These highlights do not include all the information needed to use CASPOFUNGIN ACETATE FOR INJECTION safely and effectively. See full prescribing information for CASPOFUNGIN ACETATE FOR INJECTION.

CASPOFUNGIN ACETATE for injection, for intravenous use Initial U.S. Approval: 2001

- INDICATIONS AND USAGE

Caspofungin acetate for injection is an echinocandin antifungal indicated in adults and pediatric patients (3 months of age and older) for:

- Empirical therapy for presumed fungal infections in febrile, neutropenic patients. (1)
 Treatment of candidemia and the following *Candida* infec-
- tions: intra-abdominal abscesses, peritonitis and pleural space infections. (1)
- Treatment of esophageal candidiasis. (1) Treatment of invasive aspergillosis in patients who are refrac-tory to or intolerant of other therapies. (1)

- DOSAGE AND ADMINISTRATION

- Important Administration Instructions for All Patients (2.1):
 Administer by slow intravenous (IV) infusion over approximately 1 hour. Do not administer by intravenous (IV) bolus administration.
- Do not mix or co-infuse caspofungin acetate for injection with other medications. Do not use diluents containing dextrose (α -D-glucose).
- Dosage in Adults [18 years of age and older] (2.2):
 Administer a single 70 mg loading dose on Day 1, followed by 50 mg once daily for all indications except esophageal candidiasis.
 For esophageal candidiasis, use 50 mg once daily with no
- loading dose.
- Dosage in Pediatric Patients [3 months to 17 years of age] (2.3): Dosing should be based on the patient's body surface area.
- For all indications, administer a single 70 mg/m² loading dose on Day 1, followed by 50 mg/m² once daily thereafter.
 Maximum loading dose and daily maintenance dose should
- not exceed 70 mg, regardless of the patient's calculated

Dosage Adjustments in Patients with Hepatic Impairment (2.4): Reduce dosage for adult patients with moderate hepatic impairment (35 mg once daily, with a 70 mg loading dose on Day 1 where appropriate).

Dosage Adjustments in Patients Receiving Concomitant Inducers of Hepatic CYP Enzymes (2.5): • Use 70 mg once daily dose for adult patients on rifampin.

- Consider dose increase to 70 mg once daily for adult patients on nevirapine, efavirenz, carbamazepine, dexamethasone, or phenytoin.
- Prediatric patients receiving these same concomitant medica-tions may also require an increase in dose to 70 mg/m² once daily (maximum daily dose not to exceed 70 mg).

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 1.2 Treatment of Candidemia and Other Candida Infec-tional Infection Infectina Infection Infection Infection Infection Infection Infection tions
- Treatment of Esophageal Candidiasis Treatment of Invasive Aspergillosis in Patients Who Are Refractory to or Intolerant of Other Therapies

2 DOSAGE AND ADMINISTRATION

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FRESENIUS

451328A/Revised: December 2016

for Injection

Caspofungin Acetate

6.1 Clinical Trials Experience6.2 Postmarketing Experience

FULL PRESCRIBING INFORMATION

- INDICATIONS AND USAGE
- Empirical Therapy for Presumed Fungal Infections in Febrile, Neutropenic Patients Caspofungin acetate for injection is indicated as empirical therapy for presumed fungal infections in febrile, neutro-penic adult and pediatric patients (3 months of age and older) [see Clinical Studies (14.1, 14.5)]. 1.1
- Treatment of Candidemia and Other Candida Infections 1.2 Caspofungin acetate for injection is indicated for the treatment of candidemia and the following *Candida* infections: intra-abdominal abscesses, peritonitis, and pleural space infections in adult and pediatric patients (3 months of age and older) [see *Clinical Studies* (14.2, 14.5)].

Limitation of Use: Caspofungin acetate for injection has not been studied in endocarditis, osteomyelitis, and meningitis due to Candida.

Treatment of Esophageal Candidiasis

Caspofungin acetate for injection is indicated for the treatment of esophageal candidiasis in adult and pediatric patients (3 months of age and older) [see Clinical Studies (14.3, 14.5)].

<u>Limitation of Use:</u> Caspofungin acetate for injection has not been approved for the treatment of oropharyngeal candidiasis (OPC). In the study that evaluated the efficacy

-DOSAGE FORMS AND STRENGTHS

For Injection: 50 or 70 mg lyophilized powder (plus allowance for overfill) in a single dose vial for reconstitution. (3)

- CONTRAINDICATIONS -

Caspofundin is contraindicated in patients with known hypersensitivity to any component of this product. (4)

WARNINGS AND PRECAUTIONS

- Hypersensitivity: Anaphylaxis has been reported. If this occurs, discontinue caspofungin and administer appropriate treatment.
 - Possible histamine-mediated adverse reactions, including rash, facial swelling, angioedema, pruritus, sensation of warmth or bronchospasm have been reported and may require discontinuation and/or administration of appropriate treatment. (5.1) Hepatic Effects: Can cause abnormalities in liver enzymes.
- Isolated cases of hepatic dysfunction, hepatitis, or hepatic failure have been reported. Monitor patients who develop abnormal liver enzymes for evidence of worsening hepatic function, and evaluate risk/benefit of continuing caspofungin. (5.2)
- (5.2) Abnormal Liver Enzymes during Concomitant use with Cyclosporine: Limit use to patients for whom potential benefit outweighs potential risk. Monitor patients who develop abnormal liver function tests (LFTs) during concomitant use with concentration. with caspofungin. (5.3)

- ADVERSE REACTIONS

- Adults: Most common adverse reactions (incidence 10% or greater) are diarrhea, pyrexia, ALT/AST increased, blood alkaline phosphatase increased, and blood potassium decreased. (6.1)
- Pediatric patients: Most common adverse reactions (inci-dence 10% or greater) are pyrexia, diarrhea, rash, ALT/AST increased, blood potassium decreased, hypotension, and chills. (6.2)

To report SUSPECTED ADVERSE REACTIONS, contact Fresenius Kabi USA, LLC at 1-800-551-7176 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

-USE IN SPECIFIC POPULATIONS

- Pregnancy: Based on animal data, may cause fetal harm. (8.1)
- Pediatric Use: Safety and efficacy in neonates and infants less than 3 months old have not been established. (8.4)
- Hepatic Impairment: Reduce dose for adult patients with moderate hepatic impairment (35 mg once daily, with a 70 mg loading dose on Day 1 where appropriate). No data are available in adults with severe impairment or in pediatric patients with any degree of hepatic impairment. (2.4, 8.6, 12.3)

See 17 for PATIENT COUNSELING INFORMATION.

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*Sections or subsections omitted from the full prescribing information are not listed

microbiological response. In general, continue antifungal therapy for at least 14 days after the last positive culture. Patients with neutropenia who remain persistently neutro-penic may warrant a longer course of therapy pending resolution of the neutropenia.

Esophageal Candidiasis The dose is 50 mg once daily for 7 to 14 days after symptom resolution. A 70 mg loading dose has not been studied for this indication. Because of the risk of relapse of propharmageal candidicasis in patients with HIV infortions oropharyngeal candidiasis in patients with HIV infections, suppressive oral therapy could be considered [see Clinical Studies (14.3)].

Invasive Aspergillosis Administer a single 70 mg loading dose on Day 1, followed by 50 mg once daily thereafter. Duration of treatment should be based upon the severity of the patient's underlying disease, recovery from immunosuppression, and clinical response.

after. The maximum loading dose and the daily main-tenance dose should not exceed 70 mg, regardless of the patient's calculated dose. Dosing in pediatric

patients (3 months to 17 years of age) should be based on the patient's body surface area (BSA) as calculated by the Mortellus Correction Defension (15)

- **Recommended Dosing in Pediatric Patients [3 months** 2.3 to 17 years of age] For all indications, administer a single 70 mg/m² loading dose on Day 1, followed by 50 mg/m² once daily there-
- of caspofungin acetate for injection in the treatment of esophageal candidiasis, patients with concomitant OPC had higher relapse rate of the OPC [see Clinical Studies (14.3)].
- Treatment of Invasive Aspergillosis in Patients Who Are Refractory to or Intolerant of Other Therapies Caspofungin acetate for injection is indicated for the treatment of invasive aspergillosis in adult and pediatric patients (3 months of age and older) who are refractory to printolerant of other therapies [see Clinical Studies (14.4, 14.5)].

Limitation of Use: Caspofungin acetate for injection has not been studied as initial therapy for invasive aspergillosis.

DOSAGE AND ADMINISTRATION 2

Important Administration Instructions for Use in All 2.1 Patients

Administer caspofungin acetate for injection by slow intravenous (IV) infusion over approximately 1 hour. Do not administer caspofungin acetate for injection by intra-venous (IV) bolus administration.

Recommended Dosage in Adult Patients [18 years of 2.2 age and older] The dosage and duration of caspofungin acetate for injec-

tion treatment for each indication are as follows:

Empirical Therapy for Presumed Fungal Infections in

Febrile Neutropenic Patients Administer a single 70 mg loading dose on Day 1, followed by 50 mg once daily thereafter. Duration of treatment should be based on the patient's clinical response. Continue empirical therapy until resolution of neutropenia. In general, treat patients found to have a fungal infection for a minimum of 14 days after the last positive culture and continue treatment for at least 7 days after both neutropenia and clinical symptoms are resolved. If the 50 mg dose is well tolerated but does not provide an adequate clinical response, the daily dose can be increased to 70 mg.

<u>Candidemia and Other Candida Infections</u> Administer a single 70 mg loading dose on Day 1, followed by 50 mg once daily thereafter. Duration of treat-ment should be dictated by the patient's clinical and

the Mosteller Formula /see References (15)/:

BSA (m²) =
$$\sqrt{\frac{\text{Height (cm) X Weight (kg)}}{3600}}$$

Following calculation of the patient's BSA, the loading dose in milligrams should be calculated as BSA $(m^2) \times 70 \text{ mg/m}^2$. The maintenance dose in milligrams should be calculated as BSA (m^2) x 50 mg/ m^2 .

Duration of treatment should be individualized to the indication, as described for each indication in adults [see Dosage and Administration (2.2)]. If the 50 mg/m² daily dose is well tolerated but does not provide an adequate clinical response, the daily dose can be increased to 70 mg/m² daily (not to exceed 70 mg).

