TACROLIMUS- tacrolimus capsule
Direct_Rx

Tacrolimus

WARNING: MALIGNANCIES AND SERIOUS INFECTIONS

Increased risk for developing serious infections and malignancies with tacrolimus or other immunosuppressants that may lead to hospitalization or death. (5.1, 5.2)

1.1 Prophylaxis of Organ Rejection in Kidney, Liver, or Heart Transplant

Tacrolimus capsules are indicated for the prophylaxis of organ rejection, in adult patients receiving allogeneic kidney transplant [see Clinical Studies (14.1)], liver transplant [see Clinical Studies (14.2)], and heart transplant [see Clinical Studies (14.3)], and pediatric patients receiving allogeneic liver transplants [see Clinical Studies (14.2)] in combination with other immunosuppressants.

Additional pediatric use information is approved for Astellas Pharma US, Inc.'s Prograf (tacrolimus) products. However, due to Astellas Pharma US, Inc.'s marketing exclusivity rights, this drug product is not labeled with that information.

2.1 Important Administration Instructions

Tacrolimus capsules should not be used without supervision by a physician with experience in immunosuppressive therapy.

Tacrolimus capsules are not interchangeable or substitutable for other tacrolimus extended-release products. This is because rate of absorption following the administration of an extended-release tacrolimus product is not equivalent to that of an immediate-release tacrolimus drug product. Under- or overexposure to tacrolimus may result in graft rejection or other serious adverse reactions. Changes between tacrolimus immediate-release and extended-release dosage forms must occur under physician supervision [see Warnings and Precautions (5.3)].

Intravenous Formulation – Administration Precautions due to Risk of Anaphylaxis

Intravenous use is recommended for patients who cannot tolerate oral formulations, and conversion from intravenous to oral tacrolimus is recommended as soon as oral therapy can be tolerated to minimize the risk of anaphylactic reactions that occurred with injectables containing castor oil derivatives [see Warnings and Precautions (5.9)].

Oral Formulation (Capsules)

If patients are able to initiate oral therapy, the recommended starting doses should be initiated. Tacrolimus capsules may be taken with or without food. However, since the presence of food affects the bioavailability of tacrolimus, if taken with food, it should be taken consistently the same way each time [see Clinical Pharmacology (12.3)].

General Administration Instructions

Patients should not eat grapefruit or drink grapefruit juice in combination with tacrolimus capsules [see Drug Interactions (7.2)].

Tacrolimus should not be used simultaneously with cyclosporine. Tacrolimus or cyclosporine should be discontinued at least 24 hours before initiating the other. In the presence of elevated tacrolimus or cyclosporine concentrations, dosing with the other drug usually should be further delayed.

Therapeutic drug monitoring (TDM) is recommended for all patients receiving tacrolimus capsules [see Dosage and Administration (2.6)].

2.2 Dosage Recommendations for Adult Kidney, Liver, or Heart Transplant Patients – Capsules

Capsules

If patients are able to tolerate oral therapy, the recommended oral starting doses should be initiated. The initial dose of tacrolimus capsules should be administered no sooner than 6 hours after transplantation in the liver and heart transplant patients. In kidney transplant patients, the initial dose of tacrolimus capsules may be administered within 24 hours of transplantation, but should be delayed until renal function has recovered.

The initial oral tacrolimus capsule dosage recommendations for adult patients with kidney, liver, or heart transplants and whole blood trough concentration range are shown in Table 1. Perform therapeutic drug monitoring (TDM) to ensure that patients are within the ranges listed in Table 1.

Table 1. Summary of Initial Oral Tacrolimus Capsules Dosage Recommendations and Whole Blood Trough Concentration Range in Adults

Patient Population	Tacrolimus Capsules	Initial Oral Dosage*	Whole Blood Trough Concentration Range
Kidney Transplant			
With Azathioprine		0.2 mg/kg/day, divided in two doses, administered every 12 hours	Month 1 to 3: 7 to 20 ng/mL Month 4 to 12: 5 to 15 ng/mL
With MMF/IL-2 receptor antagonist†		0.1 mg/kg/day, divided in two doses, administered every 12 hours	

*
African-American patients may require higher doses compared to Caucasians (see Table 2)
†
In a second smaller trial, the initial dose of tacrolimus was 0.15 to 0.2 mg/kg/day and observed tacrolimus concentrations were 6 to 16 ng/mL during month 1 to 3 and 5 to 12 ng/mL during month 4 to 12 [see Clinical Studies (14.1)].

Month 1 to 12: 4 to 11 ng/mL

Liver Transplant

With corticosteroids only

0.10 to 0.15 mg/kg/day, divided in two doses, administered every 12 hours

Month 1 to 12: 5 to 20 ng/mL

Heart Transplant

With azathioprine or MMF

0.075 mg/kg/day, divided in two doses, administered every 12 hours

Month 1 to 3: 10 to 20 ng/mL

Month ≥4: 5 to 15 ng/mL

Dosage should be titrated based on clinical assessments of rejection and tolerability. Tacrolimus capsules dosages lower than the recommended initial dosage may be sufficient as maintenance therapy. Adjunct therapy with adrenal corticosteroids is recommended early post-transplant.

The data in kidney transplant patients indicate that the African-American patients required a higher dose to attain comparable trough concentrations compared to Caucasian patients (Table 2) [see Use in Specific Populations (8.8) and Clinical Pharmacology (12.3)].

Table 2. Comparative Dose and Trough Concentrations Based on Race

Time After Transplant

Caucasian

N=114

African-American

N=56

Dose

(mg/kg)

Trough Concentrations

(ng/mL)

Dose

(mg/kg)

Trough Concentrations (ng/mL)

Day 7

0.18

12.0

0.23

10.9

Month 1

0.17

12.8

0.26

12.9

Month 6

0.14

11.8

0.24

11.5

Month 12

0.13

10.1

0.19

11.0

Intravenous Injection

Anaphylactic reactions have occurred with injectables containing castor oil derivatives, such as tacrolimus injection. Therefore, monitoring for signs and symptoms of anaphylaxis is recommended [see Warnings and Precautions (5.9)].

2.3 Dosage Recommendations for Pediatric Liver Transplant Patients

Oral formulation (capsules)

Pediatric patients, in general, need higher tacrolimus doses compared to adults: the higher dose requirements may decrease as the child grows older. Recommendations for the initial oral dosage for pediatric transplant patients and whole blood trough concentration range are shown in Table 3. Perform TDM to ensure that patients are within the ranges listed in Table 3.

Table 3. Summary of Initial Tacrolimus Capsule Dosage Recommendations and Whole Blood Trough Concentration Range in Children

*
See Clinical Studies (14.2), Liver Transplantation

Patient Population

Initial Tacrolimus Capsule Dosing

Whole Blood Trough Concentration Range

Pediatric liver transplant patients*

0.15 to 0.2 mg/kg/day capsules, divided in two doses, administered every 12 hours

Month 1 to 12: 5 to 20 ng/mL

For conversion of pediatric patients from tacrolimus granules to tacrolimus capsules or from tacrolimus capsules to tacrolimus granules, the total daily dose should remain the same. Following conversion from one formulation to another formulation of tacrolimus, therapeutic drug monitoring is recommended [see Dosage and Administration (2.6)].

Additional pediatric use information is approved for Astellas Pharma US, Inc.'s Prograf (tacrolimus) products. However, due to Astellas Pharma US, Inc.'s marketing exclusivity rights, this drug product is not labeled with that information.

2.4 Dosage Modification for Patients with Renal Impairment

Due to its potential for nephrotoxicity, consider dosing tacrolimus capsules at the lower end of the therapeutic dosing range in patients who have received a liver, or heart transplant, and have pre-existing renal impairment. Further reductions in dose below the targeted range may be required.

In kidney transplant patients with post-operative oliguria, the initial dose of tacrolimus capsules should be administered no sooner than 6 hours and within 24 hours of transplantation, but may be delayed until renal function shows evidence of recovery [see Dosage and Administration (2.2), Warnings and Precautions (5.5), Use in Specific Populations (8.6), and Clinical Pharmacology (12.3)].

2.5 Dosage Modification for Patients with Hepatic Impairment

Due to the reduced clearance and prolonged half-life, patients with severe hepatic impairment (Child-Pugh ≥10) may require lower doses of tacrolimus capsules. Close monitoring of blood concentrations is warranted.

The use of tacrolimus capsules in liver transplant recipients experiencing post-transplant hepatic impairment may be associated with increased risk of developing renal insufficiency related to high whole blood concentrations of tacrolimus. These patients should be monitored closely, and dosage adjustments should be considered. Some evidence suggests that lower doses should be used in these patients [see Dosage and Administration (2.2), Warnings and Precautions (5.5), Use in Specific Populations (8.7), and Clinical Pharmacology (12.3)].

2.6 Therapeutic Drug Monitoring

Monitoring of tacrolimus blood concentrations in conjunction with other laboratory and clinical parameters is considered an essential aid to patient management for the evaluation of rejection, toxicity, dose adjustments, and compliance. Whole blood trough concentration range can be found in Table 1.

Factors influencing frequency of monitoring include but are not limited to hepatic or renal dysfunction, the addition or discontinuation of potentially interacting drugs and the post-transplant time. Blood concentration monitoring is not a replacement for renal and liver function monitoring and tissue biopsies. Data from clinical trials show that tacrolimus whole blood concentrations were most variable during the first week post-transplantation.

The relative risks of toxicity and efficacy failure are related to tacrolimus whole blood trough concentrations. Therefore, monitoring of whole blood trough concentrations is recommended to assist in the clinical evaluation of toxicity and efficacy failure.

Methods commonly used for the assay of tacrolimus include high-performance liquid chromatography with tandem mass spectrometric detection (HPLC/MS/MS) and immunoassays. Immunoassays may react with metabolites as well as parent compound. Therefore, assay results obtained with immunoassays may have a positive bias relative to results of HPLC/MS. The bias may depend upon the specific assay and laboratory. Comparison of the concentrations in published literature to patient concentrations using the current assays must be made with detailed knowledge of the assay methods and biological matrices employed. Whole blood is the matrix of choice and specimens should be collected into tubes containing ethylene diamine tetraacetic acid (EDTA) anti-coagulant. Heparin anti-coagulation is not recommended because of the tendency to form clots on storage. Samples which are not analyzed immediately should be stored at room temperature or in a refrigerator and assayed within 7 days; see assay instructions for specifics. If samples are to be kept longer, they should be deep frozen at -20° C. One study showed drug recovery >90% for samples stored at -20° C for 6 months, with reduced recovery observed after 6 months.

Tacrolimus capsules, USP are available in 0.5 mg, 1 mg, and 5 mg strengths.

Tacrolimus capsules, USP containing white to off white powder equivalent to 0.5 mg of anhydrous tacrolimus, are hard gelatin capsules with white opaque body and ivory cap. The body is imprinted ‘643’ and cap is imprinted ‘ ['S'] ’ in black ink.

Tacrolimus capsules, USP containing white to off white powder equivalent to 1 mg of anhydrous tacrolimus, are hard gelatin capsules with white opaque body and brown cap. The body is imprinted ‘644’ and cap is imprinted ‘ ['S'] ’ in black ink.

Tacrolimus capsules, USP containing white to off white powder equivalent to 5 mg of anhydrous tacrolimus, are hard gelatin capsules with white opaque body and orange cap. The body is imprinted ‘645’ and cap is imprinted ‘ ['S'] ’ in black ink.

Tacrolimus capsules are contraindicated in patients with a hypersensitivity to tacrolimus. Hypersensitivity symptoms reported include dyspnea, rash, pruritus, and acute respiratory distress syndrome [see Adverse Reactions (6)].

5.1 Lymphoma and Other Malignancies

Patients receiving immunosuppressants, including tacrolimus, are at increased risk of developing lymphomas and other malignancies, particularly of the skin. The risk appears to be related to the intensity and duration of immunosuppression rather than to the use of any specific agent.

As usual for patients with increased risk for skin cancer, examine patients for skin changes;exposure to sunlight and UV light should be limited by wearing protective clothing and using a broad-spectrum sunscreen with a high protection factor.

Post-transplant lymphoproliferative disorder (PTLD) has been reported in immunosuppressed organ transplant recipients. The majority of PTLD events appear related to Epstein-Barr Virus (EBV) infection. The risk of PTLD appears greatest in those individuals who are EBV seronegative, a population which includes many young children. Monitor EBV serology during treatment.

5.2 Serious Infections

Patients receiving immunosuppressants, including tacrolimus, are at increased risk of developing bacterial, viral, fungal, and protozoal infections, including opportunistic

infections. These infections may lead to serious, including fatal, outcomes. Serious viral infections reported include:

- Polyomavirus-associated nephropathy (PVAN), mostly due to BK virus infection
- JC virus-associated progressive multifocal leukoencephalopathy (PML)
- Cytomegalovirus infections: CMV seronegative transplant patients who receive an organ from a CMV seropositive donor disease are at higher risk of developing CMV viremia and CMV disease.

Monitor for the development of infection and adjust the immunosuppressive regimen to balance the risk of rejection with the risk of infection [see Adverse Reactions (6.1, 6.2)].

5.3 Not Interchangeable with Extended-Release Tacrolimus Products – Medication Errors

Medication errors, including substitution and dispensing errors, between tacrolimus immediate-release products and tacrolimus extended-release products were reported outside the U.S. This led to serious adverse reactions, including graft rejection, or other adverse reactions due to under- or overexposure to tacrolimus. Tacrolimus is not interchangeable or substitutable for tacrolimus extended-release products. Changes between tacrolimus immediate-release and extended-release dosage forms must occur under physician supervision. Instruct patients and caregivers to recognize the appearance of tacrolimus dosage forms [see Dosage Forms and Strengths (3)] and to confirm with the healthcare provider if a different product is dispensed.

5.4 New Onset Diabetes After Transplant

Tacrolimus was shown to cause new onset diabetes mellitus in clinical trials of kidney, liver, or heart transplantation. New onset diabetes after transplantation may be reversible in some patients. African-American and Hispanic kidney transplant patients are at an increased risk. Blood glucose concentrations should be monitored closely in patients using tacrolimus [see Adverse Reactions (6.1)].

