPA function than therapeutically equivalent oral doses of prednisone. Since budesonide is absorbed into the circulation and can be systemically active at higher doses, the beneficial effects of SYMBICORT in minimizing HPA dysfunction may

be expected only when recommended dosages are not exceeded and individual patients are titrated to the lowest effective dose.

Because of the possibility of systemic absorption of inhaled corticosteroids, patients treated with SYMBICORT should be observed carefully for any evidence of systemic corticosteroid effects. Particular care should be taken in observing patients postoperatively or during periods of stress for evidence of inadequate adrenal response.

It is possible that systemic corticosteroid effects such as hypercorticism and adrenal suppression (including adrenal crisis) may appear in a small number of patients, particularly when budesonide is administered at higher than recommended doses over prolonged periods of time. If such effects occur, the dosage of SYMBICORT should be reduced slowly, consistent with accepted procedures for reducing systemic corticosteroids and for management of asthma symptoms.

### **5.9 Drug Interactions With Strong Cytochrome P450 3A4 Inhibitors**

Caution should be exercised when considering the coadministration of SYMBICORT with ketoconazole, and other known strong CYP3A4 inhibitors (e.g., ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nefazodone, nelfinavir, saquinavir, telithromycin) because adverse effects related to increased systemic exposure to budesonide may occur [*see Drug Interactions (7.1), Clinical Pharmacology (12.3)*]

### **5.10 Paradoxical Bronchospasm and Upper Airway Symptoms**

As with other inhaled medications, SYMBICORT can produce paradoxical bronchospasm, which may be life threatening. If paradoxical bronchospasm occurs following dosing with SYMBICORT, it should be treated immediately with an inhaled, short-acting bronchodilator, SYMBICORT should be discontinued immediately, and alternative therapy should be instituted.

### **5.11 Immediate Hypersensitivity Reactions**

Immediate hypersensitivity reactions may occur after administration of SYMBICORT, as demonstrated by cases of urticaria, angioedema, rash, and bronchospasm.

### **5.12 Cardiovascular and Central Nervous System Effects**

Excessive beta-adrenergic stimulation has been associated with seizures, angina, hypertension or hypotension, tachycardia with rates up to 200 beats/min, arrhythmias, nervousness, headache, tremor, palpitation, nausea, dizziness, fatigue, malaise, and insomnia [see *Overdosage (10)*]. Therefore, SYMBICORT, like all products containing sympathomimetic amines, should be used with caution in patients with cardiovascular disorders, especially coronary insufficiency, cardiac arrhythmias, and hypertension.

Formoterol, a component of SYMBICORT, can produce a clinically significant cardiovascular effect in some patients as measured by pulse rate, blood pressure, and/or symptoms. Although such effects are uncommon after administration of formoterol at recommended doses, if they occur, the drug may need to be discontinued. In addition, beta-agonists have been reported to produce ECG changes, such as flattening of the T wave, prolongation of the QTc interval, and ST segment depression. The clinical significance of these findings is unknown. Fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs.

### **5.13 Reduction in Bone Mineral Density**

Decreases in bone mineral density (BMD) have been observed with long-term administration of products containing inhaled corticosteroids. The clinical significance of small changes in BMD with regard to long-term consequences such as fracture is unknown. Patients with major risk factors for decreased bone mineral content, such as prolonged immobilization, family history of osteoporosis, post menopausal status, tobacco use, advanced age, poor nutrition, or chronic use of drugs that can reduce bone mass (e.g., anticonvulsants, oral corticosteroids) should be monitored and treated with established standards of care. Since patients with COPD often have multiple risk factors for reduced BMD, assessment of BMD is recommended prior to initiating SYMBICORT and periodically thereafter. If significant reductions in BMD are seen and SYMBICORT is still considered medically important for that patient's COPD therapy, use of medication to treat or prevent osteoporosis should be strongly considered.

Effects of treatment with SYMBICORT 160/4.5, SYMBICORT 80/4.5, formoterol 4.5, or placebo on BMD was evaluated in a subset of 326 patients (females and males 41 to 88 years of age) with COPD in the 12-month study. BMD evaluations of the hip and lumbar spine regions were conducted at baseline and 52 weeks using dual energy x-ray absorptiometry (DEXA) scans. Mean changes in BMD from

baseline to end of treatment were small (mean changes ranged from -0.01 - 0.01 g/cm<sup>2</sup>). ANCOVA results for total spine and total hip BMD based on the end of treatment time point showed that all geometric LS Mean ratios for the pairwise treatment group comparisons were close to 1, indicating that overall, bone mineral density for total hip and total spine regions for the 12 month time point were stable over the entire treatment period.

#### **5.14 Effect on Growth**

Orally inhaled corticosteroids may cause a reduction in growth velocity when administered to pediatric patients. Monitor the growth of pediatric patients receiving SYMBICORT routinely (e.g., via stadiometry). To minimize the systemic effects of orally inhaled corticosteroids, including SYMBICORT, titrate each patient's dose to the lowest dosage that effectively controls his/her symptoms. *[See Dosage and Administration (2.1), Use in Specific Populations (8.4).]*

#### **5.15 Glaucoma and Cataracts**

Glaucoma, increased intraocular pressure, and cataracts have been reported in patients with asthma and COPD following the long-term administration of inhaled corticosteroids, including budesonide, a component of SYMBICORT. Therefore, close monitoring is warranted in patients with a change in vision or with history of increased intraocular pressure, glaucoma, and/or cataracts.

Effects of treatment with SYMBICORT 160/4.5, SYMBICORT 80/4.5, formoterol 4.5, or placebo on development of cataracts or glaucoma were evaluated in a subset of 461 patients with COPD in the 12-month study. Ophthalmic examinations were conducted at baseline, 24 weeks, and 52 weeks. There were 26 subjects (6%) with an increase in posterior subcapsular score from baseline to maximum value (>0.7) during the randomized treatment period. Changes in posterior subcapsular scores of >0.7 from baseline to treatment maximum occurred in 11 patients (9.0%) in the SYMBICORT 160/4.5 group, 4 patients (3.8%) in the SYMBICORT 80/4.5 group, 5 patients (4.2%) in the formoterol group, and 6 patients (5.2%) in the placebo group.

#### **5.16 Eosinophilic Conditions and Churg-Strauss Syndrome**

In rare cases, patients on inhaled corticosteroids may present with systemic eosinophilic conditions. Some of these patients have clinical features of vasculitis consistent with Churg-Strauss syndrome, a condition that is often treated with

systemic corticosteroid therapy. These events usually, but not always, have been associated with the reduction and/or withdrawal of oral corticosteroid therapy following the introduction of inhaled corticosteroids. Physicians should be alert to eosinophilia, vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in their patients. A causal relationship between budesonide and these underlying conditions has not been established.

### 5.17 Coexisting Conditions

SYMBICORT, like all medications containing sympathomimetic amines, should be used with caution in patients with convulsive disorders or thyrotoxicosis and in those who are unusually responsive to sympathomimetic amines. Doses of the related beta<sub>2</sub>-adrenoceptor agonist albuterol, when administered intravenously, have been reported to aggravate preexisting diabetes mellitus and ketoacidosis.

### 5.18 Hypokalemia and Hyperglycemia

Beta-adrenergic agonist medications may produce significant hypokalemia in some patients, possibly through intracellular shunting, which has the potential to produce adverse cardiovascular effects [*see Clinical Pharmacology (12.2)*]. The decrease in serum potassium is usually transient, not requiring supplementation. Clinically significant changes in blood glucose and/or serum potassium were seen infrequently during clinical studies with SYMBICORT at recommended doses.

## 6 ADVERSE REACTIONS

**Long-acting beta<sub>2</sub>-adrenergic agonists, such as formoterol one of the active ingredients in SYMBICORT, increase the risk of asthma-related death. Currently available data are inadequate to determine whether concurrent use of inhaled corticosteroids or other long-term asthma control drugs mitigates the increased risk of asthma-related death from LABA. Available data from controlled clinical trials suggest that LABA increase the risk of asthma-related hospitalization in pediatric and adolescent patients.** Data from a large placebo-controlled US study that compared the safety of another long-acting beta<sub>2</sub>-adrenergic agonist (salmeterol) or placebo added to usual asthma therapy showed an increase in asthma-related deaths in patients receiving salmeterol. [*see Warnings and Precautions (5.1)*].

Systemic and inhaled corticosteroid use may result in the following:

- *Candida albicans* infection [see *Warnings and Precautions (5.4)*]
- Pneumonia or lower respiratory tract infections in patients with COPD [see *Warnings and Precautions (5.5)*]
- Immunosuppression [see *Warnings and Precautions (5.6)*]
- Hypercorticism and adrenal suppression [see *Warnings and Precautions (5.8)*]
- Growth effects in pediatric patients [see *Warnings and Precautions (5.14)*]
- Glaucoma and cataracts [see *Warnings and Precautions (5.15)*]

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

## **6.1 Clinical Trials Experience in Asthma Patients 12 years and older**

The overall safety data in adults and adolescents are based upon 10 active- and placebo-controlled clinical trials in which 3393 patients ages 12 years and older (2052 females and 1341 males) with asthma of varying severity were treated with SYMBICORT 80/4.5 or 160/4.5 mcg taken two inhalations once or twice daily for 12 to 52 weeks. In these trials, the patients on SYMBICORT had a mean age of 38 years and were predominantly Caucasian (82%).

The incidence of common adverse events in Table 1 below is based upon pooled data from three 12-week, double-blind, placebo-controlled clinical studies in which 401 adult and adolescent patients (148 males and 253 females) age 12 years and older were treated with two inhalations of SYMBICORT 80/4.5 or SYMBICORT 160/4.5 twice daily. The SYMBICORT group was composed of mostly Caucasian (84%) patients with a mean age of 38 years, and a mean percent predicted FEV<sub>1</sub> at baseline of 76 and 68 for the 80/4.5 mcg and 160/4.5 mcg treatment groups, respectively. Control arms for comparison included two inhalations of budesonide HFA metered dose inhaler (MDI) 80 or 160 mcg, formoterol dry powder inhaler (DPI) 4.5 mcg, or placebo (MDI and DPI) twice daily. Table 1 includes all adverse events that occurred at an incidence of  $\geq 3\%$  in any one SYMBICORT group and more commonly than in the placebo group with twice-daily dosing. In considering these data, the increased average duration of patient exposure for SYMBICORT patients should

be taken into account, as incidences are not adjusted for an imbalance of treatment duration.

**Table 1** Adverse-reactions occurring at an incidence of  $\geq 3\%$  and more commonly than placebo in the SYMBICORT groups: pooled data from three 12-week, double-blind, placebo-controlled clinical asthma trials in patients 12 years and older

Treatment*	SYMBICORT		Budesonide		Formoterol	Placebo
Adverse Event	80/4.5 mcg N = 277 %	160/4.5 mcg N = 124 %	80 mcg N = 121 %	160 mcg N = 109 %	4.5 mcg N = 237 %	N = 400 %
Nasopharyngitis	10.5	9.7	14.0	11.0	10.1	9.0
Headache	6.5	11.3	11.6	12.8	8.9	6.5
Upper respiratory tract infection	7.6	10.5	8.3	9.2	7.6	7.8
Pharyngolaryngeal pain	6.1	8.9	5.0	7.3	3.0	4.8
Sinusitis	5.8	4.8	5.8	2.8	6.3	4.8
Influenza	3.2	2.4	6.6	0.9	3.0	1.3
Back pain	3.2	1.6	2.5	5.5	2.1	0.8
Nasal congestion	2.5	3.2	2.5	3.7	1.3	1.0
Stomach discomfort	1.1	6.5	2.5	4.6	1.3	1.8
Vomiting	1.4	3.2	0.8	2.8	1.7	1.0
Oral Candidiasis	1.4	3.2	0	0	0	0.8
<b>Average Duration of Exposure (days)</b>	<b>77.7</b>	<b>73.8</b>	<b>77.0</b>	<b>71.4</b>	<b>62.4</b>	<b>55.9</b>

\*All treatments were administered as two inhalations twice daily.

### Long-term safety - asthma clinical trials in patients 12 years and older

Long-term safety studies in adolescent and adult patients 12 years of age and older, treated for up to 1 year at doses up to 1280/36 mcg/day (640/18 mcg twice daily), revealed neither clinically important changes in the incidence nor new types of adverse events emerging after longer periods of treatment. Similarly, no significant or unexpected patterns of abnormalities were observed for up to 1 year in safety measures including chemistry, hematology, ECG, Holter monitor, and HPA-axis assessments.

