TREANDA® (bendamustine hydrochloride) for Injection, for intravenous infusion

1.2 Non-Hodgkin’s Lymphoma (NHL)

Full Prescribing Information: Contents

1 INDICATIONS AND USAGE
1.1 Chronic Lymphocytic Leukemia (CLL)
   • Efficacy relative to first line therapies other than chlorambucil has not been established. (1.1)
   • Indolent B-cell non-Hodgkin’s lymphoma (NHL) that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen. (1.2)

1.2 Non-Hodgkin’s Lymphoma (NHL)

2 DOSAGE AND ADMINISTRATION
2.1 Dosing Instructions for CLL
   • 100 mg/m² infused intravenously over 30 minutes on Days 1 and 2 of a 28-day cycle, up to 6 cycles (2.1)
   • Dose modifications for hematologic toxicity: for Grade 3 or greater toxicity, reduce dose to 50 mg/m² on Days 1 and 2; if Grade 3 or greater toxicity recurs, reduce dose to 25 mg/m² on Days 1 and 2. (2.1)
   • Dose modifications for non-hematologic toxicity: for clinically significant Grade 3 or greater toxicity, reduce the dose to 50 mg/m² on Days 1 and 2 of each cycle. (2.1)
   • Dose re-escalation may be considered. (2.1)
   • For NHL:
     • 120 mg/m² infused intravenously over 60 minutes on Days 1 and 2 of a 21-day cycle, up to 8 cycles (2.2)
     • Dose modifications for hematologic toxicity: for Grade 4 toxicity, reduce the dose to 90 mg/m² on Days 1 and 2 of each cycle; if Grade 4 toxicity recurs, reduce the dose to 60 mg/m² on Days 1 and 2 of each cycle. (2.2)
     • Dose modifications for non-hematologic toxicity: for Grade 3 or greater toxicity, reduce the dose to 90 mg/m² on Days 1 and 2 of each cycle; if Grade 3 or greater toxicity recurs, reduce the dose to 60 mg/m² on Days 1 and 2 of each cycle. (2.2)
     • General Dosing Considerations:
       • Delay treatment for Grade 4 hematologic toxicity or clinically significant ≥ Grade 2 non-hematologic toxicity. (2.1, 2.2)
       • TREATANDA for Injection must be reconstituted and further diluted prior to infusion. (2.3)

3 DOSAGE FORMS AND STRENGTHS
TREANDA® for Injection single-use vial containing either 25 mg or 100 mg of bendamustine HCl as lyophilized powder

4 CONTRAINDICATIONS
Known hypersensitivity to bendamustine or mannitol. (4)

5 WARNINGS AND PRECAUTIONS
5.1 Myelosuppression
5.2 Infecations

6 ADVERSE REACTIONS
Most common non-hematologic adverse reactions for CLL (frequency ≥15%) are pyrexia, nausea, and vomiting. (6.1)
Most common non-hematologic adverse reactions for NHL (frequency ≥15%) are nausea, fatigue, vomiting, diarrhea, pyrexia, constipation, anorexia, cough, headache, weight decreased, dyspnea, rash, and stomatitis. (6.2)

7 DRUG INTERACTIONS
Concomitant CYPIA2 inducers or inhibitors have the potential to affect the exposure of bendamustine. (7)

8 USE IN SPECIFIC POPULATIONS
- Renal impairment: Do not use if CrCL is <40 mL/min. Use with caution in lesser degrees of renal impairment. (8.6)
- Hepatic impairment: Do not use in moderate or severe hepatic impairment. Use with caution in mild hepatic impairment. (8.7)

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Revised 02/2010
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8.7 Hepatic Impairment
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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE
1.1 Chronic Lymphocytic Leukemia (CLL)
TREANDA® is indicated for the treatment of patients with chronic lymphocytic leukemia. Efficacy relative to first line therapies other than chlorambucil has not been established.

1.2 Non-Hodgkin’s Lymphoma (NHL)
TREANDA for Injection is indicated for the treatment of patients with indolent B-cell non-Hodgkin’s lymphoma that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen.

2 DOSAGE AND ADMINISTRATION
2.1 Dosing Instructions for CLL
Recommended Dose:
The recommended dose is 100 mg/m² administered intravenously over 30 minutes on Days 1 and 2 of a 28-day cycle, up to 6 cycles.

Dose Delays, Dose Modifications and Reination of Therapy for CLL:
TREANDA administration should be delayed in the event of Grade 4 hematologic toxicity or clinically significant ≥ Grade 2 non-hematologic toxicity. Once non-hematologic toxicity has recovered to ≤ Grade 1 and/or the blood counts have improved [Absolute Neutrophil Count (ANC) ≥ 1 x 10^9/L, platelets ≥ 75 x 10^9/L], TREANDA can be reinitiated at the discretion of the treating physician. In addition, dose reduction may be warranted. [See Warnings and Precautions (5.1)]

Dose modifications for hematologic toxicity: for Grade 3 or greater toxicity, reduce the dose to 50 mg/m² on Days 1 and 2 of each cycle; if Grade 3 or greater toxicity recurs, reduce the dose to 25 mg/m² on Days 1 and 2 of each cycle.

Dose modifications for non-hematologic toxicity: for clinically significant Grade 3 or greater toxicity, reduce the dose to 50 mg/m² on Days 1 and 2 of each cycle.

Dose re-escalation in subsequent cycles may be considered at the discretion of the treating physician.

Dose Delays, Dose Modifications and Reinitiation of Therapy for NHL:
TREANDA administration should be delayed in the event of a Grade 4 hematologic toxicity or clinically significant ≥ Grade 2 non-hematologic toxicity. Once non-hematologic toxicity has recovered to ≤ Grade 1 and/or the blood counts have improved [Absolute Neutrophil Count (ANC) ≥ 1 x 10^9/L, platelets ≥ 75 x 10^9/L], TREANDA can be reinitiated at the discretion of the treating physician. In addition, dose reduction may be warranted. [See Warnings and Precautions (5.1)]

Dose modifications for hematologic toxicity: for Grade 4 toxicity, reduce the dose to 90 mg/m² on Days 1 and 2 of each cycle; if Grade 4 toxicity recurs, reduce the dose to 60 mg/m² on Days 1 and 2 of each cycle.

