SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Fingolimod 0.25 mg hard capsules

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each hard capsule contains 0.25 mg fingolimod (as hydrochloride).

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Hard capsules

Size ‘3’ hard gelatin capsules with ivory opaque cap and body, imprint with black ink “F 0.25” on cap, containing white to off-white powder mixture.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Fingolimod is indicated as single disease modifying therapy in highly active relapsing remitting multiple sclerosis for the following groups of adult patients and paediatric patients aged 10 years and older:

- Patients with highly active disease despite a full and adequate course of treatment with at least one disease modifying therapy (for exceptions and information about washout periods see sections 4.4 and 5.1).

or

- Patients with rapidly evolving severe relapsing remitting multiple sclerosis defined by 2 or more disabling relapses in one year, and with 1 or more Gadolinium enhancing lesions on brain MRI or a significant increase in T2 lesion load as compared to a previous recent MRI.

4.2 Posology and method of administration

The treatment should be initiated and supervised by a physician experienced in multiple sclerosis.

Posology

In adults, the recommended dose of Fingolimod is one 0.5 mg capsule taken orally once daily.

In paediatric patients (10 years of age and above), the recommended dose is dependent on body weight:

- Paediatric patients with body weight ≤40 kg: one 0.25 mg capsule taken orally once daily.
- Paediatric patients with body weight >40 kg: one 0.5 mg capsule taken orally once daily.

Paediatric patients who start on 0.25 mg capsules and subsequently reach a stable body weight above 40 kg should be switched to 0.5 mg capsules.

When switching from a 0.25 mg to a 0.5 mg daily dose, it is recommended to repeat the same first dose monitoring as for treatment initiation.

The same first dose monitoring as for treatment initiation is recommended when treatment is interrupted for:

- 1 day or more during the first 2 weeks of treatment.
- more than 7 days during weeks 3 and 4 of treatment.
- more than 2 weeks after one month of treatment.

If the treatment interruption is of shorter duration than the above, the treatment should be continued with the next dose as planned (see section 4.4).

Special populations

Elderly population

Fingolimod should be used with caution in patients aged 65 years and over due to insufficient data on safety and efficacy (see section 5.2).

Renal impairment

Fingolimod was not studied in patients with renal impairment in the multiple sclerosis pivotal studies. Based on clinical pharmacology studies, no dose adjustments are needed in patients with mild to severe renal impairment.

Hepatic impairment

Fingolimod must not be used in patients with severe hepatic impairment (Child-Pugh class C) (see section 4.3). Although no dose adjustments are needed in patients with mild or moderate hepatic impairment, caution should be exercised when initiating treatment in these patients (see sections 4.4 and 5.2).

Paediatric population

The safety and efficacy of fingolimod in children aged below 10 years have not yet been established. No data are available.

There are very limited data available in children between 10-12 years old (see sections 4.4, 4.8 and 5.1).

Method of administration

This medicinal product is for oral use.

Fingolimod can be taken with or without food (see section 5.2).

The capsules should always be swallowed intact, without opening them.

4.3 Contraindications

- Immunodeficiency syndrome.
- Patients with increased risk for opportunistic infections, including immunocompromised patients (including those currently receiving immunosuppressive therapies or those immunocompromised by prior therapies).
- Suspected or confirmed progressive multifocal leukoencephalopathy (PML) (see section 4.4).
- Severe active infections, active chronic infections (hepatitis, tuberculosis).
- Active malignancies.
- Severe liver impairment (Child-Pugh class C).
- Patients who in the previous 6 months had myocardial infarction (MI), unstable angina pectoris, stroke/transient ischaemic attack (TIA), decompensated heart failure (requiring inpatient treatment), or New York Heart Association (NYHA) class III/IV heart failure (see section 4.4).
- Patients with severe cardiac arrhythmias requiring anti-arrhythmic treatment with class Ia or class III anti-arrhythmic medicinal products (see section 4.4).
- Patients with second-degree Mobitz type II atrioventricular (AV) block or third-degree AV block, or sick-sinus syndrome, if they do not wear a pacemaker (see section 4.4).
- Patients with a baseline QTc interval ≥500 msec (see section 4.4).

- During pregnancy and in women of childbearing potential not using effective contraception (see sections 4.4 and 4.6).
- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

Bradyarrhythmia

Initiation of fingolimod treatment results in a transient decrease in heart rate and may also be associated with atrioventricular conduction delays, including the occurrence of isolated reports of transient, spontaneously resolving complete AV block (see sections 4.8 and 5.1).

After the first dose, the decline in heart rate starts within one hour, and is maximal within 6 hours. This post-dose effect persists over the following days, although usually to a milder extent, and usually abates over the next weeks. With continued administration, the average heart rate returns towards baseline within one month. However individual patients may not return to baseline heart rate by the end of the first month. Conduction abnormalities were typically transient and asymptomatic. They usually did not require treatment and resolved within the first 24 hours on treatment. If necessary, the decrease in heart rate induced by fingolimod can be reversed by parenteral doses of atropine or isoprenaline.

All patients should have an ECG and blood pressure measurement performed prior to and 6 hours after the first dose of fingolimod. All patients should be monitored for a period of 6 hours for signs and symptoms of bradycardia with hourly heart rate and blood pressure measurement. Continuous (real time) ECG monitoring during this 6 hour period is recommended.

The same precautions as for the first dose are recommended when patients are switched from the 0.25 mg to the 0.5 mg daily dose.

Should post-dose bradyarrhythmia-related symptoms occur, appropriate clinical management should be initiated and monitoring should be continued until the symptoms have resolved. Should a patient require pharmacological intervention during the first-dose monitoring, overnight monitoring in a medical facility should be instituted and the first-dose monitoring should be repeated after the second dose of fingolimod.

If the heart rate at 6 hours is the lowest since the first dose was administered (suggesting that the maximum pharmacodynamic effect on the heart may not yet be manifest), monitoring should be extended by at least 2 hours and until heart rate increases again. Additionally, if after 6 hours, the heart rate is <45 bpm in adults, <55 bpm in paediatric patients aged 12 years and above, or <60 bpm in paediatric patients aged 10 to below 12 years, or the ECG shows new onset second degree or higher grade AV block or a QTc interval ≥500 msec, extended monitoring (at least overnight monitoring), should be performed, and until the findings have resolved. The occurrence at any time of third degree AV block should also lead to extended monitoring (at least overnight monitoring).

The effects on heart rate and atrioventricular conduction may recur on re-introduction of fingolimod treatment depending on duration of the interruption and time since start

of fingolimod treatment. The same first dose monitoring as for treatment initiation is recommended when treatment is interrupted (see section 4.2).

Very rare cases of T-wave inversion have been reported in adult patients treated with fingolimod. In case of T-wave inversion, the prescriber should ensure that there are no associated myocardial ischaemia signs or symptoms. If myocardial ischaemia is suspected, it is recommended to seek advice from a cardiologist.

Due to the risk of serious rhythm disturbances or significant bradycardia, Fingolimod should not be used in patients with sino-atrial heart block, a history of symptomatic bradycardia, recurrent syncope or cardiac arrest, or in patients with significant QT prolongation (QTc >470 msec [adult female], QTc >460 msec [paediatric female] or >450 msec [adult and paediatric male]), uncontrolled hypertension or severe sleep apnoea (see also section 4.3). In such patients, treatment with fingolimod should be considered only if the anticipated benefits outweigh the potential risks, and advice from a cardiologist sought prior to initiation of treatment in order to determine the most appropriate monitoring. At least overnight extended monitoring is recommended for treatment initiation (see also section 4.5).

Fingolimod has not been studied in patients with arrhythmias requiring treatment with class Ia (e.g. quinidine, disopyramide) or class III (e.g. amiodarone, sotalol) antiarrhythmic medicinal products. Class Ia and class III antiarrhythmic medicinal products have been associated with cases of torsades de pointes in patients with bradycardia (see section 4.3).

Experience with fingolimod is limited in patients receiving concurrent therapy with beta blockers, heart-rate-lowering calcium channel blockers (such as verapamil or diltiazem), or other substances which may decrease heart rate (e.g. ivabradine, digoxin, anticholinesteratic agents or pilocarpine). Since the initiation of fingolimod treatment is also associated with slowing of the heart rate (see also section 4.8 “Bradyarrhythmia”), concomitant use of these substances during fingolimod initiation may be associated with severe bradycardia and heart block. Because of the potential additive effect on heart rate treatment with fingolimod should not be initiated in patients who are concurrently treated with these substances (see also section 4.5). In such patients, treatment with fingolimod should be considered only if the anticipated benefits outweigh the potential risks. If treatment with fingolimod is considered, advice from a cardiologist should be sought regarding the switch to non-heart-rate-lowering medicinal products prior to initiation of treatment. If the heart-rate-lowering treatment cannot be stopped, cardiologist’s advice should be sought to determine appropriate first dose monitoring, at least overnight extended monitoring is recommended (see also section 4.5).

