	with peated						
Deferasirox Tablets 013.2024-11 2 103903							
HIGHLIGHTS OF PRESCRIBING INFORMATION These highlights do not include all the information needed to use DEFERASIROX TABLETS safely and effectively. See full prescribing information for	WARNINGS AND PRECAUTIONS Acute Kidney Injury: Measure serum creatinine in duplicate before starting therapy. Monitor renal function during deferasirox therapy and reduce dose or interrupt therapy for toxicity. (2, 1, 2, 4, 5, 1)	Perform auditory and ophthalmic testin 12 months). If disturbances are noted, m			e starting deferasirox treatr	nent and thereafter at i	regular inte
DEFERASIROX TABLETS.	Hepatic Toxicity: Monitor hepatic function. Reduce dose or interrupt therapy for toxicity. (5.2)	6 ADVERSE REACTIONS The following clinically significant adver	rea reactions are also discussed in	n other eactions of the labeling:			
DEFERASIROX tablets, for oral use Initial U.S. Approval: 2005	 Fatal and Nonfatal Gastrointestinal (GI) Bleeding, Ulceration, and Irritation: Risk may be greater in patients who are taking deferasirox in combination with drugs that have known ulcerogenic or hemorrhagic potential. (5.3) 	 Acute Kidney Injury, Including Ac 	cute Renal Failure Requiring Dialys	sis, and Renal Tubular Toxicity In	cluding Fanconi Syndrome /s	see Warnings and Preca	utions (5
WARNING: RENAL FAILURE, HEPATIC FAILURE, and GASTROINTESTINAL HEMORRHAGE	 Bone Marrow Suppression: Neutropenia, agranulocytosis, worsening anemia, and thrombocytopenia, including fatal events; monitor blood counts during deferasirox therapy. Interrupt therapy for toxicity. (5.4) 	 Hepatic Toxicity and Failure /see GI Hemorrhage /see Warnings and 		5.6)/			
See full prescribing information for complete boxed warning. Deferasirox may cause serious and fatal:	Age-related Risk of Toxicity: Monitor elderly and pediatric patients closely for toxicity. (5.5)	 Bone Marrow Suppression /see V Hypersensitivity /see Warnings a 					
acute kidney injury, including acute renal failure requiring dialysis and renal tubular toxicity including Fanconi syndrome (5.1)	 Hypersensitivity Reactions: Discontinue deferasirox for severe reactions and institute medical intervention. (5.7) Severe Skin Reactions including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug reaction with eosinophilia and systemic symptoms (DRESS): 	 Severe Skin Reactions /see Warn Skin Rash /see Warnings and Pre 	nings and Precautions (5.8)]				
hepatic toxicity, including failure (5.2) gastrointestinal hemorrhage (5.3)	Discontinue deferasirox. (5.8)	Auditory and Ocular Abnormalitie		s (5.10)]			
Deferasirox therapy requires close patient monitoring, including laboratory tests of renal and hepatic function. (5)	ADVERSE REACTIONS	6.1 Clinical Trials Experience					
	increases in serum creatinine. In deferasirox-treated patients with NTDT syndromes, the most frequently occurring (greater than 5%) adverse reactions are diarrhea, rash, and nausea. (6.1)	Because clinical trials are conducted un clinical trials of another drug and may no					
Deferasirox tablets are indicated for the treatment of chronic iron overload in patients 10 years of age and older with non-transfusion-dependent thalassemia (NTDT) syndromes, and with a liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight (Fe/g dw) and a serum ferritin greater than 300 mcg/L. (1.2)	To report SUSPECTED ADVERSE REACTIONS, contact Annora Pharma Private Limited at 1-866-495-1995 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.	with deferasirox tablets. Deferasirox ta with deferasirox tablets for oral suspens		ingredient as deferasirox tablets	for oral suspension. The fo	llowing adverse reactio	ins have
Limitations of Use:	DRUG INTERACTIONS	Transfusional Iron Overload					
The safety and efficacy of deferasirox tablets when administered with other iron chelation therapy have not been established. (1.3) DOSAGE AND ADMINISTRATION	 Do not take deferasirox with aluminum-containing antacid preparations. (7.1) Deferasirox increases the exposure of repaglinide. Consider repaglinide dose reduction and monitor blood glucose levels. (7.3) 	A total of 700 adult and pediatric paties anemias, and 132 with sickle cell disea					
• Transfusional Iron Overload: Initial dose for patients with estimated glomerular filtration rate (eGFR) greater than 60 mL/min/1.73 m ² is 14 mg per kg (calculated to nearest	 Avoid the use of deferasirox with theophylline as theophylline levels could be increased. (7.4) Deferasirox increases exposure of busulfan. Monitor plasma concentrations of busulfan when coadministered with deferasirox to allow dose adjustment of busulfan, as 	population, 89% of patients were black	. Median treatment duration amo	ong the sickle cell patients was 5	1 weeks. Of the 700 patient	ts treated, 469 (403 be	eta-thala:
 whole tablet) once daily. (2.1) NTDT Syndromes: Initial dose for patients with eGFR greater than 60 mL/min/1.73 m² is 7 mg per kg (calculated to nearest whole tablet) once daily. (2.2) 	needed. (7.7)	rare anemias) were entered into extension Six hundred twenty-seven (627) patient					
• See full prescribing information for information regarding monitoring, administration, and dose-reductions for organ impairment. (2.1, 2.2, 2.3, 2.4)	USE IN SPECIFIC POPULATIONS Lactation: Advise women not to breastfeed. (8.2)	discontinuation rate across studies in t efficacy 1%). Among 47 patients enrolle				, other 4%, lab abnorm	alities 3
Tablets: 90 mg, 180 mg, 360 mg. (3)	See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.	Table 1 displays adverse reactions occu				l disease patients (Stud	ly 3), and
CONTRAINDICATIONS		MDS (MDS pool). Abdominal pain, naus relationship to deferasirox. Gastrointest				t adverse reactions repo	orted wit
Estimated GFR less than 40 mL/min/1.73 m ² . (4) Patients with poor performance status. (4)		Table 1. Adverse Reactions ^a Occurri					
Patients with high-risk myelodysplastic syndrome (MDS). (4)	Revised: 11/2024			Study 1		udy 3	
· · · · · · · · · · · · · · · · · · ·			(Beta-ti Deferasirox	thalassemia) Deferoxamine	(Sickle C Deferasirox	ell Disease) Deferoxamine	M De
 Patients with advanced malignancies. (4) Patients with platelet counts less than 50 x 10³/L. (4) 			N = 296	N = 290	N = 132	N = 63	1
Patients with advanced malignancies. (4)			(0/)				
 Patients with advanced malignancies. (4) Patients with platelet counts less than 50 x 10³/L. (4) 		Adverse Reactions	n (%)	n (%)	n (%)	n (%)	_
Patients with advanced malignancies. (4) Patients with platelet counts less than 50 x 10 ³ /L. (4) Known hypersensitivity to deferasirox or any component of deferasirox tablets. (4) FULL PRESCRIBING INFORMATION: CONTENTS*	7 DRUG INTERACTIONS	Adverse Reactions Abdominal Pain ^b Diarrhea	n (%) 63 (21) 35 (12)	n (%) 41 (14) 21 (7)	n (%) 37 (28) 26 (20)	9 (14)	
 Patients with advanced malignancies. (4) Patients with platelet counts less than 50 x 10³/L. (4) Known hypersensitivity to deferasirox or any component of deferasirox tablets. (4) 	7.1 Aluminum-Containing Antacid Preparations 7.2 Agents Metabolized by CYP3A4	Abdominal Pain ^b	63 (21)	41 (14)	37 (28)	9 (14)	
Patients with advanced malignancies. (4) Patients with platelet counts less than 50 x 10 ⁷ /L. (4) Known hypersensitivity to deferasirox or any component of deferasirox tablets. (4) FULL PRESCRIBING INFORMATION: CONTENTS* WARNING: RENAL FAILURE, HEPATIC FAILURE, and GASTROINTESTINAL HEMORRHAGE 1 INDICATIONS AND USAGE 1.1 Treatment of Chronic Iron Overload Due to Blood Transfusions (Transfusional Iron Overload)	7.1 Aluminum-Containing Antacid Preparations 7.2 Agents Metabolized by CYP3A4 7.3 Agents Metabolized by CYP2C8	Abdominal Pain ^b Diarrhea Creatinine Increased ⁶ Nausea	63 (21) 35 (12) 33 (11) 31 (11)	41 (14) 21 (7) 0 (0) 14 (5)	37 (28) 26 (20) 9 (7) 30 (23)	9 (14) 3 (5) 0 7 (11)	
