

PRODUCT MONOGRAPH
INCLUDING PATIENT MEDICATION INFORMATION

Pr **CIBINQO**[®]

Abrocitinib tablets

Tablets, 50 mg, 100 mg and 200 mg abrocitinib, oral

Selective immunosuppressant

Pfizer Canada ULC
17,300 TransCanada Highway
Kirkland, Quebec H9J 2M5

Date of Initial Approval:
JUN 28, 2022

Date of Revision:
AUG 5, 2022

Submission Control No: 245854

RECENT MAJOR LABEL CHANGES

Not applicable

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PrCIBINQO®

abrocitinib tablets

PART I: HEALTH PROFESSIONAL INFORMATION

1 INDICATIONS

CIBINQO (abrocitinib) is indicated for the treatment of patients 12 years and older with refractory moderate to severe atopic dermatitis, including the relief of pruritus, who have had an inadequate response to other systemic drugs (e.g. steroid or biologic), or for whom these treatments are not advisable.

CIBINQO can be used with or without medicated topical therapies for atopic dermatitis.

Limitations of Use: Use of CIBINQO in combination with other JAK inhibitors, biologic immunomodulators, or potent immunosuppressants such as methotrexate and cyclosporine has not been studied and is not recommended (see **7 WARNINGS AND PRECAUTIONS, Immune**).

1.1 Pediatrics

Pediatrics (12-17 years of age): Based on the data submitted and reviewed by Health Canada, the safety and efficacy of CIBINQO in pediatric patients 12-17 years of age has been established for treatment of moderate to severe atopic dermatitis.

Pediatrics under 12 years of age: The safety and efficacy of CIBINQO in pediatric patients under 12 years of age have not yet been established. Therefore, Health Canada has not authorized an indication for pediatric use in pediatric patients under 12 years of age.

1.2 Geriatrics

Geriatrics ≥65 years of age: Caution should be used when treating geriatric patients with CIBINQO. There are limited data in patients 75 years of age and older. Clinical study results indicated that elderly patients were at increased risk for specific serious adverse events. (see **4.2 Recommended Dose and Dosage Adjustment**, and **7.1.4 Geriatrics**).

2 CONTRAINDICATIONS

CIBINQO is contraindicated in patients who are hypersensitive to this drug or to any ingredient in the formulation, including any non-medicinal ingredient, or component of the container. For a complete listing, see **6 Dosage Forms, Strengths, Composition and Packaging**.

3 SERIOUS WARNINGS AND PRECAUTIONS BOX

Serious Warnings and Precautions

- **SERIOUS INFECTIONS**
Patients treated with CIBINQO may be at increased risk for developing serious bacterial, fungal, viral and opportunistic infections that may lead to hospitalization or death; more frequently reported serious infections were predominately viral. [see 7 **WARNINGS AND PRECAUTIONS**, 8 **ADVERSE REACTIONS**]. If a serious infection develops, interrupt CIBINQO until the infection is controlled. The risks and benefits of treatment with CIBINQO should be carefully considered prior to initiating therapy in patients with chronic or recurrent infection. Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with CIBINQO, including the possible development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy [see 7 **WARNINGS AND PRECAUTIONS**].
- **MALIGNANCIES**
Lymphoma and other malignancies have been observed in patients treated with Janus kinase inhibitors used to treat inflammatory conditions. Malignancies were more frequently observed in Rheumatoid Arthritis (RA) patients in a clinical trial with another JAK inhibitor, when compared to the use of TNF inhibitors. [see 7 **WARNINGS AND PRECAUTIONS**].
- **THROMBOSIS**
Thrombosis, including deep venous thrombosis, pulmonary embolism, and arterial thrombosis have occurred in patients treated with Janus kinase inhibitors used to treat inflammatory conditions. Many of these adverse events were serious and some resulted in death. Consider the risks and benefits prior to treating patients who may be at increased risk. In a clinical trial in RA patients 50 years of age and older, a higher rate of all-cause mortality and thrombosis occurred in patients treated with another JAK inhibitor compared to those treated with TNF inhibitors. Patients with symptoms of thrombosis should be promptly evaluated and treated appropriately [see 7 **WARNINGS AND PRECAUTIONS**].
- **MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE)**
MACE, including non-fatal myocardial infarction, were observed more frequently in RA patients 50 years of age and older in a clinical trial with a different JAK inhibitor compared to TNF inhibitors [see 7 **WARNINGS AND PRECAUTIONS**].

4 DOSAGE AND ADMINISTRATION

4.1 Dosing Considerations

CIBINQO should be taken orally once daily with or without food at approximately the same time each day.

In patients who experience nausea while taking CIBINQO, taking with food may improve nausea.

Treatment with CIBINQO should not be initiated in patients with a platelet count less than $150 \times 10^3/\text{mm}^3$, an absolute lymphocyte count (ALC) less than $0.5 \times 10^3/\text{mm}^3$, an absolute neutrophil count (ANC) less than $1 \times 10^3/\text{mm}^3$ or who have a hemoglobin value less than 8 g/dL.

4.2 Recommended Dose and Dosage Adjustment

The recommended dose of CIBINQO is 100 mg or 200 mg orally once daily for adolescents and adults under 65 years of age, based on individual goal of therapy and potential risk for adverse reactions. For patients using the 200 mg once daily dosage, after symptom control is achieved by week 12, consider dose reduction to 100 mg once daily. Relative to patients who maintained the 200 mg dose, the risk of occurrence of serious adverse reactions decreased in patients who reduced their dose to 100 mg beyond 12 weeks in clinical studies. If symptom control is lost after dose reduction, the dose can be increased to 200 mg. Exceeding a daily dosage of 200 mg is not recommended.

CIBINQO can be used with or without medicated topical therapies for atopic dermatitis.

Elderly population

The recommended starting dose for patients ≥ 65 years of age is 100 mg. Some side effects that were more common in elderly patients in clinical trials, including herpes zoster, lymphopenia, and thrombocytopenia, occurred more frequently at the 200 mg daily dosage (see **8.2 Clinical Trial Adverse Reactions**).

Pediatric population

For pediatric patients 12 to < 18 years of age, the starting recommended dose of CIBINQO is 100 mg or 200 mg once daily. Dosage adjustment should be considered based on individual goal of therapy and potential risk for adverse reactions.

The safety and efficacy of CIBINQO in pediatric patients under 12 years of age have not yet been established. No data are available.

Renal Impairment

No dose adjustment is required in patients with mild renal impairment, i.e., estimated glomerular filtration rate (eGFR) of 60 to <90 mL/min. In patients with moderate (eGFR 30 to <60 mL/min) or severe (eGFR <30 mL/min) renal impairment, the recommended dose of CIBINQO is to be reduced by 50% as shown in Table 1.

The use of CIBINQO has not been studied in patients with end-stage renal disease (ESRD) on renal replacement therapy.

Table 1. Dose Adjustments for Renal Impairment

| Renal Impairment Stage | Estimated Glomerular Filtration rate (eGFR) | Dose Adjustment | |
|------------------------|---|----------------------------------|----------------------------------|
| | | Indicated Dose 100 mg Once Daily | Indicated Dose 200 mg Once Daily |
| Mild | 60 to <90 mL/min | None | None |
| Moderate | 30 to <60 mL/min | CIBINQO 50 mg once daily | CIBINQO 100 mg once daily |
| Severe | <30 mL/min | CIBINQO 50 mg once daily | CIBINQO 100 mg once daily |

Hepatic Impairment

No dose adjustment is required in patients with mild (Child Pugh A) or moderate (Child Pugh B) hepatic impairment. The safety of CIBINQO following daily dosing has not been studied in patients with hepatic impairment.

CIBINQO has not been studied in patients with severe hepatic impairment (Child Pugh C).

Concomitant use of CYP2C19 and CYP2C9 inhibitors

The dosage of CIBINQO should be reduced in half when co-administered with strong CYP2C19 and moderate CYP2C9 inhibitors (see **9.4 Drug-Drug Interactions**).

Concomitant use of CYP2C19 and CYP2C9 inducers

Co-administration of CIBINQO with CYP2C19/2C9 inducers is not recommended (see **9.4 Drug-Drug Interactions**).

4.3 Administration

CIBINQO should be taken orally once daily with or without food at approximately the same time each day.

Swallow CIBINQO tablets whole and intact with water. Do not crush, split, or chew CIBINQO tablets.

In patients who experience nausea while taking CIBINQO, taking with food may improve nausea.

4.4 Reconstitution

Not applicable

4.5 Missed Dose

If a dose is missed, patients should be advised to take the dose as soon as possible unless it is less than 12 hours before the next dose, in which case the patient should not take the missed dose. Thereafter, resume dosing at the regular scheduled time.

Dose interruption

If a patient develops a serious infection, sepsis or opportunistic infection, interruption of treatment with CIBINQO until the infection is controlled should be considered (see Section **7 WARNINGS AND PRECAUTIONS**).

Interruption of dosing may be needed for management of laboratory abnormalities as described in Table 3.

5 OVERDOSAGE

There is no experience with overdose of CIBINQO. There is no specific antidote for overdose with CIBINQO. In case of an overdose, it is recommended that the patient be monitored for signs and symptoms of adverse reactions. Treatment should be symptomatic and supportive.

Pharmacokinetic data up to and including a single dose of 800 mg in healthy volunteers indicate that more than 90% of the administered dose is expected to be eliminated within 48 hours.

For management of a suspected drug overdose, contact your regional poison control centre.

6 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING

Table 2 – Dosage Forms, Strengths, Composition and Packaging.

| Route of Administration | Dosage Form / Strength/Composition | Non-medicinal Ingredients |
|-------------------------|--|---|
| Oral | Tablet 50 mg, 100 mg, 200 mg / abrocitinib | Dibasic calcium phosphate anhydrous, Hypromellose, Iron oxide, Lactose monohydrate, Magnesium stearate, Microcrystalline cellulose, Sodium starch glycolate, Macrogol/PEG, Titanium dioxide and Triacetin |

CIBINQO is packaged in bottles or in blisters. Each blister pack contains (7 tablets x 4 blisters) 28 tablets and each bottle contains 30 tablets.

7 WARNINGS AND PRECAUTIONS

Please see the **3 SERIOUS WARNINGS AND PRECAUTIONS BOX** at the beginning of Part I: Health Professional Information.

Cardiovascular

Venous thromboembolism

Events of deep venous thrombosis (DVT) and pulmonary embolism (PE) have been reported in patients receiving Janus kinase (JAK) inhibitors, including CIBINQO. In a large, randomized, postmarketing safety study of another JAK inhibitor in RA patients 50 years of age and older with at least one cardiovascular risk factor, higher rates of overall thrombosis, DVT, and PE were observed compared to those treated with TNF blockers. CIBINQO should be used with caution in patients at high risk for DVT/PE. Risk factors that should be considered in determining the patient's risk for DVT/PE include older age, obesity, a medical history of DVT/PE, prothrombotic disorder, use of combined hormonal contraceptives or hormone replacement therapy, patients undergoing major surgery, or prolonged immobilization. If clinical features of DVT/PE occur, CIBINQO treatment should be discontinued and patients should be evaluated promptly, followed by appropriate treatment.