QT interval

In a thorough QT interval study of doses of 1.25 or 2.5 mg fingolimod at steady-state, when a negative chronotropic effect of fingolimod was still present, fingolimod treatment resulted in a prolongation of QTcI, with the upper limit of the 90% CI ≤13.0 ms. There is no dose- or exposure-response relationship of fingolimod and QTcI prolongation. There is no consistent signal of increased incidence of QTcI outliers, either absolute or change from baseline, associated with fingolimod treatment.

The clinical relevance of this finding is unknown. In the multiple sclerosis studies, clinically relevant effects on prolongation of the QTc-interval have not been observed but patients at risk for QT prolongation were not included in clinical studies.

Medicinal products that may prolong QTc interval are best avoided in patients with relevant risk factors, for example, hypokalaemia or congenital QT prolongation.

Immunosuppressive effects

Fingolimod has an immunosuppressive effect that predisposes patients to an infection risk, including opportunistic infections that can be fatal, and increases the risk of developing lymphomas and other malignancies, particularly those of the skin. Physicians should carefully monitor patients, especially those with concurrent conditions or known factors, such as previous immunosuppressive therapy. If this risk is suspected, discontinuation of treatment should be considered by the physician on a case-by-case basis (see also section 4.4 “Infections” and “Cutaneous neoplasms” and section 4.8 “Lymphomas”).

Infections

A core pharmacodynamic effect of fingolimod is a dose-dependent reduction of the peripheral lymphocyte count to 20-30% of baseline values. This is due to the reversible sequestration of lymphocytes in lymphoid tissues (see section 5.1).

Before initiating treatment with fingolimod, a recent complete blood count (CBC) (i.e. within 6 months or after discontinuation of prior therapy) should be available. Assessments of CBC are also recommended periodically during treatment, at month 3 and at least yearly thereafter, and in case of signs of infection. Absolute lymphocyte count $<0.2x10^9$/L, if confirmed, should lead to treatment interruption until recovery, because in clinical studies, fingolimod treatment was interrupted in patients with absolute lymphocyte count $<0.2x10^9$/L.

Initiation of treatment with fingolimod should be delayed in patients with severe active infection until resolution.

The immune system effects of fingolimod may increase the risk of infections, including opportunistic infections (see section 4.8). Effective diagnostic and therapeutic strategies should be employed in patients with symptoms of infection while on therapy. When evaluating a patient with a suspected infection that could be serious, referral to a physician experienced in treating infections should be considered. During treatment, patients should be instructed to report promptly symptoms of infection to their physician.

Suspension of fingolimod should be considered if a patient develops a serious infection and consideration of benefit-risk should be undertaken prior to re-initiation of therapy.

Elimination of fingolimod following discontinuation of therapy may take up to two months and vigilance for infection should therefore be continued throughout this period. Patients should be instructed to report symptoms of infection up to 2 months after discontinuation of fingolimod.

Herpes viral infection

Serious, life-threatening, and sometimes fatal cases of encephalitis, meningitis or meningoencephalitis caused by herpes simplex and varicella zoster viruses have occurred with fingolimod at any time during treatment. If herpes encephalitis, meningitis or meningoencephalitis occur, fingolimod should be discontinued and appropriate treatment for the respective infection should be administered.

Patients need to be assessed for their immunity to varicella (chickenpox) prior to fingolimod treatment. It is recommended that patients without a health care professional confirmed history of chickenpox or documentation of a full course of vaccination with varicella vaccine undergo antibody testing to varicella zoster virus (VZV) before initiating fingolimod therapy. A full course of vaccination for antibody-negative patients with varicella vaccine is recommended prior to commencing treatment with fingolimod (see section 4.8). Initiation of treatment with fingolimod should be postponed for 1 month to allow full effect of vaccination to occur.

Cryptococcal meningitis

Cases of cryptococcal meningitis (a fungal infection), sometimes fatal, have been reported in the post-marketing setting after approximately 2-3 years of treatment, although an exact relationship with the duration of treatment is unknown (see section 4.8). Patients with symptoms and signs consistent with cryptococcal meningitis (e.g. headache accompanied by mental changes such as confusion, hallucinations, and/or personality changes) should undergo prompt diagnostic evaluation. If cryptococcal meningitis is diagnosed, fingolimod should be suspended and appropriate treatment should be initiated. A multidisciplinary consultation (i.e. infectious disease specialist) should be undertaken if re-initiation of fingolimod is warranted.

Progressive multifocal leukoencephalopathy

PML has been reported under fingolimod treatment since marketing authorisation (see section 4.8). PML is an opportunistic infection caused by John Cunningham virus (JCV), which may be fatal or result in severe disability. The majority of PML cases have occurred after 2 or more years of fingolimod treatment. In addition to duration of fingolimod exposure, other potential risk factors for PML include prior therapy with immunosuppressants or immunomodulators, and/or severe lymphopenia ($<0.5x10^9$/l). Patients at increased risk should be closely monitored for any signs or symptoms of PML. PML can only occur in the presence of a JCV infection. If JCV testing is undertaken, it should be considered that the influence of lymphopenia on the accuracy of anti-JCV antibody testing has not been studied in fingolimod-treated patients. A negative anti-JCV antibody test does not preclude the possibility of subsequent JCV infection. Before initiating treatment with fingolimod, a baseline MRI should be available (usually within 3 months) as a reference. During routine MRI (in accordance with national and local recommendations), physicians should pay attention to PML suggestive lesions. MRI findings may be apparent before clinical signs or symptoms.

Annual MRIs may be considered as part of increased vigilance especially in patients at increased risk of PML. Cases of asymptomatic PML based on MRI findings and positive JCV DNA in the cerebrospinal fluid have been reported in patients treated with fingolimod. If PML is suspected, MRI should be performed immediately for diagnostic purposes and treatment with fingolimod should be suspended until PML has been excluded. If PML is confirmed, treatment with fingolimod must be permanently discontinued (see also section 4.3).

Immune reconstitution inflammatory syndrome (IRIS) has been reported in patients treated with sphingosine 1-phosphate (S1P) receptor modulators, including fingolimod, who developed PML and subsequently discontinued treatment. IRIS presents as a clinical decline in the patient’s condition that may be rapid, can lead to serious neurological complications or death, and is often associated with characteristic changes on MRI. The time to onset of IRIS in patients with PML was usually from weeks to months after S1P receptor modulator discontinuation.

Monitoring for development of IRIS and appropriate treatment of the associated inflammation should be undertaken.

Human papilloma virus infection

Human papilloma virus (HPV) infection, including papilloma, dysplasia, warts and HPV-related cancer, has been reported under treatment with fingolimod in the post-marketing setting (see section 4.8). Due to the immunosuppressive properties of fingolimod, vaccination against HPV should be considered prior to treatment initiation with fingolimod taking into account vaccination recommendations. Cancer screening, including Pap test, is recommended as per standard of care.

Macular oedema

Macular oedema with or without visual symptoms has been reported in 0.5% of patients treated with fingolimod 0.5 mg, occurring predominantly in the first 3-4 months of therapy (see section 4.8). An ophthalmological evaluation is therefore recommended at 3-4 months after treatment initiation. If patients report visual disturbances at any time while on therapy, evaluation of the fundus, including the macula, should be carried out.

Patients with history of uveitis and patients with diabetes mellitus are at increased risk of macular oedema (see section 4.8). Fingolimod has not been studied in multiple sclerosis patients with concomitant diabetes mellitus. It is recommended that multiple sclerosis patients with diabetes mellitus or a history of uveitis undergo an ophthalmological evaluation prior to initiating therapy and have follow-up evaluations while receiving therapy.

Continuation of treatment in patients with macular oedema has not been evaluated. It is recommended that fingolimod be discontinued if a patient develops macular oedema. A decision on whether or not fingolimod therapy should be re-initiated after resolution of macular oedema needs to take into account the potential benefits and risks for the individual patient.