Dose modifications for non-hematologic toxicity: for Grade 3 or greater toxicity, reduce the dose to 90 mg/m² on Days 1 and 2 of each cycle; if Grade 3 or greater toxicity recurs, reduce the dose to 60 mg/m² on Days 1 and 2 of each cycle.

2.3 Reconstitution/Preparation for Intravenous Administration

• Aseptically reconstitute each TREANDA vial as follows:
  o 25 mg TREANDA vial: Add 5 mL of only Sterile Water for Injection, USP.
  o 100 mg TREANDA vial: Add 20 mL of only Sterile Water for Injection, USP.

Shake well to yield a clear, colorless to a pale yellow solution with a bendamustine HCl concentration of 5 mg/mL. The lyophilized powder should completely dissolve in 5 minutes. If particulate matter is observed, the reconstituted product should not be used.

• Aseptically withdraw the volume needed for the required dose (based on 5 mg/mL concentration) and immediately transfer to a 500 mL infusion bag of 0.9% Sodium Chloride Injection, USP (normal saline). As an alternative to 0.9% Sodium Chloride Injection, USP (normal saline), a 500
mL infusion bag of 2.5% Dextrose/0.45% Sodium Chloride Injection, USP, may be considered. The resulting final concentration of bendamustine HCl in the infusion bag should be within 0.2 – 0.6 mg/mL. The reconstituted solution must be transferred to the infusion bag within 30 minutes of reconstitution. After transferring, thoroughly mix the contents of the infusion bag. The admixture should be a clear and colorless to slightly yellow solution.

Use Sterile Water for Injection, USP, for reconstitution and then either 0.9% Sodium Chloride Injection, USP, or 2.5% Dextrose/0.45% Sodium Chloride Injection, USP, for dilution, as outlined above. No other diluents have been shown to be compatible.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit. Any unused solution should be discarded according to institutional procedures for antineoplastics.

2.4 Admixture Stability
TREANDA contains no antimicrobial preservative. The admixture should be prepared as close as possible to the time of patient administration. Once diluted with either 0.9% Sodium Chloride Injection, USP, or 2.5% Dextrose/0.45% Sodium Chloride Injection, USP, the final admixture is stable for 24 hours when stored refrigerated (2-8°C or 36-47°F) or for 3 hours when stored at room temperature (15-30°C or 59-86°F) and room light. Administration of TREANDA must be completed within this period.

3 DOSAGE FORMS AND STRENGTHS
TREANDA for Injection single-use vial containing either 25 mg or 100 mg of bendamustine HCl as white to off-white lyophilized powder.

4 CONTRAINDICATIONS
TREANDA is contraindicated in patients with a known hypersensitivity (e.g., anaphylactic and anaphylactoid reactions) to bendamustine or mannitol. [See Warnings and Precautions (5.3)]

5 WARNINGS AND PRECAUTIONS
5.1 Myelosuppression
Patients treated with TREANDA are likely to experience myelosuppression. In the two NHL studies, 98% of patients had Grade 3-4 myelosuppression (see Table 4). Three patients (2%) died from myelosuppression-related adverse reactions; one each from neutropenic sepsis, diffuse alveolar hemorrhage with Grade 3 thrombocytopenia, and pneumonia from an opportunistic infection (CMV).

In the event of treatment-related myelosuppression, monitor leukocytes, platelets, hemoglobin (Hgb), and neutrophils closely. In the clinical trials, blood counts were monitored every week initially. Hematologic nadirs were observed predominantly in the third week of therapy. Hematologic nadirs may require dose delays if recovery to the recommended values have not occurred by the first day of the next scheduled cycle. Prior to the initiation of the next cycle of therapy, the ANC should be ≥ 1 x 10^9/L and the platelet count should be ≥ 75 x 10^9/L. [See Dosage and Administration (2.1) and (2.2)]

5.2 Infections
Infection, including pneumonia and sepsis, has been reported in patients in clinical trials and in post-marketing reports. Infection has been associated with hospitalization, septic shock and death. Patients with myelosuppression following treatment with TREANDA are more susceptible to infections. Patients with myelosuppression following TREANDA treatment should be advised to contact a physician if they have symptoms or signs of infection.

5.3 Infusion Reactions and Anaphylaxis
Infusion reactions to TREANDA have occurred commonly in clinical trials. Symptoms include fever, chills, pruritus and rash. In rare instances severe anaphylactic and anaphylactoid reactions have occurred, particularly in the second and subsequent cycles of therapy. Monitor clinically and discontinue drug for severe reactions. Patients should be asked about symptoms suggestive of infusion reactions after their first cycle of therapy. Patients who experienced Grade 3 or worse allergic-type reactions were not typically rechallenged. Measures to prevent severe reactions, including antihistamines, antipyretics and corticosteroids should be considered in subsequent cycles in patients who have previously experienced Grade 1 or 2 infusion reactions. Discontinuation should be considered in patients with Grade 3 or 4 infusion reactions.

5.4 Tumor Lysis Syndrome
Tumor lysis syndrome associated with TREANDA treatment has been reported in patients in clinical trials and in post-marketing reports. The onset tends to be within the first treatment cycle of TREANDA and, without intervention, may lead to acute renal failure and death. Preventive measures include maintaining adequate volume status, and close monitoring of blood chemistry, particularly potassium and uric acid levels. Allopurinol has also been used during the beginning of TREANDA therapy. However, there may be an increased risk of severe skin toxicity when TREANDA and allopurinol are administered concomitantly [see Warnings and Precautions (5.5)].

5.5 Skin Reactions
A number of skin reactions have been reported in clinical trials and post-marketing safety reports. These events have included rash, toxic skin reactions and bullous exanthema. Some events occurred when TREANDA was given in combination with other anticancer agents, so the precise relationship to TREANDA is uncertain.

In a study of TREANDA (90 mg/m^2) in combination with rituximab, one case of toxic epidermal necrolysis (TEN) occurred. TEN has been reported for rituximab (see rituximab package insert). Cases of Stevens-Johnson syndrome (SJS) and TEN, some fatal, have been reported when TREANDA was administered concomitantly with allopurinol and other medications known to cause these syndromes. The relationship to TREANDA cannot be determined.

