

▼ This medicinal product is subject to additional monitoring in Australia. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse events at [www.tga.gov.au/reporting-problems](http://www.tga.gov.au/reporting-problems).

## **AUSTRALIAN PRODUCT INFORMATION REVESTIVE® (Teduglutide)**

### **1 NAME OF THE MEDICINE**

Teduglutide.

### **2 QUALITATIVE AND QUANTITATIVE COMPOSITION**

REVESTIVE contains teduglutide powder and solvent for solution for injection. Each single-use vial contains 5 mg of teduglutide as a white lyophilised powder. The solvent is water for injections. After reconstitution, each vial contains 5 mg teduglutide in 0.5 mL of solution, corresponding to a concentration of 10 mg/mL.

The active ingredient teduglutide (rDNA origin) is a 33 amino acid glucagon-like peptide-2 (GLP-2) analogue manufactured using a strain of Escherichia coli modified by recombinant DNA technology.

See Section 6.7 PHYSICOCHEMICAL PROPERTIES for the chemical composition and structural formula.

For the full list of excipients, see Section 6.1 LIST OF EXCIPIENTS.

### **3 PHARMACEUTICAL FORM**

Powder for solution for injection.

### **4 CLINICAL PARTICULARS**

#### **4.1 THERAPEUTIC INDICATIONS**

REVESTIVE is indicated for the treatment of adult and paediatric patients 2 years of age and above with Short Bowel Syndrome (SBS) who are dependent on parenteral support.

Patients should be stable for at least 4 weeks on their parenteral support regimen before initiating teduglutide therapy.

#### **4.2 DOSE AND METHOD OF ADMINISTRATION**

Treatment should be initiated under the supervision of a medical professional with experience in the treatment of SBS. REVESTIVE may be self-administered or administered by a caregiver only after training in subcutaneous injection technique by a healthcare professional.

##### Paediatric (2 years of age and above)

See also general instructions for adults in this section.

REVESTIVE should not be administered to children weighing less than 10 kg. Treatment should be evaluated after 6 months. If no overall improvement is achieved, the need for

continued treatment should be re-assessed. There are no data available in paediatric patients after 6 months of continued treatment (see section 5.1, clinical trials).

### Adult

Treatment effect should be evaluated on an ongoing basis. Clinical assessment by the physician should consider individual treatment objectives and patient preferences. If no overall improvement is achieved after 12 months for adults, the need for continued treatment should be assessed.

Continued treatment is recommended for patients who have weaned off parenteral nutrition.

### **Dosage**

The recommended dose of REVESTIVE for both adults and paediatric patients (aged 2 years and above) is 0.05 mg/kg body weight administered by subcutaneous injection once daily.

After reconstitution with the solvent (0.5 mL water for injections), the prepared solution from each vial contains 10 mg/mL of teduglutide.

### *Special populations*

Elderly: No dose adjustment is necessary in patients above the age of 65 years.

Hepatic impairment: No dose adjustment is necessary for patients with mild and moderate hepatic impairment based on a study conducted in Child-Pugh grade B subjects. Teduglutide has not been formally studied in subjects with severe hepatic impairment.

Renal impairment: Reduce the dose by 50% in adult or paediatric patients with moderate and severe renal impairment (creatinine clearance less than 50 mL/min), and end-stage renal disease. No dose adjustment is necessary for patients with mild renal impairment.

### **Administration**

Detailed instructions on the preparation (including assembly of the pre-filled syringe, dissolving the powder, preparing the injection syringe) and injection of REVESTIVE reconstituted solution are provided in the package leaflet.

The reconstituted solution must be injected subcutaneously into a cleaned area on the abdomen, or if this is not possible, on the thigh using a thin needle for subcutaneous injection. REVESTIVE should not be administered intravenously or intramuscularly. If a dose is missed, that dose should be taken as soon as possible on that day. Do not take 2 doses on the same day.

Alternation of sites for subcutaneous injection is recommended. Sites of injection include the thighs, arms, and the quadrants of the abdomen.

Determination of the number of vials needed for administration of one dose must be based on the individual patient's weight and the recommended dose of 0.05 mg/kg/day. The physician should at each visit weigh the patient, determine the daily dose to be administered until next visit and inform the patient accordingly. Injection volume per body weight is provided in Table 1:

<b>Table 1: Injection volume per body weight</b>	
<b>Body weight</b>	<b>Volume to be injected</b>
10-11 kg	0.05 mL
12-13 kg	0.06 mL
14-17 kg	0.08 mL
18-21 kg	0.10 mL
22-25 kg	0.12 mL
26-29 kg	0.14 mL
30-33 kg	0.16 mL
34-37 kg	0.18 mL
38-41 kg	0.20 mL
42-45 kg	0.22 mL
46-49 kg	0.24 mL
50-53 kg	0.26 mL
54-57 kg	0.28 mL
58-61 kg	0.30 mL
62-65 kg	0.32 mL
66-69 kg	0.34 mL
70-73 kg	0.36 mL
74-77 kg	0.38 mL
78-81 kg	0.40 mL
82-85 kg	0.42 mL
86-89 kg	0.44 mL
90-93 kg	0.46 mL

The powder in the vial must be dissolved by adding all the solvent from the pre-filled syringe. The vial should not be shaken, but can be rolled between the palms and gently turned upside-down once.

Reconstituted REVESTIVE is a sterile, clear, colourless to light straw-coloured solution, which should be free from particulates. The drug should be completely dissolved before the solution is withdrawn from the vial. Do not shake or freeze the reconstituted solution. The solution should not be used if it is cloudy or contains particulate matter. REVESTIVE does not contain any preservatives and should be used within 3 hours after reconstitution. The product is for single use in one patient only. Discard any residue.

Once the drug is completely dissolved, withdraw the prescribed dose solution into an injection syringe (up to 1 mL with scale intervals of 0.02 mL or smaller for paediatric use).

If two vials are needed, the procedure for the second vial must be repeated and the additional solution drawn up into the injection syringe containing the solution from the first vial. Any volume exceeding the prescribed dose in mL must be expelled and discarded.

