

# Tecentriq®



**Atezolizumab**

Concentrate for solution for infusion

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## NAME OF THE MEDICINAL PRODUCT

Tecentriq

## QUALITATIVE AND QUANTITATIVE COMPOSITION

One vial of 20 mL concentrate contains 1,200 mg atezolizumab, corresponding to a concentration before dilution of 60 mg/mL.

For dilution and other handling recommendations, see section 2.3.

For the full list of excipients, see section 11.

## PHARMACEUTICAL FORM

Concentrate for solution for infusion (sterile concentrate).

Clear, colourless to slightly yellowish liquid.

## CLINICAL PARTICULARS

### 1 INDICATIONS AND USAGE

#### 1.1 Locally Advanced or Metastatic Urothelial Carcinoma

TECENTRIQ (atezolizumab) is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy.

TECENTRIQ is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following any platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant chemotherapy.

*[see Clinical Studies (14.1)]*

#### 1.2 Metastatic Non-Small Cell Lung Cancer

TECENTRIQ is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) who are naïve to anti-PD-L1 or anti-PD-1 therapies and have disease progression during or following platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on approved therapy for these aberrations prior to receiving TECENTRIQ *[see Clinical Studies (14.2)]*.

## 2 DOSAGE AND ADMINISTRATION

### 2.1 Recommended Dosing

The recommended dose of TECENTRIQ is 1200 mg administered as an intravenous infusion over 60 minutes every 3 weeks until disease progression or unacceptable toxicity. If the first infusion is tolerated, all subsequent infusions may be delivered over 30 minutes. Do not administer TECENTRIQ as an intravenous push or bolus.

### 2.2 Dose Modifications

No dose reductions of TECENTRIQ are recommended.

Withhold TECENTRIQ for any of the following:

- Grade 2 pneumonitis [*see Warnings and Precautions (5.1)*]
- Aspartate aminotransferase (AST) or alanine aminotransferase (ALT) greater than 3 and up to 5 times upper limit of normal (ULN) or total bilirubin greater than 1.5 and up to 3 times ULN [*see Warnings and Precautions (5.2)*]
- Grade 2 or 3 diarrhea or colitis [*see Warnings and Precautions (5.3)*]
- Symptomatic hypophysitis, adrenal insufficiency, hypothyroidism, hyperthyroidism, or Grade 3 or 4 hyperglycemia [*see Warnings and Precautions (5.4)*]
- Grade 2 ocular inflammatory toxicity [*see Warnings and Precautions (5.5)*]
- Grade 2 or 3 pancreatitis, or Grade 3 or 4 increases in amylase or lipase levels (greater than 2.0 times ULN) [*see Warnings and Precautions (5.5)*]
- Grade 3 or 4 infection [*see Warnings and Precautions (5.6)*]
- Grade 2 infusion-related reactions [*see Warnings and Precautions (5.7)*]
- Grade 3 rash

TECENTRIQ may be resumed in patients whose adverse reactions recover to Grade 0–1.

Permanently discontinue TECENTRIQ for any of the following:

- Grade 3 or 4 pneumonitis [*see Warnings and Precautions (5.1)*]
- AST or ALT greater than 5 times ULN or total bilirubin greater than 3 times ULN [*see Warnings and Precautions (5.2)*]
- Grade 4 diarrhea or colitis [*see Warnings and Precautions (5.3)*]
- Grade 4 hypophysitis [*see Warnings and Precautions (5.4)*]
- Myasthenic syndrome/myasthenia gravis, Guillain-Barré or meningoencephalitis (all grades) [*see Warnings and Precautions (5.5)*]
- Grade 3 or 4 ocular inflammatory toxicity [*see Warnings and Precautions (5.5)*]
- Grade 4 or any grade of recurrent pancreatitis [*see Warnings and Precautions (5.5)*]
- Grade 3 or 4 infusion-related reactions [*see Warnings and Precautions (5.7)*]
- Grade 4 rash

## 2.3 Preparation and Administration

### Preparation

Visually inspect drug product for particulate matter and discoloration prior to administration whenever solution and container permit. TECENTRIQ is a colorless to slightly yellow solution. Discard the vial if the solution is cloudy, discolored, or visible particles are observed. Do not shake the vial.

Prepare the solution for infusion as follows:

- Withdraw 20 mL of TECENTRIQ from the vial.
- Dilute into a 250 mL polyvinyl chloride (PVC), polyethylene (PE), or polyolefin (PO) infusion bag containing 0.9% Sodium Chloride Injection, USP.
- Dilute with 0.9% Sodium Chloride Injection only.
- Mix diluted solution by gentle inversion. Do not shake.
- Discard used or empty vials of TECENTRIQ.

### Storage of Infusion Solution

This product does not contain a preservative.

Administer immediately once prepared. If diluted TECENTRIQ infusion solution is not used immediately, it can be stored either:

- At ambient temperature ( $\leq 30^{\circ}\text{C}$ ) for no more than 8 hours from the time of preparation. This includes room temperature storage of the infusion in the infusion bag and time for administration for infusion.
- Under refrigeration at  $2^{\circ}\text{C}$ – $8^{\circ}\text{C}$  for no more than 24 hours.
- From a microbiological point of view, the prepared solution for infusion should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user.

Do not freeze.

Do not shake.

### Administration

Administer the initial infusion over 60 minutes through an intravenous line with or without a sterile, non-pyrogenic, low-protein binding in-line filter (pore size of 0.2–0.22 micron). If the first infusion is tolerated, all subsequent infusions may be delivered over 30 minutes.

Do not co-administer other drugs through the same intravenous line.

## 3 DOSAGE FORMS AND STRENGTHS

Injection: 1200 mg/20 mL (60 mg/mL) colorless to slightly yellow solution in a single-dose vial.

## 4 CONTRAINDICATIONS

Hypersensitivity to the active substance or to any of the excipients.

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Immune-Related Pneumonitis

Immune-mediated pneumonitis or interstitial lung disease, defined as requiring use of corticosteroids and with no clear alternate etiology, occurred in patients receiving TECENTRIQ. Monitor patients for signs with radiographic imaging and for symptoms of pneumonitis. Administer steroids at a dose of 1 to 2 mg/kg/day prednisone equivalents for Grade 2 or greater pneumonitis, followed by corticosteroid taper. Withhold TECENTRIQ until resolution for Grade 2 pneumonitis. Permanently discontinue TECENTRIQ for Grade 3 or 4 pneumonitis [*see Dosage and Administration (2.2)*].

Across clinical trials, 2.6% (51/1978) of patients developed pneumonitis. Fatal pneumonitis occurred in two patients.

#### Urothelial Carcinoma

In 523 patients with urothelial carcinoma who received TECENTRIQ, pneumonitis occurred in six (1.1%) patients. Of these patients, there was one patient with fatal pneumonitis, one patient with Grade 3, three patients with Grade 2, and one patient with Grade 1 pneumonitis. TECENTRIQ was held in all cases. Pneumonitis resolved in three patients. The median time to onset was 2.6 months (range: 15 days to 4.2 months). The median duration was 15 days (range: 6 days to 3.1+ months). Immune-mediated pneumonitis occurred in 5 (1.0%) patients.

#### NSCLC

In 1027 patients with NSCLC who received TECENTRIQ, pneumonitis occurred in 38 (3.7%) patients. Of these patients, there was one patient with fatal pneumonitis, two patients with Grade 4, thirteen patients with Grade 3, eleven patients with Grade 2, and eleven patients with Grade 1 pneumonitis. TECENTRIQ was held in 24 patients and 21 patients were treated with corticosteroids. Pneumonitis resolved in 26 of the 38 patients. The median time to onset was 3.3 months (range: 3 days to 18.7 months). The median duration was 1.4 months (range: 0 days to 12.6+ months).