5.5 Nephrotoxicity due to Tacrolimus and Drug Interactions

Tacrolimus, like other calcineurin inhibitors, can cause acute or chronic nephrotoxicity in transplant patients due to its vasoconstrictive effect on renal vasculature, toxic tubulopathy and tubular-interstitial effects. Nephrotoxicity was reported in clinical trials [see Adverse Reactions (6.1)].

Acute renal impairment associated with tacrolimus toxicity can result in high serum creatinine, hyperkalemia, decreased secretion of urea and hyperuricemia, and is usually reversible. In patients with elevated serum creatinine and tacrolimus whole blood trough concentrations greater than the recommended range, consider dosage reduction or temporary interruption of tacrolimus administration.

The risk for nephrotoxicity may increase when tacrolimus is concomitantly administered with CYP3A inhibitors (by increasing tacrolimus whole blood concentrations) or drugs associated with nephrotoxicity (e.g., aminoglycosides, ganciclovir, amphotericin B, cisplatin, nucleotide reverse transcriptase inhibitors, protease inhibitors). When tacrolimus is used concurrently with other known nephrotoxic drugs, monitor renal function and tacrolimus blood concentrations, and adjust doses of both tacrolimus and/or concomitant medications during concurrent use [see Drug Interactions (7.2)].

5.6 Neurotoxicity

Tacrolimus may cause a spectrum of neurotoxicities. The most severe neurotoxicities include posterior reversible encephalopathy syndrome (PRES), delirium, seizure and coma; others include tremors, paresthesias, headache, mental status changes, and changes in motor and sensory functions [see Adverse Reactions (6.1, 6.2)]. As symptoms may be associated with tacrolimus whole blood trough concentrations at or above the recommended range, monitor for neurologic symptoms and consider dosage reduction or discontinuation of tacrolimus if neurotoxicity occurs.

5.7 Hyperkalemia

Hyperkalemia has been reported with tacrolimus use. Serum potassium levels should be monitored. Careful consideration should be given prior to use of other agents also associated with hyperkalemia (e.g., potassium-sparing diuretics, ACE inhibitors, angiotensin receptor blockers) during tacrolimus therapy [see Adverse Reactions (6.1)]. Monitor serum potassium levels periodically during treatment.

5.8 Hypertension

Hypertension is a common adverse effect of tacrolimus therapy and may require antihypertensive therapy [see Adverse Reactions (6.1)]. The control of blood pressure can be accomplished with any of the common antihypertensive agents, though careful consideration should be given prior to use of antihypertensive agents associated with hyperkalemia (e.g., potassium-sparing diuretics, ACE inhibitors, angiotensin receptor blockers) [see Warnings and Precautions (5.7)]. Calcium-channel blocking agents may increase tacrolimus blood concentrations and therefore require dosage reduction of tacrolimus [see Drug Interactions (7.2)].

5.9 Anaphylactic Reactions with Tacrolimus Injection

Anaphylactic reactions have occurred with injectables containing castor oil derivatives, including tacrolimus, in a small percentage of patients (0.6%). The exact cause of these reactions is not known. Tacrolimus injection should be reserved for patients who are unable to take tacrolimus capsules orally. Monitor patients for anaphylaxis when using the intravenous route of administration [see Dosage and Administration (2.1)].

5.10 Not Recommended for Use with Sirolimus

Tacrolimus is not recommended for use with sirolimus:

- The use of sirolimus with tacrolimus in studies of de novo liver transplant patients was associated with an excess mortality, graft loss, and hepatic artery thrombosis (HAT), and is not recommended.
- The use of sirolimus (2 mg per day) with tacrolimus in heart transplant patients in a U.S. trial was associated with increased risk of renal function impairment, wound healing complications, and insulin-dependent post–transplant diabetes mellitus, and is not recommended [see Clinical Studies (14.3)].
- The use of sirolimus with tacrolimus may increase the risk of thrombotic microangiopathy [see Warnings and Precautions (5.16)].

5.11 Interactions with CYP3A4 Inhibitors and Inducers

When co-administering tacrolimus with strong CYP3A4 inhibitors (e.g., telaprevir, boceprevir, ritonavir, ketoconazole, itraconazole, voriconazole, clarithromycin) and strong inducers (e.g., rifampin, rifabutin), adjustments in the dosing regimen of tacrolimus and subsequent frequent monitoring of tacrolimus whole blood trough concentrations and tacrolimus-associated adverse reactions are recommended. A rapid, sharp rise in tacrolimus levels has been reported after co-administration with a strong CYP3A4 inhibitor, clarithromycin, despite an initial reduction of tacrolimus dose. Early and frequent monitoring of tacrolimus whole blood trough levels is recommended [see Drug Interactions (7.2)].

5.12 QT Prolongation

Tacrolimus may prolong the QT/QTc interval and may cause Torsades de pointes. Avoid tacrolimus in patients with congenital long QT syndrome. In patients with congestive heart failure, bradyarrhythmias, those taking certain antiarrhythmic medications or other medicinal products that lead to QT prolongation, and those with electrolyte disturbances such as hypokalemia, hypocalcemia, or hypomagnesemia, consider obtaining electrocardiograms and monitoring electrolytes (magnesium, potassium, calcium) periodically during treatment.

When co-administering tacrolimus with other substrates and/or inhibitors of CYP3A4 that also have the potential to prolong the QT interval, a reduction in tacrolimus dose, frequent monitoring of tacrolimus whole blood concentrations, and monitoring for QT prolongation is recommended. Use of tacrolimus with amiodarone has been reported to result in increased tacrolimus whole blood concentrations with or without concurrent QT prolongation [see Drug Interactions (7.2)].

5.13 Myocardial Hypertrophy

Myocardial hypertrophy has been reported in infants, children, and adults, particularly those with high tacrolimus trough concentrations, and is generally manifested by echocardiographically demonstrated concentric increases in left ventricular posterior wall and interventricular septum thickness. This condition appears reversible in most cases following dose reduction or discontinuance of therapy. In patients who develop renal failure or clinical manifestations of ventricular dysfunction while receiving tacrolimus therapy, echocardiographic evaluation should be considered. If myocardial hypertrophy is diagnosed, dosage reduction or discontinuation of tacrolimus should be considered [see Adverse Reactions (6.2)].

5.14 Immunizations

Whenever possible, administer the complete complement of vaccines before transplantation and treatment with tacrolimus.

The use of live vaccines should be avoided during treatment with tacrolimus; examples include (not limited to) the following: intranasal influenza, measles, mumps, rubella, oral polio, BCG, yellow fever, varicella, and TY21a typhoid vaccines.

Inactivated vaccines noted to be safe for administration after transplantation may not be sufficiently immunogenic during treatment with tacrolimus.

5.15 Pure Red Cell Aplasia

Cases of pure red cell aplasia (PRCA) have been reported in patients treated with tacrolimus. A mechanism for tacrolimus-induced PRCA has not been elucidated. All

patients reported risk factors for PRCA such as parvovirus B19 infection, underlying disease, or concomitant medications associated with PRCA. If PRCA is diagnosed, discontinuation of tacrolimus should be considered [see Adverse Reactions (6.2)].

5.16 Thrombotic Microangiopathy (Including Hemolytic Uremic Syndrome and Thrombotic Thrombocytopenic Purpura)

Cases of thrombotic microangiopathy (TMA), including hemolytic uremic syndrome (HUS) and thrombotic thrombocytopenic purpura (TTP), have been reported in patients treated with tacrolimus. TMA may have a multifactorial etiology. Risk factors for TMA that can occur in transplant patients include, for example, severe infections, graft-versus¬host disease (GVHD), Human Leukocyte Antigen (HLA) mismatch, the use of calcineurin inhibitors and mammalian target of rapamycin (mTOR) inhibitors. These risk factors may, either alone or combined, contribute to the risk of TMA.

In patients with signs and symptoms of TMA, consider tacrolimus as a risk factor. Concurrent use of tacrolimus and mTOR inhibitors may contribute to the risk of TMA.

5.17 Cannabidiol Drug Interactions

When cannabidiol and tacrolimus are co-administered, closely monitor for an increase in tacrolimus blood levels and for adverse reactions suggestive of tacrolimus toxicity. A dose reduction of tacrolimus should be considered as needed when tacrolimus is co-administered with cannabidiol [see Dosage and Administration (2.2, 2.6) and Drug Interactions (7.3)].

The following serious and otherwise important adverse drug reactions are discussed in greater detail in other sections of labeling:

- Lymphoma and Other Malignancies [see Warnings and Precautions (5.1)]
- Serious Infections [see Warnings and Precautions (5.2)]
- New Onset Diabetes After Transplant [see Warnings and Precautions (5.4)]
- Nephrotoxicity [see Warnings and Precautions (5.5)]
- Neurotoxicity [see Warnings and Precautions (5.6)]
- Hyperkalemia [see Warnings and Precautions (5.7)]
- Hypertension [see Warnings and Precautions (5.8)]
- Anaphylactic Reactions with Tacrolimus Injection [see Warnings and Precautions (5.9)]
- Myocardial Hypertrophy [see Warnings and Precautions (5.13)]
- Pure Red Cell Aplasia [see Warnings and Precautions (5.15)]
- Thrombotic Microangiopathy, Including Hemolytic Uremic Syndrome and Thrombotic Thrombocytopenic Purpura [see Warnings and Precautions (5.16)]

6.1 Clinical Studies Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. In addition, the clinical trials were not designed to establish comparative differences across study arms with regards to the adverse reactions discussed below.

Kidney Transplantation

The incidence of adverse reactions was determined in three randomized kidney transplant trials. One of the trials used azathioprine (AZA) and corticosteroids and two of the trials used mycophenolate mofetil (MMF) and corticosteroids concomitantly for maintenance immunosuppression.

Tacrolimus-based immunosuppression in conjunction with azathioprine and corticosteroids following kidney transplantation was assessed in a trial where 205 patients received tacrolimus-based immunosuppression and 207 patients received cyclosporine-based immunosuppression. The trial population had a mean age of 43 years (mean ± SD was 43±13 years on tacrolimus and 44±12 years on cyclosporine arm), the distribution was 61% male, and the composition was White (58%), African-American (25%), Hispanic (12%), and Other (5%). The 12-month post-transplant information from this trial is presented below.

The most common adverse reactions (≥30%) observed in tacrolimus-treated kidney transplant patients are: infection, tremor, hypertension, abnormal renal function, constipation, diarrhea, headache, abdominal pain, insomnia, nausea, hypomagnesemia, urinary tract infection, hypophosphatemia, peripheral edema, asthenia, pain, hyperlipidemia, hyperkalemia, and anemia. Based on reported adverse reaction terms related to decreased renal function, nephrotoxicity was reported in approximately 52% of kidney transplantation patients.

Adverse reactions that occurred in ≥15% of kidney transplant patients treated with tacrolimus in conjunction with azathioprine are presented below:

Table 4. Kidney Transplantation: Adverse Reactions Occurring in ≥15% of Patients Treated with Tacrolimus in Conjunction with Azathioprine (AZA)

Tacrolimus /AZA

(N=205)

Cyclosporine/AZA
(N=207)

Nervous System

Tremor

54%

34%

Headache

44%

38%

Insomnia

32%
30%
Paresthesia
23%
16%
Dizziness
19%
16%
Gastrointestinal
Diarrhea
44%
41%
Nausea
38%
36%
Constipation
35%
43%
Vomiting
29%
23%
Dyspepsia
28%
20%
Cardiovascular
Hypertension
50%
52%
Chest Pain
19%
13%
Urogenital
Creatinine Increased

45%

42%

Urinary Tract Infection

34%

35%

Metabolic and Nutritional

Hypophosphatemia

49%

53%

Hypomagnesemia

34%

17%

Hyperlipemia

31%

38%

Hyperkalemia

31%

32%

Diabetes Mellitus

24%

9%

Hypokalemia

22%

25%

Hyperglycemia

22%

16%

Edema

18%

19%

Hemic and Lymphatic

Anemia

30%

24%

Leukopenia

15%

17%

Miscellaneous

Infection

45%

49%

Peripheral Edema

36%

48%

Asthenia

34%

30%

Abdominal Pain

33%

31%

Pain

32%

30%

Fever

29%

29%

Back Pain

24%

20%

Respiratory System

Dyspnea

22%

18%

Cough Increased

18%

15%

Musculoskeletal

Arthralgia

25%

24%

Skin

Rash

17%

12%

Pruritus

15%

7%

Two trials were conducted for tacrolimus-based immunosuppression in conjunction with MMF and corticosteroids. In the non-US trial (Study 1), the incidence of adverse reactions was based on 1,195 kidney transplant patients that received tacrolimus (Group C, n=403), or one of two cyclosporine (CsA) regimens (Group A, n=384 and Group B, n=408) in combination with MMF and corticosteroids; all patients, except those in one of the two cyclosporine groups, also received induction with daclizumab. The trial population had a mean age of 46 years (range 17 to 76); the distribution was 65% male, and the composition was 93% Caucasian. The 12-month post-transplant information from this trial is presented below.

Adverse reactions that occurred in ≥10% of kidney transplant patients treated with tacrolimus in conjunction with MMF in Study 1 [Note: This trial was conducted entirely outside of the United States. Such trials often report a lower incidence of adverse reactions in comparison to U.S. trials] are presented below:

Table 5. Kidney Transplantation: Adverse Reactions Occurring in ≥10% of Patients Treated with Tacrolimus in Conjunction with MMF (Study 1)

Tacrolimus (Group C)

Cyclosporine (Group A)

Cyclosporine (Group B)

(N=403)

(N=384)

(N=408)

Diarrhea

25%

16%

13%

Urinary Tract Infection

24%

28%

24%

Anemia

17%

19%

17%

Hypertension

13%

14%

12%

Leukopenia

13%

10%

10%

Edema Peripheral

11%

12%

13%

Hyperlipidemia

10%

15%

13%

Key: Group A = CsA/MMF/CS, B = CsA/MMF/CS/Daclizumab, C = Tac/MMF/CS/Daclizumab CsA = Cyclosporine, CS = Corticosteroids, Tac = Tacrolimus, MMF = mycophenolate mofetil

In the U.S. trial (Study 2) with tacrolimus-based immunosuppression in conjunction with MMF and corticosteroids, 424 kidney transplant patients received tacrolimus (n=212) or cyclosporine (n=212) in combination with MMF 1 gram twice daily, basiliximab induction, and corticosteroids. The trial population had a mean age of 48 years (range 17 to 77); the distribution was 63% male, and the composition was White (74%), African-American (20%), Asian (3%), and Other (3%). The 12-month post-transplant information from this trial is presented below.