Dosage Adjustments in Patients with Hepatic Impair-2.4 ment

Adult patients with mild hepatic impairment (Child-Pugh score 5 to 6) do not need a dosage adjustment. For adult patients with moderate hepatic impairment (Child-Pugh score 7 to 9), caspofungin acetate for injection 35 mg once daily is recommended based upon pharmacokinetic data [see Clinical Pharmacology (12.3)] with a 70 mg loading dose administered on Day 1 where appropriate. There is no clinical experience in adult patients with severe hepatic impairment (Child-Pugh score greater than 9) and in pedi-atria patients with a val degreater of hepatic impairment atric patients with any degree of hepatic impairment

Dosage Adjustments in Patients Receiving Concomitant Inducers of Hepatic CYP Enzymes Adult Patients:

Adult patients on rifampin should receive 70 mg of caspofungin acetate for injection once daily. When caspofungin acetate for injection is co-administered to adult patients with other inducers of hepatic CYP enzymes such as nevirapine, efavirenz, carbamazepine, dexamethasone, or phenytoin, administration of a daily dose of 70 mg of caspofungin acetate for injection should be considered [see Drug Interactions (7)].

Pediatric Patients:

Pediatric patients on rifampin should receive 70 mg/m² of caspofungin acetate for injection daily (not to exceed an actual daily dose of 70 mg). When caspofungin acetate for injection is co-administered to pediatric patients with other rapine, phenytoin, dexamethasone, or carbamazepine, a caspofungin acetate for injection dose of 70 mg/m² once daily (not to exceed 70 mg) should be considered [see Drug Interactions (7)].

2.6 Preparation for Administration

- Reconstitution of Caspofungin for Intravenous Infusion A. Aseptically add 10.8 mL of 0.9% Sodium Chloride Injection, Sterile Water for Injection, Bacteriostatic Water for Injection with methylparaben and propylparaben, or Bacteriostatic Water for Injection with 0.9% benzyl alcohol to the vial.
- B. Each vial of caspofungin acetate for injection contains an intentional overfill of caspofungin acetate for injec-tion. Thus, the drug concentration of the resulting solu-tion is listed in Table 1 below.

Table 1: Information for Preparation of Caspofungin Acetate for Injection

Caspofungin Content Reconstitution Concentrat				
	Acetate for Injection vial	(including overfill)	Volume to be added	following Reconstitution
	50 mg	54.6 mg	10.8 mL	5 mg/mL
	70 mg	77.2 mg	10.8 mL	7 mg/mL

- C. The white to off-white cake will dissolve completely Mix gently until a clear solution is obtained. Visually inspect the reconstituted solution for particulate matter or discoloration during reconstitution and prior to infu-sion. Do not use if the solution is cloudy or has precipi-tated
- D. The reconstituted solution of caspofungin acetate for injection in the vial may be stored for up to one hour at ≤ 25°C (≤ 77°F) prior to the preparation of the infusion solution in the intravenous bag or bottle.
 E. Caspofungin acetate for injection vials are for single dose only. Discard unused portion.

Dilution of the Reconstituted Solution in the Intravenous

- Bag for Infusion A. Aseptically transfer the appropriate volume (mL) of reconstituted caspofungin acetate for injection to an intravenous (IV) bag (or bottle) containing 250 mL of 0.9%, 0.45%, or 0.225% Sodium Chloride Injection or
- Lactated Ringers Injection. B. Alternatively, the volume (mL) of reconstituted caspo B. Alternatively, the volume (mL) of reconstituted caspo-fungin acetate for injection can be added to a reduced volume of 0.9%, 0.45%, or 0.225% Sodium Chloride Injection or Lactated Ringers Injection, not to exceed a final concentration of 0.5 mg/mL.
 C. This diluted infusion solution in the intravenous bag or bottle must be used within 24 hours if stored at ≤ 25°C (≤ 77°F) or within 48 hours if stored refrigerated at 2° to 8°C (36° to 46°F).

Important Reconstitution and Dilution Instructions for Pediatric Patients 3 Months of Age and Older Follow the reconstitution procedures described above using either the 70 mg or 50 mg vial to create the reconsti-tuted solution (see Dosage and Administration (2.3)). From the reconstituted solution in the vial, remove the volume of drug equal to the calculated loading dose or calculated maintenance dose based on a concentration of 7 mg/mL (if reconstituted from the 70 mg vial) or a concentration of 5 mg/mL (if reconstituted from the 50 mg vial).

The choice of vial should be based on total milligram dose of drug to be administered to the pediatric patient. To help ensure accurate dosing, it is recommended for pediatric doses less than 50 mg that 50 mg vials (with a concentration of 5 mg/mL) be used if available. The 70 mg vial should be reserved for pediatric patients requiring doses greater than 50 mg.

The maximum loading dose and the daily maintenance dose should not exceed 70 mg, regardless of the patient's calculated dose.

2.7

Drug Incompatibilities Do not mix or co-infuse caspofungin acetate for injection with other medications, as there are no data available on the compatibility of caspofungin acetate for injection with other intravenous substances, additives, or medications.

Do not use diluents containing dextrose (α -D-glucose), as caspofungin acetate for injection is not stable in diluents containing dextrose.

3

DOSAGE FORMS AND STRENGTHS Caspofungin acetate for injection, 50 mg, is a white to off-white lyophilized cake or powder for reconstitution in a single dose glass vial, which contains 54.6 mg of caspofungin free base.

Caspofungin acetate for injection, 70 mg, is a white to off-white lyophilized cake or powder for reconstitution in a single dose glass vial, which contains 77.2 mg of caspofungin free base.

CONTRAINDICATIONS 4

Caspofungin is contraindicated in patients with known hypersensitivity (e.g., anaphylaxis) to any component of this product [see Adverse Reactions (6)].

5 WARNINGS AND PRECAUTIONS 5.1

Hypersensitivity Anaphylaxis has been reported during administration of caspofungin. If this occurs, discontinue caspofungin and administer appropriate treatment.

Possible histamine-mediated adverse reactions, including rash, facial swelling, angioedema, pruritus, sensation of warmth or bronchospasm have been reported and may require discontinuation and/or administration of appro-priate treatment.

Hepatic Effects 5.2

Hepatic Effects Laboratory abnormalities in liver function tests have been seen in healthy volunteers and in adult and pediatric patients treated with caspofungin. In some adult and pediatric patients with serious underlying conditions who were receiving multiple concomitant medications with caspofungin, isolated cases of clinically significant hepatic dysfunction, hepatitis, and hepatic failure have been reported; a causal relationship to caspofungin has not been established. Monitor patients who develop abnormal liver function tests during caspofungin therany

underlying medical conditions (e.g., hematologic or other malignancy, recent major surgery, HIV) requiring multiple concomitant medications. Patients in the noncompararedications. Patients in the honcompara-tive Aspergillus studies often had serious predisposing medical conditions (e.g., bone marrow or peripheral stem cell transplants, hematologic malignancy, solid tumors or organ transplants) requiring multiple concomitant medications.

medications. <u>Empirical Therapy for Presumed Fungal Infections in</u> <u>Febrile Neutropenic Patients</u>. In the randomized, double-blinded empirical therapy study, patients received either caspofungin 50 mg/day (following a 70 mg loading dose) or AmBisome® (ampho-tericin B liposome for injection, 3 mg/kg/day). In this study clinical or laboratory hepatic adverse reactions were reported in 39% and 45% of patients in the caspofungin and AmBisome groups, respectively. Also reported was an isolated, serious adverse reaction of hyperbilirubinemia. Adverse reactions occurring in 7.5% or greater of the patients in either treatment group are presented in Table 2.

Table 2: Adverse Reactions Among Patients with Persistent Fever and Neutropenia Incidence 7.5% or Greater for at Least One Treatment Group

Adverse Reactions	Caspofungin* N=564 (percent)	AmBisome [†] N=547 (percent)
All Systems, Any Adverse Reaction	95	97
Investigations	58	63
Alanine Aminotransferase Increased	18	20
Blood Alkaline Phosphatase Increased	15	23
Blood Potassium Decreased	15	23
Aspartate Aminotransferase Increased	14	17
Blood Bilirubin Increased	10	14
Blood Magnesium Decreased	7	9
Blood Glucose Increased	6	9
Bilirubin Conjugated Increased	5	9
Blood Urea Increased	4	8
Blood Creatinine Increased	3	11
General Disorders and Administration Site Conditions	57	63
Pyrexia	27	29
Chills	23	31
Edema Peripheral	11	12
Mucosal Inflammation	6	8
Gastrointestinal Disorders	50	55
Diarrhea	20	16
Nausea	11	20
Abdominal Pain	9	11
Vomiting	9	17
Respiratory, Thoracic and Mediastinal Disorders	47	49
Dyspnea	9	10
Skin and Subcutaneous Tissue Disorders	42	37
Rash	16	14
Nervous System Disorders	25	27
Headache	11	12
Metabolism and Nutrition Disorders	21	24
Hypokalemia	6	8
Vascular Disorders	20	23
Hypotension	6	10
Cardiac Disorders	16	19
Tachycardia	7	9

Within any system organ class, individuals may experience more than 1 adverse reaction. * 70 mg on Day 1, then 50 mg once daily for the remainder of treatment; daily dose was increased to 70 mg for 73 patients. * 3 mg/kg/day; daily dose was increased to 5 mg/kg for 74 patients.

The proportion of patients who experienced an infusionrelated adverse reaction (defined as a systemic event, related adverse reaction (defined as a systemic event, such as pyrexia, chills, flushing, hypotension, hyperten-sion, tachycardia, dyspnea, tachypnea, rash, or anaphy-laxis, that developed during the study therapy infusion and one hour following infusion) was significantly lower in the group treated with caspofungin (35%) than in the group treated with AmBisome (52%).

To evaluate the effect of caspofungin and AmBisome on renal function, nephrotoxicity was defined as doubling of serum creatinine relative to baseline or an increase of greater than or equal to 1 mg/dL in serum creatinine if baseline serum creatinine was above the upper limit of the normal range. Among patients whose baseline creatinine clearance was greater than 30 mL/min, the incidence of nephrotoxicity was significantly lower in the group treated nephrotoxicity was significantly lower in the group treated with caspofungin (3%) than in the group treated with AmBisome (12%).

<u>Candidemia and Other Candida Infections</u> In the randomized, double-blinded invasive candidiasis study, patients received either caspofungin 50 mg/day (following a 70 mg loading dose) or amphotericin B 0.6 to 1 mg/kg/day. Adverse reactions occurring in 10% or greater of the patients in either treatment group are presented in Table 3. presented in Table 3.