### 5.2 Immune-Related Hepatitis

Immune-mediated hepatitis, defined as requiring use of corticosteroids and with no clear alternate etiology, occurred in patients receiving TECENTRIQ treatment. Liver test abnormalities occurred in patients who received TECENTRIQ. Monitor patients for signs and symptoms of hepatitis. Monitor AST, ALT, and bilirubin prior to and periodically during treatment with TECENTRIQ. Administer corticosteroids at a dose of 1–2 mg/kg/day prednisone equivalents for Grade 2 or greater transaminase elevations, with or without concomitant elevation in total bilirubin, followed by corticosteroid taper. Withhold TECENTRIQ for Grade 2 and permanently discontinue TECENTRIQ for Grade 3 or 4 immune-mediated hepatitis [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

Across clinical trials (n=1978), Grade 3 or 4 elevation occurred in ALT (2.5%), AST (2.3%), and total bilirubin (1.6%).

#### Urothelial Carcinoma

In patients with urothelial carcinoma (n=523), Grade 3 or 4 elevation occurred in ALT (2.5%), AST (2.5%), and total bilirubin (2.1%). Immune-mediated hepatitis occurred in 1.3% (7/523) of patients. Of these cases, one patient died from hepatitis, five patients had Grade 3, and one patient had Grade 2 hepatitis. The median time to onset was 1.1 months (range: 0.4 to 7.7

months). TECENTRIQ was temporarily interrupted in four patients; none of these patients developed recurrence of hepatitis after resuming TECENTRIQ.

### NSCLC

In patients with NSCLC, Grade 3 or 4 elevation occurred in ALT (1.4%), AST (1.3%), and total bilirubin (0.6%). Immune-mediated hepatitis occurred in 0.9% (9/1027) of patients. Of these nine patients, one patient had Grade 4, four patients had Grade 3, three patients had Grade 2, and one patient had Grade 1 immune-mediated hepatitis. The median time to onset was 28 days (range: 15 days to 4.2 months). TECENTRIQ was temporarily interrupted in seven patients; none of these patients developed recurrence of hepatitis after resuming TECENTRIQ.

### 5.3 Immune-Related Colitis

Immune-mediated colitis or diarrhea, defined as requiring use of corticosteroids and with no clear alternate etiology, occurred in patients receiving TECENTRIQ. Monitor patients for signs and symptoms of diarrhea or colitis. Withhold treatment with TECENTRIQ for Grade 2 diarrhea or colitis. If symptoms persist for longer than 5 days or recur, administer 1–2 mg/kg prednisone or equivalent per day. Withhold treatment with TECENTRIQ for Grade 3 diarrhea or colitis. Treat with IV methylprednisolone 1–2 mg/kg per day and convert to oral steroids once the patient has improved. For both Grade 2 and Grade 3 diarrhea or colitis, when symptoms improve to Grade 0 or Grade 1, taper steroids over  $\geq 1$  month. Resume treatment with TECENTRIQ if the event improves to Grade 0 or 1 within 12 weeks and corticosteroids have been reduced to the equivalent of  $\leq 10$  mg oral prednisone per day. Permanently discontinue TECENTRIQ for Grade 4 diarrhea or colitis [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

Across clinical trials, colitis or diarrhea occurred in 19.7% (389/1978) of all patients.

### Urothelial Carcinoma

In 523 patients with urothelial carcinoma who received TECENTRIQ, colitis or diarrhea occurred in 98 (18.7%) patients. Ten patients (1.9%) developed Grade 3 or 4 diarrhea. Four patients (0.8%) had immune-mediated colitis or diarrhea with a median time to onset of 1.7 months (range: 1.1 to 3.1 months). Immune-mediated colitis resolved with corticosteroid administration in three of these patients, while the other patient died without resolution of colitis in the setting of diarrhea-associated renal failure.

### NSCLC

In 1027 patients with NSCLC who received TECENTRIQ, colitis or diarrhea occurred in 198 (19.3%) patients. Twelve patients (1.2%) developed Grade 3 colitis or diarrhea. Five patients (0.5%) had immune-mediated colitis or diarrhea with a median time to onset of 21 days (range: 12 days to 3.4 months). Of these patients, one had Grade 3, two had Grade 2, and two had Grade 1 immune-mediated colitis or diarrhea. Immune-mediated colitis or diarrhea resolved with corticosteroid administration in four of these patients, while the fifth patient died due to disease progression prior to resolution of colitis.

### 5.4 Immune-Related Endocrinopathies

Immune-related thyroid disorders, adrenal insufficiency, and type 1 diabetes mellitus, including diabetic ketoacidosis, have occurred in patients receiving TECENTRIQ. Monitor patients for clinical signs and symptoms of endocrinopathies.

***Hypophysitis***

Hypophysitis occurred in 0.2% (1/523) of patients with urothelial cancer receiving TECENTRIQ. Monitor for signs and symptoms of hypophysitis. Administer corticosteroids and hormone replacement as clinically indicated. Withhold TECENTRIQ for Grade 2 or Grade 3 and permanently discontinue for Grade 4 hypophysitis [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

***Thyroid Disorders***

Thyroid function was assessed routinely only at baseline and the end of the study. Monitor thyroid function prior to and periodically during treatment with TECENTRIQ. Asymptomatic patients with abnormal thyroid function tests can receive TECENTRIQ. For symptomatic hypothyroidism, withhold TECENTRIQ and initiate thyroid hormone replacement as needed. Manage isolated hypothyroidism with replacement therapy and without corticosteroids. For symptomatic hyperthyroidism, withhold TECENTRIQ and initiate an anti-thyroid drug as needed. Resume treatment with TECENTRIQ when symptoms of hypothyroidism or hyperthyroidism are controlled and thyroid function is improving [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

Across clinical trials, hypothyroidism and hyperthyroidism occurred in 3.9% (77/1978) and 1.0% (20/1978) of patients, respectively.

***Urothelial Carcinoma***

In 523 patients with urothelial carcinoma who received TECENTRIQ, hypothyroidism occurred in 2.5% (13/523). One patient had Grade 3 and twelve patients had Grade 1–2 hypothyroidism. The median time to first onset was 5.4 months (range: 21 days to 11.3 months). Thyroid stimulating hormone (TSH) was elevated and above the patient's baseline in 16% (21/131) of patients with a follow-up measurement.

Hyperthyroidism occurred in 0.6% (3/523) of patients with urothelial carcinoma. Of the three urothelial carcinoma patients, one patient had Grade 2 and two patients had Grade 1 hyperthyroidism. The median time to onset was 3.2 months (range: 1.4 to 5.8 months). TSH was decreased and below the patient's baseline in 3.8% (5/131) of patients with a follow-up measurement.

***NSCLC***

In 1027 patients with NSCLC who received TECENTRIQ, hypothyroidism occurred in 4.2% (43/1027). Three patients had Grade 3 and forty patients had Grade 1–2 hypothyroidism. The median time to onset was 4.8 months (range 15 days to 31 months.) TSH was elevated and above the patient's baseline in 17% (54/315) of patients with follow-up measurement.

Hyperthyroidism occurred in 1.1% (11/1027) of patients with NSCLC. Eight patients had Grade 2 and three patients had Grade 1 hyperthyroidism. The median time to onset was 4.9 months (range: 21 days to 31 months). TSH was decreased and below the patient's baseline in 7.6% (24/315) of patients with a follow-up measurement.

***Adrenal Insufficiency***

Adrenal insufficiency occurred in 0.4% (7/1978) of patients across clinical trials, including two patients with Grade 3, four patients with Grade 2, and one patient with Grade 1. Adrenal insufficiency resolved in two patients.

For symptomatic adrenal insufficiency, withhold TECENTRIQ and administer methylprednisolone 1–2 mg/kg per day IV followed by oral prednisone 1–2 mg/kg per day or equivalent once symptoms improve. Start steroid taper when symptoms improve to ≤ Grade 1 and taper steroids over ≥ 1 month. Resume treatment with TECENTRIQ if the event improves to ≤ Grade 1 within 12 weeks and corticosteroids have been reduced to the equivalent of ≤ 10 mg oral prednisone per day and the patient is stable on replacement therapy, if required [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

### ***Diabetes Mellitus***

New onset diabetes with ketoacidosis has occurred in patients receiving TECENTRIQ. Diabetes mellitus without an alternative etiology occurred in one (0.2%) patient with urothelial carcinoma and three (0.3%) patients with NSCLC.

