

## OFFICE OF CLINICAL PHARMACOLOGY REVIEW

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NDA: 22-056	Submission Date(s): December, 20, 2006, March 15, 2007, May 2, 2007, Aug 29, 2007
Brand Name	Prilosec®
Generic Name	Omeprazole Magnesium
Reviewer	PeiFan Bai, Ph.D.
Team Leader	Sue-Chih Lee, Ph.D.
OCP Division	Division of Clinical Pharmacology 3
OND division	Division of Gastroenterology Products
Sponsor	AstraZeneca LP
Submission Type; Code	Original
Formulation; Strength(s)	PRILOSEC® (omeprazole magnesium) FOR DELAYED-RELEASE ORAL SUSPENSION 2.5 mg omeprazole /packet and 10 mg omeprazole/ packet
Indication	Symptomatic and/or endoscopically proven Gastroesophageal Reflux Disease (GERD)

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## 1 Executive Summary

### 1.1 Recommendation

This submission fulfills the sponsor's Phase IV commitment to develop an appropriate formulation for patients aged 0-2 years. The application is acceptable from the clinical pharmacology perspective provided the labeling comments are adequately addressed by the sponsor.

### 1.2 Phase IV Commitments

This NDA was submitted to fulfill the Phase IV commitment made at the time of approval of NDA 19810/S-74.

### 1.3 Summary of Important Clinical Pharmacology and Biopharmaceutics Findings

**Product:** Prilosec® for delayed-release oral suspension (to-be-marketed formulation) contains omeprazole magnesium. Based on the amount of omeprazole, there are two strengths, 2.5 mg and 10 mg. Omeprazole, a racemic mixture, is a proton pump inhibitor (PPI) that suppresses gastric acid secretion by specifically inhibiting the H/K<sup>+</sup>-ATPase of gastric parietal cells. The proposed indication is symptomatic and/or endoscopically proven Gastroesophageal Reflux Disease (GERD) in patients aged 0-2 years.

**Regulatory background:** In response to the Agency's Pediatric Written Request of July-1-1999, NDA 19-810/S-74 (Prilosec® capsules) was submitted for treating GERD in patients aged 0-16 years. Pediatric exclusivity was granted to the sponsor following the submission of NDA 19-810/S-74. NDA 19-810/S-74 was approved only for patients aged 2-16 years due to the Agency's concern that the granules of Prilosec® delayed release capsules were too large for children aged 0-2 years. The current NDA was submitted to fulfill the Phase IV commitment made upon the approval of NDA [redacted] in which the sponsor was committed to develop an appropriate formulation for children aged 0-2 years. The granules of the to-be-marketed formulation are the same as those used in manufacturing the Prilosec® OTC tablets (NDA 21229, oral delayed release tablet, 20 mg base), but are smaller than those in Prilosec® capsules (NDA 19-810).

The studies conducted in children aged 0-2 years (Study 251, Study 292, and Study 250) and Study I-678 in children aged 1-16 years submitted to NDA 19-

810 (Prilosec® capsules) are referenced in the current NDA. In the efficacy (Study 251) and pharmacokinetics/ pharmacodynamics (Study 250) studies, patients aged 0-2 years were dosed with a suspension of omeprazole granules of Prilosec® capsule in 8.4% NaHCO<sub>3</sub> (2mg omeprazole/ml). To this NDA, a relative bioavailability study (Study D9586C00002) was submitted to bridge the clinical and to-be-marketed formulations.

**Bioavailability comparison (Study D9586C00002):**

A three-way cross-over study, which compared the oral bioavailabilities (BA) of three formulations, is submitted to this NDA. The three formulations compared are Prilosec® capsule (Omeprazole 20mg with 200 ml water), the clinical formulation (oral suspension of Prilosec® capsule granules containing 20 mg omeprazole in 10 ml 8.4% NaHCO<sub>3</sub> followed by an intake of 190 ml water), and the to-be-marketed formulation containing 20mg omeprazole (in 30 ml water followed by an intake of 170 ml water). The dose regimen was 20-mg of omeprazole given once daily for 5 days. The Prilosec® capsule and clinical formulation contained omeprazole while the to-be-marketed formulation contains omeprazole magnesium. The mean PK parameters for the three formulations on Day 1 are presented in Table 1. Higher concentrations were observed on Day 5 for all formulations (see individual study review).

**Table 1. Estimated geometric means and 90% CIs of AUC<sub>∞</sub>, C<sub>max</sub>, and AUC<sub>t</sub> from the day 1 dose in healthy adults**

Variable	Treatment	N	Estimate	90% CI	
				Lower	Upper
AUC (ng·h/mL)	Sachet	19	348	266	456
	Suspension	24	388	298	506
	Capsule	20	400	305	523
C <sub>max</sub> (ng/mL)	Sachet	23	190	150	240
	Suspension	24	392	310	496
	Capsule	24	215	170	271
AUC <sub>t</sub> (ng·h/mL)	Sachet	23	323	245	425
	Suspension	24	374	285	492
	Capsule	24	359	273	472

Note: Sachet: the to-be-marketed formulation (granules from OTC tablet suspended in water); clinical formulation: capsule granules suspended in 8.4% sodium bicarbonate solution; and capsule: whole capsule (administered with water).

T<sub>1/2</sub> was 0.71-0.84 hr for all formulations while t<sub>max</sub> was 0.39 hr for 20 mg clinical formulation, 1.72hr for capsule, and 2.14 hr for the to-be-marketed formulation.

Comparisons (ratios) of Day-1 PK parameters between formulations are shown in Table 2. Although higher concentrations were observed on Day 5, similar trend between formulations was observed using the Day 5 data.

Table 2. Comparison of single dose PK Parameters (Day 1 data from 5 days of administration)

Parameter	to-be-marketed formulation /clinical formulation	clinical formulation/ whole capsule	to-be-marketed formulation / whole capsules
	Ratio (90% CI)	Ratio (90% CI)	Ratio (90% CI)
AUC <sub>∞</sub> (ng*h/ml)	0.896 (77.9%-103.1%)	0.971 (84.6%-111.5%)	0.871 (75%-101.0%)
AUC <sub>0-t</sub> (ng*h/ml)	0.863 (75.2%-99.1%)	1.043 (91.1%-119.4%)	0.901 (78.5%-103.3%)
C <sub>max</sub> (ng /ml)	0.484 (39.9%-58.6%)	1.827 (151.2%-220.8%)	0.884 (72.9%-107.1%)

The results showed that the to-be-marketed formulation was not bioequivalent to the clinical formulation (Table 2). The AUC<sub>∞</sub> of the to-be-marketed formulation was lower than that of the clinical formulation, and the 90% CI of the geometric mean ratio of AUC (77.9%-103.1%) lied outside the range 80%-125% (bioequivalence acceptance criteria). The C<sub>max</sub> value of the to-be-marketed formulation was much lower (ratio: 0.484) than that of the clinical formulation with the 90% CI of the geometric mean ratio being 39.9%-58.6%. It should be noted that the C<sub>max</sub> ratio of the to-be-marketed formulation versus capsule was 0.884 with the 90% CI of the geometric mean ratio being 72.9%-107.1%.

A discussion with the clinical division revealed that dosing with sodium bicarbonate in children aged 0-2 years is undesirable because of safety concerns. Additional studies comparing the to-be-marketed and clinical formulations using sodium bicarbonate in administering omeprazole for both formulations was thus not pursued. After OCP internal discussions, the results of the bridging study are considered acceptable based on the following reasons.

- Study D9586C00002: Sodium bicarbonate was used in administering the clinical formulation while water was used in administering the to-be-marketed formulation and whole capsules. The presence of sodium bicarbonate facilitated dissolution and absorption of omeprazole, thereby causing a higher C<sub>max</sub> and shorter T<sub>max</sub> for the clinical formulation compared to the to-be-market formulation and whole capsules.

- Study I-678: The granules of approved capsule sprinkled in juice or yogurt, but not in sodium bicarbonate, was effective in treating GERD in children aged 0-16. Although there were few patients younger than 2 years old in this study, the study demonstrated that capsule granules without sodium bicarbonate was efficacious in treating children with GERD. As such, the much higher C<sub>max</sub> observed with the clinical formulation was not essential for the efficacy.
- Literature: Omeprazole inhibits gastric acid secretion via a non-competitive antagonism of the H<sup>+</sup>/K<sup>+</sup>-ATPase (proton pump) in the parietal cell secretory membrane through the formation of an irreversible linkage of a disulfide bond with the proton pump. Suppression of acid secretion was associated with the AUC of omeprazole (Clin Pharmacokinet 20 (1): 38-49. 1991), which could be described by an E<sub>max</sub> model. There was no correlation between the temporal concentrations and pharmacodynamic effect.
- Study D9586C00002 shows the following:  
The mean single-dose AUC of the to-be-marketed formulation was comparable to those of the clinical formulation. The mean AUC, C<sub>max</sub> and t<sub>max</sub> of the to-be-marketed formulation were comparable to those of the approved capsules.