Major Adverse Cardiovascular Events

Major adverse cardiovascular events were reported in clinical studies of CIBINQO for atopic dermatitis. In a large, randomized, post-marketing safety study of another JAK inhibitor in RA patients 50 years of age and older with at least one cardiovascular risk factor, a higher rate of MACE (defined as cardiovascular death, non-fatal myocardial infarction, and non-fatal stroke) was observed with the JAK inhibitor compared to those treated with TNF blockers. CIBINQO is not approved for use in RA. Patients who are current or past smokers are at additional increased risk.

Consider the benefits and risks for the individual patient prior to initiating or continuing therapy with CIBINQO, particularly in patients who are current or past smokers and patients with other

cardiovascular risk factors. Patients should be informed about the symptoms of serious cardiovascular events and the steps to take if they occur. Discontinue CIBINQO in patients that have experienced a myocardial infarction or stroke.

Driving and Operating Machinery

Dizziness has been reported in patients receiving CIBINQO, which could influence the ability to drive or operate machines [see **8 ADVERSE REACTIONS**]. Due caution should be exercised when driving or operating a vehicle or potentially dangerous machinery. Patients experiencing dizziness should be advised not to drive or operate machines until symptoms abate.

Endocrine and Metabolism

Lipids

Dose-dependent increase in blood lipid parameters were reported in patients treated with CIBINQO. Lipid parameters should be assessed approximately 4 weeks following initiation of CIBINQO therapy and thereafter patients should be managed according to clinical guidelines for hyperlipidemia. The effect of these lipid parameter elevations on cardiovascular morbidity and mortality has not been determined.

Hematological

Hematologic abnormalities

Confirmed ALC $<0.5 \times 10^3/\text{mm}^3$ and platelet count $<50 \times 10^3/\text{mm}^3$ were observed in less than 0.5% of patients in clinical studies. Treatment with CIBINQO should not be initiated in patients with a platelet count $<150 \times 10^3/\text{mm}^3$, an ALC $<0.5 \times 10^3/\text{mm}^3$, an ANC $<1 \times 10^3/\text{mm}^3$ or who have a hemoglobin value <8 g/dL. Platelet count and ALC should be monitored 4 weeks after initiation of therapy with CIBINQO and thereafter according to routine patient management.

Immune

CIBINQO should not be used concomitantly with other potent immunosuppressants. Concomitant use of CIBINQO with other potent immunosuppressants (such as methotrexate and cyclosporine) or other JAK inhibitors has not been evaluated in clinical studies. There is a risk of additive immunosuppression when CIBINQO is co-administered with potent immunosuppressant drugs.

Vaccination

Avoid use of live, attenuated vaccines during or immediately prior to CIBINQO therapy. Prior to initiating CIBINQO, it is recommended that patients be brought up to date with all immunizations, including prophylactic herpes zoster vaccinations, in agreement with current immunization guidelines.

Infections

Serious infections have been reported in patients receiving CIBINQO. The most frequent serious infections in clinical studies were herpes simplex, herpes zoster, and pneumonia. The risks and benefits of treatment with CIBINQO should be carefully considered prior to initiating in patients with active, chronic, or recurrent infections.

Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with CIBINQO. A patient who develops a new infection during treatment with CIBINQO should undergo prompt and complete diagnostic testing and appropriate antimicrobial therapy should be initiated. The patient should be closely monitored and CIBINQO therapy should be interrupted if the patient is not responding to standard therapy.

Tuberculosis

Patients should be screened for tuberculosis (TB) before starting CIBINQO therapy and consider yearly screening for patients in highly endemic areas for TB. CIBINQO should not be given to patients with active TB. For patients with a new diagnosis of latent TB or prior untreated latent TB, preventive therapy for latent TB should be started prior to initiation of CIBINQO.

Viral reactivation

Viral reactivation, including herpes virus reactivation (e.g., herpes zoster, herpes simplex), was reported in clinical studies. The rate of herpes zoster infections was higher in patients 65 years of age and older.

Screening for viral hepatitis should be performed in accordance with clinical guidelines before starting therapy and during therapy with CIBINQO. Patients with evidence of active hepatitis B or hepatitis C (positive hepatitis C PCR) infection were excluded from clinical studies. Patients who were hepatitis B surface antigen negative, hepatitis B core antibody positive, and hepatitis B surface antibody positive had testing for hepatitis B virus (HBV) DNA. Patients who had HBV DNA above the lower limit of quantification (LLQ) were excluded. Patients who had HBV DNA negative or below LLQ could initiate treatment with CIBINQO; such patients had HBV DNA monitored. If HBV DNA is detected, a liver specialist should be consulted.

Malignancy

Malignancies, including non-melanoma skin cancer (NMSC), were observed in clinical studies with CIBINQO. Clinical data are insufficient to assess the potential relationship of exposure to CIBINQO and the development of malignancies. Long-term safety evaluations are ongoing.

Malignancies, including lymphomas, have occurred in patients receiving JAK inhibitors used to treat other inflammatory conditions. In a large, randomized, post-marketing safety study of another JAK inhibitor in RA patients, a higher rate of malignancies (excluding non-melanoma skin cancer (NMSC)) was observed in patients treated with the JAK inhibitor compared to those treated with TNF blockers. CIBINQO is not approved for use in RA. A higher rate of lymphomas was observed in patients treated with the JAK inhibitor compared to those treated with TNF blockers. A higher rate of lung cancers was observed in current or past smokers treated with the JAK inhibitor compared to those treated with TNF blockers. In this study, current or past smokers had an additional increased risk of overall malignancies.

The risks and benefits of CIBINQO treatment should be considered prior to initiating in patients with a known malignancy other than a successfully treated NMSC or cervical cancer in situ or when considering continuing CIBINQO therapy in patients who develop a malignancy. Periodic skin examination is recommended for patients who are at increased risk for skin cancer.

Monitoring and Laboratory Tests

Table 3. Laboratory monitoring guidance

| Laboratory measure | Monitoring guidance | Action |
|--|---|--|
| Complete blood count including Platelet Count, Absolute Lymphocyte Count (ALC), Absolute Neutrophil Count (ANC), and Hemoglobin (Hb) | Before treatment initiation, 4 weeks after initiation and thereafter according to routine patient management. | Platelets: Treatment should be discontinued if platelet counts are $< 50 \times 10^3/\text{mm}^3$. |
| | | ALC: Treatment should be interrupted if ALC is $< 0.5 \times 10^3/\text{mm}^3$ and may be restarted once ALC returns above this value. Treatment should be |

| | | |
|------------------|---|--|
| | | discontinued if confirmed. |
| | | ANC: Treatment should be interrupted if ANC is $< 1 \times 10^3/\text{mm}^3$ and may be restarted once ANC returns above this value. |
| | | Hb: Treatment should be interrupted if Hb $< 8 \text{ g/dL}$ and may be restarted once Hb returns above this value. |
| Lipid parameters | Before treatment initiation, 4 weeks after initiation and thereafter according to clinical guidelines for hyperlipidemia. | Patients should be monitored according to clinical guidelines for hyperlipidemia. |

Reproductive Health: Female and Male Potential

Fertility:

Based on findings in rats, oral administration of CIBINQO may impair female fertility. Impaired fertility in female rats was reversible 1 month after cessation of abrocitinib oral administration (see **16 NON-CLINICAL TOXICOLOGY**, Reproductive and developmental toxicity).

7.1 Special Populations

7.1.1 Pregnant Women

Women of childbearing potential:

Women of reproductive potential should be advised to use effective contraception during treatment with CIBINQO and for at least 1 month after the last dose. Consider pregnancy planning and prevention for females of reproductive potential.

Pregnancy:

The limited human data on use of CIBINQO in pregnant women are not sufficient to evaluate a drug-associated risk for major birth defects or miscarriage. In animal embryo-fetal development studies, oral administration of CIBINQO to pregnant rats during organogenesis resulted in fetotoxicity at exposures equal to approximately 17 times the unbound human AUC at the maximum recommended clinical dose of 200 mg once daily. No fetal malformations were observed. CIBINQO increased the incidence of skeletal variations at equal to or greater than 11 times the unbound human AUC at the maximum recommended clinical dose of 200 mg once daily (see **16 NON-CLINICAL TOXICOLOGY**, Reproductive and developmental toxicity).

In a pre- and postnatal development study in pregnant rats, CIBINQO oral administration during gestation and through lactation resulted in lower postnatal survival, lower offspring body weights and/or dystocia with prolonged parturition at exposures equal to or greater than approximately 11 times the unbound human AUC at the maximum recommended clinical dose of 200 mg once daily (see **16 NON-CLINICAL TOXICOLOGY**, Reproductive and developmental toxicity). CIBINQO should not be used during pregnancy unless clearly necessary.

7.1.2 Breast-feeding

There are no data on the presence of CIBINQO in human milk, the effects on the breast-fed infant, or the effects on milk production. CIBINQO was secreted in milk of lactating rats. Women should not breast-feed while treated with CIBINQO. A risk to newborns and infants cannot be excluded and CIBINQO should not be used during breast-feeding.

7.1.3 Pediatrics

Pediatrics (12-17 years of age):

Based on the data submitted and reviewed by Health Canada, the safety and efficacy of CIBINQO in pediatric patients 12-17 years of age has been established for treatment of moderate to severe atopic dermatitis.

Of the 2856 patients with atopic dermatitis exposed to CIBINQO, a total of 364 adolescents (12 to less than 18 years of age) were enrolled in CIBINQO studies. The safety profile observed in adolescents in atopic dermatitis clinical studies was similar to that of the adult population. There were no adolescent patients who developed platelet counts $<75 \times 10^3/\text{mm}^3$ or ALC $<0.5 \times 10^3/\text{mm}^3$.

Pediatrics under 12 years of age:

The safety and efficacy of CIBINQO in pediatric patients under 12 years of age have not yet been established. Therefore, Health Canada has not authorized an indication for pediatric use in pediatric patients under 12 years of age.

7.1.4 Geriatrics

A total of 145 patients 65 years of age and older were enrolled in CIBINQO studies. The safety profile observed in elderly patients was generally similar to that of the adult population overall. A higher proportion of patients 65 years of age and older discontinued from clinical studies compared to younger patients. Among all patients exposed to CIBINQO, including the long-term extension study, confirmed ALC $<0.5 \times 10^3/\text{mm}^3$ occurred only in patients 65 years of age and older. A higher proportion of patients 65 years of age and older had platelet counts $<75 \times 10^3/\text{mm}^3$. The incidence rate of herpes zoster in patients 65 years of age and older treated with CIBINQO (7.40 per 100 patient-years) was higher than that of patients 18 to less than 65 years of age (3.44 per 100 patient-years) and less than that of patients younger than 18 years of age (2.12 per 100 patient-years). There are limited data in patients above 75 years of age. (see **10 ACTION AND CLINICAL PHARMACOLOGY**, Special Populations and Conditions)

For more information on the Cibirin Education Program (Prescriber Brochure and Patient Card), please visit www.pfizer.ca.