Patients with advanced malignancies. (4) Patients with platelet counts less than 50 x 10 ⁷ /L. (4) Known hypersensitivity to deferasirox or any component of deferasirox tablets. (4) FULL PRESCRIBING INFORMATION: CONTENTS* WARNING: RENAL FAILURE, HEPATIC FAILURE, and GASTROINTESTINAL HEMORRHAGE I INDICATIONS AND USAGE 1. INDICATIONS AND USAGE 1.1 Treatment of Chronic Iron Overload Due to Blood Transfusions (Transfusional Iron Overload) 1.2 Treatment of Chronic Iron Overload In Non-Transfusion-Dependent Thalassemia Syndromes 1.3 Limitations of Use	7.1 Aluminum-Containing Antacid Preparations 7.2 Agents Metabolized by CYP3A4 7.3 Agents Metabolized by CYP2C8 7.4 Agents Metabolized by CYP1A2 7.5 Agents Inducing UDP-glucuronosyltransferase (UGT) Metabolism	Abdominal Pain ^a Diarrhea Creatinine Increased ⁶ Nausea Vomiting	63 (21) 35 (12) 33 (11) 31 (11) 30 (10)	41 (14) 21 (7) 0 (0) 14 (5) 28 (10)	37 (28) 26 (20) 9 (7) 30 (23) 28 (21)	9 (14) 3 (5) 0 7 (11) 10 (16)	
Patients with advanced malignancies. (4) Patients with platelet counts less than 50 x 10 ⁷ /L. (4) Known hypersensitivity to deferasirox or any component of deferasirox tablets. (4) FULL PRESCRIBING INFORMATION: CONTENTS* WARNING: RENAL FAILURE, HEPATIC FAILURE, and GASTROINTESTINAL HEMORRHAGE I NIDICATIONS AND USAGE 1.1 Treatment of Chronic Iron Overload Due to Blood Transfusions (Transfusional Iron Overload) 1.2 Treatment of Chronic Iron Overload in Non-Transfusion-Dependent Thalassemia Syndromes	7.1 Aluminum-Containing Antacid Preparations 7.2 Agents Metabolized by CYP3A4 7.3 Agents Metabolized by CYP2C8 7.4 Agents Metabolized by CYP1A2 7.5 Agents Inducing UDP-glucuronosyltransferase (UGT) Metabolism 7.6 Bile Acid Sequestrants 7.7 Busulfan	Abdominal Pain ^a Diarrhea Creatinine Increased ^e Nausea Vomiting Rash	63 (21) 35 (12) 33 (11) 31 (11) 30 (10) 25 (8)	41 (14) 21 (7) 0 (0) 14 (5)	37 (28) 26 (20) 9 (7) 30 (23)	9 (14) 3 (5) 0 7 (11)	
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 Patients with advanced malignancies. (4) Patients with platelet counts less than 50 x 10⁷/L. (4) Known hypersensitivity to deferasirox or any component of deferasirox tablets. (4) FULL PRESCRIBING INFORMATION: CONTENTS* WARNING: RENAL FAILURE, HEPATIC FAILURE, and GASTROINTESTINAL HEMORRHAGE 1 Introductions AND USAGE 1.1 Treatment of Chronic Iron Overload Due to Blood Transfusions (Transfusional Iron Overload) 1.2 Treatment of Chronic Iron Overload Due to Blood Transfusion-Dependent Thalassemia Syndromes 1.3 Limitations of Use 2 DOSAGE AND ADMINISTRATION 2.1 Transfusional Iron Overload 2.2 Iron Overload in Non-Transfusion-Dependent Thalassemia Syndromes 2.3 Administration 2.4 Use in Patients with Baseline Hepatic or Renal Impairment 2.5 Dose Modifications Based on Concomitant Medications 3 DOSAGE FORMS AND STRENCTHS	7.1 Aluminum-Containing Antacid Preparations 7.2 Agents Metabolized by CYP3A4 7.3 Agents Metabolized by CYP1A2 7.4 Agents Inducing UDP-glucuronosyltransferase (UGT) Metabolism 7.5 Agents Inducing UDP-glucuronosyltransferase (UGT) Metabolism 7.6 Bile Acid Sequestrants 7.7 Busulfan 8 USE IN SPECIFIC POPULATIONS 8.1 Pregnancy 8.2 Lactation 8.3 Females and Males of Reproductive Potential	Abdominal Pain ⁵ Diarrhea Creatinine Increased ⁶ Nausea Vomiting Rash Abbreviation: MDS, myelodysplastic ' Adverse reaction frequencies are ba ⁵ Includes 'abdominal pain', 'abdomin ' Includes 'blood creatinine increased	63 (21) 35 (12) 33 (11) 31 (11) 30 (10) 25 (8) syndrome. ased on AEs reported regardless of al pain lower', and 'abdominal pa i' and 'blood creatinine abnormal' s treated with deferasirox had inc.	41 (14) 21 (7) 0 (0) 14 (5) 28 (10) 9 (3) of relationship to study drug. ain upper'. '. See also Table 2. creases in serum creatinine great red to be dose related <i>/see Warn</i>	37 (28) 26 (20) 9 (7) 30 (23) 28 (21) 14 (11) er than 33% above baseline inings and Precautions (6.1)/	9 (14) 3 (5) 0 7 (11) 10 (16) 3 (5) on 2 separate occasion. In this study, 17 (6%)	ns (Table
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 Patients with advanced malignancies. (4) Patients with platelet counts less than 50 x 10^o/L. (4) Known hypersensitivity to deferasirox or any component of deferasirox tablets. (4) FULL PRESCRIBING INFORMATION: CONTENTS* WARNING: RENAL FAILURE, HEPATIC FAILURE, and GASTROINTESTINAL HEMORRHAGE INDICATIONS AND USAGE I. Treatment of Chronic Iron Overload Due to Blood Transfusions (Transfusional Iron Overload) 1. Treatment of Chronic Iron Overload Due to Blood Transfusions (Transfusional Iron Overload) Treatment of Chronic Iron Overload in Non-Transfusion-Dependent Thalassemia Syndromes J. Limitations of Use DOSAGE AND ADMINISTRATION I. Transfusional Iron Overload Z. Iron Overload in Non-Transfusion-Dependent Thalassemia Syndromes J. Administration 4. Use in Patients with Baseline Hepatic or Renal Impairment Dos Modifications for Decreases in Renal Function While on Deferasirox Tablets Dos Modifications Based on Concomitant Medications DOSAGE FORMS AND STRENGTHS CONTRAINDICATIONS MARININGS AND PRECAUTIONS S. Acute Kidney Injury. Including Acute Renal Failure Requiring Dialysis and Renal Tubular Toxicity Including Fanconi Syndrome Hepatic Toxicity and Failure Gase Storintestinal (G) Ulceration, Hemorrhage, and Perforation Bone Marrow Suppression Acute Kidney Injury. Including Acute Renal Failure Requiring Dialysis and Renal Tubular Toxicity Including Fanconi Syndrome Hepatic Toxicity and Failure Goverchelat Risk of Toxicity Deverchelat Risk of Toxicity Goverchelat Risk of Toxicity Severe Skin Reactions Skin Rash 	7.1 Aluminum-Containing Antacid Preparations 7.2 Agents Metabolized by CYP3A4 7.3 Agents Metabolized by CYP2C8 7.4 Agents Metabolized by CYP1A2 7.5 Agents Inducing UDP-glucuronosyltransferase (UGT) Metabolism 7.6 Bile Acid Sequestrants 7.7 Busulfan 8 USEIN SPECIFIC POPULATIONS 8.1 Pregnancy 8.2 Lactation 8.3 Fernales and Males of Reproductive Potential 8.4 Pediatric Use 8.5 Geriatric Use 8.6 Renal Impairment 8.7 Hepatic Impairment 8.7 Hepatic Impairment 8.7 Hepatic Impairment 8.7 Hepatic Impairment 8.8 ECRIPTION 10 OVERDOSAGE 11 DESCRIPTION 12 CLINICAL PHARMACOLOGY 12.3 Pharmacokinetics 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility 14 CLINICAL STUDIES	Abdominal Pain* Diarrhea Creatinine Increased* Nausea Vomiting Rash Abbreviation: MDS, myelodysplastic * Adverse reaction frequencies are ba* * Includes 'abdominal pain', 'abdomin * Includes 'blood creatinine increased In Study 1, a total of 113 (38%) patients patients Radivers proven drug-in elevations in serupatients had liver blopsy proven drug-in elevations in SGPT/ALT greater than 5 Adverse reactions that led to discontint Schönlein purpura, hyperactivity/insom In Study 3, a total of 48 (36%) patients to deferasirox group developed elevations is deferasirox group developed elevations discontinued. Four additional patients gallstones, atypical tuberculosis, and % In the MDS pool, in the first year, a tot	63 (21) 35 (12) 33 (11) 31 (11) 30 (10) 25 (8) syndrome. ased on AEs reported regardless of al pain lower', and 'abdominal pa t' and 'blood creatinine abnormal' s treated with deferasirox had incre eases in serum creatinine appears mglutamic-pyruvic transaminase duced hepatitis and both disconti t itimes the ULN, discontinued def uations included abnormal liver fu ing, drug fever, and cataract (1 pai treated with deferasirox had incre who experienced creatinine incre is in SGPT/ALT levels greater th is in SGPT/ALT levels greater th si facontinued due to adverse re- cin rash. tal of 229 (37%) patients treated ths permanently discontinued <i>lsee</i> the most frequent adverse reaction	41 (14) 21 (7) 0 (0) 14 (5) 28 (10) 9 (3) of relationship to study drug. ain upper'. '. See also Table 2. creases in serum creatinine great treat to be dose related <i>(see Warn</i> e (SGPT)/ALT levels greater than inced deferasirox therapy <i>(see W ferasirox because of increased S anction tests (2 patients) and dru atient each). eases in Study 3, 8 deferasirox- bactions with a suspected relat d with deferasirox had increases d with deferasirox had increases of the deferasirox had increases nos that led to discontinuation in </i>	37 (28) 26 (20) 9 (7) 30 (23) 28 (21) 14 (11)	9 (14) 3 (5) 0 7 (11) 10 (16) 3 (5) on 2 separate occasion. In this study, 17 (6%) rmal (ULN) at 2 consec 2//. An additional 2 pati saminases did not app nts), skin rash, glycosu 12 separate occasions (see reductions. In this s t subsequently had de uding diarrhea, pancre r than 33% above basis ts developed SGPT/AL	Is (Table) patient ients, where the second ients, where the second ients, where the second ients, where the second ient secon