Based on the above discussion, the results of the study submitted to this NDA are considered acceptable for the fulfillment of the Phase IV commitment.

**Food effect:** In the May-2-2007 amendment in response to our April-23-2007 request for the food effect pharmacokinetic data, the sponsor indicated that the to-be-marketed formulation are only to be administered before meals, which is the same as that indicated in the labeling of Prilosec® capsules. Therefore, a food effect study was not conducted. In the approved NDA 19-810 labeling, no food effect or study is mentioned. After internal discussions, it is concluded that the sponsor's response is acceptable.

**DSI report:** The DSI report cited several analytical deficiencies at analytical CRO site [REDACTED]. The majority were documentation deficiencies. There are two major issues identified: light protection during analytical procedure and no stability raw data for omeprazole including long-term, bench top, and freeze thaw stability data. Upon our request, the sponsor satisfactorily addressed the issues.

## 2 Question Based Review

### 2.1 General Attributes

#### 2.1.1 What are the components and composition of Prilosec® Delayed-Release Granules for Oral Suspension?

Prilosec® (omeprazole magnesium) for delayed-release oral suspension was developed for children aged 0-24 months. The proposed formulation contains two types of granules, granules containing omeprazole magnesium and excipient granules. The active granules containing omeprazole magnesium are the same as those used in manufacturing the Prilosec® OTC tablets, 20 mg (NDA 21-229).

Table 3. components and composition of Prilosec® Delayed-Release Granules for Oral Suspension

Components (name according to AstraZeneca)	Quantity (mg/sachet)		Function	Standard
	2.5 mg strength	10 mg strength		
Omeprazole pellets <sup>a</sup>				
Omeprazole (corresponding to omeprazole magnesium <sup>b</sup> )	2.5	10	Active substance	AstraZeneca
Glyceryl monostearate				
Hydroxypropyl cellulose				
Hydroxypropyl methylcellulose				
Magnesium stearate				
Methacrylic acid copolymer type C				
Polysorbate				
Sugar spheres,				
Talc				
Triethyl citrate				
Weight of omeprazole pellets				

### 2.1.2 What is the proposed indication of Prilosec® Granules for Delayed-Release Oral Suspension?

[redacted] treatment of gastroesophageal reflux disease (GERD), [redacted] healing of erosive esophagitis. The proposed daily dose by body weight for pediatric patients [redacted] 5 mg for 5 to <10 kg, 10 mg for 10 to <20 kg, and 20 mg for  $\geq 20$  kg.

### 2.1.3 What is the proposed mechanism of action of Prilosec?

Omeprazole inhibits gastric acid secretion via a selective and [redacted] antagonism of the H<sup>+</sup>/K<sup>+</sup>-ATPase (proton pump) in the parietal cell secretory membrane. [redacted].

### 2.1.4 What is the exposure-response relationship for omeprazole?

For the response/exposure relationship of omeprazole, there are several publications suggesting that the AUC correlated with pharmacodynamic responses. The data presented in figures 1-4 were taken from Gut, 1983, 24, 270-276. The C<sub>max</sub> after oral administration occurred less than 1 hr (Fig 1); however, the inhibitory effect of omeprazole on intravenous pentagastrin-induced acid secretion lasted for more than 4 hrs (Fig 2).

As shown in Figure 3, studies of different doses of omeprazole and inhibition of acid secretion showed that the response/exposure relationship followed an E<sub>max</sub> model of Hill function with  $\gamma \sim 1$ . The exposure examined was AUC. Figure 4 showed that single dose was not enough for, but continued exposure to omeprazole from multiple doses is needed for, achieving the maximal efficacy. In another study, a sigmoid relationship was observed between the response and dose (Fig. 5). Similar observation was made for lansoprazole (Ref 4).

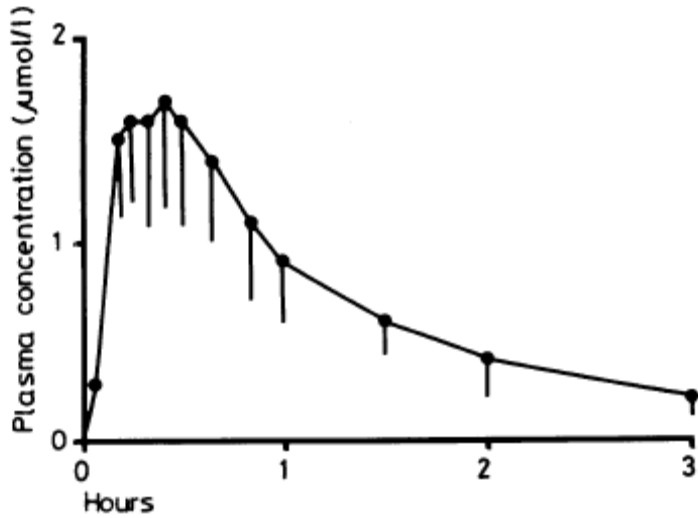


Figure 1. Plasma concentrations of omeprazole in six healthy subjects given 40 mg orally. Values are mean  $\pm$  1 SEM. During the second hour after omeprazole administration the acid response was reduced by  $51\pm 9\%$  and  $86\pm 4\%$  respectively, with the 20 and 40 mg doses

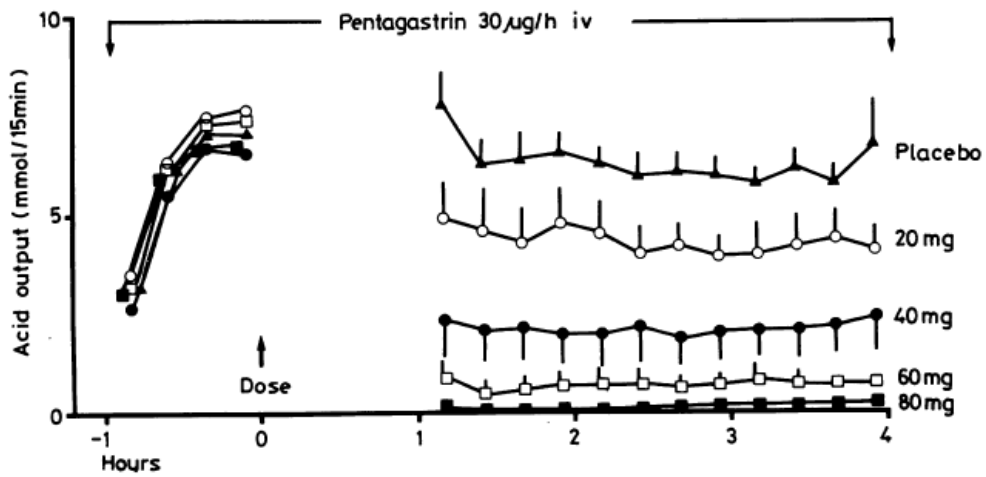


Figure 2. Effect of oral omeprazole on pentagastrin induced acid secretion in six healthy subjects. Values are mean  $\pm$  1 SEM.



