

OXALIPLATIN

5 mg/mL Concentrate for Solution for IV Infusion



1.0 PHARMACOLOGIC CATEGORY

Antineoplastic (Platinum compound)

2.0 DESCRIPTION

Oxaliplatin is a white to off white crystalline powder. It is slightly soluble in water, very slightly soluble in methanol and practically insoluble in ethanol.

One mL of concentrate for solution for infusion contains 5 mg oxaliplatin.

10 mL of concentrate for solution for infusion contains 50 mg of oxaliplatin.

For the full list of excipients, see section **6.5 List of excipients**.

3.0 FORMULATION/ COMPOSITION

Each vial contains sterile solution of 50 mg and 100 mg Oxaliplatin in Water for Injections to make 10 mL and 20 mL solution

4.0 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Oxaliplatin in combination with 5-fluorouracil (5-FU) and folinic acid (FA) is indicated for:

- Adjuvant treatment of stage III (Duke's C) colon cancer after complete resection of primary tumor
- Treatment of metastatic colorectal cancer.

4.2 Dosage and Method of Administration

The preparation of injectable solutions of cytotoxic agents must be carried out by trained specialist personnel with knowledge of the medicinal product used, in conditions that guarantee the integrity of the medicinal product, the protection of the environment and in particular the protection of the personnel handling the medicinal products, in accordance with hospital policy. It requires a preparation area reserved for this purpose. It is forbidden to smoke, eat or drink in this area (see section **6.6 Special Precautions for Disposal and Other Handling**).

Dosage

FOR ADULTS ONLY

The recommended dose for oxaliplatin in adjuvant setting is 85 mg/m² intravenously repeated every 2 weeks for 12 cycles (6 months).

The recommended dose for oxaliplatin in treatment of metastatic colorectal cancer is 85 mg/m² intravenously repeated every 2 weeks until disease progression or unacceptable toxicity. Dosage given

should be adjusted according to tolerability (see section **4.4 Special Warnings and Precautions for Use**).

Oxaliplatin should always be administered before fluoropyrimidines – i.e. 5-fluorouracil.

Oxaliplatin is administered as a 2- to 6-hour intravenous infusion in 250 to 500 mL of glucose 5% solution (50 mg/mL) to give a concentration between 0.2 mg/mL and 0.70 mg/mL; 0.70 mg/mL is the highest concentration in clinical practice for an oxaliplatin dose of 85 mg/m².

Oxaliplatin has mainly been used in combination with continuous infusion 5-fluorouracil based regimens. For the two-weekly treatment schedule 5-fluorouracil regimens combining bolus and continuous infusion have been used.

Special Populations

- Renal impairment:

Oxaliplatin must not be administered in patients with severe renal impairment (see sections **4.3 Contraindications** and **5.2 Pharmacokinetic Properties**).

In patients with mild to moderate renal impairment, the recommended dose of oxaliplatin is 85 mg/m² (see sections **4.4 Special Warnings and Precautions for Use** and **5.2 Pharmacokinetic Properties**).

- Hepatic insufficiency:

In a phase I study including patients with several levels of hepatic impairment, frequency and severity of hepatobiliary disorders appeared to be related to progressive disease and impaired liver function tests at baseline. No specific dose adjustment for patients with abnormal liver function tests was performed during clinical development.

- Elderly patients:

No increase in severe toxicities was observed when oxaliplatin was used as a single agent or in combination with 5-fluorouracil in patients over the age of 65. In consequence no specific dose adaptation is required for elderly patients.

- Pediatric patients:

There is no relevant indication for use of Oxaliplatin in children. The effectiveness of oxaliplatin as single agent in the pediatric populations with solid tumors has not been established (see section **5.1 Pharmacodynamic Properties**).

Method of administration

Oxaliplatin is administered by intravenous infusion.

The administration of oxaliplatin does not require hyperhydration.

Oxaliplatin diluted in 250 to 500 mL of glucose 5% solution (50 mg/mL) to give a concentration not less than 0.2 mg/mL must be infused either via a central venous line or peripheral vein over 2 to 6 hours. Oxaliplatin infusion must always precede that of 5-fluorouracil.

In the event of extravasation, administration must be discontinued immediately.

Instructions for use:

Oxaliplatin must be diluted before use. Only 5% glucose diluent is to be used to dilute the concentrate for solution for infusion product. (See section **6.6 Special Precautions for Disposal and Other Handling**).

4.3 Contraindications

Oxaliplatin is contraindicated in patients who

- have a known history of hypersensitivity to oxaliplatin or to any of the excipients listed in section **6.5 List of Excipients**.
- are breast feeding.
- have myelosuppression prior to starting first course, as evidenced by baseline neutrophils $<2 \times 10^9/l$ and/or platelet count of $<100 \times 10^9/l$.
- have a peripheral sensory neuropathy with functional impairment prior to first course.
- have a severely impaired renal function (creatinine clearance less than 30 mL/min) (see section **5.2 Pharmacokinetic Properties**).

4.4 Special Warnings and Precautions for Use

Oxaliplatin should only be used in specialized departments of oncology and should be administered under the supervision of an experienced oncologist.

Renal impairment

Patients with mild to moderate renal impairment should be closely monitored for adverse reactions and dose adjusted according to toxicity (see section **5.2 Pharmacokinetic Properties**).

Hypersensitivity reactions

Special surveillance should be ensured for patients with a history of allergic manifestations to other products containing platinum. In case of anaphylactic manifestations, the infusion should be interrupted immediately and an appropriate symptomatic treatment started. Re-administration of oxaliplatin to such patients is contraindicated. Cross reactions, sometimes fatal, have been reported with all platinum compounds.

Extravasation

In case of oxaliplatin extravasation, the infusion must be stopped immediately and usual local symptomatic treatment initiated.

Neurological Symptoms

Neurological toxicity of oxaliplatin should be carefully monitored, especially if co-administered with other medicinal products with specific neurological toxicity. A neurological examination should be performed before each administration and periodically thereafter.

