

MitoXANTRONE Injection, USP (concentrate)

Rx only

WARNING

Mitoxantrone Injection, USP (concentrate) should be administered under the supervision of a physician experienced in the use of cytotoxic chemotherapy agents.

Mitoxantrone Injection, USP (concentrate) should be given slowly into a freely flowing intravenous infusion. It must **never** be given subcutaneously, intramuscularly, or intra-arterially. Severe local tissue damage may occur if there is extravasation during administration. (See **ADVERSE REACTIONS, General**, Cutaneous and **DOSAGE AND ADMINISTRATION, Preparation and Administration Precautions**).

NOT FOR INTRATHECAL USE. Severe injury with permanent sequelae can result from intrathecal administration. (See **WARNINGS, General**)

Except for the treatment of acute nonlymphocytic leukemia, mitoxantrone therapy generally should not be given to patients with baseline neutrophil counts of less than 1,500 cells/mm³. In order to monitor the occurrence of bone marrow suppression, primarily neutropenia, which may be severe and result in infection, it is recommended that frequent peripheral blood cell counts be performed on all patients receiving mitoxantrone.

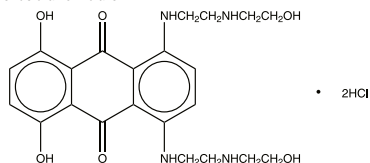
Use of mitoxantrone has been associated with cardiotoxicity. Cardiotoxicity can occur at any time during mitoxantrone therapy, and the risk increases with cumulative dose. Congestive heart failure (CHF), potentially fatal, may occur either during therapy with mitoxantrone or months to years after termination of therapy. All patients should be carefully assessed for cardiac signs and symptoms by history and physical examination prior to start of mitoxantrone therapy. Baseline evaluation of left ventricular ejection fraction (LVEF) by echocardiogram or multi-gated radionuclide angiography (MUGA) should be performed. In cancer patients, the risk of symptomatic congestive heart failure (CHF) was estimated to be 2.6% for patients receiving up to a cumulative dose of 140 mg/m². Presence or history of cardiovascular disease, prior or concomitant radiotherapy to the mediastinal/pericardial area, previous therapy with other anthracyclines or anthracenediones, or concomitant use of other cardiotoxic drugs may increase the risk of cardiac toxicity. Cardiac toxicity with mitoxantrone may occur whether or not cardiac risk factors are present. For additional information, see **WARNINGS, Cardiac Effects**, and **DOSAGE AND ADMINISTRATION**.

Secondary acute myelogenous leukemia (AML) has been reported in cancer patients treated with mitoxantrone. Postmarketing cases of secondary AML have also been reported. In 1774 patients with breast cancer who received mitoxantrone concomitantly with other cytotoxic agents and radiotherapy, the cumulative risk of developing treatment-related AML, was estimated as 1.1% and 1.6% at 5 and 10 years, respectively (see **WARNINGS** section). Secondary acute myelogenous leukemia (AML) has also been reported in cancer patients treated with anthracyclines. Mitoxantrone is an anthracenedione, a related drug.

The occurrence of refractory secondary leukemia is more common when anthracyclines are given in combination with DNA-damaging antineoplastic agents, when patients have been heavily pretreated with cytotoxic drugs, or when doses of anthracyclines have been escalated.

DESCRIPTION

Mitoxantrone Injection, USP (concentrate) is a synthetic antineoplastic anthracenedione for intravenous use. The molecular formula is C₂₂H₁₄N₂O₄·2HCl and the molecular weight is 517.41. It is supplied as a concentrate that **MUST BE DILUTED PRIOR TO INJECTION**. The concentrate is a sterile, nonpyrogenic, dark blue aqueous solution containing mitoxantrone hydrochloride equivalent to 2 mg/mL mitoxantrone free base, with sodium chloride (0.80% w/v), sodium acetate (0.005% w/v), acetic acid (0.046% w/v), and Water for Injection, USP as inactive ingredients. The solution has a pH of 3.0 to 4.5 and contains 0.14 mEq of sodium per mL. The product does not contain preservatives. The chemical name is 1, 4-dihydroxy-5, 8-bis[[2-(2-hydroxyethyl) amino]ethyl]amino]-9,10-anthracenedione dihydrochloride and the structural formula is:



CLINICAL PHARMACOLOGY

Mechanism of Action: Mitoxantrone, a DNA-reactive agent that intercalates into deoxyribonucleic acid (DNA) through hydrogen bonding, causes crosslinks and strand breaks. Mitoxantrone also interferes with ribonucleic acid (RNA) and is a potent inhibitor of topoisomerase II, an enzyme responsible for uncoupling and repairing damaged DNA. It has a cytotoxic effect on both proliferating and nonproliferating cultured human cells, suggesting lack of cell cycle phase specificity.

Mitoxantrone has been shown *in vitro* to inhibit B cell, T cell, and macrophage proliferation and impair antigen presentation, as well as the secretion of interferon gamma, TNF α , and IL-2.

Pharmacokinetics: Pharmacokinetics of mitoxantrone in patients following a single intravenous administration of mitoxantrone can be characterized by a three-compartment model. The mean alpha half-life of mitoxantrone is 6 to 12 minutes, the mean beta half-life is 1.1 to 3.1 hours and the mean gamma (terminal or elimination) half-life is 23 to 215 hours (median approximately 75 hours). Pharmacokinetic studies have not been performed in humans receiving multiple daily dosing. Distribution to tissues is extensive; steady-state volume of distribution exceeds 1,000 L/m². Tissue concentrations of mitoxantrone appear to exceed those in the blood during the terminal elimination phase. In the healthy monkey, distribution to brain, spinal cord, eye, and spinal fluid is low.

