ERLEADA® (apalutamide) tablets

- Fractures occurred in patients receiving ERLEADA. Evaluate patients for fracture risk and treat patients with bone-targeted agents according to established guidelines. (5.2)
- Falls occurred in patients receiving ERLEADA with increased incidence in the elderly. Evaluate patients for fall risk. (5.3)
- Seizure occurred in 0.4% of patients receiving ERLEADA. Permanently discontinue ERLEADA in patients who develop a seizure during treatment. (5.4)
- Severe Cutaneous Adverse Reactions (SCARs), including Stevens-Johnson syndrome/toxic epidermal necrolysis (SJS/TEN) and drug reaction with eosinophilia and systemic symptoms (DRESS), occurred in patients treated with ERLEADA. Interrupt ERLEADA if signs or symptoms of SCARs develop. Permanently discontinue if SCARs are confirmed. (5.5)
- Embryo-Fetal Toxicity: ERLEADA can cause fetal harm. Advise males with female partners of reproductive potential to use effective contraception. (5.6, 8.1, 8.3)

ADVERSE REACTIONS

The most common adverse reactions (≥10%) are fatigue, arthralgia, rash, decreased appetite, fall, weight decreased, hypertension, hot flush, diarrhea, and fracture. (8.1)

To report SUSPECTED ADVERSE REACTIONS, contact Janssen Products, LP at 1-800-526-7736 (1-800-JANSSEN) or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

Concomitant use with medications that are sensitive substrates of CYP3A4, CYP2C19, CYP2C9, UGT, P-gp, BCRP, or OATP1B1 may result in loss of activity of these medications. (7.2)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 02/2023

FULL PRESCRIBING INFORMATION: CONTENTS*

1 INDICATIONS AND USAGE
2 DOSAGE AND ADMINISTRATION
3 DOSAGE FORMS AND STRENGTHS
4 CONTRAINDICATIONS
5 WARNINGS AND PRECAUTIONS
6 ADVERSE REACTIONS
7 DRUG INTERACTIONS
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9 NONCLINICAL TOXICOLOGY
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11 DESCRIPTION
12 CLINICAL PHARMACOLOGY
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14 HOW SUPPLIED/STORAGE AND HANDLING
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*Sections or subsections omitted from the full prescribing information are not listed.
ERLEADA® (apalutamide) tablets

5.3 Falls

Evaluate patients for fall risk.

In a randomized study (SPARTAN), falls occurred in 16% of patients treated with ERLEADA compared to 9% of patients treated with placebo. Falls were not associated with loss of consciousness or seizure.

5.4 Seizure

Seizure occurred in patients receiving ERLEADA. Permanently discontinue ERLEADA in patients who develop a seizure during treatment. It is unknown whether anti-epileptic medications will prevent seizures with ERLEADA. Advise patients of the risk of developing a seizure while receiving ERLEADA and of engaging in any activity where sudden loss of consciousness could cause harm to themselves or others.

5.5 Severe Cutaneous Adverse Reactions

Fetal and life threatening cases of severe cutaneous adverse reactions (SCARs), including Stevens-Johnson syndrome/toxic epidermal necrolysis (SJS/TEN), and drug reaction with eosinophilia and systemic symptoms (DRESS), occurred in patients receiving ERLEADA [see Adverse Reactions (6.2)].

Monitor patients for the development of SCARs. Advise patients of the signs and symptoms of SCARs (e.g., a prodrome of fever, flu-like symptoms, mucosal lesions, progressive skin rash, or lymphadenopathy).

If a SCAR is suspected, interrupt ERLEADA until the etiology of the reaction has been determined. Consultation with a dermatologist is recommended. If a SCAR is confirmed, or for other grade 4 skin reactions, permanently discontinue ERLEADA [see Dosage and Administration (2.2) and Adverse Reactions (6.1)].

5.6 Embryo-Fetal Toxicity

The safety and efficacy of ERLEADA have not been established in females. Based on findings from animals and its mechanism of action, ERLEADA can cause fetal harm and loss of pregnancy when administered to a pregnant female. In an animal reproduction study, oral administration of apalutamide to pregnant rats during and after organogenesis resulted in fetal abnormalities and embryo-fetal lethality at maternal exposures ≥ 2 times the human clinical exposure (AUC) at the recommended dose. Advise males with female partners of reproductive potential to use effective contraception during treatment and for 3 months after the last dose of ERLEADA [see Use in Specific Populations (8.1, 8.3) and Clinical Pharmacology (12.1)].

6 ADVERSE REACTIONS

The following are discussed in more detail in other sections of the labeling:

- Cerebrovascular and Ischemic Cardiovascular Events [see Warnings and Precautions (5.1)].
- Fractures [see Warnings and Precautions (5.2)].
- Falls [see Warnings and Precautions (5.3)].
- Seizure [see Warnings and Precautions (5.4)].
- Severe Cutaneous Adverse Reactions (SCARs) [see Warnings and Precautions (5.5)].

6.1 Clinical Trial Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The most common adverse reactions (≥ 10%) that occurred more frequently in the ERLEADA-treated patients (≥ 2% over placebo) from the randomized placebo-controlled clinical trials (TITAN and SPARTAN) were fatigue, arthralgia, rash, decreased appetite, fall, weight decreased, hypertension, hot flush, diarrhea, and fracture.

5.2 Fractures

Fractures occurred in patients receiving ERLEADA. Evaluate patients for fracture risk. Monitor and manage patients at risk for fractures according to established treatment guidelines and consider use of bone-targeted agents.

In a randomized study (SPARTAN) of patients with nmCRPC, ischemic cardiovascular events occurred in 3.7% of patients treated with ERLEADA and 2% of patients treated with placebo. In a randomized study (TITAN) in patients with mCSPC, ischemic cardiovascular events occurred in 4.4% of patients treated with ERLEADA and 1.5% of patients treated with placebo. Across the SPARTAN and TITAN studies, 4 patients (0.3%) treated with ERLEADA, and 2 patients (0.2%) treated with placebo died from an ischemic cardiovascular event.