Table 3: Adverse Reactions Among Patients with Candidemia or other Candida Infections* Incidence

10% or Greater for at Least One Treatment Group				
Adverse Reactions	Caspofungin 50 mg [†] N=114 (percent)	Amphotericin B N=125 (percent)		
All Systems, Any Adverse Reaction	96	99		
Investigations	67	82		
Blood Potassium Decreased	23	32		
Blood Alkaline Phosphatase Increased	21	32		
Hemoglobin Decreased	18	23		
Alanine Aminotransferase Increased	16	15		
Aspartate Aminotransferase Increased	16	14		
Blood Bilirubin Increased	13	17		
Hematocrit Decreased	13	18		
Blood Creatinine Increased	11	28		
Red Blood Cells Urine Positive	10	10		
Blood Urea Increased	9	23		
Bilirubin Conjugated Increased	8	14		
Gastrointestinal Disorders	49	53		
Vomiting	17	16		
Diarrhea	14	10		
Nausea	9	17		
General Disorders and Administration Site Conditions	47	63		
Pyrexia	13	33		
Edema Peripheral	11	12		
Chills	9	30		
Respiratory, Thoracic and Mediastinal Disorders	40	54		
Tachypnea	1	11		
Cardiac Disorders	26	34		
Tachycardia	8	12		
Skin and Subcutaneous Tissue Disorders	25	28		
Rash	4	10		
Vascular Disorders	25	38		
Hypotension	10	16		
Blood and Lymphatic System Disorders	15	13		
Anemia	11	9		

The proportion of patients who experienced an infusion-related adverse reaction (defined as a systemic event, such as pyrexia, chills, flushing, hypotension, hyperten-sion, tachycardia, dyspnea, tachypnea, rash, or anaphy-laxis, that developed during the study therapy infusion and one hour following infusion) was significantly lower in the group treated with caspofungin (20%) than in the group treated with amphotericin B (49%).

To evaluate the effect of caspofungin and amphotericin B on renal function, nephrotoxicity was defined as doubling of serum creatinine relative to baseline or an increase of greater than or equal to 1 mg/dL in serum creatinine if baseline serum creatinine was above the upper limit of the normal range. In a subgroup of patients whose baseline creatinine clearance was greater than 30 mL/min, the incidence of nephrotoxicity was significantly lower in the group treated with caspofungin than in the group treated with amphotericin B.

In a second randomized, double-blinded invasive candidi-asis study, patients received either caspofungin 50 mg/day (following a 70 mg loading dose) or caspofungin 150 mg/day. The proportion of patients who experienced any adverse reaction was similar in the 2 treatment groups; however, this study was not large enough to detect differ-ences in rare or unexpected adverse reactions. Adverse reactions occurring in 5% or greater of the patients in either treatment group are presented in Table 4.

Table 4: Adverse Reactions Among Patients with Candidemia or other Candida Infections* Incidence 5% or Greater for at Least One Treatment Group

or Greater for at Least One Treatment Group				
Caspofungin 50 mg† N=104 (percent)	Caspofungin 150 mg N=100 (percent)			
83	83			
33	27			
6	6			
30	33			
11	6			
6	7			
5	7			
28	35			
12	9			
6	9			
6	8			
4	7			
19	18			
7	3			
5	6			
	50 mg ^r N=104 (percent) 83 33 6 30 11 6 5 28 12 6 6 4 4 19 7			

1 adverse event.

¹ Intra-abdominal abscesses, peritonitis and pleural space infections.
 ¹ Patients received caspofungin 70 mg on Day 1, then 50 mg once daily for the remainder of their treatment.

Esophageal Candidiasis and Oropharyngeal Candidiasis Adverse reactions occurring in 10% or greater of patients with esophageal and/or oropharyngeal candidiasis are presented in Table 5

Table 5: Adverse Reactions Among Patients with Esophageal and/or Oropharyngeal Candidiasis Incidence

10% or Greater for at Least One Treatment Group				
Adverse Reactions	Caspofungin 50 mg* N=83 (percent)	Fluconazole intravenous (IV) 200 mg* N=94 (percent)		
All Systems, Any Adverse Reaction	90	93		
Gastrointestinal Disorders	58	50		
Diarrhea	27	18		
Nausea	15	15		
Investigations	53	61		
Hemoglobin Decreased	21	16		
Hematocrit Decreased	18	16		
Aspartate Aminotransferase Increased	13	19		
Blood Alkaline Phosphatase Increased	13	17		
Alanine Aminotransferase Increased	12	17		
White Blood Cell Count Decreased	12	19		
General Disorders and Administration Site Conditions	31	36		
Pyrexia	21	21		
Vascular Disorders	19	15		
Phlebitis	18	11		
Nervous System Disorders	18	17		
Headache	15	9		
Within any system organ class individuals may experience more than				

Within any system organ class, individuals may experience more than 1 adverse reaction

* Derived from a comparator-controlled clinical study

abnormal liver function tests during caspofungin therapy for evidence of worsening hepatic function and evaluated for risk/benefit of continuing caspofungin therapy.

Elevated Liver Enzymes During Concomitant Use with 5.3

Elevated liver enzymes have occurred in patients receiving caspofungin and cyclosporine concomitantly. Only use caspofungin and cyclosporine in those patients for whom the potential benefit outweighs the potential risk. Patients who develop abnormal liver enzymes during concomi-tant therapy should be monitored and the risk/benefit of continuing therapy should be evaluated.

ADVERSE REACTIONS 6

ADVENSE HEAC HONS The following serious adverse reactions are discussed in detail in another section of the labeling: • Hypersensitivity [see Warnings and Precautions (5.1)] • Hepatic Effects [see Warnings and Precautions (5.2)] • Elevated Liver Enzymes During Concomitant Use with Device Liver Enzymes During Concomitant Use with

- Cyclosporine [see Warnings and Precautions (5.3)]

6.1

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

<u>Clinical Trials Experience in Adults</u> The overall safety of caspofungin was assessed in 1,865 adult individuals who received single or multiple doses of caspofungin: 564 febrile, neutropenic patients (empirical therapy study); 382 patients with candidemia and/or intra-abdominal abscesses, peritonitis, or pleural space infections (including 4 patients with chronic dissemi-nated candidiasis); 297 patients with esophageal and/or oropharyngeal candidiasis; 228 patients with invasive aspergillosis; and 394 individuals in phase I studies. In the empirical therapy study patients had undergone hema-topoietic stem-cell transplantation or chemotherapy. In the studies involving patients with documented *Candida* infections, the majority of the patients had serious

Within any system organ class, individuals may experience more than 1 adverse reaction.

Intra-abdominal abscesses, peritonitis and pleural space infections. Patients received caspofungin 70 mg on Day 1, then 50 mg once daily for the remainder of their treatment.

Invasive Aspergillosis In an open-label, noncomparative aspergillosis study, in which 69 patients received caspofungin (70 mg loading dose on Day 1 followed by 50 mg daily), the following adverse reactions were observed with an incidence of 12.5% or greater: blood alkaline phosphatase increased (22%) hopotopsion (20%), respiratory failure (20%) (22%), hypotension (20%), respiratory failure (20%), pyrexia (17%), diarrhea (15%), nausea (15%), headache (15%), rash (13%), alanine aminotransferase increased (13%) aspartate aminotransferase increased (13%) blood (13%). Also reported in this patient population were pulmoand radiographic infiltrates.

Clinical Trials Experience in Pediatric Patients

(<u>3 months to 17 years of age)</u> The overall safety of caspofungin was assessed in 171 pediatric patients who received single or multiple doses of caspofungin. The distribution among the 153 pediatric patients who were over the age of 3 months was as follows: 104 febrile, neutropenic patients; 38 patients with candidemia and/or intra-adominal 38 patients with candidemia and/or intra-abdominal abscesses, peritoritis, or pleural space infections; 1 patient with esophageal candidasis; and 10 patients with invasive aspergillosis. The overall safety profile of caspofungin in pediatric patients is comparable to that in adult patients. Table 6 shows the incidence of adverse caspitation of 2.5% or reactor of acdiatric patients reactions reported in 7.5% or greater of pediatric patients in clinical studies.

One patient (0.6%) receiving caspofungin, and three patients (12%) receiving AmBisome developed a serious drug-related adverse reaction. Two patients (1%) were discontinued from caspofungin and three patients (12%) were discontinued from AmBisome due to a drug-related adverse reaction. The proportion of patients who experi-enced an infusion-related adverse reaction (defined as a systemic event, such as pyrexia, chills, flushing, hypotension, hypertension, tachycardia, dyspnea, tachypnea, rash, or anaphylaxis, that developed during the study therapy infusion and one hour following infusion) was 22% in the group treated with caspofungin and 35% in the group treated with AmBisome.

Table 6: Adverse Reactions Among Pediatric Patients (0 months to 17 years of age) Incidence 7.5% or Greater for at Least One Treatment Group

Greater for at Least One Treatment Group			-Controlled	
	Noncomparative Clinical Studies	Clinical Study of Empirical Therapy		
Adverse Reactions	Caspofungin Any Dose N=115 (percent)	Caspofungin 50 mg/m²* N=56 (percent)	AmBisome 3 mg/kg N=26 (percent)	
All Systems, Any Adverse Reaction	95	96	89	
Investigations	55	41	50	
Blood Potassium Decreased	18	9	27	
Aspartate Aminotransferase Increased	17	2	12	
Alanine Aminotransferase Increased	14	5	12	
Blood Potassium Increased	3	0	8	
General Disorders and Administration Site Conditions	47	59	42	
Pyrexia	29	30	23	
Chills	10	13	8	
Mucosal Inflammation	10	4	4	
Edema	3	4	8	
Gastrointestinal Disorders	42	41	35	
Diarrhea	17	7	15	
Vomiting	8	11	12	
Abdominal Pain	7	4	12	
Nausea	4	4	8	
Infections and Infestations	40	30	35	
Central Line Infection	1	9	0	
Skin and Subcutaneous Tissue Disorders	33	41	39	
Pruritus	7	6	8	
Rash	6	23	8	
Erythema	4	9	0	
Vascular Disorders	24	21	19	
Hypotension	12	9	8	
Hypertension	10	9	4	
Metabolism and Nutrition Disorders	22	11	23	
Hypokalemia	8	5	4	
Cardiac Disorders	17	13	19	
Tachycardia	4	11	19	
Nervous System Disorders	13	16	8	
Headache	5	9	4	
Musculoskeletal and Connective Tissue Disorders	11	14	12	
Back Pain	4	0	8	
Blood and Lymphatic System Disorders	10	2	15	
Anemia Within any system orga	2	0	8	

organ adverse reaction 70 mg/m² on Day 1, then 50 mg/m² once daily for the remainder of

Overall Safety Experience of Caspofungin in Clinical

<u>**Overall Safety Experience of Casponangin in Clinica**. <u>**Trials**</u> The overall safety of caspofungin was assessed in 2,036 individuals (including 1,642 adult or pediatric patients and 394 volunteers) from 34 clinical studies. These individuals received single or multiple (once daily) doses of caspo-fungin, ranging from 5 mg to 210 mg. Full safety data is available from 1,951 individuals, as the safety data from 85 patients enrolled in 2 compassionate use studies was limited solelv to serious adverse reactions. Adverse reac-</u> limited solely to serious adverse reactions. Adverse reac-tions which occurred in 5% or greater of all individuals who received caspofungin in these trials are shown in Table 7. Overall, 1,665 of the 1,951 (85%) patients/volunteers who received caspofungin experienced an adverse reaction.

