

Evrysdi[®] 5 mg tablets



Risdiplam

Film coated tablets

1. NAME OF THE MEDICINAL PRODUCT

Evrysdi 5 mg tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 5 mg of risdiplam.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet.

Pale yellow film-coated tablet, round and curved, approximately 6.5 mm in diameter, with EVR debossed on one side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Evrysdi is indicated for the treatment of spinal muscular atrophy (SMA) types 1, 2 and 3 in pediatric and adult patients.

4.2 Posology and method of administration

Treatment with risdiplam should be initiated by a physician with experience in the management of SMA.

Posology

The recommended once daily dose of risdiplam film-coated tablet for patients ≥ 2 years of age with ≥ 20 kg body weight is 5 mg.

There is an alternative oral solution available for patients of all age groups. Refer to the Evrysdi powder for oral solution Prescribing Information.

The physician should prescribe the appropriate pharmaceutical form according to the dose required and the patient's needs, including the patient's ability to swallow. For patients with difficulty swallowing a whole tablet, or who require administration via a nasogastric or gastrostomy tube, the film-coated tablet can be dispersed in water, or the powder for oral solution can be prescribed.

Treatment with a daily dose above 5 mg has not been studied.

Delayed or missed doses

If a planned dose is missed, it should be administered as soon as possible if still within 6 hours of the scheduled dose. Otherwise, the missed dose should be skipped and the next dose should be administered at the regularly scheduled time the next day.

If a dose is not fully swallowed or vomiting occurs after taking a dose of risdiplam, another dose should not be administered to make up for the incomplete dose. The next dose should be administered at the regularly scheduled time.

Elderly

No dose adjustment is required in elderly patients based on limited data in subjects aged 65 years and older (see section 5.2).

Renal impairment

Risdiplam has not been studied in this population. No dose adjustment is expected to be required in patients with renal impairment (see section 5.2).

Hepatic impairment

No dose adjustment is required in patients with mild or moderate hepatic impairment. Patients with severe hepatic impairment have not been studied and may have increased risdiplam exposure (see sections 5.1 and 5.2).

Paediatric population

There is no relevant use of risdiplam film-coated tablets in children < 2 years of age and < 20 kg.

Method of administration

Oral use.

It is recommended that a healthcare professional (HCP) discuss with the patient or caregiver how to prepare the prescribed daily dose prior to administration of the first dose.

Evrysdi is taken orally once a day with or without food at approximately the same time each day.

The film-coated tablets should be swallowed whole or dispersed in a small amount of room temperature water (see Section 6.6). Do not chew, cut, or crush the tablets.

If Evrysdi is dispersed in water, take it immediately. Evrysdi must not be dispersed in any liquid other than water. Discard the prepared mixture if it is not used within 10 minutes of adding water. Do not expose the prepared mixture to sunlight.

If the prepared mixture of Evrysdi spills or gets on the skin, the area should be washed with soap and water.

If administration through a nasogastric or gastrostomy tube is required, a tube that is 8 French or higher should be used to administer the prepared Evrysdi mixture after the dispersion is complete. After the administration of the Evrysdi mixture, the tube should be flushed with the water (at least 15 mL) used to rinse the dispersion cup.

Detailed instructions on the administration of the tablet prepared as a mixture are given in the Instructions for Use (IFU) at the end of the patient leaflet.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

Potential embryo-foetal toxicity

Embryo-foetal toxicity has been observed in animal studies (see section 5.3). Patients of reproductive potential should be informed of the risks and must use highly effective contraception during treatment and until at least 1 month after the last dose in female patients, and 4 months after the last dose in male patients. The pregnancy status of female patients of reproductive potential should be verified prior to initiating risdiplam therapy (see section 4.6).

Potential effects on male fertility

Based on observations from animal studies, male patients should not donate sperm while on treatment and for 4 months after the last dose of risdiplam. Prior to initiating treatment, fertility preservation strategies should be discussed with male patients of reproductive potential (see sections 4.6 and 5.3). The effects of risdiplam on male fertility have not been investigated in humans.

Excipients

Sodium

Evrysdi contains less than 1 mmol sodium (23 mg) per 5 mg dose, i.e. is essentially ‘sodium-free’.

4.5 Interaction with other medicinal products and other forms of interaction

Effects of other medicinal products on risdiplam

Omeprazole had no impact on the pharmacokinetics of risdiplam administered as a tablet. The risdiplam tablet may therefore be administered concomitantly with medication that increases the gastric pH (proton pump inhibitors, H₂ antagonists, and antacids).

Co-administration of 200 mg itraconazole twice daily, a strong CYP3A inhibitor, with a single oral dose of 6 mg risdiplam did not exhibit a clinically relevant effect on the PK parameters of risdiplam (11% increase in AUC, 9% decrease in C_{max}). No dose adjustments are required when risdiplam is co-administered with a CYP3A inhibitor.

No drug-drug interactions are expected via the FMO1 and FMO3 pathway.

Effects of risdiplam on other medicinal products

Risdiplam is a weak inhibitor of CYP3A. In healthy adult subjects, oral administration of risdiplam once daily for 2 weeks slightly increased the exposure of midazolam, a sensitive CYP3A substrate (11% increase in AUC, 16% increase in C_{max}). The extent of the interaction is not considered clinically relevant, and therefore no dose adjustment is required for CYP3A substrates.

In vitro studies have shown that risdiplam and its major human metabolite M1 are not significant inhibitors of human MDR1, organic anion-transporting polypeptide (OATP)1B1, OATP1B3, organic anion transporter 1 and 3 (OAT 1 and 3). However, risdiplam and its metabolite are *in vitro* inhibitors of the human organic cation transporter 2 (OCT2) and the multidrug and toxin extrusion (MATE)1 and MATE2-K transporters. At therapeutic drug concentrations, no interaction is expected with OCT2 substrates. The effect of co-administration of risdiplam on the pharmacokinetics of MATE1 and MATE2-K substrates in humans is unknown. Based on *in vitro* data, risdiplam may increase plasma concentrations of medicinal products eliminated via MATE1 or MATE2-K, such as metformin. If co-administration cannot be avoided, drug-related toxicities should be monitored and dosage reduction of the co-administered medicinal product should be considered if needed.

There is no efficacy or safety data to support the concomitant use of risdiplam and nusinersen.

