

For the use only of a Registered Medical Practitioner (Oncologist) or a Hospital or a Laboratory.

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# Lorlatinib Tablets

## LORBRIQUA<sup>®</sup>

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### 1. GENERIC NAME

Lorlatinib Tablets

### 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film coated tablet contains 25 mg or 100 mg of Lorlatinib

#### List of excipients

##### Tablet core contains:

Microcrystalline cellulose, Dibasic calcium phosphate anhydrous, Sodium starch glycolate, Magnesium stearate

##### Colored film-coating contains:

Hydroxypropyl methylcellulose (HPMC)/Hypromellose, Lactose monohydrate, Macrogol 4000/PEG 3350, Triacetin, Titanium dioxide, Black iron oxide, Iron oxide red

All strengths/presentations mentioned in this document might not be available in the market.

### 3. DOSAGE FORM AND STRENGTH

Tablets:

- 25 mg: 8 mm round, tan, immediate release, film-coated, debossed with “Pfizer” on one side and “25” and “LLN” on the other side
- 100 mg: 8.5 mm × 17 mm oval, lavender, immediate release, film-coated, debossed with “Pfizer” on one side and “LLN 100” on the other side

### 4. CLINICAL PARTICULARS

#### 4.1. Therapeutic indication

Lorlatinib is indicated for the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive.

## 4.2. Posology and method of administration

### Patient Selection

Select patients for the treatment of metastatic NSCLC with Lorlatinib based on the presence of ALK positivity in tumor specimens [see sections 4.1 and 5.3].

### Recommended Dosage

The recommended dosage of Lorlatinib is 100 mg orally once daily, with or without food, until disease progression or unacceptable toxicity [see section 5.3].

Swallow tablets whole. Do not chew, crush or split tablets. Do not ingest if tablets are broken, cracked, or otherwise not intact.

Take Lorlatinib at the same time each day. If a dose is missed, then take the missed dose unless the next dose is due within 4 hours. Do not take 2 doses at the same time to make up for a missed dose.

Do not take an additional dose if vomiting occurs after Lorlatinib but continue with the next scheduled dose.

### Dosage Modifications for Adverse Reactions

The recommended dose reductions are:

- First dose reduction: Lorlatinib 75 mg orally once daily
- Second dose reduction: Lorlatinib 50 mg orally once daily

Permanently discontinue Lorlatinib in patients who are unable to tolerate 50 mg orally once daily.

Dosage modifications for adverse reactions of Lorlatinib are provided in Table 1.

**Table 1 Recommended Lorlatinib Dosage Modifications for Adverse Reactions**

Adverse Reaction <sup>a</sup>	Dosage Modifications
<b>Central Nervous System Effects</b> [see section 4.4]	
Grade 1	Continue at the same dose or withhold the dose until recovery to baseline. Resume Lorlatinib at the same dose or at a reduced dose.
Grade 2 <u>OR</u> Grade 3	Withhold dose until Grade 0 or 1. Resume Lorlatinib at a reduced dose.
Grade 4	Permanently discontinue Lorlatinib.
<b>Hyperlipidemia</b> [see section 4.4]	
Grade 4 hypercholesterolemia <u>OR</u> Grade 4 hypertriglyceridemia	Withhold Lorlatinib until recovery of hypercholesterolemia and/or hypertriglyceridemia to less than or equal to Grade 2. Resume Lorlatinib at the same dose.  If severe hypercholesterolemia and/or hypertriglyceridemia recurs, resume Lorlatinib at a reduced dose.

**Table 1 Recommended Lorlatinib Dosage Modifications for Adverse Reactions**

<b>Adverse Reaction<sup>a</sup></b>	<b>Dosage Modifications</b>
<b>Atrioventricular (AV) Block</b> [see section 4.4]	
Second-degree AV block	Withhold Lorlatinib until PR interval is less than 200 ms. Resume Lorlatinib at a reduced dose.
First occurrence of complete AV block	Withhold Lorlatinib until <ul style="list-style-type: none"> <li>• pacemaker placed <u>OR</u></li> <li>• PR interval less than 200 ms.</li> </ul> <p>If a pacemaker is placed, resume Lorlatinib at the same dose.</p> <p>If no pacemaker is placed, resume Lorlatinib at a reduced dose.</p>
Recurrent complete AV block	Place pacemaker or permanently discontinue Lorlatinib.
<b>Interstitial Lung Disease (ILD)/Pneumonitis</b> [see section 4.4]	
Any Grade treatment-related ILD/Pneumonitis	Permanently discontinue Lorlatinib.
<b>Hypertension</b> [see section 4.4]	
Grade 3 (SBP greater than or equal to 160 mmHg or DBP greater than or equal to 100 mmHg; medical intervention indicated; more than one antihypertensive drug, or more intensive therapy than previously used indicated)	Withhold Lorlatinib until hypertension has recovered to Grade 1 or less (SBP less than 140 mmHg and DBP less than 90 mmHg), then resume Lorlatinib at the same dose.
	If Grade 3 hypertension recurs, withhold Lorlatinib until recovery to Grade 1 or less, and resume at a reduced dose.
	If adequate hypertension control cannot be achieved with optimal medical management, permanently discontinue Lorlatinib.
Grade 4 (life-threatening consequences, urgent intervention indicated)	Withhold Lorlatinib until recovery to Grade 1 or less, and resume at a reduced dose or permanently discontinue Lorlatinib.
	If Grade 4 hypertension recurs, permanently discontinue Lorlatinib.
<b>Hyperglycemia</b> [see section 4.4]	
Grade 3 (greater than 250 mg/dL) despite optimal anti-hyperglycemic therapy <u>OR</u> Grade 4	Withhold Lorlatinib until hyperglycemia is adequately controlled, then resume Lorlatinib at the next lower dosage.
	If adequate hyperglycemic control cannot be achieved with optimal medical management, permanently discontinue Lorlatinib.
<b>Other Adverse Reactions</b>	
Grade 1 <u>OR</u> Grade 2	Continue Lorlatinib at same dose or reduced dose.
Grade 3 <u>OR</u> Grade 4	Withhold Lorlatinib until symptoms resolve to less than or equal to Grade 2 or baseline. Resume Lorlatinib at reduced dose.

Abbreviation: AV=atrioventricular; DBP=diastolic blood pressure; SBP=systolic blood pressure.

<sup>a</sup> Grade based on National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE) version 4.03.

## Dosage Modifications for Drug Interactions

### Strong CYP3A Inducers

Lorlatinib is contraindicated in patients taking strong CYP3A inducers. Discontinue strong CYP3A inducers for 3 plasma half-lives of the strong CYP3A inducer prior to initiating Lorlatinib [see sections 4.3, 4.4, 4.5 and 5.3].

### Moderate CYP3A Inducers

Avoid concomitant use of moderate CYP3A inducers with Lorlatinib. If concomitant use with moderate CYP3A inducers is unavoidable, increase the Lorlatinib dose to 125 mg once daily [see sections 4.5 and 5.3].

### Strong CYP3A Inhibitors

Avoid concomitant use of Lorlatinib with strong CYP3A inhibitors. If concomitant use with a strong CYP3A inhibitor is unavoidable, reduce the starting dose of Lorlatinib from 100 mg orally once daily to 75 mg orally once daily.

In patients who have had a dose reduction to 75 mg orally once daily due to adverse reactions and who initiate a strong CYP3A inhibitor, reduce the Lorlatinib dose to 50 mg orally once daily.

If concomitant use of a strong CYP3A inhibitor is discontinued, increase the Lorlatinib dose (after 3 plasma half-lives of the strong CYP3A inhibitor) to the dose that was used before starting the strong inhibitor [see sections 4.5 and 5.3].

### Fluconazole

Avoid concomitant use of Lorlatinib with fluconazole [see section 5.3]. If concomitant use is unavoidable, reduce the starting dose of Lorlatinib from 100 mg orally once daily to 75 mg orally once daily [see sections 4.5 and 5.3].

## Recommended Dosage for Severe Hepatic Impairment

The recommended dosage of Lorlatinib for patients with severe hepatic impairment (Child-Pugh C) is 50 mg orally once daily [see sections 4.6 and 5.3].

## Recommended Dosage for Renal Impairment

The recommended dosage of Lorlatinib for patients with creatinine clearance [ $CL_{cr}$ ] 15 to < 30 mL/min (estimated by Cockcroft-Gault) is 75 mg orally once daily [see sections 4.6 and 5.3].

## 4.3. Contraindications

Lorlatinib is contraindicated in patients taking strong CYP3A inducers, due to the potential for serious hepatotoxicity [see section 4.4].