8 ADVERSE REACTIONS

8.1 Adverse Reaction Overview

The most commonly reported dose-related adverse reactions (ARs) occurring in $\geq 2\%$ of patients treated with CIBINQO in placebo-controlled studies were nausea (10.3%), headache (6.8%), herpes simplex (3.8%), acne (3.2%), blood creatine phosphokinase increased (2.6%), dizziness (2.3%), and vomiting (2.3%). The most frequent serious adverse reactions were infections.

8.2 Clinical Trial Adverse Reactions

Because clinical trials are conducted under very specific conditions, the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.

A total of 2856 patients were treated with CIBINQO in Phase 2 and Phase 3 clinical studies in atopic dermatitis representing 1614 patient-years of exposure. There were 606 patients with more than 1 year of exposure to CIBINQO. The median age was 31.0 years, 12.7% were adolescents, and 5.1% were 65 years of age or older. Nearly half of the subjects (45.6%) were female. The majority of the subjects were White (72.2%); however, a substantial proportion were Asian (19.4%) and Black or African American (6%).

Four placebo-controlled studies were integrated (608 patients on 100 mg once daily, 590 patients on 200 mg once daily and 342 patients on placebo) to evaluate the safety of CIBINQO in comparison to placebo for up to 16 weeks. Table 4 presents dose-related ADRs from these studies by Preferred term (PT) for CIBINQO listed by decreasing medical seriousness.

Table 4. Adverse Reactions Reported in ≥1% of Patients with CIBINQO up to 16 weeks

| | Number (%) of Patients | | |
|--------------------------|------------------------|---------------------------|---------------------------|
| | Placebo N = 342 | CIBINQO 100 mg N = 608 | CIBINQO 200 mg N = 590 |
| Nausea, n (%) | 7 (2.0) | 37 (6.1) | 86 (14.6) |
| Vomiting, n (%) | 3 (0.9) | 9 (1.5) | 19 (3.2) |
| Abdominal pain upper (%) | 0 | 4 (0.7) | 11 (1.9%) |
| Herpes simplex* | 6 (1.8) | 20 (3.3) | 25 (4.2) |
| Headache | 12 (3.5) | 36 (5.9) | 46 (7.8) |
| Dizziness | 3 (0.9) | 11 (1.8) | 17 (2.9) |
| Acne | 0 | 10 (1.6) | 28 (4.7) |
| Blood CPK increased | 5 (1.5) | 14 (2.3) | 17 (2.9) |

* Herpes simplex includes oral herpes, ophthalmic herpes simplex, genital herpes, and herpes dermatitis.

Other adverse reactions reported in less than 2% of patients treated with CIBINQO in placebo-controlled studies for up to 12 or 16 weeks included pneumonia, and herpes zoster.

Overall Infections:

In placebo-controlled studies, for up to 16 weeks, overall infections have been reported in 26.3% of patients treated with placebo and in 35.2% and 34.6% of patients treated with CIBINQO 100 mg and 200 mg, respectively. Most infections were mild or moderate.

Serious Infections:

In placebo-controlled studies, for up to 16 weeks, serious infections have been reported in 2 patients (2.31 per 100 patient-years) treated with placebo, 6 patients (3.80 per 100 patient-years) treated with CIBINQO 100 mg, and 2 patients (1.28 per 100 patient-years) treated with CIBINQO 200 mg. Among all patients treated with CIBINQO, including the long-term extension study, serious infections were reported in 17 patients (2.65 per 100 patient-years) treated with CIBINQO 100 mg and 24 patients (2.33 per 100 patient-years) treated with CIBINQO 200 mg. The most commonly reported serious infections were herpes simplex, herpes zoster and pneumonia.

Opportunistic Infections:

All observed opportunistic infections were cases of multidermatomal cutaneous herpes zoster. Among all patients treated with CIBINQO, including the long-term extension study, opportunistic infections were reported in 1 patient (0.16 per 100 patient-years) treated with CIBINQO 100 mg and 9 patients (0.87 per 100 patient-years) treated with CIBINQO 200 mg. Most cases of opportunistic herpes zoster were mild or moderate.

Venous Thromboembolism:

Among all patients treated with CIBINQO, including the long-term extension study, PE was reported in 3 patients (0.18 per 100 patient-years), all treated with CIBINQO 200 mg. Events of DVT were reported in 2 patients (0.09 per 100 patient-years) treated with CIBINQO 200 mg.

Thrombocytopenia:

In placebo-controlled studies, for up to 16 weeks, treatment with CIBINQO was associated with a dose-related decrease in platelet count. Maximum effects on platelets were observed within 4 weeks, after which the platelet count returned towards baseline despite continued therapy. Confirmed platelet counts of $<50 \times 10^3/\text{mm}^3$ were reported in 1 patient (0.1%) exposed to CIBINQO 200 mg, 0 patients treated with CIBINQO 100 mg or placebo. Among all patients exposed to CIBINQO, including the long-term extension study, confirmed platelet counts of $<50 \times 10^3/\text{mm}^3$ were reported in 2 patients (0.1%), both treated with CIBINQO 200 mg.

Lymphopenia:

In placebo-controlled studies, for up to 16 weeks, confirmed ALC $<0.5 \times 10^3/\text{mm}^3$ occurred in 2 patients (0.3%) treated with CIBINQO 200 mg and 0 patients treated with CIBINQO 100 mg or placebo. Both cases occurred in the first 4 weeks of exposure. Among all patients exposed to CIBINQO, including the long-term extension study, confirmed ALC $<0.5 \times 10^3/\text{mm}^3$ were reported in 4 patients (0.1%) treated with 200 mg of CIBINQO and 0 patients treated with CIBINQO 100 mg.

Nausea:

Nausea was most frequent in the first week of CIBINQO therapy and generally resolved with continued therapy. The median duration of nausea was 15 days. Most of the cases were mild to moderate in severity.

Pediatric population:

Of the 2,856 patients with atopic dermatitis exposed to CIBINQO, a total of 364 adolescents (12 to less than 18 years of age) were enrolled in CIBINQO studies. The safety profile observed in adolescents in atopic dermatitis clinical studies was similar to that of the adult population. There were no adolescent patients who developed platelet counts $<75 \times 10^3/\text{mm}^3$ or ALC $<0.5 \times 10^3/\text{mm}^3$.

Elderly:

A total of 145 patients 65 years of age and older were enrolled in CIBINQO studies. The safety profile observed in elderly patients was similar to that of the adult population overall. A higher proportion of patients 65 years of age and older discontinued from clinical studies compared to younger patients. Among all patients exposed to CIBINQO, including the long-term extension study, confirmed ALC $<0.5 \times 10^3/\text{mm}^3$ occurred only in patients 65 years of age and older. A higher proportion of patients 65 years of age and older had platelet counts $<75 \times 10^3/\text{mm}^3$. The incidence rate of herpes zoster in patients 65 years of age and older treated with CIBINQO (7.40 per 100 patient-years) was higher than that of patients 18 to less than 65 years of age.

(3.44 per 100 patient-years) and less than 18 years of age (2.12 per 100 patient-years). There are limited data in patients above 75 years of age.

8.3 Less Common Clinical Trial Adverse Reactions

Blood and lymphatic system disorders: Thrombocytopenia, Lymphopenia

Metabolism and nutrition disorders: Hyperlipidemia (dyslipidemia and hypercholesterolemia)

Vascular disorders: Venous thromboembolism (includes pulmonary embolism and deep vein thrombosis)

8.4 Abnormal Laboratory Findings: Hematologic, Clinical Chemistry and Other Quantitative Data

Lipid Elevations:

In placebo-controlled studies, for up to 16 weeks, there was a dose-related percent increase in low-density lipoprotein cholesterol (LDL-c), total cholesterol, and high-density lipoprotein cholesterol (HDL-c) relative to placebo at Week 4 which remained elevated through the final visit in the treatment period. There was no change in the LDL/HDL ratio or triglycerides. Events related to hyperlipidemia occurred in 1 patient (0.2%) exposed to CIBINQO 100 mg, 7 patients (1.2%) exposed to CIBINQO 200 mg and 0 patients exposed to placebo.

Creatine Phosphokinase Elevations (CPK):

In placebo-controlled studies, for up to 16 weeks, events of blood CPK increased were reported in 1.5% of patients treated with placebo, 2.3% and 2.9% of patients treated with 100 mg and 200 mg of CIBINQO, respectively. Most elevations were transient, and none led to discontinuation. In the clinical studies, there were no reported events of rhabdomyolysis.

8.5 Clinical Trial Adverse Reactions (Pediatrics)

In the All Exposure Pool (which included subjects from 5 clinical studies plus a long-term extension study), adolescent subjects were more likely to have any Adverse Event (AE) relative to the 18 - <65-year-old subgroup. The results of an additional study conducted in adolescents using a combination therapy of CIBINQO with medicated topical treatments were consistent with this finding. There was no clustering of AEs driving the difference and, as such, the overall AE profile was similar.

In the All Exposure Pool, there were no meaningful differences in the proportions of adolescent subjects having serious infection relative to the other age groups. The IR for all herpes zoster infections was lowest in the adolescent subgroup relative to the other age groups. No adolescent subject had hematology laboratory values meeting pre-specified discontinuation criteria. In the Primary Pool, a similar proportion of adolescent subjects in the placebo and abrocitinib groups had shifts above 130 mg/dL in LDL.

8.6 Post-Market Adverse Reactions

Not applicable.

9 DRUG INTERACTIONS

9.2 Drug Interactions Overview

When indicated dose is 100 mg or 200 mg CIBINQO dose should be reduced by half to 50 mg or 100 mg once daily respectively in patients receiving strong inhibitors of cytochrome P450 (CYP) 2C19 (e.g., fluconazole, fluvoxamine, fluoxetine) and in patients receiving one or more concomitant medicinal products that result in both moderate inhibition of CYP2C9 (e.g., amiodarone, fluconazole) as well as strong inhibition of CYP2C19. The use of CIBINQO is not recommended concomitantly with strong inducers of CYP enzymes (e.g., rifampin).

9.4 Drug-Drug Interactions

The drugs listed in table 5 are based on either drug interaction case reports or studies, or potential interactions due to the expected magnitude and seriousness of the interaction (i.e., those identified as contraindicated).

Potential for Other Drugs to Affect Pharmacokinetics of Abrocitinib:

Abrocitinib is metabolized predominantly by CYP2C19 and CYP2C9 enzymes, and its active metabolites are renally excreted and are substrates of the organic anion transporter 3 (OAT3). Therefore, exposures of abrocitinib and/or its active metabolites may be affected by medicinal products that strongly inhibit or induce CYP2C19 or CYP2C9 or inhibit the OAT3 transporter. Dose adjustments, as appropriate, based on these results are outlined below.