### **4.3 CONTRAINDICATIONS**

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

Active or suspected malignancy.

Patients with a history of malignancies in the gastrointestinal tract including the hepatobiliary system within the last 5 years.

## 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

### Colorectal Polyps/Neoplasia

#### Adults:

Colorectal polyps were identified during the clinical trials. Colonoscopy of the entire colon with removal of polyps should be done within 6 months prior to starting treatment with teduglutide. A follow-up colonoscopy (or alternate imaging) is recommended between 1-2 years after initiating teduglutide. Subsequent colonoscopies should be done every 5 years or more often as needed in high risk individuals. If a polyp is found, adherence to current polyp follow-up guidelines is recommended. In case of diagnosis of colorectal cancer, teduglutide therapy should be discontinued.

#### Paediatric:

See also general precautions for adults in this section.

Prior to initiating treatment with REVESTIVE, faecal occult blood testing should be done for all children and adolescents. Colonoscopy/sigmoidoscopy is required if there is unexplained blood in the stool. Subsequent faecal occult blood testing should be done annually in children and adolescents while they are receiving REVESTIVE.

Colonoscopy/sigmoidoscopy is recommended for all children and adolescents after one year of treatment, every 5 years thereafter while on continuous treatment with REVESTIVE, and if they have new or unexplained gastrointestinal bleeding.

### Gastrointestinal Neoplasia including Hepatobiliary Tract

Based on the pharmacologic activity and findings in animals and humans, teduglutide has the potential to cause hyperplastic changes, including neoplasia, in the small bowel and hepatobiliary tract. These observations were not confirmed in clinical studies of more than one year duration.

Patients should be monitored clinically for small bowel and hepatobiliary neoplasia. Upper GI endoscopy or other imaging is recommended before and during the treatment with teduglutide per clinical discretion. If a benign neoplasm is found, it should be removed. In patients with active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), teduglutide therapy should be discontinued. In patients with active non-gastrointestinal malignancy or who are at increased risk for malignancy, the clinical decision to continue teduglutide should be made based on risk-benefit considerations.

### Gallbladder and Bile Tract Disease

Cholecystitis, cholangitis, and cholelithiasis have been reported in clinical studies. For identification of the onset or worsening of gallbladder/biliary disease, patients should undergo laboratory assessment of bilirubin and alkaline phosphatase prior to starting teduglutide, and while on teduglutide. If clinically meaningful changes are seen, further evaluation including imaging of the gallbladder and/or biliary tract is recommended and the need for continued teduglutide treatment should be reassessed.

### Pancreatic Diseases

Pancreatic adverse events such as chronic and acute pancreatitis, pancreatic duct stenosis, pancreas infection and increased blood amylase and lipase have been reported in clinical

studies.

For identification of onset or worsening of pancreatic disease, patients should undergo laboratory assessment of lipase and amylase prior to starting teduglutide, and while on teduglutide. If clinically meaningful changes are seen, further evaluation such as imaging of the pancreas is recommended; and the need for continued teduglutide treatment should be reassessed.

### **Intestinal Obstruction**

Intestinal obstruction has been reported in clinical trials. In patients who develop intestinal or stomal obstruction, teduglutide should be temporarily discontinued while the patient is clinically managed. Teduglutide may be restarted when the obstructive presentation resolves, if clinically indicated.

### **Fluid and Electrolyte Balance**

To avoid fluid overload or dehydration, careful adjustment of parenteral support is required in patients taking teduglutide. Electrolyte balance and fluid status should be carefully monitored throughout treatment, especially during initial therapeutic response and discontinuation of teduglutide treatment.

#### ***Fluid Overload***

Fluid overload and congestive heart failure have been observed in clinical trials. Fluid overload adverse events occurred most frequently during the first 4 weeks of therapy and decreased over time. There is a theoretical rationale that, during the initial several weeks of teduglutide treatment, subjects may become volume expanded if their parenteral nutrition and intravenous fluids (PN/IV) volumes are not appropriately down titrated.

Due to increased fluid absorption, patients with and without a history of cardiovascular disease, such as cardiac insufficiency and hypertension, should be monitored with regard to fluid overload, especially during initiation of therapy. Patients should be advised to contact their physician in case of sudden weight gain, face swelling, swollen ankles and/or dyspnoea. In general, fluid overload can be prevented by appropriate and timely assessment and adjustment of parenteral nutrition needs. This assessment should be conducted more frequently within the first months of treatment with close monitoring afterwards.

In case of a significant deterioration of cardiovascular disease, the need for continued teduglutide treatment should be reassessed.

#### ***Dehydration***

Patients with SBS are susceptible to dehydration that may lead to acute renal failure. Fluid and electrolyte imbalance leading to dehydration and acute renal impairment/failure was similarly observed between patients with SBS receiving teduglutide and patients not receiving teduglutide. In general, dehydration can be prevented by appropriate and timely monitoring for fluid and electrolyte imbalance, and subsequent adjustment of parenteral fluid and electrolytes. This assessment should be conducted more frequently within the first few months after treatment response, at discontinuation of treatment, and during times of dehydration and acute metabolic stress such as intercurrent infection, intestinal obstruction, and during the post-operative period.

## **Concomitant Medication**

Patients receiving oral concomitant medicinal products requiring titration or with a narrow therapeutic index should be monitored closely due to potential increased absorption and may require dose adjustment of these medications while on teduglutide. Examples of such medications include benzodiazepines, opioids, digoxin, anti-hypertensives.

## **Special Clinical Conditions**

REVESTIVE has not been studied in patients with severe, clinically unstable concomitant diseases (e.g. cardiovascular, respiratory, renal, infectious, endocrine, hepatic, or CNS), or in patients with malignancies within the last 5 years (also see CONTRAINDICATIONS).

## **Discontinuation of Treatment**

Discontinuation of treatment with REVESTIVE may result in fluid and electrolyte imbalance leading to potential dehydration. Therefore, patients' fluid and electrolyte status should be carefully monitored.

