

**DR. REDDY'S LABORATORIES (PTY) LTD  
APPROVED PROFESSIONAL INFORMATION:  
AZACITIDINE DRL  
(lyophilised powder for injection)**

## **SCHEDULING STATUS**

**S4**

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

AZACITIDINE DRL lyophilised powder for injection.

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

Each vial contains 100 mg azacitidine.

The reconstituted suspension contains 25 mg/ml azacitidine.

Excipient with known effect:

100 mg mannitol per vial

For the full list of excipients, see Section 6.1.

### **3. PHARMACEUTICAL FORM**

White to off - white lyophilised powder for injection.

### **4. CLINICAL PARTICULARS**

#### **4.1 Therapeutic indications**

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AZACITIDINE DRL is indicated for the treatment of adult patients with myelodysplastic syndromes (MDS) including the following subtypes of the French-American-British classification:

- Refractory anaemia (RA) according to the French-American-British classification (FAB) system, plus neutropenia or thrombocytopenia or requiring transfusions;
- Refractory anaemia with ringed sideroblasts (RARS) according to the FAB system, plus neutropenia or thrombocytopenia or requiring transfusions;
- Refractory anaemia with excess blasts (RAEB) according to the FAB system;
- Refractory anaemia with excess blasts in transformation (RAEB-T) according to the FAB system (or acute myeloid leukaemia with 20 to 30 % bone marrow blasts and multilineage dysplasia according to World Health Organisation (WHO) classification).
- AZACITIDINE DRL is also indicated for treating adult patients with chronic myelomonocytic leukaemia (CMML) according to the FAB system.
- Acute myeloid leukaemia (AML) with > 30 % bone marrow blasts according to the WHO classification, in patients who are not eligible for hematopoietic stem cell transplantation (HSCT).

#### **4.2 Posology and Method of Administration**

##### Posology

The recommended starting dose for the first treatment cycle, for all patients regardless of baseline haematology laboratory values, is 75 mg/m<sup>2</sup> subcutaneously or intravenously, daily for seven (7) days, followed by a rest period of 21 days (28-day treatment cycle). It is recommended that patients be treated for a minimum of 6 cycles. Treatment should be continued as long as the patient continues to benefit or until disease progression.

Patients should be monitored for haematologic response/toxicity and renal toxicities (see Section 4.8), a delay in starting the next cycle or a dose reduction as described below may be necessary.

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*Dosage Adjustment due to haematological toxicity:*

Patients with baseline blood counts (i.e., White Blood Cells (WBC) > 3,0 x 10<sup>9</sup>/l and absolute neutrophil count (ANC) > 1,5 x10<sup>9</sup>/l, and platelets > 75,0 x 10<sup>9</sup>/l).

If haematological toxicity is observed following AZACITIDINE DRL treatment, the next cycle of AZACITIDINE DRL therapy should be delayed until the platelet count and the ANC have recovered.

If recovery is achieved within 14 days, no dose adjustment is necessary. However, if recovery has not been achieved within 14 days, the dose should be reduced according to the following table.

Following dose modifications, the cycle duration should return to 28 days.

<b>Nadir Counts</b>		<b>% Dose in the next cycle, if recovery* is not achieved within 14 days</b>
ANC (10 <sup>9</sup> /L)	Platelets (10 <sup>9</sup> /L)	
< 1,0	< 50,0	50 %
> 1,0	> 50,0	100 %

\*Recovery= counts≥ Nadir count + (0,5 x [ baseline count- Nadir count])

*Patients baseline blood counts (i.e., WBC < 3,0 x 10<sup>9</sup>/l or ANC < 1,5 x 10<sup>9</sup>/l or platelets < 75,0 x10<sup>9</sup>/l):*

Following AZACITIDINE DRL treatment, if the decrease in WBC or ANC or platelets from baseline is less than 50 %, or greater than 50 % but with an improvement in any cell line differentiation, the next cycle should not be delayed and no dose adjustment be made.

