



Talzenna

TALAZOPARIB

Hard Capsules

CDS

AfME Markets using same as LPD: Ghana, Kenya, Nigeria, Tanzania

## 1. NAME OF THE MEDICINAL PRODUCT

TALZENNA 0.25 mg hard capsules

TALZENNA 1 mg hard capsules

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

TALZENNA 0.25 mg hard capsules

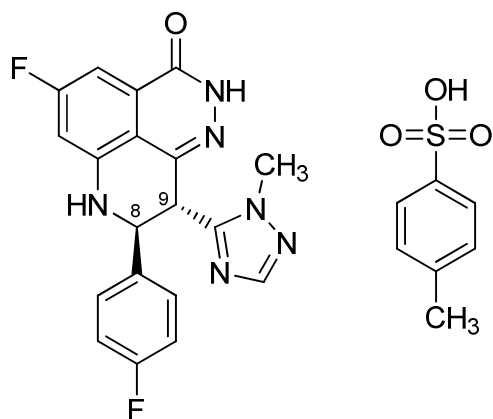
Each capsule contains 0.363 mg talazoparib tosylate equivalent to 0.25 mg talazoparib free base.

TALZENNA 1 mg hard capsules

Each capsule contains 1.453 mg talazoparib tosylate equivalent to 1 mg talazoparib free base.

For the full list of excipients, see Section 6.1.

Structure:



## 3. PHARMACEUTICAL FORM

Hard capsule.

TALZENNA 0.25 mg hard capsules

Opaque, size #4 hard hypromellose (HPMC) capsule with an ivory cap (printed with “Pfizer” in black) and a white body (printed with “TLZ 0.25” in black).

TALZENNA 1 mg hard capsules

Opaque, size #4 hard hypromellose (HPMC) capsule with a light red cap (printed with “Pfizer” in black) and a white body (printed with “TLZ 1” in black).

## 4. CLINICAL PARTICULARS

### 4.1. Therapeutic indications

TALZENNA is indicated for the treatment of adult patients with germline breast cancer susceptibility gene (BRCA)-mutated (gBRCAm) human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer.

#### 4.2. Posology and method of administration

Treatment with TALZENNA should be initiated and supervised by a physician experienced in the use of anticancer medicinal products.

##### Treatment of gBRCAm HER2-negative locally advanced or metastatic breast cancer

Detection of mutations in hereditary breast cancer-related BRCA1 and BRCA2 genes should be determined by an experienced laboratory using a validated test method (see Section 5.1).

##### *Recommended dosing for gBRCAm HER2-negative locally advanced or metastatic breast cancer*

The recommended dose of TALZENNA is 1 mg capsule taken orally once daily. Patients should be treated until disease progression or unacceptable toxicity occurs.

##### *Missing dose*

TALZENNA may be taken with or without food. If the patient vomits or misses a dose, an additional dose should not be taken. The next prescribed dose should be taken at the usual time.

##### *Dose modifications and reductions*

To manage adverse reactions, consider interruption of treatment or dose reduction based on severity and clinical presentation. Recommended dose reductions are indicated in Table 2

Complete blood count should be obtained prior to starting TALZENNA therapy and monitored monthly and as clinically indicated (see Table 1 and Section 4.4).

**Table 1. Dose adjustments for adverse reactions**

	<b>Withhold TALZENNA until levels resolve to</b>	<b>Resume TALZENNA</b>
Haemoglobin <8 g/dL	≥9 g/dL	Resume TALZENNA at a reduced dose
Platelet count <50,000/μL	≥50,000/μL	
Neutrophil count <1,000/μL	≥1,500/μL	
Non-haematologic adverse reaction Grade 3 or Grade 4	≤Grade 1	Consider resuming TALZENNA at a reduced dose or discontinue

##### gBRCAm HER2-negative locally advanced or metastatic breast cancer

**Table 2. Dose reduction levels for talazoparib monotherapy (breast cancer)**

	<b>Talazoparib dose level (breast cancer)</b>
Recommended starting dose	1 mg once daily
First dose reduction	0.75 mg once daily
Second dose reduction	0.5 mg once daily

Third dose reduction	0.25 mg once daily
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### Concomitant treatment with inhibitors of P-glycoprotein (P-gp)

#### *gBRCAm HER2-negative locally advanced or metastatic breast cancer*

Strong inhibitors of P-gp may lead to increased talazoparib exposure. Concomitant use of strong P-gp inhibitors during treatment with talazoparib should be avoided. Coadministration should only be considered after careful evaluation of the potential benefits and risks. If coadministration with a strong P-gp inhibitor is unavoidable, the TALZENNA dose should be reduced to the next lower dose. When the strong P-gp inhibitor is discontinued, the TALZENNA dose should be increased (after 3–5 half-lives of the P-gp inhibitor) to the dose used prior to the initiation of the strong P-gp inhibitor (see Section 4.5).

#### *Concomitant treatment with inhibitors of Breast Cancer Resistance Protein (BCRP)*

The effect of coadministration of BCRP inhibitors with TALZENNA has not been studied. Therefore, concomitant use of strong BCRP inhibitors during treatment with talazoparib should be avoided (see Section 4.5).

### Special populations

#### *Hepatic impairment*

No dose adjustment is required for patients with mild hepatic impairment (total bilirubin  $\leq 1 \times$  upper limit of normal [ULN] and aspartate aminotransferase (AST)  $> \text{ULN}$ , or total bilirubin  $> 1.0$  to  $1.5 \times \text{ULN}$  and any AST), moderate hepatic impairment (total bilirubin  $> 1.5$  to  $3.0 \times \text{ULN}$  and any AST), or severe hepatic impairment (total bilirubin  $> 3.0 \times \text{ULN}$  and any AST) (see Section 5.2).