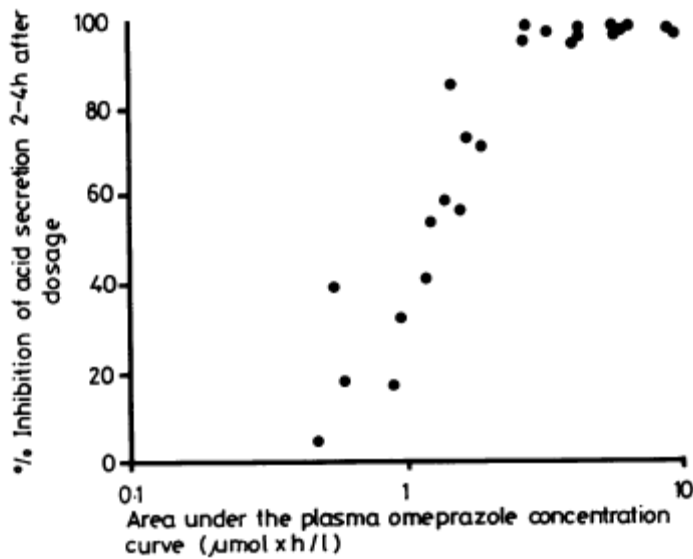


Figure 3. Relationship between percent inhibition of pentagastrin (30  $\mu\text{g/lh}$  intravenously) induced acid secretion during the second to fourth hour after drug administration and the area under the plasma omeprazole concentration-time curve. Correlation coefficient = 0.93,  $p < 0.001$ ,  $n = 24$ . Ref: Gut, 1983, 24, 270-276

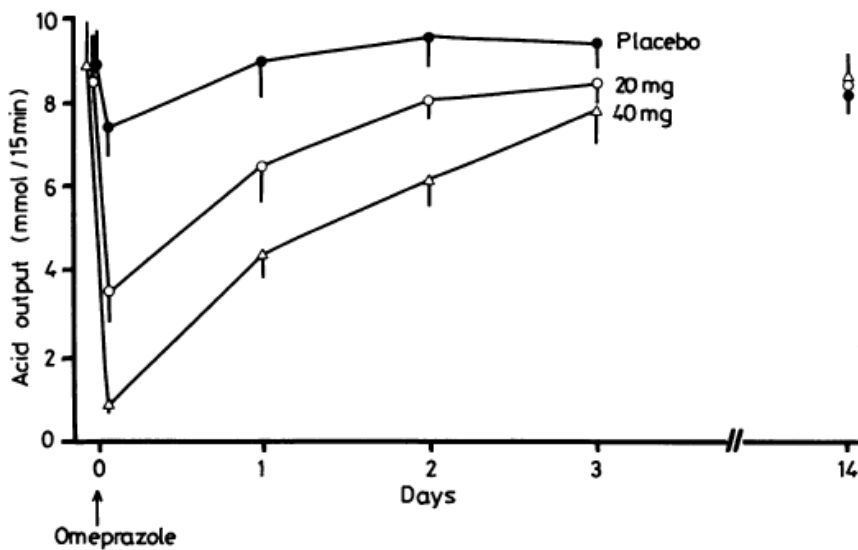


Figure 4. Duration of action of two different single oral doses of omeprazole in six healthy subjects estimated by repeated measurements of maximal responses to the one hr infusion of 91  $\mu\text{g}$  pentagastrin. Values are mean  $\pm$  1 SEM.

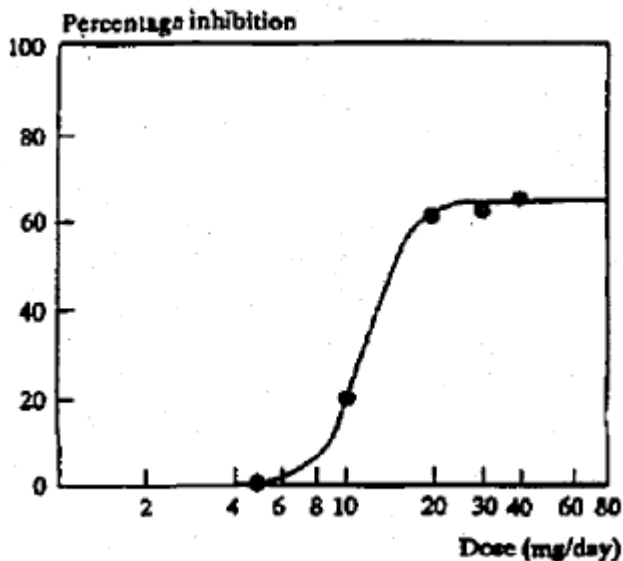


Figure 5 The dose-response curve for repeated once daily intravenous omeprazole (Lind et al. 1986). This was taken from (Clin Pharmacol Biopharm Review of 21-229 by Suliman I. Al-Fayoumi for the submissions dated 1/28/2000, 8/16/2000 and 11/1/2000) (Scand J Gastroenterol. 1986 Oct;21(8):1004-10; Scand J Gastroenterol Suppl. 1986;118:105-7.)

**Reviewer's comments:** The results published in Gut, 1983, 24, 270-276 are consistent with the report by Tolman et al (J Clin Gastroenterol 24(2): 65-70, 1997) in that the AUC of omeprazole correlated with the percent of inhibition on acid secretion and the mean 24-hr gastric pH. The maximal inhibition (66%) of gastric acid secretion occurred approximately 6 hrs after a single oral dose (30 mg) of encapsulated enteric-coated granules of omeprazole (ref 1). After one-week administration of daily 30 mg, the basal acid output was 100% inhibited. Omeprazole had a mean tmax of approximately 1.7 hrs after oral administration of omeprazole capsules, a half-life of 0.7-0.8 hrs, and AUC profiles close to completion approximately 6-7 hours after oral administration.

### 2.1.5 What are the proposed dosage and route of administration?

The product is available in 2 strengths of omeprazole, 2.5 mg and 10 mg, for oral suspension. The total contents of a proposed dose, is added to water to form a viscous suspension prior to use. For reconstitution of the 2.5 mg strength 5 mL of water is used and for the 10 mg strength 15 mL of water is used. The proposed daily dose by body weight is 2.5 mg for 2.5 to 5 kg, 5 mg for 5 to 10 kg, 10 mg for 10 to 20 kg, and 20 mg for > 20 kg.

## 2.1.6 What is the regulatory background?

A. The FDA issued a PWR for Prilosec on July 1, 1999. The key points stated in the PWR are single and multiple dose studies in the pediatric population ages 0-24 months, as listed below.

1. PK, PD and safety study in at least 80 patients of both sexes with symptomatic and/or endoscopically proven GERD.
2. Clinical outcome and safety evaluation of at least 80 patients of both sexes with symptomatic and/or endoscopically proven GERD.

B. In response to the PWR, the firm submitted NDA 19-810/S-074.

\* NDA 19-810/S-74 for the pediatric labeling for the age range of 0-16 years was submitted Dec. 22, 2000 (based on the Written Request for pediatric studies issued by FDA). The 6-month exclusivity was granted in May 2001.

\* The formulation submitted to NDA 19-810 was Prilosec delayed-release capsules. The clinical efficacy studies submitted to NDA 19-810/S-074 employed dosing methods of sprinkling the clinical formulation on the yogurt, or suspending clinical formulation in sodium bicarbonate or in juice.

\* The supplement was found approvable on Oct 22, 2001.

\* NDA 19-810 was only approved for children aged 2-16 years. The approval of 19-810/S-74 included a Phase IV commitment. For the Phase IV Commitment, the sponsor was committed to the development of an age-appropriate formulation of Prilosec for patients 0-2 years of age. The Agency recommends that for this pediatric formulation the enteric coating of the granules remain intact before oral drug administration.

\* In response to the Agency's request, the sponsor submitted a commitment statement on April 12, 2001. This formed the basis of this NDA (22-056) submission.

## 2.2 General Clinical Pharmacology

### 2.2.1 What efficacy and pharmacokinetic studies related to the pediatric population aged 0-24 months were submitted to NDA 19-810?

The pharmacokinetic, efficacy and safety studies of omeprazole magnesium for children aged 0 to 2 years, which were submitted to NDA 19810/S-074, and the administration methods used in these studies, are listed below:

1. Study 251, "A multicenter, randomized, single-blind study to evaluate omeprazole for the treatment of clinically diagnosed GERD in pediatric population aged 0 months through 24 months, inclusive." In this study, the clinical formulation was the granules of Prilosec® delayed release capsule suspended in 8.4% sodium bicarbonate solution. Three doses of 0.5 mg/kg, 1 mg/kg, and 1.5 mg/kg of omeprazole were administered in 8.4% sodium bicarbonate (2 mg/ml solution). N=79.
2. Study 292, "A multicenter, retrospective study to evaluate the effect of multiple doses of omeprazole on gastric or esophageal pH in a pediatric population (aged 0 months to 24 months)." It is not clear how omeprazole granules were administered in this study based on the previous review by Dr. Scheldon Kress. N=43.
3. Study I-678, "Omeprazole in children with reflux esophagitis-an open-dose finding study and an evaluation of the safety and efficacy during maintenance treatment (Ages 1 through 16)." There were only 2 patients younger than 2 years old. Omeprazole was given as intact capsule, or in fruit juice or yogurt (or by gastrostomy tube where necessary). The normalized median dose was 1 mg/kg (1.3 mg/kg, 1.1 mg/kg and 0.7 mg/kg) and total daily dose ranged from 7.5 mg to 80 mg.
4. Study 250, "Pharmacokinetic and pH assessment study to evaluate single and multiple doses of omeprazole in a pediatric population ages 0-24 months, inclusive." Three doses of 0.5 mg/kg, 1 mg/kg, and 1.5 mg/kg of omeprazole were administered by suspending the granules of Prilosec delayed release capsule in 8.4% sodium bicarbonate solution (clinical formulation). Twenty five subjects participated in the study.