Study 3 (Sickle Cell Disease) (Beta-thalassemia MDS Pool Deferasirox Defer Deferasirox

N = 627

n (%)

229 (37)

126 (20)

9 (1)

5 (1)

N = 63

n (%)

- FULL PRESCRIBING INFORMATION monitor renal function more frequently, by evaluating tubular and glomerular function. Titrate dosing based on renal injury. Consider dose reduction or interruption and less nephrotoxic therapies until improvement of renal function. If signs of renal tubular or glomerular injury occur in the presence of other risk factors such as volume depletion, WARNING: RENAL FAILURE, HEPATIC FAILURE, and GASTROINTESTINAL HEMORRHAGE Deferoxamine Deferasirox utions (5.1)) All Patients (regardless of age):

 Discontinue therapy for eGFR less than 40 mL/min/1.73 m²/see Contraindications (4)). N = 296 N = 290 N = 132 Deferasirox can cause acute renal failure and death, particularly in patients with comorbidities and those who are in the advanced stages of their Laboratory Parameter n (%) n (%) n (%) hematologic disorders. Evaluate baseline renal function prior to starting or increasing deferasirox dosing in all patients. Deferasirox is contraindicated in adult and pediatric Serum Creatinine Non-Transfusion-Dependent Thalassemia Syndrome patients with eGFR less than 40 mL/min/1.73 m². Measure serum creatinine in duplicate prior to initiation of therapy. Monitor renal function at least reatinine increase > 33% at Adults. 113 (38) monthly. For patients with baseline renal impairment or increased risk of acute renal failure, monitor renal function weekly for the first month, then at least monthly. Reduce the starting dose in patients with preexisting renal disease. During therapy, increase the frequency of monitoring and modify the dose for 41 (14) 48 (36) If the serum creatinine increases by 33% or more above the average baseline measurement, repeat the serum creatinine within 1 week, and if still elevated by 33% or more, interrupt therapy if the dose is 3.5 mg per kg, or reduce by 50% if the dose is 7 or 14 mg per kg. 2 consecutive post-baseline visit reatinine increase > 33% and > ULN patients with an increased risk of renal impairment, including use of concomitant nephrotoxic drugs, and pediatric patients with volume depletion or overchelation/see Dosage and Administration (2.1, 2.4, 2.5), Warnings and Precautions (5.1), Adverse Reactions (6.1, 6.2)). 7 (2) 3 (2) 1 (0) at 2 consecutive post-baseline visits Pediatric Patients (ages 10 years to 17 years): Reduce the dose by 3.5 mg per kg if eGFR decreases by greater than 33% below the average baseline measurement and repeat the eGFR within 1 week. SGPT/ALT epatic Failure SGPT/ALT > 5 x ULN at 2 post-baseline Increase monitoring frequency for pediatric patients who have acute illnesses, which can cause volume depletion, such as vomiting, diarrhea, or prolonged decreased oral Deferasirox can cause hepatic injury including hepatic failure and death. 25 (8) 7 (2) 2 (2) intake. Consider dose interruption until oral intake and volume status are normal. Avoid use of other nephrotoxic drugs [see Warnings and Precautions (5.1)]. VISITS SGPT/ALT > 5 x ULN at 2 consecutive Measure serum transaminases and bilirubin in all patients prior to initiating treatment, every 2 weeks during the first month, and at least monthly In the setting of decreased renal function, evaluate the risk benefit profile of continued deferasirox tablets use. Use the minimum effective deferasirox tablets dose and monitor renal function more frequently, by evaluating tubular and glomerular function. Titrate dosing based on renal injury. Consider dose reduction or interruption and less 17 (6) 5 (4) 5 (2) post-baseline visits Avoid use of deferasirox in patients with severe (Child-Pugh C) hepatic impairment and reduce the dose in patients with moderate (Child-Pugh B) hepatic nephrotoxic therapies until improvement of renal function. If signs of renal tubular or glomerular injury occur in the presence of other risk factors such as volume depletion, Abbreviations: ALT, alanine transaminase; MDS, myelodysplastic syndrome; SGPT, serum glutamic-pyruvic transaminase; ULN, upper limit of normal impairment/see Dosage and Administration (2.4), Warnings and Precautions (5.2)). reduce or interrupt deferasirox tablets to prevent severe and irreversible renal injury *(see Warnings and Precautions (5.1))*. itestinal Hemorrhage Non-Transfusion-Dependent Thalassemia Syndromes All Patients (regardless of age):
 Discontinue therapy for eGFR less than 40 mL/min/1.73 m²/see Contraindications (4)). Deferasirox can cause gastrointestinal (GI) hemorrhages, which may be fatal, especially in elderly patients who have advanced hematologic malignancie In Study 5, 110 patients with NTDT received 1 year of treatment with deferasirox 5 or 10 mg/kg/day and 56 patients received placebo in a double-blind, randomized trial. In Study 6, and/or low platelet counts. Monitor patients and discontinue deferasirox for suspected GI ulceration or hemorrhage *(see Warnings and Precautions (5.3)*/. 2.6 Dose Modifications Based on Concomitant Medication INDICATIONS AND USAGE UDP-glucuronosyltransferases (UGT) Inducers Concountant use of UGT inducers decreases systemic exposure. Avoid the concomitant use of strong UGT inducers (e.g., rifampicin, phenytoin, phenytoin, phenobarbital, ritonavir). If you must administer deferasirox tablets with a strong UGT inducer, consider increasing the initial dose by 50%, and monitor serum ferritin levels and clinical responses for further dose 1.1 Treatment of Chronic Iron Overload Due to Blood Transfusions (Transfusional Iron Overload) tablets are indicated for the tre nic iron overload due to blood transfus in patients 2 years of age and olde Table 3. Adverse Reactions Occurring in Greater Than 5% Patients with NTDT modification [see Dosage and Administration (2.1, 2.2), Drug Interactions (7.5)]. 1.2 Treatment of Chronic Iron Overload in Non-Transfusion-Dependent Thalassemia Syndromes Bile Acid Sequestrants Concomitant use of bile acid sequestrants decreases systemic exposure. Avoid the concomitant use of bile acid sequestrants (e.g., cholestyramine, colesevelam, colestipol). If you must administer deferasirox tablets with a bile acid sequestrant, consider increasing the initial dose by 50%, and monitor serum ferritin levels and clinical responses for further dose modification (*see Dosage and Administration (2.1, 2.2)*, Drug Interactions (7.6)]. 1.3 Limitations of Use The safety and efficacy of deferasirox tablets when administered with other iron chelation therapy have not been established. 3 DOSAGE FORMS AND STRENGTHS 90 mg deferasirox tablets are white to off white, film coated, oval biconvex tablets, debossed with '56' on one side and 'V' on the other side. 180 mg deferasirox tablets are white to off white, film coated, oval biconvex tablets, debossed with '57' on one side and 'V' on the other side. 360 mg deferasirox tablets are white to off white, film coated, oval biconvex tablets, debossed with '58' on one side and 'V' on the other side. DOSAGE AND ADMINISTRATION 2.1 Transfusional Iron Overload Deferasirox therapy should only be considered when a patient has evidence of chronic transfusional iron overload. The evidence should include the transfusion of at least 100 mL/kg of packed red blood cells (e.g., at least 20 units of packed red blood cells for a 40 kg person or more in individuals weighing more than 40 kg), and a serum ferritin consi CONTRAINDICATIONS than 1,000 mcg/L. Deferasirox tablets are contraindicated in patients with: Prior to starting therapy, or increasing dose, evaluate Estimated GFR less than 40 ml/min(1.73 m²/see Dosage and Administration (2.5), Warnings and Precautions (5.1); Poor performance status *[see Warnings and Precautions (5.1, 5.3)*]; Abbreviation: NTDT, non-transfusion-dependent thalassemia. ¹The occurrence of nausea, and rash are included for Study 6 and rash for Study 7 for consistency. There were no additional adverse Serum ferritin level Baseline renal function High-risk myelodysplastic syndromes (this patient population was not studied and is not expected to benefit from chelation therapy); Advanced malignancies [see Warnings and Precautions (5.1, 5.3]); reactions with a suspected relationship to study drug occurring in >5% of patients in Study 6 and Study 7. Obtain serum creatinine in duplicate (due to variations in m Calculate the estimated glomerular filtration rate (eGFR). Use a prediction equation appropriate for adult patients (e.g., CKD-EPI, MDRD method) and in pediatric Platelet counts less than 50 x 10° /L/see Warnings and Precautions (5.3, 5.4)]; patients (e.g., Schwartz equations). Known hypersensitivity to deferasirox or any component of deferasirox tablets [see Warnings and Precautions (5.7), Adverse Reactions (6.2)]. Declaration (S.g., Control Exquestion); O Dbtain urinalyses and serum electrolytes to evaluate renal tubular function (see Dosage and Administration (2.4), Warnings and Precautions (5.1)]. Serum transaminases and bilirubin (see Dosage and Administration (2.4), Warnings and Precautions (5.2)] WARNINGS AND PRECAUTIONS 5.1 Acute Kidney Injury, Including Acute Renal Failure Requiring Dialysis and Renal Tubular Toxicity Including Fanconi Syndrome Deferasirox is contraindicated in patients with eGFR less than 40 mL/min/1.73 m². Exercise caution in pediatric patients with eGFR between 40 and 60 mL/min/1.73 m². If treatment is needed, use the minimum effective dose and monitor renal function frequently. Individualize dose titration based on improvement in renal injury *(see Use in Specific Populations*) Baseline auditory and ophthalmic examinations /see Warnings and Precautions (5.10) presented in Table 4 below Initiating Therapy: The recommended initial dose of deferasirox tablets for patients 2 years of age and older with eGFR greater than 60 mL/min/1.73 m² is 14 mg per kg body weight orally, once daily. Table 4. Number (%) of Patients with NTDT with Increases in Serum Creatinine or SGPT/ALT (8.6)]. For patients with renal impairment (eGFR 40 to 60 mL/min/1.73 m²) reduce the starting dose by 50% [see Dosage and Administration (2.4, 2.5), Use in Specific Popul Calculate doses (mg per kg per day) to the nearest whole tablet. Changes in weight of pediatric patients over time must be taken into account when calculating the dose. (8.6)]. During Therapy: Deferasirox can cause acute kidney injury including renal failure requiring dialysis that has resulted in fatal outcomes. Based on postmarketing experience, most fatalities have Monitor serum ferritin monthly and adjust the dose of deferasirox, if necessary, every 3 to 6 months based on serum ferritin trends. porcurred in patients with multiple comorbidities and who were in advanced stages of their hematological disorders. In the clinical and pediatric deferasinx-treated patients with multiple comorbidities and who were in advanced stages of their hematological disorders. In the clinical and pediatric deferasinx-treated patients with no preexisting renal disease experienced dose-dependent mild, non-progressive increases in serum creatinine and proteinuria. Preexisting renal disease and Use the minimum effective dose to achieve a trend of decreasing ferritin. Make dose adjustments in steps of 3.5 or 7 mg per kg and tailor adjustments to the individual patient's response and therapeutic goals. In patients not adequately concordent of the part of an equivalence of the patients of the pat concomitant use of other nephrotoxic drugs may increase the risk of acute kidney injury in adult and pediatric patients. Acute illnesses associated with volume depletion and concomment use of other helphotoxic order helphotoxic order helphotoxic patients. And the message associated with round dependent and overchelation may increase the risk of acute kidney injury in pediatric patients. In pediatric patients, small decreases in effect and increases in deferasion exposure, particularly in younger patients with body surface area typical of patients less than age 7 years. This can lead to a cycle of worsening renal function and further increases in deferasion exposure, Adjust dose based on serum ferritin levels o If the serum ferritin falls below 1,000 mcg/L at 2 consecutive visits, consider dose reduction especially if the deferasirox dose is greater than 17.5 mg/kg/day [see Adverse Reactions (6.1)]. o If the serum ferritin falls below 500 mcg/L, interrupt deferasirox therapy to minimize the risk of overchelation, and continue monthly monitoring *(see Warnings and* Precautions (5.6)]. Evaluate renal olomerular and tubular function before initiating therapy or increasing the dose. Use prediction equations validated for use in adult and pediatric patients to estimate o Evaluate the need for ongoing chelation therapy for patients whose conditions no longer require regular blood transfusions GFR. Obtain serum electrolytes and urinalysis in all patients to evaluate renal tubular function (see Dosage and Administration (2.1, 2.2)). Use the minimum effective dose to maintain iron burden in the target range [see Warnings and Prec tinns (5.6)]. Monitor all patients for changes in eGFR and for renal tubular toxicity weekly during the first month after initiation or modification of therapy and at least monthly thereafter. Dose Monitor blood counts, liver function, renal function and ferritin monthly [see Warnings and Precautions (5.1, 5.2, 5.4]]. reduction or interruption may be considered if abnormalities occur in levels of markers of renal tubular function and/or as clinically indicated. Monitor serum ferritin monthly to Interrupt deferasitox for pediatric patients who have acute illnesses, which can cause volume depletion, such as vomiting, diarrhea, or prolonged decreased oral intake, and monitor more frequently. Resume therapy as appropriate, based on assessments of renal function, when oral intake and volume status are normal *(see Dosage and Administration (2.4, 2.5), Warnings and Precautions (5.1), Use in Specific Populations (8.4), Clinical Pharmacology (12.3)/.* evaluate for overchelation. Use the minimum dose to establish and maintain a low iron burden. Monitor renal function more frequently in patients with preexisting renal disease or decreased renal function. In pediatric patients, interrupt deferasirox during acute illnesses, which can cause volume depletion such as vomiting, diarrhea, or prolonged decreased function, when oral intake and volume status are normal *(see Dosage and Administration (2.5), Warnings and Precautions (5.6), Adverse Reactions (6.1, 6.2), Use in Specific Populations (8.4).* Other Adverse Reactions 2.2 Iron Overload in Non-Transfusion-Dependent Thalassemia Syndromes Deferasirox therapy should only be considered when a patient with NTDT syndrome has an LIC of at least 5 mg Fe/g dw and a serum ferritin greater than 300 mcg/L. Prior to starting therapy, obtain: 5.2 Hepatic Toxicity and Failure LIC by liver biopsy or by an FDA-cleared or approved method for identifying patients for treatment with deferasirox therapy Deferasirox can cause hepatic injury, fatal in some patients. In Study 1, 4 patients (1.3%) discontinued deferasirox because of hepatic toxicity (drug-induced hepatitis in 2 patients Serum ferritin level on at least 2 measurements 1-month apart [see Clinical Studies (14)] and increased serum transaminases in 2 additional patients). Hepatic toxicity appears to be more common in patients greater than 55 years of age. Hepatic failure was more common in patients with significant comorbidities, including liver cirrhosis and multiorgan failure /see Adverse Reactions (6.1)/. Baseline renal function: creatinine, and increased serum transaminases. Obtain serum creatinine in duplicate (due to variations in mea Acute liver injury and failure, including fatal outcomes, have occurred in pediatric deferasirox-treated patients. Liver failure occurred in association with acute kidney injury in Occurrent optimization optimization in a comparison optimization in the comparison optimization opti optimization optimization optimization opti optimization opt Pooled Analysis of Pediatric Clinical Trial Data pediatric patients at risk for overchelation during a volume-depleting event. Interrupt deferasirox therapy when acute liver injury or acute kidney injury is suspected and during volume depletion. Monitor liver and renal function more frequently in pediatric patients who are receiving defeasirox in the 14to 28 mg/kg/kg/ar range and when iron burden is approaching normal. Use the minimum effective dose to achieve and maintain a low iron burden *(see Dosage and Administration (2.5), Warnings and Precautions (5.6), Adverse* level, separately and combined, on kidney function. Among 1213 children (aged 2 to 15 years) with transfusion-dependent thalassemia, 162 cases of acute kidney injury (eGFR \leq 90 mL/min/1.73 m²) and 621 matched-controls with normal kidney function (eGFR \geq 120 mL/min/1.73 m²) were identified. The primary findings were: Serum transaminases and bilirubin (see Dosage and Administration (2.4), Warnings and Precautions (5.2)) Baseline auditory and ophthalmic examinations (see Warnings and Precautions (5.10)) . Reactions (6.1)]. • Measure transaminases [aspartate transaminase (AST) and alanine transaminase (ALT)] and bilirubin in all patients before the initiation of treatment and every 2 weeks during the first month and at least monthly thereafter. Consider dose modifications or interruption of treatment for severe or persistent elevations. A 25% increased risk for acute kidney injury was observed with each 250 mcg/L decrease in serum ferritin starting at 205mcg/L (95% CI: 1.01 to 1.56). Initiating Therapy: ended initial dose of deferasirox for patients with eGFR greater than 60 mL/min/1.73 m² is 7 mg per kg body weight orally once daily. Calculate doses (mg per kg The re Avoid the use of deferasirox in patients with severe (Child-Pugh C) hepatic impairment. Reduce the starting dose in patients with moderate (Child-Pugh B) hepatic impairment [see per day) to the nearest whole tablet If the baseline LIC is greater than 15 mg Fe/g dw, consider increasing the dose to 14 mg/kg/day after 4 weeks. Dosage and Administration (2.4), Use in Specific Populations (8.7)]. Patients with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment may be at higher risk for overchelation. hepatic toxicity. During Therapy: Monitor serum ferritin monthly to assess the patient's response to therapy and to minimize the risk of overchelation */see Warnings and Precautions (5.6)*. Interrupt treatment when serum ferritin is less than 300 mcg/L and obtain an LIC to determine whether the LIC has fallen to less than 3 mg Fe/g dw. 5.3 Gastrointestinal (GI) Ulceration. Hemorrhage, and Perforation GI hemorrhage, including deaths, has been reported, especially in elderly patients who had advanced hematologic malignancies and/or low platelet counts. Nonfatal upper GI Use the minimum effective dose to achieve a trend of decreasing ferritin.

Monitor LIC every 6 months.

