

HIGHLIGHTS OF PRESCRIBING INFORMATION

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

OFEV® (nintedanib) capsules, for oral use
Initial U.S. Approval: 2014

RECENT MAJOR CHANGES

Dosage and Administration, Testing Prior to OFEV Administration (2.1)	2/2016
Dosage and Administration, Recommended Dosage (2.2)	2/2016
Dosage and Administration, Dosage Modification Due to Adverse reactions (2.3)	2/2016
Warnings and Precautions, Hepatic Impairment (5.1)	2/2016
Warnings and Precautions, Embryo-Fetal Toxicity (5.4)	2/2016

INDICATIONS AND USAGE

OFEV is a kinase inhibitor indicated for the treatment of idiopathic pulmonary fibrosis (IPF). (1)

DOSAGE AND ADMINISTRATION

- Recommended dosage: 150 mg twice daily approximately 12 hours apart taken with food. (2.2)
- Recommended dosage in patients with mild hepatic impairment (Child Pugh A): 100 mg twice daily approximately 12 hours apart taken with food. (2.2, 8.6)
- Consider temporary dose reduction to 100 mg, treatment interruption, or discontinuation for management of adverse reactions. (2.3, 5.2, 5.3, 6)
- Prior to treatment, conduct liver function tests and a pregnancy test. (2.1, 5.2, 5.4)

DOSAGE FORMS AND STRENGTHS

Capsules: 150 mg and 100 mg (3)

CONTRAINDICATIONS

None

WARNINGS AND PRECAUTIONS

- Hepatic impairment: OFEV is not recommended for use in patients with moderate or severe hepatic impairment. In patients with mild hepatic impairment (Child Pugh A), the recommended dosage is 100 mg twice daily approximately 12 hours apart taken with food. Consider treatment interruption, or discontinuation for management of adverse reactions in these patients. (2.2, 2.3, 5.1, 8.6, 12.3)

- Elevated liver enzymes: ALT, AST, and bilirubin elevations have occurred with OFEV. Monitor ALT, AST, and bilirubin before and during treatment. Temporary dosage reductions or discontinuations may be required. (2.1, 2.3, 5.2)
- Gastrointestinal disorders: Diarrhea, nausea, and vomiting have occurred with OFEV. Treat patients at first signs with adequate hydration and antidiarrheal medicine (e.g., loperamide) or anti-emetics. Discontinue OFEV if severe diarrhea, nausea, or vomiting persists despite symptomatic treatment. (5.3)
- Embryo-Fetal toxicity: Can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and to use effective contraception. (5.4, 8.1, 8.3)
- Arterial thromboembolic events have been reported. Use caution when treating patients at higher cardiovascular risk including known coronary artery disease. (5.5)
- Bleeding events have been reported. Use OFEV in patients with known bleeding risk only if anticipated benefit outweighs the potential risk. (5.6)
- Gastrointestinal perforation has been reported. Use OFEV with caution when treating patients with recent abdominal surgery. Discontinue OFEV in patients who develop gastrointestinal perforation. Only use OFEV in patients with known risk of gastrointestinal perforation if the anticipated benefit outweighs the potential risk. (5.7)

ADVERSE REACTIONS

Most common adverse reactions (≥5%) are: diarrhea, nausea, abdominal pain, vomiting, liver enzyme elevation, decreased appetite, headache, weight decreased, and hypertension. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Boehringer Ingelheim Pharmaceuticals, Inc. at (800) 542-6257 or (800) 459-9906 TTY or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Coadministration of P-gp and CYP3A4 inhibitors may increase nintedanib exposure. Monitor patients closely for tolerability of OFEV. (7.1)

USE IN SPECIFIC POPULATIONS

- Lactation: Breastfeeding is not recommended. (8.2)
- Renal impairment: The safety and efficacy of OFEV have not been studied in patients with severe renal impairment and end-stage renal disease. (8.7, 12.3)
- Smokers: Decreased exposure has been noted in smokers which may alter the efficacy profile of OFEV. (8.8)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 2/2016

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

OFEV is indicated for the treatment of idiopathic pulmonary fibrosis (IPF).

2 DOSAGE AND ADMINISTRATION

2.1 Testing Prior to OFEV Administration

Conduct liver function tests and a pregnancy test prior to initiating treatment with OFEV [see *Warnings and Precautions (5.2, 5.4)*].

2.2 Recommended Dosage

The recommended dosage of OFEV is 150 mg twice daily administered approximately 12 hours apart.

OFEV capsules should be taken with food [see *Clinical Pharmacology (12.3)*] and swallowed whole with liquid. OFEV capsules should not be chewed or crushed because of a bitter taste. The effect of chewing or crushing of the capsule on the pharmacokinetics of nintedanib is not known.

If a dose of OFEV is missed, the next dose should be taken at the next scheduled time. Advise the patient to not make up for a missed dose. Do not exceed the recommended maximum daily dosage of 300 mg.

In patients with mild hepatic impairment (Child Pugh A), the recommended dosage of OFEV is 100 mg twice daily approximately 12 hours apart taken with food.

2.3 Dosage Modification due to Adverse Reactions

In addition to symptomatic treatment, if applicable, the management of adverse reactions of OFEV may require dose reduction or temporary interruption until the specific adverse reaction resolves to levels that allow continuation of therapy. OFEV treatment may be resumed at the full dosage (150 mg twice daily), or at the reduced dosage (100 mg twice daily), which subsequently may be increased to the full dosage. If a patient does not tolerate 100 mg twice daily, discontinue treatment with OFEV [see *Warnings and Precautions (5.2, 5.3, 5.5, 5.7) and Adverse Reactions (6.1)*].

Dose modifications or interruptions may be necessary for liver enzyme elevations. For aspartate aminotransferase (AST) or alanine aminotransferase (ALT) >3 times to <5 times the upper limit of normal (ULN) without signs of severe liver damage, interrupt treatment or reduce OFEV to 100 mg twice daily. Once liver enzymes have returned to baseline values, treatment with OFEV may be reintroduced at a reduced dosage (100 mg twice daily), which subsequently may be increased to the full dosage (150 mg twice daily) [see *Warnings and Precautions (5.2) and Adverse Reactions (6.1)*]. Discontinue OFEV for AST or ALT elevations >5 times ULN or >3 times ULN with signs or symptoms of severe liver damage.

In patients with mild hepatic impairment (Child Pugh A), consider treatment interruption, or discontinuation for management of adverse reactions.

3 DOSAGE FORMS AND STRENGTHS

150 mg capsules: brown, opaque, oblong, soft capsules imprinted in black with the Boehringer Ingelheim company symbol and "150".