### **2.2.2 What are the design features of the submitted study used to support the fulfillment of Phase IV commitments?**

The Phase IV commitment states that "Commitment to the development of an age-appropriate formulation of Prilosec for pediatric patients 0-2 years of age." The Agency recommended that this pediatric formulation be one in which the enteric coating of the granules remains intact before oral drug administration.

Based on the fact that the Phase IV commitment did not require a bioequivalence study, a relative bioavailability study is deemed acceptable.

The design features of the submitted study are described below.

In the bridging study, there were two differences between the clinical and to-be-marketed formulations: the media used in omeprazole administration and the salt form of omeprazole. The clinical formulation of omeprazole 20 mg was administered in 10 ml 8.4% NaHCO<sub>3</sub> followed by an intake of 190 ml water while the to-be-marketed formulation of omeprazole 20 mg was administered in 30 ml water followed by an intake of 170 ml water. Note that in the pivotal clinical study in patients aged 0-2 years (Study 251), the clinical formulation was administered by suspending Prilosec capsule granules in 10 ml 8.4% NaHCO<sub>3</sub> (2 mg/ml). The other difference was that the to-be-marketed formulation contained omeprazole magnesium while the clinical formulation contained omeprazole.

The submitted study is an open-label, randomized, three-way crossover bioavailability study in which healthy male and female subjects under fasting conditions received 5 days of repeated doses of omeprazole 20mg, either in to-be-marketed formulation, clinical formulation or approved Prilosec delayed release capsule (NDA 19-810/S-74).

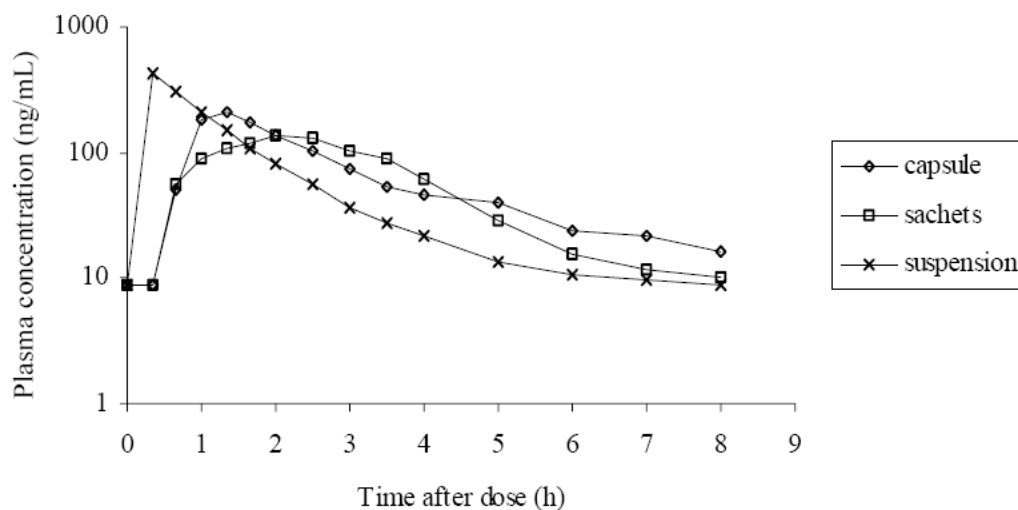
Days 1 and 5: The subjects arrived at the study site in the morning of study days 1 and 5 in each treatment period. They were instructed to abstain from all food and liquid from 22:00 pm on the evening before. On study days 1 and 5, blood samples for pharmacokinetic assessment were collected before and at selected intervals over 8 hours after intake of the investigational products.

Days 2, 3, and 4: The subjects arrived fasting at the study site in the morning of study days 2, 3, and 4 in each treatment period. They were instructed to abstain from all food and liquid during 4 hours before administration of the investigational product on study days 2, 3, and 4. The washout period between each treatment period was 13 days.

### **2.2.3 What is the relative bioavailability of the to-be-marketed formulation compared to the approved capsule (NDA 19-810) or clinical formulation?**

The clinical formulation consisted of granules of the approved capsule suspended in 8.4% sodium bicarbonate for administration. To-be-marketed formulation and capsules were administered in water. For all three formulations, the total volumes of water used were 200 ml.

Pharmacokinetic results



Note: Sachet: the to-be-marketed formulation (suspended in water), suspension: clinical formulation (suspended in a sod. bicarbonate solution), and capsule: whole capsule (administered with water).

Table 4. The relative bioavailability of the to-be-marketed formulation as compared to the clinical formulation and capsule.

	AUCt (ng *h/ml)	Bioavailability (%) relative to clinical formulation	Bioavailability (%) relative to capsule	N
to-be-marketed	323	90%	90%	19
clinical formulation	374	100%		24
Capsule	359		100%	20

**Table 5. Comparison of the PK parameters between the to-be-marketed and clinical formulations.**

	N	Point Estimate	90% CI
AUC <sub>∞</sub> (ng * h/ml)	19/24	0.896	77.9%-103.1%
C <sub>max</sub> (ng/ml)	23/24	0.484	39.9%-58.6%
AUCt(ng * h/ml)	23/24	0.863	75.2%-99.1%

The pivotal efficacy study (study 251) was performed in the age group of 0-24 months and clinical formulations were administered in 8.4% sodium bicarbonate at the dose of 0.5 mg/kg, 1 mg/kg, or 1.5 mg/kg. Based on the 90% CI of bioequivalence (BE) acceptance criteria of 80%-125%, the to-be-marketed formulation are not bioequivalent to clinical formulation considering both C<sub>max</sub> and AUC.

Plasma concentrations on Day 5 were higher than those on Day 1 for all formulations. This is consistent with the findings in previous studies. The relative bioavailability on Day 5 was similar to that observed on Day 1.

**Reviewer's comments:** The results demonstrated that the to-be-marketed formulation administered in water were not bioequivalent to the clinical formulation administered in sodium bicarbonate. Sodium bicarbonate likely dissolved the delayed-release coating of granules and protected omeprazole from degradation by gastric acid, resulting in much higher C<sub>max</sub>.

In addition, the approved capsule formulation had a comparable C<sub>max</sub> with the proposed granule formulation. The AUC ratio of the to-be-marketed formulation versus clinical formulation was 0.863 with the 90% CI close to the bioequivalence acceptance criteria. It is concluded that the to-be-marketed versus clinical formulations showed comparable systemic exposures of omeprazole based on the followings:

- Study D9586C00002: Sodium bicarbonate was used in administering the clinical formulation while water was used in administering the to-be-marketed formulation and whole capsules. The presence of sodium bicarbonate facilitated dissolution and absorption of omeprazole, thereby causing a higher C<sub>max</sub> and shorter T<sub>max</sub> for the clinical formulation compared to the to-be-market formulation and whole capsules.
- Study I-678: The granules of approved capsule sprinkled in juice or yogurt, but not in sodium bicarbonate, was effective in treating GERD in children aged 0-16. Although there were few patients younger than 2 years old in this study, the study demonstrated that capsule granules without sodium bicarbonate was efficacious in treating children with GERD. As such, the much higher C<sub>max</sub> observed with the clinical formulation was not essential for the efficacy.
- Literature: Omeprazole inhibits gastric acid secretion via a non-competitive antagonism of the H<sup>+</sup>/K<sup>+</sup>-ATPase (proton pump) in the parietal cell secretory membrane through the formation of an irreversible linkage of a disulfide bond with the proton pump. Suppression of acid secretion was associated with the AUC of omeprazole (Clin Pharmacokinet 20 (1): 38-49. 1991), which could be described by an E<sub>max</sub> model. There was no correlation between the temporal concentrations and pharmacodynamic effect.
- Study D9586C00002 shows the following:  
The mean single-dose AUC of the to-be-marketed formulation was comparable to those of the clinical formulation. The mean AUC, C<sub>max</sub> and t<sub>max</sub> of the to-be-marketed formulation were comparable to those of the approved capsules.

