TEMODAR® (temozolomide) capsules, for oral use
TEMODAR® (temozolomide) for injection, for intravenous use

Initial U.S. Approval: 1999

INDICATIONS AND USAGE

TEMODAR is an alkylating drug indicated for the treatment of adult patients with:

- Newly diagnosed glioblastoma concomitantly with radiotherapy and then as maintenance treatment. (1.1)
- Refractory anaplastic astrocytoma who have experienced disease progression on a drug regimen containing nitrosourea and procarbazine. (1.2)

DOSE AND ADMINISTRATION

- Administer either orally or intravenously.
  - Newly Diagnosed Glioblastoma:
    - 75 mg/m² once daily for 42 days concomitant with focal radiotherapy followed by initial maintenance dose of 150 mg/m² once daily for Days 1 to 5 of each 28-day cycle for 6 cycles. May increase maintenance dose to 200 mg/m² for cycles 2 to 6 based on toxicity. (2.1)
    - Provide Pneumocystis pneumonia (PCP) prophylaxis during concomitant phase and continue in patients who develop lymphopenia until resolution to Grade 1 or less. (2.1)
  - Refractory Anaplastic Astrocytoma: Initial dose of 150 mg/m² once daily on Days 1 to 5 of each 28-day cycle. (2.2)

DOSE FORMS AND STRENGTHS

- Capsules: 5 mg, 20 mg, 100 mg, 140 mg, 180 mg, and 250 mg. (3)
  - For injection: 100 mg as a lyophilized powder in single-dose vial for reconstitution. (3)

CONTRAINDICATIONS

- History of hypersensitivity to temozolomide or any other ingredients in TEMODAR and dacarbazine.

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FULL PRESCRIBING INFORMATION

1  INDICATIONS AND USAGE

1.1  Newly Diagnosed Glioblastoma

TEMODAR® is indicated for the treatment of adult patients with newly diagnosed glioblastoma concomitantly with radiotherapy and then as maintenance treatment.

1.2  Refractory Anaplastic Astrocytoma

TEMODAR is indicated for the treatment of adult patients with refractory anaplastic astrocytoma who have experienced disease progression on a drug regimen containing nitrosourea and procarbazine.

2  DOSAGE AND ADMINISTRATION

2.1  Recommended Dosage and Dosage Modifications for Newly Diagnosed Glioblastoma

Administer TEMODAR either orally or intravenously once daily for 42 consecutive days during the concomitant phase with focal radiotherapy and then once daily on Days 1 to 5 of each 28-day cycle for 6 cycles during the maintenance phase.

Provide Pneumocystis pneumonia (PCP) prophylaxis during the concomitant phase and continue in patients who develop lymphocytopenia until resolution to Grade 1 or less [see Warnings and Precautions (5.3)].

Concomitant Phase

The recommended dosage of TEMODAR is 75 mg/m² either orally or intravenously once daily for 42 days (up to 49 days) concomitant with focal radiotherapy (60 Gy administered in 30 fractions). Focal radiotherapy includes the tumor bed or resection site with a 2- to 3-cm margin.

Obtain a complete blood count weekly. No dose reductions are recommended during the concomitant phase. The recommended dosage modifications during the concomitant phase are provided in Table 1.

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Interruption</th>
<th>Discontinuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute Neutrophil Count</td>
<td>Withhold TEMODAR if ANC is greater than or equal to 0.5 x 10^9/L and less than 1.5 x 10^9/L. Resume TEMODAR when ANC is greater than or equal to 1.5 x 10^9/L.</td>
<td>Discontinue TEMODAR if platelet count is less than 0.5 x 10^9/L.</td>
</tr>
<tr>
<td>Platelet Count</td>
<td>Withhold TEMODAR if platelet count is greater than or equal to 100 x 10^9/L. Resume TEMODAR when platelet count is greater than or equal to 100 x 10^9/L.</td>
<td>Discontinue TEMODAR if platelet count is less than 10 x 10^9/L.</td>
</tr>
<tr>
<td>Non-hematological Adverse Reaction (except for alopecia, nausea, vomiting)</td>
<td>Withhold TEMODAR if Grade 2 adverse reaction occurs. Resume TEMODAR when resolution to Grade 1 or less.</td>
<td>Discontinue TEMODAR if Grade 3 or 4 adverse reaction occurs.</td>
</tr>
</tbody>
</table>

Maintenance Phase:

Beginning 4 weeks after Concomitant Phase completion, administer TEMODAR either orally or intravenously once daily on Days 1 to 5 of each 28-day cycle for 6 cycles. The recommended dosage of TEMODAR is as follows:

- Cycle 1: 150 mg/m² per day
- Cycles 2 to 6: May increase to 200 mg/m² per day if the following conditions are met before starting cycle 2. If the dose was not escalated at the onset of Cycle 2, do not increase the dose for Cycles 3 to 6.
  - Nonhematologic toxicity is Grade 2 or less (except for alopecia, nausea, and vomiting)
  - ANC is greater than or equal to 1.5 x 10^9/L, and
  - Platelet count is greater than or equal to 100 x 10^9/L.

Obtain a complete blood count on Day 22 and then weekly until the ANC is above 1.5 x 10^9/L and the platelet count is above 100 x 10^9/L. Do not start the next cycle until the ANC and platelet count exceed these levels.

The recommended dosage modifications during the maintenance phase are provided in Table 2. If TEMODAR is withheld, reduce the dose for the next cycle by 50 mg/m² per day. Permanently discontinue TEMODAR in patients who are unable to tolerate a dose of 100 mg/m² per day.

| Table 2: Temozolomide Dosage Modifications During Maintenance Treatment |

TABLE 2: Temozolomide Dosage Modifications During Maintenance Treatment
### 2.2 Recommended Dosage and Dosage Modifications for Refractory Anaplastic Astrocytoma

The recommended initial dosage of TEMODAR is 150 mg/m² once daily on Days 1 to 5 of each 28-day cycle. Increase the TEMODAR dose to 200 mg/m² per day if the following conditions are met at the nadir and on Day 1 of the next cycle:

- ANC is greater than or equal to 1.5 x 10⁹/L, and
- Platelet count is greater than or equal to 100 x 10⁹/L.