#### *Renal impairment*

No dose adjustment is required for patients with mild renal impairment ( $60 \text{ mL/min} \leq$  creatinine clearance [CrCL]  $< 90 \text{ mL/min}$ ). For patients with moderate renal impairment ( $30 \text{ mL/min} \leq \text{CrCL} < 60 \text{ mL/min}$ ), the recommended dose of TALZENNA is 0.75 mg once daily. For patients with severe renal impairment ( $15 \text{ mL/min} \leq \text{CrCL} < 30 \text{ mL/min}$ ), the recommended dose of TALZENNA is 0.5 mg once daily. TALZENNA has not been studied in patients requiring hemodialysis (see Section 5.2).

#### *Elderly population*

No dose adjustment is necessary in elderly ( $\geq 65$  years of age) patients (see Section 5.2).

#### *Pediatric population*

The safety and efficacy of TALZENNA in children and adolescents  $< 18$  years of age have not been established.

## **4.3. Contraindications**

None.

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

##### Myelosuppression

Myelosuppression consisting of anemia, leukopenia/neutropenia, and/or thrombocytopenia, have been reported in patients treated with talazoparib (see Section 4.8). Do not start talazoparib until patients have recovered from hematological toxicity caused by previous therapy ( $\leq$  Grade 1).

Precautions should be taken to routinely monitor hematology parameters and signs and symptoms associated with anemia, leukopenia/neutropenia, and/or thrombocytopenia in patients receiving talazoparib. If such events occur, dose modifications (reduction or interruption) are recommended (see Section 4.2). Supportive care with or without blood and/or platelet transfusions and/or administration of colony stimulating factors may be used as appropriate.

##### Myelodysplastic syndrome/Acute Myeloid Leukemia

Myelodysplastic syndrome/Acute Myeloid Leukemia (MDS/AML) have been reported in patients who received poly(adenosine diphosphate [ADP] ribose) polymerase (PARP) inhibitors. Overall, MDS/AML has been reported in  $<1\%$  of solid tumor patients treated with talazoparib in clinical studies. Potential contributing factors for the development of MDS/AML include previous platinum-containing chemotherapy, other DNA damaging agents or radiotherapy. Complete blood counts should be obtained at baseline and monitored monthly for signs of hematologic toxicity during treatment. If MDS/AML is confirmed, talazoparib should be discontinued.

##### Embryo-fetal toxicity

Studies in animals have shown embryo-fetal toxicity and talazoparib was clastogenic in in vitro and in in vivo assays (see Section 5.3). Talazoparib should not be given to pregnant patients or those who plan to become pregnant during treatment. Women of childbearing potential should be advised to avoid becoming pregnant while receiving TALZENNA. TALZENNA may cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to the fetus (see Section 4.6).

A highly effective method of contraception is required for female patients during treatment with TALZENNA, and for at least 7 months after completing therapy. Advise male patients with female partners of reproductive potential and pregnant partners to use effective contraception (even after vasectomy), during treatment with TALZENNA and for at least 4 months after the final dose.

#### **4.5. Interaction with other medicinal products and other forms of interaction**

Talazoparib is a substrate for drug transporters P-gp and BCRP and mainly eliminated by renal clearance as unchanged compound.

## Agents that may affect talazoparib plasma concentrations

### *Effect of P-gp inhibitors*

Data from a drug-drug interaction study in patients with advanced solid tumors indicated that coadministration of multiple daily doses of a P-gp inhibitor, itraconazole 100 mg twice daily with a single 0.5 mg talazoparib dose increased talazoparib total exposure ( $AUC_{inf}$ ) and peak concentration ( $C_{max}$ ) by approximately 56% and 40%, respectively, relative to a single 0.5 mg talazoparib dose administered alone. Population pharmacokinetic (PK) analysis has shown that concomitant use of strong P-gp inhibitors with TALZENNA increased talazoparib exposure by 44.7%, relative to TALZENNA given alone. If patients must be coadministered a strong P-gp inhibitor, those that result in  $\geq 2$ -fold increase in the exposure of an in vivo probe P-gp substrate, (including but not limited to amiodarone, carvedilol, clarithromycin, cobicistat, darunavir, dronedarone, erythromycin, indinavir, itraconazole, ketoconazole, lapatinib, lopinavir, propafenone, quinidine, ranolazine, ritonavir, saquinavir, telaprevir, tipranavir, valsopodar, and verapamil), reduce the TALZENNA dose (see Section 4.2).

Population PK analysis has shown that coadministration with relatively weak P-gp inhibitors (including azithromycin, atorvastatin, diltiazem, felodipine, fluvoxamine, and quercetin) in clinical studies had no significant effect on talazoparib exposure.

### *Effect of P-gp inducers*

Data from a drug-drug interaction study in patients with advanced solid tumors indicated that coadministration of a P-gp inducer (rifampin 600 mg once daily) with a single 1 mg talazoparib dose increased talazoparib  $C_{max}$  by 37% with no effect on talazoparib exposure.

### *Effect of BCRP inhibitors*

The effect of BCRP inhibitors on PK of talazoparib has not been studied. Concomitant use of strong BCRP inhibitors (including but not limited to curcumin, cyclosporine, and elacridar [GF120918]) should be avoided (see Section 4.2).

### *Effect of acid-reducing agents*

Population PK analysis indicates that coadministration of acid-reducing agents including proton pump inhibitors (PPI), histamine receptor 2 antagonists ( $H_2RA$ ), or other acid-reducing agents had no significant impact on the absorption of talazoparib.

## **4.6. Fertility, pregnancy and lactation**

### Women of childbearing potential/contraception in males and females

Women of childbearing potential should not become pregnant while receiving TALZENNA and should not be pregnant at the beginning of treatment. A pregnancy test should be performed on all women of child bearing potential prior to treatment (see Section 4.4).

A highly effective method of contraception is required for female patients during treatment with TALZENNA, and for at least 7 months after completing therapy. Advise male patients with female partners of reproductive potential and pregnant partners to use a condom (even after vasectomy) during treatment with TALZENNA and for at least 4 months after the final dose (see Section 4.4).