Where skin reactions occur, they may be progressive and increase in severity with further treatment. Therefore, patients with skin reactions should be monitored closely. If skin reactions are severe or progressive, TREANDA should be withheld or discontinued.
5.6 Other Malignancies
There are reports of pre-malignant and malignant diseases that have developed in patients who have been treated with TREANDA, including myelodysplastic syndrome, myeloproliferative disorders, acute myeloid leukemia and bronchial carcinoma. The association with TREANDA therapy has not been determined.

5.7 Extravasation
There are postmarketing reports of bendamustine extravasations resulting in hospitalizations from erythema, marked swelling, and pain. Precautions should be taken to avoid extravasation, including monitoring of the intravenous infusion site for redness, swelling, pain, infection, and necrosis during and after administration of TREANDA.

5.8 Use in Pregnancy
TREANDA can cause fetal harm when administered to a pregnant woman. Single intraperitoneal doses of bendamustine in mice and rats administered during organogenesis caused an increase in resorptions, skeletal and visceral malformations, and decreased fetal body weights. [See Use in Specific Populations (8.1)]

6 ADVERSE REACTIONS
The data described below reflect exposure to TREANDA in 349 patients who participated in an actively-controlled trial (N=153) for the treatment of CLL and two single-arm studies (N=176) for the treatment of indolent B-cell NHL. 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.

The following serious adverse reactions have been associated with TREANDA in clinical trials and are discussed in greater detail in other sections of the label.

- Myelosuppression [See Warnings and Precautions (5.1)]
- Infections [See Warnings and Precautions (5.2)]
- Infusion Reactions and Anaphylaxis [See Warnings and Precautions (5.3)]
- Tumor Lysis Syndrome [See Warnings and Precautions (5.4)]
- Skin Reactions [See Warnings and Precautions (5.5)]
- Other Malignancies [See Warnings and Precautions (5.6)]

6.1 Clinical Trials Experience in CLL
The data described below reflect exposure to TREANDA in 153 patients. TREANDA was studied in an active-controlled trial. The population was 45-77 years of age, 63% male, 100% white, and had treatment naïve CLL. All patients started the study at a dose of 100 mg/m² intravenously over 30 minutes on days 1 and 2 every 28 days.

Adverse reactions were reported according to NCI CTC v.2.0. In the randomized CLL clinical study, non-hematologic adverse reactions (any grade) in the TREANDA group that occurred with a frequency greater than 15% were pyrexia (24%), nausea (20%), and vomiting (16%).

Other adverse reactions seen frequently in one or more studies included asthenia, fatigue, malaise, and weakness; dry mouth; somnolence; cough; constipation; headache; mucosal inflammation and stomatitis.

Worsening hypertension was reported in 4 patients treated with TREANDA in the randomized CLL clinical study and none treated with chlorambucil. Three of these 4 adverse reactions were described as a hypertensive crisis and were managed with oral medications and resolved.

The most frequent adverse reactions leading to study withdrawal for patients receiving TREANDA were hypersensitivity (2%) and pyrexia (1%).

Table 1 contains the treatment emergent adverse reactions, regardless of attribution, that were reported in ≥ 5% of patients in either treatment group in the randomized CLL clinical study.
Table 1: Non-Hematologic Adverse Reactions Occurring in Randomized CLL Clinical Study in at Least 5% of Patients

<table>
<thead>
<tr>
<th>Preferred term</th>
<th>All Grades</th>
<th>Grade 3/4</th>
<th>All Grades</th>
<th>Grade 3/4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients with at least 1 adverse reaction</td>
<td>121 (79)</td>
<td>52 (34)</td>
<td>96 (67)</td>
<td>25 (17)</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>31 (20)</td>
<td>1 (&lt;1)</td>
<td>21 (15)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>24 (16)</td>
<td>1 (&lt;1)</td>
<td>9 (6)</td>
<td>0</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>14 (9)</td>
<td>2 (1)</td>
<td>5 (3)</td>
<td>0</td>
</tr>
<tr>
<td>General disorders and administration site conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pyrexia</td>
<td>36 (24)</td>
<td>6 (4)</td>
<td>8 (6)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>14 (9)</td>
<td>2 (1)</td>
<td>8 (6)</td>
<td>0</td>
</tr>
<tr>
<td>Asthenia</td>
<td>13 (8)</td>
<td>0</td>
<td>6 (4)</td>
<td>0</td>
</tr>
<tr>
<td>Chills</td>
<td>9 (6)</td>
<td>0</td>
<td>1 (&lt;1)</td>
<td>0</td>
</tr>
<tr>
<td>Immune system disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypersensitivity</td>
<td>7 (5)</td>
<td>2 (1)</td>
<td>3 (2)</td>
<td>0</td>
</tr>
<tr>
<td>Infections and infestations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>10 (7)</td>
<td>0</td>
<td>12 (8)</td>
<td>0</td>
</tr>
<tr>
<td>Infection</td>
<td>9 (6)</td>
<td>3 (2)</td>
<td>1 (&lt;1)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>Herpes simplex</td>
<td>5 (3)</td>
<td>0</td>
<td>7 (5)</td>
<td>0</td>
</tr>
<tr>
<td>Investigations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight decreased</td>
<td>11 (7)</td>
<td>0</td>
<td>5 (3)</td>
<td>0</td>
</tr>
<tr>
<td>Metabolism and nutrition disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperuricemia</td>
<td>11 (7)</td>
<td>3 (2)</td>
<td>2 (1)</td>
<td>0</td>
</tr>
<tr>
<td>Respiratory, thoracic and mediastinal disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>6 (4)</td>
<td>1 (&lt;1)</td>
<td>7 (5)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td>12 (8)</td>
<td>4 (3)</td>
<td>7 (5)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Pruritus</td>
<td>8 (5)</td>
<td>0</td>
<td>2 (1)</td>
<td>0</td>
</tr>
</tbody>
</table>

The Grade 3 and 4 hematology laboratory test values by treatment group in the randomized CLL clinical study are described in Table 2. These findings confirm the myelosuppressive effects seen in patients treated with TREANDA. Red blood cell transfusions were administered to 20% of patients receiving TREANDA compared with 6% of patients receiving chlorambucil.
Table 2: Incidence of Hematology Laboratory Abnormalities in Patients Who Received TREANDA or Chlorambucil in the Randomized CLL Clinical Study