Adverse reactions that occurred in ≥15% of kidney transplant patients treated with tacrolimus in conjunction with MMF in Study 2 are presented below:

Table 6. Kidney Transplantation: Adverse Reactions Occurring in ≥15% of Patients

Treated with Tacrolimus in Conjunction with MMF (Study 2)

Tacrolimus /MMF

Cyclosporine/MMF

(N=212)

(N=212)

Gastrointestinal Disorders

Diarrhea

44%

26%

Nausea

39%

47%

Constipation

36%

41%

Vomiting

26%

25%

Dyspepsia

18%

15%

Injury, Poisoning, and Procedural Complications

Post-Procedural Pain

29%

27%

Incision Site Complication

28%

23%

Graft Dysfunction

24%

18%

Metabolism and Nutrition Disorders

Hypomagnesemia

28%
22%
Hypophosphatemia
28%
21%
Hyperkalemia
26%
19%
Hyperglycemia
21%
15%
Hyperlipidemia
18%
25%
Hypokalemia
16%
18%
Nervous System Disorders
Tremor
34%
20%
Headache
24%
25%
Blood and Lymphatic System Disorders
Anemia
30%
28%
Leukopenia
16%
12%
Miscellaneous
Edema Peripheral

35%

46%

Hypertension

32%

35%

Insomnia

30%

21%

Urinary Tract Infection

26%

22%

Blood Creatinine Increased

23%

23%

Less frequently observed adverse reactions in kidney transplantation patients are described under the subsection “Less Frequently Reported Adverse Reactions (> 3% and <15%) in Liver, Kidney, and Heart Transplant Studies.”

Liver Transplantation

There were two randomized comparative liver transplant trials. In the U.S. trial, 263 adult and pediatric patients received tacrolimus and steroids and 266 patients received cyclosporine-based immunosuppressive regimen (CsA/AZA). The trial population had a mean age of 44 years (range 0.4 to 70); the distribution was 52% male, and the composition was White (78%), African-American (5%), Asian (2%), Hispanic (13%), and Other (2%). In the European trial, 270 patients received tacrolimus and steroids and 275 patients received CsA/AZA. The trial population had a mean age of 46 years (range 15 to 68); the distribution was 59% male, and the composition was White (95.4%), Black (1%), Asian (2%), and Other (2%).

The proportion of patients reporting more than one adverse event was >99% in both the tacrolimus group and the CsA/AZA group. Precautions must be taken when comparing the incidence of adverse reactions in the U.S. trial to that in the European trial. The 12-month post-transplant information from the U.S. trial and from the European trial is presented below. The two trials also included different patient populations and patients were treated with immunosuppressive regimens of differing intensities. Adverse reactions reported in ≥15% in tacrolimus patients (combined trial results) are presented below for the two controlled trials in liver transplantation.

The most common adverse reactions (≥40%) observed in tacrolimus-treated liver transplant patients are: tremor, headache, diarrhea, hypertension, nausea, abnormal renal function, abdominal pain, insomnia, paresthesia, anemia, pain, fever, asthenia, hyperkalemia, hypomagnesemia, and hyperglycemia. These all occur with oral administration of tacrolimus and some may respond to a reduction in dosing (e.g., tremor, headache, paresthesia, hypertension). Diarrhea was sometimes associated with

other gastrointestinal complaints such as nausea and vomiting. Based on reported adverse reaction terms related to decreased renal function, nephrotoxicity was reported in approximately 40% and 36% of liver transplantation patients receiving tacrolimus in the U.S. and European randomized trials.

Table 7. Liver Transplantation: Adverse Reactions Occurring in ≥15% of Patients Treated with Tacrolimus

U.S. TRIAL

EUROPEAN TRIAL

Tacrolimus (N=250)

Cyclosporine/AZA (N=250)

Tacrolimus (N=264)

Cyclosporine/AZA (N=265)

Nervous System

Headache

64%

60%

37%

26%

Insomnia

64%

68%

32%

23%

Tremor

56%

46%

48%

32%

Paresthesia

40%

30%

17%

17%

Gastrointestinal

Diarrhea

72%

47%

37%

27%

Nausea

46%

37%

32%

27%

LFT Abnormal

36%

30%

6%

5%

Anorexia

34%

24%

7%

5%

Vomiting

27%

15%

14%

11%

Constipation

24%

27%

23%

21%

Cardiovascular

Hypertension

47%

56%
38%
43%
Urogenital
Kidney Function Abnormal
40%
27%
36%
23%
Creatinine Increased
39%
25%
24%
19%
BUN Increased
30%
22%
12%
9%
Oliguria
18%
15%
19%
12%
Urinary Tract Infection
16%
18%
21%
19%
Metabolic and Nutritional
Hypomagnesemia
48%
45%

16%
9%
Hyperglycemia
47%
38%
33%
22%
Hyperkalemia
45%
26%
13%
9%
Hypokalemia
29%
34%
13%
16%
Hemic and Lymphatic
Anemia
47%
38%
5%
1%
Leukocytosis
32%
26%
8%
8%
Thrombocytopenia
24%
20%
14%
19%

Miscellaneous
Pain
63%
57%
24%
22%
Abdominal Pain
59%
54%
29%
22%
Asthenia
52%
48%
11%
7%
Fever
48%
56%
19%
22%
Back Pain
30%
29%
17%
17%
Ascites
27%
22%
7%
8%
Peripheral Edema
26%

26%

12%

14%

Respiratory System

Pleural Effusion

30%

32%

36%

35%

Dyspnea

29%

23%

5%

4%

Atelectasis

28%

30%

5%

4%

Skin and Appendages

Pruritus

36%

20%

15%

7%

Rash

24%

19%

10%

4%

Less frequently observed adverse reactions in liver transplantation patients are described under the subsection “Less Frequently Reported Adverse Reactions (>3% and <15%) in Liver, Kidney, and Heart Transplant Studies.”

Heart Transplantation

The incidence of adverse reactions was determined based on two trials in primary orthotopic heart transplantation. In a trial conducted in Europe, 314 patients received a regimen of antibody induction, corticosteroids, and azathioprine (AZA) in combination with tacrolimus (n=157) or cyclosporine (n=157) for 18 months. The trial population had a mean age of 51 years (range 18 to 65); the distribution was 82% male, and the composition was White (96%), Black (3%), and Other (1%).

The most common adverse reactions (≥15%) observed in tacrolimus-treated heart transplant patients are: abnormal renal function, hypertension, diabetes mellitus, CMV infection, tremor, hyperglycemia, leukopenia, infection, anemia, bronchitis, pericardial effusion, urinary tract infection, and hyperlipemia. Based on reported adverse reaction terms related to decreased renal function, nephrotoxicity was reported in approximately 59% of heart transplantation patients in the European trial.

Adverse reactions in heart transplant patients in the European trial are presented below:

Table 9. Heart Transplantation: Adverse Reactions Occurring in ≥15% of Patients Treated with Tacrolimus in Conjunction with Azathioprine (AZA)

Tacrolimus/AZA

Cyclosporine/AZA

(N=157)

(N=157)

Cardiovascular System

Hypertension

62%

69%

Pericardial Effusion

15%

14%

Body as a Whole

CMV Infection

32%

30%

Infection

24%

21%

Metabolic and Nutritional Disorders

Diabetes Mellitus

26%

16%

Hyperglycemia

23%

17%

Hyperlipemia

18%

27%

Hemic and Lymphatic System

Anemia

50%

36%

Leukopenia

48%

39%

Urogenital System

Kidney Function Abnormal

56%

57%

Urinary Tract Infection

16%

12%

Respiratory System

Bronchitis

17%

18%

Nervous System

Tremor

15%

6%

In the European trial, the cyclosporine trough concentrations were above the pre-defined target range (i.e., 100 to 200 ng/mL) at Day 122 and beyond in 32% to 68% of the patients in the cyclosporine treatment arm, whereas the tacrolimus trough concentrations were within the pre-defined target range (i.e., 5 to 15 ng/mL) in 74% to 86% of the patients in the tacrolimus treatment arm.

In a U.S. trial, the incidence of adverse reactions was based on 331 heart transplant patients that received corticosteroids and tacrolimus in combination with sirolimus (n=109), tacrolimus in combination with MMF (n=107) or cyclosporine modified in combination with MMF (n=115) for 1 year. The trial population had a mean age of 53 years (range 18 to 75); the distribution was 78% male, and the composition was White (83%), African-American (13%) and Other (4%).

Only selected targeted treatment-emergent adverse reactions were collected in the U.S. heart transplantation trial. Those reactions that were reported at a rate of 15% or greater in patients treated with tacrolimus and MMF include the following: any target adverse reactions (99%), hypertension (89%), hyperglycemia requiring antihyperglycemic therapy (70%), hypertriglyceridemia (65%), anemia (hemoglobin <10 g/dL) (65%), fasting blood glucose >140 mg/dL (on two separate occasions) (61%), hypercholesterolemia (57%), hyperlipidemia (34%), WBCs <3000 cells/mcL (34%), serious bacterial infections (30%), magnesium <1.2 mEq/L (24%), platelet count <75,000 cells/mcL (19%), and other opportunistic infections (15%).

Other targeted treatment-emergent adverse reactions in tacrolimus-treated patients occurred at a rate of less than 15%, and include the following: Cushingoid features, impaired wound healing, hyperkalemia, Candida infection, and CMV infection/syndrome. Other less frequently observed adverse reactions in heart transplantation patients are described under the subsection “Less Frequently Reported Adverse Reactions (>3% and <15%) in Liver, Kidney and Heart Transplant Studies.”

New Onset Diabetes After Transplant

Kidney Transplantation

New Onset Diabetes After Transplant (NODAT) is defined as a composite of fasting plasma glucose ≥126 mg/dL, HbA1C ≥6%, insulin use ≥30 days, or oral hypoglycemic use. In a trial in kidney transplant patients (Study 2), NODAT was observed in 75% in the tacrolimus-treated and 61% in the NEORAL-treated patients without pre-transplant history of diabetes mellitus (Table 10) [see Clinical Studies (14.1)].

Table 10. Incidence of New Onset Diabetes After Transplant at 1 Year in Kidney Transplant Recipients in a Phase 3 Trial (Study 2)

Parameter

Treatment Group

Tacrolimus/MMF

(N=212)

NEORAL/MMF

(N=212)

NODAT

112/150 (75%)

93/152 (61%)

Fasting Plasma Glucose ≥126 mg/dL

96/150 (64%)

80/152 (53%)

HbA1C ≥6%

59/150 (39%)

28/152 (18%)

Insulin Use ≥30 days

9/150 (6%)

4/152 (3%)

Oral Hypoglycemic Use

15/150 (10%)

5/152 (3%)

In early trials of tacrolimus, Post-Transplant Diabetes Mellitus (PTDM) was evaluated with a more limited criterion of “use of insulin for 30 or more consecutive days with <5-day gap” in patients without a prior history of insulin-dependent diabetes mellitus or non-insulin dependent diabetes mellitus. Data are presented in Tables 11 to 14. PTDM was reported in 20% of tacrolimus/Azathioprine (AZA)-treated kidney transplant patients without pre-transplant history of diabetes mellitus in a Phase 3 trial (Table 11). The median time to onset of PTDM was 68 days. Insulin dependence was reversible in 15% of these PTDM patients at one year and in 50% at 2 years post-transplant. African-American and Hispanic kidney transplant patients were at an increased risk of development of PTDM (Table 12).

Table 11. Incidence of Post-Transplant Diabetes Mellitus and Insulin Use at 2 Years in Kidney Transplant Recipients in a Phase 3 Trial using Azathioprine (AZA)

*
Use of insulin for 30 or more consecutive days, with <5-day gap, without a prior history of insulin-dependent diabetes mellitus or non-insulin dependent diabetes mellitus.

Status of PTDM*

Tacrolimus/AZA

CsA/AZA

Patients without pre-transplant history of diabetes mellitus

151

151

New onset PTDM*, 1st Year

30/151 (20%)

6/151 (4%)

Still insulin-dependent at one year in those without prior history of diabetes

25/151 (17%)

5/151 (3%)

New onset PTDM* post 1 year

1

0

Patients with PTDM* at 2 years

16/151 (11%)

5/151 (3%)

Table 12. Development of Post-Transplant Diabetes Mellitus by Race or Ethnicity and by Treatment Group During First Year Post Kidney Transplantation in a Phase 3 Trial

*
Use of insulin for 30 or more consecutive days, with <5-day gap, without a prior history of insulin-dependent diabetes mellitus or non-insulin dependent diabetes mellitus.

Patient Race

Patients Who Developed PTDM*

Tacrolimus

Cyclosporine

African-American

15/41 (37%)

3 (8%)

Hispanic

5/17 (29%)

1 (6%)

Caucasian

10/82 (12%)

1 (1%)

Other

0/11 (0%)

1 (10%)

Total

30/151 (20%)

6 (4%)

Liver Transplantation

Insulin-dependent PTDM was reported in 18% and 11% of tacrolimus-treated liver transplant patients and was reversible in 45% and 31% of these patients at 1 year post-transplant, in the U.S. and European randomized trials, respectively (Table 13). Hyperglycemia was associated with the use of tacrolimus in 47% and 33% of liver

transplant recipients in the U.S. and European randomized trials, respectively, and may require treatment [see Adverse Reactions (6.1)].

Table 13. Incidence of Post-Transplant Diabetes Mellitus and Insulin Use at 1 Year in Liver Transplant Recipients

*
Use of insulin for 30 or more consecutive days, with <5 day gap, without a prior history of insulin-dependent diabetes mellitus or non-insulin dependent diabetes mellitus.
†
Patients without pre-transplant history of diabetes mellitus.

Status of PTDM*

US Trial

European Trial

Tacrolimus

Cyclosporine

Tacrolimus

Cyclosporine

Patients at risk†

239

236

239

249

New Onset PTDM*

42 (18%)

30 (13%)

26 (11%)

12 (5%)

Patients still on insulin at 1 year

23 (10%)

19 (8%)

18 (8%)

6 (2%)

Heart Transplantation

Insulin-dependent PTDM was reported in 13% and 22% of tacrolimus-treated heart transplant patients receiving mycophenolate mofetil (MMF) or azathioprine (AZA) and was reversible in 30% and 17% of these patients at one year post-transplant, in the U.S. and European randomized trials, respectively (Table 14). Hyperglycemia, defined as two

fasting plasma glucose levels ≥126 mg/dL, was reported with the use of tacrolimus plus MMF or AZA in 32% and 35% of heart transplant recipients in the U.S. and European randomized trials, respectively, and may require treatment [see Adverse Reactions (6.1)].

