PRODUCT MONOGRAPH

INCLUDING PATIENT MEDICATION INFORMATION

[Pr]pms-EDOXABAN

Edoxaban Tablets

Tablets, 15 mg, 30 mg and 60 mg, edoxaban (as edoxaban tosylate monohydrate), Oral

Anticoagulant

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RECENT MAJOR LABEL CHANGES

None at the time of authorization	

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Sections or subsections that are not applicable at the time of authorization are not listed.

PART I: HEALTH PROFESSIONAL INFORMATION

1 INDICATIONS

pms-EDOXABAN (edoxaban tablets) is indicated for:

- Prevention of stroke and systemic embolic events in patients with atrial fibrillation, in whom anticoagulation is appropriate.
- Treatment of venous thromboembolism (VTE) (deep vein thrombosis [DVT], pulmonary embolism [PE]) and the prevention of recurrent DVT and PE.

1.1 Pediatrics (< 18 years of age)

The safety and efficacy of edoxaban tablets in children under the age of 18 years have not yet been established. Therefore, use of pms-EDOXABAN is not recommended in these patients.

1.2 Geriatrics (> 65 years of age)

Clinical studies in stroke prevention in patients with atrial fibrillation (SPAF), treatment of VTE and prevention of recurrent DVT and PE, included patients > 65 years of age (see 7 WARNINGS AND PRECAUTIONS - Table 5, 4 DOSAGE AND ADMINISTRATION, and 14 CLINICAL TRIALS).

2 CONTRAINDICATIONS

The use of pms-EDOXABAN is contraindicated in the following conditions:

- Clinically significant active bleeding, including gastrointestinal bleeding
- Lesions or conditions at increased risk of clinically significant bleeding, e.g., recent cerebral infarction (hemorrhagic or ischemic), active peptic ulcer disease with recent bleeding, patients with spontaneous or acquired impairment of hemostasis
- Hepatic disease associated with coagulopathy and clinically relevant bleeding risk (see 10 CLINICAL PHARMACOLOGY - Hepatic Insufficiency)
- Concomitant treatment with any other anticoagulant, including
    - unfractionated heparin (UFH), except at doses used to maintain a patent central venous or arterial catheter,
    - low molecular weight heparins (LMWH), such as enoxaparin and dalteparin,
    - heparin derivatives, such as fondaparinux, and
    - oral anticoagulants, such as warfarin, dabigatran, apixaban, rivaroxaban except under circumstances of switching therapy to or from pms-EDOXABAN.
- Pregnancy (See 7 WARNING AND PRECAUTIONS - Special Populations, Pregnant Women)
- Nursing Women (See 7 WARNING AND PRECAUTIONS - Special Populations, Breast-feeding)
- Hypersensitivity to edoxaban or to any ingredients of the formulation. For a complete listing of ingredients see 6 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING.

4 DOSAGE AND ADMINISTRATION

4.1 Dosing Considerations

As for any non-vitamin K antagonist oral anticoagulant (NOAC) drug, before initiating pms-EDOXABAN, ensure that the patient understands and is prepared to accept adherence to NOAC therapy, as directed.

pms-EDOXABAN should be taken regularly, as prescribed, to ensure optimal effectiveness. All temporary discontinuations should be avoided, unless medically indicated.

Determine estimated creatinine clearance (eCrCl) in all patients before instituting pms-EDOXABAN, and monitor renal function during pms-EDOXABAN treatment, as clinically appropriate. Determination of renal function by eCrCL should occur at least once per year, and especially during circumstances when renal function may be expected to be compromised, ie, acute myocardial infarction (AMI), acute decompensated heart failure (AHF), increased use of diuretics, dehydration, hypovolemia, etc. Clinically relevant deterioration of renal function may require dosage adjustment or discontinuation of pms-EDOXABAN (see below, *Renal Impairment*).

The method used to estimate renal function (CrCL in mL/min) during the clinical development of pms-EDOXABAN was the Cockcroft-Gault method. The formula is as follows in:

Males: $\frac{(140\text{-age (years)}) \times \text{weight (kg)} \times 1.23}{\text{serum creatinine (µmol/L)}}$ or, $\frac{(140\text{-age (years)}) \times \text{weight (kg)}}{72 \times \text{serum creatinine (mg/100 mL)}}$

Females: $\frac{(140\text{-age (years)}) \times \text{weight (kg)} \times 1.04}{\text{serum creatinine (µmol/L)}}$ or, $\frac{(140\text{-age (years)}) \times \text{weight (kg)} \times 0.85}{72 \times \text{serum creatinine (mg/100 mL)}}$

4.2 Recommended Dose and Dosage Adjustment

SPAF

The usual recommended dose of pms-EDOXABAN is 60 mg once daily.

Treatment of VTE and Prevention of Recurrent DVT and PE

The recommended dose of pms-EDOXABAN is 60 mg once daily following initial use of a parenteral anticoagulant for 5-10 days.

The duration of therapy should be individualized after careful assessment of the treatment benefit against the risk of bleeding. Short duration of therapy (at least 3 months) should be based on transient risk factors (e.g. surgery, trauma, immobilisation), while extended duration should be based on permanent risk factors or idiopathic DVT or PE.

Dose reductions for SPAF and VTE

The recommended dose of pms-EDOXABAN is 30 mg once daily in patients with one or more of the following clinical factors:

- Moderate renal impairment (creatinine clearance (CrCL) 30- 50 mL/min or severe renal impairment (CrCL 15-29 mL/min)
- Low body weight ≤ 60 kg (132 lbs)
- Concomitant use of P-gp inhibitors except amiodarone and verapamil.

Table 1 – Summary Dosing in SPAF and VTE (DVT and PE)

Summary Guide for Dosing	
SPAF: Recommended dose	60 mg once daily
VTE: Recommended dose	60 mg once daily (following initial use of heparin)
Renal Impairment*:* Moderate (CrCL 30 - 50 mL/min) or Severe (CrCL 15 - 29 mL/min) Low Body Weight: ≤ 60 kg P-gp Inhibitors except amiodarone and verapamil	30 mg once daily

Renal impairment

There are limited data in patients with end stage renal impairment (CrCl < 15 mL/min) or on dialysis as these patients were excluded from pivotal Phase III trials. Therefore, pms-EDOXABAN is not recommended in these patients (see 7 WARNINGS AND PRECAUTIONS - Renal).

Table 2 – Summary Posology in Renal Impairment for SPAF and VTE

Renal Impairment Status	**Creatinine Clearance (CrCL) mL/min**	**pms-EDOXABAN Dose Once Daily**
Mild	>50-80	60 mg
Moderate	30-50	30 mg
Severe	15-29	30 mg
End Stage Renal Disease or on Dialysis*	<15	Not recommended (see 7 WARNINGS AND PRECAUTIONS and 10 CLINICAL PHARMACOLOGY).

*Hemodialysis does not significantly contribute to edoxaban clearance.

Hepatic impairment
In patients with mild to moderate hepatic impairment the recommended dose of pms-EDOXABAN is 60 mg once daily (see 10 CLINICAL PHARMACOLOGY).

Edoxaban has not been studied in patients with severe hepatic impairment (see 10 CLINICAL PHARMACOLOGY). Therefore, its use in these patients is not recommended.

pms-EDOXABAN is contraindicated in patients with hepatic disease associated with intrinsic coagulation abnormalities (see 7 WARNINGS AND PRECAUTIONS and 10 CLINICAL PHARMACOLOGY).

Patients undergoing cardioversion
pms-EDOXABAN can be initiated or continued in patients who may require cardioversion. For transoesophageal echocardiogram (TEE) guided cardioversion in patients not previously treated with anticoagulants, pms-EDOXABAN treatment should be started at least 2 hours before cardioversion to ensure adequate anticoagulation (see ACTION AND CLINICAL PHARMACOLOGY, Pharmacodynamics and Pharmacokinetics). Cardioversion should be performed no later than 12 hours after the dose of edoxaban on the day of the procedure.

For all patients undergoing cardioversion: confirmation should be sought prior to cardioversion that the patient has taken pms-EDOXABAN as prescribed. Decisions on initiation and duration of treatment should follow established guidelines for anticoagulant treatment in patients undergoing cardioversion.

Elderly Population
No dose reduction is generally required. Increasing age may be associated with declining renal function (see 10 CLINICAL PHARMACOLOGY).

Pediatrics (<18 years)
Health Canada has not authorized an indication for pediatric use.

Switching to and from pms-EDOXABAN
Continued anticoagulant therapy is important in patients with SPAF and in the treatment of VTE. There may be situations that warrant a change in anticoagulation therapy.

Table 3 – Recommendation for switching to and from pms-EDOXABAN

Switching from:	To: pms-EDOXABAN
Vitamin K Antagonist (VKA)	Discontinue the VKA and start pms-EDOXABAN when the international normalised ratio (INR) is ≤ 2.5.
Oral anticoagulants other than VKA	Discontinue the non-VKA oral anticoagulant and start pms-EDOXABAN at the time of the next non-VKA dose (see 14 CLINICAL TRIALS).
Subcutaneous anticoagulant	Discontinue subcutaneous anticoagulant and start pms-EDOXABAN at the time of the next scheduled subcutaneous anticoagulant dose.
Unfractionated heparin	Discontinue the infusion and start pms-EDOXABAN 4 hours later.
Switching from:	**To: Another Treatment**
pms-EDOXABAN	*VKA oral option:* Administer a pms-EDOXABAN dose of 30 mg (15 mg for patients on a reduced dose for one or more of the following: moderate to severe renal impairment (CrCL 15 – 50 mL/min), low body weight, or use with P-gp inhibitors (except amiodarone and verapamil), together with an appropriate VKA dose. INR must be measured at least weekly and just prior to the daily dose of pms-EDOXABAN to minimize the influence of edoxaban on INR measurements. Once a stable INR of ≥ 2.0 is achieved, pms-EDOXABAN must be discontinued.
	VKA parenteral option: Discontinue pms-EDOXABAN and administer a parenteral anticoagulant and VKA at the time of the next scheduled pms-EDOXABAN dose. Once a stable INR of ≥ 2.0 is achieved, the parenteral anticoagulant must be discontinued and the VKA continued.
	Oral anticoagulants other than VKA: Discontinue pms-EDOXABAN and start the non-VKA anticoagulant at the time of the next scheduled dose of pms-EDOXABAN.
	Parenteral anticoagulants: Discontinue pms-EDOXABAN and start the parenteral anticoagulant at the time of the next scheduled dose of pms-EDOXABAN.

4.4 Administration

pms-EDOXABAN should be taken once daily, with or without food see 9.5 Drug-Food Interactions.

For patients who are unable to swallow whole tablets, pms-EDOXABAN tablets may be crushed and mixed with water or apple puree and immediately administered orally.

Alternatively, pms-EDOXABAN tablets may be crushed and suspended in 60 to 90 mL of water and immediately delivered through a nasogastric tube (a gauge of 10 to 18FR and length of 120 cm was utilized in the in vitro study) (see 10 CLINICAL PHARMACOLOGY, Pharmacokinetics). The tube should be flushed with water after delivering pms-EDOXABAN. pms-EDOXABAN

suspension should be administered within 4 hours of preparation. If not used immediately shake the suspension before administration.

Crushed pms-EDOXABAN tablets are stable in water and apple puree for up to 4 hours.

4.5 Missed Dose

If a dose of pms-EDOXABAN is missed, the dose must be taken as soon as possible on the same day. The dose of pms-EDOXABAN must not be doubled to make up for a missed dose. Return to normal dosing schedule the next day.

5 OVERDOSAGE

Overdose with pms-EDOXABAN may lead to hemorrhage. Experience with overdose cases is very limited. In cases of overdose, depending on the clinical situation pms-EDOXABAN must be stopped or the next dose delayed, taking the half-life (t½) of edoxaban tablets (10-14 hours) into account. In cases of bleeding, initiate appropriate measures such as packed red blood cells and/or hemostasis.

A specific reversal agent for edoxaban tablets is not available. Although not evaluated in patients, 3- factor or 4-factor prothrombin complex concentrate (PCC), activated prothrombin complex concentrates (aPCCs), or recombinant Factor VIIa could be considered for the reversal of the anticoagulant effect of pms-EDOXABAN.

4-factor prothrombin complex concentrate (PCC): In healthy subjects, the administration of 4-factor PCC at 50 IU/kg reversed the anticoagulant effect of edoxaban tablets within 30 minutes after completing the infusion.

3-factor PCC: In healthy volunteers, a 3-factor PCC restored thrombin generation but did not normalize PT.

In animal models PCC, aPCC, and recombinant Factor VIIa agents have reversed coagulation biomarkers and bleeding.

The following are not expected to reverse the anticoagulant effects of edoxaban tablets: protamine sulfate, vitamin K, and tranexamic acid.

Hemodialysis does not significantly contribute to edoxaban tablets clearance.

For the most recent information in the management of a suspected drug overdose, contact your regional poison control centre or Health Canada's toll-free number, 1-844 POISON-X (1-844-764-7669).

6 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING

Table 4 – Dosage Forms, Strengths, Composition and Packaging

Route of Administration	Dosage Form / Strength / Composition	Non-medicinal Ingredients
Oral	Tablet 15 mg, 30 mg and 60 mg	calcium carbonate, carmellose sodium, crospovidone, glucose monohydrate, hydroxypropylcellulose, iron oxide red (15 mg and 30 mg), iron oxide yellow (15 mg and 60 mg), lecithin, maltodextrin, magnesium stearate, mannitol, pregelatinized starch, silica colloidal anhydrous.

pms-EDOXABAN 15 mg is: orange, round-shaped film-coated tablets debossed with "15" on one side and plain on the other side. Each 15 mg tablet contains 20.2 mg edoxaban tosylate monohydrate equivalent to 15 mg of edoxaban.

pms-EDOXABAN 30 mg is: pink, round-shaped film-coated tablets debossed with "30" on one side and plain on the other side. Each 30 mg tablet contains 40.41 mg edoxaban tosylate monohydrate equivalent to 30 mg of edoxaban.

pms-EDOXABAN 60 mg is: yellow, round-shaped film-coated tablets debossed with "60" on one side and plain on the other side. Each 60 mg tablet contains 80.82 mg edoxaban tosylate monohydrate equivalent to 60 mg of edoxaban.

pms-EDOXABAN tablets are supplied in HDPE bottles of 90 tablets and 500 tablets and blisters pack of 14 tablets (for 15 mg and 30 mg) and pack of 10 tablets (for 60 mg).

7 WARNINGS AND PRECAUTIONS

PREMATURE DISCONTINUATION OF ANY ORAL ANTICOAGULANT, INCLUDING pms-EDOXABAN, INCREASES THE RISK OF THROMBOTIC EVENTS.

To reduce this risk, consider coverage with another anticoagulant if pms-EDOXABAN is discontinued for a reason other than pathological bleeding or completion of a course of therapy (see 4 DOSAGE AND ADMINISTRATION).

The following Warnings and Precautions are listed in alphabetical order.

Bleeding

Edoxaban tablets increase the risk of bleeding and can cause serious, potentially fatal bleeding. Promptly evaluate any signs or symptoms of blood loss. Discontinue pms-EDOXABAN in patients with clinically significant active bleeding. pms-EDOXABAN, like other anticoagulants, must be used with caution in patients with any increased risk of bleeding. Patients at high risk of bleeding should not be prescribed pms-EDOXABAN (see 2 CONTRAINDICATIONS).

Should severe bleeding occur, treatment with pms-EDOXABAN must be discontinued and the source of bleeding investigated promptly.

Close clinical surveillance (looking for signs of bleeding or anemia) is recommended throughout the treatment period, especially in the presence of multiple risk factors for bleeding (see Table 5 below).