In patients administered 15 to 90 mg/m² of mitoxantrone intravenously, there is a linear relationship between dose and the area under the concentration-time curve (AUC).

Mitoxantrone is 78% bound to plasma proteins in the observed concentration range of 26 to 455 ng/mL. This binding is independent of concentration and is not affected by the presence of phenytoin, doxorubicin, methotrexate, prednisone, prednisolone, heparin, or aspirin.

Metabolism and Elimination: Mitoxantrone is excreted in urine and feces as either unchanged drug or as inactive metabolites. In human studies, 11% and 25% of the dose were recovered in urine and feces, respectively, as either parent drug or metabolite during the 5-day period following drug administration. Of the material recovered in urine, 65% was unchanged drug. The remaining 35% was composed of monocarboxylic and dicarboxylic acid derivatives and their glucuronide conjugates. The pathways leading to the metabolism of mitoxantrone have not been elucidated.

Special Populations:

Gender - The effect of gender on mitoxantrone pharmacokinetics is unknown.

Geriatric - In elderly patients with breast cancer, the systemic mitoxantrone clearance was 21.3 L/hr/m², compared with 28.3 L/hr/m² and 16.2 L/hr/m² for non-elderly patients with nasopharyngeal carcinoma and malignant lymphoma, respectively.

Pediatric - Mitoxantrone pharmacokinetics in the pediatric population are unknown.

Race - The effect of race on mitoxantrone pharmacokinetics is unknown.

Renal Impairment - Mitoxantrone pharmacokinetics in patients with renal impairment are unknown.

Hepatic Impairment - Mitoxantrone clearance is reduced by hepatic impairment. Patients with severe hepatic dysfunction (bilirubin > 3.4 mg/dL) have an AUC more than three times greater than that of patients with normal hepatic function receiving the same dose. Patients who have hepatic impairment should ordinarily not be treated with mitoxantrone. Other patients with hepatic impairment should be treated with caution and dosage adjustment may be required.

Drug Interactions: *In vitro* drug interaction studies have demonstrated that mitoxantrone did not inhibit CYP450 1A2, 2A6, 2C9, 2C19, 2D6, 2E1 and 3A4 across a broad concentration range. The results of *in vitro* induction studies are inconclusive, but suggest that mitoxantrone is a weak inducer of CYP450 2E1 activity.

Pharmacokinetic studies of the interaction of mitoxantrone with concomitantly administered medications in humans have not been performed. The pathways leading to the metabolism of mitoxantrone have not been elucidated. To date, post-marketing experience has not revealed any significant drug interactions in patients who have received mitoxantrone for treatment of cancer.

CLINICAL TRIALS

Advanced Hormone-Refractory Prostate Cancer: A multicenter Phase 2 trial of mitoxantrone and low-dose prednisone (M + P) was conducted in 27 symptomatic patients with hormone-refractory prostate cancer. Using NPCP (National Prostate Cancer Project) criteria for disease response, there was one partial responder and 12 patients with stable disease. However, nine patients or 33% achieved a palliative response defined on the basis of reduction in analgesic use or pain intensity.

These findings led to the initiation of a randomized multicenter trial (CCI-NOV22) comparing the effectiveness of (M + P) to low-dose prednisone alone (P). Eligible patients were required to have metastatic or locally advanced disease that had progressed on standard hormonal therapy, a castrate serum testosterone level, and at least mild pain at study entry. Mitoxantrone was administered at a dose of 12 mg/m² by short IV infusion every 3 weeks. Prednisone was administered orally at a dose of 5 mg twice a day. Patients randomized to the prednisone arm were crossed over to the M + P arm if they progressed or if they were not improved after a minimum of 6 weeks of therapy with prednisone alone.

A total of 161 patients were randomized, 80 to the M + P arm and 81 to the P arm. The median mitoxantrone dose administered was 12 mg/m² per cycle. The median cumulative mitoxantrone dose administered was 73 mg/m² (range of 12 to 212 mg/m²).

A primary palliative response (defined as a 2-point decrease in pain intensity in a 6-point pain scale, associated with stable analgesic use, and lasting a minimum of 6 weeks) was achieved in 29% of patients randomized to M + P compared to 12% of patients randomized to P alone (p = 0.011). Two responders left the study after meeting primary response criterion for two consecutive cycles. For the purposes of this analysis, these two patients were assigned a response duration of zero days. A secondary palliative response was defined as a 50% or greater decrease in analgesic use, associated with stable pain intensity, and lasting a minimum of 6 weeks. An overall palliative response (defined as primary plus secondary responses) was achieved in 38% of patients randomized to M + P compared to 21% of patients randomized to P (p = 0.025).

The median duration of primary palliative response for patients randomized to M + P was 7.6 months compared to 2.1 months for patients randomized to P alone (p = 0.0009).

The median duration of overall palliative response for patients randomized to M + P was 5.6 months compared to 1.9 months for patients randomized to P alone (p = 0.0004).