- After 6 months of therapy, if the LIC remains greater than 7 mg Fe/g dw, increase the dose of defensirox to a maximum of 14 mg/kg/day. Do not exceed a maximum of 14 mg/kg/day.
- If a fter 6 months of therapy, the LIC is 3 to 7 mg Felg dw, continue treatment with deferasirox at no more than 7 mg/kg/day When the LIC is less than 3 mg Felg dw, cinterrupt treatment with deferasirox and continue to monitor the LIC.
- Monitor blood counts, liver function, renal function and ferritin monthly (see Warnings and Precautions (5.1, 5.2, 5.4)).
- Increase monitoring frequency for pediatric patients who have acute illness which can cause volume depletion, such as vomiting, diarrhea, or prolonged decreased oral intake. Consider dose interruption until oral intake and volume status are normal *(see Dosage and Administration (2.4, 2.5), Warnings and Precautions (5.1), Use in Specific* Populations (8.4), Clinical Pharmacology (12.3)). Restart treatment when the LIC rises again to more than 5 mg Fe/g dw

2.3 Administration

Swallow deferasirox tablets once daily with water or other liquids, preferably at the same time each day. Take deferasirox tablets on an empty stomach or with a light meal (contains less than 7% fast content and approximately 250 calories). Examples of light meals include 1 whole wheat English mulfin, 1 packet jelly (0.5 ounces), and skim milk (8 fluid ounces) or a turkey sandwich (2 oz. turkey on whole wheat bread w/ lettuce, tomato, and 1 packet mustard). Do not take deferasirox tablets with aluminum-containing antacid products *[see Drug Interactions (7.1]/*. For patients who have difficulty swallowing whole tablets, deferasirox tablets may be crushed and mixed with soft foods (e.g., yogurt or applesauce) immediately prior to use and administered orally. Commercial crushers with serrated surfaces should be avoided for crushing a single 90 mg tablet. The dose should be med and not stored for future use. ediately and complete

For patients who are currently on chelation therapy with deferasirox tablets for oral suspension and converting to deferasirox tablets, the dose should be about 30% lower, rounded to the nearest whole tablet. The table below provides additional information on dosing conversion to deferasirox tablets

	Deferasirox Tablets for oral suspension	
Fransfusion-Dependent Iron Overload		
Starting Dose	20 mg/kg/day	14 mg/kg/day
Titration Increments	5 to 10 mg/kg	3.5 to 7 mg/kg
Maximum Dose	40 mg/kg/day	28 mg/kg/day
lon-Transfusion-Dependent Thalassemia	a Syndromes	
Starting Dose	10 mg/kg/day	7 mg/kg/day
Titration Increments	5 to 10 mg/kg	3.5 to 7 mg/kg
Maximum Dose	20 mg/kg/day	14 mg/kg/day

2.4 Use in Patients With Baseline Hepatic or Renal Impairment

Patients with Baseline Hepatic Impairme

Mild (Child-Pugh A) Hepatic Impairment: No dose adjustment is necessary.

Noderate (Child-Pugh B) Hepatic Impairment: Reduce the starting dose by 50%.

Severe (Child-Pugh C) Hepatic Impairment: Avoid deferasirox tablets [see Warnings and Precautions (5.2), Use in Specific Populations (8.7)].

- Patients with Baseline Renal Impairmen
- Do not use deferasirox in adult or pediatric patients with eGFR less than 40 mL/min/1.73 m² (see Dosage and Administration (2.5), Contraindications (4)).

irritation, ulceration and hemorrhage have been reported in patients, including children and adolescents, receiving deferasirox [see Adverse Reactions (6.1)]. Monitor for signs and symptoms of GI ulceration and hemorrhage during deferasirox therapy, and promptly initiate additional evaluation and treatment if a serious GI adverse reaction is suspected. The risk of GI hemorrhage may be increased when administering deferasirox in combination with drugs that have ulcerogenic or hemorrhagic potential, such as nonsteroidal anti-inflammatory drugs (NSAIDs), corticosteroids, oral bisphosphonates, or anticoagulants. There have been reports of ulcers complicated with GI perforation (including fatal outcome) [see Adverse Reactions (6.2)].

5.4 Bone Marrow Suppression

Neutropenia, agranulocytosis, worsening anemia, and thrombocytopenia, including fatal events, have been reported in patients treated with deferasirox. Preexisting hematologic disorders may increase this risk. Monitor blood counts in all patients. Interrupt treatment with deferasirox in patients who develop cytopenias until the cause of the cytopenia has been determined. Deferasirox is contraindicated in patients with platelet counts below 50 x 10°/L.

5.5 Age-Related Risk of Toxicity Elderly Patients

Deferasinox has been associated with serious and fatal adverse reactions in the postmarketing setting among adults, predominantly in elderly patients. Monitor elderly patients treated with deferasinox more frequently for toxicity *(see Use in Specific Populations (8.5))*.

Pediatric Patients Deferasitors has been associated with serious and fatal adverse reactions in pediatric patients in the postmarketing setting. These events were frequently associated with volume depletion or with continued deferasirox tablets for oral suspension doses in the 20 to 40 mg/kg/day range equivalent to 14 to 28 mg/kg/day deferasirox when body iron burden was approaching or in the normal range. Interrupt deferasirox in patients with volume depletion, and resume deferasirox when renal function and fluid volume have normalized. Monitor liver and renal function more frequently during volume depletion and in patients with rotatine depletion, and result with the letter solution with renal renal function more frequently during volume depletion and in patients receiving defeasirox in the 14 to 28 mg/kg/day range when iron burden is approaching the normal range. Use the minimum effective dose to achieve and maintain a low iron burden/see Dosage and Administration (2.4), Warnings and Precautions (5.6), Use in Specific Populations (8.4)).

5.6 Overchelation

For patients with transfusional iron overload, measure serum ferritin monthly to assess the patient's response to therapy and minimize the risk of overchelation. An analysis of pediatric patients treated with deferasirox tablets for oral suspension in pooled clinical trials (n = 158), found a higher rate of renal adverse reactions among patients receiving doses greater than 25 mg/kg/day equivalent to 17.5 mg/kg/day deferasirox while their serum ferritin values were less than 1,000 mcg/L. Consider dose reduction or closer monitoring of renal and hepatic function, and serum ferritin levels during these periods. Use the minimum effective dose to maintain a low-iron burden (see Adverse Reactions (6.1), Use in Specific Populations (8.4)).

If the serum ferritin falls below 1,000 mcg/L at 2 consecutive visits, consider dose reduction, especially if the deferasirox dose is greater than 17.5 mg/kg/day /see Adverse Reactions (6.1)/. If the serum fortian falls below 500 mcg/L, interrupt therapy with deferasirox and continue monthly monitoring. Evaluate the need for ongoing chelation for patients whose conditions do not require regular blood transfusions. Use the minimum effective dose to maintain iron burden in the target range. Continued administration of deferasirox in the 14 to 28 mg/kg/day range, when the body iron burden is approaching or within the normal range can result in life-threatening adverse reactions *// see Dosage and* histration (2.1)].

For patients with NTDT, measure LIC by liver biopsy or by using an FDA-cleared or approved method for monitoring patients receiving deferasirox therapy every 6 months on treatment. Interrupt deferasirox administration when the LIC is less than 3 mg Fe/g dw. Measure serum ferritin monthly, and if the serum ferritin falls below 300 mcg/L, interrupt deferasirox and obtain a confirmatory LIC *(see Clinical Studies (14))*.

5.7 Hypersensitivity

ors may cause serious hypersensitivity reactions (such as anaphylaxis and angioedema), with the onset of the reaction usually occurring within the first month of treatment Defer [see Adverse Reactions (6.2]). If reactions are severe, discontinue defensions and institute appropriate medical intervention. Defensions is contraindicated in patients with known hypersensitivity to deferasirox products and should not be reintroduced in patients who have experienced previous hypersensitivity reactions on deferasirox products due to the risk

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13 of the patients who completed Study Svere treated with open-label defension at 5, 10, or 20 mg/kg/day (depending on the baseline LLC) for 1 year (see Clinical Studies (14)). In Study 7, 134 patients with NTDT of 10 years of age or older with iron overload, received defensions at 5, 10, or 20 mg/kg/day (depending on the baseline LLC) for 1 year (see Clinical Studies (14)). mg/kg/day followed by dose adjustment at Week4, and then approximately every 6 months thereafter based on LIC levels. Table 3 and 4 display the frequency of adverse reactions in patients with NTDT. Adverse reactions with a suspected relationship to study drug were included in Table 3 if they occurred at \geq 5% of patients in Study 5.

	Stu	Study 5		Study 7	
	Deferasirox	Placebo	Deferasirox	Deferasirox	
	N = 110	N = 56	N = 130	N = 134	
	n (%)	n (%)	n (%)	n (%)	
Any adverse reaction	31 (28)	9 (16)	27 (21)	50 (37)	
Nausea	7 (6)	4 (7)	2 (2)°	7 (5)	
Rash	7 (6)	1 (2)	2 (2)°	3 (2)"	
Diarrhea	5 (5)	1 (2)	7 (5)	8 (6)	

In Study 5, 1 patient in the placebo 10 mg/kg/day group experienced an ALT increase to greater than 5 times ULN and greater than 2 times baseline (Table 4). Three deferasiroxtreated patients (all in the 10 mg/kg/day group) had 2 consecutive serum creatinine level increases greater than 33% from baseline and greater than ULN. Serum creatinine returned to normal in all 3 patients (in 1 spontaneously and in the other 2 after drug interruption). Two additional cases of ALT increase and 2 additional cases of serum creatinine increases were observed in the 1-year extension of Study 5. The number (%) of patients with NTDT with increase in serum creatinine or SGPT/ALT in Study 5, Study 6, and Study 7 are

	Study 5		Study 6	Study 7	
	Deferasirox	Placebo	Deferasirox	Deferasirox	
Laboratory Parameter	N = 110	N = 56	N = 130	N = 134	
	n (%)	n (%)	n (%)	n (%)	
Serum creatinine (> 33% increase from baseline and > ULN at \geq 2 consecutive post-baseline values)	3 (3)	0	2 (2)	2 (2)	
SGPT/ALT (> 5 x ULN and > 2 x baseline)	1 (1)	1 (2)	2 (2)	1 (1)	

In clinical studies, urine protein was measured monthly. Intermittent proteinuria (urine protein/creatinine ratio greater than 0.6 mg/mg) occurred in 18.6% of deferasirox-treated patients compared to 7.2% of deferoxamine-treated patients in Study 1 [see Warnings and Precautions [5.1]].

In the population of more than 5,000 patients with transfusional iron overload, who have been treated with deferasirox during clinical trials, adverse reactions occurring in 0.1% to The opportunity of the second state of the sec

conditions). Adverse reactions occurring in 0.01% to 0.1% of patients included optic neuritis, esophagitis, erythema multiforme, and drug reaction with eosinophilia and systemic symptoms (DRESS). Adverse reactions, which most frequently led to dose interruption or dose adjustment during clinical trials were rash, GI disorders, infections, increased serum

A nested case control analysis was conducted within a deferasirox tablets for oral suspension pediatric-pooled clinical trial dataset to evaluate the effects of dose and serum ferritin

A 26% increased risk of acute kidney injury was observed with each 5 mg/kg increase in daily deferasirox tablets for oral suspension dosage equivalent to 3.5 mg/kg

Among pediatric patients with a serum ferritin < 1,000 mcg/L, those who received deferasirox tablets for oral suspension dosage > 30 mg/kg/day, equivalent to 21 mg/kg/day deferasirox compared to those who received dosages, had a higher risk for acute kidney injury (0dds ratio (0R) = 4.47, 95% Cl: 1.25 to 15.95), consistent with

In addition, a cohort-based analysis of ARs was conducted in the deferasirox tablets for oral suspension pediatric pooled clinical trial data. Pediatric patients who received deferasions tablets for oral suspension does > 25 mg/kg/day equivalent to 17.5 mg/kg/day deferasions when their serum fertitin was < 1,000 mcg/L (n = 158), had a 6-fold greater rate of renal adverse reactions (Incidence Rate Ratio (IRR) = 6.00, 95% CI: 1.75 to 21.36), and a 2-fold greater rate of does interruptions (IRR = 2.06, 95% CI: 1.33 to 3.17) compared to the time-period prior to meeting these simultaneous criteria. Adverse reactions of special interest (cytopenia, renal, hearing, and Gl disorders) occurred 1.9-fold more frequently when these simultaneous criteria were met, compared to preceding time-periods (IRR = 1.91, 95% Cl: 1.05 to 3.48) *(see Warnings and Precautions (5.6))*.

6.2 Postmarketing Experience

The following adverse reactions have been spontaneously reported during post-approval use of deferasirox in the transfusional iron overload setting. Because these reactions are eported voluntarily from a population of uncertain size, in which patients may have received concomitant medication, it is not always possible to reliably estimate frequency or establish a causal relationship to drug exposure.