If the decrease in WBC or ANC or platelets is greater than 50 % from that prior to treatment, with no improvement in cell line differentiation, the next cycle of AZACITIDINE DRL therapy should be delayed until the platelet count and the ANC have recovered.

If recovery is achieved within 14 days, no dose adjustment is necessary. However, if recovery has not been achieved within 14 days, bone marrow cellularity should be determined. If the bone marrow cellularity is > 50 %, no dose adjustments should be made.

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If bone marrow cellularity is  $\leq 50\%$ , treatment should be delayed, and the dose reduced according to the following table:

Bone Marrow Biopsy Cellularity	% Dose in the next cycle, if recovery is not achieved within 14 days	
	Recovery * $\leq 21$ days	Recovery * $> 21$ days
15 to 50 %	100 %	50 %
< 15 %	100 %	33 %

\*Recovery= counts  $\geq$  Nadir count + (0,5 x [ baseline count- Nadir count])

Following dose modifications, the cycle duration should return to 28 days.

**Special Populations:**

*Patients with Renal Impairment:*

AZACITIDINE DRL can be administered to patients with renal impairment without initial dose adjustment. If unexplained reductions in serum bicarbonate levels to less than 20 mmol/l occur, the dose should be reduced by 50 % on the next cycle. If unexplained elevations in serum creatinine or blood urea occur, the next cycle should be delayed until values return to normal or baseline and the dose should be reduced by 50 % on the next treatment cycle (see Section 4.4).

*Patients with Hepatic Impairment:*

No formal studies have been conducted in patients with hepatic impairment (see Section 4.4).

AZACITIDINE DRL is contraindicated in patients with malignant hepatic tumours (see Sections 4.3 and 4.4).

*Elderly:*

No specific dose adjustments are recommended for the elderly. Because elderly patients are more likely to have decreased renal function, it may be useful to monitor renal function.

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*Paediatric population:*

AZACITIDINE DRL is not recommended for use in children below 18 years of age, due to insufficient data on safety and efficacy.

*Laboratory tests*

Liver function tests and serum creatinine should be determined prior to initiation of therapy.

Complete blood counts should be performed prior to initiation of therapy and as needed to monitor response and toxicity, but at a minimum, prior to each treatment cycle.

**Method of Administration:**

AZACITIDINE DRL should be administered under the supervision of a medical practitioner qualified in the use of anticancer agents.

Patients should be premedicated with anti-emetics for nausea and vomiting.

*Subcutaneous administration*

- Reconstituted AZACITIDINE DRL should be injected subcutaneously into the upper arm, thigh or abdomen.
- Rotate sites for injection.
- New injections should be given at least 2,5 cm from an old site and never into areas where the site is tender, bruised, red or hard.

*Intravenous administration*

- AZACITIDINE DRL solution is administered intravenously.
- Administer the total dose over a period of 10 to 40 minutes.
- The administration must be completed within 1 hour of reconstitution of the AZACITIDINE DRL vial.

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For instructions on reconstitution of the medicine, see Section 6.6.

### **4.3 Contraindications**

AZACITIDINE DRL is contraindicated in the following:

- Patients who have a known hypersensitivity to azacitidine or to any of its excipients (see Section 6.1).
- Patients with advanced malignant hepatic tumours (see Section 4.4).
- Patients must not receive live vaccines while being treated with AZACITIDINE DRL.
- Pregnancy and breastfeeding (see Section 4.6).
- AZACITIDINE DRL is not recommended for use in children and adolescents below the age of 18.

### **4.4 Special warnings and precautions for use**

#### *Haematological toxicity*

Treatment with AZACITIDINE DRL is associated with anaemia, neutropenia and thrombocytopenia, particularly during the first 2 cycles (see Section 4.8).

At least prior to each treatment cycle, complete blood counts should be performed as needed to monitor response and toxicity. After administration of the recommended dose for the first cycle, the dose for subsequent cycles should be reduced or its administration delayed based on nadir counts and haematological response (see Section 4.2). Patients should be advised to promptly report febrile episodes. Patients and physicians should be advised to be observant for signs and symptoms of bleeding.