In the SPARTAN study, cerebrovascular events occurred in 2.5% of patients treated with ERLEADA and 1% of patients treated with placebo [see Adverse Reactions (5.1)]. In the TITAN study, cerebrovascular events occurred in 1.3% of patients treated with ERLEADA and 2.1% of patients treated with placebo. Across the SPARTAN and TITAN studies, 3 patients (0.2%) treated with ERLEADA, and 2 patients (0.2%) treated with placebo died from a cerebrovascular event.

Patients with history of unstable angina, myocardial infarction, congestive heart failure, stroke, or transient ischemic attack within six months of randomization were excluded from the SPARTAN and TITAN studies.

5.3 Falls

Falls occurred in patients receiving ERLEADA with increased frequency in the elderly [see Use in Specific Populations (8.5)]. Evaluate patients for fall risk.
ERLEADA® (apalutamide) tablets

Table 1: Adverse Reactions in TITAN (mCSPC)

<table>
<thead>
<tr>
<th>System/Organ Class</th>
<th>Adverse reaction</th>
<th>ERLEADA N=524</th>
<th>Placebo N=527</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Grades</td>
<td>Grade 3-4</td>
<td>All Grades</td>
</tr>
<tr>
<td>Musculoskeletal and connective tissue disorders</td>
<td>Arthralgia&lt;sup&gt;a&lt;/sup&gt;</td>
<td>17</td>
<td>0.4</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td>Rash&lt;sup&gt;b&lt;/sup&gt;</td>
<td>28</td>
<td>6</td>
</tr>
<tr>
<td>Vascular disorders</td>
<td>Hot flush</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td>18</td>
<td>8</td>
</tr>
</tbody>
</table>

<sup>a</sup> Per the Common Terminology Criteria for Adverse Reactions (CTCAE), the highest severity for these events is Grade 3.

<sup>b</sup> Includes rash, rash maculo-papular, rash generalized, urticaria, rash pruritic, rash macular, conjunctivitis, erythema multiforme, rash papular, skin exfoliation, genital rash, rash erythematous, stomatitis, drug eruption, mouth ulceration, rash pustular, blister, papule, pemphigoid, skin erosion, dermatitis, and rash vesicular.

Additional adverse reactions of interest occurring in 2%, but less than 10% of patients treated with ERLEADA included diarrhea (9% versus 6% on placebo), muscle spasm (3.1% versus 1.9% on placebo), dysgeusia (3.2% versus 0.8% on placebo), and hypothyroidism (3.6% versus 0.6% on placebo).

Table 2: Laboratory Abnormalities Occurring in ≥ 15% of ERLEADA-Treated Patients and at a Higher Incidence than Placebo (Between Arm Difference > 5% All Grades) in TITAN (mCSPC)

<table>
<thead>
<tr>
<th>Laboratory Abnormality</th>
<th>ERLEADA N=524</th>
<th>Placebo N=527</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White blood cell decreased</td>
<td>27</td>
<td>0.4</td>
</tr>
<tr>
<td>Chemistry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertriglyceridemia&lt;sup&gt;a&lt;/sup&gt;</td>
<td>17</td>
<td>2.5</td>
</tr>
</tbody>
</table>

<sup>a</sup> Does not reflect fasting values.

Non-metastatic Castration-resistant Prostate Cancer (nmCRPC)

SPARTAN, a randomized (2:1), double-blind, placebo-controlled, multi-center clinical study, enrolled patients who had nmCRPC. In this study, patients received either ERLEADA at a dose of 240 mg daily or a placebo. All patients in the SPARTAN study received a concomitant gonadotropin-releasing hormone (GnRH) analog or had a bilateral orchietomy. The median duration of exposure was 33 months (range: 0.1 to 75 months) in patients who received ERLEADA and 11 months (range: 0.1 to 37 months) in patients who received placebo.

Twenty-four patients (3%) who were treated with ERLEADA died from adverse reactions. The reasons for death with ≥ 2 patients included infection (n=7), myocardial infarction (n=3), cerebrovascular event (n=2), and unknown reason (n=3). ERLEADA was discontinued due to adverse reactions in 11% of patients, most commonly from rash (2.2%). Adverse reactions leading to dose interruption or reduction of ERLEADA occurred in 33% of patients; the most common (>1%) were rash, diarrhea, fatigue, nausea, vomiting, hypotension, and hematuria. Serious adverse reactions occurred in 33% of patients; the most common (>1%) were rash, diarrhea, fatigue, nausea, vomiting, hypotension, and hematuria. Serious adverse reactions occurred in 33% of patients; the most common (>1%) were rash, diarrhea, fatigue, nausea, vomiting, hypotension, and hematuria. Serious adverse reactions occurred in 33% of patients; the most common (>1%) were rash, diarrhea, fatigue, nausea, vomiting, hypotension, and hematuria. Serious adverse reactions occurred in 33% of patients; the most common (>1%) were rash, diarrhea, fatigue, nausea, vomiting, hypotension, and hematuria.

Rash

In the combined data of two randomized, placebo-controlled clinical studies, SPARTAN and TITAN, rash associated with ERLEADA was most commonly described as macular or maculo-papular. Adverse reactions of rash were reported for 26% of patients treated with ERLEADA versus 8% of patients treated with placebo. Grade 3 rashes (defined as covering >30% body surface area [BSA]) were reported with ERLEADA treatment (6%) versus placebo (0.5%).

The onset of rash occurred at a median of 83 days of ERLEADA treatment. Rash resolved in 78% of patients within a median of 78 days from onset of rash. Rash was commonly managed with oral antihistamines, topical corticosteroids, and 19% of patients received systemic corticosteroids. Dose reduction or dose interruption occurred in 14% and 28% of patients, respectively. Of the patients who had dose interruption, 59% experienced recurrence of rash upon reintroduction of ERLEADA.

