

HIGHLIGHTS OF PRESCRIBING INFORMATION

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

ZYTIGA® (abiraterone acetate) Tablets
For Oral Administration
Initial U.S. Approval – 2011

RECENT MAJOR CHANGES

Dosage and Administration, Recommended Dosage (2.1) 12/2011

INDICATIONS AND USAGE

ZYTIGA is a CYP17 inhibitor indicated for use in combination with prednisone for the treatment of patients with metastatic castration-resistant prostate cancer who have received prior chemotherapy containing docetaxel. (1)

DOSAGE AND ADMINISTRATION

Recommended dose: ZYTIGA 1,000 mg (four 250 mg tablets) administered orally once daily in combination with prednisone 5 mg administered orally twice daily. ZYTIGA must be taken on an empty stomach. No food should be consumed for at least two hours before the dose of ZYTIGA is taken and for at least one hour after the dose of ZYTIGA is taken. The tablets should be swallowed whole with water. Do not crush or chew tablets. (2.1)

- For patients with baseline moderate hepatic impairment (Child-Pugh Class B), reduce the ZYTIGA starting dose to 250 mg once daily. (2.2)
- For patients who develop hepatotoxicity during treatment, hold ZYTIGA until recovery. Retreatment may be initiated at a reduced dose. ZYTIGA should be discontinued if patients develop severe hepatotoxicity. (2.2)

DOSAGE FORMS AND STRENGTHS

Tablet 250 mg (3)

CONTRAINDICATIONS

- ZYTIGA is contraindicated in women who are or may become pregnant. (4.1)

WARNINGS AND PRECAUTIONS

- Mineralocorticoid excess: Use ZYTIGA with caution in patients with a history of cardiovascular disease. The safety of ZYTIGA in patients with LVEF < 50% or NYHA Class III or IV heart failure is not established. Control hypertension and correct hypokalemia before treatment. Monitor blood pressure, serum potassium and symptoms of fluid retention at least monthly. (5.1)
- Adrenocortical insufficiency: Monitor for symptoms and signs of adrenocortical insufficiency. Increased dosage of corticosteroids may be indicated before, during and after stressful situations. (5.2)
- Hepatotoxicity: Increases in liver enzymes have led to drug interruption, dose modification and/or discontinuation. Monitor liver function and modify, interrupt, or discontinue ZYTIGA dosing as recommended. (5.3)
- Food Effect: ZYTIGA must be taken on an empty stomach. Exposure (area under the curve) of abiraterone increases up to 10 fold when abiraterone acetate is taken with meals. (5.4)

ADVERSE REACTIONS

The most common adverse reactions (≥ 5%) are joint swelling or discomfort, hypokalemia, edema, muscle discomfort, hot flush, diarrhea, urinary tract infection, cough, hypertension, arrhythmia, urinary frequency, nocturia, dyspepsia, fractures and upper respiratory tract infection. (6)

To report SUSPECTED ADVERSE REACTIONS, contact Janssen Biotech, Inc. at 1-800-526-7736 (1-800-JANSSEN) or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

ZYTIGA is an inhibitor of the hepatic drug-metabolizing enzyme CYP2D6. Avoid co-administration of ZYTIGA with CYP2D6 substrates that have a narrow therapeutic index. If an alternative treatment cannot be used, exercise caution and consider a dose reduction of the concomitant CYP2D6 substrate. (7)

USE IN SPECIFIC POPULATIONS

- Do not use ZYTIGA in patients with baseline severe hepatic impairment (Child-Pugh Class C). (8.6)

See 17 for Patient Counseling Information and FDA-approved patient labeling.

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

ZYTIGA in combination with prednisone is indicated for the treatment of patients with metastatic castration-resistant prostate cancer (CRPC) who have received prior chemotherapy containing docetaxel.

2 DOSAGE AND ADMINISTRATION

2.1 Recommended Dosage

The recommended dose of ZYTIGA is 1,000 mg (four 250 mg tablets) administered orally once daily in combination with prednisone 5 mg administered orally twice daily. ZYTIGA must be taken on an empty stomach. No food should be consumed for at least two hours before the dose of ZYTIGA is taken and for at least one hour after the dose of ZYTIGA is taken [see *Clinical Pharmacology (12.3)*]. The tablets should be swallowed whole with water. Do not crush or chew tablets.

2.2 Dose Modification Guidelines

Hepatic Impairment

In patients with baseline moderate hepatic impairment (Child-Pugh Class B), reduce the recommended dose of ZYTIGA to 250 mg once daily. A once daily dose of 250 mg in patients with moderate hepatic impairment is predicted to result in an area under the concentration curve (AUC) similar to the AUC seen in patients with normal hepatic function receiving 1,000 mg once daily. However, there are no clinical data at the dose of 250 mg once daily in patients with moderate hepatic impairment and caution is advised. In patients with moderate hepatic impairment monitor ALT, AST, and bilirubin prior to the start of treatment, every week for the first month, every two weeks for the following two months of treatment and monthly thereafter. If elevations in ALT and/or AST greater than 5X upper limit of normal (ULN) or total bilirubin greater than 3X ULN occur in patients with baseline moderate hepatic impairment, discontinue ZYTIGA and do not re-treat patients with ZYTIGA [see *Use in Specific Populations (8.6)* and *Clinical Pharmacology (12.3)*].

Avoid ZYTIGA in patients with baseline severe hepatic impairment (Child-Pugh Class C), as ZYTIGA has not been studied in this population, and no dose adjustment can be predicted.

Hepatotoxicity

For patients who develop hepatotoxicity during treatment with ZYTIGA (ALT and/or AST greater than 5X ULN or total bilirubin greater than 3X ULN), interrupt treatment with ZYTIGA [see *Warnings and Precautions (5.3)*]. Treatment may be restarted at a reduced

dose of 750 mg once daily following return of liver function tests to the patient's baseline or to AST and ALT less than or equal to 2.5X ULN and total bilirubin less than or equal to 1.5X ULN. For patients who resume treatment, monitor serum transaminases and bilirubin at a minimum of every two weeks for three months and monthly thereafter.

