
Australian Product Information - FAMVIR[®] (famciclovir)

1. NAME OF THE MEDICINE

famciclovir

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Famvir tablets contain 125, 250 or 500 mg of famciclovir.

Excipients of known effects: sugars as lactose (125 and 250 mg tablets only). See also Section 4.4 **SPECIAL WARNINGS AND PRECAUTIONS FOR USE**).

For the full list of excipients, see Section 6.1 **LIST OF EXCIPIENTS**.

3. PHARMACEUTICAL FORM

Tablets: 125 mg (white, round, film coated, biconvex) debossed with "FV" on one side and 125 on the reverse side.

Tablets: 250 mg (white, round, film coated, biconvex) debossed with "FV" on one side and 250 on the reverse side.

Tablets: 500 mg (white, oval, film coated, biconvex) debossed with "FV 500" on one side and no markings on the reverse side.

4. CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Famvir is indicated for the treatment of herpes zoster infection in adult patients who commence therapy within 72 hours of the onset of rash. Greatest benefit occurs if the drug is started within 48 hours.

Efficacy has not been demonstrated in patients less than 50 years of age, although the occasional younger patient with severe herpes zoster may benefit from therapy with famciclovir. Herpes zoster infection is generally a milder condition in younger patients.

Famvir is also indicated for the treatment of recurrent episodes of genital herpes in adults and adolescents 12 years of age and older.

Famvir is also indicated for suppression of recurrent genital herpes.

Famvir is also indicated for the treatment of recurrent herpes labialis (cold sores) in immunocompetent adult patients.

Famvir is also indicated in immunocompromised patients for:

- treatment of uncomplicated herpes zoster
- treatment of recurrent herpes simplex
- suppression of recurrent herpes simplex

4.2 DOSE AND METHOD OF ADMINISTRATION

Dosage

Immunocompetent

Herpes zoster:

The recommended dosage of Famvir is 250 mg three times daily for seven days. Treatment should be initiated as soon as possible after herpes zoster is diagnosed. Studies have shown Famvir to be of benefit when started within 72 hours of the onset of rash. Greatest benefit occurs if Famvir is started within 48 hours.

Recurrent genital herpes infections (HSV):

The recommended dosage is either:

- i. 125 mg twice each day for 5 days or
- ii. 500 mg statim, then 250 mg 12 hourly for 3 doses or
- iii. 1000 mg twice daily for 1 day.

Initiation of treatment is recommended during the prodromal period or as soon as possible after onset of lesions.

Suppression of recurrent genital herpes (HSV):

The recommended dose for the suppression of recurrent genital herpes is 250 mg twice daily. As studies conducted to date have not extended beyond 12 months, therapy should be re-evaluated after this period in order to observe possible changes in the natural history of the disease.

Recurrent herpes labialis (cold sores):

The recommended dosage is 1500 mg as a single dose or 750 mg twice daily at 12 hourly intervals for one day [see Section **5.1 PHARMACODYNAMIC PROPERTIES - Clinical trials - Herpes Labialis (Cold Sores)**]. Initiate therapy at the earliest sign or symptom of a cold sore (e.g. tingling, itching or burning). Treatment was initiated within 1 hour of symptom onset in the recurrent herpes labialis clinical study.

Immunocompromised

Herpes zoster:

The recommended dosage of Famvir is 500 mg three times daily for ten days. Initiation of treatment is recommended as soon as possible after rash onset. Studies have shown Famvir to be of benefit when started within 72 hours of the onset of rash.

Recurrent HSV infections:

For treating herpes simplex infections in immunocompromised adults, the recommended dose is 500 mg twice daily for seven days.

Initiation of treatment is recommended during the prodromal period or as soon as possible after onset of lesions.

Suppression of recurrent genital herpes (HSV) in HIV:

For suppression of recurrent genital herpes infections, a dose of 500 mg twice a day has been shown to be efficacious in HIV patients.

Renal impairment

As reduced clearance of penciclovir is related to reduced renal function, as measured by creatinine clearance, special attention should be given to dosages in patients with impaired renal function. The following modifications in dosage are recommended:

Immunocompetent

For the treatment of herpes zoster infection:

<u>Creatinine Clearance (mL/min/1.73m²)</u>	<u>Dosage</u>
≥ 30	No dosage adjustment necessary
10 - 29	250 mg / 24 hours

For the treatment or suppression of recurrent genital herpes infections:

5-day treatment

<u>Creatinine Clearance (mL/min/1.73m²)</u>	<u>Dosage</u>
≥ 30	No dose adjustment necessary
10 - 29	125 mg / 12 hours

1-day treatment

<u>Creatinine Clearance (mL/min/1.73m²)</u>	<u>Dosage</u>
≥ 60	No dose adjustment necessary
40 -59	500 mg / 12 hours
20 -39	500 mg / 24 hours
< 20	250 mg / 24 hours

For the treatment of recurrent herpes labialis:

<u>Creatinine Clearance (mL/min/1.73m²)</u>	<u>Dosage</u>
≥ 60	No dose adjustment necessary
40 - 59	750 single dose
20 - 39	500 single dose
10 - 20	250 single dose
for patients on haemodialysis	250 single dose

Immunocompromised

For the treatment of herpes zoster infection:

<u>Creatinine Clearance (mL/min/1.73m²)</u>	<u>Dosage</u>
≥ 50	No dose adjustment necessary
30 - 49	250 mg / 8 hours
10 - 29	250 mg / 24 hours

For the treatment of recurrent herpes simplex infections:

<u>Creatinine Clearance (mL/min/1.73m²)</u>	<u>Dosage</u>
≥ 50	No dose adjustment necessary
30 - 49	250 mg / 12 hours
10 - 29	125 mg / 24 hours

For suppression of genital herpes infections:

<u>Creatinine Clearance (mL/min/1.73m²)</u>	<u>Dosage</u>
≥ 50	No dose adjustment necessary
30 - 49	250 mg / 12 hours
10 - 29	125 mg / 12 hours

As these recommendations are not based on repeated dose data, patients with impaired renal function should be closely monitored for adverse effects. There are insufficient data to recommend a dosage for patients with creatinine clearance less than 10 mL/min/1.73m².

