

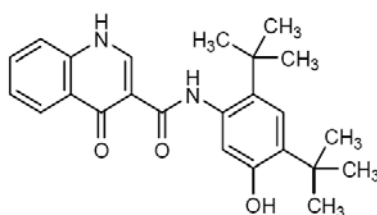
PRODUCT INFORMATION

KALYDECO[®] (ivacaftor)

NAME OF THE MEDICINE

Ivacaftor is *N*-(2,4-di-tert-butyl-5-hydroxyphenyl)-1,4-dihydro-4-oxoquinoline-3-carboxamide. The empirical formula of ivacaftor is C₂₄H₂₈N₂O₃ and its molecular weight is 392.49. The pKa values of ivacaftor are 9.40 and 11.60. The log D value of ivacaftor is 5.68 at pH=7.4 and 25°C.

Its structural formula is:



CAS Number: 873054-44-5

DESCRIPTION

Ivacaftor is a white to off-white powder that is practically insoluble in water (<0.05 microgram/mL).

KALYDECO is available as a light blue, capsule-shaped, film-coated tablet for oral administration containing 150 mg of ivacaftor. Each tablet contains the following inactive ingredients: cellulose-microcrystalline, lactose, hypromellose acetate succinate, croscarmellose sodium, sodium lauryl sulfate, silicon dioxide, magnesium stearate, carnauba wax, Opadry II complete film coating system 85F90614 Blue, OPACODE monogramming ink S-1-17823 BLACK.

PHARMACOLOGY

Mechanism of Action

Ivacaftor is a selective potentiator of the Cystic Fibrosis Transmembrane conductance Regulator (CFTR) protein. *In vitro*, ivacaftor increases the open probability of the CFTR channel gate to enhance chloride transport. This has been demonstrated in normal CFTR and in mutant forms of CFTR that have reduced channel-open probability, such as G551D-CFTR and R117H-CFTR. However, the exact mechanism leading ivacaftor to prolong the gating activity of some mutant CFTR forms has not been completely elucidated.

Pharmacodynamics

In clinical trials (Studies 1 and 2) in patients with the *G551D* mutation in one allele of the *CFTR* gene, ivacaftor led to rapid (15 days), substantial [the mean change in sweat chloride from baseline through Week 24 was -48 mmol/L (95% CI -51, -45) and -54 mmol/L (95% CI -62, -47), respectively], and sustained (through 48 weeks) reduction in sweat chloride concentration.

In a clinical trial in patients who had a non-*G551D* gating mutation in the *CFTR* gene (Study 5), treatment with ivacaftor led to a rapid (15 days) and substantial mean change in sweat chloride from baseline of -49 mmol/L (95% CI -57, -41) after 8 weeks of treatment.

In a clinical trial (Study 6) in 69 patients age 6 years or older with CF who had an *R117H* mutation in the *CFTR* gene, the treatment difference in mean change in sweat chloride from baseline through 24 weeks of treatment was -24 mmol/L (95% CI -28, -20) and in patients 18 years or older it was -22 mmol/L (95% CI -26, -17). The mean sweat chloride change was consistent across subgroups, including age, poly-T status, and FEV₁.

Pharmacokinetics

The pharmacokinetics of ivacaftor are similar between healthy adult volunteers and patients with CF. After oral administration of a single 150-mg dose to healthy volunteers in a fed state, the mean (\pm SD) for AUC and C_{max} were 10600 (5260) ng*hr/mL and 768 (233) ng/mL, respectively. The apparent terminal half-life was approximately 12 hours following a single dose in the fed state. The apparent clearance (CL/F) of ivacaftor was similar for healthy subjects and patients with CF. The mean (\pm SD) of CL/F for the 150 mg dose was 17.3 (8.4) L/hr in healthy subjects at steady state.

After every 12-hour dosing, steady-state plasma concentrations of ivacaftor were reached by Days 3 to 5, with an accumulation ratio ranging from 2.2 to 2.9.

Absorption

Following multiple oral dose administrations of ivacaftor, the exposure of ivacaftor generally increased with a dose from 25 mg every 12 hours to 450 mg every 12 hours. The exposure of ivacaftor increased approximately 2.5- to 4-fold when given with food containing fat. Therefore, ivacaftor should be administered with fat-containing food. The median (range) t_{max} is approximately 4.0 (3.0, 6.0) hours in the fed state.

Distribution

Ivacaftor is approximately 99% bound to plasma proteins, primarily to alpha 1-acid glycoprotein and albumin. Ivacaftor does not bind to human red blood cells.

After oral administration of 150 mg every 12 hours for 7 days in healthy volunteers in a fed state, the mean (\pm SD) apparent volume of distribution was 353 (122) L.

Metabolism

Ivacaftor is extensively metabolised in humans. *In vitro* and *in vivo* data indicate that ivacaftor is primarily metabolised by CYP3A. M1 and M6 are the two major metabolites of ivacaftor in humans. M1 has approximately one-sixth the potency of ivacaftor and is considered pharmacologically active. M6 has less than one-fiftieth the potency of ivacaftor and is not considered pharmacologically active.

Excretion

Following oral administration, the majority of ivacaftor (88%) is excreted in the faeces after metabolic conversion. The major metabolites M1 and M6 accounted for approximately 65% of the total dose excreted with 22% as M1 and 43% as M6. There was negligible urinary excretion of ivacaftor as unchanged parent and minimal urinary excretion (6.6%) of ivacaftor plus metabolites.

Special Populations

Children and Adolescents

Based on population PK analysis, the predicted total body clearance was lower in children (e.g., 7 L/h for a 20-kg male) than in adults (e.g., 18.2 L/h for a 70-kg male), which resulted in a higher AUC by exposure determination from observed data in children than in adults.

Based on exposure determinations from observed data in Phase 2 and 3 studies, the 150-mg q12h dose regimen resulted in median and mean (SD) ivacaftor C_{\min} of 1070 and 1240 (621) ng/mL for 6- to 11-year-old subjects, 518 and 562 (275) ng/mL for 12- to 17-year-old subjects, and 612 and 683 (306) ng/mL for adult subjects. The corresponding AUC median and mean (SD) values were 17400 and 19300 (8240) ng*hr/mL for children 6 to 11 years old, 7810 and 8790 (3610) ng*hr/mL for adolescents 12 to 17 years old, and 9500 and 10300 (3860) ng*hr/mL for adults.

Gender

The effect of gender on ivacaftor pharmacokinetics was evaluated using population pharmacokinetics of data from clinical studies of ivacaftor. No dose adjustments are necessary based on gender.

Renal Impairment

Pharmacokinetic studies have not been performed with ivacaftor in patients with renal impairment. In a human pharmacokinetic study, there was minimal elimination of ivacaftor and its metabolites in urine (only 6.6% of total radioactivity was recovered in the urine). There was negligible urinary excretion of ivacaftor as unchanged parent (less than 0.01% following a single oral dose of 500 mg). Therefore, no dose adjustments are recommended for mild and moderate renal impairment. However, caution is recommended when administering ivacaftor to patients with severe renal impairment (creatinine clearance less than or equal to 30 mL/min) or end-stage renal disease (see DOSAGE AND ADMINISTRATION and PRECAUTIONS).