If hepatotoxicity recurs at the dose of 750 mg once daily, re-treatment may be restarted at a reduced dose of 500 mg once daily following return of liver function tests to the patient's baseline or to AST and ALT less than or equal to 2.5X ULN and total bilirubin less than or equal to 1.5X ULN.

If hepatotoxicity recurs at the reduced dose of 500 mg once daily, discontinue treatment with ZYTIGA. The safety of ZYTIGA re-treatment of patients who develop AST or ALT greater than or equal to 20X ULN and/or bilirubin greater than or equal to 10X ULN is unknown.

3 DOSAGE FORMS AND STRENGTHS

ZYTIGA (abiraterone acetate) 250 mg tablets are white to off-white, oval-shaped tablets debossed with AA250 on one side.

4 CONTRAINDICATIONS

4.1 Pregnancy

ZYTIGA may cause fetal harm when administered to a pregnant woman. ZYTIGA is contraindicated in women who are or may become pregnant. 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.

5 WARNINGS AND PRECAUTIONS

5.1 Hypertension, Hypokalemia and Fluid Retention Due to Mineralocorticoid Excess

Use ZYTIGA with caution in patients with a history of cardiovascular disease. ZYTIGA may cause hypertension, hypokalemia, and fluid retention as a consequence of increased mineralocorticoid levels resulting from CYP17 inhibition [*see Adverse Reactions (6) and Clinical Pharmacology (12.1)*]. Co-administration of a corticosteroid suppresses adrenocorticotrophic hormone (ACTH) drive, resulting in a reduction in the incidence and severity of these adverse reactions. Use caution when treating patients whose underlying medical conditions might be compromised by increases in blood pressure, hypokalemia or fluid retention, e.g., those with heart failure, recent myocardial infarction or ventricular arrhythmia. The safety of ZYTIGA in patients with left ventricular ejection fraction <50% or NYHA Class III or IV heart failure has not been established because these patients were excluded from the randomized clinical trial. Monitor patients for hypertension, hypokalemia,

and fluid retention at least once a month. Control hypertension and correct hypokalemia before and during treatment with ZYTIGA.

5.2 Adrenocortical Insufficiency

Adrenocortical insufficiency has been reported in clinical trials in patients receiving ZYTIGA in combination with prednisone, following interruption of daily steroids and/or with concurrent infection or stress. Use caution and monitor for symptoms and signs of adrenocortical insufficiency, particularly if patients are withdrawn from prednisone, have prednisone dose reductions, or experience unusual stress. Symptoms and signs of adrenocortical insufficiency may be masked by adverse reactions associated with mineralocorticoid excess seen in patients treated with ZYTIGA. If clinically indicated, perform appropriate tests to confirm the diagnosis of adrenocortical insufficiency. Increased dosage of corticosteroids may be indicated before, during and after stressful situations [*see Warnings and Precautions (5.1)*].

5.3 Hepatotoxicity

Marked increases in liver enzymes leading to drug discontinuation or dosage modification have occurred [*see Adverse Reactions (6)*]. Measure serum transaminases (ALT and AST) and bilirubin levels prior to starting treatment with ZYTIGA, every two weeks for the first three months of treatment and monthly thereafter. In patients with baseline moderate hepatic impairment receiving a reduced ZYTIGA dose of 250 mg, measure ALT, AST, and bilirubin prior to the start of treatment, every week for the first month, every two weeks for the following two months of treatment and monthly thereafter. Promptly measure serum total bilirubin, AST, and ALT if clinical symptoms or signs suggestive of hepatotoxicity develop. Elevations of AST, ALT, or bilirubin from the patient's baseline should prompt more frequent monitoring. If at any time AST or ALT rise above five times the ULN, or the bilirubin rises above three times the ULN, interrupt ZYTIGA treatment and closely monitor liver function.

Re-treatment with ZYTIGA at a reduced dose level may take place only after return of liver function tests to the patient's baseline or to AST and ALT less than or equal to 2.5X ULN and total bilirubin less than or equal to 1.5X ULN [*see Dosage and Administration (2.2)*].

The safety of ZYTIGA re-treatment of patients who develop AST or ALT greater than or equal to 20X ULN and/or bilirubin greater than or equal to 10X ULN is unknown.

5.4 Food Effect

ZYTIGA must be taken on an empty stomach. No food should be consumed for at least two hours before the dose of ZYTIGA is taken and for at least one hour after the dose of

ZYTIGA is taken. Abiraterone C_{\max} and $AUC_{0-\infty}$ (exposure) were increased up to 17- and 10-fold higher, respectively, when a single dose of abiraterone acetate was administered with a meal compared to a fasted state. The safety of these increased exposures when multiple doses of abiraterone acetate are taken with food has not been assessed [see *Dosage and Administration (2.1) and Clinical Pharmacology (12.3)*].

6 ADVERSE REACTIONS

The following are discussed in more detail in other sections of the labeling:

- Hypertension, hypokalemia, and fluid retention due to mineralocorticoid excess [see *Warnings and Precautions (5.1)*].
- Adrenocortical insufficiency [see *Warnings and Precautions (5.2)*].
- Hepatotoxicity [see *Warnings and Precautions (5.3)*].
- Food effect [see *Warnings and Precautions (5.4)*].

6.1 Clinical Trial Experience

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 clinical practice.

In a placebo-controlled, multicenter phase 3 clinical trial of patients with metastatic castration-resistant prostate cancer who were using a gonadotropin-releasing hormone (GnRH) agonist or were previously treated with orchiectomy, ZYTIGA was administered at a dose of 1,000 mg daily in combination with prednisone 5 mg twice daily in the active treatment arm (N = 791). Placebo plus prednisone 5 mg twice daily was given to control patients (N = 394). The median duration of treatment with ZYTIGA was 8 months.

The most common adverse drug reactions ($\geq 5\%$) reported in clinical studies were joint swelling or discomfort, hypokalemia, edema, muscle discomfort, hot flush, diarrhea, urinary tract infection, cough, hypertension, arrhythmia, urinary frequency, nocturia, dyspepsia, fractures and upper respiratory tract infection.