100 mg capsules: peach, opaque, oblong, soft capsules imprinted in black with the Boehringer Ingelheim company symbol and "100".

4 CONTRAINDICATIONS

None

5 WARNINGS AND PRECAUTIONS

5.1 Hepatic Impairment

Treatment with OFEV is not recommended in patients with moderate (Child Pugh B) or severe (Child Pugh C) hepatic impairment [see *Use in Specific Populations (8.6) and Clinical Pharmacology (12.3)*]. Patients with mild hepatic impairment (Child Pugh A) can be treated with a reduced dose of OFEV [see *Dosage and Administration (2.2)*].

5.2 Elevated Liver Enzymes

In clinical trials, administration of OFEV was associated with elevations of liver enzymes (ALT, AST, ALKP, GGT). Liver enzyme increases were reversible with dose modification or interruption and not associated with clinical signs or symptoms of liver injury. The majority (94%) of patients with ALT and/or AST elevations had elevations <5 times ULN. Administration of OFEV was also associated with elevations of bilirubin. The majority (95%) of patients with bilirubin elevations had elevations <2 times ULN [see *Use in Specific Populations (8.6) and Clinical Pharmacology (12.3)*]. Conduct liver function tests (ALT, AST, and bilirubin) prior to treatment with OFEV, monthly for 3 months, and every 3 months thereafter, and as clinically indicated. Dosage modifications or interruption may be necessary for liver enzyme elevations [see *Dosage and Administration (2.1, 2.3)*].

5.3 Gastrointestinal Disorders

Diarrhea

Diarrhea was the most frequent gastrointestinal event reported in 62% versus 18% of patients treated with OFEV and placebo, respectively [see *Adverse Reactions (6.1)*]. In most patients, the event was of mild to moderate intensity and occurred within the first 3 months of treatment. Diarrhea led to permanent dose reduction in 11% of patients treated with OFEV compared to 0 placebo-treated patients. Diarrhea led to discontinuation of OFEV in 5% of the patients compared to <1% of placebo-treated patients.

Dosage modifications or treatment interruptions may be necessary in patients with adverse reactions of diarrhea. Treat diarrhea at first signs with adequate hydration and antidiarrheal medication (e.g., loperamide), and consider treatment interruption if diarrhea continues [see *Dosage and Administration (2.3)*]. OFEV treatment may be resumed at the full dosage (150 mg twice daily), or at the reduced dosage (100 mg twice daily), which subsequently may be increased to the full dosage. If severe diarrhea persists despite symptomatic treatment, discontinue treatment with OFEV.

Nausea and Vomiting

Nausea was reported in 24% versus 7% and vomiting was reported in 12% versus 3% of patients treated with OFEV and placebo, respectively [see *Adverse Reactions (6.1)*]. In most patients, these events were of mild to moderate intensity. Nausea led to discontinuation of OFEV in 2% of patients. Vomiting led to discontinuation of OFEV in 1% of the patients.

For nausea or vomiting that persists despite appropriate supportive care including anti-emetic therapy, dose reduction or treatment interruption may be required [see *Dosage and Administration (2.3)*]. OFEV treatment may be resumed at the full dosage (150 mg twice daily), or at the reduced dosage (100 mg twice daily), which subsequently may be increased to the full dosage. If severe nausea or vomiting does not resolve, discontinue treatment with OFEV.

5.4 Embryo-Fetal Toxicity

Based on findings from animal studies and its mechanism of action, OFEV can cause fetal harm when administered to a pregnant woman. Nintedanib caused embryo-fetal deaths and structural abnormalities in rats and rabbits when administered during organogenesis at less than (rats) and approximately 5 times (rabbits) the maximum recommended human dose (MRHD) in adults. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to avoid becoming pregnant while receiving treatment with OFEV and to use effective contraception during treatment and at least 3 months after the last dose of OFEV. Verify pregnancy status prior to treatment with OFEV [see *Use in Specific Populations (8.1, 8.3) and Clinical Pharmacology (12.1)*].

5.5 Arterial Thromboembolic Events

Arterial thromboembolic events have been reported in patients taking OFEV. In clinical trials, arterial thromboembolic events were reported in 2.5% of patients treated with OFEV and 0.8% of placebo-treated patients. Myocardial infarction was the most common adverse reaction under arterial thromboembolic events, occurring in 1.5% of OFEV-treated patients compared to 0.4% of placebo-treated patients.

Use caution when treating patients at higher cardiovascular risk including known coronary artery disease. Consider treatment interruption in patients who develop signs or symptoms of acute myocardial ischemia.

5.6 Risk of Bleeding

Based on the mechanism of action (VEGFR inhibition), OFEV may increase the risk of bleeding. In clinical trials, bleeding events were reported in 10% of patients treated with OFEV and in 7% of patients treated with placebo.

Use OFEV in patients with known risk of bleeding only if the anticipated benefit outweighs the potential risk.

5.7 Gastrointestinal Perforation

Based on the mechanism of action, OFEV may increase the risk of gastrointestinal perforation. In clinical trials, gastrointestinal perforation was reported in 0.3% of patients treated with OFEV, compared to 0 cases in the placebo-treated patients.

Use caution when treating patients who have had recent abdominal surgery. Discontinue therapy with OFEV in patients who develop gastrointestinal perforation. Only use OFEV in patients with known risk of gastrointestinal perforation if the anticipated benefit outweighs the potential risk.

6 ADVERSE REACTIONS

The following adverse reactions are discussed in greater detail in other sections of the labeling:

- Liver Enzyme and Bilirubin Elevations [see *Warnings and Precautions (5.2)*]
- Gastrointestinal Disorders [see *Warnings and Precautions (5.3)*]
- Embryo-Fetal Toxicity [see *Warnings and Precautions (5.4)*]
- Arterial Thromboembolic Events [see *Warnings and Precautions (5.5)*]
- Risk of Bleeding [see *Warnings and Precautions (5.6)*]
- Gastrointestinal Perforation [see *Warnings and Precautions (5.7)*]

6.1 Clinical Trials 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 practice.

The safety of OFEV was evaluated in over 1000 IPF patients with over 200 patients exposed to OFEV for more than 2 years in clinical trials.

OFEV was studied in three randomized, double-blind, placebo-controlled, 52-week trials. In the phase 2 (Study 1) and phase 3 (Studies 2 and 3) trials, 723 patients with IPF received OFEV 150 mg twice daily and 508 patients received placebo. The median duration of exposure was 10 months for patients treated with OFEV and 11 months for patients treated with placebo. Subjects ranged in age from 42 to 89 years (median age of 67 years). Most patients were male (79%) and Caucasian (60%).

