

## FULL PRESCRIBING INFORMATION

### 1 INDICATIONS AND USAGE

LUMAKRAS is indicated for the treatment of adult patients with *KRAS G12C*-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), who have received at least one prior systemic therapy.

### 2 DOSAGE AND ADMINISTRATION

#### 2.1 Patient Selection

Select patients for treatment of locally advanced or metastatic NSCLC with LUMAKRAS based on the presence of *KRAS G12C* mutation in tumor or plasma specimens [see *Clinical Studies (14)*]. If no mutation is detected in a plasma specimen, test tumor tissue.

#### 2.2 Recommended Dosage and Administration

The recommended dosage of LUMAKRAS is 960 mg (eight 120 mg tablets) orally once daily until disease progression or unacceptable toxicity.

Take LUMAKRAS at the same time each day with or without food [see *Clinical Pharmacology (12.3)*]. Swallow tablets whole. Do not chew, crush or split tablets. If a dose of LUMAKRAS is missed by more than 6 hours, take the next dose as prescribed the next day. Do not take 2 doses at the same time to make up for the missed dose.

If vomiting occurs after taking LUMAKRAS, do not take an additional dose. Take the next dose as prescribed the next day.

#### Administration to Patients Who Have Difficulty Swallowing Solids

Disperse tablets in 120 mL (4 ounces) of non-carbonated, room-temperature water without crushing. No other liquids should be used. Stir until tablets are dispersed into small pieces (the tablets will not completely dissolve) and drink immediately or within 2 hours. The appearance of the mixture may range from pale yellow to bright yellow. Swallow the tablet dispersion. Do not chew pieces of the tablet. Rinse the container with an additional 120 mL (4 ounces) of water and drink. If the mixture is not consumed immediately, stir the mixture again to ensure that tablets are dispersed.

#### 2.3 Dosage Modifications for Adverse Reactions

LUMAKRAS dose reduction levels are summarized in Table 1. Dosage modifications for adverse reactions are provided in Table 2.

If adverse reactions occur, a maximum of two dose reductions are permitted. Discontinue LUMAKRAS if patients are unable to tolerate the minimum dose of 240 mg once daily.

**Table 1. Recommended LUMAKRAS Dose Reduction Levels for Adverse Reactions**

Dose Reduction Level	Dose
First dose reduction	480 mg (4 tablets) once daily
Second dose reduction	240 mg (2 tablets) once daily

**Table 2. Recommended LUMAKRAS Dosage Modifications for Adverse Reactions**

<b>Adverse Reaction</b>	<b>Severity<sup>a</sup></b>	<b>Dosage Modification</b>
Hepatotoxicity [ <i>see Warnings and Precautions (5.1)</i> ]	Grade 2 AST or ALT with symptoms or Grade 3 to 4 AST or ALT	<ul style="list-style-type: none"> <li>Withhold LUMAKRAS until recovery to <math>\leq</math> Grade 1 or baseline.</li> <li>Resume LUMAKRAS at the next lower dose level.</li> </ul>
	AST or ALT $> 3 \times$ ULN with total bilirubin $> 2 \times$ ULN in the absence of alternative causes	<ul style="list-style-type: none"> <li>Permanently discontinue LUMAKRAS.</li> </ul>
Interstitial Lung Disease (ILD)/ pneumonitis [ <i>see Warnings and Precautions (5.2)</i> ]	Any Grade	<ul style="list-style-type: none"> <li>Withhold LUMAKRAS if ILD/pneumonitis is suspected.</li> <li>Permanently discontinue LUMAKRAS if ILD/pneumonitis is confirmed.</li> </ul>
Nausea or vomiting despite appropriate supportive care (including anti-emetic therapy) [ <i>see Adverse Reactions (6.1)</i> ]	Grade 3 to 4	<ul style="list-style-type: none"> <li>Withhold LUMAKRAS until recovery to <math>\leq</math> Grade 1 or baseline.</li> <li>Resume LUMAKRAS at the next lower dose level.</li> </ul>
Diarrhea despite appropriate supportive care (including anti-diarrheal therapy) [ <i>see Adverse Reactions (6.1)</i> ]	Grade 3 to 4	<ul style="list-style-type: none"> <li>Withhold LUMAKRAS until recovery to <math>\leq</math> Grade 1 or baseline.</li> <li>Resume LUMAKRAS at the next lower dose level.</li> </ul>
Other adverse reactions [ <i>see Adverse Reactions (6.1)</i> ]	Grade 3 to 4	<ul style="list-style-type: none"> <li>Withhold LUMAKRAS until recovery to <math>\leq</math> Grade 1 or baseline.</li> <li>Resume LUMAKRAS at the next lower dose level.</li> </ul>