Hepatic Impairment

Following a single dose of 150 mg of ivacaftor, subjects with moderately impaired hepatic function (Child-Pugh Class B, score 7 to 9) had similar ivacaftor C_{\max} (mean (\pm SD) of 735 (331) ng/mL), but an approximately 2-fold increase in ivacaftor $AUC_{0-\infty}$ (mean (\pm SD) of 16800 (6140) ng*hr/mL) compared with healthy subjects matched for demographics. Simulations for predicting the steady-state exposure of ivacaftor showed that by reducing the dosage from 150 mg q12h to 150 mg once daily, subjects with moderate hepatic impairment would have comparable steady-state C_{\min} values as those obtained with a dose of 150 mg q12h in subjects without hepatic impairment. Therefore, a reduced dose of 150 mg once daily is recommended in patients with moderate hepatic impairment. The impact of mild hepatic impairment (Child-Pugh Class A, score 5 to 6) on the pharmacokinetics of ivacaftor has not been studied, but the increase in ivacaftor $AUC_{0-\infty}$ is expected to be less than two-fold. Therefore, no dose adjustment is necessary for patients with mild hepatic impairment.

Studies have not been conducted in patients with severe hepatic impairment (Child-Pugh Class C, score 10 to 15), but exposure is expected to be higher than in patients with moderate hepatic impairment. The use of KALYDECO in patients with severe hepatic impairment is therefore not recommended unless the benefits outweigh the risks. In such cases, the starting dose should be 150 mg every other day. Dosing intervals should be modified according to clinical response and tolerability (see DOSAGE AND ADMINISTRATION and PRECAUTIONS).

CLINICAL TRIALS

The efficacy of KALYDECO has been evaluated in five clinical trials including two Phase 3, randomised, double-blind, placebo-controlled, multi-centre studies of clinically stable patients with CF who had the *G551D* mutation in the *CFTR* gene on at least 1 allele and had FEV₁ (forced expiratory volume exhaled in the first second) $\geq 40\%$ predicted.

Patients in both studies were randomised 1:1 to receive either 150 mg of KALYDECO or placebo every 12 hours with food containing fat for 48 weeks in addition to their prescribed CF therapies (e.g., tobramycin, dornase alfa). The use of inhaled hypertonic saline was not permitted.

Study 1: Study in Patients with CF (≥ 12 years) with a *G551D-CFTR* Mutation

Study 1 evaluated 161 patients who were 12 years of age or older; 122 (75.8%) patients had the *F508del* mutation in the second allele. At the start of the study, patients in the placebo group used some medicinal products at a higher frequency than the ivacaftor group. These medications included dornase alfa (73.1% versus 65.1%), salbutamol (53.8% versus 42.2%), tobramycin (44.9% versus 33.7%), and salmeterol/fluticasone (41.0% versus 27.7%). At baseline, mean predicted FEV₁ was 63.6% (range: 31.6% to 98.2%) and mean age was 26 years (range: 12 to 53 years).

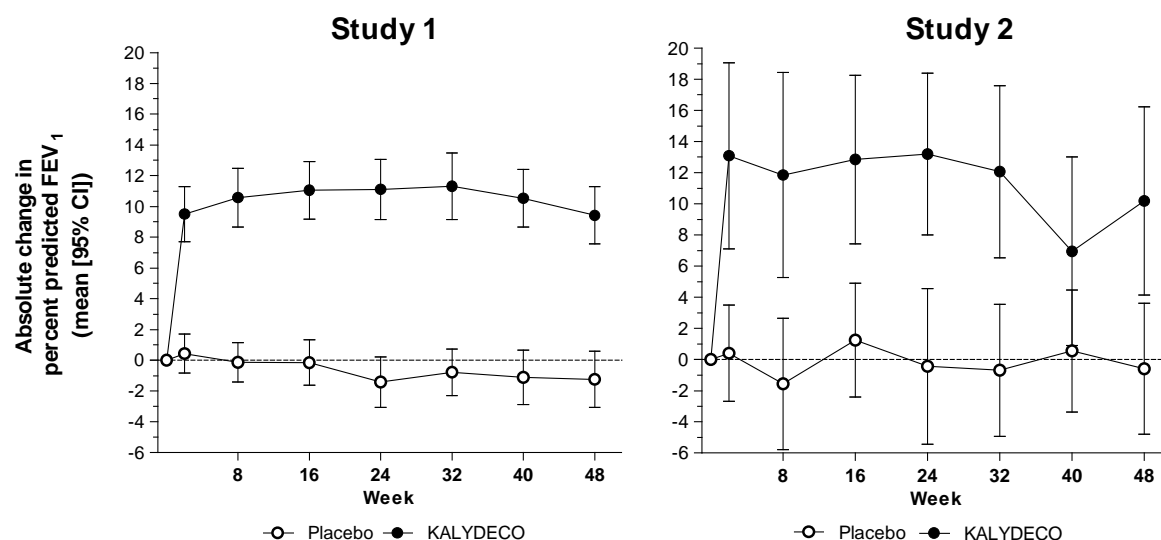
Study 2: Study in Patients with CF (6 – 11 years) with a *G551D-CFTR* Mutation

Study 2 evaluated 52 patients who were 6 to 11 years of age at screening; mean (SD) body weight was 30.9 (8.63) kg; 42 (80.8%) of patients had the *F508del* mutation in the second allele. At baseline, mean predicted FEV₁ was 84.2% (range: 44.0% to 133.8%) and mean age was 9 years (range: 6 to 12 years); 8 (30.8%) patients in the placebo group and 4 (15.4%) patients in the ivacaftor group had an FEV₁ less than 70% predicted at baseline.

The primary efficacy endpoint in both studies was the mean absolute change from baseline in percent predicted FEV₁ through 24 weeks of treatment.

The treatment difference between ivacaftor and placebo for the mean absolute change (95% CI) in percent predicted FEV₁ from baseline through Week 24 was 10.6 percentage points (8.6, 12.6) in Study 1 and 12.5 percentage points (6.6, 18.3) in Study 2 (Figure 1). The treatment difference between ivacaftor and placebo for the mean relative change (95% CI) in percent predicted FEV₁ from baseline through Week 24 was 17.1% (13.9, 20.2) in Study 1 and 15.8% (8.4, 23.2) in Study 2. The mean change from baseline through Week 24 in FEV₁ (L) was 0.37 L in the ivacaftor group and 0.01 L in the placebo group in Study 1 and 0.30 L in the ivacaftor group and 0.07 L in the placebo group in Study 2. In both studies, improvements in percent predicted FEV₁ were rapid in onset (Day 15 $P < 0.0001$ and $P = 0.0004$ for Study 1 and 2, respectively) and durable through 48 weeks ($P < 0.0001$ and $P = 0.0017$ for Study 1 and 2, respectively).

Figure 1: Mean Absolute Change from Baseline in Percent Predicted FEV₁



FEV₁ results at 24 and 48 weeks by age subgroups are shown in Table 1.

Subgroup Age (years)	Study	Through Week 24 (percentage points) (95% CI)	Through Week 48 (percentage points) (95% CI)
6 to 11	2	12.5 (6.6, 18.3)	10.0 (4.5, 15.5)
12 to 17	1	11.9 (5.9, 17.9)	11.4 (5.4, 17.4)
≥18	1	9.9 (7.8, 12.0)	9.9 (7.7, 12.0)

CI: confidence interval; FEV₁: forced expiratory volume in 1 second; MMRM: mixed-effects model for repeated measures

The results for clinically relevant secondary endpoints are shown in Table 2.