Skin and Subcutaneous Tissue Disorders: Stevens-Johnson syndrome (SJS), leukocytoclastic vasculitis, urticaria, alopecia, toxic epidermal necrolysis (TEN)

Immune System Disorders: hypersensitivity reactions (including anaphylactic reaction and angioedema Renal and Urinary Disorders: acute renal failure, tubulointerstitial nephritis

- Henatobiliary Disorders: henatic failure
- GI Disorders: GI perforation Blood and Lymphatic System Disorders: worsening anemia

5-Year Pediatric Registry

In a 5-year observational study, 267 pediatric patients 2 to < 6 years of age (at enrollment) with transfusional hemosiderosis received deferasirox. Of the 242 patients who had preand post-baseline eGFR measurements, 116 (48%) patients had a decrease in eGFR of $\geq 33\%$ observed at least once. Twenty-one (18%) of these 116 patients with decreased eGFR had a dose interruption, and 15(13%) of these 16 patients had a dose decreases within 30 days. Adverse reactions leading to permanent discontinuous for patients within double to the study included live in jury (n = 11), vomiting (n = 2), renal tubular disorder (n = 1), proteinuria (n = 1), hematuria (n = 1), upper GI hemorrhage (n = 1), add hypokalemia (n = 1). n from the study included live DRUG INTERACTIONS

- 7.1 Aluminum-Containing Antacid Preparations

concomitant administration of deferasirox and aluminum-containing antacid preparations has not been formally studied. Although deferasirox has a lower affinity for aluminum than for iron, do not take deferasirox with aluminum containing antacid preparations

7.2 Agents Metabolized by CYP3A4

Deferacions may induce CVP3A4 resulting in a decrease in CYP3A4 substrate concentration when these drugs are coadministered. Closely monitor patients for signs of reduced effectiveness when deferasirox is administered with drugs metabolized by CYP3A4 (e.g., alfentanil, aprepitant, budesonide, buspirone, conivaptan, cyclosporine, darifenacion, encourses when decisions is administered with origin measured by in GAC tegy, anentonic, popprant, ouesprinte, compront, compro compront, comprost, compr triazolam, ticagrelor, and vardenafil)/see Clinical Pharmacology (12.3)].

7.3 Agents Metabolized by CYP2C8

Deferasirox inhibits CYP2C8 resulting in an increase in CYP2C8 substrate (e.g., repaglinide and paclitaxel) concentration when these drugs are coadministered. If deferasirox and personant minors of 200 resuming in an increase in CT 200 substrate (e.g., repagning and personant substrate out and end of 200 resuming and commission of 120 resuming and commission of

7.4 Agents Metabolized by CYP1A?

Deferasion inhibits CYP1A2 resulting in an increase in CYP1A2 substrate (e.g., alosetron, caffeine, duloxetine, melatonin, ramelteon, tacrine, theophylline, tizanidine) concentration when these drugs are coadministered. An increase in theophylline plasma concentrations could lead to clinically significant theophylline induced CNS or other adverse reactions. Avoid the concomitant use of theophylline or other CYP1A2 substrates with a narrow therapeutic index (e.g., tizanidine) with defensions. Monitor theophylline concentrations and consider theophylline dose modification if you must coadminister theophylline with deferasirox. Closely monitor patients for signs of exposure related toxicity when deferasirox is coadministered with other drugs metabolized by CYP1A2 [see Clinical Pharmacology (12.3)].

use bine e to our our soft soft tren nay nay soft tren tren tren tren tren tren tren tre		ritonavir) may result in a decrease in deferasirox efficacy due to a possible decrease in deferasirox concentration. Avoid the concomitant use of strong UGT inducers with deferasirox. Consider increasing the initial dose of deferasirox if you must coadminister these agents together (<i>see Dosage and Administration (2.5), Clinical Pharmacology (12.3)).</i> 7.6 Bile Acid Sequestrants Avoid the concomitant use of bile acid sequestrants (e.g., cholestyramine, colesevelam, colestipol) with deferasirox due to a possible decrease in deferasirox concentration. If you must coadminister these agents together, consider increasing the initial dose of deferasirox. <i>See Dosage and Administration (2.5), Clinical Pharmacology (12.3)).</i> 7.7 Busulfan Increased exposure of busulfan was observed with concomitant use with deferasirox. Monitor plasma concentrations of busulfan when coadministered with deferasirox to allow dose adjustment of busulfan as needed [see Clinical Pharmacology (12.3)].
MEDICATION GUIDE Defension via policity Defension via policity Mhat is the most important information I should know about defension viablets? Defension viablets can cause serious side effects, including: What is the most important information I should know about defension viablets? Defension viablets can cause serious side effects, including: Kidney problems: Defension viablets can cause serious side effects, including: Mhat is problems; of sudden kidney problems; including: Kidney problems: Defension viablets can cause serious side effects, including: Mine sponder right many in people who also have other health problems; and had a blood disorder that vars in an advanced stage. Adults and divident about all the effects including: Mine sponder right many in people who also have other health problems; and had a blood disorder that vars in an advanced stage. Adults and viablets reprovide many in the defension viablets. Call your healthcare provider right many if: Your healthcare provider should do blood and urine tests to check your or your child via defont that vars in an advanced stage. Adults and viablets. Four child may be abree that your child becomes since with the defension viablets. Call your child becomes since who had not chan y problems. We can chan a stage that can sometimes cause death. With defension viablets can cause series provider many up the defension viablets can cause series provider many many to the most varies of subtex. Your child the dehydration to help prevent kidney problems. We cause dependent with defension viablets can cause series provide many viablets can cause seture provide many viablets. Defension viablets can s	• blood thimer medicines defensions tablets, tell your healthcare provider if you are taking one of these medicines. Ask your healthcare provider if you are not the stomach or intestine, or severe bleading, your healthcare provider may stop defensions tablets. I a higher risk of developing serious side effects and death due to serious side effects with defensions tablets. Provider if you get hearthurn during treatment with defensions tablets. Provider if you get hearthurn during treatment with defensions tablets. Provider if you get hearthurn during treatment with defensions tablets. Since allote and defensions tablets?" for more information about side effects. Is allote an increased amount of iron in their blood for a long period of time (chronic), caused by repeated blood transfusio years of age or older with thalassemia who have an increased amount of iron in their blood. Since tablets are safe and effective when used with other medicines to treat an increased amount of iron in their blood dor acceleration and effective when used with other medicines to treat an increased amount of iron in the blood. Since tablets are safe and effective when used with other under 10 years of age with thalassemia who have an increased amount of iron in their blood transfusio years of age or older with thalassemia who there an increased amount of iron in the blood. Since tablets are safe and effective for treating children under 10 years of age with thalassemia who have an increased amount of iron ion treesiving regular blood transfusions. At ablets are safe and effective for treating children under 10 years of age with thalassemia who have an increased amount of iron of or any of the ingredients indefensions tablets. See the end of this medication guide for a list of the ingredients indefensions table of or or any of the ingredients indefension tablets. See the end of this medication guide for a list of the ingredients indefension table or or or any of the ingredients indefension tablets. See the end of this medication gui	an avarened raneer. See "Do not take defension x tablets if you?" have albord disorder that may increase your risk for bleeding are gregnant or plan to become pregnant. It is on known if defensions tablets. The about disorder that may increase your risk for bleeding are pregnant or plan to become pregnant. It is on known if defensions tablets. The nonseduring them - Tell your healthcear how will rederes in a provider about other birth control options of the time if used during treatment with defensions tablets. You could become pregnant. 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See "What is the most impor- tormation is hould work about defensions tablets of a matcaip problems on a affect how defensions tablets and interp problems on a affect how defensions tablets of correction medicines to lower your cholesterol. Called blie acid sequestrants. A your healthceare provider fullow in the polylyline. I the ophylyline is a first of them to show your healthcare provider talls you to. Before stablets or at bless or at bless or at the synon the medicines your healthcare provider talls you to. Take defension tablets or at the synon tablets or at the synon the medicines or at bless or at the synon tablets or at the synon tablets or at the synon tablets o

Artwork information					
Customer	Camber	Market	USA		
Dimensions (mm)	400 x 800 mm	Non Printing Colors	Die cut		
Pharma Code No.	Front-992 & Back-993				
Printing Colours (01) Black					
Others: Pharma code position and Orientation are tentative, will be changed based on folding size.					



A total of 586 patients were randomized and treated, 296 with deferasirox tablets for oral suspension and 290 with deferoxamine. The mean age was 17.1 years (range, 2 to 53 years); 52% were females and 88% were Caucasian. The primary efficacy population consisted of 553 patients (deferasirox tablets for oral suspension n = 276; deferoxamine n = 277) who had LIC evaluated at baseline and 12 months or discontinued due to an adverse reaction. The percentage of patients achieving the primary endpoint was 52.9% for

In patients who had an LIC at baseline and at end of study, the mean change in LIC was +2.4 mg Fe/g dry weight in patients treated with deferasirox tablets for oral suspension and

Reduction of LIC and serum ferritin was observed with deferasirox tablet for oral suspension doses of 20 to 30 mg per kg per day. Deferasirox tablets for oral suspension doses below 20 mg per kg per day failed to provide consistent lowering of LIC and serum ferritin levels (Figure 1). Therefore, a starting dose of 20 mg per kg per day is recommended /see

not he determi

Ferritin Following Deferasirox Tablets for Oral Suspension (5 to 30 mg per kg per day) in Study 1

nsion and 66.4% for deferoxamine. The relative eff

🔲 Liver iron content Serum ferritin

- 20 -

-2.9 mg Fe/g dry weight in patients treated with deferoxamine.

Dosage and Administration (2.1)]. Figure 1. Changes in Liver Iron Conc

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary There are no studies with the use of deferasirox in pregnant women to inform drug-associated risks.

Administration of deferasirox to rats during pregnancy resulted in decreased offspring viability and an increase in renal anomalies in male offspring at doses that were about or less than the recommended human dose on a mg/m² basis. No fetal effects were noted in pregnant rabbits at doses equivalent to the human recommended dose on an mg/m² basis.

irox should be used during pregnancy only if the pot efit justifies the potential risk to the fetus.

The background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies had a background risk of birth defect, loss, or other adverse outcomes. However, the background risk in the U.S. general population of major birth defects is 2% to 4% and of miscarriage is 15% to 20% of clinically recognized pregnancies.

Data Animal Data

In embryo-fetal developmental studies, pregnant rats and rabbits received oral deferasirox during the period of organogenesis at doses up to 100 mg/kg/day in rats and 50 mg/kg/day in rabbits (1.2 times the maximum recommended human dose (MRHD) on an mg/m² basis). These doses resulted in maternal toxicity but no fetal harm was observed

In a prenatal and postnatal developmental study, pregnant rats received oral deferasirox daily from organogenesis through lactation day 20 at doses of 10, 30, and 90 mg/kg/day (0.1, 0.3, and 1.0 times the MRHD on a mg/m² basis). Maternal toxicity, loss of litters, and decreased of fspring visibility occurred at 90 mg/kg/day (1.0 times the MRHD on a mg/m² basis). Maternal toxicity, loss of litters, and decreased of fspring visibility occurred at 90 mg/kg/day (1.0 times the MRHD on a mg/m² basis).

8.2 Lactation Risk Summary

No data are available regarding the presence of deferasirox or its metabolites in human milk, the effects of the drug on the breastfed child, or the effects of the drug on milk The data are available regarding the presence of decretation of in at mike about an manimum, the effects of the data of the break of the data of the effects of the data of th importance of the drug to the mother

8.3 Females and Males of Reproductive Potential

<u>Contraception</u>

Counsel patients to use non-hormonal method(s) of contraception since deferasirox can render hormonal contraceptives ineffective (see Drug Interactions (7.2)).

8.4 Pediatric Use

The safety and effectiveness of deferasirox have been established in pediatric patients 2 years of age and older for the treatment of transfusional iron overload /see Dosage and

ntion (2.1)].

Safety and effectiveness have not been established in pediatric patients less than 2 years of age for the treatment of transfusional iron overload

Pediatric approval for treatment of transfusional iron overload was based on clinical studies of 292 pediatric patients 2 years to less than 16 years of age with variou:

and acquired anemias. Seventy percent of these patients had beta-thalassemia /see Indications and Usage (1), Dosage and Administration (2.1), Clinical Studies (14)). In those linical studies, 173 children (ages 2 to < 12 years) and 119 adolescents (ages 12 to < 17 years) were exposed to deferas

A trial conducted in treatment naïve pediatric patients, 2 to < 18 years of age with transfusional iron overload (NCT02435212) did not provide additional relevant information about the safety or effectiveness of the deferasirox granules dosage form compared to the deferasirox oral tablets for suspension dosage form.