Table 14. Incidence of Post-Transplant Diabetes Mellitus and Insulin Use at 1 Year in Heart Transplant Recipients

*
Use of insulin for 30 or more consecutive days without a prior history of insulin-dependent diabetes mellitus or non-insulin dependent diabetes mellitus.
†
Patients without pre-transplant history of diabetes mellitus.
‡
7 to 12 months for the U.S. trial.

Status of PTDM*

US Trial

European Trial

Tacrolimus/MMF

Cyclosporine/MMF

Tacrolimus/AZA

Cyclosporine/AZA

Patients at risk†

75

83

132

138

New Onset PTDM*

10 (13%)

6 (7%)

29 (22%)

5 (4%)

Patients still on insulin at 1 year‡

7 (9%)

1 (1%)

24
18%)

4 (3%)

Less Frequently Reported Adverse Reactions (>3% and <15%) in Liver, Kidney, and Heart Transplant Studies

The following adverse reactions were reported in either liver, kidney, and/or heart transplant recipients who were treated with tacrolimus in clinical trials.

•
Nervous System

Abnormal dreams, agitation, amnesia, anxiety, confusion, convulsion, crying, depression, elevated mood, emotional lability, encephalopathy, hemorrhagic stroke, hallucinations, hypertonia, incoordination, monoparesis, myoclonus, nerve compression, nervousness, neuralgia, neuropathy, paralysis flaccid, psychomotor skills impaired, psychosis, quadriparesis, somnolence, thinking abnormal, vertigo, writing impaired

•
Special Senses

Abnormal vision, amblyopia, ear pain, otitis media, tinnitus

•
Gastrointestinal

Cholangitis, cholestatic jaundice, duodenitis, dysphagia, esophagitis, flatulence, gastritis, gastroesophagitis, gastrointestinal hemorrhage, GGT increase, GI disorder, GI perforation, hepatitis, hepatitis granulomatous, ileus, increased appetite, jaundice, liver damage, esophagitis ulcerative, oral moniliasis, pancreatic pseudocyst, stomatitis

•
Cardiovascular

Abnormal ECG, angina pectoris, arrhythmia, atrial fibrillation, atrial flutter, bradycardia, cardiac fibrillation, cardiopulmonary failure, congestive heart failure, deep thrombophlebitis, echocardiogram abnormal, electrocardiogram QRS complex abnormal, electrocardiogram ST segment abnormal, heart failure, heart rate decreased, hemorrhage, hypotension, phlebitis, postural hypotension, syncope, tachycardia, thrombosis, vasodilatation

•
Urogenital

Acute kidney failure, albuminuria, BK nephropathy, bladder spasm, cystitis, dysuria, hematuria, hydronephrosis, kidney failure, kidney tubular necrosis, nocturia, pyuria, toxic nephropathy, urge incontinence, urinary frequency, urinary incontinence, urinary retention, vaginitis

•
Metabolic/Nutritional

Acidosis, alkaline phosphatase increased, alkalosis, ALT (SGPT) increased, AST (SGOT) increased, bicarbonate decreased, bilirubinemia, dehydration, GGT increased, gout, healing abnormal, hypercalcemia, hypercholesterolemia, hyperphosphatemia, hyperuricemia, hypervolemia, hypocalcemia, hypoglycemia, hyponatremia, hypoproteinemia, lactic dehydrogenase increased, weight gain

•
Endocrine

Cushing’s syndrome

•

Hemic/Lymphatic

Coagulation disorder, ecchymosis, hematocrit increased, hypochromic anemia, leukocytosis, polycythemia, prothrombin decreased, serum iron decreased

•

Miscellaneous

Abdomen enlarged, abscess, accidental injury, allergic reaction, cellulitis, chills, fall, flu syndrome, generalized edema, hernia, mobility decreased, peritonitis, photosensitivity reaction, sepsis, temperature intolerance, ulcer

•

Musculoskeletal

Arthralgia, cramps, generalized spasm, leg cramps, myalgia, myasthenia, osteoporosis

•

Respiratory

Asthma, emphysema, hiccups, lung function decreased, pharyngitis, pneumonia, pneumothorax, pulmonary edema, rhinitis, sinusitis, voice alteration

•

Skin

Acne, alopecia, exfoliative dermatitis, fungal dermatitis, herpes simplex, herpes zoster, hirsutism, neoplasm skin benign, skin discoloration, skin ulcer, sweating

Additional pediatric use information is approved for Astellas Pharma US, Inc.’s Prograf (tacrolimus) products. However, due to Astellas Pharma US, Inc.’s marketing exclusivity rights, this drug product is not labeled with that information

6.2 Postmarketing Experience

The following adverse reactions have been reported from worldwide marketing experience with tacrolimus. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. Decisions to include these reactions in labeling are typically based on one or more of the following factors: (1) seriousness of the reaction, (2) frequency of the reporting, or (3) strength of causal connection to the drug.

Other reactions include:

•

Cardiovascular

Atrial fibrillation, atrial flutter, cardiac arrhythmia, cardiac arrest, electrocardiogram T wave abnormal, flushing, myocardial infarction, myocardial ischemia, pericardial effusion, QT prolongation, Torsades de pointes, venous thrombosis deep limb, ventricular extrasystoles, ventricular fibrillation, myocardial hypertrophy

•

Gastrointestinal

Bile duct stenosis, colitis, enterocolitis, gastroenteritis, gastroesophageal reflux disease, hepatic cytolysis, hepatic necrosis, hepatotoxicity, impaired gastric emptying, liver fatty, mouth ulceration, pancreatitis hemorrhagic, pancreatitis necrotizing, stomach ulcer, veno-occlusive liver disease

•

Hemic/Lymphatic

Agranulocytosis, disseminated intravascular coagulation, hemolytic anemia, neutropenia, febrile neutropenia, pancytopenia, thrombocytopenic purpura, thrombotic thrombocytopenic purpura, pure red cell aplasia, thrombotic microangiopathy

•

Infections

Cases of progressive multifocal leukoencephalopathy (PML), sometimes fatal; polyoma virus-associated nephropathy (PVAN) including graft loss

•

Metabolic/Nutritional

Glycosuria, increased amylase including pancreatitis, weight decreased

•

Miscellaneous

Feeling hot and cold, feeling jittery, hot flushes, multi-organ failure, primary graft dysfunction

•

Musculoskeletal and Connective Tissue Disorders

Pain in extremity including Calcineurin-Inhibitor Induced Pain Syndrome (CIPS)

•

Nervous System

Carpal tunnel syndrome, cerebral infarction, hemiparesis, leukoencephalopathy, mental disorder, mutism, posterior reversible encephalopathy syndrome (PRES), progressive multifocal leukoencephalopathy (PML), quadriplegia, speech disorder, syncope

•

Respiratory

Acute respiratory distress syndrome, interstitial lung disease, lung infiltration, respiratory distress, respiratory failure

•

Skin

Stevens-Johnson syndrome, toxic epidermal necrolysis

•

Special Senses

Blindness, optic neuropathy, blindness cortical, hearing loss including deafness, photophobia

•
Urogenital

Acute renal failure, cystitis hemorrhagic, hemolytic-uremic syndrome

7.1 Mycophenolic Acid

When tacrolimus is prescribed with a given dose of a mycophenolic acid (MPA) product, exposure to MPA is higher with tacrolimus co-administration than with cyclosporine co-administration with MPA, because cyclosporine interrupts the enterohepatic recirculation of MPA while tacrolimus does not. Monitor for MPA-associated adverse reactions and reduce the dose of concomitantly administered mycophenolic acid products as needed.

7.2 Effects of Other Drugs on Tacrolimus

Table 15 displays the effects of other drugs on tacrolimus.

*
Tacrolimus dosage adjustment recommendation based on observed effect of co-administered drug on tacrolimus exposures [see Clinical Pharmacology (12.3)], literature reports of altered tacrolimus exposures, or the other drug's known CYP3A inhibitor/inducer status.
†
High dose or double strength grapefruit juice is a strong CYP3A inhibitor; low dose or single strength grapefruit juice is a moderate CYP3A inhibitor.

Table 15. Effects of Other Drugs/Substances on Tacrolimus*

Drug/Substance Class or Name

Drug Interaction Effect

Recommendations

Grapefruit or grapefruit juice†

May increase tacrolimus whole blood trough concentrations and increase the risk of serious adverse reactions (e.g., neurotoxicity, QT prolongation) [see Warnings and Precautions (5.6, 5.11,

5.12)].

Avoid grapefruit or grapefruit juice.

Strong CYP3A Inducers:Antimycobacterials (e.g., rifampin, rifabutin), anticonvulsants (e.g., phenytoin, carbamazepine and phenobarbital), St John's wort

May decrease tacrolimus whole blood trough concentrations and increase the risk of

rejection [see Warnings and Precautions (5.11)].

Increase tacrolimus dose and monitor tacrolimus whole blood trough concentrations [see Dosage and Administration (2.2, 2.6) and Clinical Pharmacology (12.3)].

Strong CYP3A Inhibitor:

Protease inhibitors (e.g., nelfinavir, telaprevir, boceprevir, ritonavir), azole antifungals (e.g., voriconazole, posaconazole, itraconazole, ketoconazole), antibiotics (e.g., clarithromycin, troleandomycin, chloramphenicol), nefazodone, letermovir, Schisandra sphenanthera extracts

May increase tacrolimus whole blood trough concentrations and increase the risk of serious adverse reactions (e.g., neurotoxicity, QT prolongation). A rapid, sharp rise in tacrolimus levels may occur early, despite an immediate reduction of tacrolimus dose [see Warnings and Precautions (5.6, 5.11, 5.12)].

Reduce tacrolimus dose (for voriconazole and posaconazole, give one-third of the original dose) and adjust dose based on tacrolimus whole blood trough concentrations [see Dosage and Administration (2.2, 2.6) and Clinical Pharmacology (12.3)]. Early and frequent monitoring of tacrolimus whole blood trough levels should start within 1-3 days and continue monitoring as necessary [see Warnings and Precautions (5.11)].

Mild or Moderate CYP3A Inhibitors: Clotrimazole, antibiotics (e.g., erythromycin, fluconazole), calcium channel blockers (e.g., verapamil, diltiazem, nifedipine, nicardipine), amiodarone, danazol, ethinyl estradiol, cimetidine, lansoprazole and omeprazole

May increase tacrolimus whole blood trough concentrations and increase the risk of serious adverse reactions (e.g., neurotoxicity, QT prolongation) [see Warnings and Precautions (5.6, 5.11, 5.12)].

Monitor tacrolimus whole blood trough concentrations and reduce tacrolimus dose if needed [see Dosage and Administration (2.2, 2.6) and Clinical Pharmacology (12.3)].

Other drugs, such as:

Magnesium and aluminum hydroxide antacids

Metoclopramide

May increase tacrolimus whole blood trough concentrations and increase the risk of serious adverse reactions (e.g., neurotoxicity, QT prolongation) [see Warnings and Precautions (5.6, 5.11,

5.12)].

Monitor tacrolimus whole blood trough concentrations and reduce tacrolimus dose if needed [see Dosage and Administration (2.2, 2.6) and Clinical Pharmacology (12.3)].

Mild or Moderate CYP3A Inducers

Methylprednisolone, prednisone

May decrease tacrolimus whole blood trough concentrations.

Monitor tacrolimus whole blood trough concentrations and adjust tacrolimus dose if needed [see Dosage and Administration (2.2, 2.6)].

Caspofungin

May decrease tacrolimus whole blood trough concentrations.

Monitor tacrolimus whole blood trough concentrations and adjust tacrolimus dose if needed [see Dosage and Administration (2.2, 2.6)].

Direct Acting Antiviral (DAA) Therapy

The pharmacokinetics of tacrolimus may be impacted by changes in liver function during DAA therapy, related to clearance of HCV virus. Close monitoring and potential dose adjustment of tacrolimus is warranted to ensure continued efficacy and safety [see Dosage and Administration (2.2, 2.6)].

7.3 Cannabidiol

The blood levels of tacrolimus may increase upon concomitant use with cannabidiol. When cannabidiol and tacrolimus are co-administered, closely monitor for an increase in tacrolimus blood levels and for adverse reactions suggestive of tacrolimus toxicity. A dose reduction of tacrolimus should be considered as needed when tacrolimus is co-administered with cannabidiol [see Dosage and Administration (2.2, 2.6) and Warnings and Precautions (5.17)].

8.1 Pregnancy

Pregnancy Exposure Registry

There is a pregnancy registry that monitors pregnancy outcomes in women exposed to tacrolimus during pregnancy. The Transplantation Pregnancy Registry International (TPRI) is a voluntary pregnancy exposure registry that monitors outcomes of pregnancy in female transplant recipients and those fathered by male transplant recipients exposed to immunosuppressants including tacrolimus. Healthcare providers are encouraged to advise their patients to register by contacting the Transplantation Pregnancy Registry International at 1-877-955-6877 or HTTPS://WWW.TRANSPLANTPREGNANCYREGISTRY.ORG/.

Risk Summary

Tacrolimus can cause fetal harm when administered to a pregnant woman. Data from postmarketing surveillance and TPRI suggest that infants exposed to tacrolimus in utero are at a risk of prematurity, birth defects/congenital anomalies, low birth weight, and fetal distress [see Human Data]. Advise pregnant women of the potential risk to the fetus.

Administration of oral tacrolimus to pregnant rabbits and rats throughout the period of

organogenesis was associated with maternal toxicity/lethality, and an increased incidence of abortion, malformation and embryofetal death at clinically relevant doses (0.5 to 6.9 times the recommended clinical dose range [0.2 to 0.075 mg/kg/day], on a mg/m2 basis). Administration of oral tacrolimus to pregnant rats after organogenesis and throughout lactation produced maternal toxicity, effects on parturition, reduced pup viability and reduced pup weight at clinically relevant doses (0.8 to 6.9 times the recommended clinical dose range, on a mg/m2 basis). Administration of oral tacrolimus to rats prior to mating, and throughout gestation and lactation produced maternal toxicity/lethality, marked effects on parturition, embryofetal loss, malformations, and reduced pup viability at clinically relevant doses (0.8 to 6.9 times the recommended clinical dose range, on a mg/m2 basis). Interventricular septal defects, hydronephrosis, craniofacial malformations and skeletal effects were observed in offspring that died [see Animal Data].