Endpoint	Study 1		Study 2	
	Treatment difference ^a (95% CI)	P value	Treatment difference ^a (95% CI)	P value
Mean absolute change from baseline in CFQ-R^b respiratory domain score (points)^c				
Through Week 24	8.1 (4.7, 11.4)	<0.0001	6.1 (-1.4, 13.5)	0.1092
Through Week 48	8.6 (5.3, 11.9)	<0.0001	5.1 (-1.6, 11.8)	0.1354
Relative risk of pulmonary exacerbation				
Through Week 24	0.40 ^d	0.0016	NA	NA
Through Week 48	0.46 ^d	0.0012	NA	NA
Mean absolute change from baseline in body weight (kg)				
At Week 24	2.8 (1.8, 3.7)	<0.0001	1.9 (0.9, 2.9)	0.0004
At Week 48	2.7 (1.3, 4.1)	0.0001	2.8 (1.3, 4.2)	0.0002

Mean absolute change from baseline in BMI (kg/m²)				
At Week 24	0.94 (0.62, 1.26)	<0.0001	0.81 (0.34, 1.28)	0.0008
At Week 48	0.93 (0.48, 1.38)	<0.0001	1.09 (0.51, 1.67)	0.0003
Mean change from baseline in z-scores				
Weight-for-age z-score at Week 48 ^e	0.33 (0.04, 0.62)	0.0260	0.39 (0.24, 0.53)	<0.0001
BMI-for-age z-score at Week 48 ^e	0.33 (0.002, 0.65)	0.0490	0.45 (0.26, 0.65)	<0.0001
CI: confidence interval; NA: not analysed due to low incidence of events				
^a Treatment difference = effect of ivacaftor – effect of placebo				
^b CFQ-R: Cystic Fibrosis Questionnaire-Revised is a disease-specific, health-related quality-of-life measure for CF. Minimum Clinically Important Difference (MCID) = 4 units.				
^c Study 1 data were pooled from CFQ-R for adults/adolescents and CFQ-R for children 12 to 13 years of age; Study 2 data were obtained from CFQ-R for children 6 to 11 years of age.				
^d Hazard ratio for time to first pulmonary exacerbation				
^e In subjects under 20 years of age (CDC growth charts)				

Study 3: Study in Patients with CF with the *F508del* Mutation in the *CFTR* Gene

Study 3 (Part A) was a 16-week, 4:1 randomised, double-blind, placebo-controlled, parallel-group, Phase 2 study of ivacaftor (150 mg every 12 hours) in 140 patients with CF age 12 years and older who were homozygous for the *F508del* mutation in the *CFTR* gene and who had FEV₁ ≥40% predicted (see PRECAUTIONS).

The mean absolute change from baseline through Week 16 in percent predicted FEV₁ (primary efficacy endpoint) was 1.5 percentage points in the ivacaftor group and -0.2 percentage points in the placebo group. The estimated treatment difference for ivacaftor versus placebo was 1.7 percentage points (95% CI -0.6, 4.1); this difference was not statistically significant (*P*=0.15).

Study 4: Open-Label Extension Study

Study 4 is an open-label extension study to evaluate the safety and efficacy of long-term treatment of orally administered ivacaftor (150 mg every 12 hours) in patients continuing from Studies 1 and 2. It enrolled 144 adolescents/adults who completed Study 1 (age ≥12 years) and 48 children who completed Study 2 (age 6-11 years). The percent predicted FEV₁ range at the beginning of Study 4 was 29.1% to 126.7%. The use of inhaled hypertonic saline was permitted. A pre-specified analysis of all patients' data was performed after all patients from Studies 1 and 2 who had not discontinued received 96 weeks of treatment with ivacaftor in Study 4 (for a total exposure of 144 weeks for patients who received ivacaftor in Studies 1 and 2).

In Study 4, the substantial lung function improvement and weight gain (as seen in Studies 1 and 2) (Table 3) and CFQ-R changes (as seen in Study 1) persisted through 144 weeks of cumulative KALYDECO treatment. The time-to-first pulmonary exacerbation showed a consistent trend across 144 weeks for patients treated with KALYDECO from Study 1. Too few patients experienced pulmonary exacerbations in Study 2 to perform a meaningful statistical analysis.

Attachment 1: Product information for AusPAR Kaldyeco (ivacaftor) PM-2014-04248-1-5 Final 5 January 2017. This Product Information was approved at the time this AusPAR was published.

Table 3. Effect of KALYDECO in Study 4					
Original study and treatment group	Duration of KALYDECO treatment (weeks)	Absolute change in percent predicted FEV ₁ (percentage points)		Absolute change in body weight (kg)	
		N	Mean (SD)	N	Mean (SD)
Study 1					
KALYDECO	48*	77	9.4 (8.3)	77	3.4 (4.9)
	144	72	9.4 (10.8)	72	4.1 (7.1)
Placebo	0*	67	-1.2 (7.8) [†]	67	0.3 (2.7) [†]
	96	55	9.5 (11.2)	55	3.0 (4.7)
Study 2					
KALYDECO	48*	26	10.2 (15.7)	26	6.1 (2.9)
	144	25	10.3 (12.4)	25	14.8 (5.7)
Placebo	0*	22	-0.6 (10.1) [†]	22	2.9 (1.8) [†]
	96	21	10.5 (11.5)	21	10.1 (4.1)

* Treatment occurred during blinded, controlled, 48-week, Phase 3 study.
[†] Change from prior study baseline after 48 weeks of placebo treatment.

Figure 2: Mean Absolute Change in Percent Predicted FEV₁ from Baseline in Studies 1 and 2 to Week 144 in Study 4