## **Paediatric use**

REVESTIVE should not be used in children under 2 years of age. Data on safety and efficacy of REVESTIVE in children under 2 years of age is limited.

## **Use in the elderly**

No differences were observed between healthy subjects younger than 65 years and those older than 65 years. Experience in subjects 75 years and above is limited.

## **Effects on laboratory tests**

No data available.

## **4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS**

Based upon the pharmacodynamic effects of teduglutide, there is a potential for increased absorption of concomitant oral medications, which should be considered if these drugs require titration or have a narrow therapeutic index.

Clinical interaction studies were not performed. No inhibition or induction of the cytochrome P450 enzyme system (CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP2E1, and CYP3A4 [10HMDZ and 6 $\beta$ T]) has been observed based on *in vitro* studies, although the relevance of *in vitro* studies to an *in vivo* setting is unknown. Teduglutide treatment is unlikely to result in P-glycoprotein-mediated drug interactions.

## **4.6 FERTILITY, PREGNANCY AND LACTATION**

### **Effects on fertility**

There are no data on the effects of teduglutide on human fertility. There were no effects on fertility in rats administered with teduglutide at subcutaneous doses up to 50 mg/kg/day (about 180 times the recommended human dose of 0.05 mg/kg/day, based on body surface area).

### **Use in pregnancy**

Australian Pregnancy Categorisation (Category B1).

There are limited data from the use of teduglutide in pregnant women. Available data from case reports with teduglutide use in pregnant women have not identified a drug associated risk of major birth defects, miscarriage, or adverse maternal or foetal outcomes. A risk to the pregnant woman or developing foetus cannot be excluded. A decision should be made whether to initiate or discontinue treatment with teduglutide, taking into account the risk/benefit of therapy.

In animal studies, no adverse effects on embryofoetal development were observed in rats or rabbits given teduglutide during the period of organogenesis at subcutaneous doses up to 50 mg/kg/day (plasma AUC exposure more than 400 times clinical exposure at the recommended human dose of 0.05 mg/kg/day). There were no adverse effects on pre- and postnatal development in rats given teduglutide from early gestation to weaning at subcutaneous doses up to 50 mg/kg/day (about 180 times the recommended human dose of 0.05 mg/kg/day, based on body surface area). Pharmacokinetic data demonstrated that the teduglutide exposure of foetal rabbits and suckling rat pups was low. Because animal reproductive studies are not always predictive of human response, REVESTIVE should be used during pregnancy only if clearly needed.

### **Use in lactation**

It is not known whether teduglutide is excreted in human milk. Teduglutide was excreted in the noncolostral milk of lactating rats (highest concentration 2.9% of the plasma concentration) following a single subcutaneous injection of 25 mg/kg (about 90 times the recommended human dose, based on body surface area). Because many drugs are excreted in human milk, because of the potential for serious adverse reactions to nursing infants from teduglutide and because of the potential for tumorigenicity shown for teduglutide in mice and rats, 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.

## **4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES**

Teduglutide has minor influence on the ability to drive and use machines. However, cases of syncope have been reported in clinical studies. Such events might impact the ability to drive and use machines.

## **4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)**

Adverse events in REVESTIVE-treated patients with SBS participating in 2 randomised, placebo-controlled, 24-week, double-blind clinical studies (Studies CL0600-020 and CL0600-004, involving in total 109 patients treated with REVESTIVE) are listed in Table 2 below. The most commonly reported adverse events were abdominal pain (28%) and

abdominal distension (17%), nausea (26%), injection site reactions (26%), headache (16%), vomiting (14%), urinary tract infection (13%), and nasopharyngitis (13%). Approximately 38% of the treated patients with a stoma experienced gastrointestinal stoma complications. The majority of these events were mild or moderate.

<b>Table 2: Summary of Treatment-emergent Adverse Events by System Organ Class and Preferred Term (Reported in ≥5% of Subjects in All Teduglutide) - Safety Population - SBS Placebo-controlled Studies</b>		
	<b>Placebo (N=59)</b>	<b>Teduglutide (N=109)</b>
	<b>n (%)</b>	<b>n (%)</b>
<b>Gastrointestinal Disorders</b>		
Abdominal pain	12 (20.3)	31 (28.4)
Nausea	12 (20.3)	28 (25.7)
Abdominal distension	1 (1.7)	18 (16.5)
Vomiting	6 (10.2)	15 (13.8)
Flatulence	4 (6.8)	9 (8.3)
Diarrhoea	6 (10.2)	7 (6.4)
Abdominal pain upper	1 (1.7)	6 (5.5)
<b>General Disorders and Administration Site Conditions</b>		
Injection site haematoma	3 (5.1)	12 (11.0)
Fatigue	5 (8.5)	10 (9.2)
Pyrexia	5 (8.5)	10 (9.2)
Oedema peripheral	2 (3.4)	9 (8.3)
Injection site erythema	0	8 (7.3)
<b>Infections and Infestations</b>		
Nasopharyngitis	2 (3.4)	14 (12.8)
Urinary tract infection	7 (11.9)	14 (12.8)
Catheter sepsis	2 (3.4)	9 (8.3)
Influenza	1 (1.7)	8 (7.3)
Catheter related infection	1 (1.7)	6 (5.5)
<b>Injury, Poisoning and Procedural Complications</b>		
Gastrointestinal stoma complication	3 (5.1)	17 (15.6)
<b>Metabolism and Nutrition Disorders</b>		
Decreased appetite	2 (3.4)	8 (7.3)
<b>Musculoskeletal and Connective Tissue Disorders</b>		
Arthralgia	3 (5.1)	7 (6.4)
<b>Nervous System Disorders</b>		
Headache	8 (13.6)	17 (15.6)

Adverse reactions are listed by MedDRA system organ class and by frequency. Frequencies are defined as very common ( $\geq 1/10$ ); common ( $\geq 1/100$  to  $< 1/10$ ); uncommon ( $\geq 1/1,000$  to  $< 1/100$ ); rare ( $\geq 1/10,000$  to  $< 1/1,000$ ); very rare ( $< 1/10,000$ ). Adverse reactions from postmarketing experience are italicised.

