

FULL PRESCRIBING INFORMATION: CONTENTS

1 INDICATIONS AND USAGE

- 1.1 Adjuvant Treatment
- 1.2 First-Line Treatment
- 1.3 Second-Line Treatment

2 DOSAGE AND ADMINISTRATION

- 2.1 Recommended Dose
- 2.2 Patients with Hepatic Impairment

3 DOSAGE FORMS AND STRENGTHS

4 CONTRAINDICATIONS

- 4.1 Pregnancy and Premenopausal Women
- 4.2 Hypersensitivity

5 WARNINGS AND PRECAUTIONS

- 5.1 Ischemic Cardiovascular Events
- 5.2 Bone Effects
- 5.3 Cholesterol

6 ADVERSE REACTIONS

- 6.1 Clinical Trials Experience
- 6.2 Post-Marketing Experience

7 DRUG INTERACTIONS

- 7.1 Tamoxifen
- 7.2 Estrogen
- 7.3 Warfarin
- 7.4 Cytochrome P450

8 USE IN SPECIFIC POPULATIONS

- 8.1 Pregnancy
- 8.3 Nursing Mothers
- 8.4 Pediatric Use
 - Gynecomastia Study
 - McCune-Albright Syndrome Study
 - Pharmacokinetics in Pediatric Patients
- 8.5 Geriatric Use
- 8.6 Renal Impairment
- 8.7 Hepatic Impairment

10 OVERDOSAGE

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY

- 12.1 Mechanism of Action
- 12.2 Pharmacodynamics
- 12.3 Pharmacokinetics

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

13.2 Animal Toxicology and/or Pharmacology

14 CLINICAL STUDIES

14.1 Adjuvant Treatment of Breast Cancer in Postmenopausal Women

14.2 First Line Therapy in Postmenopausal Women with Advanced Breast Cancer

14.3 Second-Line Therapy in Postmenopausal Women with Advanced Breast Cancer who had Disease

Progression following Tamoxifen Therapy

16 HOW SUPPLIED/STORAGE AND HANDLING

Storage

FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

1.1 Adjuvant Treatment

Anastrozole tablets are indicated for adjuvant treatment of postmenopausal women with hormone receptor-positive early breast cancer.

1.2 First-Line Treatment

Anastrozole tablets are indicated for the first-line treatment of postmenopausal women with hormone receptor-positive or hormone receptor unknown locally advanced or metastatic breast cancer.

1.3 Second-Line Treatment

Anastrozole tablets are indicated for the treatment of advanced breast cancer in postmenopausal women with disease progression following tamoxifen therapy. Patients with ER-negative disease and patients who did not respond to previous tamoxifen therapy rarely responded to anastrozole tablets.

2 DOSAGE AND ADMINISTRATION

2.1 Recommended Dose

The dose of anastrozole tablet is one 1 mg tablet taken once a day. For patients with advanced breast cancer, anastrozole tablets should be continued until tumor progression. Anastrozole tablets can be taken with or without food.

For adjuvant treatment of early breast cancer in postmenopausal women, the optimal duration of therapy is unknown. In the ATAC trial, anastrozole was administered for five years [see *Clinical Studies (14.1)*].

No dosage adjustment is necessary for patients with renal impairment or for elderly patients [see *Use in Specific Populations (8.6)*].

2.2 Patients with Hepatic Impairment

No changes in dose are recommended for patients with mild-to-moderate hepatic impairment. Anastrozole has not been studied in patients with severe hepatic impairment [see *Use in Specific Populations (8.7)*].

3 DOSAGE FORMS AND STRENGTHS

The tablets are white to off-white, round biconvex, film coated tablets, with "AHI" debossing on one side and plain on other side.

4 CONTRAINDICATIONS

4.1 Pregnancy and Premenopausal Women

Anastrozole may cause fetal harm when administered to a pregnant woman and offers no clinical benefit to premenopausal women with breast cancer. Anastrozole is contraindicated in women who are or may become pregnant. There are no adequate and well-controlled studies in pregnant women using anastrozole. If anastrozole is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to a fetus or potential risk for loss of the pregnancy [see *Use in Specific Populations (8.1)*].

4.2 Hypersensitivity

Anastrozole is contraindicated in any patient who has shown a hypersensitivity reaction to the drug or to any of the excipients. Observed reactions include anaphylaxis, angioedema, and urticaria [see *Adverse Reactions (6.2)*].

5 WARNINGS AND PRECAUTIONS

5.1 Ischemic Cardiovascular Events

In women with pre-existing ischemic heart disease, an increased incidence of ischemic cardiovascular events was observed with anastrozole in the ATAC trial (17% of patients on anastrozole and 10% of patients on tamoxifen). Consider risk and benefits of

anastrozole therapy in patients with pre-existing ischemic heart disease. [*see Adverse Reactions (6.1)*]

5.2 Bone Effects

Results from the ATAC trial bone substudy at 12 and 24 months demonstrated that patients receiving anastrozole had a mean decrease in both lumbar spine and total hip bone mineral density (BMD) compared to baseline. Patients receiving tamoxifen had a mean increase in both lumbar spine and total hip BMD compared to baseline [*see Adverse Reactions, (6.1)*].

5.3 Cholesterol

During the ATAC trial, more patients receiving anastrozole were reported to have elevated serum cholesterol compared to patients receiving tamoxifen (9% versus 3.5%, respectively) [*see Adverse Reactions, (6.1)*].

6 ADVERSE REACTIONS

Serious adverse reactions with anastrozole occurring in less than 1 in 10,000 patients, are: 1) skin reactions such as lesions, ulcers, or blisters; 2) allergic reactions with swelling of the face, lips, tongue, and/or throat. This may cause difficulty in swallowing and/or breathing; and 3) changes in blood tests of the liver function, including inflammation of the liver with symptoms that may include a general feeling of not being well, with or without jaundice, liver pain or liver swelling [*see Adverse Reactions (6.2)*].

Common adverse reactions (occurring with an incidence of >10%) in women taking anastrozole included: hot flashes, asthenia, arthritis, pain, arthralgia, pharyngitis, hypertension, depression, nausea and vomiting, rash, osteoporosis, fractures, back pain, insomnia, pain, headache, bone pain, peripheral edema, increased cough, dyspnea, pharyngitis and lymphedema.

In the ATAC trial, the most common reported adverse reaction (>0.1%) leading to discontinuation of therapy for both treatment groups was hot flashes, although there were fewer patients who discontinued therapy as a result of hot flashes in the anastrozole group.

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.

6.1 Clinical Trials Experience

Adjuvant Therapy

Adverse reaction data for adjuvant therapy are based on the ATAC trial [see *Clinical Studies (14.1)*]. The median duration of adjuvant treatment for safety evaluation was 59.8 months and 59.6 months for patients receiving anastrozole 1 mg and tamoxifen 20 mg, respectively.

Adverse reactions occurring with an incidence of at least 5% in either treatment group during treatment or within 14 days of the end of treatment are presented in Table 1.

Table 1 - Adverse reactions occurring with an incidence of at least 5% in either treatment group during treatment, or within 14 days of the end of treatment in the ATAC trial

Body system and adverse reactions by COSTART preferred term	Anastrozole 1 mg (N = 3092)	Tamoxifen 20 mg (NHealthcare = 3094)
--	--------------------------------	---

The combination arm was discontinued due to lack of efficacy benefit at 33 months of follow-up.

COSTART Coding Symbols for Thesaurus of Adverse Reaction Terms.

A patient may have had more than 1 adverse reaction, including more than 1 adverse reaction in the same body system.

N=Number of patients receiving the treatment.

Vaginal Hemorrhage without further diagnosis.

Body as a whole

Asthenia	575 (19)	544 (18)
Pain	533 (17)	485 (16)
Back pain	321 (10)	309 (10)
Headache	314 (10)	249 (8)
Abdominal pain	271 (9)	276 (9)
Infection	285 (9)	276 (9)
Accidental injury	311 (10)	303 (10)
Flu syndrome	175 (6)	195 (6)

Table 1 - Adverse reactions occurring with an incidence of at least 5% in either treatment group during treatment, or within 14 days of the end of treatment in the ATAC trial

Body system and adverse reactions by COSTART preferred term	Anastrozole 1 mg (N = 3092)	Tamoxifen 20 mg (NHealthcare = 3094)
Chest pain	200 (7)	150 (5)
Neoplasm	162 (5)	144 (5)
Cyst	138 (5)	162 (5)
Cardiovascular		
Vasodilatation	1104 (36)	1264 (41)
Hypertension	402 (13)	349 (11)
Digestive		
Nausea	343 (11)	335 (11)
Constipation	249 (8)	252 (8)
Diarrhea	265 (9)	216 (7)
Dyspepsia	206 (7)	169 (6)
Gastrointestinal disorder	210 (7)	158 (5)
Hemic and lymphatic		
Lymphedema	304 (10)	341 (11)
Anemia	113 (4)	159 (5)
Metabolic and nutritional		
Peripheral edema	311 (10)	343 (11)
Weight gain	285 (9)	274 (9)
Hypercholesterolemia	278 (9)	108 (3.5)
Musculoskeletal		
Arthritis	512 (17)	445 (14)
Arthralgia	467 (15)	344 (11)
Osteoporosis	325 (11)	226 (7)
Fracture	315 (10)	209 (7)
Bone pain	201 (7)	185 (6)
Arthrosis	207 (7)	156 (5)
Joint Disorder	184 (6)	160 (5)
Myalgia	179 (6)	160 (5)
Nervous system		
Depression	413 (13)	382 (12)
Insomnia	309 (10)	281 (9)
Dizziness	236 (8)	234 (8)

Table 1 - Adverse reactions occurring with an incidence of at least 5% in either treatment group during treatment, or within 14 days of the end of treatment in the ATAC trial

Body system and adverse reactions by COSTART preferred term	Anastrozole 1 mg (N = 3092)	Tamoxifen 20 mg (N Healthcare = 3094)
Anxiety	195 (6)	180 (6)
Paresthesia	215 (7)	145 (5)
Respiratory		
Pharyngitis	443 (14)	422 (14)
Cough increased	261 (8)	287 (9)
Dyspnea	234 (8)	237 (8)
Sinusitis	184 (6)	159 (5)
Bronchitis	167 (5)	153 (5)
Skin and appendages		
Rash	333 (11)	387 (13)
Sweating	145 (5)	177 (6)
Special Senses		
Cataract Specified	182 (6)	213 (7)
Urogenital		
Leukorrhea	86 (3)	286 (9)
Urinary tract infection	244 (8)	313 (10)
Breast pain	251 (8)	169 (6)
Breast Neoplasm	164 (5)	139 (5)
Vulvovaginitis	194 (6)	150 (5)
Vaginal Hemorrhage†	122 (4)	180 (6)
Vaginitis	125 (4)	158 (5)

Certain adverse reactions and combinations of adverse reactions were prospectively specified for analysis, based on the known pharmacologic properties and side effect profiles of the two drugs (see Table 2).