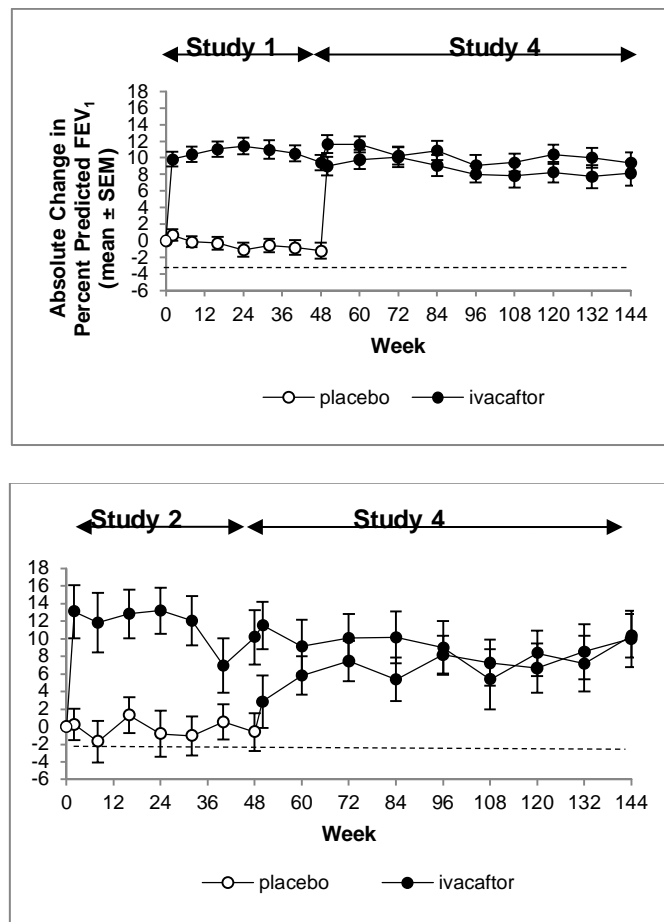


Figure 3: Absolute Change in Weight in Studies 1 and 2 to Week 144 in Study 4

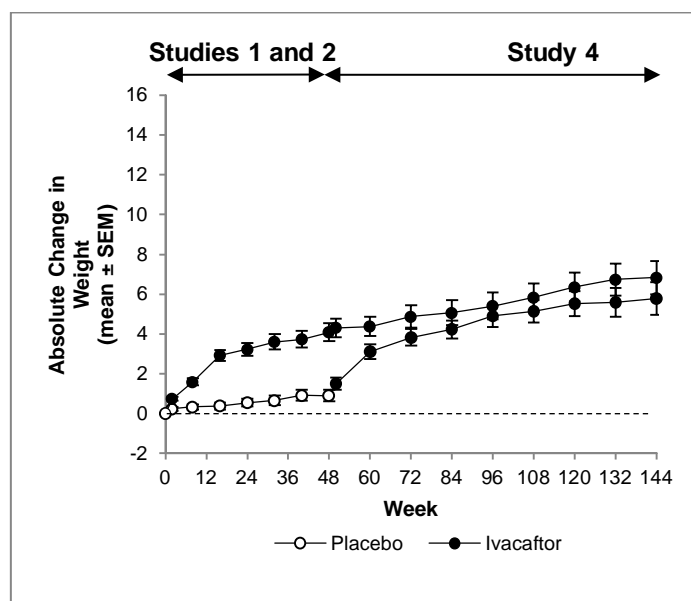
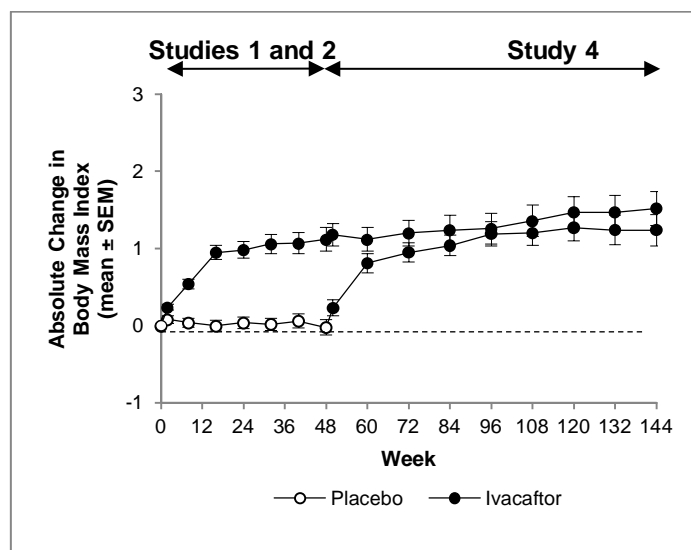


Figure 4: Absolute Change in Body Mass Index (BMI) in Studies 1 and 2 to Week 144 in Study 4



Study 5: Study in Patients with CF with non-G551D Gating Mutations

Study 5 was a Phase 3, two-part, randomised, double-blind, placebo-controlled, crossover study (Part 1) with an open-label extension period (Part 2) to evaluate the efficacy and safety of ivacaftor in subjects with CF who have a non-G551D gating mutation in the *CFTR* gene (*G178R*, *S549N*, *S549R*, *G551S*, *G970R*, *G1244E*, *S1251N*, *S1255P*, or *G1349D*). Patients who completed Part 1 of this study (randomised, double-blind, placebo-controlled, 8-week crossover) continued into the 16-week open-label Part 2 of the study.

Study 5 evaluated 39 subjects with CF who were 6 years of age or older (mean age 23 years) with baseline FEV₁ ≥40% predicted [mean FEV₁ 78% predicted (range: 43% to 119%)].

In Part 1, patients were randomised 1:1 to receive either 150 mg of ivacaftor or placebo every 12 hours with fat-containing food for 8 weeks in addition to their prescribed CF therapies during the first Treatment Period and crossed over to the other treatment for the second 8 weeks. The two 8-week Treatment Periods were separated by a 4- to 8-week Washout Period. The use of inhaled hypertonic saline was not permitted.

The primary efficacy endpoint was improvement in lung function as determined by the mean absolute change from baseline in percent predicted FEV₁ through 8 weeks of treatment.

In Part 1 of Study 5, the observed treatment difference between ivacaftor and placebo for the mean absolute change in percent predicted FEV₁ from baseline through Week 8 was 10.7 percentage points ($P < 0.0001$). Improvements in percent predicted FEV₁ were observed regardless of age, disease severity, sex, geographic region, and *Pseudomonas aeruginosa* infection status at baseline. Improvement in percent predicted FEV₁ was rapid in onset (Day 15, $P < 0.0001$) and durable through 8 weeks ($P < 0.0001$) of treatment with ivacaftor.

Treatment with ivacaftor resulted in substantial, consistent, and statistically significant treatment effects across the secondary endpoints of absolute change from baseline in BMI and BMI-for-age z-score at Week 8 (0.7 kg/m²; $P < 0.0001$ and 0.3 points; $P = 0.0010$, respectively); and CFQ-R respiratory domain score through Week 8 (9.6 points; $P = 0.0004$; Minimum Clinically Important Difference = 4 units) when compared to placebo. Together, these results demonstrate the positive effects of ivacaftor treatment on pulmonary and extrapulmonary measures.

Study 6: Study in Patients with CF with an *R117H* Mutation in the *CFTR* Gene

The efficacy and safety of KALYDECO in patients with CF who have an *R117H* mutation in the *CFTR* gene were evaluated in a randomized, double-blind, placebo-controlled, parallel-group clinical trial of patients aged 6 years and older with cystic fibrosis. Fifty-nine of 69 patients completed 24 weeks of treatment. Two patients discontinued and 8 patients did not complete treatment due to study termination. Patients who were 12 years and older had FEV₁ at screening between 40-90% predicted, and patients who were 6-11 years of age had FEV₁ at screening between 40-105% predicted. The patients had well preserved BMIs (mean overall: 23.76 kg/m²) and a high proportion were pancreatic sufficient as assessed by a low rate of pancreatic enzyme replacement therapy use (pancreatin: 11.6%; pancrelipase: 5.8%). Patients who had persistent *Burkholderia cenocepacia*, *Burkholderia dolosa*, or *Mycobacterium abscessus* isolated from sputum at screening, and those with abnormal liver function defined as 3 or more liver function tests (ALT, AST, AP, GGT, total bilirubin) ≥ 3 times the ULN, were excluded.

Patients were randomized 1:1 to receive either 150 mg of KALYDECO (n=34) or placebo (n=35) every 12 hours with food containing fat for 24 weeks in addition to their prescribed CF therapies.

The primary efficacy endpoint was improvement in lung function as determined by the mean absolute change from baseline in percent predicted FEV₁ through 24 weeks of treatment. The treatment difference for absolute change in percent predicted FEV₁ through Week 24 was 2.1 percentage points (analysis conducted with the full analysis set which included all 69 patients), and did not reach statistical significance.

In a subgroup analysis in patients 18 years and older, the treatment difference for the mean absolute change from baseline through Week 24 in percent predicted FEV₁ was 5.0 percent points (95% CI 1.1, 8.8). In a subgroup analysis in patients 6-11 years of age, the treatment difference for the mean absolute change from baseline through Week 24 in percent predicted

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FEV₁ was -6.3 percentage points (95% CI -12.0, -0.7). No statistical analysis was conducted for subjects 12 to 17 years of age because only 2 patients were enrolled in the clinical study (Table 4).

Other efficacy variables that were analyzed included absolute change in sweat chloride from baseline through Week 24, improvement in cystic fibrosis respiratory symptoms through Week 24 as assessed by the CFQ-R respiratory domain score (Table 4), absolute change in body mass index (BMI) at Week 24, and time to first pulmonary exacerbation. The overall treatment difference for the absolute change from baseline in BMI at Week 24 was 0.3 kg/m² and the calculated hazard ratio for time to first pulmonary exacerbation was 0.93, which were not statistically significant.

Statistically significant improvements in clinical efficacy (FEV₁, CFQ-R respiratory domain) were seen in several subgroup analyses, and decreases in sweat chloride were observed in all subgroups. Subgroups analyzed included those based on age, lung function, and poly-T status (Table 4).