Table 7: Adverse Reactions* in Patients Who Received Caspofungin in Clinical Trials[†] Incidence 5% or Greater for at Least One Treatment Group

Adverse Reactions [‡]	Caspol (N = 1	ungin ,951)	
	N	(%)	
All Systems, Any Adverse Reaction	1,665	(85)	
Investigations	901	(46)	
Alanine Aminotransferase Increased	258	(13)	
Aspartate Aminotransferase Increased	233	(12)	
Blood Alkaline Phosphatase Increased	232	(12)	
Blood Potassium Decreased	220	(11)	
Blood Bilirubin Increased	117	(6)	
General Disorders and Administration Site Conditions	843	(43)	
Pyrexia	381	(20)	
Chills	192	(10)	
Edema Peripheral	110	(6)	
Gastrointestinal Disorders	754	(39)	
Diarrhea	273	(14)	
Nausea	166	(9)	
Vomiting	146	(8)	
Abdominal Pain	112	(6)	
Infections and Infestations	730	(37)	
Pneumonia	115	(6)	
Respiratory, Thoracic, and Mediastinal Disorders	613	(31)	
Cough	111	(6)	
Skin and Subcutaneous Tissue Disorders	520	(27)	
Rash	159	(8)	
Erythema	98	(5)	
Nervous System Disorders	412	(21)	
Headache	193	(10)	
Vascular Disorders	344	(18)	
Hypotension	118	(6)	

Clinically significant adverse reactions, regardless of causality or incidence which occurred in less than 5% of patients are listed below.

- Blood and lymphatic system disorders: anemia, coag-ulopathy, febrile neutropenia, neutropenia, thrombocytonenia
- Cardiac disorders: arrhythmia, atrial fibrillation, brady-cardia, cardiac arrest, myocardial infarction, tachycardia
- Gastrointestinal disorders: abdominal distension, abdominal pain upper, constipation, dyspepsia
 General disorders and administration site conditions:
- asthenia, fatigue, infusion site pain/pruritus/swelling, mucosal inflammation, edema Hepatobiliary disorders: hepatic failure, hepatomegaly,
- hepatotoxicity, hyperbilirubinemia, jaundice
 Infections and infestations: bacteremia, sepsis, urinary tract infection
- Metabolic and nutrition disorders: anorexia, decreased appetite, fluid overload, hypomagnesemia, hypercal-cemia, hyperglycemia, hypokalemia
- Musculoskeletal, connective tissue, and bone disor-ders: arthralgia, back pain, pain in extremity
 Nervous system disorders: convulsion, dizziness,
- somnolence, tremor
 Psychiatric disorders: anxiety, confusional state,
- depression, insomnia
- depression, insomnia
 Renal and urinary disorders: hematuria, renal failure
 Respiratory, thoracic, and mediastinal disorders: dyspnea, epistaxis, hypoxia, tachypnea
 Skin and subcutaneous tissue disorders: erythema, petechiae, skin lesion, urticaria
 Vascular disorders: flushing, hypertension, phlebitis

- 6.2

Postmarketing Experience The following additional adverse reactions have been identified during the post-approval use of caspofungin. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.
Gastrointestinal disorders: pancreatitis

- Hepatobiliary disorders: hepatic necrosis
 Skin and subcutaneous tissue disorders: erythema multiforme, toxic epidermal necrolysis, Stevens-Johnson syndrome, and skin extoliation • Renal and urinary disorders: clinically significant renal
- dysfunction
- General disorders and administration site conditions: swelling and peripheral edema
 Laboratory abnormalities: gamma-glutamyltransferase
- increased

DRUG INTERACTIONS 7

DRUG INTERACTIONS <u>Cyclosporine</u>: In two adult clinical studies, cyclosporine (one 4 mg/kg dose or two 3 mg/kg doses) increased the AUC of caspofungin. Caspofungin did not increase the plasma levels of cyclosporine. There were transient increases in liver ALT and AST when caspofungin and cyclosporine were co-administered. Monitor patients when develop observed liver approved during concerning the develop observed liver approved during the develop observed during the during the devel who develop abnormal liver enzymes during concomi-tant therapy and evaluate the risk/benefit of continuing therapy [see Warnings and Precautions (5.2) and Clinical Pharmacology (12.3)].

<u>Tacrolimus</u>: For patients receiving caspofungin and tacro-limus, standard monitoring of tacrolimus trough whole blood concentrations and appropriate tacrolimus dosage adjustments are recommended.

Inducers of Hepatic CYP Enzymes

<u>*Rifampin:*</u> Rifampin is a potent CYP3A4 inducer and concomitant administration with caspofungin is expected to reduce the plasma concentrations of caspofungin. Therefore, adult patients on rifampin should receive 70 mg of caspofungin daily and pediatric patients on rifampin should receive 70 mg/m² of caspofungin daily (not to exceed an actual daily dose of 70 mg) [see Dosage and Administration (2.5) and Clinical Pharmacology (12.3)].

Other Inducers of Hepatic CYP Enzymes

Adults: When caspofungin is co-administered to adult Audus. With other inducers of hepatic CYP enzymes, such as efavirenz, nevirapine, phenytoin, dexamethasone, or carbamazepine, administration of a daily dose of 70 mg of caspofungin should be considered [see Dosage and Administration (2.5) and Clinical Pharmacology (12.3)].

Pediatric Patients: When caspofungin is co-administered to pediatric patients with other inducers of hepatic CYP enzymes, such as efavirenz, nevirapine, phenytoin, dexa-methasone, or carbamazepine, administration of a daily dose of 70 mg/m² caspofungin (not to exceed an actual daily dose of 70 mg) should be considered [see Dosage and Administration (2.5) and Clinical Pharmacology (12.3)]. USE IN SPECIFIC POPULATIONS

8

8.1 Pregnancy

Pregnancy Category C There are no adequate and well-controlled studies with the use of caspofungin in pregnant women. In animal studies, caspofungin caused embryofetal toxicity, including increased resorptions, increased peri-implan-tation loss, and incomplete ossification at multiple fetal sites. Caspofungin should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. In offspring born to pregnant rats treated with caspofungin at doses comparable to the human dose based on body surface area comparisons, there was incomplete ossifica-tion of the skull and torso and increased incidences of cervical rib. There was also an increase in resorptions and peri-implantation losses. In pregnant rabbits treated with caspofungin at doses comparable to 2 times the human dose based on body surface area comparisons, there

was an increased incidence of incomplete ossification of the talus/calcaneus in offspring and increases in fetal resorptions. Caspofungin crossed the placenta in rats and rabbits and was detectable in fetal plasma. Nursing Mothers It is not known whether caspofungin is present in human

8.3

milk. Caspofungin was found in the milk of lactating, drug-treated rats. Because many drugs are excreted in human milk, caution should be exercised when caspofungin is administered to a nursing woman.

8.4 Pediatric Use

Defined as an adverse reaction, regardless of causality, while on caspo fungin or during the 14 day post-caspofungin follow-up period.

[†] Incidence for each preferred term is 5% or greater among individuals who received at least 1 dose of caspofungin.
 [‡] Within any system organ class, individuals may experience more than

1 adverse event

Pediatric Use The safety and effectiveness of caspofungin in pediatric patients 3 months to 17 years of age are supported by evidence from adequate and well-controlled studies in adults, pharmacokinetic data in pediatric patients, and additional data from prospective studies in pediatric patients 3 months to 17 years of age for the following indications [see Indications and Usage (1)]:

- Empirical therapy for presumed fungal infections in febrile, neutropenic patients.
- Treatment of candidemia and the following *Candida* infections: intra-abdominal abscesses, peritonitis, and pleural space infections.
- Treatment of esophageal candidiasis.
- Treatment of invasive aspergillosis in patients who are refractory to or intolerant of other therapies (e.g., amphotericin B, lipid formulations of amphotericin B, itraconazole).

The efficacy and safety of caspofungin has not been adequately studied in prospective clinical trials involving neonates and infants under 3 months of age. Although limited pharmacokinetic data were collected in neonates and infants below 3 months of age, these data are insufficient to establish a safe and effective dose of caspofungin in the treatment of neonatal candidiasis. Invasive candidiasis in neonates has a higher rate of CNS and of caspofungin to penetrate the blood-brain barrier and to treat patients with meningitis and endocarditis is unknown.

Caspofungin has not been studied in pediatric patients with endocarditis, osteomyelitis, and meningitis due to *Candida*. Caspofungin has also not been studied as initial therapy for invasive aspergillosis in pediatric patients.

In clinical trials, 171 pediatric patients (0 months to 17 years of age), including 18 patients who were less than 3 months of age, were given intravenous caspofungin. Pharmacokinetic studies enrolled a total of 66 pediatric patients, and an additional 105 pediatric patients received caspolungin in safety and efficacy studies [see Clinical Pharmacology (12.3) and Clinical Studies (14.5)]. The majority of the pediatric patients received caspofungin at a once-daily maintenance dose of 50 mg/m^2 for a mean duration of 12 days (median 9, range 1 to 87 days).

In all studies, safety was assessed by the investigator throughout study therapy and for 14 days following cessation of study therapy. The most common adverse reactions in pediatric patients treated with caspofungin were pyrexia (29%), blood potassium decreased (15%), diarrhea (14%), increased aspartate aminotransferase (12%), rash (12%), increased alanine aminotransferase (11%), hypotension (11%), and chills (11%) [see Adverse Reactions (6.2)].

