

## **PRODUCT MONOGRAPH**

**Pr TARO-ZOLEDRONIC ACID CONCENTRATE**

**(Zoledronic acid for Injection)**

**4 mg zoledronic acid/5 mL incorporated as the monohydrate**

Sterile concentrate for injection

**Must Be Diluted Before Use**

Bone Metabolism Regulator

**Taro Pharmaceuticals Inc.**  
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Brampton, Ontario, Canada  
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**(Zoledronic acid for Injection)**

**4 mg zoledronic acid/5 mL incorporated as the monohydrate**  
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## **PART I: HEALTH PROFESSIONAL INFORMATION**

### **SUMMARY PRODUCT INFORMATION**

<b>Route of Administration</b>	<b>Dosage Form/ Strength</b>	<b>Clinically Relevant Nonmedicinal Ingredients</b>
Intravenous injection	▪Concentrate: 4 mg zoledronic acid/5 mL <sup>†</sup>	▪Concentrate: mannitol, sodium citrate and water. <i>For a complete listing see Dosage Forms, Composition and Packaging section.</i>

<sup>†</sup> This corresponds to 4.264 mg zoledronic acid monohydrate

### **INDICATIONS AND CLINICAL USE**

#### **Tumour-Induced Hypercalcaemia (TIH)**

TARO-ZOLEDRONIC ACID CONCENTRATE (Zoledronic acid for Injection) is indicated for the treatment of Tumour-Induced Hypercalcaemia, defined as albumin-corrected serum calcium (cCa)  $\geq 12.0$  mg/dL (3.0 mmol/L), following adequate saline rehydration. Prior to treatment with TARO-ZOLEDRONIC ACID CONCENTRATE, renal excretion of excess calcium should be promoted by restoring and maintaining adequate fluid balance and urine output.

#### **Bone Metastases of Solid Tumours and Osteolytic Lesions of Multiple Myeloma**

TARO-ZOLEDRONIC ACID CONCENTRATE is indicated for the treatment of patients with documented bone metastases from solid tumours (including prostate cancer, breast cancer, lung cancer, renal cell carcinoma and other solid tumours) and patients with osteolytic lesions of multiple myeloma in conjunction with standard care in order to prevent or delay potential complications from the bone lesions (see **WARNINGS AND PRECAUTIONS, – Deterioration in Renal function**).

TARO-ZOLEDRONIC ACID CONCENTRATE must only be administered to patients by healthcare professionals experienced in the administration of intravenous bisphosphonates.

## CONTRAINDICATIONS

- Hypersensitivity to zoledronic acid or other bisphosphonates, or any of the excipients in the formulation of TARO-ZOLEDRONIC ACID CONCENTRATE (Zoledronic acid for injection) (see **DOSAGE FORMS, COMPOSITION AND PACKAGING**).
- Non-corrected hypocalcaemia at the time of infusion (see **WARNINGS AND PRECAUTIONS, Hypocalcaemia**)
- TARO-ZOLEDRONIC ACID CONCENTRATE is contraindicated in pregnancy and breast-feeding women (see **WARNINGS AND PRECAUTIONS, Special Populations**)

## WARNINGS AND PRECAUTIONS

### Serious Warnings and Precautions

- **Osteonecrosis of the jaw (ONJ)**, (See **WARNINGS AND PRECAUTIONS, General**)
- **Deterioration in renal function** (See **WARNINGS AND PRECAUTIONS, Renal**)
- The use of TARO-ZOLEDRONIC ACID CONCENTRATE (Zoledronic acid for Injection) is **not recommended in patients with severe renal impairment** (See **WARNINGS AND PRECAUTIONS, Special Populations**)
- **Hypocalcaemia** (See **WARNINGS AND PRECAUTIONS, General, Hypocalcaemia**)
- Single doses of TARO-ZOLEDRONIC ACID CONCENTRATE should not exceed 4 mg and the duration of the infusion should be no less than 15 minutes. (See **WARNINGS AND PRECAUTIONS, Renal** and **DOSAGE AND ADMINISTRATION**)

### General

#### Drug Interactions

TARO-ZOLEDRONIC ACID CONCENTRATE should not be given together with other zoledronic acid preparations or other bisphosphonates since the combined effects of these agents are unknown.

TARO-ZOLEDRONIC ACID CONCENTRATE is eliminated by renal excretion. Caution is indicated when zoledronic acid is administered in conjunction with drugs that are potentially nephrotoxic (e.g. aminoglycosides, other antineoplastic agents, ASA, NSAIDs), or that can significantly impact renal function (e.g. diuretics, ACE inhibitors, leading to dehydration).

Caution is advised when TARO-ZOLEDRONIC ACID CONCENTRATE is administered with anti-angiogenic drugs, as cases of ONJ have been observed in patients treated concomitantly with these drugs (see **DRUG INTERACTIONS/Drug-Drug Interactions**).

Caution is advised when TARO-ZOLEDRONIC ACID CONCENTRATE is administered with

loop diuretics (particularly in patients treated for TIH) or with aminoglycosides, since there may be an additive effect on the risk of developing hypocalcaemia.

**TARO-ZOLEDRONIC ACID CONCENTRATE should be used with extreme caution in conjunction with other antineoplastic agents that are known to produce renal dysfunction (it is advised that renal function be monitored) or where the dose depends upon renal function (for example platinum-containing agents).**

TARO-ZOLEDRONIC ACID CONCENTRATE should not be mixed with calcium-containing intravenous infusion.

### **Effects on ability to drive or use machines**

In rare cases, somnolence and/or dizziness may occur, in which case the patient should not drive, operate potentially dangerous machinery or engage in other activities that may be hazardous.

### **Musculoskeletal Pain**

In post-marketing experience, severe and occasionally incapacitating bone, joint, and/or muscle pain have been reported in patients taking bisphosphonates (see **ADVERSE REACTIONS**). The time to onset of symptoms varied from one day to several months after starting treatment. TARO-ZOLEDRONIC ACID CONCENTRATE should be discontinued if symptoms are severe. Most patients had relief of symptoms after stopping treatment. A subset had recurrence of symptoms when re-challenged with the same drug or another bisphosphonate.

### **Osteonecrosis of the Jaw**

Osteonecrosis of the jaw (ONJ), has been reported in cancer patients treated with bisphosphonates, including zoledronic acid. Although no causal relationship has been established, there is an association between bisphosphonate use and the development of ONJ. Post-marketing experience suggests a greater frequency of reports of ONJ based on tumour type (advanced breast cancer, multiple myeloma) and dental status (dental extractions, periodontal disease and local trauma including poorly fitting dentures); these are associated with a greater risk of developing ONJ. Cancer patients also receive other treatments that may play a role in the development of ONJ, such as chemotherapy and glucocorticosteroids. Many patients had signs of local infection including osteomyelitis.

Presentation of ONJ may include altered local sensation (hyperaesthesia or numbness), maxillofacial pain, “toothaches”, denture sore spots, loose teeth, exposed bone in the oral cavity, impaired healing, recurrent or persistent soft tissue infection in the oral cavity and marked oral odour. The onset can be from months to years after commencing bisphosphonate therapy. Cancer patients should maintain good oral hygiene; it is recommended that advanced cancer patients be encouraged to have an oral examination of both hard and soft tissues, with preventive dentistry prior to treatment with bisphosphonates, and that such assessments continue at regularly scheduled intervals after bisphosphonate therapy is initiated. While on bisphosphonate treatment, these patients should avoid invasive dental procedures if possible. Biopsies are not recommended

unless metastasis to the jaw is suspected. For patients who develop ONJ while on bisphosphonate therapy, dental surgery may exacerbate the condition. For patients requiring dental procedures, there is no data available to suggest whether discontinuation of bisphosphonate treatment reduces the risk of ONJ. Clinical judgment of the treating physician should guide the management plan of each patient based on individual benefit/risk assessment.

### **Atypical fractures of the femur**

Atypical subtrochanteric and diaphyseal femoral fractures have been reported in patients receiving bisphosphonate therapy, primarily in patients receiving long-term treatment for osteoporosis. Reports of atypical femoral fracture have also been received in patients treated with zoledronic acid. These transverse or short oblique fractures can occur anywhere along the femur from just below the lesser trochanter to just above the supracondylar flare. These fractures occur after minimal or no trauma and some patients experience thigh or groin pain, often associated with imaging features of stress fractures, weeks to months before presenting with a completed femoral fracture. Fractures are often bilateral; therefore the contralateral femur should be examined in zoledronic acid treated patients, who have sustained a femoral shaft fracture. Poor healing of these fractures has also been reported. Discontinuation of TARO-ZOLEDRONIC ACID CONCENTRATE therapy in patients suspected to have an atypical femur fracture should be considered pending evaluation of the patient, based on an individual benefit risk assessment.

During TARO-ZOLEDRONIC ACID CONCENTRATE treatment patients should be advised to report any thigh, hip or groin pain and any patient presenting with such symptoms should be evaluated for an incomplete femur fracture.

### **Hypocalcaemia**

Hypocalcaemia has been reported in patients treated with zoledronic acid. QTc prolongation and neurologic adverse events (tonic-clonic seizures, tetany and numbness) have been reported secondary to cases of severe hypocalcaemia. In some instances, the hypocalcaemia required hospitalization and/or was life-threatening.

Patients who have undergone thyroid surgery may be particularly susceptible to develop hypocalcaemia due to relative hypoparathyroidism.

Serum albumin-corrected calcium should be measured prior to each dose and during therapy with TARO-ZOLEDRONIC ACID CONCENTRATE. TARO-ZOLEDRONIC ACID CONCENTRATE is contraindicated in patients who have non-corrected hypocalcaemia at the time of infusion (see **CONTRAINDICATIONS**).

### **Tumour-Induced Hypercalcaemia**

It is essential in the initial treatment of tumour-induced hypercalcaemia that intravenous rehydration be instituted to restore urine output. All patients, including patients with mild to moderate renal impairment, should be hydrated adequately throughout treatment, but overhydration must be avoided.

In patients with cardiac disease, especially in the elderly, additional saline overload may precipitate cardiac failure (left ventricular failure or congestive heart failure). Fever (influenzalike symptoms) may also contribute to this deterioration.

### **Carcinogenesis and Mutagenesis**

In carcinogenicity studies, zoledronic acid was administered orally (gavage) to rats and mice for at least 104 weeks without evidence of carcinogenic potential. Chronic parenteral administration was not feasible given the potential of the compound to cause severe local irritation. The pharmacological bone changes (nonproliferative hyperostosis) typically observed following long term bisphosphonate administration to young animals with growing skeletons gave clear evidence of systemic exposure to zoledronic acid in both species at all doses.

Six mutagenicity studies were conducted with zoledronic acid: three Ames Assays (using *E. coli* and/or *S. typhimurium*), a gene mutation assay using V79 hamster cells, a cytogenetics test with Chinese hamster cells and an in vivo micronucleus assay in rats. There was no evidence of mutagenic potential.

### **Cardiovascular**

In a 3-year, randomized, double-blind controlled trial that evaluated the efficacy and safety of zoledronic acid 5 mg dose once yearly vs. placebo in the treatment of post menopausal osteoporosis (PMO), the overall incidence of atrial fibrillation was 2.5% (96 out of 3,862) and 1.9% (75 out of 3,852) in patients receiving zoledronic acid 5 mg and placebo, respectively. The rate of atrial fibrillation serious adverse events was 1.3% (51 out of 3,862) and 0.6% (22 out of 3,852) in patients receiving zoledronic acid 5 mg and placebo, respectively. The imbalance observed in this trial has not been observed in other trials with zoledronic acid, including those with Zoledronic acid 4 mg administered every 3-4 weeks in oncology patients. The mechanism behind the increased incidence of atrial fibrillation in this single clinical trial is unknown.

### **Hepatic/Biliary/Pancreatic**

#### **Hepatic Impairment**

As only limited clinical data are available for patients with hepatic impairment, dosage recommendations cannot be given for this group.

### **Ophthalmologic**

Ocular disturbances (conjunctivitis, uveitis, episcleritis, scleritis and orbital inflammation) have been reported with Zoledronic acid therapy. Patients with ocular events other than uncomplicated conjunctivitis should be referred to an ophthalmologist for evaluation. Treatment may need to be discontinued.

## **Peri-Operative Considerations**

Patients treated with TARO-ZOLEDRONIC ACID CONCENTRATE should avoid invasive dental procedures if possible. Biopsies are not recommended unless metastasis to the jaw is suspected. For patients who develop ONJ while on bisphosphonate therapy, dental surgery may exacerbate the condition. For patients requiring dental procedures, there is no data available to suggest whether discontinuation of bisphosphonate treatment reduces the risk of ONJ. Clinical judgment of the treating physician should guide the management plan of each patient based on individual benefit/risk assessment.

(See also **WARNINGS AND PRECAUTIONS, General, Osteonecrosis of the Jaw**)

## **Renal**

Assessment of renal function is recommended in all patients prior to the administration of each dose and during therapy with TARO-ZOLEDRONIC ACID CONCENTRATE.

### **Deterioration in Renal Function**

**DUE TO THE RISK OF CLINICALLY SIGNIFICANT DETERIORATION IN RENAL FUNCTION, WHICH MAY PROGRESS TO RENAL FAILURE, SINGLE DOSES OF TARO-ZOLEDRONIC ACID CONCENTRATE SHOULD NOT EXCEED 4 MG AND THE DURATION OF THE INFUSION SHOULD BE NO LESS THAN 15 MINUTES.**

(See also **DOSAGE AND ADMINISTRATION**)

Bisphosphonates, including zoledronic acid, have been associated with reports of renal function deterioration. **Factors that may increase the potential for deterioration in renal function include dehydration, pre-existing renal impairment, multiple cycles of zoledronic acid or other bisphosphonates or using a shorter infusion time than currently recommended (the 4-mg dose is given as a single-dose intravenous infusion over not less than 15 minutes in not less than 100 mL diluent). Concomitant use of potentially nephrotoxic drugs (i.e. ASA, NSAIDS, diuretics, ACE inhibitors etc.) may also increase the potential for renal function deterioration. Renal function should be monitored appropriately during therapy with TARO-ZOLEDRONIC ACID CONCENTRATE.** Renal deterioration, progression to renal failure (some with fatal outcome) and dialysis have been reported very rarely in cancer patients (e.g., those with hypercalcaemia of malignancy and/or pre-existing renal disease) after the initial dose or a single dose of zoledronic acid. Increases in serum creatinine may occur in some patients with chronic administration of TARO-ZOLEDRONIC ACID CONCENTRATE at recommended doses. Patients with evidence of deterioration in renal function should be appropriately evaluated with consideration given as to whether the potential benefit of continued treatment with TARO-ZOLEDRONIC ACID CONCENTRATE outweighs the possible risk.

**TARO-ZOLEDRONIC ACID CONCENTRATE should be used with extreme caution in conjunction with other antineoplastic agents that are either known to produce renal impairment (it is advised that renal function be monitored); or where the dose depends upon renal function (for example platinum-containing agents).**



## **Respiratory**

### **Patients with Asthma**

While not observed in clinical trials with zoledronic acid, administration of other bisphosphonates has been associated with bronchoconstriction in acetylsalicylic acid (ASA)-sensitive asthmatic patients. TARO-ZOLEDRONIC ACID CONCENTRATE should be used with caution in patients with aspirin-sensitive asthma.