Table 5 – Factors Which Increase Hemorrhagic Risk

Factors increasing edoxaban plasma levels*	Severe renal impairment (CrCl 15-29 mL/min) Moderate renal impairment (CrCl 30 – 50 mL/min)
	Concomitant systemic treatment with P-gp inhibitors
	Low body weight ≤ 60 kg
Pharmacodynamic interactions	Chronic use of NSAIDs
	Platelet aggregation inhibitors, including ASA, clopidogrel, prasugrel, ticagrelor
	Selective serotonin reuptake inhibitors (SSRIs), and serotonin norepinephrine reuptake inhibitors (SNRIs)
Diseases / procedures with special hemorrhagic risks	Congenital or acquired coagulation disorders
	Thrombocytopenia or functional platelet defects
	Active ulcerative gastrointestinal disease
	Recent gastrointestinal bleeding
	Recent intracranial hemorrhage or ischemia
	Recent brain, spinal or ophthalmological surgery
Others	Age > 75 years

* see 4 DOSAGE AND ADMINISTRATION for dose reductions.

Coadministration with Anticoagulants, Antiplatelets, Thrombolytics, and SSRIs/SNRIs
Concomitant use of drugs affecting hemostasis may increase the risk of bleeding. These include antiplatelet agents, such as aspirin (ASA), P2Y12 platelet inhibitors, other antithrombotic agents, fibrinolytic therapy, selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs) due to reported known effects on abnormal platelet aggregation, and chronic nonsteroidal anti-inflammatory drugs (NSAIDs).

Long term concomitant treatment with pms-EDOXABAN and other anticoagulants is therefore not recommended due to increased risk of bleeding. Short term co-administration may be needed for patients transitioning to or from pms-EDOXABAN (see 4 DOSAGE AND ADMINISTRATION). Concomitant use of pms-EDOXABAN with unfractionated heparin (UFH) is contraindicated, except at doses used to maintain a patent central venous or arterial catheter.

In clinical studies with edoxaban tablets, concomitant use of low dose (≤ 100 mg/day) ASA or thienopyridines (clopidogrel), and NSAIDs resulted in increased rates of clinically relevant bleeding. Other platelet aggregation inhibitors such as prasugrel and ticagrelor, have not been studied with edoxaban tablets in any patient population, and are **not** recommended as concomitant therapy (see 9 DRUG INTERACTIONS).

Cardiovascular

Valvular Disease
Safety and efficacy of edoxaban tablets have not been studied in patients with prosthetic mechanical heart valves or those with hemodynamically significant rheumatic heart disease, especially mitral stenosis. Therefore, pms-EDOXABAN is not recommended in these patients. Of note, the ENGAGE AF-TIMI 48 study that evaluated edoxaban tablets in SPAF, has included patients with other valvular heart disease (e.g. aortic stenosis, aortic and or mitral regurgitation) as well as with prosthetic biological valves (see 14 CLINICAL TRIALS).

Cardioversion
Patients can be initiated or maintained on pms-EDOXABAN while being cardioverted.

Hepatic/Biliary

Hepatic Impairment
Patients with significant liver disease (e.g., acute hepatitis, chronic active hepatitis, cirrhosis) were excluded from clinical trials of edoxaban tablets. Therefore, pms-EDOXABAN is contraindicated in patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk.

Edoxaban tablets have not been studied in patients with severe hepatic impairment; therefore, it is not recommended. pms-EDOXABAN should be used with caution in patients with mild to moderate hepatic impairment (see 4 DOSAGE AND ADMINISTRATION and 10 CLINICAL PHARMACOLOGY).

Monitoring and Laboratory Tests

A specific anticoagulant reversal agent for edoxaban tablets is not commercially available. The pharmacodynamic effects measured by anti-factor Xa (FXa) assay are predictable and correlate with the dose and the concentration of edoxaban tablets. As a result of FXa inhibition, edoxaban tablets also prolong clotting time in tests such as prothrombin time (PT), and activated partial thromboplastin time (aPTT). Changes observed in these clotting tests at the expected therapeutic dose, however, are small, subject to a high degree of variability, and not useful in monitoring the anticoagulation effect of edoxaban tablets.

Although pms-EDOXABAN therapy will lead to an elevated INR, depending on the timing of the measurement, the INR is not a valid measure to assess the anticoagulant activity of pms-EDOXABAN(see 4 DOSAGE AND ADMINISTRATION, Switching from pms-EDOXABAN to VKA, Considerations for INR Monitoring of VKA Activity during Concomitant pms-EDOXABAN Therapy). The INR is only calibrated and validated for vitamin K antagonists (VKA) and should not be used for any other anticoagulant, including pms-EDOXABAN.

Although there is no need to monitor anticoagulation effect of pms-EDOXABAN during routine clinical practice, in certain infrequent situations such as overdosage, acute bleeding, urgent surgery, in cases of suspected non-compliance, or in other unusual circumstances, assessment of the anticoagulant effect of pms-EDOXABAN may be appropriate. Accordingly, a calibrated quantitative anti- FXa assay may be useful to inform clinical decisions in these circumstances (see 10 CLINICAL PHARMACOLOGY - Pharmacodynamics, Table 12) for predicted steady-state peak and trough anti-FXa activity in different indications and for different doses of edoxaban tablets).

Patients with antiphospholipid syndrome

Direct oral anticoagulants (DOACs) including edoxaban are **not** recommended for patients with a history of thrombosis who are diagnosed with antiphospholipid syndrome. In particular for patients that are triple positive (for lupus anticoagulant, anticardiolipin antibodies, and anti-beta 2-glycoprotein I antibodies), treatment with DOACs could be associated with increased rates of recurrent thrombotic events compared with vitamin K antagonist therapy.

Peri-Operative/ Procedural Considerations

As with any anticoagulant, patients on pms-EDOXABAN who undergo surgery or invasive procedures are at increased risk for bleeding. In these circumstances, temporary discontinuation of pms-EDOXABAN may be required.

Pre-Operative Phase

If an invasive procedure or surgical intervention is required, pms-EDOXABAN should be stopped at least 24 hours before the intervention, if possible, due to increased risk of bleeding, and based on clinical judgment of the physician. If the procedure cannot be delayed, the increased risk of bleeding should be assessed against the urgency of the intervention. Although there are

limited data in patients at higher risk of bleeding or in major surgery where complete hemostasis may be required, consider stopping pms-EDOXABAN at least 48 hours before surgery, depending on clinical circumstances. pms-EDOXABAN should be restarted after surgery or interventional procedures as soon as it has been determined that adequate hemostasis has been established.

Peri-Operative Spinal/Epidural Anesthesia, Lumbar Puncture
When neuraxial (epidural/spinal) anesthesia or spinal puncture is performed, patients treated with antithrombotics for prevention of thromboembolic complications are at risk for developing an epidural or spinal hematoma that may result in long-term neurological injury or permanent paralysis.

The risk of these events is even further increased by the use of indwelling catheters or the concomitant use of drugs affecting hemostasis. Accordingly, indwelling epidural or intrathecal catheters must be removed at least 5 hours prior to the first dose of pms-EDOXABAN. The risk may also be increased by traumatic or repeated epidural or spinal puncture. If traumatic puncture occurs, the administration of pms-EDOXABAN should be delayed for 24 hours.

Patients who have undergone epidural puncture and who are receiving pms-EDOXABAN should be frequently monitored for signs and symptoms of neurological impairment (e.g., numbness or weakness of the legs, bowel or bladder dysfunction). If neurological deficits are noted, urgent diagnosis and treatment is necessary.

The physician should consider the potential benefit versus the risk before neuraxial intervention in patients anticoagulated or to be anticoagulated for thromboprophylaxis and use pms-EDOXABAN only when the benefits clearly outweigh the possible risks. An epidural catheter should not be withdrawn earlier than 24 hours after the last administration of pms-EDOXABAN.

Post-Procedural Period
pms-EDOXABAN should be restarted following an invasive procedure or surgical intervention as soon as adequate hemostasis has been established and the clinical situation allows, in order to avoid unnecessary increased risk of thrombosis.

Orthopedic Surgery
pms-EDOXABAN is not recommended for the prevention of VTE in patients who have undergone elective total Knee or hip surgery, since the safety and efficacy of edoxaban tablets have not been established in these clinical situations.

Pulmonary

pms-EDOXABAN is not recommended as an alternative to unfractionated heparin in patients with pulmonary embolism who are haemodynamically unstable or may receive thrombolysis or pulmonary embolectomy since the safety and efficacy of edoxaban tablets have not been established in these clinical situations.

Renal

Renal Impairment
Plasma concentration of edoxaban tablets is increased with the degree of renal impairment. Therefore, renal function: CrCL should be monitored at the beginning of the treatment in all patients and afterwards when clinically indicated.

There are limited data in patients with end stage renal disease (CrCl<15 mL/min) or on dialysis as these patients were excluded from pivotal Phase III trials. Therefore, pms-EDOXABAN is not recommended in these patients. Patients who develop acute renal failure while on pms-EDOXABAN should discontinue such treatment (see 4 DOSAGE AND ADMINISTRATION and 10 CLINICAL PHARMACOLOGY).

Anticoagulant-related nephropathy
There have been post-marketing reports of anticoagulant-related nephropathy (ARN) following edoxaban use, presenting as acute kidney injury. Close monitoring including renal function evaluation is advised in patients with excessive anticoagulation, compromised renal function and hematuria.

7.1 Special Populations

7.1.1 Pregnant Women
No data are available on the use of edoxaban tablets in pregnant women. Based on animal data, use of pms-EDOXABAN is contraindicated throughout pregnancy (see 2 CONTRAINDICATIONS, and 16 NON- CLINICAL TOXICOLOGY - Reproductive Toxicology and Lactation).

If pms-EDOXABAN is to be used in women of childbearing potential, pregnancy should be avoided.

The safety and effectiveness of edoxaban tablets during labor and delivery have not been studied in clinical studies. The risk for pregnancy-related hemorrhage and/or emergent delivery is increased with the use of an anticoagulant that is not readily reversible.

Animal reproductive and development toxicity studies showed maternal and embryo-fetal toxicities in rats and rabbits at higher doses. Reproductive performance was unaffected in both rats and rabbits (see 16 NON-CLINICAL TOXICOLOGY).

7.1.2 Breast-feeding
No data are available on the use of edoxaban tablets in nursing mothers. In a non-clinical study, edoxaban was excreted in the breast milk of rats. pms-EDOXABAN should only be administrated after breastfeeding is discontinued (see 16 NON-CLINICAL TOXICOLOGY - Reproductive Toxicology and Lactation).

It is not known if edoxaban or its metabolites are excreted in human milk. Because many drugs are excreted in human milk caution should be exercised and a decision made whether to discontinue breastfeeding or discontinue pms-EDOXABAN, taking into account the importance

of the drug to the mother.

7.1.3 Pediatrics (< 18 years of age)

The safety and efficacy of edoxaban tablets in children under age 18 years have not been yet established. Therefore, use of pms-EDOXABAN is not recommended in these patients.

7.1.4 Geriatrics (> 65 years of age)

No change in dose is generally required based on age (see 10 CLINICAL PHARMACOLOGY).

8 ADVERSE REACTIONS

8.1 Adverse Reaction Overview

SPAF

In the pivotal double-blind randomized ENGAGE AF-TIMI 48 study, a total of 21,026 subjects with documented atrial fibrillation (AF) received at least one dose of edoxaban 60 mg (N=7012), edoxaban 30 mg (N=7002), or warfarin (N=7012). The duration of edoxaban exposure was ≥360days for 11,479 subjects and ≥720 days for 10,075 subjects. Median study drug exposure for the
edoxaban and warfarin treatment group was 2.5 years.

In the ENGAGE AF-TIMI 48 study, 2256 (32.2%) of the subjects treated with edoxaban 60 mg (30 mg dose-reduced) experienced adverse reactions. Non-endpoint adverse events resulted in study drug discontinuation in 11.2% and 11.0% of the subjects in the edoxaban 60 mg, and the warfarin treatment groups, respectively.

Treatment of VTE and Prevention of Recurrent DVT and PE

In the pivotal double-blind randomized HOKUSAI-VTE study, subjects with acute, symptomatic DVT involving the popliteal, femoral or iliac veins, or PE requiring anticoagulant therapy were treated with edoxaban (N=4118) or warfarin (N=4122) after a heparin-based initial treatment of ≥5 days. These 8240 subjects comprised the safety population. The median time on treatment was 8.8 months in both groups. The duration of drug exposure for edoxaban was ≤ 6 months for 1561 (37.9%) of subjects, > 6 months for 2557 (62.1%) of subjects and 12 months for 1661 (40.3%) of subjects.

In the HOKUSAI-VTE study, in total, 1249 (30.3%) of the subjects treated with edoxaban 60 mg (30 mg dose-reduced) experienced adverse reactions. The frequency of non-endpoint adverse events resulting in permanent study drug discontinuation was 5.7% in the edoxaban group and 5.4% in the warfarin group.

Bleeding in Patients with VTE in the Hokusai VTE Cancer Study

In the Hokusai VTE Cancer, randomized, open-label, non-inferiority study, evaluating the efficacy and safety of edoxaban 60 mg once daily after at least 5 days of low molecular weight heparin (LMWH) versus dalteparin (200 IU/kg day 1-30; 150 IU/kg day 31 to the end of treatment) in 1050 patients with acute VTE and predominantly advanced cancer (see 10 CLINICAL PHARMACOLOGY).

The median duration of edoxaban exposure was 211 days (range, 2 to 423). The safety outcome was major bleeding that occurred during or within three days of stopping study treatment. The incidence of major bleeding was higher in the edoxaban arm than in the dalteparin arm [HR (95% CI): 2.00 (1.09, 3.66)].

Table 6: Analysis of Adjudicated Bleeding Events, Safety Analysis Set - On-Treatment Study Period

	Edoxaban (N=522)	Dalteparin (N=524)	HR (95% CI)	p-value
Major Bleeding, n (%)	32 (6.1)	16 (3.1)	2.00 (1.089, 3.657)	0.0254
Major + CRNM Bleeding, n (%)	91 (17.4)	59 (11.3)	1.55 (1.113, 2.151)	0.0094
CRNM Bleeding, n (%)	70 (13.4)	48 (9.2)	1.45 (1.002, 2.099)	0.0488
Nuisance Bleeding, n (%)	56 (10.7)	60 (11.5)	0.91 (0.636, 1.311)	0.6219
Any Confirmed Bleeding, n (%)	137 (26.2)	104 (19.8)	1.31 (1.018, 1.696)	0.0361

Abbreviations: HR = hazard ratio, CI = confidence interval, CRNM = clinically relevant non-major
Note: The HR, 2-sided CI and p-value for pairwise comparisons versus dalteparin are based on the Cox regression model with counting process approach for on-treatment including treatment and the 2 stratification factors as covariates: the dichotomized bleeding risk and the dichotomized dose-adjustment factor.

In patients with GI cancer at randomization, major bleeding occurred in 13.2% (18/136) in the edoxaban group and 2.4% (3/125) in the dalteparin group. In patients without GI cancer at randomization, major bleeding occurred in 3.6% (14/386) in the edoxaban group and 3.3% (13/399) in the dalteparin group.

8.2 Clinical Trial Adverse Reactions

Clinical trials are conducted under very specific conditions. The adverse reaction rates observed in the clinical trials; therefore, may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse reaction information from clinical trials may be useful in identifying and approximating rates of adverse drug reactions in real-world use.

Bleeding Events

The most notable adverse reactions reported with edoxaban were related to bleeding. Bleeding of any type of severity occurred at a rate of 14.2 % per year among subjects with AF treated with edoxaban in the ENGAGE-AF TIMI 48 study and in 21.7 % in the HOKUSAI-VTE study. Bleeding can occur at any site and may be severe, life-threatening, and even fatal (see 7 WARNINGS AND PRECAUTIONS). Known complications secondary to severe bleeding, such as acute renal injury due to hypoperfusion, have been reported.

In both studies, the most common adverse reactions related to bleeding with edoxaban 60 mg (30 mg dose-reduced) group included cutaneous soft tissue hemorrhage (≤ 5.9%) and epistaxis (≤ 4.7%), while vaginal hemorrhage (9.0%) was the most common bleeding-related adverse reaction in HOKUSAI-VTE study only.