Continue TEMODAR until disease progression or unacceptable toxicity. In the clinical trial, treatment could be continued for a maximum of 2 years, but the optimum duration of therapy is not known.

Obtain a complete blood count on Day 22 and then weekly until the ANC is above 1.5 x 10⁹/L and the platelet count is above 100 x 10⁹/L. Do not start the next cycle until the ANC and platelet count exceed these levels.

If the ANC is less than 1 x 10⁹/L or the platelet count is less than 50 x 10⁹/L during any cycle, reduce the TEMODAR dose for the next cycle by 50 mg/m² per day. Permanently discontinue TEMODAR in patients who are unable to tolerate a dose of 100 mg/m² per day.

### 2.3 Preparation and Administration

TEMODAR is a cytotoxic drug. Follow applicable special handling and disposal procedures.

**TEMODAR capsules**

Administer TEMODAR consistently with respect to food (fasting vs. nonfasting) [see Clinical Pharmacology (12.3)]. To reduce nausea and vomiting, take TEMODAR on an empty stomach or at bedtime and consider antiemetic therapy prior to and/or following TEMODAR administration.

Swallow TEMODAR capsules whole. Do not open or chew capsules.

If capsules are accidentally opened or damaged, take precautions to avoid inhalation or contact with the skin or mucous membranes. In case of powder contact, the hands should be washed.

**TEMODAR for injection**

Bring the vial to room temperature prior to reconstitution with Sterile Water for Injection.

Reconstitute the vial with 41 mL of Sterile Water for Injection to yield a TEMODAR solution with a concentration of 2.5 mg/mL temozolomide. Reconstituted TEMODAR is a clear solution and essentially free of visible particles.

Gently swirl vial. Do not shake.

Visually inspect reconstituted solution for particulate matter and discoloration. Discard if particulate matter or discoloration is observed.

Do not further dilute the reconstituted solution.

Store reconstituted solution at room temperature (25°C [77°F]). Discard reconstituted solution if not used within 14 hours, including infusion time.

Withdraw up to 40 mL from each vial to make up the total dose and discard any unused portion. Transfer reconstituted solution from each vial into an empty 250 mL infusion bag.
Administer reconstituted solution using a pump over a period of 90 minutes. Administer TEMODAR by intravenous infusion only. Infusion over a shorter or longer period of time may result in suboptimal dosing. Flush the lines before and after each infusion. TEMODAR for injection may be administered in the same intravenous line with 0.9% Sodium Chloride injection only.

Because no data are available on the compatibility of TEMODAR for injection with other intravenous substances or additives, do not infuse other medications simultaneously through the same intravenous line.

3 DOSAGE FORMS AND STRENGTHS

- Capsules:
  - 5 mg: opaque white bodies with green caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with "TEMODAR."
  - 20 mg: opaque white bodies with yellow caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with "TEMODAR."
  - 100 mg: opaque white bodies with pink caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with "TEMODAR."
  - 140 mg: opaque white bodies with blue caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with "TEMODAR."
  - 180 mg: opaque white bodies with orange caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with "TEMODAR."
  - 250 mg: opaque white bodies with white caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with "TEMODAR."

- For injection: 100 mg white to light tan/light pink lyophilized powder for reconstitution in a single-dose vial.

4 CONTRAINDICATIONS

TEMODAR is contraindicated in patients with a history of hypersensitivity reactions to:

- temozolomide or any other ingredients in TEMODAR;
- dacarbazine, since both temozolomide and dacarbazine are metabolized to the same active metabolite 5-(3-methyltriazen-1-yl)-imidazole-4-carboxamide.

Reactions to TEMODAR have included anaphylaxis [see Adverse Reactions (6.2)].

5 WARNINGS AND PRECAUTIONS

5.1 Myelosuppression

Myelosuppression, including pancytopenia, leukopenia and anemia, some with fatal outcomes, have occurred with TEMODAR [see Adverse Reactions (6.1, 6.2)]. Geriatric patients and women have been shown in clinical trials to have a higher risk of developing myelosuppression.

Prior to dosing, patients must have an ANC of 1.5 x 10⁹/L or greater and a platelet count of 100 x 10⁹/L or greater.

For the concomitant phase with radiotherapy, obtain a complete blood count prior to initiation of treatment and weekly during treatment [see Dosage and Administration (2.1)].

For the 28-day treatment cycles, obtain a complete blood count prior to treatment on Day 1 and on Day 22 of each cycle. Perform complete blood counts weekly until recovery if the ANC falls below 1.5 x 10⁹/L and the platelet count falls below 100 x 10⁹/L [see Dosage and Administration (2.1, 2.2)].

5.2 Myelodysplastic Syndrome and Secondary Malignancies

Cases of myelodysplastic syndrome and secondary malignancies, including myeloid leukemia, have been observed following TEMODAR administration.

5.3 Pneumocystis Pneumonia

Pneumocystis pneumonia (PCP) can occur in patients receiving TEMODAR. The risk of PCP is increased in patients receiving steroids or with longer treatment regimens.

For patients with newly diagnosed glioblastoma, provide PCP prophylaxis for all patients during the concomitant phase. Continue in patients who experience lymphopenia until resolution to Grade 1 or less [see Dosage and Administration (2.1)].

Monitor all patients receiving TEMODAR for the development of lymphopenia and PCP.