## **Special Populations**

### **Renal Impairment:**

Zoledronic acid is excreted exclusively via the kidney and the risk of adverse reactions may be greater in patients with impaired renal function. **The use of TARO-ZOLEDRONIC ACID CONCENTRATE is not recommended in patients with severe renal impairment** due to the potential impact of bisphosphonates, including TARO-ZOLEDRONIC ACID CONCENTRATE, on renal function and the lack of extensive clinical safety data in these patients. Patients with severe renal impairment were excluded from clinical trials defined as (serum creatinine > 400 µmol/L or > 4.5 mg/dL in patients with tumour-induced hypercalcaemia and serum creatinine > 265 µmol/L or > 3.0 mg/dL in patients with bone metastases of solid tumours and osteolytic lesions of multiple myeloma) and from limited pharmacokinetic studies (defined as creatinine clearance [CrCl] < 30 mL/min) zoledronic acid.

Close monitoring of renal function is necessary in patients who are receiving concomitant drugs with nephrotoxic potential.

Patients should have their serum creatinine levels assessed prior to each dose of TARO-ZOLEDRONIC ACID CONCENTRATE.

Upon initiation of treatment in patients with bone metastases of solid tumours and osteolytic lesions of multiple myeloma, with mild-to-moderate renal impairment, lower doses of TARO-ZOLEDRONIC ACID CONCENTRATE are recommended. In patients who show evidence of renal deterioration during treatment, appropriate evaluation should be carried out and consideration should be given as to whether the potential benefit outweighs the possible risk. If TARO-ZOLEDRONIC ACID CONCENTRATE treatment is to be continued in these patients, TARO-ZOLEDRONIC ACID CONCENTRATE should only be resumed when serum creatinine returns to within 10% of baseline (see **DOSAGE AND ADMINISTRATION**).

### **Pregnant Women:**

TARO-ZOLEDRONIC ACID CONCENTRATE should not be administered during pregnancy (see **CONTRAINDICATIONS**). There is no clinical evidence to support the use of TARO-ZOLEDRONIC ACID CONCENTRATE in pregnant women, and animal studies suggest TARO-ZOLEDRONIC ACID CONCENTRATE may cause foetal harm when administered to a pregnant woman.

In animal reproduction studies zoledronic acid was administered subcutaneously to rats and rabbits. Teratogenicity manifested by external, visceral and skeletal malformations was observed in the rat at doses  $\geq 0.2$  mg/kg. There was also evidence of maternal toxicity at  $\geq 0.2$  mg/kg as well as foetal toxicity at 0.4 mg/kg. In the rabbit, maternal toxicity was marked at  $\geq 0.1$  mg/kg due to decreased serum calcium. Bisphosphonates readily cross the placental barrier and are taken up into the developing foetal skeleton; thus, the teratogenicity observed in the rat was attributed to the compound's potency in lowering serum calcium and binding to foetal bone.

### **Nursing Women:**

TARO-ZOLEDRONIC ACID CONCENTRATE should not be administered to breast-feeding women (see **CONTRAINDICATIONS**). There is no clinical experience with zoledronic acid in lactating women and it is not known whether zoledronic acid passes into breast milk. A study in lactating rats has shown that another bisphosphonate AREDIA\*. (pamidronate) passes into the milk. Mothers treated with TARO-ZOLEDRONIC ACID CONCENTRATE should therefore not breast feed their infants.

### **Paediatrics (<18 years of age):**

The safety and efficacy of zoledronic acid in children have not been established. Until further experience is gained, TARO-ZOLEDRONIC ACID CONCENTRATE can only be recommended for use in adult patients.

### **Geriatrics (> 65 years of age):**

Controlled clinical studies of zoledronic acid in TIH do not provide a sufficient number of geriatric subjects to determine whether patients 65 years and older respond differently. The median age in the two controlled clinical trials in patients with tumour-induced hypercalcaemia was 61 years old (range: 21-87 years old).

Controlled clinical studies of zoledronic acid in the treatment of bone metastases of solid tumours and osteolytic lesions of multiple myeloma in patients over age 65 revealed similar efficacy and safety compared to younger patients. The proportion of patients experiencing SREs is lower in the zoledronic acid treatment group when compared to placebo and similar to AREDIA\* (pamidronate) 90 mg. Older patients generally had adverse events similar to those of the overall population. However, because of the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy in elderly patients, TARO-ZOLEDRONIC ACID CONCENTRATE should be administered with caution in this patient population.

### **Race:**

Japanese female subjects had substantially higher systemic exposure, i.e., 47% higher AUC<sub>0-24h</sub> and 39% higher C<sub>max</sub> than the North American population (see **ACTION AND CLINICAL PHARMACOLOGY, Special Populations and Conditions, Race**).

## **Monitoring and Laboratory Tests**

Serum electrolytes, creatinine, phosphate, magnesium and calcium, and CBC with differential must be closely monitored in all patients treated with TARO-ZOLEDRONIC ACID CONCENTRATE. Renal function should be assessed prior to the administration of each dose and should be monitored appropriately during therapy with TARO-ZOLEDRONIC ACID CONCENTRATE (see **WARNINGS AND PRECAUTIONS, Renal**). Serum albumin-corrected calcium should be measured prior to each dose and should be monitored during therapy with TARO-ZOLEDRONIC ACID CONCENTRATE (see **CONTRAINDICATIONS** and **WARNINGS AND PRECAUTIONS, Hypocalcaemia**).

Patients with anaemia, leukopenia or thrombocytopenia should have regular haematology assessments

In tumour-induced hypercalcaemia, either ionized calcium or total serum calcium corrected (adjusted) for albumin should be monitored during treatment with TARO-ZOLEDRONIC ACID CONCENTRATE. Serum calcium levels in patients who have hypercalcaemia of malignancy may not reflect the severity of hypercalcaemia, since hypoalbuminaemia is commonly present. Corrected serum calcium values should be calculated using established algorithms, such as: Albumin-corrected serum calcium (CSC, mmol/L) = tCa + 0.02 (mid-range albumin-measured albumin).

## **ADVERSE REACTIONS**

### **Adverse Drug Reaction Overview**

The most serious adverse drug reactions reported in patients receiving zoledronic acid are: anaphylactic reaction, ocular adverse events, osteonecrosis of the jaw, atypical femoral fracture, atrial fibrillation, renal function deterioration, acute phase reaction and hypocalcaemia.

Adverse reactions to zoledronic acid are usually mild and transient and similar to those reported for other bisphosphonates. Intravenous administration has been most commonly associated with fever. Within three days after zoledronic acid administration, an acute phase reaction has commonly been reported, with symptoms including pyrexia, fatigue, bone pain and/or arthralgias, myalgias, chills and influenza-like illness, arthritis and joint swelling; these symptoms usually resolve within a few days.

Gastrointestinal reactions such as nausea and vomiting have been commonly reported following intravenous infusion of zoledronic acid. Local reactions at the infusion site, such as redness or swelling and/or pain, were observed infrequently.

Rash or pruritis and chest pain have been uncommonly reported following treatment with zoledronic acid.

As with other bisphosphonates, isolated cases of hypomagnesaemia have been reported. Isolated

cases of uveitis, episcleritis and cases of conjunctivitis have also been commonly reported.

### **Clinical Trial Adverse Drug Reactions**

#### **Tumour-Induced Hypercalcaemia Clinical Trials**

Patients with tumour-induced hypercalcaemia may have numerous confounding medical conditions that make causality of adverse events difficult to assess due to the prevalence and wide variety of symptoms related to the underlying disease, its progression, and the side effects of cytotoxic chemotherapy.

In patients treated with zoledronic acid, serum calcium may fall to asymptomatic hypocalcaemic levels. This frequently leads to a reduction in renal calcium excretion which is accompanied by a fall in serum phosphate levels that does not require treatment.

Grade 3 [Common Toxicity Criteria (CTC)] serum creatinine was seen in 2.3% and 3.0% of patients receiving zoledronic acid 4mg and AREDIA\* (pamidronate) 90 mg, respectively in the clinical trials in tumour-induced hypercalcaemia. Grade 4 (CTC) serum creatinine was seen in 0% and 1.0% in patients receiving zoledronic acid 4 mg and AREDIA\* (pamidronate) 90 mg respectively.

Table 1 lists the adverse events considered to be treatment-related in the tumour-induced hypercalcaemia trials.

**Table 1 - Treatment-Related Adverse Events Reported in  
Tumour-Induced Hypercalcaemia Clinical Trials**

	<b>Zoledronic acid 4 mg % (N= 86)</b>	<b>AREDIA* 90 mg % (N=103)</b>
Fever	7.0	9.7
Hypocalcaemia	5.8	1.9
Hypophosphataemia	3.5	1.0
Nausea	1.2	1.0
Pruritus	1.2	0
Skeletal pain	1.2	1.0
Hypomagnesaemia	1.2	0
Taste perversion	1.2	0
Thirst	1.2	0
Pancytopenia	1.2	0
Arthralgia	1.2	0
Bradycardia	1.2	0
Confusion	1.2	0
Fatigue	1.2	0
Hallucination	1.2	0
Vomiting	1.2	0
Chest pain	1.2	0

## Bone Metastases of Solid Tumours and Osteolytic Lesions of Multiple Myeloma Clinical Trials

The adverse event data pertaining to bone metastases of solid tumours and osteolytic lesions of multiple myeloma are based upon the core and extension phases of the three pivotal controlled trials in this indication (see **DETAILED PHARMACOLOGY** and **CLINICAL STUDIES**). These trials included 2042 safety evaluable patients treated with either zoledronic acid 4 mg, AREDIA\* 90 mg or placebo. Of these 2042 patients who entered the core phase of the trials: 969 completed the core phase, 619 entered the safety extension phase, and 347 completed the extension phase. The median duration of exposure to zoledronic acid 4 mg (core plus extension phases) was 10.5 months for patients with prostate cancer, 12.8 months for patients with breast cancer and multiple myeloma, and 4.0 months for patients with lung cancer and other solid tumours. The mean duration of exposure to zoledronic acid 4 mg (core plus extension phases) was 11.8 months for patients with prostate cancer, 13.9 months for patients with breast cancer and multiple myeloma, and 5.7 months for patients with lung cancer and other solid tumours (see **CLINICAL STUDIES**).

In general, zoledronic acid was well tolerated across all studies for various tumour types in patients with bone metastases and in patients with multiple myeloma. The proportion of patients experiencing Grade 3 and Grade 4 laboratory abnormalities and adverse events were similar in patients treated with zoledronic acid and AREDIA\* (pamidronate).

Grade 3 [Common Toxicity Criteria (CTC)] serum creatinine was seen in 1.3%, 1.5% and 1.7% of patients receiving zoledronic acid 4mg, AREDIA\* 90 mg and placebo, respectively. Grade 4 (CTC) serum creatinine was in 0.4%, 0.4% and 0% of patients receiving zoledronic acid 4 mg, AREDIA\* 90 mg and placebo, respectively.

The most commonly reported (>15%) adverse events occurred with similar frequencies in the zoledronic acid, AREDIA\* and placebo treatment groups, and most of these events may have been related to the underlying disease state or cancer therapy. Table 2 lists the events which occurred in ≥15% of patients regardless of study drug relationship by preferred term and treatment group, in the bone metastases trials.

**Table 2 - Commonly Reported Events in Three Bone Metastases Clinical Trials**

	<b>Zoledronic acid 4mg n (%)</b>	<b>AREDIA* 90 mg n (%)</b>	<b>Placebo n (%)</b>
<b>Patients studied</b>			
Total no. of patients studied	1031 (100)	556 (100)	455 (100)
Total no. of patients with an AE	1015 (98.4)	548 (98.6)	445 (97.8)
<b>Adverse events (preferred term)</b>			
Bone pain	55.2%	56.8%	62.4%
Nausea	46.2%	47.8%	37.6%
Fatigue	38.6%	43.2%	28.6%
Anaemia	33.4%	31.5%	28.1%

Vomiting	32.3%	32.9%	26.8%
Pyrexia	31.8%	30.9%	19.6%
Constipation	31.0%	29.1%	38.2%
Dyspnoea NOS	27.4%	27.9%	23.5%
Weakness	24.4%	19.4%	25.1%
Diarrhoea NOS	24.2%	29.1%	18.2%
Myalgia	23.2%	25.7%	16.3%
Anorexia	22.4%	14.6%	23.1%
Cough	21.7%	23.2%	14.3%
Arthralgia	21.0%	23.6%	16.0%
Oedema lower limb	20.9%	22.7%	18.5%
Malignant neoplasm aggravated	19.9%	17.4%	19.6%
Headache NOS	18.5%	26.8%	11.0%
Dizziness (excl. vertigo)	17.5%	16.4%	12.7%
Insomnia NEC	16.1%	20.0%	16.0%
Weight decreased	15.9%	9.0%	13.4%
Back pain	15.1%	19.1%	8.8%
Paresthesia NEC	14.5%	15.3%	7.7%
Depression NEC	14.2%	17.1%	10.8%
Pain in limb	13.9%	15.1%	11.4%

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NOS: Not otherwise specified NEC: Not elsewhere classified

The adverse events occurring during the studies were generally of a type and frequency expected in patients with cancer and bone metastases, many of whom were undergoing antineoplastic therapy. Except for pyrexia, the absolute difference in the proportions of patients in the zoledronic acid 4 mg group compared with the placebo group for any of the common adverse events did not exceed 10%. Pyrexia, or fever, may occur as part of an acute phase reaction with bisphosphonate administration.

Among less commonly occurring adverse events (< 15% of patients in any group), hypocalcaemia was reported in 4.7%, 2.5%, and 0.7% of patients in the zoledronic acid 4 mg, AREDIA\*, and placebo groups, respectively. Hypokalaemia was reported in 9.7%, 9.0%, and 4.8% of patients in the zoledronic acid 4 mg, AREDIA\*, and placebo groups, respectively. Arthritis was reported in 2.42%, 4.32% and 3.08% of patients and joint swelling was reported in 1.55%, 2.88% and 1.32% of patients in the zoledronic acid, 4 mg, AREDIA\* and placebo groups, respectively.

### Hypotension

Based on the clinical trial experience, the frequency of non serious hypotensive events is uncommon (between 0.1% and 1.0%).

### Deterioration in Renal Function

In a pooled analysis of the laboratory data from the three registration trials of zoledronic acid for the treatment of multiple myeloma and bone metastases from breast, prostate, lung and other solid tumours, renal deterioration was defined as an increase of 44.2 µmol/L (0.5 mg/dL) for patients with normal baseline creatinine (< 123.76 µmol/L or < 1.4 mg/dL) or an increase of 88.4 µmol/L (1.0 mg/dL) for patients with an abnormal baseline creatinine (≥123.76 µmol/L or ≥1.4 mg/dL). The following are data on the incidence of renal deterioration in patients receiving zoledronic acid 4 mg over 15 minutes in these trials (see Table 3).

**Table 3 - Percentage of Patients with Renal Function Deterioration Who Were Randomized Following the 15-Minute Infusion Amendment**

<b>Patient Population/Baseline Creatinine</b>				
<b>Multiple Myeloma and Breast Cancer</b>	<b>Zoledronic acid 4 mg</b>		<b>AREDIA* 90 mg</b>	
	n/N	(%)	n/N	(%)
Normal	27/246	(11.0%)	23/246	(9.3%)
Abnormal	2/26	(7.7%)	2/22	(9.1%)
Total	29/272	(10.7%)	25/268	(9.3%)
<b>Solid Tumours</b>	<b>Zoledronic acid 4 mg</b>		<b>Placebo</b>	
	n/N	(%)	n/N	(%)
Normal	17/154	(11%)	10/143	(7%)
Abnormal	1/11	(9.1%)	1/20	(5%)
Total	18/165	(10.9%)	11/163	(6.7%)
<b>Prostate Cancer</b>	<b>Zoledronic acid 4 mg</b>		<b>Placebo</b>	
	n/N	(%)	n/N	(%)
Normal	12/82	(14.6%)	8/68	(11.8%)
Abnormal	4/10	(40%)	2/10	(20%)
Total	16/92	(17.4%)	10/78	(12.8%)

The risk of deterioration in renal function appeared to be related to time on study, whether patients were receiving zoledronic acid (4 mg over 15 minutes), placebo, or AREDIA\*.