#### 4.4. Special warnings and precautions for use

##### **Risk of Serious Hepatotoxicity with Concomitant Use of Strong CYP3A Inducers**

Severe hepatotoxicity occurred in 10 of 12 healthy subjects receiving a single dose of Lorlatinib with multiple daily doses of rifampin, a strong CYP3A inducer. Grade 4 alanine aminotransferase (ALT) or aspartate aminotransferase (AST) elevations occurred in 50% of subjects, Grade 3 ALT or AST elevations occurred in 33% and Grade 2 ALT or AST elevations occurred in 8%. ALT or AST elevations occurred within 3 days and returned to within normal limits after a median of 15 days (7 to 34 days); the median time to recovery was 18 days in subjects with Grade 3 or 4 ALT or AST elevations and 7 days in subjects with Grade 2 ALT or AST elevations [see section 4.5].

Lorlatinib is contraindicated in patients taking strong CYP3A inducers. Discontinue strong CYP3A inducers for 3 plasma half-lives of the strong CYP3A inducer prior to initiating Lorlatinib [see sections 4.3 and 4.5].

##### **Central Nervous System Effects**

A broad spectrum of central nervous system (CNS) effects can occur in patients receiving Lorlatinib. These include seizures, psychotic effects and changes in cognitive function, mood (including suicidal ideation), speech, mental status, and sleep. Overall, CNS effects occurred in 52% of the 476 patients who received 100 mg Lorlatinib once daily in clinical trials [see section 4.8]. Cognitive effects occurred in 28% of the 476 patients; 2.9% of these events were severe (Grade 3 or 4). Mood effects occurred in 21% of patients; 1.7% of these events were severe. Speech effects occurred in 11% of patients; 0.6% of these events were severe. Psychotic effects occurred in 7% of patients; 0.6% of these events were severe. Mental status changes occurred in 1.3% of patients; 1.1% of these events were severe. Seizures occurred in 1.9% of patients, sometimes in conjunction with other neurologic findings. Sleep effects occurred in 12% of patients. The median time to first onset of any CNS effect was 1.4 months (1 day to 3.4 years). Overall, 2.1% of patients required permanent discontinuation of Lorlatinib for a CNS effect; 10% required temporary discontinuation and 8% required dose reduction.

Withhold and resume at the same dose or at a reduced dose or permanently discontinue Lorlatinib based on severity [see section 4.2].

##### **Hyperlipidemia**

Increases in serum cholesterol and triglycerides can occur in patients receiving Lorlatinib [see section 4.8]. Grade 3 or 4 elevations in total cholesterol occurred in 18% and Grade 3 or 4 elevations in triglycerides occurred in 19% of the 476 patients who received 100 mg Lorlatinib once daily. The median time to onset was 15 days for both hypercholesterolemia and hypertriglyceridemia. Approximately 4% and 7% of patients required temporary discontinuation and 1% and 3% of patients required dose reduction of Lorlatinib for elevations in cholesterol and in triglycerides in Study B7461001 and Study B7461006, respectively. Eighty-three percent of patients required initiation of lipid-lowering medications, with a median time to onset of start of such medications of 17 days.

Initiate or increase the dose of lipid-lowering agents in patients with hyperlipidemia. Monitor serum cholesterol and triglycerides before initiating Lorlatinib, 1 and 2 months after initiating Lorlatinib, and periodically thereafter. Withhold and resume at the same dose for the first

occurrence; resume at the same or a reduced dose of Lorlatinib for recurrence based on severity [see section 4.2].

### **Atrioventricular Block**

PR interval prolongation and atrioventricular (AV) block can occur in patients receiving Lorlatinib [see sections 4.8 and 5.2]. In 476 patients who received 100 mg Lorlatinib once daily who had a baseline electrocardiography (ECG), 1.9% experienced AV block and 0.2% experienced Grade 3 AV block and underwent pacemaker placement.

Monitor ECG prior to initiating Lorlatinib and periodically thereafter. Withhold and resume at a reduced dose or at the same dose in patients who undergo pacemaker placement. Permanently discontinue for recurrence in patients without a pacemaker [see section 4.2].

### **Interstitial Lung Disease/Pneumonitis**

Severe or life-threatening pulmonary adverse reactions consistent with interstitial lung disease (ILD)/pneumonitis can occur with Lorlatinib. ILD/pneumonitis occurred in 1.9% of patients who received 100 mg Lorlatinib once daily, including Grade 3 or 4 ILD/pneumonitis in 0.6% of patients. Four patients (0.8%) discontinued Lorlatinib for ILD/pneumonitis.

Promptly investigate for ILD/pneumonitis in any patient who presents with worsening of respiratory symptoms indicative of ILD/pneumonitis (e.g., dyspnea, cough, and fever). Immediately withhold Lorlatinib in patients with suspected ILD/pneumonitis. Permanently discontinue Lorlatinib for treatment-related ILD/pneumonitis of any severity [see section 4.2].

### **Hypertension**

Hypertension can occur in patients receiving Lorlatinib [see section 4.8]. Hypertension occurred in 13% of patients who received 100 mg Lorlatinib once daily, including Grade 3 or 4 in 6% of patients. The median time to onset of hypertension was 6.4 months (1 day to 2.8 years), and 2.3% of patients temporarily discontinued Lorlatinib for hypertension.

Control blood pressure prior to initiation of Lorlatinib. Monitor blood pressure after 2 weeks and at least monthly thereafter during treatment with Lorlatinib. Withhold and resume at a reduced dose or permanently discontinue Lorlatinib based on severity [see section 4.2].

### **Hyperglycemia**

Hyperglycemia can occur in patients receiving Lorlatinib [see section 4.8]. Hyperglycemia occurred in 9% of patients who received 100 mg Lorlatinib, including Grade 3 or 4 in 3.2% of patients. The median time to onset of hyperglycemia was 4.8 months (1 day to 2.9 years), and 0.8% of patients temporarily discontinued Lorlatinib for hyperglycemia.

Assess fasting serum glucose prior to initiation of Lorlatinib and monitor periodically thereafter. Withhold and resume at a reduced dose or permanently discontinue Lorlatinib based on severity [see section 4.2].

### **Embryo-Fetal Toxicity**

Based on findings from animal studies and its mechanism of action, Lorlatinib can cause fetal harm when administered to a pregnant woman. Administration of lorlatinib to pregnant rats and

rabbits by oral gavage during the period of organogenesis resulted in malformations, increased post-implantation loss, and abortion at maternal exposures that were equal to or less than the human exposure at the recommended dose of 100 mg once daily based on area under the curve (AUC).

Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use an effective non-hormonal method of contraception, since Lorlatinib can render hormonal contraceptives ineffective, during treatment with Lorlatinib and for at least 6 months after the final dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with Lorlatinib and for 3 months after the final dose [see sections 4.5, 4.6 and 6.1].

## **4.5. Drugs interactions**

### **Effect of Other Drugs on Lorlatinib**

#### Strong CYP3A Inducers

Lorlatinib is contraindicated in patients taking strong CYP3A inducers [see section 4.3]. Discontinue strong CYP3A inducers for 3 plasma half-lives of the strong CYP3A inducer prior to initiating Lorlatinib [see section 4.2].

Concomitant use of Lorlatinib with a strong CYP3A inducer decreased Lorlatinib plasma concentrations [see section 5.3], which may decrease the efficacy of Lorlatinib.

Severe hepatotoxicity occurred in healthy subjects receiving Lorlatinib with rifampin, a strong CYP3A inducer. In 12 healthy subjects receiving a single 100 mg dose of Lorlatinib with multiple daily doses of rifampin, Grade 3 or 4 increases in ALT or AST occurred in 83% of subjects and Grade 2 increases in ALT or AST occurred in 8%. A possible mechanism for hepatotoxicity is through activation of the pregnane X receptor (PXR) by Lorlatinib and rifampin, which are both PXR agonists.

#### Moderate CYP3A Inducers

Avoid concomitant use of moderate CYP3A inducers with Lorlatinib. If concomitant use is unavoidable, increase the Lorlatinib dose [see section 4.2].

Concomitant use of Lorlatinib with a moderate CYP3A inducer decreased Lorlatinib plasma concentrations, which may decrease the efficacy of Lorlatinib [see section 5.3].

#### Strong CYP3A Inhibitors

Avoid concomitant use of Lorlatinib with a strong CYP3A inhibitor. If concomitant use cannot be avoided, reduce the Lorlatinib dosage [see section 4.2].

Concomitant use with a strong CYP3A inhibitor increased Lorlatinib plasma concentrations [see section 5.3], which may increase the incidence and severity of adverse reactions of Lorlatinib.

#### Fluconazole

Avoid the concomitant use of Lorlatinib with fluconazole. If concomitant use cannot be avoided, reduce the Lorlatinib dosage [see section 4.2].