For a patient on haemodialysis, who has been prescribed famciclovir for conditions other than herpes labialis, a dosage interval of 48 hours is recommended for periods between dialysis. Since 4 hours of haemodialysis results in approximately 75 % reduction in plasma concentrations of penciclovir, the full adjusted dose (for patients with severe renal impairment) of famciclovir should be administered immediately following dialysis.

Hepatic impairment

Dosage modification is not required for patients with well compensated hepatic impairment.

Black patients with recurrent genital herpes

A placebo-controlled study in immunocompetent Black patients with recurrent genital herpes showed no difference in efficacy between patients receiving famciclovir 1 g b.i.d. for 1 day and placebo. There were no unexpected or new safety findings in this trial in Black patients.

The relevance of these study results to other indications in Black patients is unknown (see Sections **5.1 PHARMACODYNAMIC PROPERTIES - Clinical trials** and **5.2 PHARMACOKINETIC PROPERTIES**).

Administration

Famciclovir can be taken without regard to meals (see Section **5.2 PHARMACOKINETIC PROPERTIES - Effect of food**).

4.3 CONTRAINDICATIONS

Famvir is contraindicated in patients with known hypersensitivity to famciclovir or other constituents of Famvir.

It is also contraindicated in those patients who have shown hypersensitivity to penciclovir, the active metabolite of famciclovir.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Famvir 125 mg and 250 mg tablets contain lactose. Patients with rare hereditary problems of galactose intolerance, a severe lactase deficiency or glucose-galactose malabsorption should not take Famvir tablets.

Efficacy has not been studied in ophthalmic zoster, chicken pox or zoster encephalomyelitis patients.

Genital herpes is a sexually transmitted disease. The risk of transmission is increased during acute episodes. Patients should be advised to use condoms between episodes to reduce the risk of transmission and to avoid sexual intercourse when symptoms are present, even if treatment with an antiviral has been initiated. Genital herpes can also be transmitted in the absence of symptoms through asymptomatic viral shedding. Therefore, in addition to therapy with Famvir, it is recommended that patients use “safer sex” practices.

Use in hepatic impairment

Famciclovir has not been studied in patients with severe hepatic impairment. Conversion of famciclovir to the active metabolite penciclovir may be impaired in these patients resulting in lower penciclovir plasma concentrations, and thus possibly a decrease of efficacy of famciclovir (see Section **5 PHARMACOLOGICAL PROPERTIES**). No special precautions are required for elderly patients with mild or moderate hepatic impairment.

Use in renal impairment

Special attention should be paid to patients with impaired renal function and dosage adjustment may be necessary. Appropriate dosage adjustments for renally impaired patients are provided (see Section **4.2 DOSE AND METHOD OF ADMINISTRATION**). No special precautions are required for elderly patients with normal renal function.

Use in the elderly

No special precautions are required for elderly patients with normal renal function and well-compensated hepatic impairment.

Paediatric use

Safety and efficacy in children has not been established.

Effects on laboratory tests

Please see Section **4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS) - Hepatobiliary disorders**.

4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS

Effects of other medicinal products on famciclovir

No clinically significant interactions have been identified with famciclovir or penciclovir.

Probenecid: Concurrent use of Probenecid may result in increased plasma concentrations of penciclovir (active metabolite of famciclovir, see Section **5 PHARMACOLOGICAL PROPERTIES**).

Other drugs that affect renal physiology: could affect plasma levels of penciclovir (the active metabolite of famciclovir, see Section **5 PHARMACOLOGICAL PROPERTIES**).

Evidence from preclinical studies has shown no potential for induction of cytochrome P450.

Zidovudine: In a phase I study, no significant drug interactions were observed after coadministration of zidovudine and famciclovir.

The conversion of the inactive metabolite 6-deoxy penciclovir to penciclovir is catalysed by aldehyde oxidase. Interactions with other drugs metabolized by this enzyme and/or inhibiting this enzyme could potentially occur. Clinical interaction studies of famciclovir with cimetidine and promethazine, *in vitro* inhibitors of aldehyde oxidase, did not show relevant effects on the formation of penciclovir. However, raloxifene, the most potent aldehyde oxidase inhibitor observed *in vitro*, could affect the formation of penciclovir and thus the efficacy of famciclovir. When raloxifene is co-administered with famciclovir, the clinical efficacy should be monitored.

Effects of famciclovir on other medicinal products

Although famciclovir is only a weak inhibitor of aldehyde oxidase *in vitro*, interactions with drugs metabolized by aldehyde oxidase could potentially occur. Evidence from preclinical studies has shown no potential for induction of cytochrome P450 enzymes or inhibition of CYP3A4.