#### *Hepatic impairment*

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No formal studies have been conducted in patients with hepatic impairment. Patients suffering with extensive tumour burden due to metastatic disease and especially such patients with baseline serum albumin < 30 g/l have experienced progressive hepatic coma and death during AZACITIDINE DRL treatment. AZACITIDINE DRL is contraindicated in patients with advanced malignant hepatic tumours (see Section 4.3).

*Renal impairment*

Renal abnormalities ranging from elevated serum creatinine to renal failure and death were reported in patients treated with intravenous (IV) AZACITIDINE DRL in combination with other chemotherapeutic agents for non-MDS conditions. In addition, renal tubular acidosis, (defined as a fall in serum bicarbonate to < 20 mmol/l in association with an alkaline urine and hypokalaemia (serum potassium < 3 mmol/l) developed in [5]-subject with chronic myelogenous leukaemia (CML) who were treated with azacitidine and etoposide. If unexplained reductions in serum bicarbonate (< 20 mmol/l) or elevations of serum creatinine or BUN (blood urea nitrogen) occur, the dose should be reduced or administration delayed.

Patients should be advised to report oliguria and anuria to their healthcare professional immediately.

Patients with renal impairment should be closely monitored for toxicity since azacitidine and/or its metabolites are primarily excreted by the kidney (see Section 4.2).

*Laboratory tests*

Liver function tests, serum creatinine and serum bicarbonate should be determined prior to initiation of therapy and prior to each treatment cycle. Complete blood counts should be performed prior to initiation of therapy and as needed to monitor response and toxicity, but at a minimum, prior to each treatment cycle (see Sections 4.2 and 4,8).

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*Cardiac and pulmonary disease*

Safety and efficacy of AZACITIDINE DRL has not been established in patients with a history of severe congestive heart failure, clinically unstable cardiac disease or pulmonary disease. It is therefore advised to exercise caution when prescribing AZACITIDINE DRL to these patients. A cardiopulmonary assessment before and during the treatment should be considered.

*Necrotising fasciitis*

Necrotising fasciitis, including fatal cases, have been reported in patients treated with azacitidine. Treatment with AZACITIDINE DRL should be discontinued in patients who develop necrotising fasciitis and appropriate treatment should be promptly initiated.

*Tumour lysis syndrome*

The patients at risk of tumour lysis syndrome are those with high tumour burden prior to treatment. These patients should be monitored closely and appropriate precautions taken.

*Differentiation syndrome*

Cases of differentiation syndrome (also known as retinoic acid syndrome) have been reported in patients receiving injectable azacitidine as contained in AZACITIDINE DRL. Differentiation syndrome may be fatal and symptoms and clinical findings include respiratory distress, pulmonary infiltrates, fever, rash, pulmonary oedema, peripheral oedema, rapid weight gain, pleural effusions, pericardial effusions, hypotension and renal dysfunction (see Section 4.8).

Treatment with high-dose IV corticosteroids and haemodynamic monitoring should be considered at first onset of symptoms or signs suggestive of differentiation syndrome.

Temporary discontinuation of injectable azacitidine should be considered until resolution of symptoms and if resumed, caution is advised.

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AZACITIDINE DRL contains mannitol and may have a laxative effect.

#### **4.5 Interaction with other medicines and other forms of interaction**

No formal clinical drug interaction studies have been conducted with AZACITIDINE DRL. Based on *in vitro* data, azacitidine metabolism does not appear to be mediated by cytochrome P450 isoenzymes (CYPs), UDP- glucuronosyltransferases (UGTs), sulfotransferases (SULTs), and glutathione transferases (GSTs). Therefore, interactions related to these metabolising enzymes, *in vivo*, are considered unlikely.

Clinically significant inhibitory or inductive effects of azacitidine on cytochrome P450 enzymes are unlikely (see Section 5.2).

#### **4.6 Fertility, pregnancy and lactation**

##### *Women of childbearing potential / Contraception in males and females*

Women of childbearing potential should be advised to avoid falling pregnant while taking AZACITIDINE DRL.