In a pooled analysis of safety data from the three registration trials of zoledronic acid for the treatment of multiple myeloma and bone metastases from breast, prostate, lung and other solid tumours, the frequency of renal function adverse events (adverse reactions) suspected to be related to zoledronic acid was as follows: multiple myeloma (3.2%), prostate cancer (3.1%), breast cancer (4.3%), lung and other solid tumours (3.2%).

The frequency distribution of chemotherapy-associated adverse events by chemotherapy, renal involvement and treatment group for patients in the primary safety population is provided in Table 4. This includes patients who were administered at least one chemotherapeutic agent during the study (i.e. patients treated with only hormonal agents are not included). Each chemotherapeutic agent is classified in one of the three categories: renally excreted, nephrotoxic, or no renal involvement (see Tables 4-1 and 4-2). For a chemotherapy that is both renally

excreted and nephrotoxic, the agent is classified as nephrotoxic.

Patients receiving renally excreted drugs that were not nephrotoxic had a similar incidence of nausea for the zoledronic acid and placebo treatment groups when compared to the nephrotoxic agents. Nausea was higher for the AREDIA\* treatment group for the nephrotoxic agents when compared to the agents that were not nephrotoxic and renally excreted. Vomiting, stomatitis and anorexia were similar for all of the treatment groups whether or not the agent was renally excreted or nephrotoxic. Alopecia was higher in all groups treated with nephrotoxic drugs when compared to renally excreted drugs.

**Table 4 -Frequency distribution of chemotoxicities (>1%) by renal involvement and treatment group for patients who were treated with at least one chemotherapy agent (Safety evaluable patients)**

Renal involvement †	Zoledronic acid 4 mg	AREDIA* 90 mg	Placebo
<b>Renally excreted</b>	221	163	76
Number of patients	161 (72.9%)	100 (61.3%)	54 (71.1%)
Total with chemotoxicity	113 (51.1%)	68 (41.7%)	37 (48.7%)
Nausea	75 (33.9%)	48 (29.4%)	23 (30.3%)
Vomiting NOS <sup>1</sup>	55 (24.9%)	23 (14.1%)	28 (36.8%)
Anorexia	39 (17.6%)	16 (9.8%)	7 (9.2%)
Appetite decreased NOS	25 (11.3%)	21 (12.9%)	6 (7.9%)
Stomatitis	24 (10.9%)	18 (11.0%)	9 (11.8%)
Alopecia	6 (2.7%)	3 (1.8%)	5 (6.6%)
Malaise	4 (1.8%)	1 (0.6%)	3 (3.9%)
Cachexia	3 (1.4%)	3 (1.8%)	0 (0.0%)
Gingivitis	3 (1.4%)	2 (1.2%)	0 (0.0%)
Mouth ulceration	0 (0.0%)	0 (0.0%)	1 (1.3%)
Gingival disorder NOS	0 (0.0%)	2 (1.2%)	0 (0.0%)
Malnutrition NOS	0 (0.0%)	0 (0.0%)	1 (1.3%)
Pallor			
<b>Nephrotoxic</b>	471	248	164
Number of patients	345 (73.2%)	191 (77.0%)	116 (70.7%)
Total with chemotoxicity	249 (52.9%)	136 (54.8%)	73 (44.5%)
Nausea	194 (41.2%)	99 (39.9%)	58 (35.4%)
Vomiting NOS	117 (24.8%)	46 (18.5%)	48 (29.3%)
Anorexia	93 (19.7%)	54 (21.8%)	24 (14.6%)
Alopecia	63 (13.4%)	23 (9.3%)	17 (10.4%)
Appetite decreased NOS	59 (12.5%)	36 (14.5%)	7 (4.3%)
Stomatitis	18 (3.8%)	10 (4.0%)	8 (4.9%)
Malaise	13 (2.8%)	5 (2.0%)	1 (0.6%)
Mouth ulceration	6 (1.3%)	2 (0.8%)	1 (0.6%)
Malnutrition NOS	6 (1.3%)	2 (0.8%)	2 (1.2%)
Pallor	5 (1.1%)	2 (0.8%)	0 (0.0%)
Gingivitis	3 (0.6%)	0 (0.0%)	4 (2.4%)
Cachexia			
<b>No renal involvement</b>	0	1	0
Number of patients	0 (0%)	1 (100%)	0 (0%)
Total with chemotoxicity			



Nausea	0 (0%)	1 (100%)	0 (0%)
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<sup>1</sup> NOS: Not otherwise specified.

† Each chemotherapeutic agent is classified in one of the three categories: renally excreted, nephrotoxic, or no renal involvement (See Tables 4-1 and 4-2)

**Table 4-1 - Listing of chemotherapy agents by renal involvement †**

Renal toxic	
Preferred term	Preferred term
Adriamycin + Cyclophosphamide	Methotrexate
Adriamycin + Vincristine + MTX	Methotrexate sodium
Aldesleukin	Mitomycin
BCG Vaccine	Oxaliplatin
Carboplatin	Paclitaxel
Cisplatin	Raltitrexed
Cyclophosphamide	Streptozocin
Cyclophosphamide + 5-FU + Methotrexate	Strontium-89
Cyclophosphamide + 5-FU + Prednisolone	Taxol + Carboplatin
Cyclophosphamide + Doxorubicin + 5-FU	Tegafur
Cyclophosphamide + Epirubicin	Tegafur Uracil
Dacarbazine	Teniposide
Etanercept	Thalidomide
Gallium Nitrate	Thiotepa
Gemcitabine	Topotecan Hydrochloride
Gemcitabine Hydrochloride	Trastuzumab
Hydroxycarbamide	Carboplatin + Etoposide
Ifosfamide	CMF + Dexamethasone
Interferon	CMF + Tamoxifen
Interferon Alfa	FAC + Tamoxifen Citrate
Interferon Beta	Topotecan
Interferon Gamma	EVCMF
Interferon NOS <sup>1</sup>	(Epirubicine+Vincri.+Cycloph.+MTX+5FU)
Interleukin-2	
M – VAC	

<sup>1</sup> NOS: Not otherwise specified.

†David S. Fischer, M.Tish Knobf, Henry J. Durivage. The Cancer Chemotherapy Handbook, 5<sup>th</sup> edition. 1997.

**Table 4-2 - Listing of chemotherapy agents by renal involvement†****Renally excreted**

<b>Preferred term</b>	<b>Preferred term</b>
5-FU + Calciumfolinat	Floxuridine
Adriamycin + 5-FU	Fluorouracil
Betamethasone	Formestane
Betamethasone Sodium Phosphate	Irinotecan
Bleomycin	Irinotecan Hydrochloride
Bleomycin Sulfate	Lomustine
Busulfan	Melphalan
Capecitabine	Melphalan + Prednisolone
Carmustine	Mitoxantrone
Cytarabine	Mitoxantrone Hydrochloride
Daunorubicin	Tropisetron Hydrochloride
Dexrazoxane Hydrochloride	Vinblastine
Docetaxel	Vinblastine Sulfate
Doxorubicin	Vincristine
Doxorubicin Hydrochloride	Vincristine Sulfate
Epirubicin	Vindesine
Epirubicin Hydrochloride	Vinorelbine
Etoposide	Vinorelbine Bitartrate
Exemestane	Vinorelbine Ditartrate
	Pirarubicin

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†David S. Fischer, M.Tish Knobf, Henry J. Durivage. The Cancer Chemotherapy Handbook, 5<sup>th</sup> edition. 1997.

**Bone metastases from breast cancer: Placebo-controlled trial in Japanese Patients**

In a placebo-controlled clinical study in breast cancer patients with bone metastases, 227 patients were evaluated for safety (114 Zoledronic acid and 113 Placebo) (see **CLINICAL TRIALS**). Table 5 below illustrates AEs that occurred more frequently in the Zoledronic acid arm compared to placebo. The adverse events occurring during the study were generally of a type and frequency expected in patients with cancer and bone metastases, many of whom were undergoing concurrent antineoplastic therapy.

**Table 5 - Most Commonly Reported AEs (incidence >10 %) occurring more frequently in the Zoledronic acid arm compared to Placebo**

	<b>Zoledronic acid 4 mg (n=114)</b>	<b>Placebo (n=113)</b>
	<b>n (%)</b>	<b>n (%)</b>
Pyrexia	63 (55.3)	37 (32.7)
Malaise	51 (44.7)	36 (31.9)
Headache NOS	34 (29.8)	32 (28.3)
Hypoaesthesia	28 (24.6)	22 (19.5)
Arthralgia	24 (21.1)	18 (15.9)
Dyspnoea NOS	21 (18.4)	15 (13.3)
Epigastric pain	19 (16.7)	8 (7.1)
Leukopenia NOS	17(14.9)	16(14.2)
Myalgia	15 (13.2)	13 (11.5)
Pruritus NOS	13 (11.4)	12 (10.6)
Oedema lower limb	13 (11.4)	4 (3.5)
Anaemia NOS	12 (10.5)	7 (6.2)
Pain NOS	12 (10.5)	11 (9.7)

Shows no. of subjects experiencing at least 1 AE in category in question

### **Post-Market Adverse Drug Reactions**

Cases of ONJ are uncommon. However, a large retrospective study of the frequency and risk factors for ONJ in cancer patients receiving intravenous bisphosphonates (Hoff, A. et al., 2008) indicated a higher proportion of reported cases in certain cancers, such as advanced breast cancer (1.2%) and multiple myeloma (2.4%), compared to the overall study population (0.72%). The majority of reported cases of ONJ are associated with invasive dental procedures (such as tooth extraction or dental surgery and local trauma including poorly fitting dentures) or periodontal disease (see **WARNINGS AND PRECAUTIONS, Osteonecrosis of the Jaw**). Many patients reporting ONJ had signs of local infection including osteomyelitis.

Cases of anaphylactic reactions/shock, atrial fibrillation, hypotension leading to syncope or circulatory collapse (primarily in patients with underlying risk factors), somnolence, uveitis, episcleritis, scleritis and orbital inflammation as well as hypersensitivity reactions including cases of severe allergic reactions, bronchospasm, interstitial lung disease (ILD) and urticaria, severe and occasionally incapacitating bone, joint, and/or muscle pain, atypical subtrochanteric and diaphyseal femoral fractures have also been reported. There were reports that had ocular events, bone, joint, and/or muscle pain, and ILD with a bisphosphonate, including zoledronic acid, and had a re-occurrence when re-challenged.

Post marketing events of arthritis and joint swelling, likely occurring as part of an acute phase reaction, have been reported with zoledronic acid administration.

In clinical trials and from post-market surveillance, hypocalcaemia has been reported in patients treated with zoledronic acid. QTc prolongation and neurologic adverse events (including seizures, numbness and tetany) have been reported secondary to cases of severe hypocalcaemia. In addition, cardiac arrhythmias have been reported with cases of severe hypocalcaemia. Cases of severe hypocalcaemia requiring hospitalisation have been reported. In some instances, the hypocalcaemia was life-threatening. Time from the first injection of zoledronic acid to the initial hypocalcaemia-related neurologic or cardiac adverse events ranged from 1 day to several months.

Evidence supports a causal relationship between hypocalcaemia and zoledronic acid therapy based on temporal relationship and the secondary QTc prolongation and neurological events as sequelae of the hypocalcaemia.

Spontaneously reported adverse drug reactions are presented above. Because these events are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or clearly establish a causal relationship to zoledronic acid exposure.

## **DRUG INTERACTIONS**

Zoledronic acid is not systemically metabolized and does not affect human cytochrome P450 enzymes *in vitro*. Zoledronic acid is not highly bound to plasma proteins (approximately 55%) and therefore, interactions resulting from displacement of highly protein-bound drugs are unlikely.

### **Drug-Drug Interactions**

Co-administration of thalidomide (100 mg once daily for 14 days and then 200 mg thereafter) with Zoledronic acid for injection (4 mg given as a 15-minute infusion) in a Phase III study did not significantly change the pharmacokinetics of Zoledronic acid or creatinine clearance in patients with multiple myeloma.

Although not clearly established, a potential drug interaction with zoledronic acid therapy was identified with concomitant use of anti-angiogenic drugs in reported cases of ONJ. Some retrospective analyses suggest that the risk of ONJ may be increased in patients treated with bisphosphonates and anti-angiogenic drugs concomitantly.

## **DOSAGE AND ADMINISTRATION**

### **Dosing Considerations**

Renal function should be assessed in all patients prior to the administration of each dose of TARO-ZOLEDRONIC ACID CONCENTRATE (Zoledronic acid for Injection). Patients with mild to moderate renal impairment require a reduction in dose (see **DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment**). TARO-ZOLEDRONIC ACID CONCENTRATE is not recommended in patients with severe renal impairment (see **WARNINGS AND PRECAUTIONS**).

Serum calcium should be measured prior to each dose of TARO-ZOLEDRONIC ACID CONCENTRATE. TARO-ZOLEDRONIC ACID CONCENTRATE is contraindicated in patients who have non-corrected hypocalcaemia at the time of infusion (see **CONTRAINDICATIONS**).

Patients must be maintained in a well hydrated state prior to and following administration of TARO-ZOLEDRONIC ACID CONCENTRATE.

### **Renal Impairment**

TARO-ZOLEDRONIC ACID CONCENTRATE is excreted exclusively via the kidney and the risk of adverse reactions may be greater in patients with impaired renal function.

Zoledronic acid has not been tested in patients with severe renal impairment (defined in clinical trials as serum creatinine > 400 µmol/L or > 4.5 mg/dL in patients with tumour-induced hypercalcaemia; and serum creatinine > 265 µmol/L or > 3.0 mg/dL in patients with bone metastases of solid tumours and osteolytic lesions of multiple myeloma (defined in pharmacokinetic studies as baseline creatinine clearance <30mL/min). Therefore, its use is not recommended in this patient population (see **ACTION AND CLINICAL PHARMACOLOGY, Special Populations and Conditions**).

### **Hepatic Impairment**

As only limited clinical data are available for patients with hepatic impairment, dosage recommendations cannot be given for this group.

### **Recommended Dose and Dosage Adjustment**

#### **Tumour-Induced Hypercalcaemia**

The recommended dose of TARO-ZOLEDRONIC ACID CONCENTRATE in hypercalcaemia (albumin-corrected serum calcium  $\geq 3.0$  mmol/L (12 mg/dL)) is 4 mg given as a single-dose intravenous infusion over no less than 15 minutes following standard rehydration procedures.

Albumin-corrected serum calcium (CSC, mmol/L) =  $tCa + 0.02$  (mid-range albumin-measured albumin).

Prior to treatment with TARO-ZOLEDRONIC ACID CONCENTRATE for injection renal excretion of excess calcium should be promoted by restoring and maintaining adequate fluid balance and urine output.