Iron Overload in Non-Transfusion-Dependent Thalassemia Syndromes

The safety and effectiveness of deferasion knows been established in patients 10 years of age and older for the treatment of chronic iron overload with non-transfusion-dependent thalassemia (NTDT) syndromes [see Dosage and Administration (2.2)].

Safety and effectiveness have not been established in patients less than 10 years of age with chronic iron overload in NTDT syndromes.

Pediatric approval for treatment of NTDT syndromes with liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight and a serum ferritin greater than 300 mcg/L was based on 16 pediatric patients treated with deferasirox therapy (10 years to less than 16 years of age) with chronic iron overload and NTDT. Use of deferasirox in these age groups is supported by evidence from adequate and well-controlled studies of deferasirox in adult and pediatric patients (see Indications and Usage (1.2), Dosage and inistration (2.2), Clinical Studies (14)].

In general, risk factors for deferasirox-associated kidney injury include preexisting renal disease, volume depletion, overchelation, and concomitant use of other nephrotoxic drugs. Acute kidney injury, and acute liver injury and failure has occurred in pediatric patients. The pole safety analysis, pediatric patients with higher deferasions exposures had a greater probability of renal toxicity and decreased renal function, resulting in increased deferasirox exposure and progressive renal toxicity/kidney injury. Higher rates of renal AEs have been identified among pediatric patients receiving deferasirox tablets for oral suspension doses greater than 25 mg/kg/day equivalent to 17.5 mg/kg/day deferasirox when their serum ferritin values were less than 1,000 mcg/L (see Dosage and Administration (2.5), Warnings and Precautions (5.1, 5.6), Adverse Reactions (6.1, 6.2)).

Monitoring recommendations for all pediatric patients with Transfusional Iron Overload and NTDT

renal function. Avoid use of other nephrotoxic drugs [see Dosage and Administration (2.5), Warnings and Precautions (5.1)].

juvenile rats compared to adult rats at a dose based on right" approximately 0.4 times the recommended with when deferasirox was administered to non-iron overloaded animals compared to iron overloaded animals.

It is recommended that serum ferritin be monitored every month to assess the patient's response to therapy and to minimize the risk of overchelation /see Warnings and Precaution: (5.6)].

Monitor renal function by estimating GFR using an eGFR prediction equation appropriate for pediatric patients and evaluate renal tubular function. Monitor renal function more frequently in pediatric patients in the presence of renal toxicity risk factors, including episodes of dehydration, fever and acute illness that may result in volume depletion or decreased renal perfusion. Use the minimum effective dose/see Warnings and Precautions (5.1)]. Interrupt deferasirox in pediatric patients with transfusional iron overload, and consider dose interruption in pediatric patients with pon-transfusion-dependent iron overload. for

actual illesses, which can cause volume depletion, such as voniting, diarrhea, or prolonged decreased oral intake, and monitor more frequently. Resume therapy as appropriate, based on assessments of renal function, when oral intake and volume status are normal. Evaluate the risk benefit profile of continued defensions use in the setting of decreased

Renal toxicity was observed in adult mice, rats, and marmoset monkeys administered deferasirox at therapeutic doses. In a neonatal and juvenile toxicity study in rats, deferasirox was administered orally from postpartum Day 7 through 70, which equates to a human age range of term neonate through adolescence. Increased renal toxicity was identified in

nded dose of 20 mg/kg/day. A higher frequency of renal abnormalities was noted

Non-Transfusion-Dependent Thalassemia

combined placebo groups.

Study 5 (NCT00873041) was a randomized, double-blind, placebo-controlled trial of treatment with deferasirox tablets for oral suspension for patients 10 years of age or older with NTD Tsyndromes and iron overlaad. Eligible patients had an LIC of at least 5 mg Fejg dw maxed by R2 MR1 and a serum ferritin acceding 300 mcg/L at screening (2 consecutive values at least 14 days apart from each other). A total of 166 patients were randomized, 55 to the deferasirox tablets for oral suspension 5 mg/kg/day dose group, 55 to the deferasirox tablets for oral suspension 10 mg/kg/day dose group, and 56 to placebo (28 to each matching placebo group). Doses could be increased after 6 months if the LIC exceeded 7 mg Fe/g dw and the LIC reduction from baseline was less than 15%. The patients enrolled included 89 males and 77 females. The underlying disease was beta-thalassemia intermediation 95 (57%) patients, HbE beta-thalassemia in 49 (30%) patients, and alpha-thalassemia in 22 (13%) patients. There were 17 pediatric patients in the study. Caucasians comprised 57% of the study nonulation and Asians comprised 42% The median haseline LIC (range) for all natients was 12 1 (2 6 to 49 1) mg Fe/d dw Follow-up was for 1 year. The primary efficacy endpoint of change in LIC from baseline to Week 52 was statistically significant in favor of both deferasirox dose groups compared with placebo (pless than or equal to 0.001) (Table 5). Furthermore, a statistically significant dose effect of deferasirox was observed in favor of the 10 mg/kg/day dose group (10 versus 5 mg/kg/day, p = 0.009). In a descriptive analysis, the target LIC (less than 5 mg Fe/g dw) was reached by 15 (27%) of 55 patients in the 10 mg/kg/day arm, 8 (15%) of 55 patients in the 5 mg/kg/day arm and 2 (4%) of 56 patients in the

Study 2 (NCT00061763) was an open-label, noncomparative trial of efficacy and safety of deferasirox tablets for oral suspension given for 1 year to patients with chronic anemias and transfusional hemosiderosis. Similar to Study 1, patients received 5, 10, 20, or 30 mg per kg per day of deferasirox tablets for oral suspension based on baseline LIC.

Deferasirox Dose (mg/kg/day)

n=15 n=15 n=68 n=73 n=77 n=80 n=108 n=115[⊥] -4000

A total of 184 patients were treated in this study: 85 patients with beta-thalassemia and 99 patients with other congenital or acquired anemias (myelodysplastic syndromes a que to reor potention to require to the contract of the potential to the contract of the potential of the

Study 3 (NCT00067080) was a multicenter, open-label, randomized trial of the safety and efficacy of deferasirox tablets for oral suspension relative to deferoxamine given for 1 year in patients with sickle cell disease and transfusional hemosiderosis. Patients were randomized to deferasirox tablets for oral suspension at doses of 5, 10, 20, or 30 mg per kg per day or subcutaneous deferoxamine at doses of 20 to 60 mg per kg per day for 5 days per week according to baseline LIC.

A total of 195 patients were treated in this study: 132 with deferasirox tablets for oral suspension and 63 with deferoxamine. Forty-four percent (44%) of patients were less than 16 years of age and 91% were black. At end of study, the mean change in LIC (as measured by magnetic susceptometry by a superconducting quantum interference device) in the per protocol-1 (PP-1) population, which consisted of patients who had at least 1 post-baseline LIC assessment, was -1.3 mg Fe/g dry weight for patients receiving deferasirox tablets for oral suspension (n = 113) and -0.7 mg Fe/g dry weight for patients receiving deferoxamine (n = 54).

One-hundred five (105) patients with thalassemia major and cardiac iron overload were enrolled in a study assessing the change in cardiac magnetic resonance imaging (MRI) T2* value (measured in milliseconds, [ms]) before and after treatment with deferasirox. Cardiac T2* values at baseline ranged from 5 to less than 20 ms. The geometric mean of cardiac T2* in the 68 patients who completed 3 years of deferasirox tablets for oral suspension therapy increased from 11.98 ms at baseline to 17.12 ms at 3 years. Cardiac T2* value improved in patients with severe cardiac iron overload (less than 10 ms) and in those with mild to moderate cardiac iron overload (greater than or equal to 10 to less than 20 ms). The clinical significance of these observations is unknown

Six hundred twenty-seven (627) patients with MDS were enrolled across 5 uncontrolled trials. Two hundred thirty-nine of the 627 patients were enrolled in trials that limited enrollment to patients with IPSS Low or Intermediate 1 risk MDS, and the remaining 388 patients were enrolled in trials that did not specify MDS risk stratification but required a life expectancy of greater than 1 year. Planned duration of treatment in these trials ranged from 1 year (365 patients) to 5 years (47 patients). These trials evaluated the effects of deferasion tables for oral supersion therapy on parameters of iron overload, including LI(125 patients) and sum ferritin (527 patients). The percent of patients completing planned duration of treatment was 51% in the largest 1-year study, 52% in the 3-year study and 22% in the 5-year study. The major causes for treatment discontinuation were withdrawal of consent, adverse reaction, and death. Over 1 year of follow-up across these pooled studies, mean change in serum ferritin was 332.8 (± 2615.59) mcg/L (n = 593) and mean change in LIC was -5.9 (± 8.32) mg Fe/g dw (n = 68). Results of these pooled studies in 627 patients with MDS suggest a progressive decrease in serum ferritin and LIC beyond 1 year in those patients who are able to continue deferasirox tablets for oral suspension.

Study 4 (TELESTO; NCT 00940602) was a randomized, double-blind, placebo-controlled trial performed in 225 patients with MDS (Low/Int-1 risk) and transfusional iron overload of which 149 were treated with deferasirox and 76 received placebo. The observed hazard ratio of 0.64 (95% CI: 0.42, 0.96) suggests a positive impact of deferasirox on event-free survival (EFS, a composite endpoint defined as death, worsening cardiac function, hospitalization for congestive heart failure, liver function impairment, liver cirrhosis, or progression to acute myeloid leukemia; whichever occurred first).

enty-five (225) of these o 75 years of age. The m when the constraint of the particular is the second of the hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy. Dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range.

Four hundred thirty-one (431) patients greater than or equal to 65 years of age were studied in clinical trials of deferasirox in the transfusional iron overload setting. Two hundred

In elderly patients, including those with MDS, individualize the decision to remove accumulated iron based on clinical circumstances and the anticipated clinical benefit and risks of deferasirox tablets for oral suspension therapy.

8.6 Renal Impairment

Juvenile Animal Toxicity Data

8.5 Geriatric Use

Deferasions's contraindicated in patients with eGFR less than 40 mL/min/1.73 m²/see Contraindications (4)). For patients with renal impairment (eGFR 40 to 60 mL/min/1.73 m²), reduce the starting dose by 50% (see Dosage and Administration (2.4), Clinical Pharmacology (12.3). Exercise caution in pediatric patients with an eGFR between 40 and 60 mL/min/1.73 m²(see Dosage and Administration (2.4)). If treatment is needed, use the minimum effective dose with enhanced monitoring of glomerular and renal tubular function.

Individualize dose titration based on improvement in renal injury [see Dosage and Administration (2.4, 2.5)]. Deferasino: can cause glomerular dysfunction, renal tubular toxicity, or both, and can result in acute renal failure. Monitor all patients closely for changes in eGFR and renal tubular dysfunction during deferasirox treatment. If either develops, consider dose reduction, interruption or discontinuation of deferasirox until glomerular or renal tubular function returns to baseline (see Dosage and Administration (2.4, 2.5), Warnings and Precautions (5, 1)].

8.7 Hepatic Impairment

Avoid use in patients with severe (Child-Pugh C) hepatic impairment. For patients with moderate (Child-Pugh B) hepatic impairment, reduce the starting dose by 50%. Closely Avoid use in patients with severe (climer ugin c) neparte impainment, on patients with induce are (climer ugin c) neparte impainment, reduce the starting use of 90 k. closely monitor patients with mid (Child-Pugh A) neofaret (Child-Pugh B) hepatic impairment for efficacy and adverse reactions that may require dose titration [see Dosage and Administration (2.4), Warnings and Precautions (5.2), Clinical Pharmacology (12.3)].

10 OVERDOSAGE

Cases of overdose (2 to 3 times the prescribed dose for several weeks) have been reported. In one case, this resulted in hepatitis which resolved without long-term consequences after a dose interruption. In one pediatric case, a dose of 2 to 3 times the prescribed dose for 6 days resulted in acute renal failure requiring hemofiltration and acute liver injury/failure, which were reversible with intensive care support. Single doses of deferasirox up to 80 mg per kg per day with the tablet for oral suspension formulation in ironoverloaded beta-thalassemic patients have been tolerated with nausea and diarrhea noted. In healthy subjects, single doses of up to 40 mg per kg per day with the tablet for oral nsion formulation were tolerated.

Early signs of acute overdose are digestive effects such as abdominal pain, diarrhea, nausea, and vomiting. Hepatic and renal disorders have been reported, including cases of liver enzyme and creatinine increased with recovery after treatment discontinuation. An erroneously administered single dose of 90 mg/kg led to Fanconi syndrome which resolved after

There is no specific antidote for deferasing . In case of overdose, it may be treated with induction of vomiting or gastric layage, and by symptomatic treatment.