The most common adverse drug reactions that resulted in drug discontinuation were aspartate aminotransferase increased, alanine aminotransferase increased, urosepsis and cardiac failure (each in $<1\%$ of patients taking ZYTIGA).

Adverse reactions and laboratory abnormalities related to mineralocorticoid effects were reported more commonly in patients treated with ZYTIGA than in patients treated with placebo: hypokalemia 28% versus 20%, hypertension 9% versus 7% and fluid retention (edema) 27% versus 18%, respectively (see Table 1). In patients treated with ZYTIGA,

grades 3 to 4 hypokalemia occurred in 5% of patients and grades 3 to 4 hypertension was reported in 1% of patients [see Warnings and Precautions (5.1)].

Table 1 shows adverse reactions due to ZYTIGA that occurred with either a $\geq 2\%$ absolute increase in frequency compared to placebo, or were events of special interest (mineralocorticoid excess, cardiac adverse reactions, and liver toxicities).

Table 1: Adverse Reactions due to ZYTIGA in a Placebo-Controlled Phase 3 Trial

System/Organ Class Adverse reaction	ZYTIGA with Prednisone (N=791)		Placebo with Prednisone (N=394)	
	All Grades ¹ %	Grade 3-4 %	All Grades %	Grade 3-4 %
Musculoskeletal and connective tissue disorders				
Joint swelling/ discomfort ²	29.5	4.2	23.4	4.1
Muscle discomfort ³	26.2	3.0	23.1	2.3
General disorders				
Edema ⁴	26.7	1.9	18.3	0.8
Vascular disorders				
Hot flush	19.0	0.3	16.8	0.3
Hypertension	8.5	1.3	6.9	0.3
Gastrointestinal disorders				
Diarrhea	17.6	0.6	13.5	1.3
Dyspepsia	6.1	0	3.3	0
Infections and infestations				
Urinary tract infection	11.5	2.1	7.1	0.5
Upper respiratory tract infection	5.4	0	2.5	0
Respiratory, thoracic and mediastinal disorders				
Cough	10.6	0	7.6	0
Renal and urinary disorders				
Urinary frequency	7.2	0.3	5.1	0.3
Nocturia	6.2	0	4.1	0
Injury, poisoning and procedural complications				
Fractures ⁵	5.9	1.4	2.3	0
Cardiac disorders				
Arrhythmia ⁶	7.2	1.1	4.6	1.0
Chest pain or chest discomfort ⁷	3.8	0.5	2.8	0
Cardiac failure ⁸	2.3	1.9	1.0	0.3

¹ Adverse events graded according to CTCAE version 3.0

² Includes terms Arthritis, Arthralgia, Joint swelling, and Joint stiffness

³ Includes terms Muscle spasms, Musculoskeletal pain, Myalgia, Musculoskeletal discomfort, and Musculoskeletal stiffness

⁴ Includes terms Edema, Edema peripheral, Pitting edema, and Generalized edema

⁵ Includes all fractures with the exception of pathological fracture

⁶ Includes terms Arrhythmia, Tachycardia, Atrial fibrillation, Supraventricular tachycardia, Atrial tachycardia, Ventricular tachycardia, Atrial flutter, Bradycardia, Atrioventricular block complete, Conduction disorder, and Bradyarrhythmia

⁷ Includes terms Angina pectoris, Chest pain, and Angina unstable. Myocardial infarction or ischemia occurred more commonly in the placebo arm than in the ZYTIGA arm (1.3% vs. 1.1% respectively).

⁸ Includes terms Cardiac failure, Cardiac failure congestive, Left ventricular dysfunction, Cardiogenic shock, Cardiomegaly, Cardiomyopathy, and Ejection fraction decreased

Cardiovascular Adverse Reactions:

Cardiovascular adverse reactions in the phase 3 trial are shown in Table 1. The majority of arrhythmias were grade 1 or 2. Grade 3-4 arrhythmias occurred at similar rates in the two arms. There was one death associated with arrhythmia and one patient with sudden death in the ZYTIGA arm. No patients had sudden death or arrhythmia associated with death in the placebo arm. Cardiac ischemia or myocardial infarction led to death in 2 patients in the placebo arm and 1 death in the ZYTIGA arm. Cardiac failure resulting in death occurred in 1 patient on both arms.

Hepatotoxicity:

Drug-associated hepatotoxicity with elevated ALT, AST, and total bilirubin has been reported in patients treated with ZYTIGA. Across all clinical trials, liver function test elevations (ALT or AST increases of > 5X ULN) were reported in 2.3% of patients who received ZYTIGA, typically during the first 3 months after starting treatment. In the phase 3 trial, patients whose baseline ALT or AST were elevated were more likely to experience liver function test elevations than those beginning with normal values. When elevations of either ALT or AST > 5X ULN, or elevations in bilirubin > 3X ULN were observed, ZYTIGA was withheld or discontinued. In two instances marked increases in liver function tests occurred [see *Warnings and Precautions (5.3)*]. These two patients with normal baseline hepatic function, experienced ALT or AST elevations 15 to 40X ULN and bilirubin elevations 2 to 6 X ULN. Upon discontinuation of ZYTIGA, both patients had normalization of their liver function tests and one patient was re-treated with ZYTIGA without recurrence of the elevations.

In clinical trials, the following patients were excluded: patients with active hepatitis, patients with baseline ALT and/or AST \geq 2.5X ULN in the absence of liver metastases, and patients with ALT and/or AST > 5X ULN in the presence of liver metastases. Abnormal liver function tests developing in patients participating in clinical trials were managed by treatment interruption, dose modification and/or discontinuation [see *Dosage and Administration (2.2) and Warnings and Precautions (5.3)*]. Patients with elevations of ALT or AST > 20X ULN were not re-treated.

Other Adverse Reactions:

Adrenal insufficiency occurred in two patients on the abiraterone arm of the phase 3 clinical trial (< 1%).