Patients who show complete or partial response initially may be retreated with TARO-ZOLEDRONIC ACID CONCENTRATE if serum calcium does not return to normal or does not remain normal after initial treatment although retreatment with zoledronic acid 4 mg in TIIH patients has not been assessed for efficacy and safety in prospective studies. It is recommended that at least one week must elapse before retreatment to allow for a full response to the initial dose. In addition, retreatment should be given to **only** those patients who can tolerate the

standard rehydration procedures (i.e., 3 to 5 litres of fluids per day and more than 400 meq of sodium chloride per day). In any patient requiring repeated administration, serum BUN and creatinine must be evaluated and possible deterioration in renal function must be assessed prior to each re-administration (see **WARNINGS AND PRECAUTIONS**).

#### ***Dosage Adjustment: Mild to Moderate Renal Impairment***

Dose reduction in patients with tumour-induced hypercalcaemia with mild to moderate renal impairment is not recommended.

#### **Bone Metastases of Solid Tumours and Osteolytic Lesions of Multiple Myeloma**

The recommended dose of TARO-ZOLEDRONIC ACID CONCENTRATE in patients with documented metastatic bone lesions from solid tumours and patients with osteolytic lesions of multiple myeloma for patients with CrCl > 60 mL/min is 4 mg, given as a single dose intravenous infusion over no less than 15 minutes every 3 to 4 weeks. In patients requiring antineoplastic therapy, TARO-ZOLEDRONIC ACID CONCENTRATE should be administered either prior to or after this treatment. Patients will be required to take an oral calcium supplement of 500 mg and a multivitamin containing at least 400 IU of Vitamin D daily. If a patient has a prior history of hypercalcaemia or develops hypercalcaemia during treatment with calcium and Vitamin D supplementation, the patient is advised to discontinue taking calcium and Vitamin D.

Zoledronic acid has been used with cyclophosphamide, doxorubicin, paclitaxel, anastrozole, melphalan and tamoxifen. It has been given less frequently with docetaxel, dexamethasone, prednisone, carboplatin, letrozole, vinorelbine, cisplatin and gemcitabine.

#### ***Dosage Adjustment: Mild to Moderate Renal Impairment***

Zoledronic acid has been used in patients with bone metastases of solid tumours and osteolytic lesions of multiple myeloma with mild to moderate renal impairment in clinical trials; their risk of renal deterioration was increased compared to that of patients with normal renal function. Therefore, if zoledronic acid is to be administered to patients with mild to moderate renal impairment (defined as baseline CrCl 30 mL/min to 60 mL/min), doses should be reduced. The following dosing recommendations are based on data from pharmacokinetic studies however, the efficacy and safety of adjusted dosing has not been prospectively assessed in clinical trials.

Upon treatment initiation, the recommended TARO-ZOLEDRONIC ACID CONCENTRATE doses for patients with reduced renal function (mild and moderate renal impairment) are listed in the following table. These doses are calculated based on pharmacokinetic data in order to achieve the same AUC as that achieved in patients with CrCl of 75 mL/min (see **ACTION AND CLINICAL PHARMACOLOGY - Special Populations and Conditions and Renal Impairment**). Creatinine clearance is calculated using the Cockcroft-Gault formula<sup>†</sup>.

$$^{\dagger} \text{CrCl (mL/min)} = \frac{1.2 [140 - \text{age (years)}] \times [\text{total body weight (kg)}]}{\text{serum creatinine } (\mu\text{mol/L})} \{ \text{multiply by 0.85 for females} \}$$

Baseline Creatinine Clearance (mL/min)	Taro-Zoledronate Conc Recommended Dose <sup>‡</sup>
> 60	4.0 mg
50-60	3.5 mg
40-49	3.3 mg
30-39	3.0 mg

<sup>‡</sup> Doses calculated assuming target AUC of 0.66 (mg.hr/L) (CrCl = 75 mL/min)

During treatment, serum creatinine should be measured before each TARO-ZOLEDRONIC ACID CONCENTRATE dose and treatment should be withheld if renal function has deteriorated. In the clinical studies, renal deterioration was defined as follows:

- For patients with normal baseline creatinine (< 123 µmol/L or < 1.4 mg/dL), an increase of 44 µmol/L or 0.5 mg/dL
- For patients with abnormal baseline creatinine (> 123 µmol/L or >1.4 mg/dL), an increase of 88 µmol/L or 1.0 mg/dL

In the clinical studies, zoledronic acid treatment was resumed only when the creatinine returned to within 10% of the baseline value. Zoledronic acid should be re-initiated at the same dose as that prior to treatment interruption.

Renal function should be monitored appropriately during therapy with TARO-ZOLEDRONIC ACID CONCENTRATE. Patients with evidence of renal function deterioration should be appropriately evaluated and consideration should be given as to whether the potential benefit outweighs the possible risk.

## **Administration**

### **Reconstitution:**

### ***Method of Preparation***

#### ***TARO-ZOLEDRONIC ACID CONCENTRATE***

Vials of TARO-ZOLEDRONIC ACID CONCENTRATE contain overfill allowing for the withdrawal of 5 mL of concentrate (equivalent to 4 mg zoledronic acid for injection). The content of the vials is withdrawn using a sterile syringe. This concentrate should immediately be diluted in 100 mL of sterile 0.9% w/v Sodium Chloride Injection, USP, or 5% w/v Dextrose Injection, USP. Do not store undiluted concentrate in a syringe, to avoid inadvertent injection. Any unused portion of TARO-ZOLEDRONIC ACID CONCENTRATE should be discarded.

**Reduced Doses for Patients with Baseline CrCl ≤ 60 mL/min:** Withdraw an appropriate volume of the 5 mL – TARO-ZOLEDRONIC ACID CONCENTRATE as needed:

- 4.4 mL for 3.5 mg dose
- 4.1 mL for 3.3 mg dose

- 3.8 mL for 3.0 mg dose

The withdrawn concentrate must be diluted in 100 mL of sterile 0.9% w/v Sodium Chloride Injection, USP, or 5% w/v Dextrose Injection, USP. The dose must be given as a single intravenous injection over no less than 15 minutes.

### **Incompatibilities**

**TARO-ZOLEDRONIC ACID CONCENTRATE must not be mixed or come into contact with calcium-or other divalent cation-containing infusion solutions, such as Lactated Ringer's solution, and should be administered as a single intravenous solution in a line separate from all other drugs over no less than 15 minutes.**

Studies with glass bottles, as well as several types of infusion bags and infusion lines made from polyvinylchloride, polyethylene and polypropylene (pre-filled with 0.9 % sodium chloride solution or 5 % glucose solution), showed no incompatibility with zoledronic acid.

### **Stability of Diluted Taro-Zoledronate Conc Solutions**

After aseptic reconstitution and dilution, it is preferable to use the product immediately. If not used immediately after dilution with infusion media, for microbiological integrity, the solution should be stored at 2°C - 8°C. If refrigerated, the solution should be equilibrated to room temperature prior to administration. The total time between dilution, storage at 2°C - 8°C, and end of administration must not exceed 24 hours.

Strict adherence to the intravenous route is recommended for the parenteral administration of TARO-ZOLEDRONIC ACID CONCENTRATE.

***Note: Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.***

Store TARO-ZOLEDRONIC ACID CONCENTRATE at room temperature (15°C – 30°C).

### **OVERDOSAGE**

Clinical experience of acute overdose with zoledronic acid is limited. There have been two patients who received maladministration of 32 mg of Zoledronic acid given over 5 minutes. Neither patient experienced any clinical nor laboratory toxicity. Clinically relevant hypocalcaemia should be corrected by intravenous administration of calcium gluconate.

In an open label study of Zoledronic acid 4 mg in breast cancer patients, a female patient received a single 48 mg dose of zoledronic acid in error. Two days after the overdose the patient experienced a single episode of hyperthermia (38.C), which resolved after treatment. All other evaluations were normal, and the patient was discharged seven days after the overdose.

A patient with Non-Hodgkin's Lymphoma received Zoledronic acid 4 mg daily on four successive days for a total dose of 16 mg. The patient developed paresthesia and abnormal liver



function tests with increased GGT (nearly 100U/L, exact value unknown). The outcome of this case is not known.

Patients who have received doses higher than those recommended should be carefully monitored, since renal function impairment (including renal failure) and serum electrolyte (including calcium, phosphorus and magnesium) abnormalities have been observed.

For management of a suspected drug overdose, contact your regional poison centre.
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## **ACTION AND CLINICAL PHARMACOLOGY**

### **Mechanism of Action**

The principal pharmacologic action of zoledronic acid for injection is inhibition of bone resorption. Although the antiresorptive mechanism is not completely understood, several factors are thought to contribute to this action. Zoledronic acid accumulates in bone, where it blocks the resorption of mineralized bone and cartilage. *In vitro*, zoledronic acid has a very large ratio between the desired inhibition of bone resorption and the adverse effects on bone mineralization. *In vitro*, zoledronic acid inhibits osteoclastic activity and induces apoptosis in osteoclasts, as well as reducing the formation and recruitment of osteoclasts into bone. Zoledronic acid inhibits the osteoclastic hyperactivity and accelerated bone resorption induced by various stimulatory factors released by tumours. In long-term animal studies, doses of zoledronic acid similar to those recommended for the treatment of hypercalcaemia inhibit bone resorption without adversely affecting the formation, mineralization, or mechanical properties of bone.

In addition to inhibiting osteoclastic bone resorption, zoledronic acid exerts direct anti-tumour effects on cultured human myeloma and breast cancer cells, inhibiting their proliferation and inducing apoptosis. Zoledronic acid also inhibits the proliferation of human endothelial cells *in vitro* and is anti-angiogenic in animal tumour models. *In vitro* zoledronic acid reduces the invasion of human breast cancer cells into the extracellular matrix.

Preclinical data suggest that low micromolar concentrations of zoledronic acid are cytostatic and pro-apoptotic *in vitro* to a range of human cancer cell lines (breast, prostate, lung, bladder, myeloma). This anti-tumour efficacy may be enhanced when used in combination with other anti-cancer drugs. Preclinical data suggest that zoledronic acid is also anti-proliferative for human foetal osteoblasts and promotes their differentiation, a property that may be potentially relevant for the treatment of bone metastases in prostate cancer. Zoledronic acid has been shown to inhibit the proliferation of human endothelial cells *in vitro* and is anti-angiogenic *in vivo*. Zoledronic acid at picomolar concentrations has been shown to inhibit tumour cell invasion through extracellular matrix in preclinical cancer models.

### **Pharmacodynamics**

Clinical studies in TIH demonstrated that the effect of Zoledronic acid is characterized by decreases in serum calcium and urinary calcium excretion. Normalization of serum calcium by day 4 was greater for the Zoledronic acid 4 mg and 8 mg doses (45% and 56%, respectively) compared with ARELIA\* (pamidronate) 90 mg (33%).

## **Tumour-Induced Hypercalcaemia**

Osteoclastic hyperactivity resulting in excessive bone resorption is the underlying pathophysiologic derangement in tumour-induced hypercalcaemia (TIH, hypercalcaemia of malignancy) and metastatic bone disease. Excessive release of calcium into the blood as bone is resorbed results in polyuria and gastrointestinal disturbances, with progressive dehydration and decreasing glomerular filtration rate. This results in increased renal resorption of calcium, setting up a cycle of worsening systemic hypercalcaemia. Correction of excessive bone resorption and adequate fluid administration to correct volume deficits are, therefore, essential to the management of hypercalcaemia.

Most cases of hypercalcaemia associated with malignancy occur in patients who have breast cancer, squamous-cell tumours of the lung or head and neck, renal cell carcinoma, and certain hematologic malignancies, such as multiple myeloma and some types of lymphomas. A few less common malignancies, including vasoactive intestinal-peptide-producing tumours and cholangiocarcinoma, have a high incidence of hypercalcaemia as a metabolic complication. Patients who have tumour-induced hypercalcaemia can generally be divided into two groups according to the pathophysiologic mechanism involved.

In humoral hypercalcaemia, osteoclasts are activated and bone resorption is stimulated by factors such as parathyroid-hormone-related protein, which are elaborated by the tumour and circulate systemically. Humoral hypercalcaemia usually occurs in squamous-cell malignancies of the lung or head and neck or in genitourinary tumours such as renal cell carcinoma or ovarian cancer. Skeletal metastases may be absent or minimal in these patients.

Extensive invasion of bone by tumour cells can also result in hypercalcaemia due to local tumour products that stimulate bone resorption by osteoclasts. Tumours commonly associated with locally mediated hypercalcaemia include breast cancer and multiple myeloma.

Total serum calcium levels in patients who have tumour-induced hypercalcaemia may not reflect the severity of hypercalcaemia, since concomitant hypoalbuminaemia is commonly present. Ideally, ionized calcium levels should be used to diagnose and follow hypercalcaemic conditions; however, these are not commonly or rapidly available in many clinical situations. Therefore, adjustment of the total serum calcium value for differences in albumin levels is often used in place of measurement of ionized calcium; several nomograms are in use for this type of calculation (see **DOSAGE AND ADMINISTRATION**).

## **Bone Metastases of Solid Tumours and Osteolytic Lesions of Multiple Myeloma**

Osteolytic bone lesions and metastases commonly occur in patients with multiple myeloma, breast cancer, non-small cell lung cancer, renal cell carcinoma and a variety of other solid tumours. Bone lesions associated with bone metastases from prostate carcinoma classically are osteoblastic in contrast to those from other carcinomas, which are usually osteolytic or mixed osteolytic/osteoblastic. Adenocarcinoma of the prostate spreads most commonly to the well vascularized areas of the skeleton such as the vertebral column, ribs, skull, and the proximal ends

of the long bones. Prostate carcinoma cells have long been believed to gain access to the vertebral column and ribs via the Batson venous plexus, which is a low pressure, high volume plexus of vertebral veins that join the intercostal veins.

These bone changes in patients with evidence of osteolytic and osteoblastic skeletal destruction may cause severe bone pain that requires either radiation therapy or narcotic analgesics (or both) for symptomatic relief. These changes also cause pathologic fractures of bone in both the axial and appendicular skeleton. Axial skeletal fractures of the vertebral bodies may lead to spinal cord compression or vertebral body collapse with significant neurologic complications. Patients may also experience episode(s) of hypercalcaemia.

### **Pharmacokinetics**

**Summary:** Single or multiple (q 28 days) 5-minute or 15-minute infusions of 2, 4, 8 or 16 mg Zoledronic acid were given to 64 cancer patients with bone metastases. The post infusion decline of zoledronic acid concentrations in plasma was consistent with a triphasic process showing a rapid decrease from peak concentrations at end-of-infusion to <1% of C<sub>max</sub> after 24 hours post infusion with population half-lives of  $t_{1/2\alpha}$  0.24 hours and  $t_{1/2\beta}$  1.87 hours for the early disposition phases of the drug, followed by a prolonged period of very low concentrations in plasma between days 2 and 28 post infusion, with a terminal elimination half-life  $t_{1/2\gamma}$  of 146 hours. The area under the plasma concentration versus time curve (AUC<sub>0-24h</sub>) of zoledronic acid was linearly related to dose. The accumulation of zoledronic acid following a 28-day dosing schedule over 3 cycles was low, with mean AUC<sub>0-24h</sub> ratios cycles 2 and 3 versus 1 of  $1.13 \pm 0.30$  and  $1.16 \pm 0.36$ , respectively.

**Distribution:** *In vitro* and *ex vivo* studies showed no affinity of zoledronic acid for the cellular components of human blood and the plasma protein binding was low (with the unbound fraction ranging from 60 to 77%) and slightly dependent on the concentration of zoledronic acid.

**Biotransformation/Metabolism:** Zoledronic acid does not inhibit human P-450 enzymes *in vitro*. Zoledronic acid does not experience biotransformation.

