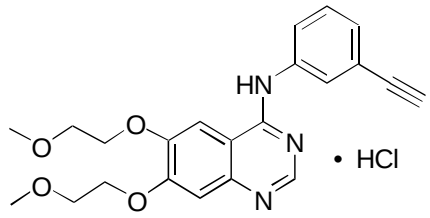
PACKAGE INSERT

TARCEVA®
(erlotinib)
Tablets

RX Only

DESCRIPTION

TARCEVA (erlotinib) is a Human Epidermal Growth Factor Receptor Type 1/Epidermal Growth Factor Receptor (HER1/EGFR) tyrosine kinase inhibitor. Erlotinib is a quinazolinamine with the chemical name N-(3-ethynylphenyl)-6,7-bis(2-methoxyethoxy)-4-quinazolinamine. TARCEVA contains erlotinib as the hydrochloride salt that has the following structural formula:



Erlotinib hydrochloride has the molecular formula $C_{22}H_{23}N_3O_4.HCl$ and a molecular weight of 429.90. The molecule has a pK_a of 5.42 at 25°C. Erlotinib hydrochloride is very slightly soluble in water, slightly soluble in methanol and practically insoluble in acetonitrile, acetone, ethyl acetate and hexane.

Aqueous solubility of erlotinib hydrochloride is dependent on pH with increased solubility at a pH of less than 5 due to protonation of the secondary amine. Over the pH range of 1.4 to 9.6, maximal solubility of approximately 0.4 mg/mL occurs at a pH of approximately 2.

TARCEVA tablets are available in three dosage strengths containing erlotinib hydrochloride (27.3 mg, 109.3 mg and 163.9 mg) equivalent to 25 mg, 100 mg and 150 mg erlotinib and the following inactive ingredients: lactose monohydrate, hypromellose, hydroxypropyl cellulose, magnesium stearate, microcrystalline cellulose, sodium starch glycolate, sodium lauryl sulfate and titanium dioxide. The tablets also contain trace amounts of color additives, including FD&C Yellow #6 (25 mg only) for product identification.

CLINICAL PHARMACOLOGY

Mechanism of Action and Pharmacodynamics

The mechanism of clinical antitumor action of erlotinib is not fully characterized. Erlotinib inhibits the intracellular phosphorylation of tyrosine kinase associated with the epidermal growth factor receptor (EGFR). Specificity of inhibition with regard to other tyrosine kinase receptors has not been fully characterized. EGFR is expressed on the cell surface of normal cells and cancer cells.

Pharmacokinetics

Erlotinib is about 60% absorbed after oral administration and its bioavailability is substantially increased by food to almost 100%. Its half-life is about 36 hours and it is cleared predominantly by CYP3A4 metabolism and to a lesser extent by CYP1A2.

Absorption and Distribution

Bioavailability of erlotinib following a 150 mg oral dose of TARCEVA is about 60% and peak plasma levels occur 4 hrs after dosing. Food increases bioavailability substantially, to almost 100%.

Following absorption, erlotinib is approximately 93% protein bound to albumin and alpha-1 acid glycoprotein (AAG). Erlotinib has an apparent volume of distribution of 232 liters.

Metabolism and Elimination

In vitro assays of cytochrome P450 metabolism showed that erlotinib is metabolized primarily by CYP3A4 and to a lesser extent by CYP1A2, and the extrahepatic isoform CYP1A1. Following a 100 mg oral dose, 91% of the dose was recovered: 83% in feces (1% of the dose as intact parent) and 8% in urine (0.3% of the dose as intact parent).

A population pharmacokinetic analysis in 591 patients receiving single-agent TARCEVA showed a median half-life of 36.2 hours. Time to reach steady state plasma concentration would therefore be 7 – 8 days. No significant relationships of clearance to covariates of patient age, body weight or gender were observed. Smokers had a 24% higher rate of erlotinib clearance (see **Interactions** section).

A second population pharmacokinetic analysis was conducted that incorporated erlotinib data from 204 pancreatic cancer patients who received erlotinib plus gemcitabine. This analysis demonstrated that covariates affecting erlotinib clearance in patients from the pancreatic study were very similar to those seen in the prior single-agent pharmacokinetic analysis. No new covariate effects were identified. Co-administration of gemcitabine had no effect on erlotinib plasma clearance.

Special Populations

Patients with Hepatic Impairment

Patients with hepatic impairment (total bilirubin > ULN or Child Pugh A, B and C) should be closely monitored during therapy with TARCEVA. Treatment with TARCEVA should be used with extra caution in patients with total bilirubin > 3 x ULN (see **WARNINGS**, **ADVERSE REACTIONS,** and **DOSAGE AND ADMINISTRATION** sections).

In vitro and in vivo evidence suggest that erlotinib is cleared primarily by the liver. However, erlotinib exposure was similar in patients with moderately impaired hepatic function (Child-Pugh B) compared with patients with adequate hepatic function including patients with primary liver cancer or hepatic metastases.

Patients with Renal Impairment

Less than 9% of a single dose is excreted in the urine. No clinical studies have been conducted in patients with compromised renal function.

Interactions

Erlotinib is metabolized predominantly by CYP3A4, and inhibitors of CYP3A4 would be expected to increase exposure. Co-treatment with the potent CYP3A4 inhibitor ketoconazole increased erlotinib AUC by 2/3. When TARCEVA was co-administered with ciprofloxacin, an inhibitor of both CYP3A4 and CYP1A2, the erlotinib exposure [AUC] and maximum concentration [C_{max}] increased by 39% and 17% respectively (see **PRECAUTIONS - Drug Interactions** and **DOSAGE AND ADMINISTRATION - Dose Modifications** sections).

Pretreatment with the CYP3A4 inducer rifampicin for 7 days prior to TARCEVA administration increased erlotinib clearance by 3-fold and reduced AUC by 2/3. In a separate study, treatment with rifampicin for 11 days, with coadministration of a single 450 mg dose of TARCEVA on day 8 resulted in a mean erlotinib exposure (AUC) that was 57.6% of that observed following a single 150 mg TARCEVA dose in the absence of rifampicin treatment (see **PRECAUTIONS – Drug Interactions** and **DOSAGE AND ADMINISTRATION** – **Dose Modifications** sections).

The solubility of erlotinib is pH dependent. Erlotinib solubility decreases as pH increases. Co-administration of TARCEVA with omeprazole, a proton pump inhibitor, decreased the erlotinib exposure [AUC] and maximum concentration [C_{max}] by 46% and 61% respectively. There was no change to erlotinib half-life (see **PRECAUTIONS - Drug Interactions** sections).

Pretreatment and coadministration of TARCEVA decreased the AUC of CYP3A4 substrate, midazolam, by 24%. The mechanism is not clear.

In a Phase Ib study, there were no significant effects of gemcitabine on the pharmacokinetics of erlotinib nor were there significant effects of erlotinib on the pharmacokinetics of gemcitabine.

In the pivotal Phase III NSCLC trial, current smokers achieved erlotinib trough plasma concentrations that were approximately 2-fold less than the former smokers or patients who had never smoked. This effect was accompanied by a 24% increase in apparent erlotinib plasma clearance. When the single dose pharmacokinetics of erlotinib were evaluated in healthy volunteers, current smokers cleared the drug significantly faster than former smoker or volunteers who had never smoked. The $AUC_{0\text{-infinity}}$ in smokers is about 1/3 of that in never/former smokers. This reduced exposure in current smokers is presumably due to induction of CYP1A1 in lung and CYP1A2 in the liver (see **PRECAUTIONS – Information for Patients** section).

CLINICAL STUDIES

Non-Small Cell Lung Cancer (NSCLC) – TARCEVA Administered as a Single Agent

The efficacy and safety of single-agent TARCEVA was assessed in a randomized, double blind, placebo-controlled trial in 731 patients with locally advanced or metastatic NSCLC after failure of at least one chemotherapy regimen. Patients were randomized 2:1 to receive TARCEVA 150 mg or placebo (488 TARCEVA, 243 placebo) orally once daily until disease progression or unacceptable toxicity. Study endpoints included overall survival, response rate, and progression-free survival (PFS). Duration of response was also examined. The primary endpoint was survival. The study was conducted in 17 countries. About half the patients (326) had EGFR expression status characterized.

Table 1 summarizes the demographic and disease characteristics of the study population. Demographic characteristics were well balanced between the two treatment groups. About two-thirds of the patients were male. Approximately one-fourth had a baseline ECOG performance status (PS) of 2, and 9% had a baseline ECOG PS of 3. Fifty percent of the patients had received only one prior regimen of chemotherapy. About three quarters of these patients were known to have smoked at some time.