Laboratory Abnormalities of Interest:

Table 2 shows laboratory values of interest from the phase 3 placebo-controlled clinical trial. Grade 3-4 low serum phosphate (7.2%) and potassium (5.3%) occurred more frequently in the ZYTIGA arm.

Table 2: Laboratory Abnormalities of Interest in a Phase 3 Placebo-Controlled Clinical Trial

Laboratory Abnormality	Abiraterone (N=791)		Placebo (N=394)	
	All Grades (%)	Grade 3-4 (%)	All Grades (%)	Grade 3-4 (%)
High Triglyceride	62.5	0.4	53.0	0
High AST	30.6	2.1	36.3	1.5
Low Potassium	28.3	5.3	19.8	1.0
Low Phosphorus	23.8	7.2	15.7	5.8
High ALT	11.1	1.4	10.4	0.8
High Total Bilirubin	6.6	0.1	4.6	0

7 DRUG INTERACTIONS

7.1 Effects of Abiraterone on Drug Metabolizing Enzymes

ZYTIGA is an inhibitor of the hepatic drug-metabolizing enzyme CYP2D6. In a CYP2D6 drug-drug interaction trial, the C_{max} and AUC of dextromethorphan (CYP2D6 substrate) were increased 2.8- and 2.9-fold, respectively, when dextromethorphan was given with abiraterone acetate 1,000 mg daily and prednisone 5 mg twice daily. Avoid co-administration of abiraterone acetate with substrates of CYP2D6 with a narrow therapeutic index (e.g., thioridazine). If alternative treatments cannot be used, exercise caution and consider a dose reduction of the concomitant CYP2D6 substrate drug [see *Clinical Pharmacology (12.3)*].

7.2 Drugs that Inhibit or Induce CYP3A4 Enzymes

Based on *in vitro* data, ZYTIGA is a substrate of CYP3A4. The effects of strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin, atazanavir, nefazodone, saquinavir, telithromycin, ritonavir, indinavir, nelfinavir, voriconazole) or inducers (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, phenobarbital) on the pharmacokinetics of abiraterone have not been evaluated, *in vivo*. Avoid or use with caution, strong inhibitors and inducers of CYP3A4 during ZYTIGA treatment [see *Clinical Pharmacology (12.3)*].

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category X [see *Contraindications (4.1)*].

ZYTIGA is contraindicated in women who are or may become pregnant while receiving the drug. 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 and the potential risk for pregnancy loss. Women of childbearing potential should be advised to avoid becoming pregnant during treatment with ZYTIGA.

8.3 Nursing Mothers

ZYTIGA is not indicated for use in women. It is not known if abiraterone acetate is excreted in human milk. Because many drugs are excreted in human milk, and because of the potential for serious adverse reactions in nursing infants from ZYTIGA, a decision should be made to either discontinue nursing, or discontinue the drug taking into account the importance of the drug to the mother.

8.4 Pediatric Use

ZYTIGA is not indicated in children.

8.5 Geriatric Use

Of the total number of patients in a phase 3 trial of ZYTIGA, 71% of patients were 65 years and over and 28% were 75 years and over. No overall differences in safety or effectiveness were observed between these elderly patients and younger patients.

8.6 Patients with Hepatic Impairment

The pharmacokinetics of abiraterone were examined in subjects with baseline mild (n = 8) or moderate (n = 8) hepatic impairment (Child-Pugh Class A and B, respectively) and in 8 healthy control subjects with normal hepatic function. The systemic exposure (AUC) of abiraterone after a single oral 1,000 mg dose of ZYTIGA increased by approximately 1.1-fold and 3.6-fold in subjects with mild and moderate baseline hepatic impairment, respectively compared to subjects with normal hepatic function.

No dosage adjustment is necessary for patients with baseline mild hepatic impairment. In patients with baseline moderate hepatic impairment (Child-Pugh Class B), reduce the recommended dose of ZYTIGA to 250 mg once daily. If elevations in ALT or AST >5X ULN or total bilirubin >3X ULN occur in patients with baseline moderate hepatic impairment, discontinue ZYTIGA treatment [*see Dosage and Administration (2.1) and Clinical Pharmacology (12.3)*].

The safety of ZYTIGA in patients with baseline severe hepatic impairment has not been studied. These patients should not receive ZYTIGA.

For patients who develop hepatotoxicity during treatment, interruption of treatment and dosage adjustment may be required [see *Dosage and Administration* (2.2), *Warnings and Precautions* (5.3), and *Clinical Pharmacology* (12.3)].

8.7 Patients with Renal Impairment

In a dedicated renal impairment trial, the mean PK parameters were comparable between healthy subjects with normal renal function (N=8) and those with end stage renal disease (ESRD) on hemodialysis (N=8) after a single oral 1,000 mg dose of ZYTIGA. No dosage adjustment is necessary for patients with renal impairment [see *Dosage and Administration* (2.1) and *Clinical Pharmacology* (12.3)].

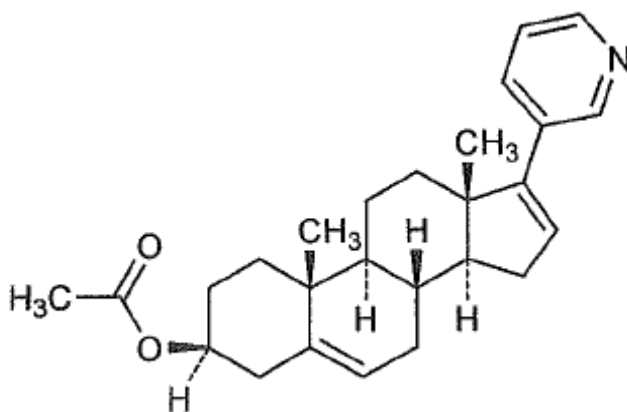
10 OVERDOSAGE

There have been no reports of overdose of ZYTIGA during clinical studies.

There is no specific antidote. In the event of an overdose, stop ZYTIGA, undertake general supportive measures, including monitoring for arrhythmias and cardiac failure and assess liver function.