## Pregnancy

There are no data from the use of TALZENNA in pregnant women. Studies in animals have shown embryo-fetal toxicity (see Section 5.3). TALZENNA may cause fetal harm when administered to a pregnant woman. TALZENNA is not recommended during pregnancy or for women of childbearing potential not using contraception (see Section 4.4).

## Breastfeeding

It is unknown whether TALZENNA is excreted in human breast milk. A risk to newborns/infants cannot be excluded and therefore breastfeeding is not recommended during treatment with TALZENNA and for at least 1 month after the final dose.

## Fertility

There is no information on fertility in patients. Based on non-clinical findings in testes and ovary, male and female fertility may be compromised by treatment with TALZENNA (see Section 5.3).

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

No studies have been conducted on the effects of talazoparib on the ability to drive or operate machinery. However, patients experiencing fatigue/asthenia or dizziness while taking talazoparib should exercise caution when driving or operating machinery.

### **4.8. Undesirable effects**

The overall safety profile of TALZENNA is based on pooled data from 1088 patients including 690 patients who received talazoparib monotherapy at 1 mg daily in clinical studies for solid tumors.

The most common ( $\geq 20\%$ ) adverse reactions in patients receiving talazoparib in these clinical studies were anaemia (55.6%), fatigue (52.5%), nausea (35.8%), neutropenia (30.3%), thrombocytopenia (25.2%), and decreased appetite (21.1%). The most common ( $\geq 10\%$ ) Grade  $\geq 3$  adverse reactions of talazoparib were anaemia (39.2%), neutropenia (16.5%), and thrombocytopenia (11.1%).

Dose modifications (dose reductions or dose interruptions) due to any adverse reaction occurred in 58.7% of patients receiving TALZENNA 1 mg monotherapy. The most common adverse reactions leading to dose modifications were anaemia (33.5%), neutropenia (11.7%), and thrombocytopenia (9.9%). Permanent discontinuation due to an adverse reaction occurred in 2.9% of patients receiving TALZENNA; the most common was anaemia (0.6%). The median duration of exposure was 5.6 months (range 0.00 to 70.2).

**Table 3: Adverse Reaction Table\***

System Organ Class	Adverse Reactions
Neoplasms benign, malignant, and unspecified (including cysts and polyps)	Myelodysplastic syndrome/Acute myeloid leukaemia
Blood and lymphatic system disorders	Anaemia <sup>a</sup> Thrombocytopenia <sup>b</sup> Neutropenia <sup>c</sup> Leukopenia <sup>d</sup> Lymphopenia <sup>e</sup>
Metabolism and nutrition disorders	Decreased appetite
Nervous system disorders	Dizziness Headache Dysgeusia
Gastrointestinal disorders	Vomiting Diarrhoea Nausea Abdominal pain <sup>f</sup> Stomatitis Dyspepsia
Skin and subcutaneous tissue disorders	Alopecia
General disorders and administration site conditions	Fatigue <sup>g</sup>

\* There were no Grade 5 adverse reactions.

a. Includes preferred terms of anaemia, haematocrit decreased, haemoglobin decreased, and red blood cell count decreased.

b. Includes preferred terms of thrombocytopenia and platelet count decreased.

c. Includes preferred terms of neutropenia and neutrophil count decreased.

d. Includes preferred terms of leukopenia and white blood cell count decreased.

e. Includes preferred terms of lymphocyte count decreased and lymphopenia.

f. Includes preferred terms of abdominal pain, abdominal pain upper, abdominal discomfort, and abdominal pain lower.

g. Includes preferred terms of fatigue and asthenia.

### Reporting of suspected 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 their local country requirements.

### 4.9. Overdose

There is no specific treatment in the event of talazoparib overdose, and symptoms of overdose are not established. In the event of overdose, treatment with talazoparib should be stopped, and physicians should consider gastric decontamination, follow general supportive measures and treat symptomatically.



## 5. PHARMACOLOGICAL PROPERTIES

### 5.1. Pharmacodynamic properties

#### Mechanism of action and pharmacodynamics effects

TALZENNA is a potent inhibitor of PARP enzymes, PARP1 ( $IC_{50}=0.7$  nM), and PARP2 ( $IC_{50}=0.3$  nM). PARP enzymes are involved in cellular DNA damage response signaling pathways such as DNA repair, gene transcription, cell cycle regulation, and cell death. PARP inhibitors (PARPi) exert cytotoxic effects on cancer cells by 2 mechanisms, inhibition of PARP catalytic activity and by PARP trapping, whereby PARP protein bound to a PARPi does not readily dissociate from a DNA lesion, thus preventing DNA repair, replication, and transcription and ultimately leading to apoptosis and/or cell death. Treatment of cancer cell lines that are harboring defects in DNA repair genes with talazoparib single agent leads to increased  $\gamma$ H2AX, which is a marker of double stranded DNA breaks, resulting in decreased cell proliferation and increased apoptosis. The potent cytotoxicity observed with talazoparib against multiple tumor cell lines harboring mutations in the DNA damage response (DDR) pathways, can be attributed to its inhibition of PARP catalytic activity and robust PARP trapping. Talazoparib anti-tumor activity was also observed in a patient-derived xenograft (PDX) BRCA-mutant breast cancer model that was previously treated with a platinum-based regimen. In these PDX models talazoparib decreased tumor growth and increased  $\gamma$ H2AX level and apoptosis in the tumors.

#### *Detection of BRCA mutation*

Patients are eligible for TALZENNA treatment if they have a confirmed deleterious or suspected deleterious germline BRCA mutation (i.e., a mutation that disrupts normal gene function; detected using an appropriately validated test).