**Excretion:** In animal studies <3% of the administered intravenous dose was found in the faeces, with the balance either recovered in the urine or taken up by bone, indicating that the drug is eliminated intact via the kidney. Following an intravenous dose of 20 nCi <sup>14</sup>C-zoledronic acid in a cancer patient with bone metastases, the radioactivity excreted in the urine consisted solely of intact drug.

In 64 cancer patients with bone metastases on average ( $\pm$  s.d.)  $39 \pm 16\%$  of the administered dose was recovered in the urine within 24 hours, with only trace amounts of drug found in urine post day 2. The cumulative percent of drug excreted in the urine over 0-24 hours was independent of dose. The balance of drug not recovered in urine over 0-24 hours, representing drug presumably bound to bone tissue is slowly released back into the systemic circulation, giving rise to the observed prolonged low plasma concentrations days 2 to 28 post dose. The 0–24 h renal clearance of zoledronic acid was on average ( $\pm$ s.d.)  $3.7 \pm 2.0$  L/h.

**Linearity/Non-linearity:** Zoledronic acid clearance was reasonably independent of dose and demographic variables, with effects of body weight, gender, and race on clearance being within the bounds of the inter-patient variability of clearance, which was 36%.

Increasing the infusion time from 5 minutes to 15 minutes caused a 30% decrease in the zoledronic acid concentration at the end of the infusion, but had no effect on the area under the plasma concentration versus time curve.

### **Special Populations and Conditions**

There are no pharmacokinetic data in patients with hypercalcaemia.

**Paediatrics:** There are no pharmacokinetic data in paediatric patients (see **WARNINGS AND PRECAUTIONS**).

**Geriatrics:** The pharmacokinetics of zoledronic acid were not affected by age in cancer patients with bone metastases aged 38 years to 84 years.

**Race:** The pharmacokinetics of 2 mg, 4 mg and 8 mg zoledronic acid have been evaluated in a Phase I study of Japanese patients with cancer and bone metastasis.

Japanese female subjects had substantially higher systemic exposure, i.e., 47% higher AUC<sub>0-24h</sub> and 39% higher C<sub>max</sub> than the North American population (see the Table below) following a single dose intravenous of zoledronic acid (4 mg over 15 minutes). The exposure of Japanese males were comparable to that of the North American population based on the limited data (n=4 and 1 for AUC and C<sub>max</sub>, respectively).

<b>Comparative PK between Japanese and North American Population (mean ± SD)</b>				
	Japan		North America	
	Female (n=14)	Male (n=4 or 1)	Female (n=16)	Male (n=29)
AUC <sub>0-24h</sub> , ng-h/mL	154 ± 38	118 ± 40	114 ± 22	100 ± 32
C <sub>max</sub> , ng-h/mL	111 ± 22	64	87 ± 20	77 ± 28

**Hepatic Impairment:** There are no pharmacokinetic data in patients with impaired liver function. Zoledronic acid is not cleared by the liver, therefore impaired liver function may not affect the pharmacokinetics of TARO-ZOLEDRONIC ACID CONCENTRATE (Zoledronic acid for Injection).

**Renal Impairment:** Limited pharmacokinetic data are available for zoledronic acid in patients with severe renal impairment (creatinine clearance [CrCl] <30 mL/min). The pharmacokinetic studies were conducted in cancer patients (n=64) typical of the target clinical population, showing renal function mainly in the range of normal to moderately impaired [mean (± s.d.) creatinine clearance 84 ± 29 mL/min, range 22 - 143 mL/min]. In these 64 patients the renal clearance of zoledronic acid was found to closely correlate with creatinine clearance, representing in the mean (± s.d.) 75 ± 33% of the creatinine clearance. Creatinine clearance is calculated by the Cockcroft-Gault formula (see **DOSAGE AND ADMINISTRATION**):

$$\text{CrCl (mL/min)} = \frac{1.2 [140 - \text{age (years)}] \times [\text{total body weight (kg)}] \{\text{multiply by 0.85 for females}\}}{\text{serum creatinine (}\mu\text{mol/L)}}$$

Patients with mild renal impairment (creatinine clearance 50 - 80 mL/min) showed increases in plasma AUC of 26% to 36%, whereas patients with moderate renal impairment (creatinine clearance 30 - 50 mL/min) showed increases in plasma AUC of 27 - 41%, compared to patients with normal renal function (creatinine clearance > 80 mL/min). However, there were no further increases in the systemic exposure after multiple doses in patients with impaired renal function (see **WARNINGS AND PRECAUTIONS**).

The population-derived relationship of zoledronic acid clearance with creatinine clearance offers an algorithm for dose reduction in renal impairment. Zoledronic acid systemic clearance (CL) in individual patients can be calculated from the population clearance of zoledronic acid and that individual's creatinine clearance, as  $\text{CL (L/h)} = 6.5 \times (\text{CrCl}/90)^{0.4}$ . This formula can be used to predict zoledronic acid AUC in patients, where  $\text{CL} = \text{Dose}/\text{AUC}_{0-\infty}$ . The average  $\text{AUC}_{0-24}$  in patients with normal renal function was 0.42 mg•h/L and the calculated  $\text{AUC}_{0-\infty}$  for a patient with creatinine clearance of 75 mL/min was 0.66 mg•h/L following a 4 mg dose of zoledronic acid.

## STORAGE AND STABILITY

Store TARO-ZOLEDRONIC ACID CONCENTRATE (Zoledronic acid for Injection) at room temperature (15°C – 30°C).

After aseptic reconstitution and dilution, it is preferable to use the product immediately. If not used immediately after dilution with infusion media, the solution should be stored at 2°C – 8°C. If refrigerated, the solution should be equilibrated to room temperature prior to administration. The total time between dilution, storage at 2°C – 8°C, and end of administration must not exceed 24 hours. Any unused solution should be discarded. Only clear solution free from particles and discoloration should be used (see **DOSAGE AND ADMINISTRATION, Administration**).

TARO-ZOLEDRONIC ACID CONCENTRATE must be kept out of the reach and sight of children and pets.

## DOSAGE FORMS, COMPOSITION AND PACKAGING

TARO-ZOLEDRONIC ACID CONCENTRATE (Zoledronic acid for Injection) is available as a clear, colourless solution in “siliconized glass vials”, with rubber stoppers and baby blue flip off seals. Each vial of TARO-ZOLEDRONIC ACID CONCENTRATE delivers 4 mg of zoledronic acid corresponding to 4.264 mg zoledronic acid monohydrate.

Available in cartons containing 1 vial.

### Composition:

#### TARO-ZOLEDRONIC ACID CONCENTRATE:

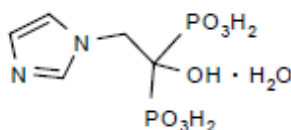
Each 5 mL vial of TARO-ZOLEDRONIC ACID CONCENTRATE contains 4 mg zoledronic acid sterile liquid concentrate. This corresponds to 4.264 mg of zoledronic acid monohydrate. Inactive Ingredients (per vial): 220 mg mannitol, USP, as bulking agent and 24 mg sodium citrate, USP, as buffering agent and water for injection (q.s. to 5 mL).

## PART II: SCIENTIFIC INFORMATION

### PHARMACEUTICAL INFORMATION

#### Drug Substance

Common name:	Zoledronic acid monohydrate
Chemical name:	(1-Hydroxy-2-imidazol-1-yl-phosphonoethyl) phosphonic acid monohydrate
Molecular formula:	$C_5H_{10}N_2O_7P_2 \cdot H_2O$
Molecular mass:	290.11
Structural formula:	



#### Physicochemical properties:

Description:	White to almost white crystalline powder
Solubility:	Highly soluble in 0.1N sodium hydroxide solution, sparingly soluble in water and 0.1N hydrochloric acid, and practically insoluble in organic solvents
pH:	The pH of a 0.7% solution of zoledronic acid in water is approximately 2.0

### CLINICAL TRIALS

#### Tumor-Induced Hypercalcaemia

Two identical multicenter, randomized, double-blind, double-dummy studies of zoledronic acid 4 mg given as a 5-minute infusion or AREDIA\* (pamidronate) 90 mg given as a 2-hour infusion were conducted in patients with tumour-induced hypercalcaemia (TIH). **Note: Administration of zoledronic acid 4 mg given as a 5-minute intravenous infusion has been shown to result in an increased risk of renal toxicity, as measured by increases in serum creatinine, which can progress to renal failure. The incidence of renal toxicity and renal failure has been**

shown to be reduced when zoledronic acid 4 mg is given as a 15-minute intravenous infusion over no less than 15 minutes. (See **WARNINGS AND PRECAUTIONS** and **DOSAGE AND ADMINISTRATION**). TIH was defined as corrected serum calcium (CSC) concentration of  $\geq 12.0$  mg/dL (3.00 mmol/L). The primary efficacy variable was the proportion of patients having a complete response, defined as the lowering of the CSC to  $\leq 10.8$  mg/dL (2.70 mmol/L) within ten days after drug infusion. Each treatment group was considered efficacious if the lower bound of the 95% confidence interval for the proportion of complete responders was  $>70\%$ . This was achieved for the zoledronic acid 4 mg group in each study, but not for the AREDIA\* 90 mg group. To assess the effects of zoledronic acid 4 mg versus those of AREDIA\*, the two multicenter TIH studies were combined in a pre-planned analysis. The results showed that zoledronic acid 4 mg was statistically superior to AREDIA\* 90 mg for the proportion of complete responders at day 7 and day 10. The results also demonstrated a faster normalization of CSC by day 7 for zoledronic acid 4 mg.

The following response rates were observed (Table 6):

**Table 6 - Proportion of Complete Responders by Day in pooled TIH studies**

	<b>Day 4</b>	<b>Day 7</b>	<b>Day 10</b>
Zoledronic acid 4 mg (N=86)	45.3% (p=0.104)	82.6% (p=0.005)	88.4% (p=0.002)
AREDIA* 90 mg (N=99)	33.3%	63.6%	69.7%

P-values vs AREDIA\* 90mg based on Cochran-Mantel Haenszel adjusting for baseline CSC

Secondary efficacy variables, time to relapse and duration of complete response, were also assessed. Time to relapse was defined as the duration (in days) from study infusion until the last CSC value  $\leq 11.6$  mg/dL (2.90 mmol/L). Patients who did not have a complete response were assigned a time to relapse of 0 days. Duration of complete response was defined as the duration (in days) from the occurrence of a complete response until the last CSC  $\leq 10.8$  mg/dL (2.70 mmol/L). The results showed that zoledronic acid 4 mg had a statistically longer time to relapse than AREDIA\*.

**Table 7 - Results for Secondary Efficacy Variables in pooled TIH studies**

	<b>Zoledronic acid 4 mg</b>			<b>AREDIA* 90 mg</b>	
	N	Median (days)	P-value	N	Median (days)
<b>Time to relapse</b>	86	30	0	99	17
<b>Duration of complete response</b>	76	32	NA	69	18

P-values vs. AREDIA\* 90 mg based on Cox regression adjusted for baseline CSC

NA: Duration of complete response was not analyzed in the subset of complete responders

### **Bone Metastases of Solid Tumours and Osteolytic Lesions of Multiple Myeloma**

Three randomized, controlled trials in patients with bone metastases of solid tumours and osteolytic lesions of multiple myeloma were conducted with zoledronic acid. The planned duration of therapy in the core studies were 15 months in the trial in patients with prostate cancer, 13 months in the trial in patients with breast cancer and multiple myeloma, and 9 months in the trial in patients with lung cancer and other solid tumours. In addition, an extension phase was included in each trial in order to primarily determine the safety of long-term exposure to



zoledronic acid. Patients who successfully completed the primary core phase of treatment were given the option to extend treatment for a total of 24 months (prostate cancer), 25 months (breast cancer and multiple myeloma), and 21 months (lung and other solid tumours). In the trials with patients with breast cancer and multiple myeloma, and in patients with lung cancer and other solid tumours, only the core phase was reported for efficacy as a high percentage of patients did not choose to participate in the extension phase.

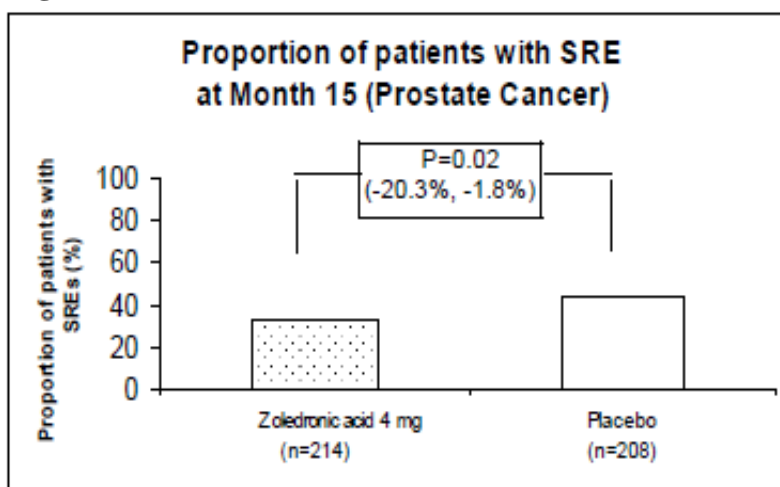
The studies were amended twice because of renal toxicity. The zoledronic acid infusion duration was increased from 5 minutes to 15 minutes. After all patients had been accrued, but while dosing and follow-up continued, patients in the 8-mg zoledronic acid treatment arm were switched to 4 mg. Patients who were randomized to the zoledronic acid 8-mg group are not included in these analyses.

Each study evaluated skeletal-related events (SREs), defined as any of the following: pathologic fracture (vertebral or non-vertebral), radiation therapy to bone (including the use of radioisotopes), surgery to bone or spinal cord compression. A change in antineoplastic therapy due to increased pain was considered as an SRE in the prostate cancer study only. Planned analyses included the proportion of patients with an SRE during the core phase of the study (the primary efficacy endpoint) and main secondary efficacy endpoints including time to the first SRE (i.e. the hazard ratio for the first occurrence of an SRE not taking death into consideration (censoring deaths), and multiple event analysis. Multiple event analysis using the Andersen-Gill approach was performed to evaluate the overall effect of zoledronic acid on the occurrence of skeletal complications. This analysis takes into account all clinically meaningful events experienced by the study patients, and considers the total number of events experienced as well as the time from randomization to each event. However, the assumptions required for this analysis are strong and it is difficult to assess whether the data meet the assumptions. For the multiple event analysis, events that occurred in close proximity were counted as one event.

Radiation therapy to bone and pathological fractures were the most common type of skeletal related events.

### **Bone Metastases due to Prostate Cancer**

In a phase III randomized, double-blind trial, zoledronic acid was compared to placebo for the prevention of Skeletal Related Events (SREs) in prostate cancer patients with bone metastases. A total of 422 patients (214 zoledronic acid 4 mg, 208 placebo) with metastatic bone disease from prostate cancer with a rising serum PSA despite hormonal treatment were randomized to receive either zoledronic acid 4 mg administered over 15 minutes or placebo every 3 weeks. The primary efficacy variable was the proportion of patients having an SRE at 15 months. The proportion of patients experiencing at least one SRE (33% for zoledronic acid 4 mg vs. 44% for placebo,  $p = 0.02$ ) demonstrated statistically significant superiority for zoledronic acid vs. placebo (See Figure 1).

**Figure 1**

Zoledronic acid was superior to placebo for time to first SRE at 15 months (hazard ratio of 0.67, 95% CI: 0.49, 0.91), median of 321 days for placebo vs. median not reached for zoledronic acid 4 mg. Zoledronic acid demonstrated a statistically significant superiority over placebo for time to fracture ( $p=0.01$ ).