<table>
<thead>
<tr>
<th>Laboratory Abnormality</th>
<th>TREANDA N=150</th>
<th>Chlorambucil N=141</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades n (%)</td>
<td>Grade 3/4 n (%)</td>
</tr>
<tr>
<td>Hemoglobin Decreased</td>
<td>134 (89)</td>
<td>20 (13)</td>
</tr>
<tr>
<td>Platelets Decreased</td>
<td>116 (77)</td>
<td>16 (11)</td>
</tr>
<tr>
<td>Leukocytes Decreased</td>
<td>92 (61)</td>
<td>42 (28)</td>
</tr>
<tr>
<td>Lymphocytes Decreased</td>
<td>102 (68)</td>
<td>70 (47)</td>
</tr>
<tr>
<td>Neutrophils Decreased</td>
<td>113 (75)</td>
<td>65 (43)</td>
</tr>
</tbody>
</table>

In the randomized CLL clinical study, 34% of patients had bilirubin elevations, some without associated significant elevations in AST and ALT. Grade 3 or 4 increased bilirubin occurred in 3% of patients. Increases in AST and ALT of Grade 3 or 4 were limited to 1% and 3% of patients, respectively. Patients treated with TREANDA may also have changes in their creatinine levels. If abnormalities are detected, monitoring of these parameters should be continued to ensure that significant deterioration does not occur.

6.2 Clinical Trials Experience in NHL

The data described below reflect exposure to TREANDA in 176 patients with indolent B-cell NHL treated in two single-arm studies. The population was 31-84 years of age, 60% male, and 40% female. The race distribution was 89% White, 7% Black, 3% Hispanic, 1% other, and <1% Asian. These patients received TREANDA at a dose of 120 mg/m² intravenously on Days 1 and 2 for up to 8 21-day cycles.

The adverse reactions occurring in at least 5% of the NHL patients, regardless of severity, are shown in Table 3. The most common non-hematologic adverse reactions (≥30%) were nausea (75%), fatigue (57%), vomiting (40%), diarrhea (37%) and pyrexia (34%). The most common non-hematologic Grade 3 or 4 adverse reactions (≥5%) were fatigue (11%), febrile neutropenia (6%), and pneumonia, hypokalemia and dehydration, each reported in 5% of patients.

Table 3: Non-Hematologic Adverse Reactions Occurring in at Least 5% of NHL Patients Treated with TREANDA by System Organ Class and Preferred Term (N=176)

<table>
<thead>
<tr>
<th>System organ class</th>
<th>Preferred term</th>
<th>Number (%) of patients*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>All Grades</td>
</tr>
<tr>
<td>Total number of patients with at least 1 adverse reaction</td>
<td>176 (100)</td>
<td>94 (53)</td>
</tr>
<tr>
<td><strong>Cardiac disorders</strong></td>
<td>Tachycardia</td>
<td>13 (7)</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal disorders</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>132 (75)</td>
<td>7 (4)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>71 (40)</td>
<td>5 (3)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>65 (37)</td>
<td>6 (3)</td>
</tr>
<tr>
<td>Constipation</td>
<td>51 (29)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>Stomatitis</td>
<td>27 (15)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>22 (13)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>20 (11)</td>
<td>0</td>
</tr>
<tr>
<td>Gastroesophageal reflux disease</td>
<td>18 (10)</td>
<td>0</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>15 (9)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>Abdominal pain upper</td>
<td>8 (5)</td>
<td>0</td>
</tr>
<tr>
<td>Abdominal distension</td>
<td>8 (5)</td>
<td>0</td>
</tr>
<tr>
<td><strong>General disorders and administration site conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>101 (57)</td>
<td>19 (11)</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>59 (34)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Chills</td>
<td>24 (14)</td>
<td>0</td>
</tr>
<tr>
<td>Edema peripheral</td>
<td>23 (13)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>Asthenia</td>
<td>19 (11)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Chest pain</td>
<td>11 (6)</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td>Infusion site pain</td>
<td>11 (6)</td>
<td>0</td>
</tr>
</tbody>
</table>
## Pain
- Pain: 10 (6) 0
- Catheter site pain: 8 (5) 0

## Infections and infestations
- Herpes zoster: 18 (10) 5 (3)
- Upper respiratory tract infection: 18 (10) 0
- Urinary tract infection: 17 (10) 4 (2)
- Sinusitis: 15 (9) 0
- Pneumonia: 14 (8) 9 (5)
- Febrile Neutropenia: 11 (6) 11 (6)
- Oral Candidiasis: 11 (6) 2 (1)
- Nasopharyngitis: 11 (6) 0

## Investigations
- Weight decreased: 31 (18) 3 (2)

## Metabolism and nutrition disorders
- Anorexia: 40 (23) 3 (2)
- Dehydration: 24 (14) 8 (5)
- Decreased appetite: 22 (13) 1 (<1)
- Hypokalemia: 15 (9) 9 (5)

## Musculoskeletal and connective tissue disorders
- Back pain: 25 (14) 5 (3)
- Arthralgia: 11 (6) 0
- Pain in extremity: 8 (5) 2 (1)
- Bone pain: 8 (5) 0

## Nervous system disorders
- Headache: 36 (21) 0
- Dizziness: 25 (14) 0
- Dysgeusia: 13 (7) 0

## Psychiatric disorders
- Insomnia: 23 (13) 0
- Anxiety: 14 (8) 1 (<1)
- Depression: 10 (6) 0

## Respiratory, thoracic and mediastinal disorders
- Cough: 38 (22) 1 (<1)
- Dyspnea: 28 (16) 3 (2)
- Pharyngolaryngeal pain: 14 (8) 1 (<1)
- Wheezing: 8 (5) 0
- Nasal congestion: 8 (5) 0

## Skin and subcutaneous tissue disorders
- Rash: 28 (16) 1 (<1)
- Pruritus: 11 (6) 0
- Dry skin: 9 (5) 0
- Night sweats: 9 (5) 0
- Hyperhidrosis: 8 (5) 0

## Vascular disorders
- Hypotension: 10 (6) 2 (1)

*Patients may have reported more than 1 adverse reaction.