## 6.2 Clinical Trials Experience in Chronic Obstructive Pulmonary Disease

The incidence of common adverse events in Table 2 below is based upon pooled data from two double-blind, placebo-controlled clinical studies (6 and 12 months in duration) in which 771 adult COPD patients (496 males and 275 females)



40 years of age and older were treated with SYMBICORT 160/4.5, two inhalations twice daily. Of these patients 651 were treated for 6 months and 366 were treated for 12 months. The SYMBICORT group was composed of mostly Caucasian (93%) patients with a mean age of 63 years, and a mean percent predicted FEV<sub>1</sub> at baseline of 33%. Control arms for comparison included two inhalations of budesonide HFA (MDI) 160 mcg, formoterol (DPI) 4.5 mcg or placebo (MDI and DPI) twice daily. Table 2 includes all adverse events that occurred at an incidence of  $\geq 3\%$  in the SYMBICORT group and more commonly than in the placebo group. In considering these data, the increased average duration of patient exposure to SYMBICORT should be taken into account, as incidences are not adjusted for an imbalance of treatment duration.

**Table 2 Adverse reactions occurring at an incidence of  $\geq 3\%$  and more commonly than placebo in the SYMBICORT group: pooled data from two double-blind, placebo-controlled clinical COPD trials**

Treatment*	SYMBICORT	Budesonide	Formoterol	Placebo
	160/4.5 mcg N = 771	160 mcg N = 275	4.5 mcg N = 779	N = 781
Adverse Event	%	%	%	%
Nasopharyngitis	7.3	3.3	5.8	4.9
Oral candidiasis	6.0	4.4	1.2	1.8
Bronchitis	5.4	4.7	4.5	3.5
Sinusitis	3.5	1.5	3.1	1.8
Upper respiratory tract infection viral	3.5	1.8	3.6	2.7
<b>Average Duration of Exposure (days)</b>	<b>255.2</b>	<b>157.1</b>	<b>240.3</b>	<b>223.7</b>

\* All treatments were administered as two inhalations twice daily.

Lung infections other than pneumonia (mostly bronchitis) occurred in a greater percentage of subjects treated with SYMBICORT 160/4.5 compared with placebo (7.9% vs. 5.1%, respectively). There were no clinically important or unexpected patterns of abnormalities observed for up to 1 year in chemistry, haematology, ECG, ECG (Holter) monitoring, HPA-axis, bone mineral density and ophthalmology assessments.

### 6.3 Postmarketing Experience

The following adverse reactions have been reported during post-approval use of SYMBICORT. Because these reactions

are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. Some of these adverse reactions may also have been observed in clinical studies with SYMBICORT.

*Cardiac disorders:* angina pectoris, tachycardia, atrial and ventricular tachyarrhythmias, atrial fibrillation, extrasystoles, palpitations

*Endocrine disorders:* hypercorticism, growth velocity reduction in pediatric patients

*Eye disorders:* cataract, glaucoma, increased intraocular pressure

*Gastrointestinal disorders:* oropharyngeal candidiasis, nausea

*Immune system disorders:* immediate and delayed hypersensitivity reactions, such as anaphylactic reaction, angioedema, bronchospasm, urticaria, exanthema, dermatitis, pruritus

*Metabolic and nutrition disorders:* hyperglycemia, hypokalemia

*Musculoskeletal, connective tissue, and bone disorders:* muscle cramps

*Nervous system disorders:* tremor, dizziness

*Psychiatric disorders:* behavior disturbances, sleep disturbances, nervousness, agitation, depression, restlessness

*Respiratory, thoracic, and mediastinal disorders:* dysphonia, cough, throat irritation

*Skin and subcutaneous tissue disorders:* skin bruising

*Vascular disorders:* hypotension, hypertension

## **7 DRUG INTERACTIONS**

In clinical studies, concurrent administration of SYMBICORT and other drugs, such as short-acting beta<sub>2</sub>-agonists, intranasal corticosteroids, and antihistamines/decongestants has not resulted in an increased frequency of adverse reactions. No formal drug interaction studies have been performed with SYMBICORT.

### **7.1 Inhibitors of Cytochrome P4503A4**

The main route of metabolism of corticosteroids, including budesonide, a component of SYMBICORT, is via cytochrome P450 (CYP) isoenzyme 3A4 (CYP3A4). After oral administration of ketoconazole, a strong inhibitor of CYP3A4, the mean plasma concentration of orally administered budesonide increased. Concomitant administration of CYP3A4 may inhibit the metabolism of, and increase the systemic exposure to, budesonide. Caution should be exercised when considering the coadministration of SYMBICORT with long-term ketoconazole and other known strong CYP3A4 inhibitors (e.g., ritonavir, atazanavir,

clarithromycin, indinavir, itraconazole, nefazodone, nelfinavir, saquinavir, telithromycin) [*see Warnings and Precautions (5.9)*].

## **7.2 Monoamine Oxidase Inhibitors and Tricyclic Antidepressants**

SYMBICORT should be administered with caution to patients being treated with monoamine oxidase inhibitors or tricyclic antidepressants, or within 2 weeks of discontinuation of such agents, because the action of formoterol, a component of SYMBICORT, on the vascular system may be potentiated by these agents. In clinical trials with SYMBICORT, a limited number of COPD and asthma patients received tricyclic antidepressants, and, therefore, no clinically meaningful conclusions on adverse events can be made.

## **7.3 Beta-Adrenergic Receptor Blocking Agents**

Beta-blockers (including eye drops) may not only block the pulmonary effect of beta-agonists, such as formoterol, a component of SYMBICORT, but may produce severe bronchospasm in patients with asthma. Therefore, patients with asthma should not normally be treated with beta-blockers. However, under certain circumstances, there may be no acceptable alternatives to the use of beta-adrenergic blocking agents in patients with asthma. In this setting, cardioselective beta-blockers could be considered, although they should be administered with caution.

## **7.4 Diuretics**

The ECG changes and/or hypokalemia that may result from the administration of non-potassium-sparing diuretics (such as loop or thiazide diuretics) can be acutely worsened by beta-agonists, especially when the recommended dose of the beta-agonist is exceeded. Although the clinical significance of these effects is not known, caution is advised in the coadministration of SYMBICORT with non-potassium-sparing diuretics.

# **8 USE IN SPECIFIC POPULATIONS**

## **8.1 Pregnancy**

### **Teratogenic Effects: Pregnancy Category C.**

There are no adequate and well-controlled studies of SYMBICORT in pregnant women. SYMBICORT was teratogenic and embryocidal in rats. Budesonide alone was teratogenic and embryocidal in rats and rabbits, but not in humans at therapeutic doses. Formoterol fumarate alone was teratogenic in rats and rabbits. Formoterol fumarate was also embryocidal, increased pup loss at birth and during lactation, and decreased pup weight in rats. SYMBICORT should be

used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

### **SYMBICORT**

In a reproduction study in rats, budesonide combined with formoterol fumarate by the inhalation route at doses approximately 1/7 and 1/3, respectively, the maximum recommended human daily inhalation dose on a mg/m<sup>2</sup> basis produced umbilical hernia. No teratogenic or embryocidal effects were detected with budesonide combined with formoterol fumarate by the inhalation route at doses approximately 1/32 and 1/16, respectively, the maximum recommended human daily inhalation dose on a mg/m<sup>2</sup> basis.

### **Budesonide**

Studies of pregnant women have not shown that inhaled budesonide increases the risk of abnormalities when administered during pregnancy. The results from a large population-based prospective cohort epidemiological study reviewing data from three Swedish registries covering approximately 99% of the pregnancies from 1995-1997 (ie, Swedish Medical Birth Registry; Registry of Congenital Malformations; Child Cardiology Registry) indicate no increased risk for congenital malformations from the use of inhaled budesonide during early pregnancy. Congenital malformations were studied in 2014 infants born to mothers reporting the use of inhaled budesonide for asthma in early pregnancy (usually 10-12 weeks after the last menstrual period), the period when most major organ malformations occur. The rate of recorded congenital malformations was similar compared to the general population rate (3.8% vs 3.5%, respectively). In addition, after exposure to inhaled budesonide, the number of infants born with orofacial clefts was similar to the expected number in the normal population (4 children vs 3.3, respectively).

These same data were utilized in a second study bringing the total to 2534 infants whose mothers were exposed to inhaled budesonide. In this study, the rate of congenital malformations among infants whose mothers were exposed to inhaled budesonide during early pregnancy was not different from the rate for all newborn babies during the same period (3.6%).

Budesonide produced fetal loss, decreased pup weight, and skeletal abnormalities at subcutaneous doses in rabbits less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis and in rats at doses approximately 6 times the maximum recommended human daily inhalation dose on a

mcg/m<sup>2</sup> basis. In another study in rats, no teratogenic or embryocidal effects were seen at inhalation doses up to 3 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis.

Experience with oral corticosteroids since their introduction in pharmacologic as opposed to physiologic doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans.

### **Formoterol**

Formoterol fumarate has been shown to be teratogenic, embryocidal, to increase pup loss at birth and during lactation, and to decrease pup weights in rats when given at oral doses 1400 times and greater the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis. Umbilical hernia was observed in rat fetuses at oral doses 1400 times and greater the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis. Brachygnathia was observed in rat fetuses at an oral dose 7000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis. Pregnancy was prolonged at an oral dose 7000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis. In another study in rats, no teratogenic effects were seen at inhalation doses up to 500 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis.

Subcapsular cysts on the liver were observed in rabbit fetuses at an oral dose 54,000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis. No teratogenic effects were observed at oral doses up to 3200 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis.

### **Nonteratogenic Effects**

Hypoadrenalism may occur in infants born of mothers receiving corticosteroids during pregnancy. Such infants should be carefully observed.

## **8.2 Labor and Delivery**

There are no well-controlled human studies that have investigated the effects of SYMBICORT on preterm labor or labor at term. Because of the potential for beta-agonist interference with uterine contractility, use of SYMBICORT for management of asthma during labor should be restricted to those patients in whom the benefits clearly outweigh the risks.

### 8.3 Nursing Mothers

Since there are no data from controlled trials on the use of SYMBICORT by nursing mothers, a decision should be made whether to discontinue nursing or to discontinue SYMBICORT, taking into account the importance of SYMBICORT to the mother.

Budesonide, like other corticosteroids, is secreted in human milk. Data with budesonide delivered via dry powder inhaler indicates that the total daily oral dose of budesonide available in breast milk to the infant is approximately 0.3% to 1% of the dose inhaled by the mother [*see Clinical Pharmacology, Pharmacokinetics (12.3)*]. For SYMBICORT, the dose of budesonide available to the infant in breast milk, as a percentage of the maternal dose, would be expected to be similar.

In reproductive studies in rats, formoterol was excreted in the milk. It is not known whether formoterol is excreted in human milk.

### 8.4 Pediatric Use

Safety and effectiveness of SYMBICORT in asthma patients 12 years of age and older have been established in studies up to 12 months. In the two 12-week, double-blind, placebo-controlled US pivotal studies 25 patients 12 to 17 years of age were treated with SYMBICORT twice daily [*see Clinical Studies (14.1)*]. Efficacy results in this age group were similar to those observed in patients 18 years and older. There were no obvious differences in the type or frequency of adverse events reported in this age group compared with patients 18 years of age and older.

The safety and effectiveness of SYMBICORT in asthma patients 6 to <12 years of age has not been established.

Overall 1447 asthma patients 6 to <12 years of age participated in placebo- and active-controlled SYMBICORT studies. Of these 1447 patients, 539 received SYMBICORT twice daily. The overall safety profile of these patients was similar to that observed in patients  $\geq 12$  years of age who also received SYMBICORT twice daily in studies of similar design.

Controlled clinical studies have shown that orally inhaled corticosteroids including budesonide, a component of SYMBICORT, may cause a reduction in growth velocity in pediatric patients. This effect has been observed in the absence of laboratory evidence of HPA-axis suppression, suggesting that growth velocity is a more sensitive indicator of

systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA-axis function. The long-term effect of this reduction in growth velocity associated with orally inhaled corticosteroids, including the impact on final height are unknown. The potential for “catch-up” growth following discontinuation of treatment with orally inhaled corticosteroids has not been adequately studied.

In a study of asthmatic children 5-12 years of age, those treated with budesonide DPI 200 mcg twice daily (n=311) had a 1.1 centimeter reduction in growth compared with those receiving placebo (n=418) at the end of one year; the difference between these two treatment groups did not increase further over three years of additional treatment. By the end of 4 years, children treated with budesonide DPI and children treated with placebo had similar growth velocities. Conclusions drawn from this study may be confounded by the unequal use of corticosteroids in the treatment groups and inclusion of data from patients attaining puberty during the course of the study.