#### Infections and infestations

Very common: Nasopharyngitis

Common: Influenza; *Influenza-like illness*

#### Immune system disorders

Not known: *Hypersensitivity*

#### Metabolism and nutrition disorders

Common: Decreased appetite

Uncommon: Fluid overload



### Psychiatric disorders

Common: Insomnia

### Nervous system disorders

Very common: Headache

### Cardiac disorders

Common: Cardiac failure congestive

### Respiratory, thoracic and mediastinal disorders

Common: Cough; Dyspnoea

### Gastrointestinal disorders

Very common: Abdominal distension; Abdominal pain; Flatulence; Nausea; Vomiting

Common: Colonic polyp; Intestinal obstruction; Pancreatitis\*; Small intestinal stenosis

Uncommon: Duodenal polyp; Colonic stenosis; Pancreatic duct stenosis

### Hepatobiliary disorders

Common: Cholecystitis; Cholecystitis acute

### General disorders and administration site conditions

Very common: Injection site reaction\*\*; Oedema peripheral

Not known: *Fluid retention*

### Injury, poisoning and procedural complications

Very common: Gastrointestinal stoma complication

\* Includes the following preferred terms: Pancreatitis, *Pancreatitis acute*, and Pancreatitis chronic.

\*\* Includes the following preferred terms: Injection site haematoma, Injection site erythema, Injection site pain, Injection site swelling and Injection site haemorrhage.

## **Immunogenicity**

Based on data from a trial and its extension in adults with SBS (a 6-month randomised placebo-controlled trial, followed by a 24-month open-label extension), the development of anti-teduglutide antibodies in subjects who received subcutaneous administration of 0.05 mg/kg teduglutide once daily was 3% (2/60) at Month 3, 17% (13/77) at Month 6, 24% (16/67) at Month 12, 33% (11/33) at Month 24 and 48% (14/29) at Month 30.

The antibody formation has not been associated with clinically relevant safety findings, reduced efficacy or changed pharmacokinetics of REVESTIVE.

The rate of anti-teduglutide antibody formation in the 24-week paediatric study was 19%, similar to the rate of antibody formation in adult subjects. However, with the longer duration of treatment, the rate of anti-teduglutide formation at Month 12 was higher in paediatric patients with 54% (14/26), compared to that of adults (24%). Of the 14 paediatric patients who had developed antibodies to teduglutide at Month 12, 1 patient had neutralizing antibodies. Among the small number of paediatric patients who developed anti-teduglutide antibodies, no association with adverse events of hypersensitivity or lack of efficacy was observed.

## Reporting suspected adverse effects

Reporting suspected adverse reactions after registration of the medicinal product is important. It allows continued monitoring of the benefit-risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions at <http://www.tga.gov.au/reporting-problems>.

### 4.9 OVERDOSE

The maximum dose of REVESTIVE studied during clinical development was 80 mg/day for 8 days. No unexpected systemic adverse reactions were seen. In the event of overdose, the patient should be carefully monitored by the medical professional.

For information on the management of overdose, contact the Poison Information Centre on 131126 (Australia), or the National Poisons Centre on 0800 POISON (0800 764766) in New Zealand.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 PHARMACODYNAMIC PROPERTIES

Pharmacotherapeutic group: Other alimentary tract and metabolism products, various alimentary tract and metabolism products.  
ATC code: A16AX08.

#### Mechanism of Action

Teduglutide is an analogue of naturally occurring human GLP-2, a peptide secreted by L-cells of the distal intestine. Similar to GLP-2, teduglutide is 33 amino acids in length with an amino acid substitution of alanine by glycine at the second position of the N-terminus. The single amino acid substitution relative to naturally occurring GLP-2 results in resistance to *in vivo* degradation by the enzyme dipeptidyl peptidase-IV (DPP-IV), resulting in an extended half-life. GLP-2 is known to increase intestinal and portal blood flow, decrease intestinal motility and inhibit gastric acid secretion. Teduglutide binds to the GLP-2 receptors located in intestinal subpopulations of enteroendocrine cells, subepithelial myofibroblasts and enteric neurons of the submucosal and myenteric plexus. Activation of these receptors results in the local release of multiple mediators including insulin-like growth factor (IGF)-1, nitric oxide and keratinocyte growth factor (KGF). Teduglutide has been shown to preserve mucosal integrity by promoting repair and normal growth of the intestine through an increase of villus height and crypt depth.

#### Pharmacodynamic Effects

The ability of teduglutide to improve intestinal absorption of fluid and nutrients was studied in 17 adult subjects with Short Bowel Syndrome (SBS) using daily doses of 0.03, 0.10, and 0.15 mg/kg (n=2-3 per dose group) in a 21-day, open-label, multi-centre, dose-ranging study. All subcutaneous (abdomen) doses studied, except 0.03 mg/kg once daily, decreased stomal output or fecal fluid and macronutrient excretion, resulted in enhanced gastrointestinal fluid (wet weight) absorption of approximately 750-1000 mL/day, and increased villus height and crypt depth of the intestinal mucosa.

At a dose 5 times the maximum recommended dose, teduglutide did not prolong the QTc interval to any clinically relevant extent.

## Clinical trials

### Adults with SBS

The safety and clinical evidence of efficacy of REVESTIVE in adult patients with SBS is derived from 2 randomised placebo-controlled trials and 2 extension trials. In these studies, 173 patients received REVESTIVE at doses of 0.05 mg/kg (n=134) or 0.10 mg/kg (n=39) via subcutaneous injection.

#### *Study CL0600-020*

The efficacy, safety, and tolerability of REVESTIVE was evaluated in a randomised, double-blind, placebo-controlled, parallel-group, multinational, multi-centre clinical trial in adults with SBS who were dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 months and required PN at least 3 times per week.

For 8 weeks (or less) prior to randomisation, investigators optimised the PN/IV volume of all subjects. Optimisation was followed by a 4-week to 8-week period of fluid stabilisation. Subjects then were randomised (1:1) to placebo (n=43) or REVESTIVE 0.05 mg/kg/day (n=43). Study treatment was administered subcutaneously once daily for 24 weeks. PN/IV volume adjustments (up to 30% decrease) and clinical assessments were made at 2, 4, 8, 12, 16, 20, and 24 weeks.