11 DESCRIPTION

Abiraterone acetate, the active ingredient of ZYTIGA is the acetyl ester of abiraterone. Abiraterone is an inhibitor of CYP17 (17 α -hydroxylase/C17,20-lyase). Each ZYTIGA tablet contains 250 mg of abiraterone acetate. Abiraterone acetate is designated chemically as (3 β)-17-(3-pyridinyl)androsta-5,16-dien-3-yl acetate and its structure is:



Abiraterone acetate is a white to off-white, non-hygroscopic, crystalline powder. Its molecular formula is C₂₆H₃₃NO₂ and it has a molecular weight of 391.55. Abiraterone acetate is a lipophilic compound with an octanol-water partition coefficient of 5.12 (Log P) and is practically insoluble in water. The pK_a of the aromatic nitrogen is 5.19.

Inactive ingredients in the tablets are lactose monohydrate, microcrystalline cellulose, croscarmellose sodium, povidone, sodium lauryl sulfate, magnesium stearate, and colloidal silicon dioxide.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Abiraterone acetate (ZYTIGA) is converted *in vivo* to abiraterone, an androgen biosynthesis inhibitor, that inhibits 17 α -hydroxylase/C17,20-lyase (CYP17). This enzyme is expressed in testicular, adrenal, and prostatic tumor tissues and is required for androgen biosynthesis.

CYP17 catalyzes two sequential reactions: 1) the conversion of pregnenolone and progesterone to their 17 α -hydroxy derivatives by 17 α -hydroxylase activity and 2) the subsequent formation of dehydroepiandrosterone (DHEA) and androstenedione, respectively, by C17, 20 lyase activity. DHEA and androstenedione are androgens and are precursors of testosterone. Inhibition of CYP17 by abiraterone can also result in increased mineralocorticoid production by the adrenals (*see Warnings and Precautions [5.1]*).

Androgen sensitive prostatic carcinoma responds to treatment that decreases androgen levels. Androgen deprivation therapies, such as treatment with GnRH agonists or orchiectomy, decrease androgen production in the testes but do not affect androgen production by the adrenals or in the tumor.

ZYTIGA decreased serum testosterone and other androgens in patients in the placebo-controlled phase 3 clinical trial. It is not necessary to monitor the effect of ZYTIGA on serum testosterone levels.

Changes in serum prostate specific antigen (PSA) levels may be observed but have not been shown to correlate with clinical benefit in individual patients.

12.3 Pharmacokinetics

Following administration of abiraterone acetate, the pharmacokinetics of abiraterone and abiraterone acetate have been studied in healthy subjects and in patients with metastatic castration-resistant prostate cancer (CRPC). *In vivo*, abiraterone acetate is converted to abiraterone. In clinical studies, abiraterone acetate plasma concentrations were below detectable levels (< 0.2 ng/mL) in > 99% of the analyzed samples.

Absorption

Following oral administration of abiraterone acetate to patients with metastatic CRPC, the median time to reach maximum plasma abiraterone concentrations is 2 hours. Abiraterone

accumulation is observed at steady-state, with a 2-fold higher exposure (steady-state AUC) compared to a single 1,000 mg dose of abiraterone acetate.

At the dose of 1,000 mg daily in patients with metastatic CRPC, steady-state values (mean \pm SD) of C_{\max} were 226 ± 178 ng/mL and of AUC were 1173 ± 690 ng.hr/mL. No major deviation from dose proportionality was observed in the dose range of 250 mg to 1,000 mg.

Systemic exposure of abiraterone is increased when abiraterone acetate is administered with food. Abiraterone C_{\max} and $AUC_{0-\infty}$ were approximately 7- and 5-fold higher, respectively, when abiraterone acetate was administered with a low-fat meal (7% fat, 300 calories) and approximately 17- and 10-fold higher, respectively, when abiraterone acetate was administered with a high-fat (57% fat, 825 calories) meal. Given the normal variation in the content and composition of meals, taking ZYTIGA with meals has the potential to result in increased and highly variable exposures. Therefore, no food should be consumed for at least two hours before the dose of ZYTIGA is taken and for at least one hour after the dose of ZYTIGA is taken. The tablets should be swallowed whole with water [see *Dosage and Administration (2.1)*].

Distribution and Protein Binding

Abiraterone is highly bound (>99%) to the human plasma proteins, albumin and alpha-1 acid glycoprotein. The apparent steady-state volume of distribution (mean \pm SD) is $19,669 \pm 13,358$ L. *In vitro* studies show that at clinically relevant concentrations, abiraterone acetate and abiraterone are not substrates of P-glycoprotein (P-gp) and that abiraterone acetate is an inhibitor of P-gp. No studies have been conducted with other transporter proteins.

Metabolism

Following oral administration of ^{14}C -abiraterone acetate as capsules, abiraterone acetate is hydrolyzed to abiraterone (active metabolite). The conversion is likely through esterase activity (the esterases have not been identified) and is not CYP mediated. The two main circulating metabolites of abiraterone in human plasma are abiraterone sulphate (inactive) and N-oxide abiraterone sulphate (inactive), which account for about 43% of exposure each. CYP3A4 and SULT2A1 are the enzymes involved in the formation of N-oxide abiraterone sulphate and SULT2A1 is involved in the formation of abiraterone sulphate.

Excretion

In patients with metastatic CRPC, the mean terminal half-life of abiraterone in plasma (mean \pm SD) is 12 ± 5 hours. Following oral administration of ^{14}C -abiraterone acetate, approximately 88% of the radioactive dose is recovered in feces and approximately 5% in

urine. The major compounds present in feces are unchanged abiraterone acetate and abiraterone (approximately 55% and 22% of the administered dose, respectively).