For patients who develop acute laryngopharyngeal dysesthesia (see section **4.8 Undesirable Effects**), during or within the hours following the 2-hour infusion, the next oxaliplatin infusion should be administered over 6 hours.

Peripheral neuropathy

If neurological symptoms (paresthesia, dysesthesia) occur, the following recommended oxaliplatin dosage adjustment should be based on the duration and severity of these symptoms:

- If symptoms last longer than seven days and are troublesome, the subsequent oxaliplatin dose should be reduced from 85 to 65 mg/m² (metastatic setting) or 75 mg/m² (adjuvant setting).
- If paresthesia without functional impairment persists until the next cycle, the subsequent oxaliplatin dose should be reduced from 85 to 65 mg/m² (metastatic setting) or 75 mg/m² (adjuvant setting).
- If paresthesia with functional impairment persists until the next cycle, oxaliplatin should be discontinued.
- If these symptoms improve following discontinuation of oxaliplatin therapy, resumption of therapy may be considered.

Patients should be informed of the possibilities of persistent symptoms of peripheral sensory neuropathy after the end of the treatment. Localized moderate paresthesias or parasthesias that may interfere with functional activities can persist after up to 3 years following treatment cessation in the adjuvant setting.

Reversible Posterior Leukoencephalopathy Syndrome (RPLS)

Cases of Reversible Posterior Leukoencephalopathy Syndrome (RPLS also known as PRES, Posterior Reversible Encephalopathy Syndrome) have been reported in patients receiving oxaliplatin in combination chemotherapy. RPLS is a rare, reversible, rapidly evolving neurological condition, which can include seizure, hypertension, headache, confusion, blindness, and other visual and neurological disturbances (see section **4.8 Undesirable Effects**). Diagnosis of RPLS is based upon confirmation by brain imaging, preferably MRI (Magnetic Resonance Imaging).

Nausea, vomiting, diarrhea, dehydration, and hematological changes

Gastrointestinal toxicity, which manifests as nausea and vomiting, warrants prophylactic and/or therapeutic anti-emetic therapy (see section **4.8 Undesirable Effects**).

Dehydration, paralytic ileus, intestinal obstruction, hypokalemia, metabolic acidosis and renal impairment may be caused by severe diarrhea/emesis particularly when combining oxaliplatin with 5-fluorouracil.

Cases of intestinal ischemia, including fatal outcomes, have been reported with oxaliplatin treatment. In case of intestinal ischemia, oxaliplatin treatment should be discontinued and appropriate measures initiated. (see section **4.8 Undesirable Effects**).

If hematological toxicity occurs (neutrophils < 1.5x10⁹/l or platelets < 50x10⁹/l), administration of the next course of therapy should be postponed until hematological values return to acceptable levels. A full blood count with white cell differential should be performed prior to start of therapy and before each subsequent course.

Patients must be adequately informed of the risk of diarrhea/emesis, mucositis/stomatitis and neutropenia after oxaliplatin and /5-fluorouracil administration so that they can urgently contact their treating physician for appropriate management. If mucositis/stomatitis occurs with or without neutropenia, the next treatment should be delayed until recovery from mucositis/stomatitis to grade 1 or less and/or until the neutrophil count is $\geq 1.5 \times 10^9/l$.

For oxaliplatin combined with 5-fluorouracil (with or without folinic acid), the usual dose adjustments for 5-fluorouracil associated toxicities should apply.

If grade 4 diarrhea, grade 3-4 neutropenia (neutrophils <1.0 x 10⁹/l), febrile neutropenia (fever of unknown origin without clinically or microbiologically documented infection with an absolute neutrophil count <1.0 x 10⁹/l, a single temperature of >38.3°C or a sustained temperature of >38°C for more than one hour), or

grade 3-4 thrombocytopenia (platelets $< 50 \times 10^9/l$) occur, the dose of oxaliplatin should be reduced from 85 to 65 mg/m² (metastatic setting) or 75 mg/m² (adjuvant setting), in addition to any 5-fluorouracil dose reductions required.

Pulmonary

In the case of unexplained respiratory symptoms such as non-productive cough, dyspnea, crackles or radiological pulmonary infiltrates, oxaliplatin should be discontinued until further pulmonary investigations exclude an interstitial lung disease or pulmonary fibrosis (see section **4.8 Undesirable Effects**).

Blood disorders

Hemolytic-uremic syndrome (HUS) is a life-threatening side effect (frequency not known). Oxaliplatin should be discontinued at the first signs of any evidence of microangiopathic hemolytic anemia, such as rapidly falling hemoglobin with concomitant thrombocytopenia, elevation of serum bilirubin, serum creatinine, blood urea nitrogen, or LDH. Renal failure may not be reversible with discontinuation of therapy and dialysis may be required.

Disseminated intravascular coagulation (DIC), including fatal outcomes, has been reported in association with oxaliplatin treatment. If DIC is present, oxaliplatin treatment should be discontinued and appropriate treatment should be administered. (see section **4.8 Undesirable Effects**)

QT prolongation

QT prolongation may lead to an increased risk for ventricular arrhythmias including Torsade de Pointes, which can be fatal (see section **4.8 Undesirable Effects**). The QT interval should be closely monitored on a regular basis before and after administration of oxaliplatin. Caution should be exercised in patients with a history or a predisposition for prolongation of QT, those who are taking medicinal products known to prolong QT interval, and those with electrolyte disturbances such as hypokalemia, hypocalcemia, or hypomagnesaemia. In case of QT prolongation, oxaliplatin treatment should be discontinued. (see sections **4.5 Interaction with Other Medicinal Products and Other Forms of Interaction** and **4.8 Undesirable Effects**).