In addition, of the 146 (81 zoledronic acid, 65 placebo) patients who completed the core phase of the trial, 132 (74 zoledronic acid, 58 placebo) consented to enter the extension phase and 85 (49 zoledronic acid and 36 placebo) completed it. At 24 months, the zoledronic acid 4 mg group had a significantly lower proportion of patients experiencing at least one SRE (of all patients initially randomized) when compared with placebo (38% for zoledronic acid 4 mg, 49% for placebo,  $p=0.03$ ). No adjustments to the p-values for the two analysis time points were made. The multiple event analysis indicated that prostate cancer patients receiving zoledronic acid 4 mg had a 36% overall reduction in risk (hazard ratio of 0.64, 95% CI: 0.485, 0.84;  $p=0.002$ ) for skeletal complications compared to placebo over the course of the trial. See Table 8 for the results of the main secondary efficacy analyses.

**Table 8 - Results of main secondary efficacy variables (Core + Extension Phase)**  
**Prostate Cancer Patients**

	All SRE		Core + Extension Phase	
	Core Phase		Core + Extension Phase	
	Zoledronic acid 4mg	Placebo	Zoledronic acid 4mg	Placebo
N	214	208	214	208
Time to First SRE Hazard Ratio (95% CI) vs. placebo	0.67 (0.49, 0.91)		0.68 (0.50, 0.91)	
Median Time to SRE <sup>§</sup> (days)	n.r. <sup>§§</sup>	321	488	321
P-Value <sup>†</sup>	0.01		0.01	
Multiple Event Analysis Hazard Ratio (95% CI) vs. placebo	0.64 (0.47, 0.87)		0.64 (0.48, 0.84)	
P-Value <sup>†</sup>	0.004		0.002	

<sup>§</sup> Median Time to first SRE not taking death into consideration (i.e. deaths were censored).

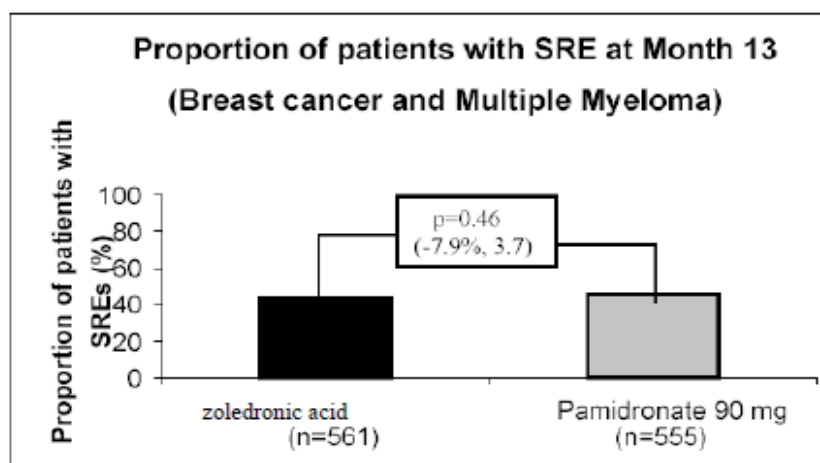
§§ Not reached.

†p-values vs. placebo based on Cox-regression stratified by presence of distant metastases at initial diagnosis or not.

### **Bone Metastases from Breast Cancer and Osteolytic Lesions of Multiple Myeloma**

The second phase III randomized, double-blind trial was designed to demonstrate comparable efficacy of zoledronic acid 4 mg to AREDIA\* 90 mg. A total of 1116 patients (561 Zoledronic acid 4 mg, 555 AREDIA\* 90 mg) with either Durie-Salmon Stage III multiple myeloma or Stage IV breast cancer with at least one bone lesion were treated with zoledronic acid 4 mg via 15-minute intravenous (IV) infusion or AREDIA\* 90 mg via 2-hour IV infusion every 3 to 4 weeks. The primary efficacy endpoint was the proportion of patients experiencing at least one skeletal-related event (SRE) at 13 months. The proportion of patients with an SRE was 44% and 46% for zoledronic acid 4 mg and AREDIA\* 90 mg, respectively (p=0.46) (See Figure 2).

**Figure 2**



Zoledronic acid was demonstrated to be comparable to AREDIA\* in efficacy for the endpoint of the proportion of patients with an SRE in a non-inferiority analysis. There were no significant differences between zoledronic acid and AREDIA\* in time to first SRE.

The multiple event analysis indicated that patients with breast cancer and multiple myeloma receiving zoledronic acid in this trial had an 11.5% overall reduction in risk (hazard ratio of 0.88, 95% CI: 0.75, 1.05; p=0.15) for skeletal complications, compared to patients receiving AREDIA\* 90 mg over the core phase of the trial. See Table 9 for the results of the main secondary efficacy analyses.

**Table 9 - Results of main secondary efficacy variables (Core Phase)  
Breast Cancer and Multiple Myeloma Patients  
All SRE**

	<b>Zoledronic acid 4 mg</b>	<b>AREDIA* 90mg</b>
N	561	555
Time to First SRE Hazard Ratio (95% CI) vs. AREDIA* 90 mg	0.91 (0.77, 1.09)	
Median Time to SRE <sup>§</sup> (days)	373	363
P-Value <sup>†</sup>	0.32	
Multiple Event Analysis Hazard Ratio (95% CI) vs. AREDIA* 90 mg	0.88 (0.75, 1.05)	
P-Value <sup>†</sup>	0.15	

Median Time to first SRE not taking death into consideration (i.e. deaths were censored).

†p-value vs. AREDIA\* 90 mg based on Cox-regression stratified by cancer type.

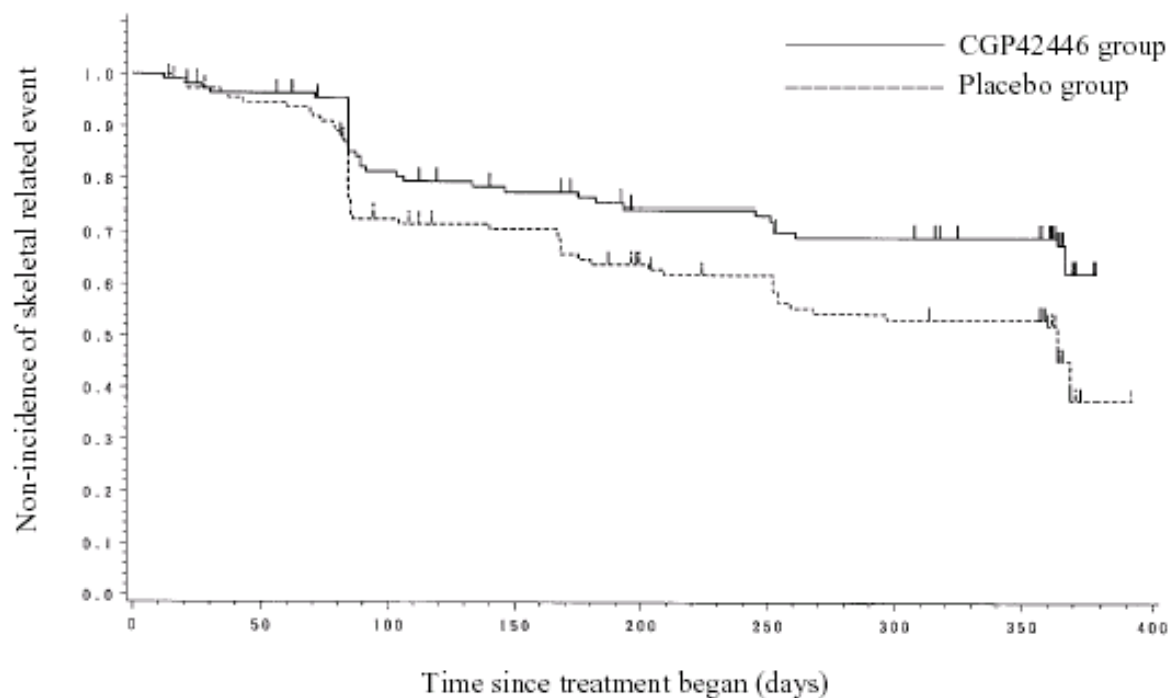
In addition, of the 690 (353 Zoledronic acid 337 AREDIA\*) patients who completed the core phase of the trial, 417 (212 Zoledronic acid, 205 AREDIA\*) consented to enter the extension phase. Another 111 patients continued with open-label AREDIA\* which at the time was the standard of care. A total of 246 (123 Zoledronic acid, 123 AREDIA\*) patients completed the extension phase. In the extension phase, only the safety data are reported (see **ADVERSE REACTIONS**).

#### **Bone metastases from breast cancer: Placebo-controlled trial in Japanese Patients**

Zoledronic acid was also studied in a double-blind, randomized, placebo-controlled, Phase III trial in 228 patients with documented bone metastases from breast cancer to evaluate the effect of zoledronic acid on the skeletal related event (SRE) rate ratio, calculated as the total number of SRE events (excluding hypercalcaemia and adjusted for prior fracture), divided by the total risk period. Patients received either 4 mg zoledronic acid or placebo every four weeks for one year. Patients were evenly distributed between zoledronic acid -treated and placebo groups.

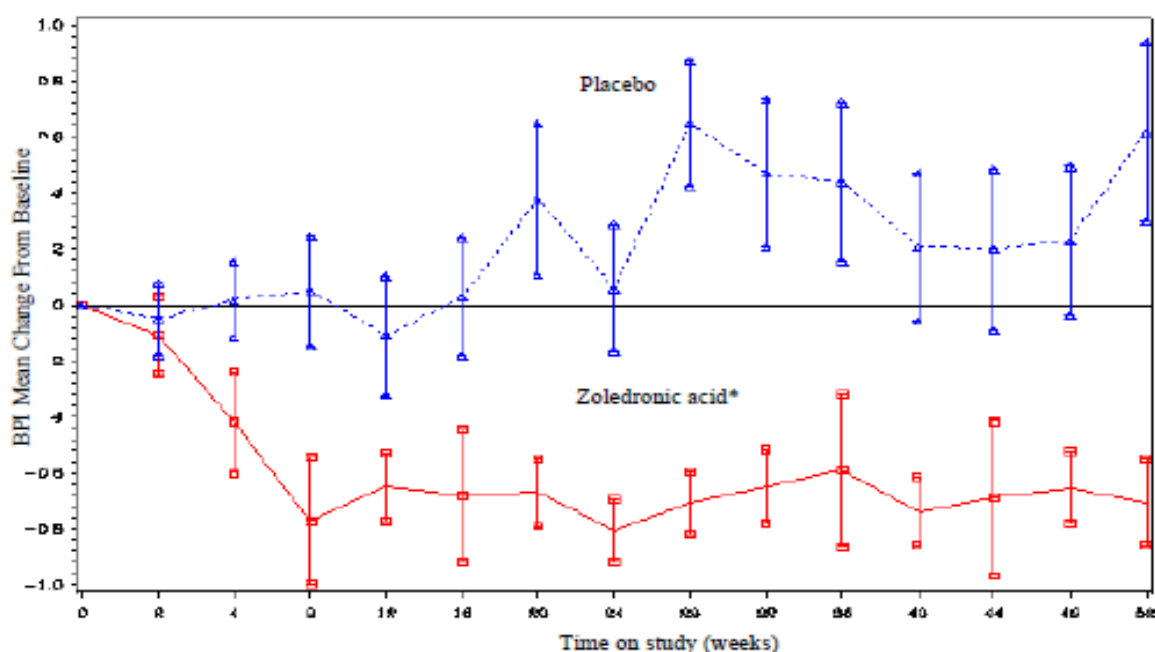
The SRE rate ratio at one year was 0.61, indicating that treatment with zoledronic acid reduced the rate of occurrence of SREs by 39% compared with placebo (p=0.027). The proportion of patients with at least one SRE (excluding hypercalcaemia) was 29.8% in the zoledronic acid-treated group versus 49.6% in the placebo group (p=0.003). Median time to onset of the first SRE was not reached in the zoledronic acid -treated arm at the end of the study and was significantly prolonged compared to placebo (p=0.007). Zoledronic acid reduced the risk of SREs by 41% in a multiple event analysis (risk ratio=0.59, p=0.019) compared with placebo.

**Figure 3 - Time to onset of the first SRE (–TIH)**



In the zoledronic acid -treated group, decreases in pain scores from baseline (using the Brief Pain Inventory, BPI) occurred from 4 weeks onwards and at every subsequent time point during the study, while the pain score in the placebo group remained unchanged or increased from baseline (Figure 4). Zoledronic acid inhibited the worsening of the analgesic score more than placebo. In addition, 71.8% of zoledronic acid -treated patients versus 63.1% of placebo patients showed improvement or no change in the Eastern Cooperative Oncology Group (ECOG) performance score at the final observation.

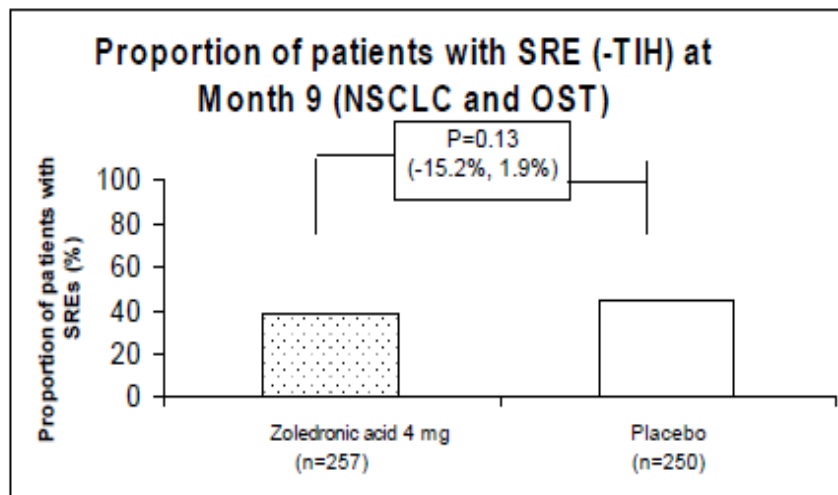
**Figure 4 -Mean change from baseline in Brief Pain Inventory (BPI) pain scores by treatment group and time on study**



### **Bone metastases from solid tumours other than breast cancer or prostate cancer**

A third phase III randomized, double-blind, placebo-controlled trial compared zoledronic acid to placebo for the prevention of SREs in patients who had solid tumours other than breast cancer or prostate cancer, with osteolytic or mixed bone metastases. Patients had to have at least 1 lytic metastasis for study entry. A total of 257 patients were randomized to zoledronic acid 4 mg; 134 patients with non-small cell lung cancer (NSCLC) and 123 with other solid tumours (OST). A total of 250 patients were randomized to placebo (130 patients with NSCLC, 120 with OST). Patients received either an intravenous infusion of zoledronic acid 4 mg or placebo every 3 weeks. The primary efficacy variable was the proportion of patients having an SRE at nine months. At nine months, the zoledronic acid 4 mg group had a lower proportion of patients experiencing an SRE when compared with placebo (38% for zoledronic acid 4 mg, 44% for placebo,  $p=0.13$ ), see Figure 5. The difference for the primary efficacy variable was not statistically significant. However, when tumour-induced hypercalcaemia (TIH) was also included as an SRE, the proportion of patients having an SRE reached statistical significance favouring zoledronic acid 4 mg over placebo (38% for zoledronic acid 4 mg and 47% for placebo,  $p=0.04$ ).