Women of childbearing potential must use highly effective contraception during and for at least 6 months after treatment.

Men should be advised not to father a child while receiving treatment and must use effective contraception during and for at least 3 months after treatment.

##### *Pregnancy*

AZACITIDINE DRL may cause foetal harm when administered to a pregnant woman.

Azacitidine was teratogenic in animals. If this medicine is used during pregnancy or if a patient becomes pregnant while taking AZACITIDINE DRL, the patient should be apprised of the potential hazard to the foetus.

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Female partners of male patients receiving AZACITIDINE DRL should not become pregnant.

#### *Lactation*

Due to the potential serious adverse reactions in the nursing child, breast-feeding is contraindicated during AZACITIDINE DRL therapy.

#### *Fertility*

There are no human data on the effect of azacitidine on fertility. In animals, adverse reactions with azacitidine use on male fertility have been documented. Before starting treatment, male patients should be advised to seek counselling on sperm storage.

#### **4.7 Effects on ability to drive and use machines**

AZACITIDINE DRL may have minor or moderate effect on mental and/or physical abilities to perform or execute tasks or activities requiring mental alertness, judgment and/or sound coordination and vision.

Patients who experience dizziness should not drive or use machines when taking AZACITIDINE DRL.

#### **4.8 Undesirable effects**

##### **Summary of the safety profile**

The most frequently reported adverse reactions were gastrointestinal (nausea, vomiting and diarrhoea), haematological (anaemia, thrombocytopenia, leukopenia/neutropenia), and injection site reactions.

Adverse reactions associated with intravenously administered azacitidine were similar in frequency and severity compared with subcutaneously administered azacitidine.

#### **Table 1: Tabulated summary of adverse reactions**

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<b>System Organ Class</b>	<b>Frequent</b>	<b>Less frequent</b>	<b>Frequency not known</b>
<b>Infections and infestations</b>	pneumonia* (including bacterial, viral and fungal), nasopharyngitis, sepsis* (including bacterial, viral and fungal), neutropenic sepsis*, respiratory tract infection (includes upper and bronchitis), urinary tract infection, cellulitis, diverticulitis, oral fungal infection, sinusitis, pharyngitis, rhinitis, herpes simplex, skin infection		necrotising fasciitis *
<b>Neoplasms benign, malignant and unspecified (including cysts and polyps)</b>			differentiation syndrome (see <i>Section 4.4</i> )
<b>Blood and lymphatic system disorders</b>	febrile neutropenia*, neutropenia, leukopenia, thrombocytopenia, anaemia, pancytopenia*, bone marrow failure		
<b>Immune system disorders</b>		hypersensitivity reactions	

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<b>Metabolism and nutrition disorders</b>	anorexia, decreased appetite, hypokalemia, dehydration	tumour lysis syndrome		
<b>Psychiatric disorders</b>	Insomnia, confusional state, anxiety			
<b>Nervous system disorders</b>	dizziness, headache, intracranial haemorrhage*, syncope, somnolence, lethargy			
<b>Eye disorders</b>	eye haemorrhage, conjunctival haemorrhage			
<b>Cardiac disorders</b>	pericardial effusion	pericarditis		
<b>Vascular disorders</b>	hypotension*, hypertension, orthostatic hypotension, haematoma			
<b>Respiratory, thoracic and mediastinal disorders</b>	dyspnoea, epistaxis, pleural effusion, dyspnoea exertional, pharyngolaryngeal pain	interstitial lung disease		
<b>Gastro-intestinal disorders</b>	diarrhoea, vomiting, constipation, nausea, abdominal pain (includes upper and abdominal discomfort), gastrointestinal haemorrhage* (includes mouth haemorrhage), haemorrhoidal haemorrhage,			