Time to progression was defined as a 1-point increase in pain intensity, or a > 25% increase in analgesic use, or evidence of disease progression on radiographic studies, or requirement for radiotherapy. The median time to progression for all patients randomized to M + P was 4.4 months compared to 2.3 months for all patients randomized to P alone (p = 0.0001). Median time to death was 11.3 months for all patients on the M + P arm compared to 10.8 months for all patients on P alone (p = 0.2324).

Forty-eight patients on the P arm crossed over to receive M + P. Of these, thirty patients had progressed on P, while 18 had stable disease on P. The median cycle of crossover was 5 cycles (range of 2 to 16 cycles). Time trends for pain intensity prior to crossover were significantly worse for patients who crossed over than for those who remained on P alone (p = 0.012). Nine patients (19%) demonstrated a palliative response on M + P after crossover. The median time to death for patients who crossed over to M + P was 12.7 months.

The clinical significance of a fall in prostate-specific antigen (PSA) concentrations after chemotherapy is unclear. On the CCI-NOV22 trial, a PSA fall of 50% or greater for two consecutive follow-up assessments after baseline was reported in 33% of all patients randomized to the M + P arm and 9% of all patients randomized to the P arm.

These findings should be interpreted with caution since PSA responses were not defined prospectively. A number of patients were inevaluable for response, and there was an imbalance between treatment arms in the numbers of evaluable patients. In addition, PSA reduction did not correlate precisely with palliative response, the primary efficacy endpoint of this study. For example, among the 26 evaluable patients randomized to the M + P arm who had \geq 50% reduction in PSA, only 13 had a primary palliative response. Also, among 42 evaluable patients on this arm who did not have this reduction in PSA, 8 nonetheless had a primary palliative response.





MitoXANTRONE Injection, USP (concentrate)

Investigators at Cancer and Leukemia Group B (CALGB) conducted a Phase 3 comparative trial of mitoxantrone plus hydrocortisone (M + H) versus hydrocortisone alone (H) in patients with hormone-refractory prostate cancer (CALGB 9182). Eligible patients were required to have metastatic disease that had progressed despite at least one hormonal therapy. Progression at study entry was defined on the basis of progressive symptoms, increases in measurable or osseous disease, or rising PSA levels. Mitoxantrone was administered intravenously at a dose of 14 mg/m² every 21 days and hydrocortisone was administered orally at a daily dose of 40 mg. A total of 242 subjects were randomized, 119 to the M + H arm and 123 to the H arm. There were no differences in survival between the two arms, with a median of 11.1 months in the M + H arm and 12 months in the H arm (p = 0.3298).

Using NPCP criteria for response, partial responses were achieved in 10 patients (8.4%) randomized to the M + H arm compared with 2 patients (1.6%) randomized to the H arm (p = 0.018). The median time to progression, defined by NPCP criteria, for patients randomized to the M + H arm was 7.3 months compared to 4.1 months for patients randomized to H alone (p = 0.0654).

Approximately 60% of patients on each arm required analgesics at baseline. Analgesic use was measured in this study using a 5-point scale. The best percent change from baseline in mean analgesic use was -17% for 61 patients with available data on the M + H arm, compared with +17% for 61 patients on H alone (p = 0.014). A time trend analysis for analgesic use in individual patients also showed a trend favoring the M + H arm over H alone but was not statistically significant.

Pain intensity was measured using the Symptom Distress Scale (SDS) Pain Item 2 (a 5-point scale). The best percent change from baseline in mean pain intensity was -14% for 37 patients with available data on the M + H arm, compared with +8% for 38 patients on H alone (p = 0.057). A time trend analysis for pain intensity in individual patients showed no difference between treatment arms.

Acute Nonlymphocytic Leukemia: In two large randomized multicenter trials, remission induction therapy for acute nonlymphocytic leukemia (ANLL) with mitoxantrone 12 mg/m² daily for 3 days as a 10-minute intravenous infusion and cytarabine 100 mg/m² for 7 days given as a continuous 24-hour infusion was compared with daunorubicin 45 mg/m² daily by intravenous infusion for 3 days plus the same dose and schedule of cytarabine used with mitoxantrone. Patients who had an incomplete antileukemic response received a second induction course in which mitoxantrone or daunorubicin was administered for 2 days and cytarabine for 5 days using the same daily dosage schedule. Response rates and median survival information for both the U.S. and international multicenter trials are given in Table 1:

Table 1: Response Rates, Time to Response, and Survival in U.S. and International Trials

Trial	% Complete Response (CR)		Median Time to CR (days)		Survival (days)	
	MIT	DAUN	MIT	DAUN	MIT	DAUN
U.S.	63 (62/98)	53 (54/102)	35	42	312	237
International	50 (56/112)	51 (62/123)	36	42	192	230

MIT = mitoxantrone + cytarabine

DAUN = daunorubicin + cytarabine

In these studies, two consolidation courses were administered to complete responders on each arm. Consolidation therapy consisted of the same drug and daily dosage used for remission induction, but only 5 days of cytarabine and 2 days of mitoxantrone or daunorubicin were given. The first consolidation course was administered 6 weeks after the start of the final induction course if the patient achieved a complete remission. The second consolidation course was generally administered 4 weeks later. Full hematologic recovery was necessary for patients to receive consolidation therapy. For the U.S. trial, median granulocyte nadirs for patients receiving mitoxantrone + cytarabine for consolidation courses 1 and 2 were 10/mm³ for both courses, and for those patients receiving daunorubicin + cytarabine nadirs were 170/mm³ and 260/mm³, respectively. Median platelet nadirs for patients who received mitoxantrone + cytarabine for consolidation courses 1 and 2 were 17,000/mm³ and 14,000/mm³, respectively, and were 33,000/mm³ and 22,000/mm³ in courses 1 and 2 for those patients who received daunorubicin + cytarabine. The benefit of consolidation therapy in ANLL patients who achieve a complete remission remains controversial. However, in the only well-controlled prospective, randomized multicenter trials with mitoxantrone in ANLL, consolidation therapy was given to all patients who achieved a complete remission. During consolidation in the U.S. study, two myelosuppression-related deaths occurred in the mitoxantrone arm and one on the daunorubicin arm. However, in the international study there were eight deaths on the mitoxantrone arm during consolidation which were related to the myelosuppression and none on the daunorubicin arm where less myelosuppression occurred.