**Figure 5**



Study patients had a median overall survival of 6 months. Zoledronic acid extended the median time to an SRE by greater than two months (67 days) [median of 230 days vs. 163 days,  $p = 0.02$ ; see Table 10].

The multiple event analysis indicated that patients with lung cancer and other solid tumours (other than breast cancer or prostate cancer) receiving zoledronic acid 4 mg had a 27% overall reduction in risk (hazard ratio of 0.73, 95% CI: 0.57, 0.95;  $p=0.02$ ) for skeletal complications compared to placebo over the core phase of the trial. See Table 9 for the results of the main secondary efficacy analyses.

**Table 10 - Results of main secondary efficacy variables (Core Phase)  
NSCLC and OST Patients  
All SRE (-TIH)**

	Zoledronic acid 4 mg	Placebo
N	257	250
Time to First SRE Hazard Ratio (95% CI) vs. Placebo	0.73 (0.55, 0.96)	
Median Time to SRE <sup>§</sup> (days)	230	163
P-Value <sup>†</sup>	0.02	
Multiple Event Analysis Hazard Ratio (95% CI) vs. Placebo	0.73 (0.57, 0.95)	
P-Value <sup>†</sup>	0.02	

<sup>§</sup>Median Time to first SRE not taking death into consideration (i.e. deaths were censored).

<sup>†</sup>p-value vs. placebo based on Cox-regression stratified by cancer type.

In addition, of the 131 (68 Zoledronic acid, 63 Placebo) patients who completed the core phase of the trial, 69 (34 Zoledronic acid, 35 Placebo) consented to enter the extension phase and 16 (8 Zoledronic acid, 8 Placebo) completed it. In the extension phase, only the safety data are

reported (see **ADVERSE REACTIONS**).

## DETAILED PHARMACOLOGY

Zoledronic acid belongs to a highly potent class of bisphosphonates which act specifically on bone. It is an inhibitor of osteoclastic bone resorption.

The selective action of bisphosphonates on bone is based on their high affinity for mineralized bone, but the precise molecular mechanism leading to the inhibition of osteoclastic activity is still unclear. In a variety of preclinical assays of bone metabolism, zoledronic acid inhibits bone resorption in vitro at concentrations of 0.3-30 nM, and in vivo at doses of 0.3-30 µg/kg without exerting any untoward effects on either bone formation or mineralization.

In addition to inhibiting osteoclastic bone resorption, zoledronic acid exerts direct anti-tumour effects on cultured human myeloma and breast cancer cells, inhibiting proliferation and inducing apoptosis. It also inhibits human endothelial cell proliferation in vitro and is anti-angiogenic in animals. Moreover, the observation that zoledronic acid reduces the invasion of human breast cancer cells through extracellular matrix in vitro indicates that it may possibly have anti-metastatic properties.

In broad safety screening, no adverse effects were detected on the cardiovascular or central nervous systems at pharmacologically relevant doses for the inhibition of bone resorption.

## TOXICOLOGY

### Acute Toxicity

Species	Route	Doses (mg/kg)	Findings
Rat	i.v.	0.6, 6, 30, 60, 80	> 6 mg/kg: mortality and clinical signs 6 mg/kg: renal findings LD <sub>50</sub> = approximately 13 mg/kg
Rat	i.v.	1.6, 8, 16, 32	> 8 mg/kg: mortality, clinical signs, necropsy findings in kidney, liver, GI tract > 1.6 mg/kg: ↓ BW, FC, injection site irritation max. non lethal dose: 1.6 mg/kg min. lethal dose: 8 mg/kg
Dog	i.v.	2,10	2 mg/kg: no clinical signs 10 mg/kg: mortality
Mouse	s.c.	10,50	10 mg/kg: no clinical signs 50 mg/kg: mortality, clinical signs LD <sub>50</sub> = 10-50 mg/kg in males and > 10 mg/kg in females
Rat	p.o.	200, 2000	> 200 mg/kg: ↓ FC,BW, clinical signs, necropsy findings in stomach: enlarged, red lesions 2000 mg/kg: 100% mortality

The acute parenteral toxicity of zoledronic acid was moderate to marked in the mouse, rat and



dog. The estimated LD50 in the mouse (s.c.) and rat (i.v.) was 10-50 mg/kg (males)/>10 mg/kg (females) and 13 mg/kg (males), respectively. Compound-related renal tubular lesions were observed in the rat after one dose at 6 mg/kg. A single intravenous injection in the dog produced clinical signs, intestinal haemorrhage and mortality after 6 days in one male at 10 mg/kg. The other male received 2 mg/kg and survived the 14-day post-dose observation period without clinical signs.

## Subacute and Chronic Toxicity

Study Type	Species	Route	Doses [mg/kg]	Findings
<b>Intravenous</b>				
10-Day range Finding	Rat	i.v.	0.06, 0.6, 6	0.06 mg/kg: well tolerated 0.6 mg/kg: clin. signs; micro in kidneys, liver 6 mg/kg: sacrifice due to severe clin. signs; micro in bone, kidneys, stomach, liver, thymus, spleen, lymph nodes NOAEL: 0.06 mg/kg
2-Week	Rat	i.v.	0.06, 0.6, 3.2 (every third day for 18 days)	≥ 0.06 mg/kg: local irritation, non-proliferative hyperostosis ≥ 0.6 mg/kg: gastric lesions 3.2 mg/kg: mortality, clin signs; ↓BW/FC, clin lab alterations, ↑adrenal, kidney, liver wgt, nephropathy, hepatocellular hypertrophy NOAEL: not established
10-Day range finding	Dog	i.v.	0.1, 1	≥ 0.1 mg/kg: micro in bone rib, injection sites 1 mg/kg: clin. signs; micro findings in stomach, intestine, liver, lung, thymus NOAEL: 0.1 mg/kg
4-Week + 1 mo. Recovery	Dog	i.v.	0.02, 0.06, 0.2	≥ 0.06 mg/kg: clinical signs 0.2 mg/kg: clin. signs; micro in GI tract NOAEL: 0.02 mg/kg
3-Month + 1 mo. Recovery	Dog	i.v.	0.01, 0.03, 0.1-->0.2	≥0.01 mg/kg: genital tract atrophy (F); ↑primary spongiosa in bone; splenic histiocytosis; lung inflammation, thymic atrophy ≥ 0.03 mg/kg: moribund sacrifice at 0.1 --> 0.2 mg/kg due to inj. site irritation, ↓BW/FC, ↑ALAT/ASAT, ↓bone AP, PO <sub>4</sub> , creatinine and ↓RBC indices; inj. site ulceration, kidney lesions, genital tract (M) & pancreatic atrophy, inflammation of urinary bladder, esophagus, stomach and liver. NOAEL: not established
26/52-wk+ 6 mo. Recovery	Dog	i.v.	0.005, 0.03, 0.1	All doses: inj site irritation; ↓phosphate; non-proliferative hyperostosis ≥0.03 mg/kg : micro in kidneys, GI tract; ↑BUN, ↑total protein. 0.1 mg/kg: ↓creatinine, ↑ASAT, ↓Ca. NOAEL: 0.005 mg/kg
Bone analyses (26/52-wk + 6 mo. Recovery)	Dog	i.v.	0.005, 0.03, 0.1	All biomechanical parameters assessing bone quality showed either no deleterious effect or an increase in quality at pharmacologically efficacious doses.
<b>Subcutaneous</b>				
10-Day range-finding	Rat	s.c.	0.2,0.6,2	2 mg/kg: clin. signs; microscopic changes in kidneys, liver; spleen, thymus, lymph nodes, lung and adrenals. ≥ 0.6 mg/kg: clin. Signs ≥0.2 mg/kg: Local irritation at the injection sites

1-Month +1 mo recovery	Rat	s.c.	0.02, 0.06, 0.2	0.2 mg/kg: swelling at injection site; clin. signs; micro findings in liver, lymph nodes ≥ 0.06 mg/kg: clin. signs; micro findings of spleen, injection sites, skeletal muscle; NOAEL: 0.02 mg/kg
3-Month +1 mo recovery	Rat	s.c.	0.01, 0.03, 0.1	Tolerated without mortality at doses up to and including 0.1 mg/kg. Non-proliferative hyperostosis. NOAEL 0.01 mg/kg in females. No NOAEL in males due to reduced BW/FC at all doses.
6/12-Month+ 6 mo recovery	Rat	s.c.	0.001, 0.003, 0.01	≥0.001 mg/kg: ↓ bone AP, ↑ reticulocyte count, splenic hemosiderosis and congestion, ↑ splenic hematopoiesis, ↑ cellularity of femoral/tibial marrow, non-proliferative hyperostosis. Following bone morphometry, no deleterious effects after administration for 12 months. ≥0.003 mg/kg: ↓ RBC parameters, ↑ fibrinogen, renal tubular changes, progressive nephropathy. 0.01 mg/kg: testicular tubular atrophy Bone morphometry on bone (tibia) did not reveal deleterious effects NOAEL: 0.001 mg/kg
<b>Oral</b>				
13-week	Mouse	p.o.	0, 0.3, 3, 10, 30 -->20	0.3 – 30 -->20 mg/kg: mortality; respiratory signs; ↓ FC; non-proliferative hyperostosis 3 – 30 -->20 mg/kg: ↓ BW; laryngeal, tracheal & bronchial inflammation
10-Day range-finding	Rat	p.o.	1,10,100	1 and 10 mg/kg: well-tolerated 100 mg/kg: mortality & moribund sacrifice after 1 wk; clin. signs; gastritis, GI tract necrosis, acute renal tubular lesions, liver changes; lymphoid depletion spleen, thymus.
1-Month +1 mo recovery	Rat	p.o.	62060	6 mg/kg: well-tolerated ≥20 mg/kg: clin signs; liver, spleen, lymph nodes 60 mg/kg: mortality; GI tract, kidneys, salivary glands, thymus, adrenal, lung, trachea NOAEL: 6 mg/kg
6-Month +1 mo recovery	Rat	p.o.	0.1,1,10	≥0.1 mg/kg: bone ≥1 mg/kg: clin signs 10 mg/kg: mortality NOAEL: 0.1 mg/kg
10-Day	Dog	p.o.	1 → 30, 10 (for 9d); 30 (for 10d) <sup>a</sup>	1 →30 mg/kg: clin. signs; micro findings in kidneys, esophagus, liver; non-proliferative hyperostosis. 10 mg/kg: no significant findings
1-Month	Dog	p.o.	3,10, 30	≥ 3 mg/kg: clin signs ≥ 10 mg/kg: mortality; liver, lung, thymus 30 mg/kg: gingiva, pancreas, adrenals
6-Month +1 mo. recovery	Dog	p.o.	0.01, 0.1, 1	Well-tolerated at doses of up to 1 mg/kg. Histological bone changes were considered pharmacologic NOAEL: 1 mg/kg

<sup>a</sup>From day 9 of dosing: 30 mg/kg for an additional 10 days

## Reproductive Toxicity Studies

Zoledronic acid was evaluated for potential adverse effects on fertility, labour, delivery and lactation of the parental generation rats as well as development, behaviour and fertility of the F1 generation at doses of 0.01, 0.03 and 0.1 mg/kg; however, many females in the treated groups either died or were sacrificed while moribund at parturition due to difficulty in delivery (dystocia) such that the study was terminated on lactation day 7.

Teratology studies were performed in two species, both via subcutaneous administration. Teratogenicity was observed in the rat at doses  $\geq 0.2$  mg/kg manifested by external, visceral and skeletal malformations. There were also dose-related increases in the incidence of poor skeletal ossification at  $\geq 0.2$  mg/kg and evidence of maternal toxicity at  $\geq 0.2$  mg/kg as well as foetal toxicity at 0.4 mg/kg. In the rabbit, reduced number of litters with viable foetuses, increased post-implantation loss and total resorption were observed at 0.1 mg/kg. Fatality was shown in dams with decreased serum calcium level at all doses.

Study Type	Species	Route	Doses (mg/kg)	Findings
Segment I	Rat	s.c.	0.01, 0.03, 0.1	$\geq 0.01$ : maternal toxicity and severe effects on parturition such that the study was terminated on lactation day 7.
Segment II range finding	Rat	s.c.	0.2, 0.6, 2	$\geq 0.2$ mg/kg: irritation at injection site $\geq 0.6$ mg/kg: $\downarrow$ maternal BW. 9/10 dams with total resorption (embryo/foetal death) of progeny; remaining dam w/ only 2 foetuses (one with cleft palate).
Segment II	Rat	s.c.	0.1, 0.2, 0.4	$\geq 0.2$ mg/kg: $\downarrow$ maternal BW; $\downarrow$ foetal wgt; anomalies of viscera and/or skeleton w/ wavy ribs & delay in skeletal maturation. 0.4 mg/kg: 9/24 dams with total resorption of foetuses; some foetuses with oedema, cleft palate, short lower jaw, abnormal ossification
Segment II finding (pregnant)	Rabbit	s.c.	0.1, 0.2, 0.4	0.2, 0.4 mg/kg: early termination due to severe clinical range signs/toxicity. 0.1 mg/kg: Reduced foetal weight; foetal visceral and skeletal development were not examined.
Segment II	Rabbit	s.c.	0.01, 0.03, 0.1	Maternal toxicity at $\geq 0.01$ mg/kg due to $\downarrow$ blood calcium. Reduced number of litters with viable foetuses, increased post-implantation loss and total resorption at 0.1 mg/kg. Foetal/embryo development abnormalities cannot be assessed due to an insufficient exposure in the surviving dams.

## Carcinogenicity

Zoledronic acid was administered orally (gavage) to rats and mice for at least 104 weeks without evidence of carcinogenic potential. Chronic parenteral administration was not feasible given the potential of the compound to cause severe local irritation, often after only one or several doses. As zoledronic acid, and bisphosphonates in general, manifest poor oral

bioavailability, fasting procedures were instituted to facilitate absorption. Nevertheless the pharmacological bone changes typically observed following long term bisphosphonate administration (non-proliferative hyperostosis) to young animals with growing skeletons gave clear evidence of systemic exposure to zoledronic acid in both species at all doses. An increased incidence of Harderian gland adenomas/adenocarcinomas was observed in males at 0.1 and 1.0 mg/kg and females at doses  $\geq 0.3$  mg/kg. These increases were not considered to be related to zoledronic acid administration or biologically meaningful as the Harderian gland is a unique, highly specialized organ which is not present or known to have any correlate in humans; thus, it has no relevance.

Species	Route	Doses (mg/kg)	Findings
Mouse	p.o.	0.1, 0.3, 1.0	$\geq 0.1$ mg/kg: non-proliferative hyperostosis $\geq 0.3$ mg/kg: $\downarrow$ BW
Rat	p.o.	0.1, 0.5, 2.0	$\geq 0.1$ mg/kg: non-proliferative hyperostosis $\geq 0.5$ mg/kg: $\downarrow$ BW, FC 2.0 mg/kg: $\uparrow$ extramedullary hematopoiesis

### Mutagenicity

Study Type	Findings
in vitro: Ames <sup>a</sup> , Ames <sup>b</sup> , Ames <sup>c</sup> Range: <sup>a</sup> 5000 $\mu$ g/plate (-S9/+S9), <sup>b</sup> 390 - 25000 $\mu$ g/plate, <sup>c</sup> 1250 $\mu$ g/plate (-S9/+S9)	Negative
in vitro: Cytogenetics test on Chinese hamster cells Range: 9.7 - 1250 $\mu$ g/mL	Negative
in vitro: Gene mutation test using V79 Chinese hamster cells Range: 2 - 15 $\mu$ g/mL	Negative
in vivo: Micronucleus in rats Range: 2.6 - 10.4 mg/kg	Negative

<sup>a</sup>Bacterial test systems (*S. typhimurium*), with/without metabolic activation.