The most frequent serious adverse reactions reported in patients treated with OFEV, more than placebo, were bronchitis (1.2% vs. 0.8%) and myocardial infarction (1.5% vs. 0.4%). The most common adverse events leading to death in patients treated with OFEV, more than placebo, were pneumonia (0.7% vs. 0.6%), lung neoplasm malignant (0.3% vs. 0%), and myocardial infarction (0.3% vs. 0.2%). In the predefined category of major adverse cardiovascular events (MACE) including MI, fatal events were reported in 0.6% of OFEV-treated patients and 1.8% of placebo-treated patients.

Adverse reactions leading to permanent dose reductions were reported in 16% of OFEV-treated patients and 1% of placebo-treated patients. The most frequent adverse reaction that led to permanent dose reduction in the patients treated with OFEV was diarrhea (11%).

Adverse reactions leading to discontinuation were reported in 21% of OFEV-treated patients and 15% of placebo-treated patients. The most frequent adverse reactions that led to discontinuation in OFEV-treated patients were diarrhea (5%), nausea (2%), and decreased appetite (2%).

The most common adverse reactions with an incidence of $\geq 5\%$ and more frequent in the OFEV than placebo treatment group are listed in Table 1.

Table 1 Adverse Reactions Occurring in $\geq 5\%$ of OFEV-treated Patients and More Commonly Than Placebo in Studies 1, 2, and 3

Adverse Reaction	OFEV, 150 mg n=723	Placebo n=508
Gastrointestinal disorders		
Diarrhea	62%	18%
Nausea	24%	7%
Abdominal pain ^a	15%	6%
Vomiting	12%	3%
Hepatobiliary disorders		
Liver enzyme elevation ^b	14%	3%
Metabolism and nutrition disorders		
Decreased appetite	11%	5%
Nervous systemic disorders		
Headache	8%	5%
Investigations		
Weight decreased	10%	3%
Vascular disorders		
Hypertension ^c	5%	4%

^a Includes abdominal pain, abdominal pain upper, abdominal pain lower, gastrointestinal pain and abdominal tenderness.

^b Includes gamma-glutamyltransferase increased, hepatic enzyme increased, alanine aminotransferase increased, aspartate aminotransferase increased, hepatic function abnormal, liver function test abnormal, transaminase increased, blood alkaline phosphatase-increased, alanine aminotransferase abnormal, aspartate aminotransferase abnormal, and gamma-glutamyltransferase abnormal.

^c Includes hypertension, blood pressure increased, hypertensive crisis, and hypertensive cardiomyopathy.

In addition, hypothyroidism was reported in patients treated with OFEV, more than placebo (1.1% vs. 0.6%).

7 DRUG INTERACTIONS

7.1 P-glycoprotein (P-gp) and CYP3A4 Inhibitors and Inducers

Nintedanib is a substrate of P-gp and, to a minor extent, CYP3A4 [see *Clinical Pharmacology (12.3)*]. Coadministration with oral doses of a P-gp and CYP3A4 inhibitor, ketoconazole, increased exposure to nintedanib by 60%. Concomitant use of P-gp and CYP3A4 inhibitors (e.g., erythromycin) with OFEV may increase exposure to nintedanib [see *Clinical Pharmacology (12.3)*]. In such cases, patients should be monitored closely for tolerability of OFEV. Management of adverse reactions may require interruption, dose reduction, or discontinuation of therapy with OFEV [see *Dosage and Administration (2.3)*].

Coadministration with oral doses of a P-gp and CYP3A4 inducer, rifampicin, decreased exposure to nintedanib by 50%. Concomitant use of P-gp and CYP3A4 inducers (e.g., carbamazepine, phenytoin, and St. John's wort) with OFEV should be avoided as these drugs may decrease exposure to nintedanib [see *Clinical Pharmacology (12.3)*].

7.2 Anticoagulants

Nintedanib is a VEGFR inhibitor, and may increase the risk of bleeding. Monitor patients on full anticoagulation therapy closely for bleeding and adjust anticoagulation treatment as necessary [see *Warnings and Precautions (5.6)*].

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Based on findings from animal studies and its mechanism of action [see *Clinical Pharmacology (12.1)*], OFEV can cause fetal harm when administered to a pregnant woman. There are no data on the use of OFEV during pregnancy. In animal studies of pregnant rats and rabbits treated during organogenesis, nintedanib caused embryo-fetal deaths and structural abnormalities at less than (rats) and approximately 5 times (rabbits) the maximum recommended human dose [see *Data*]. Advise pregnant women of the potential risk to a fetus.

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects is 2% to 4% and miscarriage in clinically recognized pregnancies is 15% to 20%.

Data

Animal Data

In animal reproduction toxicity studies, nintedanib caused embryo-fetal deaths and structural abnormalities in rats and rabbits at less than and approximately 5 times the maximum recommended human dose (MRHD) in adults (on a plasma AUC basis at maternal oral doses of 2.5 and 15 mg/kg/day in rats and rabbits, respectively). Malformations included abnormalities in the vasculature, urogenital, and skeletal systems. Vasculature anomalies included missing or additional major blood vessels. Skeletal anomalies included abnormalities in the thoracic, lumbar, and caudal vertebrae (e.g., hemivertebra, missing, or asymmetrically ossified), ribs (bifid or fused), and sternbrae (fused, split, or unilaterally ossified). In some fetuses, organs in the urogenital system were missing. In rabbits, a significant change in sex ratio was observed in fetuses (female:male ratio of approximately 71%:29%) at approximately 15 times the MRHD in adults (on an AUC basis at a maternal oral dose of 60 mg/kg/day). Nintedanib decreased post-natal viability of rat pups during the first 4 post-natal days when dams were exposed to less than the MRHD (on an AUC basis at a maternal oral dose of 10 mg/kg/day).

8.2 Lactation

Risk Summary

There is no information on the presence of nintedanib in human milk, the effects on the breast-fed infant or the effects on milk production. Nintedanib and/or its metabolites are present in the milk of lactating rats [see *Data*]. Because of the potential for serious adverse reactions in nursing infants from OFEV, advise women that breastfeeding is not recommended during treatment with OFEV.

Data

Milk and plasma of lactating rats have similar concentrations of nintedanib and its metabolites.