Hypothyroidism

In the combined data of two randomized, placebo-controlled clinical studies, SPARTAN and TITAN, hypothyroidism was reported for 5% of patients treated with ERLEADA and 1.5% of patients treated with placebo based on assessments of thyroid-stimulating hormone (TSH) every 4 months. Elevated TSH occurred in 25% of patients treated with ERLEADA and 7% of patients treated with placebo. The median onset was at the first scheduled assessment. There were no Grade 3 or 4 adverse reactions. Thyroid replacement therapy was initiated in 4.3% of patients treated with ERLEADA. Thyroid replacement therapy, when clinically indicated, should be initiated or dose-adjusted (see Drug Interactions.[7,2])

Table 3: Adverse Reactions in SPARTAN (nmCRPC) (continued)

<table>
<thead>
<tr>
<th>System/Organ Class</th>
<th>Adverse reaction</th>
<th>ERLEADA N=803</th>
<th>Placebo N=398</th>
</tr>
</thead>
<tbody>
<tr>
<td>General disorders and administration site conditions</td>
<td>Fatigue&lt;sup&gt;ab&lt;/sup&gt;</td>
<td>39</td>
<td>1.4</td>
</tr>
<tr>
<td>Musculoskeletal and connective tissue disorders</td>
<td>Arthralgia&lt;sup&gt;a&lt;/sup&gt;</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td>Rash&lt;sup&gt;b&lt;/sup&gt;</td>
<td>25</td>
<td>5.2</td>
</tr>
<tr>
<td>Metabolism and nutrition disorders</td>
<td>Decreased appetite&lt;sup&gt;a&lt;/sup&gt;</td>
<td>12</td>
<td>0.1</td>
</tr>
<tr>
<td>Peripheral edema&lt;sup&gt;a&lt;/sup&gt;</td>
<td>11</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>
ERLEADA® (apalutamide) tablets

6.2 Post-Marketing Experience

6.4 Drug Interactions

7 Drug Interactions

7.1 Effect of Other Drugs on ERLEADA

Strong CYP2C8 or CYP3A4 Inhibitors

Co-administration of a strong CYP2C8 or CYP3A4 inhibitor is predicted to increase the steady-state exposure of the active moieties (sum of unbound apalutamide plus the potency-adjusted unbound N-desmethyl-apalutamide). No initial dose adjustment is necessary however, reduce the ERLEADA dose based on tolerability [see Dosage and Administration (2.2)]. Mid or moderate inhibitors of CYP2C8 or CYP3A4 are not expected to affect the exposure of apalutamide.

7.2 Effect of ERLEADA on Other Drugs

CYP3A4, CYP2C9, CYP2C19 and UGT Substrates

ERLEADA is a strong inducer of CYP3A4 and CYP2C19, and a weak inducer of CYP2C9 in humans. Concomitant use of ERLEADA with medications that are primarily metabolized by CYP3A4, CYP2C19, or CYP2C9 can result in lower exposure to these medications. Substitution for these medications is recommended when possible or evaluate for loss of efficacy if medication is continued. Concomitant administration of ERLEADA with medications that are substrates of UDP-glucuronosyl transferase (UGT) can result in decreased exposure. Use caution if substrates of UGT must be co-administered with ERLEADA and evaluate for loss of activity [see Clinical Pharmacology (12.3)].

P-gp, BCRP or OATP1B1 Substrates

Apalutamide was shown to be a weak inducer of P-glycoprotein (P-gp), breast cancer resistance protein (BCRP), and organic anion transporting polypeptide 1B1 (OATP1B1) clinically. At steady-state, apalutamide reduced the plasma exposure to fexofenadine (a P-gp substrate) and rosuvastatin (a BCRP/OATP1B1 substrate). Concomitant use of ERLEADA with medications that are substrates of P-gp, BCRP, or OATP1B1 can result in lower exposure of these medications. Use caution if substrates of P-gp, BCRP or OATP1B1 must be co-administered with ERLEADA and evaluate for loss of activity if medication is continued [see Clinical Pharmacology (12.3)].

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

The safety and efficacy of ERLEADA have not been established in females. Based on findings from animals and its mechanism of action, ERLEADA can cause fetal harm and loss of pregnancy when administered to a pregnant female [see Clinical Pharmacology (12.1)]. There are no available data on ERLEADA use in pregnant women to inform a drug-associated risk. In an animal reproduction study, oral administration of apalutamide to pregnant rats during and after organogenesis resulted in fetal abnormalities and embryo-fetal lethality at maternal exposures ≥2 times the human clinical exposure (AUC) at the recommended dose [see Data].

Data

Animal Data

In a pilot embryo-fetal developmental toxicity study in rats, apalutamide caused developmental toxicity when administered at oral doses of 25, 50 or 100 mg/kg/day throughout and after the period of organogenesis (gestational days 6-20). Findings included embryo-fetal lethality (resorptions) at doses ≥50 mg/kg/day, decreased fetal anogenital distance, misshapen pituitary gland, and skeletal variations (unossified phalanges, supernumerary short thoracolumbar rib(s), and small, incomplete ossification, and/or misshapen hyoid bone) at ≥25 mg/kg/day. A dose of 100 mg/kg/day caused maternal toxicity. The doses tested in rats resulted in systemic exposures (AUC) approximately 2, 4 and 6 times, respectively, the AUC in patients.

8.2 Lactation

Risk Summary

The safety and efficacy of ERLEADA have not been established in females. There are no data on the presence of apalutamide or its metabolites in human milk, the effect on the breastfed child, or the effect on milk production.

8.3 Females and Males of Reproductive Potential

Contraception

Males

Based on the mechanism of action and findings in an animal reproduction study, advise male patients with female partners of reproductive potential to use effective contraception during treatment and for 3 months after the last dose of ERLEADA [see Use in Specific Populations (8.1)].

Infertility

Males

Based on animal studies, ERLEADA may impair fertility in males of reproductive potential [see Nonclinical Toxicology (13.1)].

8.4 Pediatric Use

Safety and effectiveness of ERLEADA in pediatric patients have not been established.