4.6 Fertility, pregnancy and lactation

Patients of reproductive potential

Contraception in male and female patients

Male and female patients of reproductive potential should adhere to the following contraception requirements:

- Female patients of childbearing potential should use highly effective contraception during treatment and for at least 1 month after the last dose.
- Male patients, and their female partners of childbearing potential, should both ensure that highly effective contraception is achieved during treatment and for at least 4 months after the last dose.

Pregnancy testing

The pregnancy status of female patients of reproductive potential should be verified prior to initiating risdiplam therapy. Pregnant women should be clearly advised of the potential risk to the foetus.

Pregnancy

There are no data from the use of risdiplam in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3).

Risdiplam is not recommended during pregnancy and in women of childbearing potential not using contraception (see section 4.4).

Breast-feeding

It is not known whether risdiplam is excreted in human breast milk. Studies in rats show that risdiplam is excreted into milk (see section 5.3). As the potential for harm to the breastfed infant is unknown, it is recommended not to breastfeed during treatment.

Fertility

Male patients

Male fertility may be compromised while on treatment, based on nonclinical findings. In rat and monkey reproductive organs, sperm degeneration and reduced sperm numbers were observed (see section 5.3). Based on observations from animal studies, the effects on sperm cells are expected to be reversible upon discontinuation of risdiplam.

Male patients may consider sperm preservation prior to treatment initiation or after a treatment-free period of at least 4 months. Male patients who wish to father a child should stop treatment for a minimum of 4 months. Treatment may be re-started after conception.

Female patients

Based on nonclinical data (see section 5.3), an impact of risdiplam on female fertility is not expected.

4.7 Effects on ability to drive and use machines

Risdiplam has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

Summary of the safety profile

In infantile-onset SMA patients, the most common adverse reactions observed in risdiplam clinical studies were pyrexia (54.8%), rash (29.0%) and diarrhoea (19.4%).

In later-onset SMA patients, the most common adverse reactions observed in risdiplam clinical studies were pyrexia (21.7%), headache (20.0%), diarrhoea (16.7%), and rash (16.7%).

The adverse reactions listed above occurred without an identifiable clinical or time pattern and generally resolved despite ongoing treatment in infantile-onset and later-onset SMA patients.

Tabulated list of adverse reactions

The corresponding frequency category for each adverse drug reaction is based on the following convention: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1,000$), very rare ($< 1/10,000$), not known (cannot be estimated from the available data). Adverse drug reactions from clinical studies (Table 1) are listed by MedDRA system organ class.

Table 1. Adverse drug reactions occurring in patients with infantile-onset and later-onset SMA based on risdiplam clinical studies and postmarketing experience

System Organ Class	Infantile-onset SMA (Type 1)	Later-onset SMA (Type 2 and 3)
Infections and infestations		
Urinary tract infection (including cystitis)	Common	Common
Nervous system disorders		
Headache	Not applicable	Very common
Gastrointestinal disorders		
Diarrhoea	Very common	Very common
Nausea	Not applicable	Common
Mouth ulcerations and aphthous ulcers	Common	Common
Skin and subcutaneous tissue disorders		
Rash*	Very common	Very common
Cutaneous vasculitis**	Not known	
Musculoskeletal and connective tissue disorders		
Arthralgia	Not applicable	Common
General disorders and administration site conditions		
Pyrexia (including hyperpyrexia)	Very common	Very common

*Includes dermatitis, dermatitis acneiform, dermatitis allergic, erythema, folliculitis, rash, rash erythematous, rash maculo-papular, rash papular

**Cutaneous vasculitis was reported during post-marketing experience. Symptoms recovered after permanent discontinuation of risdiplam. The frequency cannot be estimated based on available data.

Safety profile in pre-symptomatic patients

Based on the primary analysis of RAINBOWFISH, the safety profile of Evrysdi in pre-symptomatic patients is consistent with the safety profile of symptomatic infantile-onset and later-onset SMA patients. The RAINBOWFISH study enrolled 26 patients with pre-symptomatic SMA between 16 and 41 days of age at the time of the first dose (weight range 3.1 to 5.7 kg). The median exposure duration was 20.4 months (range: 10.6 to 41.9 months). Limited post-marketing data are available in neonates <20 days of age.

Safety profile in patients previously treated with other SMA-modifying therapies

The safety profile of risdiplam in SMA treatment non-naïve patients (including those previously treated with nusinersen or with onasemnogene abeparvovec) is consistent with the safety profile in SMA treatment-naïve patients treated with risdiplam in the FIREFISH, SUNFISH and RAINBOWFISH clinical studies (see section 5.1).

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form: <https://sideeffects.health.gov.il/>

4.9 Overdose

There is no known antidote for overdosage of risdiplam. In the event of an overdose, the patient should be closely supervised and supportive care instituted.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other drugs for disorders of the musculo-skeletal system
ATC code: M09AX10

Mechanism of action

Risdiplam is a survival of motor neuron 2 (*SMN2*) pre-mRNA splicing modifier designed to treat SMA caused by mutations of the *SMN1* gene in chromosome 5q that lead to SMN protein deficiency. Functional SMN protein deficiency is directly linked to the SMA pathophysiology which includes progressive loss of motor neurons and muscle weakness. Risdiplam corrects the splicing of *SMN2* to shift the balance from exon 7 exclusion to exon 7 inclusion into the mRNA transcript, leading to an increased production of functional and stable SMN protein. Thus, risdiplam treats SMA by increasing and sustaining functional SMN protein levels.

Pharmacodynamic effects

In the studies FIREFISH (patients aged 2-7 months at enrolment), SUNFISH (patients aged 2-25 years at enrolment), and JEWELFISH (patients aged 1-60 years at enrolment) in infantile-onset SMA and later-onset SMA patients, risdiplam led to an increase in SMN protein in blood with a greater than 2-fold median change from baseline within 4 weeks of treatment initiation across all SMA types studied. The increase was sustained throughout the treatment period (of at least 24 months).

Cardiac electrophysiology

The effect of risdiplam on the QTc interval was evaluated in a study in 47 healthy adult subjects. At the therapeutic exposure, risdiplam did not prolong the QTc interval.