The primary efficacy endpoint was based on a clinical response, defined as a subject achieving at least 20% reduction in weekly PN/IV volume from baseline (immediately before randomisation) to both weeks 20 and 24.

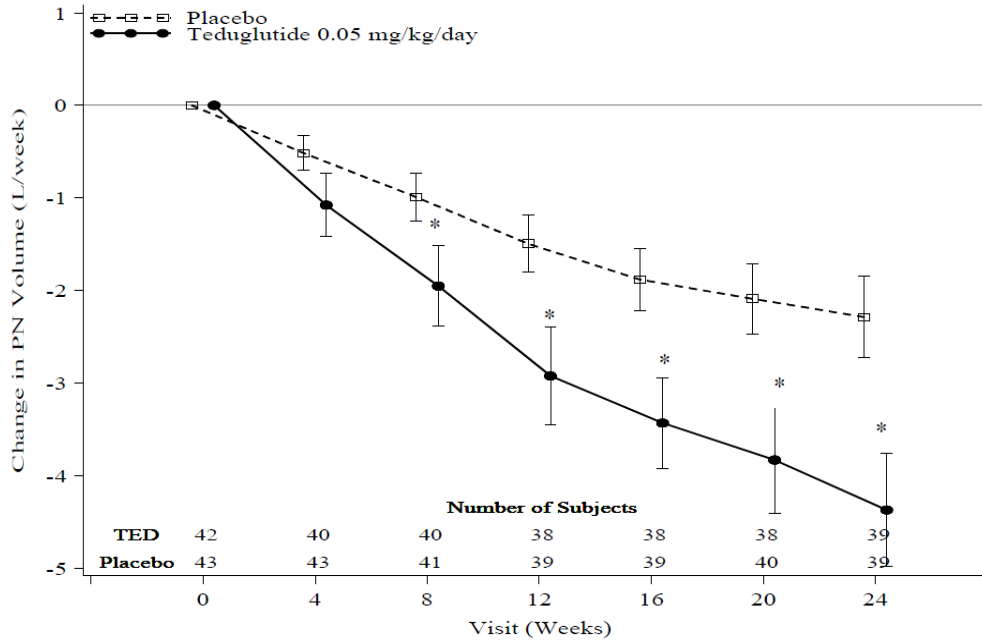
The mean age of subjects was 50.3 years. Mean duration of PN/IV dependency prior to enrolment was 6.25 years (range 1-25.8 years). The most common reasons for intestinal resection leading to SBS were vascular disease (34.1%, 29/85), Crohn's Disease (21.2%, 18/85), and "other" (21.2%, 18/85). Stoma was present in 44.7% (38/85) of subjects, and the most common type was jejunostomy/ileostomy (81.6%, 31/38). The mean length of remaining small intestine was 77.3±64.4 cm (range: 5 to 343 cm). The colon was not in continuity in 43.5% (37/85) of subjects. At baseline, the mean (±SD) prescribed days per week for PN/IV infusion was 5.73 (±1.59) days.

The percentages of treatment group responders were compared in the intent-to-treat population of this study which was defined as all randomised patients. Sixty-three percent (27/43) of subjects treated with REVESTIVE versus 30% (13/43) of placebo-treated subjects were considered responders (p=0.002).

At week 24, the mean reduction in weekly PN/IV volume was 4.4 L for subjects treated with REVESTIVE (from pre-treatment baseline of 12.9 L) versus 2.3 L for placebo-treated subjects (from pre-treatment baseline of 13.2 L/week) (p<0.001).

The mean changes from baseline in PN/IV volume by visit are shown in Figure 1.

**Figure 1: Change ( $\pm$ SE) in PN/IV volume (L/week)**



L=liter; SE=standard error, TED=teduglutide  
\* p < 0.05

### Study CL0600-021

CL0600-021 was a 2-year open-label extension of CL0600-020, in which 88 subjects received REVESTIVE 0.05 mg/kg/day. Ninety-seven percent (76/78) of subjects who completed CL0600-020 elected to enrol in CL0600-021 (37 received REVESTIVE; 39 received placebo). An additional 12 subjects whom entered CL0600-021 had been optimised and stabilised but not randomised in CL0600-020 because of closed enrolment.

#### 24 months exposure

Of the 39 placebo subjects from CL0600-020 entering CL0600-021, 29 completed 24 months of treatment with REVESTIVE. The mean reduction in PN/IV was 3.11 L/week (an additional 28.3% reduction) from the start of CL0600-021. Sixteen (55.2%) of the 29 completers achieved a 20% or greater reduction in parenteral support. At the end of the study, 14 (48.3%), 7 (24.1%) and 5 (17.2%) subjects achieved a reduction of 1, 2, or 3 days per week in PN/IV support, respectively. Two subjects were weaned off their PN/IV support while on REVESTIVE.

Of the 12 subjects entering CL0600-021 directly, 6 completed 24 months of treatment with REVESTIVE. Similar effects were seen. One of the six subjects was weaned off their PN/IV support while on REVESTIVE.

#### 30 months exposure

Thirty subjects on REVESTIVE completed a total duration of 30 months (CL0600-020 followed by CL0600-021 treatment). Of these, 28 subjects (93%) achieved a 20% or greater reduction of parenteral support. Of the responders in CL0600-020 who had completed 2 additional years of continuous treatment with REVESTIVE, 96% (21/22) demonstrated durability in the effect of REVESTIVE.

The mean reduction in PN/IV (n=30) was 7.55 L/week (a 65.6% reduction from baseline). Ten subjects were weaned off their PN/IV support while on treatment with REVESTIVE for

30 months. Subjects were maintained on REVESTIVE even if no longer requiring PN/IV support. These 10 subjects had required PN/IV support for 1.2 to 15.5 years, and prior to REVESTIVE had required between 3.5 L/week and 13.4 L/week of PN/IV support. At 24 months, 21 (70%), 18 (60%) and 18 (60%) of the 30 completers achieved a reduction of 1, 2, or 3 days per week in PN/IV support, respectively.