Patients with Hepatic Impairment

The pharmacokinetics of abiraterone was examined in subjects with baseline mild (n = 8) or moderate (n = 8) hepatic impairment (Child-Pugh Class A and B, respectively) and in 8 healthy control subjects with normal hepatic function. Systemic exposure to abiraterone after a single oral 1,000 mg dose given under fasting conditions increased approximately 1.1-fold and 3.6-fold in subjects with mild and moderate baseline hepatic impairment, respectively. The mean half-life of abiraterone is prolonged to approximately 18 hours in subjects with mild hepatic impairment and to approximately 19 hours in subjects with moderate hepatic impairment. ZYTIGA has not been studied in patients with baseline severe hepatic impairment (Child-Pugh Class C) [*see Dosage and Administration (2.2) and Use in Specific Populations (8.6)*].

Patients with Renal Impairment

The pharmacokinetics of abiraterone were examined in patients with end-stage renal disease (ESRD) on a stable hemodialysis schedule (N=8) and in matched control subjects with normal renal function (N=8). In the ESRD cohort of the trial, a single 1,000 mg ZYTIGA dose was given under fasting conditions 1 hour after dialysis, and samples for pharmacokinetic analysis were collected up to 96 hours post dose. Systemic exposure to abiraterone after a single oral 1,000 mg dose did not increase in subjects with end-stage renal disease on dialysis, compared to subjects with normal renal function [*see Use in Specific Populations (8.7)*].

Drug Interactions

In vitro studies with human hepatic microsomes showed that abiraterone is a strong inhibitor of CYP1A2 and CYP2D6 and a moderate inhibitor of CYP2C9, CYP2C19 and CYP3A4/5.

In an *in vivo* drug-drug interaction trial, the C_{max} and AUC of dextromethorphan (CYP2D6 substrate) were increased 2.8- and 2.9-fold, respectively when dextromethorphan 30 mg was given with abiraterone acetate 1,000 mg daily (plus prednisone 5 mg twice daily). The AUC for dextromethorphan, the active metabolite of dextromethorphan, increased approximately 1.3 fold [*see Drug Interactions (7.1)*].

In a clinical study to determine the effects of abiraterone acetate 1,000 mg daily (plus prednisone 5 mg twice daily) on a single 100 mg dose of the CYP1A2 substrate theophylline, no increase in systemic exposure of theophylline was observed.

Abiraterone is a substrate of CYP3A4, *in vitro*. The effects of strong CYP3A4 inhibitors or inducers on the pharmacokinetics of abiraterone have not been evaluated, *in vivo*. Strong inhibitors and inducers of CYP3A4 should be avoided or used with caution [see *Drug Interactions (7.2)*].

12.4 QT Prolongation

In a multi-center, open-label, single-arm trial, 33 patients with metastatic CRPC received ZYTIGA orally at a dose of 1,000 mg once daily at least 1 hour before or 2 hours after a meal in combination with prednisone 5 mg orally twice daily. Assessments up to Cycle 2 Day 2 showed no large changes in the QTc interval (i.e., >20 ms) from baseline. However, small increases in the QTc interval (i.e., <10 ms) due to abiraterone acetate cannot be excluded due to study design limitations.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, and Impairment of Fertility

Long-term animal studies have not been conducted to evaluate the carcinogenic potential of abiraterone acetate.

Abiraterone acetate and abiraterone did not induce mutations in the microbial mutagenesis (Ames) assay and was not clastogenic in both the *in vitro* cytogenetic assay using primary human lymphocytes and in the *in vivo* rat micronucleus assay.

Developmental or reproductive toxicology studies were not conducted with abiraterone acetate. In studies in rats (13- and 26-weeks) and monkeys (39-weeks), atrophy, aspermia/hypospermia, and hyperplasia in the reproductive system were observed at ≥ 50 mg/kg/day in rats and ≥ 250 mg/kg/day in monkeys and were consistent with the antiandrogenic pharmacological activity of abiraterone [see *Nonclinical Toxicology (13.2)*]. These effects were observed in rats and monkeys at approximately 1.14 and 0.6-fold greater than the human clinical exposure based on AUC, respectively.

13.2 Animal Toxicology and/or Pharmacology

In 13- and 26-week studies in rats and 13- and 39-week studies in monkeys, a reduction in circulating testosterone levels occurred with abiraterone acetate at approximately one half the human clinical exposure based on AUC. As a result, decreases in organ weights and toxicities were observed in the male and female reproductive system, adrenal glands, liver, pituitary (rats only), and male mammary glands. The changes in the reproductive organs are consistent with the antiandrogenic pharmacological activity of abiraterone acetate. A dose-dependent increase in cataracts was observed in rats at 26 weeks starting at ≥ 50 mg/kg/day (1.14-fold greater than the human clinical exposure based on AUC). In the 39-week

monkey study, no cataracts were observed at higher doses (2-fold greater than the clinical exposure based on AUC). All other toxicities associated with abiraterone acetate reversed or were partially resolved after a 4-week recovery period.

14 CLINICAL STUDIES

The efficacy and safety of ZYTIGA in patients with metastatic castration-resistant prostate cancer (CRPC) who had received prior chemotherapy containing docetaxel were assessed in a randomized, placebo-controlled, multicenter phase 3 clinical trial. A total of 1195 patients were randomized 2:1 to receive either ZYTIGA orally at a dose of 1,000 mg once daily in combination with prednisone 5 mg orally twice daily (N=797) or placebo once daily plus prednisone 5 mg orally twice daily (N=398). Patients randomized to either arm were to continue treatment until disease progression (defined as a 25% increase in PSA over the patient's baseline/nadir together with protocol-defined radiographic progression and symptomatic or clinical progression), initiation of new treatment, unacceptable toxicity or withdrawal. Patients with prior ketoconazole treatment for prostate cancer and a history of adrenal gland or pituitary disorders were excluded from this trial.

The following patient demographics and baseline disease characteristics were balanced between the treatment arms. The median age was 69 years (range 39-95) and the racial distribution was 93.3% Caucasian, 3.6% Black, 1.7% Asian, and 1.6% Other. Eighty-nine percent of patients enrolled had an ECOG performance status score of 0-1 and 45% had a Brief Pain Inventory score of ≥ 4 (patient's reported worst pain over the previous 24 hours). Ninety percent of patients had metastases in bone and 30% had visceral involvement. Seventy percent of patients had radiographic evidence of disease progression and 30% had PSA-only progression. Seventy percent of patients had previously received one cytotoxic chemotherapy regimen and 30% received two regimens.