The growth of pediatric patients receiving orally inhaled corticosteroids, including SYMBICORT, should be monitored. If a child or adolescent on any corticosteroid appears to have growth suppression, the possibility that he/she is particularly sensitive to this effect should be considered. The potential growth effects of prolonged treatment should be weighed against the clinical benefits obtained. To minimize the systemic effects of orally inhaled corticosteroids, including SYMBICORT, each patient should be titrated to the lowest strength that effectively controls his/her asthma [*see Dosage and Administration (2)*].

## **8.5 Geriatric Use**

Of the total number of patients in asthma clinical studies treated with SYMBICORT twice daily, 149 were 65 years of age or older, of whom 25 were 75 years of age or older.

In the COPD studies of 6 to 12 months duration, 349 patients treated with SYMBICORT 160/4.5 twice daily were 65 years old and above and of those, 73 patients were 75 years of age and older. No overall differences in safety or effectiveness were observed between these patients and younger patients, and other reported clinical experience has not identified differences in responses between the elderly and younger patients.

As with other products containing beta<sub>2</sub>-agonists, special caution should be observed when using SYMBICORT in

geriatric patients who have concomitant cardiovascular disease that could be adversely affected by beta<sub>2</sub>-agonists.

Based on available data for SYMBICORT or its active components, no adjustment of dosage of SYMBICORT in geriatric patients is warranted.

## **8.6 Hepatic Impairment**

Formal pharmacokinetic studies using SYMBICORT have not been conducted in patients with hepatic impairment. However, since both budesonide and formoterol fumarate are predominantly cleared by hepatic metabolism, impairment of liver function may lead to accumulation of budesonide and formoterol fumarate in plasma. Therefore, patients with hepatic disease should be closely monitored.

## **8.7 Renal Impairment**

Formal pharmacokinetic studies using SYMBICORT have not been conducted in patients with renal impairment.

## **10 OVERDOSAGE**

### **SYMBICORT**

SYMBICORT contains both budesonide and formoterol; therefore, the risks associated with overdosage for the individual components described below apply to SYMBICORT. In pharmacokinetic studies, single doses of 960/54 mcg (12 actuations of SYMBICORT 80/4.5) and 1280/36 mcg (8 actuations of 160/4.5), were administered to patients with COPD. A total of 1920/54 mcg (12 actuations of SYMBICORT 160/4.5) was administered as a single dose to both healthy subjects and patients with asthma. In a long-term active-controlled safety study in asthma patients, SYMBICORT 160/4.5 was administered for up to 12 months at doses up to twice the highest recommended daily dose. There were no clinically significant adverse reactions observed in any of these studies.

Clinical signs in dogs that received a single inhalation dose of SYMBICORT (a combination of budesonide and formoterol) in a dry powder included tremor, mucosal redness, nasal catarrh, redness of intact skin, abdominal respiration, vomiting, and salivation; in the rat, the only clinical sign observed was increased respiratory rate in the first hour after dosing. No deaths occurred in rats given a combination of budesonide and formoterol at acute inhalation doses of 97 and 3 mg/kg, respectively (approximately 1200 and 1350 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). No deaths occurred in dogs given a combination of budesonide and formoterol at the acute



inhalation doses of 732 and 22 mcg/kg, respectively (approximately 30 times the maximum recommended human daily inhalation dose of budesonide and formoterol on a mcg/m<sup>2</sup> basis).

### **Budesonide**

The potential for acute toxic effects following overdose of budesonide is low. If used at excessive doses for prolonged periods, systemic corticosteroid effects such as hypercorticism may occur [*see Warnings and Precautions (5)*]. Budesonide at five times the highest recommended dose (3200 mcg daily) administered to humans for 6 weeks caused a significant reduction (27%) in the plasma cortisol response to a 6-hour infusion of ACTH compared with placebo (+1%). The corresponding effect of 10 mg prednisone daily was a 35% reduction in the plasma cortisol response to ACTH.

In mice, the minimal inhalation lethal dose was 100 mg/kg (approximately 600 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). In rats, there were no deaths following the administration of an inhalation dose of 68 mg/kg (approximately 900 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). The minimal oral lethal dose in mice was 200 mg/kg (approximately 1300 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis) and less than 100 mg/kg in rats (approximately 1300 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis).

### **Formoterol**

An overdose of formoterol would likely lead to an exaggeration of effects that are typical for beta<sub>2</sub>-agonists: seizures, angina, hypertension, hypotension, tachycardia, atrial and ventricular tachyarrhythmias, nervousness, headache, tremor, palpitations, muscle cramps, nausea, dizziness, sleep disturbances, metabolic acidosis, hyperglycemia, hypokalemia. As with all sympathomimetic medications, cardiac arrest and even death may be associated with abuse of formoterol. No clinically significant adverse reactions were seen when formoterol was delivered to adult patients with acute bronchoconstriction at a dose of 90 mcg/day over 3 hours or to stable asthmatics 3 times a day at a total dose of 54 mcg/day for 3 days.

Treatment of formoterol overdosage consists of discontinuation of the medication together with institution of appropriate symptomatic and/or supportive therapy. The judicious use of a cardioselective beta-receptor blocker may be considered, bearing in mind that such medication can

produce bronchospasm. There is insufficient evidence to determine if dialysis is beneficial for overdose of formoterol. Cardiac monitoring is recommended in cases of overdose.

No deaths were seen in mice given formoterol at an inhalation dose of 276 mg/kg (more than 62,200 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). In rats, the minimum lethal inhalation dose was 40 mg/kg (approximately 18,000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). No deaths were seen in mice that received an oral dose of 2000 mg/kg (more than 450,000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). Maximum nonlethal oral doses were 252 mg/kg in young rats and 1500 mg/kg in adult rats (approximately 114,000 times and 675,000 times the maximum recommended human inhalation dose on a mcg/m<sup>2</sup> basis).

## 11 DESCRIPTION

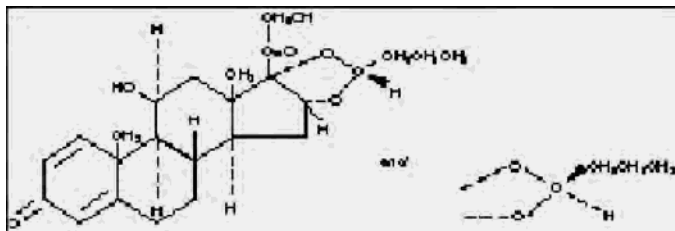
SYMBICORT 80/4.5 and SYMBICORT 160/4.5 each contain micronized budesonide and micronized formoterol fumarate dihydrate for oral inhalation only.

Each SYMBICORT 80/4.5 and SYMBICORT 160/4.5 canister is formulated as a hydrofluoroalkane (HFA 227; 1,1,1,2,3,3,3-heptafluoropropane)-propelled pressurized metered dose inhaler containing either 60 or 120 actuations [see *Dosage Forms and Strengths (3) and How Supplied/Storage and Handling (16)*]. After priming, each actuation meters either 91/5.1 mcg or 181/5.1 mcg from the valve and delivers either 80/4.5 mcg, or 160/4.5 mcg (budesonide micronized/formoterol fumarate dihydrate micronized) from the actuator. The actual amount of drug delivered to the lung may depend on patient factors, such as the coordination between actuation of the device and inspiration through the delivery system. SYMBICORT also contains povidone K25 USP as a suspending agent and polyethylene glycol 1000 NF as a lubricant.

SYMBICORT should be primed before using for the first time by releasing two test sprays into the air away from the face, shaking well for 5 seconds before each spray. In cases where the inhaler has not been used for more than 7 days or when it has been dropped, prime the inhaler again by shaking well for 5 seconds before each spray and releasing two test sprays into the air away from the face.

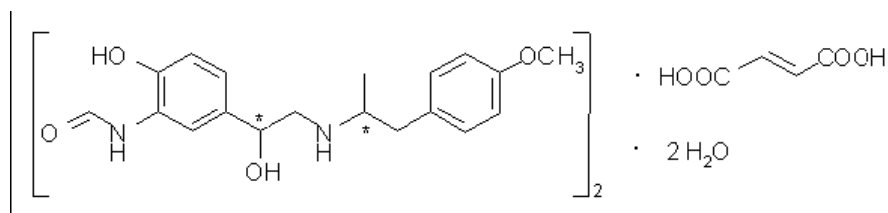
One active component of SYMBICORT is budesonide, a corticosteroid designated chemically as (RS)-11 $\beta$ , 16 $\alpha$ , 17,21-

Tetrahydroxypregna-1,4-diene-3,20-dione cyclic 16,17-acetal with butyraldehyde. Budesonide is provided as a mixture of two epimers (22R and 22S). The empirical formula of budesonide is  $C_{25}H_{34}O_6$  and its molecular weight is 430.5. Its structural formula is:



Budesonide is a white to off-white, tasteless, odorless powder which is practically insoluble in water and in heptane, sparingly soluble in ethanol, and freely soluble in chloroform. Its partition coefficient between octanol and water at pH 7.4 is  $1.6 \times 10^3$ .

The other active component of SYMBICORT is formoterol fumarate dihydrate, a selective  $\beta_2$ -agonist designated chemically as (R\*,R\*)-(±)-N-[2-hydroxy-5-[1-hydroxy-2-[[2-(4-methoxyphenyl)-1-methylethyl]amino]ethyl]phenyl]formamide, (E)-2-butendioate(2:1), dihydrate. The empirical formula of formoterol is  $C_{42}H_{56}N_4O_{14}$  and its molecular weight is 840.9. Its structural formula is:



Formoterol fumarate dihydrate is a powder which is slightly soluble in water. Its octanol-water partition coefficient at pH 7.4 is 2.6. The pKa of formoterol fumarate dihydrate at 25°C is 7.9 for the phenolic group and 9.2 for the amino group.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

#### SYMBICORT

SYMBICORT contains both budesonide and formoterol; therefore, the mechanisms of action described below for the individual components apply to SYMBICORT. These drugs represent two classes of medications (a synthetic

corticosteroid and a long-acting selective beta<sub>2</sub>-adrenoceptor agonist) that have different effects on clinical, physiological, and inflammatory indices of Chronic Obstructive Pulmonary Disease (COPD) and asthma.

### **Budesonide**

Budesonide is an anti-inflammatory corticosteroid that exhibits potent glucocorticoid activity and weak mineralocorticoid activity. In standard *in vitro* and animal models, budesonide has approximately a 200-fold higher affinity for the glucocorticoid receptor and a 1000-fold higher topical anti-inflammatory potency than cortisol (rat croton oil ear edema assay). As a measure of systemic activity, budesonide is 40 times more potent than cortisol when administered subcutaneously and 25 times more potent when administered orally in the rat thymus involution assay.

In glucocorticoid receptor affinity studies, the 22R form of budesonide was two times as active as the 22S epimer. *In vitro* studies indicated that the two forms of budesonide do not interconvert.

Inflammation is an important component in the pathogenesis of COPD and asthma. Corticosteroids have a wide range of inhibitory activities against multiple cell types (eg, mast cells, eosinophils, neutrophils, macrophages, and lymphocytes) and mediators (eg, histamine, eicosanoids, leukotrienes, and cytokines) involved in allergic and non-allergic-mediated inflammation. These anti-inflammatory actions of corticosteroids may contribute to their efficacy in COPD and asthma.

Studies in asthmatic patients have shown a favorable ratio between topical anti-inflammatory activity and systemic corticosteroid effects over a wide range of doses of budesonide. This is explained by a combination of a relatively high local anti-inflammatory effect, extensive first pass hepatic degradation of orally absorbed drug (85%-95%), and the low potency of formed metabolites.

### **Formoterol**

Formoterol fumarate is a long-acting selective beta<sub>2</sub>-adrenergic agonist (beta<sub>2</sub>-agonist) with a rapid onset of action. Inhaled formoterol fumarate acts locally in the lung as a bronchodilator. *In vitro* studies have shown that formoterol has more than 200-fold greater agonist activity at beta<sub>2</sub>-receptors than at beta<sub>1</sub>-receptors. The *in vitro* binding selectivity to beta<sub>2</sub>- over beta<sub>1</sub>-adrenoceptors is higher for formoterol than for albuterol (5 times), whereas salmeterol has a higher (3 times) beta<sub>2</sub>-selectivity ratio than formoterol.

Although beta<sub>2</sub>-receptors are the predominant adrenergic receptors in bronchial smooth muscle and beta<sub>1</sub>-receptors are the predominant receptors in the heart, there are also beta<sub>2</sub>-receptors in the human heart comprising 10% to 50% of the total beta-adrenergic receptors. The precise function of these receptors has not been established, but they raise the possibility that even highly selective beta<sub>2</sub>-agonists may have cardiac effects.