Liver injury

Increased hepatic enzymes, in particular alanine aminotransaminase (ALT) but also gamma-glutamyltransferase (GGT) and aspartate transaminase (AST) have been reported in multiple sclerosis patients treated with fingolimod. Some cases of acute liver failure requiring liver transplant and clinically significant liver injury have also been reported. Signs of liver injury, including markedly elevated serum hepatic enzymes and elevated total bilirubin, have occurred as early as ten days after the first dose and have also been reported after prolonged use. In clinical trials, elevations 3-fold the upper limit of normal (ULN) or greater in ALT occurred in 8.0% of adult patients treated with fingolimod 0.5 mg compared to 1.9% of placebo patients. Elevations 5-fold the ULN occurred in 1.8% of patients on fingolimod and 0.9% of patients on placebo. In clinical trials, fingolimod was discontinued if the elevation exceeded 5 times the ULN. Recurrence of liver transaminase elevations occurred with rechallenge in some patients, supporting a relationship to fingolimod. In clinical studies, transaminase elevations occurred at any time during treatment although the majority occurred within the first 12 months. Serum transaminase levels returned to normal within approximately 2 months after discontinuation of fingolimod.

Fingolimod has not been studied in patients with severe pre-existing hepatic injury (Child-Pugh class C) and should not be used in these patients (see section 4.3).

Due to the immunosuppressive properties of fingolimod, initiation of treatment should be delayed in patients with active viral hepatitis until resolution.

Recent (i.e. within last 6 months) transaminase and bilirubin levels should be available before initiation of treatment. In the absence of clinical symptoms, liver transaminases and serum bilirubin should be monitored at months 1, 3, 6, 9 and 12 on therapy and periodically thereafter until 2 months after fingolimod discontinuation. In the absence of clinical symptoms, if liver transaminases are greater than 3 but less than 5 times the ULN without increase in serum bilirubin, more frequent monitoring including serum bilirubin and alkaline phosphatase (ALP) measurement. should be instituted to determine if further increases occur and in order to discern if an alternative aetiology of hepatic dysfunction is present. If liver transaminases are at least 5 times the ULN or at least 3 times the ULN associated with any increase in serum bilirubin, fingolimod should be discontinued. Hepatic monitoring should be continued. If serum levels return to normal (including if an alternative cause of the hepatic dysfunction is discovered), fingolimod may be restarted based on a careful benefit-risk assessment of the patient.

Patients who develop symptoms suggestive of hepatic dysfunction, such as unexplained nausea, vomiting, abdominal pain, fatigue, anorexia, or jaundice and/or dark urine, should have liver enzymes and bilirubin checked promptly and treatment should be discontinued if significant liver injury is confirmed. Treatment should not be resumed unless a plausible alternative aetiology for the signs and symptoms of liver injury can be established.

Although there are no data to establish that patients with pre-existing liver disease are at increased risk of developing elevated liver function tests when taking fingolimod, caution in the use of fingolimod should be exercised in patients with a history of significant liver disease.

Blood pressure effects

Patients with hypertension uncontrolled by medication were excluded from participation in premarketing clinical trials and special care is indicated if patients with uncontrolled hypertension are treated with fingolimod.

In MS clinical trials, patients treated with fingolimod 0.5 mg had an average increase of approximately 3 mmHg in systolic pressure and approximately 1 mmHg in diastolic pressure, first detected approximately 1 month after treatment initiation and persisting with continued treatment. In the two-year placebo-controlled study, hypertension was reported as an adverse event in 6.5% of patients on fingolimod 0.5 mg and in 3.3% of patients on placebo. Therefore, blood pressure should be regularly monitored during treatment.

Respiratory effects

Minor dose-dependent reductions in values for forced expiratory volume (FEV_1) and diffusion capacity for carbon monoxide (DLCO) were observed with fingolimod treatment starting at month 1 and remaining stable thereafter. Fingolimod should be used with caution in patients with severe respiratory disease, pulmonary fibrosis and chronic obstructive pulmonary disease (see also section 4.8).

Posterior reversible encephalopathy syndrome

Rare cases of posterior reversible encephalopathy syndrome (PRES) have been reported at the 0.5 mg dose in clinical trials and in the post-marketing setting (see

section 4.8). Symptoms reported included sudden onset of severe headache, nausea, vomiting, altered mental status, visual disturbances and seizure. Symptoms of PRES are usually reversible but may evolve into ischaemic stroke or cerebral haemorrhage. Delay in diagnosis and treatment may lead to permanent neurological sequelae. If PRES is suspected, fingolimod should be discontinued.

Prior treatment with immunosuppressive or immunomodulatory therapies

There have been no studies performed to evaluate the efficacy and safety of fingolimod when switching patients from teriflunomide, dimethyl fumarate or alemtuzumab treatment to fingolimod. When switching patients from another disease modifying therapy to fingolimod, the elimination half-life and mode of action of the other therapy must be considered in order to avoid an additive immune effect whilst at the same time minimising the risk of disease reactivation. A CBC is recommended prior to initiating fingolimod to ensure that immune effects of the previous therapy (i.e. cytopenia) have resolved.

Fingolimod can generally be started immediately after discontinuation of interferon or glatiramer acetate.

For dimethyl fumarate, the washout period should be sufficient for CBC to recover before treatment with fingolimod is started.

Due to the long elimination half-life of natalizumab, elimination usually takes up to 2-3 months following discontinuation. Teriflunomide is also eliminated slowly from the plasma. Without an accelerated elimination procedure, clearance of teriflunomide from plasma can take from several months up to 2 years. An accelerated elimination procedure as defined in the teriflunomide summary of product characteristics is recommended or alternatively washout period should not be shorter than 3.5 months. Caution regarding potential concomitant immune effects is required when switching patients from natalizumab or teriflunomide to fingolimod.

Alemtuzumab has profound and prolonged immunosuppressive effects. As the actual duration of these effects is unknown, initiating treatment with fingolimod after alemtuzumab is not recommended unless the benefits of such treatment clearly outweigh the risks for the individual patient.

A decision to use prolonged concomitant treatment with corticosteroids should be taken after careful consideration.

Co-administration with potent CYP450 inducers

The combination of fingolimod with potent CYP450 inducers should be used with caution. Concomitant administration with St John's Wort is not recommended (see section 4.5).

Malignancies

Cutaneous malignancies

Basal cell carcinoma (BCC) and other cutaneous neoplasms, including malignant melanoma, squamous cell carcinoma, Kaposi's sarcoma and Merkel cell carcinoma, have been reported in patients receiving fingolimod (see section 4.8). Vigilance for skin lesions is warranted and a medical evaluation of the skin is recommended at initiation, and then every 6 to 12 months taking into consideration clinical judgement. The patient should be referred to a dermatologist in case suspicious lesions are detected.

Since there is a potential risk of malignant skin growths, patients treated with fingolimod should be cautioned against exposure to sunlight without protection. These patients should not receive concomitant phototherapy with UV-B-radiation or PUVA-photochemotherapy.

Lymphomas

There have been cases of lymphoma in clinical studies and the post-marketing setting (see section 4.8). The cases reported were heterogeneous in nature, mainly non-Hodgkin's lymphoma, including B-cell and T-cell lymphomas. Cases of cutaneous T-cell lymphoma (mycosis fungoides) have been observed. A fatal case of Epstein-Barr virus (EBV) positive B-cell lymphoma has also been observed. If lymphoma is suspected, treatment should be discontinued.

Women of childbearing potential

Due to risk to the foetus, fingolimod is contraindicated during pregnancy and in women of childbearing potential not using effective contraception. Before initiation of treatment, women of childbearing potential must be informed of this risk to the foetus, must have a negative pregnancy test and must use effective contraception during treatment and for 2 months after treatment discontinuation (see sections 4.3 and 4.6 and the information contained in the Physician Information Pack).

Tumefactive lesions

Rare cases of tumefactive lesions associated with MS relapse were reported in the post-marketing setting. In case of severe relapses, MRI should be performed to exclude tumefactive lesions. Discontinuation of fingolimod should be considered by the physician on a case-by-case basis taking into account individual benefits and risks.

Return of disease activity (rebound) after fingolimod discontinuation

In the post-marketing setting, severe exacerbation of disease has been observed rarely in some patients stopping fingolimod. This has generally been observed within 12 weeks after stopping fingolimod, but has also been reported up to 24 weeks after fingolimod discontinuation. Caution is therefore indicated when stopping fingolimod therapy. If discontinuation of fingolimod is deemed necessary, the possibility of recurrence of exceptionally high disease activity should be considered and patients should be monitored for relevant signs and symptoms and appropriate treatment initiated as required (see "Stopping therapy" below).