**NOTE:** Patients counted only once in each preferred term category and once in each system organ class category.

Hematologic toxicities, based on laboratory values and CTC grade, in NHL patients treated in both single arm studies combined are described in Table 4. Clinically important chemistry laboratory values that were new or worsened from baseline and occurred in >1% of patients at grade 3 or 4, in NHL patients treated in both single arm studies combined were hyperglycemia (3%), elevated creatinine (2%), hyponatremia (2%), and hypocalcemia (2%).
Table 4: Incidence of Hematology Laboratory Abnormalities in Patients Who Received TREANDA in the NHL Studies

<table>
<thead>
<tr>
<th>Hematology variable</th>
<th>Percent of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades</td>
</tr>
<tr>
<td>Lymphocytes Decreased</td>
<td>99</td>
</tr>
<tr>
<td>Leukocytes Decreased</td>
<td>94</td>
</tr>
<tr>
<td>Hemoglobin Decreased</td>
<td>88</td>
</tr>
<tr>
<td>Neutrophils Decreased</td>
<td>86</td>
</tr>
<tr>
<td>Platelets Decreased</td>
<td>86</td>
</tr>
</tbody>
</table>

In both studies, serious adverse reactions, regardless of causality, were reported in 37% of patients receiving TREANDA. The most common serious adverse reactions occurring in ≥5% of patients were febrile neutropenia and pneumonia. Other important serious adverse reactions reported in clinical trials and/or post-marketing experience were acute renal failure, cardiac failure, hypersensitivity, skin reactions, pulmonary fibrosis, and myelodysplastic syndrome.

Serious drug-related adverse reactions reported in clinical trials included myelosuppression, infection, pneumonia, tumor lysis syndrome and infusion reactions [see Warnings and Precautions (5)]. Adverse reactions occurring less frequently but possibly related to TREANDA treatment were hemolysis, dysgeusia/taste disorder, atypical pneumonia, sepsis, herpes zoster, erythema, dermatitis, and skin necrosis.

6.3 Post-Marketing Experience

The following adverse reactions have been identified during post-approval use of TREANDA. 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: anaphylaxis, and injection or infusion site reactions including pruritus, irritation, pain, and swelling.

Skin reactions including SJS and TEN have occurred when TREANDA was administered concomitantly with allopurinol and other medications known to cause these syndromes. [See Warnings and Precautions (5.5)].

7 DRUG INTERACTIONS

No formal clinical assessments of pharmacokinetic drug-drug interactions between TREANDA and other drugs have been conducted.

Bendamustine's active metabolites, gamma-hydroxy bendamustine (M3) and N-desmethyl-bendamustine (M4), are formed via cytochrome P450 CYP1A2. Inhibitors of CYP1A2 (e.g., fluvoxamine, ciprofloxacin) have potential to increase plasma concentrations of bendamustine and decrease plasma concentrations of active metabolites. Inducers of CYP1A2 (e.g., omeprazole, smoking) have potential to decrease plasma concentrations of bendamustine and increase plasma concentrations of its active metabolites. Caution should be used, or alternative treatments considered if concomitant treatment with CYP1A2 inhibitors or inducers is needed.

The role of active transport systems in bendamustine distribution has not been fully evaluated. In vitro data suggest that P-glycoprotein, breast cancer resistance protein (BCRP), and/or other efflux transporters may have a role in bendamustine transport.

Based on in vitro data, bendamustine is not likely to inhibit metabolism via human CYP isoenzymes CYP1A2, 2C9/10, 2D6, 2E1, or 3A4/5, or to induce metabolism of substrates of cytochrome P450 enzymes.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category D [See Warnings and Precautions (5.8)]

TREANDA can cause fetal harm when administered to a pregnant woman. Single intraperitoneal doses of bendamustine from 210 mg/m² (70 mg/kg) in mice administered during organogenesis caused an increase in resorptions, skeletal and visceral malformations (exencephaly, cleft palates, accessory rib, and spinal deformities) and decreased fetal body weights. This dose did not appear to be maternally toxic and lower doses were not evaluated. Repeat intraperitoneal dosing in mice on gestation days 7-11 resulted in an increase in resorptions from 75 mg/m² (25 mg/kg) and an increase in abnormalities from 112.5 mg/m² (37.5 mg/kg) similar to those seen after a single intraperitoneal administration. Single intraperitoneal doses of bendamustine from 120 mg/m² (20 mg/kg) in rats administered on gestation days 4, 7, 9, 11, or 13 caused embryo and fetal lethality as indicated by increased resorptions and a decrease in live fetuses. A significant increase in external [effect on tail, head, and herniation of external organs (exomphalos)] and internal (hydronephrosis and hydrocephalus) malformations were seen in dosed rats. There are no adequate and well-controlled studies in pregnant women. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

8.3 Nursing Mothers

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants and tumorigenicity shown for bendamustine in animal studies, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

The safety and effectiveness of TREANDA in pediatric patients have not been established.
8.5 Geriatric Use
In CLL and NHL studies, there were no clinically significant differences in the adverse reaction profile between geriatric (≥ 65 years of age) and younger patients.

**Chronic Lymphocytic Leukemia**
In the randomized CLL clinical study, 153 patients received TREANDA. The overall response rate for patients younger than 65 years of age was 70% (n=82) for TREANDA and 30% (n=69) for chlorambucil. The overall response rate for patients 65 years or older was 47% (n=71) for TREANDA and 22% (n=79) for chlorambucil. In patients younger than 65 years of age, the median progression-free survival was 19 months in the TREANDA group and 8 months in the chlorambucil group. In patients 65 years or older, the median progression-free survival was 12 months in the TREANDA group and 8 months in the chlorambucil group.

**Non-Hodgkin’s Lymphoma**
Efficacy (Overall Response Rate and Duration of Response) was similar in patients < 65 years of age and patients ≥ 65 years. Irrespective of age, all of the 176 patients experienced at least one adverse reaction.

