



VYNDAMAX

Tafamidis

61 mg Capsules for oral administration

Reference Market: United States

AfME Markets using same as LPD: Saudi Arabia

SUMMARY OF PRODUCT CHARACTERISTICS

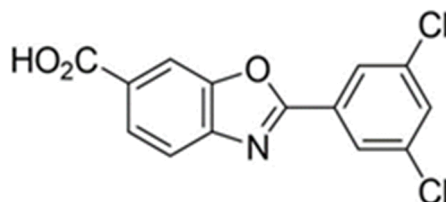
1. NAME OF THE MEDICINAL PRODUCT

VYNDAMAX 61 mg capsules, for oral administration

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

VYNDAMAX contain tafamidis as the active moiety, which is a selective stabilizer of transthyretin.

The chemical name of tafamidis is 2-(3,5-dichlorophenyl)-1,3-benzoxazole-6-carboxylic acid. The molecular formula is $C_{14}H_7Cl_2NO_3$, and the molecular weight is 308.12 g/mol. The structural formula is:



Tafamidis 61-mg soft gelatin capsule for oral use contains a white to pink colored suspension of tafamidis 61 mg.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Soft gelatin capsules.

reddish brown, opaque, oblong capsule, printed with “VYN 61” in white.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

VYNDAMAX is indicated for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular mortality and cardiovascular-related hospitalization.

4.2 Posology and method of administration

The recommended dosage is VYNDAMAX 61 mg (one 61-mg tafamidis capsule) orally once daily.

VYNDAMAX is not substitutable on a per mg basis [see section 5 Pharmacological Properties].

Administration Instructions

The capsules should be swallowed whole and not crushed or cut.

If a dose is missed, instruct patients to take the dose as soon as remembered or to skip the missed dose and take the next dose at the regularly scheduled time. Do not double the dose.

Special population

Pediatric Use

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

Geriatric Use

No dosage adjustment is required for elderly patients (≥ 65 years) [see section 5 Pharmacological Properties]. Of the total number of patients in the clinical study (n=441), 90.5% were 65 and over, with a median age of 75 years.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

Pregnancy

Pregnant women and females of reproductive potential should be aware of the potential risk to a fetus. Females should inform their healthcare provider of a known or suspected pregnancy [see section 4.6 Fertility, pregnancy and lactation].

Lactation

Females should not breastfeed during treatment with VYNDAMAX [see section 4.6 Fertility, pregnancy and lactation].

This medicinal product contains sorbitol.

4.5 Interaction with other medicinal products and other forms of interaction

BCRP Substrates

Tafamidis inhibits breast cancer resistant protein (BCRP) in humans (see Clinical Pharmacology). Coadministration of tafamidis and drugs that are BCRP substrates may increase the exposure of substrates of this transporter (e.g., methotrexate, rosuvastatin, imatinib) and the risk of the substrate-related toxicities. Monitor for signs of BCRP substrate-related toxicities and modify dosage of the substrate if appropriate.

4.6 Fertility, pregnancy and lactation

Pregnancy

Risk Summary

Based on findings from animal studies, VYNDAMAX may cause fetal harm when administered to a pregnant woman. However, limited available human data with VYNDAQEL use in pregnant women (at a dose of 20 mg per day) have not identified any drug-associated risks for major birth defects, miscarriage, or adverse maternal or fetal outcomes. In animal reproductive studies, oral administration of tafamidis meglumine to pregnant rabbits during organogenesis resulted in adverse effects on development (embryofetal mortality, fetal body weight reduction and fetal malformation) at a dosage providing approximately 9 times the human exposure (AUC) at the maximum recommended human dose (MRHD) of VYNDAQEL (80 mg), and increased incidence of fetal skeletal variation at a dosage providing equivalent human exposure (AUC) at the MRHD. Postnatal mortality, growth retardation, and impaired learning and memory were observed in offspring of pregnant rats administered tafamidis meglumine during gestation and lactation at a dosage approximately 2 times the MRHD based on body surface area (mg/m²) (see Data). Advise pregnant women of the potential risk to a fetus.