<sup>b</sup> Batch control

<sup>c</sup>Bacterial test system (*S. typhimurium*/ *E. coli*), with/without metabolic activation.

There was no evidence of mutagenicity for zoledronic acid in a battery of tests covering various endpoints of genotoxicity.

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## ZOMETA Concentrate PM – Part III Consumer Information

**PART III: CONSUMER INFORMATION**

**Taro-Zoledronic Acid Concentrate (4 mg/5 mL)**  
**(Zoledronic acid for Injection)**  
**Must be diluted before use**

This leaflet is part III of a three-part "Product Monograph" published when Taro-Zoledronic Acid Concentrate was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about Taro-Zoledronic Acid Conc. Contact your doctor or pharmacist if you have any questions about the drug.

Please read this information carefully before starting treatment with Taro-Zoledronic Acid Concentrate (Zoledronic acid for Injection).

### ABOUT THIS MEDICATION

#### What the medication is used for:

Taro-Zoledronic Acid Concentrate is used to:

- 1) reduce the abnormal amount of calcium in the blood for example, in the presence of a tumour. This is because tumours can accelerate normal bone change in such a way that the release of calcium from bone is increased. This condition is known as tumour-induced hypercalcaemia.
- 2) prevent or delay skeletal complications for example, fractures of the bone and bone pain requiring surgery or radiotherapy, as a result of bone metastases (cancer that has spread from the tumour to the bone) due to different types of tumours.

#### What it does:

Taro-Zoledronic Acid Concentrate is a member of a group of substances called bisphosphonates. These strongly bind to the bone and slow down the rate of bone change. In addition, Taro-Zoledronic Acid Concentrate may prevent bone destruction and uncontrolled bone growth associated with the tumour spreading to the bone.

#### When it should not be used:

You should not be given Taro-Zoledronic Acid Concentrate if you are:

- pregnant
- breastfeeding
- allergic to zoledronic acid, other bisphosphonates (the group of substances to which Taro-Zoledronic Acid Concentrate belongs) or to any other non medicinal ingredients in Taro-Zoledronic Acid Concentrate.
- hypocalcaemic (have low calcium levels in your blood)

#### What the medicinal ingredient is:

Zoledronic acid.

#### What the important nonmedicinal ingredients are:

Mannitol and sodium citrate.

#### What dosage forms it comes in:

Taro-Zoledronic Acid Concentrate is available as a clear, colourless concentrate solution in glass vials with a baby blue flip off seal. Each vial of Taro-Zoledronic Acid Concentrate delivers 4 mg of zoledronic acid. It is available in cartons containing 1 vial.

### WARNINGS AND PRECAUTIONS

#### **Serious Warnings and Precautions**

Serious side effects which have been reported with the use of Taro-Zoledronic Acid Concentrate include:

- **osteonecrosis of the jaw (ONJ)**
- **deterioration in renal function** Taro-Zoledronic Acid Concentrate is not recommended in patients with severe kidney impairment.
- **hypocalcaemia** (low calcium levels in your blood)

If you are being treated with Taro-Zoledronic Acid Concentrate, you should not be treated with another intravenous form of zoledronic acid or other bisphosphonates (e.g. alendronate, risedronate, clodronate, etidronate and pamidronate) at the same time.

Your doctor may request a dental examination prior to and while on treatment with Taro-Zoledronic Acid Concentrate. This may be required since some patients have experienced side effects following dental procedures (such as tooth extraction) while on Taro-Zoledronic Acid Concentrate; as well, since patients with dental infections or periodontal disease (disease affecting surrounding tissues of a tooth) may be at increased risk of problems with their jaw bones following dental procedures (such as tooth extraction) while on treatment with Taro-Zoledronic Acid Concentrate.

#### **BEFORE you use Taro-Zoledronic Acid Concentrate talk to your doctor or pharmacist if you:**

- **have a kidney problem.** Worsening of kidney function, including kidney failure (very rarely with fatal outcome), has been reported with the use of Taro-Zoledronic Acid Concentrate.
- have low calcium in your blood. Your calcium level will have to be corrected before you start Taro-Zoledronic Acid Concentrate.
- are or think you may be pregnant. Taro-Zoledronic Acid Concentrate should not be given during pregnancy.
- are breastfeeding. Taro-Zoledronic Acid Concentrate should not be given if you are breastfeeding.
- have asthma and are also allergic to acetylsalicylic acid (ASA).
- had or have a heart problem. Cases of irregular heart beat (atrial fibrillation) have been observed with the use of Taro-Zoledronic Acid Concentrate.
- **have any dental problems or any dental procedures planned in the future.**



## **After starting treatment with Taro-Zoledronic Acid Concentrate**

It is important that your doctor checks your progress at regular intervals. He or she may want to take repeated blood tests, especially after starting your treatment with Taro-Zoledronic Acid Concentrate.

If possible, you should not undergo tooth extraction or other dental procedures (excluding regular dental cleaning) while you are receiving treatment with Taro-Zoledronic Acid Concentrate. Please consult your doctor if a dental procedure (excluding regular dental cleaning) is required while you are receiving treatment with Taro-Zoledronic Acid Concentrate. It is important to maintain good dental hygiene; regularly scheduled dental examinations are recommended.

## **Driving and using machines**

Taro-Zoledronic Acid Concentrate may affect your ability to drive a car or to operate machinery. Do not drive a car or operate machinery until you know how Taro-Zoledronic Acid Concentrate affects you.

## **Use in Children**

So far children have not been treated with Taro-Zoledronic Acid Concentrate. Until further experience is gained, Taro-Zoledronic Acid Concentrate can only be recommended for use in adult patients.

## **INTERACTIONS WITH THIS MEDICATION**

Tell your doctor about any other medicines or herbal preparations you are taking or have recently been taking, including any you have bought without a prescription. It is particularly important that your doctor knows if you are also taking aminoglycosides (a type of medicine used to treat severe infections) or loop diuretics (a type of medicine used to treat high blood pressure or oedema), since the combination of these with bisphosphonates may cause the calcium level in the blood to become too low. Examples of aminoglycosides include gentamycin sulfate, tobramycin sulfate and streptomycin sulphate; examples of loop diuretics include furosemide, torsemide and ethacrinic acid.

It is also important to inform your doctor if you are taking any drugs that can have an effect on the kidney, since combining these drugs with Taro-Zoledronic Acid Concentrate may cause kidney function to deteriorate. Some examples of these drugs include aminoglycosides, acetylsalicylic acid (ASA), nonsteroidal anti-inflammatories (e.g. ibuprofen, diclofenac, celecoxib), diuretics (e.g. hydrochlorothiazide, amiloride, spironolactone and indapamide) and Angiotensin-Converting Enzyme (ACE) inhibitors (e.g. enalapril, ramipril, fosinopril).

Tell your doctor if you are taking anti-angiogenic medicines (type of medicines used to treat cancer, e.g. thalidomide, bortezomid, lenalidomide, bevacizumab) as part of your cancer treatment because the combination of these medicines with bisphosphonates may increase the risk of bone damage in the jaw (osteonecrosis).

## **PROPER USE OF THIS MEDICATION**

### **Usual dose:**

Taro-Zoledronic Acid Concentrate must be diluted before use as directed and is given by an infusion into a vein which should last no less than 15 minutes. The dose is usually 4 mg. If you have a kidney problem, your doctor may give you a lower dose depending on the severity of your kidney problem. Single dose of 4 mg should not be exceeded.

If you are being treated for multiple myeloma or bone metastases of solid tumours, you will be given one infusion of Taro-Zoledronic Acid Concentrate every three to four weeks. If you require antineoplastic therapy (therapy that blocks the growth of cancer cells), Taro-Zoledronic Acid Concentrate should be administered either prior to or after this treatment. You will also be asked to take an oral calcium supplement of 500 mg and a multivitamin containing at least 400 IU of Vitamin D daily. If you have a prior history of hypercalcaemia or develop hypercalcaemia during treatment with calcium and Vitamin D, you may be advised to discontinue taking calcium and Vitamin D supplements by your doctor.

Your doctor will decide how many infusions you need and how often you should receive them.

If you are being treated for Tumour-Induced Hypercalcaemia (TIH), you will normally only be given one infusion of Taro-Zoledronic Acid Concentrate. Prior to treatment with Taro-Zoledronic Acid Concentrate, restoring and maintaining adequate fluid regulation in your body and urine output is necessary as it may help to eliminate excess calcium from your kidneys.

### **Overdose:**

In case of drug overdose, contact a health care practitioner, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms. You may develop serum electrolyte abnormalities and changes in kidney function, including severe kidney impairment.

## **SIDE EFFECTS AND WHAT TO DO ABOUT THEM**

Like all medicines, Taro-Zoledronic Acid Concentrate may have, in addition to its beneficial effects, some unwanted effects. These are usually mild and will probably disappear after a short time. The most common side effect is short-lasting fever. Patients may experience a flu-like condition including fever, fatigue, weakness, drowsiness and chills. In some patients, these symptoms may also be accompanied by bone, joint and/or muscle ache, arthritis and joint swelling. In most cases, no specific treatment is required and the symptoms subside after a couple of hours or days. Other common side effects include gastrointestinal problems such as nausea, vomiting and thirst as well as loss of appetite.

Occasionally, skin reactions (redness and swelling) at the infusion site may occur. Cases of low blood pressure have also occasionally been reported; in very rare cases, this resulted in fainting.

Rare cases of rash, itching, chest pain, swelling mainly of the face and throat, high level of potassium and sodium in the blood, slow heart beat and confusion have been observed.

Very rare cases of severe bone, joint, and/or muscle pain, occasionally incapacitating, as well as sleepiness, irregular heart beat (atrial fibrillation), difficulty breathing with wheezing or coughing, lung disease, severe allergic reaction and itchy rash have also been reported.

Reduced levels of calcium in the blood (hypocalcaemia), sometimes leading to muscle cramps, dry skin or burning sensation, have been reported in patients treated with Zoledronic Acid.

Irregular heart beat (cardiac arrhythmia) has also been reported. Abnormal electrical signal of the heart called “prolongation of the QT interval”, seizures, spasm and twitching (tetany) have been reported as secondary to severe hypocalcaemia. In some instances, hypocalcaemia may be life-threatening and require hospitalization. If any of these apply to you, **tell your doctor straight away**

Blood tests indicating worsening of kidney function (higher levels of creatinine) including severe kidney failure have been reported with Zoledronic Acid; such changes are also known to occur with other drugs of the bisphosphonate class. Your doctor will carry out blood tests to monitor your kidney function prior to each dose of Taro-Zoledronic Acid Concentrate. If these tests indicate worsening of kidney function, your doctor will withhold further treatment with Taro-Zoledronic Acid Concentrate until these tests have returned to normal.

The level of calcium, phosphate and/or magnesium in the blood may become too low, but your doctor will monitor this and take necessary measures.

Other bisphosphonates can cause breathing difficulties in patients with asthma who are allergic to acetylsalicylic acid (ASA). This has not been reported with Zoledronic Acid, in studies done to date.

Eye pain, redness, photophobia (sensitivity to light), excessive tearing or decreased vision should be reported to your physician as they may indicate more serious eye complications which have been associated with Zoledronic Acid.

Some patients have reported problems with their jaw bones while receiving cancer treatments that include Zoledronic Acid. Dental hygiene is an important element of your overall cancer care and is important in possibly decreasing the chances of this type of problem occurring. Removable dentures should fit properly and should be removed at night. Please consult with your doctor if you experience pain in your mouth, teeth or jaw, or if your gums or mouth heals poorly. Any non-healing of a dental extraction site or chronic dental infection should be reported and assessed. In addition, if possible you should not undergo tooth extraction or other dental procedures (excluding regular dental cleaning) while on therapy with Taro-Zoledronic Acid Concentrate. Please consult your doctor if a dental procedure (excluding regular dental cleaning) is required while you are receiving treatment with Taro-Zoledronic Acid Concentrate.

Unusual fracture of the thigh bone may occur while receiving treatment with Taro-Zoledronic Acid Concentrate. Contact your doctor if you experience pain, weakness or discomfort in your thigh, hip or groin as this may be an early sign of a possible fracture of the thigh bone.

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM				
Symptom / effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
<b>Common</b>	<ul style="list-style-type: none"> <li>Worsening of kidney function (higher levels of creatinine)</li> <li>Bone, joint and/or muscle pain, joint stiffness</li> <li>Conjunctivitis</li> </ul>	✓	✓	✓
<b>Uncommon</b>	<ul style="list-style-type: none"> <li>Kidney failure (changes in urine color or absence of urine production, changes in kidney function laboratory tests, lower back pain, fatigue, nausea, loss of appetite)</li> <li>Eye disorders (painful red and/or swollen eye, excessive tearing, light sensitivity, or decreased vision)</li> <li>Allergic reaction to Taro-Zoledronic Acid Concentrate (swelling of the face, eyes or tongue, difficulty breathing, hives, rash, sudden onset of low blood pressure)</li> <li>Dizziness</li> <li>Osteonecrosis of the jaw (numbness or feeling of heaviness in the</li> </ul>		✓	✓

# SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom / effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
	jaw, poor healing of the gums especially after dental work, loose teeth, exposed bone in mouth, pain in the mouth, teeth or jaw, swelling or gum infections, bad breath)			
Unknown <sup>1</sup>	Difficulty breathing with wheezing or coughing			✓
	Irregular heart beat (atrial fibrillation)			✓
	Sleepiness	✓		
	Severe allergic reaction (anaphylactic reaction/shock)			✓
	Itchy rash			✓
	Thigh pain, weakness of or discomfort/ Unusual fracture of the thigh bone			✓
	Muscle cramps or twitching, dry skin, burning sensation, or irregular heartbeat (hypocalcaemia or reduced levels of calcium in the blood)		✓	

<sup>1</sup>The frequency with which these side effects may occur cannot be reliably estimated.

*This is not a complete list of side effects. For any unexpected effects while taking Taro-Zoledronic Acid Concentrate, contact your doctor or pharmacist.*

# HOW TO STORE TARO-ZOLEDRONIC ACID CONCENTRATE

Vials (concentrate)

- Store Taro-Zoledronic Acid Concentrate vials at room temperature (between 15°C – 30°C).

Taro-Zoledronic Acid Concentrate must be kept out of reach and sight of children and pets.

# REPORTING SUSPECTED SIDE EFFECTS

You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:

- Report online at [www.healthcanada.gc.ca/medeffect](http://www.healthcanada.gc.ca/medeffect)
- Call toll-free at 1-866-234-2345
- Complete a Canada Vigilance Reporting Form and:
  - Fax toll-free to 1-866-678-6789
  - Mail to: Canada Vigilance Program  
Health Canada  
Postal Locator 0701E  
Ottawa, Ontario  
K1A 0K9

Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines are available on the MedEffect™ Canada Web site at [www.healthcanada.gc.ca/medeffect](http://www.healthcanada.gc.ca/medeffect).

**NOTE:** Should you require information related to the management of the side effects, please contact your health professional. The Canada Vigilance Program does not provide medical advice.

# MORE INFORMATION

This document plus the full product monograph, prepared for health professionals can be found at:

<http://www.taro.ca>

or by contacting the sponsor,

**Taro Pharmaceuticals Inc.**  
130 East Drive, Brampton  
Ontario L6T 1C1  
1-800-268-1975

This leaflet was prepared by Taro Pharmaceuticals Inc.

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