Table 2 — Number of Patients with Pre-specified Adverse Reactions in ATAC Trial*

Anastrozole	Tamoxifen	Odds-ratio	95% CI
N=3092	N=3094		
(%)	(%)		

*

Patients with multiple events in the same category are counted only once in that category.

Table 2 — Number of Patients with Pre-specified Adverse Reactions in ATAC Trial*

	Anastrozole	Tamoxifen	Odds-ratio	95% CI
	N=3092	N=3094		
	(%)	(%)		
†	Refers to joint symptoms, including joint disorder, arthritis, arthrosis and arthralgia.			
‡	Percentages calculated based upon the numbers of patients with an intact uterus at baseline			
Hot Flashes	1104 (36)	1264 (41)	0.80	0.73 to 0.89
Musculoskeletal Events†	1100 (36)	911 (29)	1.32	1.19 to 1.47
Fatigue/Asthenia	575 (19)	544 (18)	1.07	0.94 to 1.22
Mood Disturbances	597 (19)	554 (18)	1.10	0.97 to 1.25
Nausea and Vomiting	393 (13)	384 (12)	1.03	0.88 to 1.19
All Fractures	315 (10)	209 (7)	1.57	1.30 to 1.88
Fractures of Spine, Hip, or Wrist	133 (4)	91 (3)	1.48	1.13 to 1.95
Wrist/Colles' fractures	67 (2)	50 (2)		
Spine fractures	43 (1)	22 (1)		
Hip fractures	28 (1)	26 (1)		
Cataracts	182 (6)	213 (7)	0.85	0.69 to 1.04
Vaginal Bleeding	167 (5)	317 (10)	0.50	0.41 to 0.61
Ischemic Cardiovascular Disease	127 (4)	104 (3)	1.23	0.95 to 1.60
Vaginal Discharge	109 (4)	408 (13)	0.24	0.19 to 0.30
Venous Thromboembolic events	87 (3)	140 (5)	0.61	0.47 to 0.80
Deep Venous Thromboembolic Events	48 (2)	74 (2)	0.64	0.45 to 0.93
Ischemic Cerebrovascular Event	62 (2)	88 (3)	0.70	0.50 to 0.97
Endometrial Cancer‡	4 (0.2)	13 (0.6)	0.31	0.10 to 0.94

Ischemic Cardiovascular Events

Between treatment arms in the overall population of 6186 patients, there was no statistical difference in ischemic cardiovascular events (4% anastrozole vs. 3% tamoxifen). In the overall population, angina pectoris was reported in 71/3092 (2.3%) patients in the anastrozole arm and 51/3094 (1.6%) patients in the tamoxifen arm; myocardial infarction was reported in 37/3092 (1.2%) patients in the anastrozole arm and 34/3094 (1.1%) patients in the tamoxifen arm.

In women with pre-existing ischemic heart disease 465/6186 (7.5%), the incidence of ischemic cardiovascular events was 17% in patients on anastrozole and 10% in patients on tamoxifen. In this patient population, angina pectoris was reported in 25/216 (11.6%) patients receiving anastrozole and 13/249 (5.2%) patients receiving tamoxifen; myocardial infarction was reported in 2/216 (0.9%) patients receiving anastrozole and 8/249 (3.2%) patients receiving tamoxifen.

Bone Mineral Density Findings

Results from the ATAC trial bone substudy at 12 and 24 months demonstrated that patients receiving anastrozole had a mean decrease in both lumbar spine and total hip bone mineral density (BMD) compared to baseline. Patients receiving tamoxifen had a mean increase in both lumbar spine and total hip BMD compared to baseline.

Because anastrozole lowers circulating estrogen levels it may cause a reduction in bone mineral density.

A post-marketing trial assessed the combined effects of anastrozole and the bisphosphonate risedronate on changes from baseline in BMD and markers of bone resorption and formation in postmenopausal women with hormone receptor-positive early breast cancer. All patients received calcium and vitamin D supplementation. At 12 months, small reductions in lumbar spine bone mineral density were noted in patients not receiving bisphosphonates. Bisphosphonate treatment preserved bone density in most patients at risk of fracture.

Postmenopausal women with early breast cancer scheduled to be treated with anastrozole should have their bone status managed according to treatment guidelines already available for postmenopausal women at similar risk of fragility fracture.

Cholesterol

During the ATAC trial, more patients receiving anastrozole were reported to have an elevated serum cholesterol compared to patients receiving tamoxifen (9% versus 3.5%, respectively).

A post-marketing trial also evaluated any potential effects of anastrozole on lipid profile. In the primary analysis population for lipids (anastrozole alone), there was no clinically

significant change in LDL-C from baseline to 12 months and HDL-C from baseline to 12 months

In secondary population for lipids (anastrozole + risedronate), there also was no clinically significant change in LDL-C and HDL-C from baseline to 12 months.

In both populations for lipids, there was no clinically significant difference in total cholesterol (TC) or serum triglycerides (TG) at 12 months compared with baseline.

In this trial, treatment for 12 months with anastrozole alone had a neutral effect on lipid profile. Combination treatment with anastrozole and risedronate also had a neutral effect on lipid profile.

The trial provides evidence that postmenopausal women with early breast cancer scheduled to be treated with anastrozole should be managed using the current National Cholesterol Education Program guidelines for cardiovascular risk-based management of individual patients with LDL elevations.

Other Adverse Reactions

Patients receiving anastrozole had an increase in joint disorders (including arthritis, arthrosis and arthralgia) compared with patients receiving tamoxifen. Patients receiving anastrozole had an increase in the incidence of all fractures (specifically fractures of spine, hip and wrist) [315 (10%)] compared with patients receiving tamoxifen [209 (7%)].

Patients receiving anastrozole had a higher incidence of carpal tunnel syndrome [78 (2.5%)] compared with patients receiving tamoxifen [22 (0.7%)].

Vaginal bleeding occurred more frequently in the tamoxifen-treated patients versus the anastrozole-treated patients 317 (10%) versus 167 (5%), respectively.

Patients receiving anastrozole had a lower incidence of hot flashes, vaginal bleeding, vaginal discharge, endometrial cancer, venous thromboembolic events and ischemic cerebrovascular events compared with patients receiving tamoxifen.

10-year median follow-up Safety Results from the ATAC Trial

- Results are consistent with the previous analyses.
- Serious adverse reactions were similar between anastrozole (50%) and tamoxifen (51%).

- Cardiovascular events were consistent with the known safety profiles of anastrozole and tamoxifen.
- The cumulative incidences of all first fractures (both serious and non-serious, occurring either during or after treatment) was higher in the anastrozole group (15%) compared to the tamoxifen group (11%). This increased first fracture rate during treatment did not continue in the post-treatment follow-up period.
- The cumulative incidence of new primary cancers was similar in the anastrozole group (13.7%) compared to the tamoxifen group (13.9%). Consistent with the previous analyses, endometrial cancer was higher in the tamoxifen group (0.8%) compared to the anastrozole group (0.2%).
- The overall number of deaths (during or off-trial treatment) was similar between the treatment groups. There were more deaths related to breast cancer in the tamoxifen than in the anastrozole treatment group.

First-Line Therapy

Adverse reactions occurring with an incidence of at least 5% in either treatment group of trials 0030 and 0027 during or within 2 weeks of the end of treatment are shown in Table 3.

Table 3 — Adverse Reactions Occurring with an Incidence of at Least 5% in Trials 0030 and 0027

Body system Adverse Reaction*	Number (%) of subjects	
	Anastrozole (n=506)	Tamoxifen (n=511)
Whole body		
Asthenia	83 (16)	81 (16)

*
A patient may have had more than 1 adverse event.

Table 3 — Adverse Reactions Occurring with an Incidence of at Least 5% in Trials 0030 and 0027

Body system Adverse Reaction*	Number (%) of subjects	
	Anastrozole (n=506)	Tamoxifen (n=511)
Pain	70 (14)	73 (14)
Back pain	60 (12)	68 (13)
Headache	47 (9)	40 (8)
Abdominal pain	40 (8)	38 (7)
Chest pain	37 (7)	37 (7)
Flu syndrome	35 (7)	30 (6)
Pelvic pain	23 (5)	30 (6)
Cardiovascular		
Vasodilation	128 (25)	106 (21)
Hypertension	25 (5)	36 (7)
Digestive		
Nausea	94 (19)	106 (21)
Constipation	47 (9)	66 (13)
Diarrhea	40 (8)	33 (6)
Vomiting	38 (8)	36 (7)
Anorexia	26 (5)	46 (9)
Metabolic and Nutritional		
Peripheral edema	51 (10)	41 (8)
Musculoskeletal		
Bone pain	54 (11)	52 (10)
Nervous		
Dizziness	30 (6)	22 (4)
Insomnia	30 (6)	38 (7)
Depression	23 (5)	32 (6)
Hypertonia	16 (3)	26 (5)
Respiratory		
Cough increased	55 (11)	52 (10)
Dyspnea	51 (10)	47 (9)
Pharyngitis	49 (10)	68 (13)
Skin and appendages		
Rash	38 (8)	34 (8)

Table 3 — Adverse Reactions Occurring with an Incidence of at Least 5% in Trials 0030 and 0027

Body system Adverse Reaction*	Number (%) of subjects	
	Anastrozole (n=506)	Tamoxifen (n=511)
Urogenital		
Leukorrhea	9 (2)	31 (6)

Less frequent adverse experiences reported in patients receiving anastrozole 1 mg in either Trial 0030 or Trial 0027 were similar to those reported for second-line therapy.