Since the patient populations treated with edoxaban for different indications are not interchangeable, a summary description of major and total bleeding is provided by indication and pivotal trial below.

ENGAGE AF-TIMI 48 study

Table 7 – Adjudicated Bleeding Events in SPAF Patients, ENGAGE AF-TIMI 48 study

	Edoxaban 60mg (30mg dose-reduced) (N=7012)	Warfarin (N=7012)	Edoxaban 60mg (30mg dose- reduced) vs Warfarin	
Bleeding Category - First Event	**n (%/yr)[a]**	**n (%/yr) [a]**	**HR (95% CI)**	**p-value**
Major[b]	418 (2.75)	524 (3.43)	0.80 (0.707, 0.914)	0.0009
ICH[c]	61 (0.39)	132 (0.85)	0.47 (0.344, 0.631)	<0.0001
Gastrointestinal	232 (1.51)	190 (1.23)	1.23 (1.019, 1.496)	0.0311
Fatal	32 (0.21)	59 (0.38)	0.55 (0.355, 0.840)	0.0059
ICH[c]	24 (0.15)	42 (0.27)	0.58 (0.349, 0.951)	0.0312
Non-ICH	8 (0.05)	17 (0.11)	0.47 (0.204, 1.095)	0.0804
CRNM[d]	1214 (8.67)	1396 (10.15)	0.86 (0.795, 0.927)	0.0001
Any Confirmed Bleeds[e]	1865 (14.15)	2114 (16.40)	0.87 (0.816, 0.924)	<0.0001

Abbreviations: CI = Confidence Interval; ICH = Intracranial Hemorrhage; HR = Hazard Ratio versus Warfarin; yr = year; CRNM = Clinically Relevant Non-Major

Note: Adjudicated bleeding events include events during treatment or within 3 days of stopping study treatment. A subject can be included in multiple sub-categories if he/she had an event for those categories. The first event of each category is included in the analysis

[a]: The event rate (%/yr) is calculated as # of events/subject-year exposure.

[b]: A Major Bleeding event (the study primary safety endpoint) was defined as clinically overt bleeding that met one of the following criteria: fatal bleeding; symptomatic bleeding in a critical site such as retroperitoneal, intracranial, intraocular, intraspinal, intra-articular, pericardial, or intramuscular with compartment syndrome; a clinically overt bleeding event that caused a fall in hemoglobin of at least 2.0 g/dL (or a fall in hematocrit of at least 6.0% in the absence of hemoglobin data), when adjusted for transfusions (1 unit of transfusion = 1.0 g/dL drop in hemoglobin).

[c]: ICH includes primary hemorrhagic stroke, subarachnoid hemorrhage, epi/subdural hemorrhage, and ischemic stroke with major hemorrhagic conversion.

[d]: CRNM (Clinically Relevant Non-Major bleeding) was defined as an overt bleeding event that required medical attention, including those that may have resulted in diagnostic or therapeutic measures.

[e]: Any Confirmed Bleed includes those that the adjudicator defined as clinically overt.

The site of major bleeds was mostly in the gastrointestinal (GI) tract, followed by intracranial, and intra-ocular. There were more Major GI bleeds in the edoxaban 60 mg (30 mg dose-reduced) group than the warfarin group (1.5% and 1.2% per year, respectively).

A higher proportion of edoxaban treated patients reported anemia related events; 8.2% (578/7012) of the 60 mg patients (30 mg dose-reduced) as compared to 5.6 % (396/7012) of warfarin treated patients. Similarly, more anemia and anemia-related events were reported to be serious or severe for edoxaban 60 mg (30 mg dose-reduced) group (1.4%) compared to the warfarin group (0.7%). The majority of the bleeding events occurring in edoxaban 60 mg (30 mg dose-reduced) treated patients with either serious or severe anemia/anemia-related events were from the GI tract. A number of risk factors have been identified to increase the risk of bleeding which may result in post hemorrhagic anemia (see 7 WARNINGS AND PRECAUTIONS - Table 5) and are associated with dose adjustments (see 4 DOSAGE AND ADMINISTRATION).

The percentage of subjects who discontinued study drug due to Investigator-reported bleeding events was 3.9% and 4.1%, respectively, for the edoxaban 60 mg (30 mg dose-reduced) and the warfarin treatment groups.

HOKUSAI-VTE study

Table 8 – Adjudicated Bleeding Events in VTE Patients, HOKUSAI-VTE Study

Adjudicated Bleeding	Edoxaban 60mg (30mg dose-reduced) N=4118	Warfarin N=4122	Edoxaban vs. Warfarin	
			HR (95% CI)	p-value
Major/CRNM Bleeding, n (%)	349 (8.5)	423 (10.3)	0.81 (0.705, 0.936) [a]	0.0040 [a]
ICH, n (%)	5 (0.1)	18 (0.4)	-	-
Gastrointestinal, n (%)	98 (2.4)	94 (2.3)	-	-
Major Bleeding, n (%) [b]	56 (1.4)	66 (1.6)	0.84 (0.592, 1.205) [a]	0.3521 [a]
ICH, n (%)	5 (0.1)	18 (0.4)	-	-
Fatal ICH, n (%)	0 (0)	6 (0.1)	-	-
Gastrointestinal, n (%)	27 (0.7)	18 (0.4)	-	-
All Bleeding, n (%)	895 (21.7)	1056 (25.6)	0.82 (0.750, 0.896)	<0.0001

Abbreviations: CI = Confidence Interval, CRNM = Clinically Relevant Non-Major, HR = Hazard Ratio vs. Warfarin, ICH: intracranial hemorrhage; N = number of subjects in analysis set, n = number of subjects meeting event criteria.
Note: Adjudicated bleeding events include events during treatment or within 3 days of stopping study treatment.
[a] The HR and two-sided CI are based on the Cox proportional hazards regression model including treatment and the following randomization stratification factors as covariates: presenting diagnosis (PE with or without DVT, DVT only), baseline risk factors (temporary factors, all others), and the need for 30 mg edoxaban/edoxaban placebo dose at randomization (yes, no), p-value α =0.01 [two-sided].
[b] A Major Bleeding event was defined as clinically overt bleeding that met one of the following criteria: associated with a fall in hemoglobin level of 2.0 g/dL or more, or leading to transfusion of two or more units of packed red cells

or whole blood; occurring in a critical site or organ: intracranial, intraspinal, intraocular, pericardial, intra-articular, intramuscular with compartment syndrome, retroperitoneal; contributing to death.

The percentage of subjects who discontinued study drug due to Investigator-reported bleeding events was 1.4% in both groups.

Most Common Adverse Drug Reaction

The most common non-bleeding treatment-emergent adverse reactions reported in the ENGAGE AF-TIMI 48 Study for edoxaban 60 mg (30 mg dose-reduced) group versus warfarin were rash (4.2% vs 4.1%), and abnormal liver function tests (4.8% vs. 4.6%), respectively. Results are presented below in Table 9.

Table 9 – Common Adverse Drug Reactions observed in ≥ 1% of Edoxaban-treated Patients in ENGAGE AF-TIMI 48 Study

	Edoxaban 60 mg (30 mg Dose - Reduced) N = 7012 n (%)[a]	Warfarin N = 7012 n (%)[a]
Respiratory, Thoracic and Mediastinal Disorders		
Epistaxis	392 (2.6)	359 (2.4)
Gastrointestinal Disorders		
Lower GI hemorrhage	411 (2.7)	264 (1.7)
Upper GI hemorrhage	187 (1.2)	144 (0.9)
Skin and Subcutaneous Tissue Disorders		
Cutaneous soft tissue hemorrhage	577 (3.8)	947 (6.6)
Renal and Urinary Disorders		
Macroscopic hematuria/urethral	293 (1.9)	255 (1.7)
Blood and Lymphatic System Disorders		
Anaemia	368 (5.2)	242 (3.5)
Skin and Subcutaneous Tissue Disorders		
Rash	295 (4.2)	289 (4.1)
Investigations		
Liver function test abnormal	337 (4.8)	326 (4.6)

[a] Summary of adjudicated bleeding events by location (%/year).

The most common treatment-emergent adverse drug reactions in the HOKUSAI-VTE Study are presented below in Table 10.

Table 10 – Common Adverse Reactions observed in ≥ 1% of Edoxaban-treated Patients in HOKUSAI-VTE Study

	Edoxaban 60 mg (30 mg Dose-Reduced) N = 4118 n (%)[a]	Warfarin N = 4122 n (%)[a]
Respiratory, Thoracic and Mediastinal Disorders		
Epistaxis	195 (4.7)	237 (5.7)
Gastrointestinal Disorders		
Lower GI hemorrhage	141 (3.4)	126 (3.1)
Oral/Pharyngeal hemorrhage	138 (3.4)	162 (3.9)
General		
Puncture site hemorrhage	56 (1.4)	99 (2.4)
Skin and Subcutaneous Tissue Disorders		
Cutaneous soft tissue hemorrhage	245 (5.9)	414 (10.0)
Rash	147 (3.6)	151 (3.7)
Renal and Urinary Disorders		
Macroscopic hematuria/urethral	91 (2.2)	117 (2.8)
Reproductive System and Breast Disorders		
Vaginal hemorrhage	158 (9.0)	126 (7.1)
Blood and Lymphatic System Disorders		
Anaemia	72 (1.7)	55 (1.3)
Investigations		
Liver function test abnormal	322 (7.8)	322 (7.8)

[a] Summary of adjudicated bleeding events by location (%). For gender specific category (vaginal bleeding) the event rate is based on the gender specific subject numbers

8.3 Less Common Clinical Trial Adverse Reactions

ENGAGE AF-TIMI 48

Cardiovascular Disorders: Pericardial hemorrhage
Eye Disorders: Intraocular hemorrhage
Gastrointestinal Disorders: Oral/Pharyngeal hemorrhage, Retroperitoneal hemorrhage
General: Puncture site hemorrhage
Injury, Poisoning and Procedural Complications: Surgical site hemorrhage
Musculoskeletal and Connective Tissue Disorders: Intramuscular (no compartment syndrome), Intra-articular hemorrhage
Reproductive System and Breast Disorders: Vaginal hemorrhage
Respiratory, Thoracic and Mediastinal Disorders: Haemoptysis, Interstitial Lung Disease
Vascular: Other hemorrhage (including subconjunctival, ear, pleural)

Hokusai VTE
Cardiovascular Disorders: Pericardial hemorrhage
Eye Disorders: Conjunctival/Scleral hemorrhage, Intraocular hemorrhage
Respiratory, Thoracic and Mediastinal Disorders: Haemoptysis
Injury, Poisoning and Procedural Complications: Subdural hemorrhage, Procedural hemorrhage
Musculoskeletal and Connective Tissue Disorders: Intramuscular (no compartment syndrome), Intra-articular hemorrhage
Vascular: Other hemorrhage (including surgical site, pleural)

8.5 Post-Market Adverse Reactions
The following adverse reactions have been identified during post-approval use of edoxaban. The frequency of these adverse reactions reported from post-marketing experience cannot be estimated. The hereafter listed Adverse Drug Reactions are coming from all reporting sources.

Blood and lymphatic system disorders: thrombocytopenia
Gastrointestinal disorders: abdominal pain
Immune system disorders: angioedema, allergic oedema, hypersensitivity, urticaria
Nervous system disorders: dizziness, headache
Renal and urinary disorders: Anticoagulant-related nephropathy (ARN).
Skin and subcutaneous tissue disorders: Stevens-Johnson syndrome

9 DRUG INTERACTIONS

9.1 Serious Drug Interactions

Serious Drug Interactions
The use of pms-EDOXABAN is contraindicated for concomitant treatment with any other anticoagulant, including o unfractionated heparin (UFH), except at doses used to maintain a patent central venous or arterial catheter, o low molecular weight heparins (LMWH), such as enoxaparin and dalteparin, o heparin derivatives, such as fondaparinux, and o oral anticoagulants, such as warfarin, dabigatran, apixaban, rivaroxaban except under circumstances of switching therapy to or from pms-EDOXABAN.

9.2 Drug Interactions Overview
In vitro studies indicate that edoxaban is a substrate of p-glycoprotein (P-gp) transporter; therefore, its plasma concentration may increase in the presence of P-gp inhibitors such as cyclosporine, dronedarone, erythromycin, ketoconazole or quinidine (see below Table 11). Edoxaban does not inhibit the major cytochrome P450 enzymes (CYP1A2, 2A6, 2B6, 2C8/9, 2C19, 2D6, 2E1, or 3A4) and does not induce CYP1A2, CYP3A4 or the P-gp transporter (MDR1). *In vitro* data also indicate that edoxaban does not inhibit the following transporters at clinically relevant concentrations: P-gp, the organic anion transporters OAT1 or OAT3; the organic cation transporters OCT1 or OCT2; or the organic ion transporting polypeptides OATP1B1 or OATP1B3.

9.3 Drug-Behavioural Interactions

pms-EDOXABAN has no or negligible influence on the ability to drive and use machines.

9.4 Drug-Drug Interactions

The drugs listed in this table are based on either drug interaction case reports or studies, or potential interactions due to the expected magnitude and seriousness of the interaction (i.e., those identified as contraindicated).

Table 11 – Established or Potential Drug-Drug Interactions

Proper name	Source of Evidence	Effect	Clinical comment
P-gp Inhibitors/Substrates			
Cyclosporine	CT	Concurrent administration of a single dose of cyclosporine 500 mg with a single dose of edoxaban tablets 60 mg increased edoxaban tablets AUC and C_{max} by 73% and 74%, respectively.	Concomitant use of pms-EDOXABAN with this drug requires dose reduction to 30 mg once daily.
Dronedarone	CT	Dronedarone 400 mg twice daily for 7days with a single concomitant dose of edoxaban tablets 60 mg on Day 5 increased edoxaban tablets AUC and C_{max} by 85% and 46%, respectively.	Concomitant use of pms-EDOXABAN with this drug requires dose reduction to 30 mg once daily.
Erythromycin	CT	Erythromycin 500 mg (systemic) four times daily for 8 days with a single concomitant dose of edoxaban tablets 60 mg on Day 7 increased the edoxaban tablets AUC and C_{max} by 85% and 68%, respectively.	Concomitant use of pms-EDOXABAN with this drug requires dose reduction to 30 mg once daily.
Ketoconazole	CT	Ketoconazole 400 mg (systemic) once daily for 7days with a single concomitant dose of edoxaban tablets 60 mg on Day 4, increased edoxaban tablets AUC and C_{max} by 87% and 89%, respectively.	Concomitant use of pms-EDOXABAN with this drug requires dose reduction to 30 mg once daily.

Table 11 – Established or Potential Drug-Drug Interactions

Proper name	Source of Evidence	Effect	Clinical comment
Quinidine	CT	Quinidine 300mg once daily on Days 1 and 4 and three times daily on Days 2 and 3, with a single concomitant dose of edoxaban tablets 60 mg on Day 3, increased edoxaban tablets AUC over 24 hours by 77% and C_{max} by 85%, respectively. Edoxaban tablets had no effect on the Cmax and AUC of quinidine.	Concomitant use of pms-EDOXABAN with this drug requires dose reduction to 30 mg once daily.
Verapamil	CT	Verapamil 240 mg once daily for 11 days with a single concomitant dose of edoxaban tablets 60 mg on Day 10 increased the edoxaban tablets AUC and C_{max} by approximately 50%. Edoxaban tablets decreased the Cmax and AUC of concomitantly administered verapamil by 14% and 16%, respectively.	No dose adjustment is required. Use with caution in taking into account specific individual patient characteristics.
Amiodarone	CT	Amiodarone 400 mg once daily for 4 days with a single dose of edoxaban tablets 60 mg on Day 4 increased the edoxaban tablets AUC and Cmax approximately 40% and 66%, respectively, Amiodarone was not at steady state in this study.	No dose adjustment is required. Use with caution in taking into account specific individual patient characteristics.
Clarithromycin	Literature	Clarithromycin (500 mg twice daily) for 10 days with a single concomitant dose of edoxaban tablets 60 mg on day 9 increased the edoxaban tablets AUC and C_{max} by approximately 53% and 27%, respectively	No dose adjustment is required. Use with caution in taking into account specific individual patient characteristics.