The pharmacologic effects of beta<sub>2</sub>-adrenoceptor agonist drugs, including formoterol, are at least in part attributable to stimulation of intracellular adenylyl cyclase, the enzyme that catalyzes the conversion of adenosine triphosphate (ATP) to cyclic-3', 5'-adenosine monophosphate (cyclic AMP). Increased cyclic AMP levels cause relaxation of bronchial smooth muscle and inhibition of release of mediators of immediate hypersensitivity from cells, especially from mast cells.

*In vitro* tests show that formoterol is an inhibitor of the release of mast cell mediators, such as histamine and leukotrienes, from the human lung. Formoterol also inhibits histamine-induced plasma albumin extravasation in anesthetized guinea pigs and inhibits allergen-induced eosinophil influx in dogs with airway hyper-responsiveness. The relevance of these *in vitro* and animal findings to humans is unknown.

## 12.2 Pharmacodynamics

### Asthma

Cardiovascular effects: In a single-dose cross-over study involving 201 patients with persistent asthma, single-dose treatments of 4.5, 9, and 18 mcg of formoterol in combination with 320 mcg of budesonide delivered via SYMBICORT were compared to budesonide 320 mcg alone. Dose-ordered improvements in FEV<sub>1</sub> were demonstrated when compared with budesonide. ECGs and blood samples for glucose and potassium were obtained postdose. For SYMBICORT, small mean increases in serum glucose and decreases in serum potassium (+0.44 mmol/L and -0.18 mmol/L at the highest dose, respectively) were observed with increasing doses of formoterol, compared to budesonide. In ECGs, SYMBICORT produced small dose-related mean increases in heart rate (approximately 3 bpm at the highest dose), and QTc intervals (3-6 msec) compared to budesonide alone. No subject had a QT or QTc value  $\geq$ 500 msec.

In the United States, five 12-week, active- and placebo-controlled studies evaluated 2152 patients aged 12 years and older with asthma. Systemic pharmacodynamic effects of formoterol (heart/pulse rate, blood pressure, QTc interval,

potassium, and glucose) were similar in patients treated with SYMBICORT, compared with patients treated with formoterol dry inhalation powder 4.5 mcg, two inhalations twice daily. No patient had a QT or QTc value  $\geq 500$  msec during treatment.

In three placebo-controlled studies in adolescents and adults with asthma, aged 12 years and older, a total of 1232 patients (553 patients in the SYMBICORT group) had evaluable continuous 24-hour electrocardiographic monitoring. Overall, there were no important differences in the occurrence of ventricular or supraventricular ectopy and no evidence of increased risk for clinically significant dysrhythmia in the SYMBICORT group compared to placebo.

HPA axis effects: Overall, no clinically important effects on HPA axis, as measured by 24-hour urinary cortisol, were observed for SYMBICORT treated adult or adolescent patients at doses up to 640/18 mcg/day compared to budesonide.

Chronic Obstructive Pulmonary Disease:

Cardiovascular effects: In 2 clinical studies, 6 months and 12 months in duration including 3668 COPD patients, no clinically important differences were seen in pulse rate, blood pressure, potassium, and glucose between SYMBICORT, the individual components of SYMBICORT, and placebo. [*see Clinical Studies (14.2)*].

ECGs recorded at multiple clinic visits on treatment in both studies showed no clinically important differences for heart rate, PR interval, QRS duration, heart rate, signs of cardiac ischemia or arrhythmias between SYMBICORT 160/4.5 the monoproducts and placebo, all administered as two inhalations twice daily. Based on ECGs, 6 patients treated with SYMBICORT 160/4.5, 6 patients treated with formoterol 4.5, and 6 patients in the placebo group experienced atrial fibrillation or flutter that was not present at baseline. There were no cases of nonsustained ventricular tachycardia in the SYMBICORT 160/4.5, formoterol 4.5, or placebo groups.

In the 12-month study, 520 patients had evaluable continuous 24-hour ECG (Holter) monitoring prior to the first dose and after approximately 1 and 4 months on treatment. No clinically important differences in ventricular or supraventricular arrhythmias, ventricular or supraventricular ectopic beats, or heart rate were observed among the groups treated with SYMBICORT 160/4.5, formoterol or placebo taken as two inhalations twice daily. Based on ECG (Holter)

monitoring, one patient on SYMBICORT 160/4.5, no patients on formoterol 4.5, and three patients in the placebo group experienced atrial fibrillation or flutter that was not present at baseline.

HPA axis effects: Twenty-four hour urinary cortisol measurements were collected in a pooled subset (n=616) of patients from two COPD studies. The data indicated approximately 30% lower mean 24-hour urinary free cortisol values following chronic administration (> 6 months) of SYMBICORT relative to placebo. SYMBICORT appeared to exhibit comparable cortisol suppression to budesonide 160 mcg alone or coadministration of budesonide 160 mcg and formoterol 4.5 mcg. For patients treated with SYMBICORT or placebo for up to 12 months, the percentage of patients who shifted from normal to low for this measure were generally comparable.

### **Other Budesonide Products**

To confirm that systemic absorption is not a significant factor in the clinical efficacy of inhaled budesonide, a clinical study in patients with asthma was performed comparing 400 mcg budesonide administered via a pressurized metered dose inhaler with a tube spacer to 1400 mcg of oral budesonide and placebo. The study demonstrated the efficacy of inhaled budesonide but not orally ingested budesonide, despite comparable systemic levels. Thus, the therapeutic effect of conventional doses of orally inhaled budesonide are largely explained by its direct action on the respiratory tract.

Inhaled budesonide has been shown to decrease airway reactivity to various challenge models, including histamine, methacholine, sodium metabisulfite, and adenosine monophosphate in patients with hyperreactive airways. The clinical relevance of these models is not certain.

Pretreatment with inhaled budesonide, 1600 mcg daily (800 mcg twice daily) for 2 weeks reduced the acute (early-phase reaction) and delayed (late-phase reaction) decrease in FEV<sub>1</sub> following inhaled allergen challenge.

The systemic effects of inhaled corticosteroids are related to the systemic exposure to such drugs. Pharmacokinetic studies have demonstrated that in both adults and children with asthma the systemic exposure to budesonide is lower with SYMBICORT compared with inhaled budesonide administered at the same delivered dose via a dry powder inhaler [see *Clinical Pharmacology, Pharmacokinetics, SYMBICORT (12.3)*]. Therefore, the systemic effects (HPA axis and growth) of budesonide delivered from SYMBICORT

would be expected to be no greater than what is reported for inhaled budesonide when administered at comparable doses via the dry powder inhaler [see *Use in Specific Populations, Pediatric Use (8.4)*].

***HPA Axis Effects:*** The effects of inhaled budesonide administered via a dry powder inhaler on the hypothalamic-pituitary-adrenal (HPA) axis were studied in 905 adults and 404 pediatric patients with asthma. For most patients, the ability to increase cortisol production in response to stress, as assessed by cosyntropin (ACTH) stimulation test, remained intact with budesonide treatment at recommended doses. For adult patients treated with 100, 200, 400, or 800 mcg twice daily for 12 weeks, 4%, 2%, 6%, and 13%, respectively, had an abnormal stimulated cortisol response (peak cortisol <14.5 mcg/dL assessed by liquid chromatography following short-cosyntropin test) as compared to 8% of patients treated with placebo. Similar results were obtained in pediatric patients. In another study in adults, doses of 400, 800, and 1600 mcg of inhaled budesonide twice daily for 6 weeks were examined; 1600 mcg twice daily (twice the maximum recommended dose) resulted in a 27% reduction in stimulated cortisol (6-hour ACTH infusion) while 10-mg prednisone resulted in a 35% reduction. In this study, no patient on budesonide at doses of 400 and 800 mcg twice daily met the criterion for an abnormal stimulated-cortisol response (peak cortisol <14.5 mcg/dL assessed by liquid chromatography) following ACTH infusion. An open-label, long-term follow-up of 1133 patients for up to 52 weeks confirmed the minimal effect on the HPA axis (both basal- and stimulated-plasma cortisol) of budesonide when administered at recommended doses. In patients who had previously been oral-steroid-dependent, use of budesonide in recommended doses was associated with higher stimulated-cortisol response compared to baseline following 1 year of therapy.

### **Other Formoterol Products**

While the pharmacodynamic effect is via stimulation of beta-adrenergic receptors, excessive activation of these receptors commonly leads to skeletal muscle tremor and cramps, insomnia, tachycardia, decreases in plasma potassium, and increases in plasma glucose. Inhaled formoterol, like other beta<sub>2</sub>-adrenergic agonist drugs, can produce dose-related cardiovascular effects and effects on blood glucose and/or serum potassium [see *Warnings and Precautions (5)*]. For SYMBICORT, these effects are detailed in the *Clinical Pharmacology, Pharmacodynamics, SYMBICORT (12.2)* section.



Use of long-acting beta<sub>2</sub>-adrenergic agonist drugs can result in tolerance to bronchoprotective and bronchodilatory effects.

Rebound bronchial hyperresponsiveness after cessation of chronic long-acting beta-agonist therapy has not been observed.

### 12.3 Pharmacokinetics

#### SYMBICORT

*Absorption: Budesonide: Healthy Subjects:* Orally inhaled budesonide is rapidly absorbed in the lungs and peak concentration is typically reached within 20 minutes. After oral administration of budesonide peak plasma concentration was achieved in about 1 to 2 hours and the absolute systemic availability was 6%-13% due to extensive first pass metabolism. In contrast, most of the budesonide delivered to the lungs was systemically absorbed. In healthy subjects, 34% of the metered dose was deposited in the lung (as assessed by plasma concentration method and using a budesonide-containing dry powder inhaler) with an absolute systemic availability of 39% of the metered dose.

Following administration of SYMBICORT 160/4.5 mcg, two or four inhalations twice daily) for 5 days in healthy subjects, plasma concentration of budesonide generally increased in proportion to dose. The accumulation index for the group that received two inhalations twice daily was 1.32 for budesonide.

*Asthma Patients:* In a single-dose study, higher than recommended doses of SYMBICORT (12 inhalations of SYMBICORT 160/4.5 mcg) were administered to patients with moderate asthma. Peak budesonide plasma concentration of 4.5 nmol/L occurred at 20 minutes following dosing. This study demonstrated that the total systemic exposure to budesonide from SYMBICORT was approximately 30% lower than from inhaled budesonide via a dry powder inhaler (DPI) at the same delivered dose. Following administration of SYMBICORT, the half-life of the budesonide component was 4.7 hours.

In a repeat dose study, the highest recommended dose of SYMBICORT (160/4.5 mcg, two inhalations twice daily) was administered to patients with moderate asthma and healthy subjects for 1 week. Peak budesonide plasma concentration of 1.2 nmol/L occurred at 21 minutes in asthma patients. Peak budesonide plasma concentration was 27% lower in asthma patients compared to that in healthy subjects. However, the total systemic exposure of budesonide was comparable to that in asthma patients.

Peak steady-state plasma concentrations of budesonide administered by DPI in adults with asthma averaged 0.6 and 1.6 nmol/L at doses of 180 mcg and 360 mcg twice daily, respectively. In asthmatic patients, budesonide showed a linear increase in AUC and  $C_{max}$  with increasing dose after both single and repeated dosing of inhaled budesonide.

*COPD Patients:* In a single-dose study, 12 inhalations of SYMBICORT 80/4.5 mcg (total dose 960/54 mcg) were administered to patients with COPD. Mean budesonide peak plasma concentration of 3.3 nmol/L occurred at 30 minutes following dosing. Budesonide systemic exposure was comparable between SYMBICORT pMDI and coadministration of budesonide via a metered-dose inhaler and formoterol via a dry powder inhaler (budesonide 960 mcg and formoterol 54 mcg). In the same study, an open-label group of moderate asthma patients also received the same higher dose of SYMBICORT. For budesonide, COPD patients exhibited 12% greater AUC and 10% lower  $C_{max}$  compared to asthma patients.

In the 6 month pivotal clinical study, steady-state pharmacokinetic data of budesonide was obtained in a subset of COPD patients with treatment arms of SYMBICORT pMDI 160/4.5 mcg, SYMBICORT pMDI 80/4.5 mcg, budesonide 160 mcg, budesonide 160 mcg and formoterol 4.5 mcg given together, all administered as two inhalations twice daily. Budesonide systemic exposure (AUC and  $C_{max}$ ) increased proportionally with doses from 80 mcg to 160 mcg and was generally similar between the 3 treatment groups receiving the same dose of budesonide (SYMBICORT pMDI 160/4.5 mcg, budesonide 160 mcg, budesonide 160 mcg and formoterol 4.5 mcg administered together).