ALT = alanine aminotransferase; AST = aspartate aminotransferase; ULN = upper limit of normal

<sup>a</sup> Grading defined by National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE) version 5.0

## 2.4 Coadministration of LUMAKRAS with Acid-Reducing Agents

Avoid coadministration of proton pump inhibitors (PPIs) and H<sub>2</sub> receptor antagonists with LUMAKRAS. If treatment with an acid-reducing agent cannot be avoided, take LUMAKRAS 4 hours before or 10 hours after administration of a local antacid [*see Drug Interactions (7.1) and Clinical Pharmacology (12.3)*].

## 3 DOSAGE FORMS AND STRENGTHS

Tablets: 120 mg, yellow, oblong-shaped, immediate release, film-coated, debossed with “AMG” on one side and “120” on the opposite side.

## 4 CONTRAINDICATIONS

None.

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Hepatotoxicity

LUMAKRAS can cause hepatotoxicity, which may lead to drug-induced liver injury and hepatitis. Among 357 patients who received LUMAKRAS in CodeBreak 100 [*see Adverse Reactions (6.1)*], hepatotoxicity occurred

in 1.7% (all grades) and 1.4% (Grade 3). A total of 18% of patients who received LUMAKRAS had increased alanine aminotransferase (ALT)/increased aspartate aminotransferase (AST); 6% were Grade 3 and 0.6% were Grade 4. The median time to first onset of increased ALT/AST was 9 weeks (range: 0.3 to 42). Increased ALT/AST leading to dose interruption or reduction occurred in 7% of patients. LUMAKRAS was discontinued due to increased ALT/AST in 2.0% of patients. In addition to dose interruption or reduction, 5% of patients received corticosteroids for the treatment of hepatotoxicity.

Monitor liver function tests (ALT, AST, and total bilirubin) prior to the start of LUMAKRAS, every 3 weeks for the first 3 months of treatment, then once a month or as clinically indicated, with more frequent testing in patients who develop transaminase and/or bilirubin elevations. Withhold, dose reduce or permanently discontinue LUMAKRAS based on severity of adverse reaction [see *Dosage and Administration* (2.3) and *Adverse Reactions* (6.1)].

## **5.2 Interstitial Lung Disease (ILD)/Pneumonitis**

LUMAKRAS can cause ILD/pneumonitis that can be fatal. Among 357 patients who received LUMAKRAS in CodeBreak 100 [see *Adverse Reactions* (6.1)], ILD/pneumonitis occurred in 0.8% of patients, all cases were Grade 3 or 4 at onset, and 1 case was fatal. The median time to first onset for ILD/pneumonitis was 2 weeks (range: 2 to 18 weeks). LUMAKRAS was discontinued due to ILD/pneumonitis in 0.6% of patients. Monitor patients for new or worsening pulmonary symptoms indicative of ILD/pneumonitis (e.g., dyspnea, cough, fever). Immediately withhold LUMAKRAS in patients with suspected ILD/pneumonitis and permanently discontinue LUMAKRAS if no other potential causes of ILD/pneumonitis are identified [see *Dosage and Administration* (2.3) and *Adverse Reactions* (6.1)].

## **6 ADVERSE REACTIONS**

The following clinically significant adverse reactions are discussed in greater detail in other sections of the labeling:

- Hepatotoxicity [see *Warnings and Precautions* (5.1)]
- Interstitial Lung Disease (ILD)/Pneumonitis [see *Warnings and Precautions* (5.2)]

### **6.1 Clinical Trials Experience**

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

The pooled safety population described in the WARNINGS AND PRECAUTIONS reflect exposure to LUMAKRAS as a single agent at 960 mg orally once daily in 357 patients with NSCLC and other solid tumors with *KRAS G12C* mutation enrolled in CodeBreak 100, 28% were exposed for 6 months or longer and 3% were exposed for greater than one year.