Concomitant use of Lorlatinib with fluconazole may increase lorlatinib plasma concentrations [see section 5.3], which may increase the incidence and severity of adverse reactions of Lorlatinib.

## **Effect of Lorlatinib on Other Drugs**

### Certain CYP3A Substrates

Avoid concomitant use of Lorlatinib with certain CYP3A substrates, for which minimal concentration changes may lead to serious therapeutic failures. If concomitant use is unavoidable, increase the CYP3A substrate dosage in accordance with approved product labeling.

Lorlatinib is a moderate CYP3A inducer. Concomitant use of Lorlatinib decreases the concentration of CYP3A substrates [see section 5.3], which may reduce the efficacy of these substrates.

### Certain P-glycoprotein (P-gp) Substrates

Avoid concomitant use of Lorlatinib with certain P-gp substrates for which minimal concentration changes may lead to serious therapeutic failures. If concomitant use is unavoidable, increase the P-gp substrate dosage in accordance with approved product labeling.

Lorlatinib is a moderate P-gp inducer. Concomitant use of Lorlatinib decreases the concentration of P-gp substrates [see section 5.3], which may reduce the efficacy of these substrates.

## **4.6. Use in special populations**

### **Pregnancy**

#### Risk Summary

Based on findings from animal studies and its mechanism of action [see section 5.1], Lorlatinib can cause embryo-fetal harm when administered to a pregnant woman. There are no available data on Lorlatinib use in pregnant women. Administration of lorlatinib to pregnant rats and rabbits by oral gavage during the period of organogenesis resulted in malformations, increased post-implantation loss, and abortion at maternal exposures that were equal to or less than the human exposure at the recommended dose of 100 mg once daily based on AUC (see Data). Advise a pregnant woman of the potential risk to a fetus.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies are 2 to 4% and 15 to 20%, respectively.

#### Data

##### *Animal Data*

Preliminary embryo-fetal development studies investigating the administration of Lorlatinib during the period of organogenesis were conducted in rats and rabbits. In rabbits, Lorlatinib administration resulted in abortion and total loss of pregnancy at doses of 15 mg/kg (approximately 3 times the human exposure at the recommended dose of 100 mg) or greater. At a dose of 4 mg/kg (approximately 0.6 times the human exposure at the recommended dose of 100 mg) toxicities included increased post-implantation loss and malformations including rotated limbs, malformed kidneys, domed head, high arched palate, and dilation of the cerebral ventricles. In rats, administration of Lorlatinib resulted in total loss of pregnancy at doses of 4

mg/kg (approximately 5 times the human exposure at the recommended dose of 100 mg) or greater. At a dose of 1 mg/kg (approximately equal to the human exposure at the recommended dose of 100 mg) there was increased post-implantation loss, decreased fetal body weight, and malformations including gastroschisis, rotated limbs, supernumerary digits, and vessel abnormalities.

## **Lactation**

### Risk Summary

There are no data on the presence of Lorlatinib or its metabolites in either human or animal milk or its effects on the breastfed infant or on milk production. Because of the potential for serious adverse reactions in breastfed infants, instruct women not to breastfeed during treatment with Lorlatinib and for 7 days after the final dose.

## **Females and Males of Reproductive Potential**

### Pregnancy Testing

Verify pregnancy status in females of reproductive potential prior to initiating Lorlatinib [*see section 4.6*].

### Contraception

Lorlatinib can cause embryo-fetal harm when administered to a pregnant woman [*see section 4.6*].

#### *Females*

Advise female patients of reproductive potential to use effective non-hormonal contraception during treatment with Lorlatinib and for at least 6 months after the final dose. Advise females of reproductive potential to use a non-hormonal method of contraception, because Lorlatinib can render hormonal contraceptives ineffective [*see section 4.5*].

#### *Males*

Based on genotoxicity findings, advise males with female partners of reproductive potential to use effective contraception during treatment with Lorlatinib and for at least 3 months after the final dose [*see section 6.1*].

### Infertility

#### *Males*

Based on findings from animal studies, Lorlatinib may transiently impair male fertility [*see section 6.1*].

## **Pediatric Use**

The safety and effectiveness of Lorlatinib in pediatric patients have not been established.

## **Geriatric Use**

Of the patients in Study B7461001 (N=295) and Study B7461006 (N=149) who received 100 mg Lorlatinib orally once daily, 18% and 40% of patients, respectively, were aged 65 years or older. No clinically important differences in safety or efficacy were observed between patients aged 65 years or older and younger patients.

## Hepatic Impairment

In patients with severe hepatic impairment (Child-Pugh C), the recommended dosage of Lorlatinib is 50 mg orally once daily [see sections 4.2 and 5.3].

No dose adjustment is recommended for patients with mild (total bilirubin  $\leq$  ULN with AST  $>$  ULN or total bilirubin  $>1$  to  $1.5 \times$  ULN with any AST) to moderate (Child-Pugh B) hepatic impairment [see section 5.3].

## Renal Impairment

In patients with  $CL_{cr}$  15 to  $<30$  mL/min (estimated by Cockcroft-Gault), the recommended dosage of Lorlatinib is 75 mg orally once daily [see sections 4.2 and 5.3].

No dose adjustment is recommended for patients with  $CL_{cr}$  30 to 89 mL/min (estimated by Cockcroft-Gault) [see section 5.3].

## 4.7. Effects on ability to drive and use machines

No data

## 4.8. Undesirable effects

The following adverse reactions are described elsewhere in the labeling:

- Risk of Serious Hepatotoxicity with Concomitant Use of Strong CYP3A Inducers [see section 4.4]
- Central Nervous System Effects [see section 4.4]
- Hyperlipidemia [see section 4.4]
- Atrioventricular Block [see section 4.4]
- Interstitial Lung Disease/Pneumonitis [see section 4.4]
- Hypertension [see section 4.4]
- Hyperglycemia [see section 4.4]

## 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 pooled safety population described in the Warnings and Precautions section reflects exposure to Lorlatinib in 476 patients who received 100 mg Lorlatinib once daily in Study B7461001 (N=327) and Study B7461006 (N=149). Among 476 patients who received Lorlatinib, 75% were exposed for 6 months or longer and 61% were exposed for greater than 1 year. In this pooled safety population, the most frequent adverse reactions in  $\geq 20\%$  of 476 patients who received Lorlatinib were edema (56%), peripheral neuropathy (44%), weight gain (31%), cognitive effects (28%), fatigue (27%), dyspnea (27%), arthralgia (24%), diarrhea (23%), mood effects (21%), and cough (21%). The most frequent Grade 3-4 laboratory abnormalities in  $\geq 20\%$  of 476 patients who received Lorlatinib were hypercholesterolemia (21%) and hypertriglyceridemia (21%).

Previously Untreated ALK-Positive Metastatic NSCLC (CROWN Study)

The safety of Lorlatinib was evaluated in 149 patients with ALK-positive NSCLC in a randomized, open-label, active-controlled trial for the treatment of patients with ALK-positive, locally advanced or metastatic, NSCLC who had not received previous systemic treatment for advanced disease [see section 5.3]. The median duration of exposure to Lorlatinib was 16.7 months (4 days to 34.3 months) and 76% received Lorlatinib for at least 12 months.

Serious adverse reactions occurred in 34% of patients treated with Lorlatinib; the most frequently reported serious adverse reactions were pneumonia (4.7%), dyspnea (2.7%), respiratory failure (2.7%), cognitive effects (2.0%), and pyrexia (2.0%). Fatal adverse reactions occurred in 3.4% of patients treated with Lorlatinib and included pneumonia (0.7%), respiratory failure (0.7%), cardiac failure acute (0.7%), pulmonary embolism (0.7%), and sudden death (0.7%).

Permanent discontinuation of Lorlatinib due to adverse reactions occurred in 6.7% of patients. The most frequent adverse reaction that led to permanent discontinuation of Lorlatinib was cognitive effects (1.3%). Adverse reactions leading to dose interruptions occurred in 49% of patients treated with Lorlatinib. The most frequent adverse reactions that led to dose interruptions of Lorlatinib were hypertriglyceridemia (7%), edema (5%), pneumonia (4.7%) cognitive effects (4.0%), mood effects (4.0%), and hypercholesterolemia (3.4%). Adverse reactions leading to dose reductions occurred in 21% of patients treated with Lorlatinib. The most frequent adverse reactions that led to dose reductions were edema (5%), hypertriglyceridemia (4.0%), and peripheral neuropathy (3.4%).

Tables 2 and 3 summarize most frequent adverse reactions and laboratory abnormalities, respectively, in patients treated with Lorlatinib in Study B7461006.