INDICATIONS AND USAGE

Mitoxantrone in combination with corticosteroids is indicated as initial chemotherapy for the treatment of patients with pain related to advanced hormone-refractory prostate cancer.

Mitoxantrone in combination with other approved drug(s) is indicated in the initial therapy of acute nonlymphocytic leukemia (ANLL) in adults. This category includes myelogenous, promyelocytic, monocytic, and erythroid acute leukemias.

CONTRAINDICATIONS

Mitoxantrone is contraindicated in patients who have demonstrated prior hypersensitivity to it.

WARNINGS

WHEN MITOXANTRONE IS USED IN HIGH DOSES (> 14 mg/m²/d x 3 days) SUCH AS INDICATED FOR THE TREATMENT OF LEUKEMIA, SEVERE MYELOSUPPRESSION WILL OCCUR. THEREFORE, IT IS RECOMMENDED THAT MITOXANTRONE BE ADMINISTERED ONLY BY PHYSICIANS EXPERIENCED IN THE CHEMOTHERAPY OF THIS DISEASE. LABORATORY AND SUPPORTIVE SERVICES MUST BE AVAILABLE FOR HEMATOLOGIC AND CHEMISTRY MONITORING AND ADJUNCTIVE THERAPIES, INCLUDING ANTIBIOTICS, BLOOD AND BLOOD PRODUCTS MUST BE AVAILABLE TO SUPPORT PATIENTS DURING THE EXPECTED PERIOD OF MEDULLARY HYPOPLASIA AND SEVERE MYELOSUPPRESSION. PARTICULAR CARE SHOULD BE GIVEN TO ASSURING FULL HEMATOLOGIC RECOVERY BEFORE UNDERTAKING CONSOLIDATION THERAPY (IF THIS TREATMENT IS USED) AND PATIENTS SHOULD BE MONITORED CLOSELY DURING THIS PHASE. MITOXANTRONE ADMINISTERED AT ANY DOSE CAN CAUSE MYELOSUPPRESSION.

General: Patients with preexisting myelosuppression as the result of prior drug therapy should not receive mitoxantrone unless it is felt that the possible benefit from such treatment warrants the risk of further medullary suppression.

The safety of Mitoxantrone Injection, USP (concentrate) in patients with hepatic insufficiency is not established (see **CLINICAL PHARMACOLOGY**).

Safety for use by routes other than intravenous administration has not been established.

Mitoxantrone is not indicated for subcutaneous, intramuscular, or intra-arterial injection. There have been reports of local/regional neuropathy, some irreversible, following intra-arterial injection.

Mitoxantrone must not be given by intrathecal injection. There have been reports of neuropathy and neurotoxicity, both central and peripheral, following intrathecal injection. These reports have included seizures leading to coma and severe neurologic sequelae, and paralysis with bowel and bladder dysfunction.

Topoisomerase II inhibitors, including mitoxantrone, have been associated with the development of secondary AML and myelosuppression.

Cardiac Effects: Because of the possible danger of cardiac effects in patients previously treated with daunorubicin or doxorubicin, the benefit-to-risk ratio of mitoxantrone therapy in such patients should be determined before starting therapy.

Functional cardiac changes including decreases in left ventricular ejection fraction (LVEF) and irreversible congestive heart failure can occur with mitoxantrone. Cardiac toxicity may be more common in patients with prior treatment with anthracyclines, prior mediastinal radiotherapy, or with preexisting cardiovascular disease. Such patients should have regular cardiac monitoring of LVEF from the initiation of therapy. Cancer patients who received cumulative doses of 140 mg/m² either alone or in combination with other chemotherapeutic agents had a cumulative 2.6% probability of clinical congestive heart failure. In comparative oncology trials, the overall cumulative probability rate of moderate or severe decreases in LVEF at this dose was 13%.

Leukemia: Acute congestive heart failure may occasionally occur in patients treated with mitoxantrone for ANLL. In first-line comparative trials of mitoxantrone + cytarabine vs. daunorubicin + cytarabine in adult patients with previously untreated ANLL, therapy was associated with congestive heart failure in 6.5% of patients on each arm. A causal relationship between drug therapy and cardiac effects is difficult to establish in this setting since myocardial function is frequently depressed by the anemia, fever, and infection, and hemorrhage that often accompany the underlying disease.

Hormone-Refractory Prostate Cancer: Functional cardiac changes such as decreases in LVEF and congestive heart failure may occur in patients with hormone-refractory prostate cancer treated with mitoxantrone. In a randomized comparative trial of mitoxantrone plus low-dose prednisone vs. low-dose prednisone, 7 of 128 patients (5.5%) treated with mitoxantrone had a cardiac event defined as any decrease in LVEF below the normal range, congestive heart failure (n = 3), or myocardial ischemia. Two patients had a prior history of cardiac disease. The total mitoxantrone dose administered to patients with cardiac effects ranged from > 48 to 212 mg/m².