#### Non-Small Cell Lung Cancer

The safety of LUMAKRAS was evaluated in a subset of patients with *KRAS G12C*-mutated locally advanced or metastatic NSCLC in CodeBreak 100 [see *Clinical Studies* (14)]. Patients received LUMAKRAS 960 mg orally once daily until disease progression or unacceptable toxicity (n = 204). Among patients who received LUMAKRAS, 39% were exposed for 6 months or longer and 3% were exposed for greater than one year.

The median age of patients who received LUMAKRAS was 66 years (range: 37 to 86); 55% female; 80% White, 15% Asian, and 3% Black.

Serious adverse reactions occurred in 50% of patients treated with LUMAKRAS. Serious adverse reactions in  $\geq 2\%$  of patients were pneumonia (8%), hepatotoxicity (3.4%), and diarrhea (2%). Fatal adverse reactions occurred in 3.4% of patients who received LUMAKRAS due to respiratory failure (0.8%), pneumonitis (0.4%), cardiac arrest (0.4%), cardiac failure (0.4%), gastric ulcer (0.4%), and pneumonia (0.4%).

Permanent discontinuation of LUMAKRAS due to an adverse reaction occurred in 9% of patients. Adverse reactions resulting in permanent discontinuation of LUMAKRAS in  $\geq 2\%$  of patients included hepatotoxicity (4.9%).

Dosage interruptions of LUMAKRAS due to an adverse reaction occurred in 34% of patients. Adverse reactions which required dosage interruption in  $\geq 2\%$  of patients were hepatotoxicity (11%), diarrhea (8%), musculoskeletal pain (3.9%), nausea (2.9%), and pneumonia (2.5%).

Dose reductions of LUMAKRAS due to an adverse reaction occurred in 5% of patients. Adverse reactions which required dose reductions in  $\geq 2\%$  of patients included increased ALT (2.9%) and increased AST (2.5%).

The most common adverse reactions ( $\geq 20\%$ ) were diarrhea, musculoskeletal pain, nausea, fatigue, hepatotoxicity, and cough. The most common laboratory abnormalities ( $\geq 25\%$ ) were decreased lymphocytes, decreased hemoglobin, increased aspartate aminotransferase, increased alanine aminotransferase, decreased calcium, increased alkaline phosphatase, increased urine protein, and decreased sodium.

Table 3 summarizes the common adverse reactions observed in CodeBreaK 100.

**Table 3. Adverse Reactions ( $\geq 10\%$ ) of Patients With *KRAS G12C*-Mutated NSCLC Who Received LUMAKRAS in CodeBreaK 100\***

Adverse Reaction	LUMAKRAS N = 204	
	All Grades (%)	Grade 3 to 4 (%)
<b>Gastrointestinal disorders</b>		
Diarrhea	42	5
Nausea	26	1
Vomiting	17	1.5
Constipation	16	0.5
Abdominal pain <sup>a</sup>	15	1.0
<b>Hepatobiliary disorders</b>		
Hepatotoxicity <sup>b</sup>	25	12
<b>Respiratory, thoracic, and mediastinal disorders</b>		
Cough <sup>c</sup>	20	1.5
Dyspnea <sup>d</sup>	16	2.9
<b>Musculoskeletal and connective tissue disorders</b>		
Musculoskeletal pain <sup>e</sup>	35	8
Arthralgia	12	1.0
<b>General disorders and administration site conditions</b>		
Fatigue <sup>f</sup>	26	2.0
Edema <sup>g</sup>	15	0
<b>Metabolism and nutrition disorders</b>		
Decreased appetite	13	1.0
<b>Infections and infestations</b>		
Pneumonia <sup>h</sup>	12	7
<b>Skin and subcutaneous tissue disorders</b>		
Rash <sup>i</sup>	12	0

\* Grading defined by NCI CTCAE version 5.0.

<sup>a</sup> Abdominal pain includes abdominal pain, abdominal pain upper, and abdominal pain lower.