#### ***Study CL0600-004***

CL0600-004 was a randomised, double-blind, placebo-controlled, three-arm parallel-group, multinational study in adults with SBS who were dependent on PN/IV support for at least 12 months and required PN at least 3 times per week. After a period of optimisation and stabilisation similar to CL0600-020, subjects were randomised to receive 24 weeks of one of the following treatment regimens: REVESTIVE 0.05 mg/kg/day (n=35), REVESTIVE 0.10 mg/kg/day dose (n=33), or placebo (n=16). The primary efficacy endpoint was a graded categorical score that did not achieve statistical significance for the high dose (0.10 mg/kg/day).

#### ***Study CL0600-005***

CL0600-005 was a randomised, double-blinded, parallel-group, extension of CL0600-004, in which 65 subjects from CL0600-004 received REVESTIVE for up to an additional 28 weeks of treatment. Of the responders in CL0600-004 who entered CL0600-005, 75% (12/16) demonstrated durability in the effect of REVESTIVE after one year of treatment. In the REVESTIVE 0.05 mg/kg/day dose group, a 20% or greater reduction of parenteral support was achieved in 68% (17/25) of subjects. The mean reduction of weekly PN/IV volume was 4.9 L/week (52% reduction from baseline) after one year of continuous treatment with REVESTIVE. The subjects who had been completely weaned off PN/IV support in CL0600-004 remained off parenteral support through CL0600-005. During CL0600-005, an additional subject from CL0600-005 was weaned off parenteral support.

#### **Paediatric from 1 to 17 years with SBS**

The efficacy data presented are derived from 2 controlled studies in paediatric patients of 24-weeks and 12 weeks duration. These studies included 87 patients treated with teduglutide (41 with 0.05mg/kg/day) and while 4 subjects aged 1 to < 2 years received teduglutide, only 1 received 0.05mg/kg/day. 14 other subjects received standard care only (no teduglutide). Otherwise, despite the limited sample size, which did not allow meaningful statistical comparisons, clinically meaningful, numerical reductions in the requirement for parenteral support were observed across all age groups.

#### ***TED-C14-006***

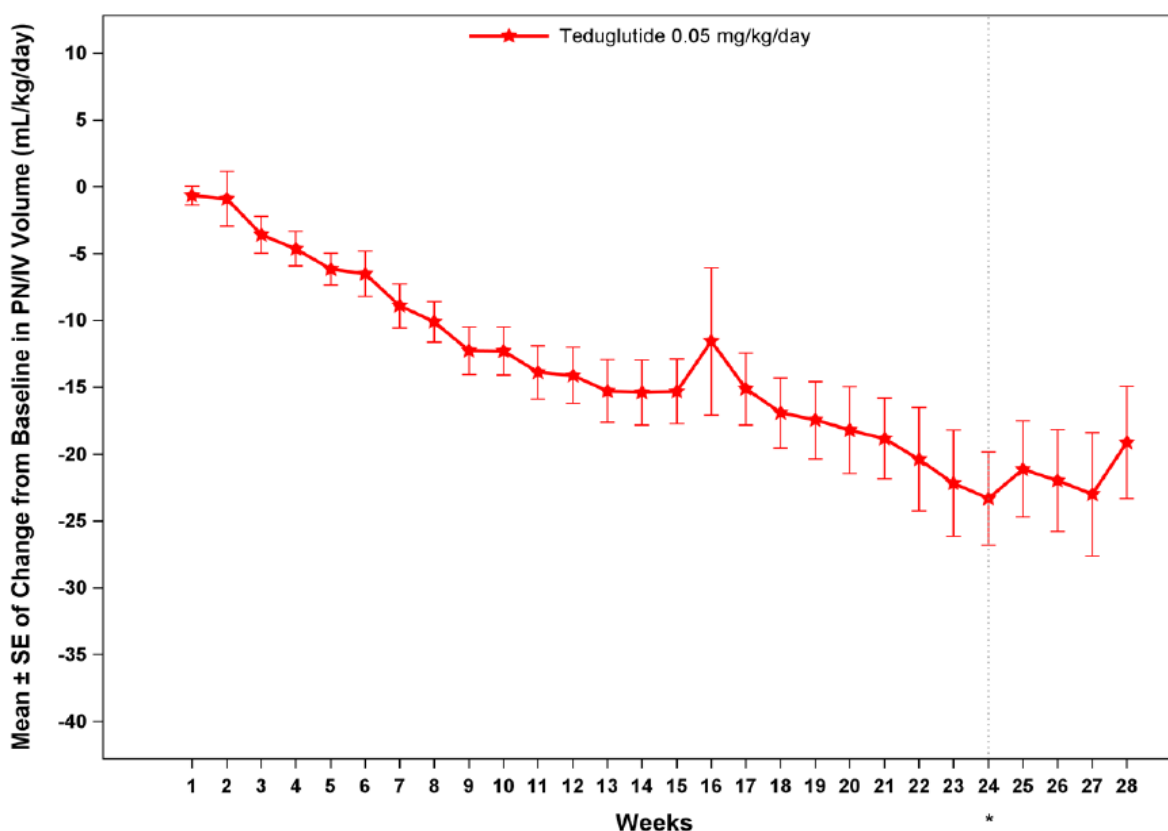
A 24-week, randomized, double-blind, multicentre study was conducted in 59 paediatric subjects aged 1 year through 17 years who were dependent on PS. Subjects chose whether to receive REVESTIVE or standard of care (SOC). Subjects in the REVESTIVE treatment arm were randomized in a double-blind manner to 0.025 mg/kg/day (n=24) or 0.05 mg/kg/day (n=26), while 9 subjects enrolled in the SOC arm. Results described below correspond to subject diary data in the ITT population at the recommended dose of 0.05 mg/kg SC once daily.