**Formoterol:**

Inhaled formoterol is rapidly absorbed; peak plasma concentrations are typically reached at the first plasma sampling time, within 5-10 minutes after dosing. As with many drug products for oral inhalation, it is likely that the majority of the inhaled formoterol delivered is swallowed and then absorbed from the gastrointestinal tract.

*Healthy Subjects:* Following administration of SYMBICORT (160/4.5 mcg, two or four inhalations twice daily) for 5 days in healthy subjects, plasma concentration of formoterol generally increased in proportion to dose. The accumulation index for the group that received two inhalations twice daily was 1.77 for formoterol.

*Asthma patients:* In a single-dose study, higher than recommended doses of SYMBICORT (12 inhalations of SYMBICORT 160/4.5 mcg) were administered to patients with moderate asthma. Peak plasma concentration for formoterol of 136 pmol occurred at 10 minutes following dosing. Approximately 8% of the delivered dose of formoterol was recovered in the urine as unchanged drug.

In a repeat dose study, the highest recommended dose of SYMBICORT (160/4.5 mcg, two inhalations twice daily) was administered to patients with moderate asthma and healthy subjects for 1 week. Peak formoterol plasma concentration of 28 pmol/L occurred at 10 minutes in asthma patients. Peak formoterol plasma concentration was about 42% lower in asthma patients compared to that in healthy subjects. However, the total systemic exposure of formoterol was comparable to that in asthma patients.

*COPD patients:* Following single-dose administration of 12 inhalations of SYMBICORT 80/4.5, mean peak formoterol plasma concentration of 167 pmol/L was rapidly achieved at 15 minutes after dosing. Formoterol exposure was slightly greater (~16-18%) from SYMBICORT pMDI compared to coadministration of budesonide via a metered-dose inhaler and formoterol via a dry powder inhaler (total dose of budesonide 960 mcg and formoterol 54 mcg). In the same study, an open label group of moderate asthma patients received the same dose of SYMBICORT. COPD patients exhibited 12-15% greater AUC and  $C_{max}$  for formoterol compared to asthma patients.

In the 6 month pivotal clinical study, steady-state pharmacokinetic data of formoterol was obtained in a subset of COPD patients with treatment arms of SYMBICORT pMDI 160/4.5 mcg, SYMBICORT pMDI 80/4.5 mcg, formoterol 4.5 mcg, budesonide 160 mcg and formoterol 4.5 mcg given together, all administered as two inhalations twice daily. The systemic exposure of formoterol as evidenced by AUC, was about 30% and 16% higher from SYMBICORT pMDI compared to formoterol alone treatment arm and coadministration of individual components of budesonide and formoterol treatment arm, respectively.

**Distribution:** *Budesonide:* The volume of distribution of budesonide was approximately 3 L/kg. It was 85%-90% bound to plasma proteins. Protein binding was constant over the concentration range (1-100 nmol/L) achieved with, and exceeding, recommended inhaled doses. Budesonide showed little or no binding to corticosteroid binding globulin. Budesonide rapidly equilibrated with red blood cells in a

concentration independent manner with a blood plasma ratio of about 0.8.

*Formoterol:* Over the concentration range of 10-500 nmol/L, plasma protein binding for the RR and SS enantiomers of formoterol was 46% and 58%, respectively. The concentrations of formoterol used to assess the plasma protein binding were higher than those achieved in plasma following inhalation of a single 54 mcg dose.

**Metabolism:** *Budesonide:* *In vitro* studies with human liver homogenates have shown that budesonide was rapidly and extensively metabolized. Two major metabolites formed via cytochrome P450 (CYP) isoenzyme 3A4 (CYP3A4) catalyzed biotransformation have been isolated and identified as 16 $\alpha$ -hydroxyprednisolone and 6 $\beta$ -hydroxybudesonide. The corticosteroid activity of each of these two metabolites was less than 1% of that of the parent compound. No qualitative differences between the *in vitro* and *in vivo* metabolic patterns were detected. Negligible metabolic inactivation was observed in human lung and serum preparations.

*Formoterol:* The primary metabolism of formoterol is by direct glucuronidation and by O-demethylation followed by conjugation to inactive metabolites. Secondary metabolic pathways include deformylation and sulfate conjugation. CYP2D6 and CYP2C have been identified as being primarily responsible for O-demethylation.

**Elimination:** *Budesonide:* Budesonide was excreted in urine and feces in the form of metabolites. Approximately 60% of an intravenous radiolabeled dose was recovered in the urine.

No unchanged budesonide was detected in the urine. The 22R form of budesonide was preferentially cleared by the liver with systemic clearance of 1.4 L/min vs 1.0 L/min for the 22S form. The terminal half-life, 2 to 3 hours, was the same for both epimers and was independent of dose.

*Formoterol:* The excretion of formoterol was studied in four healthy subjects following simultaneous administration of radiolabeled formoterol via the oral and IV routes. In that study, 62% of the radiolabeled formoterol was excreted in the urine while 24% was eliminated in the feces.

## Special Populations

### *Geriatric*

The pharmacokinetics of SYMBICORT in geriatric patients have not been specifically studied.

### *Pediatric*

Plasma concentrations of budesonide were measured following administration of four inhalations of SYMBICORT 160/4.5 mcg in a single-dose study in pediatric patients with asthma, 6-11 years of age. Urine was collected for determination of formoterol excretion. Peak budesonide concentrations of 1.4 nmol/L occurred at 20 minutes post-dose. Approximately 3.5% of the delivered formoterol dose was recovered in the urine as unchanged formoterol. This study also demonstrated that the total systemic exposure to budesonide from SYMBICORT was approximately 30% lower than from inhaled budesonide via a dry powder inhaler that was also evaluated at the same delivered dose.

### *Gender/Race*

Specific studies to examine the effects of gender and race on the pharmacokinetics of SYMBICORT have not been conducted. Population PK analysis of the SYMBICORT data indicates that gender does not affect the pharmacokinetics of budesonide and formoterol. No conclusions can be drawn on the effect of race due to the low number of non-Caucasians evaluated for PK.

### *Nursing Mothers*

The disposition of budesonide when delivered by inhalation from a dry powder inhaler at doses of 200 or 400 mcg twice daily for at least 3 months was studied in eight lactating women with asthma from 1 to 6 months postpartum. Systemic exposure to budesonide in these women appears to be comparable to that in non-lactating women with asthma from other studies. Breast milk obtained over eight hours post-dose revealed that the maximum concentration of budesonide for the 400 and 800 mcg total daily doses was 0.39 and 0.78 nmol/L, respectively, and occurred within 45 minutes after dosing. The estimated oral daily dose of budesonide from breast milk to the infant is approximately 0.007 and 0.014 mcg/kg/day for the two dose regimens used in this study, which represents approximately 0.3% to 1% of the dose inhaled by the mother. Budesonide levels in plasma samples obtained from five infants at about 90 minutes after breastfeeding (and about 140 minutes after drug administration to the mother) were below quantifiable levels (<0.02 nmol/L in four infants and <0.04 nmol/L in one infant) [see *Use in Specific Populations, Nursing Mothers (8.3)*].

### *Renal or Hepatic Insufficiency*

There are no data regarding the specific use of SYMBICORT in patients with hepatic or renal impairment. Reduced liver function may affect the elimination of corticosteroids. Budesonide pharmacokinetics was affected by compromised

liver function as evidenced by a doubled systemic availability after oral ingestion. The intravenous budesonide pharmacokinetics was, however, similar in cirrhotic patients and in healthy subjects. Specific data with formoterol is not available, but because formoterol is primarily eliminated via hepatic metabolism, an increased exposure can be expected in patients with severe liver impairment.

### *Drug-Drug Interactions*

A single-dose crossover study was conducted to compare the pharmacokinetics of eight inhalations of the following: budesonide, formoterol, and budesonide plus formoterol administered concurrently. The results of the study indicated that there was no evidence of a pharmacokinetic interaction between the two components of SYMBICORT.

### *Inhibitors of cytochrome P450 enzymes*

Ketoconazole: Ketoconazole, a strong inhibitor of cytochrome P450 (CYP) isoenzyme 3A4 (CYP3A4), the main metabolic enzyme for corticosteroids, increased plasma levels of orally ingested budesonide.

Cimetidine: At recommended doses, cimetidine, a non-specific inhibitor of CYP enzymes, had a slight but clinically insignificant effect on the pharmacokinetics of oral budesonide.

Specific drug-drug interaction studies with formoterol have not been performed.

## **13 NONCLINICAL TOXICOLOGY**

### **13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility**

#### **Budesonide**

Long-term studies were conducted in rats and mice using oral administration to evaluate the carcinogenic potential of budesonide.

In a 2-year study in Sprague-Dawley rats, budesonide caused a statistically significant increase in the incidence of gliomas in male rats at an oral dose of 50 mcg/kg (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). No tumorigenicity was seen in male and female rats at respective oral doses up to 25 and 50 mcg/kg (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). In two additional 2-year studies in male Fischer and Sprague-Dawley rats, budesonide caused no gliomas at an oral dose of 50 mcg/kg (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup>

basis). However, in the male Sprague-Dawley rats, budesonide caused a statistically significant increase in the incidence of hepatocellular tumors at an oral dose of 50 mcg/kg (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). The concurrent reference corticosteroids (prednisolone and triamcinolone acetonide) in these two studies showed similar findings.

In a 91-week study in mice, budesonide caused no treatment-related carcinogenicity at oral doses up to 200 mcg/kg (approximately equal to the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis).

Budesonide was not mutagenic or clastogenic in six different test systems: Ames *Salmonella*/microsome plate test, mouse micronucleus test, mouse lymphoma test, chromosome aberration test in human lymphocytes, sex-linked recessive lethal test in *Drosophila melanogaster*, and DNA repair analysis in rat hepatocyte culture.

In rats, budesonide had no effect on fertility at subcutaneous doses up to 80 mcg/kg (approximately equal to the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). However, it caused a decrease in prenatal viability and viability in the pups at birth and during lactation, along with a decrease in maternal body-weight gain, at subcutaneous doses of 20 mcg/kg and above (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). No such effects were noted at 5 mcg/kg (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis).

### **Formoterol**

Long-term studies were conducted in mice using oral administration and rats using inhalation administration to evaluate the carcinogenic potential of formoterol fumarate.

In a 24-month carcinogenicity study in CD-1 mice, formoterol at oral doses of 0.1 mg/kg and above (approximately 20 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis) caused a dose-related increase in the incidence of uterine leiomyomas.

In a 24-month carcinogenicity study in Sprague-Dawley rats, an increased incidence of mesovarian leiomyoma and uterine leiomyosarcoma were observed at the inhaled dose of 130 mcg/kg (approximately 60 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). No tumors were seen at 22 mcg/kg (approximately 10 times the

maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis).

Other beta-agonist drugs have similarly demonstrated increases in leiomyomas of the genital tract in female rodents. The relevance of these findings to human use is unknown.

Formoterol was not mutagenic or clastogenic in Ames *Salmonella*/microsome plate test, mouse lymphoma test, chromosome aberration test in human lymphocytes, and rat micronucleus test.

A reduction in fertility and/or reproductive performance was identified in male rats treated with formoterol at an oral dose of 15 mg/kg (approximately 7000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). In a separate study with male rats treated with an oral dose of 15 mg/kg (approximately 7000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis), there were findings of testicular tubular atrophy and spermatic debris in the testes and oligospermia in the epididymides. No such effect was seen at 3 mg/kg (approximately 1400 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). No effect on fertility was detected in female rats at doses up to 15 mg/kg (approximately 7000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis).

## 13.2 Animal Toxicology and/or Pharmacology

**Preclinical:** Studies in laboratory animals (minipigs, rodents, and dogs) have demonstrated the occurrence of cardiac arrhythmias and sudden death (with histologic evidence of myocardial necrosis) when beta-agonists and methylxanthines are administered concurrently. The clinical significance of these findings is unknown.

### **Reproductive Toxicology Studies:**

#### **SYMBICORT**

SYMBICORT has been shown to be teratogenic and embryocidal in rats when given at inhalation doses of 12/0.66 mcg/kg (budesonide/formoterol) and above (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). Umbilical hernia, a malformation, was observed for fetuses at doses of 12/0.66 mcg/kg and above (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). No teratogenic or embryocidal effects were detected at 2.5/0.14 mcg/kg (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis).