#### Clinical efficacy and safety

#### *Treatment of gBRCAm HER2-negative locally advanced or metastatic breast cancer*

#### Randomized phase 3 study EMBRACA

EMBRACA was an open-label, randomized, parallel, 2-arm multicenter study of TALZENNA versus chemotherapy (capecitabine, eribulin, gemcitabine, vinorelbine) in patients with germline BRCA-mutated HER2-negative locally advanced or metastatic breast cancer who received no more than 3 prior cytotoxic chemotherapy regimens for their metastatic or locally advanced disease. Patients were required to have received treatment with an anthracycline and/or a taxane (unless contraindicated) in the neoadjuvant, adjuvant and/or metastatic setting. Patients with prior platinum therapy for advanced disease were required to have no evidence of disease progression during platinum therapy. No prior treatment with a PARPi was permitted.

A total of 431 patients were randomized 2:1 to receive TALZENNA 1 mg capsules once daily or chemotherapy at standard doses until progression or unacceptable toxicity. Of the 431 patients randomized onto EMBRACA, 287 were randomized to the TALZENNA arm and 144 to the chemotherapy arm. Randomization was stratified by prior use of chemotherapy for metastatic disease (0 versus 1, 2, or 3), by triple-negative disease status (triple-negative breast cancer [TNBC] versus non-TNBC), and history of central nervous system metastasis (yes versus no). The majority of patients 408/431 (95%) were selected using the BRCA $Analysis$  test and BRCA

mutation status (breast cancer susceptibility gene 1 [BRCA1] positive or breast cancer susceptibility gene 2 [BRCA2] positive) was similar across both treatment arms.

Patient demographic and baseline characteristics were generally similar between the study treatment arms. The median age of patients treated with TALZENNA was 45 years (range 27 to 84) and 50 years (range 24 to 88) among patients treated with chemotherapy. Of note, 63% versus 47% of patients were <50 years of age in the talazoparib and chemotherapy arms, respectively, 27% versus 47% were 50 to <65 years of age, and 9% versus 7% were ≥65 years of age. Among all randomized patients, 1% versus 2% were males, 66.9% versus 75.0% were White; 10.8% versus 11.1% were Asian, and 4.2% versus 0.7% were Black or African American in the talazoparib and chemotherapy arms, respectively. Almost all patients (97.7%) in both arms had an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1. Approximately 55.9% of patients had hormone receptor-positive (either estrogen receptor [ER]-positive- or progesterone receptor [PR]-positive) disease; 44.1% of patients had triple-negative disease and the proportions were balanced across treatment arms. The median time from initial diagnosis of breast cancer to diagnosis of advanced breast cancer was 1.9 years (range 0 to 22) on the talazoparib arm and 2.7 years (range 0 to 24) on the chemotherapy arm. The reported disease-free interval (DFI) was <12 months in 37.6% of patients on the talazoparib arm and in 29.2% of patients on the chemotherapy arms. Among all patients enrolled, the median number of prior cytotoxic regimens for advanced breast cancer was 1 where 38.3% of patients received no prior regimens for advanced or metastatic disease, 37.4% received 1, 19.7% received 2, and 4.6% received >3 prior regimens, respectively. Sixteen percent of patients in the talazoparib arm and 20.8% of patients in the chemotherapy arm had received prior platinum treatment.

The primary efficacy endpoint was progression-free survival (PFS) evaluated according to Response Evaluation Criteria in Solid Tumors (RECIST) version 1.1, as assessed by blinded independent central review (BICR). The secondary objectives were objective response rate (ORR), overall survival (OS), safety, and PK. Exploratory objectives included duration of response (DOR), Clinical Benefit Rate at 24 weeks (CBR24), quality of life (QoL) assessed using the European Organisation for Research and Treatment of Cancer (EORTC) Quality of Life Questionnaire – Core 30 (QLQ-C30)/EORTC Quality of Life Questionnaire – Breast Cancer Module (QLQ-BR23) and biomarker research.

The study met its primary objective of demonstrating a statistically significant improvement in PFS for TALZENNA compared with chemotherapy (hazard ratio [HR] 0.54; 95% confidence interval [CI]: 0.41, 0.71; p-value <0.0001). A sensitivity analysis of investigator-assessed PFS was consistent with the BICR-assessed PFS results. Efficacy data for EMBRACA are summarized in Table 4 and the Kaplan-Meier curves for PFS and OS are shown in Figures 1 and 3. Consistent results were observed across pre-specified patient subgroups (Figure 2).

**Table 4. Summary of Efficacy Results – EMBRACA Study\***

	<b>Talazoparib</b>	<b>Chemotherapy</b>
<b>PFS by BICR</b>	<b>N=287</b>	<b>N=144</b>
Events, number (%)	186 (65%)	83 (58%)
Median (95% CI), months	8.6 (7.2, 9.3)	5.6 (4.2, 6.7)
Hazard ratio (95% CI)	0.54 (0.41, 0.71)	
2-sided p-value <sup>a</sup>	p<0.0001	
<b>OS (final analysis)<sup>b</sup></b>	<b>N=287</b>	<b>N=144</b>
Events, number (%)	216 (75.3%)	108 (75.0%)
Median (95% CI), months	19.3 (16.6, 22.5)	19.5 (17.4, 22.4)
Hazard ratio <sup>**</sup> (95% CI)	0.85 (0.67, 1.07) <sup>b</sup>	
2-sided p-value <sup>a</sup>	p=0.1693	
24-Month Survival Probability, % (95% CI)	42 (36, 47)	38 (30, 47)
36-Month Survival Probability, % (95% CI)	27 (22, 33)	21 (14, 29)
<b>Objective Response by Investigator<sup>c,d</sup></b>	<b>N=219</b>	<b>N=114</b>
ORR, % (95% CI)	62.6 (55.8, 69.0)	27.2 (19.3, 36.3)
Odds ratio (95% CI)	4.99 (2.9, 8.8)	
2-sided p-value <sup>e</sup>	p<0.0001	
<b>Duration of Response by Investigator<sup>c</sup></b>	<b>N=137</b>	<b>N=31</b>
Median (IQR), months	5.4 (2.8, 11.2)	3.1 (2.4, 6.7)

Abbreviations: BICR=blinded independent central review; CI=confidence interval; CMH=Cochran-Mantel-Haenszel; CR=complete response; IQR=interquartile range; ITT=intent-to-treat; ORR=objective response rate; OS=overall survival; PARP=poly (adenosine diphosphate [ADP] ribose) polymerase; PFS=progression-free survival; PR=partial response; RECIST 1.1=Response Evaluation Criteria in Solid Tumors version 1.1.