8.6 Renal Impairment
No formal studies assessing the impact of renal impairment on the pharmacokinetics of bendamustine have been conducted. TREANDA should be used with caution in patients with mild or moderate renal impairment. TREANDA should not be used in patients with CrCL < 40 mL/min. [See Clinical Pharmacology (12.3)]

8.7 Hepatic Impairment
No formal studies assessing the impact of hepatic impairment on the pharmacokinetics of bendamustine have been conducted. TREANDA should be used with caution in patients with mild hepatic impairment. TREANDA should not be used in patients with moderate (AST or ALT 2.5-10 X ULN and total bilirubin 1.5-3 X ULN) or severe (total bilirubin > 3 X ULN) hepatic impairment. [See Clinical Pharmacology (12.3)]

8.8 Effect of Gender
No clinically significant differences between genders were seen in the overall incidences of adverse reactions in either CLL or NHL studies.

**Chronic Lymphocytic Leukemia**
In the randomized CLL clinical study, the overall response rate (ORR) for men (n=97) and women (n=56) in the TREANDA group was 60% and 57%, respectively. The ORR for men (n=90) and women (n=58) in the chlorambucil group was 24% and 28%, respectively. In this study, the median progression-free survival for men was 19 months in the TREANDA treatment group and 6 months in the chlorambucil treatment group. For women, the median progression-free survival was 13 months in the TREANDA treatment group and 8 months in the chlorambucil treatment group.

**Non-Hodgkin’s Lymphoma**
The pharmacokinetics of bendamustine were similar in male and female patients with indolent NHL. No clinically-relevant differences between genders were seen in efficacy (ORR and DR).

10 OVERDOSAGE
The intravenous LD50 of bendamustine HCl is 240 mg/m² in the mouse and rat. Toxicities included sedation, tremor, ataxia, convulsions and respiratory distress.

Across all clinical experience, the reported maximum single dose received was 280 mg/m². Three of four patients treated at this dose showed ECG changes considered dose-limiting at 7 and 21 days post-dosing. These changes included QT prolongation (one patient), sinus tachycardia (one patient), ST and T wave deviations (two patients) and left anterior fascicular block (one patient). Cardiac enzymes and ejection fractions remained normal in all patients.

No specific antidote for TREANDA overdose is known. Management of overdose should include general supportive measures, including monitoring of hematologic parameters and ECGs.

11 DESCRIPTION
TREANDA contains bendamustine hydrochloride, an alkylating drug, as the active ingredient. The chemical name of bendamustine hydrochloride is 1H-benzimidazole-2-butanoic acid, 5-[bis(2-chloroethyl)amino]-1 methyl-, monohydrochloride. Its empirical molecular formula is C16H21Cl2N3O2 · HCl, and the molecular weight is 394.7. Bendamustine hydrochloride contains a mechlorethamine group and a benzimidazole heterocyclic ring with a butyric acid substituent, and has the following structural formula:

![Structural formula of bendamustine hydrochloride](image)

TREANDA (bendamustine hydrochloride) for Injection is intended for intravenous infusion only after reconstitution with Sterile Water for Injection, USP, and after further dilution with either 0.9% Sodium Chloride Injection, USP, or 2.5% Dextrose/0.45% Sodium Chloride Injection, USP. It is supplied as a sterile non-pyrogenic white to off-white lyophilized powder in a single-use vial. Each 25-mg vial contains 25 mg of
bendamustine hydrochloride and 42.5 mg of mannitol, USP. Each 100-mg vial contains 100 mg of bendamustine hydrochloride and 170 mg of mannitol, USP. The pH of the reconstituted solution is 2.5 - 3.5.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action
Bendamustine is a bifunctional mechlorethamine derivative containing a purine-like benzimidazole ring. Mechlorethamine and its derivatives form electrophilic alkyl groups. These groups form covalent bonds with electron-rich nucleophilic moieties, resulting in interstrand DNA crosslinks. The bifunctional covalent linkage can lead to cell death via several pathways. Bendamustine is active against both quiescent and dividing cells. The exact mechanism of action of bendamustine remains unknown.

12.3 Pharmacokinetics
Absorption
Following a single IV dose of bendamustine hydrochloride $C_{\text{max}}$ typically occurred at the end of infusion. The dose proportionality of bendamustine has not been studied.

Distribution
In vitro, the binding of bendamustine to human serum plasma proteins ranged from 94-96% and was concentration independent from 1-50 $\mu$g/mL. Data suggest that bendamustine is not likely to displace or to be displaced by highly protein-bound drugs. The blood to plasma concentration ratios in human blood ranged from 0.84 to 0.86 over a concentration range of 10 to 100 $\mu$g/mL indicating that bendamustine distributes freely in human red blood cells. In humans, the mean steady state volume of distribution ($V_{ss}$) was approximately 25 L.

Metabolism
In vitro data indicate that bendamustine is primarily metabolized via hydrolysis to metabolites with low cytotoxic activity. In vitro, studies indicate that two active minor metabolites, M3 and M4, are primarily formed via CYP1A2. However, concentrations of these metabolites in plasma are 1/10 and 1/100 that of the parent compound, respectively, suggesting that the cytotoxic activity is primarily due to bendamustine.

In vitro studies using human liver microsomes indicate that bendamustine does not inhibit CYP1A2, 2C9/10, 2D6, 2E1, or 3A4/5. Bendamustine did not induce metabolism of CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2E1, or CYP3A4/5 enzymes in primary cultures of human hepatocytes.

Elimination
No mass balance study has been undertaken in humans. Preclinical radiolabeled bendamustine studies showed that approximately 90% of drug administered was recovered in excreta primarily in the feces.

Bendamustine clearance in humans is approximately 700 mL/minute. After a single dose of 120 mg/m² bendamustine IV over 1-hour the intermediate $t_1/2$ of the parent compound is approximately 40 minutes. The mean apparent terminal elimination $t_1/2$ of M3 and M4 are approximately 3 hours and 30 minutes respectively. Little or no accumulation in plasma is expected for bendamustine administered on Days 1 and 2 of a 28-day cycle.

Renal Impairment
In a population pharmacokinetic analysis of bendamustine in patients receiving 120 mg/m² there was no meaningful effect of renal impairment (CrCL 40 - 80 mL/min, N=31) on the pharmacokinetics of bendamustine. Bendamustine has not been studied in patients with CrCL < 40 mL/min.