**Table 2 Adverse Reactions (≥10% for all NCI CTCAE Grades or ≥2% for Grades 3-4) in Patients Treated with Lorlatinib in Study B7461006\***

Adverse Reaction	Lorlatinib N=149		Crizotinib N=142	
	All Grades (%)	Grade 3 or 4 (%)	All Grades (%)	Grade 3 or 4 (%)
Psychiatric				
Mood effects <sup>a</sup>	16	2	5	0
Nervous system				
Peripheral neuropathy <sup>b</sup>	34	2	15	0.7
Cognitive effects <sup>c</sup>	21	2	6	0
Headache	17	0	18	0.7
Dizziness	11	0	14	0
Sleep effects <sup>d</sup>	11	1.3	10	0
Respiratory				
Dyspnea	20	2.7	16	2.1
Cough	16	0	18	0
Respiratory failure	2.7	2	0	0
Vascular disorders				
Hypertension	18	10	2.1	0
Ocular				
Vision disorder <sup>e</sup>	18	0	39	0.7
Gastrointestinal				
Diarrhea	21	1.3	52	0.7

Adverse Reaction	Lorlatinib N=149		Crizotinib N=142	
	All Grades (%)	Grade 3 or 4 (%)	All Grades (%)	Grade 3 or 4 (%)
Nausea	15	0.7	52	2.1
Constipation	17	0	30	0.7
Vomiting	13	0.7	39	1.4
Musculoskeletal and connective tissue				
Arthralgia	19	0.7	11	0
Myalgia <sup>f</sup>	15	0.7	7	0
Back pain	15	0.7	11	0
Pain in extremity	17	0	8	0
General				
Edema <sup>g</sup>	56	4	40	1.4
Weight gain	38	17	13	2.1
Fatigue <sup>h</sup>	19	1.3	32	2.8
Pyrexia	17	1.3	13	1.4
Chest pain	11	1.3	14	0.7
Infections				
Upper respiratory tract infection <sup>i</sup>	11	0.7	7.7	1.4
Pneumonia	7.4	2	8.5	3.5
Bronchitis	6.7	2	2.1	0
Skin				
Rash <sup>j</sup>	11	0	8.5	0

\* Adverse reactions were graded using NCI CTCAE version 4.03.

Abbreviations: NCI CTCAE=National Cancer Institute Common Terminology Criteria for Adverse Events; SOC=System organ class.

- <sup>a</sup> Mood effects (including affective disorder, affect lability, agitation, anger, anxiety, bipolar I disorder, depressed mood, depression, depressive symptom, euphoric mood, intentional self-injury, irritability, mood altered, mood swings, stress).
- <sup>b</sup> Peripheral neuropathy (including dysesthesia, gait disturbance, hypoesthesia, motor dysfunction, muscular weakness, neuralgia, neuropathy peripheral, paresthesia, peripheral motor neuropathy, peripheral sensory neuropathy).
- <sup>c</sup> Cognitive effects (including events from SOC Nervous system disorders: amnesia, cognitive disorder, disturbance in attention, memory impairment, mental impairment; and also including events from SOC Psychiatric disorders: confusional state, delirium, disorientation).
- <sup>d</sup> Sleep effects (including insomnia, nightmare, sleep disorder, somnambulism).
- <sup>e</sup> Vision disorder (including diplopia, photophobia, photopsia, vision blurred, visual acuity reduced, visual impairment, vitreous floaters).
- <sup>f</sup> Myalgia (including musculoskeletal pain, myalgia).
- <sup>g</sup> Edema (including edema, edema peripheral, eyelid edema, face edema, generalized edema, localized edema, periorbital edema, peripheral swelling, swelling).
- <sup>h</sup> Fatigue (including asthenia, fatigue).
- <sup>i</sup> Upper respiratory tract infection (including upper respiratory infection).
- <sup>j</sup> Rash (including dermatitis acneiform, maculopapular rash, rash).

Additional clinically significant adverse reactions occurring at an incidence between 1% and 10% were speech effects (6.7%) and psychotic effects (3.4%).

**Table 3 Laboratory Abnormalities Worsening from Baseline in  $\geq 20\%$  of Patients in Study B7461006**

Laboratory Abnormality	Lorlatinib N=149		Crizotinib N=142	
	All Grades (%)	Grade 3 or 4 (%)	All Grades (%)	Grade 3 or 4 (%)
<b>Chemistry</b>				
Hypertriglyceridemia <sup>a,A</sup>	95	22	27	0
Hypercholesterolemia <sup>a,A</sup>	91	19	12	0
Increased creatinine <sup>a,A</sup>	81	0.7	99	2.1
Increased GGT <sup>a,A</sup>	52	6	41	6
Increased AST <sup>a,A</sup>	48	2	75	3.5
Hyperglycemia <sup>a,A</sup>	48	7	27	2.1
Increased ALT <sup>a,A</sup>	44	2.7	75	4.3
Increased CPK <sup>a,A</sup>	39	2	64	5
Hypoalbuminemia <sup>a,A</sup>	36	0.7	61	6
Increased lipase <sup>a,A</sup>	28	7	34	5
Increased alkaline phosphatase <sup>a,A</sup>	23	0	50	0.7
Hyperkalemia <sup>a,A</sup>	21	1.3	27	2.1
Increased amylase <sup>b,A</sup>	20	1.4	32	1.4
<b>Hematology</b>				
Anemia <sup>a,A</sup>	48	2	38	2.8
Activated PTT <sup>c,B</sup>	25	0	14	0
Lymphopenia <sup>a,A</sup>	23	2.7	43	6
Thrombocytopenia <sup>a,A</sup>	23	0	7	0.7

\* Grades using NCI CTCAE version 4.03.

Abbreviations: ALT=alanine aminotransferase; AST=aspartate aminotransferase; CPK=creatinine phosphokinase; GGT=gamma glutamyl transferase; NCI CTCAE=National Cancer Institute Common Terminology Criteria for Adverse Events; PTT=partial thromboplastin time.

N=number of patients who had at least one on-study assessment for the parameter of interest.

<sup>a</sup> N=149 (Lorlatinib).

<sup>A</sup> N=141 (Crizotinib).

<sup>b</sup> N=148 (Lorlatinib).

<sup>B</sup> N=135 (Crizotinib).

<sup>c</sup> N=138 (Lorlatinib).

### Previously Treated ALK-Positive Metastatic NSCLC

The data described below reflect exposure to Lorlatinib in 295 patients with ALK-positive or ROS1-positive metastatic NSCLC who received Lorlatinib 100 mg orally once daily in Study B7461001, a multi-cohort, non-comparative trial [see section 5.3]. The median duration of exposure to Lorlatinib was 12.5 months (1 day to 35 months) and 52% received Lorlatinib for  $\geq 12$  months. Patient characteristics were a median age of 53 years (19 to 85 years), age  $\geq 65$  years (18%), female (58%), White (49%), Asian (37%), and ECOG performance status 0 or 1 (96%).

The most frequent ( $\geq 20\%$ ) adverse reactions were edema, peripheral neuropathy, cognitive effects, dyspnea, fatigue, weight gain, arthralgia, mood effects, and diarrhea. Of the worsening laboratory values occurring in  $\geq 20\%$  of patients, the most frequent were hypercholesterolemia, hypertriglyceridemia, anemia, hyperglycemia, increased AST, hypoalbuminemia, increased ALT, increased lipase, and increased alkaline phosphatase.

Serious adverse reactions occurred in 32% of the 295 patients; the most frequently reported serious adverse reactions were pneumonia (3.4%), dyspnea (2.7%), pyrexia (2%), mental status changes (1.4%), and respiratory failure (1.4%). Fatal adverse reactions occurred in 2.7% of patients and included pneumonia (0.7%), myocardial infarction (0.7%), acute pulmonary edema (0.3%), embolism (0.3%), peripheral artery occlusion (0.3%), and respiratory distress (0.3%). Permanent discontinuation of Lorlatinib for adverse reactions occurred in 8% of patients.

The most frequent adverse reactions that led to permanent discontinuation were respiratory failure (1.4%), dyspnea (0.7%), myocardial infarction (0.7%), cognitive effects (0.7%) and mood effects (0.7%). Approximately 48% of patients required dose interruption. The most frequent adverse reactions that led to dose interruptions were edema (7%), hypertriglyceridemia (6%), peripheral neuropathy (5%), cognitive effects (4.4%), increased lipase (3.7%), hypercholesterolemia (3.4%), mood effects (3.1%), dyspnea (2.7%), pneumonia (2.7%), and hypertension (2.0%). Approximately 24% of patients required at least 1 dose reduction for adverse reactions. The most frequent adverse reactions that led to dose reductions were edema (6%), peripheral neuropathy (4.7%), cognitive effects (4.1%), and mood effects (3.1%).