Rhabdomyolysis

Rhabdomyolysis has been reported in patients treated with oxaliplatin, including fatal outcomes. In case of muscle pain and swelling, in combination with weakness, fever or darkened urine, oxaliplatin treatment should be discontinued. If rhabdomyolysis is confirmed, appropriate measures should be taken. Caution is recommended if medicinal products associated with rhabdomyolysis are administered concomitantly with oxaliplatin. (see sections **4.5 Interaction with Other Medicinal Products and Other Forms of Interaction** and **4.8 Undesirable Effects**)

Gastrointestinal ulcer/Gastrointestinal hemorrhage and perforation

Oxaliplatin treatment can cause gastrointestinal ulcer and potential complications, such as duodenal ulcer hemorrhage and perforation, which can be fatal. In case of duodenal ulcer, oxaliplatin treatment should be discontinued and appropriate measures taken. (see section **4.8 Undesirable Effects**)

Hepatic

In cases of abnormal test results of liver function or portal hypertension, which does not obviously result from liver metastases, very rare cases of drug induced hepatic vascular disorder should be considered.

Pregnancy

For use in pregnant women, see section **4.6 Fertility, Pregnancy and Lactation**.

Fertility

Genotoxic effects were observed with oxaliplatin in the preclinical studies. Therefore male patients treated with oxaliplatin are advised not to father a child during and up to 6 months after treatment and to seek advice on conservation of sperm prior to treatment because oxaliplatin may have an anti-fertility effect, which could be irreversible.

Women should not become pregnant during treatment with oxaliplatin and should use an effective method of contraception (see section **4.6 Fertility, Pregnancy and Lactation**).

Peritoneal hemorrhage may occur when oxaliplatin is administered by intraperitoneal route (off-label route of administration).

4.5 Interaction with Other Medicinal Products and Other Forms of Interaction

In patients who have received a single dose of 85 mg/m² of oxaliplatin, immediately before administration of 5-fluorouracil, no change in the level of exposure to 5-fluorouracil has been observed.

In vitro, no significant displacement of oxaliplatin binding to plasma proteins has been observed with the following agents: erythromycin, salicylates, granisetron, paclitaxel, and sodium valproate.

Caution is advised when oxaliplatin treatment is co-administered with other medicinal products known to cause QT interval prolongation. In case of combination with such medicinal products, the QT interval should be closely monitored (see section **4.4 Special Warnings and Precautions for Use**). Caution is advised when oxaliplatin treatment is administered concomitantly with other medicinal products known to be associated with rhabdomyolysis. (see section **4.4 Special Warnings and Precautions for Use**).

4.6 Fertility Pregnancy, and Lactation

To date there is no available information on safety of use in pregnant women. In animal studies, reproductive toxicity was observed. Consequently, oxaliplatin is not recommended during pregnancy and in women of childbearing potential not using contraceptive measures.

The use of oxaliplatin should only be considered after suitably appraising the patient of the risk to the fetus and with patient's consent.

Appropriate contraceptive measures must be taken during and after cessation of therapy during 4 months for women and 6 months for men.

Excretion in breast milk has not been studied. Breast-feeding is contra-indicated during oxaliplatin therapy. Oxaliplatin may have an anti-fertility effect (see section **4.4 Special Warnings and Precautions for Use**).

4.7 Effects on Ability to Drive and Use Machines

No studies on the effects on the ability to drive and use machinery have been performed. However, oxaliplatin treatment resulting in an increased risk of dizziness, nausea and vomiting, and other neurological symptoms that affect gait and balance may lead to a minor or moderate influence on the ability to drive and use machines.

Vision abnormalities, in particular transient vision loss (reversible following therapy discontinuation), may affect patient's ability to drive and use machines. Therefore, patients should be warned of the potential effect of these events on the ability to drive or use machines.

4.8 Undesirable Effects

The most frequent adverse events of oxaliplatin in combination with 5-fluorouracil/folinic acid (5-FU/FA) were gastrointestinal (diarrhea, nausea, vomiting and mucositis), hematological (neutropenia, thrombocytopenia) and neurological (acute and dose cumulative peripheral sensory neuropathy). Overall these adverse events were more frequent and severe with oxaliplatin and 5-FU/FA combination than with 5-FU/FA alone.

The frequencies reported in the table below are derived from clinical trials in the metastatic and adjuvant settings (having included 416 and 1108 patients respectively in the oxaliplatin + 5-FU/FA treatment arms) and from post marketing experience.

Frequencies in this table are defined using the following convention: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1000$ to $< 1/100$), rare ($\geq 1/10000$ to $< 1/1000$), very rare ($< 1/10000$) not known (cannot be estimated from the available data). Further details are given after the table.

Infections and infestations*		
	Very Common	Infection
	Common	Rhinitis, Upper respiratory tract infection, Neutropenic sepsis
Blood and lymphatic system disorders*		
	Very Common	Anemia, Neutropenia, Thrombocytopenia, Leukopenia, Lymphopenia
	Common	Febrile neutropenia
	Rare	Immunoallergic thrombocytopenia, Hemolytic anemia, Disseminated intravascular coagulation (DIC), including fatal outcomes ²
	Not Known ¹	Hemolytic uremic syndrome, Autoimmune pancytopenia
Immune system disorders*		
	Very Common	Allergy/allergic reaction ³
Metabolism and nutrition disorders		
	Very Common	Anorexia, Hyperglycemia, Hypokalemia, Hyponatremia
	Common	Dehydration, Hypocalcemia
	Uncommon	Metabolic acidosis
Psychiatric disorders		
	Common	Depression, Insomnia
	Uncommon	Nervousness
Nervous system disorders*		
	Very Common	Peripheral sensory neuropathy, Sensory disturbance, Dysgeusia, Headache
	Common	Dizziness, Motor neuritis, Meningism
	Rare	Dysarthria, Reversible Posterior Leukoencephalopathy syndrome (RPLS or PRES) ²
	Not Known ¹	Convulsion
Eye disorders		
	Common	Conjunctivitis, Visual disturbances
	Rare	Visual acuity reduced transiently, Visual field disturbance, Optic neuritis, Transient vision loss (reversible, following therapy discontinuation)
Ear and labyrinth disorders		
	Uncommon	Ototoxicity
	Rare	Deafness
Cardiac disorders		
	Not Known ¹	Acute coronary syndrome ⁴ , QT Prolongation ⁵
Vascular disorders		
	Common	Hemorrhage, Flushing, Deep vein thrombosis, Hypertension
Respiratory, thoracic and mediastinal disorders		
	Very Common	Dyspnea, Coughing, Epistaxis
	Common	Hiccups, Pulmonary embolism
	Rare	Interstitial lung disease, sometimes fatal, Pulmonary fibrosis ²
	Not Known ¹	Laryngospasm
Gastrointestinal disorders*		
	Very Common	Nausea, Diarrhea, Vomiting, Stomatitis/mucositis, Abdominal pain, Constipation
	Common	Dyspepsia, Gastroesophageal reflux, Rectal hemorrhage, Gastrointestinal hemorrhage
	Uncommon	Ileus, Intestinal obstruction
	Rare	Colitis including <i>Clostridium difficile</i> diarrhea, Pancreatitis