Table 11 – Established or Potential Drug-Drug Interactions

Proper name	Source of Evidence	Effect	Clinical comment
CYP 3A4 and P-gp Inducers			
Rifampicin	CT	Rifampicin 600 mg once daily for 7 days with a single dose of edoxaban tablets 60 mg on Day 7 decreased the AUC of edoxaban tablets by 34% without an apparent effect on $C_{max.}$	Combined use with strong CYP3A4 and P-gp inducers (e.g. phenytoin, carbamazepine and phenobarbital) should generally be avoided, since efficacy of pms-EDOXABAN may be compromised.
P-gp Substrates			
Digoxin	CT	Multiple daily doses of digoxin 0.25 mg with co-administration of edoxaban tablets 60 mg one daily for Days 8-14 increased the C_{max} of edoxaban tablets by 17%, with no significant effect on AUC or renal clearance at steady-state. Edoxaban tablets increased the Cmax of concomitantly administered digoxin by 28%; however, the AUC was not affected.	No dose modification is necessary when pms-EDOXABAN is administered with digoxin.
CYP3A4 Inhibitors and Inducers	CT	Less than 10% of an orally administered edoxaban tablets dose is metabolised via CYP3A4 in subjects with normal renal function. Therefore, no interaction is anticipated with CYP3A4 inhibitors or inducers.	No dose modification is necessary for patients taking CYP inhibitors or inducers.
Proton-Pump Inhibitors (PPIs)			
Esomeprazole	CT	Esomeprazole 40 mg once daily for 5 days with a single concomitant dose of edoxaban tablets 60 mg on Day 5 had no effect on the AUC of edoxaban tablets but the C_{max} decreased by approximately 33%.	No dose modification is necessary when pms-EDOXABAN is administered with esomeprazole.

Table 11 – Established or Potential Drug-Drug Interactions

Proper name	Source of Evidence	Effect	Clinical comment
Anticoagulants	CT, T	A single subcutaneous dose of 1 mg/kg enoxaparin did not have an effect on the PK of a single oral dose of edoxaban tablets 60 mg when administered concomitantly or within 12 hours of each other.	Co-administration of pms-EDOXABAN with other anticoagulants is contraindicated due to increased risk of bleeding (see 2 CONTRAINDICATION)
Platelet Inhibitors			
Acetylsalicylic acid (ASA)	CT	Co-administration of ASA (100 mg or 325 mg) and edoxaban tablets increased bleeding time relative to either medicine alone. Co-administration of high-dose ASA (325 mg) increased the steady state C_{max} and AUC of edoxaban tablets by 35% and 32%, respectively. In clinical studies concomitant use of ASA (low dose ≤100 mg/day) was permitted and resulted in increased clinically relevant bleeding although with a lower risk of bleeding on edoxaban tablets compared to warfarin (see 7WARNINGS AND PRECAUTIONS).	pms-EDOXABAN can be co-administered with low-dose ASA (≤ 100 mg/day). Assess bleeding risk before co-administration, and use with caution, if deemed necessary.
Thienopyridines (e.g. Clopidogrel)	CT	In ENGAGE AF-TIMI 48 there was very limited experience on the use of edoxaban tablets with dual antiplatelet therapy or fibrinolytic agents.	Concomitant use of drugs affecting hemostasis may increase the risk of bleeding. Use with caution, if deemed necessary.
NSAIDs			
Naproxen	CT	Co-administration of naproxen and edoxaban tablets increased bleeding time relative to either medicine alone. Naproxen had no effect on the C_{max} and AUC of edoxaban tablets. In clinical studies, co-administration of NSAIDs resulted in increased clinically relevant bleeding.	Chronic use of NSAIDs with pms-EDOXABAN is not recommended. Short term use should be used with caution, if deemed necessary.

Other medications

Table 11 – Established or Potential Drug-Drug Interactions

Proper name	Source of Evidence	Effect	Clinical comment
Atorvastatin	CT	Atorvastatin 80 mg once daily for 8 days with a single concomitant dose of edoxaban tablets 60 mg on Day 7 decreased the Cmax or AUC of edoxaban tablets by 15%.	Use with caution in taking into account specific individual patient characteristics.
HIV protease inhibitors, e.g. darunavir/ ritonavir, lopinavir/ritonavir	T	No specific drug-drug interaction has been performed with HIV protease inhibitors in combination with edoxaban tablets. HIV protease inhibitors can inhibit P-gp (besides CYP3A) and potentially increase edoxaban tablets exposure by 1.5 to 2-fold.	Use with caution, if deemed necessary.
Selective serotonin reuptake inhibitors (SSRIs)/ Serotonin norepinephrine reuptake inhibitors (SNRIs)	CT, T	As with other anticoagulants, patients on edoxaban tablets are at an increased risk of bleeding in case of concomitant use with SSRIs or SNRIs due to their reported effect on abnormal platelet aggregation.	Use with caution, if deemed necessary (see 7 WARNINGS AND PRECAUTIONS).

Legend: C = Case Study; CT = Clinical Trial; T = Theoretical

9.5 Drug-Food Interactions

pms-EDOXABAN can be taken with or without food.

9.6 Drug-Herb Interactions

Drug-herb interactions have not been established.

9.7 Drug-Laboratory Test Interactions

Drug-lab interactions have not been established.

10 CLINICAL PHARMACOLOGY

10.1 Mechanism of Action

Edoxaban is a highly selective, direct and reversible inhibitor of factor Xa, the serine protease located in the final common pathway of the coagulation cascade. Edoxaban inhibits free factor Xa, and prothrombinase activity. Inhibition of factor Xa in the coagulation cascade reduces thrombin generation and prolongs clotting time and reduces the risk of formation or provoked thrombus formation.

10.2 Pharmacodynamics

Edoxaban produces rapid onset of pharmacodynamic effects within 1-2 hours, which corresponds with peak edoxaban exposure (C_{max}). The pharmacodynamic effects measured by anti-factor Xa assay are predictable and correlate with the dose and the concentration of edoxaban. As a result of FXa inhibition, edoxaban also prolongs clotting time in tests such as prothrombin time (PT) and activated partial thromboplastin time (aPTT). Changes observed in these clotting tests at the expected therapeutic dose, however, are small, subject to a high degree of variability, and not useful in monitoring the anticoagulation effect of pms-EDOXABAN.

Table 12 – Predicted Edoxaban Steady State Exposure and Anti-FXa Activity

ENGAGE-AF				
Edoxaban Dose	**Edoxaban**			
	Cmin (ng/mL)	**Cmax (ng/mL)**	**Anti-FXa activity Min[a] (IU/mL)**	**Anti-FXa activity Max[b], (IU/mL)**
	Median **[2.5-97.5%]**			
60 mg full dose	27.3 (14.6 – 45.5)	217 (129 – 302)	0.65 (0.11 – 3.50)	3.96 (0.23 – 8.0)
Dose reduced to 30 mg	21.0 (10.2 – 30.7)	143 (91.1 - 198)	0.53 (0.05 – 2.15)	2.88 (0.24 – 6.15)
HOKUSAI VTE				
Edoxaban Dose	**Edoxaban**			
	Cmin (ng/mL)	**Cmax (ng/mL)**	**Anti-Xa activity Min[c], (IU/mL)**	**Anti-Xa activity Max[d], (IU/mL)**
	Median **[2.5-97.5%]**			
60 mg full dose	15.2 (8.37 –31.1)	211 (135 – 296)	0.28 (0.10 – 2.73)	2.79 (0.21 – 5.67)
Dose reduced to 30 mg	11.7 (4.55 – 23.5)	141 (91.9 – 190)	0.26 (0.10 – 1.66)	1.95 (0.19 – 4.98)

[a] In ENGAGE-AF Edoxaban Anti-Xa activity Min was assessed on day 29 pre-dose
[b] In ENGAGE-AF Edoxaban Anti-Xa activity Max was assessed on day 29 post-dose
[c] For HOKUSAI-VTE Edoxaban Anti-Xa activity Min was assessed over 3 months, pre-dose
[d] For HOKUSAI-VTE Edoxaban Anti-Xa activity Max was assessed over 3 months, post-dose

Effects on coagulation markers when switching from rivaroxaban, dabigatran, and apixaban to edoxaban

In clinical pharmacology studies, healthy subjects received rivaroxaban 20 mg once daily, dabigatran 150 mg twice daily, or apixaban 5 mg twice daily, followed by a single dose of edoxaban 60 mg on Day 4. Following the switch to edoxaban on Day 4, effects on PT, aPTT, and anti-FXa (rivaroxaban, or apixaban) were comparable to those seen when edoxaban was dosed alone for 4 days. After switching to edoxaban from dabigatran, aPTT values were comparable to those seen on dabigatran. Based on these data, the first dose of pms-EDOXABAN can be initiated at the next scheduled dose of the previous anticoagulant.

Variants of the Vitamin K epoxide reductase complex subunit 1(VKORC1) and CYP2C9 genes that

are known to affect warfarin sensitivity had no effect on bleeding in patients treated with edoxaban.

Effects on coagulation markers when switching from Warfarin to Edoxaban
In a double-blind study after a single 60 mg dose of edoxaban administered 24 h after the last warfarin dose, mean INR values increased from 2.25 (24 h time point) to peak levels of approximately 3.7. Mean INR values then decreased and attained levels close to the mean pre-dose value at approximately 12 h post dose (36 h).

QT/QTc Prolongation
In a randomized, double-blind, single dose, placebo- and active-controlled, four-period cross-over study, edoxaban at 90 mg and 180 mg doses in healthy subjects (N=62) was not observed to affect the QTc interval, the QRS duration, the PR interval, or heart rate.

10.3 Pharmacokinetics

Table 13 – Summary of Edoxaban Pharmacokinetic Parameters in Healthy Subjects (Single Oral 1 x 60 mg Dose), Fasting Conditions.

	$AUC_{0\text{-}inf}$ (ng.h/mL)	C_{max} (ng/mL)	T_{max} [1] (h)	$t_{½}$ (h)	CL/F (L/h)	Vd/F (L)
Single dose arithmetic mean ± SD (n=30)	1769 ± 461	249.5 ± 84.5	1.00 [0.50 - 2.50]	13.33 ± 6.87	36.66 ± 11.73	701 ± 429

[1] Expressed as median [range] only.

Absorption:
Edoxaban is absorbed with peak plasma concentrations attained within 1-2 hours. The absolute bioavailability is 62%.

Effect of Food
Food increases peak exposure to varying degrees but has minimal effect on total exposure. Edoxaban was administered with or without food in the ENGAGE AF-TIMI 48 and the HOKUSAI-VTE studies.

Effect of Gastric pH Modulators
Edoxaban is poorly soluble at pH of 6.0 or higher. It is predominantly absorbed in the upper GI tract. Thus, drugs or disease conditions that increase the stomach pH or increase gastric emptying and gut motility have the possibility of reducing edoxaban dissolution and absorption. However, co-administration of proton pump inhibitors (esomeprazole) did not impact edoxaban exposure (see 9 DRUG INTERACTIONS).

Alternate Modes of Administration
In a phase I, open-label, cross-over study, the administration of a crushed 60 mg edoxaban tablet either, orally mixed into apple puree or, suspended in water and given through a nasogastric tube, showed similar exposure (both mean AUC and Cmax) compared to the administration of an intact tablet.

Distribution:
Disposition is biphasic. The steady-state volume of distribution (Vdss) following intravenous administration of edoxaban is 107 ± 19.9 L (mean ±SD). In vitro plasma protein binding is approximately 55%. There is no clinically relevant accumulation of edoxaban (accumulation ratio 1.14) with once daily dosing. Steady state concentrations are achieved within 3 days.

Metabolism:
Unchanged edoxaban is the predominant form in plasma. There is minimal metabolism (<10%) via hydrolysis (mediated by carboxylesterase 1), conjugation or oxidation by CYP3A4. The predominant metabolite (M-4), formed by hydrolysis is active and reaches < 10% of the exposure of the parent compound in healthy subjects. Exposure to the other metabolites is < 5%.

Elimination:
In healthy subjects, edoxaban is cleared both through metabolism and as unchanged drug in urine and feces. Renal clearance (11 L/hour) of unchanged drug contributes approximately 50% to total clearance (22 L/hour) with the remaining 50% non-renal clearance occurring through metabolism and biliary secretion. The t½ for oral administration is 10-14 hours.

Linearity/non-linearity
Edoxaban displays approximately dose-proportional pharmacokinetics for doses of 15 mg to 60 mg in healthy subjects.

Pharmacokinetic/pharmacodynamic relationship(s)
PT, INR, aPTT and Anti-factor Xa correlate linearly with edoxaban concentrations.

<u>Special Populations and Conditions</u>

Pediatrics
A Phase 1 single-dose study demonstrated that the exposures to edoxaban in the pediatric patients (6 months to <18 years of age, n=54), the median AUC_{inf} and C_{max}, ranged from 0.69 to 1.17 fold and from 0.89 to 1.47 fold, respectively, relative to those in adults with venous thromboembolism who were administered edoxaban at 30 or 60 mg once daily (QD).

Geriatrics
After taking renal function and body weight into account, age had no additional clinically significant effect on edoxaban pharmacokinetics in a population pharmacokinetic analysis of subjects ≥ 75 years of age in the ENGAGE AF-TIMI 48 study.

Sex
After accounting for body weight, gender had no additional clinically significant effect on edoxaban pharmacokinetics in a population pharmacokinetic analysis of the ENGAGE AF-TIMI 48 study.

Genetic Polymorphism
Variants of the ABCB1 gene, which encodes P-gp, had no effect on edoxaban pharmacokinetics in healthy subjects.

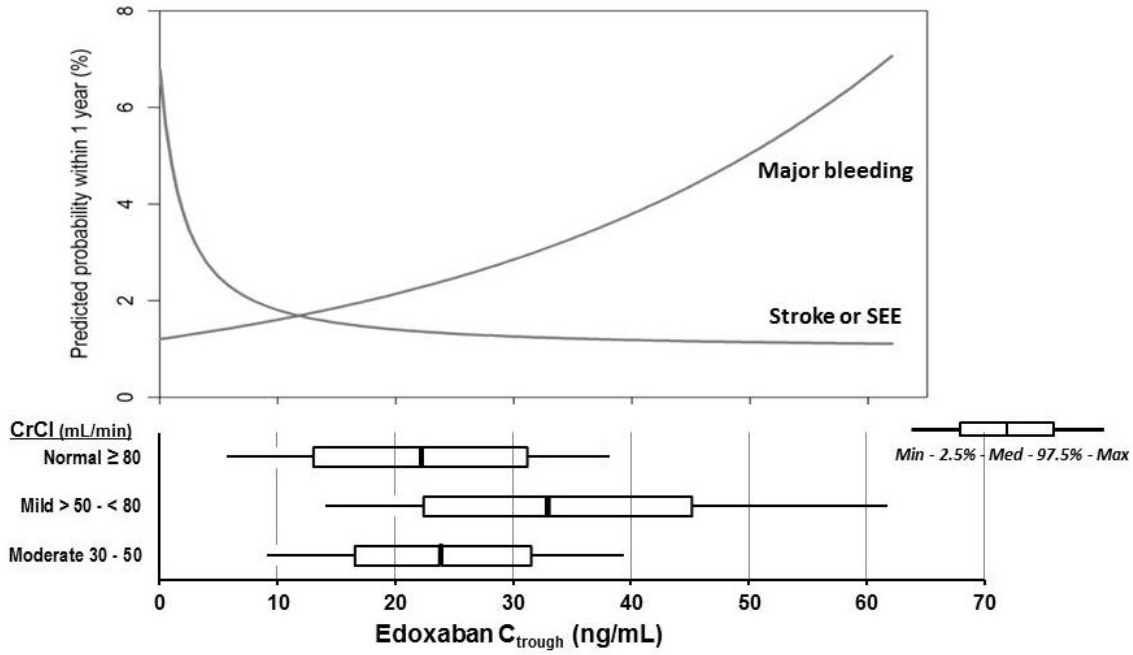
Ethnic Origin
In a population pharmacokinetic analysis of the ENGAGE AF-TIMI 48 study, peak and total exposure in Asian patients and non-Asian patients were comparable.