ERLEADA® (apalutamide) tablets are available in 240 mg tablets and 60 mg tablets with the following inactive ingredients:

- 240 mg film-coated tablets: colloidal anhydrous silica, croscarmellose sodium, hydroxypropyl methylcellulose-acetate succinate, silicified microcrystalline cellulose, and magnesium stearate. The coating contains glyceryl monacrylo lactate, iron oxide black, polyvinyl alcohol, talc, titanium dioxide, and vinyl alcohol grafted copolymer.
- 60 mg film-coated tablets: colloidal anhydrous silica, croscarmellose sodium, hydroxypropyl methylcellulose-acetate succinate, magnesium stearate, microcrystalline cellulose, and silicified microcrystalline cellulose. The coating contains iron oxide black, iron oxide yellow, polyethylene glycol, polyvinyl alcohol, talc, and titanium dioxide.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Apalutamide is an Androgen Receptor (AR) inhibitor that binds directly to the ligand-binding domain of the AR. Apalutamide inhibits AR nuclear translocation, inhibits DNA binding, and impedes AR-mediated transcription. A major metabolite, N-desmethyl apalutamide, is a less potent inhibitor of AR, and exhibited one-third the activity of apalutamide in an in vitro transcriptional reporter assay. Apalutamide administration caused decreased tumor cell proliferation and increased apoptosis leading to decreased tumor volume in mouse xenograft models of prostate cancer.

12.2 Pharmacokinetics

Cardiac Electrophysiology

The effect of apalutamide 240 mg once daily on the QTc interval was assessed in an open-label, uncontrolled, multi-center, single-arm dedicated QT study in 45 patients with CRPC. The maximum mean QTcF change from baseline was 12.4 ms (2-sided 95% CI: 6.0, 18.8 ms). An exposure-QT analysis suggested a concentration-dependent increase in QTcF for apalutamide and its active metabolite.

12.3 Pharmacokinetic Properties

Apalutamide pharmacokinetic parameters are presented as the mean [standard deviation (SD)] unless otherwise specified. Apalutamide C max and area under the curve (AUC) are area under the concentration curve (AUC) increased proportionally following repeated once-daily dosing of 30 to 480 mg (0.125 to 2 times the recommended dosage). Following administration of the recommended dosage, apalutamide steady-state was achieved after 4 weeks and the mean accumulation ratio was approximately 2-fold. Apalutamide C max was 5.9 mcg/mL (1.0) and AUC was 100 mcg*hr/mL (32) at steady-state. Daily fluctuations in apalutamide plasma concentrations were low, with mean peak-to-trough ratio of 1.63. An increase in apparent clearance (CL/F) was observed with repeat dosing, likely due to induction of apalutamide’s own metabolism. The auto-induction effect likely reached its maximum at the recommended dosage because exposure of apalutamide across the dose range of 30 to 480 mg is dose-proportional.

The major active metabolite N-desmethyl apalutamide C max was 5.9 mcg/mL (1.0) and AUC was 124 mcg*hr/mL (32) at steady-state after the recommended dosage.
ERLEADA® (apalutamide) tablets

N-desmethyl apalutamide was characterized by a flat concentration-time profile at steady-state with a mean peak-to-trough ratio of 1.27. Mean AUC metabolite/parent drug ratio for N-desmethyl apalutamide following repeat-dose administration was 1.3. Based on systemic exposure, relative potency, and pharmacokinetic properties, N-desmethyl apalutamide likely contributed to the clinical activity of apalutamide.

**Absorption**
Mean absolute oral bioavailability was approximately 100%. Median time to achieve peak plasma concentration (t_{max}) was 2 hours (range: 1 to 5 hours).

Oral administration of four 60 mg apalutamide tablets dispersed in applesauce resulted in no clinically relevant changes in C_{min} and AUC when compared to administration of four intact 60 mg tablets under fasting condition.

**Effect of Food**
Administration of apalutamide to healthy subjects under fasting conditions and with a high-fat meal (approximately 500 to 600 fat calories, 250 carbohydrate calories, and 150 protein calories) resulted in no clinically relevant changes in C_{min} and AUC. Median time to reach t_{max} was delayed approximately 2 hours with food.

**Distribution**
The mean apparent volume of distribution at steady-state of apalutamide was approximately 276 L.

Apalutamide was 96% and N-desmethyl apalutamide was 95% bound to plasma proteins with no concentration dependency.

**Elimination**
The CL/F of apalutamide was 1.3 L/h after single dosing and increased to 2.0 L/h at steady-state after once-daily dosing likely due to CYP3A4 auto-induction. The mean effective half-life for apalutamide in patients was approximately 3 days at steady-state.

**Metabolism**
Metabolism is the main route of elimination of apalutamide. Apalutamide is primarily metabolized by CYP2C8 and CYP3A4 to form active metabolite, N-desmethyl apalutamide. The contribution of CYP2C8 and CYP3A4 in the metabolism of apalutamide is estimated to be 98% and 13% following single dose but changes to 40% and 37%, respectively at steady-state.

Apalutamide represented 45% and N-desmethyl apalutamide represented 44% of the total AUC following a single oral administration of radiolabeled apalutamide 240 mg.

**Excretion**
Up to 70 days following a single oral administration of radiolabeled apalutamide, 65% of the dose was recovered in urine (1.2% of dose as unchanged apalutamide and 2.7% as N-desmethyl apalutamide) and 24% was recovered in feces (1.5% of dose as unchanged apalutamide and 2% as N-desmethyl apalutamide).

**Specific Populations**

No clinically significant differences in the pharmacokinetics of apalutamide or N-desmethyl apalutamide were observed based on age (18-94 years), race (Black, non-Japanese Asian, Japanese), mild to moderate (eGFR 30-89 mL/min/1.73 m², and 2% as N-desmethyl apalutamide) and 24% was recovered in feces (1.5% of dose as unchanged apalutamide and 2% as N-desmethyl apalutamide).

**Co-administration of ERLEADA with other medications**

- **Effect of ERLEADA on Other Drugs**
- **CYP substrates**
In vitro studies showed that apalutamide and N-desmethyl apalutamide are moderate to strong CYP3A4 and CYP2B6 inducers, are moderate inhibitors of CYP2B6 and CYP2C8, and weak inhibitors of CYP2C9, CYP2C19, and CYP3A4. Apalutamide and N-desmethyl apalutamide do not affect CYP1A2 and CYP2D6 at therapeutically relevant concentrations.

Co-administration of ERLEADA with single oral doses of sensitive CYP substrates resulted in a 92% decrease in the AUC of midazolam (a CYP3A4 substrate), 85% decrease in the AUC of omeprazole (a CYP2C9 substrate), and 46% decrease in the AUC of S-warfarin (a CYP2C9 substrate). ERLEADA did not cause clinically significant changes in exposure to a CYP2B6 substrate.