\* PFS, ORR, and Duration of Response are based on the data cutoff date of 15 September 2017. OS is based on the data cutoff date 30 September 2019, and is based on a median follow up of 44.9 months (95% CI: 37.9, 47.0) in the talazoparib arm and 36.8 months (95% CI: 34.3, 43.0) in the chemotherapy arm.

\*\* Hazard ratio was based on stratified Cox regression model with treatment as the only covariate (stratification factors: number of prior cytotoxic chemotherapy regimens, triple-negative status, history of central nervous system metastasis) and was relative to overall chemotherapy with <1 favouring talazoparib.

<sup>a</sup>. Stratified Log-rank test.

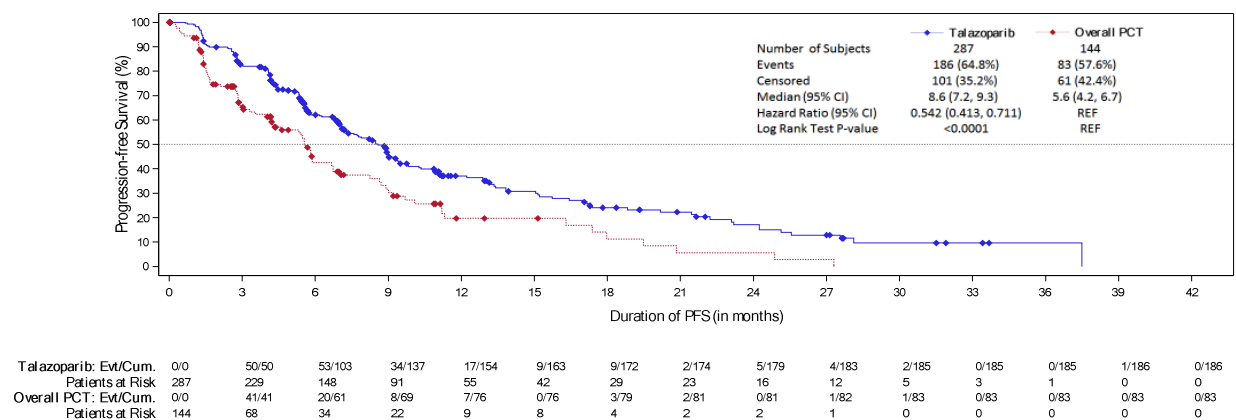
<sup>b</sup>. At the time of the final OS analysis, 46.3% versus 41.7% of patients randomized in the talazoparib and chemotherapy arms, respectively, received subsequently a platinum therapy, and 4.5% versus 32.6% received subsequently a PARP inhibitor treatment.

<sup>c</sup>. Conducted in ITT with measurable disease population who had an objective response. The complete response rate was 5.5% for talazoparib compared to 0% for the chemotherapy arm.

<sup>d</sup>. Per RECIST 1.1, confirmation of CR/PR was not required.

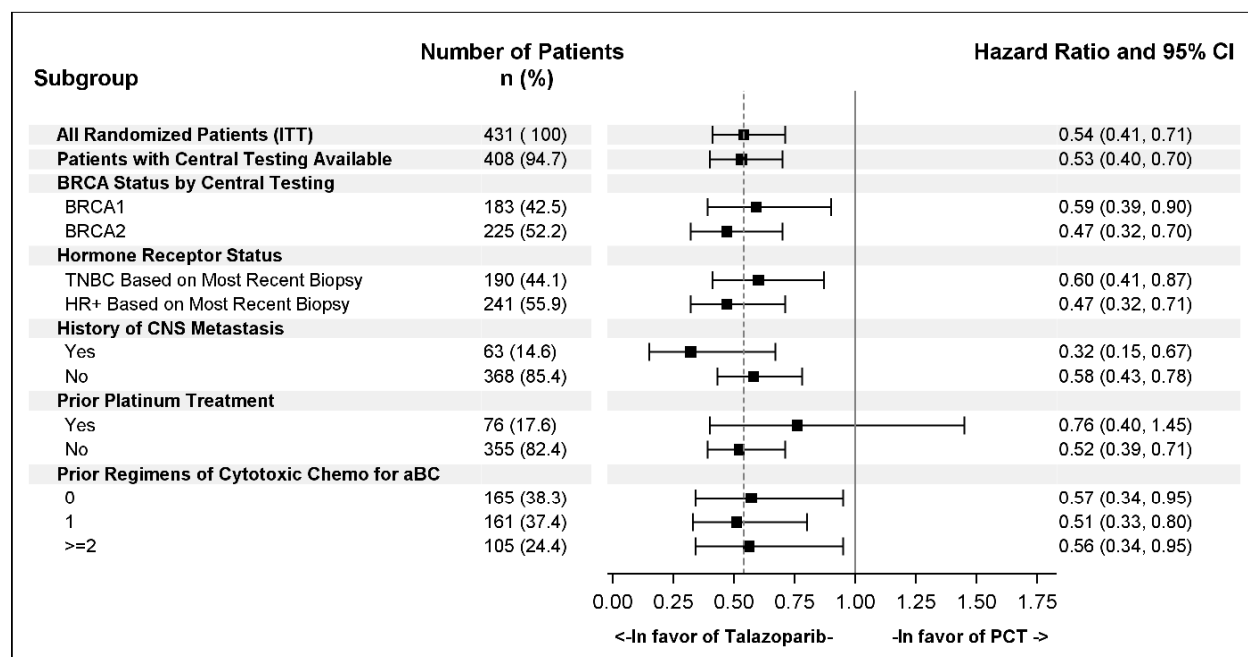
<sup>e</sup>. Stratified CMH test.