4.6 FERTILITY, PREGNANCY AND LACTATION

Effects on fertility

Testicular toxicity was observed in rats, mice and dogs following repeated administration of famciclovir or penciclovir. Testicular changes included atrophy of seminiferous tubules, reduction in sperm count and/or increased incidence of sperm with abnormal morphology or reduced motility. The degree of testicular toxicity was related to dose and duration of exposure and tended to reverse after the cessation of dosing. In male rats, decreased fertility was observed after 10 weeks dosing at 500 mg/kg/day, or approximately 3 to 20 times the human systemic exposure (AUC). Testicular toxicity was also seen in mice and dogs following chronic administration at exposures to penciclovir ranging from 2 to 14 times the human systemic exposure (AUC). However, there were no clinically significant effects on sperm count, morphology and motility in male patients receiving 250 mg famciclovir b.i.d. for 18 weeks. Famciclovir had no effect on fertility in female rats at doses of up to 1000 mg/kg/day, approximately 4 to 27 times the human systemic exposure (AUC).

Use in pregnancy

Category B1

Famciclovir was tested for effects on embryo-foetal development in rats and rabbits at oral doses up to 1000 mg/kg/day (approximately 4 to 27 times and 2 to 12 times the human systemic exposure to penciclovir in rats and rabbits, respectively [AUC]), and intravenous doses of 360 mg/kg/day in rats (1.9 to 12 times the human dose based on body surface area [BSA] comparisons) or 120 mg/kg/day in rabbits (1.2 to 7.1 times the human dose [BSA]). No adverse effects were observed on embryo-foetal development. Similarly, no adverse effects were observed following intravenous administration of penciclovir to rats (80 mg/kg/day, 0.4 to 2.6 times the human dose [BSA]) or rabbits (60 mg/kg/day, 0.6 to 3.6 times the human dose [BSA]). Although animal studies have not shown any embryotoxic or teratogenic effects with famciclovir or penciclovir (the active metabolite of famciclovir), the safety of famciclovir in human pregnancy has not been established. Famvir should therefore not be used during pregnancy unless the potential benefits are considered to outweigh the potential risks associated with treatment.

Use in lactation

Famciclovir should not be used by nursing mothers unless the potential benefits are considered to outweigh the potential risks associated with treatment. Following oral administration of famciclovir to lactating rats, penciclovir was excreted in milk at concentrations higher than those seen in plasma. There is no information on excretion in human milk.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Patients who experience dizziness, somnolence, confusion or other central nervous system disturbances while taking Famvir should refrain from driving or operating machinery.

4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)

Famvir has been well tolerated in human studies. Headache, fatigue and nausea have been reported in clinical trials. These were generally mild or moderate and occurred at a similar incidence in patients receiving placebo treatment. Confusion, predominantly in the elderly, has been reported rarely.

Table 1: Adverse Events (related, possibly related, unassessable or unknown) reported by ≥1% of immunocompetent subjects during clinical trials

Adverse Event	Famvir (n=3996)	Placebo (n=880)
Headache	5.3 %	4.8 %
Nausea	4.6 %	4.5 %
Dizziness	1.5 %	1.5 %
Diarrhoea	1.5 %	1.3 %
Fatigue	1.2 %	0.9 %
Abdominal pain	1.1 %	1.3 %
Vomiting	1.1 %	0.5 %
Somnolence	0.6 %	1.1 %

Table 2: Adverse Events (related, possibly related, unassessable or unknown) reported by ≥1% of immunocompetent subjects during clinical trials in Herpes labialis

Adverse Event	Famvir 1500 mg	Famvir 750 mg	Placebo
	q.d. N=227	b.i.d. N=220	N=254
	N (%)	N (%)	N (%)
Patients with AE(s)	63 (27.8)	54 (24.5)	53 (20.9)
AE preferred term			
Headache	22 (9.7)	16 (7.3)	17 (6.7)
Diarrhoea	4 (1.8)	3 (1.4)	2 (0.8)
Nausea	5 (2.2)	5 (2.3)	10 (3.9)
Nasopharyngitis	6 (2.6)	3 (1.4)	2 (0.8)

Table 3 Adverse Events (related, possibly related, unassessable or unknown) reported by ≥ 1% of immunocompetent subjects during the clinical trial comparing the 2-day and 5-day recurrent genital herpes treatments^a

Adverse Event	Famvir 2-day course	Famvir 5-day course
	(n=521 recurrences)	(n=517 recurrences)
	N (%)	N (%)
Recurrences with ≥1 AE(s)	185 (35.5)	176 (34.0)
No. of AEs	377	336
MedDRA preferred term ^{b,c} :		
Headache	83 (15.9)	94 (18.2)
Nausea	15 (2.9)	22 (4.3)
Diarrhoea	12 (2.3)	16 (3.1)
Abdominal pain	12 (2.3)	5 (1.0)
Dizziness	10 (1.9)	10 (1.9)
Fatigue	9 (1.7)	13 (2.5)

Where: 2-day course: 2-day famciclovir regimen (500 mg loading dose then 250 mg 12-hourly)

5-day course: 5-day famciclovir regimen (125 mg 12-hourly)

a On or for 4 days after date of starting study medication

b The denominator is the number of recurrences in the safety recurrence population for each treatment group

c If a patient had more than 1 recurrence of a specific AE during a recurrence, the AE is counted only once for that recurrence

Table 4 Adverse Events (related, possibly related, unassessable or unknown) reported by $\geq 1\%$ of immunocompetent subjects during a clinical trial of 1 g b.i.d. for 1 day vs placebo in recurrent genital herpes