These results are however limited, and therefore bendamustine should be used with caution in patients with mild or moderate renal impairment. Bendamustine should not be used in patients with CrCL < 40 mL/min. [See Use in Specific Populations (8.6)]

Hepatic Impairment
In a population pharmacokinetic analysis of bendamustine in patients receiving 120 mg/m² there was no meaningful effect of mild (total bilirubin $\leq$ ULN, AST $\geq$ ULN to 2.5 x ULN, and/or ALP $\geq$ ULN to 5.0 x ULN, N=26) hepatic impairment on the pharmacokinetics of bendamustine. Bendamustine has not been studied in patients with moderate or severe hepatic impairment.

These results are however limited, and therefore bendamustine should be used with caution in patients with mild hepatic impairment. Bendamustine should not be used in patients with moderate (AST or ALT 2.5 - 10 x ULN and total bilirubin 1.5 - 3 x ULN) or severe (total bilirubin > 3 x ULN) hepatic impairment. [See Use in Specific Populations (8.7)]

Effect of Age
Bendamustine exposure (as measured by AUC and $C_{\text{max}}$) has been studied in patients ages 31 through 84 years. The pharmacokinetics of bendamustine (AUC and $C_{\text{max}}$) were not significantly different between patients less than or greater than/equal to 65 years of age. [See Use in Specific Populations (8.4, 8.5)]

Effect of Gender
The pharmacokinetics of bendamustine were similar in male and female patients. [See Use in Specific Populations (8.8)]

Effect of Race
The effect of race on the safety, and/or efficacy of TREANDA has not been established. Based on a cross-study comparison, Japanese subjects (n = 6) had on average exposures that were 40% higher than non-Japanese subjects receiving the same dose. The significance of this difference on the safety and efficacy of TREANDA in Japanese subjects has not been established.

12.4 Pharmacokinetics/Pharmacodynamics
Based on the pharmacokinetics/pharmacodynamics analyses of data from NHL patients, a correlation was observed between nausea and bendamustine C\textsubscript{max}.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Bendamustine was carcinogenic in mice. After intraperitoneal injections at 37.5 mg/m\textsuperscript{2}/day (12.5 mg/kg/day, the lowest dose tested) and 75 mg/m\textsuperscript{2}/day (25 mg/kg/day) for four days, peritoneal sarcomas in female AB/jena mice were produced. Oral administration at 187.5 mg/m\textsuperscript{2}/day (62.5 mg/kg/day, the only dose tested) for four days induced mammary carcinomas and pulmonary adenomas.

Bendamustine is a mutagen and clastogen. In a reverse bacterial mutation assay (Ames assay), bendamustine was shown to increase revertant frequency in the absence and presence of metabolic activation. Bendamustine was clastogenic in human lymphocytes \textit{in vitro}, and in rat bone marrow cells \textit{in vivo} (increase in micronucleated polychromatic erythrocytes) from 37.5 mg/m\textsuperscript{2}, the lowest dose tested.

Impaired spermatogenesis, azoospermia, and total germinal aplasia have been reported in male patients treated with alkylating agents, especially in combination with other drugs. In some instances spermatogenesis may return in patients in remission, but this may occur only several years after intensive chemotherapy has been discontinued. Patients should be warned of the potential risk to their reproductive capacities.

14 CLINICAL STUDIES

14.1 Chronic Lymphocytic Leukemia (CLL)

The safety and efficacy of TREANDA were evaluated in an open-label, randomized, controlled multicenter trial comparing TREANDA to chlorambucil. The trial was conducted in 301 previously-untreated patients with Binet Stage B or C (Rai Stages I - IV) CLL requiring treatment. Need-to-treat criteria included hematopoietic insufficiency, B-symptoms, rapidly progressive disease or risk of complications from bulky lymphadenopathy. Patients with autoimmune hemolytic anemia or autoimmune thrombocytopenia, Richter’s syndrome, or transformation to prolymphocytic leukemia were excluded from the study.

The patient populations in the TREANDA and chlorambucil treatment groups were balanced with regard to the following baseline characteristics: age (median 63 vs. 66 years), gender (63% vs. 61% male), Binet stage (71% vs. 69% Binet B), lymphadenopathy (79% vs. 82%), enlarged spleen (76% vs. 80%), enlarged liver (48% vs. 46%), hypercellular bone marrow (79% vs. 73%), “B” symptoms (51% vs. 53%), lymphocyte count (mean 65.7x10\textsuperscript{9}/L vs. 65.1x10\textsuperscript{9}/L), and serum lactate dehydrogenase concentration (mean 370.2 vs. 388.4 U/L). Ninety percent of patients in both treatment groups had immuno-phenotypic confirmation of CLL (CD5, CD23 and either CD19 or CD20 or both).

Patients were randomly assigned to receive either TREANDA at 100 mg/m\textsuperscript{2}, administered intravenously over a period of 30 minutes on Days 1 and 2 or chlorambucil at 0.8 mg/kg (Broca’s normal weight) administered orally on Days 1 and 15 of each 28-day cycle. Efficacy endpoints of objective response rate and progression-free survival were calculated using a pre-specified algorithm based on NCI working group criteria for CLL\textsuperscript{1}.

The results of this open-label randomized study demonstrated a higher rate of overall response and a longer progression-free survival for TREANDA compared to chlorambucil (see Table 5). Survival data are not mature.

Table 5: Efficacy Data for CLL

<table>
<thead>
<tr>
<th></th>
<th>TREANDA (N=153)</th>
<th>Chlorambucil (N=148)</th>
<th>(p)-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response Rate n(%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall response</td>
<td>90 (59)</td>
<td>38 (26)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>(95% CI)</td>
<td>(51.0, 66.6)</td>
<td>(18.6, 32.7)</td>
<td></td>
</tr>
<tr>
<td>Complete response (CR)*</td>
<td>13 (8)</td>
<td>1 (&lt;1)</td>
<td></td>
</tr>
<tr>
<td>Nodular partial response (nPR)**</td>
<td>4 (3)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Partial response (PR)†</td>
<td>73 (48)</td>
<td>37 (25)</td>
<td></td>
</tr>
<tr>
<td><strong>Progression-Free Survival††</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median, months (95% CI)</td>
<td>18 (11.7, 23.5)</td>
<td>6 (5.6, 8.6)</td>
<td></td>
</tr>
<tr>
<td>Hazard ratio (95% CI)</td>
<td>0.27 (0.17, 0.43)</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
</tbody>
</table>

\(CI = \text{confidence interval}\)

\* CR was defined as peripheral lymphocyte count \(\leq 4.0 \times 10^{9}/L\), neutrophils \(\geq 1.5 \times 10^{9}/L\), platelets \(>100 \times 10^{9}/L\), hemoglobin > 110g/L, without transfusions, absence of palpable hepatosplenomegaly, lymph nodes \(\leq 1.5 \text{ cm}\), < 30% lymphocytes without nodularity in at least a normocellular bone marrow and absence of “B” symptoms. The clinical and laboratory criteria were required to be maintained for a period of at least 56 days.