Table 1: Demographic and Disease Characteristics

	TARCEVA (N = 488)		**Placebo (N = 243)**	
Characteristics	**n**	**(%)**	**n**	**(%)**
Gender				
Female	173	(35)	83	(34)
Male	315	(65)	160	(66)
Age (years)				
< 65	299	(61)	153	(63)
≥ 65	189	(39)	90	(37)
Race				
Caucasian	379	(78)	188	(77)
Black	18	(4)	12	(5)
Asian	63	(13)	28	(12)

	TARCEVA (N = 488)		Placebo (N = 243)	
Characteristics	**n**	**(%)**	**n**	**(%)**
Other	28	(6)	15	(6)
ECOG Performance Status at Baseline*				
0	64	(13)	34	(14)
1	256	(52)	132	(54)
2	126	(26)	56	(23)
3	42	(9)	21	(9)
Weight Loss in Previous 6 Months				
< 5%	320	(66)	166	(68)
5 – 10%	96	(20)	36	(15)
> 10%	52	(11)	29	(12)
Unknown	20	(4)	12	(5)
Smoking History				
Never Smoked	104	(21)	42	(17)
Current or Ex-smoker	358	(73)	187	(77)
Unknown	26	(5)	14	(6)
Histological Classification				
Adenocarcinoma	246	(50)	119	(49)
Squamous	144	(30)	78	(32)
Undifferentiated Large Cell	41	(8)	23	(9)
Mixed Non-Small Cell	11	(2)	2	(<1)
Other	46	(9)	21	(9)
Time from Initial Diagnosis to Randomization (Months)				
< 6	63	(13)	34	(14)
6 – 12	157	(32)	85	(35)
> 12	268	(55)	124	(51)
Best Response to Prior Therapy at Baseline*				
CR/PR	196	(40)	96	(40)
PD	101	(21)	51	(21)
SD	191	(39)	96	(40)

	TARCEVA (N = 488)		Placebo (N = 243)	
Characteristics	**n**	**(%)**	**n**	**(%)**
Number of Prior Regimens at Baseline*				
1	243	(50)	121	(50)
2	238	(49)	119	(49)
3	7	(1)	3	(1)
Exposure to Prior Platinum at Baseline*				
Yes	454	(93)	224	(92)
No	34	(7)	19	(8)

* Stratification factor as documented at baseline; distribution differs slightly from values reported at time of randomization.

The results of the study are shown in Table 2.

Table 2: Efficacy Results

	TARCEVA	Placebo	Hazard Ratio (1)	95% CI	p-value
Survival	Median 6.7 mo	Median 4.7 mo	0.73	0.61 – 0.86	<0.001 (2)
1-year Survival	31.2%	21.5%			
Progression-Free Survival	Median 9.9 wk	Median 7.9 wk	0.59	0.50 – 0.70	<0.001 (2)
Tumor Response (CR+PR)	8.9%	0.9%			<0.001 (3)
Response Duration	Median 34.3 wk	Median 15.9 wk			

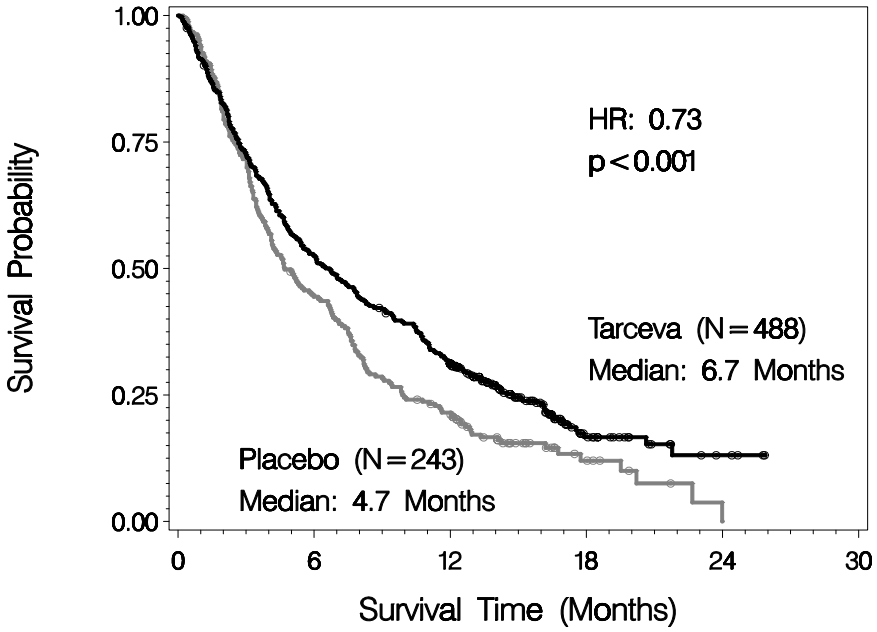
(1) Cox regression model with the following covariates: ECOG performance status, number of prior regimens, prior platinum, best response to prior chemotherapy.

(2) Two-sided Log-Rank test stratified by ECOG performance status, number of prior regimens, prior platinum, best response to prior chemotherapy.

(3) Two-sided Fisher's exact test

Survival was evaluated in the intent-to-treat population. Figure 1 depicts the Kaplan-Meier curves for overall survival. The primary survival and PFS analyses were two-sided Log-Rank tests stratified by ECOG performance status, number of prior regimens, prior platinum, best response to prior chemotherapy.

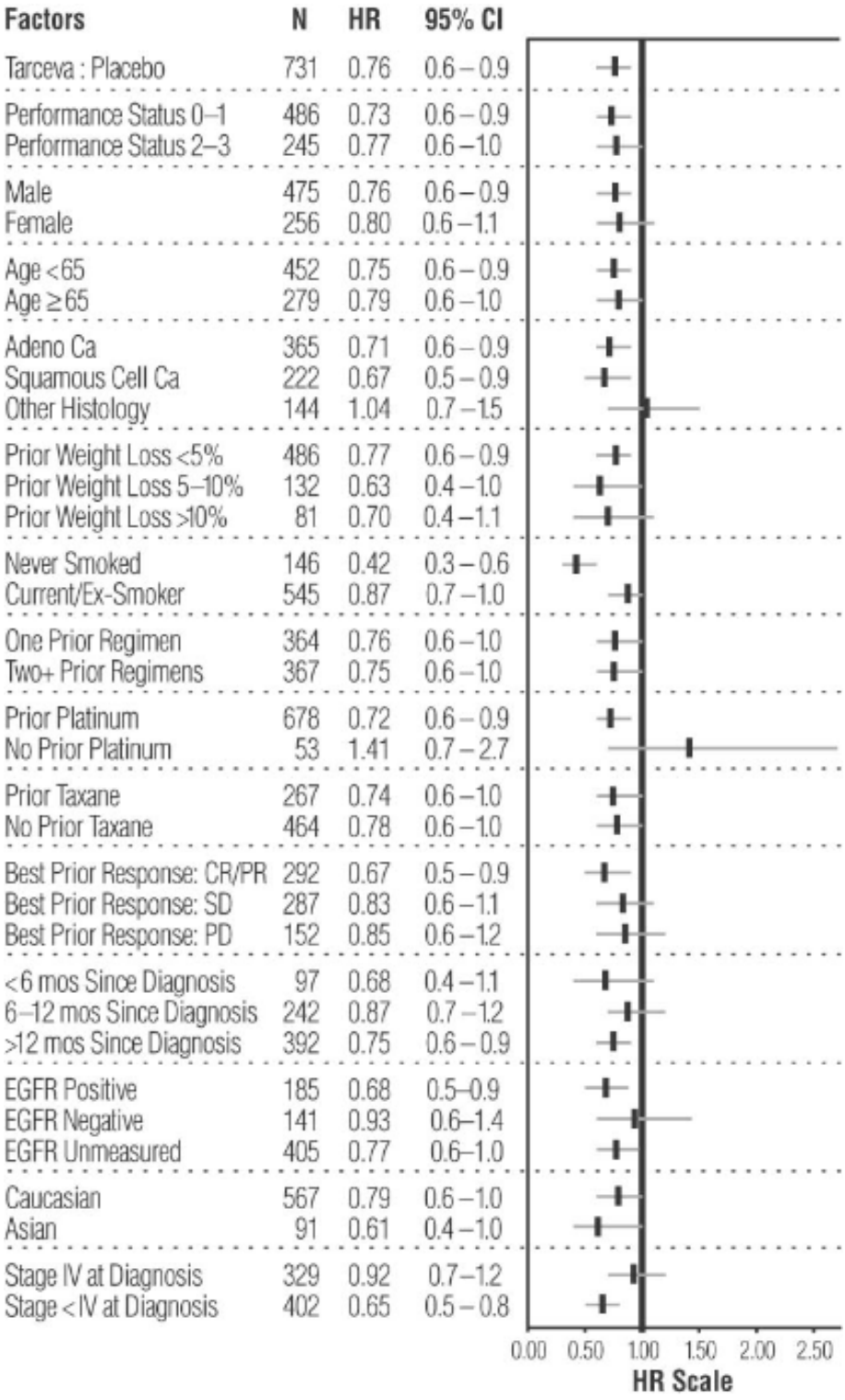
Figure 1: Kaplan – Meier Curve for Overall Survival of Patients by Treatment Group



Note: HR is from Cox regression model with the following covariates: ECOG performance status, number of prior regimens, prior platinum, best response to prior chemotherapy. P-value is from two-sided Log-Rank test stratified by ECOG performance status, number of prior regimens, prior platinum, best response to prior chemotherapy.