11 DESCRIPTION

Deferasirox is an iron-chelating agent provided as a tablet for oral use. Deferasirox is designated chemically as 4-[3,5-Bis(2-hydroxyphenyl)-1H-1,2,4-triazol-1-yl]benzoic acid and has the following structural formula



Deferasirox is an off white to slight yellow color crystalline powder. It has a molecular formula C22H1, N2O2 and molecular weight of 373.36 g/mol. It is insoluble in water with a pH of suspension of 4.1.

Deferasirox tablets contain 90 mg, 180 mg, or 360 mg deferasirox. Inactive ingredients include colloidal silicon dioxide, crospovidone, microcrystalline cellulose, poloxamer 188, oating contains hypromellose, polyethylene glycol, talc and titanium dioxd povidone, and sodium stearyl fumarate

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Deferasirox is an orally active chelator that is selective for iron (as Fe³). It is a tridentate ligand that binds iron with high affinity in a 2:1 ratio. Although deferasirox has very low affinity for zinc and copper, there are variable decreases in the serum concentration of these trace metals after the administration of deferasirox. The clinical significance of these eases is uncertain.

12.2 Pharmacodynamics

Pharmacodynamic effects tested in an iron balance metabolic study with the tablet for oral suspension formulation showed that deferasirox (10, 20, and 40 mg per kg per day) was able to induce a mean net iron excretion (0.119, 0.329, and 0.445 mg Fe/kg body weight per day, respectively) within the clinically relevant range (0.1 to 0.5 mg per kg per day). Iron retion was predominantly fecal.

An analysis of pooled pediatric clinical trial data found a statistically significant relationship between exposure and the probability of renal toxicity (increase in serum creatinine and urinary protein), resulting in a decrease in renal function. Decreases in renal function resulted in an increase in deferasirox exposure which may increase the probability of renal

Cardiac Electrophysiology

At the maximum approved recommended dose, deferasirox does not prolong the QT interval to any clinically relevant extent.

12.3 Pharmacokinetics

Based on studies in patients with the tablet for oral suspension, deferasirox is absorbed following oral administration with median times to maximum plasma concentration (T_,) of about 1.5 to 4 hours. In healthy subjects, defersions showed comparable T_{max}. The maximal concentrations (C_{max}) and area under the curve (AUC_{n b 12}, AUC_n) of defersions increase approximately linearly with dose after both single administration and under steady-state conditions. Exposure to defersions increased by an accumulation factor of 1.3 to 2.3 after multiple doses with the tablet for oral suspension formulation

The absolute bioavailability [as measured by area under the curve over time to infinity (AUC_{ini})] of deferasirox tablets for oral suspension is 70% compared to an intravenous dose. The bioaxial biotection is the terms of terms of the terms of te increased by 30%. The 30% increase in $\rm C_{\rm max}$ observed with deferasirox tablets is not clinically meaningful.

The administration of deferasirox tablets with a light meal (approximately 250 calories with fat content less than 7% of total calories) indicated that the AUC... and C.... were similar The duministration of dereasing conditions. The administration of defersions tables with a high-fat meal (approximately 1.00 clarics with fat content greater than 50% of total calories), increased AUC, by 18% and C, by 29% compared to that under fasting conditions.

Distribution

Deferasirox is highly (~99%) protein bound almost exclusively to serum albumin. The percentage of deferasirox confined to the blood cells was 5% in humans. The volume of distribution at steady state (V_{ss}) of deferasirox is 14.37 ± 2.69 L in adults.

Metabolism

Glucuronidation is the main metabolic pathway for deferasirox, with subsequent biliary excretion. Deconjugation of glucuronidates in the intestine and subsequent reabsorptic Gucuronidation is the main metabolic pathway for dererasivox, with subsequent Dillary excretion. Deconjugation of gucuronidates in the intestine and subsequent reabsorption (enterohepatic recycling) is likely to occur. Deferasirox is mainly glucuronidated by UGT1A1 and to a lesser extent UGT1A3. CYP450-catalyzed (oxidative) metabolism of deferasirox appears to be minor in humans (about 8%). Deconjugation of glucuronide metabolites in the intestine and subsequent reabsorption (enterohepatic recycling) was confirmed in a healthy subjects study in which the administration of cholestyramine 12 g twice daily (strongly binds to deferasirox and its conjugates) 4 and 10 hours after a single dose of deferasirox resulted in a 45% decrease in deferasirox exposure (AUC_{us}) by interfering with the enterohepatic recycling of deferasirox.

Excretion

Deferasirox and metabolites are primarily (84% of the dose) excreted in the feces. Renal excretion of deferasirox and metabolites is minimal (8% of the dose). The mean elimination half-life $(t_{1/2})$ ranged from 8 to 16 hours following oral administration

Drug Interactions

Midazolam: The concomitant administration of deferasirox tablets for oral suspension and CYP3A4 probe substrate midazolam resulted in a decrease of midazolam C_ by 23% and AUC w by 17%. In the clinical setting, this effect may be more pronounced, as the study was not adequately designed to conclusively assess the potential induction of CYP3A4 by deferasirox [see Drug Interactions (7.2)].

Repaglinide: The concomitant administration of deferasirox tablets for oral suspension (30 mg per kg/day for 4 days) and the CYP2C8 probe substrate repaglinide (single dose of

0.5 mg) increased repaglinide AUC_{in} to 2.3-fold and C_{inv} of 1.6-fold *(see Drug Interactions (7.3)*]. Theophylline: The concomitant administration of deferasirox tablets for oral suspension (repeated dose of 30 mg per kg/day) and the CYP1A2 substrate theophylline (single dose of 120 mg) resulted in an approximate doubling of the theophylline AUC_{un} and elimination half-life. The single dose C_{un} was not affected, but an increase in theophylline C_{un} is expected

to occur with chronic dosing /see Drug Interactions (7.4)].

<u>Rifampicin</u>: The concomitant administration of deferasirox tablets for oral suspension (single dose of 30 mg per kg) and the strong uridine diphosphate glucuronosyltransferase (UGT) inducer rifampicin (600 mg per day for 9 days) decreased deferasirox AUC_{at} by 44% *[see Drug Interactions (7.5)]*.

Cholestyramine: The concomitant administration of cholestyramine after a single dose of deferasirox tablets for oral suspension decreased deferasirox AUC why 45% / see Drug

Busulfan: Concomitant administration of deferasirox and busulfan resulted in an increase of busulfan exposure (AUC).

In vitro Studies: Deferasirox inhibited human CYP2A6, CYP2D6, and CYP2C19 in vitro.

Deferasirox is not a substrate of P-glycoprotein, MRP1 or MRP2.

Pharmacokinetics in Specific Populations

Pediatric: Following oral administration of single or multiple doses, systemic exposure of adolescents and children to deferasirox was less than in adult patients. In children less than 6 years of age, systemic exposure was about 50% lower than in adults.

Sex: The apparent clearance is 17.5% lower in females compared to males

Renal Impairment; Compared to patients with MDS and eGFR greater than 60 mL/min/1.73 m², patients with MDS and eGFR 40 to 60 mL/min/1.73 m²(n = 34) had annoximately

Hepatic Impairment: In a single dose (20 mg/kg) study in patients with varying degrees of hepatic impairment, deferasirox exposure was increased compared to patients with normal hepatic function. The average total (free and bound) AUC of deferasirox increased 16% in 6 patients with mild (Child-Pugh A) hepatic impairment, and 76% in 6 patients

with moderate (Child-Pugh B) hepatic impairment compared to 6 patients with normal hepatic function. The impact of severe (Child-Pugh C) hepatic impairment was assessed in only 1 patient.

Deferasirox at oral doses up to 75 mg/kg/day (0.9 times the MRHD on a mg/m²basis) was found to have no adverse effect on fertility and reproductive performance of male and

13 NONCLINICAL TOXICOLOGY

female rats

14 CLINICAL STUD Deferasirox was evaluat for oral suspension. The

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

A 104-week oral carcinogenicity study in Wistar rats showed no evidence of carcinogenicity from deferasirox at doses up to 60 mg/kg/day (0.7 times the MRHD on an mg/m² basis). A De-week oral carcinogenicity study in p52 (+) transport mice has shown on evidence of carcinogenicity from deferasirox at doses up to 200 mg/kg/day (1.2 times the MRHD or a mg/m² basis) in males and 300 mg/kg/day (1.7 times the MRHD on a mg/m² basis) in females. A 26-week oral carcinoger Deferasirox was negative in the Ames test and chromosome aberration test with human peripheral blood lymphocytes. It was positive in 1 of 3 in vivo oral rat micronucleus tests.

Study 6 (NCT00873041) was an open-label trial of deferasirox tablets for oral suspension for the treatment of patients previously enrolled on Study 5, including cross-over to active treatment for those previously treated with placebo. The starting dose of deferasirox tablets for oral suspension in Study 6 was assigned based on the patient's LIC at Patients could continue on 5 mg/kg/day if they had previously exhibited at least a 30% reduction in LIC. Doses could be increased to a maximum of 20 mg/kg/day after 6 months if the LIC was more than 7 mg Fe/g dw and the LIC reduction from baseline was less than 15%. The primary efficacy endpoint in Study 6 was the proportion of patients achieving an LIC less than 5 mg Fe/g dw. A total of 133 patients were enrolled. Twenty patients began Study 6 with an LIC less than 5 mg Fe/g dw. Of the 113 patients with a baseline LIC of at least 5 mg Fe/g dw in Study 6, the target LIC (less than 5 mg Fe/g dw) was reached by 39 patients (35%). The responders included 4 (10%) of 39 patients treated at 20 mg/kg/day for a baseline LIC exceeding 15 mg Fe/g dw, and 31 (51%) of 61 patients treated at 10 mg/kg/day for a baseline LIC between 5 and 15 mg Fe/g dw. The absolute change in LIC at Week 52 by starting dose is shown in Table 5 below.

Study 7 (NCT01709838) was an open-label, single-arm, multi-center, 5-year study to evaluate the efficacy and safety of deferasirox tablets for oral susp patients with NTDT of 10 years of age or older. All patients started treatment on 10 mg/kg/day deferasirox tablets for oral suspension for four weeks. At Week 4, dose escalation was based on baseline LIC. At Week 24 and every 6 months thereafter, further dose adjustments were made according to the LIC at that visit. Treatment was interrupted when LIC < 3 mg Fe/g dw or serum ferritin < 300 ng/mL and was re-started at 10 mg/kg/day when LIC ≥ 5 mg Fe/g dw and serum ferritin ≥ 300 ng/mL. Throughout the study, the

maximum dose of deferasirox tablets for oral suspension given was 30 mg/kg/day. A total of 134 patients were enrolled in the study. Eligible patients were required to have an LIC of at least 5 mg Fe/g dw measured by R2 MRI and a serum ferritin at least of 300 ng/mL at screening. The mean absolute change of LIC from Baseline to Week 52 was -6.7 mg Fe/g dw. The reduction in LIC was sustained until Week 260 (5 years) with the mean absolute channe in LIC from Baseline to Week 260 of -10.6 mm Fe/n dw. In the subset of natients with Baseline LIC > 15 mm Fe/n dw (49 natients) 51 0% achieved a first LIC < 5 mg Fe/g dw (95% CI: 37.5, 64.4) with a median time of 28.6 months. In the subset of patients with target LIC of < 3 mg Fe/g dw (61 patients), 39.3% developed first LIC \geq 5 mg Fe/g dw in the follow-up period, with a median time of 13.9 months.

Table 5. Absolute Change in LIC at Week 52 in Patients with NTDT

Deferasirox Tablets for Oral Suspension Starting Dose [*]					
	Placebo	5 mg/kg/day	10 mg/kg/day	20 mg/kg/day	
Study 5 ^t					
Number of Patients	n = 54	n = 51	n = 54		
Mean LIC at Baseline (mg Fe/g dw)	16.1	13.4	14.4		
Mean Change (mg Fe/g dw)	+0.4	-2.0	-3.8		
(95% Confidence Interval)	(-0.6, +1.3)	(-2.9, -1.0)	(-4.8, -2.9)		
Study 6					

Number of Patients		n = 8	n = 77	n = 43
Mean LIC at Baseline (mg Fe/g dw)		5.6	8.8	23.5
Mean Change (mg Fe/g dw)		·1.5	-2.8	·9.1
(95% Confidence Interval)		(-3.7, +0.7)	(-3.4, -2.2)	(-11.0, -7.3)
Study 7				
Number of Patients			n = 127	
Mean LIC at Baseline (mg Fe/ g dw)			15.1	
Mean Change (mg Fe/ g dw)			-6.7	
(95% Confidence Interval)			(-7.9, -5.5)	
	UTRT . C.I.I.	1		

Abbreviation: LIC, liver iron concentration; NTDT, non-transfusion-dependent thalassemia $^{\circ} Randomized$ dose in Study 5 or assigned starting dose in Study 6 and Study 7.