Table 5 - Established or Potential Drug-Drug Interactions

| <Proper/Common name> | Source of Evidence | Effect | Clinical comment |
|----------------------------|--------------------|--|--|
| Fluvoxamine Fluconazole | CT | When CIBINQO 100 mg was administered concomitantly with fluvoxamine (a strong CYP2C19 and moderate CYP3A inhibitor) or fluconazole (a strong CYP2C19, moderate CYP2C9 and CYP3A inhibitor), the extent of exposure of abrocitinib active moiety increased by 91% and 155%, respectively, compared with administration alone. | Caution should be exercised when administering CIBINQO with dual strong CYP2C19/ and moderate CYP2C9 inhibitors, or strong CYP2C19 inhibitors alone. Dosage reduction of CIBINQO is recommended <i>[see 4.2 Recommended Dose and Dosage Adjustment, 10 ACTION AND CLINICAL PHARMACOLOGY]</i> |
| Rifampin | CT | Administration of CIBINQO 200 mg after multiple dosing with rifampin, a strong inducer of CYP enzymes, resulted in reduction of abrocitinib active moiety exposures by approximately 56%. | Coadministration of CIBINQO with strong or moderate CYP2C19/CYP2C9 inducers is not recommended <i>[see 10 ACTION AND CLINICAL PHARMACOLOGY]</i> |

| | | | |
|------------|----|--|--|
| Probenecid | CT | When CIBINQO 200 mg was administered concomitantly with probenecid, an OAT3 inhibitor, abrocitinib active moiety exposures increased by approximately 66%. | This is not clinically significant, and a dose adjustment is not needed. |
|------------|----|--|--|

Legend: C = Case Study; CT = Clinical Trial; T = Theoretical

Potential for Abrocitinib to Affect Pharmacokinetics of Other Drugs:

In vitro, abrocitinib or its metabolites were not significant inhibitors or inducers of CYPs (CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, and CYP3A4) or of uridine diphosphate-glucuronyltransferases (UGTs) (UGT1A1, UGT1A4, UGT1A6, UGT1A9, and UGT2B7). In vitro, abrocitinib is an inhibitor of P-glycoprotein (P-gp), organic anion transporter (OAT)3, organic cation transporter (OCT)1, multidrug and toxin compound extrusion protein (MATE)1/2K and breast cancer resistance protein (BCRP) but is not an inhibitor of organic anion transporting polypeptide (OATP)1B1/1B3, bile salt export pump (BSEP), OAT1 or OCT2 at clinically meaningful concentrations. The metabolites do not change the transporter inhibition risk compared to abrocitinib.

No clinically significant effects of CIBINQO were observed in drug interaction studies with oral contraceptives (e.g., ethinyl estradiol/levonorgestrel), or with substrates of BCRP and OAT3 (e.g., rosuvastatin), MATE1/2K (e.g., metformin) and CYP3A4 (e.g., midazolam).

Coadministration of dabigatran etexilate (a P-gp substrate), with a single dose of CIBINQO 200 mg increased dabigatran AUC_{inf} and C_{max} by approximately 53% and 40%, respectively, compared with administration alone.

9.5 Drug-Food Interactions

CIBINQO was administered without regard to food.

9.6 Drug-Herb Interactions

Interactions with herbal products have not been evaluated.

9.7 Drug-Laboratory Test Interactions

Interactions with laboratory tests have not been evaluated.

9.8 Drug-Lifestyle Interactions

Interactions with lifestyle have not been evaluated.

10 ACTION AND CLINICAL PHARMACOLOGY

10.1 Mechanism of Action

Abrocitinib is a highly selective Janus kinase (JAK)1 inhibitor. JAKs are intracellular enzymes which transmit signals arising from cytokine or growth factor-receptor interactions on the cellular membrane to influence cellular processes of hematopoiesis and immune cell function. Within

signaling pathways, JAKs phosphorylate and activate Signal Transducers and Activators of Transcription (STATs) which modulate intracellular activity including gene expression. Abrocitinib modulates the signaling pathway at the point of JAK1, preventing the phosphorylation and activation of STATs.

Abrocitinib reversibly and selectively inhibits JAK1 by blocking the adenosine triphosphate (ATP) binding site. In a cell-free isolated enzyme assay, abrocitinib has biochemical selectivity for JAK1 over the other 3 JAK isoforms JAK2 (28-fold), JAK3 (>340-fold) and tyrosine kinase (TYK) 2 (43-fold), and even higher selectivity over the broader kinome. In cellular settings, where JAK enzymes transmit signals in pairs (i.e., JAK1/JAK2, JAK1/JAK3, JAK1/TYK2, JAK2/JAK2, JAK2/TYK2), abrocitinib preferentially inhibits cytokine-induced STAT phosphorylation mediated by receptors utilizing JAK1 relative to receptors utilizing JAK2 only or JAK2/TYK2 pairs. The relevance of inhibition of specific JAK enzymes to therapeutic effectiveness is not currently known. Both the parent compound and the active metabolites (M1 and M2) inhibit cytokine signaling with similar levels of selectivity.

10.2 Pharmacodynamics

Treatment with CIBINQO was associated with dose-dependent reduction in serum markers of inflammation, including high sensitivity C-reactive protein (hsCRP), interleukin-31 (IL-31) and thymus and activation-regulated chemokine (TARC). These changes returned to near baseline within 4 weeks of drug discontinuation.

10.3 Pharmacokinetics

Table 6 - Summary of Abrocitinib and its Active Metabolites Pharmacokinetic Parameters after Single Oral Administration* of Abrocitinib in Healthy Participants**

| | C_{max} (ng/mL) ^a | T_{max} (h) ^b | $t_{1/2}$ (h) ^c | $AUC_{0-\infty}$ (ng·h/mL) ^a | CL/F (L/h) ^a | Vz/F (L) ^a |
|--------------------|-----------------------------------|----------------------------|----------------------------|--|-------------------------|-----------------------|
| 100 mg | | | | | | |
| Abrocitinib | 420.2 | 1 | 4.3 | 1578 | 63.41 | 323.3 |
| M1 | 49.0 | 1 | 4.3 | 565.6 | N/A | N/A |
| M2 | 95.8 | 1 | 2.9 | 532.9 | N/A | N/A |
| 200 mg | | | | | | |
| Abrocitinib | 756.5 | 1 | 5.9 | 3902 | 51.24 | 375.2 |
| M1 | 210.2 | 1 | 4.2 | 998.5 | N/A | N/A |
| M2 | 162.1 | 2 | 3.9 | 1197 | N/A | N/A |

* Steady-state C_{max} of the unbound active moiety (abrocitinib + M1 + M2) was approximately 1.37-fold higher relative to the single-dose.

** C_{max} and AUC values of abrocitinib in AD patients are ~30% higher at steady-state relative to healthy volunteers, based on population PK analysis.

^a Geometric mean

^b Median

^c Arithmetic mean
(M1 and M2 metabolites)

Absorption: Abrocitinib is well-absorbed with over 91% extent of oral absorption and absolute oral bioavailability of approximately 60%. Both C_{max} and AUC of abrocitinib increased dose

proportionally over the recommended daily dosage range. Coadministration of CIBINQO with a high-fat meal had no clinically relevant effect on abrocitinib exposures (AUC and C_{max} increased by approximately 26% and 29%, respectively, and T_{max} was prolonged by 2 hours). In clinical studies, CIBINQO was administered without regard to food./

Distribution: After intravenous administration, the volume of distribution of CIBINQO is about 100 L. Approximately 64%, 37% and 29% of circulating abrocitinib and its active metabolites M1 and M2, respectively, are bound to plasma proteins. Abrocitinib and its active metabolites bind predominantly to albumin. Abrocitinib and its active metabolites distribute equally between red blood cells and plasma.

Metabolism: The metabolism of abrocitinib is mediated by multiple CYP enzymes, CYP2C19 (~53%), CYP2C9 (~30%), CYP3A4 (~11%) and CYP2B6 (~6%). In a human radiolabeled study, abrocitinib was the most prevalent circulating species, with 3 polar mono-hydroxylated metabolites identified as M1 (3-hydroxypropyl), M2 (2-hydroxypropyl), and M4 (pyrrolidinone pyrimidine). Of the 3 metabolites in circulation, M1 and M2 have similar JAK inhibitory profiles as abrocitinib, while M4 was pharmacologically inactive. The pharmacologic activity of CIBINQO is attributable to the unbound exposures of parent molecule (~60%) as well as M1 (~10%) and M2 (~30%) in systemic circulation. The sum of unbound exposures of abrocitinib, M1 and M2, each expressed in molar units and adjusted for relative potencies, is referred to as the abrocitinib active moiety.

Elimination: CIBINQO is eliminated primarily by metabolic clearance mechanisms, with less than 1% of the dose excreted in urine as unchanged drug. The metabolites of abrocitinib, M1, M2 and M4 are excreted predominantly in urine, and are substrates of OAT3 transporter.

Special Populations and Conditions

Pediatrics:

Adolescents (12 to less than 18 years of age):

Based on population pharmacokinetic analysis, mean CIBINQO steady-state exposure in adolescent patients is estimated to be approximately 30% lower compared to adults of the same weight, with similar range of exposures in adult and adolescent patients. These differences in mean exposures were not considered clinically significant.

Pediatric (under 12 years of age):

The pharmacokinetics of CIBINQO in pediatric patients under 12 years of age have not yet been established.

Geriatrics:

After considering hepatic or renal impairment effects related to increasing age in the elderly, age ≥ 65 years does not have a clinically significant effect on exposures of abrocitinib or active moiety.

Sex:

Body weight, gender, CYP2C19/2C9 genotype, race, and age did not have a clinically meaningful effect on CIBINQO exposure.

Pregnancy and Breast-feeding:

Women of reproductive potential should be advised to use effective contraception during treatment and for 1 month following the final dose of CIBINQO. The limited human data on use

of CIBINQO in pregnant women are not sufficient to evaluate a drug-associated risk for major birth defects or miscarriage.

In a pre- and postnatal development study in pregnant rats, CIBINQO oral administration during gestation and through lactation resulted in lower postnatal survival and lower offspring body weights at exposures equal to or greater than approximately 11 times the unbound human AUC the maximum recommended clinical dose of 200 mg once. CIBINQO should not be used during pregnancy unless clearly necessary.

Renal impairment:

In a renal impairment study, patients with severe (eGFR <30 mL/min) and moderate (eGFR 30 to <60 mL/min) renal impairment had approximately 191% and 110% increase in active moiety AUC_{inf}, respectively, compared to patients with normal renal function (eGFR ≥90 mL/min). Based on these results, a clinically significant increase in abrocitinib active moiety is not expected in patients with mild renal impairment (creatinine clearance 60 to <90 mL/min). The eGFR in individual patients was estimated using Modification of Diet in Renal Disease (MDRD) formula.