Clinical efficacy and safety

The efficacy of risdiplam for the treatment of SMA patients with infantile-onset (SMA Type 1) and later-onset SMA (SMA type 2 and 3) was evaluated in 2 pivotal clinical studies, FIREFISH and SUNFISH. Efficacy data of risdiplam for the treatment of pre-symptomatic SMA patients was evaluated in the RAINBOWFISH clinical study. Patients with a clinical diagnosis of Type 4 SMA have not been studied in clinical trials.

Infantile-onset SMA

Study BP39056 (FIREFISH) is an open-label, 2-part study to investigate the efficacy, safety, PK and pharmacodynamics (PD) of risdiplam in symptomatic Type 1 SMA patients (all patients had genetically confirmed disease with 2 copies of the *SMN2* gene). Part 1 of FIREFISH was designed as a dose-finding part of the study. The confirmatory Part 2 of the FIREFISH study assessed the efficacy of risdiplam. Patients from Part 1 did not take part in Part 2.

The key efficacy endpoint was the ability to sit without support for at least 5 seconds, as measured by Item 22 of the Bayley Scales of Infant and Toddler Development – Third Edition (BSID-III) gross motor scale, after 12 months of treatment.

FIREFISH Part 2

In FIREFISH Part 2, 41 patients with Type 1 SMA were enrolled. The median age of onset of clinical signs and symptoms of Type 1 SMA was 1.5 months (range: 1.0-3.0 months), 54% were female, 54% Caucasian and 34% Asian. The median age at enrolment was 5.3 months (range: 2.2-6.9 months) and the median time between onset of symptoms and first dose was 3.4 months (range: 1.0-6.0 months). At baseline, the median Children's Hospital of Philadelphia Infant Test for Neuromuscular Disease (CHOP-INTEND) score was 22.0 points (range: 8.0-37.0) and the median Hammersmith Infant Neurological Examination Module 2 (HINE-2) score was 1.0 (range: 0.0-5.0).

The primary endpoint was the proportion of patients with the ability to sit without support for at least 5 seconds after 12 months of treatment (BSID-III gross motor scale, Item 22). The key efficacy endpoints of risdiplam treated patients are shown in Table 2.

Table 2. Summary of key efficacy results at month 12 and month 24 (FIREFISH Part 2)

Efficacy Endpoints	Proportion of Patients N=41 (90% CI)	
	Month 12	Month 24
<u>Motor function and development milestones</u>		
BSID-III: sitting without support for at least 5 seconds	29.3% (17.8%, 43.1%) p <0.0001 ^a	61.0% (46.9%, 73.8%)
CHOP-INTEND: score of 40 or higher	56.1% (42.1%, 69.4%)	75.6% (62.2%, 86.1%)
CHOP-INTEND: increase of ≥ 4 points from baseline	90.2% (79.1%, 96.6%)	90.2% (79.1%, 96.6%)
HINE-2: motor milestone responders ^b	78.0% (64.8%, 88.0%)	85.4% (73.2%, 93.4%)
HINE-2: sitting without support ^c	24.4% (13.9%, 37.9%)	53.7% (39.8%, 67.1%)
<u>Survival and event-free survival</u>		
Event-free survival ^d	85.4% (73.4%, 92.2%)	82.9% (70.5%, 90.4%)
Alive	92.7% (82.2%, 97.1%)	92.7% (82.2%, 97.1%)
<u>Feeding</u>		
Ability to feed orally ^e	82.9% (70.3%, 91.7%)	85.4% (73.2%, 93.4%)

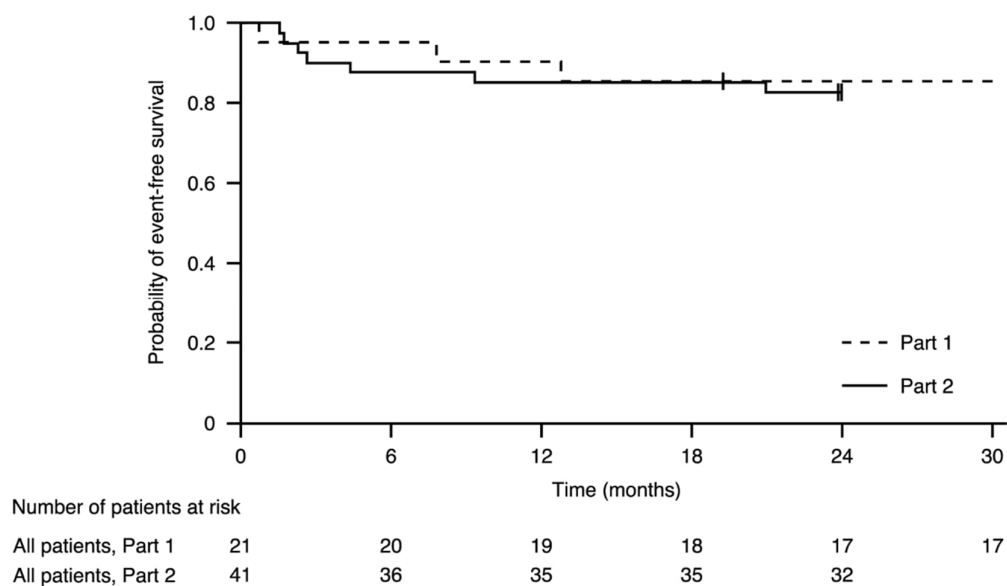
Abbreviations: CHOP-INTEND=Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders; HINE-2=Module 2 of the Hammersmith Infant Neurological Examination.

- ^a p-value is based on a one-sided exact binomial test. The result is compared to a threshold of 5%.
- ^b According to HINE-2: ≥ 2 point increase [or maximal score] in ability to kick, OR ≥ 1 point increase in the motor milestones of head control, rolling, sitting, crawling, standing or walking, AND improvement in more categories of motor milestones than worsening is defined as a responder for this analysis.
- ^c Sitting without support includes patients that achieved "stable sit" (24%, 10/41) and "pivots (rotates)" (29%, 12/41) as assessed by the HINE-2 at Month 24.
- ^d An event is meeting the endpoint of permanent ventilation defined as tracheostomy or ≥ 16 hours of non-invasive ventilation per day or intubation for > 21 consecutive days in the absence of, or following the resolution of, an acute reversible event. Three patients died within the first 3 months following study enrolment and 4 patients met the endpoint of permanent ventilation before Month 24. These 4 patients achieved an increase of at least 4 points in their CHOP-INTEND score from baseline.
- ^e Includes patients who were fed exclusively orally (29 patients overall) and those who were fed orally in combination with a feeding tube (6 patients overall) at Month 24.