Among 112 patients evaluable for safety on the mitoxantrone + hydrocortisone arm of the CALGB trial, 18 patients (19%) had a reduction in cardiac function, 5 patients (5%) had cardiac ischemia, and 2 patients (2%) experienced pulmonary edema. The range of total mitoxantrone doses administered to these patients is not available.

Pregnancy: Mitoxantrone may cause fetal harm when administered to a pregnant woman. Women of childbearing potential should be advised to avoid becoming pregnant. Mitoxantrone is considered a potential human teratogen because of its mechanism of action and the developmental effects demonstrated by related agents. Treatment of pregnant rats during the organogenesis period of gestation was associated with fetal growth retardation at doses ≥ 0.1 mg/kg/day (0.01 times the recommended human dose on a mg/m² basis). When pregnant rabbits were treated during organogenesis, an increased incidence of premature delivery was observed at doses ≥ 0.1 mg/kg/day (0.01 times the recommended human dose on a mg/m² basis). No teratogenic effects were observed in these studies, but the maximum doses tested were well below the recommended human dose (0.02 and 0.05 times in rats and rabbits, respectively, on a mg/m² basis). There are no adequate and well-controlled studies in pregnant women. Women who are biologically capable of becoming pregnant should have a pregnancy test prior to each dose, and the results should be known prior to administration of the drug. If this drug is used during pregnancy or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential risk to the fetus.

Secondary Leukemia: Secondary acute myelogenous leukemia (AML) has been reported in cancer patients treated with mitoxantrone. Postmarketing cases of secondary AML have also been reported. In 1774 patients with breast cancer who received mitoxantrone concomitantly with other cytotoxic agents and the radiotherapy, the cumulative risk of developing treatment-related AML was estimated as 1.1% and 1.6% at 5 and 10 years, respectively. The second largest report involved 449 patients with breast cancer treated with mitoxantrone, usually in combination with radiotherapy and/or other cytotoxic agents. In this study, the cumulative probability of developing secondary leukemia was estimated to be 2.2% at 4 years.

Secondary AML has also been reported in cancer patients treated with anthracyclines. Mitoxantrone is an anthracenedione, a related drug. The occurrence of refractory secondary leukemia is more common when anthracyclines are given in combination with DNA-damaging antineoplastic agents, when patients have been heavily pretreated with cytotoxic drugs, or when doses of anthracyclines have been escalated.

PRECAUTIONS

General: Therapy with mitoxantrone should be accompanied by close and frequent monitoring of hematologic and chemical laboratory parameters, as well as frequent patient observation.

Systemic infections should be treated concomitantly with or just prior to commencing therapy with mitoxantrone.

Information for Patients: Mitoxantrone may impart a blue-green color to the urine for 24 hours after administration, and patients should be advised to expect this during therapy. Bluish discoloration of the sclera may also occur. Patients should be advised of the signs and symptoms of myelosuppression.

Laboratory Tests: A complete blood count, including platelets, should be obtained prior to each course of mitoxantrone and in the event that signs and symptoms of infection develop. Liver function tests should also be performed prior to each course of therapy. In leukemia treatment, hyperuricemia may occur as a result of rapid lysis of tumor cells by mitoxantrone. Serum uric acid levels should be monitored and hypouricemic therapy instituted prior to the initiation of antileukemic therapy.

Carcinogenesis, Mutagenesis, Impairment of Fertility:

Carcinogenesis: Intravenous treatment of rats and mice, once every 21 days for 24 months, with mitoxantrone resulted in an increased incidence of fibroma and external auditory canal tumors in rats at a dose of 0.03 mg/kg (0.02 fold the recommended human dose, on a mg/m² basis), and hepatocellular adenoma in male mice at a dose of 0.1 mg/kg (0.03 fold the recommended human dose, on a mg/m² basis). Intravenous treatment of rats, once every 21 days for 12 months with mitoxantrone resulted in an increased incidence of external auditory canal tumors in rats at a dose of 0.3 mg/kg (0.15 fold the recommended human dose, on a mg/m² basis).

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Mutagenesis - Mitoxantrone was clastogenic in the in vivo rat bone marrow assay. Mitoxantrone was also clastogenic in two in vitro assays; it induced DNA damage in primary rat hepatocytes and sister chromatid exchanges in Chinese hamster ovary cells. Mitoxantrone was mutagenic in bacterial and mammalian test systems (Ames/ Salmonella and E. coli and L5178Y TK+/-mouse lymphoma).

Drug Interactions: Mitoxantrone and its metabolites are excreted in bile and urine, but it is not known whether the metabolic or excretory pathways are saturable, may be inhibited or induced, or if mitoxantrone and its metabolites undergo enterohepatic circulation. To date, post-marketing experience has not revealed any significant drug interactions in patients who have received mitoxantrone for treatment of cancer.

Following concurrent administration of mitoxantrone with corticosteroids, no evidence of drug interactions has been observed.

Special Populations:

Hepatic Impairment - Mitoxantrone should be administered with caution to other patients with hepatic impairment. In patients with severe hepatic impairment, the AUC is more than three times greater than the value observed in patients with normal hepatic function.