CIBINQO has not been studied in patients with ESRD on renal replacement therapy. In Phase 3 clinical studies, CIBINQO was not evaluated in patients with atopic dermatitis with baseline creatinine clearance values less than 40 mL/min.

Hepatic impairment:

Patients with mild (Child Pugh A) and moderate (Child Pugh B) hepatic impairment had approximately 4% decrease and 15% increase in active moiety AUC_{inf}, respectively, compared to patients with normal hepatic function. These changes are not clinically significant, and no dose adjustment is required in patients with mild or moderate hepatic impairment. In clinical studies, CIBINQO was not evaluated in patients with severe (Child Pugh C) hepatic impairment, or in patients screened positive for active hepatitis B or hepatitis C.

11 STORAGE, STABILITY AND DISPOSAL

Store CIBINQO at room temperature, 15°C - 30°C in original package.

12 SPECIAL HANDLING INSTRUCTIONS

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

PART II: SCIENTIFIC INFORMATION

13 PHARMACEUTICAL INFORMATION

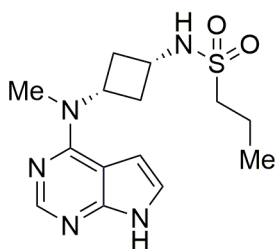
Drug Substance

Proper name: abrocitinib

Chemical name: *N*-((1*S*,3*S*)-3-(methyl(7*H*-pyrrolo[2,3-*d*]pyrimidin-4-yl)amino)cyclobutyl)propane-1-sulfonamide

Molecular formula and molecular mass: C₁₄H₂₁N₅O₂S and 323.42 Daltons

Structural formula



Physicochemical properties:

Appearance: Abrocitinib is a white to pale-colored powder.

Aqueous Solubility: The solubility of abrocitinib in water is 0.04 mg/mL at 25°C. When pH values are less than 4.0, the compound demonstrates the characteristics of a high solubility compound, dissolving rapidly. At pH values greater than 4.0, the compound demonstrates the characteristics of a low solubility compound and thus dissolves more slowly.

Polymorphism: Only one crystalline anhydrous form (Form 1) of abrocitinib has been identified.

14 CLINICAL TRIALS

14.1 Trial Design and Study Demographics

Table 7 - Summary of patient demographics for clinical trials in Atopic Dermatitis

| Study # | Trial design | Dosage, route of administration and duration | Study subjects (n) | Mean age (Range) (years) And Gender | Efficacy endpoints |
|-----------------------------|---|---|---|---|--|
| MONO-1 B7451012 | Phase 3 randomized, double-blind, placebo-controlled, parallel group, multi-center study. | Abrocitinib 100 mg QD Abrocitinib 200 mg QD Placebo. Treatment duration was 12 weeks (randomized period). | Randomized: 387 100 mg: 156 200 mg: 154 Placebo: 77 | Mean age: 29 years (Range: 12 - 65 years) Female: 43.2% Male: 56.8% | Co-primary <ul style="list-style-type: none"> IGA response^a at Week 12 EASI-75^b at Week 12 |
| MONO-2 B7451013 | Phase 3 randomized, double-blind, placebo-controlled, parallel group, multi-center study. | Abrocitinib: 100 mg QD Abrocitinib 200 mg QD Placebo Treatment duration was 12 weeks (randomized period). | Randomized: 391 (randomized 2:2:1) 100 mg: 158 200 mg: 155 Placebo: 78 | Mean age: 35.1 (Range: 12 - 65 years) Female: 41.4% Male: 58.5% | Key secondary <ul style="list-style-type: none"> PP-NRS4 at Weeks 2, 4, and 12 Change from baseline in PSAAD at Week 12 |
| REGIMEN B7451014 | Phase 3 randomized withdrawal, double-blind, placebo-controlled, multi-center study. | 12-weeks of 200 mg QD open label. Responders were then randomized to 200 mg QD, 100 mg QD or matching placebo up to 52 weeks. | Randomized: 798 (controlled phase) (randomized 1:1:1) 100 mg: 265 200 mg: 266 Placebo: 267 | Female and Male Mean age: (Range: 12 years and Older) | Primary Endpoint: Loss of response requiring rescue treatment was compared among groups during the blinded treatment period. Loss of response was defined as a loss of at least 50% of the EASI response at Week 12 and an IGA score of 2 or higher. Key Secondary Endpoint: Loss of response based on an IGA score of 2 or higher. |
| EXTEND B7451015 | Phase 3 multi-center, LTE study in subjects at least 12 years of age with moderate-to-severe atopic dermatitis. | Subjects previously randomized to abrocitinib 200 mg or 100 mg QD in the qualifying Phase 3 study will be allocated to the same dose. | Planned: 3000 | Female and Male Mean age: (Range: 12 years and Older) | Primary Long-term safety (Incidence of clinical abnormalities and change from baseline in clinical laboratory values, ECG measurements, and vital signs.) |

| Study # | Trial design | Dosage, route of administration and duration | Study subjects (n) | Mean age (Range) (years) And Gender | Efficacy endpoints |
|-------------------------|--|--|---|--|---|
| COMPARE B7451029 | Randomized, double-blind, placebo-controlled, double-dummy, parallel group, multi-center study to investigate the efficacy and safety of abrocitinib and dupilumab in comparison with placebo in adults on background topical therapy who have moderate-to-severe atopic dermatitis. | Abrocitinib: 200 mg or 100 mg QD taken orally. Dupilumab: 300 mg administered subcutaneously every other week (with a loading dose of 600 mg at baseline). Matching placebo will be administered accordingly. The total treatment period is 20 weeks. | Total randomized: 838 (randomized 2:2:2:1) Abrocitinib 200 mg: 226 Abrocitinib 100 mg: 238 Dupilumab 300 mg: 243 Placebo: 131 | Mean age; 37.7 (Range: 18 years and Older) 93.5% ≥65 years of age 6.5% Female: 51.1% Male: 48.9% | Co-primary <ul style="list-style-type: none"> IGA response at Week 12 EASI-75 at Week 12 Key secondary <ul style="list-style-type: none"> PP-NRS4 at Week 2 IGA response at Week 16 EASI-75 at Week 16 |
| TEEN B7451036 | Phase 3, randomized, double-blind, placebo-controlled, multi-center study investigating the efficacy and safety of abrocitinib co-administered with background medicated topical therapy in adolescent participants 12 to <18 years of age with moderate-to-severe atopic dermatitis | Abrocitinib 100 mg QD Abrocitinib 200 mg QD Placebo Treatment duration = 12 weeks | Randomized: 297 (randomized 1:1:1) 100 mg: 95 200 mg: 96 Placebo: 96 | Mean age: 14.9 (Range: 12 to <18 years of age) Female: 49.1% Male: 50.1% | Primary Endpoints: Response based on the IGA score of clear (0) or almost clear (1) (on a 5-point scale) and a reduction from baseline of ≤2 points at Week 12 Response based on the EASI-75 response at Week 12 Key Secondary Endpoints: Response based on at least 4 points improvement in the PP-NRS from baseline at Weeks 2, 4, and 12; Change from baseline in PSAAD total score at Week 12. |

Abbreviations: ABR=abrocitinib; CI=confidence interval; EASI=Eczema Area and Severity Index; LSM=least squares mean; IGA=Investigator Global Assessment; LTE = long term extension, N=number of patients randomized; PP-NRS=Peak Pruritus Numerical Rating Scale; PSAAD=Pruritus and Symptoms Assessment for Atopic Dermatitis

a. IGA responders were patients with IGA score of clear (0) or almost clear (1) (on a 5-point scale) and a reduction from baseline of ≥2 points at week 12.

b. EASI-75 responders were patients with ≥75% improvement in EASI, from baseline at week 12.

c. PP-NRS4 responders were patients with ≥4-point improvement in PP-NRS from baseline.

The efficacy and safety of CIBINQO as monotherapy and in combination with background medicated topical therapies were evaluated in 3 pivotal randomized, double-blind, placebo-controlled studies [MONO-1, MONO-2, and COMPARE] in 1616 patients 12 years of age and older with moderate-to-severe atopic dermatitis as defined by Investigator's Global Assessment (IGA) score ≥ 3 , Eczema Area and Severity Index (EASI) score ≥ 16 , body surface area (BSA) involvement $\geq 10\%$, and Peak Pruritus Numerical Rating Scale (PP-NRS) ≥ 4 at the baseline visit prior to randomization.

Patients in these studies were those who had inadequate response to previous topical medication, or were patients for whom topical treatments were medically inadvisable, or who had received systemic therapies, including dupilumab. In each of the pivotal studies, over 40% of patients had prior exposure to systemic therapy. In MONO-1 and MONO-2, 6% of the patients had received dupilumab, whereas prior use of dupilumab was not allowed in COMPARE.

Eligible patients from qualifying parent studies were able to enroll in the long-term extension study EXTEND, e.g., if they completed the full treatment period of the any of the pivotal qualifying parent studies.

MONO-1, MONO-2, and COMPARE assessed the co-primary endpoints of IGA and EASI-75 responses at Week 12. Key secondary endpoints in MONO-1 and MONO-2 included improvement of ≥ 4 points in the severity of PP-NRS (PP-NRS4) at Week 12 and change from baseline to Week 12 for the Pruritus and Symptoms Assessment for Atopic Dermatitis (PSAAD). The PSAAD is an 11-item, self-reported instrument using a 24-hour recall period, designed to assess the severity of key symptoms and signs of atopic dermatitis including itching, pain, dryness, flaking, cracking, bumps, redness, discoloration, bleeding, fluid, and swelling. Key secondary endpoints in COMPARE were PP-NRS4 at Week 2 in addition to IGA response and EASI-75 at Week 16. The designs of the pivotal and long-term extension studies are summarized in Table 7.

14.2 Study Results

Treatment with CIBINQO 100 mg or 200 mg once daily as monotherapy or in combination with background medicated topical therapy resulted in improvement in objective signs of atopic dermatitis and patient-reported pruritus.

Monotherapy Studies:

In both pivotal monotherapy studies (MONO-1, MONO-2), the proportion of patients who achieved IGA and/or EASI-75 response was significantly higher in patients who received CIBINQO 100 mg or 200 mg once daily compared with placebo at Week 12 (see Table 78). Higher proportion of patients also achieved EASI-90 with CIBINQO 100 mg or 200 mg once daily compared with placebo at Week 12 (18.6% and 38.6% vs. 5.3% in MONO-1; 23.9% and 37.7% vs. 3.9% in MONO-2).