	Not Known ¹	Intestinal ischemia, including fatal outcomes ² , Gastrointestinal ulcer and perforation, which can be fatal ² , Esophagitis
Hepato-biliary disorders		
	Very Common	Hepatic enzyme increase, Blood bilirubin increase
	Very Rare	Liver sinusoidal obstruction syndrome (also known as veno-occlusive disease of liver) ⁶
Skin and subcutaneous tissue disorders		
	Very Common	Skin disorder, Alopecia
	Common	Skin exfoliation (i.e., Hand and foot syndrome), Rash erythematous, Rash, Hyperhidrosis, Nail disorder
	Not Known ¹	Hyper-sensitivity vasculitis
Musculo-skeletal, connective tissue disorders		
	Very Common	Back pain
	Common	Arthralgia, Bone pain
	Not Known ¹	Rhabdomyolysis (including fatal outcomes) ²
Renal and urinary disorders		
	Common	Dysuria, Micturition frequency abnormal, Hematuria,
	Very Rare	Acute tubular necrosis, Acute interstitial nephritis, Acute renal failure
General disorders and administration site conditions		
	Very Common	Fatigue, Fever ⁷ , Asthenia, Pain, Injection site reaction ⁸ , Rigors
Investigations		
	Very Common	Blood alkaline phosphatase increase, Blood lactate dehydrogenase increase, Weight increase (adjuvant setting)
	Common	Weight decrease (metastatic setting), Blood creatinine increase
Injury, poisoning and procedural complications		
	Common	Fall
<p>*See detailed section below</p> <p>¹ Post-marketing experience with frequency unknown.</p> <p>² See section 4.4 Special Warnings and Precautions for Use.</p> <p>³ Very common allergies/allergic reactions occurring mainly during infusion, sometimes fatal. Common allergic reactions include such as skin rash (particularly urticaria), conjunctivitis and rhinitis. Common anaphylactic or anaphylactoid reactions, including, bronchospasm, sensation of chest pain, angioedema, hypotension and anaphylactic shock. Delayed hypersensitivity has also been reported with oxaliplatin hours or even days after the infusion.</p> <p>⁴ Acute coronary syndrome, including myocardial infarction and coronary arteriospasm and angina pectoris in patients treated with oxaliplatin in combination with 5-FU and bevacizumab.</p> <p>⁵ QT prolongation may lead to ventricular arrhythmias including Torsade de Pointes, which may be fatal (see section 4.4 Special Warnings and Precautions for Use).</p> <p>⁶ Or pathological manifestations related to such liver disorder, including peliosis hepatis, nodular regenerative hyperplasia, perisinusoidal fibrosis. Clinical manifestations may be portal hypertension and/or increased transaminases.</p> <p>⁷ Very common fever, rigors (tremors), either from infection (with or without febrile neutropenia) or possibly from immunological mechanism.</p> <p>⁸ Injection site reaction including local pain, redness, swelling and thrombosis have been reported. Extravasation may result in local pain and inflammation which may be severe and lead to complications, including necrosis, especially when oxaliplatin is infused through a peripheral vein (see section 4.4 Special Warnings and Precautions for Use).</p>		

Blood and lymphatic system disorders

Incidence by patient (%), by grade

Oxaliplatin and 5FU/FA 85 mg/m ² every 2 weeks	Metastatic Setting			Adjuvant Setting		
	All grades	Gr 3	Gr 4	All grades	Gr 3	Gr 4
Anemia	82.2	3	<1	75.6	0.7	0.1
Neutropenia	71.4	28	14	78.9	28.8	12.3

Thrombocytopenia	71.6	4	<1	77.4	1.5	0.2
Febrile neutropenia	5.0	3.6	1.4	0.7	0.7	0.0
Neutropenic sepsis	1.1	0.7	0.4	1.1	0.6	0.4

Immune system disorders

Incidence of allergic reactions by patient (%), by grade

Oxaliplatin and 5FU/FA 85 mg/m ² every 2 weeks	Metastatic Setting			Adjuvant Setting		
	All grades	Gr 3	Gr 4	All grades	Gr 3	Gr 4
Allergic reactions / Allergy	9.1	1	<1	10.3	2.3	0.6

Nervous system disorders

The dose limiting toxicity of oxaliplatin is neurological. It involves a sensory peripheral neuropathy characterized by dysesthesia and/or paresthesia of the extremities with or without cramps, often triggered by the cold. These symptoms occur in up to 95% of patients treated. The duration of these symptoms, which usually regress between courses of treatment, increases with the number of treatment cycles.

The onset of pain and/or a functional disorder are indications, depending on the duration of the symptoms, for dose adjustment, or even treatment discontinuation (see section **4.4 Special Warnings and Precautions for Use**).

This functional disorder includes difficulties in executing delicate movements and is a possible consequence of sensory impairment. The risk of occurrence of persistent symptoms for a cumulative dose of 850 mg/m² (10 cycles) is approximately 10% and 20% for a cumulative dose of 1020 mg/m² (12 cycles).