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	stomatitis, gingival bleeding, dyspepsia		
<b>Hepato-biliary disorders</b>		hepatic failure*, progressive hepatic coma	
<b>Skin and sub-cutaneous tissue disorders</b>	petechiae, pruritus (includes generalized), rash, ecchymosis, purpura, alopecia, urticaria, erythema, rash macular	acute febrile neutrophilic dermatosis, pyoderma gangrenosum	
<b>Musculo-skeletal and connective tissue disorders</b>	arthralgia, musculoskeletal pain (includes back, bone and pain in extremity), muscle spasms, myalgia		
<b>Renal and urinary disorders</b>	renal failure*, haematuria, elevated serum creatinine	renal tubular acidosis	
<b>General disorders and administration site conditions</b>	pyrexia*, fatigue, asthenia, chest pain, injection site erythema, injection site pain, injection site reaction (unspecified), bruising, haematoma, induration, rash, pruritus, inflammation, discoloration, nodule and haemorrhage (at injection site), malaise, chills, catheter site hemorrhage	injection site necrosis (at injection site)	

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<b>Investigations</b>	weight decreased			
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\* = rarely fatal cases have been reported

Description of selected adverse reactions

*Haematologic adverse reactions*

The most frequently reported haematological adverse reactions associated with azacitidine treatment include anaemia, thrombocytopenia, neutropenia and leukopenia. There is a greater risk of these events occurring during the first 2 cycles, after which they occur with less frequency in patients with restoration of haematological function. Most haematological adverse reactions were managed by routine monitoring of complete blood counts and delaying azacitidine administration in the next cycle, prophylactic antibiotics and/or growth factor support (e.g., G-CSF) for neutropenia and transfusions for anaemia or thrombocytopenia as required.

*Infections*

Myelosuppression may lead to neutropenia and an increased risk of infection. Serious adverse reactions such as sepsis, including neutropenic sepsis, and pneumonia were reported in patients receiving azacitidine, some with a fatal outcome. Infections may be managed with the use of anti-infectives plus growth factor support (e.g., G-CSF) for neutropenia.

*Bleeding*

Bleeding may occur with patients receiving azacitidine. Serious adverse reactions such as gastrointestinal haemorrhage and intracranial haemorrhage have been reported. Patients should be monitored for signs and symptoms of bleeding, particularly those with pre-existing or treatment-related thrombocytopenia.

*Hypersensitivity*

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Serious hypersensitivity reactions have been reported in patients receiving azacitidine. In case of an anaphylactic-like reaction, treatment with azacitidine should be immediately discontinued and appropriate symptomatic treatment initiated.

*Skin and subcutaneous tissue adverse reactions*

The majority of skin and subcutaneous adverse reactions were associated with the injection site. The majority of adverse reactions occurred during the first 2 cycles and tended to decrease with subsequent cycles. Subcutaneous adverse reactions such as injection site rash, inflammation, pruritus, erythema and skin lesion may require management with concomitant medicinal products, such as antihistamines, corticosteroids and non-steroidal anti-inflammatory medicinal products (NSAIDs).

*Gastrointestinal adverse reactions*

The most frequently reported gastrointestinal adverse reactions associated with azacitidine treatment included constipation, diarrhoea, nausea and vomiting. These adverse reactions were managed symptomatically with anti-emetics for nausea and vomiting; anti-diarrhoeals for diarrhoea, and laxatives and/or stool softeners for constipation.

*Renal adverse reactions*

Renal abnormalities, ranging from elevated serum creatinine to renal tubular acidosis, renal failure and death were reported in patients treated with azacitidine (see Section 4.4).

*Hepatic adverse reactions*

Patients with extensive tumour burden due to metastatic disease have been reported to experience progressive hepatic coma and death during azacitidine treatment (see Section 4.4).

*Cardiac events*

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Data from a clinical trial allowing enrolment of patients with known history of cardiovascular or pulmonary disease showed an increase in cardiac events in patients with newly diagnosed AML treated with azacitidine (see Section 4.4).

#### *Elderly population*

There is limited safety information available with azacitidine in patients  $\geq$  85 years.

#### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Health care providers are requested to report any suspected adverse drug reactions to SAHPRA via the Med Safety APP (Medsafety X SAHPRA) and eReporting platform ([who-umc.org](http://who-umc.org)) found on SAHPRA website.