A significantly higher proportion of patients who achieved PP-NRS4 (defined as an improvement of ≥ 4 points in the severity of PP-NRS) with CIBINQO 100 mg or 200 mg once daily compared with placebo was observed as soon as Week 2 and persisting through Week 12 (see Table 8). Higher proportions of patients achieved PP-NRS4 with CIBINQO 100 mg or 200 mg once daily compared with placebo by Day 6 and Day 3 (2 days after the first dose), respectively. Higher proportion of patients also achieved PP-NRS (0 or 1) with CIBINQO 100 mg or 200 mg once

daily compared with placebo at Week 12 (21.1% and 35.4% vs. 3.2% in MONO-1; 21.3% and 32.4% vs. 5.5% in MONO-2).

Table 8. Efficacy Results of CIBINQO Monotherapy at Week 12

| | MONO-1 | | | MONO-2 | | |
|--|-----------------------------------|-----------------------------------|---------------------|-----------------------------------|-----------------------------------|---------------------|
| | ABR | | Placebo N=77 | ABR | | Placebo N=78 |
| | 200 mg QD N=154 | 100 mg QD N=156 | | 200 mg QD N=155 | 100 mg QD N=158 | |
| % Responders (95% CI) | | | | | | |
| IGA 0 or 1 ^a | 43.8 ^g (35.9, 51.7) | 23.7 ^e (17.0, 30.4) | 7.9 (1.8, 14.0) | 38.1 ^g (30.4, 45.7) | 28.4 ^f (21.3, 35.5) | 9.1 (2.7, 15.5) |
| EASI-75 ^b | 62.7 ^g (55.1, 70.4) | 39.7 ^g (32.1, 47.4) | 11.8 (4.6, 19.1) | 61.0 ^g (53.3, 68.7) | 44.5 ^g (36.7, 52.3) | 10.4 (3.6, 17.2) |
| PP-NRS4 ^{c,d} | 57.2 ^g (48.8, 65.6) | 37.7 ^f (29.2, 46.3) | 15.3 (6.6, 24.0) | 55.3 ^g (47.2, 63.5) | 45.2 ^g (37.1, 53.3) | 11.5 (4.1, 19.0) |
| Change from baseline (95% CI) | | | | | | |
| LSM | -3.2 ^g | -2.2 ^e | -1.1 | -3.0 ^g | -2.4 ^g | -0.8 |
| PSAAD | (-3.6, -2.8) | (-2.6, -1.9) | (-1.7, -0.6) | (-3.3, -2.7) | (-2.8, -2.1) | (-1.3, -0.3) |

Abbreviations: ABR=abrocitinib; CI=confidence interval; EASI=Eczema Area and Severity Index; LSM=least squares mean; IGA=Investigator Global Assessment; N=number of patients randomized; PP-NRS4=Peak Pruritus Numerical Rating Scale; PSAAD=Pruritus and Symptoms Assessment for Atopic Dermatitis; QD=once daily.

- IGA responders were patients with IGA score of clear (0) or almost clear (1) (on a 5-point scale) and a reduction from baseline of ≥ 2 points.
- EASI-75 responders were patients with $\geq 75\%$ improvement in EASI, from baseline.
- The proportion of PP-NRS4 responders was also significantly higher with CIBINQO 200 mg and 100 mg once daily than placebo at Week 2 and Week 4 in both MONO-1 and MONO-2.
- PP-NRS4 responders were patients with ≥ 4 -point improvement in PP-NRS from baseline.
- Multiplicity-controlled $p < 0.01$ versus placebo.
- Multiplicity-controlled $p < 0.001$ versus placebo.
- Multiplicity-controlled $p < 0.0001$ versus placebo.

Treatment effects in subgroups (e.g., weight, age, sex, race, and prior systemic immunosuppressant treatment) in MONO-1 and MONO-2 were consistent with the results in the overall study population.

Combination Therapy Study:

In the pivotal combination therapy study (COMPARE), the proportion of patients who achieved IGA or EASI-75 response was significantly higher in patients who received CIBINQO 100 mg or 200 mg once daily compared with placebo at Week 12 (see Table 89). Higher proportion of patients also achieved EASI-90 with CIBINQO 100 mg or 200 mg once daily compared with placebo at Week 16 (38.0% and 48.9% vs. 11.3%).

The proportions of patients achieving PP-NRS4 with CIBINQO 100 mg and 200 mg once daily were significantly higher than placebo by Day 9 and Day 4, respectively, and remained significantly higher than placebo with both CIBINQO doses at Week 2 (Figure 1). Higher proportion of patients also achieved PP-NRS (0 or 1) with CIBINQO 100 mg or 200 mg once daily compared with placebo at Week 16 (24.7% and 32.0% vs. 11.7%).

Abrocitinib 200 mg QD had more rapid onset of relief of pruritus than dupilumab. The proportion of patients achieving PP-NRS4 with CIBINQO 200 mg once daily was significantly higher than dupilumab as early as Day 4 and remained significantly higher than dupilumab at Week 2. The proportion of patients achieving PP-NRS4 was similar between CIBINQO 100 mg once daily and dupilumab at Week 2.

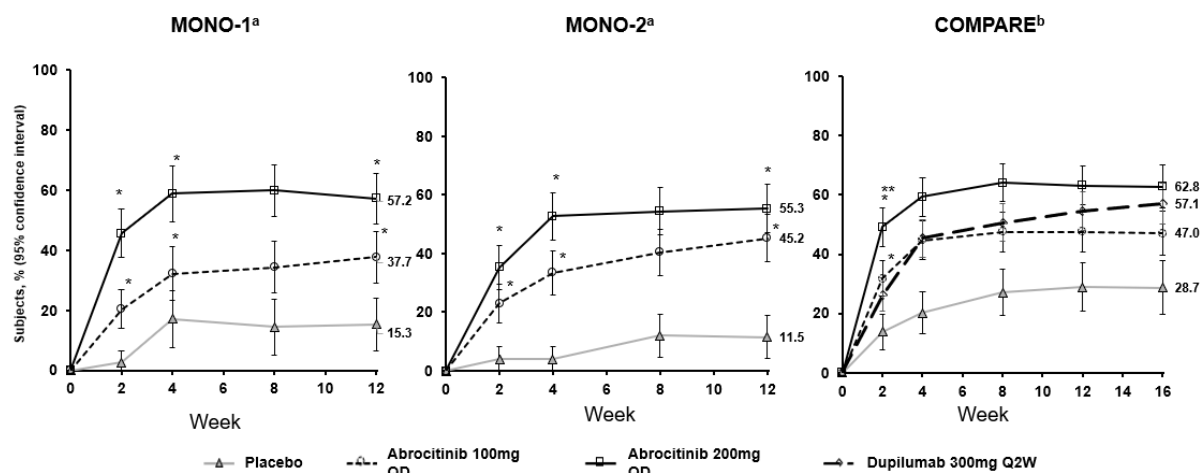
Table 9. Efficacy Results of CIBINQO with Concomitant Topical Therapy

| | Week 2 | | | | Week 12 | | | | Week 16 | | | |
|-------------------------|---------------------|-------------------|--------------|--------------|-------------------|-------------------|--------------|--------------|-------------------|-------------------|--------------|--------------|
| | ABR | | PBO N=131 | DUP N=243 | ABR | | PBO N=131 | DUP N=243 | ABR | | PBO N=131 | DUP N=243 |
| | 200 mg N=226 | 100 mg N=238 | | | 200 mg N=226 | 100 mg N=238 | | | 200 mg N=226 | 100 mg N=238 | | |
| | % Responders | | | | | | | | | | | |
| IGA 0 or 1 ^a | 18.4 | 15.2 | 6.3 | 4.7 | 48.4 ^e | 36.6 ^e | 14.0 | 36.5 | 47.5 ^e | 34.8 ^e | 12.9 | 38.8 |
| EASI-75 ^b | 30.0 | 25.4 | 10.9 | 14.0 | 70.3 ^e | 58.7 ^e | 27.1 | 58.1 | 71.0 ^e | 60.3 ^e | 30.6 | 65.5 |
| PP-NRS4 ^c | 49.1 ^{e,f} | 31.8 ^d | 13.8 | 26.4 | 63.1 | 47.5 | 28.9 | 54.5 | 62.8 | 47.0 | 28.7 | 57.1 |

Abbreviations: ABR=abrocitinib; DUP=dupilumab; EASI=Eczema Area and Severity Index; N=number of patients randomized; PBO=placebo; PP-NRS=Peak pruritus numerical rating scale

- a. IGA responders were patients with IGA score of clear (0) or almost clear (1) (on a 5-point scale) and a reduction from baseline of ≥ 2 points.
- b. EASI-75 responders were patients with ≥ 75 improvement in EASI, respectively, from baseline.
- c. PP-NRS4 responders were patients with ≥ 4 -point improvement in PP-NRS from baseline.
- d. Multiplicity-controlled $p < 0.001$ vs. placebo
- e. Multiplicity-controlled $p < 0.0001$ vs. placebo
- f. Multiplicity-controlled $p < 0.0001$ vs. dupilumab. Statistical comparison between either abrocitinib dose and dupilumab was only performed on the proportion of patients achieving PP-NRS4 at Week 2.

Figure 1. Proportion of patients who achieved PP-NRS4 over time in MONO-1, MONO-2 and COMPARE



Abbreviations: PP-NRS=Peak Pruritus Numerical Rating Scale; QD=once daily. PP-NRS4 responders were patients with ≥ 4 -point improvement in PP-NRS from baseline.

- a. Abrocitinib used as monotherapy.
- b. Abrocitinib used in combination with medicated topical therapy.
- * Statistically significant with adjustment for multiplicity versus placebo.
- ** Statistically significant with adjustment for multiplicity versus dupilumab.

Treatment effects in subgroups (e.g., weight, age, sex, race, and prior systemic immunosuppressant treatment) in COMPARE were consistent with the results in the overall study population.

Early onset of treatment effect, prior to the time-points selected for formal efficacy assessments, was observed for both doses of abrocitinib for the proportion of subjects who achieved IGA response, EASI-75, or PP-NRS4 response in all studies, and for change in PSAAD from baseline in the monotherapy studies.

Abrocitinib 200 mg QD had more rapid onset of relief of pruritus than dupilumab. Starting at Day 2 through Week 16, abrocitinib 200 mg QD had higher PP-NRS4 responder proportion than dupilumab, whereas abrocitinib 100 mg was similar to dupilumab over time.

The totality of data demonstrates that both abrocitinib doses relieved the signs and symptoms of moderate-to-severe AD, including skin clearance, itch relief and improvement of quality of life, either as monotherapy or in combination with background medicated topical therapy in adults and adolescents.

Switch from Dupilumab to Abrocitinib:

Patients who received dupilumab and subsequently enrolled in EXTEND were randomized to either CIBINQO 100 mg or 200 mg once daily upon entering EXTEND. Among responders to dupilumab in COMPARE, the majority did not show evidence of a loss of response 12 weeks after switching to CIBINQO. Some non-responders to dupilumab in COMPARE also demonstrated an IGA and EASI-75 response after switching to CIBINQO, though response rates relative to a comparator were not determined.