Postmarketing hepatobiliary adverse reactions have been reported in pediatric patients with serious underlying medical conditions [see Warnings and Precautions (5.3)]

Geriatric Use 8.5

Geriatric Use Clinical studies of caspofungin did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients. Although the number of elderly patients was not large enough for a statistical analysis, no overall differences in safety or efficacy were observed between these and younger patients. Plasma concentrations of caspofungin in healthy older men and women (65 years of age and older) were increased slightly (approximately 28% in AUC) compared to young healthy men. A similar effect of age on pharmacokinetics was seen in patients with candidemia or other *Candida* infections (intra-abdominal abscesses, peritonitis, or pleural space infections). No dose adjust-ment is recommended for the elderly; however, greater sensitivity of some older individuals cannot be ruled out. **Patients with Hepatic Impairment**

8.6

sensitivity of some older individuals cannot be ruled out. Patients with Hepatic Impairment Adult patients with mild hepatic impairment (Child-Pugh score 5 to 6) do not need a dosage adjustment. For adult patients with moderate hepatic impairment (Child-Pugh score 7 to 9), caspofungin 35 mg once daily is recom-mended based upon pharmacokinetic data (see *Clinical Pharmacology (12.3)*]. However, where recommended, a 70 mg loading dose should still be administered on Day 1 [see Dosage and Administration (2.4) and Clinical *Pharmacology (12.3)*]. There is no clinical experience in adult patients with severe hepatic impairment (Child-Pugh score greater than 9) and in pediatric patients 3 months to 17 years of age with any degree of hepatic impairment. Patients with Renal Impairment

Patients with Renal Impairment

No dosage adjustment is necessary for patients with renal impairment. Caspofungin is not dialyzable; thus, supple-mentary dosing is not required following hemodialysis [see Clinical Pharmacology (12.3)].

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OVERDOSAGE In 6 healthy subjects who received a single 210 mg dose, no significant adverse reactions were reported. Multiple doses above 150 mg daily have not been studied. Caspofungin is not dialyzable.

In clinical trials, one pediatric patient (16 years of age) unintentionally received a single dose of caspofungin of 113 mg (on Day 1), followed by 80 mg daily for an addi-tional 7 days. No clinically significant adverse reactions were reported were reported.

DESCRIPTION 11

DESCRIPTION Caspofungin acetate for injection is a sterile, lyophi-lized product for intravenous (IV) infusion that contains a semisynthetic lipopeptide (echinocandin) compound synthesized from a fermentation product of *Glarea lozoy-ensis*. Caspofungin acetate is an echinocandin antifungal that inhibits the synthesis of β (1,3)-D-glucan, an integral component of the fungal cell wall.

The second seco



$C_{52}H_{88}N_{10}O_{15} \cdot 2C_2H_4O_2$

CLINICAL PHARMACOLOGY

12.1 Mechanism of Action Caspofungin is an echinocandin antifungal drug [see Clinical Pharmacology (12.4)].

M.W. 1213.42

12.3 Pharmacokinetics Adult and pediatric pharmacokinetic parameters are presented in Table 8.

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presented in Table 8. <u>Distribution</u> Plasma concentrations of caspofungin decline in a poly-phasic manner following single 1 hour intravenous infu-sions. A short α -phase occurs immediately postinfusion, followed by a β -phase (half-life of 9 to 11 hours) that characterizes much of the profile and exhibits clear log-linear behavior from 6 to 48 hours postdose during which the plasma concentration decreases 10-fold. An addi-tional, longer half-life phase, γ -phase, (half-life of 40 to 50 hours), also occurs. Distribution, rather than excretion or biotransformation, is the dominant mechanism influencing plasma clearance. Caspofungin is extensively bound to albumin (approximately 97%), and distribution into red blood cells is minimal. Mass balance results showed that approximately 92% of the administered radioactivity was distributed to tissues by 36 to 48 hours after a single

pharmacokinetics were similar in healthy adult volunteers with mild renal impairment (creatinine clearance 50 to 80 mL/min) and control subjects. Moderate (creatinine clearance 31 to 49 mL/min), severe (creatinine clearance 5 to 30 mL/min), and end-stage (creatinine clearance less than 10 mL/min and dialysis dependent) renal impairment moderately increased caspofungin plasma concentrations after single-dose administration (range: 30 to 49% for AUC). However, in adult patients with invasive aspergillosis, candidemia, or other *Candida* infections (intra-abdominal abscesses, peritonitis, or pleural space infections) who received multiple daily doses of caspofuncient of mild to mild to mild to mild the significant effect of mild to functions) who received multiple daily doses of caspo-fungin 50 mg, there was no significant effect of mild to end-stage renal impairment on caspofungin concentra-tions. No dosage adjustment is necessary for patients with renal impairment. Caspofungin is not dialyzable, thus supplementary dosing is not required following hemodialysis.

Hendolaysis. <u>Hepatic Impairment</u>. Plasma concentrations of caspofungin after a single 70 mg dose in adult patients with mild hepatic impairment (Child-Pugh score 5 to 6) were increased by approximately 55% in AUC compared to healthy control subjects. In a 14 day multiple-dose study (70 mg on Day 1 followed by 50 mg daily thereafter), plasma concentrations in adult patients with mild hepatic impairment were increased modestly (19 to 25% in AUC) on Days 7 and 14 relative to healthy control subjects. No dosage adjustment is recommended control subjects. No dosage adjustment is recommended for patients with mild hepatic impairment.

Adult patients with moderate hepatic impairment. Adult patients with moderate hepatic impairment (Child-Pugh score 7 to 9) who received a single 70 mg dose of caspofungin had an average plasma caspofungin increase of 76% in AUC compared to control subjects. A dosage reduction is recommended for adult patients with moderate hepatic impairment based upon these pharmacokinetic data [see Dosage and Administration (2.4)] (2.4)].

There is no clinical experience in adult patients with severe hepatic impairment (Child-Pugh score greater than 9) or in pediatric patients with any degree of hepatic impairment.

<u>Gender</u> Plasma concentrations of caspofungin in healthy adult men and women were similar following a single 70 mg dose. After 13 daily 50 mg doses, caspofungin plasma concentrations in women were elevated slightly (approxi-mately 22% in area under the curve [AUC]) relative to men. No dosage adjustment is necessary based on gender.

<u>Race</u>

Regression analyses of patient pharmacokinetic data indicated that no clinically significant differences in the pharmacokinetics of caspofungin were seen among Caucasians, Blacks, and Hispanics. No dosage adjust-ment is necessary on the basis of race.

Geriatric Patients Plasma concentrations of caspofungin in healthy older men and women (65 years of age and older) were increased slightly (approximately 28% AUC) compared to young healthy men after a single 70 mg dose of caspo-fungin. In patients who were treated empirically or who had candidemia or other *Candida* infections (intra-abdom-inal absecses peritonitis or plaural space infections). inal abscesses, peritonitis, or pleural space infections (intra-abdomi-similar modest effect of age was seen in older patients relative to younger patients. No dosage adjustment is necessary for the elderly [see Use in Specific Populations (# 51)] (8.5)].

Pediatric Patients Caspofungin has been studied in five prospective studies involving pediatric patients under 18 years of age, including three pediatric pharmacokinetic studies [initial study in adolescents (12 to 17 years of age) and children (2 to 11 years of age) followed by a study in younger patients (3 to 23 months of age) and then followed by a study in neonates and infants (less than 3 months of age)] [see Use in Specific Populations (8.4)].

Pharmacokinetic parameters following multiple doses of caspofungin in pediatric and adult patients are presented in Table 8.

Table 8: Pharmacokinetic Parameters Following Multiple Doses of Caspofungin in Pediatric (3 months to 17 years) and Adult Patients

				'			
			Pharmacokinetic Parameters (Mean ± Standard Deviation)				
Population	N	Daily Dose	AUC _{0-24hr} (mcg • hr/mL)	C _{1hr} (mcg/mL)	C _{24hr} (mcg/mL)	t _{1/2} (hr)*	CI (mL/min)
PEDIATRIC PATIEN	rs						
Adolescents, Aged 12 to 17 years	8	50 mg/m ²	124.9 ± 50.4	14.0 ± 6.9	2.4 ± 1.0	11.2 ± 1.7	12.6 ± 5.5
Children, Aged 2 to 11 years	9	50 mg/m ²	120.0 ± 33.4	16.1 ± 4.2	1.7 ± 0.8	8.2 ± 2.4	6.4 ± 2.6
Young Children, Aged 3 to 23 months	8	50 mg/m ²	131.2 ± 17.7	17.6 ± 3.9	1.7 ± 0.7	8.8 ± 2.1	3.2 ± 0.4
ADULT PATIENTS							
Adults with Esophageal Candidiasis	6†	50 mg	87.3 ± 30.0	8.7 ± 2.1	1.7 ± 0.7	13.0 ± 1.9	10.6 ± 3.8
Adults receiving Empirical Therapy	119 [‡]	50 mg§		8.0 ± 3.4	1.6 ± 0.7		

* Harmonic Mean \pm jackknife standard deviation. † N=5 for C_{1hr} and AUC_{0.24hr}, N=6 for C_{24hr}. * N=117 for C_{24hr}. P=119 for C_{1hr}. § Following an initial 70 mg loading dose on day 1.

Drug Interactions [see Drug Interactions (7)] Studies in vitro show that caspofungin acetate is not an inhibitor of any enzyme in the cytochrome P (CYP) system. Caspofungin is not a substrate for P-glycoprotein and is a poor substrate for CYP enzymes.

In clinical studies, caspofungin did not induce the CYP3A4 metabolism of other drugs. Clinical studies in adult healthy volunteers also demonstrated that the pharmacokinetics of caspofungin are not altered by itraconazole, amphotericin B, mycophenolate, nelfinavir, or tacrolimus. Caspofungin has no effect on the pharmacokinetics of itraconazole, amphotericin B, or the active metabolite of mycophenolate.

Cyclosporine: In two adult clinical studies, cyclosporine (one 4 mg/kg dose or two 3 mg/kg doses) increased the AUC of caspofungin by approximately 35%. Caspofungin did not increase the plasma levels of cyclosporine. There were transient increases in liver ALT and AST when caspofungin and evaluations were a administrated [see Warnings and Precautions (5.2)]

species. Beta (1,3)-D-glucan is not present in mammalian cells. Caspofungin has shown activity against *Candida* species and in regions of active cell growth of the hyphae of *Aspergillus fumigatus*.