### **Budesonide**

As with other corticosteroids, budesonide has been shown to be teratogenic and embryocidal in rabbits and rats. Budesonide produced fetal loss, decreased pup weight, and skeletal abnormalities at subcutaneous doses of 25 mcg/kg/day in rabbits (less than the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis) and 500 mcg/kg/day in rats (approximately 6 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). In another study in rats, no teratogenic or embryocidal effects were seen at inhalation doses up to 250 mcg/kg/day (approximately 3 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis).

### **Formoterol**

Formoterol fumarate has been shown to be teratogenic, embryocidal, to increase pup loss at birth and during lactation, and to decrease pup weights in rats when given at oral doses of 3 mg/kg/day and above (approximately 1400 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). Umbilical hernia, a malformation, was observed in rat fetuses at oral doses of 3 mg/kg/day and above (approximately 1400 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). Brachygnathia, a skeletal malformation, was observed in rat fetuses at an oral dose of 15 mg/kg/day (approximately 7000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). Pregnancy was prolonged at an oral dose of 15 mg/kg/day (approximately 7000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). In another study in rats, no teratogenic effects were seen at inhalation doses up to 1.2 mg/kg/day (approximately 500 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis).

Formoterol fumarate has been shown to be teratogenic in rabbits when given at an oral dose of 60 mg/kg (approximately 54,000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). Subcapsular cysts on the liver were observed in rabbit fetuses at an oral dose of 60 mg/kg (approximately 54,000 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis). No teratogenic effects were observed at oral doses up to 3.5 mg/kg (approximately 3200 times the maximum recommended human daily inhalation dose on a mcg/m<sup>2</sup> basis).

## 14 CLINICAL STUDIES

### 14.1 Asthma

SYMBICORT has been studied in patients with asthma 12 years of age and older. In two clinical studies comparing SYMBICORT with the individual components, improvements in most efficacy end points were greater with SYMBICORT than with the use of either budesonide or formoterol alone. In addition, one clinical study showed similar results between SYMBICORT and the concurrent use of budesonide and formoterol at corresponding doses from separate inhalers.

The safety and efficacy of SYMBICORT were demonstrated in two randomized, double-blind, placebo-controlled US clinical studies involving 1076 patients 12 years of age and older. Fixed SYMBICORT dosages of 160/9 mcg, and 320/9 mcg twice daily (each dose administered as two inhalations of the 80/4.5 and 160/4.5 mcg strengths, respectively) were compared with the monocomponents (budesonide and formoterol) and placebo to provide information about appropriate dosing to cover a range of asthma severity.

#### **Study 1: Clinical Study with SYMBICORT 160/4.5**

This 12-week study evaluated 596 patients 12 years of age and older by comparing SYMBICORT 160/4.5 mcg, the free combination of budesonide 160 mcg plus formoterol 4.5 mcg in separate inhalers, budesonide 160 mcg, formoterol 4.5 mcg, and placebo; each administered as two inhalations twice daily. The study included a 2-week run-in period with budesonide 80 mcg, two inhalations twice daily. Most patients had moderate to severe asthma and were using moderate to high doses of inhaled corticosteroids prior to study entry. Randomization was stratified by previous inhaled corticosteroid treatment (71.6% on moderate- and 28.4% on high-dose inhaled corticosteroid). Mean percent predicted FEV<sub>1</sub> at baseline was 68.1% and was similar across treatment groups. The coprimary efficacy end points were 12-hour-average postdose FEV<sub>1</sub> at week 2, and predose FEV<sub>1</sub> averaged over the course of the study. The study also required that patients who satisfied a predefined asthma-worsening criterion be withdrawn. The predefined asthma-worsening criteria were a clinically important decrease in FEV<sub>1</sub> or peak expiratory flow (PEF), increase in rescue albuterol use, nighttime awakening due to asthma, emergency intervention or hospitalization due to asthma, or requirement for asthma medication not allowed by the protocol. For the criterion of nighttime awakening due to asthma, patients were allowed to remain in the study at the discretion of the investigator if none of the other asthma-worsening criteria were met. The percentage of patients

withdrawing due to or meeting predefined criteria for worsening asthma is shown in Table 3.

**Table 3**                    **The number and percentage of patients withdrawing due to or meeting predefined criteria for worsening asthma (Study 1)**

	<b>SYMBICORT 160/4.5 mcg n=124</b>	<b>Budesonide 160 mcg plus Formoterol 4.5 mcg n=115</b>	<b>Budesonide 160 mcg n=109</b>	<b>Formoterol 4.5 mcg n=123</b>	<b>Placebo n=125</b>
Patients withdrawn due to predefined asthma event*	13 (10.5)	13 (11.3)	22 (20.2)	44 (35.8)	62 (49.6)
Patients with a predefined asthma event*†	37 (29.8)	24 (20.9)	48 (44.0)	68 (55.3)	84 (67.2)
Decrease in FEV <sub>1</sub>	4 (3.2)	8 (7.0)	7 (6.4)	15 (12.2)	14 (11.2)
Rescue medication use	2 (1.6)	0	3 (2.8)	3 (2.4)	7 (5.6)
Decrease in AM PEF	2 (1.6)	5 (4.3)	5 (4.6)	17 (13.8)	15 (12.0)
Nighttime awakenings‡	24 (19.4)	11 (9.6)	29 (26.6)	32 (26.0)	49 (39.2)
Clinical exacerbation	7 (5.6)	6 (5.2)	5 (4.6)	17 (3.8)	16 (12.8)

\*These criteria were assessed on a daily basis irrespective of the timing of the clinic visit, with the exception of FEV<sub>1</sub>, which was assessed at each clinic visit.

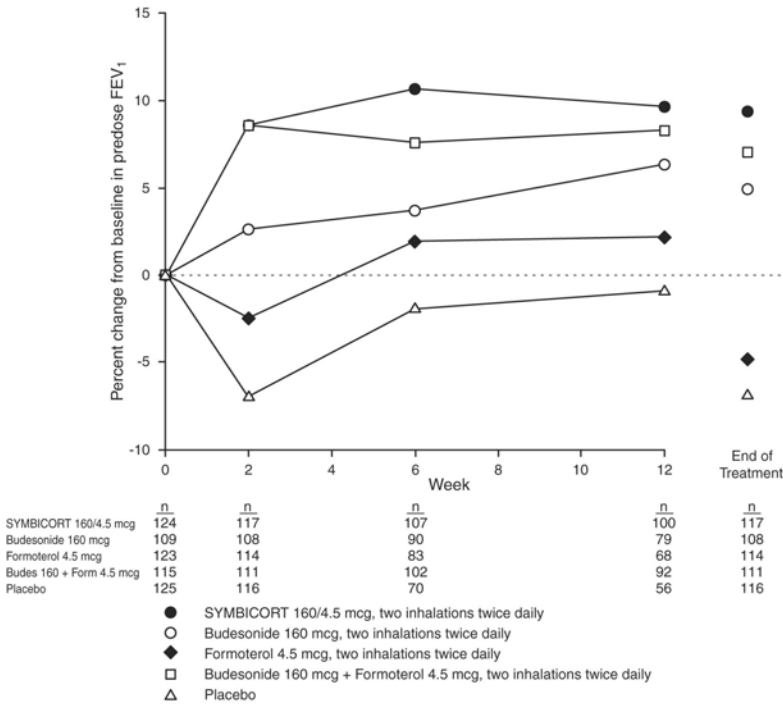
†Individual criteria are shown for patients meeting any predefined asthma event, regardless of withdrawal status.

‡For the criterion of nighttime awakening due to asthma, patients were allowed to remain in the study at the discretion of the investigator if none of the other criteria were met.

Mean percent change from baseline in FEV<sub>1</sub> measured immediately prior to dosing (predose) over 12 weeks is displayed in Figure 1. Because this study used predefined withdrawal criteria for worsening asthma, which caused a differential withdrawal rate in the treatment groups, predose FEV<sub>1</sub> results at the last available study visit (end of treatment,

EOT) are also provided. Patients receiving SYMBICORT 160/4.5 mcg had significantly greater mean improvements from baseline in pre-dose FEV<sub>1</sub> at the end of treatment (0.19 L, 9.4%), compared with budesonide 160 mcg (0.10 L, 4.9%), formoterol 4.5 mcg (-0.12 L, -4.8%), and placebo (-0.17 L, -6.9%).

**Figure 1 - Mean Percent Change From Baseline in Pre-dose FEV<sub>1</sub> Over 12 Weeks (Study 1)**



The effect of SYMBICORT 160/4.5 mcg two inhalations twice daily on selected secondary efficacy variables, including morning and evening PEF, albuterol rescue use, and asthma symptoms over 24 hours on a 0-3 scale is shown in Table 4.

**Table 4**                      **Mean values for selected secondary efficacy variables**  
**(Study 1)**

<b>Efficacy Variable</b>	<b>SYMBICORT 160/4.5 mcg (n*=124)</b>	<b>Budesonide 160 mcg plus Formoterol 4.5 mcg (n*=115)</b>	<b>Budesonide 160 mcg (n*=109)</b>	<b>Formoterol 4.5 mcg (n*=123)</b>	<b>Placebo (n*=125)</b>
<b>AM PEF (L/min)</b>					
Baseline	341	338	342	339	355
Change from Baseline	35	28	9	-9	-18
<b>PM PEF (L/min)</b>					
Baseline	351	348	357	354	369
Change from Baseline	34	26	7	-7	-18
<b>Albuterol rescue use</b>					
Baseline	2.1	2.3	2.7	2.5	2.4
Change from Baseline	-1.0	-1.5	-0.8	-0.3	0.8
<b>Average symptom score/day (0-3 scale)</b>					
Baseline	0.99	1.03	1.04	1.04	1.08
Change from Baseline	-0.28	-0.32	-0.14	-0.05	0.10

\*Number of patients (n) varies slightly due to the number of patients for whom data were available for each variable. Results shown are based on last available data for each variable.

The subjective impact of asthma on patients' health-related quality of life was evaluated through the use of the standardized Asthma Quality of Life Questionnaire (AQLQ(S)) (based on a 7-point scale where 1 = maximum impairment and 7 = no impairment). Patients receiving SYMBICORT 160/4.5 had clinically meaningful improvement in overall asthma-specific quality of life, as defined by a mean difference between treatment groups of >0.5 points in change from baseline in overall AQLQ score (difference in AQLQ score of 0.70 [95% CI 0.47, 0.93], compared to placebo).

## Study 2: Clinical Study with SYMBICORT 80/4.5

This 12-week study was similar in design to Study 1, and included 480 patients 12 years of age and older. This study compared SYMBICORT 80/4.5 mcg, budesonide 80 mcg, formoterol 4.5 mcg, and placebo; each administered as two inhalations twice daily. The study included a 2-week placebo run-in period. Most patients had mild to moderate asthma and were using low to moderate doses of inhaled corticosteroids prior to study entry. Mean percent predicted FEV<sub>1</sub> at baseline was 71.3% and was similar across treatment groups. Efficacy variables and end points were identical to those in Study 1.

The percentage of patients withdrawing due to or meeting predefined criteria for worsening asthma is shown in Table 5. The method of assessment and criteria used were identical to that in Study 1.