Based on results from second-line therapy and the established safety profile of tamoxifen, the incidences of 9 pre-specified adverse event categories potentially causally related to one or both of the therapies because of their pharmacology were statistically analyzed. No significant differences were seen between treatment groups.

Table 4 — Number of Patients with Pre-specified Adverse Reactions in Trials 0030 and 0027

Adverse Reaction*	Number (n) and Percentage of Patients	
	Anastrozole 1 mg (n=506) n (%)	NOLVADEX 20 mg (n=511) n (%)
Depression	23 (5)	32 (6)
Tumor Flare	15 (3)	18 (4)
Thromboembolic Disease†	18 (4)	33 (6)
Venous‡	5	15
Coronary and Cerebral‡	13	19
Gastrointestinal Disturbance	170 (34)	196 (38)
Hot Flushes	134 (26)	118 (23)
Vaginal Dryness	9 (2)	3 (1)

*

A patient may have had more than 1 adverse reaction.

†

Includes pulmonary embolus, thrombophlebitis, retinal vein thrombosis.

‡

Includes myocardial infarction, myocardial ischemia, angina pectoris, cerebrovascular accident, cerebral ischemia and cerebral infarct.

Table 4 — Number of Patients with Pre-specified Adverse Reactions in Trials 0030 and 0027

Adverse Reaction*	Number (n) and Percentage of Patients	
	Anastrozole	NOLVADEX
	1 mg	20 mg
	(n=506)	(n=511)
	n (%)	n (%)
Lethargy	6 (1)	15 (3)
Vaginal Bleeding	5 (1)	11 (2)
Weight Gain	11 (2)	8 (2)

Second-Line Therapy

Anastrozole was tolerated in two controlled clinical trials (i.e., Trials 0004 and 0005), with less than 3.3% of the anastrozole-treated patients and 4.0% of the megestrol acetate-treated patients withdrawing due to an adverse reaction.

The principal adverse reaction more common with anastrozole than megestrol acetate was diarrhea. Adverse reactions reported in greater than 5% of the patients in any of the treatment groups in these two well-controlled clinical trials, regardless of causality, are presented below:

Table 5 — Number (N) and Percentage of Patients with Adverse Reactions in Trials 0004 and 0005*

Adverse Reaction	Anastrozole		Anastrozole		Megesterol Acetate	
	1 mg		10 mg		160 mg	
	(n=262)		(n=246)		(n=253)	
	n	%	n	%	n	%

*

A patient may have had more than one adverse reaction.

Asthenia	42	(16)	33	(13)	47	(19)
Nausea	41	(16)	48	(20)	28	(11)
Headache	34	(13)	44	(18)	24	(9)
Hot Flashes	32	(12)	29	(11)	21	(8)
Pain	28	(11)	38	(15)	29	(11)
Back Pain	28	(11)	26	(11)	19	(8)
Dyspnea	24	(9)	27	(11)	53	(21)

Table 5 — Number (N) and Percentage of Patients with Adverse Reactions in Trials 0004 and 0005*

Adverse Reaction	Anastrozole		Anastrozole		Megesterol Acetate	
	1 mg		10 mg		160 mg	
	(n=262)		(n=246)		(n=253)	
	n	%	n	%	n	%
Vomiting	24	(9)	26	(11)	16	(6)
Cough Increased	22	(8)	18	(7)	19	(8)
Diarrhea	22	(8)	18	(7)	7	(3)
Constipation	18	(7)	18	(7)	21	(8)
Abdominal Pain	18	(7)	14	(6)	18	(7)
Anorexia	18	(7)	19	(8)	11	(4)
Bone Pain	17	(6)	26	(12)	19	(8)
Pharyngitis	16	(6)	23	(9)	15	(6)
Dizziness	16	(6)	12	(5)	15	(6)
Rash	15	(6)	15	(6)	19	(8)
Dry Mouth	15	(6)	11	(4)	13	(5)
Peripheral Edema	14	(5)	21	(9)	28	(11)
Pelvic Pain	14	(5)	17	(7)	13	(5)
Depression	14	(5)	6	(2)	5	(2)
Chest Pain	13	(5)	18	(7)	13	(5)
Paresthesia	12	(5)	15	(6)	9	(4)
Vaginal Hemorrhage	6	(2)	4	(2)	13	(5)
Weight Gain	4	(2)	9	(4)	30	(12)
Sweating	4	(2)	3	(1)	16	(6)
Increased Appetite	0	(0)	1	(0)	13	(5)

Other less frequent (2% to 5%) adverse reactions reported in patients receiving anastrozole 1 mg in either Trial 0004 or Trial 0005 are listed below. These adverse experiences are listed by body system and are in order of decreasing frequency within each body system regardless of assessed causality.

Body as a Whole: Flu syndrome; fever; neck pain; malaise; accidental injury; infection

Cardiovascular: Hypertension; thrombophlebitis

Hepatic: Gamma GT increased; SGOT increased; SGPT increased

Hematologic: Anemia; leukopenia

Metabolic and Nutritional: Alkaline phosphatase increased; weight loss

Mean serum total cholesterol levels increased by 0.5 mmol/L among patients receiving anastrozole. Increases in LDL cholesterol have been shown to contribute to these changes.

Musculoskeletal: Myalgia; arthralgia; pathological fracture

Nervous: Somnolence; confusion; insomnia; anxiety; nervousness

Respiratory: Sinusitis; bronchitis; rhinitis

Skin and Appendages: Hair thinning (alopecia); pruritus

Urogenital: Urinary tract infection; breast pain

The incidences of the following adverse reaction groups potentially causally related to one or both of the therapies because of their pharmacology, were statistically analyzed: weight gain, edema, thromboembolic disease, gastrointestinal disturbance, hot flushes, and vaginal dryness. These six groups, and the adverse reactions captured in the groups, were prospectively defined. The results are shown in the table below.

Table 6 — Number (n) and Percentage of Patients with Pre-specified Adverse Reactions in Trials 0004 and 0005

Adverse Event Group	Anastrozole		Anastrozole		Megestrol Acetate	
	1 mg (n=262)		10 mg (n=246)		160 mg (n=253)	
	n	(%)	n	(%)	n	(%)
Gastrointestinal Disturbance	77	(29)	81	(33)	54	(21)
Hot Flushes	33	(13)	29	(12)	35	(14)
Edema	19	(7)	28	(11)	35	(14)
Thromboembolic Disease	9	(3)	4	(2)	12	(5)
Vaginal Dryness	5	(2)	3	(1)	2	(1)
Weight Gain	4	(2)	10	(4)	30	(12)

6.2 Post-Marketing Experience

Hepatobiliary events including increases in alkaline phosphatase, alanine aminotransferase, aspartate aminotransferase have been reported ($\leq 1\%$ and $< 10\%$) and gamma-GT, bilirubin and hepatitis have been reported ($\leq 0.1\%$ and $< 1\%$) in patients receiving anastrozole.

Anastrozole may also be associated with rash including cases of mucocutaneous disorders such as erythema multiforme and Stevens-Johnson syndrome.

Cases of allergic reactions including angioedema, urticaria and anaphylaxis have been reported in patients receiving anastrozole. [see *Contraindications (4.2)*]

Trigger finger has been reported ($> 0.1\%$ and $< 1\%$) in patients receiving anastrozole.

7 DRUG INTERACTIONS

7.1 Tamoxifen

Co-administration of anastrozole and tamoxifen in breast cancer patients reduced anastrozole plasma concentration by 27%. However, the co-administration did not affect the pharmacokinetics of tamoxifen or N-desmethyltamoxifen. At a median follow-up of 33 months, the combination of anastrozole and tamoxifen did not demonstrate any efficacy benefit when compared with tamoxifen in all patients as well as in the hormone receptor-positive subpopulation. This treatment arm was discontinued from the trial [see *Clinical Studies (14.1)*]. Based on clinical and pharmacokinetic results from the ATAC trial, tamoxifen should not be administered with anastrozole.

7.2 Estrogen

Estrogen-containing therapies should not be used with anastrozole as they may diminish its pharmacological action.

7.3 Warfarin

In a study conducted in 16 male volunteers, anastrozole did not alter the exposure (as measured by C_{max} and AUC), and anticoagulant activity (as measured by prothrombin

time, activated partial thromboplastin time, and thrombin time) of both R- and S-warfarin.

7.4 Cytochrome P450

Based on *in vitro* and *in vivo* results, it is unlikely that co-administration of anastrozole 1 mg will affect other drugs as a result inhibition of cytochrome P450 [see *Clinical Pharmacology* (12.3)].

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

PREGNANCY CATEGORY X [see *Contraindications* (4.1)]

Anastrozole may cause fetal harm when administered to a pregnant woman and offers no clinical benefit to premenopausal women with breast cancer. Anastrozole is contraindicated in women who are or may become pregnant. In animal studies, anastrozole caused pregnancy failure, increased pregnancy loss, and signs of delayed fetal development. There are no studies of anastrozole use in pregnant women. If anastrozole is used during pregnancy, or if the patient becomes pregnant while receiving this drug, the patient should be apprised of the potential hazard to the fetus and potential risk for pregnancy loss.