Stopping therapy

If a decision is made to stop treatment with fingolimod a 6 week interval without therapy is needed, based on half-life, to clear fingolimod from the circulation (see section 5.2). Lymphocyte counts progressively return to normal range within 1-2 months of stopping therapy in most patients (see section 5.1) although full recovery can take significantly longer in some patients. Starting other therapies during this interval will result in concomitant exposure to fingolimod. Use of immunosuppressants soon after the discontinuation of fingolimod may lead to an additive effect on the immune system and caution is therefore indicated.

After stopping fingolimod in the setting of PML, it is recommended to monitor patients for development of immune reconstitution inflammatory syndrome (PML-IRIS) (see “Progressive multifocal leukoencephalopathy” above).

Caution is also indicated when stopping fingolimod therapy due to the risk of a rebound (see “Return of disease activity (rebound) after fingolimod discontinuation” above). If discontinuation of fingolimod is deemed necessary, patients should be monitored during this time for relevant signs of a possible rebound.

Interference with serological testing

Since fingolimod reduces blood lymphocyte counts via re-distribution in secondary lymphoid organs, peripheral blood lymphocyte counts cannot be utilised to evaluate the lymphocyte subset status of a patient treated with fingolimod. Laboratory tests involving the use of circulating mononuclear cells require larger blood volumes due to reduction in the number of circulating lymphocytes.

Paediatric population

The safety profile in paediatric patients is similar to that in adults and the warnings and precautions for adults therefore also apply to paediatric patients.

In particular, the following should be noted when prescribing fingolimod to paediatric patients:

- Precautions should be followed at the time of the first dose (see “Bradyarrhythmia” above). The same precautions as for the first dose are recommended when patients are switched from the 0.25 mg to the 0.5 mg daily dose.
- In the controlled paediatric trial D2311, cases of seizures, anxiety, depressed mood and depression have been reported with a higher incidence in patients treated with fingolimod compared to patients treated with interferon beta-1a. Caution is required in this subgroup population (see “Paediatric population” in section 4.8).
- Mild isolated bilirubin increases have been noted in paediatric patients on fingolimod.
- It is recommended that paediatric patients complete all immunisations in accordance with current immunisation guidelines before starting fingolimod therapy (see “Infections” above).
- There are very limited data available in children between 10-12 years old, less than 40 kg or at Tanner stage <2 (see sections 4.8 and 5.1). Caution is required in these subgroups due to very limited knowledge available from the clinical study.
- Long-term safety data in the paediatric population are not available.

Excipients

This medicine contains less than 1 mmol sodium (23 mg) per capsule, that is to say ‘sodium-free’.

4.5 Interaction with other medicinal products and other forms of interaction

Anti-neoplastic, immunomodulatory or immunosuppressive therapies

Anti-neoplastic, immunomodulatory or immunosuppressive therapies should not be co-administered due to the risk of additive immune system effects (see sections 4.3 and 4.4).

Caution should also be exercised when switching patients from long-acting therapies with immune effects such as natalizumab, teriflunomide or mitoxantrone (see section 4.4). In multiple sclerosis clinical studies the concomitant treatment of relapses with a short course of corticosteroids was not associated with an increased rate of infection.

Vaccination

During and for up to two months after treatment with fingolimod vaccination may be less effective. The use of live attenuated vaccines may carry a risk of infections and should therefore be avoided (see sections 4.4 and 4.8).

Bradycardia-inducing substances

Fingolimod has been studied in combination with atenolol and diltiazem. When fingolimod was used with atenolol in an interaction study in healthy volunteers, there was an additional 15% reduction of heart rate at fingolimod treatment initiation, an effect not seen with diltiazem. Treatment with fingolimod should not be initiated in patients receiving beta blockers, or other substances which may decrease heart rate, such as class Ia and III antiarrhythmics, calcium channel blockers (such as verapamil or diltiazem), ivabradine, digoxin, anticholinesteratic agents or pilocarpine because of the potential additive effects on heart rate (see sections 4.4 and 4.8). If treatment with fingolimod is considered in such patients, advice from a cardiologist should be sought regarding the switch to non-heart-rate-lowering medicinal products or appropriate monitoring for treatment initiation, at least overnight monitoring is recommended, if the heart-rate-lowering medication cannot be stopped.

Pharmacokinetic interactions of other substances on fingolimod

Fingolimod is metabolised mainly by CYP4F2. Other enzymes like CYP3A4 may also contribute to its metabolism, notably in the case of strong induction of CYP3A4. Potent inhibitors of transporter proteins are not expected to influence fingolimod disposition. Co-administration of fingolimod with ketoconazole resulted in a 1.7-fold increase in fingolimod and fingolimod phosphate exposure (AUC) by inhibition of CYP4F2. Caution should be exercised with substances that may inhibit CYP3A4 (protease inhibitors, azole antifungals, some macrolides such as clarithromycin or telithromycin).

Co-administration of carbamazepine 600 mg twice daily at steady-state and a single dose of fingolimod 2 mg reduced the AUC of fingolimod and its metabolite by approximately 40%. Other strong CYP3A4 enzyme inducers, for example rifampicin,

phenobarbital, phenytoin, efavirenz and St. John's Wort, may reduce the AUC of fingolimod and its metabolite at least to this extent. As this could potentially impair the efficacy, their co-administration should be used with caution. Concomitant administration with St. John's Wort is however not recommended (see section 4.4).

Pharmacokinetic interactions of fingolimod on other substances

Fingolimod is unlikely to interact with substances mainly cleared by the CYP450 enzymes or by substrates of the main transporter proteins.

Co-administration of fingolimod with ciclosporin did not elicit any change in the ciclosporin or fingolimod exposure. Therefore, fingolimod is not expected to alter the pharmacokinetics of medicinal products that are CYP3A4 substrates.

Co-administration of fingolimod with oral contraceptives (ethinylestradiol and levonorgestrel) did not elicit any change in oral contraceptive exposure. No interaction studies have been performed with oral contraceptives containing other progestagens, however an effect of fingolimod on their exposure is not expected.

4.6 Fertility, pregnancy and lactation

Women of childbearing potential / Contraception in females

Fingolimod is contraindicated in women of childbearing potential not using effective contraception (see section 4.3). Therefore, before initiation of treatment in women of childbearing potential, a negative pregnancy test result must be available, and counselling should be provided regarding the serious risk to the foetus. Women of childbearing potential must use effective contraception during treatment and for 2 months after discontinuation of fingolimod, since fingolimod takes approximately 2 months to eliminate from the body after treatment discontinuation (see section 4.4).

Specific measures are also included in the Physician Information Pack. These measures must be implemented before fingolimod is prescribed to female patients and during treatment.

When stopping fingolimod therapy for planning a pregnancy the possible return of disease activity should be considered (see section 4.4).

Pregnancy

Based on human experience, post-marketing data suggest that use of fingolimod is associated with a 2-fold increased risk of major congenital malformations when administered during pregnancy compared with the rate observed in the general population (2-3%; EUROCAT).

The following major malformations were most frequently reported:

- Congenital heart disease such as atrial and ventricular septal defects, tetralogy of Fallot
- Renal abnormalities
- Musculoskeletal abnormalities.

There are no data on the effects of fingolimod on labour and delivery.

Animal studies have shown reproductive toxicity including foetal loss and organ defects, notably persistent truncus arteriosus and ventricular septal defect (see section 5.3). Furthermore, the receptor affected by fingolimod (sphingosine 1-phosphate receptor) is known to be involved in vascular formation during embryogenesis.

Consequently, fingolimod is contraindicated during pregnancy (see section 4.3). Fingolimod should be stopped 2 months before planning a pregnancy (see section 4.4). If a woman becomes pregnant during treatment, fingolimod must be discontinued. Medical advice should be given regarding the risk of harmful effects to the foetus associated with treatment and ultrasonography examinations should be performed.

Breast-feeding

Fingolimod is excreted in milk of treated animals during lactation (see section 5.3). Due to the potential for serious adverse reactions to fingolimod in nursing infants, women receiving fingolimod should not breastfeed.

Fertility

Data from preclinical studies do not suggest that fingolimod would be associated with an increased risk of reduced fertility (see section 5.3).

4.7 Effects on ability to drive and use machines

Fingolimod has no or negligible influence on the ability to drive and use machines.

However, dizziness or drowsiness may occasionally occur when initiating treatment. On initiation of fingolimod treatment it is recommended that patients be observed for a period of 6 hours (see section 4.4, Bradyarrhythmia).