8.3 Females and Males of Reproductive Potential

Based on findings from animal studies and its mechanism of action, OFEV can cause fetal harm when administered to a pregnant woman and may reduce fertility in females of reproductive potential [see *Use in Specific Populations (8.1), Clinical Pharmacology (12.1), and Nonclinical Toxicology (13.1)*]. Counsel patients on pregnancy prevention and planning.

Pregnancy Testing

Verify the pregnancy status of females of reproductive potential prior to treatment with OFEV [see *Dosage and Administration (2.1), Warnings and Precautions (5.4) and Use in Specific Populations (8.1)*].

Contraception

Advise females of reproductive potential to avoid becoming pregnant while receiving treatment with OFEV. Advise females of reproductive potential to use effective contraception during treatment, and for at least 3 months after taking the last dose of OFEV.

Infertility

Based on animal data, OFEV may reduce fertility in females of reproductive potential [see *Nonclinical Toxicology (13.1)*].

8.4 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.5 Geriatric Use

Of the total number of subjects in phase 2 and 3 clinical studies of OFEV, 60.8% were 65 and over, while 16.3% were 75 and over. In phase 3 studies, no overall differences in effectiveness were observed between subjects who were 65 and over and younger subjects; no overall differences in safety were observed between subjects who were 65 and over or 75 and over and younger subjects, but greater sensitivity of some older individuals cannot be ruled out.

8.6 Hepatic Impairment

Nintedanib is predominantly eliminated via biliary/fecal excretion (>90%). In a PK study performed in patients with hepatic impairment (Child Pugh A, Child Pugh B), exposure to nintedanib was increased [see *Clinical Pharmacology (12.3)*]. In patients with mild hepatic impairment (Child Pugh A), the recommended dosage of OFEV is 100 mg twice daily [see *Dosage and Administration (2.2)*]. Monitor for adverse reactions and consider treatment interruption, or discontinuation for management of adverse reactions in these patients [see *Dosage and Administration (2.3)*]. Treatment of patients with moderate (Child Pugh B) and severe (Child Pugh C) hepatic impairment with OFEV is not recommended [see *Warnings and Precautions (5.1)*].

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Nintedanib is a small molecule that inhibits multiple receptor tyrosine kinases (RTKs) and non-receptor tyrosine kinases (nRTKs). Nintedanib inhibits the following RTKs: platelet-derived growth factor receptor (PDGFR) α and β , fibroblast growth factor receptor (FGFR) 1-3, vascular endothelial growth factor receptor (VEGFR) 1-3, and Fms-like tyrosine kinase-3 (FLT3). Among them, FGFR, PDGFR, and VEGFR have been implicated in IPF pathogenesis. Nintedanib binds competitively to the adenosine triphosphate (ATP) binding pocket of these receptors and blocks the intracellular signaling which is crucial for the proliferation, migration, and transformation of fibroblasts representing essential mechanisms of the IPF pathology. In addition, nintedanib inhibits the following nRTKs: Lck, Lyn and Src kinases. The contribution of FLT3 and nRTK inhibition to IPF efficacy is unknown.

12.2 Pharmacodynamics

Cardiac Electrophysiology

In a study in renal cell cancer patients, QT/QTc measurements were recorded and showed that a single oral dose of 200 mg nintedanib as well as multiple oral doses of 200 mg nintedanib administered twice daily for 15 days did not prolong the QTcF interval.

12.3 Pharmacokinetics

The PK properties of nintedanib were similar in healthy volunteers, patients with IPF, and cancer patients. The PK of nintedanib is linear. Dose proportionality was shown by an increase of nintedanib exposure with increasing doses (dose range 50 to 450 mg once daily and 150 to 300 mg twice daily). Accumulation upon multiple administrations in patients with IPF was 1.76-fold for AUC. Steady-state plasma concentrations were achieved within one week of dosing. Nintedanib trough concentrations remained stable for more than one year. The inter-individual variability in the PK of nintedanib was moderate to high (coefficient of variation of standard PK parameters in the range of 30% to 70%), intra-individual variability low to moderate (coefficients of variation below 40%).

Absorption

Nintedanib reached maximum plasma concentrations approximately 2 to 4 hours after oral administration as a soft gelatin capsule under fed conditions. The absolute bioavailability of a 100 mg dose was 4.7% (90% CI: 3.62 to 6.08) in healthy volunteers. Absorption and bioavailability are decreased by transporter effects and substantial first-pass metabolism.

After food intake, nintedanib exposure increased by approximately 20% compared to administration under fasted conditions (90% CI: 95.3% to 152.5%) and absorption was delayed (median t_{\max} fasted: 2.00 hours; fed: 3.98 hours), irrespective of the food type.

Distribution

Nintedanib follows bi-phasic disposition kinetics. After intravenous infusion, a high volume of distribution which was larger than total body volume (V_{ss} : 1050 L) was observed.

The *in vitro* protein binding of nintedanib in human plasma was high, with a bound fraction of 97.8%. Serum albumin is considered to be the major binding protein. Nintedanib is preferentially distributed in plasma with a blood to plasma ratio of 0.87.

Elimination

The effective half-life of nintedanib in patients with IPF was 9.5 hours (gCV 31.9%). Total plasma clearance after intravenous infusion was high (CL: 1390 mL/min; gCV 28.8%). Urinary excretion of unchanged drug

within 48 hours was about 0.05% of the dose after oral and about 1.4% of the dose after intravenous administration; the renal clearance was 20 mL/min.

Metabolism

The prevalent metabolic reaction for nintedanib is hydrolytic cleavage by esterases resulting in the free acid moiety BIBF 1202. BIBF 1202 is subsequently glucuronidated by UGT enzymes, namely UGT 1A1, UGT 1A7, UGT 1A8, and UGT 1A10 to BIBF 1202 glucuronide. Only a minor extent of the biotransformation of nintedanib consisted of CYP pathways, with CYP 3A4 being the predominant enzyme involved. The major CYP-dependent metabolite could not be detected in plasma in the human absorption, distribution, metabolism, and elimination study. *In vitro*, CYP-dependent metabolism accounted for about 5% compared to about 25% ester cleavage.

Excretion

The major route of elimination of drug-related radioactivity after oral administration of [¹⁴C] nintedanib was via fecal/biliary excretion (93.4% of dose), and the majority of OFEV was excreted as BIBF 1202. The contribution of renal excretion to the total clearance was low (0.65% of dose). The overall recovery was considered complete (above 90%) within 4 days after dosing.

Specific Populations

Age, Body Weight, and Sex

Based on population PK analysis, age and body weight were correlated with nintedanib exposure. However, their effects on exposure are not sufficient to warrant a dose adjustment. There was no influence of sex on the exposure of nintedanib.