5.4 Hepatotoxicity

Fatal and severe hepatotoxicity have been reported in patients receiving TEMODAR. Perform liver tests at baseline, midway through the first cycle, prior to each subsequent cycle, and approximately two to four weeks after the last dose of TEMODAR.

5.5 Embryo-Fetal Toxicity

Based on findings from animal studies and its mechanism of action, TEMODAR can cause fetal harm when administered to a pregnant woman. Adverse developmental outcomes have been reported in both pregnant patients and pregnant partners of male
patients. Oral administration of temozolomide to rats and rabbits during the period of organogenesis resulted in embryolethality and polynomalformations at doses less than the maximum human dose based on body surface area.

Advise pregnant women of the potential risk to the fetus. Advise females of reproductive potential to use effective contraception during treatment with TEMODAR and for at least 6 months after the final dose. Because of potential risk of genotoxic effects on sperm, advise male patients with female partners of reproductive potential to use condoms during treatment with TEMODAR and for at least 3 months after the final dose. Advise male patients not to donate semen during treatment with TEMODAR and for at least 3 months after the final dose [see Use in Specific Populations (8.1, 8.3)].

6 ADVERSE REACTIONS

The following clinically significant adverse reactions are described elsewhere in the labeling:

- Myelosuppression [see Warnings and Precautions (5.1)].
- Myelodysplastic Syndrome and Secondary Malignancies [see Warnings and Precautions (5.2)].
- Pneumocystis Pneumonia [see Warnings and Precautions (5.3)].
- Hepatotoxicity [see Warnings and Precautions (5.4)].

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.

Newly Diagnosed Glioblastoma

The safety of TEMODAR was evaluated in Study MK-7365-051 [see Clinical Studies (14.1)].

Forty-nine percent (49%) of patients treated with TEMODAR reported one or more severe or life-threatening reactions, most commonly fatigue (13%), convulsions (6%), headache (5%), and thrombocytopenia (5%).

The most common adverse reactions (≥20%) across the cumulative TEMODAR experience were alopecia, fatigue, nausea, and vomiting. Table 3 summarizes the adverse reactions in Newly Diagnosed Glioblastoma Trial. Overall, the pattern of reactions during the maintenance phase was consistent with the known safety profile of TEMODAR.

<table>
<thead>
<tr>
<th>Table 3: Adverse Reactions (≥5%) in Patients Receiving TEMODAR in Newly Diagnosed Glioblastoma Trial</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adverse Reactions</strong></td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>All Grades (%)</td>
</tr>
<tr>
<td>Skin and Subcutaneous Tissue</td>
</tr>
<tr>
<td>Alopecia</td>
</tr>
<tr>
<td>Rash</td>
</tr>
<tr>
<td>Dry Skin</td>
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<tr>
<td>Pruritus</td>
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<tr>
<td>Erythema</td>
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<tr>
<td>General</td>
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<tr>
<td>Fatigue</td>
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<tr>
<td>Anorexia</td>
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<tr>
<td>Headache</td>
</tr>
<tr>
<td>Weakness</td>
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<tr>
<td>Dizziness</td>
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<tr>
<td>Gastrointestinal System</td>
</tr>
<tr>
<td>Nausea</td>
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<tr>
<td>Vomiting</td>
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<tr>
<td>Constipation</td>
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<tr>
<td>Diarrhea</td>
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<tr>
<td>Adverse Reactions</td>
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<td>------------------------------------</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Gastrointestinal System</td>
</tr>
<tr>
<td>Nausea</td>
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<tr>
<td>Abdominal Pain</td>
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<tr>
<td>Stomatitis</td>
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<tr>
<td>Vision Blurred</td>
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<tr>
<td>Eye</td>
</tr>
<tr>
<td>Radiation Injury NOS</td>
</tr>
<tr>
<td>Central and Peripheral Nervous System</td>
</tr>
<tr>
<td>Convulsions</td>
</tr>
<tr>
<td>Memory Impairment</td>
</tr>
<tr>
<td>Confusion</td>
</tr>
<tr>
<td>Special Senses Other</td>
</tr>
<tr>
<td>Taste Perversion</td>
</tr>
<tr>
<td>Respiratory System</td>
</tr>
<tr>
<td>Coughing</td>
</tr>
<tr>
<td>Dyspnea</td>
</tr>
<tr>
<td>Psychiatric</td>
</tr>
<tr>
<td>Insomnia</td>
</tr>
<tr>
<td>Immune System</td>
</tr>
<tr>
<td>Allergic Reaction</td>
</tr>
<tr>
<td>Platelet, Bleeding and Clotting</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
</tr>
<tr>
<td>Musculoskeletal System</td>
</tr>
<tr>
<td>Arthralgia</td>
</tr>
</tbody>
</table>

* One patient who was randomized to radiation therapy-only arm received radiation therapy and TEMODAR.

NOS = not otherwise specified.

Note: Grade 5 (fatal) adverse reactions are included in the Grade ≥3 column.

When laboratory abnormalities and adverse reactions were combined, Grade 3 or Grade 4 neutrophil abnormalities including neutropenic reactions were observed in 8% of patients, and Grade 3 or Grade 4 platelet abnormalities including thrombocytopenic reactions were observed in 14% of patients.

Refractory Anaplastic Astrocytoma

The safety of TEMODAR was evaluated in Study MK-7365-006 [see Clinical Studies (14.2)].

Myelosuppression (thrombocytopenia and neutropenia) was the dose-limiting adverse reaction. It usually occurred within the first few cycles of therapy and was not cumulative. Myelosuppression occurred late in the treatment cycle and returned to normal, on average, within 14 days of nadir counts. The median nadirs occurred at 26 days for platelets (range: 21 to 40 days) and 28 days for neutrophils (range: 1 to 44 days). Only 14% (22/158) of patients had a neutrophil nadir and 20% (32/158) of patients had a platelet nadir, which may have delayed the start of the next cycle. Less than 10% of patients required hospitalization, blood transfusion, or discontinuation of therapy due to myelosuppression.