**Table 5** The number and percentage of patients withdrawing due to or meeting predefined criteria for worsening asthma (Study 2)

	<b>SYMBICORT 80/4.5 mcg (n=123)</b>	<b>Budesonide 80 mcg (n=121)</b>	<b>Formoterol 4.5 mcg (n=114)</b>	<b>Placebo (n=122)</b>
Patients withdrawn due to predefined asthma event*	9 (7.3)	8 (6.6)	21 (18.4)	40 (32.8)
Patients with a predefined asthma event* <sup>†</sup>	23 (18.7)	26 (21.5)	48 (42.1)	69 (56.6)
Decrease in FEV <sub>1</sub>	3 (2.4)	3 (2.5)	11 (9.6)	9 (7.4)
Rescue medication use	1 (0.8)	3 (2.5)	1 (0.9)	3 (2.5)
Decrease in AM PEF	3 (2.4)	1 (0.8)	8 (7.0)	14 (11.5)
Nighttime awakening <sup>‡</sup>	17 (13.8)	20 (16.5)	31 (27.2)	52 (42.6)
Clinical exacerbation	1 (0.8)	3 (2.5)	5 (4.4)	20 (16.4)

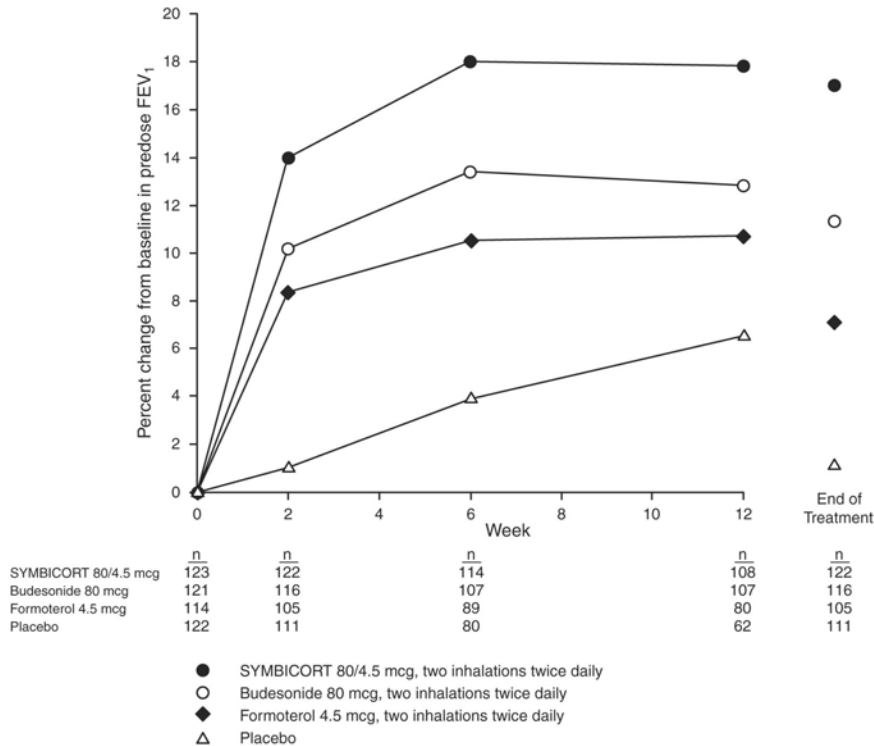
\*These criteria were assessed on a daily basis irrespective of the timing of the clinic visit, with the exception of FEV<sub>1</sub>, which was assessed at each clinic visit.

†Individual criteria are shown for patients meeting any predefined asthma event, regardless of withdrawal status.

‡For the criterion of nighttime awakening due to asthma, patients were allowed to remain in the study at the discretion of the investigator if none of the other criteria were met.

Mean percent change from baseline in predose FEV<sub>1</sub> over 12 weeks is displayed in Figure 2.

**Figure 2 - Mean Percent Change From Baseline in Predose FEV<sub>1</sub> Over 12 Weeks (Study 2)**



Efficacy results for other secondary end points, including quality of life, were similar to those observed in Study 1.

### Onset and Duration of Action and Progression of Improvement in Asthma Control

The onset of action and progression of improvement in asthma control were evaluated in the two pivotal clinical studies. The median time to onset of clinically significant bronchodilation (>15% improvement in FEV<sub>1</sub>) was seen within 15 minutes. Maximum improvement in FEV<sub>1</sub> occurred within 3 hours, and clinically significant improvement was maintained over 12 hours. Figures 3 and 4 show the percent change from baseline in postdose FEV<sub>1</sub> over 12 hours on the day of randomization and on the last day of treatment for Study 1.

Reduction in asthma symptoms and in albuterol rescue use, as well as improvement in morning and evening PEF, occurred

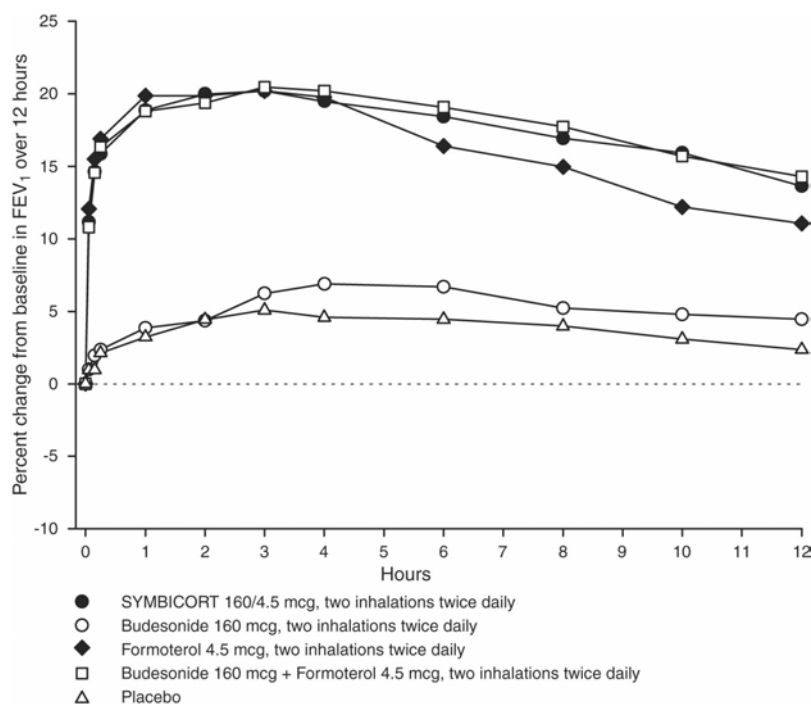
within 1 day of the first dose of SYMBICORT; improvement in these variables was maintained over the 12 weeks of therapy.

Following the initial dose of SYMBICORT, FEV<sub>1</sub> improved markedly during the first 2 weeks of treatment, continued to show improvement at the Week 6 assessment, and was maintained through Week 12 for both studies.

No diminution in the 12-hour bronchodilator effect was observed with either SYMBICORT 80/4.5 mcg or SYMBICORT 160/4.5 mcg, as assessed by FEV<sub>1</sub>, following 12 weeks of therapy or at the last available visit.

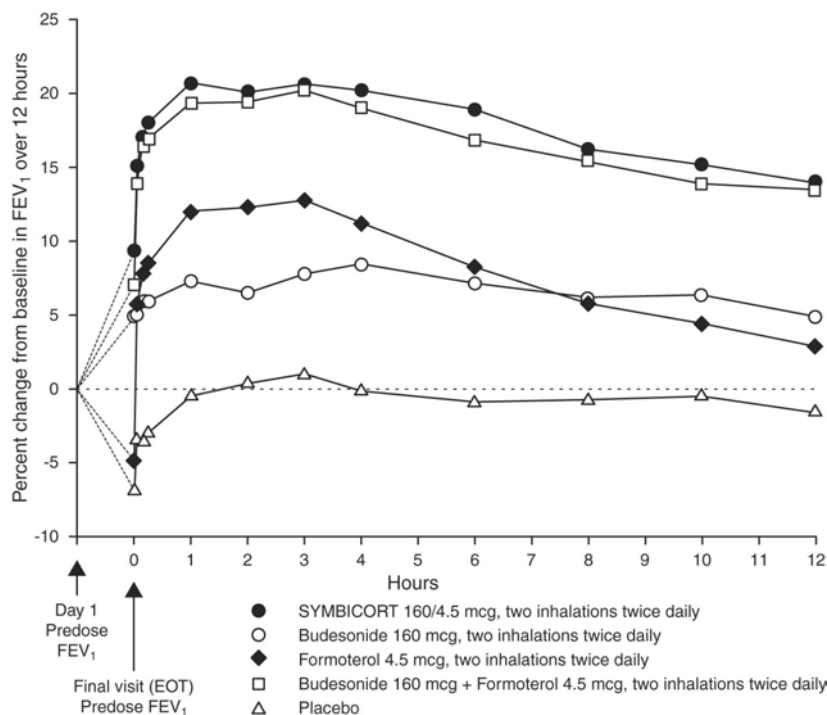
FEV<sub>1</sub> data from Study 1 evaluating SYMBICORT 160/4.5 mcg is displayed in Figures 3 and 4.

**Figure 3 - Mean Percent Change From Baseline in FEV<sub>1</sub> on Day of Randomization (Study 1)**



**Figure 4 - Mean Percent Change From Baseline in FEV<sub>1</sub> At End of Treatment (Study 1)**





## 14.2 Chronic Obstructive Pulmonary Disease (COPD)

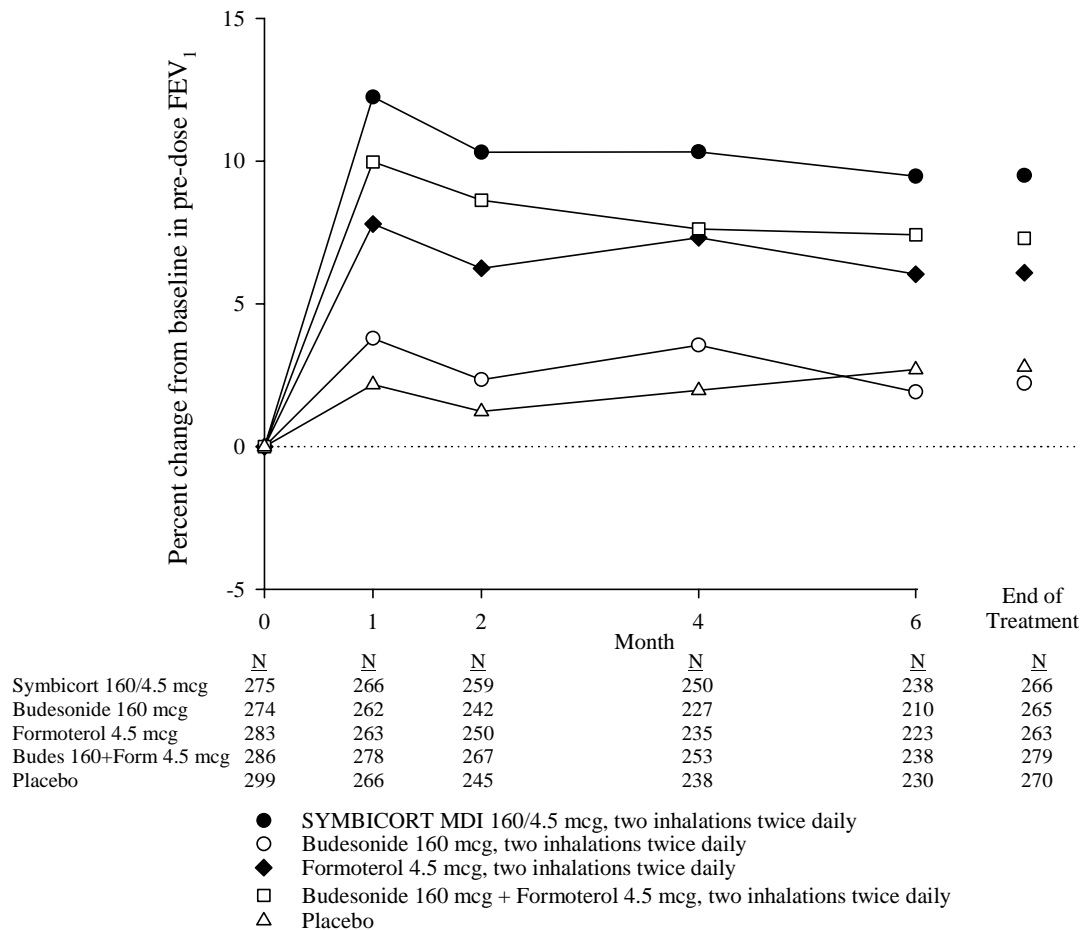
The efficacy of SYMBICORT 80/4.5 and SYMBICORT 160/4.5 in the maintenance treatment of airflow obstruction in COPD patients was evaluated in two randomized, double-blind, placebo-controlled multinational studies, conducted over 6 months (Study 1) and 12 months (Study 2), in a total of 3668 patients (2416 males and 1252 females). The majority of patients (93%) were Caucasian. All patients were required to be at least 40 years of age, with a FEV<sub>1</sub> of less than or equal to 50% predicted, a clinical diagnosis of COPD with symptoms for at least 2 years, and a smoking history of at least 10 pack years, prior to entering the trial. The mean prebronchodilator FEV<sub>1</sub> at baseline of the patients enrolled in the study was 34% predicted. Forty-eight percent of the patients enrolled were on inhaled corticosteroids and 52.7% of patients were on short-acting anticholinergic bronchodilators during run-in. On randomization, inhaled corticosteroids were discontinued, and ipratropium bromide was allowed at a stable dose for those patients previously treated with short-acting anticholinergic bronchodilators. The co-primary efficacy variables in both studies were the change from baseline in average pre-dose and 1-hour post-dose FEV<sub>1</sub> over the treatment period. The results of both studies 1 and 2 are described below.