Adverse Event	Famvir (n=163) N (%)	Placebo (n=166) N (%)
Patients with AE(s)	43 (26.4)	40 (24.1)
AE preferred term		
Headache	22 (13.5)	9 (5.4)
Diarrhoea	8 (4.9)	2 (1.2)
Nausea	4 (2.5)	6 (3.6)
Insomnia	3 (1.8)	2 (1.2)
Dysmenorrhoea	3 (1.8)	1 (0.6)
Pharyngolaryngeal pain	3 (1.8)	1 (0.6)
Back pain	2 (1.2)	1 (0.6)
Anxiety	2 (1.2)	0
Dry mouth	2 (1.2)	0
Palpitations	2 (1.2)	0
Stomach Discomfort	2 (1.2)	1 (0.6)
Vomiting	2 (1.2)	1 (0.6)
Abdominal pain upper	1 (0.6)	4 (2.4)
Dizziness	0	4 (2.4)
Abdominal pain	0	2 (1.2)
Fungal infection	0	2 (1.2)
Nasopharyngitis	0	2 (1.2)

Table 5 Adverse Events reported by $\geq 5\%$ of patients receiving Famvir 500 mg daily or placebo for >10 months

Adverse Event	Famvir (n=154)	Placebo (n=63)
Headache	37.7 %	42.9 %
URTI	31.8 %	31.7 %
Infection (viral)	24.7 %	25.4 %
Injury	18.8 %	23.8 %
Sinusitis	19.5 %	15.9 %
Back pain	12.3 %	14.3 %
Pharyngitis	11.0 %	14.3 %
UTI	7.1 %	4.8 %
Dyspepsia	5.2 %	11.1 %

Famciclovir has also been well tolerated in immunocompromised patients. Adverse effects reported from clinical studies were similar to those reported in the immunocompetent population.

Post-marketing Data

In addition to the adverse events reported in the clinical trials, the following Adverse reactions (**Table 6**) have been reported in post-marketing surveillance. They are ranked under headings of frequency, according to the following convention: very common ($\geq 1/10$); common ($\geq 1/100$, $< 1/10$); uncommon ($\geq 1/1,000$, $< 1/100$); rare ($\geq 10,000$, $< 1/1,000$); very rare ($< 1/10,000$), including isolated reports.

Table 6: Adverse Events reported by patients receiving Famvir

Blood and lymphatic system disorders	
Very rare:	Thrombocytopenia
Psychiatric disorders	
Uncommon:	Confusional state (predominantly in the elderly)
Rare:	Hallucinations
Nervous system disorders	

Very common:	Headache
Common:	Dizziness
Uncommon:	Somnolence (predominantly in the elderly)
Not known:	Seizure
Cardiac disorders	
Rare:	Palpitations
Gastrointestinal disorders	
Common:	Vomiting, nausea, abdominal pain, diarrhoea
Hepatobiliary disorders	
Common:	Liver function test abnormal
Rare:	Jaundice cholestatic
Immune system disorders	
Not known:	Anaphylactic shock, anaphylactic reaction
Skin and subcutaneous tissue disorders	
Common:	Rash, pruritus
Uncommon:	Angioedema (e.g. face oedema, eyelid oedema, periorbital oedema, pharyngeal oedema), urticaria
Very rare:	Serious skin reactions (e.g. erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis)
Not known:	Hypersensitivity vasculitis
Musculoskeletal disorders	
Very rare:	arthralgia, myalgia

Reporting suspected adverse reactions

Reporting suspected adverse reactions after registration of the medicinal product is important. It allows continued monitoring of the benefit-risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions at <https://www.tga.gov.au/reporting-problems>.

4.9 OVERDOSE

For information on the management of overdose, contact the Poison Information Centre on 131126 (Australia).

Symptomatic and supportive therapy should be given as appropriate. Acute renal failure has been reported rarely in patients with underlying renal disease. The famciclovir dosage in these patients had not been appropriately reduced for the level of renal function.

Penciclovir, the active metabolite of famciclovir, is dialysable; plasma concentrations are reduced by approximately 75% following 4 hours of haemodialysis.

5. PHARMACOLOGICAL PROPERTIES

Pharmacotherapeutic group: Oral antiviral agent, ATC code: JO5A B09

5.1 PHARMACODYNAMIC PROPERTIES

Mechanism of action

Virology

Famciclovir is the oral form of the antiviral compound: penciclovir. Famciclovir is rapidly converted *in vivo* into penciclovir, which has demonstrable *in vitro* activity against herpes simplex viruses (HSV types 1 and 2)

and varicella zoster virus (VZV). The antiviral effect of orally administered famciclovir has been demonstrated in several animal models: this effect is due to *in vivo* conversion to penciclovir.

Penciclovir targets virus-infected cells where it is rapidly converted into penciclovir-triphosphate (mediated via virus-induced thymidine kinase). The triphosphate inhibits viral DNA polymerase by competition with deoxyguanosine triphosphate and is incorporated into the extending DNA chain, preventing significant chain elongation. Consequently, viral DNA synthesis and, therefore, viral replication are inhibited.

This triphosphate persists in infected cells in excess of 12 hours. The long intracellular half-life of penciclovir triphosphate ensures prolonged antiviral activity, as demonstrated in cell cultures with HSV-1 and HSV-2 and in animal studies.

Penciclovir is only readily phosphorylated in virus-infected cells. In uninfected cells treated with penciclovir, concentrations of penciclovir-triphosphate are only barely detectable. Accordingly, uninfected cells are unlikely to be affected by therapeutic concentrations of penciclovir.

The most common form of resistance encountered with aciclovir among HSV strains is a deficiency in the production of the thymidine kinase (TK) enzyme. Such TK deficient strains would be expected to be cross-resistant to both penciclovir and aciclovir. However, penciclovir has been shown to be active against a clinically isolated aciclovir-resistant herpes simplex type 1 strain with an altered DNA polymerase.