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

Clinical Considerations

Disease-Associated Maternal and/or Embryo-Fetal Risk

Risks during pregnancy are increased in organ transplant recipients.

The risk of premature delivery following transplantation is increased. Pre-existing hypertension and diabetes confer additional risk to the pregnancy of an organ transplant recipient. Pre-gestational and gestational diabetes are associated with birth defects/congenital anomalies, hypertension, low birth weight and fetal death.

Cholestasis of pregnancy (COP) was reported in 7% of liver or liver-kidney (LK) transplant recipients, compared with approximately 1% of pregnancies in the general population. However, COP symptoms resolved postpartum and no long-term effects on the offspring were reported.

Maternal Adverse Reactions

Tacrolimus may increase hyperglycemia in pregnant women with diabetes (including gestational diabetes). Monitor maternal blood glucose levels regularly [see Warnings and Precautions (5.4)].

Tacrolimus may exacerbate hypertension in pregnant women and increase pre-eclampsia. Monitor and control blood pressure [see Warnings and Precautions (5.7, 5.8)].

Fetal/Neonatal Adverse Reactions

Renal dysfunction, transient neonatal hyperkalemia and low birth weight have been reported at the time of delivery in infants of mothers taking tacrolimus.

Labor or Delivery

There is an increased risk for premature delivery (<37 weeks) following transplantation and maternal exposure to tacrolimus.

Data

Human Data

There are no adequate and well controlled studies on the effects of tacrolimus in human pregnancy.

Safety data from the TPRI and postmarketing surveillance suggest infants exposed to tacrolimus in utero have an increased risk for miscarriage, pre-term delivery (<37 weeks), low birth weight (<2500 g), birth defects/congenital anomalies and fetal distress.

TPRI reported 450 and 241 total pregnancies in kidney and liver transplant recipients exposed to tacrolimus, respectively. The TPRI pregnancy outcomes are summarized in Table 16. In the table below, the number of recipients exposed to tacrolimus concomitantly with mycophenolic acid (MPA) products during the preconception and first trimester periods is high (27% and 29% for renal and liver transplant recipients, respectively). Because MPA products may also cause birth defects, the birth defect rate may be confounded and this should be taken into consideration when reviewing the data, particularly for birth defects. Birth defects observed include cardiac malformations, craniofacial malformations, renal/urogenital disorders, skeletal abnormalities, neurological abnormalities and multiple malformations.

Table 16. TPRI Reported Pregnancy Outcomes in Transplant Recipients with Exposure to Tacrolimus

*
Includes multiple births and terminations.
†
Birth defect rate confounded by concomitant MPA products exposure in over half of offspring with birth defects.

Kidney

Liver

Pregnancy Outcomes*

462

253

Miscarriage

24.5%

25%

Live births

331

180

Pre-term delivery (< 37 weeks)

49%

42%

Low birth weight (< 2500 g)

42%

30%

Birth defects

8%†

5%

Additional information reported by TPRI in pregnant transplant patients receiving tacrolimus included diabetes during pregnancy in 9% of kidney recipients and 13% of liver recipients, and hypertension during pregnancy in 53% of kidney recipients and 16.2% of liver recipients.

Animal Data

Administration of oral tacrolimus to pregnant rabbits throughout organogenesis produced maternal toxicity and abortion at 0.32 mg/kg (0.5 to 1.4 times the recommended clinical dose range [0.2 to 0.075 mg/kg/day], on a mg/m2 basis). At 1 mg/kg (1.6 to 4.3 times the recommended clinical dose range), embryofetal lethality and fetal malformations (ventricular hypoplasia, interventricular septal defect, bulbous aortic arch, stenosis of ductus arteriosus, omphalocele, gallbladder agenesis, skeletal anomalies) were observed. Administration of 3.2 mg/kg oral tacrolimus (2.6 to 6.9 times the recommended clinical dose range) to pregnant rats throughout organogenesis produced maternal toxicity/lethality, embryofetal lethality and decreased fetal body weight in the offspring of C-sectioned dams; and decreased pup viability and interventricular septal defect in offspring of dams that delivered.

In a peri-/postnatal development study, oral administration of tacrolimus to pregnant rats during late gestation (after organogenesis) and throughout lactation produced maternal toxicity, effects on parturition, and reduced pup viability at 3.2 mg/kg (2.6 to 6.9 times the recommended clinical dose range); among these pups that died early, an increased incidence of kidney hydronephrosis was observed. Reduced pup weight was observed at 1.0 mg/kg (0.8 to 2.2 times the recommended clinical dose range).

Administration of oral tacrolimus to rats prior to mating, and throughout gestation and lactation, produced maternal toxicity/lethality, embryofetal loss and reduced pup viability at 3.2 mg/kg (2.6 to 6.9 times the recommended clinical dose range). Interventricular septal defects, hydronephrosis, craniofacial malformations and skeletal effects were observed in offspring that died. Effects on parturition (incomplete delivery of nonviable pups) were observed at 1 mg/kg (0.8 to 2.2 times the recommended clinical dose range) [see Nonclinical Toxicology (13.1)].

8.2 Lactation

Risk Summary

Controlled lactation studies have not been conducted in humans; however, tacrolimus has been reported to be present in human milk. The effects of tacrolimus on the breastfed infant, or on milk production have not been assessed. Tacrolimus is excreted in rat milk and in peri-/postnatal rat studies; exposure to tacrolimus during the postnatal period was associated with developmental toxicity in the offspring at clinically relevant doses [see Use in Specific Populations (8.1) and Nonclinical Toxicology (13.1)].

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for tacrolimus and any potential adverse effects on the breastfed child from tacrolimus or from the underlying maternal condition.

8.3 Females and Males of Reproductive Potential

Contraception

Tacrolimus can cause fetal harm when administered to pregnant women. Advise female and male patients of reproductive potential to speak to their healthcare provider on family planning options including appropriate contraception prior to starting treatment with tacrolimus [see Use in Specific Populations (8.1) and Nonclinical Toxicology (13.1)].

Infertility

Based on findings in animals, male and female fertility may be compromised by treatment with tacrolimus [see Nonclinical Toxicology (13.1)].

8.4 Pediatric Use

Safety and effectiveness have been established in pediatric liver transplant patients.

Liver Transplantation

Safety and efficacy in pediatric liver transplant patients less than 16 years of age are based on evidence from active controlled studies that included 56 pediatric patients, 31 of which received tacrolimus. Additionally, 122 pediatric patients were studied in an uncontrolled trial of tacrolimus in living related donor liver transplantation. Pediatric patients generally required higher doses of tacrolimus to maintain blood trough concentrations of tacrolimus similar to adult patients [see Dosage and Administration (2.3), Adverse Reactions (6.1), Clinical Pharmacology (12.3) and Clinical Studies (14.2)].

Additional pediatric use information is approved for Astellas Pharma US, Inc.'s Prograf (tacrolimus) products. However, due to Astellas Pharma US, Inc.'s marketing exclusivity rights, this drug product is not labeled with that information.

8.5 Geriatric Use

Clinical trials of tacrolimus did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

8.6 Renal Impairment

The pharmacokinetics of tacrolimus in patients with renal impairment was similar to that in healthy volunteers with normal renal function. However, consideration should be given to dosing tacrolimus at the lower end of the therapeutic dosing range in patients who have received a liver or heart transplant and have pre-existing renal impairment. Further reductions in dose below the targeted range may be required [see Dosage and Administration (2.4) and Clinical Pharmacology (12.3)].

8.7 Hepatic Impairment

The mean clearance of tacrolimus was substantially lower in patients with severe hepatic impairment (mean Child-Pugh score: >10) compared to healthy volunteers with normal hepatic function. Close monitoring of tacrolimus trough concentrations is warranted in patients with hepatic impairment [see Clinical Pharmacology (12.3)].

The use of tacrolimus in liver transplant recipients experiencing post-transplant hepatic impairment may be associated with increased risk of developing renal insufficiency related to high whole blood trough concentrations of tacrolimus. These patients should be monitored closely and dosage adjustments should be considered. Some evidence suggests that lower doses should be used in these patients [see Dosage and Administration (2.5) and Clinical Pharmacology (12.3)].

8.8 Race or Ethnicity

African-American patients may need to be titrated to higher dosages to attain comparable trough concentrations compared to Caucasian patients [see Dosage and Administration (2.2) and Clinical Pharmacology (12.3)].

African-American and Hispanic patients are at increased risk for new onset diabetes after transplant. Monitor blood glucose concentrations and treat appropriately [see Warnings and Precautions (5.4)].

Limited overdosage experience is available. Acute overdosages of up to 30 times the intended dose have been reported. Almost all cases have been asymptomatic and all patients recovered with no sequelae. Acute overdosage was sometimes followed by adverse reactions consistent with those reported with the use of tacrolimus [see Adverse Reactions (6.1, 6.2)], including tremors, abnormal renal function, hypertension, and peripheral edema; in one case of acute overdosage, transient urticaria and lethargy were observed. Based on the poor aqueous solubility and extensive erythrocyte and plasma protein binding, it is anticipated that tacrolimus is not dialyzable to any significant extent; there is no experience with charcoal hemoperfusion. The oral use of activated charcoal has been reported in treating acute overdoses, but experience has not been sufficient to warrant recommending its use. General supportive measures and treatment of specific symptoms should be followed in all cases of overdosage.

Tacrolimus, previously known as FK506, is the active ingredient in tacrolimus capsules. Tacrolimus is a calcineurin-inhibitor immunosuppressant produced by Streptomyces tsukubaensis. Chemically, tacrolimus is designated as [3S-[3R*[E(1S*,3S*,4S*)],4S*,5R*,8S*,9E,12R* ,14R*, 15S*,16R*,18S*,19S*,26aR*]]-5,6,8,11,12,13,14,15,16,17,18,19,24,25,26,26a-hexadecahydro-5,19-dihydroxy-3-[2-(4-hydroxy-3-methoxycyclohexyl)-1-methylethenyl]-14,16-dimethoxy-4,10,12,18-tetramethyl-8-(2-propenyl)-15,19-epoxy-3H-pyrido[2,1-c][1,4]oxaazacyclotricosine-1,7,20,21(4H,23H)-tetrone, monohydrate.

The chemical structure of tacrolimus is:

[chemical structure]

Tacrolimus has a molecular formula of C44H69NO12•H2O and a formula weight of 822.03. Tacrolimus appears as white crystals or crystalline powder. It is practically insoluble in water, freely soluble in ethanol, and very soluble in methanol and chloroform.

Tacrolimus capsules, USP are available for oral administration containing the equivalent of 0.5 mg, 1 mg or 5 mg of anhydrous tacrolimus. In addition, each capsule contains the following inactive ingredients: croscarmellose sodium, hypromellose, lactose monohydrate, and magnesium stearate.

The tacrolimus capsule shell for 0.5 mg strength consists of gelatin, titanium dioxide and yellow iron oxide.

The tacrolimus capsule shell for 1 mg strength consists of black iron oxide, gelatin, red iron oxide, titanium dioxide, and yellow iron oxide.

The tacrolimus capsule shell for 5 mg strength consists of red iron oxide, gelatin, and titanium dioxide.

Tacrolimus capsules, USP 0.5 mg, 1 mg and 5 mg are printed with edible black ink. The black ink is comprised of ammonia, black iron oxide, butyl alcohol, potassium hydroxide, propylene glycol, and shellac.

USP Dissolution test 2 and Organic Impurities procedure 2 used.

12.1 Mechanism of Action

Tacrolimus binds to an intracellular protein, FKBP-12. A complex of tacrolimus-FKBP-12, calcium, calmodulin, and calcineurin (a ubiquitous mammalian intracellular enzyme) is then formed, after which the phosphatase activity of calcineurin is inhibited. Such inhibition prevents the dephosphorylation and translocation of various factors such as the nuclear factor of activated T-cells (NF-AT), and nuclear factor kappa-light-chain enhancer of activated B-cells (NF-κB).

Tacrolimus inhibits the expression and/or production of several cytokines that include interleukin (IL)-1 beta, IL-2, IL-3, IL-4, IL-5, IL-6, IL-8, IL-10, gamma interferon, tumor necrosis factor-alpha, and granulocyte macrophage colony-stimulating factor. Tacrolimus also inhibits IL-2 receptor expression and nitric oxide release, induces apoptosis and production of transforming growth factor beta that can lead to immunosuppressive activity. The net result is the inhibition of T-lymphocyte activation and proliferation, as well as T-helper-cell-dependent B-cell response (i.e., immunosuppression).

12.3 Pharmacokinetics

Tacrolimus activity is primarily due to the parent drug. The pharmacokinetic parameters (mean ± S.D.) of tacrolimus have been determined following intravenous (IV) and/or oral (PO) administration in healthy volunteers, and in kidney transplant, liver transplant, and heart transplant patients (Table 17).