<sup>b</sup> Hepatotoxicity includes alanine aminotransferase increased, aspartate aminotransferase increased, blood bilirubin increased, drug-induced liver injury, hepatitis, hepatotoxicity, liver function test increased, and transaminases increased.

<sup>c</sup> Cough includes cough, productive cough, and upper-airway cough syndrome.

<sup>d</sup> Dyspnea includes dyspnea and dyspnea exertional.

<sup>e</sup> Musculoskeletal pain includes back pain, bone pain, musculoskeletal chest pain, musculoskeletal discomfort, musculoskeletal pain, myalgia, neck pain, non-cardiac chest pain, and pain in extremity.

<sup>f</sup> Fatigue includes fatigue and asthenia.

<sup>g</sup> Edema includes generalized edema, localized edema, edema, edema peripheral, periorbital edema, and testicular edema.

<sup>h</sup> Pneumonia includes pneumonia, pneumonia aspiration, pneumonia bacterial, and pneumonia staphylococcal.

<sup>1</sup> Rash includes dermatitis, dermatitis acneiform, rash, rash-maculopapular, and rash pustular.

Table 4 summarizes the selected laboratory adverse reactions observed in CodeBreaK 100.

**Table 4. Select Laboratory Abnormalities ( $\geq 20\%$ ) That Worsened from Baseline in Patients With *KRAS G12C*-Mutated NSCLC Who Received LUMAKRAS in CodeBreaK 100**

Laboratory Abnormalities	LUMAKRAS	
	N = 204*	
	Grades 1 to 4 (%)	Grades 3 to 4 (%)
<b>Chemistry</b>		
Increased aspartate aminotransferase	39	9
Increased alanine aminotransferase	38	11
Decreased calcium	35	0
Increased alkaline phosphatase	33	2.5
Increased urine protein	29	3.9
Decreased sodium	28	1.0
Decreased albumin	22	0.5
<b>Hematology</b>		
Decreased lymphocytes	48	2
Decreased hemoglobin	43	0.5
Increased activated partial thromboplastin time	23	1.5

\*N = number of patients who had at least one on-study assessment for the parameter of interest.

## 7 DRUG INTERACTIONS

### 7.1 Effects of Other Drugs on LUMAKRAS

#### Acid-Reducing Agents

Coadministration of LUMAKRAS with gastric acid-reducing agents decreased sotorasib concentrations [see *Clinical Pharmacology* (12.3)], which may reduce the efficacy of sotorasib. Avoid coadministration of LUMAKRAS with proton pump inhibitors (PPIs), H<sub>2</sub> receptor antagonists, and locally acting antacids. If coadministration with an acid-reducing agent cannot be avoided, administer LUMAKRAS 4 hours before or 10 hours after administration of a locally acting antacid [see *Dosage and Administration* (2.4)].

#### Strong CYP3A4 Inducers

Coadministration of LUMAKRAS with a strong CYP3A4 inducer decreased sotorasib concentrations [see *Clinical Pharmacology (12.3)*], which may reduce the efficacy of sotorasib. Avoid coadministration of LUMAKRAS with strong CYP3A4 inducers.

## **7.2 Effects of LUMAKRAS on Other Drugs**

### **CYP3A4 Substrates**

Coadministration of LUMAKRAS with a CYP3A4 substrate decreased its plasma concentrations [see *Clinical Pharmacology (12.3)*], which may reduce the efficacy of the substrate. Avoid coadministration of LUMAKRAS with CYP3A4 sensitive substrates, for which minimal concentration changes may lead to therapeutic failures of the substrate. If coadministration cannot be avoided, increase the sensitive CYP3A4 substrate dosage in accordance with its Prescribing Information.

### **P-glycoprotein (P-gp) Substrates**

Coadministration of LUMAKRAS with a P-gp substrate (digoxin) increased digoxin plasma concentrations [see *Clinical Pharmacology (12.3)*], which may increase the adverse reactions of digoxin. Avoid coadministration of LUMAKRAS with P-gp substrates, for which minimal concentration changes may lead to serious toxicities. If coadministration cannot be avoided, decrease the P-gp substrate dosage in accordance with its Prescribing Information.