\** nPR was defined as described for CR with the exception that the bone marrow biopsy shows persistent nodules.

† PR was defined as \(\geq 50\%\) decrease in peripheral lymphocyte count from the pretreatment baseline value, and either \(\geq 50\%\) reduction in lymphadenopathy, or \(\geq 50\%\) reduction in the size of spleen or liver, as well as one of the following hematologic improvements: neutrophils \(\geq 1.5 \times 10^{9}/L\) or 50% improvement over baseline, platelets \(>100 \times 10^{9}/L\) or 50% improvement over baseline, hemoglobin \(>110g/L\) or 50% improvement over baseline without transfusions, for a period of at least 56 days.

†† PFS was defined as time from randomization to progression or death from any cause.
Kaplan-Meier estimates of progression-free survival comparing TREANDA with chlorambucil are shown in Figure 1.

**Figure 1. Progression-Free Survival**

14.2 Non-Hodgkin’s Lymphoma (NHL)

The efficacy of TREANDA was evaluated in a single arm study of 100 patients with indolent B-cell NHL that had progressed during or within six months of treatment with rituximab or a rituximab-containing regimen. Patients were included if they relapsed within 6 months of either the first dose (monotherapy) or last dose (maintenance regimen or combination therapy) of rituximab. All patients received TREANDA intravenously at a dose of 120 mg/m², on Days 1 and 2 of a 21-day treatment cycle. Patients were treated for up to 8 cycles.

The median age was 60 years, 65% were male, and 95% had a baseline WHO performance status of 0 or 1. Major tumor subtypes were follicular lymphoma (62%), diffuse small lymphocytic lymphoma (21%), and marginal zone lymphoma (16%). Ninety-nine percent of patients had received previous chemotherapy, 91% of patients had received previous alkylator therapy, and 97% of patients had relapsed within 6 months of either the first dose (monotherapy) or last dose (maintenance regimen or combination therapy) of rituximab.

Efficacy was based on the assessments by a blinded independent review committee (IRC) and included overall response rate (complete response + complete response unconfirmed + partial response) and duration of response (DR) as summarized in Table 6.

<table>
<thead>
<tr>
<th>Table 6: Efficacy Data for NHL*</th>
</tr>
</thead>
<tbody>
<tr>
<td>TREANDA (N=100)</td>
</tr>
<tr>
<td><strong>Response Rate (%)</strong></td>
</tr>
<tr>
<td>Overall response rate (CR+CRu+PR)</td>
</tr>
<tr>
<td>(95% CI)</td>
</tr>
<tr>
<td>Complete response (CR)</td>
</tr>
<tr>
<td>Complete response unconfirmed (CRu)</td>
</tr>
<tr>
<td>Partial response (PR)</td>
</tr>
<tr>
<td><strong>Duration of Response (DR)</strong></td>
</tr>
<tr>
<td>Median, months (95% CI)</td>
</tr>
</tbody>
</table>

CI = confidence interval

*IRC assessment was based on modified International Working Group response criteria (IWG-RC). Modifications to IWG-RC specified that a persistently positive bone marrow in patients who met all other criteria for CR would be scored as PR. Bone marrow sample lengths were not required to be ≥20 mm.

15 REFERENCES


3. Preventing occupational exposures to Antineoplastic and Other Hazardous Drugs in Health Care Settings. NIOSH Alert 2004-165.


16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 Safe Handling and Disposal
As with other potentially toxic anticancer agents, care should be exercised in the handling and preparation of solutions prepared from TREANDA. The use of gloves and safety glasses is recommended to avoid exposure in case of breakage of the vial or other accidental spillage. If a solution of TREANDA contacts the skin, wash the skin immediately and thoroughly with soap and water. If TREANDA contacts the mucous membranes, flush thoroughly with water.

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

16.2 How Supplied
TREANDA (bendamustine hydrochloride) for Injection is supplied in individual cartons as follows:

- NDC 63459-390-08  TREANDA (bendamustine hydrochloride) for Injection, 25 mg in 8 mL amber single-use vial
- NDC 63459-391-20  TREANDA (bendamustine hydrochloride) for Injection, 100 mg in 20 mL amber single-use vial

16.3 Storage
TREANDA may be stored up to 25°C (77°F) with excursions permitted up to 30°C (86°F) (see USP Controlled Room Temperature). Retain in original package until time of use to protect from light.

17 PATIENT COUNSELING INFORMATION

• Allergic (Hypersensitivity) Reactions
Patients should be informed of the possibility of mild or serious allergic reactions and to immediately report rash, facial swelling, or difficulty breathing during or soon after infusion.

• Myelosuppression
Patients should be informed of the likelihood that TREANDA will cause a decrease in white blood cells, platelets, and red blood cells. They will need frequent monitoring of these parameters. They should be instructed to report shortness of breath, significant fatigue, bleeding, fever, or other signs of infection.

• Pregnancy and Nursing
TREANDA can cause fetal harm. Women should be advised to avoid becoming pregnant throughout treatment and for 3 months after TREANDA therapy has stopped. Men receiving TREANDA should use reliable contraception for the same time period. Advise patients to report pregnancy immediately. Advise patients to avoid nursing while receiving TREANDA.

• Fatigue
Advise patients that TREANDA may cause tiredness and to avoid driving any vehicle or operating any dangerous tools or machinery if they experience this side effect.

• Nausea and Vomiting
Advise patients that TREANDA may cause nausea and/or vomiting. Patients should report nausea and vomiting so that symptomatic treatment may be provided.

• Diarrhea
Advise patients that TREANDA may cause diarrhea. Patients should report diarrhea to the physician so that symptomatic treatment may be provided.

• Rash
Advise patients that a mild rash or itching may occur during treatment with TREANDA. Advise patients to immediately report severe or worsening rash or itching.