4.8 Undesirable effects

Summary of the safety profile

The most frequent adverse reactions (incidence ≥10%) at the 0.5 mg dose were headache (24.5%), hepatic enzyme increased (15.2%), diarrhoea (12.6%), cough (12.3%), influenza (11.4%), sinusitis (10.9%) and back pain (10.0%).

Tabulated list of adverse reactions

Adverse reactions reported in clinical trials and derived from post-marketing experience via spontaneous case reports or literature cases are shown below. Frequencies were defined using the following convention: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1 000 to <1/100); rare (≥1/10 000 to <1/1 000); very rare (<1/10 000); not known (cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in the order of decreasing seriousness.

Infections and infestations	
Very common	Influenza, Sinusitis
Common	Herpes viral infections Bronchitis Tinea versicolor
Uncommon	Pneumonia
Not known	Progressive multifocal leukoencephalopathy (PML)** Cryptococcal infections**
Neoplasms benign, malignant and unspecified (incl cysts and polyps)	
Common	Basal cell carcinoma
Uncommon	Malignant melanoma****
Rare	Lymphoma*** Squamous cell carcinoma****
Very rare	Kaposi's sarcoma****
Not known	Merkel cell carcinoma***
Blood and lymphatic system disorders	
Common	Lymphopenia Leucopenia
Uncommon	Thrombocytopenia
Not known	Autoimmune haemolytic anaemia*** Peripheral oedema***

Immune system disorders	
Not known	Hypersensitivity reactions, including rash, urticaria and angioedema upon treatment initiation*** Immune reconstitution inflammatory syndrome (IRIS)**
Psychiatric disorders	
Common	Depression
Uncommon	Depressed mood
Nervous system disorders	
Very common	Headache
Common	Dizziness Migraine
Uncommon	Seizure
Rare	Posterior reversible encephalopathy syndrome (PRES)*
Not known	Severe exacerbation of disease after fingolimod discontinuation***
Eye disorders	
Common	Vision blurred
Uncommon	Macular oedema
Cardiac disorders	
Common	Bradycardia Atrioventricular block
Very rare	T-wave inversion***
Vascular disorders	
Common	Hypertension
Respiratory, thoracic and mediastinal disorders	
Very common	Cough
Common	Dyspnoea
Gastrointestinal disorders	
Very common	Diarrhoea
Uncommon	Nausea***
Hepatobiliary disorders	
Not known	Acute hepatic failure***
Skin and subcutaneous tissue disorders	
Common	Eczema Alopecia

	Pruritus
Musculoskeletal and connective tissue disorders	
Very common	Back pain
Common	Myalgia Arthralgia
General disorders and administration site conditions	
Common	Asthenia
Investigations	
Very common	Hepatic enzyme increased (increased alanine transaminase, gamma glutamyltransferase, aspartate transaminase)
Common	Weight decreased*** Blood triglycerides increased
Uncommon	Neutrophil count decreased

* The frequency category was based on an estimated exposure of approximately 10 000 patients to fingolimod in all clinical trials.

** PML, IRIS and cryptococcal infections (including cases of cryptococcal meningitis) have been reported in the post-marketing setting (see section 4.4).

*** Adverse drug reactions from spontaneous reports and literature.

**** The frequency category and risk assessment were based on an estimated exposure of more than 24 000 patients to fingolimod 0.5 mg in all clinical trials.

Description of selected adverse reactions

Infections

In multiple sclerosis clinical studies the overall rate of infections (65.1%) at the 0.5 mg dose was similar to placebo. However, lower respiratory tract infections, primarily bronchitis and to a lesser extent herpes infection and pneumonia were more common in fingolimod-treated patients. Some cases of disseminated herpes infection, including fatal cases, have been reported even at the 0.5 mg dose.

In the post-marketing setting, cases of infections with opportunistic pathogens, such as viral (e.g. varicella zoster virus [VZV], John Cunningham virus [JCV] causing Progressive Multifocal Leukoencephalopathy, herpes simplex virus [HSV]), fungal (e.g. cryptococci including cryptococcal meningitis) or bacterial (e.g. atypical mycobacterium), have been reported, some of which have been fatal (see section 4.4).

Human papilloma virus (HPV) infection, including papilloma, dysplasia, warts and HPV-related cancer, has been reported under treatment with fingolimod in the post-marketing setting (see section 4.4). Due to the immunosuppressive properties of fingolimod, vaccination against HPV should be considered prior to treatment initiation with fingolimod taking into account vaccination recommendations. Cancer screening, including Pap test, is recommended as per standard of care.

Macular oedema

In multiple sclerosis clinical studies macular oedema occurred in 0.5% of patients treated with the recommended dose of 0.5 mg and 1.1% of patients treated with the higher dose of 1.25 mg. The majority of cases occurred within the first 3-4 months of therapy. Some patients presented with blurred vision or decreased visual acuity, but others were asymptomatic and diagnosed on routine ophthalmological examination. The macular oedema generally improved or resolved spontaneously after discontinuation of fingolimod. The risk of recurrence after re-challenge has not been evaluated.

Macular oedema incidence is increased in multiple sclerosis patients with a history of uveitis (17% with a history of uveitis vs. 0.6% without a history of uveitis). Fingolimod has not been studied in multiple sclerosis patients with diabetes mellitus, a disease which is associated with an increased risk for macular oedema (see section 4.4). In renal transplant clinical studies in which patients with diabetes mellitus were included, therapy with fingolimod 2.5 mg and 5 mg resulted in a 2-fold increase in the incidence of macular oedema.

Bradyarrhythmia

Initiation of treatment results in a transient decrease in heart rate and may also be associated with atrioventricular conduction delays. In multiple sclerosis clinical studies the maximal decline in heart rate was seen within 6 hours after treatment initiation, with declines in mean heart rate of 12-13 beats per minute for fingolimod 0.5 mg. Heart rate below 40 beats per minute in adults, and below 50 beats per minute in paediatric patients, was rarely observed in patients on fingolimod 0.5 mg. The average heart rate returned towards baseline within 1 month of chronic treatment. Bradycardia was generally asymptomatic but some patients experienced mild to moderate symptoms, including hypotension, dizziness, fatigue and/or palpitations, which resolved within the first 24 hours after treatment initiation (see also sections 4.4 and 5.1).

In multiple sclerosis clinical studies first-degree atrioventricular block (prolonged PR interval on ECG) was detected after treatment initiation in adult and paediatric patients. In adult clinical trials it occurred in 4.7% of patients on fingolimod 0.5 mg, in 2.8% of patients on intramuscular interferon beta-1a, and in 1.6% of patients on placebo. Second-degree atrioventricular block was detected in less than 0.2% adult patients on fingolimod 0.5 mg. In the post-marketing setting, isolated reports of transient, spontaneously resolving complete AV block have been observed during the six hour monitoring period following the first dose of fingolimod. The patients recovered spontaneously. The conduction abnormalities observed both in clinical trials and post-marketing were typically transient, asymptomatic and resolved within the first 24 hours after treatment initiation. Although most patients did not require medical intervention, one patient on fingolimod 0.5 mg received isoprenaline for asymptomatic second-degree Mobitz I atrioventricular block.

In the post-marketing setting, isolated delayed onset events, including transient asystole and unexplained death, have occurred within 24 hours of the first dose. These cases have been confounded by concomitant medicinal products and/or pre-existing disease. The relationship of such events to fingolimod is uncertain.

Blood pressure

In multiple sclerosis clinical studies fingolimod 0.5 mg was associated with an average increase of approximately 3 mmHg in systolic pressure and approximately 1 mmHg in diastolic pressure, manifesting approximately 1 month after treatment

initiation. This increase persisted with continued treatment. Hypertension was reported in 6.5% of patients on fingolimod 0.5 mg and in 3.3% of patients on placebo. In the post-marketing setting, cases of hypertension have been reported within the first month of treatment initiation and on the first day of treatment that may require treatment with antihypertensive agents or discontinuation of fingolimod (see also section 4.4, Blood pressure effects).

Liver function

Increased hepatic enzymes have been reported in adult and paediatric multiple sclerosis patients treated with fingolimod. In clinical studies 8.0% and 1.8% of adult patients treated with fingolimod 0.5 mg experienced an asymptomatic elevation in serum levels of ALT of ≥3x ULN (upper limit of normal) and ≥5x ULN, respectively. Recurrence of liver transaminase elevations has occurred upon rechallenge in some patients, supporting a relationship to the medicinal product. In clinical studies, transaminase elevations occurred at any time during treatment although the majority occurred within the first 12 months. ALT levels returned to normal within approximately 2 months after discontinuation of fingolimod. In a small number of patients (n=10 on 1.25 mg, n=2 on 0.5 mg) who experienced ALT elevations ≥5x ULN and who continued on fingolimod therapy, the ALT levels returned to normal within approximately 5 months (see also section 4.4, Liver function).