**2.2.4 What were the previous review conclusions of the pivotal efficacy studies (study 250 and study 251) for the age group submitted to this NDA?**

The following comments are taken from Dr. Kress's review (Sheldon Kress is an MO).

Study 250: "An increased exposure to omeprazole for a few patients under 5 months, while patients over 5 months have exposure levels that are consistent across ages. According to Dr. Kress's review, there was 1 patient less than 5 month old. The analysis of pH indicates that a single dose of omeprazole reduces esophageal acid exposure and increases gastric pH in pediatric patients. All doses were safely administered and well tolerated in this pediatric population."

Study 251:"It can be concluded that omeprazole administered as a bicarbonate suspension effectively reduced the number by approximately 50% and the intensity of vomiting/regurgitation episodes as well as the intensity of pain-related GERD symptoms."

**2.2.5 What were the previous review conclusions of the pharmacokinetic and pharmacodynamic (study 250) for the age group submitted to this NDA?**

The information below was taken from Dr. Suliman I. Al-Fayoumi's review for NDA: 19-810 / SE5-074, which was submitted Jan 15, 2002.



Table 1. Estimates of the geometric means of the primary PK parameters for omeprazole in pediatrics

Omeprazole Dose	PK Parameter	Geometric Mean (95% CI)
1.0 mg/kg	C <sub>max</sub>	447.6 (253.6-789.9)
	AUC <sub>0-t</sub>	658.0 (340.4-1272.1)
	AUC <sub>0-∞</sub>	1248.5 (569.3-2738.2)
1.5 mg/kg	C <sub>max</sub>	345.6 (137.7-867.4)
	AUC <sub>0-t</sub>	580.7 (274.6-1227.8)
	AUC <sub>0-∞</sub>	827.0 (352.3-1941.6)

Table 2. Estimates of the means of the primary PD Parameter (Mean change in %time pH < 4 after dosing) for omeprazole in pediatrics

Omeprazole Dose	PK Parameter	Mean PD (S.D.)
1.0 mg/kg	Esophageal pH	-2.1 (4.5)
	Gastric pH	-21.8 (18.8)
1.5 mg/kg	Esophageal pH	-6.4 (10.6)
	Gastric pH	-11.9 (10.5)

In study 250, higher mean PK (C<sub>max</sub> and AUC) and PD (mean change in % time gastric pH < 4) values were observed at the 1.0 mg/kg dose relative to the 1.5 mg/kg dose. The sponsor was requested to address the issues raised by reviewer Dr. Suliman I. Al-Fayoumi.. In Dr. Al-Fayoumi's review of the sponsor's response, it was concluded that "the sponsor's responses to Agency's Clinical Pharmacology & Biopharmaceutics-related comments to supplement SE8-074 to NDA 19-810 have been reviewed by the Office of Clinical Pharmacology and Biopharmaceutics and have been found to be acceptable."

### **2.3 Intrinsic Factors**

Omeprazole is extensively metabolized by CYP2C19 and CYP3A4 in the liver. The absolute bioavailability of omeprazole increases with repeated dosing in children due to a combination of decreased first-pass elimination and reduced systemic clearance (Clin Pharmacokinet 44(5):441-66, 2005). Genetic polymorphism of CYP enzymes will influence the exposure, and consequently pharmacologic response of omeprazole. For example, poor metabolizers of CYP 2C19 reportedly had several fold higher area under curve (AUC) than extensive metabolizers. Furthermore, diseases or genetic defects that affect CYP enzyme activities will likely impact the exposure and response of omeprazole.

### **2.4 General Biopharmaceutics**

#### **2.4.1 Is the proposed formulation identical to the one used for the pivotal efficacy study (study 251)?**

No. The formulation of this NDA is different from the clinical formulation used for the pivotal efficacy study (study 251) in that the granule size of to-be-marketed formulation is smaller and that the clinical formulation contained omeprazole while the to-be-marketed formulation omeprazole magnesium. The granules of the to-be-marketed formulations are the same as those used for manufacturing the Prilosec OTC tablets.

### **2.5 Analytical Section**

#### **2.5.1 What analytical methods were used to assess concentrations?**



Mean accuracy (Mean Dev.%) for the calibration samples was within the range of -2.6% and 2.6%, and CV% was within the range of 1.3% and 3.9%. The correlation coefficients (r<sup>2</sup>) of the standard curves were between 0.9991 and 1.0. The percent deviation from the nominal value (= mean accuracy) was determined for each quality control pool. The percent deviations were -4.4%, -1.4% and -0.7% for QC L(50 nmole/L), QC M (500 nmole/L), and QC H (1.5E<sup>+3</sup> nmole/L) , respectively.

## 2.6.2 Are the analytical assay methods adequately validated?

Yes. The linearity of the assay method was shown in the concentration range of . Intra-assay precision was evaluated for each quality control pool. The theoretical plasma concentrations of omeprazole in the quality control pools were 50, 500 and 1500 nmol/L and the intra-assay coefficients of variation were 2.4%, 0.71% and 0.64%, respectively. Inter-assay precision and accuracy were evaluated for each quality control pool. The theoretical plasma concentrations of omeprazole in the quality control pools were 50, 500 and 1500 nmol/L with the inter-assay coefficients of variation being 2.3%, 1.0% and 0.94%, respectively. The percent difference from theoretical value (= mean accuracy) was -5.7%, -6.7% and -6.8% for QC L(50 nmole/L), M(500 nmole/L) and H ( $1.5E^3$  nmole/L), respectively. In the Aug-29-2007 submission, the sponsor stated that omeprazole was stable at  $-18^{\circ}\text{C}$  for more than 1 year and the validated stability covers the analysis condition in study D9586C00002. Furthermore, the freeze-thaw and bench-top stability raw data demonstrated the sufficient stability of omeprazole during the analytical condition. The analytical assay method was adequately validated.

## 3 Detailed Labeling Recommendations

On page 25 of the annotated labeling, the pharmacokinetic data for children  months in the table, entitled “pharmacokinetic parameters of omeprazole following single and repeated oral administration in pediatric population compared with adults,” should be removed from the table.

The following statement should be added to section 12.3 Pharmacokinetics:  
Based on a relative bioavailability study, the AUC and C<sub>max</sub> of Prilosec (omeprazole magnesium) for Delayed-Release Oral Suspension were 87% and 88% of those for Prilosec Delayed-Release Capsules, respectively.



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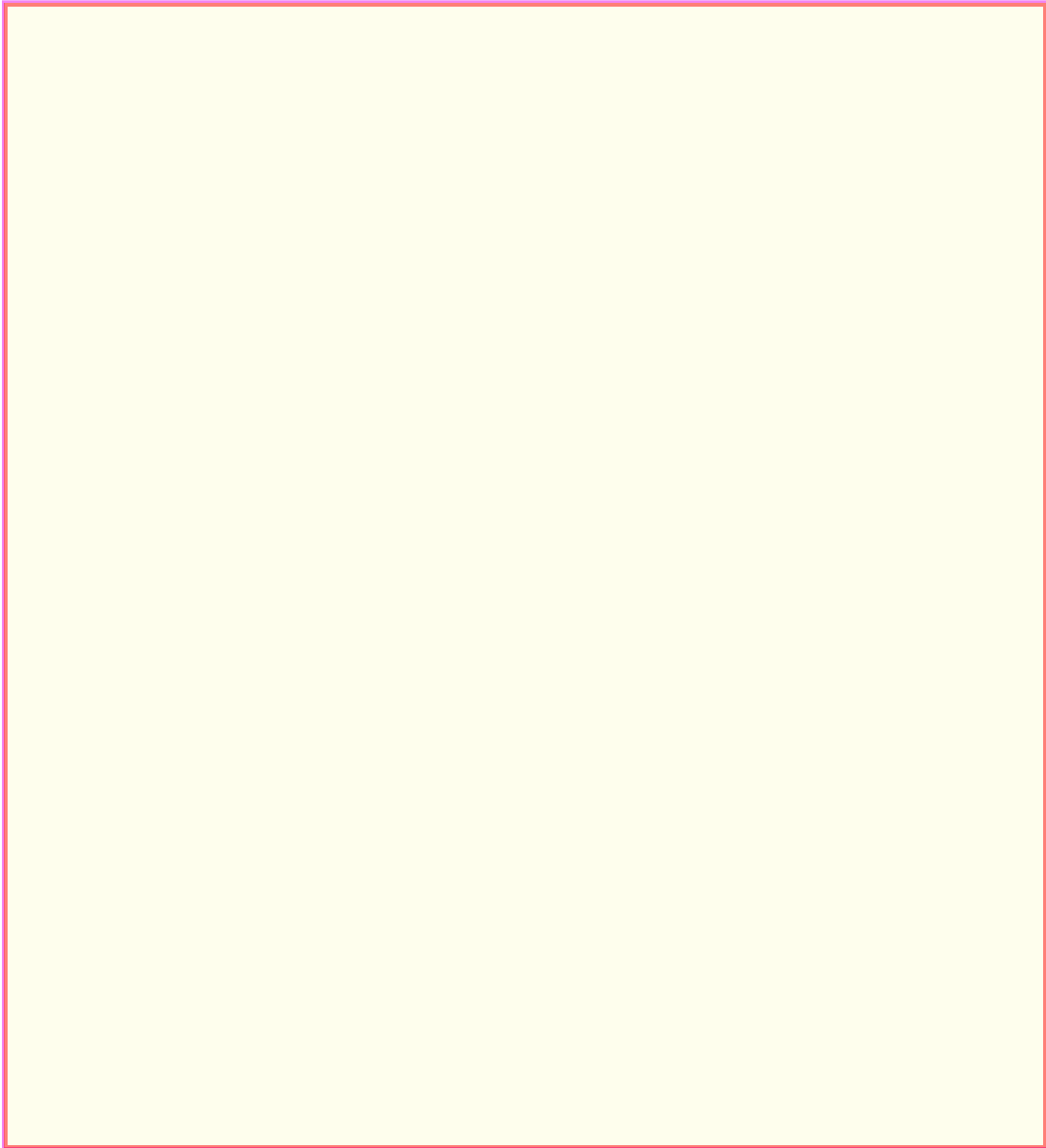