In the majority of cases, the neurological signs and symptoms improve or totally recover when treatment is discontinued. In the adjuvant setting of colon cancer, 6 months after treatment cessation, 87% of patients had no or mild symptoms. After up to 3 years of follow up, about 3% of patients presented either with persisting localized paresthesias of moderate intensity (2.3%) or with paresthesias that may interfere with functional activities (0.5%).

Acute neurosensory manifestations (see section **5.3 Preclinical Safety Data**) have been reported. They start within hours of administration and often occur on exposure to cold. They usually present as transient paresthesia, dysesthesia and hypoesthesia. An acute syndrome of pharyngolaryngeal dysesthesia occurs in 1% -2% of patients and is characterized by subjective sensations of dysphagia or dyspnea/feeling of suffocation, without any objective evidence of respiratory distress (no cyanosis or hypoxia) or of laryngospasm or bronchospasm (no stridor or wheezing). Although antihistamines and bronchodilators have been administered in such cases, the symptoms are rapidly reversible even in the absence of treatment. Prolongation of the infusion helps to reduce the incidence of this syndrome (see section **4.4 Special Warnings and Precautions for Use**). Occasionally other symptoms that have been observed include jaw spasm/muscle spasm/muscle contractions-involuntary/muscle twitching/myoclonus, coordination abnormal/gait abnormal/ataxia/balance disorders, throat or chest tightness/pressure/discomfort /pain. In addition, cranial nerve dysfunction may be associated with above mentioned events, or also occur as an isolated event such as ptosis, diplopia, aphonia/dysphonia, hoarseness, sometimes described as vocal cord paralysis, abnormal tongue sensation or dysarthria, sometimes described as aphasia, trigeminal neuralgia/facial pain/eye pain, decrease in visual acuity, visual field disorders.

Other neurological symptoms such as dysarthria, loss of deep tendon reflex and Lhermitte's sign were reported during treatment with oxaliplatin. Isolated cases of optic neuritis have been reported.

Gastrointestinal disorders

Incidence by patient (%), by grade

Oxaliplatin and 5FU/FA 85 mg/m ² Every 2 weeks	Metastatic Setting			Adjuvant Setting		
	All grades	Gr 3	Gr 4	All grades	Gr 3	Gr 4
Nausea	69.9	8	<1	73.7	4.8	0.3
Diarrhea	60.8	9	2	56.3	8.3	2.5
Vomiting	49.0	6	1	47.2	5.3	0.5
Mucositis / Stomatitis	39.9	4	<1	42.1	2.8	0.1

Prophylaxis and/or treatment with potent antiemetic agents is indicated.

Dehydration, paralytic ileus, intestinal obstruction, hypokalemia, metabolic acidosis and renal impairment may be caused by severe diarrhea/emesis particularly when combining oxaliplatin with 5-fluorouracil (see section **4.4 Special Warnings and Precautions for Use**).

4.9 Overdose and Treatment

There is no known antidote to oxaliplatin.

Symptoms

In cases of overdose, exacerbation of adverse events can be expected.

Management

Monitoring of hematological parameters should be initiated and symptomatic treatment given.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other antineoplastic agents, platinum compounds.

ATC code: L01XA 03

Mechanism of action

Studies on the mechanism of action of oxaliplatin, although not completely elucidated, show that the aqua-derivatives resulting from the biotransformation of oxaliplatin, interact with DNA to form both inter and intra-strand cross-links, resulting in the disruption of DNA synthesis leading to cytotoxic and antitumor effects.

In patients with metastatic colorectal cancer, the efficacy of oxaliplatin (85 mg/m² repeated every two weeks) combined with 5-fluorouracil/folinic acid is reported in three clinical studies:

- In front-line treatment, the 2-arm comparative phase III EFC2962 study randomized patients either to 5-fluorouracil/folinic acid alone (LV5FU2, N=210) or the combination of oxaliplatin with 5-fluorouracil/folinic (FOLFOX4, N=210)
- In pretreated patients the comparative 3-arm EFC4584 study randomized patients refractory to an irinotecan (CPT-11) + 5-fluorouracil/folinic combination either to 5-fluorouracil/folinic acid alone (LV5FU2, N=275), oxaliplatin single agent (N=275), or combination of oxaliplatin with 5-fluorouracil/folinic (FOLFOX4, N=271)
- Finally, the uncontrolled phase II EFC2964 study included patients refractory to 5-fluorouracil/folinic acid alone, that were treated with the oxaliplatin and 5-fluorouracil/folinic acid combination (FOLFOX4, N=57)

Clinical efficacy and safety

The two randomized clinical trials, EFC2962 in front-line therapy and EFC4584 in pretreated patients, demonstrated a significantly higher response rate and a prolonged progression free survival (PFS)/time to progression (TTP) as compared to treatment with 5-fluorouracil/folinic acid alone. IN EFC 4584 performed in refractory pretreated patients, the difference in median overall survival (OS) between the combination of oxaliplatin and 5-FU/FA did not reach statistical significance.

Response rate under FOLFOX4 versus LV5FU2

Response rate % (95% CI)	LV5FU2	FOLFOX4	Oxaliplatin Single agent
Independent radiological review ITT analysis			
Front-line treatment EFC2962 Response assessment every 8 weeks	22 (16-27) P value = 0.0001	49 (42-46)	NA*
Pretreated patients EFC4584 (refractory to CPT-11 + 5FU/FA) Response assessment every 6 weeks	0.7 (0.0-2.7) P value < 0.0001	11.1 (7.6-15.5)	1.1 (0.2-3.2)
Pretreated patients EFC2964 (refractory to 5-FU/FA) Response assessment every 12 weeks	NA*	23 (13-36)	NA*

NA: Not Applicable

Median Progression Free Survival (PFS) / Median Time to Progression (TTP) FOLFOX4 versus LV5FU2