Drug Resistance Drug Resistance There have been reports of clinical failures in patients receiving caspofungin therapy due to the development of drug resistance. Some of these reports have identi-fied specific mutations in the Fks subunits of the glucan synthase enzyme. These mutations are associated with higher MICs and breakthrough infection. Candida species that exhibit reduced susceptibility to caspofungin as a result of an increase in the chitin content of the fungal cell wall have also been identified, although the significance of this phenomenon *in vivo* is not well known.

<u>Drug Interactions</u> Studies *in vitro* and *in vivo* of caspofungin, in combination with amphotericin B, suggest no antagonism of antifungal activity against either A. *fumigatus* or C. *albicans*. The clinical significance of these results is unknown.

Activity in Vitro and in Clinical Infections Caspofungin has been shown to be active both in vitro and in Clinical infections against most strains of the following microorganisms:

Aspergillus fumigatus Aspergillus flavus Aspergillus terreus Candida albicans Candida glabrata Candida quilliermondii Candida krusei Candida parapsilosis Candida tropicalis

Susceptibility Testing Methods The interpretive standards for caspofungin against *Candida* species are applicable only to tests performed using Clinical Laboratory and Standards Institute (CLSI) microbroth dilution reference methods^{2,3} for MIC (partial inhibition endpoint) read at 24 hours. No interpretive criteria have been established for Appretive performed criteria have been established for Aspergillus species or other filamentous fungi.

When available, the clinical microbiology laboratory should provide the results of *in vitro* susceptibility test results for antimicrobial drug products used in resident hospitals to the physician as periodic reports that describe the susceptibility profile of pathogens. These reports should aid the physician in selecting an antifungal drug product for treatment. The techniques for Broth Microdilution are described below.

Broth Microdilution Techniques Quantitative methods are used to determine antifungal minimum inhibitory concentrations (MICs). These MICs provide estimates of the susceptibility of *Candida* spp. to antifungal agents. MICs should be determined using a standardized procedure at 24 hours^{2,3}. Standardized procedures are based on a microdilution method (broth) with standardized inoculum concentrations and standard with standardized inoculum concentrations and standard values should be interpreted according to the criteria provided in Table 9

Table 9: Susceptibility Interpretive Criteria for Caspofungin

Dothogon	Broth Microdilution MIC* (mcg/mL) at 24 hours		
Pathogen	Susceptible (S)	Non-Susceptible (NS)	
Candida species	≤ 2	> 2	

* A report of "Susceptible" indicates that the pathogen is likely to be inhibited if the antimicrobial compound in the blood reaches the concen-trations usually achievable.

<u>Quality Control</u> Standardized susceptibility test procedures require the use of quality control organisms to control the technical aspects of the test procedures. Standard caspofungin powder should provide the following range of values noted in Table 10³. Quality control microorganisms are specific strains of organisms with intrinsic biological properties relating to resistance mechanisms and their genetic expression within fungi; the specific strains used for microbiological control are not clinically significant.

Table 10: Acceptable Quality Control Ranges for Caspofungin to be used in Validation of Susceptibility Test Results

QC Strain	Broth Microdilution (MIC in mcg/mL) at 24 hours*	
Candida parapsilosis ATCC 22019	0.25 to 1.0	
Candida krusei ATCC 6258	0.12 to 1.0	

* The MIC for caspofungin is the lowest concentration at which a score of 2 (prominent decrease in turbidity [greater than 50% inhibition of growth as compared to the growth control]; see CLSI document M27-A3², Section 7.6.3) is observed after 24 hours of incubation.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility No long-term studies in animals have been performed to evaluate the carcinogenic potential of caspofungin.

evaluate the carcinogenic potential of casportingin. Caspofungin did not show evidence of mutagenic or genotoxic potential when evaluated in the following *in vitro* assays: bacterial (Ames) and mammalian cell (V79 Chinese hamster lung fibroblasts) mutagenesis assays, the alkaline elution/rat hepatocyte DNA strand break test, and the chromosome aberration assay in Chinese hamster ovary cells. Caspofungin was not genotoxic when assessed in the mouse bone marrow chromosomal test at doses up to 12.5 mg/kg (equivalent to a human dose of 1 mg/kg based on body surface area comparisons), administered intravenously. administered intravenously.

Fertility and reproductive performance were not affected by the intravenous administration of caspofungin to rats at doses up to 5 mg/kg. At 5 mg/kg exposures were similar to those seen in patients treated with the 70 mg dose.

distributed to tissues by 36 to 48 hours after a single 70 mg dose of [³H] caspofungin acetate. There is little excretion or biotransformation of caspofungin during the first 30 hours after administration

Metabolism

<u>Metabolism</u>. Caspofungin is slowly metabolized by hydrolysis and N-acetylation. Caspofungin also undergoes spontaneous chemical degradation to an open-ring peptide compound, L-747969. At later time points (5 or more days postdose), there is a low level (7 or less picomoles/mg protein, or 1.3% or less of the administered dose) of covalent binding of radiolabel in plasma following single-dose administra-tion of [³H] caspofungin acetate, which may be due to two reactive intermediates formed during the chemical degradation of caspofungin to L-747969. Additional metabolism involves hydrolysis into constitutive amino acids and their degradates, including dihydroxyhomoty-rosine and N-acetyl-dihydroxyhomotyrosine. These two tyrosine derivatives are found only in urine, suggesting rapid clearance of these derivatives by the kidneys. <u>Excretion</u>.

Excretion Two single-dose radiolabeled pharmacokinetic studies were conducted. In one study, plasma, urine, and feces were collected over 27 days, and in the second study plasma was collected over 6 months. Plasma concentraplasma was collected over 6 months. Plasma concentra-tions of radioactivity and of caspofungin were similar during the first 24 to 48 hours postdose; thereafter drug levels fell more rapidly. In plasma, caspofungin concentra-tions fell below the limit of quantitation after 6 to 8 days postdose, while radiolabel fell below the limit of quantita-tion at 22.3 weeks postdose. After single intravenous administration of [³H] caspofungin acetate, excretion of caspofungin and its metabolites in humans was 35% of dose in feces and 41% of dose in urine. A small amount of caspofungin is excreted unchanged in urine (approxiof caspofungin is excreted unchanged in urine (approxi-mately 1.4% of dose). Renal clearance of parent drug is low (approximately 0.15 mL/min) and total clearance of caspofungin is 12 mL/min.

Special Populations

Renal Impairment

In a clinical study of single 70 mg doses, caspofungin

Tacrolimus: Caspofungin reduced the blood AUC₀₋₁₂ of tacrolimus (FK-506, Prograf[®]) by approximately 20%, peak blood concentration (C_{max}) by 16%, and 12 hour blood concentration (C_{12hr}) by 26% in healthy adult subjects when tacrolimus (2 doses of 0.1 mg/kg 12 hours apart) was administered on the 10th day of caspofungin 20 mg div concentration provide the provide 70 mg daily, as compared to results from a control period in which tacrolimus was administered alone. For patients receiving both therapies, standard monitoring of tacrolimus whole blood trough concentrations and appropriate tacrolimus dosage adjustments are recommended.

<u>Rifampin</u>: A drug-drug interaction study with rifampin in adult healthy volunteers has shown a 30% decrease in caspofungin trough concentrations [see Dosage and Administration (2.5)].

Other Inducers of Hepatic CYP Enzymes

Adults: Results from regression analyses of adult patient pharmacokinetic data suggest that co-administration of other hepatic CYP enzyme inducers (e.g., efavirenz, nevirapine, phenytoin, dexamethasone, or carbamazepine) with caspofungin may result in clinically meaningful reductions in caspofungin concentrations. It is not known which drug clearance mechanism involved in caspofungin disposition may be inducible [see Dosage and Administration (2.5)].

Pediatric patients: In pediatric patients, results from regression analyses of pharmacokinetic data suggest that co-administration of dexamethasone with caspofungin may result in clinically meaningful reductions in caspo-fungin trough concentrations. This finding may indicate that pediatric patients will have similar reductions with inducers as seen in adults [see Dosage and Administration (2.5)].

12.4 Microbiology <u>Mechanism of Action</u> Caspofungin, an echinocandin, inhibits the synthesis of beta (1,3)-D-glucan, an essential component of the cell wall of susceptible Aspergillus species and Candida

13.2 Animal Toxicology and/or Pharmacology In one 5 week study in monkeys at doses which produced exposures approximately 4 to 6 times those seen in adult patients treated with a 70 mg dose, scattered small foci of subcapsular necrosis were observed microscopically in the livers of some animals (2/8 monkeys at 5 mg/kg and 4/8 monkeys at 8 mg/kg); however, this histopathological finding was not seen in another study of 27 weeks duration at similar doses.

No treatment-related findings were seen in a 5 week study in infant monkeys at doses which produced exposures approximately 3 times those achieved in pediatric patients receiving a maintenance dose of 50 mg/m² daily.

CLINICAL STUDIES 14

14.1 Empirical Therapy in Febrile, Neutropenic Patients A double-blind study enrolled 1,111 febrile, neutropenic (less than 500 cells/mm³) patients who were random-(less than 500 cells/mm³) patients who were random-ized to treatment with daily doses of caspofungin (50 mg/day following a 70 mg loading dose on Day 1) or AmBisome (3 mg/kg/day). Patients were stratified based on risk category (high-risk patients had undergone allo-geneic stem cell transplantation or had relapsed acute leukemia) and on receipt of prior antifungal prophylaxis. Twenty-four percent of patients were high risk and 56% had received prior antifungal prophylaxis. Patients who remained febrile or clinically deteriorated following 5 days of therapy could receive 70 mg/day of caspofungin or 5 mg/kg/day of AmBisome. Treatment was continued to resolution of neutropenia (but not beyond 28 days unless a fungal infection was documented). a fungal infection was documented).

An overall favorable response required meeting each of An overall tavorable response required meeting each of the following criteria: no documented breakthrough fungal infections up to 7 days after completion of treatment, survival for 7 days after completion of study therapy, no discontinuation of the study drug because of drug-related toxicity or lack of efficacy, resolution of fever during the period of neutropenia, and successful treatment of any documented baseling fungal infection documented baseline fungal infection.

Based on the composite response rates, caspofungin was as effective as AmBisome in empirical therapy of persistent febrile neutropenia (see Table 11).