Hepatic Insufficiency
Patients with mild or moderate hepatic impairment (classified as Child Pugh A or Child Pugh B) exhibited comparable pharmacokinetics and pharmacodynamics to their matched healthy control group. Edoxaban has not been studied in patients with severe hepatic impairment (see 4 DOSAGE AND ADMINISTRATION).

Renal Insufficiency
50% of unchanged edoxaban is eliminated by the kidney and the plasma AUCs for subjects with mild (50-80 mL/min), moderate (30-50 mL/min) and severe (<30 mL/min but not undergoing dialysis) renal impairment were increased by 32%, 74%, and 72%, respectively, relative to subjects with normal renal function. Population PK modeling indicates that exposure approximately doubles in patients with severe renal impairment CrCL 15- 29 mL/min relative to patients with normal renal function.

Predicated efficacy and safety responses in patients with different renal function based on modeling and simulation is shown in figure below. Figure 1 describes the modeled relationship between drug exposure and outcomes. The two curves represent the average predicted probability of a stroke/SEE or major bleeding event given an average ENGAGE AF patient, i.e. using the mean age (72 years), and weighted with the probability of risk factors for stroke/SEE (prior stroke/TIA versus no prior stroke/TIA) or major bleeding (concomitant use aspirin/antiplatelet agent (ASA) or no concomitant use of ASA). The exposure response modelling predicts minimal differences in efficacy within the range of edoxaban concentrations noted in the renal function groups, but predicts a significant increase in major bleeding over this same range. The therapeutic implications of using these data in monitoring patients on edoxaban have not been established in clinical trials.

Figure 1 – Predicted Efficacy and Safety Response for average AF Patient



Note: Edoxaban trough concentrations were predicted using population PK modelling; concentrations immediately before outcomes were not available.
Horizontal bars represent model predicted Ctrough in normal renal function (edoxaban dose 60 mg), mild renal impairment (edoxaban dose 60 mg) and moderate renal impairment (edoxaban dose 30 mg).

- Hemodialysis

A 4-hour hemodialysis session reduced total edoxaban exposures by less than 7%.

Low Body Weight

In a population pharmacokinetic analysis of the ENGAGE AF-TIMI 48 study, Cmax and AUC in patients with median low body weight (55 kg) were increased by 40% and 13%, respectively, as compared with patients with median high body weight (84 kg). In phase 3 clinical studies (both SPAF and VTE indications), patients with body weight ≤ 60 kg had a 50% edoxaban dose reduction and had consistent efficacy and safety outcomes with the overall results.

Table 14 – Summary of Edoxaban's Pharmacokinetic and Pharmacodynamics in Sub-groups of Interest in ENGAGE AF TIMI 48 Study

Edoxaban 60 mg (30 mg Dose-reduced)	Edoxaban		
	C_{trough} (ng/mL)	Anti-FXa activity Min[a] (IU/mL)	Anti-FXa activity Max[b] (IU/mL)
	Median [2.5-97.5%]		
Edoxaban 60 mg full dose	27.3 [14.6 – 45.5]	0.65 (0.11, 3.56)	3.96 (0.22, 8.0)
Edoxaban dose reduced to 30 mg (due to single or multiple factors)	21.0 [10.2 – 30.7]	0.53 (0.05, 2.16)	2.88 (0.24, 6.20)
Renal function by CrCL at baseline			
30-50 mL/min*[c]	23.7 [16.5 – 31.5]	0.56 (0.05, 2.12)	2.80 (0.24, 6.40)
>50-80 mL/min	32.8 [22.4 – 45.2]	0.74 (0.05, 3.32)	4.34 (0.23, 8.00)
>80 mL/min	22.1 [13.0 – 31.2]	0.51 (0.05, 3.92)	3.44 (0.19, 7.60)
Weight ≤60 Kg only*[c]	19.6 [9.43 – 30.9]	0.43 (0.05, 2.52)	3.20 (0.31, 6.40)
Concomitant use of P-gp inhibitors only*[c]	17.2 [9.24 – 32.4]	0.63 (0.05, 3.32)	3.28 (0.19, 8.00)
CrCL≤50 and P-gp	27.2 [15.7 – 36.7]	1.22 (0.24, 2.52)	3.52 (1.81, 6.52)
Weight ≤60 Kg and P-gp	22.4 [13.5 – 36.6]	0.66 (0.05, 2.52)	3.52 (0.24, 5.88)
North America	26.2 [14.1 – 45.0]	0.69 (0.11, 2.12)	3.44 (0.33, 7.96)
Age ≥75 years	28.2 [15.1 – 46.6]	0.68 (0.05, 2.56)	3.52 (0.28, 8.00)
Fragile patients**[d]	26.1 [15.2 – 49.3]	0.63 (0.05, 2.16)	3.18 (0.24, 8.00)

[a] In ENGAGE-AF Edoxaban Anti-Xa activity Min was assessed on day 29 pre-dose
[b] In ENGAGE –AF Edoxaban Anti-Xa activity Max was assessed on day 29 post-dose
*[c] Dose reduced to 30 mg
**[d] Fragile patients defined as ≥ 80 years, weight ≤ 50 kg, CrCL ≤ 50 ml/min and or history of fall

11 STORAGE, STABILITY AND DISPOSAL

Store at 15°C-30°C.
Keep out of the reach and sight of children.

12 SPECIAL HANDLING INSTRUCTIONS

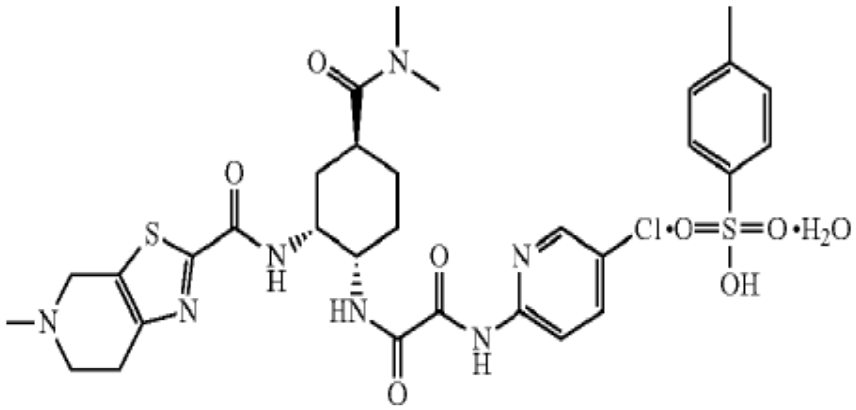
No special requirements.

PART II: SCIENTIFIC INFORMATION

13 PHARMACEUTICAL INFORMATION

Drug Substance

Proper name:	edoxaban tosylate monohydrate
Chemical name:	N-(5-Chloropyridin-2-yl)-N'-[(1S,2R,4S)-4-(N,N-dimethylcarbamoyl)-2-(5-methyl- 4,5,6,7-tetrahydro[1,3]thiazolo[5,4-c]pyridine-2-carboxamido)cyclohexyl] oxamide mono (4-methylbenzenesulfonate) monohydrate
Molecular formula:	$C_{24}H_{30}ClN_7O_4S \bullet C_7H_8O_3S$
Molecular mass:	738.27 g/mol
Structural formula:	



Physicochemical properties:

Description:	A white to yellowish powder
Solubility at pH range (1.2-6.8):	Soluble in Dimethylsulphoxide and in Methanol, very slightly soluble in Methylene Dichloride and Ethanol and Insoluble in Water.
pKa value:	6.7

14 CLINICAL TRIALS

14.1 Clinical Trials by Indication

Prevention of stroke and systemic embolism in patients with Atrial Fibrillation (SPAF)

ENGAGE AF-TIMI 48 Study

The edoxaban clinical programme for atrial fibrillation was designed to demonstrate the efficacy and safety of two dose regimens of edoxaban compared to warfarin for the prevention of stroke and systemic embolism events (SEE) in subjects with nonvalvular atrial fibrillation and at moderate to high risk of stroke and SEE.

In the pivotal ENGAGE AF-TIMI 48 study (an event-driven, phase 3, multi-centre, randomized, double-blind double-dummy parallel-group study), 21,105 subjects (21,026 of whom received study drug), with a mean CHADS2 score of 2.8, were randomized to receive either edoxaban 30 mg (15 mg dose-reduced) once daily, edoxaban 60 mg (30 mg dose-reduced) once daily treatment group or warfarin. Subjects in both edoxaban groups had their dose halved, if one or more of the following clinical factors, known to increase drug exposure, were present at randomization or during the trial: moderate renal impairment (CrCL30 – 50 mL/min), low body weight (≤ 60 kg) or concomitant use of specific P-gp inhibitors (verapamil, quinidine, dronedarone). The most common reason for dose reduction was a CrCL ≤ 50 mL/min at randomization (19% of patients).

Table 15 – Summary of Patient Demographics for clinical Trials in SPAF

Study design	Dosage, route of administration and duration	Study subjects (n = number)[b]	Mean age (Range) years	Sex (M/F) %
Randomized, double-blind, double dummy, parallel group, active controlled	Edoxaban[a]: 30 mg QD PO	n = 7002	70.6 (27 – 95)	61.2/38.8
	Edoxaban[a]: 60 mg QD PO	n = 7012	70.6 (25 – 96)	62.1/37.9
	Warfarin: QD PO Dose adjusted to maintain INR between 2.0 and 3.0	n = 7012	70.5 (27 – 95)	62.5/37.5
	Median duration of treatment 2.5 years	**Total** n = 21,026		

AF = atrial fibrillation, QD = once daily

[a] Dose reduction (30 mg to 15 mg QD; 60 mg to 30 mg QD) for moderate renal impairment, low body weight, or specified concomitant medications

[b] all treated patients receiving the drug or within 3 days from the last dose taken

Patients were well balanced with respect to demographic and baseline characteristics. The percentages of patients aged ≥ 75 years and ≥ 80 years were approximately 40% and 17%, respectively. Concomitant diseases of patients in this study included hypertension (94%), congestive heart failure (58%), and prior stroke or transient ischemic attack (28%). At baseline, approximately 30% of patients were on aspirin and approximately 2% of patients were taking a thienopyridine.

Patients were excluded if they had a creatinine clearance <30 mL/min, significant liver disease, cancer, active bleeding, acute coronary syndrome or percutaneous coronary intervention (PCI) (within the previous 30 days). Patients with prosthetic heart valves, or those with hemodynamically significant rheumatic heart disease, especially mitral stenosis, were also excluded from the study, and thus were not evaluated. Of note, approximately 20% of patients had other valvular heart disease including aortic stenosis, aortic regurgitation, and/or mitral regurgitation. Patients with a history of mitral valve repair were not excluded from the study.

The primary efficacy endpoint was the composite of stroke and systemic embolic events (SEE) that occurred during treatment or within 3 days from the last dose taken (mITT-on treatment – See Table 16 for definition). Secondary efficacy endpoints included:

- Composite of stroke, SEE, and cardiovascular mortality (CV);
- Major adverse cardiovascular event (MACE), which is the composite of non-fatal MI, non-fatal stroke, non-fatal SEE, and death due to CV cause or bleeding;
- Composite of stroke, SEE, and all-cause mortality;
- Death due to CV cause or bleeding.

The median study drug exposure for both the edoxaban 60 mg and 30 mg treatment groups was 2.5 years. The median study follow-up for both the edoxaban 60 mg and 30 mg treatment groups was 2.8 years.

Efficacy in SPAF

In the ENGAGE AF-TIMI 48 study both edoxaban 30 mg and 60 mg group regimens were non-inferior to warfarin for the primary efficacy endpoint with the upper boundary of the 97.5% CI below the pre-specified non-inferiority margin of 1.38. However, the 30 mg regimen was numerically less effective than warfarin for the primary endpoint, and was also markedly inferior in reducing the rate of ischemic stroke (Table 16).

In the warfarin group, the median TTR (time in therapeutic range, INR 2.0 to 3.0) was 68.4%.

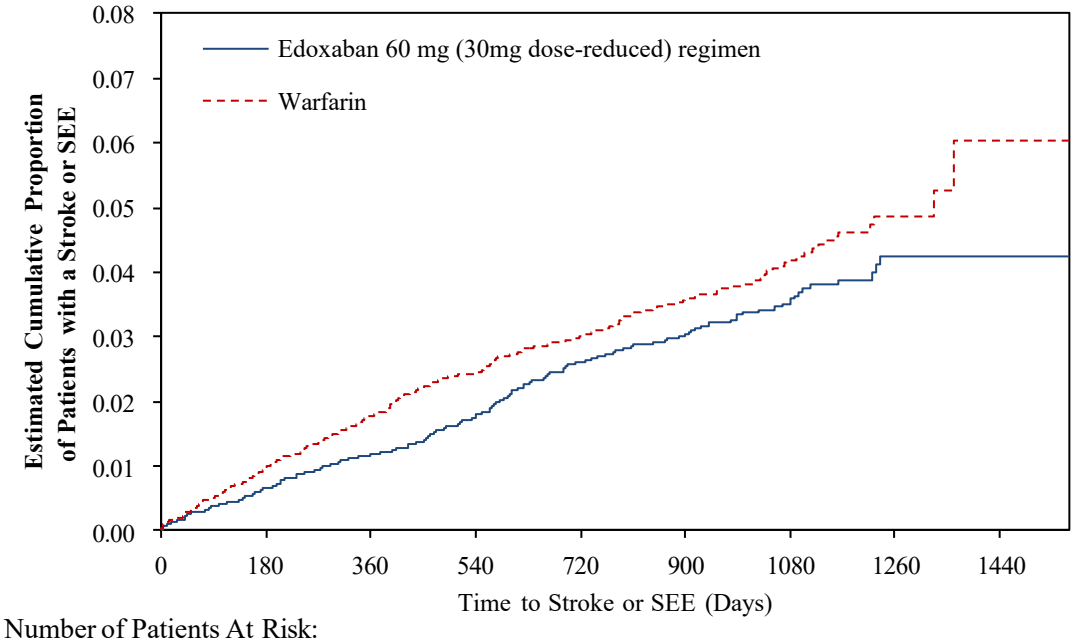
Table 16 - Efficacy Results from ENGAGE AF-TIMI 48 Study (mITT analysis set on-treatment)

Primary Endpoint	Edoxaban 30 mg (15 mg Dose-Reduced) (N=7002)	Edoxaban 60 mg (30 mg Dose-Reduced) (N = 7,012)	Warfarin (N= 7,012)
First Stroke or SEE[a]			
n (%/yr)[b]	253 (1.61)	182 (1.18)	232 (1.5)
HR (97.5% CI)	1.07 (0.874, 1.314)	0.79 (0.632, 0.985)	
p-value[c]	0.0055	<0.0001	
First Ischemic Stroke			
n (%/yr)[b]	226 (1.43)	135 (0.87)	144 (0.93)
HR (95% CI)	1.54 (1.253, 1.903)	0.94 (0.746, 1.193)	
First Hemorrhagic Stroke			
n (%/yr)[b]	18 (0.11)	40 (0.26)	76 (0.49)
HR (95% CI)	0.23 (0.139, 0.389)	0.53 (0.362, 0.778)	
First SEE			
n (%/yr)[a]	11 (0.07)	8 (0.05)	13 (0.08)
HR (95% CI)	0.83 (0.370, 1.850)	0.62 (0.257, 1.497)	

Abbreviations: HR= Hazard Ratio versus warfarin, CI= Confidence Interval, n = number of events, mITT = Modified Intent-to-treat, N = number of subjects in mITT population, SEE= Systemic Embolic Event, yr= year.
Note: The mITT population included only subjects who received at least one dose of drug; and the on- treatment period was the period during which the subject took study drug unless the patient had early drug discontinuation(s) in which case the on-treatment period included the 3 days following drug discontinuation(s).
[a] A subject can be represented in multiple rows.
[b] The event rate (%/yr) is calculated as# of events/subject-year exposure.
[c] The two-sided p-value is based on the non-inferiority margin of 1.38.