Pregnancy: Pregnancy Category D (see **WARNINGS**).

Nursing Mothers: Mitoxantrone is excreted in human milk and significant concentrations (18 ng/mL) have been reported for 28 days after the last administration. Because of the potential for serious adverse reactions in infants from mitoxantrone, breast feeding should be discontinued before starting treatment.

Pediatric Use: Safety and effectiveness in pediatric patients have not been established.

Geriatric Use: *Hormone-Refractory Prostate Cancer:* One hundred forty-six patients aged 65 and over and 52 younger patients (<65 years) have been treated with mitoxantrone in controlled clinical studies. These studies did not include sufficient numbers of younger patients to determine whether they respond differently from older patients. However, greater sensitivity of some older individuals cannot be ruled out.

Acute Nonlymphocytic Leukemia: Although definitive studies with mitoxantrone have not been performed in geriatric patients with ANLL, toxicity may be more frequent in the elderly. Elderly patients are more likely to have age-related comorbidities due to disease or disease therapy.

ADVERSE REACTIONS

Leukemia: Mitoxantrone has been studied in approximately 600 patients with acute non-lymphocytic leukemia (ANLL). Table 2 represents the adverse reaction experience in the large U.S. comparative study of mitoxantrone + cytarabine vs daunorubicin + cytarabine. Experience in the large international study was similar. A much wider experience in a variety of other tumor types revealed no additional important reactions other than cardiomyopathy (see **WARNINGS**). It should be appreciated that the listed adverse reaction categories include overlapping clinical symptoms related to the same condition, e.g., dyspnea, cough and pneumonia. In addition, the listed adverse reactions cannot all necessarily be attributed to chemotherapy as it is often impossible to distinguish effects of the drug and effects of the underlying disease. It is clear, however, that the combination of mitoxantrone + cytarabine was responsible for nausea and vomiting, alopecia, mucositis/stomatitis, and myelosuppression.

Table 2 summarizes adverse reactions occurring in patients treated with mitoxantrone + cytarabine in comparison with those who received daunorubicin + cytarabine for therapy of ANLL in a large multicenter randomized prospective U.S. trial.

Adverse reactions are presented as major categories and selected examples of clinically significant subcategories.

Event	Induction		Consolidation	
	[% pts entering induction]		[% pts entering induction]	
	MIT N = 102	DAUN N = 102	MIT N = 55	DAUN N = 49
Cardiovascular	26	28	11	24
CHF	5	6	0	0
Arrhythmias	3	3	4	4
Bleeding	37	41	20	6
GI	16	12	2	2
Petechiae/ecchymoses	7	9	11	2
Gastrointestinal	88	85	58	51
Nausea/vomiting	72	67	31	31
Diarrhea	47	47	18	8
Abdominal pain	15	9	9	4
Mucositis/stomatitis	29	33	18	8
Hepatic	10	11	14	2
Jaundice	3	8	7	0
Infections	66	73	60	43
UTI	7	2	7	2
Pneumonia	9	7	9	0
Sepsis	34	36	31	18
Fungal infections	15	13	9	6
Renal failure	8	6	0	2
Fever	78	71	24	18
Alopecia	37	40	22	16
Pulmonary	43	43	24	14
Cough	13	9	9	2
Dyspnea	18	20	6	0
CNS	30	30	34	35
Seizures	4	4	2	8
Headache	10	9	13	8
Eye	7	6	2	4
Conjunctivitis	5	1	0	0

MIT = mitoxantrone, DAUN = daunorubicin.

Hormone-Refractory Prostate Cancer: Detailed safety information is available for a total of 353 patients with hormone-refractory prostate cancer treated with mitoxantrone, including 274 patients who received mitoxantrone in combination with corticosteroids.

Table 3 summarizes adverse reactions of all grades occurring in $\geq 5\%$ of patients in Trial CCI-NOV22.

Table 3: Adverse Events of Any Intensity Occurring in $\geq 5\%$ of Patients Trial CCI-NOV22

Event	M + P (n = 80) %	P (n = 81) %
Nausea	61	35
Fatigue	39	14
Alopecia	29	0
Anorexia	25	6
Constipation	16	14
Dyspnea	11	5
Nail bed changes	11	0
Edema	10	4
Systemic infection	10	7
Muscovites	10	0
UTI	9	4
Emesis	9	5
Pain	8	9
Fever	6	3
Hemorrhage/bruise	6	1
Anemia	5	3
Cough	5	0
Decreased LVEF	5	0
Anxiety/depression	5	3
Dyspepsia	5	6
Skin infection	5	3
Blurred vision	3	5

M = mitoxantrone, P = prednisone.

No nonhematologic adverse events of Grade 3/4 were seen in $> 5\%$ of patients.

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Table 4 summarizes adverse events of all grades occurring in ≥ 5% of patients in Trial CALGB 9182.