The results from penciclovir and famciclovir patient studies, including studies of up to four months' treatment with famciclovir, showed that no resistance occurred as a result of treatment with either famciclovir or penciclovir. Penciclovir-resistant isolates were found at the start of treatment or in the placebo groups in 0.25% of the 1976 total isolates from HSV and VZV (5/1976), and in 0.19% of the 533 virus isolates from immunocompromised patients (1/533).

Clinical trials

Herpes Zoster

Placebo-controlled trial

Famvir was studied in a placebo-controlled, double-blind trial of 419 otherwise healthy patients with uncomplicated herpes zoster who were treated with Famvir 500 mg t.i.d. (n=138), Famvir 750 mg t.i.d. (n=135) or placebo (n=146). Treatment was begun within 72 hours of initial lesion appearance and therapy was continued for 7 days.

Dermatology and virology: The times to full crusting, loss of vesicles, loss of ulcers and loss of crusts were shorter for Famvir 500 mg-treated patients than for placebo-treated patients in the overall study population. The median time to full crusting in Famvir 500 mg-treated patients was 5 days compared to 7 days in placebo-treated patients. No additional efficacy was demonstrated with the higher dose of famciclovir (750 mg t.i.d.) when compared to Famvir 500 mg t.i.d. In the total population, 65.2% of patients had a positive viral culture at some time during their acute infection. Patients treated with Famvir 500 mg had a shorter median duration of viral shedding (time to last positive viral culture) than did placebo-treated patients (1 day and 2 days, respectively).

Acute pain and postherpetic neuralgia: There were no overall differences in the duration of acute pain (i.e. pain before rash healing) between Famvir and placebo-treated groups. In addition, there was no difference in the incidence of postherpetic neuralgia (i.e. pain after rash healing) between the treatment groups. In the 186 patients (44.4% of total study population) who did develop postherpetic neuralgia, the median duration of postherpetic neuralgia was shorter in patients treated with Famvir 500 mg than in those treated with placebo (63 days and 119 days, respectively).

Active-control trial

A second double-blind controlled trial in 545 otherwise healthy patients with uncomplicated herpes zoster treated within 72 hours of initial lesion appearance compared Famvir 250 mg t.i.d. (n=134), Famvir 500 mg t.i.d. (n=134), Famvir 750 mg t.i.d. (n=138) and aciclovir 800 mg 5 times per day (n=139) for 7 days. In this study, patients treated with Famvir at each dose and aciclovir had comparable times to full lesion crusting and times to loss of acute pain. There were no statistically significant differences in the time to loss of postherpetic neuralgia between Famvir and aciclovir-treated groups.

Higher doses of famciclovir (500 mg t.i.d.; 750 mg t.i.d.) have not been shown to confer greater benefit. The minimum effective dose of famciclovir in the treatment of herpes zoster has not been established.

Immunocompromised

A double-blind, controlled clinical trial was conducted in 148 oncology and transplant patients with herpes zoster infections who received Famvir 500 mg t.i.d. (n=71) or aciclovir 800 mg 5 times per day (n=77) for 10 days. Patients started study medication within 72 hours of rash onset. Overall Famvir and aciclovir showed comparable efficacy. The median times to full crusting and complete healing were 8 and 20 days for the Famvir group and 9 and 21 days for the aciclovir group. The median times to loss of all pain were 14 and 17 days for the Famvir and aciclovir groups, respectively. Withdrawal due to dissemination of zoster and continued new lesion formation beyond 10 days of onset was reported in 7% of the famciclovir group and 9% of the aciclovir group.

Genital Herpes

Placebo-controlled trials (episodic therapy)

5-day treatment: In two double-blind, placebo-controlled trials, 626 otherwise healthy patients with a recurrence of genital herpes were treated with Famvir 125 mg b.i.d. (n=160), Famvir 250 mg b.i.d. (n=169), Famvir 500 mg b.i.d. (n=154) or placebo (n=143) for 5 days. Treatment was initiated within 6 hours of either symptom onset or lesion appearance. In the two studies combined, the median time to healing in Famvir 125 mg-treated patients was 4 days compared to 5 days in placebo-treated patients. The median time to cessation of viral shedding was 1.8 vs 3.4 days in Famvir 125 mg and placebo recipients, respectively. The median time to loss of all symptoms was 3.2 days in Famvir 125 mg-treated patients vs. 3.8 days in placebo-treated patients. When used to treat acute recurrent genital herpes, no additional efficacy was demonstrated with higher doses of Famvir (250 mg b.i.d. or 500 mg b.i.d.) when compared to Famvir 125 mg b.i.d. over 5 days.

1-day treatment: In one double-blind, placebo-controlled trial, 329 immunocompetent patients with a recurrence of genital herpes were treated with Famvir 1 g b.i.d. (n=163) or placebo (n=166) for 1 day. Treatment was initiated within 6 hours of either symptom onset or lesion appearance. Among patients with non-aborted lesions, the median time to healing in Famvir 1 g-treated patients (n=125) was 4.3 days compared to 6.1 days in placebo-treated patients (n=145). The median difference in time to healing between the placebo- and Famvir-treated groups was 1.2 days (95 % CI: 0.5 – 2.0). 23 % of Famvir-treated patients had aborted lesions (no development beyond erythema) compared to 13 % in placebo-treated patients. The median time to loss of all symptoms (e.g., burning, itching, pain, tenderness, tingling), was 3.3 days in Famvir-treated patients vs. 5.4 days in placebo-treated patients.