In animal reproduction studies, pregnant rats and rabbits received anastrozole during organogenesis at doses equal to or greater than 1 (rats) and 1/3 (rabbits) the recommended human dose on a mg/m² basis. In both species, anastrozole crossed the placenta, and there was increased pregnancy loss (increased pre- and/or post-implantation loss, increased resorption, and decreased numbers of live fetuses). In rats, these effects were dose related, and placental weights were significantly increased. Fetotoxicity, including delayed fetal development (i.e., incomplete ossification and depressed fetal body weights), occurred in rats at anastrozole doses that produced peak plasma levels 19 times higher than serum levels in humans at the therapeutic dose (AUC_{0-24hr} 9 times higher). In rabbits, anastrozole caused pregnancy failure at doses equal to or greater than 16 times the recommended human dose on a mg/m² basis. [see *Animal Toxicology and/or Pharmacology* (13.2)]

8.3 Nursing Mothers

It is not known if anastrozole is excreted in human milk. Because many drugs are excreted in human milk and because of the tumorigenicity shown for anastrozole in animal studies, or the potential for serious adverse reactions in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

Clinical studies in pediatric patients included a placebo-controlled trial in pubertal boys of adolescent age with gynecomastia and a single-arm trial in girls with McCune-Albright Syndrome and progressive precocious puberty. The efficacy of anastrozole in the treatment of pubertal gynecomastia in adolescent boys and in the treatment of precocious puberty in girls with McCune-Albright Syndrome has not been demonstrated.

Gynecomastia Study

A randomized, double-blind, placebo-controlled, multi-center study enrolled 80 boys with pubertal gynecomastia aged 11 to 18 years. Patients were randomized to a daily regimen of either anastrozole 1 mg or placebo. After 6 months of treatment there was no statistically significant difference in the percentage of patients who experienced a $\geq 50\%$ reduction in gynecomastia (primary efficacy analysis). Secondary efficacy analyses (absolute change in breast volume, the percentage of patients who had any reduction in the calculated volume of gynecomastia, breast pain resolution) were consistent with the primary efficacy analysis. Serum estradiol concentrations at Month 6 of treatment were reduced by 15.4% in the anastrozole group and 4.5% in the placebo group.

Adverse reactions that were assessed as treatment-related by the investigators occurred in 16.3% of the anastrozole-treated patients and 8.1% of the placebo-treated patients with the most frequent being acne (7% anastrozole and 2.7% placebo) and headache (7% anastrozole and 0% placebo); all other adverse reactions showed small differences between treatment groups. One patient treated with anastrozole discontinued the trial because of testicular enlargement. The mean baseline-subtracted

change in testicular volume after 6 months of treatment was $+ 6.6 \pm 7.9$ cm³ in the anastrozole-treated patients and $+ 5.2 \pm 8.0$ cm³ in the placebo group.

McCune-Albright Syndrome Study

A multi-center, single-arm, open-label study was conducted in 28 girls with McCune-Albright Syndrome and progressive precocious puberty aged 2 to <10 years. All patients received a 1 mg daily dose of anastrozole. The trial duration was 12 months. Patients were enrolled on the basis of a diagnosis of typical (27/28) or atypical (1/27) McCune-Albright Syndrome, precocious puberty, history of vaginal bleeding, and/or advanced bone age. Patients' baseline characteristics included the following: a mean chronological age of 5.9 ± 2.0 years, a mean bone age of 8.6 ± 2.6 years, a mean growth rate of 7.9 ± 2.9 cm/year and a mean Tanner stage for breast of 2.7 ± 0.81 . Compared to pre-treatment data there were no on-treatment statistically significant reductions in the frequency of vaginal bleeding days, or in the rate of increase of bone age (defined as a ratio between the change in bone age over the change of chronological age). There were no clinically significant changes in Tanner staging, mean ovarian volume, mean uterine volume and mean predicted adult height. A small but statistically significant reduction of growth rate from 7.9 ± 2.9 cm/year to 6.5 ± 2.8 cm/year was observed but the absence of a control group precludes attribution of this effect to treatment or to other confounding factors such as variations in endogenous estrogen levels commonly seen in McCune-Albright Syndrome patients.

Five patients (18%) experienced adverse reactions that were considered possibly related to anastrozole. These were nausea, acne, pain in an extremity, increased alanine transaminase and aspartate transaminase, and allergic dermatitis.

Pharmacokinetics in Pediatric Patients

Following 1 mg once daily multiple administration in pediatric patients, the mean time to reach the maximum anastrozole concentration was 1 hr. The mean (range) disposition parameters of anastrozole in pediatric patients were described by a CL/F of 1.54 L/h (0.77 to 4.53 L/h) and V/F of 98.4 L (50.7 to 330.0 L). The terminal elimination half-life was 46.8 h, which was similar to that observed in postmenopausal women treated with anastrozole for breast cancer. Based on a population pharmacokinetic analysis, the

pharmacokinetics of anastrozole was similar in boys with pubertal gynecomastia and girls with McCune- Albright Syndrome.

8.5 Geriatric Use

In studies 0030 and 0027, about 50% of patients were 65 or older. Patients ≥ 65 years of age had moderately better tumor response and time to tumor progression than patients < 65 years of age regardless of randomized treatment. In studies 0004 and 0005, 50% of patients were 65 or older. Response rates and time to progression were similar for the over 65 and younger patients.

In the ATAC study, 45% of patients were 65 years of age or older. The efficacy of anastrozole compared to tamoxifen in patients who were 65 years or older (N=1413 for anastrozole and N=1410 for tamoxifen, the hazard ratio for disease-free survival was 0.93 [95% CI: 0.80, 1.08]) was less than efficacy observed in patients who were less than 65 years of age (N= 1712 for anastrozole and N=1706 for tamoxifen, the hazard ratio for disease-free survival was 0.79 [95% CI: 0.67, 0.94]).

The pharmacokinetics of anastrozole is not affected by age.

8.6 Renal Impairment

Since only about 10% of anastrozole is excreted unchanged in the urine, the renal impairment does not influence the total body clearance. Dosage adjustment in patients with renal impairment is not necessary [see *Dosage and Administration (2.1)* and *Clinical Pharmacology (12.3)*].

8.7 Hepatic Impairment

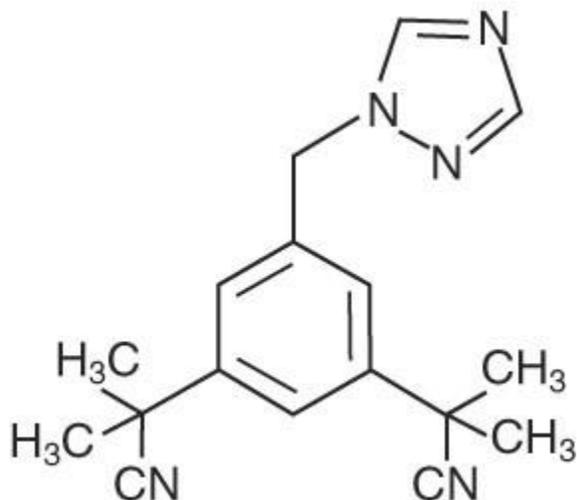
The plasma anastrozole concentrations in the subjects with hepatic cirrhosis were within the range of concentrations seen in normal subjects across all clinical trials. Therefore, dosage adjustment is also not necessary in patients with stable hepatic cirrhosis. Anastrozole has not been studied in patients with severe hepatic impairment [see *Dosage and Administration (2.2)* and *Clinical Pharmacology (12.3)*].

10 OVERDOSAGE

Clinical trials have been conducted with anastrozole, up to 60 mg in a single dose given to healthy male volunteers and up to 10 mg daily given to postmenopausal women with advanced breast cancer; these dosages were tolerated. A single dose of anastrozole that results in life-threatening symptoms has not been established. There is no specific antidote to overdose and treatment must be symptomatic. In the management of an overdose, consider that multiple agents may have been taken. Vomiting may be induced if the patient is alert. Dialysis may be helpful because anastrozole is not highly protein bound. General supportive care, including frequent monitoring of vital signs and close observation of the patient, is indicated.

11 DESCRIPTION

Anastrozole tablets for oral administration contain 1 mg of anastrozole, a non-steroidal aromatase inhibitor. It is chemically described as 1,3-Benzenediacetonitrile, a, a, a', a'-tetramethyl-5-(1H-1,2,4-triazol-1-ylmethyl). Its molecular formula is C₁₇H₁₉N₅ and its structural formula is:



Anastrozole is an off-white powder with a molecular weight of 293.4. Anastrozole has moderate aqueous solubility (0.5 mg/mL at 25°C); solubility is independent of pH in the physiological range. Anastrozole is freely soluble in methanol, acetone, ethanol, and tetrahydrofuran, and very soluble in acetonitrile.

Each tablet contains as inactive ingredients: lactose monohydrate, magnesium stearate, hypromellose, macrogol, povidone, sodium starch glycolate, and titanium dioxide.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

The growth of many cancers of the breast is stimulated or maintained by estrogens.

In postmenopausal women, estrogens are mainly derived from the action of the aromatase enzyme, which converts adrenal androgens (primarily androstenedione and testosterone) to estrone and estradiol. The suppression of estrogen biosynthesis in peripheral tissues and in the cancer tissue itself can therefore be achieved by specifically inhibiting the aromatase enzyme.

Anastrozole is a selective non-steroidal aromatase inhibitor. It significantly lowers serum estradiol concentrations and has no detectable effect on formation of adrenal corticosteroids or aldosterone.

12.2 Pharmacodynamics

Effect on Estradiol

Mean serum concentrations of estradiol were evaluated in multiple daily dosing trials with 0.5, 1, 3, 5, and 10 mg of anastrozole in postmenopausal women with advanced breast cancer. Clinically significant suppression of serum estradiol was seen with all doses. Doses of 1 mg and higher resulted in suppression of mean serum concentrations of estradiol to the lower limit of detection (3.7 pmol/L). The recommended daily dose, anastrozole 1 mg, reduced estradiol by approximately 70% within 24 hours and by approximately 80% after 14 days of daily dosing. Suppression of serum estradiol was maintained for up to 6 days after cessation of daily dosing with anastrozole 1 mg.

The effect of anastrozole in premenopausal women with early or advanced breast cancer has not been studied. Because aromatization of adrenal androgens is not a significant source of estradiol in premenopausal women, anastrozole would not be expected to lower estradiol levels in premenopausal women.