At Month 24, 44% of patients achieved sitting without support for 30 seconds (BSID-III, Item 26). Patients continued to achieve additional motor milestones as measured by the HINE-2: 80.5% were able to roll, and 27% of patients achieved a standing measure (12% supporting weight and 15% standing with support).

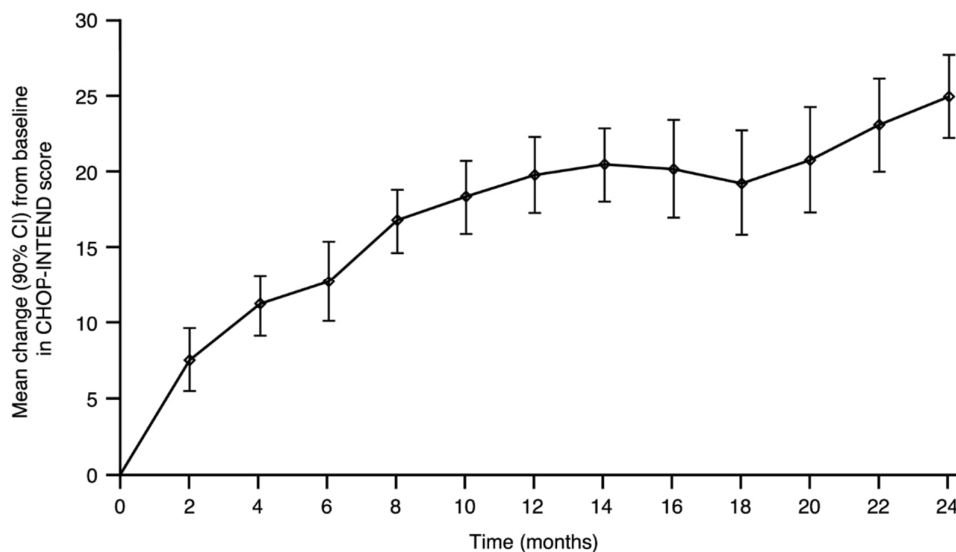
Untreated patients with infantile-onset SMA would never be able to sit without support and only 25% would be expected to survive without permanent ventilation beyond 14 months of age.

Figure 1. Kaplan-Meier plot of event-free survival (FIREFISH Part 1 and Part 2)



+ Censored: two patients in Part 2 were censored because the patients attended the Month 24 visit early, one patient in Part 1 was censored after discontinuing treatment and died 3.5 months later

Figure 2. Mean change from baseline in CHOP-INTEND total score (FIREFISH Part 2)



FIREFISH Part 1

The efficacy of risdiplam in Type 1 SMA patients is also supported by results from FIREFISH Part 1. For the 21 patients from Part 1, the baseline characteristics were consistent with symptomatic patients with Type 1 SMA. The median age at enrolment was 6.7 months (range: 3.3-6.9 months) and the median time between onset of symptoms and first dose was 4.0 months (range: 2.0-5.8 months).

A total of 17 patients received the therapeutic dose of risdiplam (dose selected for Part 2). After 12 months of treatment, 41% (7/17) of these patients were able to sit independently for at least 5 seconds (BSID-III, Item 22). After 24 months of treatment, 3 more patients receiving the therapeutic dose were able to sit independently for at least 5 seconds, leading to a total of 10 patients (59%) achieving this motor milestone.

After 12 months of treatment, 90% (19/21) of patients were alive and event-free (without permanent ventilation) and reached 15 months of age or older. After a minimum of 33 months of treatment, 81% (17/21) of patients were alive and event-free and reached an age of 37 months or older (median 41 months; range 37 to 53 months), see Figure 1. Three patients died during treatment and one patient died 3.5 months after discontinuing treatment.

Later Onset SMA

Study BP39055 (SUNFISH), is a 2-part, multicentre study to investigate the efficacy, safety, PK and PD of risdiplam in SMA Type 2 or Type 3 patients between 2-25 years of age. Part 1 was the exploratory dose-finding portion and Part 2 was the randomized, double-blind, placebo-controlled confirmatory portion. Patients from Part 1 did not take part in Part 2.

The primary endpoint was the change from baseline score at Month 12 on the Motor Function Measure-32 (MFM32). The MFM32 has the ability to assess a wide range of motor function across a broad range of SMA patients. The total MFM32 score is expressed as a percentage (range: 0-100) of the maximum possible score, with higher scores indicating greater motor function.

SUNFISH Part 2

SUNFISH Part 2 is the randomized, double-blinded, placebo-controlled portion of the SUNFISH study in 180 non-ambulant patients with Type 2 (71%) or Type 3 (29%) SMA. Patients were randomized with 2:1 ratio to receive either risdiplam at the therapeutic dose (see section 4.2) or placebo. Randomization was stratified by age group (2 to 5, 6 to 11, 12 to 17, 18 to 25 years old).

The median age of patients at the start of treatment was 9.0 years old (range 2-25 years old), the median time between onset of initial SMA symptoms to first treatment was 102.6 (1-275) months. Overall, 30% were 2 to 5 years of age, 32% were 6 to 11 years of age, 26% were 12-17 years of age, and 12% were 18 to 25 years of age at study enrolment. Of the 180 patients included in the study, 51% were female, 67% Caucasian and 19% Asian. At baseline, 67% of patients had scoliosis (32% of patients with severe scoliosis). Patients had a mean baseline MFM32 score of 46.1 and Revised Upper Limb Module (RULM) score of 20.1. The baseline demographic characteristics were balanced between risdiplam and placebo arms with the exception of scoliosis (63% of patients in the risdiplam arm and 73% of patients in the placebo control).

The primary analysis for SUNFISH Part 2, the change from baseline in MFM32 total score at Month 12, showed a clinically meaningful and statistically significant difference between patients treated with risdiplam and placebo. The results of the primary analysis and key secondary endpoints are shown in Table 3, Figure 3, and Figure 4.