Nervous system disorders

In clinical studies, rare events involving the nervous system occurred in patients treated with fingolimod at higher doses (1.25 or 5.0 mg) including ischaemic and haemorrhagic strokes and neurological atypical disorders, such as acute disseminated encephalomyelitis (ADEM)-like events.

Cases of seizures, including status epilepticus, have been reported with the use of fingolimod in clinical studies and in the post-marketing setting.

Vascular disorders

Rare cases of peripheral arterial occlusive disease occurred in patients treated with fingolimod at higher doses (1.25 mg).

Respiratory system

Minor dose-dependent reductions in values for forced expiratory volume (FEV_1) and diffusion capacity for carbon monoxide (DLCO) were observed with fingolimod treatment starting at month 1 and remaining stable thereafter. At month 24, the reduction from baseline values in percentage of predicted FEV_1 was 2.7% for fingolimod 0.5 mg and 1.2% for placebo, a difference that resolved after treatment discontinuation. For DLCO the reductions at month 24 were 3.3% for fingolimod 0.5 mg and 2.7% for placebo (see also section 4.4, Respiratory effects).

Lymphomas

There have been cases of lymphoma of different varieties, in both clinical studies and the post-marketing setting, including a fatal case of Epstein-Barr virus (EBV) positive B-cell lymphoma. The incidence of non-Hodgkin's lymphoma (B-cell and T-cell) cases was higher in clinical trials than expected in the general population. Some T-

cell lymphoma cases were also reported in the post-marketing setting, including cases of cutaneous T-cell lymphoma (mycosis fungoides) (see also section 4.4, Malignancies).

Haemophagocytic syndrome

Very rare cases of haemophagocytic syndrome (HPS) with fatal outcome have been reported in patients treated with fingolimod in the context of an infection. HPS is a rare condition that has been described in association with infections, immunosuppression and a variety of autoimmune diseases.

Paediatric population

In the controlled paediatric trial D2311 (see section 5.1), the safety profile in paediatric patients (10 to below 18 years of age) receiving fingolimod 0.25 mg or 0.5 mg daily was overall similar to that seen in adult patients. There were, nevertheless, more neurological and psychiatric disorders observed in the study. Caution is needed in this subgroup due to very limited knowledge available from the clinical study.

In the paediatric study, cases of seizures were reported in 5.6% of fingolimod-treated patients and 0.9% of interferon beta-1a-treated patients.

Depression and anxiety are known to occur with increased frequency in the multiple sclerosis population. Depression and anxiety have also been reported in paediatric patients treated with fingolimod.

Mild isolated bilirubin increases have been noted in paediatric patients on fingolimod.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via Yellow Card Scheme

Website: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

Single doses up to 80 times the recommended dose (0.5 mg) were well tolerated in healthy adult volunteers. At 40 mg, 5 of 6 subjects reported mild chest tightness or discomfort which was clinically consistent with small airway reactivity.

Fingolimod can induce bradycardia upon treatment initiation. The decline in heart rate usually starts within one hour of the first dose, and is steepest within 6 hours. The negative chronotropic effect of fingolimod persists beyond 6 hours and progressively attenuates over subsequent days of treatment (see section 4.4 for details). There have been reports of slow atrioventricular conduction, with isolated reports of transient, spontaneously resolving complete AV block (see sections 4.4 and 4.8).

If the overdose constitutes first exposure to fingolimod, it is important to monitor patients with a continuous (real time) ECG and hourly measurement of heart rate and blood pressure, at least during the first 6 hours (see section 4.4).

Additionally, if after 6 hours the heart rate is <45 bpm in adults, <55 bpm in paediatric patients aged 12 years and above, or <60 bpm in paediatric patients aged 10 years to below 12 years, or if the ECG at 6 hours after the first dose shows second degree or higher AV block, or if it shows a QTc interval ≥500 msec, monitoring should be extended at least for overnight and until the findings have resolved. The occurrence at any time of third degree AV block should also lead to extended monitoring including overnight monitoring.

Neither dialysis nor plasma exchange results in removal of fingolimod from the body.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antineoplastic and Immunomodulating Agents, Immunosuppressants, Sphingosine-1-phosphate (SIP) receptor modulators, ATC code: L04AE01

Mechanism of action

Fingolimod is a sphingosine 1-phosphate receptor modulator. Fingolimod is metabolised by sphingosine kinase to the active metabolite fingolimod phosphate. Fingolimod phosphate binds at low nanomolar concentrations to sphingosine 1-phosphate (S1P) receptor 1 located on lymphocytes, and readily crosses the blood-brain barrier to bind to S1P receptor 1 located on neural cells in the central nervous system (CNS). By acting as a functional antagonist of S1P receptors on lymphocytes, fingolimod phosphate blocks the capacity of lymphocytes to egress from lymph nodes, causing a redistribution, rather than depletion, of lymphocytes. Animal studies have shown that this redistribution reduces the infiltration of pathogenic lymphocytes, including pro-inflammatory Th17 cells, into the CNS, where they would be involved in nerve inflammation and nervous tissue damage. Animal studies and *in vitro* experiments indicate that fingolimod may also act via interaction with S1P receptors on neural cells.

Pharmacodynamic effects

Within 4-6 hours after the first dose of fingolimod 0.5 mg, the lymphocyte count decreases to approximately 75% of baseline in peripheral blood. With continued daily dosing, the lymphocyte count continues to decrease over a two-week period, reaching a minimal count of approximately 500 cells/microlitre or approximately 30% of baseline. Eighteen percent of patients reached a minimal count below 200 cells/microlitre on at least one occasion. Low lymphocyte counts are maintained with chronic daily dosing. The majority of T and B lymphocytes regularly traffic through

lymphoid organs and these are the cells mainly affected by fingolimod. Approximately 15-20% of T lymphocytes have an effector memory phenotype, cells that are important for peripheral immune surveillance. Since this lymphocyte subset typically does not traffic to lymphoid organs it is not affected by fingolimod. Peripheral lymphocyte count increases are evident within days of stopping fingolimod treatment and typically normal counts are reached within one to two months. Chronic fingolimod dosing leads to a mild decrease in the neutrophil count to approximately 80% of baseline. Monocytes are unaffected by fingolimod.

Fingolimod causes a transient reduction in heart rate and decrease in atrioventricular conduction at treatment initiation (see sections 4.4 and 4.8). The maximal decline in heart rate is seen within 6 hours post dose, with 70% of the negative chronotropic effect achieved on the first day. With continued administration heart rate returns to baseline within one month. The decrease in heart rate induced by fingolimod can be reversed by parenteral doses of atropine or isoprenaline. Inhaled salmeterol has also been shown to have a modest positive chronotropic effect. With initiation of fingolimod treatment there is an increase in atrial premature contractions, but there is no increased rate of atrial fibrillation/flutter or ventricular arrhythmias or ectopy. Fingolimod treatment is not associated with a decrease in cardiac output. Autonomic responses of the heart, including diurnal variation of heart rate and response to exercise are not affected by fingolimod treatment.

S1P4 could partially contribute to the effect but was not the main receptor responsible for the lymphoid depletion. The mechanism of action of bradycardia and vasoconstriction were also studied *in vitro* in guinea pigs and isolated rabbit aorta and coronary artery. It was concluded that bradycardia could be mediated primarily by activation of inward-rectifying potassium channel or G-protein activated inwardly rectifying K^+ channel (IKACh/GIRK) and that vasoconstriction seems to be mediated by a Rho kinase and calcium-dependent mechanism.

Fingolimod treatment with single or multiple doses of 0.5 and 1.25 mg for two weeks is not associated with a detectable increase in airway resistance as measured by FEV_1 and forced expiratory flow rate (FEF) 25-75. However, single fingolimod doses ≥5 mg (10-fold the recommended dose) are associated with a dose-dependent increase in airway resistance. Fingolimod treatment with multiple doses of 0.5, 1.25, or 5 mg is not associated with impaired oxygenation or oxygen desaturation with exercise or an increase in airway responsiveness to methacholine. Subjects on fingolimod treatment have a normal bronchodilator response to inhaled beta-agonists.