Renal Impairment

Based on a population PK analysis of data from 933 patients with IPF, exposure to nintedanib was not influenced by mild (CrCl: 60 to 90 mL/min; n=399) or moderate (CrCl: 30 to 60 mL/min; n=116) renal impairment. Data in severe renal impairment (CrCl below 30 mL/min) was limited.

Hepatic Impairment

A dedicated single-dose phase I pharmacokinetics study of OFEV compared 8 subjects with mild hepatic impairment (Child Pugh A) and 8 subjects with moderate hepatic impairment (Child Pugh B) to 17 subjects with normal hepatic function. In subjects with mild hepatic impairment, the mean exposure to nintedanib was 2.4-fold higher based on C_{max} (90% CI 1.6 to 3.6) and 2.2-fold higher based on AUC_{0-inf} (90% CI 1.4 to 3.5). In subjects with moderate hepatic impairment, exposure was 6.9-fold higher based on C_{max} (90% CI 4.4 to 11.0) and 7.6-fold higher based on AUC_{0-inf} (90% CI 5.1 to 11.3). Subjects with severe hepatic impairment (Child Pugh C) have not been studied.

Smokers

In the population PK analysis, the exposure of nintedanib was 21% lower in current smokers compared to ex- and never-smokers. The effect is not sufficient to warrant a dose adjustment.

Drug Interaction Studies

Potential for Nintedanib to Affect Other Drugs

Effect of nintedanib coadministration on pirfenidone AUC and C_{max} was evaluated in a multiple-dose study. Nintedanib did not have an effect on the exposure of pirfenidone.

In *in vitro* studies, nintedanib was shown not to be an inhibitor of OATP-1B1, OATP-1B3, OATP-2B1, OCT-2, or MRP-2. *In vitro* studies also showed that nintedanib has weak inhibitory potential on OCT-1, BCRP, and

P-gp; these findings are considered to be of low clinical relevance. Nintedanib and its metabolites, BIBF 1202 and BIBF 1202 glucuronide, did not inhibit or induce CYP enzymes *in vitro*.

Potential for Other Drugs to Affect Nintedanib

Nintedanib is a substrate of P-gp and, to a minor extent, CYP3A4. Coadministration with the P-gp and CYP3A4 inhibitor, ketoconazole, increased exposure to nintedanib 1.61-fold based on AUC and 1.83-fold based on C_{max} in a dedicated drug-drug interaction study. In a drug-drug interaction study with the P-gp and CYP3A4 inducer, rifampicin, exposure to nintedanib decreased to 50.3% based on AUC and to 60.3% based on C_{max} upon coadministration with rifampicin compared to administration of nintedanib alone.

Based on a multiple-dose study in Japanese IPF patients, exposure to nintedanib decreased to 68.3% based on AUC and to 59.2% based on C_{max} upon coadministration with pirfenidone compared to administration of nintedanib alone.

Nintedanib displays a pH-dependent solubility profile with increased solubility at acidic pH<3. However, in the clinical trials, coadministration with proton pump inhibitors or histamine H2 antagonists did not influence the exposure (trough concentrations) of nintedanib.

In *in vitro* studies, nintedanib was shown not to be a substrate of OATP-1B1, OATP-1B3, OATP-2B1, OCT-2, MRP-2, or BCRP. *In vitro* studies also showed that nintedanib was a substrate of OCT-1; these findings are considered to be of low clinical relevance.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Two-year oral carcinogenicity studies of nintedanib in rats and mice have not revealed any evidence of carcinogenic potential. Nintedanib was dosed up to 10 and 30 mg/kg/day in rats and mice, respectively. These doses were less than and approximately 4 times the MRHD on a plasma drug AUC basis.

Nintedanib was negative for genotoxicity in the *in vitro* bacterial reverse mutation assay, the mouse lymphoma cell forward mutation assay, and the *in vivo* rat micronucleus assay.

In rats, nintedanib reduced female fertility at exposure levels approximately 3 times the MRHD (on an AUC basis at an oral dose of 100 mg/kg/day). Effects included increases in resorption and post-implantation loss, and a decrease in gestation index. Changes in the number and size of corpora lutea in the ovaries were observed in chronic toxicity studies in rats and mice. An increase in the number of females with resorptions only was observed at exposures approximately equal to the MRHD (on an AUC basis at an oral dose of 20 mg/kg/day). Nintedanib had no effects on male fertility in rats at exposure levels approximately 3 times the MRHD (on an AUC basis at an oral dose of 100 mg/kg/day).

14 CLINICAL STUDIES

The clinical efficacy of OFEV has been studied in 1231 patients with IPF in one phase 2 (Study 1) and two phase 3 (Studies 2 and 3). These were randomized, double-blind, placebo-controlled studies comparing treatment with OFEV 150 mg twice daily to placebo for 52 weeks.

Studies 2 and 3 were identical in design. Study 1 was very similar in design. Patients were randomized in a 3:2 ratio (1:1 for Study 1) to either OFEV 150 mg or placebo twice daily for 52 weeks. Study 1 also included other treatment arms (50 mg daily, 50 mg twice daily, and 100 mg twice daily) that are not further discussed. The primary endpoint was the annual rate of decline in Forced Vital Capacity (FVC). Time to first acute IPF

exacerbation was a key secondary endpoint in Studies 2 and 3 and a secondary endpoint in Study 1. Change from baseline in FVC percent predicted and survival were additional secondary endpoints in all studies.

Patients were required to have a diagnosis of IPF (ATS/ERS/JRS/ALAT criteria) for <5 years. Diagnoses were centrally adjudicated based on radiologic and, if applicable, histopathologic confirmation. Patients were required to be ≥ 40 years of age with an FVC $\geq 50\%$ of predicted and a carbon monoxide diffusing capacity (DLCO, corrected for hemoglobin) 30% to 79% of predicted. Patients with relevant airways obstruction (i.e., pre-bronchodilator FEV₁/FVC <0.7) or, in the opinion of the investigator, likely to receive a lung transplant during the studies were excluded (being listed for lung transplant was acceptable for inclusion). Patients with >1.5 times ULN of ALT, AST, or bilirubin, patients with a known risk or predisposition to bleeding, patients receiving a full dose of anticoagulation treatment, and patients with a recent history of myocardial infarction or stroke were excluded from the studies. Patients were also excluded if they received other investigational therapy, azathioprine, cyclophosphamide, or cyclosporine A within 8 weeks of entry into this trial, or n-acetyl cysteine and prednisone (>15 mg/day or equivalent) within 2 weeks. The majority of patients were Caucasian (60%) or Asian (30%) and male (79%). Patients had a mean age of 67 years and a mean FVC percent predicted of 80%.