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#### 4.2 DSI report and individual Study Reviews

(Please see appendix 4.2.1, page 58)

#### 4.3 Cover sheet and OCP Filing/Review Form (Please see appendix 4.3.1, page 67)

#### 4.4 Attendees at my briefing which took place on Oct 3, 2007 (11:30 am to 12:30 pm) in room 4560, Building 21: Drs. Wen-Yi Gao (MO), Caryn Berry (MO), Hugo Gallo Torres (MO, Team Leader, GI), Hae Young Ahn (Deputy

Director, Division III, OCP), Sue-Chih Lee (Team Leader, Division III, OCP), Insook Kim, Tayo Fadiran.

#### Appendix 4.2.1

#### **Comments on DSI report**

The DSI report cited several analytical deficiencies at analytical CRO ( ). The majority were documentation deficiencies. There are two major issues identified: Light protection during analytical procedure and no stability raw data for omeprazole including long-term, bench top, and freeze thaw stability data.

#### Light sensitivity

After consulting with chemist, Maria Ysern, the concern of light sensitivity during the short-term analytical work is dismissed. It is suggested that the sponsor submit stability data cited above for review and the NDA approval is contingent upon satisfactory review of stability data validation.

The reviewer consulted with chemist Maria Ysern via the Aug-15-2007 e-mail. She commented that light sensitivity during the short-term analytical work would not cause any major concerns. Maria's e-mail is attached below.

#### No raw stability data

The OCP requested the following information from the sponsor in a letter dated Aug 21, 2007.

1. Stability report (stability raw data for omeprazole) from the sponsor (not ), which includes long-term stability, freeze thaw and bench top stability data. A statement from the sponsor to indicate that the stability conditions validated cover the actual analysis conditions was also requested.



### **Individual Study Review**

To this NDA, the firm submitted a three way cross-over study (D9586C00002) comparing bioavailabilities of three formulations of omeprazole 20 mg (to-be-marketed formulation, capsule (19810/S-074), clinical formulation (granules from NDA 19810 capsule). The pellets of the to-be-marketed formulation are smaller than those of Prilosec capsule (NDA 19810) and the clinical formulation, but the same as those used for manufacturing the Prilosec OTC delayed release tablet (omeprazole 20 mg, NDA 21-229).

In this portion of my review, the sponsor's terminology is used. Therefore, the to-be-marketed formulation, clinical formulation, and whole capsules used in the

QBR are named sachet granules, suspension granules, and capsules, respectively, in this section.

**Study D9586C00002-A** phase I, open, randomized, three-way cross-over, single-centre bioavailability study comparing three different formulations of omeprazole 20 mg following single and 5 days repeated once daily oral administration in healthy male and female subjects.

**Objectives:**

1. To compare the relative bioavailability of three different formulations of omeprazole 20 mg; an omeprazole magnesium gastro-resistant granules based proposed formulation, an omeprazole suspension and a commercial PRILOSEC capsule following single oral administration, by assessment of AUC and C<sub>max</sub> on day 1 and following repeated oral administration, by assessment of AUC and C<sub>max</sub> on day 5.
2. To evaluate the pharmacokinetics of three different formulations of omeprazole following single and repeated oral dose administration, by assessment of AUC<sub>t</sub>, T<sub>max</sub> and t<sub>1/2</sub> on days 1 and 5.
3. To study the safety and tolerability of omeprazole.

**Three formulations tested:**

Omeprazole proposed: The proposed consists of omeprazole magnesium gastroresistant granules (same as in LOSEC MUPS/PRILOSEC OTC tablets 20 mg) and excipient granules. Each proposed contains 10 mg omeprazole.

Omeprazole suspension: The granules of the omeprazole delayed-release capsules 20 mg (PRILOSEC) were dispersed in 8.4% sodium bicarbonate (2 mg omeprazole/mL).

PRILOSEC capsules. Omeprazole delayed-release capsules 20 mg commercialized in the US.

Investigational product	Dosage form and strength	Manufacturer	Formulation number	Batch number
Omeprazole magnesium	Gastro-resistant granules for oral suspension, 10 mg	AstraZeneca AB, Sweden		H 1808-01-01-01
Omeprazole	Delayed-release capsules, 20 mg (PRILOSEC) <sup>a</sup>	Merck & Co, Inc., USA	H 0431-13-07	H 0431-13-07-02

<sup>a</sup> Was also used for the preparation of the omeprazole suspension.

**Study design:** A phase I, open, randomized, three-way cross-over, single-centre bioavailability study in which healthy male and female subjects received 5 days repeated doses of omeprazole 20 mg, either as an omeprazole proposed formulation, an omeprazole suspension or as a commercial PRILOSEC capsule, under fasting conditions.

#### Subject population

Statistic	Age (years)	Height (cm)	Weight (kg)	BMI (kg/m <sup>2</sup> )
Mean	25.7	178.0	71.5	22.5
SD	3.2	8.6	9.0	2.3
Min	22.0	164.0	53.0	19.2
Median	25.0	176.0	70.5	22.2
Max	36.0	193.0	94.0	26.8

<sup>a</sup> Number of subjects who took at least 1 dose of study treatment and had at least 1 data point after dosing.

**Inclusion criteria:** 1. Provision of informed consent, healthy subjects aged 20 to 50 years and weighed 50-95 kg with negative findings of hepatitis B and C and HIV.

**Exclusion criteria:** pregnancy or lactation, clinical illness, history of diseases including metal and allergic diseases, alcohol and drug abuse, moderate to heavy smoking, use of any prescription drugs, use of over-the-counter drugs (including herbals, vitamins and minerals).

Twenty-four (24) subjects were randomized (16 males and 8 females), and twenty-two (22) subjects (15 males and 7 females) completed the study.

Oral doses of three formulations were given once daily in three treatment periods. Each treatment period consisted of 5 days, and was separated by a washout period of at least 13 days. Granules of two omeprazole proposeds were administered in 30 ml water followed by 170 ml of water. The capsules were swallowed whole orally with 200 ml of water. Omeprazole suspension was administered in 10 ml 8.4% sodium bicarbonate solution (2 mg omeprazole/mL) followed by 190 ml of water.

#### *Study days 1 and 5 in each treatment period*

The subjects arrived fasting at the study site in the morning of study days 1 and 5 in each treatment period. They were instructed to abstain from all food and liquid (except from water which was allowed until 1 hour before administration of the investigational products) from 22.00 on the evening before.

#### *Study days 2, 3 and 4 in each treatment period*

The subjects arrived fasting at the study site in the morning of study days 2, 3 and 4 in each treatment period. They were instructed to abstain from all food and liquid during 4 hours

before administration of the investigational product on study days 2, 3 and 4. On these study days the subjects were not be allowed to eat breakfast until 1 hour after dose intake.