Initiate treatment with insulin for type 1 diabetes mellitus. For ≥ Grade 3 hyperglycemia (fasting glucose >250–500 mg/dL), withhold TECENTRIQ. Resume treatment with TECENTRIQ when metabolic control is achieved on insulin replacement therapy [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

## **5.5 Other Immune-Related Adverse Reactions**

Other immune-related adverse reactions including meningoencephalitis, myasthenic syndrome/myasthenia gravis, Guillain-Barré, ocular inflammatory toxicity, and pancreatitis, including increases in serum amylase and lipase levels, have occurred in ≤ 1.0% of patients treated with TECENTRIQ.

### ***Meningitis / Encephalitis***

Monitor patients for clinical signs and symptoms of meningitis or encephalitis. Permanently discontinue TECENTRIQ for any grade of meningitis or encephalitis. Treat with IV steroids (1–2 mg/kg/day methylprednisolone or equivalent) and convert to oral steroids (prednisone 60 mg/day or equivalent) once the patient has improved. When symptoms improve to ≤ Grade 1, taper steroids over ≥ 1 month [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

### ***Motor and Sensory Neuropathy***

Monitor patients for symptoms of motor and sensory neuropathy. Permanently discontinue TECENTRIQ for any grade of myasthenic syndrome/myasthenia gravis or Guillain-Barré syndrome. Institute medical intervention as appropriate. Consider initiation of systemic corticosteroids at a dose of 1–2 mg/kg/day prednisone [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

### ***Pancreatitis***

Symptomatic pancreatitis without an alternative etiology occurred in 0.1% (2/1978) of patients across clinical trials. Monitor patients for signs and symptoms of acute pancreatitis. Withhold TECENTRIQ for ≥ Grade 3 serum amylase or lipase levels (> 2.0 ULN), or Grade 2 or 3 pancreatitis. Treat with 1–2 mg/kg IV methylprednisolone or equivalent per day. Once symptoms improve, follow with 1–2 mg/kg of oral prednisone or equivalent per day. Resume treatment with TECENTRIQ when serum amylase and lipase levels improve to ≤ Grade 1 within 12 weeks or symptoms of pancreatitis have resolved, and corticosteroids have been reduced to ≤ 10 mg oral prednisone or equivalent per day. Permanently discontinue TECENTRIQ for

Grade 4 or any grade of recurrent pancreatitis [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

## 5.6 Infection

Severe infections, including sepsis, herpes encephalitis, and mycobacterial infection leading to retroperitoneal hemorrhage occurred in patients receiving TECENTRIQ. Monitor patients for signs and symptoms of infection and treat with antibiotics for suspected or confirmed bacterial infections. Withhold TECENTRIQ for  $\geq$  Grade 3 infection [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

Across clinical trials, infections occurred in 38.4% (759/1978) of patients.

### Urothelial Carcinoma

In 523 patients with urothelial carcinoma who received TECENTRIQ, infection occurred in 197 (37.7%) patients. Grade 3 or 4 infection occurred in sixty (11.5%) patients, while three patients died due to infections. Urinary tract infections were the most common cause of Grade 3 or higher infection, occurring in 37 (7.1%) patients.

### NSCLC

In Study 3, a randomized trial in patients with NSCLC, infections were more common in patients treated with TECENTRIQ (43%) compared with those treated with docetaxel (34%). Grade 3 or 4 infections occurred in 9.2% of patients treated with TECENTRIQ compared with 2.2% in patients treated with docetaxel. Two patients (1.4%) treated with TECENTRIQ and three patients (2.2%) treated with docetaxel died due to infection. Pneumonia was the most common cause of Grade 3 or higher infection, occurring in 7.7% of patients treated with TECENTRIQ.

## 5.7 Infusion-Related Reactions

Severe infusion reactions have occurred in patients in clinical trials of TECENTRIQ. Infusion-related reactions occurred in 1.3% (25/1978) of patients across clinical trials, 1.7% (9/523) of patients with urothelial carcinoma, and 1.6% (16/1027) of patients with NSCLC. Interrupt or slow the rate of infusion in patients with mild or moderate infusion reactions. Permanently discontinue TECENTRIQ in patients with Grade 3 or 4 infusion reactions [*see Dosage and Administration (2.2) and Adverse Reactions (6.1)*].

## 5.8 Embryo-Fetal Toxicity

Based on its mechanism of action, TECENTRIQ can cause fetal harm when administered to a pregnant woman. Animal studies have demonstrated that inhibition of the PD-L1/PD-1 pathway can lead to increased risk of immune-related rejection of the developing fetus resulting in fetal death. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, advise the patient of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with TECENTRIQ and for at least 5 months after the last dose [*see Use in Specific Populations (8.1, 8.3)*].

## 6 ADVERSE REACTIONS

The following adverse reactions are discussed in greater detail in other sections of the label:

- Immune-Related Pneumonitis [*see Warnings and Precautions (5.1)*]
- Immune-Related Hepatitis [*see Warnings and Precautions (5.2)*]
- Immune-Related Colitis [*see Warnings and Precautions (5.3)*]



- Immune-Related Endocrinopathies [see *Warnings and Precautions (5.4)*]
- Other Immune-Related Adverse Reactions [see *Warnings and Precautions (5.5)*]
- Infection [see *Warnings and Precautions (5.6)*]
- Infusion-Related Reactions [see *Warnings and Precautions (5.7)*]

## 6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

### Urothelial Carcinoma

#### Cisplatin-Ineligible Patients with Locally Advanced or Metastatic Urothelial Carcinoma

The safety of TECENTRIQ was evaluated in Study 4, a multicenter, open-label, single-arm trial that included 119 patients with locally advanced or metastatic urothelial carcinoma who were ineligible for cisplatin-containing chemotherapy and were either previously untreated or had disease progression at least 12 months after neoadjuvant or adjuvant chemotherapy [see *Clinical Studies (14.1)*]. Patients received 1200 mg of TECENTRIQ intravenously every 3 weeks until either unacceptable toxicity or disease progression. The median duration of exposure was 15.0 weeks (range 0, 87 weeks).

The most common adverse reactions ( $\geq 20\%$ ) were fatigue (52%), decreased appetite (24%), diarrhea (24%), and nausea (22%). The most common Grade 3–4 adverse reactions ( $\geq 2\%$ ) were fatigue, urinary tract infection, anemia, diarrhea, blood creatinine increase, intestinal obstruction, ALT increase, hyponatremia, decreased appetite, sepsis, back/neck pain, renal failure, and hypotension.

Five patients (4.2%) who were treated with TECENTRIQ experienced one of the following events which led to death: sepsis, cardiac arrest, myocardial infarction, respiratory failure, or respiratory distress. One additional patient (0.8%) was experiencing herpetic meningoencephalitis and disease progression at the time of death. TECENTRIQ was discontinued for adverse reactions in 4.2% (5/119) of patients. The adverse reactions leading to discontinuation were diarrhea/colitis (1.7%), fatigue (0.8%), hypersensitivity (0.8%), and dyspnea (0.8%). Adverse reactions leading to interruption of TECENTRIQ occurred in 35% of patients, the most common ( $\geq 1\%$ ) were intestinal obstruction, fatigue, diarrhea, urinary tract infection, infusion related reaction, cough, abdominal pain, peripheral edema, pyrexia, respiratory tract infection, upper respiratory tract infection, creatinine increase, decreased appetite, hyponatremia, back pain, pruritus, and venous thromboembolism. Serious adverse reactions occurred in 37% of patients. The most frequent serious adverse reactions ( $\geq 2\%$ ) were diarrhea, intestinal obstruction, sepsis, acute kidney injury, and renal failure.

Immune-related adverse reactions requiring systemic corticosteroids or hormone replacement therapy occurred in 19.3% (23/119) patients, including 12.6% (15/119) patients who required systemic corticosteroid therapy and 6.7% (8/119) patients who required only hormone replacement therapy.