Annual Rate of Decline in FVC

A statistically significant reduction in the annual rate of decline of FVC (in mL) was demonstrated in patients receiving OFEV compared to patients receiving placebo based on the random coefficient regression model, adjusted for gender, height, and age. The treatment effect on FVC was consistent in all 3 studies. See Table 2 for individual study results.

Table 2 Annual Rate of Decline in FVC (mL) in Studies 1, 2, and 3^a

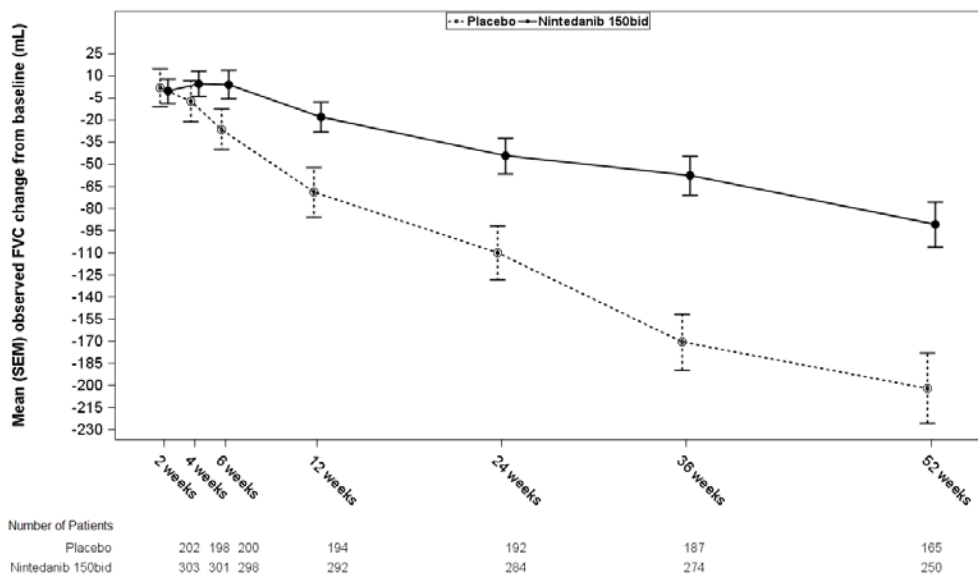
	Study 1		Study 2		Study 3	
	OFEV 150 mg twice daily	Placebo	OFEV 150 mg twice daily	Placebo	OFEV 150 mg twice daily	Placebo
Number of analyzed patients	84	83	309	204	329	219
Rate ^a of decline over 52 weeks	-60	-191	-115	-240	-114	-207
Comparison vs placebo Difference ^b	131		125		94	
95% CI	(27, 235)		(78, 173)		(45, 143)	

^aRandomized set in Study 1; treated set in Studies 2 and 3

^bEstimated based on a random coefficient regression model

Figure 1 displays the change from baseline over time in both treatment groups for Study 2. When the mean observed FVC change from baseline was plotted over time, the curves diverged at all timepoints through Week 52. Similar plots were seen for Studies 1 and 3.

Figure 1 Mean (SEM) Observed FVC Change from Baseline (mL) Over Time in Study 2

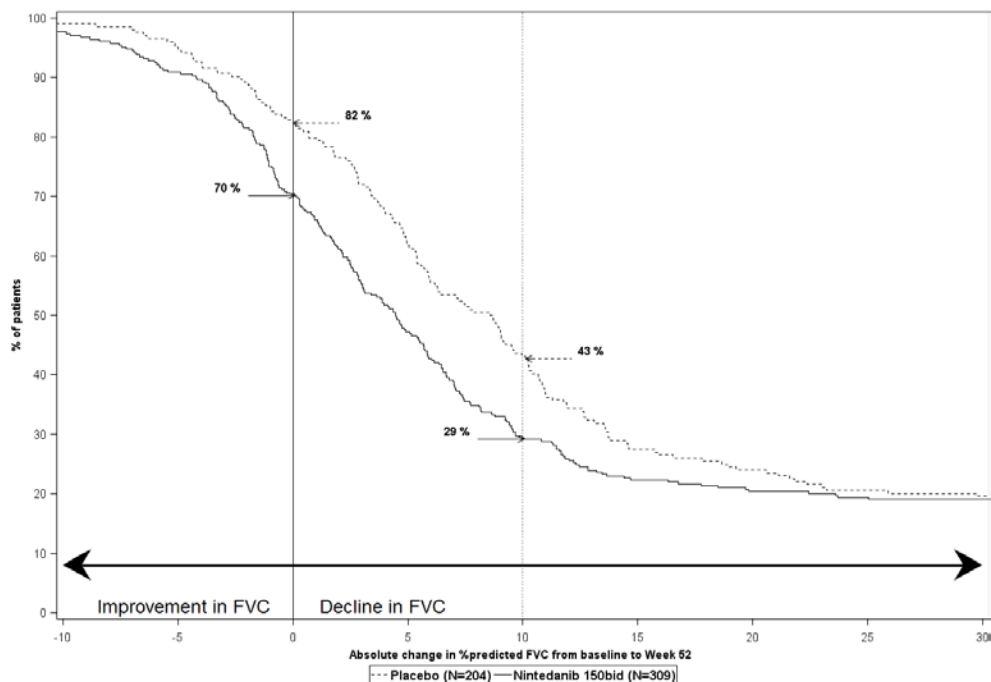


bid = twice daily

Change from Baseline in Percent Predicted Forced Vital Capacity

Figure 2 presents the cumulative distribution for all cut-offs for the change from baseline in FVC percent predicted at Week 52 for Study 2. For all categorical declines in lung function, the proportion of patients declining was lower on OFEV than on placebo. Study 3 showed similar results.

Figure 2 Cumulative Distribution of Patients by Change in Percent Predicted FVC from Baseline to Week 52 (Study 2).* The vertical lines indicate $\geq 0\%$ decline or $\geq 10\%$ decline.