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defects, loss, or other adverse outcomes. In the U.S. general

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

Data

Animal Data

In pregnant rats, oral administration of tafamidis meglumine (0, 15, 30, and 45 mg/kg/day) throughout organogenesis resulted in decreased fetal body weights at ≥ 30 mg/kg/day (approximately 10 times the human exposure at the MRHD based on AUC). The no-observed-adverse-effect-level (NOAEL) for embryofetal development in rats was 15 mg/kg/day (approximately 7 times the human exposure at the MRHD based on AUC).

In pregnant rabbits, oral administration of tafamidis meglumine (0, 0.5, 2, and 8 mg/kg/day) throughout organogenesis resulted in increased embryofetal mortality, reduced fetal body weights, and an increased incidence of fetal malformations at 8 mg/kg/day (approximately 9 times the human exposure at the MRHD based on AUC), which was also maternally toxic. Increased incidences of fetal skeletal variations were observed at doses ≥ 0.5 mg/kg/day (approximately equivalent to the human exposure at the MRHD based on AUC).

In the pre- and postnatal study, pregnant rats received oral administration of tafamidis meglumine at doses of 0, 5, 15, or 30 mg/kg/day throughout pregnancy and lactation (Gestation Day 7 to Lactation Day 20). Decreased survival and body weights, delayed male sexual maturation and neurobehavioral effects (learning and memory impairment) were observed in the offspring of dams treated at 15 mg/kg/day (approximately 2 times the MRHD on a mg/m² basis). The NOAEL for pre- and postnatal development in rats was 5 mg/kg/day (approximately equivalent to the MRHD on a mg/m² basis).

Lactation

Risk Summary

There are no available data on the presence of tafamidis in human milk, the effect on the breastfed infant, or the effect on milk production. Tafamidis is present in rat milk (*see Data*). When a drug is present in animal milk, it is likely the drug will be present in human milk. Based on findings from animal studies which suggest the potential for serious adverse reactions in the breastfed infant, advise patients that breastfeeding is not recommended during treatment with VYNDAMAX.

Data

Pregnant and lactating female rats were administered repeated daily oral doses of tafamidis meglumine (15 mg/kg/day) followed by a single oral gavage dose of ¹⁴C-tafamidis meglumine on Lactation Day 4 or 12. Radioactivity was observed in milk by 1 hour post-dose and increased thereafter. The ratio of the highest radioactivity associated with ¹⁴C tafamidis meglumine in milk (8 hours post-dose) vs. plasma (1 hour post-dose) was approximately 1.6 on Day 12, indicating tafamidis meglumine is transferred to milk after oral administration.

Females and Males of Reproductive Potential

Contraception

Females

Based on findings from animal studies, VYNDAMAX may cause fetal harm when administered to a pregnant woman. Consider pregnancy planning and prevention for females of reproductive potential.

4.7 Effects on ability to drive and use machines

No studies on the effects of VYNDAMAX on the ability to drive or use machines have been performed.

4.8 Undesirable effects

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 data reflect exposure of 377 ATTR-CM patients to 20 mg or 80 mg (administered as four 20-mg capsules) of VYNDAQEL administered daily for an average of 24.5 months (ranging from 1 day to 111 months).

Adverse events were assessed from ATTR-CM clinical trials with VYNDAQEL, primarily a 30-month placebo-controlled trial [see *Clinical Studies*]. The frequency of adverse events in patients treated with VYNDAQEL 20 mg (n=88) or 80 mg (n=176; administered as four 20-mg capsules) was similar to that with placebo (n=177).

In the 30-month placebo-controlled trial, similar proportions of VYNDAQEL-treated patients and placebo-treated patients discontinued the study drug because of an adverse event: 12 (7%), 5 (6%), and 11 (6%) from the VYNDAQEL 80-mg, VYNDAQEL 20-mg, and placebo groups, respectively.

Reporting of adverse reactions

Reporting suspected adverse reactions after marketing authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions according to national pharmacovigilance center requirements.