Median PFS/TTP, Months (95% CI)	LV5FU2	FOLFOX4	Oxaliplatin Single agent
ITT analysis with independent radiological examination			
Front-line treatment EFC2962 (PFS)	6.0 (5.5-6.5) Log-rank P value = 0.0003	8.2 (7.2-8.8)	NA*
Pretreated patients EFC4584 (TTP) (refractory to CPT-11 + 5FU/FA)	2.6 (1.8-2.9) Log-rank P value < 0.0001	5.3 (4.7-6.1)	2.1 (1.6-2.7)
Pretreated patients EFC2964 (refractory to 5-FU/FA)	NA*	5.1 (3.1-5.7)	NA*

NA: Not Applicable

Median Overall Survival (OS) under FOLFOX4 versus LV5FU2

Median OS, Months (95% CI)	LV5FU2	FOLFOX4	Oxaliplatin Single agent
ITT analysis			
Front-line treatment EFC2962	14.7 (13.0-18.2) Log-rank P value = 0.12	16.2 (14.7-18.2)	NA*
Pretreated patients EFC4584	8.8 (7.3-9.3)	9.9 (9.1-10.5)	8.1 (7.2-8.7)

(refractory to CPT-11 + 5FU/FA)	Log-rank P value = 0.09		
Pretreated patients EFC2964 (refractory to 5-FU/FA)	NA*	10.8 (9.3-12.8)	NA*

NA: Not Applicable

In pretreated patients (EFC4584), who were symptomatic at baseline, a higher proportion of those treated with oxaliplatin/5-fluorouracil/folinic acid experienced a significant improvement of their disease-related symptoms compared to those treated with 5-fluorouracil/folinic acid alone (27.7% vs 14.6% p= 0.0033).

In non-pretreated patients (EFC2962), no statistical difference between the two treatment groups was found for any of the quality of life dimensions. However, the quality of life scores was generally better in the control arm for measurement of global health status and pain and worse in the oxaliplatin arm for nausea and vomiting.

In the adjuvant setting, the MOSAIC comparative phase III study (EFC3313) randomized 2246 patients (899 stage II/Duke's B2 and 1347 stage III/Duke's C) further to complete resection of the primary tumor of colon cancer either to 5-FU/FA alone (LV5FU2) or to combination of oxaliplatin and 5-FU/FA (FOLFOX4).

EFC 3313 3-year disease free survival (ITT analysis)* for the overall population

Treatment arm	LV5FU2	FOLFOX4
Percent 3-year disease free survival (95% CI)	73.3 (70.6-75.9)	78.7 (76.2-81.1)
Hazard ratio (95% CI)	0.76 (0.64-0.89)	
Stratified log rank test	P = 0.0008	

* Median follow up 44.2 months (all patients followed for at least 3 years)

The study demonstrated an overall significant advantage in 3-year disease free survival for the oxaliplatin and 5-FU/FA combination (FOLFOX4) over 5-FU/FA alone (LV5FU2).

EFC 3313 3-year disease free survival (ITT analysis)* according to stage of disease

Patient stage	Stage II (Duke's B2)		Stage III Duke's C	
	LV5FU2	FOLFOX4	LV5FU2	FOLFOX4
Percent 3-year disease free survival (95% CI)	84.3 (80.9-87.7)	87.4 (84.3-90.5)	65.8 (62.2-69.5)	72.8 (69.4-76.2)
Hazard ratio (95% CI)	0.79 (0.57-1.09)		0.75 (0.62-0.90)	
Log-rank test	P = 0.151		P = 0.002	

* median follow up 44.2 months (all patients followed for at least 3 years)

Overall Survival (ITT analysis):

At time of the analysis of the 3-year disease free survival, which was the primary endpoint of the MOSAIC trial, 85.1% of the patients were still alive in the FOLFOX4 arm versus 83.8% in the LV5FU2 arm. This translated into an overall reduction in mortality risk of 10% in favor of the FOLFOX4 not reaching statistical significance (hazard ratio = 0.90). The figures were 92.2% versus 92.4% in the stage II (Duke's B2) sub-population (hazard ratio = 1.01) and 80.4% versus 78.1% in the stage III (Duke's C) sub-population (hazard ratio = 0.87), for FOLFOX4 and LV5FU2, respectively.

Oxaliplatin single agent has been evaluated in pediatric population in 2 Phase I (69 patients) and 2 Phase II (166 patients) studies. A total of 235 pediatric patients (7 months-22 years of age) with solid tumors

have been treated. The effectiveness of oxaliplatin single agent in the pediatric populations treated has not been established. Accrual in both Phase II studies was stopped for lack of tumor response

5.2 Pharmacokinetic properties

Absorption

The pharmacokinetics of individual active compounds have not been determined. The pharmacokinetics of ultrafiltrable platinum, representing a mixture of all unbound, active and inactive platinum species, following a two-hour infusion of oxaliplatin at 130 mg/m² every three weeks for 1 to 5 cycles and oxaliplatin at 85 mg/m² every two weeks for 1 to 3 cycles are as follows:

Summary of Platinum Pharmacokinetic Parameter Estimates in Ultrafiltrate Following Multiple Doses of Oxaliplatin at 85 mg/m² Every Two Weeks or at 130 mg/m² Every Three Weeks

Dose	C _{max}	AUC ₀₋₄₈	AUC	t _{1/2α}	t _{1/2β}	t _{1/2γ}	V _{ss}	CL
	μg/mL	μg.h/mL	μg.h/mL	h	h	h	L	L/h
85 mg/m ²								
Mean	0.814	4.19	4.68	0.43	16.8	391	440	17.4
SD	0.193	0.647	1.40	0.35	5.74	406	199	6.35
130 mg/m ²								
Mean	1.21	8.20	11.9	0.28	16.3	273	582	10.1
SD	0.10	2.40	4.60	0.06	2.90	19.0	261	3.07

Mean AUC₀₋₄₈, and C_{max} values were determined on Cycle 3 (85 mg/m²) or cycle 5 (130 mg/m²).

Mean AUC, V_{ss}, CL, and CL_{R0-48} values were determined on Cycle 1.