*Missing data for change from baseline at Week 52 in percent predicted FVC (due to death, lost to follow-up or censoring before 52 weeks) was imputed using the worst decline from baseline at Week 52 observed among all patients with available data, regardless of treatment.

bid = twice daily

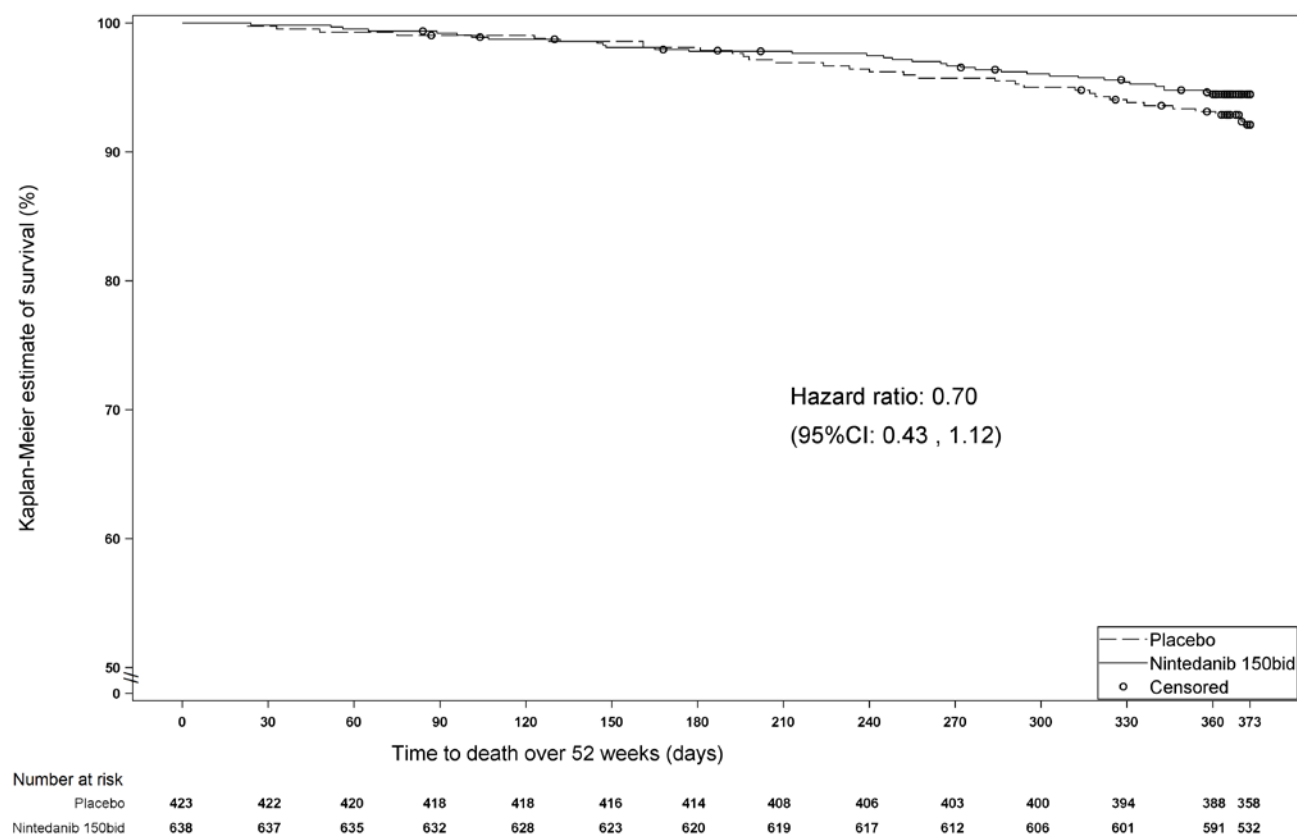
Time to First Acute IPF Exacerbation

Acute IPF exacerbation was defined as unexplained worsening or development of dyspnea within 30 days, new diffuse pulmonary infiltrates on chest x-ray, and/or new high-resolution CT parenchymal abnormalities with no pneumothorax or pleural effusion, and exclusion of alternative causes. Acute IPF exacerbation was adjudicated in Studies 2 and 3. In Studies 1 (investigator-reported) and 3 (adjudicated), the risk of first acute IPF exacerbation over 52 weeks was significantly reduced in patients receiving OFEV compared to placebo (hazard ratio [HR]: 0.16, 95% CI: 0.04, 0.71) and (HR:0.20, 95% CI: 0.07, 0.56), respectively. In Study 2 (adjudicated), there was no difference between the treatment groups (HR: 0.55, 95% CI: 0.20, 1.54).

Survival

Survival was evaluated for OFEV compared to placebo in Studies 2 and 3 as an exploratory analysis to support the primary endpoint (FVC). All-cause mortality was assessed over the study duration and available follow-up period, irrespective of cause of death and whether patients continued treatment. All-cause mortality did not show a statistically significant difference (See Figure 3).

Figure 3 Kaplan-Meier Estimates of All-Cause Mortality at Vital Status – End of Study: Studies 2 and 3



bid = twice daily

16 HOW SUPPLIED/STORAGE AND HANDLING

150 mg: brown, opaque, oblong, soft capsules imprinted in black with the Boehringer Ingelheim company symbol and "150". They are packaged in HDPE bottles with a child-resistant closure, available as follows:
Bottles of 60 NDC: 0597-0145-60

100 mg: peach, opaque, oblong, soft capsules imprinted in black with the Boehringer Ingelheim company symbol and "100". They are packaged in HDPE bottles with a child-resistant closure, available as follows:
Bottles of 60 NDC: 0597-0143-60

Storage

Store at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F) [see USP Controlled Room Temperature]. Protect from exposure to high humidity and avoid excessive heat. If repackaged, use USP tight container. Keep out of reach of children.

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Patient Information).

Liver Enzyme and Bilirubin Elevations

Advise patients that they will need to undergo liver function testing periodically. Advise patients to immediately report any symptoms of a liver problem (e.g., skin or the whites of eyes turn yellow, urine turns dark or brown (tea colored), pain on the right side of stomach, bleed or bruise more easily than normal, lethargy) [see Warnings and Precautions (5.2)].

Gastrointestinal Disorders

Inform patients that gastrointestinal disorders such as diarrhea, nausea, and vomiting were the most commonly reported gastrointestinal events occurring in patients who received OFEV. Advise patients that their healthcare provider may recommend hydration, antidiarrheal medications (e.g., loperamide), or anti-emetic medications to treat these side effects. Temporary dosage reductions or discontinuations may be required. Instruct patients to contact their healthcare provider at the first signs of diarrhea or for any severe or persistent diarrhea, nausea, or vomiting [see *Warnings and Precautions* (5.3) and *Adverse Reactions* (6.1)].