- **Saudi Arabia**

National Pharmacovigilance Center (NPC)
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- | |
|---|
| <ul style="list-style-type: none">• SFDA Call center: 19999• E-mail: npc.drug@sfd.gov.sa• Website: https://ade.sfd.gov.sa/ |
|---|

- **Other GCC states**

- <i>Please contact the relevant competent authority</i>
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4.9 Overdose

There is minimal clinical experience with overdose. During clinical trials, two patients accidentally ingested a single VYNDAQEL dose of 160 mg without adverse events. The highest dose of tafamidis meglumine given to healthy volunteers in a clinical trial was 480 mg as a single dose. There was one reported adverse event of mild hordeolum at this dose.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Mechanism of Action

Tafamidis is a selective stabilizer of TTR. Tafamidis binds to TTR at the thyroxine binding sites, stabilizing the tetramer and slowing dissociation into monomers, the rate-limiting step in the amyloidogenic process.

Pharmacodynamics

A proprietary TTR stabilization assay was utilized as a pharmacodynamic marker and assessed the stability of the TTR tetramer ex vivo. The TTR stabilization assay quantifies immunoturbidimetric measurement of the stable TTR tetramer in plasma pre- and post-treatment with 2-day in vitro denaturation with urea. Using this

proprietary assay, a dose-dependent trend for greater TTR tetramer stabilization is observed for VYNDAREL 80-mg compared to VYNDAREL 20-mg. However, the clinical relevance of a higher TTR tetramer stabilization towards cardiovascular outcomes is not known.

VYNDAREL stabilized both the wild type TTR tetramer and the tetramers of 14 TTR variants tested clinically after once-daily dosing. Tafamidis also stabilized the TTR tetramer for 25 variants tested ex vivo.

VYNDAREL and VYNDAMAX may decrease serum concentrations of total thyroxine, without an accompanying change in thyroid stimulating hormone (TSH). This reduction in total thyroxine values is probably the result of reduced thyroxine binding to or displacement from transthyretin (TTR) due to the high binding affinity of tafamidis to the TTR thyroxine receptor. No corresponding clinical findings consistent with hypothyroidism have been observed.

Biomarkers associated with heart failure (NT-proBNP and Troponin I) favored VYNDAREL over placebo.

Cardiac Electrophysiology

At approximately 2.2 times the steady state peak plasma concentration (C_{max}) at the recommended dose, tafamidis does not prolong the QTc interval to any clinically relevant extent.

CLINICAL STUDIES

Efficacy was demonstrated in a multicenter, international, randomized, double-blind, placebo-controlled study in 441 patients with wild type or hereditary ATTR-CM (NCT01994889).

Patients were randomized in a 1:2:2 ratio to receive VYNDAREL 20 mg (n=88), VYNDAREL 80 mg (administered as four 20-mg VYNDAREL capsules) (n=176), or matching placebo (n=177) once daily for 30 months, in addition to standard of care (e.g., diuretics). Treatment assignment was stratified by the presence or absence of a variant TTR genotype as well as baseline disease severity (NYHA Class). Transplant patients were excluded from this study. Table 1 describes the patient demographics and baseline characteristics.

Table 1: Patient Demographics and Baseline Characteristics

<i>Characteristic</i>	<i>Pooled Tafamidis N=264</i>	<i>Placebo N=177</i>
Age — years		
Mean (standard deviation)	74.5 (7.2)	74.1 (6.7)
Median (minimum, maximum)	75 (46, 88)	74 (51, 89)
Sex — number (%)		
Male	241 (91.3)	157 (88.7)
Female	23 (8.7)	20 (11.3)
TTR Genotype — number (%)		
ATTRm	63 (23.9)	43 (24.3)
ATTRwt	201 (76.1)	134 (75.7)
NYHA Class — number (%)		
NYHA Class I	24 (9.1)	13 (7.3)
NYHA Class II	162 (61.4)	101 (57.1)
NYHA Class III	78 (29.5)	63 (35.6)

Abbreviations: ATTRm = variant transthyretin amyloid, ATTRwt = wild type transthyretin amyloid

The primary analysis used a hierarchical combination applying the method of Finkelstein-Schoenfeld (F-S) to all-cause mortality and frequency of cardiovascular-related hospitalizations, which was defined as the number of times a subject was hospitalized (i.e., admitted to a hospital) for cardiovascular-related morbidity. The method compared each patient to every other patient within each stratum in a pair-wise manner that proceeded in a hierarchical fashion using all-cause mortality followed by frequency of cardiovascular-related hospitalizations when patients could not be differentiated based on mortality.