<b>Table 3 Summary of Efficacy Endpoints at Week 24* for TED-C14-006 – Patients treated with REVESTIVE 0.05 mg/kg/day (N = 26)</b>	
<b>Efficacy Endpoints</b>	<b>Results</b>
Reduction in PS volume of at least 20%, n/N (%)	18/26 (69%)
Achieved enteral autonomy, n/N (%)	3/26 (12%)
Reduction in PS infusion of $\geq 1$ day/week, n/N (%)	10/26 (38%)
Change in PS volume from baseline (mL/kg/day), mean (SD) and [mean% (SD)]	-23 (18) mL/kg/day [-42% (29%)]
Change from baseline in PS infusion days/week, mean (SD) and [mean% (SD)]	-1.3 ( $\pm 2.24$ ) days/week (-21.3% [ $\pm 34.09\%$ ])
Change from baseline in PS infusion hours/day, mean (SD) and [mean% (SD)]	-3.0 ( $\pm 3.84$ ) hours/day (-26.1% [ $\pm 36.14\%$ ])

\*Results based on patient diary data, ITT population

Three subjects (12%) in the 0.05 mg/kg group achieved enteral autonomy by week 24.

**Figure 2: Absolute Change from Baseline in PN/IV Volume (mL/kg/day) by Week based on Diary Data**



PN/IV = parenteral nutrition/intravenous fluids.

\*Week 24 is the end of treatment visit.

Average daily value is calculated as [(sum of non-missing daily values in the diary/number of days with non-missing values)]/last available body weight prior to the visit.

### ***TED-C13-003***

REVESTIVE was studied in a 12-week, open-label, clinical study in 42 paediatric subjects aged 1 year through 14 years with SBS who were dependent on PS. Three doses of REVESTIVE, 0.0125 mg/kg/day (n=8), 0.025 mg/kg/day (n=14), and 0.05 mg/kg/day (n=15), were investigated for 12 weeks. Five subjects were enrolled in a SOC cohort.

The clinical findings from this study were comparable to that from the study TED C14-006.

The clinical findings from this 12-week study were comparable to that from the 24-week TED C14-006 study, suggesting the most rapid clinical changes, including PS volume reductions, occurs during the first 12 weeks of teduglutide treatment.

#### *Reduction in infusion time*

Subjects in the SOC cohort showed minimal change in PS hours/day.

#### *Enteral autonomy*

Based on physician-prescribed and subject diary data, 1 subject on the recommended dose of REVESTIVE achieved enteral autonomy at the end of treatment.

## **5.2 PHARMACOKINETIC PROPERTIES**

### **Absorption**

In healthy subjects, teduglutide administered subcutaneously in the thigh/abdomen had an absolute bioavailability of 88% and reached maximum plasma teduglutide concentrations at 3-5 hours after administration. Following a 0.05 mg/kg subcutaneous dose in SBS subjects, the mean peak teduglutide concentration ( $C_{max}$ ) was 36.4 ng/mL and the mean area under the curve ( $AUC_{0-\tau}$ ) was 235 ng·h/mL. No accumulation of teduglutide was observed following repeated subcutaneous administrations.

### **Distribution**

In healthy subjects, teduglutide has a volume of distribution (103 mL/kg) similar to blood volume.

### **Metabolism**

The metabolic pathway of teduglutide was not investigated in humans. However, teduglutide is expected to be degraded into small peptides and amino acids via catabolic pathways, similar to the catabolism of endogenous GLP-2.

### **Excretion**

In healthy subjects, teduglutide plasma clearance was approximately 123 mL/h/kg which is similar to the GFR, suggesting that teduglutide is primarily cleared by the kidney.

Teduglutide has a mean terminal half-life ( $t_{1/2}$ ) of approximately 1.1 hours in SBS subjects.

### **Dose Linearity**

The  $C_{max}$  and AUC of teduglutide were dose proportional over the dose range of 0.05 to 0.4 mg/kg teduglutide.

### **Special Populations**

Gender: No clinically relevant gender differences were observed.

**Paediatrics:** Following subcutaneous administration of 0.05 mg/kg daily dose, similar  $C_{max}$  of teduglutide across age groups was demonstrated by population pharmacokinetics modelling (see Table 4). However, lower exposure (AUC) and shorter half-life were seen in paediatric patients 1 to 17 years of age, as compared with adults. The pharmacokinetic profile of teduglutide in this paediatric population, as evaluated by clearance and volume of distribution was different from that observed in adults, after correcting for body weights. Specifically, body weight corrected clearance decreases with increasing age from 1 year old to adults.

Age	Parameters (Mean ± SD)			
	$C_{max, ss}$ (ng/mL)	AUC <sub>ss</sub> (ng•h/mL)	CL/F (L/h)	$t_{1/2}$ (h)
12 to 17 years (n=3)	29.7 ± 8.4	154 ± 17.6	13.0 ± 2.3	1.0 ± 0.01
1 to 11 years (n=37)	33.5 ± 11.5	128 ± 56.7	7.45 ± 2.1	0.7 ± 0.2

**Elderly:** No differences were observed between healthy subjects younger than 65 years and those older than 65 years. Experience in subjects 75 years and above is limited.

**Hepatic impairment:** Subjects with moderate hepatic impairment had lower teduglutide  $C_{max}$  and AUC (10~15%) compared to healthy matched control subjects after a single subcutaneous dose of 20 mg teduglutide. The pharmacokinetics of teduglutide was not assessed in subjects with severe hepatic impairment.

**Renal impairment:** In subjects with moderate to severe renal impairment or end-stage renal disease (ESRD), teduglutide  $C_{max}$  and AUC<sub>0-inf</sub> increased with the degree of renal impairment following a single subcutaneous administration of 10 mg teduglutide. Teduglutide exposure increased by a factor of 2.1 ( $C_{max}$ ) and 2.6 (AUC<sub>0-inf</sub>) in ESRD subjects compared to healthy subjects. The AUC and  $C_{max}$  values of subjects with mild renal impairment were 50% higher than in subjects without renal impairment.

No data are available for paediatric patients with moderate to severe renal impairment and end-stage renal disease (ESRD).