**Figure 1. Kaplan-Meier Curves of PFS – EMBRACA Study**



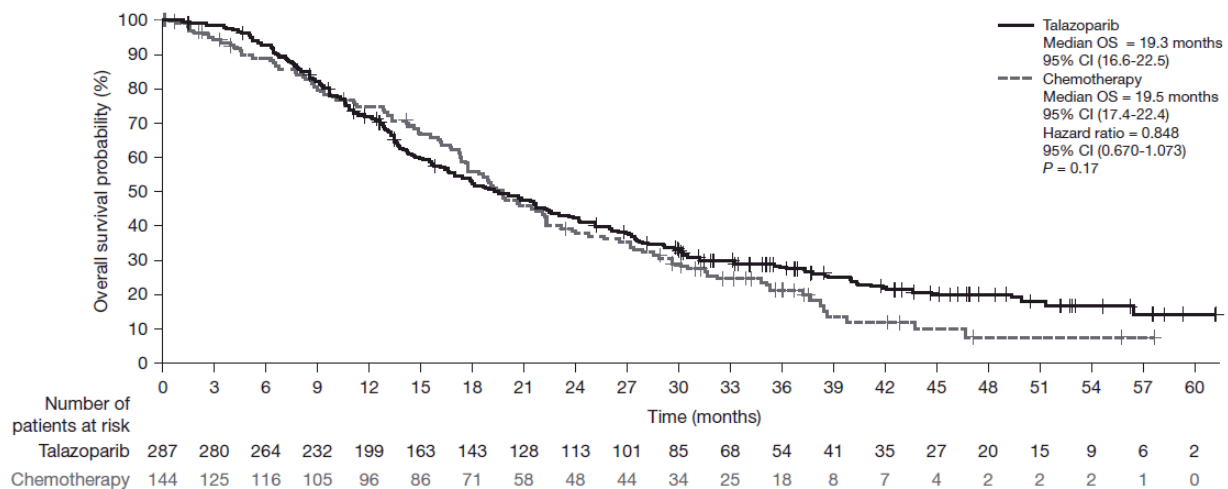
Abbreviations: CI=confidence interval; Cum=cumulative; Evt=event; PFS=progression-free survival; PCT=physician's choice treatment (chemotherapy); REF=reference treatment group.  
Primary analysis p-value was based on a stratified log-rank test.

**Figure 2. Forest Plot for PFS Analyses For Key Subgroups – EMBRACA Study**



Abbreviations: aBC=advanced breast cancer; BRCA=breast cancer susceptibility gene; CI=confidence interval; CNS=central nervous system; HR+=hormone receptor-positive; ITT=intent-to-treat; PCT=physician's choice treatment (chemotherapy); PFS=progression-free survival; TLZ=talazoparib; TNBC=triple-negative breast cancer.

**Figure 3. Kaplan-Meier Curves of OS – EMBRACA Study**



Abbreviations: CI=confidence interval; PCT=physician's choice treatment (chemotherapy); OS=overall survival. Primary analysis' p-value was based on a stratified log-rank test.

Patient-reported symptoms were assessed using the EORTC QLQ-C30 and its EORTC QLQ-BR23. A total of 262 patients in the talazoparib arm and 114 patients in the chemotherapy arm completed the questionnaire at baseline and at least 1 postbaseline visit.

A significantly greater overall improvement from baseline in global health status (GHS)/QoL was observed in the talazoparib arm (3.0 [95% CI: 1.2, 4.8]) compared to the chemotherapy arm (-5.4 [95% CI: -8.8, -2.0]) ( $p < 0.0001$ ). A significantly greater delay in time to clinically meaningful ( $\geq 10$  point decrease from baseline) definitive deterioration in GHS/QoL was observed in the talazoparib arm compared with chemotherapy [(HR: 0.38 [95% CI: 0.26, 0.55];  $p < 0.0001$ ), median 24.3 months versus 6.3 months].

A significantly greater overall improvement from baseline in breast symptoms was observed in the talazoparib arm (-5.1 [95% CI: -6.7, -3.5]) compared to the chemotherapy arm (-0.1 [95% CI: -2.9, 2.6]) ( $p = 0.002$ ). A significantly greater delay in time to clinically meaningful ( $\geq 10$  point increase from baseline) definitive deterioration in breast symptoms was observed in the talazoparib arm compared with chemotherapy (HR of 0.39 [95% CI: 0.20, 0.78];  $p = 0.005$ , median times not reached [NR]).

A significantly greater overall improvement from baseline was observed in the talazoparib arm compared to the chemotherapy arm in role functioning [12.4, 95% CI: (7.1, 17.7) ( $p < 0.0001$ )] and the following symptoms: fatigue [-12.3, 95% CI: (-17.2, -7.5) ( $p < 0.0001$ )], pain [-13.3, 95% CI: (-18.5, -8.1) ( $p < 0.0001$ )] and appetite loss [-11.7, 95% CI: (-17.6, -5.7) ( $p = 0.0001$ )].

A significantly greater delay in time to clinically meaningful deterioration in the following symptoms was observed in the talazoparib arm compared to the chemotherapy arm for fatigue, [(HR: 0.40 [95% CI: 0.28, 0.56];  $p < 0.0001$ ), median 17.1 months versus 7.1 months], pain, [(HR: 0.34 [95% CI: 0.23, 0.50];  $p < 0.0001$ ), median 22.7 months versus 7.5 months], appetite loss, [(HR: 0.32 [95% CI: 0.21, 0.49];  $p < 0.0001$ ), median NR versus 9.0 months], systemic therapy side effects, [(HR: 0.33 [95% CI: 0.22, 0.51];  $p < 0.0001$ ), median 24.6 months versus 7.9 months], arm symptoms, [(HR: 0.46 [95% CI: 0.29, 0.73];  $p = 0.0008$ ), median NR versus 13.2 months]. A significantly greater delay in time to clinically meaningful deterioration was

observed in the talazoparib arm compared to the chemotherapy arm for role functioning, [(HR: 0.36 [95% CI: 0.25, 0.52];  $p < 0.0001$ ), median 20.5 months versus 5.6 months].