The most common adverse reactions (≥20%) were nausea, vomiting, headache, fatigue, constipation, and convulsions.

Tables 4 and 5 summarize the adverse reactions and hematological laboratory abnormalities in Refractory Anaplastic Astrocytoma Trial.

### TABLE 4: Adverse Reactions (≥5%) in Patients Receiving TEMODAR in Refractory Anaplastic Astrocytoma Trial

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>TEMODAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Reactions (N=158)</td>
<td>Grades 3-4</td>
</tr>
<tr>
<td>Nausea</td>
<td>53</td>
</tr>
<tr>
<td>System</td>
<td>Effect</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Vomiting</strong></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
</tr>
<tr>
<td>Abdominal pain</td>
<td></td>
</tr>
<tr>
<td>Anorexia</td>
<td></td>
</tr>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
</tr>
<tr>
<td>Asthenia</td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td></td>
</tr>
<tr>
<td>Back pain</td>
<td></td>
</tr>
<tr>
<td><strong>Central and Peripheral Nervous System</strong></td>
<td></td>
</tr>
<tr>
<td>Convulsions</td>
<td></td>
</tr>
<tr>
<td>Hemiparesis</td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
</tr>
<tr>
<td>Coordination abnormal</td>
<td></td>
</tr>
<tr>
<td>Amnesia</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
</tr>
<tr>
<td>Paresthesia</td>
<td></td>
</tr>
<tr>
<td>Somnolence</td>
<td></td>
</tr>
<tr>
<td>Paresis</td>
<td></td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td></td>
</tr>
<tr>
<td>Ataxia</td>
<td></td>
</tr>
<tr>
<td>Dysphasia</td>
<td></td>
</tr>
<tr>
<td>Convulsions local</td>
<td></td>
</tr>
<tr>
<td>Gait abnormal</td>
<td></td>
</tr>
<tr>
<td>Confusion</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td></td>
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<tr>
<td>Edema peripheral</td>
<td></td>
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<tr>
<td><strong>Resistance Mechanism</strong></td>
<td></td>
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<tr>
<td>Infecetion viral</td>
<td></td>
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<tr>
<td><strong>Endocrine</strong></td>
<td></td>
</tr>
<tr>
<td>Adrenal hypercorticism</td>
<td></td>
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<tr>
<td><strong>Respiratory System</strong></td>
<td></td>
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<tr>
<td>Upper respiratory tract infection</td>
<td></td>
</tr>
<tr>
<td>Pharyngitis</td>
<td></td>
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<tr>
<td>Sinusitis</td>
<td></td>
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<tr>
<td>Coughing</td>
<td></td>
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<tr>
<td><strong>Skin and Appendages</strong></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
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<tr>
<td>Pruritus</td>
<td></td>
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<tr>
<td><strong>Urinary System</strong></td>
<td></td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td></td>
</tr>
<tr>
<td>Micturition increased frequency</td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric</strong></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 5: Grade 3 to 4 Adverse Hematologic Laboratory Abnormalities in Refractory Anaplastic Astrocytoma Trial

<table>
<thead>
<tr>
<th>Abnormality</th>
<th>TEMODAR+1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased lymphocytes</td>
<td>55%</td>
</tr>
<tr>
<td>Decreased platelets</td>
<td>19%</td>
</tr>
<tr>
<td>Decreased neutrophils</td>
<td>14%</td>
</tr>
<tr>
<td>Decreased leukocytes</td>
<td>11%</td>
</tr>
<tr>
<td>Decreased hemoglobin</td>
<td>4%</td>
</tr>
</tbody>
</table>

* Change from Grade 0 to 2 at baseline to Grade 3 or 4 during treatment.

Hematological Toxicities for Advanced Gliomas:

In clinical trial experience with 110 to 111 females and 169 to 174 males (depending on measurements), females experienced higher rates of Grade 4 neutropenia (ANC <0.5 x 10^9/L) and thrombocytopenia (<20 x 10^9/L) than males in the first cycle of therapy (12% vs. 5% and 9% vs. 3%, respectively).

In the entire safety database for which hematologic data exist (N=932), 7% (4/61) and 9.5% (6/63) of patients >70 years experienced Grade 4 neutropenia or thrombocytopenia in the first cycle, respectively. For patients ≤70 years, 7% (62/871) and 5.5% (48/879) experienced Grade 4 neutropenia or thrombocytopenia in the first cycle, respectively. Pancytopenia, leukopenia, and anemia also occurred.

Adverse reactions with TEMODAR for injection

Adverse reactions that were reported in 35 patients who received TEMODAR for injection that were not reported in patients who received TEMODAR capsules were pain, irritation, pruritus, warmth, swelling, and erythema at infusion site; petechiae; and hematoma.

6.2 Postmarketing Experience

The following adverse reactions have been identified during post-approval use of TEMODAR. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to the drug exposure.

**Dermatologic:** Toxic epidermal necrolysis and Stevens-Johnson syndrome

**Immune System:** Hypersensitivity reactions, including anaphylaxis. Erythema multiforme, which resolved after discontinuation of TEMODAR and, in some cases, recurred upon rechallenge.

**Hematopoietic:** Prolonged pancytopenia, which may result in aplastic anemia and fatal outcomes.

**Hepatobiliary:** Fatal and severe hepatotoxicity, elevation of liver enzymes, hyperbilirubinemia, cholestasis, and hepatitis.

**Infections:** Serious opportunistic infections, including some cases with fatal outcomes, with bacterial, viral (primary and reactivated), fungal, and protozoan organisms.