Effect on Corticosteroids

In multiple daily dosing trials with 3, 5, and 10 mg, the selectivity of anastrozole was assessed by examining effects on corticosteroid synthesis. For all doses, anastrozole

did not affect cortisol or aldosterone secretion at baseline or in response to ACTH. No glucocorticoid or mineralocorticoid replacement therapy is necessary with anastrozole.

Other Endocrine Effects

In multiple daily dosing trials with 5 and 10 mg, thyroid stimulating hormone (TSH) was measured; there was no increase in TSH during the administration of anastrozole. Anastrozole does not possess direct progestogenic, androgenic, or estrogenic activity in animals, but does perturb the circulating levels of progesterone, androgens, and estrogens.

12.3 Pharmacokinetics

Absorption

Inhibition of aromatase activity is primarily due to anastrozole, the parent drug. Absorption of anastrozole is rapid and maximum plasma concentrations typically occur within 2 hours of dosing under fasted conditions. Studies with radiolabeled drug have demonstrated that orally administered anastrozole is well absorbed into the systemic circulation. Food reduces the rate but not the overall extent of anastrozole absorption. The mean C_{max} of anastrozole decreased by 16% and the median T_{max} was delayed from 2 to 5 hours when anastrozole was administered 30 minutes after food. The pharmacokinetics of anastrozole are linear over the dose range of 1 to 20 mg, and do not change with repeated dosing. The pharmacokinetics of anastrozole were similar in patients and healthy volunteers.

Distribution

Steady-state plasma levels are approximately 3- to 4-fold higher than levels observed after a single dose of anastrozole. Plasma concentrations approach steady-state levels at about 7 days of once daily dosing. Anastrozole is 40% bound to plasma proteins in the therapeutic range.

Metabolism

Metabolism of anastrozole occurs by N-dealkylation, hydroxylation and glucuronidation. Three metabolites of anastrozole (triazole, a glucuronide conjugate of hydroxy-

anastrozole, and a glucuronide conjugate of anastrozole itself) have been identified in human plasma and urine. The major circulating metabolite of anastrozole, triazole, lacks pharmacologic activity.

Anastrozole inhibited reactions catalyzed by cytochrome P450 1A2, 2C8/9, and 3A4 in vitro with K_i values which were approximately 30 times higher than the mean steady-state C_{max} values observed following a 1 mg daily dose. Anastrozole had no inhibitory effect on reactions catalyzed by cytochrome P450 2A6 or 2D6 in vitro. Administration of a single 30 mg/kg or multiple 10 mg/kg doses of anastrozole to healthy subjects had no effect on the clearance of antipyrine or urinary recovery of antipyrine metabolites.

Excretion

Eighty-five percent of radiolabeled anastrozole was recovered in feces and urine. Hepatic metabolism accounts for approximately 85% of anastrozole elimination. Renal elimination accounts for approximately 10% of total clearance. The mean elimination half-life of anastrozole is 50 hours.

Effect of Gender and Age

Anastrozole pharmacokinetics have been investigated in postmenopausal female volunteers and patients with breast cancer. No age-related effects were seen over the range <50 to >80 years.

Effect of Race

Estradiol and estrone sulfate serum levels were similar between Japanese and Caucasian postmenopausal women who received 1 mg of anastrozole daily for 16 days. Anastrozole mean steady-state minimum plasma concentrations in Caucasian and Japanese postmenopausal women were 25.7 and 30.4 ng/mL, respectively.

Effect of Renal Impairment

Anastrozole pharmacokinetics have been investigated in subjects with renal impairment. Anastrozole renal clearance decreased proportionally with creatinine clearance and was approximately 50% lower in volunteers with severe renal impairment (creatinine clearance < 30 mL/min/1.73m²) compared to controls. Total clearance was only

reduced 10%. No dosage adjustment is needed for renal impairment. [see *Dosage and Administration (2.1)* and *Use in Specific Populations (8.6)*]

Effect of Hepatic Impairment

Anastrozole pharmacokinetics have been investigated in subjects with hepatic cirrhosis related to alcohol abuse. The apparent oral clearance (CL/F) of anastrozole was approximately 30% lower in subjects with stable hepatic cirrhosis than in control subjects with normal liver function. However, these plasma concentrations were still within the range of values observed in normal subjects. The effect of severe hepatic impairment was not studied. No dose adjustment is necessary for stable hepatic cirrhosis. [see *Dosage and Administration (2.2)* and *Use in Specific Populations (8.7)*]

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

A conventional carcinogenesis study in rats at doses of 1.0 to 25 mg/kg/day (about 10 to 243 times the daily maximum recommended human dose on a mg/m² basis) administered by oral gavage for up to 2 years revealed an increase in the incidence of hepatocellular adenoma and carcinoma and uterine stromal polyps in females and thyroid adenoma in males at the high dose. A dose-related increase was observed in the incidence of ovarian and uterine hyperplasia in females. At 25 mg/kg/day, plasma AUC_{0-24 hr} levels in rats were 110 to 125 times higher than the level exhibited in postmenopausal volunteers at the recommended dose. A separate carcinogenicity study in mice at oral doses of 5 to 50 mg/kg/day (about 24 to 243 times the daily maximum recommended human dose on a mg/m² basis) for up to 2 years produced an increase in the incidence of benign ovarian stromal, epithelial and granulosa cell tumors at all dose levels. A dose related increase in the incidence of ovarian hyperplasia was also observed in female mice. These ovarian changes are considered to be rodent-specific effects of aromatase inhibition and are of questionable significance to humans. The incidence of lymphosarcoma was increased in males and females at the high dose. At 50 mg/kg/day, plasma AUC levels in mice were 35 to 40 times higher than the level exhibited in postmenopausal volunteers at the recommended dose.

Anastrozole has not been shown to be mutagenic in *in vitro* tests (Ames and E. coli bacterial tests, CHO-K1 gene mutation assay) or clastogenic either *in vitro* (chromosome aberrations in human lymphocytes) or *in vivo* (micronucleus test in rats).

Oral administration of anastrozole to female rats (from 2 weeks before mating to pregnancy day 7) produced significant incidence of infertility and reduced numbers of viable pregnancies at 1 mg/kg/day (about 10 times the recommended human dose on a mg/m² basis and 9 times higher than the AUC_{0-24 hr} found in postmenopausal volunteers at the recommended dose). Pre-implantation loss of ova or fetus was increased at doses equal to or greater than 0.02 mg/kg/day (about one-fifth the recommended human dose on a mg/m² basis). Recovery of fertility was observed following a 5-week non-dosing period which followed 3 weeks of dosing. It is not known whether these effects observed in female rats are indicative of impaired fertility in humans.

Multiple-dose studies in rats administered anastrozole for 6 months at doses equal to or greater than 1 mg/kg/day (which produced plasma anastrozole C_{ssmax} and AUC_{0-24 hr} that were 19 and 9 times higher than the respective values found in postmenopausal volunteers at the recommended dose) resulted in hypertrophy of the ovaries and the presence of follicular cysts. In addition, hyperplastic uteri were observed in 6-month studies in female dogs administered doses equal to or greater than 1 mg/kg/day (which produced plasma anastrozole C_{ssmax} and AUC_{0-24 hr} that were 22 times and 16 times higher than the respective values found in postmenopausal women at the recommended dose). It is not known whether these effects on the reproductive organs of animals are associated with impaired fertility in premenopausal women.

13.2 Animal Toxicology and/or Pharmacology

Reproductive Toxicology

Anastrozole has been found to cross the placenta following oral administration of 0.1 mg/kg in rats and rabbits (about 1 and 1.9 times the recommended human dose, respectively, on a mg/m² basis). Studies in both rats and rabbits at doses equal to or greater than 0.1 and 0.02 mg/kg/day, respectively (about 1 and 1/3, respectively, the recommended human dose on a mg/m² basis), administered during the period of organogenesis showed that anastrozole increased pregnancy loss (increased pre-

and/or post-implantation loss, increased resorption, and decreased numbers of live fetuses); effects were dose related in rats. Placental weights were significantly increased in rats at doses of 0.1 mg/kg/day or more.

Evidence of fetotoxicity, including delayed fetal development (i.e., incomplete ossification and depressed fetal body weights), was observed in rats administered doses of 1 mg/kg/day (which produced plasma anastrozole C_{ssmax} and $AUC_{0-24\text{ hr}}$ that were 19 times and 9 times higher than the respective values found in postmenopausal volunteers at the recommended dose). There was no evidence of teratogenicity in rats administered doses up to 1.0 mg/kg/day. In rabbits, anastrozole caused pregnancy failure at doses equal to or greater than 1.0 mg/kg/day (about 16 times the recommended human dose on a mg/m² basis); there was no evidence of teratogenicity in rabbits administered 0.2 mg/kg/day (about 3 times the recommended human dose on a mg/m² basis).

14 CLINICAL STUDIES

14.1 Adjuvant Treatment of Breast Cancer in Postmenopausal Women

A multicenter, double-blind trial (ATAC) randomized 9,366 postmenopausal women with operable breast cancer to adjuvant treatment with anastrozole 1 mg daily, tamoxifen 20 mg daily, or a combination of the two treatments for five years or until recurrence of the disease.

The primary endpoint of the trial was disease-free survival (i.e., time to occurrence of a distant or local recurrence, or contralateral breast cancer or death from any cause).

Secondary endpoints of the trial included distant disease-free survival, the incidence of contralateral breast cancer and overall survival. At a median follow-up of 33 months, the combination of anastrozole and tamoxifen did not demonstrate any efficacy benefit when compared with tamoxifen in all patients as well as in the hormone receptor positive subpopulation. This treatment arm was discontinued from the trial. Based on clinical and pharmacokinetic results from the ATAC trial, tamoxifen should not be administered with anastrozole. [see *Drug Interactions (7.1)*]

Demographic and other baseline characteristics were similar among the three treatment groups (see Table 7).