A series of subsets of patients were examined in exploratory univariate analyses. The results of these analyses are shown in Figure 2.The effect of TARCEVA on survival was similar across most subsets. An apparently larger effect, however, was observed in two subsets: patients with EGFR positive tumors (HR = 0.68) and patients who never smoked (HR = 0.42). These subsets are considered further below.

Figure 2: Survival Hazard Ratio (HR) (TARCEVA: Placebo) in Subgroups According to Pretreatment Characteristics



Note: Depicted are the univariate hazard ratio (HR) for death in the TARCEVA patients relative to the placebo patients, the 95% confidence interval (CI) for the HR, and the sample size (N) in each subgroup. The hash mark on the horizontal bar represents the HR, and the length of the horizontal bar represents the 95% confidence interval. A hash mark to the left of the vertical line corresponds to a HR that is less than 1.00, which indicates that survival is better in the TARCEVA arm compared with the placebo arm in that subgroup.

Relation of Single-Agent TARCEVA Results in NSCLC to EGFR Protein Expression Status (as Determined by Immunohistochemistry)

Analysis of the impact of EGFR expression status on the treatment effect on clinical outcome is limited because EGFR status is known for 326 NSCLC study patients (45%). EGFR status was ascertained for patients who already had tissue samples prior to study enrollment. However, the survival in the EGFR tested population and the effects of single-agent TARCEVA were almost identical to that in the entire study population, suggesting that the tested population was a representative sample. A positive EGFR expression status was defined as having at least 10% of cells staining for EGFR in contrast to the 1% cut-off specified in the EGFR pharmDx™ kit instructions. The use of the pharmDx kit has not been validated for use in non-small cell lung cancer.

Single-agent TARCEVA prolonged survival in the EGFR positive subgroup (N = 185; HR = 0.68; 95% CI = 0.49 – 0.94) (Figure 3) and the subgroup whose EGFR status was unmeasured (N = 405; HR = 0.77; 95% CI = 0.61 – 0.98) (Figure 5), but did not appear to have an effect on survival in the EGFR negative subgroup (N = 141; HR = 0.93; 95% CI = 0.63 – 1.36) (Figure 4). However, the confidence intervals for the EGFR positive, negative and unmeasured subgroups of NSCLC patients are wide and overlap, so that a survival benefit due to TARCEVA in the EGFR negative subgroup cannot be excluded.

For the subgroup of NSCLC patients who never smoked, EGFR status also appeared to be predictive of TARCEVA survival benefit. Patients who never smoked and were EGFR positive had a large TARCEVA survival benefit (N = 41; HR = 0.28; 95% CI = 0.13 – 0.61). There were too few EGFR negative patients who never smoked to reach a conclusion.

Tumor responses were observed in all EGFR subgroups: 11.3% in the EGFR positive subgroup, 9.5% in the EGFR unmeasured subgroup and 3.8% in the EGFR negative subgroup. An improvement in progression free survival was demonstrated in the

EGFR positive subgroup (HR = 0.49; 95% CI = 0.35 – 0.68), the EGFR unmeasured subgroup (HR = 0.60; 95% CI = 0.47 – 0.75), and less certain in the EGFR negative subgroup (HR = 0.80; 95% CI = 0.55 – 1.16).

Figure 3: Survival in EGFR Positive Patients

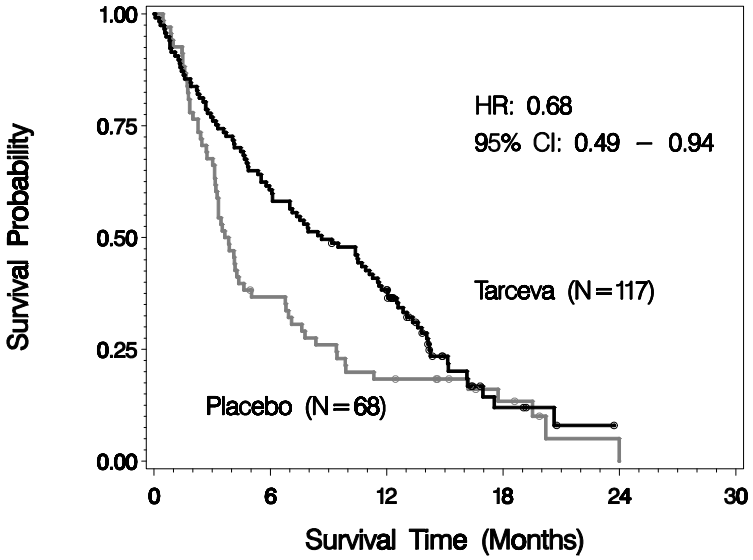


Figure 4: Survival in EGFR Negative Patients

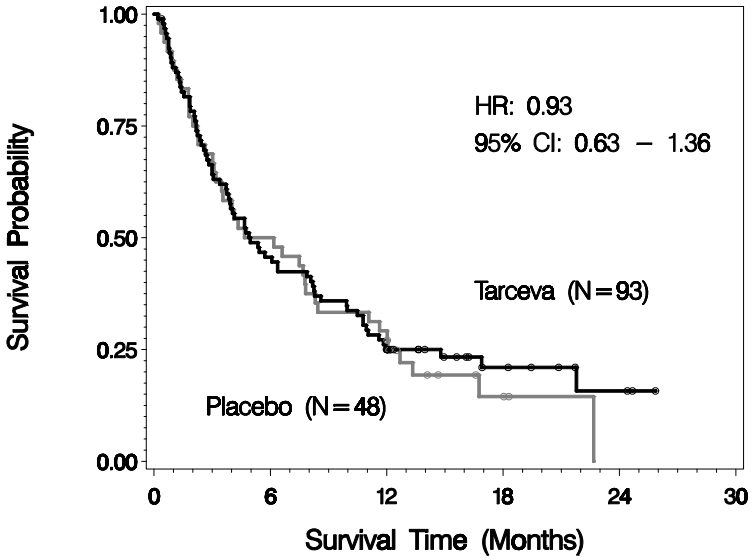
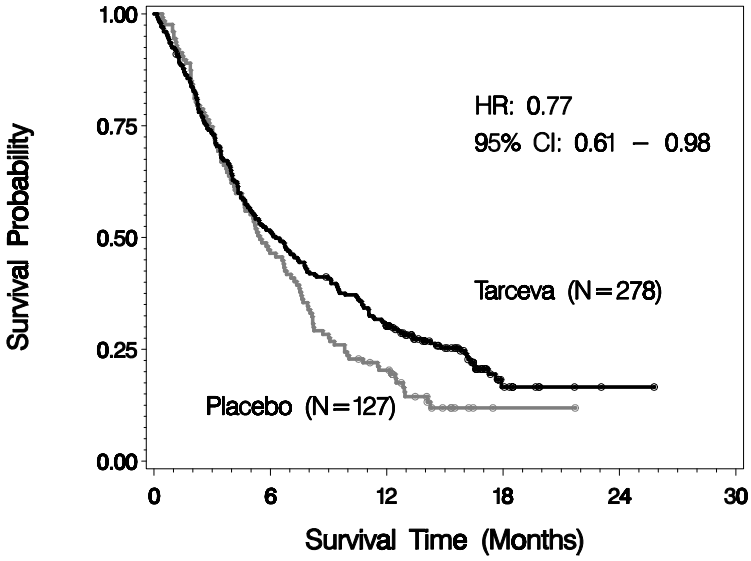


Figure 5: Survival in EGFR Unmeasured Patients



NSCLC - TARCEVA Administered Concurrently with Chemotherapy

Results from two, multicenter, placebo-controlled, randomized, trials in over 1000 patients conducted in first-line patients with locally advanced or metastatic NSCLC showed no clinical benefit with the concurrent administration of TARCEVA with platinum-based chemotherapy [carboplatin and paclitaxel (TARCEVA, N = 526) or gemcitabine and cisplatin (TARCEVA, N = 580)].