Six patients (5.0%) received an oral prednisone dose equivalent to  $\geq 40$  mg daily for an immune-mediated adverse reaction [see *Warnings and Precautions (5)*].

Table 1 summarizes the adverse reactions that occurred in  $\geq 10\%$  of patients and Table 2 summarizes Grade 3–4 selected laboratory abnormalities that occurred in  $\geq 1\%$  of patients treated with TECENTRIQ in Study 4.

**Table 1: All Grade Adverse Reactions in  
≥ 10% of Patients with Urothelial Carcinoma in Study 4**

Adverse Reaction	TECENTRIQ N = 119	
	All Grades (%)	Grades 3–4 (%)
<b>General Disorders</b>		
Fatigue <sup>a</sup>	52	8
Peripheral edema <sup>b</sup>	17	2
Pyrexia	14	0.8
<b>Gastrointestinal Disorders</b>		
Diarrhea <sup>c</sup>	24	5
Nausea	22	2
Vomiting	16	0.8
Constipation	15	2
Abdominal pain <sup>d</sup>	15	0.8
<b>Metabolism and Nutrition Disorders</b>		
Decreased appetite <sup>e</sup>	24	3
<b>Musculoskeletal and Connective Tissue Disorders</b>		
Back/Neck pain	18	3
Arthralgia	13	0
<b>Skin and Subcutaneous Tissue Disorders</b>		
Pruritus	18	0.8
Rash <sup>f</sup>	17	0.8
<b>Infections</b>		
Urinary tract infection <sup>g</sup>	17	5
<b>Respiratory, Thoracic, and Mediastinal Disorders</b>		
Cough <sup>h</sup>	14	0
Dyspnea <sup>i</sup>	12	0

<sup>a</sup> Includes fatigue, asthenia, lethargy, and malaise

<sup>b</sup> Includes edema peripheral, scrotal edema, lymphedema, and edema

<sup>c</sup> Includes diarrhea, colitis, frequent bowel movements, autoimmune colitis

<sup>d</sup> Includes abdominal pain, upper abdominal pain, lower abdominal pain, and flank pain

<sup>e</sup> Includes decreased appetite and early satiety

<sup>f</sup> Includes rash, dermatitis, dermatitis acneiform, rash maculo-papular, rash erythematous, rash pruritic, rash macular, and rash papular

<sup>g</sup> Includes urinary tract infection, urinary tract infection bacterial, cystitis, and urosepsis

<sup>h</sup> Includes cough and productive cough

<sup>i</sup> Includes dyspnea and exertional dyspnea

**Table 2: Grade 3–4 Laboratory Abnormalities in Patients with Urothelial Carcinoma in Study 4 in  $\geq 1\%$  of Patients**

Laboratory Test	Grades 3–4 (%)
Hyponatremia	15
Hyperglycemia	10
Lymphopenia	9
Anemia	7
Increased Alkaline phosphatase	7
Increased Creatinine	5
Hypophosphatemia	4
Increased ALT	4
Increased AST	4
Hyperkalemia	3
Hypermagnesemia	3
Hyperbilirubinemia	3

### Previously Treated Patients with Locally Advanced or Metastatic Urothelial Carcinoma

The safety of TECENTRIQ was evaluated in Study 1, a multicenter, open-label, single-arm trial that included 310 patients in a single arm trial with locally advanced or metastatic urothelial carcinoma who had disease progression during or following at least one platinum-containing chemotherapy regimen or who had disease progression within 12 months of treatment with a platinum-containing neoadjuvant or adjuvant chemotherapy regimen [see *Clinical Studies (14.1)*]. Patients received 1200 mg of TECENTRIQ intravenously every 3 weeks until unacceptable toxicity or either radiographic or clinical progression. The median duration of exposure was 12.3 weeks (range: 0.1, 46 weeks).

The most common adverse reactions ( $\geq 20\%$ ) were fatigue (52%), decreased appetite (26%), nausea (25%), urinary tract infection (22%), pyrexia (21%), and constipation (21%). The most common Grade 3–4 adverse reactions ( $\geq 2\%$ ) were urinary tract infection, anemia, fatigue, dehydration, intestinal obstruction, urinary obstruction, hematuria, dyspnea, acute kidney injury, abdominal pain, venous thromboembolism, sepsis, and pneumonia.

Three patients (1.0%) who were treated with TECENTRIQ experienced one of the following events which led to death: sepsis, pneumonitis, or intestinal obstruction. TECENTRIQ was discontinued for adverse reactions in 3.2% (10/310) of the 310 patients. Sepsis led to discontinuation in 0.6% (2/310) of patients. Adverse reactions leading to interruption of TECENTRIQ occurred in 27% of patients; the most common ( $> 1\%$ ) were liver enzyme increase, urinary tract infection, diarrhea, fatigue, confusional state, urinary obstruction, pyrexia, dyspnea, venous thromboembolism, and pneumonitis. Serious adverse reactions occurred in 45% of patients. The most frequent serious adverse reactions ( $> 2\%$ ) were urinary tract infection, hematuria, acute kidney injury, intestinal obstruction, pyrexia, venous thromboembolism, urinary obstruction, pneumonia, dyspnea, abdominal pain, sepsis, and confusional state.

Immune-related adverse reactions requiring systemic corticosteroids or hormone replacement therapy occurred in 11.0% (34/310) patients, including 8.4% (26/310) patients who required systemic corticosteroid therapy and 2.6% (8/310) patients who required only hormone replacement therapy.

Eighteen patients (5.8%) received an oral prednisone dose equivalent to  $\geq 40$  mg daily for an immune-mediated adverse reaction [see *Warnings and Precautions (5)*].

Table 3 summarizes the adverse reactions that occurred in  $\geq 10\%$  of patients while Table 4 summarizes Grade 3–4 selected laboratory abnormalities that occurred in  $\geq 1\%$  of patients treated with TECENTRIQ in Study 1.

**Table 3: All Grade Adverse Reactions in  $\geq 10\%$  of Patients with Urothelial Carcinoma in Study 1**

Adverse Reaction	TECENTRIQ N=310	
	All Grades (%)	Grades 3–4 (%)
<b>Gastrointestinal Disorders</b>		
Nausea	25	2
Constipation	21	0.3
Diarrhea	18	1
Abdominal pain	17	4
Vomiting	17	1
<b>General Disorders</b>		
Fatigue	52	6
Pyrexia	21	1
Peripheral edema	18	1
<b>Infections</b>		
Urinary tract infection	22	9
<b>Metabolism and Nutrition Disorders</b>		
Decreased appetite	26	1
<b>Musculoskeletal and Connective Tissue Disorders</b>		
Back/Neck pain	15	2
Arthralgia	14	1
<b>Renal and urinary disorders</b>		
Hematuria	14	3
<b>Respiratory, Thoracic, and Mediastinal Disorders</b>		
Dyspnea	16	4
Cough	14	0.3
<b>Skin and Subcutaneous Tissue Disorders</b>		
Rash	15	0.3
Pruritus	13	0.3

**Table 4: Grade 3–4 Laboratory Abnormalities in Patients with Urothelial Carcinoma in Study 1 in  $\geq 1\%$  of Patients**

Laboratory Test	Grades 3–4 (%)
Lymphopenia	10
Hyponatremia	10
Anemia	8
Hyperglycemia	5
Increased Alkaline phosphatase	4
Increased Creatinine	3
Increased ALT	2
Increased AST	2
Hypoalbuminemia	1

**NSCLC**

The safety of TECENTRIQ was evaluated in Study 3, a multicenter, international, randomized, open-label trial in patients with metastatic NSCLC who progressed during or following a platinum-containing regimen, regardless of PD-L1 expression [see *Clinical Studies (14.2)*]. Patients received 1200 mg of TECENTRIQ (n=142) administered intravenously every 3 weeks until unacceptable toxicity or either radiographic or clinical progression or docetaxel (n=135) administered intravenously at 75 mg/m<sup>2</sup> every 3 weeks until unacceptable toxicity or disease progression. The median duration of exposure was 3.7 months (range: 0–19 months) in TECENTRIQ-treated patients and 2.1 months (range: 0–17 months) in docetaxel-treated patients.