Table 4. Effect of KALYDECO on Overall Population (Percent Predicted FEV₁, CFQ-R Respiratory Domain Score, and Sweat Chloride) and in Relevant Subgroups Through 24 Weeks										
Absolute Change Through Week 24* - All Randomized Patients										
		% Predicted FEV₁ (Percentage Points)			CFQ-R Respiratory Domain Score (Points)			Sweat Chloride (mmol/L)		
Subgroup Parameter	Study Drug	n	Mean	Treatment Difference (95% CI)	n	Mean	Treatment Difference (95% CI)	n	Mean	Treatment Difference (95% CI)
R117H – All Patients										
	Placebo	35	0.5	2.1	34	-0.8	8.4	35	-2.3	-24.0
	Kalydeco	34	2.6	(-1.1, 5.4)	33	7.6	(2.2, 14.6)	32	-26.3	(-28.0, -19.9)
Subgroup by Age										
6-11	Placebo	8	3.5	-6.3	7	-1.6	-6.1	8	1.0	-27.6
	Kalydeco	9	-2.8	(-12.0, -0.7)	8	-7.7	(-15.7, 3.4)	8	-26.6	(-37.2, -18.1)
12-17	Placebo	1	---	---	1	---	---	1	---	---
	Kalydeco	1	---	---	1	---	---	1	---	---
≥18	Placebo	26	-0.5	5.0	26	-0.5	12.6	26	-4.0	-21.9
	Kalydeco	24	4.5	(1.1, 8.8)	24	12.2	(5.0, 20.3)	23	-25.9	(-26.5, -17.3)
Subgroup by Poly-T Status[†]										
5T	Placebo	24	0.7	5.3	24	-0.6	15.3	24	-4.6	-24.2
	Kalydeco	14	6.0	(1.3, 9.3)	14	14.7	(7.7, 23.0)	13	-28.7	(-30.2, -18.2)
7T	Placebo	5	-0.9	0.2	5	-6.0	5.2	5	3.9	-24.1
	Kalydeco	11	-0.7	(-8.1, 8.5)	11	-0.7	(-13.0, 23.4)	10	-20.2	(-33.9, -14.3)
Subgroup by Baseline FEV₁ % Predicted										
<70%	Placebo	15	0.4	4.0	15	3.0	11.4	15	-3.8	-25.5
	Kalydeco	13	4.5	(-2.1, 10.1)	13	14.4	(1.2, 21.6)	12	-29.3	(-31.8, -19.3)
70-90%	Placebo	14	0.2	2.6	13	-3.6	8.8	14	-3.1	-20.0
	Kalydeco	14	2.8	(-2.3, 7.5)	14	5.2	(-2.6, 20.2)	14	-23.0	(-26.9, -12.9)
>90%	Placebo	6	2.2	-4.3	6	-2.5	-0.7	6	1.0	-26.8
	Kalydeco	7	-2.1	(-9.9, 1.3)	6	-3.2	(-10.4, 9.0)	6	-25.9	(-39.5, -14.1)
* MMRM analysis with fixed effects for treatment, age, week, baseline value, treatment by week, and subject as a random effect										
[†] (n=54) Poly-T status confirmed by genotyping										

The efficacy of ivacaftor beyond 2 years of treatment has not been examined in clinical trials in children with *R117H* mutation.

INDICATIONS

KALYDECO is indicated for the treatment of cystic fibrosis (CF) in patients aged 6 years and older who have a *G551D* or other gating (class III) mutation or an *R117H* mutation in the *CFTR* gene.

CONTRAINDICATIONS

In cases of hypersensitivity to the active substance or to any component of this medication, patients should not be treated with this medicine.

PRECAUTIONS

Efficacy results from a Phase 2 study in patients with CF who were homozygous for the *F508del* mutation in the *CFTR* gene showed no statistically significant difference in FEV₁ over 16 weeks of ivacaftor treatment compared to placebo (see CLINICAL TRIALS). Therefore, use of KALYDECO in these patients is not recommended.

Effects on Fertility

Ivacaftor impaired fertility and reproductive performance indices in male and female rats at an oral dose of 200 mg/kg/day (yielding approximately 10 and 5 times, respectively, the systemic exposure anticipated in patients at the maximum recommended human dose (MRHD) based on summed AUCs of ivacaftor and its major metabolites) when dams were dosed prior to and during early pregnancy. The pregnancy rate was decreased, oestrus cycling was disrupted and pre-implantation loss was increased. These effects occurred in the presence of significant maternal toxicity. No effects on male or female fertility and reproductive performance indices were observed at ≤ 100 mg/kg/day (yielding approximately 6 and 3 times, respectively, the exposure at the MRHD based on summed AUCs of ivacaftor and its metabolites).

Use in Pregnancy

Category B3

Category B3 drugs have been taken by only a limited number of pregnant women and women of childbearing age, without an increase in the frequency of malformation or other direct or indirect harmful effects on the human foetus having been observed. Studies in animals have shown evidence of an increased occurrence of foetal damage, the significance of which is considered uncertain in humans.

There are no adequate and well-controlled studies of KALYDECO in pregnant women. Developmental toxicity studies in animals revealed no teratogenicity in rats at oral doses up to 200 mg/kg/day (yielding 5 times the summed AUC for ivacaftor and its major metabolites anticipated in patients) or in rabbits at up to 100 mg/kg/day (relative exposure based on summed AUCs, ≥ 3). Foetal weight was decreased and the incidence of minor foetal skeletal abnormalities was increased in rats treated at 200 mg/kg/day; these effects were observed in conjunction with maternal toxicity. Ivacaftor and/or its metabolites were shown to cross the placenta in rats and rabbits. As animal reproduction studies are not always predictive of human response, and given the limited experience with KALYDECO in pregnancy, KALYDECO should only be used during pregnancy if the expected benefits to the mother justify the potential risks to the foetus.

Use in Lactation

It is unknown whether ivacaftor and/or its metabolites are excreted in human milk. Ivacaftor and/or its metabolites were shown to be excreted into the milk of lactating rats. The safe use of KALYDECO during breast-feeding has not been established. KALYDECO should only be used during breast-feeding if the potential benefit outweighs the potential risk.

Paediatric Use

The safety and efficacy of KALYDECO in children aged less than 6 years have not been established.

Efficacy was not demonstrated in patients less than 18 years of age with CF who have an *R117H* mutation in clinical trials. Currently available data are described in the Pharmacology, Clinical Trials, Adverse Effects and Dosage and Administration sections.

Cataracts were seen in juvenile rats treated with ivacaftor from postnatal day 7-35 at oral doses ≥ 10 mg/kg/day, yielding exposure to ivacaftor and its major metabolites approximately 3.5-6 times lower than that in patients at the MRHD based on summed AUCs. This finding has not been observed in older animals. The potential relevance of these findings in humans is unknown.

Cataracts

Cases of non-congenital lens opacities without impact on vision have been reported in paediatric patients treated with ivacaftor. Although other risk factors were present in some cases (such as corticosteroid use and exposure to radiation), a possible risk attributable to ivacaftor cannot be excluded. Baseline and follow-up ophthalmological examinations are recommended in paediatric patients initiating ivacaftor treatment.

Use in the Elderly

Clinical studies of ivacaftor did not include a sufficient number of patients age 65 years and older to evaluate the efficacy and safety of ivacaftor in this age range. Thus, the efficacy and safety of ivacaftor in elderly patients have not been evaluated.

Renal Impairment

Caution is recommended while using ivacaftor in patients with severe renal impairment (creatinine clearance less than or equal to 30 mL/min) or end-stage renal disease (see DOSAGE AND ADMINISTRATION and PHARMACOLOGY).