Table 3. Summary of efficacy in patients with later-onset SMA at month 12 of treatment (SUNFISH Part 2)

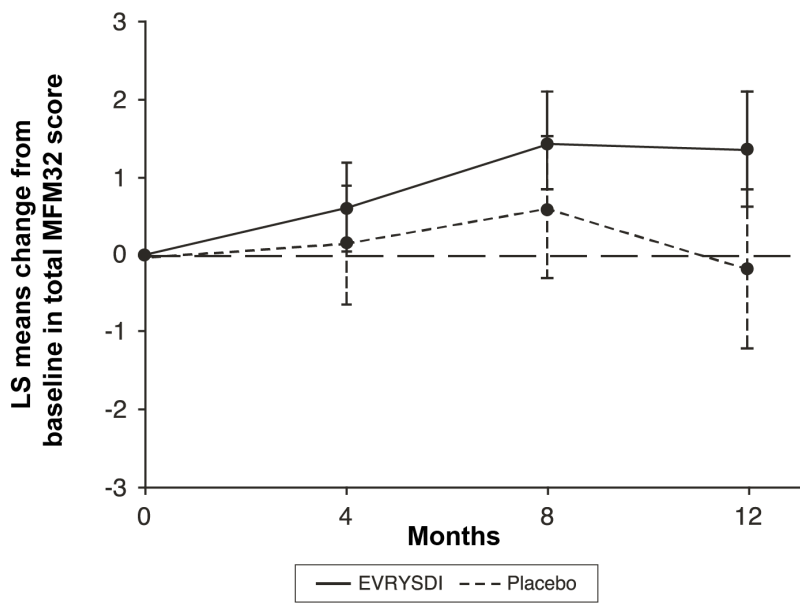
Endpoint	risdiplam (N = 120)	Placebo (N = 60)
Primary Endpoint:		
Change from baseline in MFM32 total score ¹ at Month 12 LS mean (95%, CI)	1.36 (0.61, 2.11)	-0.19 (-1.22, 0.84)
Difference from placebo Estimate (95% CI) p-value ²	1.55 (0.30, 2.81) 0.0156	
Secondary Endpoints:		
Proportion of patients with a change from baseline in MFM32 total score ¹ of 3 or more at Month 12 (95% CI) ¹	38.3% (28.9, 47.6)	23.7% (12.0, 35.4)
Odds ratio for overall response (95% CI) Adjusted(unadjusted) p-value ^{3,4}	2.35 (1.01, 5.44) 0.0469 (0.0469)	
Change from baseline in RULM total score ⁵ at Month 12 LS mean (95% CI)	1.61 (1.00, 2.22)	0.02 (-0.83, 0.87)
Difference from placebo estimate (95% CI) Adjusted (unadjusted) p-value ^{2,4}	1.59 (0.55, 2.62) 0.0469 (0.0028)	

LS=least squares

1. Based on the missing data rule for MFM32, 6 patients were excluded from the analysis (risdiplam n=115; placebo control n=59).
2. Data analysed using a mixed model repeated measure with baseline total score, treatment, visit, age group, treatment-by-visit and baseline-by-visit.
3. Data analysed using logistic regression with baseline total score, treatment and age group.
4. The adjusted p-value was obtained for the endpoints included in the hierarchical testing and was derived based on all the p-values from endpoints in order of the hierarchy up to the current endpoint
5. Based on the missing data rule for RULM, 3 patients were excluded from the analysis (risdiplam n=119; placebo control n=58).

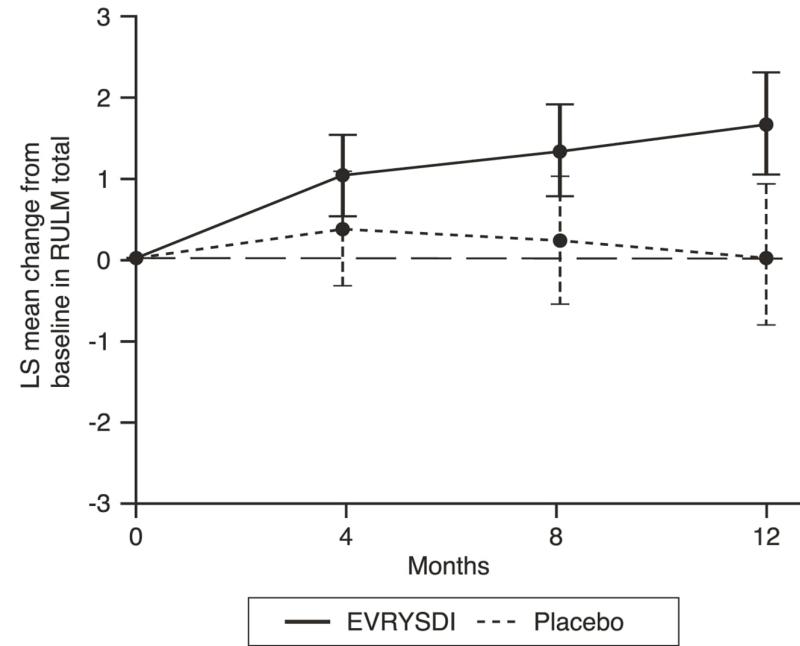
Upon completion of 12 months of treatment, 117 patients continued to receive risdiplam. At the time of the 24 month analysis, these patients who were treated with risdiplam for 24 months overall experienced maintenance of improvement in motor function between month 12 and month 24. The mean change from baseline for MFM32 was 1.83 (95% CI: 0.74, 2.92) and for RULM was 2.79 (95% CI: 1.94, 3.64).

Figure 3. Mean change from baseline in MFM32 total score over 12 months in SUNFISH Part 2¹



¹The least squares (LS) mean difference for change from baseline in MFM32 score [95% CI]

Figure 4. Mean change from baseline in RULM total score over 12 months in SUNFISH Part 2¹



¹The least squares (LS) mean difference for change from baseline in RULM score [95% CI]

SUNFISH Part 1

Efficacy in later-onset SMA patients was also supported by results from Part 1, the dose-finding part of SUNFISH. In Part 1, 51 patients with Type 2 and 3 SMA (including 7 ambulatory patients) between 2 to 25 years of age were enrolled. After 1 year of treatment there was a clinically meaningful improvement in motor function as measured by MFM32, with a mean change from baseline of 2.7 points (95% CI: 1.5, 3.8). The improvement in MFM32 was maintained up to 2 years on treatment (mean change of 2.7 points [95% CI: 1.2, 4.2]).