Clinical efficacy and safety

The efficacy of fingolimod has been demonstrated in two studies which evaluated once-daily doses of fingolimod 0.5 mg and 1.25 mg in adult patients with relapsing-remitting multiple sclerosis (RRMS). Both studies included adult patients who had experienced ≥2 relapses in the prior 2 years or ≥1 relapse during the prior year. Expanded Disability Status Score (EDSS) was between 0 and 5.5. A third study targeting the same adult patient population was completed after registration of fingolimod.

Study D2301 (FREEDOMS) was a 2-year randomised, double-blind, placebo-controlled Phase III study of 1,272 patients (n=425 on 0.5 mg, 429 on 1.25 mg, 418 on placebo). Median values for baseline characteristics were: age 37 years, disease duration 6.7 years, and EDSS score 2.0. Outcome results are shown in Table 1. There were no significant differences between the 0.5 mg and the 1.25 mg doses as regards either endpoint.

Table 1 Study D2301 (FREEDOMS): main results

	Fingolimod 0.5 mg	Placebo
Clinical endpoints		
Annualised relapse rate (primary endpoint)	0.18**	0.40
Percentage of patients remaining relapse-free at 24 months	70%**	46%
Proportion with 3-month Confirmed Disability Progression† Hazard ratio (95% CI)	17% 0.70 (0.52, 0.96)*	24%
MRI endpoints		
Median (mean) number of new or enlarging T2 lesions over 24 months	0.0 (2.5)**	5.0 (9.8)
Median (mean) number of Gd-enhancing lesions at month 24	0.0 (0.2)**	0.0 (1.1)
Median (mean) % change in brain volume over 24 months	-0.7 (-0.8)**	-1.0 (-1.3)

† Disability progression defined as 1-point increase in EDSS confirmed 3 months later.
** $p<0.001$, * $p<0.05$ compared to placebo
All analyses of clinical endpoints were intent-to-treat. MRI analyses used evaluable dataset.

Patients who completed the 24-month core FREEDOMS study could enter a dose-blinded extension study (D2301E1) and receive fingolimod. In total, 920 patients entered (n=331 continued on 0.5 mg, 289 continued on 1.25 mg, 155 switched from placebo to 0.5 mg and 145 switched from placebo to 1.25 mg). After 12 months (month 36), 856 patients (93%) were still enrolled. Between months 24 and 36, the annualised relapse rate (ARR) for patients on fingolimod 0.5 mg in the core study who remained on 0.5 mg was 0.17 (0.21 in the core study). The ARR for patients who switched from placebo to fingolimod 0.5 mg was 0.22 (0.42 in the core study).

Comparable results were shown in a replicate 2-year randomised, double-blind, placebo-controlled Phase III study on fingolimod in 1,083 patients (n=358 on 0.5 mg, 370 on 1.25 mg, 355 on placebo) with RRMS (D2309; FREEDOMS 2). Median values for baseline characteristics were: age 41 years, disease duration 8.9 years, EDSS score 2.5.

Table 2 Study D2309 (FREEDOMS 2): main results

	Fingolimod 0.5 mg	Placebo
Clinical endpoints		
Annualised relapse rate (primary endpoint)	0.21**	0.40
Percentage of patients remaining relapse-free at 24 months	71.5%**	52.7%

Proportion with 3-month Confirmed Disability Progression† Hazard ratio (95% CI)	25% 0.83 (0.61, 1.12)	29%
MRI endpoints		
Median (mean) number of new or enlarging T2 lesions over 24 months	0.0 (2.3)**	4.0 (8.9)
Median (mean) number of Gd-enhancing lesions at month 24	0.0 (0.4)**	0.0 (1.2)
Median (mean) % change in brain volume over 24 months	-0.71 (-0.86)**	-1.02 (-1.28)

† Disability progression defined as 1-point increase in EDSS confirmed 3 months later.
** p<0.001 compared to placebo
All analyses of clinical endpoints were intent-to-treat. MRI analyses used evaluable dataset.

Study D2302 (TRANSFORMS) was a 1-year randomised, double-blind, double-dummy, active (interferon beta-1a)-controlled Phase III study of 1,280 patients (n=429 on 0.5 mg, 420 on 1.25 mg, 431 on interferon beta-1a, 30 μg by intramuscular injection once weekly). Median values for baseline characteristics were: age 36 years, disease duration 5.9 years, and EDSS score 2.0. Outcome results are shown in Table 3. There were no significant differences between the 0.5 mg and the 1.25 mg doses as regards study endpoints.

Table 3 Study D2302 (TRANSFORMS): main results

	Fingolimod 0.5 mg	**Interferon beta-1a, 30 μg**
Clinical endpoints		
Annualised relapse rate (primary endpoint)	0.16**	0.33
Percentage of patients remaining relapse-free at 12 months	83%**	71%
Proportion with 3-month Confirmed Disability Progression† Hazard ratio (95% CI)	6% 0.71 (0.42, 1.21)	8%
MRI endpoints		
Median (mean) number of new or enlarging T2 lesions over 12 months	0.0 (1.7)*	1.0 (2.6)
Median (mean) number of Gd-enhancing lesions at month 12	0.0 (0.2)**	0.0 (0.5)
Median (mean) % change in brain volume over 12 months	-0.2 (-0.3)**	-0.4 (-0.5)

† Disability progression defined as 1-point increase in EDSS confirmed 3 months later.
* p<0.01, **p<0.001 compared to interferon beta-1a
All analyses of clinical endpoints were intent-to-treat. MRI analyses used

evaluable dataset.

Patients who completed the 12-month core TRANSFORMS study could enter a dose-blinded extension (D2302E1) and receive fingolimod. In total, 1,030 patients entered, however, 3 of these patients did not receive treatment (n=356 continued on 0.5 mg, 330 continued on 1.25 mg, 167 switched from interferon beta-1a to 0.5 mg and 174 from interferon beta-1a to 1.25 mg). After 12 months (month 24), 882 patients (86%) were still enrolled. Between months 12 and 24, the ARR for patients on fingolimod 0.5 mg in the core study who remained on 0.5 mg was 0.20 (0.19 in the core study). The ARR for patients who switched from interferon beta-1a to fingolimod 0.5 mg was 0.33 (0.48 in the core study).

Pooled results of Studies D2301 and D2302 showed a consistent and statistically significant reduction in annualised relapse rate compared to comparator in subgroups defined by gender, age, prior multiple sclerosis therapy, disease activity or disability levels at baseline.

Further analyses of clinical trial data demonstrate consistent treatment effects in highly active subgroups of relapsing remitting multiple sclerosis patients.

Paediatric population

The efficacy and safety of once-daily doses of fingolimod 0.25 mg or 0.5 mg (dose selected based on body weight and exposure measurements) have been established in paediatric patients aged 10 to <18 years with relapsing-remitting multiple sclerosis.

Study D2311 (PARADIGMS) was a double-blind, double-dummy, active-controlled study with flexible duration up to 24 months, with 215 patients 10 to <18 years old (n=107 on fingolimod, 108 on interferon beta-1a 30 μg by intramuscular injection once weekly).

Median values for baseline characteristics were: age 16 years, median disease duration 1.5 years and EDSS score 1.5. The majority of patients were Tanner stage 2 or higher (94.4%) and were >40 kg (95.3%). Overall, 180 (84%) of patients completed the core phase on study drug (n=99 [92.5%] on fingolimod, 81 [75%] on interferon beta-1a). Outcome results are shown in Table 4.

Table 4 Study D2311 (PARADIGMS): main results

	Fingolimod 0.25 mg or 0.5 mg	**Interferon beta-1a 30 μg**
Clinical endpoints	n=107	n=107[#]
Annualised relapse rate (primary endpoint)	0.122**	0.675
Percentage of patients remaining relapse-free at 24 months	85.7%**	38.8%
MRI endpoints		
Annualised rate of the number of new or newly enlarging T2 lesions	n=106	n=102
Adjusted mean	4.393**	9.269
Number of Gd-enhancing T1 lesions per scan up to month 24	n=106	n=101

Adjusted mean	0.436**	1.282
Annualised rate of brain atrophy from baseline up to month 24	n=96	n=89
Least Square Mean	-0.48*	-0.80

One patient randomised to receive interferon beta-1a by intramuscular injection was unable to swallow the double-dummy medication and discontinued from study. The patient was excluded from the full analysis and safety set.
* $p<0.05$, ** $p<0.001$ compared to interferon beta-1a.
All analyses of clinical endpoints were on the full analysis set.

5.2 Pharmacokinetic properties

Pharmacokinetic data were obtained in healthy adult volunteers, in renal transplant adult patients and in multiple sclerosis adult patients.