Tables 4 and 5 summarize most frequent adverse reactions and laboratory abnormalities, respectively, in patients treated with Lorlatinib in Study B7461001.

**Table 4 Adverse Reactions Occurring in  $\geq 10\%$  of Patients in Study B7461001\***

Adverse Reaction	Lorlatinib (N=295)	
	All Grades (%)	Grade 3 or 4 (%)
Psychiatric		
Mood effects <sup>a</sup>	23	1.7
Nervous system		
Peripheral neuropathy <sup>b</sup>	47	2.7
Cognitive effects <sup>c</sup>	27	2.0
Headache	18	0.7
Dizziness	16	0.7
Speech effects <sup>d</sup>	12	0.3
Sleep effects <sup>e</sup>	10	0
Respiratory		
Dyspnea	27	5.4
Cough	18	0
Ocular		
Vision disorder <sup>f</sup>	15	0.3
Gastrointestinal		
Diarrhea	22	0.7
Nausea	18	0.7
Constipation	15	0
Vomiting	12	1
Musculoskeletal and connective tissue		
Arthralgia	23	0.7
Myalgia <sup>g</sup>	17	0
Back pain	13	0.7
Pain in extremity	13	0.3
General		
Edema <sup>h</sup>	57	3.1
Fatigue <sup>i</sup>	26	0.3
Weight gain	24	4.4
Pyrexia	12	0.7

**Table 4 Adverse Reactions Occurring in  $\geq 10\%$  of Patients in Study B7461001\***

Adverse Reaction	Lorlatinib (N=295)	
	All Grades (%)	Grade 3 or 4 (%)
Infections		
Upper respiratory tract infection <sup>j</sup>	12	0
Skin		
Rash <sup>k</sup>	14	0.3

\* Adverse reactions were graded using NCI CTCAE version 4.03.

Abbreviations: NCI CTCAE=National Cancer Institute Common Terminology Criteria for Adverse Events; SOC=System organ class.

- <sup>a</sup> Mood effects (including affective disorder, affect lability, aggression, agitation, anxiety, depressed mood, depression, euphoric mood, irritability, mania, mood altered, mood swings, personality change, stress, suicidal ideation).
- <sup>b</sup> Peripheral neuropathy (including burning sensation, carpal tunnel syndrome, dysesthesia, formication, gait disturbance, hypoesthesia, muscular weakness, neuralgia, neuropathy peripheral, neurotoxicity, paresthesia, peripheral sensory neuropathy, sensory disturbance).
- <sup>c</sup> Cognitive effects (including events from SOC Nervous system disorders: amnesia, cognitive disorder, dementia, disturbance in attention, memory impairment, mental impairment; and also including events from SOC Psychiatric disorders: attention deficit/hyperactivity disorder, confusional state, delirium, disorientation, reading disorder).
- <sup>d</sup> Speech effects (including aphasia, dysarthria, slow speech, speech disorder).
- <sup>e</sup> Sleep effects (including abnormal dreams, insomnia, nightmare, sleep disorder, sleep talking, somnambulism).
- <sup>f</sup> Vision disorder (including blindness, diplopia, photophobia, photopsia, vision blurred, visual acuity reduced, visual impairment, vitreous floaters).
- <sup>g</sup> Myalgia (including musculoskeletal pain, myalgia).
- <sup>h</sup> Edema (including edema, edema peripheral, eyelid edema, face edema, generalized edema, localized edema, periorbital edema, peripheral swelling, swelling).
- <sup>i</sup> Fatigue (including asthenia, fatigue).
- <sup>j</sup> Upper respiratory infection (including fungal upper respiratory infection, upper respiratory infection, viral upper respiratory infection).
- <sup>k</sup> Rash (including dermatitis acneiform, maculopapular rash, pruritic rash, rash).

Additional clinically significant adverse reactions occurring at an incidence between 1% and 10% were psychotic effect (7%).

**Table 5 Worsening Laboratory Values Occurring in  $\geq 20\%$  of Patients in Study B7461001\***

Laboratory Abnormality	Lorlatinib	
	All Grades (%)	Grade 3 or 4 (%)
Chemistry		
Hypercholesterolemia <sup>a</sup>	96	18
Hypertriglyceridemia <sup>a</sup>	90	18
Hyperglycemia <sup>b</sup>	52	5
Increased AST <sup>a</sup>	37	2.1
Hypoalbuminemia <sup>c</sup>	33	1.0
Increased ALT <sup>a</sup>	28	2.1
Increased lipase <sup>d</sup>	24	10
Increased alkaline phosphatase <sup>a</sup>	24	1.0
Increased amylase <sup>e</sup>	22	3.9
Hypophosphatemia <sup>a</sup>	21	4.8
Hyperkalemia <sup>b</sup>	21	1.0
Hypomagnesemia <sup>a</sup>	21	0
Hematology		
Anemia <sup>b</sup>	52	4.8
Thrombocytopenia <sup>b</sup>	23	0.3
Lymphopenia <sup>a</sup>	22	3.4

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\* Grades using NCI CTCAE version 4.03.

Abbreviations: ALT=alanine aminotransferase; AST=aspartate aminotransferase; NCI CTCAE=National Cancer Institute Common Terminology Criteria for Adverse Events.

N=number of patients who had at least one on-study assessment for the parameter of interest.

<sup>a</sup> N=292.

<sup>b</sup> N=293.

<sup>c</sup> N=291.

<sup>d</sup> N=290.

<sup>e</sup> N=284.

## 4.9. Overdose

No data

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1. Mechanism of action

Lorlatinib is a kinase inhibitor with *in vitro* activity against ALK and ROS1 as well as TYK1, FER, FPS, TRKA, TRKB, TRKC, FAK, FAK2, and ACK. Lorlatinib demonstrated *in vitro* activity against multiple mutant forms of the ALK enzyme, including some mutations detected in tumors at the time of disease progression on crizotinib and other ALK inhibitors.

In mice subcutaneously implanted with tumors harboring EML4 fusions with either ALK variant 1 or ALK mutations, including the G1202R and I1171T mutations detected in tumors at the time of disease progression on ALK inhibitors, administration of Lorlatinib resulted in antitumor activity. Lorlatinib also demonstrated anti-tumor activity and prolonged survival in mice implanted intracranially with EML4-ALK-driven tumor cell lines. The overall antitumor activity of Lorlatinib in *in vivo* models was dose-dependent and correlated with inhibition of ALK phosphorylation.

### 5.2. Pharmacodynamic properties

Exposure-response relationships for Grade 3 or 4 hypercholesterolemia and for any Grade 3 or 4 adverse reaction were observed at steady-state exposures achieved at the recommended dosage, with higher probability of the occurrence of adverse reactions with increasing Lorlatinib exposure.

#### Cardiac Electrophysiology

In 295 patients who received Lorlatinib at the recommended dosage of 100 mg once daily and had an ECG measurement in Study B7461001, the maximum mean change from baseline for PR interval was 16.4 ms (2-sided 90% upper confidence interval [CI] 19.4 ms). Among the 284 patients with PR interval <200 ms at baseline, 14% had PR interval prolongation  $\geq$ 200 ms after starting Lorlatinib. The prolongation of PR interval occurred in a concentration-dependent manner. Atrioventricular block occurred in 1% of patients.

In 275 patients who received Lorlatinib at the recommended dosage in the activity-estimating portion of Study B7461001, no large mean increases from baseline in the QTcF interval (i.e., >20 ms) were detected.

### 5.3. Pharmacokinetic properties

At the recommended dosage, the mean (coefficient of variation [CV] %) maximum plasma concentration ( $C_{max}$ ) is 577 ng/mL (42%) and the  $AUC_{0-24h}$  is 5,650 ng·h/mL (39%). Steady-

state Lorlatinib  $C_{max}$  increases proportionally and AUC increased slightly less than proportionally over the dose range of 10 mg to 200 mg orally once daily (0.1 to 2 times the recommended dosage).

### Absorption

The median lorlatinib  $T_{max}$  is 1.2 hours (0.5 to 4 hours) following a single oral 100 mg dose and 2 hours (0.5 to 23 hours) following 100 mg orally once daily at steady-state.

The mean absolute bioavailability is 81% (90% CI 76%, 86%).

### *Effect of Food*

No clinically significant differences in Lorlatinib pharmacokinetics were observed following administration of a high fat, high calorie meal (approximately 1000 calories with 150 calories from protein, 250 calories from carbohydrate, and 500 to 600 calories from fat).

### Distribution

Lorlatinib is 66% bound to plasma proteins, *in vitro*. The blood-to-plasma ratio is 0.99 *in vitro*.