## 5.2. Pharmacokinetic properties

Talazoparib exposure generally increased proportionally with dose across the range of 0.025 mg to 2 mg after daily administration of multiple doses. Following repeated daily dosing of 1 mg talazoparib monotherapy to breast cancer patients, the geometric mean (% coefficient of variation [CV%]) area under the plasma concentration-time curve (AUC) and maximum observed plasma concentration ( $C_{\max}$ ) of talazoparib at steady-state was in the range of 126 (107) ng•hr/mL to 208 (37) ng•hr/mL and 11 (90) ng/mL to 19 (27) ng/mL, respectively.

Following repeated daily dosing, talazoparib plasma concentrations reached steady-state within 2 to 3 weeks when administered alone. The median accumulation ratio of talazoparib following repeated oral administration of 1 mg monotherapy once daily was in the range of 2.3 to 5.2. Talazoparib is a substrate of P-gp and BCRP transporters.

### Absorption

Following oral administration of talazoparib, the median time to  $C_{\max}$  ( $T_{\max}$ ) was generally between 1 to 2 hours after dosing. The absolute bioavailability study has not been conducted in humans. However, based on urinary excretion data the absolute bioavailability is at least 54.6% with fraction absorbed of at least 68.7% (see Elimination).

### *The effect of food*

Food intake decreased the rate but not the extent of talazoparib absorption. Following a single oral dose of talazoparib with high-fat, high-calorie food (approximately 827 calories, 57% fat), the mean  $C_{\max}$  of talazoparib was decreased by approximately 46%, the median  $T_{\max}$  was delayed from 1 to 4 hours, while the  $AUC_{\inf}$  was not affected. Based on these results, TALZENNA can be administered with or without food.

### Distribution

The population mean apparent volume of distribution ( $V_{ss}/F$ ) of talazoparib was 420 L. In vitro, talazoparib is approximately 74% bound to plasma proteins with no concentration dependence over the concentration range of 0.01  $\mu$ M to 1  $\mu$ M. Renal or hepatic impairment does not appear to impact talazoparib protein binding as there was no obvious trend in the mean talazoparib fraction of unbound drug ( $f_u$ ) in human plasma in vivo with worsening renal or hepatic function.

### Metabolism

Talazoparib undergoes minimal hepatic metabolism in humans. Following oral administration of a single 1 mg dose of [ $^{14}$ C]talazoparib to humans, no major circulating metabolites were identified in plasma, and talazoparib was the only circulating drug-derived entity identified. No metabolites that individually represented more than 10% of the administered dose were recovered in the urine or feces. The identified metabolic pathways of talazoparib in humans include: 1) mono-oxidation; 2) dehydrogenation; 3) cysteine conjugation of mono-desfluoro-talazoparib; and 4) glucuronide conjugation.

In vitro, talazoparib was not an inhibitor of cytochrome (CYP)1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, or CYP3A4/5 or inducer of CYP1A2, CYP2B6, or CYP3A4 at clinically relevant concentrations.

In vitro, talazoparib did not inhibit any of the major intestinal, hepatic or renal membrane transporters (P-gp, BCRP, organic anion transporting polypeptide [OATP]1B1, OATP1B3, organic cationic transporter [OCT]1 OCT2, organic anion transporter [OAT]1, OAT3, bile salt export pump [BSEP], multidrug and toxin extrusion [MATE]1 and MATE2-K) at clinically relevant concentrations.

In vitro, talazoparib did not inhibit any of the major uridine-diphosphate glucuronosyltransferase (UGT) isoforms (1A1, 1A4, 1A6, 1A9, 2B7, and 2B15) at clinically relevant concentrations.

### Elimination

The mean terminal plasma half-life of talazoparib was 89.8 hours and the population mean apparent oral clearance (CL/F) was 6.45 L/h in cancer patients. In 6 female patients with advanced solid tumors given a single oral dose of [<sup>14</sup>C]talazoparib, a mean of 68.7% and 19.7% of the total administered radioactive dose was recovered in urine and feces, respectively. Excretion of unchanged talazoparib in urine was the major route of elimination accounting for 54.6% of the administered dose, while unchanged talazoparib recovered in the feces accounted for 13.6%.

### Special populations

#### *Age, sex, race, and body weight*

A population PK analysis was conducted using data from 490 patients with cancer who received talazoparib 1 mg daily as monotherapy to evaluate the impact of age (ranging from 18 to 88 years), sex (53 males and 437 females), race (361 White, 41 Asian, 16 Black, 9 Others, and 63 Not reported), and body weight (ranging from 35.7 kg to 162 kg) on the PK of talazoparib. The results have shown that age, sex, race, and body weight had no clinically relevant effect on the PK of talazoparib.

#### *Pediatric population*

Pharmacokinetics of talazoparib have not been evaluated in patients <18 years of age.

#### *Elderly population*

Of the 494 patients who received TALZENNA, 85 patients were ≥65 years of age. No overall differences in safety or effectiveness of TALZENNA were observed between these patients and younger patients but greater sensitivity of some older individuals cannot be ruled out.