- **P-gp, BCRP and OATP1B1 substrates**
Co-administration of ERLEADA with single oral doses of transporter substrates resulted in a 30% decrease in the AUC of fexofenadine (a P-gp substrate) and 41% decrease in the AUC of rosuvastatin (a BCRP/OATP1B1 substrate) but had no impact on the OAT3 substrate.

**UGT substrates**
Apalutamide may induce UGT. Concomitant administration of ERLEADA with medications that are substrates of UGT may result in lower exposure to these medications.

- **OCT2, OAT1, OAT3 and MATE substrates**
In vitro, apalutamide and N-desmethyl apalutamide inhibit organic cation transporter 2 (OCT2), organic anion transporter 3 (OAT3) and multidrug and toxin extrusions (MATEs), and do not inhibit organic anion transporter 1. Apalutamide is not predicted to cause clinically significant changes in exposure to an OAT3 substrate.

**GnR analog**
In mSCCP subjects receiving leuproide acetate (a GnR analog) co-administered with apalutamide, PK data indicated that apalutamide had no apparent effect on the steady-state exposure of leuproide.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

In a 2-year carcinogenicity study in male rats, apalutamide was administered by oral gavage at doses of 5, 15 and 50 mg/kg/day. Apalutamide increased the incidence of Leydig interstitial cell adenoma in the testes at doses ≥ 5 mg/kg/day (0.2 times the human exposure based on AUC). The findings in the testes are considered to be related to the pharmacological activity of apalutamide. Rats are regarded as more sensitive than humans to developing interstitial cell tumors in the testes. Oral administration of apalutamide to male rhesus macaque transgenic mice for 6 months did not result in increased incidence of neoplasms at doses up to 30 mg/kg/day.

Apalutamide did not induce mutations in the bacterial reverse mutation (Ames) assay and was not genotoxic in either in vitro chromosome aberration assay or the in vivo rat bone marrow micronucleus assay or the in vivo rat comet assay. In repeat-dose toxicity studies in male rats (up to 26 weeks) and dogs (up to 30 weeks), atrophy of the prostate gland and seminal vesicles, aspermia/hypospermia, tubular degeneration and/or hyperplasia or hypertrophy of the interstitial cells in the reproductive system were observed at ≥ 25 mg/kg/day in rats (1.4 times the human exposure based on AUC) and ≥ 2.5 mg/kg/day in dogs (0.9 times the human exposure based on AUC).

In a fertility study in male rats, a decrease in sperm concentration and motility, increased abnormal sperm morphology, lower copulation and fertility rates (upon pairing with untreated females) along with reduced weights of the secondary sex glands and epididymis were observed following 4 weeks of dosing at ≥ 25 mg/kg/day (0.8 times the human exposure based on AUC). A reduced number of live fetuses due to increased pre- and/or post-implantation loss was observed (36 foci at 2 weeks of 150 mg/kg/day administration (5.7 times the human exposure based on AUC). Effects on male rats were reversible after 8 weeks from the last apalutamide administration.

14 CLINICAL STUDIES

The efficacy and safety of ERLEADA was established in two randomized placebo-controlled clinical trials.

TITAN (NCT02488518): Metastatic Castration-sensitive Prostate Cancer (mCSPC)
TITAN was a randomized, double-blind, placebo-controlled, multinational, clinical trial in which 1052 patients with mCSPC were randomized (1:1) to receive either ERLEADA orally at a dose of 240 mg once daily (N=526) or placebo once daily (N=526). All patients in the TITAN trial received concomitant GnRH analog or had prior bilateral orchectomy. Patients were stratified by Gleason score at diagnosis, prior docetaxel use, and region of the world. Patients with both high- and low-volume mCSPC were eligible for the study. High volume of disease was defined as metastases involving the visceral with 1 bone lesion or the presence of 4 or more bone lesions, at least 1 of which must be in a bony structure beyond the vertebral column and pelvic bones.
ERLEADA® (apalutamide) tablets

The following patient demographics and baseline disease characteristics were balanced between the treatment arms. The median age was 68 years (range 43-94) and 23% of patients were 75 years of age or older. The racial distribution was 68% Caucasian, 22% Asian, and 2% Black. Sixty-three percent (63%) of patients had high-volume disease and 37% had low-volume disease. Sixteen percent (16%) of patients had prior surgery, radiotherapy of the prostate or both. A majority of patients had a Gleason score of 8 or higher (67%). Sixty-eight percent (68%) of patients received prior treatment with an anti-androgen (bicalutamide, flutamide, or nilutamide). All patients except one in the placebo group, had an Eastern Cooperative Oncology Group Performance Status (ECOG PS) score of 0 or 1 at study entry.

The major efficacy outcome measures of the study were overall survival (OS) and radiographic progression-free survival (rPFS). Radiographic progression-free survival was based on investigator assessment and was defined as time from randomization to radiographic disease progression or death. Radiographic disease progression was defined by identification of 2 or more new bone lesions on a bone scan with confirmation (Prostate Cancer Working Group 2 criteria) and/or progression in soft tissue disease.

A statistically significant improvement in OS and rPFS was demonstrated in patients randomized to receive ERLEADA compared with patients randomized to receive placebo. The results for OS are based upon a prespecified interim efficacy analysis. An updated OS analysis was conducted at the time of final study analysis when 405 deaths were observed. The median follow-up time was 44 months. Thirty-nine percent of patients in the placebo arm crossed over to receive ERLEADA. Efficacy results of TITAN are summarized in Table 5 and Figures 1 and 2.