The most common adverse reactions ( $\geq 20\%$ ) in patients receiving TECENTRIQ were fatigue (46%), decreased appetite (35%), dyspnea (32%), cough (30%), nausea (22%), musculoskeletal pain (22%), and constipation (20%). The most common Grade 3-4 adverse reactions ( $\geq 2\%$ ) were dyspnea, pneumonia, hypoxia, hyponatremia, fatigue, anemia, musculoskeletal pain, AST increase, ALT increase, dysphagia, and arthralgia.

Nine patients (6.3%) who were treated with TECENTRIQ experienced either pulmonary embolism (2), pneumonia (2), pneumothorax, ulcer hemorrhage, cachexia secondary to dysphagia, myocardial infarction, or large intestinal perforation which led to death. TECENTRIQ was discontinued due to adverse reactions in 4% (6/142) of patients. Adverse reactions leading to interruption of TECENTRIQ occurred in 24% of patients; the most common ( $>1\%$ ) were pneumonia, liver function test abnormality, upper respiratory tract infection, pneumonitis, acute kidney injury, hypoxia, hypothyroidism, dyspnea, anemia, and fatigue. Serious adverse reactions occurred in 37% of patients. The most frequent serious adverse reactions ( $> 2\%$ ) were pneumonia, dyspnea, pleural effusion, pyrexia, and venous thromboembolism.

Table 5 summarizes adverse reactions that occurred in at least 10% of TECENTRIQ-treated patients and at a higher incidence than in the docetaxel arm. Table 6 summarizes selected laboratory abnormalities worsening from baseline that occurred in  $\geq 10\%$  of TECENTRIQ-treated patients and at a higher incidence than in the docetaxel arm.

**Table 5: Adverse Reactions Occurring in  $\geq 10\%$  of TECENTRIQ-Treated Patients with NSCLC and at a Higher Incidence than in the Docetaxel Arm (Between Arm Difference of  $\geq 5\%$  [All Grades] or  $\geq 2\%$  [Grades 3–4]) (Study 3)**

Adverse Reaction	TECENTRIQ (n=142)		Docetaxel (n=135)	
	All grades	Grade 3–4	All grades	Grade 3–4
Percentage (%) of Patients				
<b>General Disorders</b>				
Pyrexia	18	0	13	0
<b>Infections</b>				
Pneumonia	18	6	4	2
<b>Metabolism and nutrition disorders</b>				
Decreased appetite	35	1	22	0
<b>Musculoskeletal and connective tissue disorders</b>				
Arthralgia	16	2	9	2
Back pain	14	1	9	1
<b>Psychiatric Disorders</b>				
Insomnia	14	0	8	2
<b>Respiratory, thoracic and mediastinal disorders</b>				
Dyspnea	32	7	24	2
Cough	30	1	25	0

**Table 6: Selected Laboratory Abnormalities Worsening from Baseline Occurring in  $\geq 10\%$  of TECENTRIQ-Treated Patients with NSCLC and at a Higher Incidence than in the Docetaxel Arm (Between Arm Difference of  $\geq 5\%$  [All Grades] or  $\geq 2\%$  [Grades 3–4]) (Study 3)**

Test	Percentage of Patients with Worsening Laboratory Test from Baseline			
	TECENTRIQ		Docetaxel	
	All grades %	Grade 3–4 %	All grades %	Grade 3–4 %
Hyponatremia	48	13	28	8
Hypoalbuminemia	48	5	49	1
Alkaline Phosphatase increased	42	2	24	1
Aspartate aminotransferase increased	33	2	15	0
Alanine aminotransferase increased	31	2	9	1
Creatinine increased	19	1	14	2
Hypokalemia	18	2	11	4
Hypercalcemia	13	0	5	0
Total Bilirubin increased	11	0	5	1

## 6.2 Immunogenicity

As with all therapeutic proteins, there is a potential for immunogenicity. Among 275 patients in Study 1, 114 patients (41.5%) tested positive for treatment-emergent (treatment-induced or treatment-enhanced) anti-therapeutic antibodies (ATA) at one or more post-dose time points. Among 135 patients in Study 3, 73 patients (54.1%) tested positive for treatment-emergent



ATAs at one or more post-dose time points. Among 111 patients in Study 4, 53 patients (47.7%) tested positive for treatment-emergent ATAs at one or more post-dose time points. In Study 1, Study 3, and Study 4, the presence of ATAs did not appear to have a clinically significant impact on pharmacokinetics, safety or efficacy.

Immunogenicity assay results are highly dependent on several factors, including assay sensitivity and specificity, assay methodology, sample handling, timing of sample collection, concomitant medications and underlying disease. For these reasons, comparison of incidence of ATAs to TECENTRIQ with the incidence of antibodies to other products may be misleading.

### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form:

<http://forms.gov.il/globaldata/getsequence/getsequence.aspx?formType=AdversEffectMedic@moh.gov.il>

## **8 USE IN SPECIFIC POPULATIONS**

### **8.1 Pregnancy**

#### **Risk Summary**

Based on its mechanism of action, TECENTRIQ can cause fetal harm when administered to a pregnant woman [*see Clinical Pharmacology (12.1)*]. There are no available data on the use of TECENTRIQ in pregnant women. Animal studies have demonstrated that inhibition of the PD-L1/PD-1 pathway can lead to increased risk of immune-related rejection of the developing fetus resulting in fetal death [*see Data*]. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, advise the patient of the potential risk to a fetus.

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

#### **Data**

##### ***Animal Data***

Animal reproduction studies have not been conducted with TECENTRIQ to evaluate its effect on reproduction and fetal development. A literature-based assessment of the effects on reproduction demonstrated that a central function of the PD-L1/PD-1 pathway is to preserve pregnancy by maintaining maternal immune tolerance to a fetus. Blockage of PD-L1 signaling has been shown in murine models of pregnancy to disrupt tolerance to a fetus and to result in an increase in fetal loss; therefore, potential risks of administering TECENTRIQ during pregnancy include increased rates of abortion or stillbirth. As reported in the literature, there were no malformations related to the blockade of PD-L1/PD-1 signaling in the offspring of these animals; however, immune-mediated disorders occurred in PD-1 and PD-L1 knockout mice. Based on its mechanism of action, fetal exposure to atezolizumab may increase the risk of developing immune-mediated disorders or altering the normal immune response.

## **8.2 Lactation**

### **Risk Summary**

There is no information regarding the presence of atezolizumab in human milk, the effects on the breastfed infant, or the effects on milk production. As human IgG is excreted in human milk, the potential for absorption and harm to the infant is unknown. Because of the potential for serious adverse reactions in breastfed infants from TECENTRIQ, advise a lactating woman not to breastfeed during treatment and for at least 5 months after the last dose.

## **8.3 Females and Males of Reproductive Potential**

### **Contraception**

#### ***Females***

Based on its mechanism of action, TECENTRIQ can cause fetal harm when administered to a pregnant woman [see *Use in Specific Populations (8.1)*]. Advise females of reproductive potential to use effective contraception during treatment with TECENTRIQ and for at least 5 months following the last dose.

### **Infertility**

#### ***Females***

Based on animal studies, TECENTRIQ may impair fertility in females of reproductive potential while receiving treatment [see *Nonclinical Toxicology (13.1)*].

## **8.4 Pediatric Use**

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

## **8.5 Geriatric Use**

Of the 310 previously-treated patients with urothelial carcinoma treated with TECENTRIQ in Study 1, 59% were 65 years or older. Of the 142 patients with NSCLC treated with TECENTRIQ in Study 3, 39% were 65 years or older. No overall differences in safety or efficacy were observed between patients  $\geq$  65 years of age and younger patients.