C_{end}, C_{max}, AUC, AUC₀₋₄₈, V_{ss} and CL values were determined by non-compartmental analysis.

t_{1/2α}, t_{1/2β}, and t_{1/2γ}, were determined by compartmental analysis (Cycles 1-3 combined).

Distribution

At the end of a 2-hour infusion, 15% of the administered platinum is present in the systemic circulation, the remaining 85% being rapidly distributed into tissues or eliminated in the urine. Irreversible binding to red blood cells and plasma, results in half-lives in these matrices that are close to the natural turnover of red blood cells and serum albumin. No accumulation was observed in plasma ultrafiltrate following 85 mg/m² every two weeks or 130 mg/m² every three weeks and steady state was attained by cycle one in this matrix. Inter- and intra-subject variability is generally low.

Biotransformation

Biotransformation in vitro is considered to be the result of non-enzymatic degradation and there is no evidence of cytochrome P450-mediated metabolism of the diaminocyclohexane (DACH) ring.

Oxaliplatin undergoes extensive biotransformation in patients, and no intact drug was detectable in plasma ultrafiltrate at the end of a 2h-infusion. Several cytotoxic biotransformation products including the monochloro-, dichloro- and diaquo-DACH platinum species have been identified in the systemic circulation together with a number of inactive conjugates at later time points.

Elimination

Platinum is predominantly excreted in urine, with clearance mainly in the 48 hours following administration.

By day 5, approximately 54% of the total dose was recovered in the urine and < 3% in the feces.

The effect of renal impairment on the disposition of oxaliplatin was studied in patients with varying degrees of renal function.

Oxaliplatin was administered at a dose of 85 mg/m² in the control group with a normal renal function (CL_{Cr} > 80 mL/min, n=12) and in patients with mild (CL_{Cr} = 50 to 80 mL/min, n=13) and moderate (CL_{Cr} = 30 to 49 mL/min, n=11) renal impairment, and at a dose of 65 mg/m² in patients with severe renal impairment (CL_{Cr} < 30 mL/min, n=5). Median exposure was 9, 4, 6, and 3 cycles, respectively,

and PK data at cycle 1 were obtained in 11, 13, 10, and 4 patients respectively. There was an increase in plasma ultrafiltrate (PUF) platinum AUC, AUC/dose and a decrease in total and renal CL and V_{ss} with increasing renal impairment especially in the (small) group of patients with severe renal impairment: point estimate (90% CI) of estimated mean ratios by renal status versus normal renal function for AUC/dose were 1.36 (1.08, 1.71), 2.34 (1.82, 3.01) and 4.81 (3.49, 6.64) for patients with mild and moderate and in severe renal failure respectively.

Elimination of oxaliplatin is significantly correlated with the creatinine clearance. Total PUF platinum CL was respectively 0.74 (0.59, 0.92), 0.43 (0.33, 0.55) and 0.21 (0.15, 0.29) and for V_{ss} respectively 0.52 (0.41, 0.65), 0.73 (0.59, 0.91) and 0.27 (0.20, 0.36) for patients with mild, moderate and severe renal failure respectively. Total body clearance of PUF platinum was therefore reduced by respectively 26% in mild, 57% in moderate, and 79% in severe renal impairment compared to patients with normal function.

Renal clearance of PUF platinum was reduced in patients with impaired renal function by 30% in mild, 65% in moderate, and 84% in severe renal impairment compared to patients with normal function.

There was an increase in beta half life of PUF platinum with increasing degree of renal impairment mainly in the severe group.

Despite the small number of patients with severe renal dysfunction, these data are of concern in patients in severe renal failure and should be taken into account when prescribing oxaliplatin in patients with renal impairment (see sections **4.2 Dosage and Method of Administration**, **4.3 Contraindications** and **4.4 Special Warnings and Precautions for Use**).

5.3 Preclinical safety data

The target organs identified in preclinical species (mice, rats, dogs, and/or monkeys) in single- and multiple-dose studies included the bone marrow, the gastrointestinal system, the kidney, the testes, the nervous system, and the heart. The target organ toxicities observed in animals are consistent with those produced by other platinum-containing drugs and DNA-damaging, cytotoxic drugs used in the treatment of human cancers with the exception of the effects produced on the heart. Effects on the heart were observed only in the dog and included electrophysiological disturbances with lethal ventricular fibrillation. Cardiotoxicity is considered specific to the dog not only because it was observed in the dog alone but also because doses similar to those producing lethal cardiotoxicity in dogs (150 mg/m²) were well-tolerated by humans. Preclinical studies using rat sensory neurons suggest that the acute neurosensory symptoms related to Oxaliplatin may involve an interaction with voltage-gated Na⁺ channels.

Oxaliplatin was mutagenic and clastogenic in mammalian test systems and produced embryo-fetal toxicity in rats. Oxaliplatin is considered a probable carcinogen, although carcinogenic studies have not been conducted.

6. PHARMACEUTICAL PARTICULARS

6.1 Shelf-life

Please see outer package for the expiry date.

Inspect visually prior to use. Only clear solutions without particles should be used.

After dilution in 5% glucose, chemical and physical in-use stability has been demonstrated for 24 hours at +2°C - +8°C and for 6 hours at +25°C.

From a microbiological point of view, the solution for infusion should be used immediately.

If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2°C to 8°C unless dilution has taken place in controlled and validated aseptic conditions.

6.2 Storage Conditions

Store at temperatures not exceeding 30°C. Protect from light.

Medicinal product as packaged for sale: Keep the vial in the outer carton in order to protect from light. Do not freeze.

For storage conditions of the diluted medicinal product see section **6.1 Shelf-life**.

6.3 Availability

USP Type I Clear Glass Vial x 10 mL and 20 mL with rubber stopper and green (for 10 mL) or dark blue (for 20 mL) flip-off seal (Box of 1's).

6.4 Incompatibilities

This medicinal product should not be mixed with other medicinal products except for those mentioned in section 6.6. Oxaliplatin can be co-administered with folinic acid via a Y-line.