Table 5: Efficacy Results from the TITAN Study

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>ERLEADA (N=525)</th>
<th>Placebo (N=527)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Overall Survival</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaths (%)</td>
<td>83 (16%)</td>
<td>117 (22%)</td>
<td></td>
</tr>
<tr>
<td>Median, months (95% CI)**</td>
<td>NE (NE, NE)</td>
<td>NE (NE, NE)</td>
<td></td>
</tr>
<tr>
<td>Hazard Ratio (95% CI)**</td>
<td>0.67 (0.51, 0.89)</td>
<td>0.0053</td>
<td></td>
</tr>
<tr>
<td><strong>Updated Overall Survival</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaths (%)</td>
<td>170 (32%)</td>
<td>235 (45%)</td>
<td></td>
</tr>
<tr>
<td>Median, months (95% CI)**</td>
<td>NE (NE, NE)</td>
<td>52 (42, 42)</td>
<td></td>
</tr>
<tr>
<td>Hazard Ratio (95% CI)**</td>
<td>0.65 (0.53, 0.79)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Radiographic Progression-free Survival</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease progression or death (%)</td>
<td>134 (26%)</td>
<td>231 (44%)</td>
<td></td>
</tr>
<tr>
<td>Median, months (95% CI)**</td>
<td>NE (NE, NE)</td>
<td>22.1 (18, 33)</td>
<td></td>
</tr>
<tr>
<td>Hazard Ratio (95% CI)**</td>
<td>0.48 (0.39, 0.60)</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
</tbody>
</table>

* Interim analysis is based on 50% of the number of events planned for the final analysis. Allocated alpha = 0.01.

** NE=Not Estimable.

Radiographic progression-free survival was observed across the following patient subgroups: disease volume (high vs low), prior docetaxel use (yes or no), and ECOG PS score of 0 or 1 at study entry. Consistent improvement in OS and rPFS was observed across the following patient subgroups: disease volume (high vs low), prior docetaxel use (yes or no), and ECOG PS score of 0 or 1 at study entry.

Treatment with ERLEADA resulted in a statistically significant delay in the initiation of cytotoxic chemotherapy (HR = 0.39, 95% CI = 0.27, 0.56; p < 0.0001). Treatment with ERLEADA resulted in a statistically significant delay in the initiation of cytotoxic chemotherapy (HR = 0.39, 95% CI = 0.27, 0.56; p < 0.0001).

Figure 1: Kaplan-Meier Plot of Updated Overall Survival (OS); Intent-to-treat mCSPC Population (TITAN)

Figure 2: Kaplan-Meier Plot of Radiographic Progression-Free Survival (rPFS); Intent-to-treat mCSPC Population (TITAN)

SPARTAN (NCT01946204): Non-metastatic, Castration-resistant Prostate Cancer (nmCRPC) SPARTAN was a multicenter, double-blind, randomized (2:1), placebo-controlled clinical trial in which 1207 patients with nmCRPC were randomized (2:1) to receive either ERLEADA orally at a dose of 240 mg once daily (N=401) or placebo once daily (N=401). All patients in the SPARTAN trial received a concomitant GnRH analog or had a bilateral orchiectomy. Patients were stratified by Prostate Specific Antigen (PSA) Doubling Time (PSADT) ≤ 10 months and confirmation of non-metastatic disease by blinded independent central review (BICR). PSA results were blinded and were not used for treatment discontinuation. Patients randomized to either arm discontinued treatment for radiographic disease progression confirmed by BICR, locoregional-only progression, initiation of new treatment, unacceptable toxicity, or withdrawal.

The following patient demographics and baseline disease characteristics were balanced between the treatment arms. The median age was 74 years (range 48-97) and 26% of patients were 80 years of age or older. The racial distribution was 66% Caucasian, 12% Asian, and 6% Black. Seventy-seven percent (77%) of patients in both treatment arms had prior surgery or radiotherapy of the prostate. A majority of patients had a Gleason score of 7 or higher (78%). Seventy-five percent (75%) of patients had <2 cm pelvic lymph nodes at study entry. Seventy-three percent (73%) of patients received prior treatment with an anti-androgen; 69% of patients had <2 cm pelvic lymph nodes at study entry. Seventy-three percent (73%) of patients received prior treatment with an anti-androgen; 69% of patients had <2 cm pelvic lymph nodes at study entry. Seventy-three percent (73%) of patients received prior treatment with an anti-androgen; 69% of patients had <2 cm pelvic lymph nodes at study entry. Seventy-three percent (73%) of patients received prior treatment with an anti-androgen; 69% of patients had <2 cm pelvic lymph nodes at study entry.

The major efficacy outcome measure of the study was metastasis-free survival (MFS), defined as the time from randomization to the time of first evidence of BCR-conformed distant metastases, defined as new bone or soft tissue lesions or enlarged lymph nodes above the iliac bifurcation, or death due to any cause, whichever occurred first. Additional efficacy endpoints were time to metastasis (TTM), progression-free survival (PFS) which also includes locoregional progression, time to symptomatic progression, overall survival (OS), and time to initiation of cytotoxic chemotherapy. Treatment with ERLEADA resulted in a statistically significant delay in the initiation of cytotoxic chemotherapy.

A statistically significant improvement in MFS and OS was demonstrated in patients randomized to receive ERLEADA compared with patients randomized to receive placebo. The major efficacy outcome (MFS) was supported by improvements in TTM and PFS. The final analysis of OS and time to initiation of cytotoxic chemotherapy was conducted 32 months after the analysis of MFS, TTM and PFS. The efficacy results from SPARTAN are summarized in Table 6 and Figures 3 and 4.

Table 6: Efficacy Results from the SPARTAN Study

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>ERLEADA (N=806)</th>
<th>Placebo (N=401)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metastasis Free Survival</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Events (%)</td>
<td>184 (23%)</td>
<td>194 (48%)</td>
<td></td>
</tr>
<tr>
<td>Median, months (95% CI)**</td>
<td>40.5 (NE, NE)</td>
<td>16.2 (15, 18)</td>
<td></td>
</tr>
<tr>
<td>Hazard Ratio (95% CI)**</td>
<td>0.28 (0.23, 0.35)</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td><strong>Time to Metastasis</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Events (%)</td>
<td>175 (22%)</td>
<td>191 (48%)</td>
<td></td>
</tr>
<tr>
<td>Median, months (95% CI)**</td>
<td>40.5 (NE, NE)</td>
<td>16.6 (15, 18)</td>
<td></td>
</tr>
<tr>
<td>Hazard Ratio (95% CI)**</td>
<td>0.27 (0.22, 0.34)</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
</tbody>
</table>
**Table 6: Efficacy Results from the SPARTAN Study (continued)**

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>ERLEADA (N=806)</th>
<th>Placebo (N=401)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Progression-Free Survival</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Events (%)</td>
<td>200 (25%)</td>
<td>204 (51%)</td>
</tr>
<tr>
<td>Median, months (95% CI)</td>
<td>40.5 (NE, NE)</td>
<td>14.7 (14, 18)</td>
</tr>
<tr>
<td>Hazard Ratio (95% CI)</td>
<td>0.29 (0.24, 0.36)</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td><strong>Overall Survival</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Events (%)</td>
<td>274 (34%)</td>
<td>154 (38%)</td>
</tr>
<tr>
<td>Median, months (95% CI)</td>
<td>73.3 (61, NE)</td>
<td>59.9 (53, NE)</td>
</tr>
<tr>
<td>Hazard Ratio (95% CI)</td>
<td>0.78 (0.64, 0.96)</td>
<td>0.0161</td>
</tr>
</tbody>
</table>

*All analyses stratified by PSA doubling time, bone-sparing agent use, and locoregional disease status.