The pharmacologically active metabolite responsible for efficacy is fingolimod phosphate.

Absorption

Fingolimod absorption is slow (t_{max} of 12-16 hours) and extensive (≥85%). The apparent absolute oral bioavailability is 93% (95% confidence interval: 79-111%). Steady-state-blood concentrations are reached within 1 to 2 months following once-daily administration and steady-state levels are approximately 10-fold greater than with the initial dose.

Food intake does not alter C_{max} or exposure (AUC) of fingolimod. Fingolimod phosphate C_{max} was slightly decreased by 34% but AUC was unchanged. Therefore, fingolimod may be taken without regard to meals (see section 4.2).

Distribution

Fingolimod highly distributes in red blood cells, with the fraction in blood cells of 86%. Fingolimod phosphate has a smaller uptake in blood cells of <17%. Fingolimod and fingolimod phosphate are highly protein bound (>99%).

Fingolimod is extensively distributed to body tissues with a volume of distribution of about 1,200±260 litres. A study in four healthy subjects who received a single intravenous dose of a radioiodolabelled analogue of fingolimod demonstrated that fingolimod penetrates into the brain. In a study in 13 male multiple sclerosis patients

who received fingolimod 0.5 mg/day, the mean amount of fingolimod (and fingolimod phosphate) in seminal ejaculate, at steady-state, was approximately 10,000 times lower than the oral dose administered (0.5 mg).

Biotransformation

Fingolimod is transformed in humans by reversible stereoselective phosphorylation to the pharmacologically active (S)-enantiomer of fingolimod phosphate. Fingolimod is eliminated by oxidative biotransformation catalysed mainly via CYP4F2 and possibly other isoenzymes and subsequent fatty acid-like degradation to inactive metabolites. Formation of pharmacologically inactive non-polar ceramide analogues of fingolimod was also observed. The main enzyme involved in the metabolism of fingolimod is partially identified and may be either CYP4F2 or CYP3A4.

Following single oral administration of [^{14}C] fingolimod, the major fingolimod-related components in blood, as judged from their contribution to the AUC up to 34 days post dose of total radiolabelled components, are fingolimod itself (23%), fingolimod phosphate (10%), and inactive metabolites (M3 carboxylic acid metabolite (8%), M29 ceramide metabolite (9%) and M30 ceramide metabolite (7%)).

Elimination

Fingolimod blood clearance is 6.3±2.3 L/h, and the average apparent terminal half-life ($t_{1/2}$) is 6-9 days. Blood levels of fingolimod and fingolimod phosphate decline in parallel in the terminal phase, leading to similar half-lives for both.

After oral administration, about 81% of the dose is slowly excreted in the urine as inactive metabolites. Fingolimod and fingolimod phosphate are not excreted intact in urine but are the major components in the faeces, with amounts representing less than 2.5% of the dose each. After 34 days, the recovery of the administered dose is 89%.

Linearity

Fingolimod and fingolimod phosphate concentrations increase in an apparently dose proportional manner after multiple once-daily doses of 0.5 mg or 1.25 mg.

Characteristics in specific groups of patients

Gender, ethnicity and renal impairment

The pharmacokinetics of fingolimod and fingolimod phosphate do not differ in males and females, in patients of different ethnic origin, or in patients with mild to severe renal impairment.

Hepatic impairment

In subjects with mild, moderate, or severe hepatic impairment (Child-Pugh class A, B, and C), no change in fingolimod C_{max} was observed, but fingolimod AUC was increased respectively by 12%, 44%, and 103%. In patients with severe hepatic impairment (Child-Pugh class C), fingolimod-phosphate C_{max} was decreased by 22% and AUC was not substantially changed. The pharmacokinetics of fingolimod-phosphate were not evaluated in patients with mild or moderate hepatic impairment. The apparent elimination half-life of fingolimod is unchanged in subjects with mild hepatic impairment, but is prolonged by about 50% in patients with moderate or severe hepatic impairment.

Fingolimod should not be used in patients with severe hepatic impairment (Child-Pugh class C) (see section 4.3). Fingolimod should be introduced cautiously in mild and moderate hepatic impaired patients (see section 4.2).

Elderly population

Clinical experience and pharmacokinetic information in patients aged above 65 years are limited. Fingolimod should be used with caution in patients aged 65 years and over (see section 4.2).

Paediatric population

In paediatric patients (10 years of age and above), fingolimod-phosphate concentrations increase in an apparent dose proportional manner between 0.25 mg and 0.5 mg.

Fingolimod-phosphate concentration at steady state is approximately 25% lower in paediatric patients (10 years of age and above) following daily administration of 0.25 mg or 0.5 mg fingolimod compared to the concentration in adult patients treated with fingolimod 0.5 mg once daily.

There are no data available for paediatric patients below 10 years old.

5.3 Preclinical safety data

The preclinical safety profile of fingolimod was assessed in mice, rats, dogs and monkeys. The major target organs were the lymphoid system (lymphopenia and lymphoid atrophy), lungs (increased weight, smooth muscle hypertrophy at the bronchio-alveolar junction), and heart (negative chronotropic effect, increase in blood pressure, perivascular changes and myocardial degeneration) in several species; blood vessels (vasculopathy) in rats only at doses of 0.15 mg/kg and higher in a 2-year study, representing an approximate 4-fold margin based on the human systemic exposure (AUC) at a daily dose of 0.5 mg.

No evidence of carcinogenicity was observed in a 2-year bioassay in rats at oral doses of fingolimod up to the maximally tolerated dose of 2.5 mg/kg, representing an approximate 50-fold margin based on human systemic exposure (AUC) at the 0.5 mg dose. However, in a 2-year mouse study, an increased incidence of malignant lymphoma was seen at doses of 0.25 mg/kg and higher, representing an approximate 6-fold margin based on the human systemic exposure (AUC) at a daily dose of 0.5 mg.

Fingolimod was neither mutagenic nor clastogenic in animal studies.

Fingolimod had no effect on sperm count/motility or on fertility in male and female rats up to the highest dose tested (10 mg/kg), representing an approximate 150-fold margin based on human systemic exposure (AUC) at a daily dose of 0.5 mg.

Fingolimod was teratogenic in the rat when given at doses of 0.1 mg/kg or higher. Drug exposure in rats at this dose was similar to that in patients at the therapeutic dose (0.5 mg). The most common foetal visceral malformations included persistent truncus arteriosus and ventricular septum defect. The teratogenic potential in rabbits could not be fully assessed, however an increased embryo-foetal mortality was seen at doses of 1.5 mg/kg and higher, and a decrease in viable foetuses as well as foetal growth retardation was seen at 5 mg/kg. Drug exposure in rabbits at these doses was similar to that in patients.

In rats, F1 generation pup survival was decreased in the early postpartum period at doses that did not cause maternal toxicity. However, F1 body weights, development, behaviour, and fertility were not affected by treatment with fingolimod.

Fingolimod was excreted in milk of treated animals during lactation at concentrations 2-fold to 3-fold higher than that found in maternal plasma. Fingolimod and its metabolites crossed the placental barrier in pregnant rabbits.

Juvenile animal studies

Results from two toxicity studies in juvenile rats showed slight effects on neurobehavioural response, delayed sexual maturation and a decreased immune response to repeated stimulations with keyhole limpet haemocyanin (KLH), which were not considered adverse. Overall, the treatment-related effects of fingolimod in juvenile animals were comparable to those seen in adult rats at similar dose levels, with the exception of changes in bone mineral density and neurobehavioural impairment (reduced auditory startle response) observed at doses of 1.5 mg/kg and higher in juvenile animals and the absence of smooth muscle hypertrophy in the lungs of the juvenile rats.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Capsule fill:
Carmellose calcium
Sodium stearyl fumarate

Capsule shell:
Gelatin
Titanium dioxide (E171)
Yellow iron oxide (E172)

Printing ink:
Shellac
Black iron oxide
N-Butyl alcohol
Purified water
Propylene glycol
Ethanol, anhydrous
Isopropyl alcohol
Ammonium hydroxide (E527)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months

6.4 Special precautions for storage

Store below 30°C
Store in the original package to protect from moisture

6.5 Nature and contents of container

Transparent PVC/PE/PVDC-aluminium blister packs in carton boxes containing 28 hard capsules.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

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

7 MARKETING AUTHORISATION HOLDER

Flynn Pharma Ltd
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Dublin 4,
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D04 C2N4

8 MARKETING AUTHORISATION NUMBER(S)

PL 13621/0082

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

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10 DATE OF REVISION OF THE TEXT

07/08/2025