Table 17. Pharmacokinetics Parameters (mean±S.D.) of Tacrolimus in Healthy Volunteers and Patients

*
Not applicable
†

AUC0-inf
‡
Not available
§
AUC0-t
¶
Determined after the first dose
#
Median [range]
Þ
AUC0-12

Population

N

Route

(Dose)

Parameters

Cmax

(ng/mL)

Tmax

(hr)

AUC

(ng•hr/mL)

t1/2

(hr)

CL

(L/hr/kg)

V

(L/kg)

Healthy

Volunteers

8

IV

(0.025 mg/kg/4 hr)

*

*

652†± 156

34.2

± 7.7

0.040

± 0.009

1.91

± 0.31

16

PO

(5 mg) (capsules)

28.8

± 8.9

1.5

± 0.7

266†± 95

32.3

± 8.8

‡

‡

Kidney

Transplant

Patients

26

IV

(0.02 mg/kg/12 hr)

*

*

294†± 262

18.8

± 16.7

0.083

± 0.050

1.41

± 0.66

PO
(0.2 mg/kg/day)
19.2
± 10.3
3
203†± 42
‡
‡
‡
PO
(0.3 mg/kg/day)
24.2
± 15.8
1.5
288†
± 93
‡
‡
‡
Liver
Transplant
Patients
17
IV
(0.05 mg/kg/12 hr)
*
*
3300†
± 2130
11.7
± 3.9
0.053
± 0.017

0.85
± 0.30
PO
(0.3 mg/kg/day)
68.5
± 30
2.3
± 1.5
519†
± 179
‡
‡
‡
Heart
Transplant
Patients
11
IV

(0.01 mg/kg/day as a continuous infusion)
*
*
954§
± 334
23.6
± 9.22
0.051
± 0.015
‡
11
PO
(0.075 mg/kg/day)¶
14.7

± 7.79

2.1

[0.5-6]#

82.7Þ

± 63.2

*

‡

‡

14

PO

(0.15 mg/kg/day)¶

24.5

± 13.7

1.5

[0.4-4]#

142Þ

± 116

*

‡

‡

Due to intersubject variability in tacrolimus pharmacokinetics, individualization of the dosing regimen is necessary for optimal therapy [see Dosage and Administration (2.6)]. Pharmacokinetic data indicate that whole blood concentrations rather than plasma concentrations serve as the more appropriate sampling compartment to describe tacrolimus pharmacokinetics.

Absorption

Absorption of tacrolimus from the gastrointestinal tract after oral administration is incomplete and variable. The absolute bioavailability of tacrolimus was 17±10% in adult kidney transplant patients (N=26), 22±6% in adult liver transplant patients (N=17), 23±9% in adult heart transplant patients (N=11) and 18±5% in healthy volunteers (N=16).

A single dose trial conducted in 32 healthy volunteers established the bioequivalence of the 1 mg and 5 mg capsules. Another single dose trial in 32 healthy volunteers established the bioequivalence of the 0.5 mg and 1 mg capsules. Tacrolimus maximum blood concentrations (Cmax) and area under the curve (AUC) appeared to increase in a dose-proportional fashion in 18 fasted healthy volunteers receiving a single oral dose of 3, 7, and 10 mg.

In 18 kidney transplant patients, tacrolimus trough concentrations from 3 to 30 ng/mL measured at 10 to 12 hours post-dose (Cmin) correlated well with the AUC (correlation coefficient 0.93). In 24 liver transplant patients over a concentration range of 10 to 60 ng/mL, the correlation coefficient was 0.94. In 25 heart transplant patients over a concentration range of 2 to 24 ng/mL, the correlation coefficient was 0.89 after an oral dose of 0.075 or 0.15 mg/kg/day at steady-state.

If pediatric patients are converted between formulations, therapeutic drug monitoring must be performed and dose adjustments made to ensure that systemic exposure to tacrolimus is maintained.

Food Effects

The rate and extent of tacrolimus absorption were greatest under fasted conditions. The presence and composition of food decreased both the rate and extent of tacrolimus absorption when administered to 15 healthy volunteers.

The effect was most pronounced with a high-fat meal (848 kcal, 46% fat): mean AUC and Cmax were decreased 37% and 77%, respectively; Tmax was lengthened 5-fold. A high-carbohydrate meal (668 kcal, 85% carbohydrate) decreased mean AUC and mean Cmax by 28% and 65%, respectively.

In healthy volunteers (N=16), the time of the meal also affected tacrolimus bioavailability. When given immediately following the meal, mean Cmax was reduced 71%, and mean AUC was reduced 39%, relative to the fasted condition. When administered 1.5 hours following the meal, mean Cmax was reduced 63%, and mean AUC was reduced 39%, relative to the fasted condition.

In 11 liver transplant patients, tacrolimus administered 15 minutes after a high fat (400 kcal, 34% fat) breakfast, resulted in decreased AUC (27±18%) and Cmax (50±19%), as compared to a fasted state.

Tacrolimus capsules should be taken consistently every day either with or without food because the presence and composition of food decreases the bioavailability of tacrolimus [see Dosage and Administration (2.1)].

Distribution

The plasma protein binding of tacrolimus is approximately 99% and is independent of concentration over a range of 5 to 50 ng/mL. Tacrolimus is bound mainly to albumin and alpha-1-acid glycoprotein, and has a high level of association with erythrocytes. The distribution of tacrolimus between whole blood and plasma depends on several factors, such as hematocrit, temperature at the time of plasma separation, drug concentration, and plasma protein concentration. In a U.S. trial, the ratio of whole blood concentration to plasma concentration averaged 35 (range 12 to 67).

Elimination

Metabolism

Tacrolimus is extensively metabolized by the mixed-function oxidase system, primarily the cytochrome P-450 system (CYP3A4 and CYP3A5). A metabolic pathway leading to the formation of 8 possible metabolites has been proposed. Demethylation and hydroxylation were identified as the primary mechanisms of biotransformation in vitro. The major metabolite identified in incubations with human liver microsomes is 13-demethyl tacrolimus. In in vitro studies, a 31-demethyl metabolite has been reported to

have the same activity as tacrolimus.

Excretion
The mean clearance following IV administration of tacrolimus is 0.040, 0.083, 0.053, and 0.051 L/hr/kg in healthy volunteers, adult kidney transplant patients, adult liver transplant patients, and adult heart transplant patients, respectively. In man, less than 1% of the dose administered is excreted unchanged in urine.

In a mass balance study of IV-administered radiolabeled tacrolimus to 6 healthy volunteers, the mean recovery of radiolabel was 77.8±12.7%. Fecal elimination accounted for 92.4±1% and the elimination half-life based on radioactivity was 48.1±15.9 hours whereas it was 43.5±11.6 hours based on tacrolimus concentrations. The mean clearance of radiolabel was 0.029±0.015 L/hr/kg and clearance of tacrolimus was 0.029±0.009 L/hr/kg. When administered PO, the mean recovery of the radiolabel was 94.9±30.7%. Fecal elimination accounted for 92.6±30.7%, urinary elimination accounted for 2.3±1.1% and the elimination half-life based on radioactivity was 31.9±10.5 hours whereas it was 48.4±12.3 hours based on tacrolimus concentrations. The mean clearance of radiolabel was 0.226±0.116 L/hr/kg and clearance of tacrolimus was 0.172±0.088 L/hr/kg.

Specific Populations

Pediatric Patients

Tacrolimus capsules Pharmacokinetics in Pediatric Patients

Pharmacokinetics of tacrolimus have been studied in liver transplantation patients, 0.7 to 13.2 years of age. Following oral administration to 9 patients, mean AUC and Cmax were 337±167 ng·hr/mL and 48.4±27.9 ng/mL, respectively. The absolute bioavailability was 31±24%.

Pharmacokinetics of tacrolimus have also been studied in kidney transplantation patients, 8.2±2.4 years of age. Following oral administration to the same patients, mean AUC and Cmax were 181±65 ng·hr/mL and 30±11 ng/mL, respectively. The absolute bioavailability was 19±14%.

Whole blood trough concentrations from 31 patients less than 12 years old showed that pediatric patients needed higher doses than adults to achieve similar tacrolimus trough concentrations [see Dosage and Administration (2.3)].

Renal and Hepatic Impairment

The mean pharmacokinetic parameters for tacrolimus following single administrations to adult patients with renal and hepatic impairment are given in Table 19.

Table 19. Pharmacokinetics in Renal and Hepatic Impaired Adult Patients

*
Corrected for bioavailability
†
1 patient did not receive the PO dose

Population

(No. of Patients)

Dose

AUC0-t
(ng·hr/mL)
t1/2
(hr)
V
(L/kg)
Cl
(L/hr/kg)
Renal
Impairment
(n=12)
0.02
mg/kg/4hr
IV
393 ± 123
(t=60 hr)
26.3 ± 9.2
1.07
±0.20
0.038 ± 0.014
Mild Hepatic
Impairment
(n=6)
0.02
mg/kg/4hr
IV
367 ± 107
(t=72 hr)
60.6 ± 43.8
Range: 27.8 to 141
3.1±1.6
0.042 ± 0.02
7.7 mg

PO

488 ± 320

(t=72 hr)

66.1 ± 44.8

Range: 29.5 to 138

3.7±4.7*

0.034 ± 0.019*

Severe

Hepatic

Impairment

(n=6, IV)

0.02 mg/kg/4hr

IV (n=2)

0.01 mg/kg/8hr

IV (n=4)

762 ± 204

(t=120 hr)

289 ± 117

(t=144 hr)

198 ± 158

Range: 81 to 436

3.9±1

0.017 ± 0.013

(n=5, PO)†

8 mg PO

(n=1)

5 mg PO

(n=4)

4 mg PO

(n=1)

658

(t=120 hr)

533 ± 156 (t=144 hr)

119 ± 35

Range: 85 to 178

3.1±3.4*

0.016 ± 0.011*

Patients with Renal Impairment

Tacrolimus pharmacokinetics, following a single IV administration, were determined in 12 patients (7 not on dialysis and 5 on dialysis, serum creatinine of 3.9 ± 1.6 and 12 ± 2.4 mg/dL, respectively) prior to their kidney transplant. The pharmacokinetic parameters obtained were similar for both groups. The mean clearance of tacrolimus in patients with renal dysfunction was similar to that in normal volunteers (Table 19) [see Dosage and Administration (2.2) and Use in Specific Populations (8.6)].

Patients with Hepatic Impairment

Tacrolimus pharmacokinetics have been determined in six patients with mild hepatic dysfunction (mean Pugh score: 6.2) following oral administrations. The mean clearance of tacrolimus in patients with mild hepatic dysfunction was not substantially different from that in normal volunteers (see previous table). Tacrolimus pharmacokinetics were studied in 6 patients with severe hepatic dysfunction (mean Pugh score: >10). The mean clearance was substantially lower in patients with severe hepatic dysfunction, irrespective of the route of administration [see Dosage and Administration (2.5) and Use in Specific Populations (8.7)].

Racial or Ethnic Groups
The pharmacokinetics of tacrolimus have been studied following single IV and oral administration of tacrolimus to 10 African-American, 12 Latino-American, and 12 Caucasian healthy volunteers. There were no significant pharmacokinetic differences among the three ethnic groups following a 4-hour IV infusion of 0.015 mg/kg. However, after single oral administration of 5 mg, mean (±SD) tacrolimus Cmax in African-Americans (23.6±12.1 ng/mL) was significantly lower than in Caucasians (40.2±12.6 ng/mL) and the Latino-Americans (36.2±15.8 ng/mL) ($p<0.01$). Mean AUC0-inf tended to be lower in African-Americans (203±115 ng·hr/mL) than Caucasians (344±186 ng·hr/mL) and Latino-Americans (274±150 ng·hr/mL). The mean (±SD) absolute oral bioavailability (F) in African-Americans (12±4.5%) and Latino-Americans (14±7.4%) was significantly lower than in Caucasians (19±5.8%, $p=0.011$). There was no significant difference in mean terminal T1/2 among the three ethnic groups (range from approximately 25 to 30 hours). A retrospective comparison of African-American and Caucasian kidney transplant patients indicated that African-American patients required higher tacrolimus doses to attain similar trough concentrations [see Dosage and Administration (2.2)].

Male and Female Patients

A formal trial to evaluate the effect of gender on tacrolimus pharmacokinetics has not been conducted, however, there was no difference in dosing by gender in the kidney transplant trial. A retrospective comparison of pharmacokinetics in healthy volunteers, and in kidney, liver, and heart transplant patients indicated no gender-based differences.

Drug Interaction Studies

Frequent monitoring of whole blood concentrations and appropriate dosage

adjustments of tacrolimus are recommended when concomitant use of the following drugs with tacrolimus is initiated or discontinued [see Drug Interactions (7)].

- Telaprevir: In a single-dose study in 9 healthy volunteers, co-administration of tacrolimus (0.5 mg single dose) with telaprevir (750 mg three times daily for 13 days) increased the tacrolimus dose-normalized Cmax by 9.3-fold and AUC by 70-fold compared to tacrolimus alone [see Drug Interactions (7.2)].
- Boceprevir: In a single-dose study in 12 subjects, co-administration of tacrolimus (0.5 mg single dose) with boceprevir (800 mg three times daily for 11 days) increased tacrolimus Cmax by 9.9-fold and AUC by 17-fold compared to tacrolimus alone [seeDrug Interactions (7.2)].
- Nelfinavir: Based on a clinical study of 5 liver transplant recipients, co-administration of tacrolimus with nelfinavir increased blood concentrations of tacrolimus significantly and, as a result, a reduction in the tacrolimus dose by an average of 16-fold was needed to maintain mean trough tacrolimus blood concentrations of 9.7 ng/mL. It is recommended to avoid concomitant use of tacrolimus and nelfinavir unless the benefits outweigh the risks [see Drug Interactions (7.2)].
- Rifampin: In a study of 6 normal volunteers, a significant decrease in tacrolimus oral bioavailability (14±6% vs. 7±3%) was observed with concomitant rifampin administration (600 mg). In addition, there was a significant increase in tacrolimus clearance (0.036±0.008 L/hr/kg vs. 0.053±0.010 L/hr/kg) with concomitant rifampin administration [see Drug Interactions (7.2)].
- Magnesium and Aluminum-hydroxide: In a single-dose crossover study in healthy volunteers, co-administration of tacrolimus and magnesium-aluminum-hydroxide resulted in a 21% increase in the mean tacrolimus AUC and a 10% decrease in the mean tacrolimus Cmax relative to tacrolimus administration alone [see Drug Interactions (7.2)].
- Ketoconazole: In a study of 6 normal volunteers, a significant increase in tacrolimus oral bioavailability (14±5% vs. 30±8%) was observed with concomitant ketoconazole administration (200 mg). The apparent oral clearance of tacrolimus during ketoconazole administration was significantly decreased compared to tacrolimus alone (0.430±0.129 L/hr/kg vs. 0.148±0.043 L/hr/kg). Overall, IV clearance of tacrolimus was not significantly changed by ketoconazole co-administration, although it was highly variable between patients [see Drug Interactions (7.2)].
- Voriconazole (see complete prescribing information for VFEND): Repeat oral dose administration of voriconazole (400 mg every 12 hours for one day, then 200 mg every 12 hours for 6 days) increased tacrolimus (0.1 mg/kg single dose) Cmax and AUCτ in healthy subjects by an average of 2-fold (90% CI: 1.9, 2.5) and 3-fold (90% CI: 2.7, 3.8), respectively [see Drug Interactions (7.2)].
- Posaconazole (see complete prescribing information for Noxafil): Repeat oral administration of posaconazole (400 mg twice daily for 7 days) increased tacrolimus (0.05 mg/kg single dose) Cmax and AUC in healthy subjects by an average of 2-fold (90% CI: 2.01, 2.42) and 4.5-fold (90% CI: 4.03, 5.19), respectively [see Drug

Interactions (7.2)].