Subjects who received edoxaban 30 mg (dose reduced subjects in the 60 mg group) had an event rate of 1.79% per year for the primary endpoint, compared with an event rate of 2.21% per year for the matching dose reduced subjects in the warfarin group. Compared to warfarin-treated subjects, the HR in the edoxaban 30 mg (dose reduced subjects in the 60 mg group) was 0.81 (95% CI: 0.58, 1.13).

Figure 2 - Kaplan-Meier Curve Estimate of Cumulative Event Rates for Primary Endpoint (first occurrence of stroke or SEE) (mITT analysis set - on Treatment Study Period) in the ENGAGE AF-TIMI 48 study



Number of Patients At Risk:

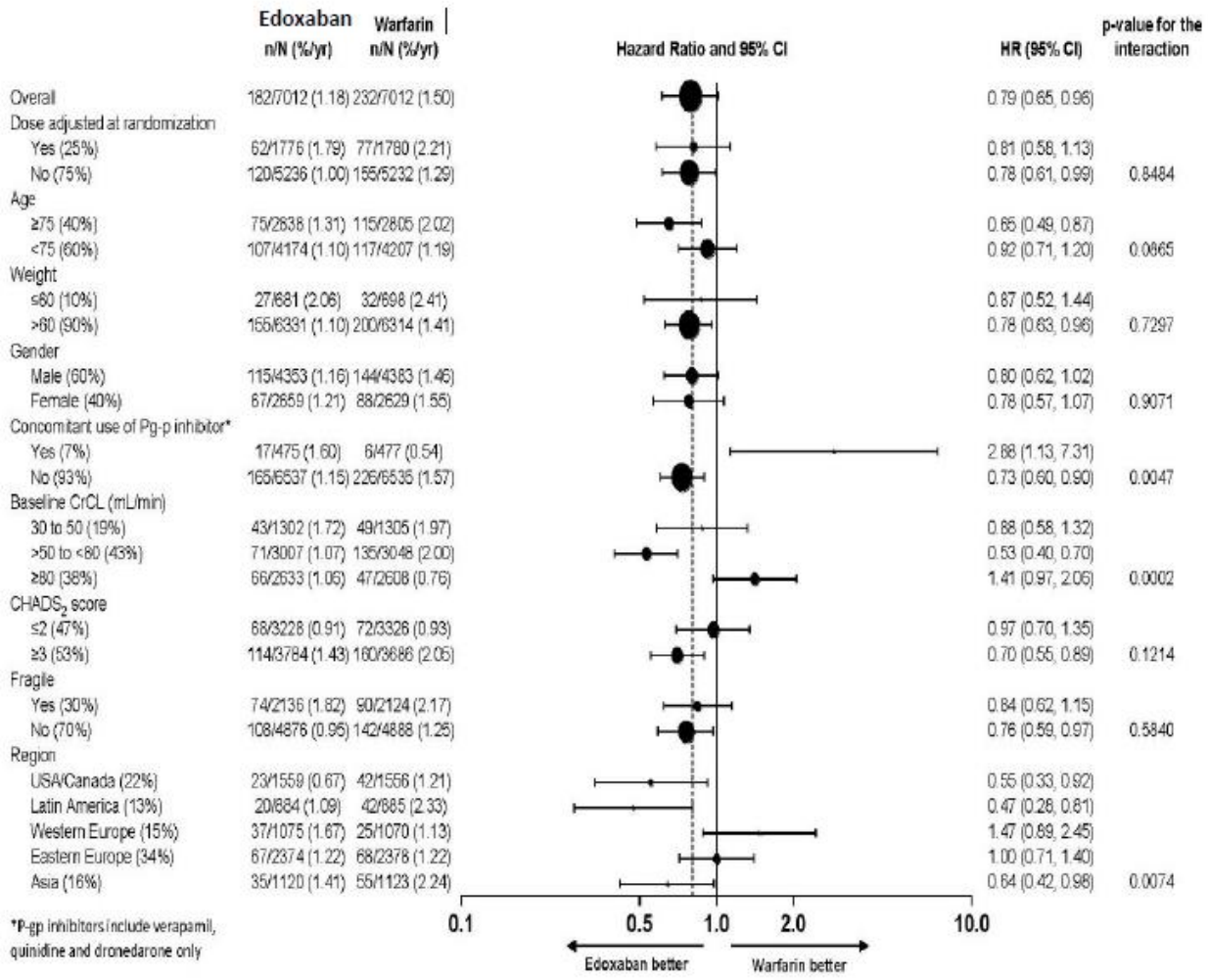
Edoxaban	7012	5699	5056	2213	46
Warfarin	7012	5724	5108	2186	55

The HR for the composite endpoints for the comparison of the edoxaban 60 mg (30 mg dose-reduced) group and warfarin for stroke, SEE, and cardiovascular (CV) mortality was 0.87 (95% CI: 0.79, 0.96), MACE was 0.89 (95% CI: 0.81, 0.97), and stroke, SEE, and all-cause mortality was 0.90 (95% CI: 0.82, 0.98), death due to CV cause was 0.86 (95% CI: 0.77, 0.97).

Results in subgroups of Interest

The efficacy results for pre-specified major subgroups (with dose reduction as required), including age, body weight, prior stroke or TIA, diabetes and P-gp inhibitors were generally consistent with the primary efficacy results for the overall population studies in the trial. However, there was a statistically significant interaction between the effect of edoxaban versus warfarin on the primary efficacy endpoint based on renal function (*HR was 1.41 in favor of warfarin for the subgroup with CrCL ≥ 80 mL/min*) and geographical regions (*HR was 1.47 in favor of warfarin for Western Europe*) (see Figure 3).

Figure 3 – ENGAGE AF-TIMI 48 Study: Primary Efficacy Endpoint by Subgroups (mITT-on treatment



Note: In the following patient groups, the edoxaban dosage was reduced to 30 mg: Weight <60 kg, CrCL 30 to 50 mL/min and concomitant use of P-gp inhibitors.
Fragile patients included patients who were ≥80 years, weight ≤50 kg, CrCL ≤50 mL/min and or history of fall.

An additional exploratory analysis was performed for the primary efficacy and safety endpoints by CrCl intervals of 20 mL/min. The observed percentage differences in efficacy in higher creatinine clearance groups between edoxaban and warfarin were numerically small, and notably, with overlapping confidence intervals. Tough the event rates of stroke/SEE in the edoxaban group were maintained in patients with CrCL between 70 and 130 mL/min, there was an unfavorable but non-significant effect of edoxaban compared to warfarin in patients with CrCL over 130 mL/min, for which there were fewer events (Figure 4). For major bleeding, the trend in favor of edoxaban 60 mg (30 mg dose-reduced) versus warfarin was preserved across the continuum of renal function (Figure 5).

Figure 4 – Stroke/SEE Event Rate by Baseline CrCl mITT Analysis Set, Overall Study Period - ENGAGE AF-TIMI 48 study

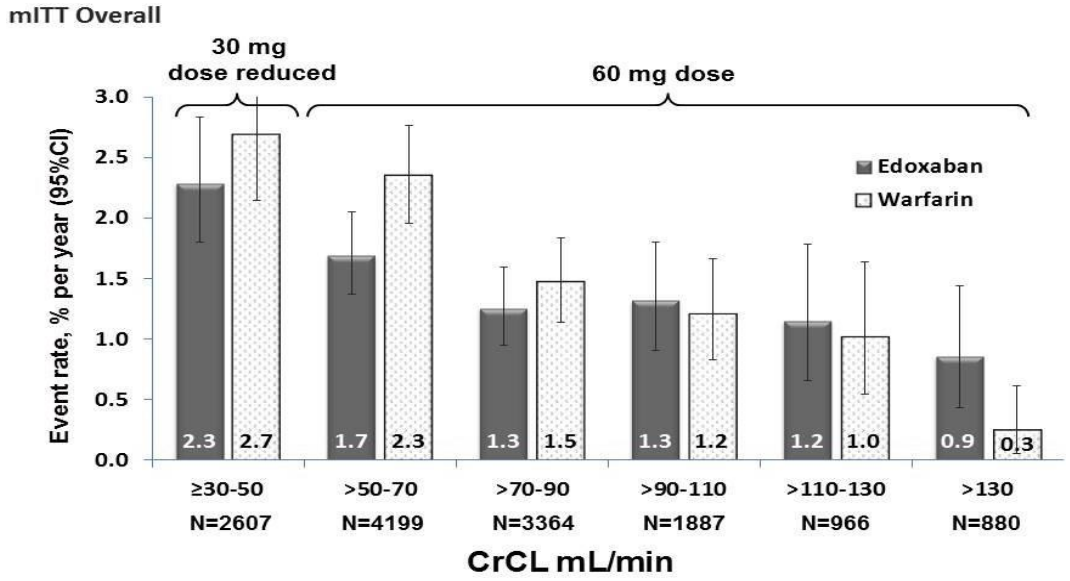
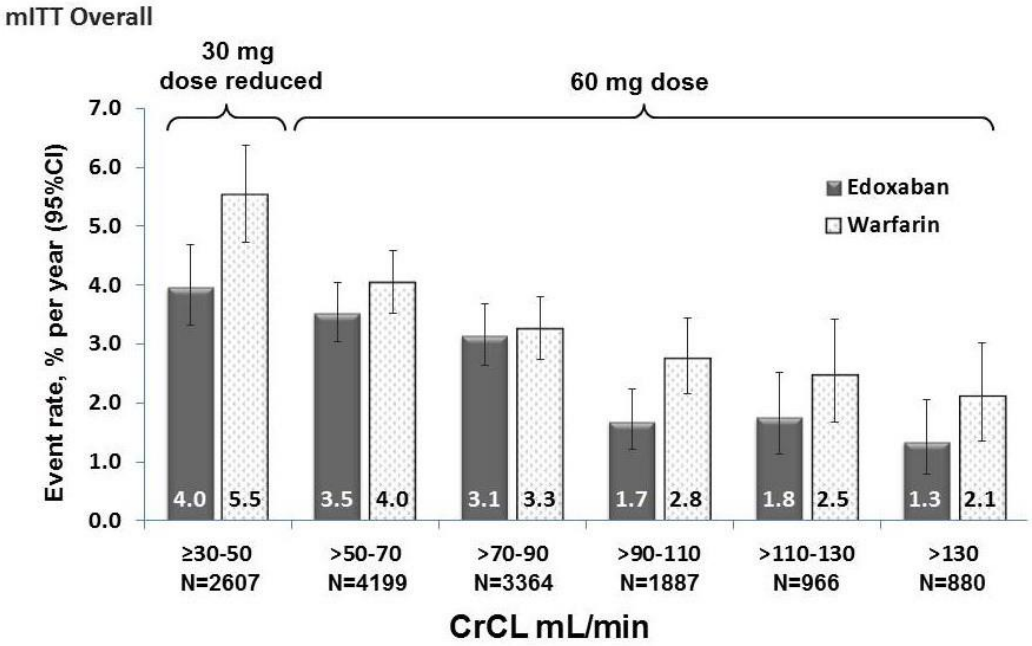


Figure 5 – Major Bleeds by Baseline CrCl Category in ENGAGE AF-TIMI 48 study



Transition to Other Anticoagulants

In the ENGAGE AF-TIMI 48 study, the transition schemes described in Table 3 (see 4 DOSAGEAND ADMINISTRATION - Switching to and from pms-EDOXABAN) were effective when transitioning to VKA, Factor Xa and IIa inhibitors at the end of the study. The transition scheme included edoxaban at half dose for ≤14 days concurrently with VKA. The rate of Stroke and SEE during the 30 days following the last dose of blinded study drug was similar for those who transitioned off of edoxaban and for those who transitioned off of warfarin. In the edoxaban 60 mg group 7 of 4529 (0.2%) subjects had a stroke or SEE compared to 7 of 4506 (0.2%) subjects in the warfarin arm.

Safety in SPAF

The primary safety endpoint was major bleeding. The secondary safety endpoint was major bleeding or clinically relevant non-major (CRNM) bleeding.

Table 7 summarises adjudicated bleeding events for the safety analysis set on-treatment period (See ADVERSE REACTIONS, Clinical Trial Adverse Reactions, Bleeding Events). Subjects in the edoxaban 60 mg (30 mg dose-reduced) group experienced significantly lower bleeding events for all bleeding categories, (major Bleeding, CRNM, and any confirmed bleeding) compared with warfarin.

The rate of major bleeding was significantly less in the edoxaban 60 mg (30 mg dose-reduced) group compared with the warfarin group (2.75%, and 3.43% per year, respectively) [HR (95% CI): 0.80 (0.71, 0.91)]; *p*=0.0009]. Similar benefits were observed in favor of the edoxaban 60 mg (30 mg dose-reduced) group compared with the warfarin group for the subset of subjects experiencing ICH (0.39%, and 0.85%), respectively [HR (95% CI): 0.47 (0.34, 0.63); *p*<0.0001]. The rate in fatal bleeds was also significantly less in the edoxaban 60 mg (30 mg dose-reduced) group compared with the warfarin group (0.21%, and 0.38%) [HR (95% CI): 0.55 (0.36, 0.84); *p*=0.0059 for superiority.

Subjects who received edoxaban 30 mg (dose reduced subjects in the 60 mg group) had an event rate of 3.05% per year for major bleeding, compared with the event rate of 4.85% per year for the matching dose reduced subjects in the warfarin group. Compared to warfarin-treated subjects, the HR in the edoxaban 30 mg (dose reduced subjects in the 60 mg group) was 0.63 (95% CI: 0.50, 0.81).

Subgroup analyses showed that edoxaban 60 mg (30 mg dose-reduced) group had a lower event rate and a hazard ratio of less than 1 for major bleeding compared to the warfarin group for all subgroups, except for subjects with history of TIA only. In the subgroup of subjects with a high risk of bleeding, such as age ≥ 75 years, CrCL 30 to ≤ 50 and >50 to < 80 mL/min, and $CHADS_2$ score ≥3, edoxaban 60 mg (30 mg dose-reduced) group had a hazard ratio less than 1 for major bleeding compared with warfarin.

Nonvalvular Atrial Fibrillation (NVAF) Patients undergoing cardioversion

A multicentre, prospective, randomised, open-label study with blinded endpoint evaluation (**ENSURE-AF**) was conducted which randomised 2199 subjects (oral anticoagulant naïve and pre-treated) with NVAF scheduled for cardioversion, to compare edoxaban 60 mg once daily with enoxaparin/warfarin to maintain a therapeutic INR of 2.0 to 3.0 (randomised 1:1), mean TTR on warfarin was 70.8%. A total of 2149 subjects were treated with either edoxaban (N = 1067) or enoxaparin/warfarin (N = 1082). Subjects in the edoxaban treatment group received 30 mg once daily if one or more of the following clinical factors were present: moderate renal impairment (CrCl 30 – 50 mL/min), low body weight (≤ 60 kg) or concomitant use of specific P-gp inhibitors. The majority of subjects in the edoxaban and warfarin groups had cardioversion performed (83.7% and 78.9%, respectively) or were auto converted (6.6% and 8.6%, respectively). TEE-guided (within 3 days of initiation) or conventional cardioversion (at least 21 days of pre-treatment) was employed. Subjects were maintained on treatment for 28 days post cardioversion.

The primary efficacy outcome consisted of a composite of all stroke, SEE, MI and CV mortality. A total of 5 (0.5%, 95% CI 0.15% - 1.06%) events occurred in subjects in the edoxaban group (N = 1095) and 11 (1.0%, 95% CI 0.50% - 1.78%) events in the warfarin group (N = 1104); odds ratio (OR) 0.46 (95% CI 0.12 - 1.43); ITT analysis set overall study period with mean duration of 66 days.