**Pulmonary:** Interstitial pneumonitis, pneumonitis, alveolitis, and pulmonary fibrosis.

**Endocrine:** Diabetes insipidus
8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Based on its mechanism of action [see Clinical Pharmacology (12.1)] and findings from animal studies, TEMODAR can cause fetal harm when administered to a pregnant woman. Available postmarketing reports describe cases of spontaneous abortions and congenital malformations, including polymalformations with central nervous system, facial, cardiac, skeletal, and genitourinary system anomalies with exposure to TEMODAR during pregnancy. These cases report similar adverse developmental outcomes to those observed in animal studies. Administration of TEMODAR to rats and rabbits during the period of organogenesis caused numerous external, internal, and skeletal malformations at doses less than the maximum human dose based on body surface area (see Data). Advise pregnant women of the potential risk to a fetus.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Data

Animal Data

Five consecutive days of oral administration of temozolomide at doses of 75 and 150 mg/m² (0.38 and 0.75 times the human dose of 200 mg/m²) in rats and rabbits, respectively, during the period of organogenesis (gestation days 8-12) caused numerous malformations of the external and internal organs and skeleton in both species. In rabbits, temozolomide at the 150 mg/m² dose (0.75 times the human dose of 200 mg/m²) caused embryolethality as indicated by increased resorptions.

8.2 Lactation

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

8.3 Females and Males of Reproductive Potential

Pregnancy Testing

Verify pregnancy status in females of reproductive potential prior to initiating TEMODAR [see Use in Specific Populations (8.1)].

Contraception

Females

TEMODAR can cause embryo-fetal harm when administered to a pregnant woman [see Use in Specific Populations (8.1)]. Advise females of reproductive potential to use effective contraception during treatment with TEMODAR and for at least 6 months after the last dose.

Males

Because of the potential for embryofetal toxicity and genotoxic effects on sperm cells, advise male patients with pregnant partners or female partners of reproductive potential to use condoms during treatment with TEMODAR and for at least 3 months after the final dose [see Use in Specific Populations (8.1), Nonclinical Toxicology (13.1)].

Advise male patients not to donate semen during treatment with TEMODAR and for at least 3 months after the final dose.

Infertility

TEMODAR may impair male fertility [see Nonclinical Toxicology (13.1)]. Limited data from male patients show changes in sperm parameters during treatment with TEMODAR; however, no information is available on the duration or reversibility of these changes.

8.4 Pediatric Use

Safety and effectiveness of TEMODAR have not been established in pediatric patients. Safety and effectiveness of TEMODAR capsules were assessed, but not established, in 2 open-label studies in pediatric patients aged 3 to 18 years. In one study, 29 patients with recurrent brain stem glioma and 34 patients with recurrent high-grade astrocytoma were enrolled. In a second study conducted by the Children’s Oncology Group (COG), 122 patients were enrolled, including patients with medulloblastoma/PNET (29), high grade astrocytoma (23), low grade astrocytoma (22), brain stem glioma (16), ependymoma (14), other CNS tumors (9), and non-CNS tumors (9). The adverse reaction profile in pediatric patients was similar to adults.

8.5 Geriatric Use

In the Newly Diagnosed Glioblastoma trial, Study MK-7365-051, 15% of patients were 65 years and older. This study did not include sufficient numbers of patients aged 65 years and older to determine differences in effectiveness from younger patients. No overall differences in safety were observed between patients ≥65 years and younger patients.

In the Refractory Anaplastic Astrocytoma trial, Study MK-7365-0006, 4% of patients were 70 years and older. This study did not include sufficient numbers of patients aged 70 years and older to determine differences in effectiveness from younger patients. Patients 70 years and older had a higher incidence of Grade 4 neutropenia (25%) and Grade 4 thrombocytopenia (20%) in the first cycle of therapy than patients less than 70 years of age [see Warnings and Precautions (5.1), Adverse Reactions (6.1)].

8.6 Renal Impairment
No dosage adjustment is recommended for patients with creatinine clearance (CLcr) of 36 to 130 mL/min/m² [see Clinical Pharmacology (12.3)]. The recommended dose of TEMODAR has not been established for patients with severe renal impairment (CLcr <36 mL/min/m²) or for patients with end-stage renal disease on dialysis.

8.7 Hepatic Impairment

No dosage adjustment is recommended for patients with mild to moderate hepatic impairment (Child Pugh class A and B) [see Clinical Pharmacology (12.3)]. The recommended dose of TEMODAR has not been established for patients with severe hepatic impairment (Child-Pugh class C).

10 OVERDOSAGE

Dose-limiting toxicity was myelosuppression and was reported with any dose but is expected to be more severe at higher doses. An overdose of 2000 mg per day for 5 days was taken by one patient and the adverse reactions reported were pancytopenia, pyrexia, multi-organ failure, and death. There are reports of patients who have taken more than 5 days of treatment (up to 64 days), with adverse reactions reported including myelosuppression, which in some cases was severe and prolonged, and infections and resulted in death. In the event of an overdose, monitor complete blood count and provide supportive measures as necessary.

11 DESCRIPTION

Temozolomide is an alkylating drug. The chemical name of temozolomide is 3,4-dihydro-3-methyl-4-oxoimidazo[5,1-d]-as-tetrazine-8-carboxamide. The structural formula of temozolomide is:

![Temozolomide Structural Formula](image)

The material is a white to light tan/light pink powder with a molecular formula of C_{6}H_{6}N_{6}O_{2} and a molecular weight of 194.15. The molecule is stable at acidic pH (<5) and labile at pH >7; hence TEMODAR can be administered orally and intravenously. The prodrug, temozolomide, is rapidly hydrolyzed to the active 5-(3-methyltriazen-1-yl) imidazole-4-carboxamide (MTIC) at neutral and alkaline pH values, with hydrolysis taking place even faster at alkaline pH.