Least square mean change for Study 5.

HOW SUPPLIED/STORAGE AND HANDLING 16

Deferasize tablets 90 mg are white to off white, film coated, oval biconvex tablets, debossed with '56' on one side and 'V' on the other side. They are available in Bottle of 30 tablets NDC 31722-011-30 NDC 31722-011-30

- Deferasirox tablets 180 mg are white to off white, film coated, oval biconvex tablets, debossed with '57' on one side and 'V' on the other side. They are available in
- NDC 31722-012-30 Bottle of 30 tablets Deferasirox tablets 360 mg are white to off white, film coated, oval biconvex tablets, debossed with '58' on one side and 'V' on the other side. They are available in Bottle of 30 tablets NDC 31722-013-30
- Store deferasirox tablets at 20°C to 25°C (68°F to 77°F); excursions are permitted between 15°C to 30°C (59°F to 86°F) [see USP Controlled Room Temperature]. Protect from

moisture. 17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide).

Dosing Instructions

Advise patients to take deferasirox tablets with water or other liquids. Advise patients to swallow deferasirox tablets once daily with water or other liquids, preferably at the same Two potents of weat one balance to the industry meretory of the same transmission of the same tr tomato, and 1 packet must and . For patients who have difficulty swallowing whole tablets, deferasirox tablets may be crushed and mixed with soft foods (e.g., yogurt or applesauce) immediately prior to use and administered orally. Advise against the use of commercial crushers with serrated surfaces for crushing a single 90 mg tablet. Advise patients to immediately and completely consume the dose and not store it for future use [see Dosage and Administration (2.3]].

Blood Testing

Advise patients that blood tests will be performed frequently to check for damage to kidneys, liver, or blood cells (see Warnings and Precautions (5.1, 5.2, 5.3, 5.4, 5.5)). Acute Kidney Injury, Including Acute Renal Failure

Caution patients about the potential for kidney toxicity when taking deferasirox tablets. Inform patients of the signs and symptoms of kidney injury. Advise patients to contact their healthcare provider immediately if they experience any of these symptoms [see Warnings and Precautions (5.1)].

Hepatic Toxicity and Failure

Caution patients about the potential for hepatic toxicity when taking deferasirox tablets. Inform patients of the signs and symptoms of hepatic toxicity. Advise patients to contact their healthcare provider immediately if they experience any of these symptoms *(see Warnings and Precautions (5.2))*.

GI Ulceration and Hemorrhage

n patients about the potential for the development of GI ulcers or bleeding when taking deferasirox in combination with drugs that have ulcerogenic or hemorrhagic potential, such as NSAIDs, corticosteroids, oral bisphosphonates, or anticoagulants. Inform patients of the signs and symptoms of GI ulcers or bleeding. Advise patients to contact their healthcare provider for symptoms of heartburn but to seek immediate medical attention for symptoms of GI hemorrhage (see Warnings and Precautions (5.3)).

Allergic Reactions

Serious allergic reactions (which include swelling of the throat) have been reported in patients taking deferasirox, usually within the first month of treatment. If reactions are severe, advise patients to stop taking deferasirox immediately and seek immediate medical attention *(see Warnings and Precautions (5.7))*.

Severe Skin Reactions

Severe skin reactions have been reported in patients taking deferasirox tablets. Inform patients of the signs and symptoms of severe skin reactions. If reactions are severe, advise patients to stop taking deferasirox tablets immediately and seek immediate medical attention (see Warnings and Precautions (5.8)).

Skin Rash

Skin rashes may occur during deferasirox treatment. If the skin rash is severe, advise patients to stop taking deferasirox and seek medical attention (see Warnings and Precautions) (5.9)

Pediatric Patients with Acute Illness

Temanty routing murrate temperature and their caregivers to contact their healthcare provider during episodes of acute illness, especially if the patient has not been drinking fluids or the patient has volume depletion due to fever, vomiting, or diarrhea */see Warnings and Precautions (5.1)*.

Auditory and Ocular Testing

Because auditory and ocular disturbances have been reported with deferasirox, conduct auditory testing and ophthalmic testing before starting deferasirox treatment and thereafter at regular intervals. Advise patients to contact their healthcare provider if they develop visual or auditory changes during treatment (see Warnings and Precautions

Drug Interactions

CAMBER

Piscataway, NJ 08854

By: Annora Pharma Pvt. Ltd.

Sangareddy · 502313, Telangana, India.

Manufactured for:

Caution patients not to take aluminum containing antacids and deferasirox tablets simultaneously *[see Drug Interactions (7.1)*].

Caution patients about potential loss of effectiveness of drugs metabolized by CYP3A4 (e.g., cyclosporine, simvastatin, hormonal contraceptive agents) when deferasirox is administered with these drugs [see Drug Interactions (7.2)].

Caution patients about potential loss of effectiveness of deferasirox when administered with druos that are potent UGT inducers (e.g., rifamoicin, phenotoin, phenobarbital,

ritonavir). Based on serum ferritin levels and clinical response, consider increases in the dose of deferasirox when concomitantly used with potent UGT inducers (see Drug Interactions (7.5)].

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Caution patients about potential loss of effectiveness of deferasirox when administered with drugs that are bile acid sequestrants (e.g., cholestyramine, colesevelam, colestipol). Based on serum ferritin levels and clinical response, consider increases in the dose of deferasirox when concomitantly used with bile acid sequestrants *(see Drug Interactions (7.6))*. Caution patients with diabetes to monitor their glucose levels more frequently when repaglinide is used concomitantly with deferasirox *(see Drug Interactions (7.3))*.

Handling Instructions tore deferasirox tablets in a dry, room-temperature environment *[see How Supplied/Storage and Handling (16)]*.

- Driving and Using Machines g dizziness to avoid driving or operating machinery /see Adverse Reactions (6.1)/.

	Revised: 11/2024
DIES	
ated in healthy subjects. There are no clinical data in patients with deferasirox. Deferasirox tablet contains the same active ingredient as deferasirox tablets e following information is based on clinical trials conducted with deferasirox tablets for oral suspension.	
verload	

Transfusional Iron Overloa The primary efficacy study, Study 1 (NCT00061750), was a multicenter, open-label, randomized, active-comparator control study to compare deferasirox tablets for oral suspension and deferoxamine in patients with beta-thalassemia and transfusional hemosiderosis. Patients greater than or equal to 2 years of age were randomized in a 1:1 ratio to receive either oral deferasirox tablets for oral suspension at starting doses of 5, 10, 20, or 30 mg per kg once daily or subcutaneous deferoxamine at starting doses of 20 to 60 mg per kg for at least 5 days per week based on LC at baseline (2 to 3, greater than 3 to 7, greater than 7 to 14, and greater than 14 mg Fe/g dry weight). Patients randomized to deferoxamine who had LIC values less than 7 mg Fe/g dry weight were permitted to continue on their prior deferoxamine dose, even though the dose may have been higher than specified in the protocol.

Patients were to have a liver biopsy at baseline and end of study (after 12 months) for LIC. The primary efficacy endpoint was defined as a reduction in LIC of greater than or equal to Tardinis were unave and and and an advantage of the second and a secon

 can happen if you take too mucin usereasinos, numerican serious, and the provider serious serious tablets or operating machinery until you know how deferasiros tablets affects you. Do not drive or operate machinery if deferasiros tablets may cause dizziness. Avoid driving or operating machinery until you know how deferasiros tablets affects you. Do not drive or operate machinery if deferasiros tablets may cause dizziness. Avoid driving or operating machinery until you know how deferasiros tablets affects you. Do not drive or operate machinery if deferasiros tablets may cause dizziness. Avoid driving or operating machinery until you know how deferasiros tablets affects you. Do not drive or operate machinery if deferasiros tablets may cause drizent tablets?

 What are the possible side effects of deferasirox tablets?

 Deferasirox tablets can cause serious side effects, including:

 See "What is the most important information I should know about deferasirox tablets?"

 Effects on your bone marrow. Deferasirox tablets can affect your bone marrow and cause you to have low white blood cell count which can be serious, decreased platelets, or worsening of your anemia, and may lead to death. Your risk for effects on your bone marrow may be increased if you already have other blood disorders. Your healthcare provider will do blood tests to monitor your blood cell counts for these problems.

 Serious allergic reactions. Deferasirox tablets serious allergic reactions, which usually start within the first month of treatment. Get medical help right away if you develop any of the following symptoms of a serious allergic reaction including:

 Genty plant
 Serious allergic machinery or you serious allergic reactions, which usually start within the first month of treatment. Get medical serious rapid hear uses.
 feeling faint
 Skin rash and severe skin reactions. Skin rashes are common Wuu uses: temporarily stop deferasirox tablets.
 Severe skin reactions can also happen with deferasirox tablets and can be life-threatening or lead to death develop any one or more of the following signs and symptoms of a severe skin reaction, including:

 rash or red skin
 blisters on your lips, or around your mouth or eyes
 high fever or flu-like symptoms
 enlarged lymph nodes
 the hearing and changes in your vision includir

 Take the dose right away. Do not save any of the deferasirox and soft food mixture for later use.
 Do not use store-bought pill crushers with serrated surfaces for crushing deferasirox 90 mg tablets.
 Do not take deferasirox tablets with aluminum-containing antacid products. See "Before taking deferasirox tablets".
 Tell your healthcare provider if you or your child gain or lose any weight. Your or your child's dose of deferasirox tablets may need to be if you take the diabetes medicine repaglinide during treatment with deferasirox tablets, you may need to test your blood sugar (glup Follow your healthcare provider's instructions about how often to test your blood sugar during this time.
 Your healthcare provider should do blood and urine tests before, and during treatment to check how you respond to deferasirox tablets is side effects. Your healthcare provider may change your dose, or temporarily or permanently stop deferasirox tablets if you have certain in people who have thalassemia, your healthcare provider will check the amount of iron in your liver before and during treatment with deferasirox tablets or you rought to the nearest hospital emergency is can happen if you take too much deferasirox tablets, call your healthcare provider right away or go to the nearest hospital emergency is can happen if you take too much deferasirox tablets include: stomach-area (abdominal) pain, diarrhea, nausea and vomiting. Manufactured for: Camber Pharmaceuticals, Inc. Piscataway, NJ 08854 **General information about the safe and effective use of deferasirox tablets** Medicines are sometimes prescribed for purposes other than those listed in a Medication prescribed. Do not give it to other people, even if they have the same symptoms you have. more information about deferasirox tablets. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-How should I store deferasirox tablets?
Store deferasirox tablets at room temperature between 68 °F to 77 °F (20 °C to 25 °C).
Keep the bottle closed tightly and away from moisture. Medication Guide available What are the ingredients in deferasirox tablets? Deferasirox tablets: For more information, call 1-866-495-1995. Other common side effects in people with too much abnormal kidney function blood test. By: Annora Pharma Pvt. Ltd. Sangareddy - 502313, Telangana, Inactive ingredients: Colloidal silicon contains hypromellose, polyethylene gly Active ingred These are not all the possible side effects of deferasirox This Medication Guide has been Revised: 11/2024 PHARMACEUTICALS, INC. **Hearing and vision problems.** Deferasirox tablets can cause decreased hearing and changes in your vision including eye, and problems with your retinas. Your healthcare provider should do hearing and vision tests before you start and healthcare provider may decrease your dose or stop deferasirox tablets if you develop hearing or vision problems. most common side effects in anyone who takes deferasirox tablets include: diarrhea and nausea. **dient:** deferasirox at http://camberpharma approved by the U.S. Food : India con dioxide, c glycol, talc c and titanium iron in their tablets and Drug , micro dioxde dication blood Adn due ysta to repeated deferasirox tablets. If you get a more blood transfus n Guide. . It may . Do no harm not use m them. 188 -1088 e deferasirox t; 1. You can ask y death.) severe x tablets for a condition k your healthcare provid g cataracts, incr d then regularly Get medical help rash, sugar need to be adjus x tablets, and to monitor yo re certain side effects. nt with deferasirox tablets. ergency room. Symptoms th your (gl healthcare (abdo reased during n for ider i right levels nr which it was r r or pharmacist E pressure i treatmen The t away if y provider pain film tor you Ξ that and often You You may not for for an