Embryo-Fetal Toxicity

Counsel patients on pregnancy prevention and planning. Advise females of reproductive potential of the potential risk to a fetus and to avoid becoming pregnant while receiving treatment with OFEV. Advise females of reproductive potential to use effective contraception during treatment, and for at least 3 months after taking the last dose of OFEV. Advise female patients to notify their doctor if they become pregnant during therapy with OFEV [see *Warnings and Precautions* (5.4) and *Use in Specific Populations* (8.1, 8.3)].

Arterial Thromboembolic Events

Advise patients about the signs and symptoms of acute myocardial ischemia and other arterial thromboembolic events and the urgency to seek immediate medical care for these conditions [see *Warnings and Precautions* (5.5)].

Risk of Bleeding

Bleeding events have been reported. Advise patients to report unusual bleeding [see *Warnings and Precautions* (5.6)].

Gastrointestinal Perforation

Serious gastrointestinal perforation events have been reported. Advise patients to report signs and symptoms of gastrointestinal perforation [see *Warnings and Precautions* (5.7)].

Lactation

Advise patients that breastfeeding is not recommended while taking OFEV [see *Use in Specific Populations* (8.2)].

Smokers

Encourage patients to stop smoking prior to treatment with OFEV and to avoid smoking when using with OFEV [see *Clinical Pharmacology* (12.3)].

Administration

Instruct patients to swallow OFEV capsules whole with liquid and not to chew or crush the capsules due to the bitter taste. Advise patients to not make up for a missed dose [see *Dosage and Administration* (2)].

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IT5950CB022016
10009642/03

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Patient Information
OFEV® (OH-fev)
(nintedanib)
capsules

What is the most important information I should know about OFEV?

OFEV can cause birth defects or death to an unborn baby. Women should not become pregnant while taking OFEV. Women who are able to become pregnant should have a pregnancy test before starting treatment with OFEV. Women who are able to become pregnant should use birth control during treatment and for at least 3 months after treatment. If you become pregnant while taking OFEV, tell your doctor right away.

What is OFEV?

- OFEV is a prescription medicine used to treat people with a lung disease called idiopathic pulmonary fibrosis (IPF).
- It is not known if OFEV is safe and effective in children.

What should I tell my doctor before taking OFEV?

Before you take OFEV, tell your doctor if you:

- have liver problems
- have heart problems
- have a history of blood clots
- have a bleeding problem or a family history of a bleeding problem
- have had recent surgery in your stomach (abdominal) area
- are a smoker
- have any other medical conditions
- are pregnant or plan to become pregnant. OFEV can harm your unborn baby. OFEV can cause birth defects or death to an unborn baby. See **“What is the most important information I should know about OFEV?”**
- are breastfeeding or plan to breastfeed. It is not known if OFEV passes into your breast milk. You **should not** breastfeed while taking OFEV.

Tell your doctor about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements such as St. John’s wort. Keep a list of the medicines you take and show it to your doctor and pharmacist when you get a new medicine.

How should I take OFEV?

- Take OFEV exactly as your doctor tells you to take it.
- Your doctor will tell you how much OFEV to take and when to take it.
- Take OFEV with food. Swallow the OFEV capsules whole with a liquid.
- **Do not** chew or crush OFEV capsules.
- If you miss a dose of OFEV, take your next dose at your regular time. **Do not** take the missed dose.
- **Do not** take more than 300 mg of OFEV in 1 day.
- If you take too much OFEV, call your doctor or go to the nearest hospital emergency room right away.
- Your doctor should do certain blood tests before you start taking OFEV.

What are the possible side effects of OFEV?

OFEV may cause serious side effects, including:

- See **“What is the most important information I should know about OFEV?”**
- **liver problems.** Call your doctor right away if you have unexplained symptoms such as yellowing of your skin or the white part of your eyes (jaundice), dark or brown (tea colored) urine, pain on the upper right side of your stomach area (abdomen), bleeding or bruising more easily than normal, or feeling tired. Your doctor will do blood tests regularly to check how well your liver function is working during your treatment with OFEV.
- **diarrhea, nausea, and vomiting.** While you are taking OFEV, your doctor may recommend that you drink fluids or take medicine to treat these side effects. Tell your doctor if you have diarrhea, nausea, or vomiting or if these symptoms do not go away or become worse. Tell your doctor if you are taking over-the-counter laxatives, stool softeners, and other medicines or dietary supplements that can cause

diarrhea.

- **heart attack.** Tell your doctor right away if you have symptoms of a heart problem. These symptoms may include chest pain or pressure, pain in your arms, back, neck or jaw, or shortness of breath.
- **stroke.** Tell your doctor right away if you have symptoms of a stroke. These symptoms may include numbness or weakness on 1 side of your body, trouble talking, headache, or dizziness.
- **bleeding problems.** OFEV may increase your chances of having bleeding problems. Tell your doctor if you have unusual bleeding, bruising, or wounds that do not heal. Tell your doctor if you are taking a blood thinner, including prescription blood thinners and over-the-counter aspirin.
- **tear in your stomach or intestinal wall (perforation).** OFEV may increase your chances of having a tear in your stomach or intestinal wall. Tell your doctor if you have pain or swelling in your stomach area.

The most common side effects of OFEV are diarrhea, nausea, stomach pain, vomiting, liver problems, decreased appetite, headache, and weight loss.

These are not all the possible side effects of OFEV. For more information, ask your doctor 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 OFEV?

- Store OFEV at room temperature between 68°F to 77°F (20°C to 25°C).
- Keep OFEV dry and protect from high heat.
- Safely throw away any OFEV that is out of date or no longer needed.

Keep OFEV and all medicines out of reach of children.

General information about the safe and effective use of OFEV.

- Medicines are sometimes prescribed for purposes other than those listed in a Patient Information leaflet. Do not use OFEV for any condition for which it was not prescribed. Do not give OFEV to other people, even if they have the same symptoms you have. It may harm them. This Patient Information leaflet summarizes the most important information about OFEV. If you would like more information, talk to your doctor. You can ask your pharmacist or doctor for information about OFEV that is written for health professionals.
- For more information, go to www.ofev.com or call Boehringer Ingelheim Pharmaceuticals, Inc. at 1-800-542-6257, or (TTY) 1-800-459-9906, or scan the code below to go to www.ofev.com.



What are the ingredients in OFEV?

Active ingredient: nintedanib.

Inactive ingredients: Fill Material: triglycerides, hard fat, lecithin. Capsule Shell: gelatin, glycerol, titanium dioxide, red ferric oxide, yellow ferric oxide, black ink.

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IT5950CB022016, 10009642/03
IT6996B, 309791-02
IT6999B, 309837-02

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

Revised: February 2016