The primary safety outcome was a composite of major and CRNM bleeding. A total of 16 (1.5%, 95% CI 0.86% - 2.42%) events occurred in subjects in the edoxaban (N = 1067) group and 11 (1.0%, 95% CI 0.51% - 1.81%) events in the warfarin (N = 1082) group; OR 1.48 (95% CI 0.64 - 3.55); safety analysis set on-treatment period.

This exploratory study showed low rates of major and CRNM bleeding and thromboembolism in the two treatment groups in the setting of cardioversion.

ETNA-AF-Europe – Phase IV Study

In addition to the Phase III ENGAGE -AF-TIMI-48 study, a multinational, multicenter, post-authorization, observational study (**ETNA-AF-Europe**) has been conducted to assess the risks and benefits of edoxaban in routine care for unselected patients with AF.

13,638 patients with non-valvular AF were treated with edoxaban, 76.6% of the patients received the standard dose of 60 mg and 23.4% received the reduced dose of 30 mg, for prevention of stroke and systemic embolism and enrolled in the study. The mean age of the patients was 73.6 years old with 50.7% of the patients been 75 years old and older. The mean $CHADS_2$ score was 1.7 and the HAS-BLED score was 2.6.

Based on the 1-year follow-up analysis [n=13224], the stroke and systemic embolism rates were 0.79%/year. Hemorrhagic stroke rates were 0.12 %/year while the ischemic stroke rates were 0.56%/year. The major bleeding (ISTH) rates were 1.15%/year. The Intracranial hemorrhage rates were 0.25%/year and the major GI bleed event rates were 0.46%/year. The CV death rates were 1.67%/year.

These results are consistent with the established efficacy and safety profile of edoxaban in this population.

Treatment of VTE and the prevention of recurrent DVT and PE

The HOKUSAI-VTE Study

The edoxaban clinical programme for venous thromboembolism (VTE) was designed to demonstrate the efficacy and safety of edoxaban in the treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and the prevention of recurrent DVT and PE.

In the pivotal HOKUSAI-VTE study, 8,292 subjects were randomized to receive initial heparin therapy (enoxaparin or unfractionated heparin for 5-10 days) followed by edoxaban 60 mg once daily or the comparator. In the comparator arm, subjects received initial heparin therapy concurrently with warfarin, titrated to a target international normalized ratio (INR) of 2.0 to 3.0, followed by warfarin alone. The treatment duration was from 3 months up to 12 months, determined by the investigator based on the patient's clinical features. Patients were excluded if they required thrombectomy, insertion of a caval filter, use of a fibrinolytic agent, had a creatinine clearance <30 mL/min, significant liver disease, or active bleeding. The primary efficacy endpoint was the recurrence of symptomatic VTE, defined as the composite of recurrent symptomatic DVT, non-fatal symptomatic PE and fatal PE in patients during the 12 months study period. Secondary efficacy outcomes included the composite clinical outcome of recurrent VTE and all-cause mortality.

Table 17 – Summary of patient demographics for clinical trials in VTE

Study design	Dosage, route of administration and duration	Study subjects (n = number)	Mean age (Range) years	Sex (M/F) %
Randomized, double-blind, matching placebo, parallel group, active controlled	Edoxaban 60 mg QD PO[a] Median duration of treatment = 267 days	n = 4118	55.7 (18 – 106)	57.3/42.7
	Warfarin QD PO[b] Median duration of treatment = 266 days	n = 4122	55.9 (18 – 95)	57.2/42.8
	Total n = 8240			

VTE = venous thromboembolism, QD = once daily

[a] Edoxaban dose halved for subjects with moderate renal impairment [CrCL ≥ 30 and ≤ 50 mL/min], low body weight [≤ 60 kg], or on concomitant strong P-gp inhibitor [eg, verapamil, quinidine].

[b] Warfarin dose adjusted to maintain INR between 2.0 and 3.0, inclusive

Subjects in the edoxabam 60 mg treatment group had their dose halved if one or more of the following were present: moderate renal impairment (CrCL30 - 50 mL/min); body weight ≤ 60 kg; concomitant use of specific P-gp inhibitors (verapamil and quinidine or the short-term concomitant administration of azithromycin, clarithromycin, erythromycin, oral itraconazole or oral ketoconazole).

Efficacy in VTE

In the HOKUSAI-VTE study (Table 18), edoxaban was demonstrated to be non-inferior to warfarin for the primary efficacy outcome, recurrent VTE, which occurred in 130 of 4118 subjects (3.2%) in the edoxaban group versus 146 of 4122 subjects (3.5%) in the warfarin group [HR (95% CI): 0.89 (0.70,1.13); *p* <0.0001 for non-inferiority to a pre-specified margin of 1.5]. In the warfarin group, the median TTR (time in therapeutic range, INR 2.0 to 3.0) was 63.5%. For subjects presenting with PE (with or without DVT), 47 (2.8%) edoxaban and 65 (3.9%) of warfarin subjects had a recurrent VTE [HR (95% CI): 0.73 (0.50, 1.06)]. For subjects presenting with DVT, 83 (3.4 %) edoxaban and 81 (3.3%) of warfarin subjects had a recurrent VTE [HR (95% CI): 1.02 (0.75, 1.38)].

For subjects who received the 30 mg dose (predominantly subjects with body weight ≤ 60 kg or moderate renal impairment) 22 (3.0%) edoxaban and 30 (4.2%) of warfarin subjects had a recurrent VTE.

The composite endpoint of recurrent VTE and all-cause mortality occurred in 228 of subjects (5.5%) in the edoxaban group and in 228 subjects (5.5%) in the warfarin group [HR: (95% CI):1.00 (0.83, 1.20)].

In the HOKUSAI-VTE study, the duration of drug exposure for edoxaban 60 mg was ≤ 6 months for 1561 (37.9%) of patients, >6 months for 2557 (62.1%) of patients and 12 months for 1661 (40.3%) of patients.

Table 18 - Efficacy Results from the HOKUSAI-VTE Study (mITT Overall Study Period)

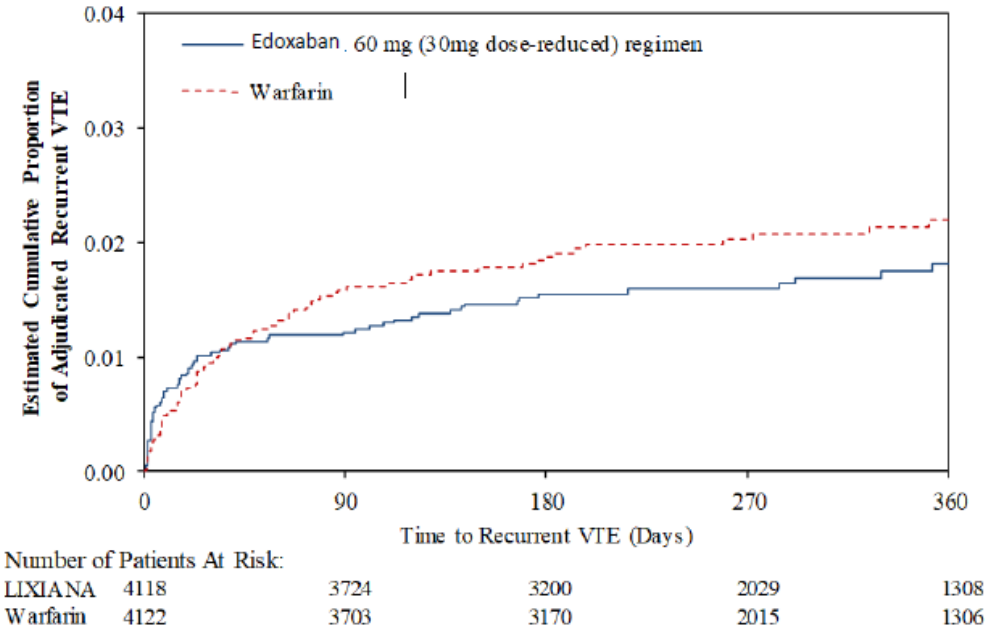
	Edoxaban 60 mg (30 mg Dose-Reduced) (N = 4118)	Warfarin (N= 4122)	Edoxaban vs Warfarin HR (95% CI)
All subjects with symptom recurrent VTE,[a] n (%)	130 (3.2)	146 (3.5)	0.89 (0.70, 1.13) p-value< 0.0001 (non-inferiority)
PE with or without DVT	73 (1.8)	83 (2.0)	
Fatal PE/Death where PE cannot be ruled out	24 (0.6)	24 (0.6)	
Non-fatal PE	49 (1.2)	59 (1.4)	
DVT only	57 (1.4)	63 (1.5)	

Abbreviations: mITT = modified intent-to-treat; HR= Hazard Ratio vs. warfarin; CI= Confidence Interval; N= number of subjects in mITT population; n= number of events

[a] Primary Efficacy Endpoint: Symptomatic recurrent VTE (i.e. the composite endpoint of DVT, non-fatal PE and fatal PE).

Note: The primary efficacy analysis was performed in the mITT Analysis Set, Overall Study Period - (all events occurring during the Overall Study Period are included regardless of study drug administration status).

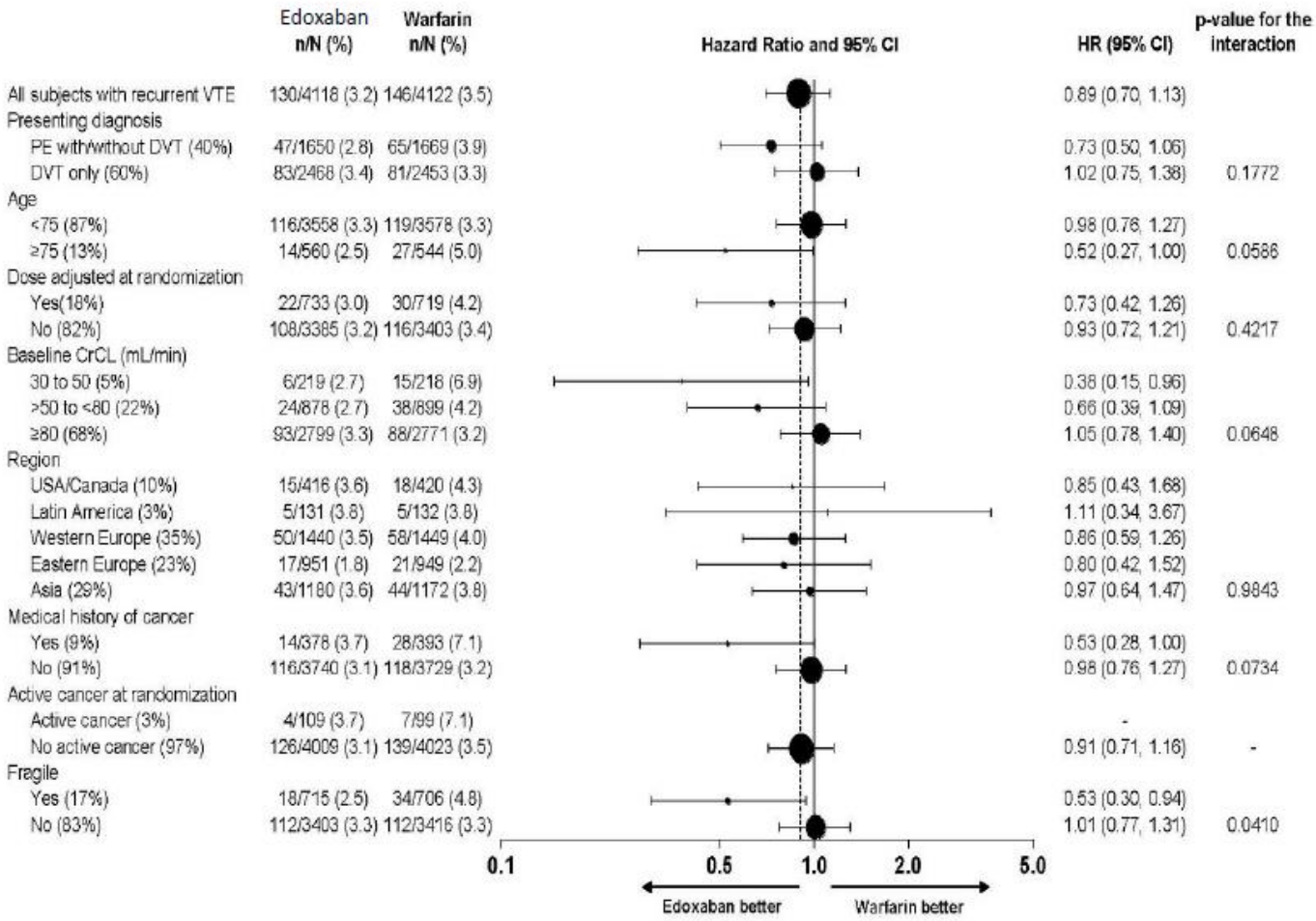
Figure 6 – Kaplan-Meier Curve Estimate of cumulative event rates for the primary efficacy endpoint (mITT-on treatment) for the HOKUSAI study



Results in subgroups of Interest

The efficacy results for pre-specified major subgroups (with dose reduction as required), including age, body weight, and P-gp inhibitors were generally consistent with the primary efficacy results for the overall population studies in the trial (Figure 7).

Figure 7 – HOKUSAI-VTE Study: Primary Efficacy Endpoint by Subgroups (mITT-overall)



Note: Fragile patients included patients who were ≥ 75 years old and/or had body weight ≤ 50 kg and/or had CrCL ≥ 30 to ≤ 50 mL/min, each as determined at randomization

Safety in VTE

The principal safety endpoint was clinically relevant bleeding (major or clinically relevant non-major - CRNM) occurring during or within three days of interrupting or stopping study treatment. An additional endpoint included Major Adverse Cardiovascular Events - MACE (non-fatal MI, non-fatal stroke, non-fatal systemic embolic events, and cardiovascular death). Table 7 summarizes adjudicated bleeding events for the safety analysis set on-treatment period (See ADVERSE REACTIONS, Clinical Trial Adverse Reactions, Bleeding Events). Edoxaban was demonstrated to be superior to warfarin for the primary safety endpoint of clinically relevant bleeding, a composite of major bleeding or CRNM, which occurred in 349 of 4118 subjects

(8.5%) in the edoxaban group and in 423 of 4122 subjects (10.3%) in the warfarin group [HR (95% CI): 0.81 (0.71 to 0.94); *p*=0.004 for superiority].

The composite endpoint of MACE was 1.2% in the edoxaban group and 1.0% in the warfarin group.

Subjects who received edoxaban 30 mg (dose reduced subjects in the 60 mg group) had an event rate of 7.9% for clinically relevant bleeding, compared with the event rate of 12.8% for the matching dose reduced subjects in the warfarin group. Compared to warfarin-treated subjects, the hazard ratio (HR) in the edoxaban 30 mg (dose reduced subjects in the 60 mg group) was 0.62 (95% CI: 0.44, 0.86).

Subgroup analyses of fragile subjects, elderly subjects, and subjects with a history of cancer demonstrated a favorable bleeding outcome with edoxaban therapy. However, numerically higher rates of GI tract and vaginal bleeding events were noted in the edoxaban group (See 8 ADVERSE REACTIONS - Clinical Trial Adverse Reactions, Bleeding events).

HOKUSAI-VTE Cancer Study

In the Hokusai VTE Cancer study, 1050 patients were randomized to receive edoxaban 60 mg once daily [30 mg dose reduced per the dose adjustment regimen used in Engage AF-TIMI 48 and Hokusai VTE studies, (*see The Hokusai VTE Study*)] after at least 5 days of low-molecular-weight heparin treatment or dalteparin (200 IU/kg day 1-30; 150 IU/kg day 31 to the end of treatment). The treatment duration was for a minimum of 6 months and upto 12 months. Patients with CrCL <30 mL/min were not eligible for enrollment in the study.