Table 11: Favorable Response of Patients with Persistent Fever and Neutropenia

	Caspofungin*	AmBisome*	% Difference (Confidence Interval) [†]	
Number of Patients [‡]	556	539		
Overall Favorable Response	190 (33.9%)	181 (33.7%)	0.2 (-5.6, 6.0)	
No documented break- through fungal infection	527 (94.8%)	515 (95.5%)	-0.8	
Survival 7 days after end of treatment	515 (92.6%)	481 (89.2%)	3.4	
No discontinuation due to toxicity or lack of efficacy	499 (89.7%)	461 (85.5%)	4.2	
Resolution of fever during neutropenia	229 (41.2%)	223 (41.4%)	-0.2	

Inclusiona
 I

penia at study entry.

The rate of successful treatment of documented baseline infections, a component of the primary endpoint, was not statistically different between treatment groups.

The response rates did not differ between treatment groups based on either of the stratification variables: risk category or prior antifungal prophylaxis.

14.2 Candidemia and the Following Other Candida Infections: Intra-Abdominal Abscesses, Peritonitis and Pleural Space Infections

and Pleural Space Infections In a randomized, double-blind study, patients with a proven diagnosis of invasive candidiasis received daily doses of caspofungin (50 mg/day following a 70 mg loading dose on Day 1) or amphotericin B deoxycholate (0.6 to 0.7 mg/kg/day for non-neutropenic patients and 0.7 to 1 mg/kg/day for neutropenic patients). Patients were stratified by both neutropenic status and APACHE II score. Patients with *Candida* endocarditis, meningitis, or osteomyelitis were excluded from this study.

Patients who met the entry criteria and received one or more doses of intravenous (IV) study therapy were included in the modified intention-to-treat [MITT] analysis of response at the end of intravenous (IV) study therapy. A favorable response at this time point required both symptom/sign resolution/improvement and microbio-logical clearance of the *Candida* infection.

Two hundred thirty-nine patients were enrolled. Patient disposition is shown in Table 12.

Table 12: Disposition in Candidemia and Other Candida Infections (Intra-abdominal abscesses, peritonitis, and pleural space infections)

una picara	i space intectio	10)
	Caspofungin*	Amphotericin B
Randomized patients	114	125
Patients completing study [†]	63 (55.3%)	69 (55.2%)
DISCONTIN	UATIONS OF STUD	Y†
All Study Discontinuations	51 (44.7%)	56 (44.8%)
Study Discontinuations due to clinical adverse events	39 (34.2%)	43 (34.4%)
Study Discontinuations due to laboratory adverse events	0 (0%)	1 (0.8%)
DISCONTINUATI	ONS OF STUDY TH	ERAPY
All Study Therapy Discontinuations	48 (42.1%)	58 (46.4%)
Study Therapy Discontinuations due to clinical adverse events	30 (26.3%)	37 (29.6%)
Study Therapy Discontinuations due to laboratory adverse events	1 (0.9%)	7 (5.6%)
Study Therapy Discontinuations due to all drug-related [‡] adverse events	3 (2.6%)	29 (23.2%)

* Patients received caspofungin 70 mg on Day 1, then 50 mg once daily for the remainder of their treatment. [†] Study defined as study treatment period and 6 to 8 week follow-up period. [‡] Determined by the investigator to be possibly, probably, or definitely

drug-related. Of the 239 patients enrolled, 224 met the criteria for inclusion in the MITT population (109 treated with caspofungin and 115 treated with amphotericin B). Of these 224 patients, 186 patients had candidemia (92 treated with caspofungin and 94 treated with amphotericin B). With caspolungin and 94 treated with amphotericin b). The majority of the patients with candidemia were non-neutropenic (87%) and had an APACHE II score less than or equal to 20 (77%) in both arms. Most candidemia infections were caused by *C. albicans* (39%), followed by *C. parapsilosis* (20%), *C. tropicalis* (17%), *C. glabrata* (8%), and *C. krusei* (3%).

At the end of intravenous (IV) study therapy, caspofungin was comparable to amphotericin B in the treatment of candidemia in the MITT population. For the other efficacy of all antifungal therapy, 2-week post-therapy follow-up, and 6- to 8-week post-therapy follow-up), caspofungin was as effective as amphotericin B.

Outcome, relapse and mortality data are shown in Table 13. Table 13: Outcomes, Relapse, & Mortality in

Candidemia and Other Candida Infections (Intra-abdominal abscesses, peritonitis, and pleural space infections)

pieural space infections)				
	Caspofungin*	Amphotericin B	% Difference [†] after adjusting for strata (Confidence Interval) [‡]	
Number of MITT§ patients	109	. 115		
FAVORABL INTRA				
All MITT patients	81/109 (74.3%)	78/115 (67.8%)	7.5 (-5.4, 20.3)	
Candidemia	67/92 (72.8%)	63/94 (67.0%)	7.0 (-7.0, 21.1)	
Neutropenic	6/14 (43%)	5/10 (50%)		
Non-neutropenic	61/78 (78%)	58/84 (69%)		
Endophthalmitis	0/1	2/3		
Multiple Sites	4/5	4/4		
Blood / Pleural	1/1	1/1		
Blood / Peritoneal	1/1	1/1		
Blood / Urine	-	1/1		
Peritoneal / Pleural	1/2	-		
Abdominal / Peritoneal	-	1/1		
Subphrenic / Peritoneal	1/1	-		
DISSEMINATED INFECTIONS, RELAPSES AND MORTALITY				
Disseminated Infections in neutropenic patients	4/14 (28.6%)	3/10 (30.0%)		
All relapses ¹	7/81 (8.6%)	8/78 (10.3%)		
Culture-confirmed relapse	5/81 (6%)	2/78 (3%)		
Overall study [#] mortality in MITT	36/109 (33.0%)	35/115 (30.4%)		
Mortality during study therapy	18/109 (17%)	13/115 (11%)		
Mortality attributed to Candida	4/109 (4%)	7/115 (6%)		

In this study, the efficacy of caspofungin in patients with In this study, the efficacy of casporting in in patients with intra-abdominal abscesses, peritonitis and pleural space *Candida* infections was evaluated in 19 non-neutropenic patients. Two of these patients had concurrent candi-demia. *Candida* was part of a polymicrobial infection that required adjunctive surgical drainage in 11 of these 19 patients. A favorable response was seen in 9 of 9 patients with peritonitis, 3 of 4 with abscesses (liver, parasplenic, and urinary bladder abscesses), 2 of 2 with pleural space infections, 1 of 2 with mixed peritoneal and pleural infection, 1 of 1 with *Candida* pneumonia peritonitis, and 0 of 1 with Candida pneumonia.

Overall, across all sites of infection included in the study the efficacy of caspofungin was comparable to that of amphotericin B for the primary endpoint.

In this study, the efficacy data for caspofungin in neutro-penic patients with candidemia were limited. In a separate compassionate use study, 4 patients with hepatosplenic candidasis received prolonged therapy with caspofungin following other long-term antifungal therapy; three of these patients had a favorable response.

In a second randomized, double-blind study, 197 patients with proven invasive candidiasis received caspofungin with proven invasive candidiasis received caspofungin 50 mg/day (following a 70 mg loading dose on Day 1) or caspofungin 150 mg/day. The diagnostic criteria, evalu-ation time points, and efficacy endpoints were similar to those employed in the prior study. Patients with *Candida* endocarditis, meningitis, or osteomyelitis were excluded. Although this study was designed to compare the safety of the two doses, it was not large enough to detect differ-ences in rare or unexpected adverse events *[see Adverse Reactions (6.1)]*. The efficacy of caspofungin at the 150 mg daily dose was not significantly better than the efficacy of the 50 mg daily dose of caspofungin. The efficacy of doses higher than 50 mg daily in the other adult patients for whom caspofungin is indicated has not been evalu-ated. Esonhageal Candidiasis (and information on oronha-

14.3 Esophageal Candidiasis (and information on oropha-**The safety and efficacy of caspofungin in the treatment**

of esophageal candidíasis was evaluated in one large, controlled, noninferiority, clinical trial and two smaller dose-response studies.

In all 3 studies, patients were required to have symp candidiasis; most patients had advanced AIDS (with CD4 counts less than 50/mm³).

Of the 166 patients in the large study who had culture-confirmed esophageal candidiasis at baseline, 120 had *Candida albicans* and 2 had *Candida tropicalis* as the sole baseline pathogen whereas 44 had mixed baseline cultures containing *C. albicans* and one or more additional Candida species.

In the large, randomized, double-blind study comparing caspofungin 50 mg/day versus intravenous fluconazole 200 mg/day for the treatment of esophageal candidiasis, 200 mg/day for the treatment of esophageal candidiasis, patients were treated for an average of 9 days (range 7 to 21 days). Favorable overall response at 5 to 7 days following discontinuation of study therapy required both complete resolution of symptoms and significant endoscopic improvement. The definition of endoscopic response was based on severity of disease at baseline using a 4-grade scale and required at least a two-grade reduction from baseline endoscopic score or reduction to grade 0 for patients with a baseline score of 2 or less to grade 0 for patients with a baseline score of 2 or less

The proportion of patients with a favorable overall response was comparable for caspofungin and flucon-azole as shown in Table 14.

Table 14: Favorable Response Rates for Patients with Esophageal Candidiasis*

	Caspofungin	Fluconazole	% Difference [†] (95% CI)
Day 5 to 7 post-treatment	66/81 (81.5%)	80/94 (85.1%)	-3.6 (-14.7, 7.5)

Analysis excluded patients without documented esophageal candidiasis or patients not receiving at least 1 day of study therapy.
 Calculated as caspofungin – fluconazole.

The proportion of patients with a favorable symptom response was also comparable (90.1% and 89.4% for caspofungin and fluconazole, respectively). In addition, the proportion of patients with a favorable endoscopic response was comparable (85.2% and 86.2% for caspofungin and fluconazole, respectively).

As shown in Table 15, the esophageal candidiasis relapse rates at the Day 14 post-treatment visit were similar for the two groups. At the Day 28 post-treatment visit, the group treated with caspofungin had a numerically higher incidence of relapse; however, the difference was not statistically significant.

Table 15: Relapse Rates at 14 and 28 Days Post-Therapy in Patients with Esophageal Candidiasis at Baseline

	Caspofungin	Fluconazole	% Difference* (95% CI)
Day 14 post-treatment	7/66 (10.6%)	6/76 (7.9%)	2.7 (-6.9, 12.3)
Day 28 post-treatment	18/64 (28.1%)	12/72 (16.7%)	11.5 (-2.5, 25.4)

Calculated as caspofungin - fluconazole.