This analysis demonstrated a significant reduction ($p=0.0006$) in all-cause mortality and frequency of cardiovascular-related hospitalizations in the pooled VYNDAQEL 20-mg and 80-mg groups versus placebo (Table 2).

Table 2: Primary Analysis Using Finkelstein-Schoenfeld (F-S) Method of All-Cause Mortality and Frequency of Cardiovascular-Related Hospitalizations

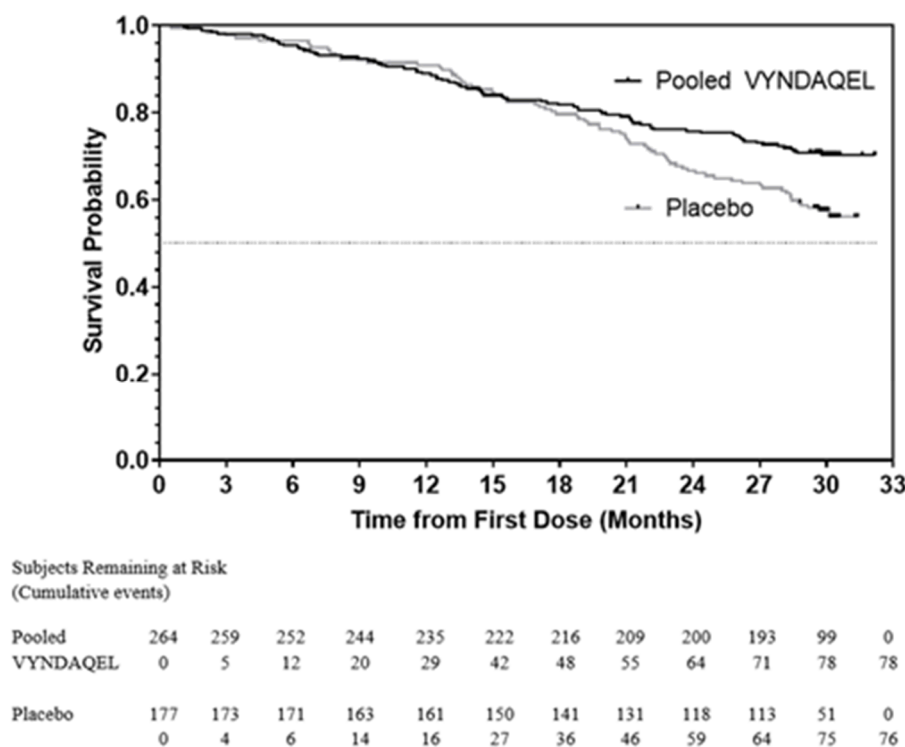
Primary Analysis	Pooled VYNDAQEL N=264	Placebo N=177
Number (%) of Subjects Alive* at Month 30	186 (70.5)	101 (57.1)
Mean Number of Cardiovascular-related Hospitalizations During 30 months (per patient per year) Among Those Alive at Month 30	0.297	0.455
p-value from F-S Method	0.0006	

* Heart transplantation and cardiac mechanical assist device implantation are considered indicators of approaching end stage. As such, these subjects are treated in the analysis as equivalent to death. Therefore, such subjects are not included in the count of “Number of Subjects Alive at Month 30” even if such subjects are alive based on 30 month vital status follow-up assessment.

Analysis of the individual components of the primary analysis (all-cause mortality and cardiovascular-related hospitalization) also demonstrated significant reductions for VYNDAQEL versus placebo.

The hazard ratio from the all-cause mortality Cox-proportional hazard model for pooled VYNDAQEL versus placebo was 0.70 (95% confidence interval [CI] 0.51, 0.96), indicating a 30% relative reduction in the risk of death relative to the placebo group ($p=0.026$). Approximately 80% of total deaths were cardiovascular-related in both treatment groups. A Kaplan-Meier plot of time to event all-cause mortality is presented in Figure 1.

Figure 1: All-Cause Mortality*



*Heart transplants and cardiac mechanical assist devices treated as death. Hazard ratio from Cox proportional hazards model with treatment, TTR genotype (variant and wild type), and NYHA baseline classification (NYHA Classes I and II combined and NYHA Class III) as factors.