†Confirmed responses assessed by BICR.

‡Locoregional-only progression is observed in 2.4% of patients overall.

NE = Not Estimable

Consistent results for MFS were observed across patient subgroups including PSADT (≤ 6 months or > 6 months), use of a prior bone-sparing agent (yes or no), and locoregional disease status.

Treatment with ERLEADA resulted in a statistically significant delay in the initiation of cytotoxic chemotherapy (HR = 0.63 [95% CI 0.49, 0.81], p = 0.0002).
**PATIENT INFORMATION**

**ERLEADA®** *(er lee'dah)*

(apalutamide) tablets

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### What is ERLEADA?

ERLEADA is a prescription medicine used for the treatment of prostate cancer:

- that has spread to other parts of the body and still responds to a medical or surgical treatment that lowers testosterone, OR
- that has not spread to other parts of the body and no longer responds to a medical or surgical treatment that lowers testosterone.

It is not known if ERLEADA is safe and effective in females.

It is not known if ERLEADA is safe and effective in children.

### Before taking ERLEADA, tell your healthcare provider about all your medical conditions, including if you:

- have a history of heart disease
- have high blood pressure
- have diabetes
- have abnormal amounts of fat or cholesterol in your blood (dyslipidemia)
- have a history of seizures, brain injury, stroke, or brain tumors
- are pregnant or plan to become pregnant. ERLEADA can cause harm to your unborn baby and loss of pregnancy (miscarriage).
- have a partner who is pregnant or may become pregnant.
  - Males who have female partners who are able to become pregnant should use effective birth control (contraception) during treatment and for 3 months after the last dose of ERLEADA.
  - Males should use a condom during sex with a pregnant female.
  - Talk with your healthcare provider if you have questions about birth control.
- are breastfeeding or plan to breastfeed. It is not known if ERLEADA passes into breast milk.

### Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. ERLEADA can interact with many other medicines.

You should not start or stop any medicine before you talk with the healthcare provider that prescribed ERLEADA.

Know the medicines you take. Keep a list of them with you to show to your healthcare provider and pharmacist when you get a new medicine.

### How should I take ERLEADA?

- Take ERLEADA exactly as your healthcare provider tells you.
- Do not stop taking your prescribed dose of ERLEADA without talking with your healthcare provider first.
- Take your prescribed dose of ERLEADA 1 time a day, at the same time each day.
- Take ERLEADA with or without food.
- Swallow ERLEADA tablets whole. Do not crush or split the tablets. If you cannot swallow ERLEADA tablets whole, see the “Instructions for Use” for detailed instructions on how to prepare and take a dose of ERLEADA by mouth. ERLEADA comes in 2 different strengths (60 mg and 240 mg). Follow the instructions for your prescribed strength of ERLEADA.
- If you have a feeding tube, the ERLEADA 240 mg tablet can be given through a feeding tube. See the “Instructions for Use” for detailed instructions on how to prepare and give a dose of ERLEADA through a feeding tube (8 French or larger).
- If you miss a dose of ERLEADA, take your normal dose as soon as possible on the same day. Return to your normal schedule on the following day. You should not take extra tablets to make up the missed dose.
- You should start or continue a gonadotropin-releasing hormone (GnRH) analog therapy during your treatment with ERLEADA unless you have had a surgery to lower the amount of testosterone in your body (surgical castration).
- If you take too much ERLEADA, call your healthcare provider or go to the nearest hospital emergency room.
What are the possible side effects of ERLEADA?

ERLEADA may cause serious side effects including:

- **Heart disease, stroke, or mini-stroke.** Bleeding in the brain or blockage of the arteries in the heart or in part of the brain have happened in some people during treatment with ERLEADA and can lead to death. Your healthcare provider will monitor you for signs and symptoms of heart or brain problems during your treatment with ERLEADA. Call your healthcare provider or get medical help right away if you get:
  - chest pain or discomfort at rest or with activity
  - shortness of breath
  - numbness or weakness of the face, arm, or leg, especially on one side of the body

- **Fractures and falls.** ERLEADA treatment can cause bones and muscles to weaken and may increase your risk for falls and fractures. Falls and fractures have happened in people during treatment with ERLEADA. Your healthcare provider will monitor your risks for falls and fractures during treatment with ERLEADA.

- **Seizure.** Treatment with ERLEADA may increase your risk of having a seizure. You should avoid activities where a sudden loss of consciousness could cause serious harm to yourself or others. Tell your healthcare provider right away if you have a loss of consciousness or seizure. Your healthcare provider will stop ERLEADA if you have a seizure during treatment.

- **Severe skin reactions.** Treatment with ERLEADA may cause severe skin reactions that can be life-threatening or may lead to death. Stop taking ERLEADA and get medical help right away if you develop any of these signs or symptoms of a severe skin reaction:
  - severe rash or rash that continues to get worse
  - fever or flu-like symptoms
  - swollen lymph nodes

The most common side effects of ERLEADA include:

- feeling very tired
- joint pain
- rash. Tell your healthcare provider if you get a rash.
- decreased appetite
- fall

Your healthcare provider may reduce your dose, temporarily stop, or permanently stop treatment with ERLEADA if you have certain side effects.

ERLEADA may cause fertility problems in males, which may affect the ability to father children. Talk to your healthcare provider if you have concerns about fertility. Do not donate sperm during treatment with ERLEADA and for 3 months after the last dose of ERLEADA.