Table 7 - Demographic and Baseline Characteristics for ATAC Trial

Demographic Characteristic	Anastrozole 1 mg (N*=3125)	Tamoxifen 20 mg (N*=3116)	Anastrozole 1 mg plus Tamoxifen 20 mg† (N*=3125)
----------------------------	----------------------------------	---------------------------------	---

*

N=Number of patients randomized to the treatment

†

The combination arm was discontinued due to lack of efficacy benefit at 33 months of follow-up

‡

Includes patients who were estrogen receptor (ER) positive or progesterone receptor (PgR) positive, or both positive

§

Includes patients with both ER negative and PgR negative receptor status

¶

Includes all other combinations of ER and PgR receptor status unknown

#

Among the patients who had breast conservation, radiotherapy was administered to 95.0% of patients in the anastrozole arm, 94.1% in the tamoxifen arm and 94.5% in the anastrozole plus tamoxifen arm.

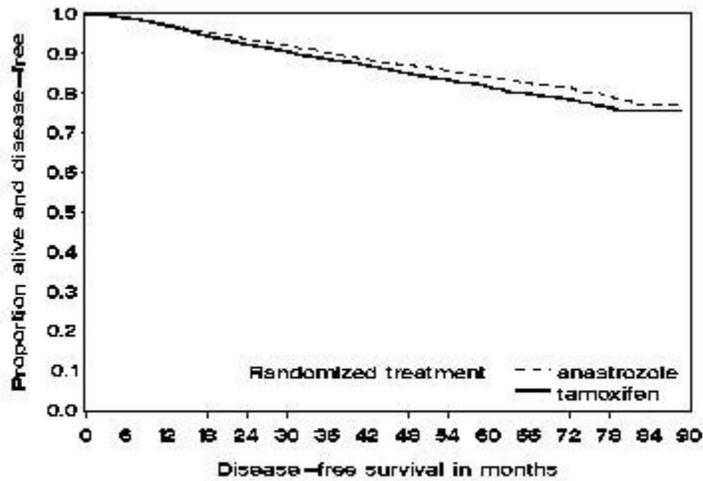
Mean age (yrs.)	64.1	64.1	64.3
Age Range (yrs.)	38.1 to 92.8	32.8 to 94.9	37 to 92.2
Age Distribution (%)			
<45 yrs.	0.7	0.4	0.5
45 to 60 yrs.	34.6	35.0	34.5
>60 <70 yrs.	38.0	37.1	37.7
>70 yrs.	26.7	27.4	27.3
Mean Weight (kg)	70.8	71.1	71.3
Receptor Status (%)			
Positive‡	83.5	83.1	84.0
Negative§	7.4	8.0	7.0
Other¶	8.8	8.6	9.0
Other Treatment (%) prior to Randomization			
Mastectomy	47.8	47.3	48.1
Breast conservation#	52.3	52.8	51.9
Axillary surgery	95.5	95.7	95.2
Radiotherapy	63.3	62.5	61.9
Chemotherapy	22.3	20.8	20.8

Table 7 - Demographic and Baseline Characteristics for ATAC Trial

Demographic Characteristic	Anastrozole 1 mg (N*=3125)	Tamoxifen 20 mg (N*=3116)	Anastrozole 1 mg plus Tamoxifen 20 mg† (N*=3125)
Neoadjuvant Tamoxifen	1.6	1.6	1.7
Primary Tumor Size (%)			
T1 (≤2 cm)	63.9	62.9	64.1
T2 (>2 cm and ≤5 cm)	32.6	34.2	32.9
T3 (>5 cm)	2.7	2.2	2.3
Nodal Status (%)			
Node positive	34.9	33.6	33.5
1 to 3 (# of nodes)	24.4	24.4	24.3
4 to 9	7.5	6.4	6.8
>9	2.9	2.7	2.3
Tumor Grade (%)			
Well-differentiated	20.8	20.5	21.2
Moderately differentiated	46.8	47.8	46.5
Poorly/undifferentiated	23.7	23.3	23.7
Not assessed/recorded	8.7	8.4	8.5

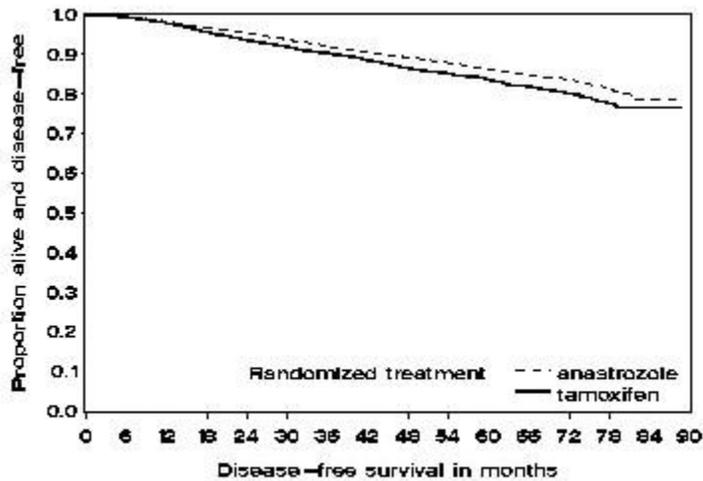
Patients in the two monotherapy arms of the ATAC trial were treated for a median of 60 months (5 years) and followed for a median of 68 months. Disease-free survival in the intent- to-treat population was statistically significantly improved [Hazard Ratio (HR) = 0.87, 95% CI: 0.78, 0.97, p=0.0127] in the anastrozole arm compared to the tamoxifen arm. In the hormone receptor-positive subpopulation representing about 84% of the trial patients, disease-free survival was also statistically significantly improved (HR = 0.83, 95% CI: 0.73, 0.94, p=0.0049) in the anastrozole arm compared to the tamoxifen arm.

Figure 1- Disease-Free Survival Kaplan Meier Survival Curve for all Patients Randomized to Anastrozole or Tamoxifen Monotherapy in the ATAC trial (Intent-to-Treat)



anastrozole	3126	3004	2874	2767	2646	2360	984	51
tamoxifen	3115	2992	2935	2709	2575	2273	933	47

Figure 2- Disease-free Survival for Hormone Receptor-Positive Subpopulation of Patients Randomized to Anastrozole or Tamoxifen Monotherapy in the ATAC Trial



anastrozole	2618	2640	2448	2366	2268	2014	830	42
tamoxifen	2598	2515	2398	2304	2199	1932	774	35

The survival data with 68 months follow-up is presented in Table 9.

In the group of patients who had previous adjuvant chemotherapy (N=698 for anastrozole and N=647 for tamoxifen), the hazard ratio for disease-free survival was 0.91 (95% CI: 0.73 to 1.13) in the anastrozole arm compared to the tamoxifen arm.

The frequency of individual events in the intent-to-treat population and the hormone receptor-positive subpopulation are described in Table 8.

Table 8 - All Recurrence and Death Events*

	Intent-To-Treat Population†		Hormone Receptor-Positive Subpopulation†	
	Anastrozole 1 mg (N‡=3125)	Tamoxifen 20 mg (N‡=3116)	Anastrozole 1 mg (N‡=2618)	Tamoxifen 20 mg (N‡=2598)
	Number (%) of Patients		Number (%) of Patients	

*

The combination arm was discontinued due to lack of efficacy benefit at 33 months of follow-up.

†

Patients may fall into more than one category.

‡

N=Number of patients randomized

Median Duration of Therapy (mo)	60	60	60	60
Median Efficacy	68	68	68	68
Follow-up (mo)				
Loco-regional recurrence	119 (3.8)	149 (4.8)	76 (2.9)	101 (3.9)
Contralateral breast cancer	35 (1.1)	59 (1.9)	26 (1.0)	54 (2.1)
Invasive	27 (0.9)	52 (1.7)	21 (0.8)	48 (1.8)
Ductal carcinoma in situ	8 (0.3)	6 (0.2)	5 (0.2)	5 (0.2)
Unknown	0	1 (<0.1)	0	1 (<0.1)
Distant recurrence	324 (10.4)	375 (12.0)	226 (8.6)	265 (10.2)
Death from Any Cause	411 (13.2)	420 (13.5)	296 (11.3)	301 (11.6)
Death breast cancer	218 (7.0)	248 (8.0)	138 (5.3)	160 (6.2)
Death other reason (including unknown)	193 (6.2)	172 (5.5)	158 (6.0)	141 (5.4)

A summary of the study efficacy results is provided in Table 9.

Table 9 - ATAC Efficacy Summary*

	Intent-To-Treat Population		Hormone Receptor-Positive Subpopulation	
	Anastrozole 1 mg (N=3125)	Tamoxifen 20 mg (N=3116)	Anastrozole 1 mg (N=2618)	Tamoxifen 20 mg (N=2598)
	Number of Events		Number of Events	

*

The combination arm was discontinued due to lack of efficacy benefit at 33 months of follow-up.

Table 9 - ATAC Efficacy Summary*

Intent-To-Treat Population Hormone Receptor-Positive Subpopulation				
	Anastrozole 1 mg (N=3125)	Tamoxifen 20 mg (N=3116)	Anastrozole 1 mg (N=2618)	Tamoxifen 20 mg (N=2598)
	Number of Events		Number of Events	
Disease-free Survival	575	651	424	497
Hazard ratio	0.87		0.83	
2-sided 95% CI	0.78 to 0.97		0.73 to 0.94	
p-value	0.0127		0.0049	
Distant Disease-free Survival	500	530	370	394
Hazard ratio	0.94		0.93	
2-sided 95% CI	0.83 to 1.06		0.80 to 1.07	
Overall Survival	411	420	296	301
Hazard ratio	0.97		0.97	
2-sided 95% CI	0.85 to 1.12		0.83 to 1.14	

10-year median follow-up Efficacy Results from the ATAC Trial

In a subsequent analysis of the ATAC trial, patients in the two monotherapy arms were followed for a median of 120 months (10 years). Patients received study treatment for a median of 60 months (5 years) (see Table 10).