In this trial, which was designed to establish noninferiority of caspofungin to fluconazole for the treatment of esophaof caspofungin to fluconazole for the treatment of esopha-geal candidiasis, 122 (70%) patients also had oropharyn-geal candidiasis. A favorable response was defined as complete resolution of all symptoms of oropharyngeal disease and all visible oropharyngeal lesions. The propor-tion of patients with a favorable oropharyngeal response at the 5- to 7-day post-treatment visit was numerically lower for caspofungin; however, the difference was not statistically significant. Oropharyngeal candidiasis relapse rates at Day 14 and Day 28 post-treatment visits were statistically significantly higher for caspofungin than for fluconazole. The results are shown in Table 16.

Table 16: Oropharyngeal Candidiasis Response Rates at 5 to 7 Days Post-Therapy and Relapse Rates at 14 and 28 Days Post-Therapy in Patients with Oropharyngeal and Esophageal Candidiasis at Baseline

* Patients received caspofungin 70 mg on Day 1, then 50 mg once daily for the remainder of their treatment.

[†] Calculated as caspofungin - amphotericin B.
 [‡] 95% Cl for candidemia, 95.6% for all patients.

§ Modified intention-to-treat.

Includes all patients who either developed a culture-confirmed recurrence of *Candida* infection or required antifungal therapy for the treatment of a proven or suspected *Candida* infection in the follow-up period. [#] Study defined as study treatment period and 6 to 8 week follow-up period.

	Caspofungin	Fluconazole	% Difference* (95% CI)
Response Rate Day 5 to 7 post-treatment	40/56 (71.4%)	55/66 (83.3%)	-11.9 (-26.8, 3.0)
Relapse Rate Day 14 post- treatment	17/40 (42.5%)	7/53 (13.2%)	29.3 (11.5, 47.1)
Relapse Rate Day 28 post- treatment	23/39 (59.0%)	18/51 (35.3%)	23.7 (3.4, 43.9)

Calculated as caspofungin – fluconazole.

The results from the two smaller dose-ranging studies corroborate the efficacy of caspofungin for esophageal candidiasis that was demonstrated in the larger study.

Caspofungin was associated with favorable outcomes in 7 of 10 esophageal *C. albicans* infections refractory to at least 200 mg of fluconazole given for 7 days, although the *in vitro* susceptibility of the infecting isolates to fluconazole was not known.

14.4 Invasive Aspergillosis

Sixty-nine patients between the ages of 18 and 80 with invasive aspergillosis were enrolled in an open-label, noncomparative study to evaluate the safety, tolerability, and efficacy of caspolungin. Enrolled patients had previously been refractory to or intolerant of other antifungal therapy (ies). Refractory patients were classified as those who had disease progression or failed to improve despite therapy for at least 7 days with amphotericin B, lipid formu-lations of amphotericin B, itraconazole, or an investiga-tional azole with reported activity against Aspergillus. Inderance to previous therapy was defined as a doubling of creatinine (or creatinine 2.5 mg/dL or greater while on therapy), other acute reactions, or infusion-related toxicity To be included in the study, patients with pulmonary disease must have had definite (positive tissue histopathology or positive culture from tissue obtained by an invasive procedure) or probable (positive radiographic or computed tomography evidence with supporting culture

from bronchoalveolar lavage or sputum, galactomannan enzyme-linked immunosorbent assay, and/or polymerase chain reaction) invasive aspergillosis. Patients with extra-pulmonary disease had to have definite invasive aspergil-losis. Patients were administered a single 70 mg loading dose of caspofungin and subsequently dosed with 50 mg daily. The mean duration of therapy was 33.7 days, with a range of 1 to 162 days.

An independent expert panel evaluated patient data, including diagnosis of invasive aspergillosis, response and tolerability to previous antifungal therapy, treatment course on caspofungin, and clinical outcome.

A favorable response was defined as either complete resolution (complete response) or clinically meaningful improvement (partial response) of all signs and symptoms and attributable radiographic findings. Stable, nonpro-gressive disease was considered to be an unfavorable response.

response. Among the 69 patients enrolled in the study, 63 met entry diagnostic criteria and had outcome data; and of these, 52 patients received treatment for greater than 7 days. Fifty-three (84%) were refractory to previous antifungal therapy and 10 (16%) were intolerant. Forty-five patients had pulmonary disease and 18 had extrapulmonary disease. Underlying conditions were hematologic malignancy (N=24), allogeneic bone marrow transplant or stem cell transplant (N=18), organ transplant (N=8), solid tumor (N=3), or other conditions (N=10). All patients in the study received concomitant therapies for their other underlying conditions. Eighteen patients received tacrolimus and caspofungin concomitantly, of whom 8 also received mycophenolate mofetil. Overall, the expert panel determined that 41% (26/63)

Overall, the expert panel determined that 41% (26/63) of patients receiving at least one dose of caspofungin had a favorable response. For those patients who received greater than 7 days of therapy with caspofungin, 50% (26/52) had a favorable response. The favorable response rates for patients who were either refractory to or intolerant of previous therapies were 36% (19/53) and 70% (7/10), respectively. The response rates among patients with pulmonary disease and extrapulmonary disease were 47% (21/45) and 28% (5/18), respectively. Among patients with extrapulmonary disease, 2 of 8 patients who also had definite, probable, or possible CNS involvement had a favorable response. Two of these 8 patients had progression of disease and maifested Overall, the expert panel determined that 41% (26/63) 8 patients had progression of disease and manifested CNS involvement while on therapy.

Caspofungin is effective for the treatment of invasive aspergillosis in patients who are refractory to or intolerant of itraconazole, amphotericin B, and/or lipid formulations of amphotericin B. However, the efficacy of caspofungin or initial treatment of invasive aspergillosis has not been evaluated in comparator-controlled clinical studies.

14.5 Pediatric Patients The safety and efficacy of caspofungin were evaluated in pediatric patients 3 months to 17 years of age in two prospective, multicenter clinical trials.

prospective, multicenter clinical trials. The first study, which enrolled 82 patients between 2 to 17 years of age, was a randomized, double-blind study comparing caspofungin (50 mg/m² intravenously once daily following a 70 mg/m² loading dose on Day 1 [not to exceed 70 mg daily]) to AmBisome (3 mg/kg intravenously daily) in a 2:1 treatment fashion (56 on caspofungin, 26 on AmBisome) as empirical therapy in pediatric patients with persistent fever and neutropenia. The study design and criteria for efficacy assessment were similar to the study in adult patients [see Clinical Studies (14.1)]. Patients were stratified based on risk category (high-risk patients had undergone allogeneic stem cell transplantation or had relapsed acute leukemia). Twenty-seven percent of patients in both treatment groups were high risk. Favorable overall response rates of pediwere high risk. Favorable overall response rates of pedi-atric patients with persistent fever and neutropenia are presented in Table 17.

Table 17: Favorable Overall Response Rates of Pediatric Patients with Persistent Fever and Neutropenia

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Caspofungin	AmBisome*	
56	25	
26/56 (46.4%)	8/25 (32.0%)	
9/15 (60.0%)	0/7 (0.0%)	
17/41 (41.5%)	8/18 (44.4%)	
	Caspofungin 56 26/56 (46.4%) 9/15 (60.0%)	

One patient excluded from analysis due to no fever at study entry

The second study was a prospective, open-label, non-comparative study estimating the safety and efficacy of caspofungin in pediatric patients (ages 3 months to 17 years) with candidemia and other *Candida* infec-tions, esophageal candidiasis, and invasive aspergillosis (as salvage therapy). The study employed diagnostic criteria which were based on established EORTC/MSG criteria of proven or probable infection; these criteria were similar to those criteria employed in the adult studies for these various indications. Similarly, the efficacy time points and endpoints used in this study were similar to those employed in the corresponding adult studies points and endpoints used in this study were similar to those employed in the corresponding adult studies [see Clinical Studies (14.2, 14.3, and 14.4)]. All patients received caspofungin at 50 mg/m² intravenously once daily following a 70 mg/m² loading dose on Day 1 (not to exceed 70 mg daily). Among the 49 enrolled patients who received caspofungin, 48 were included in the effi-cacy analysis (one patient excluded due to not having a baseline Aspergillus or Candida infection). Of these 48 patients, 37 had candidemia or other Candida infections, 10 had invasive aspergillosis, and 1 patient had esopha-48 patients, 37 had candidemia or other *Candida* infections, 10 had invasive aspergillosis, and 1 patient had esopha-geal candidiasis. Most candidemia and other *Candida* infections were caused by *C. albicans* (35%), followed by *C. parapsilosis* (22%), *C. tropicalis* (14%), and *C. glabrata* (11%). The favorable response rate, by indication, at the end of caspofungin therapy was as follows: 30/37 (81%) in candidemia or other *Candida* infections, 5/10 (50%) in invasive aspergillosis, and 1/1 in esophageal candidiasis.

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- REFERENCES 1. Mosteller RD: Simplified Calculation of Body Surface Area. N Engl J Med 1987 Oct 22;317(17): 1098 (letter). 2. Clinical and Laboratory Standards Institute (CLSI). Reference Method for Broth Dilution Antifungal econtibility Testing of tand

Caspofungin can cause hypersensitivity reactions, including rash, facial swelling, angioedema, pruritus, sensation of warmth, or bronchospasm. Inform patients to report these signs or symptoms to their healthcare providers.

Hepatic Effects

Inform patients that there have been isolated reports of serious hepatic effects from caspofungin therapy.

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HOW SUPPLIED/STORAGE AND HANDLING 16

How Supplied

Caspofungin acetate for injection is a lyophilized white to off-white cake or powder for intravenous infusion, supplied in single dose vials with a rubber stopper and an aluminum seal as follows:

Product NDC

No.	No.	Strength	
356110	63323-356-10	50 mg per vial	Packaged in cartons of 10.
259110	62222 259 10	70 mg por vial	Packagod in

358110 63323-358-10 70 mg per vial cartons of 10.

<u>Storage and Handling</u> The lyophilized vials should be stored at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature].

Reconstituted Concentrate

Reconstituted caspofungin acetate for injection in the vial may be stored at $\leq 25^{\circ}C (\leq 77^{\circ}F)$ for one hour prior to the preparation of the patient infusion solution.

<u>Diluted Product</u> The final patient infusion solution in the intravenous bag or bottle can be stored at $\leq 25^{\circ}$ C ($\leq 77^{\circ}$ F) for 24 hours or at 2° to 8°C (36° to 46°F) for 48 hours.

The container closure is not made with natural rubber latex.

PATIENT COUNSELING INFORMATION Hypersensitivity Inform patients that anaphylactic reactions have 17

been reported during administration of caspofungin.



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