## **8 USE IN SPECIFIC POPULATIONS**

### **8.1 Pregnancy**

#### **Risk Summary**

There are no available data on LUMAKRAS use in pregnant women. In rat and rabbit embryo-fetal development studies, oral sotorasib did not cause adverse developmental effects or embryo-lethality at exposures up to 4.6 times the human exposure at the 960 mg clinical dose (*see Data*).

#### **Data**

##### *Animal Data*

In a rat embryo-fetal development study, once daily oral administration of sotorasib to pregnant rats during the period of organogenesis resulted in maternal toxicity at the 540 mg/kg dose level (approximately 4.6 times the human exposure based on area under the curve (AUC) at the clinical dose of 960 mg). Sotorasib did not cause adverse developmental effects and did not affect embryo-fetal survival at doses up to 540 mg/kg.

In a rabbit embryo-fetal development study, once daily oral administration of sotorasib during the period of organogenesis resulted in lower fetal body weights and a reduction in the number of ossified metacarpals in fetuses at the 100 mg/kg dose level (approximately 2.6 times the human exposure based on AUC at the clinical dose of 960 mg), which was associated with maternal toxicity including decreased body weight gain and food consumption during the dosing phase. Sotorasib did not cause adverse developmental effects and did not affect embryo-fetal survival at doses up to 100 mg/kg.

### **8.2 Lactation**

#### **Risk Summary**

There are no data on the presence of sotorasib or its metabolites in human milk, the effects on the breastfed child, or on milk production. Because of the potential for serious adverse reactions in breastfed children, advise women not to breastfeed during treatment with LUMAKRAS and for 1 week after the final dose.

## 8.4 Pediatric Use

The safety and effectiveness of LUMAKRAS have not been established in pediatric patients.

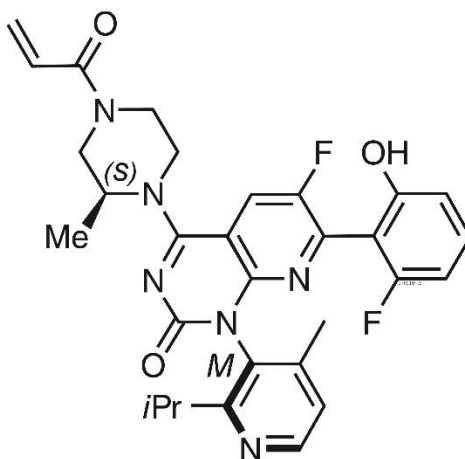
## 8.5 Geriatric Use

Of the 357 patients with any tumor type who received LUMAKRAS 960 mg orally once daily in CodeBreak 100, 46% were 65 and over, and 10% were 75 and over. No overall differences in safety or effectiveness were observed between older patients and younger patients.

## 11 DESCRIPTION

Sotorasib is an inhibitor of the RAS GTPase family. The molecular formula is  $C_{30}H_{30}F_2N_6O_3$ , and the molecular weight is 560.6 g/mol. The chemical name of sotorasib is 6-fluoro-7-(2-fluoro-6-hydroxyphenyl)-(1*M*)-1-[4-methyl-2-(propan-2-yl)pyridin-3-yl]-4-[(2*S*)-2-methyl-4-(prop-2-en-1-en-1-yl)piperazin-1-yl]pyrido[2,3-*d*]pyrimidin-2(1*H*)-one.

The chemical structure of sotorasib is shown below:



Sotorasib has pKa values of 8.06 and 4.56. The solubility of sotorasib in the aqueous media decreases over the range pH 1.2 to 6.8 from 1.3 mg/mL to 0.03 mg/mL.

LUMAKRAS is supplied as film-coated tablets for oral use containing 120 mg of sotorasib. Inactive ingredients in the tablet core are microcrystalline cellulose, lactose monohydrate, croscarmellose sodium, and magnesium stearate. The film coating material consists of polyvinyl alcohol, titanium dioxide, polyethylene glycol, talc, and iron oxide yellow.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Sotorasib is an inhibitor of KRAS<sup>G12C</sup>, a tumor-restricted, mutant-oncogenic form of the RAS GTPase, KRAS. Sotorasib forms an irreversible, covalent bond with the unique cysteine of KRAS<sup>G12C</sup>, locking the protein in an inactive state that prevents downstream signaling without affecting wild-type KRAS. Sotorasib blocked KRAS signaling, inhibited cell growth, and promoted apoptosis only in KRAS G12C tumor cell lines. Sotorasib inhibited KRAS<sup>G12C</sup> *in vitro* and *in vivo* with minimal detectable off-target activity. In mouse tumor xenograft models, sotorasib-treatment led to tumor regressions and prolonged survival, and was associated with anti-tumor immunity in KRAS G12C models.