In one, randomized (2:1), double-blind, placebo-controlled, double-blind study to assess the safety and efficacy of patient-initiated, single-day treatment, 304 black immunocompetent patients with recurrent genital herpes were treated with Famvir 1 g b.i.d. (n= 206) or placebo (n=98) 1 g b.i.d. The study was conducted in 43 centres in the USA and South Africa, in patients with a history of at least four recurrences of genital herpes in the past 12 months and laboratory confirmation of HSV-2 infection. The median time to healing among patients with non-aborted lesions was 5.4 days in Famvir-treated patients (n=152) as compared to 4.8 days in placebo-treated patients (n=78). The median difference in time to healing between the placebo and Famvir-treated groups was -0.26 days (95% CI: -0.98 – 0.40). There were no unexpected or new safety findings in this trial.

Active-control trial (episodic therapy)

2-day treatment: In a randomised, double-blind, non-inferiority, multi-centre study (59 sites in Australia and 7 in Canada), famciclovir 500 mg statim then 250 mg bd for 2 days (short-course) was compared to the standard regimen of 125 mg bd for 5 days in the treatment of adult patients with recurrent genital herpes. HIV-infected patients were eligible if CD4 \geq 500 cells/ μ L and/or CD4% \geq 25%.

The study was designed to treat and follow each eligible patient for two complete and consecutive recurrences. A total of 1038 recurrences occurred in 616 patients that were randomised and treated. Treatment was initiated by patients within 12 hours of development of a lesion or onset of symptoms.

Patients attended for assessment within 24 hours and then 5.5 days following initiation of treatment. A daily diary was used to record treatment compliance, progression of lesions and symptoms, functional impact and side effects from the treatment.

The primary endpoint was the estimated probability of being not lesion-free at 5.5 elapsed days (132 hours) after patient self-initiation of therapy. The estimated probability was 24.4% for recurrences treated with the 2-day regimen and was 27.6 % for recurrences treated with the 5-day regimen. The upper one-sided 97.5% confidence limit of the treatment difference was 1.7 % which was within the pre-defined margin for claiming non-inferiority. Non-inferiority was maintained in five sensitivity analyses, confirming a robust result.

Over the course of treatment, there were no differences between the mean symptom and functional impact scores for either the famciclovir short-course or the standard-course treatment groups.

The study concluded that the 2-day famciclovir regimen was equivalent to the 5-day regimen in the treatment of adult patients with recurrent genital herpes.

Placebo-controlled trials (suppressive therapy)

In two placebo controlled suppression studies, immunocompetent patients (n=934) with at least six recurrences of genital herpes per year received 125 mg t.i.d. (n=233), 250 mg b.i.d. (n=236), 250 mg t.i.d. (n=232) or placebo (n=233) for 52 weeks. Treatment was initiated during an asymptomatic period. Among those who received Famvir 250 mg b.i.d., the proportion of patients who remained free from virologically confirmed recurrence at the 12 month end point was 68% in one trial and 72% in the second trial compared with approximately 21% in the placebo groups. Median days to first clinically confirmed recurrence for the Famvir 250 mg b.i.d. treatment groups were >365 days for the Famvir 250 mg b.i.d. treatment groups compared to 67 days for the placebo treated group in one of the studies and 336 days for the Famvir groups compared to 47 days for the placebo group in the second study.

Immunocompromised

A randomised, double-blind controlled trial in 293 HIV-infected patients with a recurrence of genital herpes compared Famvir 500 mg b.i.d. (n=150) and aciclovir 400 mg 5 times per day (n=143) for 7 days. Treatment was initiated within 48 hours of lesion onset. Famvir and aciclovir were equally effective in prevention of new lesion formation while patients were receiving treatment. Efficacy in the three main time to event parameters were also comparable. The median times to complete healing of lesions, cessation of viral shedding and loss of lesion pain were 7 days, 2 days and 3 days for both the Famvir and aciclovir treatment groups, respectively.

A further double-blind, placebo-controlled crossover study was conducted in 48 patients with HIV to assess Famvir (500 mg b.i.d.) in the suppression of HSV recurrence for 8 weeks. Famvir showed statistically significant superiority over placebo in the efficacy parameters measured. There was an approximate 10-fold reduction in the percentage of days with HSV shedding (p=0.0003) and a 6.7-fold reduction in the proportion of patients with HSV shedding from anogenital sites (p=0.0065) in the Famvir treated group. There was also an 8.7-fold reduction in the proportion of patients with HSV shedding from any site. Overall in the Famvir group, the proportion of days of asymptomatic, symptomatic, subclinical or lesional HSV shedding from any site was significantly reduced compared to placebo (p=0.0012).

In the Famvir treatment group there was a 2.6-fold reduction in the percentage of days with lesions (p=0.0101), and a 3.6-fold reduction in the percentage of days with lesions/symptoms (p=0.0089) over the placebo group.

Herpes Labialis (Cold Sores)

Placebo-controlled trial

In one large placebo-controlled trial, 701 immunocompetent adults with recurrent herpes labialis were treated with Famvir 1500 mg once (n=227), Famvir 750 mg b.i.d. (n=220) or placebo (n=254) for 1 day. As well, patients also had to be in good general health, aged at least 18 years, have normal renal and hepatic function, had prior pregnancy tests if they were females of reproductive age, and have experienced 3 or more episodes of cold sores in the preceding 12 months. Patients were required to have a history of prodromal symptoms preceding at least 50% of the recurrent episodes, and at least 50% of these episodes had to have progressed to the vesicular lesion stage. Women of childbearing potential had to agree to use reliable birth control measures during the study. Pregnant or breast-feeding women were excluded. Patients were excluded if they had received an investigational drug in the 4 weeks prior to the study, had been previously vaccinated against herpes, or were using a topical immunosuppressive agent on or near the face or a systemic immunosuppressive agent within 1 month of screening. Patients were also excluded if they were immunosuppressed due to underlying disease or concomitant treatment had a recent history of drug or alcohol abuse, were suffering from inflammatory skin diseases (e.g. eczema or dermatitis) that would interfere with the assessment of lesions, or were allergic or hypersensitive to products containing aciclovir, penciclovir, famciclovir or other nucleoside analogs.