The efficacy of edoxaban was based upon the rate of recurrent VTE (mITT) during the overall study period. Edoxaban was non-inferior to dalteparin for the rate of recurrent VTE. Recurrent VTE occurred in 7.9% (41/522) and 11.3% (59/524) of patients in the edoxaban and dalteparin groups, respectively [HR (95% CI): 0.71 (0.48, 1.06)].

14.2 Comparative Bioavailability Studies

A randomized, two-way crossover, single-dose (1 X 60 mg) oral bioavailability study of pms-EDOXABAN Tablets, 60 mg (Pharmascience Inc.) and LIXIANA® Tablets, 60 mg (Servier Canada Inc.) was conducted in 16 healthy, adult, Asian, male subjects under fasting conditions. The results of all 16 subjects are presented in the following table.

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Edoxaban 1 × 60 mg Geometric Mean Arithmetic Mean (CV %)				
Parameter	Test[1]	Reference[2]	% Ratio of Geometric Means	90% Confidence Interval
AUC_T (ng·h/ml)	1623.5 1651.8 (18.6)	1732.0 1753.2 (15.5)	93.7	87.1 - 100.9
AUC_I (ng·h/ml)	1687.6 1714.7 (18.0)	1790.8 1812.4 (15.4)	94.2	87.7 - 101.3
C_{max} (ng/mL)	216.5 223.5 (25.8)	237.8 245.3 (25.2)	91.1	83.1 - 99.8
T_{max}[3] (h)	1.50 (0.50 - 4.00)	1.50 (0.75 - 4.50)		
$T_{½}$[4] (h)	5.4 (26.2)	5.4 (28.5)		

[1] pms-EDOXABAN (Edoxaban as Edoxaban Tosylate Monohydrate) Tablets, 60 mg (Pharmascience Inc.)
[2] LIXIANA® (Edoxaban as Edoxaban Tosylate Monohydrate) Tablets, 60 mg (Servier Canada Inc.)
[3] Expressed as median (range) only
[4] Expressed as the arithmetic mean (CV%) only

15 MICROBIOLOGY

No microbiological information is required for this drug product.

16 NON-CLINICAL TOXICOLOGY

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential, or phototoxicity.

General Toxicology (Repeat-Dose Studies)
In the repeated-dose oral toxicity studies in rats, a small number of focal hemorrhagic lesions
were observed in the pancreas, lung, and thymus of rats given edoxaban tosylate hydrate at ≥20 mg/kg/day. In repeated-dose oral toxicity studies in cynomolgus monkeys, hemorrhagic

findings and anemia were noted in some animals given the drug at ≥15 mg/kg/day, leading to deteriorated animal condition or animal deaths with chronic dosing in a few monkeys. These findings are thought to be related to the anticoagulant effect of edoxaban tosylate hydrate (its principal pharmacological action) which constitutes the only dose-limiting toxicity for this compound. Since the pharmacological activity of the drug for the cynomolgus monkey was comparable to that for humans, safety margins for hemorrhagic risk were estimated by comparison of exposures between cynomolgus monkeys and humans. The mean $AUC_{0\text{-}24h}$ values at NOAEL in the 52-week repeated dose oral toxicity study in cynomolgus monkeys were approximately 2.1 times higher than the exposures in human subjects given edoxaban at the maximum recommended clinical dose of 60 mg.

Carcinogenicity
Edoxaban was not carcinogenic when administered daily to mice and rats by oral gavage for ≤104 weeks. The highest dose tested (500 mg/kg/day) in male and female mice was 3 and 6 times, respectively, the human exposure (AUC) at the human dose of 60 mg/day, and the highest doses tested in male (600/400 mg/kg/day) and female (200 mg/kg/day) rats were 8 and 14 times, respectively, the human exposure at the human dose of 60 mg/day.

Genotoxicity
Based on the weight of evidence, edoxaban tosylate hydrate and its human-specific metabolite M-4 were not considered to pose any genotoxic risk to humans.

Reproductive and developmental Toxicology
Edoxaban showed vaginal hemorrhage at higher doses in rats and rabbits but had no effects in the reproductive performance of parent rats.

In rats, no effects on male or female fertility were seen.

In animal reproduction studies, rabbits showed increased incidence of gallbladder variations at a dosage of 200 mg/kg [approximately 65 times the maximum recommended human dose (MRHD) of 60 mg/day based on total body surface area in mg/m2]. Increased post-implantation pregnancy losses occurred in rats at 300 mg/kg/day (approximately 49 times the MRHD) and in rabbits at 200 mg/kg/day (approximately 65 times the MRHD) respectively.

Edoxaban was found in fetuses of pregnant rats and excreted in the breast milk of lactating rats.

17 SUPPORTING PRODUCT MONOGRAPHS

1- PrLIXIANA® [Tablets, 15 mg, 30 mg and 60 mg], submission control 278099, Product Monograph, Servier Canada Inc. (JAN 5, 2024)

PATIENT MEDICATION INFORMATION
READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE

[Pr]pms-EDOXABAN
Edoxaban Tablets

Read this carefully before you start taking **pms-EDOXABAN** and each time you get a refill. This leaflet is a summary and will not tell you everything about this drug. Talk to your healthcare professional about your medical condition and treatment and ask if there is any new information about **pms-EDOXABAN**.

What is pms-EDOXABAN used for?
pms-EDOXABAN is used in adults to:

- lower the risk of blood clots:
  - in the brain (stroke); and
  - in other blood vessels

  in people who have atrial fibrillation (a type of irregular heartbeat).
- treat and prevent blood clots in the veins of the legs (deep vein thrombosis) or lungs (pulmonary embolism).

It is not known if pms-EDOXABAN is safe and effective in children.

How does pms-EDOXABAN work?
pms-EDOXABAN helps to reduce the risk of the formation of blood clots. pms-EDOXABAN blocks a protein called factor Xa. Factor Xa is involved in the natural formation of blood clots.

What are the ingredients in pms-EDOXABAN?
Medicinal ingredients: edoxaban tosylate monohydrate

Non-medicinal ingredients: calcium carbonate, carmellose sodium, crospovidone, glucose monohydrate, hydroxypropylcellulose, iron oxide red (15 mg and 30 mg), iron oxide yellow (15 mg and 60 mg), lecithin, maltodextrin, magnesium stearate, mannitol, , pregelatinized starch, silica colloidal anhydrous.

pms-EDOXABAN comes in the following dosage forms:
Tablets: 15 mg, 30 mg and 60 mg edoxaban (as edoxaban tosylate monohydrate).

Do not use pms-EDOXABAN if:

- You are at risk of serious bleeding. This may be because you:
  - had recent bleeding in the brain.
  - have active ulcers that are bleeding or were recently bleeding.
- You have liver and blood-clotting problems.
- You are pregnant or breast-feeding.
- You are already being treated with a medicine that stops your blood from clotting.

Examples include: warfarin, dabigatran, or apixaban.
- You are allergic to:
  - edoxaban (active ingredient of pms-EDOXABAN) or
  - any of the other ingredients in pms-EDOXABAN.

To help avoid side effects and ensure proper use, talk to your healthcare professional before you take pms-EDOXABAN. Talk about any health conditions or problems you may have, including if you:
- are at risk of bleeding. This may be because you have or have had:
  - bleeding disorders.
  - an ulcer in your stomach or bowel.
  - bleeding in your brain, stomach or bowel.
  - very high blood pressure, not controlled by medical treatment.
  - an operation on your brain, spinal column or eye.
- take any medicine that stops your blood from clotting.
- take aspirin, naproxen or ibuprofen (non-steroidal anti-inflammatory medications) on a regular basis.
- have liver or kidney problems.
- have blood in your urine.
- have a blockage in an artery in your lungs.
- have a catheter that stays in your bladder.
- have a body weight below 132 lbs (60 kg).
- have a mechanical heart valve.
- have a heart problem as a result of rheumatic fever.
- had a recent injection into your spine such as an epidural.
- have a disease called antiphospholipid syndrome (a disorder of the immune system that causes an increased risk in blood clots).
- plan to become pregnant or if you are pregnant. It is not known if pms-EDOXABAN will harm your unborn baby. Tell your healthcare professional right away if you become pregnant during treatment with pms-EDOXABAN.
- plan to breastfeed or if you are breastfeeding. It is not known if pms-EDOXABAN passes into your breast milk. You and your healthcare professional should decide if you will take pms-EDOXABAN or breastfeed. You should not do both.
- plan to have any surgery or a dental procedure. Tell all of your healthcare professionals and dentists that you are taking pms-EDOXABAN. They should talk to the healthcare professional who prescribed pms-EDOXABAN for you. This should be done before you have any surgery or dental procedure. You may need to stop and restart your treatment with pms-EDOXABAN.

Other warnings you should know about:

Risk of bleeding
- Taking pms-EDOXABAN may result in serious bleeding. You may bleed from your organs and you may die.
- Do not stop taking pms-EDOXABAN without first talking to your healthcare professional. This is important because blood clots may occur in the brain or in other blood vessels.

This can cause death or severe disability.

Anticoagulant-Related Nephropathy (ARN): Some cases were reported in patients taking pms-EDOXABAN. It is a type of serious kidney damage caused by anticoagulant medicines. ARN causes bleeding in the kidneys, sometimes with the presence of blood in the urine. This leads to the kidneys being unable to function properly. Your healthcare professional may monitor the health of your kidneys during your treatment with pms-EDOXABAN. If you are experiencing symptoms of ARN during your treatment, tell your healthcare professional **right away**.

Tell your healthcare professional about all the medicines you take, including any drugs, vitamins, minerals, natural supplements or alternative medicines.

Serious Drug Interactions

Do not use pms-EDOXABAN if you are taking any other anticoagulant (used to prevent blood clots) such as**:**

- unfractionated heparin (UFH), except if it is used to maintain a patent central venous or arterial catheter;
- enoxaparin and dalteparin, which are low molecular weight heparins (LMWH);
- fondaparinux, which is a heparin derivative;
- warfarin, dabigatran, apixaban or rivaroxaban, which are oral anticoagulants, except if you are switching therapy to or from pms-EDOXABAN.

The following may also interact with pms-EDOXABAN:

Taking pms-EDOXABAN with some other medicines may increase the risk of bleeding. Some of these medicines are:

- Cyclosporine (used to suppress the immune system).
- Dronedarone and quinidine (used to treat an irregular heartbeat).
- Erythromycin (used to treat bacterial infections).
- Ketoconazole (used to treat fungal infections).
- Non-steroidal anti-inflammatory drugs (NSAIDs) such as acetylsalicylic acid and naproxen.
- Medicines that block the action of platelets, such as clopidogrel.
- Antidepressants called selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine, or serotonin norepinephrine reuptake inhibitors (SNRIs), such as duloxetine.

How to take pms-EDOXABAN:

- You can take pms-EDOXABAN with or without food.
- If you are unable to swallow tablets whole, the tablet may be crushed and mixed with water or apple puree and taken right away.
- Take pms-EDOXABAN exactly as prescribed by your healthcare professional. Make sure to refill your prescription before you run out.
- **Do not stop taking pms-EDOXABAN without first talking with your healthcare professional.**

- **Stopping pms-EDOXABAN may increase your risk of blood clots.**
- If you plan to have surgery, or a medical or a dental procedure, tell your healthcare professional, including your dentist, that you are taking pms-EDOXABAN. You may have to stop taking pms-EDOXABAN for a short time.
- Call your healthcare professional right away if you fall or injure yourself, especially if you hit your head. Your healthcare professional may need to examine you.

Usual dose:

- **To reduce the risk of blood clots in your brain (stroke) and other blood vessels**
  - 60 mg once a day
- **To treat and prevent blood clots in the veins of your legs or lungs**
  - 60 mg once a day.
  - You will receive pms-EDOXABAN after you have been given an injectable anticoagulant over 5-10 days.

- **Dose reductions**
  - The dose of pms-EDOXABAN is 30 mg once a day if you have one or more of the following:
    - Severe or moderate kidney problems
    - Low body weight of 60 kg (132 lbs) or less
    - You take P-gp inhibitors (type of medication) except for amiodarone and verapamil (types of P-gp inhibitor) while taking pms-EDOXABAN.

Overdose:

There are very few experiences of overdose with pms-EDOXABAN. Overdose with pms-EDOXABAN may lead to bleeding.

If you think you, or a person you are caring for, have taken too much pms-EDOXABAN, contact a healthcare professional, hospital emergency department, regional poison control centre or Health Canada's toll-free number, 1-844 POISON-X (1-844-764-7669) immediately, even if there are no signs or symptoms.

Missed Dose:

- If you miss a dose of pms-EDOXABAN, take it as soon as you remember on the same day.
- Take your next dose at your usual time the next day.
- Do not take more than one dose of pms-EDOXABAN at the same time to make up for a missed dose.

What are possible side effects from using pms-EDOXABAN?

These are not all the possible side effects you may have when taking pms-EDOXABAN. If you experience any side effects not listed here, tell your healthcare professional.
pms-EDOXABAN affects blood clotting. Most side effects are related to bleeding. pms-EDOXABAN can cause bleeding that is serious and may lead to death.

Patients treated with pms-EDOXABAN may experience the following side effects:

- Rash or itchy skin

Serious side effects and what to do about them			
Symptom / effect	**Talk to your healthcare professional**		**Stop taking drug and get immediate medical help**
	Only if severe	**In all cases**	
COMMON			
Anemia (decreased number of red blood cells): fatigue, loss of energy, weakness, shortness of breath		✓	
Bleeding from nose	✓		
Bleeding in the stomach or bowel: dark stool (like tar), bright red blood in your toilet or on toilet tissue, vomiting blood		✓	
Bleeding from mouth or gums	✓		
Bruising and swelling		✓	
Blood in urine: pink or red urine		✓	
Vaginal bleeding: Increase in or more frequent menstrual bleeding, unexpected vaginal bleeding		✓	
UNCOMMON			
Bleeding into the brain: sudden, severe and unusual headache			✓
Bleeding in eyes		✓	
Coughing blood or blood stained sputum		✓	
Bleeding from the surgical wound, an injury or other medical procedure		✓	
Allergic reactions: rash, itching, hives, trouble swallowing or breathing (angioedema), throat tightening or constriction, swelling of the face, lips or tongue, sudden low blood pressure.			✓

Serious side effects and what to do about them			
Symptom / effect	**Talk to your healthcare professional**		**Stop taking drug and get immediate medical help**
	Only if severe	**In all cases**	
Stevens-Johnson syndrome (SJS) (severe skin reactions): redness, blistering and/or peeling of the skin and/or inside of the lips, eyes, mouth, nasal passages or genitals, accompanied by fever, chills, headache, cough, body aches or swollen glands.			✓
RARE			
Bleeding into muscles: sudden pain or swelling in your muscles		✓	
Bleeding into a joint: stiff, sore, hot or painful joint		✓	
UNKNOWN FREQUENCY			
Abdominal pain	✓		
Anticoagulant-related nephropathy (ARN) (serious kidney damage caused by anticoagulant medicines): bleeding in the kidney sometimes with presence of blood in urine leading to inability of the kidneys to work properly.		✓	
Dizziness	✓		
Headache	✓		

If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, tell your healthcare professional.

Reporting Side Effects
You can report any suspected side effects associated with the use of health products to Health Canada by:

- Visiting the Web page on Adverse Reaction Reporting (canada.ca/drug-device-reporting) for information on how to report online, by mail or by fax; or
- Calling toll-free at 1-866-234-2345.

NOTE: Contact your healthcare professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.

Storage:

- Store pms-EDOXABAN at room temperature between 15°C to 30°C.
- Keep out of reach and sight of children.

If you want more information about pms-EDOXABAN:

- Talk to your healthcare professional
- Find the full product monograph that is prepared for healthcare professionals and includes the Patient Medication Information by visiting the Health Canada Product Database website (https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-product-database.html); the manufacturer's website (www.pharmascience.com), or by calling 1-888-550-6060.

This leaflet was prepared by Pharmascience Inc.

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