Pancreatic Cancer - TARCEVA Administered Concurrently with Gemcitabine

The efficacy and safety of TARCEVA in combination with gemcitabine as a first-line treatment was assessed in a randomized, double blind, placebo-controlled trial in 569 patients with locally advanced, unresectable or metastatic pancreatic cancer. Patients were randomized 1:1 to receive TARCEVA (100 mg or 150 mg) or placebo once daily on a continuous schedule plus gemcitabine IV (1000 mg/m^2, Cycle 1 - Days 1, 8, 15, 22, 29, 36 and 43 of an 8 week cycle; Cycle 2 and subsequent cycles - Days 1, 8 and 15 of a 4 week cycle [the approved dose and schedule for pancreatic cancer, see the gemcitabine package insert]). TARCEVA or placebo was taken orally once daily until disease progression or unacceptable toxicity. The primary endpoint was survival. Secondary endpoints included response rate, and progression-free survival (PFS). Duration of response and the role of EGFR tumor expression in survival were also examined. The study was conducted in 18 countries. A total of

285 patients were randomized to receive gemcitabine plus TARCEVA (261 patients in the 100 mg cohort and 24 patients in the 150 mg cohort) and 284 patients were randomized to receive gemcitabine plus placebo (260 patients in the 100 mg cohort and 24 patients in the 150 mg cohort). Too few patients were treated in the 150 mg cohort to draw conclusions.

Table 3 summarizes the demographic and disease characteristics of the study population that was randomized to receive 100 mg of TARCEVA plus gemcitabine or placebo plus gemcitabine. Baseline demographic and disease characteristics of the patients were similar between the 2 treatment groups, except for a slightly larger proportion of females in the TARCEVA arm (51%) compared with the placebo arm (44%). The median time from initial diagnosis to randomization was approximately 1.0 month. Most patients presented with metastatic disease at study entry as the initial manifestation of pancreatic cancer. About 1/4 of the patients (136/521) had EGFR expression status characterized.

Table 3: Demographic and Disease Characteristics: 100 mg Cohort

	TARCEVA+ Gemcitabine (N=261)		**Placebo + Gemcitabine (N=260)**	
Characteristics	**n**	**(%)**	**n**	**(%)**
Gender				
Female	134	(51)	114	(44)
Male	127	(49)	146	(56)
Age (Years)				
<65	136	(52)	138	(53)
≥65	125	(48)	122	(47)
Race				
Caucasian	225	(86)	231	(89)
Black	8	(3)	5	(2)
Asian	20	(8)	14	(5)
Other	8	(3)	10	(3)
ECOG Performance Status*				
0	82	(31)	83	(32)

	TARCEVA+ Gemcitabine (N=261)		Placebo + Gemcitabine (N=260)	
Characteristics	**n**	**(%)**	**n**	**(%)**
1	134	(51)	132	(51)
2	44	(17)	45	(17)
Unknown*	1	(<1)	0	(0)
Disease Status at Baseline**				
Locally Advanced	61	(23)	63	(24)
Distant Metastasis	200	(77)	197	(76)

*Unknown includes responses of 'Unknown' and missing.
**Stratification factor as documented at baseline; distribution differs slightly from values reported at time of randomization.

The results of the study are shown in Table 4.

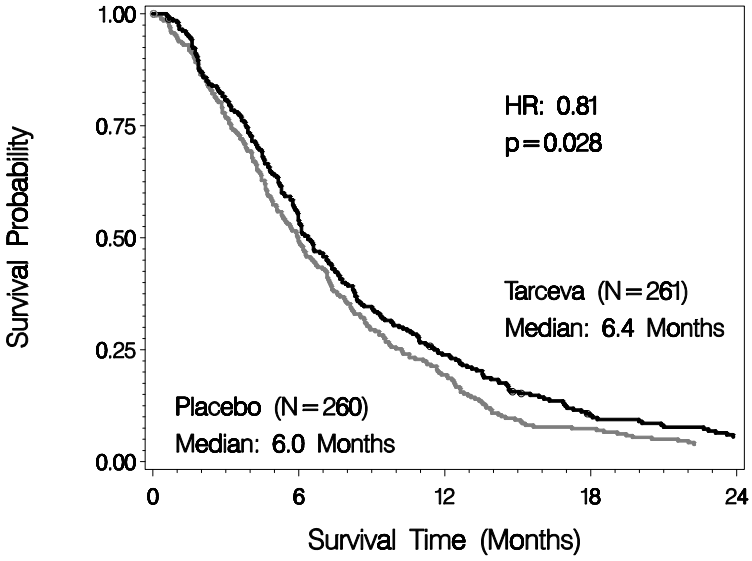
Table 4: Efficacy Results: 100 mg Cohort

	TARCEVA + Gemcitabine	Placebo+ Gemcitabine	Hazard Ratio (1)	95% CI	p-value
Survival	Median 6.4 mo 250 deaths	Median 6.0 mo 254 deaths	0.81	0.68 – 0.97	0.028 (2)
1-year Survival	23.8%	19.4%			
Progression-Free Survival	Median 3.8 mo 225 events	Median 3.5 mo 232 events	0.76	0.64 – 0.92	0.006 (2)
Tumor Response (CR+PR)	8.6%	7.9%			0.87 (3)
Response Duration	Median 23.9 wk	Median 23.3 wk			

(1) Cox regression model with the following covariates: ECOG performance status, and extent of disease.
(2) Two-sided Log-Rank test stratified by ECOG performance status and extent of disease.
(3) Two-sided Fisher's exact test.

Survival was evaluated in the intent-to-treat population. Figure 6 depicts the Kaplan-Meier curves for overall survival in the 100 mg cohort. The primary survival and PFS analyses were two-sided Log-Rank tests stratified by ECOG performance status and extent of disease.

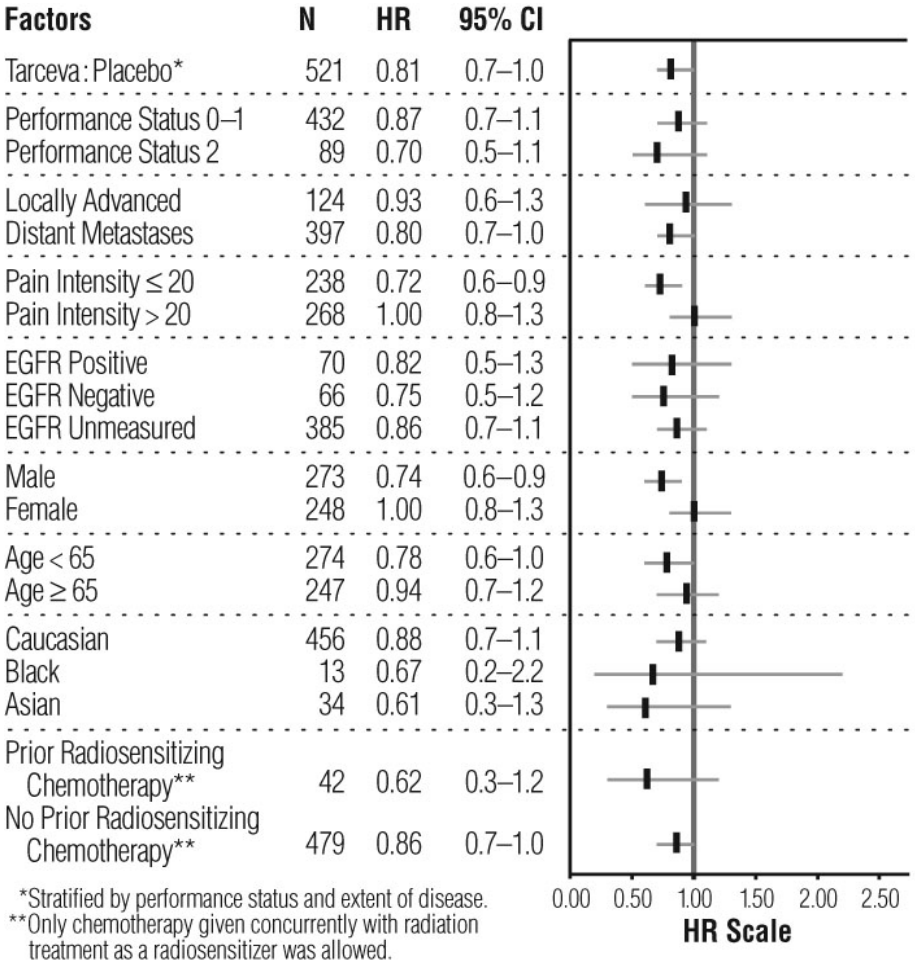
Figure 6: Kaplan – Meier Curve for Overall Survival: 100 mg Cohort



Note: HR is from Cox regression model with the following covariates: ECOG performance status and extent of disease. P-value is from two-sided Log-Rank test stratified by ECOG performance status and extent of disease.