Table 10 – Efficacy Summary

	Intent-To-Treat Population		Hormone Positive Receptor- Subpopulation	
	Anastrozole 1 mg (N=3125)	Tamoxifen 20 mg (N=3116)	Anastrozole 1 mg (N=2618)	Tamoxifen 20 mg (N=2598)
	Number of Events		Number of Events	

	Intent-To-Treat Population		Hormone Positive Receptor- Subpopulation	
	Anastrozole 1 mg (N=3125)	Tamoxifen 20 mg (N=3116)	Anastrozole 1 mg (N=2618)	Tamoxifen 20 mg (N=2598)
	Number of Events		Number of Events	
Disease free Survival	953	1022	735	924
Hazard ratio	0.91		0.86	
2-sided 95% CI	0.83 to 0.99		0.78 to 0.95	
p-value	0.0365		0.0027	
Overall Survival	734	747	563	586
Hazard ratio	0.97		0.95	

	Intent-To-Treat Population		Hormone Positive Receptor- Subpopulation	
	Anastrozole 1 mg (N=3125)		Tamoxifen 20 mg (N=3116)	
	Anastrozole 1 mg (N=2618)		Tamoxifen 20 mg (N=2598)	
	Number of Events		Number of Events	
2-sided 95% CI	0.88 to 1.08		0.84 to 1.06	

Figure 3 - Disease-Free Survival Kaplan Meier Survival Curve for all Patients Randomized to Anastrozole or Tamoxifen Monotherapy in the ATAC Trial (Intent-to-Treat) 1

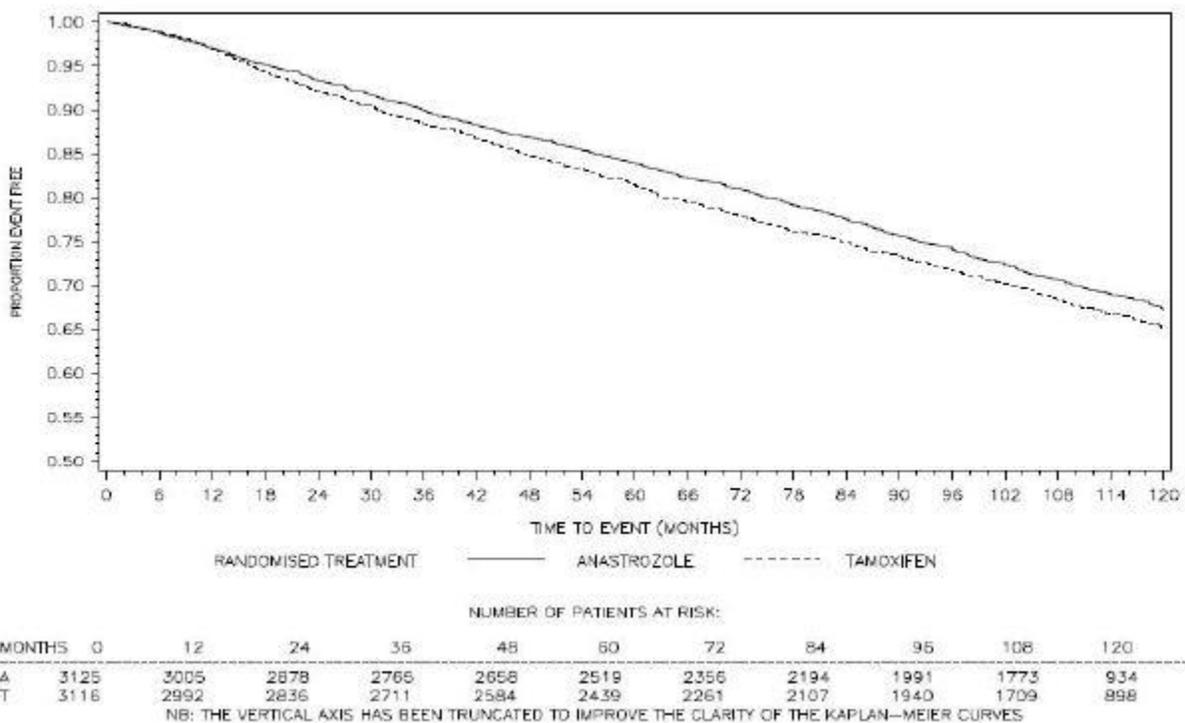
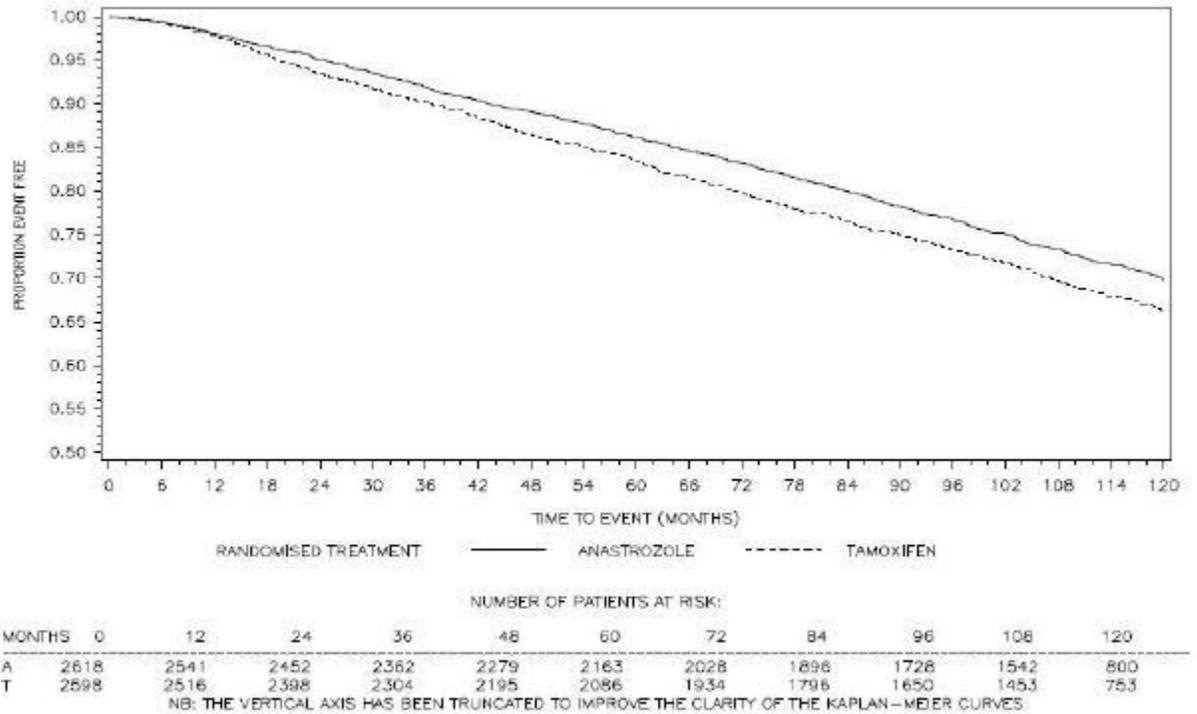


Figure 4 - Disease-Free Survival for Hormone Receptor-Positive Subpopulation of Patients Randomized to Anastrozole or Tamoxifen Monotherapy in the ATAC Trial 2



1

The proportion of patients with 120 months' follow-up was 29.4%.

2

The proportion of patients with 120 months' follow-up was 29.8%.

14.2 First Line Therapy in Postmenopausal Women with Advanced Breast Cancer

Two double-blind, controlled clinical studies of similar design (0030, a North American study and 0027, a predominately European study) were conducted to assess the efficacy of anastrozole compared with tamoxifen as first-line therapy for hormone receptor positive or hormone receptor unknown locally advanced or metastatic breast cancer in postmenopausal women. A total of 1021 patients between the ages of 30 and 92 years old were randomized to receive trial treatment. Patients were randomized to receive 1 mg of anastrozole once daily or 20 mg of tamoxifen once daily. The primary endpoints for both trials were time to tumor progression, objective tumor response rate, and safety.

Demographics and other baseline characteristics, including patients who had measurable and no measurable disease, patients who were given previous adjuvant therapy, the site of metastatic disease and ethnic origin were similar for the two treatment groups for both trials. The following table summarizes the hormone receptor status at entry for all randomized patients in trials 0030 and 0027.

Table 11 - Demographic and Other Baseline Characteristics

Receptor status	Number (%) of subjects			
	Trial 0030		Trial 0027	
	Anastrozole 1 mg (n=171)	Tamoxifen 20 mg (n=182)	Anastrozole 1 mg (n=340)	Tamoxifen 20 mg (n=328)
ER* and/or PgR†	151 (88.3)	162 (89.0)	154 (45.3)	144 (43.9)
ER* unknown, PgR†	19 (11.1)	20 (11.0)	185 (54.4)	183 (55.8)
Unknown				

*

ER=Estrogen receptor

†

PgR=Progesterone receptor

For the primary endpoints, trial 0030 showed that anastrozole had a statistically significant advantage over tamoxifen (p=0.006) for time to tumor progression; objective tumor response rates were similar for anastrozole and tamoxifen. Trial 0027 showed that anastrozole and tamoxifen had similar objective tumor response rates and time to tumor progression (see Table 12 and Figures 5 and 6)

Table 12 below summarizes the results of trial 0030 and trial 0027 for the primary efficacy endpoints.