#### **4.9 Overdose**

In the event of an overdose, side effects will be exaggerated (see section 4.8). The patient should be monitored with appropriate blood counts and should receive supportive treatment, as necessary. There is no known specific antidote for AZACITIDINE DRL overdose.

### **5. PHARMACOLOGICAL PROPERTIES**

#### **5.1 Pharmacodynamic properties**

A26 Cytostatic agents

Pharmacotherapeutic group: Antineoplastic agents, pyrimidine analogues; ATC code: L01BC07

#### *Mechanism of action*

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Azacitidine is a cytidine nucleoside analogue that incorporates into RNA and DNA. Azacitidine is believed to exert its antineoplastic effects by cytotoxicity to abnormal haematopoietic cells in the bone marrow and hypomethylation of DNA. The cytotoxic effects of azacitidine may be due to inhibition of protein synthesis and activation of DNA damage pathways, due to incorporation into RNA and DNA, respectively. Incorporation of azacitidine into DNA also results in DNA hypomethylation and may allow the re-expression of genes involved in normal cell cycle regulation and differentiation. Non-proliferating cells are relatively insensitive to azacitidine.

## **5.2 Pharmacokinetic properties**

The pharmacokinetics of azacitidine were studied following administrations of a single 75 mg/m<sup>2</sup> subcutaneous (SC) dose and a single intravenous (IV) dose.

### *Absorption:*

Azacitidine was rapidly absorbed after the SC administration, with peak plasma concentrations of 750 ± 403 ng/ml occurring at 0,5 h after dosing.

The absolute bioavailability of azacitidine after subcutaneous relative to intravenous administration (single 75 mg/m<sup>2</sup> doses) was approximately 89 % based on area under the curve (AUC).

AUC and maximum plasma concentration (C<sub>max</sub>) of subcutaneous administration of azacitidine were approximately proportional within the 25 to 100 mg/m<sup>2</sup> dose range. Multiple dosing at the recommended dose-regimen does not result in accumulation of azacitidine.

### *Distribution:*

Following intravenous administration, the mean volume of distribution was 76 ± 26 L and systemic clearance was 167 ± 49 L/h.

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*Metabolism*

Based on *in vitro* data, azacitidine metabolism does not appear to be mediated by cytochrome P450 isoenzymes (CYPs).

An *in vitro* study of azacitidine with cultured human hepatocytes indicates that at concentrations of 1,0 µM to 100 µM (i.e., up to approximately 30-fold higher than clinically achievable concentrations), azacitidine does not induce CYP 1A2, 2C19, or 3A4 or 3A5. In studies to assess inhibition of a series of P450 isoenzymes (CYP 1A2, 2B6, 2C8, 2C9, 2C19, 2D6, 2E1 and 3A4), azacitidine up to 100 µM did not produce inhibition. Therefore, CYP enzyme induction or inhibition by azacitidine at clinically achievable plasma concentrations is unlikely.

*Excretion:*

Azacitidine is cleared from plasma with a mean elimination half-life ( $t_{1/2}$ ) after subcutaneous administration of  $41 \pm 8$  minutes. Published studies indicate that urinary excretion is the primary route of elimination of azacitidine and/or its metabolites. Following intravenous and subcutaneous administration of  $^{14}\text{C}$  azacitidine, 85 % and 50 % of the administered radioactivity was recovered in urine respectively, while < 1 % was recovered in faeces. The mean elimination half-lives of total radioactivity (azacitidine and/or its metabolites) were similar after intravenous and subcutaneous administrations, i.e., about 4 hours.

*Special Populations*

The effects of hepatic impairment, gender, age, or race on the pharmacokinetics of azacitidine have not been formally studied.

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Renal impairment:

Severe renal impairment has no major effect on the PK exposure of azacitidine after single and multiple SC administrations. Therefore, azacitidine can be administered to patients with renal impairment without initial dose adjustment.