Long-term Efficacy:

The majority of patients who achieved a response at Week 12 of a qualifying study and entered EXTEND did not show evidence of a loss of the treatment response at Week 48 [60% and 70% for IGA (0 or 1) response, 79% and 87% for EASI-75, and 62% and 83% for PP-NRS4 with 100 mg once daily and 200 mg once daily, respectively].

Secondary endpoints on quality of life PRO:

There was improvement in different indexes of symptoms and quality of life in adults and adolescents with AD, consistent with the changes observed in the main efficacy parameters.

Treatment with either dose of CIBINQO as monotherapy resulted in improved patient-reported outcomes at 12 weeks compared with placebo. A larger proportion of the CIBINQO groups had clinically meaningful reductions in Dermatology Life Quality Index (DLQI) total scores (defined as a 4-point improvement) from baseline to Week 12 compared with placebo. Both CIBINQO 100 mg and 200 mg groups also had a larger proportion of patients who reported “no effect” of their disease on their quality of life (as measured by a DLQI score of 0 or 1).

Improved patient-reported atopic dermatitis symptoms and sleep disruption as measured by the Pruritus and Symptoms Assessment for Atopic Dermatitis (PSAAD), Patient Oriented Eczema Measure (POEM), Night Time Itch Scale (NTIS), and SCORing Atopic Dermatitis (SCORAD) sleep loss subscale were observed in both groups. In addition, anxiety and depression symptoms as measured by the Hospital Anxiety and Depression Scale (HADS) total score were reduced in the CIBINQO 100 mg and 200 mg groups compared with placebo at 12 weeks.

In COMPARE, a larger proportion both of the CIBINQO 100 mg and 200 mg groups had clinically meaningful reductions in DLQI total scores (defined as a 4-point improvement) from baseline to Week 12 compared with placebo. CIBINQO groups also had a larger proportion of patients who reported “no effect” of their disease on their quality of life (as measured by a DLQI score of 0 or 1).

Both CIBINQO 100 mg and 200 mg improved patient-reported atopic dermatitis symptoms and sleep disruption as measured by the POEM and SCORAD sleep loss subscale, respectively. In addition, anxiety and depression symptoms as measured by the HADS total score were reduced in both the CIBINQO 100 mg and 200 mg groups compared with placebo at 12 weeks.

Pediatric data results

Data from the Phase 3 monotherapy studies indicate that the treatment with both abrocitinib doses resulted in clinically meaningful efficacy in adults and adolescents, with demonstration of dose-dependent increase in treatment effect.

In adolescents, abrocitinib 100 mg QD and 200 mg QD achieved higher IGA responder proportions than placebo at Week 12 in both Phase 3 monotherapy studies. The treatment effect (IGA responder proportion corrected for placebo) was clinically meaningful for both abrocitinib doses (13.5% and 22.5% for 100 mg QD and 200 mg QD, respectively).

In adolescents, abrocitinib 100 mg QD and 200 mg QD achieved higher EASI-75 responder proportions than placebo at Week 12 in both Phase 3 monotherapy studies. The 95% confidence intervals for placebo-corrected responder proportions for both doses of abrocitinib excluded zero in the monotherapy pool, suggesting true treatment effects. The treatment effect was clinically meaningful for both abrocitinib doses (35.4% and 47.6% for 100 mg QD and 200 mg QD, respectively, in the monotherapy pool), with evidence of dose-dependency.

14.3 Comparative Bioavailability Studies

This Phase 1 randomized, open-label, single-dose, crossover study in healthy participants was to estimate the rBA of single 200 mg doses of the commercial tablet formulation of PF-04965842 and a variant formulation with a slower dissolution rate, compared to the Phase 3 tablet formulation. The effect of food on the BA of the commercial tablet formulation was also evaluated.

15 MICROBIOLOGY

Not applicable

16 NON-CLINICAL TOXICOLOGY

Rats (Wistar Han or Sprague Dawley) and cynomolgus monkeys were chosen as the nonclinical test systems for general toxicology studies because all the nonclinical studies of the marketed JAK1/3 inhibitor, tofacitinib (Xeljanz), were conducted in these species, and they have shown sensitivity to the pharmacological inhibition of JAK.

Genotoxicity

CIBINQO is not mutagenic in the bacterial mutagenicity assay (*Ames assay*). Although CIBINQO is aneugenic in the in vitro TK6 micronucleus assay, CIBINQO is not aneugenic or clastogenic based on the results of the in vivo rat bone marrow micronucleus assay.

Carcinogenicity

No evidence of tumorigenicity was observed in Tg.rasH2 mice administered CIBINQO for 6 months at oral doses up to 75 mg/kg/day and 60 mg/kg/day in female and male mice, respectively. In the 2-year oral carcinogenicity study, CIBINQO resulted in a statistically higher incidence of benign thymomas in female rats at exposures greater than or equal to 2.8 times the unbound human AUC at the MRHD of 200 mg. No evidence of CIBINQO -related tumorigenicity was observed following oral CIBINQO administration in female rats at exposures equal to 0.6 times the unbound human AUC at the MRHD of 200 mg, or in male rats at exposures equal to 14 times the unbound human AUC at the MRHD of 200 mg.

Reproductive and developmental toxicity

CIBINQO had no effects on rat male fertility or spermatogenesis at doses up to 70 mg/kg/ day at exposures equal to 26 times the unbound human AUC at the MRHD of 200 mg. CIBINQO resulted in effects on rat female fertility (lower fertility index, corpora lutea, and implantation sites) at exposures equal to 29 times the unbound human AUC at the MRHD of 200 mg and higher post implantation loss in rats at exposures greater than or equal to 11 times the unbound human AUC at the MRHD of 200 mg. The effects on female fertility in rats reversed 1 month after cessation of CIBINQO administration. No effects on female fertility were noted at exposures equal to 2 times the unbound human AUC at the MRHD of 200 mg.

No fetal malformations were observed in embryo-fetal development studies in rats or rabbits. In an embryo-fetal development study in pregnant rabbits, oral administration of CIBINQO during gestation days 7 to 19 had no effects on embryo-fetal survival or fetal morphological development at exposures equal to 4 times the unbound human AUC at the MRHD of 200 mg. CIBINQO resulted in an increased incidence of delayed ossification of the forelimb phalanges at exposures equal to 4 times the unbound human AUC at the MRHD of 200 mg.

In an embryo-fetal development study in pregnant rats, oral administration of CIBINQO during gestation days 6 to 17 resulted in increased embryo-fetal lethality at exposures equal to 17 times the unbound human AUC at the MRHD of 200 mg. No embryo-fetal lethality was observed in pregnant rats orally dosed with CIBINQO during organogenesis at exposures equal to 11 times the unbound human AUC at the MRHD of 200 mg. CIBINQO resulted in increased incidences of skeletal variations of short 13th ribs at exposures greater than or equal to 11 times the unbound human AUC at the MRHD of 200 mg and reduced ventral processes, thickened ribs, and unossified metatarsals at exposures equal to 17 times the unbound human AUC at the MRHD of 200 mg. No skeletal variations were noted in rats at exposures equal to 2.4 times the unbound human AUC at the MRHD of 200 mg.

In a rat pre- and postnatal development study in pregnant rats, oral administration of CIBINQO during gestation day 6 through lactation day 21 resulted in dystocia with prolonged parturition and lower offspring body weights at exposures greater than or equal to 11 times the unbound human AUC at the MRHD of 200 mg and lower postnatal survival at exposures equal to 17 times the unbound human AUC at the MRHD of 200 mg. No maternal or developmental toxicity was observed in either dams or offspring at exposures equal to 2.4 times the unbound human AUC at the MRHD of 200 mg.

Juvenile Toxicity

Administration of abrocitinib to juvenile rats (comparable to a 3-month old human) resulted in macroscopic and microscopic bone findings. When dosing was initiated at postnatal Day 10 (at exposures \geq 0.8 times the unbound human AUC at the MRHD of 200 mg), macroscopic bone findings (malrotated and/or impaired use of forelimbs or hindlimbs or paws, fractures, and/or femoral head abnormalities) were noted. Only the microscopic bone dystrophy finding (similar to that observed in rat general toxicity studies of up to 1 month) was fully reversible after cessation of treatment.

17 SUPPORTING PRODUCT MONOGRAPHS

Not applicable

READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE
PATIENT MEDICATION INFORMATION

Pr**CIBINQO**[®]

Abrocitinib Tablets

Read this carefully before you start taking **CIBINQO** and each time you get a refill. This leaflet is a summary and will not tell you everything about this drug. Talk to your healthcare professional about your medical condition and treatment and ask if there is any new information about **CIBINQO**.

Serious Warnings and Precautions

CIBINQO may cause serious side effects, including:

- **Serious infections:** CIBINQO is a medicine that affects your immune system. CIBINQO can lower the ability of your immune system to fight infections. This can cause serious infections that can lead to hospitalization or death. The most common type of infections were caused by viruses. Before you take CIBINQO tell your healthcare professional if you have an infection or get infections that often come back. Your healthcare professional will assess the risks before you begin treatment with CIBINQO if you have a chronic and reoccurring infection. They will closely monitor you for symptoms of an infection during and after your treatment with CIBINQO. This includes monitoring you for symptoms of tuberculosis. Your healthcare professional may suspend your treatment if you develop a serious infection. See “*Other warnings you should know about*” for more information.
- **Cancer:** CIBINQO may increase your risk of getting cancer, by changing the way your immune system works. Before you take CIBINQO, tell your healthcare professional if you have ever had cancer. People taking a medicine in the class of medicines called Janus kinase (JAK) inhibitors may have a higher risk of certain cancers including lymphoma. See “*Other warnings you should know about*” for more information.
- **Blood clots:** CIBINQO may increase your risk of getting blood clots in the veins of your legs (**deep vein thrombosis**), lungs (**pulmonary embolism**, or arteries (**arterial thrombosis**). These blood clots can be serious or life threatening. Your healthcare professional will assess your risk of getting blood clots and tell you if it is safe to take CIBINQO. Your healthcare professional will stop your treatment if blood clots occur. Blood clots in the veins of the legs and lungs have happened more often in people who are taking JAK inhibitors. See “*Other warnings you should know about*” for more information.
- **Heart problems, Stroke and Death:** JAK inhibitors may increase your risk of heart problems including heart attack or your risk of stroke. These can lead to death. See “*Other warnings you should know about*” for more information.

What is CIBINQO used for?

CIBINQO is used to treat patients 12 years of age and older with:

- Moderate to severe atopic dermatitis (a type of eczema).

- It includes relief of skin itching in these patients.

CIBINQO is only used in patient who:

- Have not responded sufficiently to other non-topical medicines
- Cannot take other non-topical medicines for this condition.

CIBINQO should be used with caution in elderly patients 65 years of age and over.

How does CIBINQO work?

CIBINQO interferes with an enzyme called Janus Kinase (JAK). It is a medicine known as a JAK inhibitor. Normally JAK enzymes help turn on your immune system when you need it. However, when it is too active this can also lead to inflammation that could result in swelling, redness and pain. CIBINQO works by attaching to the JAK enzyme to lower its activity.