### 12.2 Pharmacodynamics

Sotorasib exposure-response relationships and the time course of the pharmacodynamic response are unknown.

#### Cardiac Electrophysiology

At the approved recommended dosage, LUMAKRAS does not cause large mean increases in the QTc interval (> 20 msec).

### **12.3 Pharmacokinetics**

The pharmacokinetics of sotorasib have been characterized in healthy subjects and in patients with *KRAS G12C*-mutated solid tumors, including NSCLC. Sotorasib exhibited non-linear, time-dependent, pharmacokinetics over the dose range of 180 mg to 960 mg (0.19 to 1 time the approved recommended dosage) once daily with similar systemic exposure (i.e., AUC<sub>0-24h</sub> and C<sub>max</sub>) across doses at steady-state. Sotorasib systemic exposure was comparable between film-coated tablets and film-coated tablets predispersed in water administered under fasted conditions. Sotorasib plasma concentrations reached steady state within 22 days. No accumulation was observed after repeat LUMAKRAS dosages with a mean accumulation ratio of 0.56 (coefficient of variation (CV): 59%).

#### Absorption

The median time to sotorasib peak plasma concentration is 1 hour.

#### *Effect of Food*

When 960 mg LUMAKRAS was administered with a high-fat, high-calorie meal (containing approximately 800 to 1000 calories with 150, 250, and 500 to 600 calories from protein, carbohydrate and fat, respectively) in patients, sotorasib AUC<sub>0-24h</sub> increased by 25% compared to administration under fasted conditions.

#### Distribution

The sotorasib mean volume of distribution (V<sub>d</sub>) at steady state is 211 L (CV: 135%). *In vitro*, sotorasib plasma protein binding is 89%.

#### Elimination

The sotorasib mean terminal elimination half-life is 5 hours (standard deviation (SD): 2). At 960 mg LUMAKRAS once daily, the sotorasib steady state apparent clearance is 26.2 L/hr (CV: 76%).

#### *Metabolism*

The main metabolic pathways of sotorasib are non-enzymatic conjugation and oxidative metabolism with CYP3As.

#### *Excretion*

After a single dose of radiolabeled sotorasib, 74% of the dose was recovered in feces (53% unchanged) and 6% (1% unchanged) in urine.

#### Specific Populations

No clinically meaningful differences in the pharmacokinetics of sotorasib were observed based on age (28 to 86 years), sex, race (White, Black and Asian), body weight (36.8 to 157.9 kg), line of therapy, ECOG PS (0, 1), mild and moderate renal impairment (eGFR:  $\geq 30$  mL/min/1.73 m<sup>2</sup>), or mild hepatic impairment (AST or ALT < 2.5  $\times$  ULN or total bilirubin < 1.5  $\times$  ULN). The effect of severe renal impairment or moderate to severe hepatic impairment on sotorasib pharmacokinetics has not been studied.



## Drug Interaction Studies

### *Clinical Studies*

**Acid-Reducing Agents:** Coadministration of repeat doses of omeprazole (PPI) with a single dose of LUMAKRAS decreased sotorasib  $C_{\max}$  by 65% and AUC by 57% under fed conditions, and decreased sotorasib  $C_{\max}$  by 57% and AUC by 42% under fasted conditions. Coadministration of a single dose of famotidine ( $H_2$  receptor antagonist) given 10 hours prior to and 2 hours after a single dose of LUMAKRAS under fed conditions decreased sotorasib  $C_{\max}$  by 35% and AUC by 38%.

**Strong CYP3A4 Inducers:** Coadministration of repeat doses of rifampin (a strong CYP3A4 inducer) with a single dose of LUMAKRAS decreased sotorasib  $C_{\max}$  by 35% and AUC by 51%.