There were significantly fewer cardiovascular-related hospitalizations with VYND AQEL compared with placebo with a reduction in risk of 32% corresponding to a Relative Risk Ratio of 0.68 (Table 3).

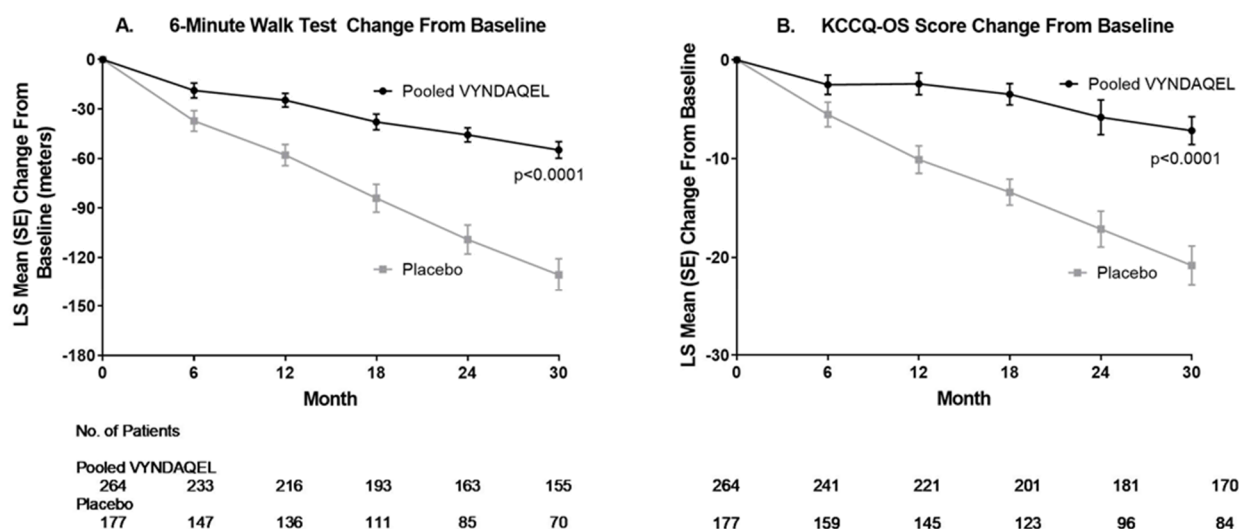
Table 3: Cardiovascular-Related Hospitalization Frequency

	Pooled VYND AQEL N=264	Placebo N=177
Total (%) Number of Subjects with Cardiovascular-related Hospitalizations	138 (52.3)	107 (60.5)
Cardiovascular-related Hospitalizations per Year*	0.48	0.70
Pooled VYND AQEL vs Placebo Treatment Difference (Relative Risk Ratio)*	0.68	
p-value*	<0.0001	

*This analysis was based on a Poisson regression model with treatment, TTR genotype (variant and wild type), New York Heart Association (NYHA). Baseline classification (NYHA Classes I and II combined and NYHA Class III), treatment-by-TTR genotype interaction, and treatment-by-NYHA baseline classification interaction terms as factors.

The treatment effects of VYND AQEL on functional capacity and health status were assessed by the 6-Minute Walk Test (6MWT) and the Kansas City Cardiomyopathy Questionnaire-Overall Summary (KCCQ-OS) score, respectively. A significant treatment effect favoring VYND AQEL was first observed at Month 6 and remained consistent through Month 30 on both 6MWT distance and KCCQ-OS score (Figure 2 and Table 4).