### Study 1

This was a 6-month, placebo-controlled study of 1704 COPD patients (mean % predicted FEV<sub>1</sub> at baseline ranging from 33.5% -34.7%) conducted to demonstrate the efficacy and safety of SYMBICORT in the treatment of airflow obstruction in COPD. The patients were randomized to one of the

following treatment groups: SYMBICORT 160/4.5 (n=277), SYMBICORT 80/4.5 (n=281), budesonide 160 mcg + formoterol 4.5 mcg (n=287), budesonide 160 mcg (n=275), formoterol 4.5 mcg (n=284), or placebo (n=300). Patients receiving SYMBICORT 160/4.5 mcg, two inhalations twice daily, had significantly greater mean improvements from baseline in pre-dose FEV<sub>1</sub> averaged over the treatment period [0.08 L, 10.7%] compared with formoterol 4.5 mcg [0.04 L, 6.9%] and placebo [0.01 L, 2.2%] (See Figure 5). Patients receiving SYMBICORT 80/4.5 mcg, two inhalations twice daily, did not have significantly greater improvement from baseline in the pre-dose FEV<sub>1</sub> averaged over the treatment period compared with formoterol 4.5 mcg.

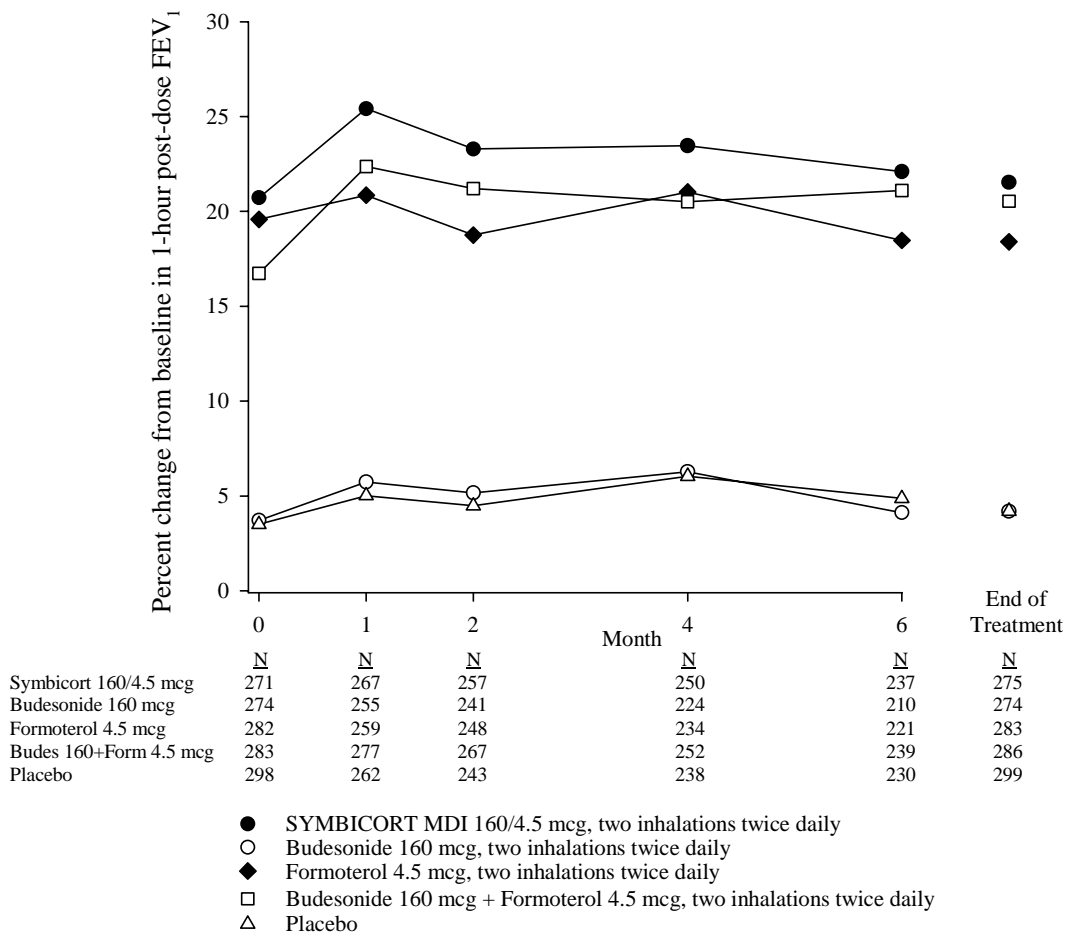
**Figure 5 Mean Percent Change From Baseline in Pre-dose FEV<sub>1</sub> Over 6 months (Study 1)**



Patients receiving SYMBICORT 160/4.5 mcg, two inhalations twice daily, had significantly greater mean improvements from baseline in 1-hour post-dose FEV<sub>1</sub> averaged over the treatment period [0.20 L, 22.6%], compared with budesonide

160 mcg [0.03 L, 4.9%] and placebo [0.03 L, 4.1%] (See Figure 6)

**Figure 6 Mean Percent Change From Baseline in 1-hour Post-dose FEV<sub>1</sub> Over 6 months (Study 1)**



## Study 2

This was a 12-month, placebo-controlled study of 1964 COPD patients (mean % predicted FEV<sub>1</sub> at baseline ranging from 33.7% -35.5%) conducted to demonstrate the efficacy and safety of SYMBICORT in the treatment of airflow obstruction in COPD. The patients were randomized to one of the following treatment groups: SYMBICORT 160/4.5 (n=494), SYMBICORT 80/4.5 (n=494), formoterol 4.5 mcg (n=495), or placebo (n=481). Patients receiving SYMBICORT 160/4.5 mcg, two inhalations twice daily, had significantly greater improvements from baseline in mean pre-dose FEV<sub>1</sub> averaged over the treatment period [0.10 L, 10.8%] compared with formoterol 4.5 mcg [0.06 L, 7.2%] and placebo [0.01 L, 2.8%]. Patients receiving SYMBICORT 80/4.5 mcg, two inhalations twice daily, did not have significantly greater improvements from baseline in the mean pre-dose FEV<sub>1</sub>

averaged over the treatment period compared to formoterol. Patients receiving SYMBICORT 160/4.5 mcg, two inhalations twice daily, also had significantly greater mean improvements from baseline in 1-hour post-dose FEV<sub>1</sub> averaged over the treatment period [0.21 L, 24.0%] compared with placebo [0.02 L, 5.2%].

Serial FEV<sub>1</sub> measures over 12 hours were obtained in a subset of patients in Study 1 (n=99) and Study 2 (n=121). The median time to onset of bronchodilation, defined as an FEV<sub>1</sub> increase of 15% or greater from baseline, occurred at 5 minutes post-dose. Maximum improvement (calculated as the average change from baseline at each timepoint) in FEV<sub>1</sub> occurred at approximately 2 hours post-dose.

In both Studies 1 and 2, improvements in secondary endpoints of morning and evening peak expiratory flow and reduction in rescue medication use were supportive of the efficacy of SYMBICORT 160/4.5.

## 16 HOW SUPPLIED/STORAGE AND HANDLING

SYMBICORT is available in two strengths and is supplied in the following package sizes:

### Dosage Forms and Strengths

Package Size	NDC
SYMBICORT 80/4.5, 120 inhalations	0186-0372-20
SYMBICORT 80/4.5, 60 inhalations (institutional pack)	0186-0372-28
SYMBICORT 160/4.5, 120 inhalations	0186-0370-20
SYMBICORT 160/4.5, 60 inhalations (institutional pack)	0186-0370-28

Each strength is supplied as a pressurized aluminium canister with an attached counting device, a red plastic actuator body with a white mouthpiece, and attached gray dust cap. Each 120 inhalation canister has a net fill weight of 10.2 grams and each 60 inhalation canister has a net fill weight of 6.9 grams (SYMBICORT 80/4.5) or 6 grams (SYMBICORT 160/4.5). Each canister is packaged in a foil overwrap pouch with

desiccant sachet and placed into a carton. Each carton contains one canister and a Medication Guide.

The SYMBICORT canister should only be used with the SYMBICORT actuator, and the SYMBICORT actuator should not be used with any other inhalation drug product.

The correct amount of medication in each inhalation cannot be ensured after the labeled number of inhalations from the canister have been used, even though the inhaler may not feel completely empty and may continue to operate. The inhaler should be discarded when the labeled number of inhalations have been used or within 3 months after removal from the foil pouch. Never immerse the canister into water to determine the amount remaining in the canister (“float test”).

Store at controlled room temperature 20°C to 25°C (68°F to 77°F) [see USP]. Store the inhaler with the mouthpiece down.

For best results, the canister should be at room temperature before use. Shake well for 5 seconds before using.

Keep out of the reach of children.

#### **CONTENTS UNDER PRESSURE.**

Do not puncture or incinerate. Do not store near heat or open flame. Exposure to temperatures over 120°F may cause bursting. Never throw container into fire or incinerator.

## **17 PATIENT COUNSELING INFORMATION**

*See Medication Guide (17.6)*

### **17.1 Asthma-Related Death**

**Patients with asthma should be informed that formoterol fumarate dihydrate, one of the active ingredients in SYMBICORT, increases the risk of asthma-related death and may increase the risk of asthma-related hospitalization in pediatric and adolescent patients.** They should also be informed that currently available data are inadequate to determine whether concurrent use of inhaled corticosteroids or other long-term asthma control drugs mitigates the increased risk of asthma-related death from LABA.

### **17.2 Not for Acute Symptoms**

SYMBICORT is not meant to relieve acute asthma symptoms or exacerbations of COPD and extra doses should not be used for that purpose. Acute symptoms should be treated with an inhaled, short-acting beta<sub>2</sub>-agonist such as albuterol. (The

physician should provide the patient with such medication and instruct the patient in how it should be used.)

Patients should be instructed to notify their physician immediately if they experience any of the following:

- Decreasing effectiveness of inhaled, short-acting beta<sub>2</sub>-agonists
- Need for more inhalations than usual of inhaled, short-acting beta<sub>2</sub>-agonists
- Significant decrease in lung function as outlined by the physician

Patients should not stop therapy with SYMBICORT without physician/provider guidance since symptoms may recur after discontinuation.

### **17.3 Do Not Use Additional Long-Acting Beta<sub>2</sub>-Agonists**

When patients are prescribed SYMBICORT, other long-acting beta<sub>2</sub>-agonists for asthma and COPD should not be used.

### **17.4 Risks Associated With Corticosteroid Therapy**

**Local Effects:** Patients should be advised that localized infections with *Candida albicans* occurred in the mouth and pharynx in some patients. If oropharyngeal candidiasis develops, it should be treated with appropriate local or systemic (i.e., oral) antifungal therapy while still continuing therapy with SYMBICORT, but at times therapy with SYMBICORT may need to be temporarily interrupted under close medical supervision. Rinsing the mouth after inhalation is advised.

**Pneumonia:** Patients with COPD have a higher risk of pneumonia and should be instructed to contact their healthcare provider if they develop symptoms of pneumonia.

**Immunosuppression:** Patients who are on immunosuppressant doses of corticosteroids should be warned to avoid exposure to chicken pox or measles and, if exposed, to consult their physician without delay. Patients should be informed of potential worsening of existing tuberculosis, fungal, bacterial, viral, or parasitic infections, or ocular herpes simplex.

**Hypercorticism and Adrenal Suppression:** Patients should be advised that SYMBICORT may cause systemic corticosteroid effects of hypercorticism and adrenal suppression. Additionally, patients should be instructed that deaths due to adrenal insufficiency have occurred during and after transfer from systemic corticosteroids. Patients should taper slowly from systemic corticosteroids if transferring to SYMBICORT.

Reduction in Bone Mineral Density: Patients who are at an increased risk for decreased BMD should be advised that the use of corticosteroids may pose an additional risk.

Reduced Growth Velocity: Patients should be informed that orally inhaled corticosteroids, component of SYMBICORT, may cause a reduction in growth velocity when administered to pediatric patients. Physicians should closely follow the growth of children and adolescents taking corticosteroids by any route.

Ocular Effects: Long-term use of inhaled corticosteroids may increase the risk of some eye problems (cataracts or glaucoma); regular eye examinations should be considered.

### **17.5 Risks Associated With Beta-Agonist Therapy**

Patients should be informed of adverse effects associated with beta<sub>2</sub>-agonists, such as palpitations, chest pain, rapid heart rate, tremor, or nervousness.

### **17.6 Medication Guide**

SYMBICORT is a trademark of the AstraZeneca group of companies.

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Manufactured for: AstraZeneca LP, Wilmington, DE 19850

By: AstraZeneca Dunkerque Production, Dunkerque, France

Product of France

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