**Other Drugs:** No clinically meaningful effect on the exposure of sotorasib was observed following coadministration of LUMAKRAS with itraconazole (a combined strong CYP3A4 and P-gp inhibitor) and a single dose of rifampin (an OATP1B1/1B3 inhibitor), or metformin (a MATE1/MATE2-K substrate).

**CYP3A4 substrates:** Coadministration of LUMAKRAS with midazolam (a sensitive CYP3A4 substrate) decreased midazolam  $C_{\max}$  by 48% and AUC by 53%.

**P-gp substrates:** Coadministration of LUMAKRAS with digoxin (a P-gp substrate) increased digoxin  $C_{\max}$  by 91% and AUC by 21%.

**MATE1/MATE2-K substrates:** No clinically meaningful effect on the exposure of metformin (a MATE1/MATE2-K substrate) was observed following coadministration of LUMAKRAS.

### *In Vitro Studies*

**Cytochrome P450 (CYP) Enzymes:** Sotorasib may induce CYP2C8, CYP2C9 and CYP2B6. Sotorasib does not inhibit CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, or CYP2D6.

**Transporter Systems:** Sotorasib may inhibit BCRP.

## 13 NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenicity studies have not been performed with sotorasib.

Sotorasib was not mutagenic in an *in vitro* bacterial reverse mutation (Ames) assay and was not genotoxic in the *in vivo* rat micronucleus and comet assays.

Fertility/early embryonic development studies were not conducted with sotorasib. There were no adverse effects on female or male reproductive organs in general toxicology studies conducted in dogs and rats.

### 13.2 Animal Toxicology and/or Pharmacology

In rats, renal toxicity including minimal to marked histologic tubular degeneration/necrosis and increased kidney weight, urea nitrogen, creatinine, and urinary biomarkers of renal tubular injury were present at doses resulting in exposures approximately  $\geq 0.5$  times the human AUC at the clinical dose of 960 mg. Increases in cysteine S-conjugate  $\beta$ -lyase pathway metabolism in the rat kidney compared to human may make rats more susceptible to renal toxicity due to local formation of a putative sulfur-containing metabolite than humans.

In the 3-month toxicology study in dogs, sotorasib induced findings in the liver (centrilobular hepatocellular hypertrophy), pituitary gland (hypertrophy of basophils), and thyroid gland (marked follicular cell atrophy, moderate to marked colloid depletion, and follicular cell hypertrophy) at exposures approximately 0.4 times the human

exposure based on AUC at the clinical dose of 960 mg. These findings may be due to an adaptive response to hepatocellular enzyme induction and subsequent reduced thyroid hormone levels (i.e. secondary hypothyroidism). Although thyroid levels were not measured in dogs, induction of uridine diphosphate glucuronosyltransferase known to be involved in thyroid hormone metabolism was confirmed in the *in vitro* dog hepatocyte assay.

## 14 CLINICAL STUDIES

The efficacy of LUMAKRAS was demonstrated in a subset of patients enrolled in a single-arm, open-label, multicenter trial (CodeBreaK 100 [NCT03600883]). Eligible patients were required to have locally advanced or metastatic *KRAS G12C*-mutated NSCLC with disease progression after receiving an immune checkpoint inhibitor and/or platinum-based chemotherapy, an Eastern Cooperative Oncology Group Performance Status (ECOG PS) of 0 or 1, and at least one measurable lesion as defined by Response Evaluation Criteria in Solid Tumors (RECIST v1.1).

All patients were required to have prospectively identified *KRAS G12C*-mutated NSCLC in tumor tissue samples by using the QIAGEN *therascreen*<sup>®</sup> *KRAS* RGQ PCR Kit performed in a central laboratory. Of 126 total enrolled subjects, 2 (2%) were unevaluable for efficacy analysis due to the absence of radiographically measurable lesions at baseline. Of the 124 patients with *KRAS G12C* mutations confirmed in tumor tissue, plasma samples from 112 patients were tested retrospectively using the Guardant360<sup>®</sup> CDx. 78/112 patients (70%) had *KRAS G12C* mutation identified in plasma specimen, 31/112 patients (28%) did not have *KRAS G12C* mutation identified in plasma specimen and 3/112 (2%) were unevaluable due to Guardant360<sup>®</sup> CDx test failure.