- Caspofungin (see complete prescribing information for CANCIDAS): Caspofungin reduced the blood AUC0-12 of tacrolimus by approximately 20%, peak blood concentration (Cmax) by 16%, and 12-hour blood concentration (C12hr) by 26% in healthy adult subjects when tacrolimus (2 doses of 0.1 mg/kg 12 hours apart) was administered on the 10th day of CANCIDAS 70 mg daily, as compared to results from a control period in which tacrolimus was administered alone [see Drug Interactions (7.2)]. The mechanism of interaction has not been confirmed.

Additional pediatric use information is approved for Astellas Pharma US, Inc.'s Prograf (tacrolimus) products. However, due to Astellas Pharma US, Inc.'s marketing exclusivity rights, this drug product is not labeled with that information.

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Carcinogenicity studies were conducted in male and female rats and mice. In the 80-week mouse oral study and in the 104-week rat oral study, no relationship of tumor incidence to tacrolimus dosage was found. The highest dose used in the mouse was 3 mg/kg/day (0.9 to 2.2 times the AUC at clinical doses of 0.075 to 0.2 mg/kg/day) and in the rat was 5 mg/kg/day (0.265 to 0.65 times the AUC at clinical doses of 0.075 to 0.2 mg/kg/day) [see Warnings and Precautions (5.1)].

A 104-week dermal carcinogenicity study was performed in mice with tacrolimus ointment (0.03% to 3%), equivalent to tacrolimus doses of 1.1 to 118 mg/kg/day or 3.3 to 354 mg/m2/day. In the study, the incidence of skin tumors was minimal and the topical application of tacrolimus was not associated with skin tumor formation under ambient room lighting. However, a statistically significant elevation in the incidence of pleomorphic lymphoma in high-dose male (25/50) and female animals (27/50) and in the incidence of undifferentiated lymphoma in high-dose female animals (13/50) was noted in the mouse dermal carcinogenicity study. Lymphomas were noted in the mouse dermal carcinogenicity study at a daily dose of 3.5 mg/kg (0.1% tacrolimus ointment). No drug-related tumors were noted in the mouse dermal carcinogenicity study at a daily dose of 1.1 mg/kg (0.03% tacrolimus ointment). The relevance of topical administration of tacrolimus in the setting of systemic tacrolimus use is unknown.

The implications of these carcinogenicity studies to the human condition are limited; doses of tacrolimus were administered that likely induced immunosuppression in these animals, impairing their immune system's ability to inhibit unrelated carcinogenesis.

Mutagenesis

No evidence of genotoxicity was seen in bacterial (Salmonella and E. coli) or mammalian (Chinese hamster lung-derived cells) in vitro assays of mutagenicity, the in vitro CHO/HGPRT assay of mutagenicity, or in vivo clastogenicity assays performed in mice; tacrolimus did not cause unscheduled DNA synthesis in rodent hepatocytes.

Impairment of Fertility

Tacrolimus, subcutaneously administered to male rats at paternally toxic doses of 2 mg/kg/day (1.6 to 4.3 times the recommended clinical dose range [0.2 to 0.075 mg/kg/day] on a mg/m2 basis) or 3 mg/kg/day (2.4 to 6.4 times the recommended clinical dose range), resulted in a dose-related decrease in sperm count. Tacrolimus,

administered orally at 1 mg/kg (0.8 to 2.2 times the clinical dose range) to male and female rats, prior to and during mating, as well as to dams during gestation and lactation, was associated with embryolethality and adverse effects on female reproduction. Effects on female reproductive function (parturition) and embryolethal effects were indicated by a higher rate of pre- and post-implantation loss and increased numbers of undelivered and nonviable pups. When administered at 3.2 mg/kg (2.6 to 6.9 times the clinical dose range based on body surface area), tacrolimus was associated with maternal and paternal toxicity as well as reproductive toxicity including marked adverse effects on estrus cycles, parturition, pup viability, and pup malformations.

14.1 Kidney Transplantation

Tacrolimus/Azathioprine (AZA)

Tacrolimus-based immunosuppression in conjunction with azathioprine and corticosteroids following kidney transplantation was assessed in a randomized, multicenter, non-blinded, prospective trial. There were 412 kidney transplant patients enrolled at 19 clinical sites in the United States. Study therapy was initiated when renal function was stable as indicated by a serum creatinine ≤4 mg/dL (median of 4 days after transplantation, range 1 to 14 days). Patients less than 6 years of age were excluded.

There were 205 patients randomized to tacrolimus-based immunosuppression and 207 patients were randomized to cyclosporine-based immunosuppression. All patients received prophylactic induction therapy consisting of an antilymphocyte antibody preparation, corticosteroids, and azathioprine. Overall, 1-year patient and graft survivals were 96.1% and 89.6%, respectively.

Data from this trial of tacrolimus in conjunction with azathioprine indicate that during the first 3 months of that trial, 80% of the patients maintained trough concentrations between 7 to 20 ng/mL, and then between 5 to 15 ng/mL, through 1 year.

Tacrolimus/Mycophenolate Mofetil (MMF)

Tacrolimus-based immunosuppression in conjunction with MMF, corticosteroids, and induction has been studied. In a randomized, open-label, multicenter trial (Study 1), 1,589 kidney transplant patients received tacrolimus (Group C, n=401), sirolimus (Group D, n=399), or one of two cyclosporine (CsA) regimens (Group A, n=390 and Group B, n=399) in combination with MMF and corticosteroids; all patients, except those in one of the two cyclosporine groups, also received induction with daclizumab. The trial was conducted outside the United States; the trial population was 93% Caucasian. In this trial, mortality at 12 months in patients receiving tacrolimus/MMF was similar (3%) compared to patients receiving cyclosporine/MMF (3% and 2%) or sirolimus/MMF (3%). Patients in the tacrolimus group exhibited higher estimated creatinine clearance rates (eCLcr) using the Cockcroft-Gault formula (Table 20) and experienced fewer efficacy failures, defined as biopsy-proven acute rejection (BPAR), graft loss, death, and/or loss to follow-up (Table 21) in comparison to each of the other three groups. Patients randomized to tacrolimus/MMF were more likely to develop diarrhea and diabetes after the transplantation and experienced similar rates of infections compared to patients randomized to either cyclosporine/MMF regimen [see Adverse Reactions (6.1)].

Table 20. Estimated Creatinine Clearance at 12 Months (Study 1)

*

All death/graft loss (n=41, 27, 23, and 42 in Groups A, B, C, and D) and patients whose last recorded creatinine values were prior to month 3 visit (n=10, 9, 7, and 9 in Groups A, B, C, and D, respectively) were imputed with Glomerular Filtration Rate (GFR) of 10 mL/min; a subject's last observed creatinine value from month 3 on was used for the remainder of subjects with missing creatinine at month 12 (n=11, 12, 15, and 19 for Groups A, B, C, and D, respectively). Weight was also imputed in the calculation of estimated GFR, if missing.
†
Adjusted for multiple (6) pairwise comparisons using Bonferroni corrections.

Group

eCLcr [mL/min] at Month 12*

N

MEAN

SD

MEDIAN

Treatment Difference with Group C (99.2% CI†)

(A) CsA/MMF/CS

390

56.5

25.8

56.9

-8.6 (-13.7, -3.7)

(B) CsA/MMF/CS/Daclizumab

399

58.9

25.6

60.9

-6.2 (-11.2, -1.2)

(C) Tac/MMF/CS/Daclizumab

401

65.1

27.4

66.2

-

(D) Siro/MMF/CS/Daclizumab

399

56.2

27.4

57.3

-8.9 (-14.1, -3.9)

Total

1589

59.2

26.8

60.5

Key: CsA=Cyclosporine, CS=Corticosteroids, Tac=Tacrolimus, Siro=Sirolimus

Table 21. Incidence of BPAR, Graft Loss, Death, or Loss to Follow-up at 12 Months (Study 1)

*
Adjusted for multiple (6) pairwise comparisons using Bonferroni corrections.

Group A

N=390

Group B

N=399

Group C

N=401

Group D

N=399

Overall Failure

141 (36.2%)

126 (31.6%)

82 (20.4%)

185 (46.4%)

Components of efficacy failure

BPAR

113 (29%)

106 (26.6%)

60 (15%)

152 (38.1%)

Graft loss excluding death

28 (7.2%)

20 (5%)

12 (3%)

30 (7.5%)

Mortality

13 (3.3%)

7 (1.8%)

11 (2.7%)

12 (3%)

Lost to follow-up

5 (1.3%)

7 (1.8%)

5 (1.3%)

6 (1.5%)

Treatment Difference of efficacy failure compared to Group C (99.2% CI*)

15.8%

(7.1%, 24.3%)

11.2%

(2.7%, 19.5%)

-

26%

(17.2%, 34.7%)

Key: Group A=CsA/MMF/CS, B=CsA/MMF/CS/Daclizumab, C=Tac/MMF/CS/Daclizumab, and D=Siro/MMF/CS/Daclizumab

The protocol-specified target tacrolimus trough concentrations (Ctrough,Tac) were 3 to 7 ng/mL; however, the observed median Ctroughs,Tac approximated 7 ng/mL throughout the 12-month trial (Table 22). Approximately 80% of patients maintained tacrolimus whole blood concentrations between 4 to 11 ng/mL through 1 year post-transplant.

Table 22. Tacrolimus Whole Blood Trough Concentration Range (Study 1)

*
10 to 90th Percentile: range of Ctrough,Tac that excludes lowest 10% and highest 10%

of Ctrough, Tac

Time

Median (P10-P90*) tacrolimus whole blood trough concentration range

(ng/mL)

Day 30 (N=366)

6.9 (4.4 to 11.3)

Day 90 (N=351)

6.8 (4.1 to 10.7)

Day 180 (N=355)

6.5 (4 to 9.6)

Day 365 (N=346)

6.5 (3.8 to 10)

The protocol-specified target cyclosporine trough concentrations (Ctrough,CsA) for Group B were 50 to 100 ng/mL; however, the observed median Ctroughs,CsA approximated 100 ng/mL throughout the 12-month trial. The protocol-specified target Ctroughs,CsA for Group A were 150 to 300 ng/mL for the first 3 months and 100 to 200 ng/mL from month 4 to month 12; the observed median Ctroughs, CsA approximated 225 ng/mL for the first 3 months and 140 ng/mL from month 4 to month 12.

While patients in all groups started MMF at 1 gram twice daily, the MMF dose was reduced to less than 2 g per day in 63% of patients in the tacrolimus treatment arm by month 12 (Table 23); approximately 50% of these MMF dose reductions were due to adverse reactions. By comparison, the MMF dose was reduced to less than 2 g per day in 49% and 45% of patients in the two cyclosporine arms (Group A and Group B, respectively), by month 12 and approximately 40% of MMF dose reductions were due to adverse reactions.

Table 23. MMF Dose Over Time in Tacrolimus/MMF (Group C) (Study 1)

*
Percentage of patients for each time-averaged MMF dose range during various treatment periods. Administration of 2 g per day of time-averaged MMF dose means that MMF dose was not reduced in those patients during the treatment periods.

Time period (Days)

Time-averaged MMF dose (grams per day)*

Less than 2

2

Greater than 2

0 to 30 (N=364)

37%

60%

2%

0 to 90 (N=373)

47%

51%

2%

0 to 180 (N=377)

56%

42%

2%

0 to 365 (N=380)

63%

36%

1%

Key: Time-averaged MMF dose = (total MMF dose)/(duration of treatment)

In a second randomized, open-label, multicenter trial (Study 2), 424 kidney transplant patients received tacrolimus (N=212) or cyclosporine (N=212) in combination with MMF 1 gram twice daily, basiliximab induction, and corticosteroids. In this trial, the rate for the combined endpoint of BPAR, graft failure, death, and/or lost to follow-up at 12 months in the tacrolimus/MMF group was similar to the rate in the cyclosporine/MMF group. There was, however, an imbalance in mortality at 12 months in those patients receiving tacrolimus/MMF (4%) compared to those receiving cyclosporine/MMF (2%), including cases attributed to over-immunosuppression (Table 24).

Table 24. Incidence of BPAR, Graft Loss, Death, or Loss to Follow-up at 12 Months (Study 2)

*
95% confidence interval calculated using Fisher's Exact Test

Tacrolimus/MMF

Cyclosporine/MMF

(N=212)

(N=212)

Overall Failure

32 (15.1%)

36 (17%)

Components of efficacy failure

BPAR

16 (7.5%)

29 (13.7%)

Graft loss excluding death

6 (2.8%)

4 (1.9%)

Mortality

9 (4.2%)

5 (2.4%)

Lost to follow-up

4 (1.9%)

1 (0.5%)

Treatment Difference of efficacy failure compared to tacrolimus/MMF group (95% CI*)

1.9% (-5.2%, 9%)

The protocol-specified target tacrolimus whole blood trough concentrations (Ctrough,Tac) in Study 2 were 7 to 16 ng/mL for the first three months and 5 to 15 ng/mL thereafter. The observed median Ctroughs,Tac approximated 10 ng/mL during the first three months and 8 ng/mL from month 4 to month 12 (Table 25). Approximately 80% of patients maintained tacrolimus whole blood trough concentrations between 6 to 16 ng/mL during months 1 through 3 and, then, between 5 to 12 ng/mL from month 4 through 1 year.

Table 25. Tacrolimus Whole Blood Trough Concentration Range (Study 2)

*
10 to 90th Percentile: range of Ctrough, Tac that excludes lowest 10% and highest 10% of Ctrough, Tac.