- DO NOT mix with alkaline medicinal products or solutions, in particular 5-fluorouracil, folinic acid preparations containing trometamol as an excipients and trometamol salts of other medicinal products. Alkaline drugs or solutions will adversely affect the stability of oxaliplatin (see section **6.6 Special Precautions for Disposal and Other Handling**).
- DO NOT dilute oxaliplatin with saline or other solutions containing chloride ions (including calcium, potassium or sodium chlorides).
- DO NOT use injection equipment containing aluminum.
- DO NOT mix with other medicinal products in the same infusion bag or line (see section **6.6 Special Precautions for Disposal and Other Handling** to check instructions related to co-administration with folinic acid).

6.5 List of Excipients

Water for Injections

Tartaric acid

Sodium Hydroxide (for pH adjustment)

6.6 Special Precautions for Disposal and Other Handling

As with other potentially toxic compounds, caution should be exercised when handling and preparing oxaliplatin solutions.

Instructions for Handling

The handling of this cytotoxic agent by healthcare personnel requires every precaution to guarantee the protection of the handler and his surroundings.

The preparation of injectable solutions of cytotoxic agents must be carried out by trained specialist personnel with knowledge of the medicines used, in conditions that guarantee the integrity of the medicinal product, the protection of the environment and in particular the protection of the personnel

handling the medicines, in accordance with the hospital policy. It requires a preparation area reserved for this purpose. It is forbidden to smoke, eat or drink in this area.

Personnel must be provided with appropriate handling materials, notably long-sleeved gowns, protection masks, caps, protective goggles, sterile single-use gloves, protective covers for the work area, containers and collection bags for waste.

Excreta and vomit must be handled with care.

Pregnant women must be warned to avoid handling cytotoxic agents.

Any broken container must be treated with the same precautions and considered as contaminated waste. Contaminated waste should be incinerated in suitably labelled rigid containers. See below chapter "Disposal".

If oxaliplatin concentrate or solution for infusion should come into contact with skin, wash immediately and thoroughly with water.

If oxaliplatin concentrate or solution for infusion should come into contact with mucous membranes, wash immediately and thoroughly with water.

Special precautions for administration

- DO NOT use injection material containing aluminum.
- DO NOT administer undiluted.
- Only glucose 5% infusion solution is to be used as a diluent. DO NOT dilute for infusion with sodium chloride or chloride containing solutions.
- DO NOT mix with any other medicinal products in the same infusion bag or administer simultaneously by the same infusion line.
- DO NOT mix with alkaline drugs or solutions, in particular 5-fluorouracil, folinic acid preparations containing trometamol as an excipients and trometamol salts of other drugs. Alkaline drugs or solutions will adversely effect the stability of oxaliplatin.

Instruction for use with folinic acid (FA) (as calcium folinate or disodium folinate)

Oxaliplatin 85 mg/m² intravenous infusion in 250 to 500 mL of glucose 5 % solution is given at the same time as folinic acid (FA) intravenous infusion in glucose 5 % solution, over 2 to 6 hours, using a Y-line placed immediately before the site of infusion.

These two medical products should **not** be combined in the same infusion bag. Folinic acid must not contain trometamol as an excipient and must only be diluted using isotonic glucose 5% solution, never in alkaline solutions or sodium chloride or chloride containing solutions.

Instructions for use with 5-fluorouracil

Oxaliplatin should always be administered before fluoropyrimidines – i.e., 5-fluorouracil. After oxaliplatin administration, flush the line and then administer 5-fluorouracil.

For additional information on drugs combined with oxaliplatin, see the corresponding manufacturer's summary of product characteristics.

Concentrate for solution for infusion

Inspect visually prior to use. Only clear solutions without particles should be used. The medicinal product is for single use only. Any unused concentrate should be discarded.

Dilution for intravenous infusion

Withdraw the required amount of concentrate from the vial(s) and then dilute with 250 mL to 500 mL of a glucose 5% solution to give an oxaliplatin concentration between 0.2 mg/mL and 0.7 mg/mL. The concentration range over which the physico-chemical stability of oxaliplatin has been demonstrated is 0.2 mg/mL to 1.3 mg/mL.

Administer by intravenous infusion.

After dilution in 5% glucose, chemical and physical in-use stability has been demonstrated for 24 hours at 2°C to 8°C and for 6 hours at 25°C.

From a microbiological point of view, this infusion preparation should be used immediately.

If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2°C to 8°C unless dilution has taken place in controlled and validated aseptic conditions.

Inspect visually prior to use. Only clear solutions without particles should be used.

The medicinal product is for single use only. Any unused infusion solution should be discarded.

NEVER use sodium chloride or chloride containing solutions for dilution.

The compatibility of Oxaliplatin solution for infusion has been tested with representative, PVC-based, administration sets.

Infusion

The administration of oxaliplatin does not require prehydration.

Oxaliplatin diluted in 250 to 500 mL of a glucose 5% solution to give a concentration not less than 0.2 mg/mL **must** be infused either by peripheral vein or central venous line over 2 to 6 hours. When oxaliplatin is administered with 5-fluorouracil, the oxaliplatin infusion must precede the administration of 5-fluorouracil.

Disposal

Remnants of the medicinal product as well as all materials that have been used for dilution and administration must be destroyed according to hospital standard procedures applicable to cytotoxic agents in accordance with local requirements related to the disposal of hazardous waste.

7.0 FDA REGISTRATION NUMBER

Oxaliplatin 5 mg/mL Concentrate for Solution for IV Infusion: DR-XY45870

8.0 DATE OF FIRST AUTHORIZATION/RENEWAL OF THE AUTHORIZATION

Oxaliplatin 5 mg/mL Concentrate for Solution for IV Infusion: 09 May 2017

Keep out of reach of children.

For suspected adverse drug reaction, report to the FDA: [www.fda.gov.ph](http://www.fda.gov/ph)

Seek medical attention immediately at the first sign of any adverse drug reaction.

CAUTION: Foods, Drugs, Devices and Cosmetics Act prohibits dispensing without prescription.

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