#### *Renal impairment*

##### Talazoparib monotherapy

Data from a PK trial in advanced cancer patients with varying degrees of renal impairment indicate that talazoparib total exposure (AUC<sub>0-24</sub>) after multiple talazoparib once-daily doses increased by 12%, 43%, and 163% in patients with mild (eGFR 60 - 89 mL/min/1.73 m<sup>2</sup>), moderate (eGFR 30 - 59 mL/min/1.73 m<sup>2</sup>), and severe (eGFR 15 - 29 mL/min/1.73 m<sup>2</sup>) renal impairment, respectively, relative to patients with normal renal function

(eGFR  $\geq 90$  mL/min/1.73 m<sup>2</sup>). Talazoparib C<sub>max</sub> increased by 11%, 32%, and 89% in patients with mild, moderate, and severe renal impairment, respectively, relative to patients with normal renal function. Consistent with these findings, a population PK analysis that included 490 patients, where 132 patients had mild renal impairment (60 mL/min  $\leq$  CrCL < 90 mL/min), 33 patients had moderate renal impairment (30 mL/min  $\leq$  CrCL < 60 mL/min), and 1 patient had severe renal impairment (CrCL < 30 mL/min), showed that talazoparib CL/F was decreased by 14.4% and 37.1% in patients with mild and moderate renal impairment, corresponding to 17% and 59% increase in AUC, respectively, when compared to patients with normal renal function (CrCL  $\geq 90$  mL/min). The PK of talazoparib has not been studied in patients requiring hemodialysis.

#### *Hepatic impairment*

Based on a population PK analysis that included 490 patients who received talazoparib 1 mg daily as monotherapy, where 118 patients had mild hepatic impairment (total bilirubin  $\leq 1.0 \times$  ULN and AST > ULN, or total bilirubin > 1.0 to  $1.5 \times$  ULN and any AST), mild hepatic impairment had no effect on the PK of talazoparib. The PK of talazoparib in patients with normal hepatic function, mild hepatic impairment, moderate hepatic impairment (total bilirubin > 1.5 to  $3.0 \times$  ULN and any AST), or severe hepatic impairment (total bilirubin >  $3.0 \times$  ULN and any AST) was studied in a PK trial. Population PK analysis using data from this PK trial indicated that mild, moderate, or severe hepatic impairment had no significant impact on the PK of talazoparib.

#### Cardiac electrophysiology

The effect of talazoparib on cardiac repolarization was evaluated using time-matched electrocardiograms (ECGs) in assessing the relationship between the change of the QT interval corrected for heart rate (QTc) from baseline and the corresponding plasma talazoparib concentrations in 37 patients with advanced solid tumors. Talazoparib did not have a clinically relevant effect on QTc prolongation at the maximum clinically recommended dose of 1 mg once daily.

### **5.3. Preclinical safety data**

#### Carcinogenicity

Carcinogenicity studies have not been conducted with talazoparib.

#### Genotoxicity

Talazoparib was not mutagenic in a bacterial reverse mutation (Ames) test. Talazoparib was clastogenic in an in vitro chromosomal aberration assay in human peripheral blood lymphocytes and in an in vivo micronucleus assay in rats at exposures similar to clinically relevant doses. This clastogenicity is consistent with genomic instability resulting from the primary pharmacology of talazoparib, indicating the potential for genotoxicity in humans.

#### Repeat-dose toxicity

In repeat-dose toxicity studies of up to 13-week duration, talazoparib was clinically tolerated in rats at 0.04 mg/kg/day and in dogs at 0.01 mg/kg/day and the AUC<sub>24</sub> exposure margins at the no adverse effect level are 0.2-fold the relevant human exposure. The main findings at subtherapeutic



exposures included bone marrow hypocellularity with dose-dependent decrease in hematopoietic cells, depletion of lymphoid tissue in multiple organs and atrophy and/or degenerative changes in testes, epididymis, and seminiferous tubules. Additional findings at higher exposures included dose-dependent increase in apoptosis/necrosis in the gastrointestinal (GI) tract, liver, and ovary. Most of the histopathologic findings were generally reversible while the testes findings were partially reversible after 4 weeks of dosing cessation. These toxicity findings are consistent with the pharmacology of talazoparib and its tissue distribution pattern.

### Reproductive toxicology

In an embryo-fetal development study in rats, talazoparib resulted in embryo-fetal death, fetal malformation (depressed eye bulge, small eye, split sternbra, fused cervical vertebral arch) and structural variations in bones at a maternal systemic AUC<sub>24</sub> exposure approximately 0.09-fold the relevant human exposure at the recommended dose.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

#### Talazoparib capsules content

Silicified microcrystalline cellulose (sMCC)

#### Capsule shell

##### *White body shell*

Hypromellose (HPMC)

Titanium dioxide (E171)

##### *Ivory cap*

Hypromellose (HPMC)

Yellow iron oxide (E172)

Titanium dioxide (E171)

##### *Light red cap*

Hypromellose (HPMC)

Red iron oxide (E172)

Yellow iron oxide (E172)

Titanium dioxide (E171)

#### Printing ink

Shellac

Propylene glycol

Ammonium hydroxide

Black iron oxide

Potassium hydroxide

### **6.2. Incompatibilities**

Not applicable.

### **6.3. Shelf life**

**Do not use TALZENNA after the expiry date which is stated on the Carton/Bottle label after EXP:.. The expiry date refers to the last day of that month.**

### **6.4. Special precautions for storage**

Store below 30 °C

This medicinal product does not require any special storage conditions.

### **6.5. Nature and contents of container**

#### TALZENNA 0.25 mg hard capsules

High-density polyethylene (HDPE) bottle and polypropylene (PP) closure with heat induction seal (HIS) liner, containing 30 hard capsules.

#### TALZENNA 1 mg hard capsules

High-density polyethylene (HDPE) bottle and polypropylene (PP) closure with heat induction seal (HIS) liner, containing 30 hard capsules.

Not all strengths may be marketed.

### **6.6. Special precautions for disposal and other handling**

Keep out of the sight and reach of children.

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. FURTHER INFORMATION**

### **MANUFACTURED BY:**

Excella GmbH & Co. KG  
Nürberger Strasse 12  
90537 Feucht  
Germany

## **8. PRESCRIPTION STATUS**

Prescription Only Medicine.

## **9. DATE OF REVISION OF THE TEXT**

November 2023