Table 4: Adverse Events of Any Intensity Occurring in ≥ 5% of Patients. Trial CALGB 9182

Event	M + H (n = 112)		H (n = 113)	
	n	%	n	%
Decreased WBC	96	87	4	4
Granulocytes/bands	88	79	3	3
Decreased hemoglobin	83	75	42	39
Lymphocytes	78	72	27	25
Pain	45	41	44	39
Platelets	43	39	8	7
Alkaline Phosphatase	41	37	42	38
Malaise/fatigue	37	34	16	14
Hyperglycemia	33	31	32	30
Edema	31	30	15	14
Nausea	28	26	9	8
Anorexia	24	22	16	14
BUN	24	22	22	20
Transaminase	22	20	16	14
Alopecia	20	20	1	1
Cardiac function	19	18	0	0
Infection	18	17	4	4
Weight loss	18	17	13	12
Dyspnea	16	15	9	8
Diarrhea	16	14	4	4
Fever in absence of infection	15	14	7	6
Weight gain	15	14	16	15
Creatinine	14	13	11	10
Other gastrointestinal	13	14	11	11
Vomiting	12	11	6	5
Other neurologic	11	11	5	5
Hypocalcemia	10	10	5	5
Hematuria	9	11	5	6
Hyponatremia	9	9	3	3
Sweats	9	9	2	2
Other liver	8	8	8	8
Stomatitis	8	8	1	1
Cardiac dysrhythmia	7	7	3	3
Hypokalemia	7	7	4	4
Neuro/constipation	7	7	2	2
Neuro/motor	7	7	3	3
Neuro/mood	6	6	2	2
Skin	6	6	4	4
Cardiac ischemia	5	5	1	1
Chills	5	5	0	0
Hemorrhage	5	5	3	3
Myalgias/arthralgias	5	5	3	3
Other kidney/bladder	5	5	3	3
Other endocrine	5	6	3	4
Other pulmonary	5	5	3	3
Hypertension	4	4	5	5
Impotence/libido	4	7	2	3
Proteinuria	4	6	2	3
Sterility	3	5	2	3

M = mitoxantrone, H = hydrocortisone

General:

Allergic Reaction - Hypotension, urticaria, dyspnea, and rashes have been reported occasionally. Anaphylaxis/anaphylactoid reactions have been reported rarely.

Cutaneous - Extravasation at the infusion site has been reported, which may result in erythema, swelling, pain, burning, and/or blue discoloration of the skin. Extravasation can result in tissue necrosis with resultant need for debridement and skin grafting. Phlebitis has also been reported at the site of the infusion.

Hematologic - Topoisomerase II inhibitors, including mitoxantrone, in combination with other antineoplastic agents, have been associated with the development of acute leukemia (see **WARNINGS**).

Leukemia - Myelosuppression is rapid in onset and is consistent with the requirement to produce significant marrow hypoplasia in order to achieve a response in acute leukemia. The incidences of infection and bleeding seen in the U.S. trial are consistent with those reported for other standard induction regimens.

Hormone-Refractory Prostate Cancer - In a randomized study where dose escalation was required for neutrophil counts greater than 1000/mm³, Grade 4 neutropenia (ANC < 500/mm³) was observed in 54% of patients treated with mitoxantrone + low-dose prednisone. In a separate randomized trial where patients were treated with 14 mg/m², Grade 4 neutropenia in 23% of patients treated with mitoxantrone + hydrocortisone was observed. Neutropenic fever/infection occurred in 11% and 10% of patients receiving mitoxantrone + corticosteroids, respectively, on the two trials. Platelets < 50,000/mm³ were noted in 4% and 3% of patients receiving mitoxantrone + corticosteroids on these trials, and there was one patient death on mitoxantrone + hydrocortisone due to intracranial hemorrhage after a fall.

Gastrointestinal - Nausea and vomiting occurred acutely in most patients and may have contributed to reports of dehydration, but were generally mild to moderate and could be controlled through the use of antiemetics. Stomatitis/mucositis occurred within 1 week of therapy.

Cardiovascular - Congestive heart failure, tachycardia, EKG changes including arrhythmias, chest pain, and asymptomatic decreases in left ventricular ejection fraction have occurred. (See **WARNINGS**).

Pulmonary - Interstitial pneumonitis has been reported in cancer patients receiving combination chemotherapy that included mitoxantrone.

OVERDOSAGE

There is no known specific antidote for mitoxantrone. Accidental overdoses have been reported. Four patients receiving 140 to 180 mg/m² as a single bolus injection died as a result of severe leukopenia with infection. Hematologic support and antimicrobial therapy may be required during prolonged periods of severe myelosuppression.

Although patients with severe renal failure have not been studied, mitoxantrone is extensively tissue bound and it is unlikely that the therapeutic effect or toxicity would be mitigated by peritoneal or hemodialysis.

DOSAGE AND ADMINISTRATION (SEE ALSO WARNINGS)

Hormone-Refractory Prostate Cancer: Based on data from two Phase 3 comparative trials of mitoxantrone plus corticosteroids versus corticosteroids alone, the recommended dosage of mitoxantrone is 12 to 14 mg/m² given as a short intravenous infusion every 21 days.

Combination Initial Therapy for ANLL in Adults: For induction, the recommended dosage is 12 mg/m² of mitoxantrone daily on Days 1 to 3 given as an intravenous infusion, and 100 mg/m² of cytarabine for 7 days given as a continuous 24 hour infusion on Days 1 to 7.

Most complete remissions will occur following the initial course of induction therapy. In the event of an incomplete anti-leukemic response, a second induction course may be given. Mitoxantrone should be given for 2 days and cytarabine for 5 days using the same daily dosage levels.

If severe or life-threatening nonhematologic toxicity is observed during the first induction course, the second induction course should be withheld until toxicity resolves.