### Elimination

The mean plasma half-life ( $t_{1/2}$ ) of Lorlatinib was 24 hours (40%) after a single oral 100 mg dose of Lorlatinib. The mean oral clearance (CL/F) was 11 L/h (35%) following a single oral 100 mg dose and increased to 18 L/h (39%) at steady state, suggesting autoinduction.

### *Metabolism*

Lorlatinib is metabolized primarily by CYP3A4 and UGT1A4, with minor contribution from CYP2C8, CYP2C19, CYP3A5, and UGT1A3.

In plasma, a benzoic acid metabolite (M8) of Lorlatinib resulting from the oxidative cleavage of the amide and aromatic ether bonds of Lorlatinib accounted for 21% of the circulating radioactivity. The oxidative cleavage metabolite, M8, is pharmacologically inactive.

### *Excretion*

Following a single oral 100 mg dose of radiolabeled Lorlatinib, 48% of the radioactivity was recovered in urine (<1% as unchanged) and 41% in feces (about 9% as unchanged).

### Specific Populations

No clinically significant differences in Lorlatinib pharmacokinetics were observed based on age (19 to 85 years), sex, race/ethnicity (52% White, 8% Black, 27% Asian), body weight (32-156 kg),  $CL_{cr}$  30 to 89 mL/min (estimated by Cockcroft Gault), mild (total bilirubin  $\leq$  ULN and AST  $>$  ULN or total bilirubin  $>$  1 to  $1.5 \times$  ULN and any AST) to moderate (Child-Pugh B) hepatic impairment, or metabolizer phenotypes for CYP3A5 and CYP2C19.

### *Patients with Moderate or Severe Hepatic Impairment*

Following administration of a single oral 100 mg dose of Lorlatinib, lorlatinib AUC increased 1.1-fold in non-cancer subjects with moderate hepatic impairment (Child-Pugh B) and 1.8-fold in non-cancer subjects with severe hepatic impairment (Child-Pugh C).

### *Patients with Renal Impairment*

Following administration of a single oral 100 mg dose of Lorlatinib, Lorlatinib AUC increased 1.4-fold in subjects with  $CL_{cr}$  15 to  $<$ 30 mL/min (estimated by Cockcroft-Gault). The pharmacokinetics of lorlatinib have not been studied in patients with end-stage renal disease requiring hemodialysis.

## Drug Interaction Studies

### *Clinical Studies and Model-Informed Approaches*

*Strong CYP3A Inducers*: Rifampin (a strong CYP3A inducer that also activates PXR) 600 mg once daily for 8 days (Days 1 to 8) coadministered with a single oral 100 mg dose of Lorlatinib on Day 8 reduced the mean lorlatinib AUC by 85% and  $C_{max}$  by 76%. Grade 2 to 4 increases in ALT or AST occurred within 3 days. Grade 4 ALT or AST elevations occurred in 50%, Grade 3 ALT or AST elevations in 33%, and Grade 2 ALT or AST elevations occurred in 8% of subjects. ALT and AST returned to within normal limits within 7 to 34 days (median 15 days).

*Moderate CYP3A Inducers* : Modafinil (a moderate CYP3A inducer) decreased Lorlatinib AUC by 23% and  $C_{max}$  by 22% of a single oral 100 mg dose of Lorlatinib.

*Strong CYP3A Inhibitors*: Itraconazole (a strong CYP3A inhibitor) increased Lorlatinib AUC 1.4-fold and  $C_{max}$  1.2-fold of a single oral 100 mg dose of Lorlatinib.

*Fluconazole* : Fluconazole is predicted to increase Lorlatinib AUC 1.6-fold and  $C_{max}$  1.3-fold following concomitant oral administration of 100 mg of Lorlatinib once daily and 200 mg fluconazole once daily .

*Moderate CYP3A Inhibitors* : No clinically significant effect on Lorlatinib pharmacokinetics is predicted when used concomitantly with verapamil or erythromycin.

*CYP3A Substrates*: Lorlatinib 150 mg orally once daily for 15 days decreased AUC by 64% and  $C_{max}$  by 50% of a single oral 2 mg dose of midazolam (a sensitive CYP3A substrate) .

*CYP2B6 Substrates*: Lorlatinib 100 mg orally once daily for 15 days decreased AUC by 25% and  $C_{max}$  by 27% of a single oral 100 mg dose of bupropion (a sensitive CYP2B6 substrate).

*CYP2C9 Substrates*: Lorlatinib 100 mg orally once daily for 15 days decreased AUC by 43% and  $C_{max}$  by 15% of a single oral 100 mg dose of tolbutamide (a sensitive CYP2C9 substrate).

*UGT1A Substrates*: Lorlatinib 100 mg orally once daily for 15 days decreased AUC by 45% and  $C_{max}$  by 28% of a single oral 100 mg dose of acetaminophen (a UGT1A substrate).

*P-gp Substrates*: Lorlatinib 100 mg orally once daily for 15 days decreased AUC by 67% and  $C_{max}$  by 63% of a single oral 60 mg dose of fexofenadine (a P-gp substrate).

*Acid-Reducing Agents*: Concomitant use of a proton pump inhibitor, rabeprazole, did not have a clinically significant effect on Lorlatinib pharmacokinetics.

### *In Vitro Studies*

*CYP Enzymes*: Lorlatinib is a time-dependent inhibitor as well as an inducer of CYP3A and activates PXR, with the net effect *in vivo* being induction. Lorlatinib induces CYP2B6 and activates the human constitutive androstane receptor (CAR). Lorlatinib and the major circulating metabolite, M8, do not inhibit CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, or CYP2D6. M8 does not inhibit CYP3A.

M8 does not induce CYP1A2, CYP2B6, or CYP3A.

UDP-glucuronosyltransferase (UGT): Lorlatinib and M8 do not inhibit UGT1A1, UGT1A4, UGT1A6, UGT1A9, UGT2B7, and UGT2B15.

Transporters Systems: Lorlatinib is an inhibitor of P-gp and activates PXR (potential to induce P-gp), with the net effect *in vivo* being induction.

Lorlatinib inhibits OCT1, OAT3, MATE1, and intestinal BCRP. Lorlatinib does not inhibit OATP1B1, OATP1B3, OAT1, OCT2, MATE2K, or systemic BCRP. M8 does not inhibit P-gp, BCRP, OATP1B1, OATP1B3, OAT1, OAT3, OCT1, OCT2, MATE1, and MATE2K.

## CLINICAL STUDIES

### Previously Untreated ALK-Positive Metastatic NSCLC (CROWN Study)

The efficacy of Lorlatinib for the treatment of patients with ALK-positive NSCLC who had not received prior systemic therapy for metastatic disease was established in an open-label, randomized, active-controlled, multicenter study (Study B7461006; NCT03052608). Patients were required to have an ECOG performance status of 0-2 and ALK-positive NSCLC as identified by the VENTANA ALK (D5F3) CDx assay. Neurologically stable patients with treated or untreated asymptomatic CNS metastases, including leptomeningeal metastases, were eligible. Patients were required to have finished radiation therapy, at least 2 weeks (for stereotactic or partial radiation) or 4 weeks (for whole brain irradiation) prior to randomization. Patients with severe acute or chronic psychiatric conditions, including recent (within the past year) or active suicidal ideation or behavior, were excluded.

Patients were randomized 1:1 to receive Lorlatinib 100 mg orally once daily or crizotinib 250 mg orally twice daily. Randomization was stratified by ethnic origin (Asian vs. non-Asian) and the presence or absence of CNS metastases at baseline. Treatment on both arms was continued until disease progression or unacceptable toxicity. The major efficacy outcome measure was progression-free survival (PFS) as determined by Blinded Independent Central Review (BICR) according to Response Evaluation Criteria in Solid Tumors (RECIST) version 1.1 (v1.1). Additional efficacy outcome measures were overall survival (OS) and tumor assessment related data by BICR, including overall response rate (ORR), and duration of response (DOR). In patients with measurable CNS metastases at baseline, additional outcome measures were intracranial overall response rate (IC-ORR) and intracranial duration of response (IC-DOR) by BICR.

A total of 296 patients were randomized to Lorlatinib (n=149) or crizotinib (n=147). The demographic characteristics of the overall study population were: median age 59 years (range: 26 to 90 years), age ≥65 years (35%), 59% female, 49% White, 44% Asian, and 0.3% Black. The ECOG performance status at baseline was 0 or 1 in 96% of patients. The majority of patients had adenocarcinoma (95%) and never smoked (59%). CNS metastases were present in 26% (n=78) of patients: of these, 30 patients had measurable CNS lesions.