*Pharmacogenomics*

The effect of known cytidine deaminase polymorphisms on azacitidine metabolism has not been formally investigated.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Mannitol

Nitrogen

Water for injection

### **6.2 Incompatibilities**

AZACITIDINE DRL must not be mixed with other medicinal products except those mentioned in section 6.6.

### **6.3 Shelf life**

*Unopened vial:*

2 years

*Reconstituted suspension for subcutaneous administration:*

- When reconstituted with refrigerated (2 °C to 8 °C) water for injections, the reconstituted suspension can be kept in the refrigerator (2 °C to 8 °C) for a maximum of 22 hours.

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- After removal from refrigerated conditions, the suspension may be allowed to equilibrate to room temperature (25 °C) for up to 30 minutes prior to administration.

*Reconstituted suspension for intravenous administration:*

- When stored at 25 °C, the reconstituted product should be administered within 1 hour.

From a microbiological point of view, the reconstituted product should be used immediately.

#### **6.4 Special precautions for storage**

Unopened vial:

Store at or below 25 °C.

Reconstituted suspension:

For storage conditions after reconstitution of the medicinal product, see

Section 6.3.

#### **6.5 Nature and contents of container**

30 ml USP type I flint tubular glass vial, with a 20 mm dark grey bromobutyl rubber stopper and sealed with 20 mm violet coloured aluminium flip-off tear seal.

#### **6.6 Special precautions for disposal and other handling**

*Instruction for safe handling:*

- AZACITIDINE DRL is a cytotoxic medicine and, as with other potentially toxic compounds, caution should be exercised when handling and preparing AZACITIDINE DRL suspensions.
- Procedures for proper handling and disposal of anticancer medicines-should be applied.
- If reconstituted AZACITIDINE DRL comes into contact with the skin, immediately and thoroughly wash with soap and water.
- If it comes into contact with mucous membranes, flush thoroughly with water.

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*Preparation for the subcutaneous administration:*

- AZACITIDINE DRL must be reconstituted to form a uniform suspension prior to administration.
- AZACITIDINE DRL should be reconstituted aseptically with 4 ml of water for injection.
- Vigorously shake the vial until a uniform cloudy suspension is achieved.
- After reconstitution each ml of suspension will contain 25 mg of azacitidine (100 mg/4 ml).
- To provide a homogeneous suspension, the contents of the syringe must be re-suspended immediately prior to administration.
- To re-suspend, vigorously roll the syringe between the palms until a uniform cloudy suspension is achieved.
- Doses greater than 4 ml should be divided equally into two syringes and injected into two separate sites.

*Preparation for the intravenous administration:*

- Parenteral drug product should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.
- Do not use the product if there is evidence of particulate matter or discoloration.
- Reconstitute the appropriate number of AZACITIDINE DRL vials to achieve the desired dose.
- Reconstitute each vial with 10 ml sterile water for injection.
- Vigorously shake or roll the vial until all solids are dissolved. The resulting solution will contain azacitidine 10 mg/ml.
- The solution should be clear.

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- Withdraw the required amount of AZACITIDINE DRL solution to deliver the desired dose and inject into a 50 to 100 ml infusion bag of either 0,9 % sodium chloride injection or lactated ringer's injection.
- AZACITIDINE DRL is incompatible with 5 % dextrose injection solutions, Hespan or solutions that contain bicarbonate.  
  
These solutions have the potential to increase the rate of degradation of AZACITIDINE DRL and should therefore be avoided.

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

## **7. HOLDER OF CERTIFICATE OF REGISTRATION**

Dr. Reddy's Laboratories (Pty) Ltd.

Block C, Woodmead North Office Park

54 Maxwell Drive

Woodmead

Sandton

Gauteng

2191

## **8. REGISTRATION NUMBER**

51/26/0144

## **9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

**DR. REDDY'S LABORATORIES (PTY) LTD  
APPROVED PROFESSIONAL INFORMATION:  
AZACITIDINE DRL  
(lyophilised powder for injection)**

Date of first authorisation: 15 September 2020

**10. DATE OF REVISION OF TEXT**

28 March 2025