The protocol pre-specified interim analysis was conducted after 552 deaths and showed a statistically significant improvement in overall survival in patients treated with ZYTIGA compared to patients in the placebo arm (Table 3 and Figure 1). An updated survival analysis was conducted when 775 deaths (97% of the planned number of deaths for final analysis) were observed. Results from this analysis were consistent with those from the interim analysis (Table 3).

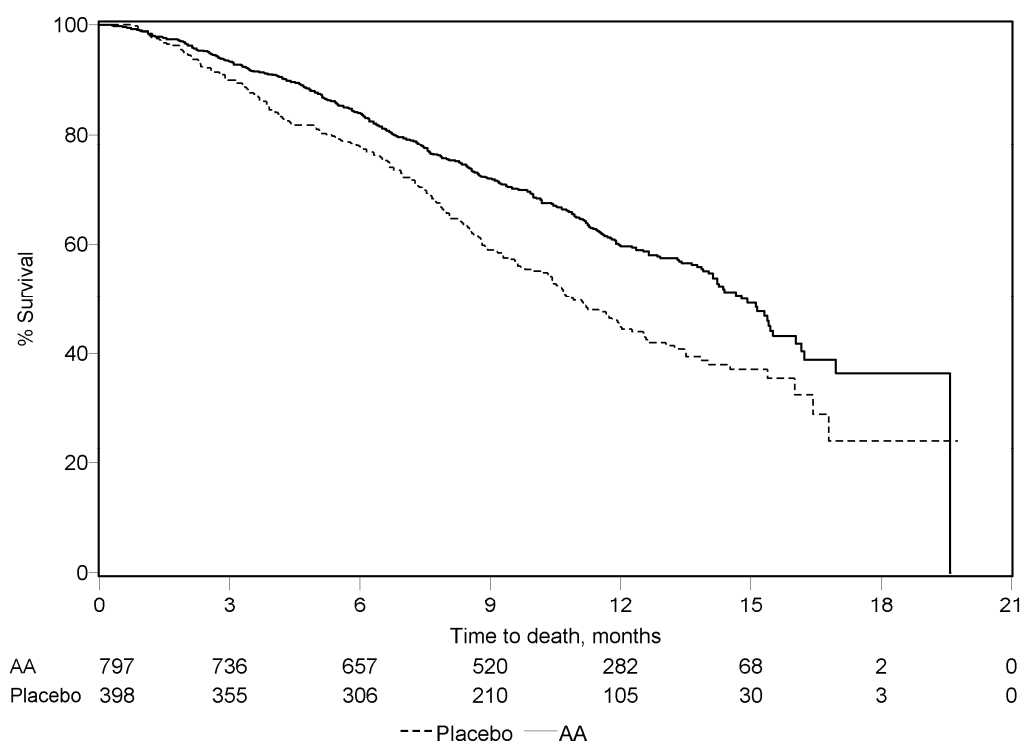
Table 3: Overall Survival of Patients Treated with Either ZYTIGA or Placebo in Combination with Prednisone (Intent-to-Treat Analysis)

	ZYTIGA (N=797)	Placebo (N=398)
Primary Survival Analysis		
Deaths (%)	333 (42%)	219 (55%)
Median survival (months) (95% CI)	14.8 (14.1, 15.4)	10.9 (10.2, 12.0)
p value ^a	< 0.0001	
Hazard ratio (95% CI) ^b	0.646 (0.543, 0.768)	
Updated Survival Analysis		
Deaths (%)	501 (63%)	274 (69%)
Median survival (months) (95% CI)	15.8 (14.8, 17.0)	11.2 (10.4, 13.1)
Hazard ratio (95% CI) ^b	0.740 (0.638, 0.859)	

^aP-value is derived from a log-rank test stratified by ECOG performance status score (0-1 vs. 2), pain score (absent vs. present), number of prior chemotherapy regimens (1 vs. 2), and type of disease progression (PSA only vs. radiographic).

^bHazard Ratio is derived from a stratified proportional hazards model. Hazard ratio <1 favors ZYTIGA

Figure 1: Kaplan-Meier Overall Survival Curves (Intent-to-Treat Analysis)



AA= ZYTIGA

16 HOW SUPPLIED/STORAGE AND HANDLING

ZYTIGA (abiraterone acetate) 250 mg tablets are white to off-white, oval tablets debossed with AA250 on one side. ZYTIGA 250 mg tablets are available in high-density polyethylene bottles of 120 tablets.

NDC Number 57894-150-12

Storage and Handling

Store at 20°C to 25°C (68°F to 77°F); excursions permitted in the range from 15°C to 30°C (59°F to 86°F) [see USP controlled room temperature].

Based on its mechanism of action, ZYTIGA may harm a developing fetus. Therefore, women who are pregnant or women who may be pregnant should not handle ZYTIGA without protection, e.g., gloves [see Use in Specific Populations (8.1)].

17 PATIENT COUNSELING INFORMATION

See FDA-approved patient labeling (Patient Information)

- Patients should be informed that ZYTIGA and prednisone are used together and that they should not interrupt or stop either of these medications without consulting their physician.
- Patients receiving GnRH agonists should be informed that they need to maintain this treatment during the course of treatment with ZYTIGA and prednisone.
- Patients should be informed that ZYTIGA must not be taken with food and that no food should be consumed for at least two hours before the dose of ZYTIGA is taken and for at least one hour after the dose of ZYTIGA is taken. They should be informed that the tablets should be swallowed whole with water without crushing or chewing. Patients should be informed that taking ZYTIGA with food causes increased exposure and this may result in adverse reactions.
- Patients should be informed that ZYTIGA is taken once daily and prednisone is taken twice daily according to their physician's instructions.
- Patients should be informed that in the event of a missed daily dose of ZYTIGA or prednisone, they should take their normal dose the following day. If more than one daily dose is skipped, patients should be told to inform their physician.
- Patients should be apprised of the common side effects associated with ZYTIGA, including peripheral edema, hypokalemia, hypertension and urinary tract infection. Direct the patient to a complete list of adverse drug reactions in PATIENT INFORMATION.
- Patients should be advised that their liver function will be monitored using blood tests.
- Patients should be informed that ZYTIGA may harm a developing fetus; thus, women who are pregnant or women who may be pregnant should not handle ZYTIGA without

protection, e.g., gloves. Patients should also be informed that it is not known whether abiraterone or its metabolites are present in semen and they should use a condom if having sex with a pregnant woman. The patient should use a condom and another effective method of birth control if he is having sex with a woman of child-bearing potential. These measures are required during and for one week after treatment with ZYTIGA.