Efficacy results from Study B7461006 as assessed by BICR are summarized in Table 6 and Figure 1. Results demonstrated a significant improvement in PFS for the Lorlatinib arm over the crizotinib arm. At the data cutoff point OS data was not mature.

**Table 6 Efficacy Results in Study B7461006 (CROWN)**

Efficacy Parameter	Lorlatinib N=149	Crizotinib N=147
<b>Progression-free survival</b>		
Number of events, n (%)	41 (28%)	86 (59%)

Progressive disease, n (%)	32 (22%)	82 (56%)
Death, n (%)	9 (6%)	4 (3%)
Median, months (95% CI) <sup>a</sup>	NE (NE, NE)	9.3 (7.6, 11.1)
Hazard ratio (95% CI) <sup>b</sup>	0.28 (0.19, 0.41)	
p-value <sup>*</sup>	<0.0001	
<b>Overall response rate</b>		
Overall response rate (95% CI) <sup>c</sup>	76% (68, 83)	58% (49, 66)
Complete response	3%	0%
Partial response	73%	58%
<b>Duration of response</b>		
Number of responders, n	113	85
Median, months (Range)	NE (0.9, 31.3)	11 (1.1, 27.5)
Response duration ≥6 months, n (%)	101 (89%)	53 (62%)
Response duration ≥12 months, n (%)	79 (70%)	23 (27%)
Response duration ≥18 months, n (%)	34 (30%)	9 (11%)

Abbreviations: CI=confidence interval; N=number of patients; NE=not estimable; PFS=progression free survival.

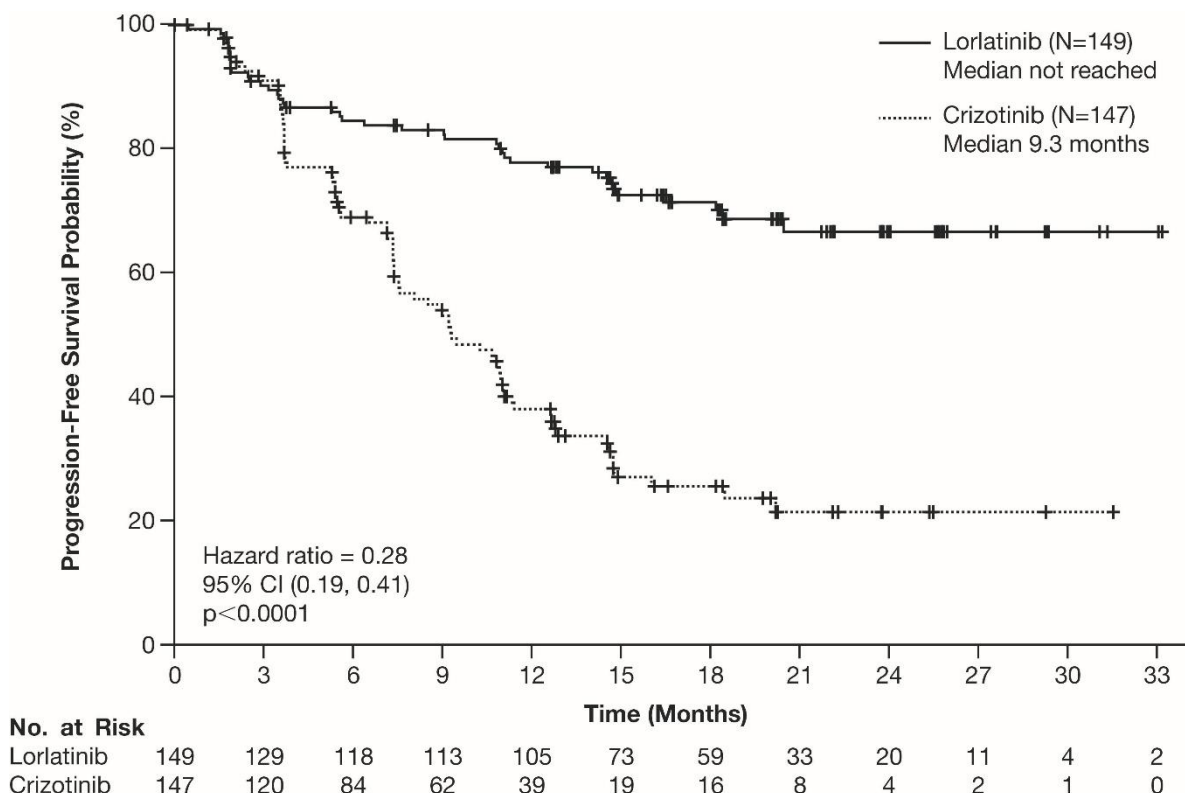
\* p-value based on 1-sided stratified log-rank test.

<sup>a</sup> Based on the Brookmeyer and Crowley method.

<sup>b</sup> Hazard ratio based on Cox proportional hazards model.

<sup>c</sup> Using exact method based on binomial distribution.

**Figure 1: Kaplan-Meier Plot of Progression-Free Survival by BICR in Study B7461006 (CROWN)**



The results of prespecified exploratory analyses of intracranial response rate in 30 patients with measurable CNS lesions at baseline as assessed by BICR are summarized in Table 7.

**Table 7 Intracranial Response Rate in Patients with Measurable Intracranial Lesions in CROWN**

<b>Intracranial Tumor Response Assessment</b>	<b>Lorlatinib N=17</b>	<b>Crizotinib N=13</b>
Intracranial response rate (95% CI) <sup>a</sup>	82% (57, 96)	23% (5, 54)
Complete response	71%	8%
Duration of response		
Number of responders, n	14	3
Response duration ≥12 months, n (%)	11 (79%)	0

Abbreviations: CI=confidence interval; N/n=number of patients.

<sup>a</sup> Using exact method based on binomial distribution.

**ALK-Positive Metastatic NSCLC Previously Treated with an ALK Kinase Inhibitor**

The efficacy of Lorlatinib was demonstrated in a subgroup of patients with ALK-positive metastatic NSCLC previously treated with one or more ALK kinase inhibitors who were enrolled in a non-randomized, dose-ranging and activity-estimating, multi-cohort, multicenter study (Study B7461001; NCT01970865). Patients included in this subgroup were required to have metastatic disease with at least 1 measurable target lesion according to RECIST v1.1, ECOG performance status of 0 to 2, and documented ALK rearrangement in tumor tissue as determined by fluorescence in situ hybridization (FISH) assay or by Immunohistochemistry (IHC), and received Lorlatinib 100 mg orally once daily. Patients with asymptomatic CNS metastases, including patients with stable or decreasing steroid use within 2 weeks prior to study entry, were eligible. Patients with severe, acute, or chronic psychiatric conditions including suicidal ideation or behavior were excluded. In addition, for patients with ALK-positive metastatic NSCLC, the extent and type of prior treatment was specified for each individual cohort (see Table 8). The major efficacy outcome measures were ORR and intracranial ORR, according to RECIST v1.1, as assessed by Independent Central Review (ICR) committee. Data were pooled across all subgroups listed in Table 8. Additional efficacy outcome measures included DOR, and intracranial DOR.

A total of 215 patients were enrolled across the subgroups in Table 8. The distribution of patients by type and extent of prior therapy is provided in Table 8. The demographic characteristics across all 215 patients were: 59% female, 51% White, 34% Asian, and the median age was 53 years (29 to 85 years) with 18% of patients ≥65 years. The ECOG performance status at baseline was 0 or 1 in 96% of patients. All patients had metastatic disease and 95% had adenocarcinoma. Brain metastases as identified by ICR were present in 69% of patients; of these, 60% had received prior radiation to the brain and 60% (n=89) had measurable disease per ICR.

**Table 8 Extent of Prior Therapy in the Subgroup of Patients with Previously Treated ALK-Positive Metastatic NSCLC in Study B7461001**

<b>Extent of prior therapy</b>	<b>Number of patients</b>
Prior crizotinib and no prior chemotherapy <sup>a</sup>	29
Prior crizotinib and 1-2 lines of prior chemotherapy <sup>a</sup>	35
Prior ALK inhibitor (not crizotinib) with or without prior chemotherapy <sup>a</sup>	28
Two prior ALK inhibitors with or without prior chemotherapy <sup>a</sup>	75
Three prior ALK inhibitors with or without prior chemotherapy <sup>a</sup>	48
Total	215

Abbreviations: ALK=anaplastic lymphoma kinase; NSCLC=non-small cell lung cancer.

<sup>a</sup> Chemotherapy administered in the metastatic setting.

Efficacy results for Study B7461001 are summarized in Tables 9 and 10.