Consolidation therapy which was used in two large randomized multicenter trials consisted of mitoxantrone, 12 mg/m² given by intravenous infusion daily on Days 1 and 2 and cytarabine, 100 mg/m² for 5 days given as a continuous 24-hour infusion on Days 1 to 5. The first course was given approximately 6 weeks after the final induction course, the second was generally administered 4 weeks after the first. Severe myelosuppression occurred. (See **CLINICAL PHARMACOLOGY**)

Hepatic Impairment: For patients with hepatic impairment, there is at present no laboratory measurement that allows for dose adjustment recommendations. (See **CLINICAL PHARMACOLOGY, Special Populations, Hepatic Impairment**)

Preparation and Administration Precautions

MITOXANTRONE INJECTION, USP (CONCENTRATE) MUST BE DILUTED PRIOR TO USE.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit. The dose of mitoxantrone should be diluted to at least 50 mL with either 0.9% Sodium Chloride Injection (USP) or 5% Dextrose Injection (USP). Mitoxantrone Injection, USP (concentrate) may be further diluted into Dextrose 5% in Water, Normal Saline or Dextrose 5% with Normal Saline and used immediately. DO NOT FREEZE.

Mitoxantrone should not be mixed in the same infusion as heparin since a precipitate may form. Because specific compatibility data are not available, it is recommended that mitoxantrone not be mixed in the same infusion with other drugs. The diluted solution should be introduced slowly into the tubing as a freely running intravenous infusion of 0.9% Sodium Chloride Injection (USP) or 5% Dextrose Injection (USP) over a period of not less than 3 minutes. Unused infusion solutions should be discarded immediately in an appropriate fashion. In the case of multidose use, after penetration of the stopper, the remaining portion of the undiluted Mitoxantrone Injection, USP concentrate should be stored not longer than 7 days between 15°-25°C (59°-77°F) or 14 days under refrigeration. DO NOT FREEZE. CONTAINS NO PRESERVATIVE.

Care in the administration of mitoxantrone will reduce the chance of extravasation. Mitoxantrone should be administered into the tubing of a freely running intravenous infusion of Sodium Chloride Injection, USP (0.9%) or 5% Dextrose Injection, USP. The tubing should be attached to a Butterfly needle or other suitable device and inserted preferably into a large vein. If possible, avoid veins over joints or in extremities with compromised venous or lymphatic drainage. Care should be taken to avoid extravasation at the infusion site and to avoid contact of mitoxantrone with the skin, mucous membranes, or eyes. MITOXANTRONE SHOULD NOT BE ADMINISTERED SUBCUTANEOUSLY. If any signs or symptoms of extravasation have occurred, including burning, pain, pruritis, erythema, swelling, blue discoloration, or ulceration, the injection or infusion should be immediately terminated and restarted in another vein. During intravenous administration of mitoxantrone extravasation may occur with or without an accompanying stinging or burning sensation even if blood returns well on aspiration of the infusion needle. If it is known or suspected that subcutaneous extravasation has occurred, it is recommended that intermittent ice packs be placed over the area of extravasation and that the affected extremity be elevated. Because of the progressive nature of extravasation reactions, the area of injection should be frequently examined and surgery consultation obtained early if there is any sign of a local reaction.

Skin accidentally exposed to mitoxantrone should be rinsed copiously with warm water and if the eyes are involved, standard irrigation techniques should be used immediately. The use of goggles, gloves, and protective gowns is recommended during preparation and administration of the drug.

Procedures for proper handling and disposal of anticancer drugs should be considered. Several guidelines on this subject have been published.¹⁻⁷ There is no general agreement that all of the procedures recommended in the guidelines are necessary or appropriate.

REFERENCES

1. Recommendations for the Safe Handling of Parenteral Antineoplastic Drugs. NIH Publication No. 83-2621. For sale by the Superintendent of Documents, US Government Printing Office, Washington, DC 20402.
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3. National Study Commission on Cytotoxic Exposure - Recommendations for Handling Cytotoxic Agents. Available from Louis P. Jeffrey, Sc D, Chairman, National Study Commission on Cytotoxic Exposure, Massachusetts College of Pharmacy and Allied Health Sciences, 179 Longwood Avenue, Boston, Massachusetts 02115.
4. Clinical Oncological Society of Australia: Guidelines and recommendations for safe handling of antineoplastic agents. Med J Australia 1983;1: 426.
5. Jones RB, et al. Safe handling of chemotherapeutic agents: A report from the Mount Sinai Medical Center. CA Cancer J Clin 1983;33: 258.
6. American Society of Hospital Pharmacists technical assistance bulletin on handling cytotoxic and hazardous drugs. Am J Hosp Pharm 1990;47: 1033.
7. Controlling occupational exposure to hazardous drugs. Am J Health-System Pharm 1996;53: 1669.

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MitoXANTRONE Injection, USP (concentrate)

HOW SUPPLIED

Mitoxantrone Injection, USP (concentrate) is a sterile aqueous solution containing mitoxantrone hydrochloride at a concentration equivalent to 2 mg mitoxantrone free base per mL supplied in vials for multidose use as follows:

NDC 61703-343-18 – 20 mg/10 mL multidose vial
NDC 61703-343-65 – 25 mg/12.5 mL multidose vial
NDC 61703-343-66 – 30 mg/15 mL multidose vial

Mitoxantrone Injection, USP (concentrate) should be stored between 15°-25°C (59°-77°F). [See USP Controlled Room Temperature]. DO NOT FREEZE. Store Upright.

Hospira, Inc.
Lake Forest, IL 60045
Product of Australia
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