Use in patients previously treated with other SMA-modifying therapies (JEWELFISH)

Study BP39054 (JEWELFISH, n = 174) is a single arm, open-label study to investigate the safety, tolerability, PK and PD of risdiplam in patients with infantile-onset and later-onset SMA (median age 14 years [range 1-60 years]), who had previously received treatment with other approved (nusinersen n = 76, onasemnogene abeparvovec n = 14) or investigational SMA modifying therapies. At baseline, out of the 168 patients aged 2-60 years, 83% of patients had scoliosis and 63% had a Hammersmith Functional Motor Scale Expanded (HFMSSE) score < 10 points.

At the analysis at month 24 of treatment, patients 2-60 years of age showed overall stabilization in motor function in MFM-32 and RULM (n = 137 and n = 133, respectively). Patients less than 2 years (n = 6) maintained or gained motor milestones such as head control, rolling and sitting independently. All ambulatory patients (aged 5-46 years, n = 15) retained their ability to walk.

Pre-symptomatic SMA (RAINBOWFISH)

Study BN40703 (RAINBOWFISH) is an open-label, single-arm, multicenter clinical study to investigate the efficacy, safety, pharmacokinetics, and pharmacodynamics of risdiplam in infants from birth to 6 weeks of age (at first dose) who have been genetically diagnosed with SMA but do not yet present with symptoms.

The efficacy in pre-symptomatic SMA patients was evaluated at Month 12 in 26 patients [intent-to-treat (ITT) population] treated with risdiplam: eight patients, 13 patients, and 5 patients had 2, 3, and ≥ 4 copies of the *SMN2* gene, respectively. The median age of these patients at first dose was 25 days (range: 16 to 41 days), 62% were female, and 85% were Caucasian. At baseline, the median CHOP-INTEND score was 51.5 (range: 35.0 to 62.0), the median HINE-2 score was 2.5 (range: 0 to 6.0), and the median ulnar nerve compound muscle action potential (CMAP) amplitude was 3.6 mV (range: 0.5 to 6.7 mV).

The primary efficacy population (N=5) included patients with 2 *SMN2* copies and a baseline CMAP amplitude ≥ 1.5 mV. In these patients, the median CHOP-INTEND score was 48.0 (range: 36.0 to 52.0), the median HINE-2 score was 2.0 (range 1.0 to 3.0), and the median CMAP amplitude was 2.6 mV (range: 1.6 to 3.8 mV) at baseline.

The primary endpoint was the proportion of patients in the primary efficacy population with the ability to sit without support for at least 5 seconds (BSID-III gross motor scale, Item 22) at Month 12; a statistically significant and clinically meaningful proportion of patients achieved this milestone compared to the predefined performance criterion of 5%.

The key efficacy endpoints of risdiplam treated patients are shown in Table 4 and 5, and in Figure 5.

Table 4. Sitting ability as defined by BSID-III Item 22 for pre-symptomatic patients at Month 12

Efficacy Endpoint	Population		
	Primary Efficacy (N=5)	Patients with 2 <i>SMN2</i> copies ^a (N=8)	ITT (N=26)
Proportion of patients sitting without support for at least 5 seconds (BSID-III, Item 22); (90% CI)	80% (34.3%, 99.0%) $p < 0.0001^b$	87.5% (52.9%, 99.4%)	96.2% (83.0%, 99.8%)

Abbreviations: BSID-III = Bayley Scales of Infant and Toddler Development – Third Edition; CI=Confidence Interval; ITT=Intent-to-treat.

^a Patients with 2 *SMN2* copies had a median CMAP amplitude of 2.0 (range 0.5 – 3.8) at baseline.

^b p-value is based on a one-sided exact binomial test. The result is compared to a threshold of 5%.

Additionally, 80% (4/5) of the primary efficacy population, 87.5% (7/8) of patients with 2 *SMN2* copies, and 80.8% (21/26) of patients in the ITT population achieved sitting without support for 30 seconds (BSID-III, Item 26).

Patients in the ITT population also achieved motor milestones as measured by the HINE-2 at Month 12 (N=25). In this population 96.0% of patients could sit [1 patient (1/8 patients with 2 *SMN2* copies) achieved stable sit and 23 patients (6/8, 13/13, 4/4 of patients with 2, 3, and ≥ 4 *SMN2* copies, respectively) could pivot/rotate]. In addition, 84% of patients could stand; 32% (N=8) patients could stand with support (3/8, 3/13 and 2/4 patients with 2, 3, and ≥ 4 *SMN2* copies, respectively) and 52% (N=13) patients could stand unaided (1/8, 10/13 and 2/4 of patients with 2, 3, and ≥ 4 *SMN2* copies, respectively). Furthermore, 72% of patients could bounce, cruise or walk; 8% (N=2) patients could bounce (2/8 patients with 2 *SMN2* copies), 16% (N=4) could cruise (3/13 and 1/4 patients with 3 and ≥ 4 *SMN2* copies, respectively) and 48% (N=12) could walk independently (1/8, 9/13 and 2/4 patients with 2, 3, and ≥ 4 *SMN2* copies, respectively). Seven patients were not tested for walking at Month 12.

Table 5. Summary of key efficacy endpoints for pre-symptomatic patients at Month 12

Efficacy Endpoints	ITT population (N=26)
<u>Motor Function</u>	
Proportion of patients who achieve a Total score of 50 or higher in the CHOP-INTEND (90 CI%)	92% ^a (76.9%, 98.6%)
Proportion of patients who achieve a Total score of 60 or higher in the CHOP-INTEND (90 CI%)	80% ^a (62.5%, 91.8%)
<u>Feeding</u>	
Proportion of patients with the ability to feed orally (90 CI%)	96.2% ^b (83.0%, 99.8%)
<u>Healthcare Utilization</u>	
Proportion of patients with no hospitalisations ^c (90 CI%)	92.3% (77.7%, 98.6%)
<u>Event-Free Survival^d</u>	
Proportion of patients with Event-Free Survival (90 CI%)	100% (100%, 100%)

Abbreviations: CHOP-INTEND=Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders; CI=Confidence Interval