Hepatic Impairment

Use of KALYDECO is not recommended in patients with severe hepatic impairment unless the benefits are expected to outweigh the risks of overexposure. In such cases, the starting dose interval should be 150 mg of KALYDECO every other day (see DOSAGE AND ADMINISTRATION and PHARMACOLOGY).

Patients after Organ Transplantation

KALYDECO has not been studied in patients with CF who have undergone organ transplantation. Therefore, use in transplanted patients is not recommended. See INTERACTIONS WITH OTHER MEDICINES for interactions with cyclosporine or tacrolimus.

Lactose

KALYDECO contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicine.

Genotoxicity

Ivacaftor was negative for genotoxicity in the following assays: Ames test for bacterial gene mutation, *in vitro* chromosomal aberration assay in Chinese hamster ovary cells, and *in vivo* mouse micronucleus test.

Carcinogenicity

Two-year oral studies in mice and rats to assess the carcinogenic potential of ivacaftor demonstrated that ivacaftor was not carcinogenic in either species. Plasma exposures to ivacaftor in mice at the non-carcinogenic dosage (200 mg/kg/day, the highest dosage tested) were approximately 4- to 7-fold higher than the plasma levels measured in humans following ivacaftor therapy, and at least 1.2 to 2.4 times higher with respect to the summed AUC for ivacaftor and its major metabolites. Plasma exposures to ivacaftor in rats at the non-carcinogenic dosage (50 mg/kg/day, the highest dosage tested) were approximately 16- to 29-fold higher than the plasma levels measured in humans following ivacaftor therapy, and 6- to 9-fold higher with respect to the summed AUC for ivacaftor and its major metabolites.

Effect on Laboratory Tests

Liver Function Tests

Moderate transaminase [alanine transaminase (ALT) or aspartate transaminase (AST)] elevations are common in subjects with CF. In Studies 1, 2, and 3, the incidence and clinical features of transaminase elevations in clinical trials were similar between subjects in the ivacaftor and placebo treatment groups (see ADVERSE EFFECTS). In the subset of patients with a medical history of elevated transaminases, increased ALT or AST has been reported more frequently in patients receiving ivacaftor compared to placebo. Therefore, liver function tests are recommended for all patients prior to initiating ivacaftor, every 3 months during the first year of treatment, and annually thereafter. For patients with a history of transaminase elevations, consider more frequent monitoring of liver function tests (see ADVERSE EFFECTS). Patients who develop unexplained increased transaminase levels during treatment should be closely monitored until the abnormalities resolve. Dosing should be interrupted in patients with ALT or AST of greater than 5 times the upper limit of normal (ULN). Following resolution of transaminase elevations, consideration should be given to the continuation of treatment after assessment of the individual benefits and risks.

Interactions with Medicinal Products

Ivacaftor is a substrate of CYP3A4 and CYP3A5 isoenzymes. Medicinal products that inhibit or induce CYP3A activity may impact the pharmacokinetics of ivacaftor (see INTERACTIONS WITH OTHER MEDICINES). The dose of KALYDECO must be adjusted when concomitantly used with strong and moderate CYP3A inhibitors. Exposure to ivacaftor may be reduced by the concomitant use of CYP3A inducers, potentially resulting in the loss of efficacy of KALYDECO (see INTERACTIONS WITH OTHER MEDICINES).

Ivacaftor is a weak CYP3A and P-glycoprotein (P-gp) inhibitor and may modify the pharmacokinetics of medicinal products that are substrates of CYP3A and/or P-gp. *In vitro* studies indicated that ivacaftor has the potential to inhibit CYP2C9.

Driving and Operating Machinery

Dizziness has been reported in patients receiving KALYDECO, which could influence the ability to drive or operate machines (see ADVERSE EFFECTS). Patients experiencing dizziness should be advised not to drive or operate machines until symptoms abate.

INTERACTIONS WITH OTHER MEDICINES

Ivacaftor is a substrate of CYP3A4 and CYP3A5. It is a weak inhibitor of CYP3A and P-gp and a potential inhibitor of CYP2C9.

Effects of Other Medicines on Ivacaftor

CYP3A Inhibitors

Ivacaftor is a sensitive CYP3A substrate. Co-administration with ketoconazole, a strong CYP3A inhibitor, increased ivacaftor exposure [measured as area under the curve (AUC)] by 8.5-fold and increased hydroxymethyl-ivacaftor (M1) to a lesser extent than ivacaftor. A reduction of the KALYDECO dose to 150 mg twice a week is recommended for co-administration with strong CYP3A inhibitors, such as ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin, and clarithromycin.

Co-administration with fluconazole, a moderate inhibitor of CYP3A, increased ivacaftor exposure by 3-fold and increased M1 to a lesser extent than ivacaftor. A reduction of the KALYDECO dose to 150 mg once daily is recommended for patients taking concomitant moderate CYP3A inhibitors, such as fluconazole and erythromycin.

Co-administration of KALYDECO with grapefruit juice, which contains one or more components that moderately inhibit CYP3A, may increase exposure to ivacaftor. Food containing grapefruit or Seville oranges should be avoided during treatment with KALYDECO.

CYP3A Inducers

Co-administration of ivacaftor with rifampicin, a strong CYP3A inducer, decreased ivacaftor exposure (AUC) by 89% and decreased M1 to a lesser extent than ivacaftor.

Co-administration with strong CYP3A inducers, such as rifampicin, rifabutin, phenobarbital, carbamazepine, phenytoin and St. John's wort (*Hypericum perforatum*), is not recommended. Concomitant use of weak to moderate inducers of CYP3A (e.g., dexamethasone, high-dose prednisone) may decrease the exposure of ivacaftor and thus may reduce KALYDECO efficacy.

Other Recommendations

Co-administration of ciprofloxacin with ivacaftor did not affect the exposure of ivacaftor. No dose adjustment is required when KALYDECO is co-administered with ciprofloxacin.

Effects of Ivacaftor on Other Medicines

CYP3A, P-gp, or CYP2C9 Substrates

Based on *in vitro* results, ivacaftor and its M1 metabolite have the potential to inhibit CYP3A and P-gp. Co-administration with (oral) midazolam, a sensitive CYP3A substrate, increased midazolam exposure 1.5-fold, consistent with weak inhibition of CYP3A by ivacaftor.

Co-administration with digoxin, a sensitive P-gp substrate, increased digoxin exposure by 1.3-fold, consistent with weak inhibition by P-gp by ivacaftor. Administration of KALYDECO may increase systemic exposure of medicinal products that are substrates of CYP3A and/or P-gp, which may increase or prolong their therapeutic effect and adverse

reactions. Use with caution and monitor for benzodiazepine-related side effects when using concomitant midazolam, alprazolam, diazepam, or triazolam. Use with caution and appropriate monitoring when using concomitant digoxin, cyclosporine, or tacrolimus. Ivacaftor may inhibit CYP2C9. Therefore, monitoring of the INR during co-administration with warfarin is recommended.

Other Recommendations

Ivacaftor has been studied with an oestrogen/progesterone oral contraceptive and was found to have no significant effect on the exposures of the oral contraceptive. Ivacaftor is not expected to modify the efficacy of oral contraceptives. Therefore, no dose adjustment of oral contraceptives is necessary.

Ivacaftor has been studied with the CYP2C8 substrate rosiglitazone. No significant effect on rosiglitazone exposure was found. Therefore, no dose adjustment of CYP2C8 substrates such as rosiglitazone is necessary.