TEMODAR capsules

TEMODAR (temozolomide) capsules for oral use contains either 5 mg, 20 mg, 100 mg, 140 mg, 180 mg, or 250 mg of temozolomide. The inactive ingredients are as follows:

- **TEMODAR 5 mg**: lactose anhydrous (132.8 mg), colloidal silicon dioxide (0.2 mg), sodium starch glycolate (7.5 mg), tartaric acid (1.5 mg), and stearic acid (3 mg).
- **TEMODAR 20 mg**: lactose anhydrous (182.2 mg), colloidal silicon dioxide (0.2 mg), sodium starch glycolate (11 mg), tartaric acid (2.2 mg), and stearic acid (4.4 mg).
- **TEMODAR 100 mg**: lactose anhydrous (175.7 mg), colloidal silicon dioxide (0.3 mg), sodium starch glycolate (15 mg), tartaric acid (3 mg), and stearic acid (6 mg).
- **TEMODAR 140 mg**: lactose anhydrous (246 mg), colloidal silicon dioxide (0.4 mg), sodium starch glycolate (21 mg), tartaric acid (4.2 mg), and stearic acid (8.4 mg).
- **TEMODAR 180 mg**: lactose anhydrous (316.3 mg), colloidal silicon dioxide (0.5 mg), sodium starch glycolate (27 mg), tartaric acid (5.4 mg), and stearic acid (10.8 mg).
- **TEMODAR 250 mg**: lactose anhydrous (154.3 mg), colloidal silicon dioxide (0.7 mg), sodium starch glycolate (22.5 mg), tartaric acid (9 mg), and stearic acid (13.5 mg).

The body of the capsules is made of gelatin, and is opaque white. The cap is also made of gelatin, and the colors vary based on the dosage strength. The capsule body and cap are imprinted with pharmaceutical branding ink, which contains shellac, dehydrated alcohol, isopropyl alcohol, butyl alcohol, propylene glycol, purified water, strong ammonia solution, potassium hydroxide, and ferric oxide.

- **TEMODAR 5 mg**: The green cap contains gelatin, titanium dioxide, iron oxide yellow, sodium lauryl sulfate, and FD&C Blue #2.
- **TEMODAR 20 mg**: The yellow cap contains gelatin, sodium lauryl sulfate, and iron oxide yellow.
- **TEMODAR 100 mg**: The pink cap contains gelatin, titanium dioxide, sodium lauryl sulfate, and iron oxide red.
- **TEMODAR 140 mg**: The blue cap contains gelatin, sodium lauryl sulfate, and FD&C Blue #2.
- **TEMODAR 180 mg**: The orange cap contains gelatin, iron oxide red, iron oxide yellow, titanium dioxide, and sodium lauryl sulfate.
- **TEMODAR 250 mg**: The white cap contains gelatin, titanium dioxide, and sodium lauryl sulfate.
TEMODAR (temozolomide) for injection is for intravenous use. Each single-dose vial contains 100 mg of sterile and pyrogen-free lyophilized powder. The inactive ingredients are: mannitol (600 mg), L-threonine (160 mg), polysorbate 80 (120 mg), sodium citrate dihydrate (235 mg), and hydrochloric acid (160 mg).

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Temozolomide is not directly active but undergoes rapid nonenzymatic conversion at physiologic pH to the reactive compound 5-(3-methyltriazen-1-yl)-imidazole-4-carboxamide (MTIC). The cytotoxicity of MTIC is thought to be primarily due to alkylation of DNA. Alkylation (methylation) occurs mainly at the O\(^6\) and N\(^7\) positions of guanine.

12.3 Pharmacokinetics

Following a single oral dose of 150 mg/m\(^2\), the mean C\(_{\text{max}}\) value for temozolomide was 7.5 mcg/mL and for MTIC was 282 ng/mL. The mean AUC value for temozolomide was 23.4 mcg·hr/mL and for MTIC was 864 ng·hr/mL.

Following a single 90-minute intravenous infusion of 150 mg/m\(^2\), the mean C\(_{\text{max}}\) value for temozolomide was 7.3 mcg/mL and for MTIC was 276 ng/mL. The mean AUC value for temozolomide was 24.6 mcg·hr/mL and for MTIC was 891 ng·hr/mL.

Temozolomide exhibits linear kinetics over the therapeutic dosing range of 75 mg/m\(^2\)/day to 250 mg/m\(^2\)/day.

Absorption

The median T\(_{\text{max}}\) is 1 hour.

Effect of Food

The mean C\(_{\text{max}}\) and AUC decreased by 32% and 9%, respectively, and median T\(_{\text{max}}\) increased by 2-fold (from 1 to 2.25 hours) when TEMODAR capsules were administered after a modified high-fat breakfast (587 calories comprised of 1 fried egg, 2 strips of bacon, 2 slices of toast, 2 pats of butter, and 8 oz whole milk).

Distribution

Temozolomide has a mean apparent volume of distribution of 0.4 L/kg (%CV=13%). The mean percent bound of drug-related total radioactivity is 15%.

Elimination

Clearance of temozolomide is about 5.5 L/hr/m\(^2\) and the mean elimination half-life is 1.8 hours.

Metabolism

Temozolomide is spontaneously hydrolyzed at physiologic pH to the active species, MTIC and to temozolomide acid metabolite. MTIC is further hydrolyzed to 5-amino-imidazole-4-carboxamide (AIC), which is known to be an intermediate in purine and nucleic acid biosynthesis, and to methylhydrazine, which is believed to be the active alkylating species. Cytochrome P450 enzymes play only a minor role in the metabolism of temozolomide and MTIC. Relative to the AUC of temozolomide, the exposure to MTIC and AIC is 2.4% and 23%, respectively.