Patients were instructed to take the first dose of study medication within 1 hour of symptom onset. However, some patients commenced treatment after 1 hour of onset of symptoms. Both famciclovir regimens significantly reduced time to healing of primary vesicular herpes labialis lesions (the primary efficacy variable) in the modified ITT population compared with placebo. The median time to healing in Famvir 1500 mg single-dose treated patients was 4.4 days compared to 4.0 days in Famvir 750 mg bid and 6.2 days in

placebo-treated patients. This translates to treatment effects of 1.8 (CI_{95%} 0.9, 2.7) and 2.2 (CI_{95%} 1.3, 3.1) days, respectively. A single 1500 mg dose of Famvir reduced the time to resolution of pain and tenderness (median time 1.7 days versus 2.9 days) compared with placebo and was marginally more effective than Famvir 750 mg b.i.d. (median time 2.1 days).

5.2 PHARMACOKINETIC PROPERTIES

Famciclovir is the oral prodrug of penciclovir. Following oral administration, famciclovir is rapidly and extensively absorbed and converted to the antivirally active compound penciclovir. The bioavailability of penciclovir after oral famciclovir administration is 77 %. Mean peak plasma concentrations (C_{max}) of penciclovir occurred at a median time of 45 minutes following administration of single oral doses of famciclovir (as shown in **Table 7**). No data is available on the pharmacokinetics of 1500 mg famciclovir as a single dose.

Table 7 Mean peak plasma concentrations (C_{max}) of penciclovir after administration of single oral doses of famciclovir

famciclovir single oral dose (mg)	C _{max} (µg/mL)
125	0.8
250	1.6
500	3.3
750	5.1
1000	6.6

Plasma concentration-time curves of penciclovir are similar following single and repeat (b.i.d. and t.i.d.) dosing and there is no accumulation of penciclovir on repeated dosing. Penciclovir and its 6-deoxy precursor are poorly (<20%) bound to plasma proteins.

Famciclovir is eliminated principally as penciclovir and its 6-deoxy precursor, which are excreted in urine. No unchanged famciclovir has been detected in urine. Tubular secretion and glomerular filtration contribute to renal elimination of the compound. The terminal plasma half-life of penciclovir after both single and repeat dosing with famciclovir is approximately 2.0 hours. There is no accumulation of penciclovir on repeated dosing with famciclovir.

Effect of food

Penciclovir C_{max} was decreased by approximately 50 % and T_{max} was delayed by 1.5 hour when a capsule formulation of famciclovir was administered 30 minutes after food. When Famvir tablets were administered 30 minutes after food, penciclovir C_{max} was reduced by approximately 20 % and T_{max} was delayed by 0.75 hour. The systemic availability (AUC) of penciclovir following either preparation was unaffected. The clinical consequences of these effects on plasma concentration are unknown.

Characteristics in special populations

Patients with Herpes Zoster

Uncomplicated Herpes virus does not significantly alter the pharmacokinetics of penciclovir measured after the oral administration of famciclovir.

Renal impairment

Plasma clearance, renal clearance and plasma elimination rate constant decreased linearly with reductions in renal function. A dosage interval adjustment is recommended for patients with renal impairment (see Section **4.2 DOSE AND METHOD OF ADMINISTRATION**).

Hepatic impairment

Well-compensated chronic liver disease (chronic hepatitis [n=6], chronic ethanol abuse [n=8] or biliary cirrhosis [n=1]) has no effect on the extent of availability (AUC) of penciclovir following a single dose of 500 mg famciclovir. No dose adjustment is recommended for patients with well-compensated hepatic impairment (see Sections **4.2 DOSE AND METHOD OF ADMINISTRATION - Hepatic impairment** and **4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE**). However, there was a 43% decrease in penciclovir mean maximum plasma concentration and the time to maximum plasma concentration was increased by a median of 0.75 hour in patients with hepatic impairment compared to normal volunteers. The pharmacokinetics have not been evaluated in patients with severe uncompensated hepatic impairment.

Elderly patients

Based on cross-study comparisons of single dose studies, the mean penciclovir AUC was approximately 30 % higher, half-life 23 % longer and penciclovir body weight adjusted renal clearance reduced by 19% in healthy elderly male volunteers (n=18, aged 65 to 79 years) compared to younger volunteers. Some of this difference may be due to differences in renal function between the two groups. No dose adjustment based on age is recommended unless renal function is impaired (see Section 4.2 DOSE AND METHOD OF ADMINISTRATION).

HIV patients

Extrapolated data from a study (n=8) where famciclovir was given as a single dose resulted in a mean AUC of 24 microgram.h/mL, which is similar to that obtained in healthy subjects.

Race

A retrospective evaluation was performed to compare the pharmacokinetic parameters obtained in Black and Caucasian subjects after single and repeat once-daily, twice-daily, or three times-daily administration of famciclovir 500 mg. Data from a study in healthy volunteers (single dose), a study in subjects with varying degrees of renal impairment (single and repeat dose) and a study in subjects with hepatic impairment (single dose) did not indicate any relevant differences in the pharmacokinetics of penciclovir between Black and Caucasian subjects.