### 5.3 PRECLINICAL SAFETY DATA

#### Genotoxicity

Teduglutide was negative in the Ames test, chromosomal aberration test in Chinese hamster ovary cells, and in an *in vivo* mouse micronucleus assay. The genotoxic potential of teduglutide is considered to be low.

#### Carcinogenicity

In a 2-year rat carcinogenicity study with subcutaneous doses of 3, 10 and 35 mg/kg/day, treatment related benign neoplasms included tumours of the bile duct epithelium in 1 out of 44 males at 10 mg/kg and 4 out of 48 males and 1 out of 48 females at 35 mg/kg, associated with respective exposures (plasma AUC) approximately 32-fold and 155-fold clinical exposure at the recommended dose. Adenomas of the jejunal mucosa were observed in 5 out of 50 males at 155-fold clinical exposure, and jejunal adenocarcinoma and jejunal adenoma



were observed in 1 out of 50 males at 3 mg/kg (approximately 10-fold clinical exposure). These tumours were not observed in females at exposures up to 97-fold clinical exposure.

In a 2-year mouse subcutaneous carcinogenicity study, treatment related benign neoplasms of the gallbladder developed in 5 out of 71, 2 out of 70 and 6 out of 70 males dosed at 1, 3.5 and 12.5 mg/kg/day respectively, associated with respective exposures (plasma AUC) approximately 12-, 45- and 186-fold clinical exposure at the recommended dose. Four out of 68 males and 1 out of 69 females dosed at 12.5 mg/kg developed a jejunal adenocarcinoma.

There is limited evidence that sub-therapeutic doses of teduglutide may accelerate tumour growth in rodent models of chemically-induced intestinal neoplasia. The human clinical relevance of rodent models of chemically-induced intestinal neoplasia is uncertain.

### **Juvenile Animal Toxicity Data**

In a juvenile toxicity study, teduglutide was administered twice daily to juvenile Göttingen minipigs at subcutaneous doses of 1, 5, and 25 mg/kg/day, from nursing to weaning (from post-natal day 7 and continuing for 90 days), followed by a 13 week recovery period. Exposures (AUC) at these doses were 24-, 50-, and 340-fold the paediatric clinical exposure for ages 1 to 11 years at 0.05 mg/kg, respectively, and 20-, 42-, and 283-fold the paediatric clinical exposure for ages 12 to 17 years at 0.05 mg/kg, respectively.

In juvenile animals, teduglutide had the same pharmacological effect and toxicological target organ findings (intestintrophic effects, gall bladder mucosal hyperplasia, bile duct mucosal hyperplasia, injection site reactions) as those observed in normal healthy adults of other species and were partially resolved following a 13 week recovery period. There were no new or unique toxicities that suggested a specific risk in the paediatric population.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 LIST OF EXCIPIENTS**

In addition to the active ingredient (teduglutide), each vial contains the following inactive ingredients: histidine, mannitol, monobasic sodium phosphate monohydrate, and dibasic sodium phosphate heptahydrate.

### **6.2 INCOMPATIBILITIES**

Incompatibilities were either not assessed or not identified as part of the registration of this medicine.

### **6.3 SHELF LIFE**

4 years.

### **6.4 SPECIAL PRECAUTIONS FOR STORAGE**

Store below 25°C. (Do not freeze.)

### **6.5 NATURE AND CONTENTS OF CONTAINER**

## Presentation

Each pack of REVESTIVE contains:

- 5 mg teduglutide powder in glass vial with rubber stopper
- 0.5 mL of solvent of sterile water for injections in pre-filled glass syringe.

## Pack size

28 vials with powder and 28 pre-filled syringes with solvent.

## 6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

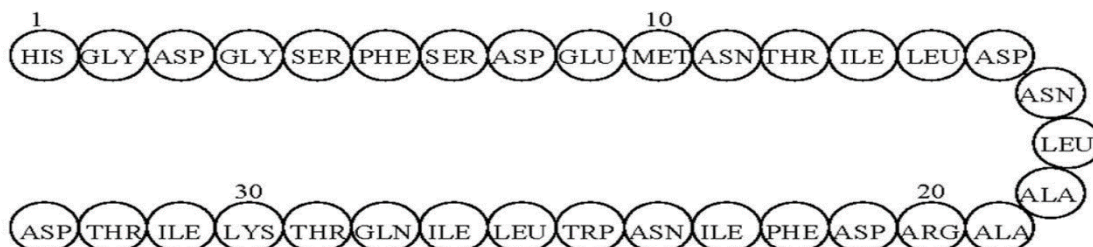
## 6.7 PHYSICOCHEMICAL PROPERTIES

### Molecular formula

$C_{164}H_{252}N_{44}O_{55}S$

### Chemical structure

The chemical composition of teduglutide is L-histidyl-L-glycyl-L-aspartyl-L-glycyl-L-seryl-L-phenylalanyl-L-seryl-L-aspartyl-L-glutamyl-L-methionyl-L-asparaginyl-L-threonyl-L-isoleucyl-L-leucyl-L-aspartyl-L-asparaginyl-L-leucyl-L-alanyl-L-alanyl-L-arginyl-L-aspartyl-L-phenylalanyl-L-isoleucyl-L-asparaginyl-L-tryptophanyl-L-leucyl-L-isoleucyl-L-glutamyl-L-threonyl-L-lysyl-L-isoleucyl-L-threonyl-L-aspartic acid.



### CAS registry number

197922-42-2

### Molecular weight

3752 Daltons.

## 7 MEDICINE SCHEDULE (POISONS STANDARD)

Prescription Medicine.

## 8 SPONSOR

Takeda Pharmaceuticals Australia Pty Ltd

Level 39  
225 George Street  
Sydney NSW 2000  
Australia  
Telephone: 1800 012 612  
[www.takeda.com/en-au](http://www.takeda.com/en-au)

## **9 DATE OF FIRST APPROVAL**

19 May 2017.

## **10 DATE OF REVISION**

31 January 2024.

### **Summary table of changes**

<b>Section Changed</b>	<b>Summary of new information</b>
4.4	Addition of warning regarding upper GI endoscopy.

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