In a series of exploratory univariate subset analyses (the stratification factors at randomization and at baseline, as well as pain intensity by visual analog score, EGFR status, gender, age, race, and any prior chemotherapy), all of the HRs in the TARCEVA plus gemcitabine arm relative to the placebo plus gemcitabine arm were less than or equal to 1.0 suggesting consistency across all patient subsets. However, in patients with pain intensity score >20, female, locally advanced, age ≥65 years, or performance status 0 or 1, the benefit of erlotinib was uncertain.

Figure 7: Survival Hazard Ratio (HR) (TARCEVA : Placebo) in Subgroups According to Pretreatment Characteristics: 100 mg Cohort



Note: Depicted are the univariate hazard ratio (HR) for death in the patients receiving TARCEVA plus gemcitabine relative to the patients receiving placebo plus gemcitabine, the 95% confidence interval (CI) for the HR, and the sample size (N) in each subgroup. The hash mark on the horizontal bar represents the HR, and the length of the horizontal bar represents the 95% confidence interval. A hash mark to the left of the vertical line corresponds to a HR that is less than 1.00, which indicates that survival is better in the TARCEVA arm compared with the placebo arm in that subgroup. Only chemotherapy given concurrently with radiation treatment as a radiosensitizer was allowed.

Relation of Pancreatic Cancer Trial Results to EGFR Protein Expression Status (as Determined by Immunohistochemistry)

Analysis of the impact of EGFR expression status on the treatment effect on clinical outcome is limited because EGFR status is known for only 136 study patients (26%) in the 100 mg cohort. There were no significant differences in patient or disease characteristics between the patients for whom results were known and the patients for whom the results were unknown, suggesting that the tested population was a representative sample. EGFR expression was determined using the EGFR pharmDx™ kit. In contrast to the 1% cut-off specified in the pharmDx kit instructions, a positive EGFR expression status was defined as having at least 10% of cells staining for EGFR. The pharmDx kit has not been validated for use in pancreatic cancer.

The survival results of TARCEVA plus gemcitabine compared to gemcitabine alone by EGFR status were as follows: EGFR positive subgroup (N = 70; HR = 0.82; 95% CI = 0.50 –1.32) (Figure 8), EGFR negative subgroup (N = 66; HR = 0.75; 95% CI = 0.46 – 1.23) (Figure 9), and the subgroup whose EGFR status was unmeasured (N = 385; HR = 0.86; 95% CI = 0.70 – 1.05) (Figure 10). The confidence intervals for each subgroup are wide and overlapping and none of the p-values reached statistical significance.

Tumor responses were observed in all EGFR subgroups receiving TARCEVA plus gemcitabine: 5.0% in the EGFR positive subgroup, 9.7% in the EGFR negative subgroup and 9.2% in the EGFR unmeasured subgroup.

Figure 8: Survival in EGFR Positive Patients: 100 mg Cohort

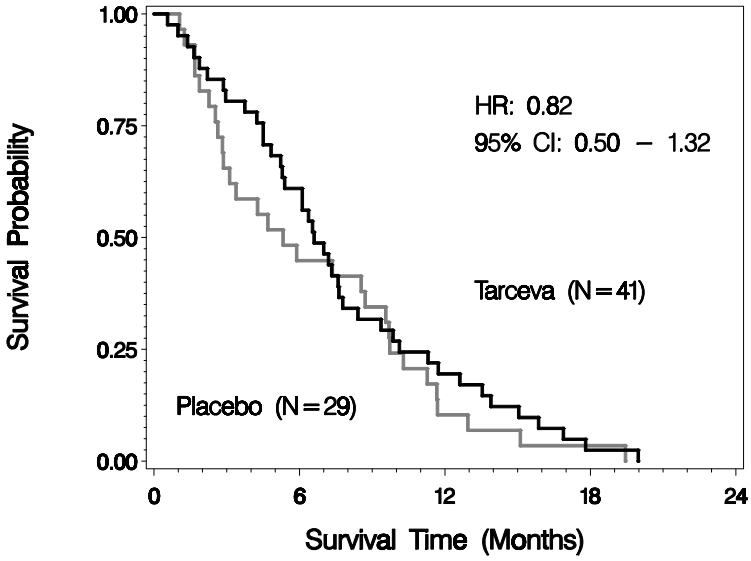


Figure 9: Survival in EGFR Negative Patients: 100 mg Cohort

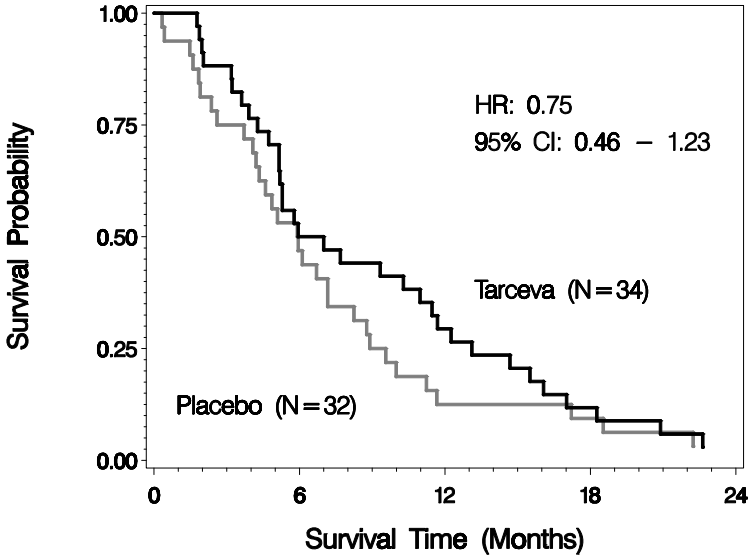
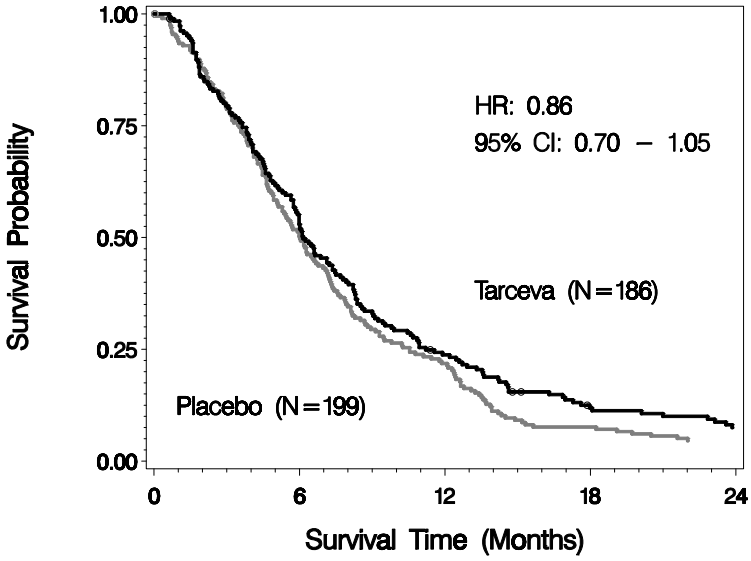


Figure 10: Survival in EGFR Unmeasured Patients: 100 mg Cohort



INDICATIONS AND USAGE

Non-Small Cell Lung Cancer

TARCEVA monotherapy is indicated for the treatment of patients with locally advanced or metastatic non-small cell lung cancer after failure of at least one prior chemotherapy regimen.

Results from two, multicenter, placebo-controlled, randomized, Phase 3 trials conducted in first-line patients with locally advanced or metastatic NSCLC showed no clinical benefit with the concurrent administration of TARCEVA with platinum-based chemotherapy [carboplatin and paclitaxel or gemcitabine and cisplatin] and its use is not recommended in that setting.

Pancreatic Cancer

TARCEVA in combination with gemcitabine is indicated for the first-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer.

CONTRAINDICATIONS

None

WARNINGS

Pulmonary Toxicity

There have been infrequent reports of serious Interstitial Lung Disease (ILD)-like events, including fatalities, in patients receiving TARCEVA for treatment of NSCLC, pancreatic cancer or other advanced solid tumors. In the randomized single-agent NSCLC study (see **CLINICAL STUDIES** section), the incidence of ILD-like events (0.8%) was the same in both the placebo and TARCEVA groups. In the pancreatic cancer study - in combination with gemcitabine - (see **CLINICAL STUDIES** section), the incidence of ILD-like events was 2.5% in the TARCEVA plus gemcitabine group vs. 0.4% in the placebo plus gemcitabine group.

The overall incidence of ILD-like events in approximately 4900 TARCEVA-treated patients from all studies (including uncontrolled studies and studies with concurrent chemotherapy) was approximately 0.7%. Reported diagnoses in patients suspected of having ILD-like events included pneumonitis, radiation pneumonitis, hypersensitivity pneumonitis, interstitial pneumonia, interstitial lung disease, obliterative bronchiolitis, pulmonary fibrosis, Acute Respiratory Distress Syndrome and lung infiltration. Symptoms started from 5 days to more than 9 months (median 39 days) after initiating TARCEVA therapy. In the lung cancer trials most of the cases were associated with confounding or contributing factors such as concomitant/prior chemotherapy, prior radiotherapy, pre-existing parenchymal lung disease, metastatic lung disease, or pulmonary infections.