A total of 124 patients had at least one measurable lesion at baseline assessed by Blinded Independent Central Review (BICR) according to RECIST v1.1 and were treated with LUMAKRAS 960 mg once daily until disease progression or unacceptable toxicity. The major efficacy outcome measures were objective response rate (ORR) and duration of response (DOR) as evaluated by BICR according to RECIST v1.1.

The baseline demographic and disease characteristics of the study population were: median age 64 years (range: 37 to 80) with 48%  $\geq 65$  years and 8%  $\geq 75$  years; 50% Female; 82% White, 15% Asian, 2% Black; 70% ECOG PS 1; 96% had stage IV disease; 99% with non-squamous histology; 81% former smokers, 12% current smokers, 5% never smokers. All patients received at least 1 prior line of systemic therapy for metastatic NSCLC; 43% received only 1 prior line of therapy, 35% received 2 prior lines of therapy, 23% received 3 prior lines of therapy; 91% received prior anti-PD-1/PD-L1 immunotherapy, 90% received prior platinum-based chemotherapy, 81% received both platinum-based chemotherapy and anti-PD-1/PD-L1. The sites of known extra-thoracic metastasis included 48% bone, 21% brain, and 21% liver.

Efficacy results are summarized in Table 5.

**Table 5. Efficacy Results for Patients with *KRAS G12C*-mutated NSCLC Who Received LUMAKRAS in CodeBreaK 100**

Efficacy Parameter	LUMAKRAS N=124
<b>Objective Response Rate (95% CI)<sup>a</sup></b>	36 (28, 45)
Complete response rate, %	2
Partial response rate, %	35
<b>Duration of Response<sup>a</sup></b>	
Median <sup>b</sup> , months (range)	10.0 (1.3+, 11.1)
Patients with duration $\geq 6$ months <sup>c</sup> , %	58%

CI = confidence interval

<sup>a</sup> Assessed by Blinded Independent Central Review (BICR)

<sup>b</sup> Estimate using Kaplan-Meier method

<sup>c</sup> Observed proportion of patients with duration of response beyond landmark time

## 16 HOW SUPPLIED/STORAGE AND HANDLING

### How Supplied

LUMAKRAS (sotorasib) 120 mg tablets are yellow, oblong-shaped, film-coated, debossed with “AMG” on one side and “120” on the opposite side are supplied as follows:

- Two HDPE bottles with child-resistant polypropylene closures and aluminum foil induction seal liners. Each HDPE bottle contains 120 film-coated tablets.
- Thirty PVC/PVDC blisters with aluminum foil backing in each carton. Each blister card contains 8 film-coated tablets.
- Thirty PVC/Aclar blisters with aluminum foil backing in each carton. Each blister card contains 8 film-coated tablets.

Not all presentations may be marketed.

### Storage and Handling

Store below 30°C.

#### HDPE bottle

Shelf-life after first opening: 60 days.

## 17 PATIENT COUNSELING INFORMATION

### Hepatotoxicity

Advise patients to immediately contact their healthcare provider for signs and symptoms of liver dysfunction [see *Warnings and Precautions* (5.1)].

### Interstitial Lung Disease (ILD)/Pneumonitis

Advise patients to contact their healthcare provider immediately to report new or worsening respiratory symptoms [see *Warnings and Precautions* (5.2)].

### Lactation

Advise women not to breastfeed during treatment with LUMAKRAS and for 1 week after the final dose [see *Use in Specific Populations* (8.2)].

### Drug Interactions

Advise patients to inform their healthcare provider of all concomitant medications, including prescription medicines, over-the-counter drugs, vitamins, dietary and herbal products. Inform patients to avoid proton pump inhibitors, and H<sub>2</sub> receptor antagonists while taking LUMAKRAS [see *Drug Interactions* (7.1) and (7.2)].

If coadministration with an acid-reducing agent cannot be avoided, inform patients to take LUMAKRAS 4 hours before or 10 hours after a locally acting antacid [see *Dosage and Administration* (2.4)].

### Missed Dose

If a dose of LUMAKRAS is missed by greater than 6 hours, resume treatment as prescribed the next day [see *Dosage and Administration* (2.2)].

### **Product Owner :**

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