Table 12 – Efficacy Results of First-line Treatment

End point	Trial 0030		Trial 0027	
	Anastrozole 1 mg (n=171)	Tamoxifen 20 mg (n=182)	Anastrozole 1 mg (n=340)	Tamoxifen 20 mg (n=328)

*

LCL=Lower Confidence Limit

†

Table 12 – Efficacy Results of First-line Treatment

End point	Trial 0030		Trial 0027	
	Anastrozole	Tamoxifen	Anastrozole	Tamoxifen
	1 mg (n=171)	20 mg (n=182)	1 mg (n=340)	20 mg (n=328)
Tamoxifen: Anastrozole				
‡	CI=Confidence Interval			
§	Two-sided Log Rank			
¶	CR=Complete Response			
#	PR=Partial Response			
▷	Anastrozole:Tamoxifen			
Time to progression (TTP)				
Median TTP (months)	11.1	5.6	8.2	8.3
Number (%) of subjects	114 (67%)	138 (76%)	249 (73%)	247 (75%)
Who progressed				
Hazard ratio (LCL*) †	1.42 (1.15)		1.01 (0.87)	
2-sided 95% CI ‡	(1.11, 1.82)		(0.85, 1.20)	
p-value §	0.006		0.920	
Best objective response rate				
Number (%) of subjects	36 (21.1%)	31 (17.0%)	112 (32.9%)	107 (32.6%)
With CR ¶ + PR #				
Odds Ratio (LCL*) ▷	1.30 (0.83)		1.01 (0.77)	

Figure 5 - Kaplan-Meier probability of time to disease progression for all randomized patients (intent-to-treat) in Trial 0030

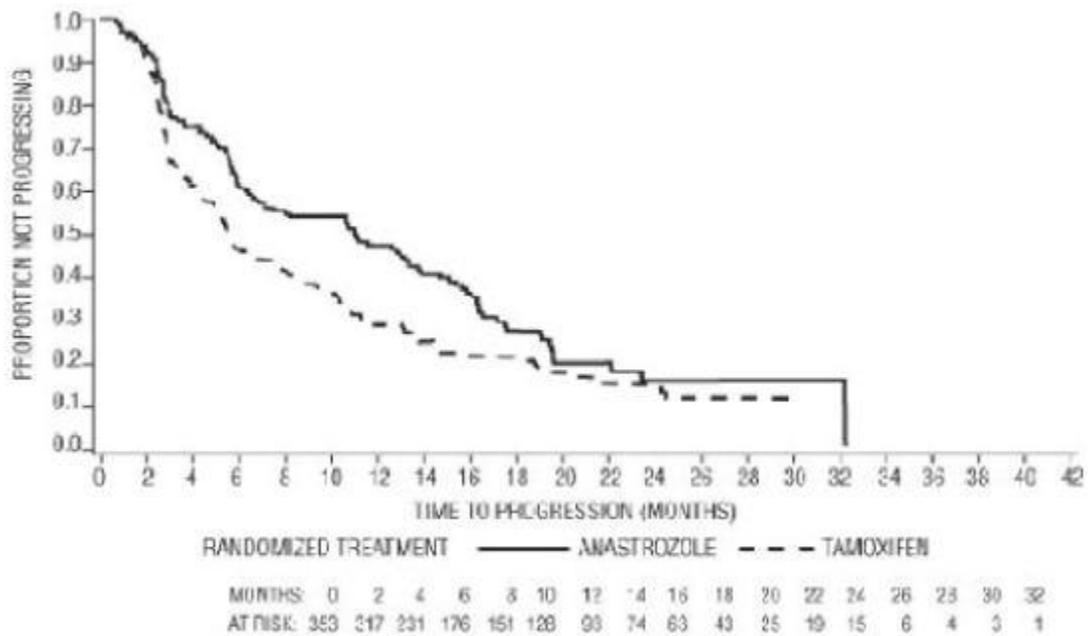
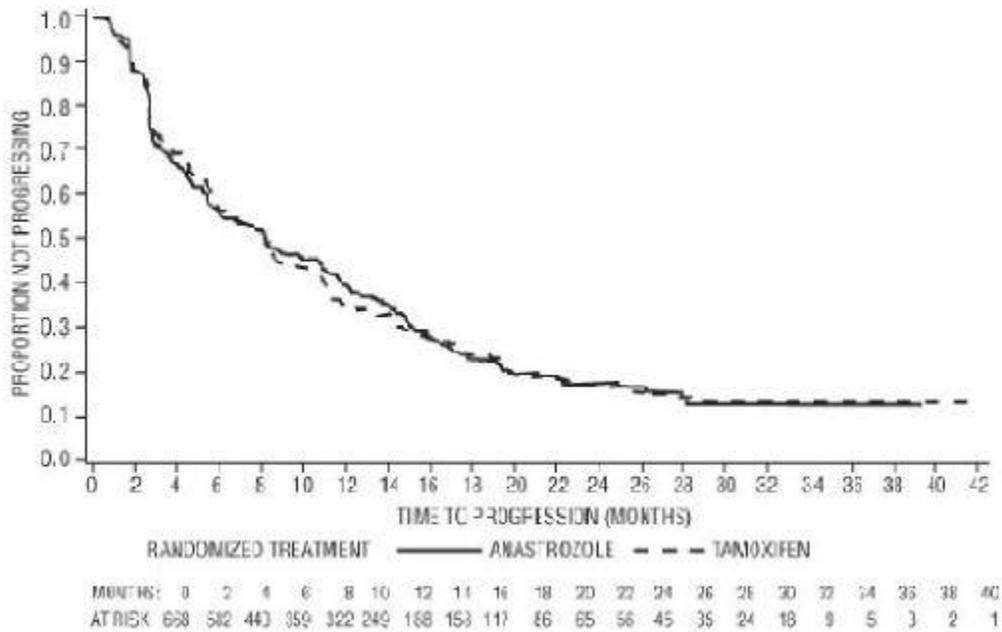


Figure 6 - Kaplan-Meier probability of time to progression for all randomized patients (intent-to-treat) in Trial 0027



Results from the secondary endpoints were supportive of the results of the primary efficacy endpoints. There were too few deaths occurring across treatment groups of both trials to draw conclusions on overall survival differences.

14.3 Second-Line Therapy in Postmenopausal Women with Advanced Breast Cancer who had Disease Progression following Tamoxifen Therapy

Anastrozole was studied in two controlled clinical trials (0004, a North American study; 0005, a predominately European study) in postmenopausal women with advanced breast cancer who had disease progression following tamoxifen therapy for either advanced or early breast cancer. Some of the patients had also received previous cytotoxic treatment. Most patients were ER-positive; a smaller fraction were ER-unknown or ER-negative; the ER-negative patients were eligible only if they had had a positive response to tamoxifen. Eligible patients with measurable and non-measurable disease were randomized to receive either a single daily dose of 1 mg or 10 mg of anastrozole or megestrol acetate 40 mg four times a day. The studies were double-blinded with respect to anastrozole. Time to progression and objective response (only patients with measurable disease could be considered partial responders) rates were the primary efficacy variables. Objective response rates were calculated based on the Union Internationale Contre le Cancer (UICC) criteria. The rate of prolonged (more than 24 weeks) stable disease, the rate of progression, and survival were also calculated.

Both trials included over 375 patients; demographics and other baseline characteristics were similar for the three treatment groups in each trial. Patients in the 0005 trial had responded better to prior tamoxifen treatment. Of the patients entered who had prior tamoxifen therapy for advanced disease (58% in Trial 0004; 57% in Trial 0005), 18% of these patients in Trial 0004 and 42% in Trial 0005 were reported by the primary investigator to have responded. In Trial 0004, 81% of patients were ER-positive, 13% were ER-unknown, and 6% were ER-negative. In Trial 0005, 58% of patients were ER-positive, 37% were ER-unknown, and 5% were ER-negative. In Trial 0004, 62% of patients had measurable disease compared to 79% in Trial 0005. The sites of metastatic disease were similar among treatment groups for each trial. On average, 40% of the patients had soft tissue metastases; 60% had bone metastases; and 40% had visceral (15% liver) metastases.

Efficacy results from the two studies were similar as presented in Table 13. In both studies there were no significant differences between treatment arms with respect to any of the efficacy parameters listed in the table below.

Table 13 – Efficacy Results of Second-line Treatment

	Anastrozole 1 mg	Anastrozole 10 mg	Megestrol Acetate 160 mg
* Surviving Patients			
Trial 0004			
(N. America)	(N=128)	(N=130)	(N=128)
Median Follow-up (months)*	31.3	30.9	32.9
Median Time to Death (months)	29.6	25.7	26.7
2 Year Survival Probability (%)	62.0	58.0	53.1
Median Time to Progression (months)	5.7	5.3	5.1
Objective Response (all patients) (%)	12.5	10.0	10.2
Stable Disease for >24 weeks (%)	35.2	29.2	32.8
Progression (%)	86.7	85.4	90.6
Trial 0005			
(Europe, Australia, S. Africa)	(N=135)	(N=118)	(N=125)
Median Follow-up (months)*	31.0	30.9	31.5
Median Time to Death (months)	24.3	24.8	19.8
2 Year Survival Probability (%)	50.5	50.9	39.1
Median Time to Progression (months)	4.4	5.3	3.9
Objective Response (all patients) (%)	12.6	15.3	14.4
Stable Disease for >24 weeks (%)	24.4	25.4	23.2
Progression (%)	91.9	89.8	92.0

When data from the two controlled trials are pooled, the objective response rates and median times to progression and death were similar for patients randomized to anastrozole 1 mg and megestrol acetate. There is, in this data, no indication that anastrozole 10 mg is superior to anastrozole 1 mg.

Table 14 – Pooled Efficacy Results of Second-line Treatment

Trials 0004 & 0005 (Pooled Data)	Anastrozole 1 mg N=263	Anastrozole 10 mg N=248	Megestrol Acetate 160 mg N=253
---	---------------------------------------	--	---

Table 14 – Pooled Efficacy Results of Second-line Treatment

Trials 0004 & 0005 (Pooled Data)	Anastrozole 1 mg N=263	Anastrozole 10 mg N=248	Megestrol Acetate 160 mg N=253
Median Time to Death (months)	26.7	25.5	22.5
2 Year Survival Probability (%)	56.1	54.6	46.3
Median Time to Progression	4.8	5.3	4.6
Objective Response (all patients) (%)	12.5	12.5	12.3

16 HOW SUPPLIED/STORAGE AND HANDLING

Anastrozole tablets, 1 mg are white to off-white, round biconvex, film coated tablets, with "AHI" debossing on one side and plain on other side and are supplied as follows:

Bottles of 30 tablets (NDC 16729-035-10)

Bottles of 90 tablets (NDC 16729-035-15)

Bottles of 500 tablets (NDC 16729-035-16)

Bottles of 1000 tablets (NDC 16729-035-17)

Storage

Store at controlled room temperature, 20 to 25°C (68 to 77°F) [see USP].