In the event of an acute onset of new or progressive, unexplained pulmonary symptoms such as dyspnea, cough, and fever, TARCEVA therapy should be interrupted pending diagnostic evaluation. If ILD is diagnosed, TARCEVA should be discontinued and appropriate treatment instituted as needed (see **ADVERSE REACTIONS** and **DOSAGE AND ADMINISTRATION - Dose Modifications** sections).

Patients with Hepatic Impairment

In a pharmacokinetic study in patients with moderate hepatic impairment (Child-Pugh B) associated with significant liver tumor burden, 10 out of 15 patients died on

treatment or within 30 days of the last TARCEVA dose. One patient died from hepatorenal syndrome, 1 patient died from rapidly progressing liver failure and the remaining 8 patients died from progressive disease. Six out of the 10 patients who died had baseline total bilirubin > 3 x ULN suggesting severe hepatic impairment. Treatment with TARCEVA should be used with extra caution in patients with total bilirubin > 3 x ULN. Patients with hepatic impairment (total bilirubin > ULN or Child-Pugh A, B and C) should be closely monitored during therapy with TARCEVA. TARCEVA dosing should be interrupted or discontinued if changes in liver function are severe such as doubling of total bilirubin and/or tripling of transaminases in the setting of pretreatment values outside normal range (see **CLINICAL PHARMACOLOGY - Special Populations - Patients with Hepatic Impairment** and **DOSAGE AND ADMINISTRATION - Dose Modifications** sections).

Hepatotoxicity

Cases of hepatic failure and hepatorenal syndrome (including fatalities) have been reported during use of TARCEVA, particularly in patients with baseline hepatic impairment. Therefore, periodic liver function testing (transaminases, bilirubin, and alkaline phosphatase) is recommended. In the setting of worsening liver function tests, dose interruption and/or dose reduction with frequent liver function test monitoring should be considered. TARCEVA dosing should be interrupted or discontinued if total bilirubin is >3 x ULN and/or transaminases are >5 x ULN in the setting of normal pretreatment values (see **ADVERSE REACTIONS** and **DOSAGE and ADMINISTRATION – Dose Modifications** sections).

Renal Failure

Cases of hepatorenal syndrome, acute renal failure (including fatalities), and renal insufficiency have been reported. Some were secondary to baseline hepatic impairment while others were associated with severe dehydration due to diarrhea, vomiting, and/or anorexia or concurrent chemotherapy use. In the event of dehydration, particularly in patients with contributing risk factors for renal failure (eg, pre-existing renal disease, medical conditions or medications that may lead to renal disease, or other predisposing conditions including advanced age), TARCEVA therapy should be interrupted and appropriate measures should be taken to intensively rehydrate the patient. Periodic monitoring of renal function and serum

electrolytes is recommended in patients at risk of dehydration (see **ADVERSE REACTIONS** and **DOSAGE AND ADMINISTRATION - Dose Modifications** sections).

Myocardial infarction/ischemia:

In the pancreatic carcinoma trial, six patients (incidence of 2.3%) in the TARCEVA/gemcitabine group developed myocardial infarction/ischemia. One of these patients died due to myocardial infarction. In comparison, 3 patients in the placebo/gemcitabine group developed myocardial infarction (incidence 1.2%) and one died due to myocardial infarction.

Cerebrovascular accident:

In the pancreatic carcinoma trial, six patients in the TARCEVA/gemcitabine group developed cerebrovascular accidents (incidence: 2.3%) One of these was hemorrhagic and was the only fatal event. In comparison, in the placebo/gemcitabine group there were no cerebrovascular accidents.

Microangiopathic Hemolytic Anemia with Thrombocytopenia:

In the pancreatic carcinoma trial, two patients in the TARCEVA/gemcitabine group developed microangiopathic hemolytic anemia with thrombocytopenia (incidence: 0.8%). Both patients received TARCEVA and gemcitabine concurrently. In comparison, in the placebo/gemcitabine group there were no cases of microangiopathic hemolytic anemia with thrombocytopenia.

Pregnancy Category D

Erlotinib has been shown to cause maternal toxicity with associated embryo/fetal lethality and abortion in rabbits when given at doses that result in plasma drug concentrations of approximately 3 times those in humans (AUCs at 150 mg daily dose). When given during the period of organogenesis to achieve plasma drug concentrations approximately equal to those in humans, based on AUC, there was no increased incidence of embryo/fetal lethality or abortion in rabbits or rats. However, female rats treated with 30 mg/m^2/day or 60 mg/m^2/day (0.3 or 0.7 times the clinical dose, on a mg/m^2 basis) of erlotinib prior to mating through the first week of pregnancy had an increase in early resorptions that resulted in a decrease in the number of live fetuses.

No teratogenic effects were observed in rabbits or rats.

There are no adequate and well-controlled studies in pregnant women using TARCEVA. Women of childbearing potential should be advised to avoid pregnancy while on TARCEVA. Adequate contraceptive methods should be used during therapy, and for at least 2 weeks after completing therapy. Treatment should only be continued in pregnant women if the potential benefit to the mother outweighs the risk to the fetus. If TARCEVA is used during pregnancy, the patient should be apprised of the potential hazard to the fetus or potential risk for loss of the pregnancy.

PRECAUTIONS

Drug Interactions

Co-treatment with the potent CYP3A4 inhibitor ketoconazole increases erlotinib AUC by 2/3. Caution should be used when administering or taking TARCEVA with ketoconazole and other strong CYP3A4 inhibitors such as, but not limited to, atazanavir, clarithromycin, indinavir, itraconazole, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, troleandomycin (TAO), voriconazole and grapefruit or grapefruit juice. When TARCEVA was co-administered with ciprofloxacin, an inhibitor of both CYP3A4 and CYP1A2, the erlotinib AUC increased by 39% (see **CLINICAL PHARMACOLOGY**-Interactions and **DOSAGE AND ADMINISTRATION - Dose Modifications** section).

Pre-treatment with the CYP3A4 inducer rifampicin decreased erlotinib AUC by about 2/3 to 4/5, which is equivalent to a dose of about 30 to 50 mg in NSCLC patients. Use of alternative treatments lacking CYP3A4 inducing activity is strongly recommended. If an alternative treatment is unavailable, adjusting the starting dose should be considered (see **DOSING AND ADMINISTRATION-Dose Modifications** section). If the TARCEVA dose is adjusted upward, the dose will need to be reduced immediately to the indicated starting dose upon discontinuation of rifampicin or other inducers. Other CYP3A4 inducers include, but are not limited to, rifabutin, rifapentine, phenytoin, carbamazepine, phenobarbital and St. John's Wort (see **CLINICAL PHARMACOLOGY-Interactions** and **DOSAGE AND ADMINISTRATION - Dose Modifications** sections).

Drugs that alter the pH of the upper GI tract may alter the solubility of erlotinib and reduce its bioavailability. Co-administration of TARCEVA with omeprazole, a proton pump inhibitor, decreased the erlotinib AUC by 46%. Increasing the dose of TARCEVA when co-administered with such agents is not likely to compensate for the loss of exposure. Since proton pump inhibitors affect pH of the upper GI tract for an extended period, separation of doses may not eliminate the interaction. The concomitant use of proton pump inhibitors with TARCEVA should be avoided if possible. The use of antacids may be considered in place of histamine 2 receptor blockers (H_2 blockers) or proton pump inhibitors in patients receiving TARCEVA. However, no clinical study has been conducted to evaluate the effect of antacids on erlotinib pharmacokinetics. If an antacid is necessary, the antacid dose and the TARCEVA dose should be separated by several hours (see **CLINICAL PHARMACOLOGY-Interactions** section).

Elevated International Normalized Ratio and Potential Bleeding

International Normalized Ratio (INR) elevations and infrequent reports of bleeding events including gastrointestinal and non-gastrointestinal bleedings have been reported in clinical studies, some associated with concomitant warfarin administration. Patients taking warfarin or other coumarin-derivative anticoagulants should be monitored regularly for changes in prothrombin time or INR (see **ADVERSE REACTIONS** section).

Carcinogenesis, Mutagenesis, Impairment of Fertility

Erlotinib has not been tested for carcinogenicity.

Erlotinib has been tested for genotoxicity in a series of *in vitro* assays (bacterial mutation, human lymphocyte chromosome aberration, and mammalian cell mutation) and an *in vivo* mouse bone marrow micronucleus test and did not cause genetic damage. Erlotinib did not impair fertility in either male or female rats.