Excretion

About 38% of the administered temozolomide total radioactive dose is recovered over 7 days: 38% in urine and 0.8% in feces. The majority of the recovery of radioactivity in urine is unchanged temozolomide (6%), AIC (12%), temozolomide acid metabolite (2.3%), and unidentified polar metabolite(s) (17%).

Specific Populations

No clinically meaningful differences in the pharmacokinetics of temozolomide were observed based on age (range: 19 to 78 years), gender, smoking status (smoker vs. non-smoker), creatinine clearance (CL\(_{\text{cr}}\)) of 36 to 130 mL/min/m\(^2\), or mild to moderate hepatic impairment (Child Pugh class A and B). The pharmacokinetics of temozolomide has not been studied in patients with CL\(_{\text{cr}}\) <36 mL/min/m\(^2\), end-stage renal disease on dialysis, or severe hepatic impairment (Child-Pugh class C).

Drug Interaction Studies

Effect of Other Drugs on Temozolomide Pharmacokinetics:

In a multiple-dose study, administration of TEMODAR capsules with ranitidine did not change the C\(_{\text{max}}\) or AUC values for temozolomide or MTIC.

A population analysis indicated that administration of valproic acid decreases the clearance of temozolomide by about 5%.

A population analysis did not demonstrate any influence of concomitantly administered dexamethasone, prochlorperazine, phenytoin, carbamazepine, ondansetron, histamine-2-receptor antagonists, or phenobarbital on the clearance of orally administered TEMODAR.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility
Temozolomide is carcinogenic in rats at doses less than the maximum recommended human dose. Temozolomide induced mammary carcinomas in both males and females at doses 0.13 to 0.63 times the maximum human dose (25-125 mg/m²) when administered orally on 5 consecutive days every 28 days for 6 cycles. Temozolomide also induced fibrosarcomas of the heart, eye, seminal vesicles, salivary glands, abdominal cavity, uterus, and prostate, carcinomas of the seminal vesicles, schwannomas of the heart, optic nerve, and harderian gland, and adenomas of the skin, lung, pituitary, and thyroid at doses 0.5 times the maximum daily dose. Mammary tumors were also induced following 3 cycles of temozolomide at the maximum recommended daily dose.

Temozolomide is a mutagen and a clastogen. In a reverse bacterial mutagenesis assay (Ames assay), temozolomide increased revertant frequency in the absence and presence of metabolic activation. Temozolomide was clastogenic in human lymphocytes in the presence and absence of metabolic activation.

Temozolomide impairs male fertility. Temozolomide caused syncytial cells/immature sperm formation at doses of 50 and 125 mg/m² (0.25 and 0.63 times the human dose of 200 mg/m²) in rats and dogs, respectively, and testicular atrophy in dogs at 125 mg/m².

13.2 Animal Toxicology and/or Pharmacology

Toxicology studies in rats and dogs identified a low incidence of hemorrhage, degeneration, and necrosis of the retina at temozolomide doses equal to or greater than 125 mg/m² (0.63 times the human dose of 200 mg/m²). These changes were most commonly seen at doses where mortality was observed.

14 CLINICAL STUDIES

14.1 Newly Diagnosed Glioblastoma

The efficacy of TEMODAR was evaluated in Study MK-7365-051, a randomized (1:1), multicenter, open-label trial. Eligible patients were required to have newly diagnosed glioblastoma. Patients were randomized to receive either radiation therapy alone or concomitant TEMODAR 75 mg/m² once daily starting the first day of radiation therapy and continuing until the last day of radiation therapy for 42 days (with a maximum of 49 days), followed by TEMODAR 150 mg/m² or 200 mg/m² once daily on Days 1 to 5 of each 28-day cycle, starting 4 weeks after the end of radiation therapy and continuing for 6 cycles. In both arms, focal radiation therapy was delivered as 60 Gy/30 fractions and included radiation to the tumor bed or resection site with a 2- to 3-cm margin. PCP prophylaxis was required during the concomitant phase regardless of lymphocyte count and continued until recovery of lymphocyte count to Grade 1 or less. The major efficacy outcome measure was overall survival.

A total of 573 patients were randomized, 287 to TEMODAR and radiation therapy and 286 to radiation therapy alone. At the time of disease progression, TEMODAR was administered as salvage therapy in 161 patients of the 282 (57%) in the radiation therapy alone arm and 62 patients of the 277 (22%) in the TEMODAR and radiation therapy arm.

The addition of concomitant and maintenance TEMODAR to radiation therapy for the treatment of patients with newly diagnosed glioblastoma showed a statistically significant improvement in overall survival compared to radiotherapy alone (Figure 1). The hazard ratio (HR) for overall survival was 0.63 (95% CI: 0.52, 0.75) with a log-rank P<0.0001 in favor of the TEMODAR arm. The median survival was increased by 2.5 months in the TEMODAR arm.
FIGURE 1: Kaplan-Meier Curves for Overall Survival (ITT Population) in Newly Diagnosed Glioblastoma Trial

14.2 Refractory Anaplastic Astrocytoma

The efficacy of TEMODAR was evaluated in Study MK-7365-006, a single-arm, multicenter trial. Eligible patients had anaplastic astrocytoma at first relapse and a baseline Karnofsky performance status (KPS) of 70 or greater. Patients had previously received radiation therapy and may also have previously received a nitrosourea with or without other chemotherapy. Fifty-four patients had disease progression on prior therapy with both a nitrosourea and procarbazine and their malignancy was considered refractory to chemotherapy (refractory anaplastic astrocytoma population). TEMODAR capsules were given on Days 1 to 5 of each 28-day cycle at a starting dose of 150 mg/m$^2$/day. If ANC was $\geq 1.5 \times 10^9$/L and platelet count was $\geq 100 \times 10^9$/L at the nadir and on Day 1 of the next cycle, the TEMODAR dose was increased to 200 mg/m$^2$/day. The major efficacy outcome measure was progression-free survival at 6 months and the additional efficacy outcome measures were overall survival and overall response rate.