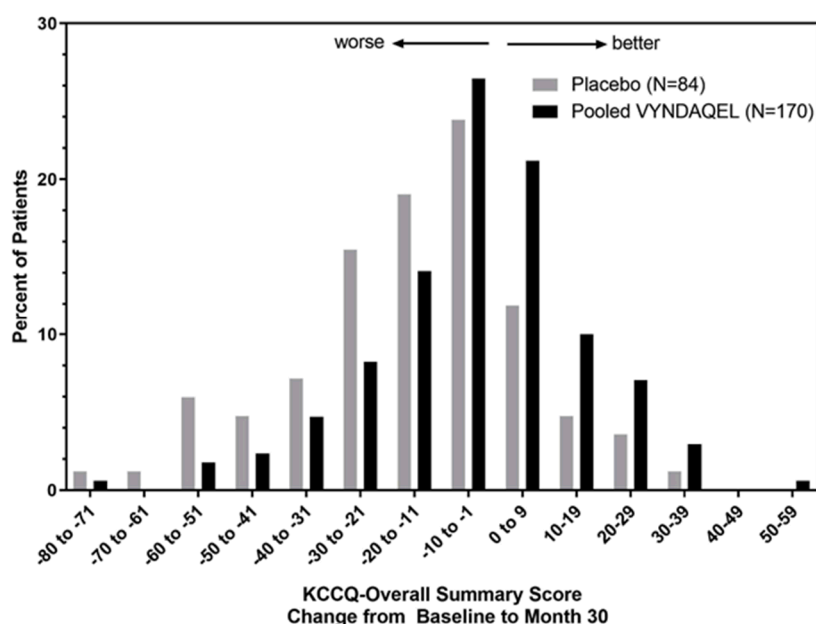
Figure 2: Change from Baseline to Month 30 in 6MWT Distance and KCCQ-OS Score



Abbreviations: 6MWT=6-Minute Walk Test, KCCQ-OS=Kansas City Cardiomyopathy Questionnaire-Overall Summary. Panel A shows change from Baseline to Month 30 in pooled VYND AQEL patients compared with placebo patients in 6MWT distance. Panel B shows change from Baseline to Month 30 in pooled VYND AQEL patients compared with placebo patients in KCCQ-OS score.

The Kansas City Cardiomyopathy Questionnaire-Overall Summary (KCCQ-OS) score is composed of four domains including Total Symptoms (Symptom Frequency and Symptom Burden), Physical Limitation, Quality of Life, and Social Limitation. The Overall Summary score and domain scores range from 0 to 100, with higher scores representing better health status. All four domains favored pooled VYND AQEL compared to placebo at Month 30, and demonstrated similar treatment effects to the KCCQ-OS score (Figure 2 and Table 4). The distribution for change from Baseline to Month 30 for KCCQ-OS (Figure 3) shows that the proportion of patients with worse KCCQ-OS scores was lower for the pooled VYND AQEL-treated group compared to placebo, and the proportion with improved scores was higher (Figure 3).

Figure 3: Histogram of Change from Baseline to Month 30 in KCCQ-Overall Summary Score



Abbreviation: KCCQ-OS=Kansas City Cardiomyopathy Questionnaire-Overall Summary.

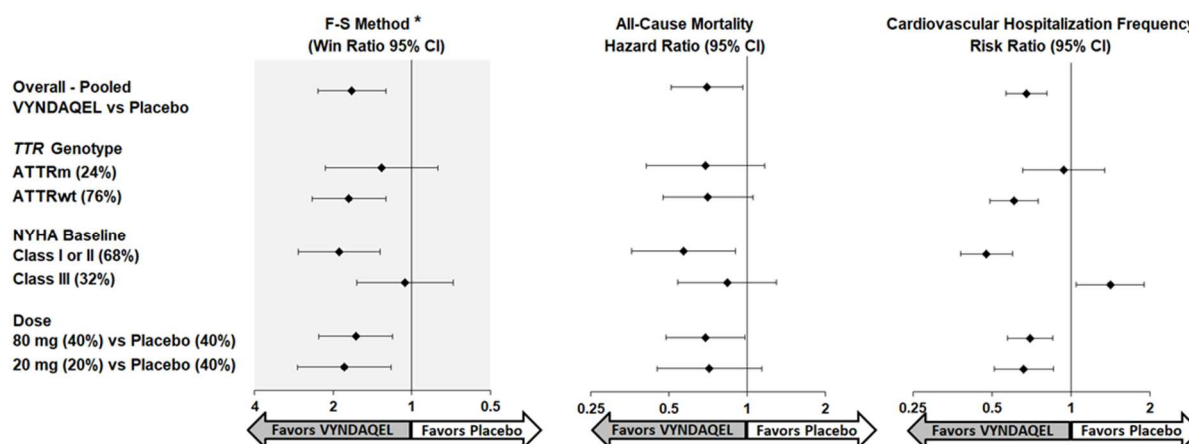
Table 4: 6MWT Distance and KCCQ-OS Scores