Ivacaftor has been studied with the CYP2D6 substrate desipramine. No significant effect on desipramine exposure was found. Therefore, no dose adjustment of CYP2D6 substrates such as desipramine is necessary.

Interaction studies have only been performed in adults.

ADVERSE EFFECTS

Experience from Clinical Trials

The safety profile of KALYDECO is based on five clinical trials: two pooled, placebo-controlled Phase 3 clinical trials (Studies 1 and 2) conducted in 213 CF patients (109 received ivacaftor and 104 received placebo up to 48 weeks) who had a *G551D* mutation in the *CFTR* gene; a 96-week open-label extension study (Study 4) that included 192 patients with a *G551D* mutation; an 8-week, Phase 3, placebo-controlled crossover design study (Study 5) in 39 patients with CF who had a non-*G551D* gating (class III) mutation in the *CFTR* gene; and a 24-week, placebo-controlled trial (Study 6) involving 69 patients with an *R117H* mutation in the *CFTR* gene. Patients treated with KALYDECO in these trials were between the ages of 6 and 68 years.

The most common adverse reactions that were more frequent in patients with a *G551D* mutation who received ivacaftor for 48 weeks in the placebo-controlled Phase 3 trials were abdominal pain (15.6% versus 12.5% on placebo), diarrhoea (12.8% versus 9.6% on placebo), dizziness (9.2% versus 1.0% on placebo), rash (12.8% versus 6.7% on placebo), upper respiratory tract reactions (including upper respiratory tract infection, nasal congestion, pharyngeal erythema, oropharyngeal pain, rhinitis, sinus congestion, and nasopharyngitis) [63.3% versus 50.0% on placebo], headache (23.9% versus 16.3% on placebo) and bacteria in sputum (7.3% versus 3.8% on placebo). One patient in the ivacaftor group reported a serious adverse reaction: abdominal pain.

Placebo-Controlled, 48-Week Clinical Trials (Studies 1 and 2)

Table 5 shows adverse events with an incidence of at least 10% in any treatment group from the two double-blind, placebo-controlled Phase 3 trials.

Table 5. Adverse Events with an Incidence of at Least 10% in any Treatment Group of Patients Age 6 Years and Older with the *G551D* Mutation in the *CFTR* Gene

Attachment 1: Product information for AusPAR Kaldyeco (ivacaftor) PM-2014-04248-1-5 Final 5 January 2017. This Product Information was approved at the time this AusPAR was published.

Preferred Term	KALYDECO N=109 n (%)	Placebo N=104 n (%)
Cystic fibrosis lung	42 (38.5)	58 (55.8)
Cough	40 (36.7)	52 (50.0)
Headache	26 (23.9)	17 (16.3)
Oropharyngeal pain	24 (22.0)	19 (18.3)
Upper respiratory tract infection	25 (22.9)	14 (13.5)
Nasal congestion	22 (20.2)	16 (15.4)
Abdominal pain	17 (15.6)	13 (12.5)
Pyrexia	16 (14.7)	16 (15.4)
Nasopharyngitis	16 (14.7)	12 (11.5)
Productive cough	14 (12.8)	16 (15.4)
Diarrhoea	14 (12.8)	10 (9.6)
Rash	14 (12.8)	7 (6.7)
Nausea	13 (11.9)	11 (10.6)
Vomiting	11 (10.1)	17 (16.3)
Rales	11 (10.1)	12 (11.5)
Haemoptysis	9 (8.3)	17 (16.3)
Pulmonary function test decreased	5 (4.6)	15 (14.4)
Abdominal pain upper	10 (9.2)	11 (10.6)

Table 6 presents the adverse reactions identified in patients aged 6 years and older who had a *G551D* mutation in at least one allele listed by system organ class, preferred term, and frequency. Adverse reactions are ranked under the MedDRA frequency classification: very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$); very rare ($< 1/10,000$); and not known (frequency cannot be estimated using the available data).

Table 6. Adverse Reactions in KALYDECO-treated Patients Age 6 Years and Older with the <i>G551D</i> Mutation in the <i>CFTR</i> Gene		
System Organ Class	Frequency Category	Adverse Reactions (Preferred term) KALYDECO N=109
Infections and infestations	very common	Nasopharyngitis
	very common	Upper respiratory tract infection
	common	Rhinitis
Nervous system disorders	very common	Headache
	common	Dizziness
Ear and labyrinth disorders	common	Ear discomfort
	common	Ear pain
	common	Tinnitus
	common	Tympanic membrane hyperaemia
	uncommon	Ear congestion

Table 6. Adverse Reactions in KALYDECO-treated Patients Age 6 Years and Older with the G551D Mutation in the CFTR Gene

System Organ Class	Frequency Category	Adverse Reactions (Preferred term) KALYDECO N=109
	uncommon	Vestibular disorder
Respiratory, thoracic, and mediastinal disorders	very common	Nasal congestion
	very common	Oropharyngeal pain
	common	Pharyngeal erythema
	common	Sinus congestion
Gastrointestinal disorders	very common	Abdominal pain
	very common	Diarrhoea
Skin and subcutaneous tissue disorders	very common	Rash
Reproductive system and breast disorders	uncommon	Breast inflammation
	uncommon	Breast mass
	uncommon	Gynaecomastia
	uncommon	Nipple disorder
	uncommon	Nipple pain
Investigations	common	Bacteria in sputum

Description of Selected Adverse Reactions

Rash

During 48-week, placebo-controlled clinical trials, the incidence of rash was 12.8% in KALYDECO-treated patients. Including data from all clinical trial and post-marketing data, most of these events were non-serious and most of these patients did not discontinue the treatment because of rash.

Ear and Labyrinth Disorders

During 48-week, placebo-controlled clinical trials, the incidence of ear and labyrinth disorders was 9.2% in KALYDECO-treated patients. Most events were described as mild to moderate in severity, 1 event of ear pain was described as severe, none were serious, and no patients discontinued treatment because of ear and labyrinth disorders.

Nervous System Disorders

Headache

During 48-week, placebo-controlled clinical trials, the incidence of headache was 23.9% in KALYDECO-treated patients. Including data from all clinical trial and post-marketing data, most of these events were non-serious and most of these patients did not discontinue the treatment because of headache.

Dizziness

During 48-week, placebo-controlled clinical trials, the incidence of dizziness was 9.2% in the KALYDECO-treated patients. Including data from all clinical trial and post-marketing data, most of these events were non-serious and most of these patients did not discontinue the treatment because of dizziness.

Upper Respiratory Tract Reactions

During 48-week, placebo-controlled clinical trials, the incidence of upper respiratory tract reactions (upper respiratory tract infection, nasal congestion, pharyngeal erythema, oropharyngeal pain, rhinitis, sinus congestion, and nasopharyngitis) was 63.3% in KALYDECO-treated patients. Most events were described as mild to moderate in severity, 1 event of upper respiratory tract infection and 1 event of nasal congestion were considered to be severe, none were serious, and no patients discontinued treatment because of upper respiratory tract reactions.

Laboratory Abnormalities

Transaminase Elevations

During the placebo-controlled Studies 1, 2, and 3, up to 48 weeks, in patients with a *G551D* mutation in the *CFTR* gene or who were homozygous for the *F508del* mutation, the incidence of maximum transaminase (ALT or AST) >8, >5 or >3 x ULN was 1.8%, 2.3%, and 5.9% in KALYDECO-treated patients and 1.5%, 2.3%, and 8.3% in placebo-treated patients, respectively. Three patients, 2 (1.5%) on placebo and 1 (0.5%) on KALYDECO, permanently discontinued treatment for elevated transaminases, which were all >8 x ULN. No KALYDECO-treated patients experienced a transaminase elevation >3 x ULN associated with elevated total bilirubin >1.5 x ULN. In KALYDECO-treated patients, most transaminase elevations up to 5 x ULN resolved without treatment interruption. KALYDECO dosing was interrupted in most patients with transaminase elevations >5 x ULN. In all instances where dosing was interrupted for elevated transaminases, KALYDECO dosing was able to be resumed (see PRECAUTIONS).