Manufactured by:

Patheon Inc.

Mississauga, Canada

Manufactured for:

Janssen Biotech, Inc.

Horsham, PA 19044

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PATIENT INFORMATION

ZYTIGA® (Zye-tee-ga) (abiraterone acetate) Tablets

Read this Patient Information that comes with ZYTIGA before you start taking it and each time you get a refill. There may be new information. This information does not take the place of talking with your healthcare provider about your medical condition or your treatment.

What is ZYTIGA?

ZYTIGA is a prescription medicine that is used along with prednisone. ZYTIGA is used to treat men with castration-resistant prostate cancer (prostate cancer that is resistant to medical or surgical treatments that lower testosterone) that has spread to other parts of the body and who have received treatment with docetaxel.

ZYTIGA is not for use in women or children.

Who should not take ZYTIGA?

Do not take ZYTIGA if you are pregnant or may become pregnant. ZYTIGA may harm your unborn baby.

Women who are pregnant or who may become pregnant should not touch ZYTIGA without protection, such as gloves.

What should I tell my healthcare provider before taking ZYTIGA?

Before you take ZYTIGA, tell your healthcare provider if you:

- have heart problems
- have liver problems
- have a history of adrenal problems
- have a history of pituitary problems
- have any other medical conditions
- plan to become pregnant. See “Who should not take ZYTIGA?”
- are breastfeeding or plan to breastfeed. It is not known if ZYTIGA passes into your breast milk. You and your healthcare provider should decide if you will take ZYTIGA or breastfeed. You should not do both. See “Who should not take ZYTIGA?”

Tell your healthcare provider about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. ZYTIGA can interact with many other medicines.

You should not start or stop any medicine before you talk with the healthcare provider that prescribed ZYTIGA.

Know the medicines you take. Keep a list of them with you to show to your healthcare provider and pharmacist when you get a new medicine.

How should I take ZYTIGA?

- Take ZYTIGA and prednisone exactly as your healthcare provider tells you.
- Take your prescribed dose of ZYTIGA one time a day.
- Your healthcare provider may change your dose if needed.
- Do not stop taking your prescribed dose of ZYTIGA or prednisone without talking with your healthcare provider first.
- Take ZYTIGA on an empty stomach. **Do not take ZYTIGA with food.** Taking ZYTIGA with food may cause more of the medicine to be absorbed by the body than is needed and this may cause side effects.
- No food should be eaten 2 hours before and 1 hour after taking ZYTIGA.
- Swallow ZYTIGA tablets whole. Do not crush or chew tablets.
- Take ZYTIGA tablets with water.
- Men who are sexually active with a pregnant woman must use a condom during and for one week after treatment with ZYTIGA. If their sexual partner may become pregnant, a condom and another form of birth control must be used during and for one week after treatment with ZYTIGA. Talk with your healthcare provider if you have questions about birth control.
- If you miss a dose of ZYTIGA or prednisone, take your prescribed dose the following day. If you miss more than 1 dose, tell your healthcare provider right away.
- Your healthcare provider will do blood tests to check for side effects.

What are the possible side effects of ZYTIGA?

ZYTIGA may cause serious side effects including:

- **High blood pressure (hypertension), low blood potassium levels (hypokalemia) and fluid retention (edema).** Tell your healthcare provider if you get any of the following symptoms:
 - dizziness
 - fast heartbeats
 - feel faint or lightheaded
 - headache
 - confusion
 - muscle weakness
 - pain in your legs
 - swelling in your legs or feet
- **Adrenal problems** may happen if you stop taking prednisone, get an infection, or are under stress.
- **Liver problems.** Your healthcare provider will do blood tests to check your liver before treatment with ZYTIGA and during treatment with ZYTIGA.

The most common side effects of ZYTIGA include:

- joint swelling or pain
- muscle aches
- hot flushes
- diarrhea
- urinary tract infection
- cough
- irregular heartbeats
- urinate more often than normal
- need to get up at night to urinate
- heartburn
- cold like symptoms
- bone fractures

Tell your healthcare provider if you have any side effect that bothers you or that does not go away.

These are not all the possible side effects of ZYTIGA. For more information, ask your healthcare provider or pharmacist.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store ZYTIGA?

- Store ZYTIGA at 59°F to 86°F (15°C to 30°C).

Keep ZYTIGA and all medicines out of the reach of children.

General information about ZYTIGA.

Medicines are sometimes prescribed for purposes other than those listed in a patient information leaflet. Do not use ZYTIGA for a condition for which it was not prescribed. Do not give your ZYTIGA to other people, even if they have the same symptoms that you have. It may harm them.

This leaflet summarizes the most important information about ZYTIGA. If you would like more information, talk with your healthcare provider. You can ask your healthcare provider or pharmacist for information about ZYTIGA that is written for healthcare professionals.

For more information contact Janssen Biotech, Inc. at 1-800-457-6399 or www.Zytiga.com.

What are the ingredients of ZYTIGA?

Active ingredient: abiraterone acetate

Inactive ingredients: lactose monohydrate, microcrystalline cellulose, croscarmellose sodium, povidone, sodium lauryl sulfate, magnesium stearate and colloidal silicon dioxide.

This Patient Information has been approved by the U.S. Food and Drug Administration.

Manufactured by:

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