Of the 119 cisplatin-ineligible patients with urothelial carcinoma treated with TECENTRIQ in Study 4, 83% were 65 years or older and 41% were 75 years or older. The overall response rate in patients 65 years or older was 23% (23/99) and in patients 75 years or older was 29% (14/49). Grade 3 or 4 adverse reactions occurred in 53% (52/99) of patients 65 years or older and 51% (25/49) of patients 75 years or older. No overall differences in safety or efficacy were observed between patients  $\geq$  75 years of age and younger patients.

## **8.6 Renal Impairment**

Based on a population pharmacokinetic analysis, no dose adjustment of TECENTRIQ is recommended for patients with renal impairment [see *Clinical Pharmacology (12.3)*].

## **8.7 Hepatic Impairment**

Based on a population pharmacokinetic analysis, no dose adjustment of TECENTRIQ is recommended for patients with mild hepatic impairment. TECENTRIQ has not been studied in patients with moderate or severe hepatic impairment [see *Clinical Pharmacology (12.3)*].

## **10 OVERDOSAGE**

There is no information on overdose with TECENTRIQ.

## 11 DESCRIPTION

Atezolizumab is an Fc-engineered, humanized, monoclonal antibody that binds to PD-L1 and blocks interactions with the PD-1 and B7.1 receptors. Atezolizumab is a non-glycosylated IgG1 kappa immunoglobulin that has a calculated molecular mass of 145 kDa.

TECENTRIQ injection for intravenous infusion is a sterile, preservative-free, colorless to slightly yellow solution in single-dose vials. Each mL of TECENTRIQ contains 60 mg of atezolizumab and is formulated in glacial acetic acid (16.5 mg), L-histidine (62 mg), sucrose (821.6 mg), polysorbate 20 (8 mg), pH 5.8.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

PD-L1 may be expressed on tumor cells and/or tumor-infiltrating immune cells and can contribute to the inhibition of the anti-tumor immune response in the tumor microenvironment. Binding of PD-L1 to the PD-1 and B7.1 receptors found on T cells and antigen presenting cells suppresses cytotoxic T-cell activity, T-cell proliferation and cytokine production.

Atezolizumab is a monoclonal antibody that binds to PD-L1 and blocks its interactions with both PD-1 and B7.1 receptors. This releases the PD-L1/PD-1 mediated inhibition of the immune response, including activation of the anti-tumor immune response without inducing antibody-dependent cellular cytotoxicity. In syngeneic mouse tumor models, blocking PD-L1 activity resulted in decreased tumor growth.

### 12.3 Pharmacokinetics

Patients' exposures to atezolizumab increased dose proportionally over the dose range of 1 mg/kg to 20 mg/kg, including the fixed dose 1200 mg administered every 3 weeks. Based on a population analysis that included 472 patients in the dose range, the typical population clearance was 0.20 L/day, volume of distribution at steady state was 6.9 L, and the terminal half-life was 27 days. The population PK analysis suggests steady state is obtained after 6 to 9 weeks (2 to 3 cycles) of repeated dosing. The systemic accumulation in area under the curve (AUC), maximum concentration (C<sub>max</sub>) and trough concentration (C<sub>min</sub>) was 1.91, 1.46 and 2.75-fold, respectively. In a post hoc analysis, atezolizumab clearance was found to decrease over time, with a mean maximal reduction (% coefficient of variation [CV%]) from baseline value of approximately 17.1% (40.6%). However, the decrease in CL was not considered clinically relevant.

*Specific Populations:* Age (21–89 years), body weight, gender, positive anti-therapeutic antibody (ATA) status, albumin levels, tumor burden, region or race, mild or moderate renal impairment (estimated glomerular filtration rate (eGFR) 30 to 89 mL/min/1.73 m<sup>2</sup>), mild hepatic impairment (bilirubin ≤ ULN and AST > ULN or bilirubin < 1.0 to 1.5 × ULN and any AST), level of PD-L1 expression, or ECOG status had no clinically significant effect on the systemic exposure of atezolizumab.

The effect of severe renal impairment (eGFR 15 to 29 mL/min/1.73 m<sup>2</sup>) or moderate or severe hepatic impairment (bilirubin > ULN and AST > ULN or bilirubin ≥ 1.0 to 1.5 × ULN and any AST) on the pharmacokinetics of atezolizumab is unknown.

### *Drug Interaction Studies*

The drug interaction potential of atezolizumab is unknown.

## 13 NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

No studies have been performed to test the potential of atezolizumab for carcinogenicity or genotoxicity.

Animal fertility studies have not been conducted with atezolizumab; however, an assessment of the male and female reproductive organs was included in a 26-week, repeat-dose toxicity study in cynomolgus monkeys. Weekly administration of atezolizumab to female monkeys at the highest dose tested caused an irregular menstrual cycle pattern and a lack of newly formed corpora lutea in the ovaries. This effect occurred at an estimated AUC approximately 6 times the AUC in patients receiving the recommended dose and was reversible. There was no effect on the male monkey reproductive organs.

### 13.2 Animal Toxicology and/or Pharmacology

In animal models, inhibition of PD-L1/PD-1 signaling increased the severity of some infections and enhanced inflammatory responses. *M. tuberculosis*-infected PD-1 knockout mice exhibit markedly decreased survival compared with wild-type controls, which correlated with increased bacterial proliferation and inflammatory responses in these animals. PD-L1 and PD-1 knockout mice and mice receiving PD-L1 blocking antibody have also shown decreased survival following infection with lymphocytic choriomeningitis virus.

## 14 CLINICAL STUDIES

### 14.1 Urothelial Carcinoma

#### Cisplatin-Ineligible Patients with Locally Advanced or Metastatic Urothelial Carcinoma

The efficacy of TECENTRIQ was investigated in Study 4, a multicenter, open-label, single-arm trial that included 119 patients with locally advanced or metastatic urothelial carcinoma who were ineligible for cisplatin-containing chemotherapy and were either previously untreated or had disease progression at least 12 months after neoadjuvant or adjuvant chemotherapy. Patients were considered cisplatin-ineligible if they met any one of the following criteria at study entry: impaired renal function (creatinine clearance of  $> 30$  but  $< 60$  mL/min), ECOG score of 2, hearing loss of  $\geq 25$  dB at two contiguous frequencies, or  $\geq$  Grade 2 peripheral neuropathy. This study excluded patients who had: a history of autoimmune disease; active or corticosteroid-dependent brain metastases; administration of a live, attenuated vaccine within 28 days prior to enrollment; or administration of systemic immunostimulatory agents within 6 weeks or systemic immunosuppressive medications within 2 weeks prior to enrollment. Patients received an intravenous infusion of 1200 mg of TECENTRIQ every 3 weeks until unacceptable toxicity or disease progression. Tumor response assessments were conducted every 9 weeks for the first 54 weeks and every 12 weeks thereafter. Major efficacy outcome measures included confirmed objective response rate (ORR) as assessed by independent review facility (IRF) using Response Evaluation Criteria in Solid Tumors (RECIST v1.1), duration of response (DoR) and overall survival (OS).

In this study, the median age was 73 years, 81% were male, and 91% were Caucasian. Thirty-five percent of patients had non-bladder urothelial carcinoma and 66% had visceral metastases. Eighty percent of patients had an ECOG score of 0-1. Reasons for patients' ineligibility for cisplatin-containing chemotherapy were: 70% had impaired renal function, 20% had an ECOG score of 2, 14% had a hearing loss of  $\geq 25$ db, and 6% had  $\geq$  Grade 2 peripheral neuropathy at baseline. Twenty percent of patients had disease progression following prior platinum-containing neoadjuvant or adjuvant chemotherapy.

Tumor specimens were evaluated prospectively using the Ventana PD-L1 (SP142) Assay at a central laboratory, and the results were used to define subgroups for pre-specified analyses. Of the 119 patients, 27% were classified as having PD-L1 expression of  $\geq 5\%$  (defined as PD-L1 stained tumor-infiltrating immune cells [IC] covering  $\geq 5\%$  of the tumor area). The remaining 73% of patients were classified as having PD-L1 expression of  $< 5\%$  (PD-L1 stained tumor-infiltrating IC covering  $< 5\%$  of the tumor area).