Paediatric Population

Table 7 lists the adverse reactions by system organ class, preferred term, and frequency in KALYDECO-treated paediatric patients age 6 to 17 in the two 48-week, Phase 3 studies in patients with CF with a *G551D* mutation. The safety data are limited to 23 patients between 6 to 11 years of age and 22 patients between 12 to 17 years of age. Adverse reactions are ranked under the MedDRA frequency classification: very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$); very rare ($< 1/10,000$); and not known (frequency cannot be estimated using the available data).

System Organ Class	Frequency Category		Adverse Reactions KALYDECO (Preferred Term)
	6 to 11 Years N=23	12 to 17 Years N=22	
Infections and infestations	very common	very common	Nasopharyngitis
	very common	very common	Upper respiratory tract infection
	common	very common	Rhinitis
Nervous system disorders	very common	very common	Headache
	not observed	very common	Dizziness
Ear and labyrinth disorders	common	common	Ear pain
	common	not observed	Tympanic membrane hyperaemia
Respiratory, thoracic, and mediastinal disorders	very common	very common	Nasal congestion
	very common	very common	Oropharyngeal pain
	common	not observed	Pharyngeal erythema
Gastrointestinal disorders	very common	very common	Abdominal pain
	very common	not observed	Diarrhoea
Skin and subcutaneous tissue	common	very common	Rash

disorders			
Investigations	common	very common	Bacteria in sputum

Long-term Safety (Study 4)

Among 192 patients with the *G551D* mutation treated with KALYDECO for 96 weeks in an open-label extension study (Study 4) following the placebo-controlled Phase 3 studies (96 to 144 weeks cumulatively), the nature of adverse events was similar to those reported in the placebo-controlled Phase 3 studies. Serious adverse reactions observed during the 96-week extension study included abdominal pain (1%), headache (1%), and vestibular disorder (0.5%).

Non-*G551D* Gating Population (Study 5)

In an 8-week, two-part, randomised, double-blind, placebo-controlled, crossover Phase 3 clinical trial of 39 patients with CF aged 6 and older who had a non-*G551D* gating mutation in the *CFTR* gene (Study 5), the safety results were consistent with those observed in studies in patients with CF who had the *G551D* mutation. In the non-*G551D* gating population, one adverse reaction occurred in more patients during treatment with KALYDECO compared with placebo: rhinitis (7.9% versus 5.4% on placebo).

R117H Population (Study 6)

In a 24-week, placebo-controlled trial (Study 6) involving 69 patients with CF aged 6 and older who had an *R117H* mutation in the *CFTR* gene, the safety results were consistent with those observed in studies in patients with CF who had the *G551D* mutation.

Post-Marketing Experience

There are no relevant updates from the post-marketing experience.

DOSAGE AND ADMINISTRATION

KALYDECO should only be prescribed by physicians with experience in the treatment of cystic fibrosis. If the patient's genotype is unknown, an accurate and validated genotyping method should be performed to confirm the presence of a gating (class III) mutation or an *R117H* mutation in at least one allele of the *CFTR* gene before starting treatment.

In patients with *R117H* mutation, analysis of the poly-T variants may be considered to better define those more likely to respond to treatment.

*Adults, adolescents and children aged 6 years and older with a *G551D* mutation or other gating (class III) mutation, or an *R117H* mutation in the *CFTR* gene*

The recommended dose is 150 mg taken orally every 12 hours (300 mg total daily dose).

KALYDECO should be taken with a fat-containing meal or snack. Meals and snacks recommended in CF guidelines or meals recommended in standard nutritional guidelines contain adequate amounts of fat. Examples of meals that contain fat are those prepared with butter or oils or those containing eggs, cheeses, nuts, avocados, whole milk, full-fat yoghurt, or meats. Food containing grapefruit or Seville oranges should be avoided during treatment with KALYDECO (see INTERACTIONS WITH OTHER MEDICINES).

Use in the Elderly

The efficacy and safety of KALYDECO in patients age 65 years or older have not been evaluated.

Use in Renal Insufficiency

No dose adjustment is necessary for patients with mild to moderate renal impairment. Caution is recommended while using ivacaftor in patients with severe renal impairment (creatinine clearance less than or equal to 30 mL/min) or end-stage renal disease (see PRECAUTIONS and PHARMACOLOGY).

Use in Hepatic Insufficiency

No dose adjustment is necessary for patients with mild hepatic impairment (Child-Pugh Class A). A reduced dose of 150 mg once daily is recommended in patients with moderate hepatic impairment (Child-Pugh Class B). There is no experience of the use of KALYDECO in patients with severe hepatic impairment. The use of KALYDECO in these patients is therefore not recommended unless the benefits outweigh the risks. In such cases, the starting dose should be 150 mg every other day. Dosing intervals should be modified according to clinical response and tolerability (see PRECAUTIONS and PHARMACOLOGY).

Use in Combination with Other Medicinal Compounds

When co-administered with strong inhibitors of CYP3A (e.g., ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin, and clarithromycin), KALYDECO should be administered at a dose of 150 mg twice a week (see PRECAUTIONS and INTERACTIONS WITH OTHER MEDICINES).

When co-administered with moderate inhibitors of CYP3A (e.g., fluconazole, erythromycin), KALYDECO should be administered at a single daily dose of 150 mg (see PRECAUTIONS and INTERACTIONS WITH OTHER MEDICINES).

Method of Administration

For oral use. Patients should be instructed to swallow the tablets whole (i.e., patients should not chew, break, or dissolve the tablet).

OVERDOSAGE

For information on the management of overdose, contact the Poisons Information Centre on 131126 (Australia).

The highest repeated dose was 450 mg (in a tablet formulation) every 12 hours for 4.5 days (9 doses) in a trial evaluating the effect of KALYDECO on ECGs in healthy subjects. Adverse events reported at a higher incidence compared to placebo included dizziness and diarrhoea.

No specific antidote is available for overdose with KALYDECO. Treatment of overdose with KALYDECO consists of general supportive measures including monitoring of vital signs, liver function tests, and observation of the clinical status of the patient.

PRESENTATION AND STORAGE CONDITIONS

KALYDECO (ivacaftor) film-coated tablets are supplied as light blue, capsule-shaped tablets (16.5 mm x 8.4 mm in modified caplet shape) containing 150 mg of ivacaftor. Each tablet is printed with "V 150" in black ink on one side only.

KALYDECO tablets are packaged in a blister pack or a child-resistant bottle with desiccant.

The following pack sizes are available:

- Blister pack containing 56 film-coated tablets
- Bottle containing 56 film-coated tablets

**Attachment 1: Product information for AusPAR Kaldyeco (ivacaftor) PM-2014-04248-1-5
Final 5 January 2017. This Product Information was approved at the time this AusPAR was
published.**

Store below 30°C.

NAME AND ADDRESS OF THE SPONSOR

Vertex Pharmaceuticals (Australia) Pty Ltd
Suite 3, Level 3
601 Pacific Highway
St Leonards
NSW 2065
Australia

POISON SCHEDULE OF THE MEDICINE

S4 - Prescription only medicine

**DATE OF FIRST INCLUSION IN THE AUSTRALIAN REGISTER OF
THERAPEUTIC GOODS**

09 July 2013

DATE OF MOST RECENT AMENDMENT

29 March 2016

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