Tell your healthcare provider if you have any side effect that bothers you or that does not go away. These are not all the possible side effects of ERLEADA.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store ERLEADA?

- Store ERLEADA at room temperature between 68 °F to 77 °F (20 °C to 25 °C).
- ERLEADA comes in a child-resistant bottle.
- Store ERLEADA in the original package to protect from light and moisture.
- The bottle of ERLEADA contains a desiccant packet to help keep your medicine dry (protect it from moisture). Do not throw away (discard) the desiccant.

Keep ERLEADA and all medicines out of the reach of children.

General information about the safe and effective use of ERLEADA.

Medicines are sometimes prescribed for purposes other than those listed in a Patient Information leaflet. Do not use ERLEADA for a condition for which it was not prescribed. Do not give ERLEADA to other people, even if they have the same symptoms that you have. It may harm them. If you would like more information, talk with your healthcare provider. You can ask your healthcare provider or pharmacist for information about ERLEADA that is written for health professionals.

What are the ingredients in ERLEADA?

**Active ingredient:** apalutamide

**Inactive ingredients:** 240 mg film-coated tablets: colloidal anhydrous silica, croscarmellose sodium, hydroxypropyl methylcellulose-acetate succinate, silicified microcrystalline cellulose, and magnesium stearate. The coating contains glyceryl moncaprylocaprate, iron oxide black, polyvinyl alcohol, talc, titanium dioxide, and vinyl alcohol grafted copolymer.

60 mg film-coated tablets: colloidal anhydrous silica, croscarmellose sodium, hydroxypropyl methylcellulose-acetate succinate, magnesium stearate, microcrystalline cellulose, and silicified microcrystalline cellulose. The coating contains iron oxide black, iron oxide yellow, polyethylene glycol, polyvinyl alcohol, talc, and titanium dioxide.

Manufactured for: Janssen Products, LP, Horsham, PA 19044, USA

For patent information: www.janssenpatents.com

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For more information, call Janssen Products, LP at 1-800-526-7736 (1-800-JANSSEN) or go to www.erleada.com.

This Patient Information has been approved by the U.S. Food and Drug Administration. Revised: 02/2023
INSTRUCTIONS FOR USE
ERLEADA® (er lee’ dah)
(apalutamide)
tablets

This Instructions for Use contains information on how to prepare and give a dose of ERLEADA tablets if you cannot swallow ERLEADA tablets whole or if you have a feeding tube. Read this Instructions for Use before you prepare and take or give the first dose of ERLEADA, and each time you get a refill. Ask your healthcare provider or pharmacist if you have any questions.

Important information you need to know before preparing a dose of ERLEADA:
• ERLEADA comes in 2 different strengths, 60 mg tablets and 240 mg tablets. Please find the instructions below that refer to your prescribed ERLEADA strength for how to prepare and take ERLEADA tablets if you cannot swallow tablets whole.
• ERLEADA 240 mg tablet can be prepared and given through a feeding tube 8 French or larger.

Preparing and taking ERLEADA if you cannot swallow tablets whole:

Preparing and taking ERLEADA 60 mg tablets by mixing with applesauce:
Step 1. Place your entire prescribed dose of ERLEADA tablets in a container that contains 4 ounces (120 mL) of applesauce and stir. Do not crush or split the tablets.
Step 2. Wait 15 minutes and stir the mixture again.
Step 3. Wait another 15 minutes and stir the mixture until the tablets are well mixed with no chunks remaining.
Step 4. Swallow the mixture right away using a spoon.
Step 5. Rinse the container with 2 ounces (60 mL) of water and drink the water mixture right away.
Step 6. Repeat the rinse with 2 ounces (60 mL) of water one more time to make sure that you take your full dose of ERLEADA. Swallow all the applesauce and medicine mixture within 1 hour of preparation. Do not store ERLEADA that is mixed with applesauce.

Preparing and taking ERLEADA 240 mg tablet by placing the tablet in non-carbonated water then mixing with orange juice, applesauce, or more non-carbonated water:
Step 1. Place the whole ERLEADA tablet in a cup. Do not crush or split the tablet.
Step 2. Add about 2 teaspoons (10 mL) of non-carbonated water to make sure that the tablet is completely covered in water.
Step 3. Wait 2 minutes until the tablet is broken up and spread out, then stir the mixture.
Step 4. Add 2 tablespoons (30 mL) of orange juice, applesauce, or non-carbonated water to the cup and stir the mixture.
Step 5. Swallow the mixture right away.
Step 6. Rinse the cup with enough non-carbonated water to make sure that you take your full dose of ERLEADA and drink it right away. Do not store ERLEADA that is mixed with non-carbonated water, orange juice, or applesauce for later use.

Preparing and giving ERLEADA 240 mg tablet through a feeding tube 8 French or larger:
Step 1. Remove the plunger out of the syringe (use at least a 20 mL syringe).
Step 2. Add one 240 mg tablet into the syringe body (barrel) and place the plunger back in the syringe. Do not crush or split the tablet.
Step 3. Withdraw 10 mL of non-carbonated water into the syringe.
Step 4. Wait 10 minutes and then shake the syringe very well (vigorously) to break the tablet apart completely.
Step 5. Attach the syringe to the feeding tube and give the mixture right away.
Step 6. Withdraw non-carbonated water into the same syringe and flush through the feeding tube. Repeat Step 6 until no pieces of tablet are left in the syringe or feeding tube.

How should I store ERLEADA?
• Store ERLEADA at room temperature between 68 °F to 77 °F (20 °C to 25 °C).
• ERLEADA comes in a child-resistant bottle.
• Store ERLEADA in the original package to protect from light and moisture.
• The bottle of ERLEADA contains a desiccant packet to help keep your medicine dry (protect it from moisture). Do not throw away (discard) the desiccant.

Keep ERLEADA and all medicines out of the reach of children.

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For patent information: www.janssenpatents.com
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For more information, call Janssen Products, LP at 1-800-526-7736 (1-800-JANSSEN) or go to www.erleada.com.

This Instructions for Use has been approved by the U.S. Food and Drug Administration. Issued: 02/2023

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