Time

Median (P10-P90*) tacrolimus whole blood trough concentration range

(ng/mL)

Day 30 (N=174)

10.5 (6.3 to 16.8)

Day 60 (N=179)

9.2 (5.9 to 15.3)

Day 120 (N=176)

8.3 (4.6 to 13.3)

Day 180 (N=171)

7.8 (5.5 to 13.2)

Day 365 (N=178)

1.2
(4.2 to 12.4)

The protocol-specified target cyclosporine whole blood concentrations (Ctrough,CsA) were 125 to 400 ng/mL for the first three months, and 100 to 300 ng/mL thereafter. The observed median Ctroughs, CsA approximated 280 ng/mL during the first three months and 190 ng/mL from month 4 to month 12.

Patients in both groups started MMF at 1 gram twice daily. The MMF dose was reduced to less than 2 grams per day by month 12 in 62% of patients in the tacrolimus/MMF group (Table 26) and in 47% of patients in the cyclosporine/MMF group. Approximately 63% and 55% of these MMF dose reductions were because of adverse reactions in the tacrolimus/MMF group and the cyclosporine/MMF group, respectively [see Adverse Reactions (6.1)].

Table 26. MMF Dose Over Time in the Tacrolimus /MMF Group (Study 2)

*
Percentage of patients for each time-averaged MMF dose range during various treatment periods. Two grams per day of time-averaged MMF dose means that the MMF dose was not reduced in those patients during the treatment periods.

Time period (Days)

Time-averaged MMF dose (g/day)*

Less than 2

2

Greater than 2

0 to 30 (N=212)

25%

69%

6%

0 to 90 (N=212)

41%

53%

6%

0 to 180 (N=212)

52%

41%

7%

0 to 365 (N=212)

62%

34%

4%

Key: Time-averaged MMF dose=(total MMF dose)/(duration of treatment)

14.2 Liver Transplantation

The safety and efficacy of tacrolimus-based immunosuppression following orthotopic liver transplantation were assessed in two prospective, randomized, non-blinded multicenter trials. The active control groups were treated with a cyclosporine-based immunosuppressive regimen (CsA/AZA). Both trials used concomitant adrenal corticosteroids as part of the immunosuppressive regimens. These trials compared patient and graft survival rates at 12 months following transplantation.

In one trial, 529 patients were enrolled at 12 clinical sites in the United States; prior to surgery, 263 were randomized to the tacrolimus-based immunosuppressive regimen and 266 to the CsA/AZA. In 10 of the 12 sites, the same CsA/AZA protocol was used, while 2 sites used different control protocols. This trial excluded patients with renal dysfunction, fulminant hepatic failure with Stage IV encephalopathy, and cancers; pediatric patients (≤12 years old) were allowed.

In the second trial, 545 patients were enrolled at 8 clinical sites in Europe; prior to surgery, 270 were randomized to the tacrolimus-based immunosuppressive regimen and 275 to CsA/AZA. In this trial, each center used its local standard CsA/AZA protocol in the active-control arm. This trial excluded pediatric patients, but did allow enrollment of subjects with renal dysfunction, fulminant hepatic failure in Stage IV encephalopathy, and cancers other than primary hepatic with metastases.

One-year patient survival and graft survival in the tacrolimus-based treatment groups were similar to those in the CsA/AZA treatment groups in both trials. The overall 1-year patient survival (CsA/AZA and tacrolimus-based treatment groups combined) was 88% in the U.S. trial and 78% in the European trial. The overall 1-year graft survival (CsA/AZA and tacrolimus-based treatment groups combined) was 81% in the U.S. trial and 73% in the European trial. In both trials, the median time to convert from IV to oral tacrolimus dosing was 2 days.

Although there is a lack of direct correlation between tacrolimus concentrations and drug efficacy, data from clinical trials of liver transplant patients have shown an increasing incidence of adverse reactions with increasing trough blood concentrations. Most patients are stable when trough whole blood concentrations are maintained between 5 to 20 ng/mL. Long-term post-transplant patients are often maintained at the low end of this target range.

Data from the U.S. clinical trial show that the median trough blood concentrations, measured at intervals from the second week to one year post-transplantation, ranged from 9.8 ng/mL to 19.4 ng/mL.

Additional pediatric use information is approved for Astellas Pharma US, Inc.’s Prograf

(tacrolimus) products. However, due to Astellas Pharma US, Inc.’s marketing exclusivity rights, this drug product is not labeled with that information.

14.3 Heart Transplantation

Two open-label, randomized, comparative trials evaluated the safety and efficacy of tacrolimus-based and cyclosporine-based immunosuppression in primary orthotopic heart transplantation. In a trial conducted in Europe, 314 patients received a regimen of antibody induction, corticosteroids, and azathioprine in combination with tacrolimus or cyclosporine modified for 18 months. In a 3-arm trial conducted in the U.S., 331 patients received corticosteroids and tacrolimus plus sirolimus, tacrolimus plus mycophenolate mofetil (MMF) or cyclosporine modified plus MMF for 1 year.

In the European trial, patient/graft survival at 18 months post-transplant was similar between treatment arms, 92% in the tacrolimus group and 90% in the cyclosporine group. In the U.S. trial, patient and graft survival at 12 months was similar with 93% survival in the tacrolimus plus MMF group and 86% survival in the cyclosporine modified plus MMF group. In the European trial, the cyclosporine trough concentrations were above the pre-defined target range (i.e., 100 to 200 ng/mL) at Day 122 and beyond in 32% to 68% of the patients in the cyclosporine treatment arm, whereas the tacrolimus trough concentrations were within the pre-defined target range (i.e., 5 to 15 ng/mL) in 74% to 86% of the patients in the tacrolimus treatment arm. Data from this European trial indicate that from 1 week to 3 months post-transplant, approximately 80% of patients maintained trough concentrations between 8 to 20 ng/mL and, from 3 months through 18 months post-transplant, approximately 80% of patients maintained trough concentrations between 6 to 18 ng/mL.

The U.S. trial contained a third arm of a combination regimen of sirolimus, 2 mg per day, and full-dose tacrolimus; however, this regimen was associated with increased risk of wound-healing complications, renal function impairment, and insulin-dependent post-transplant diabetes mellitus, and is not recommended [see Warnings and Precautions (5.10)].

16.1 Tacrolimus Capsules, USP

Tacrolimus capsules, USP containing white to off-white powder equivalent to 0.5 mg of anhydrous tacrolimus, are hard gelatin capsules with white opaque body and ivory cap. The body is imprinted ‘643’ and cap is imprinted ‘ ['S'] ’ in black ink.

They are supplied as follows:

NDC 72189-0536-30, bottle of 100 capsules with child-resistant closure

Tacrolimus capsules, USP containing white to off-white powder equivalent to 1 mg of anhydrous tacrolimus, are hard gelatin capsules with white opaque body and brown cap. The body is imprinted ‘644’ and cap is imprinted ‘ ['S'] ’ in black ink.

They are supplied as follows:

NDC 72189-0536-30, bottle of 30 capsules with child-resistant closure

Tacrolimus capsules, USP containing white to off-white powder equivalent to 5 mg of anhydrous tacrolimus, are hard gelatin capsules with white opaque body and orange cap. The body is imprinted ‘645’ and cap is imprinted ‘ ['S'] ’ in black ink.

They are supplied as follows:

NDC 0781-2104-01, bottle of 100 capsules with child-resistant closure

1. “OSHA Hazardous Drugs.” OSHA.
http://www.osha.gov/SLTC/hazardousdrugs/index.html

Store and Dispense

Tacrolimus capsules, USP should be stored at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature].

16.4 Handling and Disposal

Tacrolimus can cause fetal harm. Tacrolimus capsules should not be opened or crushed. Avoid inhalation or direct contact with skin or mucous membranes of the powder contained in tacrolimus capsules. If such contact occurs, wash the skin thoroughly with soap and water; if ocular contact occurs, rinse eyes with water. In case a spill occurs, wipe the surface with a wet paper towel. Follow applicable special handling and disposal procedures1.

Advise the patient to read the FDA-approved patient labeling (Patient Information).

17.1 Administration

Advise the patient or caregiver to:

- Inspect their tacrolimus medicine when they receive a new prescription and before taking it. If the appearance of the capsule is not the same as usual, or if dosage instructions have changed, advise patients to contact their healthcare provider as soon as possible to make sure that they have the right medicine. Other tacrolimus products cannot be substituted for tacrolimus capsules.
- Take tacrolimus capsules at the same 12-hour intervals every day to achieve consistent blood concentrations.
- Take tacrolimus capsules consistently either with or without food because the presence and composition of food decreases the bioavailability of tacrolimus capsules.
- Not to eat grapefruit or drink grapefruit juice in combination with tacrolimus capsules [see Drug Interactions (7.2)].

17.2 Development of Lymphoma and Other Malignancies

Inform patients they are at increased risk of developing lymphomas and other malignancies, particularly of the skin, due to immunosuppression. Advise patients to limit exposure to sunlight and ultraviolet (UV) light by wearing protective clothing and using a broad spectrum sunscreen with a high protection factor [see Warnings and Precautions (5.1)].

17.3 Increased Risk of Infection

Inform patients they are at increased risk of developing a variety of infections, including opportunistic infections, due to immunosuppression and to contact their physician if they develop any symptoms of infection such as fever, sweats or chills, cough or flu-like symptoms, muscle aches, or warm, red, painful areas on the skin [see Warnings and Precautions (5.2)].

17.4 New Onset Diabetes After Transplant

Inform patients that tacrolimus capsules can cause diabetes mellitus and should be advised to contact their physician if they develop frequent urination, increased thirst, or hunger [see Warnings and Precautions (5.4)].

17.5 Nephrotoxicity

Inform patients that tacrolimus can have toxic effects on the kidney that should be monitored. Advise patients to attend all visits and complete all blood tests ordered by their medical team [see Warnings and Precautions (5.5)].

17.6 Neurotoxicity

Inform patients that they are at risk of developing adverse neurologic reactions including seizure, altered mental status, and tremor. Advise patients to contact their physician should they develop vision changes, delirium, or tremors [see Warnings and Precautions (5.6)].

17.7 Hyperkalemia

Inform patients that tacrolimus can cause hyperkalemia. Monitoring of potassium levels may be necessary, especially with concomitant use of other drugs known to cause hyperkalemia [see Warnings and Precautions (5.7)].

17.8 Hypertension

Inform patients that tacrolimus capsules can cause high blood pressure which may require treatment with anti-hypertensive therapy. Advise patients to monitor their blood pressure [see Warnings and Precautions (5.8)].

17.9 Thrombotic Microangiopathy

Inform patients that tacrolimus can cause blood clotting problems. The risk of this occurring increases when patients take tacrolimus and sirolimus or everolimus concomitantly, or when patients develop certain infections. Advise them to seek medical attention promptly if they develop fever, petequiae or bruises, fatigue, confusion, jaundice, oliguria. [see Warnings and Precautions (5.16)]

17.10 Drug Interactions

Instruct patients to tell their healthcare providers when they start or stop taking any medicines, including prescription medicines and nonprescription medicines, natural or herbal remedies, nutritional supplements, and vitamins. Advise patients to avoid grapefruit and grapefruit juice [see Drug Interactions (7)].

17.11 Pregnancy, Lactation and Infertility

Inform women of childbearing potential that tacrolimus can harm the fetus. Instruct male and female patients to discuss with their healthcare provider family planning options including appropriate contraception. Also, discuss with pregnant patients the risks and benefits of breastfeeding their infant [see Use in Specific Populations (8.1, 8.2, 8.3)].

Encourage female transplant patients who become pregnant and male patients who have fathered a pregnancy, exposed to immunosuppressants including tacrolimus, to enroll in the voluntary Transplantation Pregnancy Registry International. To enroll or register, patients can call the toll free number 1-877-955-6877 or

HTTPS://WWW.TRANSPLANTPREGNANCYREGISTRY.ORG/[see Use in Specific Populations (8.1)].

Based on animal studies, tacrolimus may affect fertility in males and females [see Nonclinical Toxicology (13.1)].

17.12 Myocardial Hypertrophy

Inform patients to report symptoms of tiredness, swelling, and/or shortness of breath (heart failure).

17.13 Immunizations

Inform patients that tacrolimus capsules can interfere with the usual response to immunizations and that they should avoid live vaccines [see Warnings and Precautions (5.14)].

Manufactured in India by Sandoz Private Limited for

Sandoz Inc., Princeton, NJ 08540

TACROLIMUS

tacrolimus capsule

Product Information			
Product Type	HUMAN PRESCRIPTION DRUG	**Item Code (Source)**	NDC:72189-536(NDC:0781-2103)
Route of Administration	ORAL		

Active Ingredient/Active Moiety		
Ingredient Name	**Basis of Strength**	**Strength**
TACROLIMUS (UNII: WM0HAQ4WNM) (TACROLIMUS ANHYDROUS - UNII:Y5L2157C4J)	TACROLIMUS ANHYDROUS	1 mg

Inactive Ingredients

Ingredient Name	Strength
FERROSOFERRIC OXIDE (UNII: XM0M87F357)	
POTASSIUM HYDROXIDE (UNII: WZH3C48M4T)	
SHELLAC (UNII: 46N107B71O)	
HYPROMELLOSE 2208 (100 MPA.S) (UNII: B1QE5P712K)	
AMMONIA (UNII: 5138Q19F1X)	
BUTYL ALCOHOL (UNII: 8PJ61P6TS3)	
LACTOSE MONOHYDRATE (UNII: EWQ57Q8I5X)	
PROPYLENE GLYCOL (UNII: 6DC9Q167V3)	
FERRIC OXIDE RED (UNII: 1K09F3G675)	
FERRIC OXIDE YELLOW (UNII: EX438O2MRT)	
CROSCARMELLOSE SODIUM (UNII: M28OL1HH48)	
TITANIUM DIOXIDE (UNII: 15FIX9V2JP)	
GELATIN, UNSPECIFIED (UNII: 2G86QN327L)	
MAGNESIUM STEARATE (UNII: 70097M6I30)	

Product Characteristics

Color	white (white opaque body and brown cap)	**Score**	no score
Shape	CAPSULE	**Size**	14mm
Flavor		**Imprint Code**	644;S
Contains			

Packaging

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:72189-536-30	30 in 1 BOTTLE; Type 0: Not a Combination Product	02/07/2024	

Marketing Information

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA065461	02/07/2024	

Labeler - Direct_Rx (079254320)

Registrant - Direct_Rx (079254320)

Establishment

Name	Address	ID/FEI	Business Operations
Direct_Rx		079254320	repack(72189-536)