Confirmed ORR in all patients and the two PD-L1 subgroups are summarized in Table 7. The median follow-up time for this study was 14.4 months. In 24 patients with disease progression following neoadjuvant or adjuvant therapy, the ORR was 33.0% (95% CI: 16%, 55%).

**Table 7: Summary of Efficacy from Study 4**

	All Patients	PD-L1 Expression Subgroups	
		PD-L1 Expression of < 5% in ICs <sup>1</sup> (N=87)	PD-L1 Expression of ≥ 5% in ICs <sup>1</sup> (N=32)
	N=119		
<b>Number of IRF-assessed Confirmed Responders</b>	28	19	9
<b>ORR % (95% CI)</b>	<b>23.5% (16.2, 32.2)</b>	<b>21.8% (13.7, 32.0)</b>	<b>28.1% (13.8, 46.8)</b>
Complete Response (CR) (%)	6.7%	6.9%	6.3%
Partial Response (PR) (%)	16.8%	14.9%	21.9%
<b>Median DoR, months (range)</b>	NR (3.7, 16.6+)	NR (3.7, 16.6+)	NR (8.1, 15.6+)
NR = Not reached + Denotes a censored value <sup>1</sup> PD-L1 expression in tumor-infiltrating immune cells (ICs)			

### Previously Treated Patients with Locally Advanced or Metastatic Urothelial Carcinoma

The efficacy of TECENTRIQ was investigated in Study 1, a multicenter, open-label, single-arm trial that included 310 patients with locally advanced or metastatic urothelial carcinoma who had disease progression during or following a platinum-containing chemotherapy regimen or who had disease progression within 12 months of treatment with a platinum-containing neoadjuvant or adjuvant chemotherapy regimen. This study excluded patients who had: a history of autoimmune disease, active or corticosteroid-dependent brain metastases, administration of a live, attenuated vaccine within 28 days prior to enrollment, or administration of systemic immunostimulatory agents within 6 weeks or systemic immunosuppressive medications within 2 weeks prior to enrollment. Patients received an intravenous infusion of 1200 mg of TECENTRIQ every 3 weeks until unacceptable toxicity or either radiographic or clinical progression. Tumor response assessments were conducted every 9 weeks for the first 54 weeks and every 12 weeks thereafter. Major efficacy outcome measures included confirmed objective response rate (ORR) as assessed by independent review facility (IRF) using Response Evaluation Criteria in Solid Tumors (RECIST v1.1) and duration of response (DOR).

In this study, the median age was 66 years, 78% were male, 91% of patients were Caucasian. Twenty-six percent had non-bladder urothelial carcinoma and 78% of patients had visceral metastases. Sixty-two percent of patients had an ECOG score of 1 and 35% of patients had a baseline creatinine clearance of < 60 mL/min. Nineteen percent of patients had disease progression following prior platinum-containing neoadjuvant or adjuvant chemotherapy. Forty-one percent of patients had received ≥ 2 prior systemic regimens in the metastatic setting. Seventy-three percent of patients received prior cisplatin, 26% had prior carboplatin, and 1% were treated with other platinum-based regimens.

Tumor specimens were evaluated prospectively using the VENTANA PD-L1 (SP142) Assay at a central laboratory and the results were used to define subgroups for pre-specified analyses. Of the 310 patients, 32% were classified as having PD-L1 expression of ≥ 5% (defined as PD-L1 stained tumor-infiltrating immune cells [IC] covering ≥ 5% of the tumor area). The remaining

68% of patients were classified as having PD-L1 expression of < 5% (PD-L1 stained tumor-infiltrating IC covering < 5% of the tumor area).

Confirmed ORR in all patients and the two PD-L1 subgroups are summarized in Table 8. The median follow-up time for this study was 14.4 months. In 59 patients with disease progression following neoadjuvant or adjuvant therapy, the ORR was 22.0% (95% CI: 12.3%, 34.7%).

**Table 8: Summary of Efficacy from Study 1**

	All Patients  N=310	PD-L1 Expression Subgroups	
		PD-L1 Expression of < 5% in IC <sup>1</sup> (N=210)	PD-L1 Expression of ≥ 5% in IC <sup>1</sup> (N=100)
Number of IRF-assessed Confirmed Responders	46	20	26
ORR % (95% CI)	<b>14.8% (11.1, 19.3)</b>	<b>9.5% (5.9, 14.3)</b>	<b>26.0% (17.7, 35.7)</b>
Complete Response (CR) (%)	5.5%	2.4%	12.0%
Partial Response (PR) (%)	9.4%	7.1%	14.0%
Median DOR, months (range)	NR (2.1+, 13.8+)	12.7 (2.1+, 12.7)	NR (4.2, 13.8+)
NR = Not reached + Denotes a censored value <sup>1</sup> PD-L1 expression in tumor-infiltrating immune cells (IC)			

## 14.2 Metastatic Non-Small Cell Lung Cancer

### Previously Treated Patients with Metastatic NSCLC

The efficacy of TECENTRIQ was investigated in two multicenter, international, randomized, open-label trials in patients with metastatic NSCLC who progressed during or following a platinum-containing regimen. Study 2 was a trial in 1225 patients with the primary analysis population consisting of the first 850 randomized patients and Study 3 was a trial in 287 patients. In both studies, eligible patients were stratified by PD-L1 expression status in tumor-infiltrating immune cells (IC), by the number of prior chemotherapy regimens, and by histology. Patients were randomized (1:1) to receive either TECENTRIQ administered intravenously at 1200 mg every 3 weeks until unacceptable toxicity or either radiographic or clinical progression or docetaxel administered intravenously at 75 mg/m<sup>2</sup> every 3 weeks until unacceptable toxicity or disease progression. These studies excluded patients who had: a history of autoimmune disease, had active or corticosteroid-dependent brain metastases, administration of a live, attenuated vaccine within 28 days prior to enrollment, administration of systemic immunostimulatory agents within 4 weeks or systemic immunosuppressive medications within 2 weeks prior to enrollment. Tumor assessments were conducted every 6 weeks for the first 36 weeks, and every 9 weeks thereafter. In Study 2, tumor specimens were evaluated prospectively for PD-L1 expression on tumor cells (TC) and IC using the VENTANA PD-L1 (SP142) Assay and the results were used to define the PD-L1 expression subgroups for the analyses described below.

In Study 2, among patients in the primary analysis population, the median age was 64 years (range: 33 to 85), and 61% of patients were male. The majority of patients were white (70%).

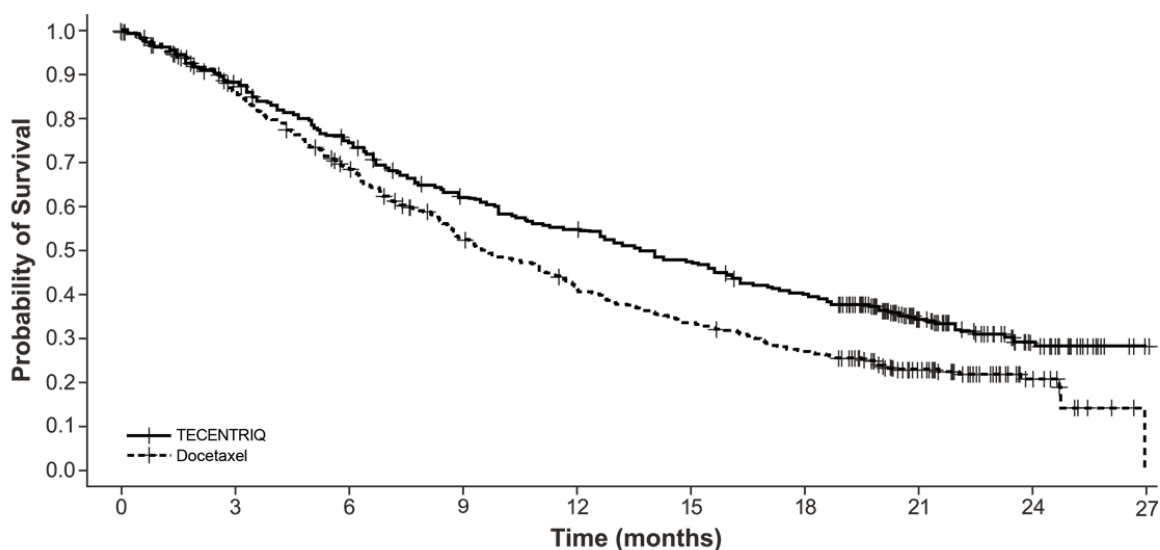
Approximately three-fourths of patients had non-squamous disease (74%), 10% had known EGFR mutation, 0.2% had known ALK rearrangements, and most patients were current or previous smokers (82%). Baseline ECOG performance status was 0 (37%) or 1 (63%). Seventy five percent of patients received only one prior platinum-based therapeutic regimen. In Study 3, the median age was 62 years (range: 36 to 84), and 59% of patients were male. The majority of patients were white (79%). Approximately two-thirds of patients had non-squamous disease (66%), 7% had known EGFR mutation, 1% had ALK rearrangements, and most patients were current or previous smokers (80%). Baseline ECOG performance status was 0 (33%) or 1 (67%). Approximately two-thirds of patients received only one prior platinum-based therapeutic regimen.