In the refractory anaplastic astrocytoma population (n=54), the median age was 42 years (range: 19 to 76); 65% were male; and 72% had a KPS of $>$80. Sixty-three percent of patients had surgery other than a biopsy at the time of initial diagnosis. Of those patients undergoing resection, 73% underwent a subtotal resection and 27% underwent a gross total resection. Eighteen percent of patients had surgery at the time of first relapse. The median time from initial diagnosis to first relapse was 13.8 months (range: 4.2 months to 6.3 years).

In the refractory anaplastic astrocytoma population, the overall response rate (CR+PR) was 22% (12 of 54 patients) and the complete response rate was 9% (5 of 54 patients). The median duration of all responses was 50 weeks (range: 16 to 114 weeks) and the median duration of complete responses was 64 weeks (range: 52 to 114 weeks). In this population, progression-free survival at 6 months was 45% (95% CI: 31%, 58%) and progression-free survival at 12 months was 29% (95% CI: 16%, 42%). Median progression-free survival was 4.4 months. Overall survival at 6 months was 74% (95% CI: 62%, 86%) and 12-month overall survival was 65% (95% CI: 52%, 78%). Median overall survival was 15.9 months.

15 REFERENCES


16 HOW SUPPLIED/STORAGE AND HANDLING

TEMODAR is a cytotoxic drug. Follow applicable special handling and disposal procedures.

TEMODAR capsules

TEMODAR capsules are supplied in child-resistant sachets containing the following capsule strengths:

- 5 mg: opaque white bodies with green caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with "TEMODAR®". They are supplied as follows:
  - 5-count – NDC 0085-3004-03
  - 14-count – NDC 0085-3004-04

- 20 mg: opaque white bodies with yellow caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with "TEMODAR®". They are supplied as follows:
100 mg: opaque white bodies with pink caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with “TEMODAR”. They are supplied as follows:
5-count – NDC 0085-1366-03
14-count – NDC 0085-1366-04

140 mg: opaque white bodies with blue caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with “TEMODAR”. They are supplied as follows:
5-count – NDC 0085-1425-03
14-count – NDC 0085-1425-04

180 mg: opaque white bodies with orange caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with “TEMODAR”. They are supplied as follows:
5-count – NDC 0085-1430-03
14-count – NDC 0085-1430-04

250 mg: opaque white bodies with white caps. The capsule body is imprinted with two stripes, the dosage strength, and the Schering-Plough logo. The cap is imprinted with “TEMODAR”. They are supplied as follows:
5-count – NDC 0085-1417-02

Store TEMODAR Capsules at 25°C (77°F); excursions permitted to 15°C to 30°C (59°F to 86°F) [see USP Controlled Room Temperature].

TEMODAR for injection
TEMODAR for injection is supplied in single-dose glass vials containing 100 mg temozolomide. The lyophilized powder is white to light tan/light pink.
NDC 0085-1381-01

Store TEMODAR for injection refrigerated at 2°C to 8°C (36°F to 46°F).

17 PATIENT COUNSELING INFORMATION
Advise the patient to read the FDA-approved patient labeling (Patient Information).

Myelosuppression
Inform patients that TEMODAR can cause low blood cell counts and the need for frequent monitoring of blood cell counts. Advise patients to contact their healthcare provider immediately for bleeding, fever, or other signs of infection [see Warnings and Precautions (5.1)].

Myelodysplastic Syndrome and Secondary Malignancies
Advise patients of the increased risk of myelodysplastic syndrome and secondary malignancies [see Warnings and Precautions (5.2)].

Pneumocystis Pneumonia
Advise patients of the increased risk of Pneumocystis pneumonia and to contact their healthcare provider immediately for new or worsening pulmonary symptoms. Inform patients that prophylaxis for Pneumocystis pneumonia may be needed [see Dosage and Administration (2.1), Warnings and Precautions (5.3)].

Hepatotoxicity
Advise patients of the increased risk of hepatotoxicity and to contact their healthcare provider immediately for signs or symptoms of hepatotoxicity [see Warnings and Precautions (5.4)].

Administration Instructions
Advise patient to not open capsules. If capsules are accidentally opened or damaged, advise patients to take rigorous precautions with capsule contents to avoid inhalation or contact with the skin or mucous membranes. In case of powder contact, the hands should be washed [see Dosage and Administration (2.3)].

Embryo-Fetal Toxicity
Advise pregnant women and females of reproductive potential of the potential risk to a fetus. Advise females to inform their healthcare provider of a known or suspected pregnancy [see Warnings and Precautions (5.5), Use in Specific Populations (8.1)].

Advise females of reproductive potential to use effective contraception during treatment with TEMODAR and for at least 6 months after the last dose [see Use in Specific Populations (8.3)].

Advise male patients with pregnant partners or female partners of reproductive potential to use condoms during treatment with TEMODAR and for at least 3 months after the final dose [see Use in Specific Populations (8.3), Nonclinical Toxicology (13.1)].

Advise male patients not to donate semen during treatment with TEMODAR and for at least 3 months after the final dose [see Use in Specific Populations (8.3), Nonclinical Toxicology (13.1)].
Lactation
Advise women not to breastfeed during treatment with TEMODAR and for at least 1 week after the final dose [see Use in Specific Populations (8.2)].

Infertility
Advise males of reproductive potential that TEMODAR may impair fertility [see Use in Specific Populations (8.3), Nonclinical Toxicology (13.1)].