Endpoints	Baseline Mean (SD)		Change from Baseline to Month 30, LS Mean (SE)		Treatment Difference from Placebo LS Mean (95% CI)
	Pooled VYNDALCEL N=264	Placebo N=177	Pooled VYNDALCEL	Placebo	
6MWT (meters)	351 (121)	353 (126)	-55 (5)	-131 (10)	76 (58, 94)
KCCQ-OS	67 (21)	66 (22)	-7 (1)	-21 (2)	14 (9, 18)

Abbreviations: 6MWT = 6-Minute Walk Test; KCCQ-OS = Kansas City Cardiomyopathy Questionnaire-Overall Summary; SD = standard deviation; LS = least squares; SE = standard error; CI = confidence interval

Results from the F-S method represented by win ratio for the combined endpoint and its components (all-cause mortality and frequency of CV-related hospitalization) consistently favored VYNDALCEL versus placebo across all subgroups (wild type, variant and NYHA Class I & II, and III), except for CV-related hospitalization frequency in NYHA Class III (Figure 4). Win ratio is the number of pairs of VYNDALCEL-treated patient “wins” divided by number of pairs of placebo patient “wins.” Analyses of 6MWT and KCCQ-OS also favored VYNDALCEL relative to placebo within each subgroup.

Figure 4: Results by Subgroup, Dose, and Components of Primary Analysis



Abbreviations: ATTRm = variant transthyretin amyloid, ATTRwt = wild type transthyretin amyloid, F-S = Finkelstein Schoenfeld, CI = Confidence Interval

*F-S results presented using win ratio (based on all-cause mortality and frequency of cardiovascular hospitalization)

Heart transplants and cardiac mechanical assist devices treated as death.

Results of the primary analysis, 6MWT at Month 30 and KCCQ-OS at Month 30 were statistically significant for both the 80-mg and 20-mg doses of VYNDAQEL vs. placebo, with similar results for both doses.

5.2 Pharmacokinetic properties

No clinically significant differences in steady state C_{max} and area under the plasma concentration over time curve (AUC) of tafamidis were observed for VYNDAMAX 61-mg capsule compared to VYNDAQEL administered as four 20-mg capsules.

Tafamidis exposure increases proportionally over single (up to 480 mg) or multiple (up to 80 mg) (1 to 6 times the approved recommended dosage) once daily dosing.

The apparent clearance were similar after single and repeated administration of VYNDAQEL 80 mg.

Absorption

Median tafamidis peak concentrations occurred within 4 hours following dosing.

Effect of Food

No clinically significant differences in the pharmacokinetics of tafamidis were observed following administration of a high fat, high calorie meal.

Distribution

The apparent steady state volume of distribution of tafamidis meglumine is 16 liters and 18.5 liters of tafamidis. Plasma protein binding of tafamidis is >99% in vitro. Tafamidis primarily binds to TTR.

Elimination

The mean half-life of tafamidis is approximately 49 hours. The apparent oral clearance of tafamidis meglumine is 0.228 L/h (0.263 L/h for tafamidis). The degree of drug accumulation at steady state after repeated tafamidis daily dosing is approximately 2.5-fold greater than that observed after a single dose.

Metabolism

The metabolism of tafamidis has not been fully characterized. However, glucuronidation has been observed.

Excretion

After a single oral dose of tafamidis meglumine 20 mg, approximately 59% of the dose was recovered in feces (mostly as the unchanged drug) and approximately 22% of the dose was recovered in urine (mostly as the glucuronide metabolite).

Specific Populations

No clinically significant differences in the pharmacokinetics of tafamidis were observed based on age, race/ethnicity (Caucasian and Japanese) or renal impairment.

Patients with Hepatic Impairment

Patients with moderate hepatic impairment (Child-Pugh Score of 7 to 9) had decreased systemic exposure (approximately 40%) and increased clearance (approximately 68%) of tafamidis compared to healthy subjects. As TTR levels are lower in subjects with moderate hepatic impairment than in healthy subjects, the exposure of tafamidis relative to the amount of TTR is sufficient to maintain stabilization of the TTR tetramer in these patients. No clinically significant differences in the pharmacokinetics of tafamidis were observed in patients with mild hepatic impairment (Child Pugh Score of 5 to 6) compared to healthy subjects. The effect of severe hepatic impairment on tafamidis is unknown.