Pregnancy

Pregnancy Category D (see **WARNINGS** and **PRECAUTIONS - Information for Patients** sections).

Nursing Mothers

It is not known whether erlotinib is excreted in human milk. Because many drugs are excreted in human milk and because the effects of TARCEVA on infants have not been studied, women should be advised against breast-feeding while receiving TARCEVA therapy.

Pediatric Use

The safety and effectiveness of TARCEVA in pediatric patients have not been studied.

Geriatric Use

Of the total number of patients participating in the randomized NSCLC trial, 62% were less than 65 years of age, and 38% of patients were aged 65 years or older. The survival benefit was maintained across both age groups (see **CLINICAL STUDIES** section). In the pancreatic cancer study, 53% of patients were younger than 65 years of age and 47% were 65 years of age or older. No meaningful differences in safety or pharmacokinetics were observed between younger and older patients in either study. Therefore, no dosage adjustments are recommended in elderly patients.

Information for Patients

If the following signs or symptoms occur, patients should seek medical advice promptly (see **WARNINGS**, **ADVERSE REACTIONS** and **DOSAGE AND ADMINISTRATION - Dose Modifications** sections).

- Onset or worsening of skin rash
- Severe or persistent diarrhea, nausea, anorexia, or vomiting
- Onset or worsening of unexplained shortness of breath or cough
- Eye irritation

Women of childbearing potential should be advised to avoid becoming pregnant while taking TARCEVA (see **WARNINGS - Pregnancy Category D** section).

Smokers should be advised to stop smoking while taking TARCEVA as plasma concentrations of erlotinib are reduced due to the effect of cigarette smoking (see **CLINICAL PHARMACOLOGY - Interactions** section).

ADVERSE REACTIONS

Safety evaluation of TARCEVA is based on 856 cancer patients who received TARCEVA as monotherapy, 308 patients who received TARCEVA 100 or 150 mg plus gemcitabine, and 1228 patients who received TARCEVA concurrently with other chemotherapies.

There have been reports of serious events, including fatalities, in patients receiving TARCEVA for treatment of NSCLC, pancreatic cancer or other advanced solid tumors (see **WARNINGS, PRECAUTIONS** and **DOSAGE AND ADMINISTRATION - Dose Modifications** sections).

Non-Small Cell Lung Cancer

Adverse events, regardless of causality, that occurred in at least 10% of patients treated with single-agent TARCEVA at 150 mg and at least 3% more often than in the placebo group in the randomized trial of patients with NSCLC are summarized by NCI-CTC (version 2.0) Grade in Table 5.

The most common adverse reactions in patients receiving single-agent TARCEVA 150 mg were rash and diarrhea. Grade 3/4 rash and diarrhea occurred in 9% and 6%, respectively, in TARCEVA-treated patients. Rash and diarrhea each resulted in study discontinuation in 1% of TARCEVA-treated patients. Six percent and 1% of patients needed dose reduction for rash and diarrhea, respectively. The median time to onset of rash was 8 days, and the median time to onset of diarrhea was 12 days.

Table 5: Adverse Events Occurring More Frequently (≥ 3%) in the Single Agent TARCEVA Group than in the Placebo Group and in ≥10% of Patients in the TARCEVA Group.

	TARCEVA 150 mg N = 485			**Placebo N = 242**		
NCI CTC Grade	**Any Grade**	**Grade 3**	**Grade 4**	**Any Grade**	**Grade 3**	**Grade 4**
MedDRA Preferred Term	**%**	**%**	**%**	**%**	**%**	**%**
Rash	75	8	<1	17	0	0
Diarrhea	54	6	<1	18	<1	0
Anorexia	52	8	1	38	5	<1

	TARCEVA 150 mg N = 485			Placebo N = 242		
NCI CTC Grade	**Any Grade**	**Grade 3**	**Grade 4**	**Any Grade**	**Grade 3**	**Grade 4**
MedDRA Preferred Term	**%**	**%**	**%**	**%**	**%**	**%**
Fatigue	52	14	4	45	16	4
Dyspnea	41	17	11	35	15	11
Cough	33	4	0	29	2	0
Nausea	33	3	0	24	2	0
Infection	24	4	0	15	2	0
Vomiting	23	2	<1	19	2	0
Stomatitis	17	<1	0	3	0	0
Pruritus	13	<1	0	5	0	0
Dry skin	12	0	0	4	0	0
Conjunctivitis	12	<1	0	2	<1	0
Keratoconjunctivitis sicca	12	0	0	3	0	0
Abdominal pain	11	2	<1	7	1	<1

Liver function test abnormalities (including elevated alanine aminotransferase (ALT), aspartate aminotransferase (AST) and bilirubin) were observed in patients receiving single-agent TARCEVA 150 mg. These elevations were mainly transient or associated with liver metastases. Grade 2 (>2.5 – 5.0 x ULN) ALT elevations occurred in 4% and <1% of TARCEVA and placebo treated patients, respectively. Grade 3 (>5.0 – 20.0 x ULN) elevations were not observed in TARCEVA-treated patients. TARCEVA dosing should be interrupted or discontinued if changes in liver function are severe (see **DOSAGE AND ADMINISTRATION – Dose Modifications** section).

Pancreatic Cancer

Adverse events, regardless of causality, that occurred in at least 10% of patients treated with TARCEVA 100 mg plus gemcitabine in the randomized trial of patients with pancreatic cancer are summarized by NCI-CTC (version 2.0) Grade in Table 6.

The most common adverse reactions in pancreatic cancer patients receiving TARCEVA 100 mg plus gemcitabine were fatigue, rash, nausea, anorexia and diarrhea. In the TARCEVA plus gemcitabine arm, Grade 3/4 rash and diarrhea were

each reported in 5% of TARCEVA plus gemcitabine-treated patients. The median time to onset of rash and diarrhea was 10 days and 15 days, respectively. Rash and diarrhea each resulted in dose reductions in 2% of patients, and resulted in study discontinuation in up to 1% of patients receiving TARCEVA plus gemcitabine. The 150 mg cohort was associated with a higher rate of certain class-specific adverse reactions including rash and required more frequent dose reduction or interruption.

Table 6: Adverse Events Occurring in ≥10% of TARCEVA-treated Pancreatic Cancer Patients: 100 mg cohort

	TARCEVA + Gemcitabine 1000 mg/m^2 IV N=259			**Placebo + Gemcitabine 1000 mg/m^2 IV N=256**		
NCI CTC Grade	**Any Grade**	**Grade 3**	**Grade 4**	**Any Grade**	**Grade 3**	**Grade 4**
MedDRA Preferred Term	**%**	**%**	**%**	**%**	**%**	**%**
Fatigue	73	14	2	70	13	2
Rash	69	5	0	30	1	0
Nausea	60	7	0	58	7	0
Anorexia	52	6	<1	52	5	<1
Diarrhea	48	5	<1	36	2	0
Abdominal pain	46	9	<1	45	12	<1
Vomiting	42	7	<1	41	4	<1
Weight decreased	39	2	0	29	<1	0
Infection*	39	13	3	30	9	2
Edema	37	3	<1	36	2	<1
Pyrexia	36	3	0	30	4	0
Constipation	31	3	1	34	5	1
Bone pain	25	4	<1	23	2	0
Dyspnea	24	5	<1	23	5	0
Stomatitis	22	<1	0	12	0	0
Myalgia	21	1	0	20	<1	0
Depression	19	2	0	14	<1	0
Dyspepsia	17	<1	0	13	<1	0
Cough	16	0	0	11	0	0
Dizziness	15	<1	0	13	0	<1
Headache	15	<1	0	10	0	0
Insomnia	15	<1	0	16	<1	0

	TARCEVA + Gemcitabine 1000 mg/m^2 IV N=259			Placebo + Gemcitabine 1000 mg/m^2 IV N=256		
NCI CTC Grade	**Any Grade**	**Grade 3**	**Grade 4**	**Any Grade**	**Grade 3**	**Grade 4**
Alopecia	14	0	0	11	0	0
Anxiety	13	1	0	11	<1	0
Neuropathy	13	1	<1	10	<1	0
Flatulence	13	0	0	9	<1	0
Rigors	12	0	0	9	0	0

*Includes all MedDRA preferred terms in the Infections and Infestations System Organ Class

In the pancreatic carcinoma trial, 10 patients in the TARCEVA/gemcitabine group developed deep venous thrombosis (incidence: 3.9%). In comparison, 3 patients in the placebo/gemcitabine group developed deep venous thrombosis (incidence 1.2%). The overall incidence of grade 3 or 4 thrombotic events, including deep venous thrombosis, was similar in the two treatment arms: 11% for TARCEVA plus gemcitabine and 9% for placebo plus gemcitabine.