*Blood samplings:* Pre-dose, 0.33, 0.67, 1, 1.33, 1.67, 2, 2.5, 3, 3.5, 4, 5, 6, 7, 8.

*Concomitant treatment(s) not allowed to avoid drug-drug interactions:* Prescribed medications, except for contraceptives, are not allowed within the two weeks before the first dose or during the study. No OTC drugs (including vitamins, herbals and minerals) were permitted during the week before the first dose or during the study.

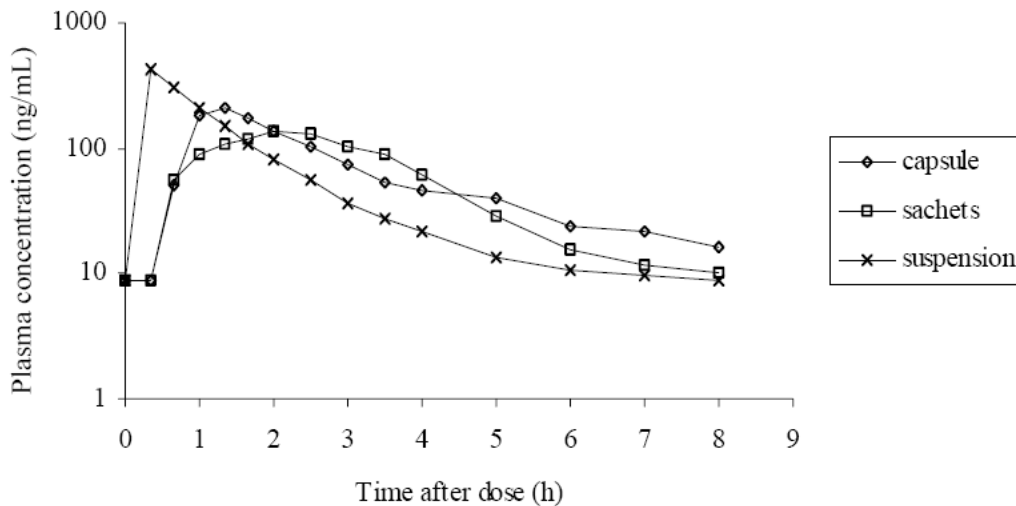
Samples for determination of omeprazole in plasma were analyzed at [redacted], [redacted], [redacted], [redacted], [redacted]. The lower limit of

quantification (LOQ) of omeprazole was 25 nmol/L. The bioanalytical results are presented in the bioanalytical study validation report 41312-0873. The method validation is documented in the report PMC-9441. The plasma samples in this study will be destroyed after approval.

## **Results**

### *Single dose*

Day 1: N=23 for proposed, 24 for capsule, and 24 for suspension



Estimated geometric means and 90% CIs of AUC, C<sub>max</sub> and AUC<sub>t</sub> on day 1 of 5 days single oral dosing of 3 different formulations of omeprazole 20 mg, in healthy male and females

Variable	Treatment	N	Estimate	90% CI	
				Lower	Upper
AUC (ng·h/mL)	Sachet	19	348	266	456
	Suspension	24	388	298	506
	Capsule	20	400	305	523
C <sub>max</sub> (ng/mL)	Sachet	23	190	150	240
	Suspension	24	392	310	496
	Capsule	24	215	170	271
AUC <sub>t</sub> (ng·h/mL)	Sachet	23	323	245	425
	Suspension	24	374	285	492
	Capsule	24	359	273	472

Ratios (proposed/suspension and proposed/capsule) of geometric means and 90% CIs for AUC, C<sub>max</sub> and AUC<sub>t</sub> on day 1 of 5 days single oral dosing of 3 different formulations of omeprazole 20 mg, in healthy male and females

Variable	Comparison	N	Estimate	90% CI	
				Lower	Upper
AUC (ng·h/mL)	Sachet/Capsule	19/20	0.871	0.750	1.010
	Sachet/Suspension	19/24	0.896	0.779	1.031
	Suspension/Capsule	24/20	0.971	0.846	1.115
C <sub>max</sub> (ng/mL)	Sachet/Capsule	23/24	0.884	0.729	1.071
	Sachet/Suspension	23/24	0.484	0.399	0.586
	Suspension/Capsule	24/24	1.827	1.512	2.208
AUC <sub>t</sub> (ng·h/mL)	Sachet/Capsule	23/24	0.901	0.785	1.033
	Sachet/Suspension	23/24	0.863	0.752	0.991
	Suspension/Capsule	24/24	1.043	0.911	1.194

Arithmetic means (SD) of t<sub>1/2</sub> were 0.71 (0.32) hr for 20 mg proposed, 0.73 (0.2) hr for 20 mg suspension, and 0.84 (0.42) for 20 mg capsule.

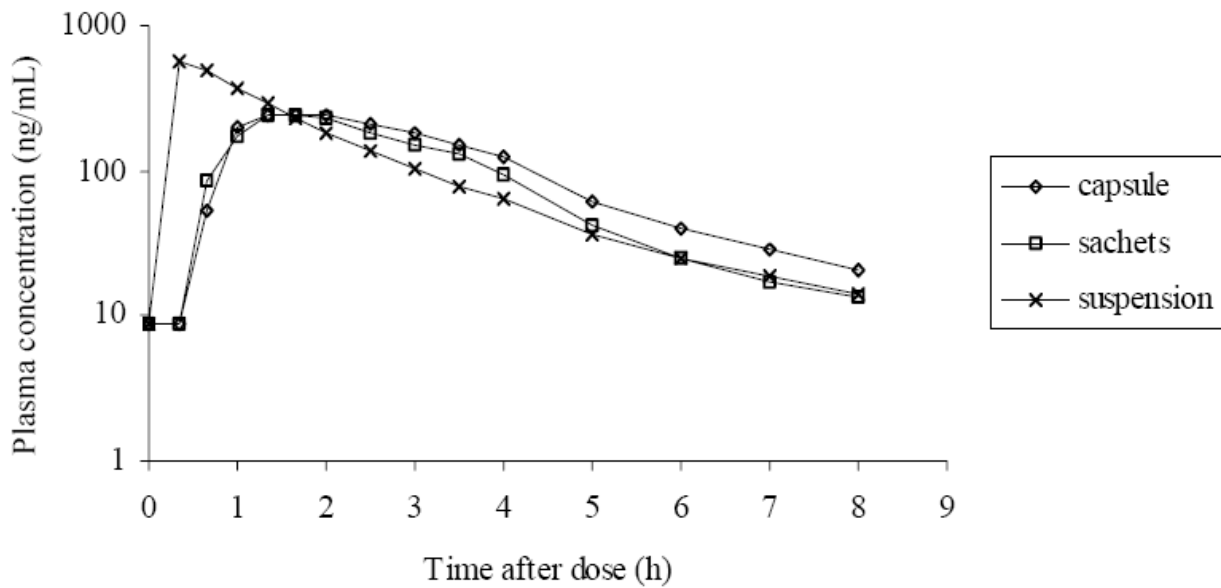
Arithmetic means (SD) of t<sub>max</sub> were 2.14 (1.15) hr for 20 mg proposed, 0.73 (0.2) hr for 20 mg suspension, and 0.84 (0.42) for 20 mg capsule.

**Reviewer's comments:** The pivotal efficacy study for the age group of 0-24 months was study 251 in which omeprazole granules of Prilosec capsules were suspended in 8.4% sodium bicarbonate solution. The to-be-marketed formulation are smaller in size than clinical formulation. Therefore, to justify the use of study 251 for this NDA and meet the requirement for the Phase IV commitment, it is imperative to compare bioavailabilities of proposed and suspension granules. In terms of AUC<sub>t</sub>, the proposed/suspension ratio is closer

to the BE acceptance criteria of 0.9-1.25. The proposed/suspension ratio for C<sub>max</sub> is less than 0.5 and the 90% CI is out the range of 0.8-1.25. Clearly, in term of 90%CI for AUC<sub>t</sub> and C<sub>max</sub>, to-be-marketed formulation administered in water were not bioequivalent to suspension granules administered in sodium bicarbonate.