Transplant patients

In a study of allogeneic bone marrow transplant or peripheral blood stem cell transplant or allogeneic renal transplant patients (n=21), intravenous penciclovir for one month was followed by oral use of famciclovir. The doses of penciclovir and famciclovir were adjusted according to creatinine clearance. During repeat dosing with famciclovir, the AUC of penciclovir was found to be 66 microgram.h/mL in subjects with creatinine clearance greater than 50 mL/min. No safety concerns were identified despite the higher than normal AUCs reported, and additional dosage adjustment in renal transplant patients is not recommended.

5.3 PRECLINICAL SAFETY DATA

Data presented below include reference to area under the plasma concentration curve (24 hour AUC) for penciclovir in humans following the lowest and highest recommended doses for famciclovir (i.e. penciclovir AUC of 4.5 microgram.h/mL at 125 mg b.i.d. for acute recurrent genital herpes, and a penciclovir AUC of 27 microgram.h/mL at 500 mg t.i.d. for herpes infections in immunocompromised patients). This is based on the assumption that the pharmacokinetics in immunocompetent subjects are similar to the pharmacokinetics in immunocompromised subjects, as shown in the study on HIV patients (see Section 5.2

PHARMACOKINETIC PROPERTIES). If the higher values of AUC obtained in the renal transplant patients were used as a basis for comparison, the multiples specified here would be decreased. Exposures in animal studies are expressed as multiples of human exposures at the highest and lowest dosing schedules based on penciclovir AUC or body surface area.

Genotoxicity

Famciclovir and penciclovir (the active metabolite of famciclovir) were tested for genotoxic potential in a series of *in vitro* and *in vivo* assays. Famciclovir showed no genotoxic potential in a series of assays for gene mutations, chromosomal damage and DNA damage. Penciclovir was positive in the L5178Y mouse lymphoma assay for gene mutations/ chromosomal damage, caused chromosomal aberrations in human lymphocytes *in vitro* and was positive in a mouse micronucleus assay *in vivo* when administered IV at doses toxic to bone marrow.

Carcinogenicity

The carcinogenic potential of famciclovir was evaluated in 2 year dietary studies in rats and mice. A significant increase in the incidence of mammary adenocarcinoma was seen in female rats receiving 600 mg/kg/day. No increases in tumour incidences were reported for male rats treated at doses of up to 240 mg/kg/day or in mice of either sex at doses of up to 600 mg/kg/day. At the no effect levels of 240 and 200 mg/kg/day in male and female rats, the daily exposures to penciclovir based on AUC were about 40 and 29 microgram.h/mL respectively, or approximately 1 to 8 times the human systemic exposures at 500 mg t.i.d or 125 mg b.i.d. Systemic exposures at the no effect dose in male and female mice were 65 and 46 microgram.h/mL respectively, or approximately 2 to 12 times the human systemic exposure (AUC).

6. PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

All Famvir film-coated tablets also contain hypolose, sodium starch glycollate and magnesium stearate as excipients. Famvir 125 mg and 250 mg tablets contain lactose (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE). Famvir 500 mg tablets do not contain lactose. The film coat, Opadry OY-S-28924, contains titanium dioxide, hypromellose and macrogol.

6.2 INCOMPATIBILITIES

Incompatibilities were either not assessed or not identified as part of the registration of this medicine.

6.3 SHELF LIFE

In Australia, information on the shelf life can be found on the public summary of the ARTG. The expiry date can be found on the packaging.

6.4 SPECIAL PRECAUTIONS FOR STORAGE

Famvir tablets should be stored below 30°C in a dry place. Store in the original package in order to protect from moisture. Keep out of the reach of children.

6.5 NATURE AND CONTENTS OF CONTAINER

Tablets: 125 mg in blister packs of 2*, 10*, 40, and 56* .

Tablets: 250 mg in blister packs of 3* (herpes zoster samples), 5* (episodic genital herpes samples), 14*, 20, 21, 30*, and 56.

Tablets: 500 mg in blister packs of 3*, 4*, 9*, 12*, 14*, 16*, 20*, 30 and 56.

* Not currently marketed

6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

In Australia, any unused medicine or waste material should be disposed of by talking to your local pharmacy.

6.7 PHYSICOCHEMICAL PROPERTIES

Famciclovir is a synthetic guanine derivative. It is a white to pale yellow crystalline solid.

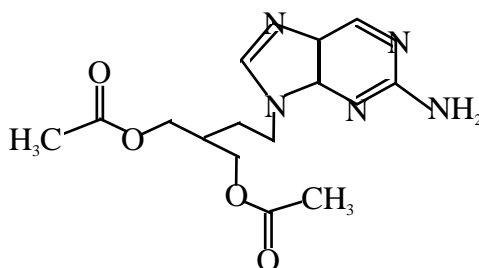
Chemical structure

Chemical names: 9-(4-acetoxy-3-acetoxymethylbut-1-yl)-2-aminopurine

Molecular weight: 321.3

Molecular formula $C_{14}H_{19}N_5O_4$

Chemical structure:



CAS number

104227-87-4

7. MEDICINE SCHEDULE (POISONS STANDARD)

Schedule 4 - Prescription Only Medicine

8. SPONSOR

Atnahs Pharma Australia Pty Ltd

Level 10 / 10 Shelley Street,

Sydney, NSW, 2000, Australia

Ph: 1800 899 005

9. DATE OF FIRST APPROVAL

16 May 1995

DATE OF REVISION

06 February 2020

Summary table of changes

Section changed	Summary of new information
All	Reformat in line with the new form
2; 3; 4; 6; 7	Editorial
8	Sponsor details updated