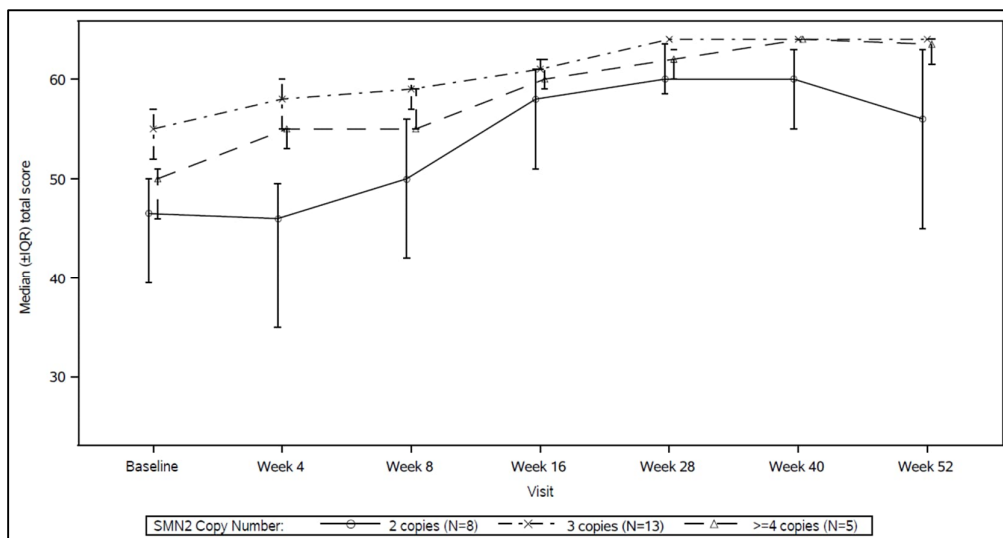
^a Based on N=25

^b One patient was not assessed.

^c Hospitalisations include all hospital admissions which spanned at least two days, and which are not due to study requirements.

^d An event refers to death or permanent ventilation; permanent ventilation is defined as tracheostomy or ≥16 hours of non-invasive ventilation per day or intubation for > 21 consecutive days in the absence of, or following the resolution of, an acute reversible event.

Figure 5. Median Total CHOP-INTEND Scores by Visit and SMN2 copy number (ITT population)



Abbreviations: IQR = Interquartile range; SMN2 = Survival of Motor Neuron 2.

5.2 Pharmacokinetic properties

Pharmacokinetic parameters have been characterised in healthy adult subjects and in patients with SMA.

After administration of treatment as an oral solution, PK of risdiplam were approximately linear between 0.6 and 18 mg. Risdiplam's PK was best described by a population PK model with three-transit-compartment absorption, two-compartment disposition and first-order elimination. Body weight and age were found to have significant effect on the PK.

The estimated exposure (mean AUC_{0-24h}) for infantile-onset SMA patients (age 2-7 months at enrolment) at the therapeutic dose of 0.2 mg/kg once daily was 1930 ng.h/mL. The estimated mean exposure in pre-symptomatic infants (16 days to <2 months of age) in the RAINBOWFISH study was 2020 ng.h/mL at 0.15 mg/kg after 2 weeks once daily administration. The estimated exposure for later-onset SMA patients (2-25 years old at enrolment) in the SUNFISH (Part 2) study at the therapeutic dose (0.25 mg/kg once daily for patients with a body weight <20 kg; 5 mg once daily for patients with a body weight ≥ 20 kg) was 2070 ng.h/mL after 1 year of treatment and 1940 ng.h/mL after 5 years of treatment. The estimated exposure (mean AUC_{0-24h}) for SMA treatment non-naïve patients (age 1-60 years at enrolment) was 1700 ng.h/mL at the therapeutic dose of 0.25 mg/kg or 5 mg. The observed maximum concentration (mean C_{max}) was 194 ng/mL at 0.2 mg/kg in FIREFISH, 140 ng/mL in SUNFISH Part 2, 129 ng/mL in JEWELFISH, and the estimated maximum concentration at 0.15 mg/kg in RAINBOWFISH is 111 ng/mL.

Absorption

Risdiplam was rapidly absorbed in the fasted state with a plasma t_{max} ranging from 2 to 4.5 hours after oral administration of the film-coated tablet swallowed whole or dispersed in water. Risdiplam exposure after administration of the film-coated tablet swallowed whole or dispersed in water was bioequivalent to the powder for oral solution. Food (high-fat, high calorie breakfast) had no relevant effect on the exposure of risdiplam. In the clinical studies, risdiplam was administered with a morning meal or after breastfeeding.

Distribution

Risdiplam distributes evenly to all parts of the body, including the central nervous system (CNS) by crossing the blood brain barrier, and thereby leading to SMN protein increase in the CNS and throughout the body. Concentrations of risdiplam in plasma and SMN protein in blood reflect its distribution and pharmacodynamic effects in tissues such as brain and muscle.

The population pharmacokinetic parameter estimates were 98 L for the apparent central volume of distribution, 93 L for the peripheral volume, and 0.68 L/hour for the inter-compartment clearance.

Risdiplam is predominantly bound to serum albumin, without any binding to alpha-1 acid glycoprotein, with a free fraction of 11%.

Biotransformation

Risdiplam is primarily metabolized by FMO1 and FMO3, and also by CYPs 1A1, 2J2, 3A4 and 3A7.

Co-administration of 200 mg itraconazole twice daily, a strong CYP3A inhibitor, with a single oral dose of 6 mg risdiplam showed no clinically relevant effect on the PK of risdiplam (11% increase in AUC, 9% decrease in C_{max}).

Elimination

Population PK analyses estimated an apparent clearance (CL/F) of 2.6 L/h for risdiplam. The effective half-life of risdiplam was approximately 50 hours in SMA patients.

Risdiplam is not a substrate of human multidrug resistance protein 1 (MDR1).

Approximately 53% of the dose (14% unchanged risdiplam) was excreted in the feces and 28% in urine (8% unchanged risdiplam). Parent drug was the major component found in plasma, accounting for 83% of drug related material in circulation. The pharmacologically inactive metabolite M1 was identified as the major circulating metabolite.

Pharmacokinetics in special populations

Paediatric population

Body weight and age were identified as covariates in the population PK analysis. On the basis of such model, the dose is therefore adjusted based on age (below and above 2 months and 2 years) and body weight (up to 20 kg) to obtain similar exposure across the age and body weight range. Limited PK data are available in patients less than 20 days of age, since only one 16-day-old neonate received risdiplam at a lower dose (0.04 mg/kg) in clinical studies.

Elderly population

No dedicated studies have been conducted to investigate PK in patients with SMA above 60 years of age. Subjects without SMA up to 69 years of age were included in the clinical PK studies, which indicates that no dose adjustment is required for patients up to 69 years of age.