### Steady state

Day 5: N=22 for proposed, 24 for capsule, and 24 for suspension



Estimated geometric means and 90% CIs of AUC, C<sub>max</sub> and AUC<sub>t</sub> on day day 5 of 5 days single oral dosing of 3 different formulations of omeprazole 20 mg, in healthy male and females

Variable	Treatment	N	Estimate	90% CI	
				Lower	Upper
AUC (ng·h/mL)	Sachet	21	528	377	739
	Suspension	24	649	466	904
	Capsule	22	587	420	820
C <sub>max</sub> (ng/mL)	Sachet	22	302	230	397
	Suspension	24	529	405	690
	Capsule	24	343	263	448
AUC <sub>t</sub> (ng·h/mL)	Sachet	22	499	356	700
	Suspension	24	623	446	871
	Capsule	24	576	413	805



Ratios (proposed/suspension and proposed/capsule) of geometric means and 90% CIs for AUC, C<sub>max</sub> and AUC<sub>t</sub> on day 5 of 5 days single oral dosing of 3 different formulations of omeprazole 20 mg, in healthy male and females

Variable	Comparison	N	Estimate	90% CI	
				Lower	Upper
AUC (ng·h/mL)	Sachet/Capsule	21/22	0.899	0.746	1.084
	Sachet/Suspension	21/24	0.813	0.679	0.974
	Suspension/Capsule	24/22	1.106	0.926	1.320
C <sub>max</sub> (ng/mL)	Sachet/Capsule	22/24	0.880	0.704	1.100
	Sachet/Suspension	22/24	0.571	0.457	0.714
	Suspension/Capsule	24/24	1.540	1.241	1.912
AUC <sub>t</sub> (ng·h/mL)	Sachet/Capsule	22/24	0.867	0.711	1.057
	Sachet/Suspension	22/24	0.801	0.657	0.977
	Suspension/Capsule	24/24	1.082	0.893	1.310

**Conclusion:** As elaborated above, a comparison of proposed and suspension granules in terms of exposure is important to meet the Phase IV commitment. At steady state, the 90% CI for C<sub>max</sub> is well below the range of 0.8-1.25 while that for AUC<sub>t</sub> is closer to the 0.8-1.25 range. Since AUC correlated with the efficacy of PPIs (ref 1-3), to-be-marketed formulation and suspension are deemed comparable in terms of AUC.

#### References:

1. Colin W. Howden, Clinical Pharmacology of Omeprazole, Clin. Pharmacokinet. 20 (1): 38-49. 1991
2. Tore Lind, Christer Cederberg, Gunnar Ekenved, Ulf Haglund, and Lars Olbe. Effect of omeprazole - a gastric proton pump inhibitor on pentagastrin stimulated acid secretion in man Gut, 1983, 24, 270-276
3. Pharmacokinetics of Proton Pump Inhibitors in children. Clin Pharmacokinet. 2005;44(5):441-66. Review
3. The Effects of Oral Doses of Lansoprazole and Omeprazole on Gastric pH. Tolman, Keith G; Sanders, Steven ; Buchi, Kenneth N; Karol, Michael D; Jennings, Dennis E; Ringham, Gary L. J Clin Gastroenterol. 1997 Mar;24(2):65-70.
4. Comparative pharmacokinetic/pharmacodynamic study of proton pump inhibitors, omeprazole and lansoprazole in rats. M Katashima, K. Yamamoto, M. Sugiura, Y. Sawada, and T Iga. Drug Met and Disposition, 23 (7): 718-723, 1995.

5. Inhibition of basal and betazole- and sham-feeding-induced acid secretion by omeprazole in man, Lind T, Cederberg C, Ekenved G, Olbe L, Scand J Gastroenterol. 1986 Oct;21(8):1004-10.

6. Olbe L, Lind T, Cederberg C, Ekenved G., Effect of omeprazole on gastric acid secretion in man. Scand J Gastroenterol Suppl. 1986;118:105-7.

4.3.1. Cover sheet and OCP Filing/Review Form

Office of Clinical Pharmacology <i>New Drug Application Filing and Review Form</i>				
<u>General Information About the Submission</u>				
	Information		Information	
NDA Number	22-056		Brand Name	Prilosec
OCP Division (I, II, III)	III		Generic Name	Omeprazole
Medical Division	Gastroenterology		Drug Class	Proton pump inhibitor
OCP Reviewers	PeiFan Bai		Indication(s)	Gastroesophageal Reflux Disease (GERD)
OCP Team Leader	Sue-Chih Lee		Dosage Form	Delayed release granules for oral suspension
Date of Submission	Dec 20, 2006		Proposed Dosing Regimen	The proposed daily dose by body weight for pediatric patients <input type="text" value="2"/> years of age is <input type="text" value="5 mg for 5 to &lt;10 kg, 10 mg for 10 to &lt;20 kg, and 20 mg for ≥ 20 kg."/> 5 mg for 5 to <10 kg, 10 mg for 10 to <20 kg, and 20 mg for ≥ 20 kg.
Estimated Due Date of OCP Review	Aug 20, 2007		Route of Administration	oral
Medical Division Due Date	Aug 20, 2007		Sponsor	AstraZeneca
PDUFA Due Date	Oct. 20, 2007		Priority Classification	standard
<i>Clin. Pharm. Information</i>				
	"X" if included at filing	Number of studies submitted	Number of studies reviewed	Critical Comments If any
<b>STUDY TYPE</b>				
Table of Contents present and sufficient to locate reports, tables, data, etc.	x			
Tabular Listing of All Human Studies	x			
HPK Summary	x			
Labeling	x			
Reference Bioanalytical and Analytical Methods	x			
<b>I. Clinical Pharmacology</b>				
Mass balance:				
Isozyme characterization:				
Blood/plasma ratio:				
Plasma protein binding:				
Pharmacokinetics (e.g., Phase I) -				

1.	<i>Healthy Volunteers-</i>				
	single dose:	X	1	1	
	multiple dose:	X	1	1	
1.1.	<b>Patients-</b>				
	single dose:				
	multiple dose:				
	<b>Dose proportionality -</b>				
	fasting / non-fasting single dose:				
	fasting / non-fasting multiple dose:				
	<b>Drug-drug interaction studies -</b>				
	In-vivo effects on primary drug:				
	In-vivo effects of primary drug:				
	In-vitro:				
	<b>Subpopulation studies -</b>				
	ethnicity:				
	gender:				
	pediatrics:				
	geriatrics:				
	renal impairment:				
	hepatic impairment:				
	<b>PD:</b>				
	Phase 2:				
	Phase 3:				
	<b>PK/PD:</b>				
	Phase 1 and/or 2, proof of concept:				
	Phase 3 clinical trial:				
	<b>Population Analyses -</b>				
	Data rich:				
	Data sparse:				
	<b>II. Biopharmaceutics</b>				
	<b>Absolute bioavailability:</b>				
	<b>Relative bioavailability -</b>				
	solution as reference:				
	alternate formulation as reference:	X	1	1	
	<b>Bioequivalence studies -</b>				
	traditional design; single / multi dose:				
	replicate design; single / multi dose:				
	<b>Food-drug interaction studies:</b>				
	<b>Dissolution:</b>				
	<b>(IVIVC):</b>				
	<b>Bio-wavier request based on BCS</b>				
	<b>BCS class</b>				
	<b>III. Other CPB Studies</b>				
	<b>Genotype/phenotype studies:</b>				
	<b>Chronopharmacokinetics</b>				
	<b>Pediatric development plan</b>				
	<b>Literature References</b>		6	6	found via PubMed and reviewed by the reviewer
	<b>Total Number of Studies</b>		2	2	
<b>Filability and QBR comments</b>					

	"X" if yes	Comments
Application filable ?	x	Reasons if the application is <u>not</u> filable (or an attachment if applicable) For example, is clinical formulation the same as the to-be-marketed one?
Comments sent to firm	x	Comments have been sent to firm (or attachment included). FDA letter date if applicable.
QBR questions (key issues to be considered)	<ul style="list-style-type: none"> <li>• What is the relative bioavailability of the to-be-marketed formulation compared to the approved capsule (NDA 19-810) or clinical formulation?</li> <li>• What are the design features of the submitted study used to support the fulfillment of Phase IV commitments?</li> </ul>	
Other comments or information not included above		
Primary reviewer Signature and Date	PeiFan Bai, Oct 15, 2007	
Secondary reviewer Signature and Date	Sue-Chih Lee, Oct 15, 2007	

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**This is a representation of an electronic record that was signed electronically and  
this page is the manifestation of the electronic signature.**  
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/s/

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Jane Bai  
10/16/2007 12:43:23 PM  
BIOPHARMACEUTICS

Sue Chih Lee  
10/16/2007 12:54:38 PM  
BIOPHARMACEUTICS