Tavlesse®▼

Film-coated tablets

fostamatinib disodium hexahydrate

ABBREVIATED PRESCRIBING INFORMATION

Please refer to Summary of Product Characteristics (SmPC) before prescribing. **Tavlesse®▼ Film coated tablets**. **Presentation: 100mg film-coated tablets:** Each film-coated tablet contains 126.2 mg of fostamatinib disodium hexahydrate equivalent to 100 mg fostamatinib. Approximately 9.0 mm round, biconvex, dark orange film-coated tablet debossed "100" on one side and "R" on the other side. **150 mg film-coated tablets:** Each film-coated tablet contains 189.3 mg of fostamatinib disodium hexahydrate equivalent to 150 mg fostamatinib. Approximately 7.25 mm x 14.5 mm oval, biconvex, light orange film-coated tablet debossed "150" on one side and "R" on the other side. *Excipient(s) with known effect:* sodium. For the full list of excipients, see the SmPC. **Therapeutic indications:** Tavlesse is indicated for the treatment of chronic immune thrombocytopenia (ITP) in adult patients who are refractory to other treatments. **Dosage:** Fostamatinib treatment should be initiated and remain under the supervision of a physician experienced in treatment of haematological diseases. Fostamatinib dosing requirements must be individualised based on the patient's platelet counts. The lowest dose of fostamatinib to achieve and maintain a platelet count of at least 50,000/µL should be used.). The recommended starting dose of fostamatinib is 100 mg twice daily. The dose can be increased to 150 mg twice daily after 4 weeks based on platelet count and tolerability. A daily dose of 300 mg daily must not be exceeded. Fostamatinib dose modification is recommended based on tolerability and platelet counts. Management of some adverse reactions may require dose interruption, reduction, or discontinuation. *Discontinuation:* Treatment with fostamatinib should be discontinued after 12 weeks of fostamatinib therapy if the platelet count does not increase to a level sufficient to avoid clinically important bleeding. For Monitoring and dose modifications please refer to SmPC. *Special populations* No dose adjustment is necessary in patients with renal impairment or the elderly. Fostamatinib should not be used in patients with severe hepatic impairment or children and adolescents less than 18 years of age because of adverse reactions on actively growing bones observed in nonclinical studies. **Administration:** Fostamatinib is for oral use. The tablets should be taken twice daily, whole with or without food. In the event of gastric upset, tablets may be taken with food. **Contra-indications:** Hypersensitivity to the active substance or to any of the excipients. Pregnancy (See SmPC) **Special warnings & Precautions (for more information see the SmPC):** Information is based on ITP placebo-controlled population unless specified. *Excipients:* Tavlesse 100 mg film-coated tablets contains 23 mg sodium per tablet, equivalent to 1.2% of the WHO recommended maximum daily intake of 2 g sodium for an adult. Tavlesse 150 mg film-coated tablets contains 34 mg sodium per tablet, equivalent to 1.7% of the WHO recommended maximum daily intake of 2 g sodium for an adult. *Hypertension:* In the ITP placebo-controlled population, increased blood pressure, including the development of hypertension, was reported in patients treated with fostamatinib. Hypertensive crisis occurred in 1 (1%) patient. Patients with pre-existing hypertension may be more susceptible to the hypertensive effects of fostamatinib. *Liver function test abnormalities and risk of hepatotoxicity:* In the placebo-controlled studies, laboratory testing showed maximum ALT/AST levels more than 3 x the upper limit of normal (ULN) in 9% of patients receiving fostamatinib and no patients receiving placebo. Sparse data suggest an increased risk of hyperbilirubinemia in patients with genetic polymorphisms of UGT1A1, e.g. Gilbert; the physician should monitor these patients frequently. For all patients, transaminases recovered generally to baseline levels within 2 to 6 weeks of dose modification. The physician should monitor liver function tests monthly during treatment. If ALT or AST increase more than 3 x ULN, the physician should manage hepatotoxicity by treatment interruption, reduction or discontinuation. Concomitant total bilirubin increases greater than 2 X ULN should lead to treatment discontinuation. *Complete blood counts (CBCs):* The physician should monitor CBCs, including platelet counts, monthly until a stable platelet count (of at least 50,000/µL) is achieved. Thereafter, the physician should continue to monitor CBCs, including neutrophils, regularly. *Diarrhoea:* Diarrhoea is the most common adverse reaction with fostamatinib treatment, but severe diarrhoea occurred in 1% of patients. Patients should be monitored for the development of diarrhoea and managed by using supportive care measures (e.g., dietary