Drug Interaction Studies

Clinical Studies

CYP3A4 substrates: No clinically significant differences in the pharmacokinetics of midazolam (a CYP3A4 substrate) or on the formation of its active metabolite (1-hydroxymidazolam) were observed when a single 7.5-mg dose of midazolam was administered prior to and after a 14-day regimen of VYNDAREL 20-mg once daily.

BCRP substrates: Tafamidis inhibits breast cancer resistant protein (BCRP). In a clinical study in healthy participants, AUC_{inf} and C_{max} of the BCRP substrate rosuvastatin increased by 96.75% and 85.59%, respectively following multiple doses of VYNDAREL 61 mg daily dosing.

In Vitro Studies

Cytochrome P450 Enzymes: Tafamidis induces CYP2B6 and CYP3A4 and does not induce CYP1A2. Tafamidis does not inhibit CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP3A4/5 or CYP2D6.

UDP glucuronosyltransferase (UGT): Tafamidis inhibits intestinal activities of UGT1A1 but neither induces nor inhibits other UDP glucuronosyltransferase (UGT) systemically.

Transporter Systems: In vitro studies and model predictions show that tafamidis has a low potential to inhibit organic anion transporters OAT1 and OAT3 at clinically relevant concentrations. Tafamidis did not show a potential to inhibit Multi-Drug Resistant Protein (MDR1) (also known as P-glycoprotein; P-gp), organic cation transporter OCT2, multidrug and toxin extrusion transporters MATE1 and MATE2K and, organic anion transporting polypeptide OATP1B1 and OATP1B3.

5.3 Preclinical safety data

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

There was no evidence of an increased incidence of neoplasia in the transgenic (Tg)-rasH2 mouse following repeated daily administration for 26 weeks at daily doses of 0, 10, 30 or 90 mg/kg. There was no evidence of increased incidence of neoplasia in a 2-year carcinogenicity study in rats at exposures up to 18 times the AUC at the MRHD.

Mutagenesis

There was no evidence of mutagenicity or clastogenicity in vitro, and an in vivo rat micronucleus study was negative.

Impairment of Fertility

There were no effects of tafamidis meglumine on fertility, reproductive performance, or mating behavior in the rat at any dose. Rats were dosed daily (0, 5, 15, and 30 mg/kg/day) prior to cohabitation (for at least 15 days for females and 28 days for males), throughout the cohabitation period to the day prior to termination of males and through to implantation of females (Gestation Day 7). No adverse effects were noted on male and female rats in toxicity, fertility, and mating behavior at any dose. The paternal and maternal no observed

adverse effect level for reproductive toxicity of tafamidis meglumine is 30 mg/kg/day, approximately 4 times the MRHD on a mg/m² basis.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Polyethylene Glycol 400
Polysorbate 20
Povidone
Butylated Hydroxytoluene

Gelatin Shell Ingredients:
Gelatin
Sorbitol Special-Glycerin Blend
Iron Oxide, Red

Gelatin Shell Printing Ingredients:
Ink, White Opacode

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months.

Do not use VYNDAMAX after the expiry date which is stated on the carton / Blister label after EXP:. The expiry date refers to the last day of that month.

6.4 Special precautions for storage

Keep out of the sight and reach of children.

Don't store above 30°C.

6.5 Nature and contents of container

Carton of 3 Aluminum foil blister cards. Each blister card contains 10 capsules (30 capsules total).

6.6 Special precautions for disposal <and other handling>

No special requirements for disposal.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

Medicines should not be disposed of via wastewater or household waste. Ask your pharmacist how to dispose of medicines no longer required. These measures will help to protect the environment.

7. MARKETING AUTHORISATION HOLDER

Pfizer Inc.
66 Hudson Boulevard East, New York, NY 10001, USA

MANUFACTURED BY

Catalent Pharma Solutions, LLC,
2725 Scherer Drive North,
Saint Petersburg, FL,
33716, United States

8. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 16-Feb-2021

Date of latest renewal:

9. DATE OF REVISION OF THE TEXT

October 2023