Renal impairment

No studies have been conducted to investigate the PK of risdiplam in patients with renal impairment. Elimination of risdiplam as unchanged entity via renal excretion is minor (8%).

Hepatic impairment

Mild and moderate hepatic impairment had no significant impact on the PK of risdiplam. After a single oral administration of 5 mg risdiplam, the mean ratios for C_{max} and AUC were 0.95 and 0.80 in mild (n=8) and 1.20 and 1.08 in moderate hepatic impaired subjects (n=8) versus matched healthy controls (n=10). The safety and PK in patients with severe hepatic impairment have not been studied.

Ethnicity

The PK of risdiplam do not differ in Japanese and Caucasian subjects.

5.3 Preclinical safety data

Impairment of fertility

Treatment with risdiplam was associated with male germ cell arrest in rats and monkeys without safety margins based on systemic exposures at the no observed adverse effect level (NOAEL). These effects led to degenerated spermatocytes, degeneration/necrosis of the seminiferous epithelium, and oligo/azpermia in the epididymis. Sperm cell effects of risdiplam are likely related to an interference of risdiplam with the cell cycle of dividing cells, which is stage specific and expected to be reversible. No effects were seen on female reproductive organs in rats and monkeys after treatment with risdiplam.

No fertility and early embryonic development studies were conducted with concomitant administration of risdiplam, as sperm cell arrest and embryotoxic potential under treatment was already identified with treatment of rats and monkeys in other toxicity studies. No impairment on male fertility or female

fertility was observed in two studies in which rats were mated, either following completion of a 13-week treatment period starting at weaning, or 8 weeks after completion of a 4-week treatment period starting at 4 days of age.

Effect on retinal structure

Chronic treatment of monkeys with risdiplam yielded evidence for an effect on the retina in terms of photoreceptor degeneration starting in the periphery of the retina. Upon cessation of treatment, the effects on the retinogram were partially reversible but the photoreceptor degeneration did not reverse. The effects were monitored by optical coherence tomography (OCT) and by electroretinography (ERG). Effects were seen with exposures in excess of 2-fold the exposure in humans at the therapeutic dose without safety margin based on systemic exposures at the NOAEL. No such findings were observed in albino or pigmented rats when dosed chronically with risdiplam at exposures exceeding those in the monkey. Such findings have not been observed in clinical trials in SMA patients with regular ophthalmological monitoring (including SD OCT and visual function assessment).

Effect on epithelial tissues

Effects on skin, larynx and eyelid histology and the gastro intestinal tract were evident in rats and monkeys treated with risdiplam. Changes started to be seen at high doses with treatment of 2 weeks and longer. With chronic treatment for 39 weeks in monkeys, the NOAEL was at an exposure in excess of 2-fold the average exposure in humans at the therapeutic dose.

Effect on haematological parameters

In the acute bone marrow micronucleus test in rats, a reduction of more than 50% in the ratio of polychromatic (young) to normochromatic (adult) erythrocytes, indicative of substantial bone marrow toxicity, was observed at the high dose level with exposure in excess of 15-times the average exposure in humans at the therapeutic dose. With longer treatment of rats for 26 weeks, the exposure margins to the NOAEL were approximately 4-fold the average exposure in humans at the therapeutic dose.

Genotoxicity

Risdiplam is not mutagenic in a bacterial reverse mutation assay. In mammalian cells in vitro and in bone marrow of rats, risdiplam increases the frequency of micronucleated cells. Micronucleus induction in bone marrow was observed in several toxicity studies in rats (adult and juvenile animals). The NOAEL across the studies is associated with an exposure of approximately 1.5-fold the exposure in humans at the therapeutic dose. Data indicated that this effect is indirect and secondary to an interference of risdiplam with the cell cycle of dividing cells. Risdiplam does not possess a potential to damage DNA directly.

Reproductive toxicity

In studies in pregnant rats treated with risdiplam, embryofoetal toxicity with lower fetal weight and delayed development was evident. The NOAEL for this effect was approximately 2-fold above the exposure levels reached at the therapeutic dose of risdiplam in patients. In studies with pregnant rabbits, dysmorphogenic effects were observed at exposures also associated with maternal toxicity. These consisted of four fetuses (4%) from 4 litters (22%) with hydrocephaly. The NOAEL was approximately 4-fold the exposure levels reached at the therapeutic dose of risdiplam in patients. In a pre- and post-natal development study in rats treated daily with risdiplam, risdiplam caused a slight delay in gestation length. Studies in pregnant and lactating rats showed that risdiplam crosses the placental barrier and is excreted into milk.

Carcinogenicity

Risdiplam did not reveal a carcinogenic potential in transgenic rasH2 mice over 6 months and in a 2 year study in rats at equivalent exposures to those in humans receiving the maximum recommended human dose (MRHD). Significantly increased tumours of the preputial gland in male rats and clitoral gland in female rats at 4 times the exposure of the MRHD are without human relevance, because both are rodent-specific organs.

Juvenile animal studies

Juvenile animal data reveal no special hazard for humans.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

microcrystalline cellulose
mannitol
crospovidone
sodium stearyl fumarate
tartaric acid
silica, colloidal anhydrous
strawberry flavour

Film-coat

polyvinyl alcohol
titanium dioxide
macrogol 3350
talc
yellow iron oxide

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

The expiry date of the product is indicated on the packaging materials

6.4 Special precautions for storage

Film-coated tablets

Do not store above 30°C. Store in the original package in order to protect from moisture.

6.5 Nature and contents of container

Evrysdi film-coated tablets are available in aluminium/aluminium perforated unit-dose blisters containing 7 film-coated tablets. Pack size of 28 x 1 film-coated tablets (4 blisters of 7 x 1 tablets).

6.6 Special precautions for disposal and other handling

Refer to the Instructions for Use at the end of the package leaflet for full details on preparation and administration of the Evrysdi film-coated tablets.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MARKETING AUTHORISATION HOLDER

Roche Pharmaceuticals (Israel) Ltd., P.O.Box 6391 Hod Hasharon 4524079.

8. MARKETING AUTHORISATION NUMBER(S)

180-15-38450-99

9. MANUFACTURER

F. Hoffmann-La Roche Ltd., Basel, Switzerland

Revised in August 2026