changes, hydration and/or antidiarrhoeal medication) early after the onset of symptoms. If diarrhoea becomes severe (Grade 3 or above), administration of fostamatinib should be interrupted, reduced, or discontinued. *Neutropenia:* Neutropenia occurred in 7% of patients treated with fostamatinib; febrile neutropenia occurred in 1% of patients. The physician should monitor the absolute neutrophil count monthly. *Infections:* Infections, including pneumonia and respiratory tract infections, have been reported during clinical trials. The patient should be monitored for infection during treatment. *Bone remodelling:* Since fostamatinib was shown in vitro to not only target SYK but also other tyrosine kinases that are involved in the bone metabolism (e.g., VEGFR, RET), any potential untargeted effects on bone remodelling or formation remain undetermined, especially in patients with osteoporosis, patients with fractures or young adults where epiphyseal fusion has not yet occurred. Closer monitoring in these patients is therefore recommended. The benefit risk of continuing therapy during the healing of a bone fracture should be thoroughly evaluated by the physician. (See SmPC for interactions with other medicinal products and other form of interactions). *Women of childbearing potential/contraception* Women of childbearing potential must use effective contraception during treatment and at least one month after the last dose. *Pregnancy* Based on findings from animal studies and its mechanism of action, fostamatinib can cause foetal harm when administered to a pregnant woman. Pregnant women should be advised about the potential risk to a foetus. Pregnancies occurring during clinical trials resulted in healthy newborns as well as stillbirths/spontaneous abortions and miscarriages. If a patient becomes pregnant while taking fostamatinib, therapy should be discontinued. Fostamatinib is contraindicated during pregnancy. *Breast-feeding* It is unknown whether fostamatinib/metabolites are excreted in human milk. Available pharmacodynamic/toxicological data in animals have shown excretion of fostamatinib metabolites in milk. A risk to the newborns/infants cannot be excluded. Breast-feeding should be discontinued during treatment with fostamatinib and for at least one month after the last dose. *Fertility* There are no data on the effect of fostamatinib on human fertility. Based on the finding of reduced pregnancy rates in animal studies, fostamatinib may affect female fertility. Studies in animals have shown no adverse effect on male fertility. Given there is no evidence for mutagenic or clastogenic potential, there is no concern for male-mediated birth defects. **Undesirable Effects:** In the ITP placebo-controlled studies, serious adverse drug reactions were febrile neutropenia, diarrhoea, pneumonia, and hypertensive crisis, which each occurred in 1% of patients receiving fostamatinib. In addition, severe adverse reactions observed in patients receiving fostamatinib included dyspnoea and hypertension (both 2%); and neutropenia, arthralgia, chest pain, diarrhoea, dizziness, nephrolithiasis, pain in extremity, toothache, syncope and hypoxia (all 1%). The most commonly reported adverse reactions associated with fostamatinib were upper respiratory tract infection, respiratory tract infection, bronchitis, lower respiratory tract infection, viral upper respiratory tract infection, neutropenia, febrile neutropenia, dizziness, dysgeusia, hypertension, diarrhoea, nausea, frequent bowel movement, upper abdominal pain, abdominal pain, rash, rash erythematous, rash macular, Chest pain, fatigue, influenza like illness, alanine aminotransferase increased, aspartate aminotransferase increased, blood pressure (BP) increased, BP diastolic abnormal, BP diastolic increased, BP systolic increased, hepatic enzyme increased, liver function test abnormalities, neutrophil count decreased. For full details please refer to the SmPC. **Incompatibilities:** Not applicable **Pharmaceutical Precautions:** Tavlesse has a shelf life of 3 years. It does not require any special temperature storage conditions. Store in the original package to protect from moisture. Keep the bottle tightly closed. Any unused medicinal product or waste material should be disposed of in accordance with local requirements. **Basic NHS Price:** Tavlesse 100mg x 60 £3,090 Tavlesse 150mg x 60 £4,635 **Legal Category:** POM **Marketing Authorisation Number:** TAVLESSE 100 mg film-coated tablets: EU/1/19/1405/001 TAVLESSE 150 mg film-coated tablets: EU/1/19/1405/002 **Marketing Authorisation Holder:** Instituto Grifols, S.A. Can Guasc, 2 - Parets del Vallès 08150 Barcelona - Spain **Last revised:** May 2020

▼This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Grifols UK Ltd. Please contact Medical Information Services on 0845 241 090 or email medinfo.uk@grifols.com

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