No differences in Grade 3 or Grade 4 hematologic laboratory toxicities were detected between the TARCEVA plus gemcitabine group compared to the placebo plus gemcitabine group.

Severe adverse events (≥grade 3 NCI CTC) in the TARCEVA plus gemcitabine group with incidences < 5% included syncope, arrhythmias, ileus, pancreatitis, hemolytic anemia including microangiopathic hemolytic anemia with thrombocytopenia, myocardial infarction/ischemia, cerebrovascular accidents including cerebral hemorrhage, and renal insufficiency (see **WARNINGS** section).

Liver function test abnormalities (including elevated alanine aminotransferase (ALT), aspartate aminotransferase (AST) and bilirubin) have been observed following the administration of TARCEVA plus gemcitabine in patients with pancreatic cancer. Table 7 displays the most severe NCI-CTC grade of liver function abnormalities that developed. TARCEVA dosing should be interrupted or discontinued if changes in liver function are severe (see **DOSAGE AND ADMINISTRATION – Dose Modifications** section).

Table 7: Liver Function Test Abnormalities (most severe NCI-CTC grade) in Pancreatic Cancer Patients: 100 mg Cohort

	TARCEVA + Gemcitabine 1000 mg/m^2 IV N = 259			Placebo + Gemcitabine 1000 mg/m^2 IV N = 256		
NCI CTC Grade	**Grade 2**	**Grade 3**	**Grade 4**	**Grade 2**	**Grade 3**	**Grade 4**
Bilirubin	17 %	10%	<1%	11%	10%	3%
ALT	31%	13%	<1%	22%	9%	0%
AST	24%	10%	<1%	19%	9%	0%

NSCLC and Pancreatic Cancer Indications

During the NSCLC and the combination pancreatic cancer trials, infrequent cases of gastrointestinal bleeding have been reported, some associated with concomitant warfarin or NSAID administration (see **PRECAUTIONS - Elevated International Normalized Ratio and Potential Bleeding** section). These adverse events were reported as peptic ulcer bleeding (gastritis, gastroduodenal ulcers), hematemesis, hematochezia, melena and hemorrhage from possible colitis. Cases of acute renal failure or renal insufficiency, including fatalities, with or without hypokalemia have been reported (see **WARNINGS** section). Cases of Grade 1 epistaxis were also reported in both the single-agent NSCLC and the pancreatic cancer clinical trials.

NCI-CTC Grade 3 conjunctivitis and keratitis have been reported infrequently in patients receiving TARCEVA therapy in the NSCLC and pancreatic cancer clinical trials. Corneal ulcerations may also occur (see **PRECAUTIONS - Information for Patients** section).

Hair and nail disorders including alopecia, hirsutism, eyelash/eyebrow changes, paronychia and brittle and loose nails have been reported in clinical trials and during post-marketing use of TARCEVA.

Hepatic failure has been reported in patients treated with single-agent TARCEVA or TARCEVA combined with chemotherapy in clinical studies and during post-marketing use of TARCEVA (see **WARNINGS** section).

In general, no notable differences in the safety of TARCEVA monotherapy or in combination with gemcitabine could be discerned between females or males and between patients younger or older than the age of 65 years. The safety of TARCEVA

appears similar in Caucasian and Asian patients (see **PRECAUTIONS - Geriatric Use** section).

OVERDOSAGE

Single oral doses of TARCEVA up to 1,000 mg in healthy subjects and weekly doses up to 1,600 mg in cancer patients have been tolerated. Repeated twice-daily doses of 200 mg single-agent TARCEVA in healthy subjects were poorly tolerated after only a few days of dosing. Based on the data from these studies, an unacceptable incidence of severe adverse events, such as diarrhea, rash, and liver transaminase elevation, may occur above the recommended dose (see **DOSAGE AND ADMINISTRATION** section). In case of suspected overdose, TARCEVA should be withheld and symptomatic treatment instituted.

DOSAGE AND ADMINISTRATION

Non-Small Cell Lung Cancer

The recommended daily dose of TARCEVA is 150 mg taken at least one hour before or two hours after the ingestion of food. Treatment should continue until disease progression or unacceptable toxicity occurs. There is no evidence that treatment beyond progression is beneficial.

Pancreatic Cancer

The recommended daily dose of TARCEVA is 100 mg taken at least one hour before or two hours after the ingestion of food, in combination with gemcitabine (see the gemcitabine package insert). Treatment should continue until disease progression or unacceptable toxicity occurs.

Dose Modifications

In patients who develop an acute onset of new or progressive pulmonary symptoms, such as dyspnea, cough or fever, treatment with TARCEVA should be interrupted pending diagnostic evaluation. If ILD is diagnosed, TARCEVA should be discontinued and appropriate treatment instituted as necessary (see **WARNINGS – Pulmonary Toxicity** section).

Diarrhea can usually be managed with loperamide. Patients with severe diarrhea who are unresponsive to loperamide or who become dehydrated may require dose

reduction or temporary interruption of therapy (see **WARNINGS – Renal Failure** section). Patients with severe skin reactions may also require dose reduction or temporary interruption of therapy.

When dose reduction is necessary, the TARCEVA dose should be reduced in 50 mg decrements.

In patients who are taking TARCEVA with a strong CYP3A4 inhibitor such as, but not limited to, atazanavir, clarithromycin, indinavir, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, troleandomycin (TAO), voriconazole, and grapefruit or grapefruit juice, a dose reduction should be considered if severe adverse reactions occur. Similarly, in patients who are taking TARCEVA with an inhibitor of both CYP3A4 and CYP1A2 like ciprofloxacin, a dose reduction of TARCEVA should be considered if severe adverse reactions occur.

Pre-treatment with the CYP3A4 inducer rifampicin decreased erlotinib AUC by about 2/3 to 4/5. Use of alternative treatments lacking CYP3A4 inducing activity is strongly recommended. If an alternative treatment is unavailable, an increase in the dose of TARCEVA should be considered as tolerated at two week intervals while monitoring the patient's safety. The maximum dose of TARCEVA studied in combination with rifampicin is 450 mg. If the TARCEVA dose is adjusted upward, the dose will need to be reduced immediately to the indicated starting dose upon discontinuation of rifampicin or other inducers. Other CYP3A4 inducers include, but are not limited to rifabutin, rifapentine, phenytoin, carbamazepine, phenobarbital and St. John's Wort. These too should be avoided if possible (see **CLINICAL PHARMACOLOGY-Interactions and PRECAUTIONS - Drug Interactions** sections).

Erlotinib is eliminated by hepatic metabolism and biliary excretion. Although erlotinib exposure was similar in patients with moderately impaired hepatic function (Child-Pugh B), patients with hepatic impairment (total bilirubin > ULN or Child-Pugh A, B and C) should be closely monitored during therapy with TARCEVA (see **WARNINGS**). Treatment with TARCEVA should be used with extra caution in patients with total bilirubin > 3 x ULN. TARCEVA dosing should be interrupted or discontinued if changes in liver function are severe such as doubling of total bilirubin and/or tripling of transaminases in the setting of pretreatment values outside normal range. In the setting of worsening liver function tests, before they become severe, dose interruption and/or dose reduction with frequent liver function test monitoring

should be considered. TARCEVA dosing should be interrupted or discontinued if total bilirubin is >3 x ULN and/or transaminases are >5 x ULN in the setting of normal pretreatment values (see **CLINICAL PHARMACOLOGY - Special Populations - Patients With Hepatic Impairment, WARNINGS - Patients With Hepatic Impairment, Hepatotoxicity** and **ADVERSE REACTIONS** sections).

HOW SUPPLIED

The 25 mg, 100 mg and 150 mg strengths are supplied as white film-coated tablets for daily oral administration.

TARCEVA® (erlotinib) Tablets, 25 mg: Round, biconvex face and straight sides, white film-coated, printed in orange with a "T" and "25" on one side and plain on the other side. Supplied in bottles of 30 tablets (NDC 50242-062-01).

TARCEVA® (erlotinib) Tablets, 100 mg: Round, biconvex face and straight sides, white film-coated, printed in gray with "T" and "100" on one side and plain on the other side. Supplied in bottles of 30 tablets (NDC 50242-063-01).

TARCEVA® (erlotinib) Tablets, 150 mg: Round, biconvex face and straight sides, white film-coated, printed in maroon with "T" and "150" on one side and plain on the other side. Supplied in bottles of 30 tablets (NDC 50242-064-01).

STORAGE

Store at 25°C (77°F); excursions permitted to 15° – 30°C (59° – 86°F). See USP Controlled Room Temperature.

Manufactured for:

OSI Pharmaceuticals Inc., Melville, NY 11747

Manufactured by:

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Distributed by:

Genentech, Inc., 1 DNA Way, South San Francisco, CA 94080-4990

For further information please call 1-877-TARCEVA (1-877-827-2382).

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