What are the ingredients in CIBINQO?

Medicinal ingredients: abrocitinib

Non-medicinal ingredients: dibasic calcium phosphate anhydrous, hypromellose, iron oxide red, lactose monohydrate, Macrogol/PEG, magnesium stearate, microcrystalline cellulose, sodium starch glycolate, titanium dioxide and triacetin.

CIBINQO comes in the following dosage forms:

Film-coated tablets: 50 mg, 100 mg and 200 mg.

Do not use CIBINQO if:

- you are allergic to abrocitinib or to any of the other ingredients in CIBINQO. If you are not sure, talk to your healthcare professional before taking CIBINQO.

To help avoid side effects and ensure proper use, talk to your healthcare professional before you take CIBINQO. Talk about any health conditions or problems you may have, including if you:

- are taking other immunosuppressant medicines such as methotrexate and cyclosporine or other JAK inhibitor medicines.
- have an infection or get infections that often come back.
- have hepatitis virus B or C infection.
- have liver problems.
- have kidney problems.
- have a low platelet count or white blood cell count.
- have or have had cancer.

Other warnings you should know about:

Serious Infections:

Tell your healthcare professional if you have an infection or get infections that often come back. Taking CIBINQO increases your risk of developing serious infections such as herpes simplex, shingles (herpes zoster) and pneumonia. CIBINQO may also make infections such as shingles and herpes simplex come back. Your healthcare professional will closely monitor you for infection during and after your treatment. They may put you on antimicrobial therapy if you develop a new infection during treatment. They might also stop your treatment with CIBINQO. They will also screen you for the following infections before and during treatment with CIBINQO:

- **Tuberculosis (TB):** You should not take CIBINQO if you have an active TB infection. Your healthcare professional may put you on preventative medication before beginning treatment with CIBINQO. You will be given this if you are newly diagnosed with inactive TB or had an untreated previous diagnosis of inactive TB.
- **Viral hepatitis:** Tell your healthcare professional if you have hepatitis virus B or C infection. They will also screen you these infections before you start treatment with CIBINQO.

Talk to your healthcare professional if you get any symptoms of an infection including, shingles, herpes simplex, pneumonia or other infection while you are taking CIBINQO. See the “Serious side effects and what to do about them” for symptoms.

Cancer:

Before you take CIBINQO, tell your healthcare professional if you have or have had cancer. CIBINQO may increase your risk of getting certain cancers. If you smoke, this might further increase your risk of getting certain cancers while taking CIBINQO. Your healthcare professional may want to examine your skin regularly for any sign of cancer.

Blood Clots:

CIBINQO may increase your risk of getting blood clots in the veins of your legs or lungs. Your healthcare professional will assess your risk of getting blood clots and tell you if it is safe to take CIBINQO. You are more likely to get blood clots while taking CIBINQO if you:

- Are immobile for a long time.
- Have major surgery.
- Are older.
- Are obese.
- Have had blood clots in the veins of your legs or lungs in the past.
- Have an inherited blood clotting disorder.
- Take hormone therapy or birth control pills.

Talk to your healthcare professional if you get any symptoms of blood clots in the veins of your legs (deep vein thrombosis) or lungs (pulmonary embolism) while you are taking CIBINQO. See the “Serious side effects and what to do about them” for symptoms.

Heart problems, Stroke and Death:

CIBINQO may increase your risk of heart attacks and stroke. You are more likely to get these if you have certain risk factors, including if you smoke. Talk to your doctor about these risk factors.

Stop taking CIBINQO and get immediate medical help if you develop any symptoms of a heart attack during treatment with CIBINQO.-See the “Serious side effects and what to do about them” for symptoms.

Vaccinations:

You should not receive live or attenuated vaccines while receiving CIBINQO or immediately before you start treatment. Your immunizations should be up to date before taking CIBINQO. This includes vaccines for shingles. Talk to your doctor before taking CIBINQO if you are planning to receive a vaccine.

Pregnancy:

Before taking CIBINQO, tell your healthcare professional if you are pregnant, think you might be pregnant or are planning to become pregnant. You should avoid becoming pregnant while you are taking CIBINQO and for at least 1 month after stopping treatment. This is because CIBINQO may harm your unborn baby. Use effective birth control during treatment and for at least 1 month after your last dose of CIBINQO. Talk to your healthcare professional about effective birth control methods. Tell your healthcare professional right away if you become pregnant or think you may be pregnant while taking CIBINQO.

Breastfeeding:

Before you take CIBINQO, tell your healthcare professional if you are breastfeeding or plan to breastfeed. You should not breastfeed while you are taking CIBINQO. This is because it may pass into your breastmilk and harm your baby. Talk to your healthcare professional about the best way to feed your baby if you are taking CIBINQO.

Monitoring and tests:

Your healthcare provider should do blood tests before you start taking CIBINQO and also while you are taking CIBINQO. You should not take CIBINQO if your white blood cell count or platelet count is too low. Your healthcare provider may stop or interrupt your treatment for a period of time depending on your blood test results. Your healthcare professional will also monitor your blood lipid levels while you are taking CIBINQO.

Driving and using machines:

CIBINQO may cause dizziness, which can affect how well you drive or use machines. Do NOT drive or use dangerous machines until you know how CIBINQO affects you.

Tell your healthcare professional about all the medicines you take, including any drugs, vitamins, minerals, natural supplements or alternative medicines.

The following may interact with CIBINQO:

- Fluconazole, used to treat fungal or yeast infections.
- Fluvoxamine, used for the treatment of some psychiatric disorders.
- Amiodarone, used to treat heart rhythm problems.
- Fluoxetine, used to treat of some psychiatric disorders.
- Miconazole, used to treat fungal or yeast infections.
- Rifampicin, used to treat tuberculosis (TB) and other infections.
- Probenecid, used to treat gout and renal problems.

How to take CIBINQO:

- Take CIBINQO exactly as your healthcare professional has told you to.

- Check with your healthcare professional if you are not sure.
- You can take CIBINQO with or without food. However, if you experience nausea taking CIBINQO with food might make your nausea better.
- Take CIBINQO at about the same time each day.
- Swallow tablets whole with water. Do not split, crush, or chew the tablets.
- CIBINQO can be used with or without prescribed topical medications for atopic dermatitis. Topical medications are lotions, creams, or ointments applied to your skin.
- If you have kidney problems, talk to your healthcare professional. You may need to take a lower dose.
- Your healthcare professional might also give you a lower dose if you are taking certain other medicines.

Usual dose in adolescents (between 12 and 18 years of age) and in adults:

The recommended dose is 100 mg or 200 mg once a day. Your healthcare professional will prescribe the dose that is right for you. They may change your dose depending on your condition and the risk of side effects.

Taking more than of 200 mg in a day is not recommended.

Patients over 65 years of age should start with 100 mg in a day.

Overdose:

If you think you, or a person you are caring for, have taken too much CIBINQO, contact your healthcare professional, hospital emergency department or regional poison control centre immediately, even if there are no symptoms.

Missed Dose:

If you miss a dose, take it as soon as you remember. But if it is almost time for your next dose, skip the missed dose and continue with your next scheduled dose. Go back to the regular dosing schedule. Never take two doses at the same time.

What are possible side effects from using CIBINQO?

These are not all the possible side effects you may feel when taking CIBINQO. If you experience any side effects not listed here, contact your healthcare professional.

The most common side effects of CIBINQO include:

- acne
- cold sores (also known as oral herpes simplex)
- dizziness
- headache
- nausea
- upper abdominal pain
- vomiting

CIBINQO can cause abnormal blood test results. Your doctor may do blood tests before you start CIBINQO and while you take it. Your doctor will decide when to perform blood tests and will interpret the results.

| Serious side effects and what to do about them | | | |
|---|--------------------------------------|--------------|---|
| Symptom / effect | Talk to your healthcare professional | | Stop taking drug and get immediate medical help |
| | Only if severe | In all cases | |
| COMMON | | | |
| Herpes simplex (infection of the genitals, eyes or skin caused by the herpes simplex virus): tingling, pain or itching in genital area, small red blisters or sores on penis, scrotum or vaginal area, redness, pain or swelling around the eye, blurred vision, watery eyes, tingling, pain or itching in genital area, small red blisters or sores on any skin area. | | | √ |
| Infections: fever, chills, muscle aches, flu-like symptoms, cough, sore throat, diarrhea or stomach pain, feeling tired. | | √ | |
| UNCOMMON | | | |
| Blood clots: Deep vein thrombosis (blood clot in legs): swelling, pain, leg may be warm to the touch and may appear red. Pulmonary embolism (blood clot in lungs): chest pain that may increase with deep breathing, cough, coughing up bloody sputum, shortness of breath. | | √ √ | |
| Cancer including skin cancer. Symptoms may be variable | | √ | |
| Myocardial infarction (heart attack): pressure or squeezing pain between the shoulder blades, in the chest, jaw, left arm or upper abdomen, shortness of breath, dizziness, fatigue, light-headedness, clammy skin, sweating, indigestion, anxiety, feeling faint and possible irregular heartbeat | | | √ |
| Lymphopenia (low white blood cells): get infections more easily. | | √ | |

| | | | |
|--|--|---|--|
| Pneumonia: (lung infection): chest pain when you breath or cough, confusion, cough which may produce phlegm, fatigue, fever, sweating and shaking, chills, nausea, vomiting or diarrhea, shortness of breath. | | √ | |
| Shingles, also known as herpes zoster (skin infection): a painful skin rash of fluid-filled blisters, blisters appear along a strip of skin, itching or tingling of the skin. | | √ | |
| Thrombocytopenia (low blood platelets): bruising or bleeding | | √ | |

If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, talk to your healthcare professional.

| |
|--|
| <p>Reporting Side Effects</p> <p>You can report any suspected side effects associated with the use of health products to Health Canada by:</p> <ul style="list-style-type: none"> • Visiting the Web page on Adverse Reaction Reporting (http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/index-eng.php) for information on how to report online, by mail or by fax; or • Calling toll-free at 1-866-234-2345. <p><i>NOTE: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.</i></p> |
|--|

Storage:

- Store CIBINQO at room temperature between 15°C - 30°C.
- Store CIBINQO in the original package.

Keep out of reach and sight of children.

If you want more information about CIBINQO:

- Talk to your healthcare professional
- Find the full product monograph that is prepared for healthcare professionals and includes this Patient Medication Information by visiting the Health Canada website (<http://hc-sc.gc.ca/index-eng.php>); the manufacturer’s website (www.pfizer.ca), or by calling 1-800-463-6001.
- For more information on the Cibinqo Education Program (Prescriber Brochure and Patient Card), please visit the the manufacturer’s website (www.pfizer.ca).

This leaflet was prepared by Pfizer Canada ULC

Last Revised AUG 5, 2022