The major efficacy outcome measure of Study 2 was overall survival (OS) in the primary analysis population (first 850 randomized patients). The major efficacy outcome measure of Study 3 was overall survival (OS). Other efficacy outcome measures for Study 3 included investigator-assessed objective response rates and duration of response per RECIST v1.1. The results of Study 2 with a median follow up of 21 months are presented in Table 9 and Figure 1.

**Table 9: Efficacy Results in the Primary Analysis Population from Study 2**

	<b>TECENTRIQ (n=425)</b>	<b>Docetaxel (n=425)</b>
<b>Overall Survival</b>		
Deaths (%)	271 (64%)	298 (70%)
Median, months (95% CI)	13.8 (11.8, 15.7)	9.6 (8.6, 11.2)
Hazard ratio <sup>1</sup> (95% CI)		0.74 (0.63, 0.87)
p-value <sup>2</sup>		0.0004
<sup>1</sup> Stratified by PD-L1 expression in tumor infiltrating immune cells, the number of prior chemotherapy regimens, and histology		
<sup>2</sup> Based on the stratified log-rank test		
CI=confidence interval		



**Figure 1: Kaplan-Meier Plot of Overall Survival in the Primary Analysis Population in Study 2**

No. Patients at Risk

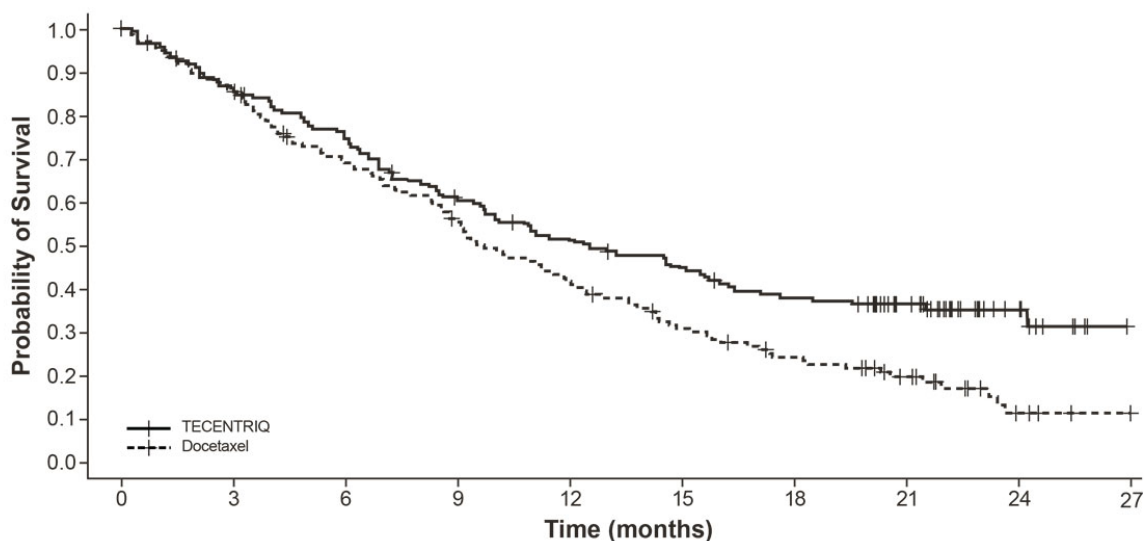
TECENTRIQ	425	407	382	363	342	326	305	279	260	248	234	223	218	205	198	188	175	163	157	141	116	74	54	41	28	15	4	1
Docetaxel	425	390	365	336	311	286	263	236	219	195	179	168	151	140	132	123	116	104	98	90	70	51	37	28	16	6	3	

Tumor specimens were evaluated prospectively using the VENTANA PD-L1 (SP142) Assay at a central laboratory and the results were used to define the PD-L1 expression subgroups for pre-specified analyses. Of the 850 patients, 16% were classified as having high PD-L1 expression, defined as having PD-L1 expression on  $\geq 50\%$  of TC or  $\geq 10\%$  of IC. In an exploratory efficacy subgroup analysis of OS based on PD-L1 expression, the hazard ratio was 0.41 (95% CI: 0.27, 0.64) in the high PD-L1 expression subgroup and 0.82 (95% CI: 0.68, 0.98) in patients who did not have high PD-L1 expression.

Results of an updated survival analysis in Study 3 with a median follow-up of 22 months are provided for all randomized patients (Table 10 and Figure 2).

**Table 10: Efficacy Results from Study 3**

	<b>TECENTRIQ (n=144)</b>	<b>Docetaxel (n=143)</b>
<b>Overall Survival</b>		
Deaths (%)	90 (63%)	110 (77%)
Median, months (95% CI)	12.6 (9.7, 16.0)	9.7 (8.6, 12.0)
Hazard ratio <sup>1</sup> (95% CI)	0.69 (0.52, 0.92)	
<b>Objective Response Rate<sup>2</sup> n (%)</b>	22 (15%)	21 (15%)
(95% CI)	(10%, 22%)	(9%, 22%)
Complete response	1 (0.7%)	0
Partial response	21 (15%)	21 (15%)
<b>Duration of Response<sup>2</sup></b>	n=22	n=21
Median (months) (95% CI)	18.6 (11.6, NE)	7.2 (5.6, 12.5)
<sup>1</sup> Stratified by PD-L1 expression in tumor-infiltrating immune cells, the number of prior chemotherapy regimens, and histology		
<sup>2</sup> per RECIST v1.1 (Response Evaluation Criteria in Solid Tumors v1.1)		
CI=confidence interval; NE=not estimable		

**Figure 2: Kaplan-Meier Plot of updated Overall Survival in Study 3**

No. of Patients at Risk

TECENTRIQ	144	139	131	123	117	110	106	95	90	84	78	73	70	67	64	60	54	52	50	49	46	34	24	14	11	5	1
Docetaxel	143	130	123	118	106	97	92	87	82	73	65	61	55	49	46	39	36	33	29	27	24	18	12	9	5	2	1

**16 HOW SUPPLIED/STORAGE AND HANDLING**

TECENTRIQ injection is a sterile, preservative-free, and colorless to slightly yellow solution for intravenous infusion supplied as a carton containing one 1200 mg/20 mL single-dose vial

**Storage:** Store vials in a refrigerator at 2°C to 8°C in the outer carton in order to protect from light. Do not freeze. Do not shake.

**17 MARKETING AUTHORISATION HOLDER**

Roche Pharmaceuticals (Israel) Ltd. P.O.B. 6391, Hod Hasharon, 4524079.

**18 MARKETING AUTHORISATION NUMBER(S):**

158.66.34982.00

**19 MANUFACTURER**

Hoffmann-La Roche Ltd, Basel, Switzerland

This leaflet format has been determined by the Ministry of Health and the content has been checked and approved in December 2017

Tecentriq PI version 2