**Table 9 Efficacy Results in Study B7461001**

<b>Efficacy Parameter</b>	<b>Overall N=215</b>
<b>Overall response rate<sup>a</sup> (95% CI)<sup>b</sup></b>	48% (42, 55)
Complete response	4%
Partial response	44%
<b>Duration of response</b>	
Median, months <sup>c</sup> (95% CI)	12.5 (8.4, 23.7)

Abbreviations: CI=confidence interval; N=number of patients.

<sup>a</sup> Per Independent Central Review.

<sup>b</sup> Using exact method based on binomial distribution.

<sup>c</sup> Estimated using the Kaplan Meier method.

An assessment of intracranial ORR and the duration of response for CNS metastases in the subgroup of 89 patients in Study B7461001 with baseline measurable lesions in the CNS according to RECIST v1.1 are summarized in Table 10. Of these, 56 (63%) patients received prior brain radiation, including 42 patients (47%) who completed brain radiation treatment at least 6 months before starting treatment with Lorlatinib.

**Table 10 Intracranial Response Rate in Patients with Measurable Intracranial Lesions in Study B7461001**

<b>Efficacy Parameter</b>	<b>Intracranial N=89</b>
<b>Intracranial response rate<sup>a</sup> (95% CI)<sup>b</sup></b>	60% (49, 70)
Complete response	21%
Partial response	38%
<b>Duration of response</b>	
Median, months <sup>c</sup> (95% CI)	19.5 (12.4, NR)

Abbreviations: CI=confidence interval; N=number of patients; NR=not reached.

<sup>a</sup> Per Independent Central Review.

<sup>b</sup> Using exact method based on binomial distribution.

<sup>c</sup> Estimated using the Kaplan-Meier method.

In exploratory analyses conducted in subgroups defined by prior therapy, the response rates to Lorlatinib were:

- ORR = 39% (95% CI: 30, 48) in 119 patients who received crizotinib and at least one other ALK inhibitor, with or without prior chemotherapy
- ORR = 31% (95% CI: 9, 61) in 13 patients who received alectinib as their only ALK inhibitor, with or without prior chemotherapy
- ORR = 46% (95% CI: 19, 75) in 13 patients who received ceritinib as their only ALK inhibitor, with or without prior chemotherapy

## 6. NONCLINICAL PROPERTIES

Carcinogenicity studies have not been conducted with lorlatinib. Lorlatinib was aneugenic in an *in vitro* assay in human lymphoblastoid TK6 cells and positive for micronuclei formation *in vivo* in the bone marrow of rats. Lorlatinib was not mutagenic in an *in vitro* bacterial reverse mutation (Ames) assay.

Dedicated fertility studies were not conducted with lorlatinib. Findings in male reproductive organs occurred in repeat-dose toxicity studies and included lower testicular, epididymal, and prostate weights; testicular tubular degeneration/atrophy; prostatic atrophy; and/or epididymal

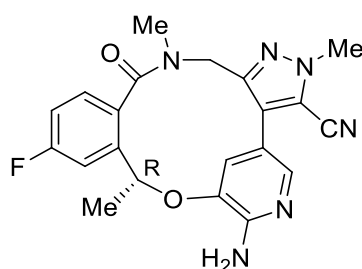
inflammation at 15 mg/kg/day and 7 mg/kg/day in rats and dogs, respectively (approximately 8 and 2 times, respectively, the human exposure at the recommended dose of 100 mg based on AUC). The effects on male reproductive organs were reversible.

## 6.1 Animal toxicology or pharmacology

Distended abdomen, skin rash, and increased cholesterol and triglycerides occurred in animals. These findings were accompanied by hyperplasia and dilation of the bile ducts in the liver and acinar atrophy of the pancreas in rats at 15 mg/kg/day and in dogs at 2 mg/kg/day (approximately 8 and 0.5 times, respectively, the human exposure at the recommended dose of 100 mg based on AUC). All effects were reversible within the recovery period.

## 7. DESCRIPTION

Lorlatinib is a kinase inhibitor for oral administration. The molecular formula is  $C_{21}H_{19}FN_6O_2$  (anhydrous form), and the molecular weight is 406.41 Daltons. The chemical name is (10*R*)-7-amino-12-fluoro-2,10,16-trimethyl-15-oxo-10,15,16,17-tetrahydro-2*H*-4,8-methenopyrazolo [4,3-*h*][2,5,11] benzoxadiazacyclotetradecine-3-carbonitrile. The chemical structure is shown below:



Lorlatinib is a white to off-white powder with a pKa of 4.92. The solubility of Lorlatinib in aqueous media decreases over the range pH 2.55 to pH 8.02 from 32.38 mg/mL to 0.17 mg/mL. The log of the distribution coefficient (octanol/water) at pH 9 is 2.45.

## 8. PHARMACEUTICAL PARTICULARS

### 8.1. Incompatibilities

Not applicable.

### 8.2. Shelf-life

36 months

[NOTE: Please refer outer carton for precise “Expiry Date” details]

### 8.3. Packaging information

25 mg: Carton with 3 blister strips, 10 tablets each and Carton with 3 blister strips, 5 tablets each

100 mg: Carton with 3 blister strips, 10 tablets each and Carton with 3 blister strips, 5 tablets each

25 mg or 100 mg: HDPE Bottle of 30 tablets each

All strengths/presentations mentioned in this document may not be marketed.

#### **8.4. Storage and handling instructions**

Store below 30°C. Keep out of reach of children.

### **9. PATIENT COUNSELLING INFORMATION**

#### Risk of Serious Hepatotoxicity with Concomitant Use of Strong CYP3A Inducers

Inform patients of the potential risk of hepatotoxicity with the concomitant use of strong CYP3A inducers.

Advise patients to inform their healthcare providers of all medications they are taking, including prescription medicines, over-the-counter drugs, vitamins, and herbal products (e.g., St. John's wort) [see section 4.4].

#### Central Nervous System (CNS) Effects

Advise patients to notify their healthcare provider if they experience new or worsening CNS symptoms [see section 4.4].

#### Hyperlipidemia

Inform patients that serum cholesterol and triglycerides will be monitored during treatment. Advise patients that initiation or an increase in the dose of lipid-lowering agents may be required [see section 4.4].

#### Atrioventricular (AV) Block

Inform patients of the risks of AV block. Advise patients to contact their healthcare provider immediately to report new or worsening cardiac symptoms [see section 4.4].

#### Interstitial Lung Disease (ILD)/Pneumonitis

Inform patients of the risks of severe ILD/pneumonitis. Advise patients to contact their healthcare provider immediately to report new or worsening respiratory symptoms [see section 4.4].

#### Hypertension

Advise patients of the risks of hypertension and to promptly report signs or symptoms of hypertension to their healthcare provider. Advise patients with hypertension that antihypertension medications may need to be initiated or adjusted during treatment with Lorlatinib [see section 4.4].

#### Hyperglycemia

Inform patients of the risks of new or worsening hyperglycemia and of the need to periodically monitor glucose levels and to promptly report hyperglycemia to their healthcare provider. Advise patients with newly occurring hyperglycemia during treatment with Lorlatinib that antihyperglycemic medications may need to be initiated. Inform patients with diabetes mellitus or glucose intolerance that antihyperglycemic medications may need to be adjusted during treatment with Lorlatinib [see section 4.4].

### Embryo-Fetal Toxicity

Advise females of reproductive potential of the potential risk to a fetus. Advise females to inform their healthcare provider of a known or suspected pregnancy [see sections 4.4 and 4.6].

Advise females of reproductive potential to use effective non-hormonal contraception during treatment with Lorlatinib and for at least 6 months after the final dose [see section 4.6].

Advise male patients with female partners of reproductive potential to use effective contraception during treatment with Lorlatinib and for at least 3 months after the final dose [see sections 4.6 and 6.1].

### Lactation

Advise women not to breastfeed during treatment with Lorlatinib and for 7 days after the final dose [see section 4.6].

### Infertility

Advise males of reproductive potential that Lorlatinib may transiently impair fertility [see sections 4.6 and 6.1].

## **10. DETAILS OF MANUFACTURER**

M/s. Pfizer Manufacturing Deutschland GmbH Betriebsstätte Freiburg Mooswaldallee 1, Freiburg – 79090, Germany

### **Imported and marketed in India by**

Pfizer Products India Private Limited,  
The Capital- B Wing, 1802, 18<sup>th</sup> Floor, Plot No. C-70, G Block,  
Bandra Kurla Complex, Bandra (East), Mumbai 400 051,  
India

## **11. DETAILS OF PERMISSION OR LICENCE NUMBER WITH DATE**

Import and Marketing permission no. IMP-ND-155-2019 dated 26-Dec-2019 and subsequent approval number IMP/SND/21/000060 dated 06-Aug-2021.

## **12. DATE OF REVISION**

February 2026