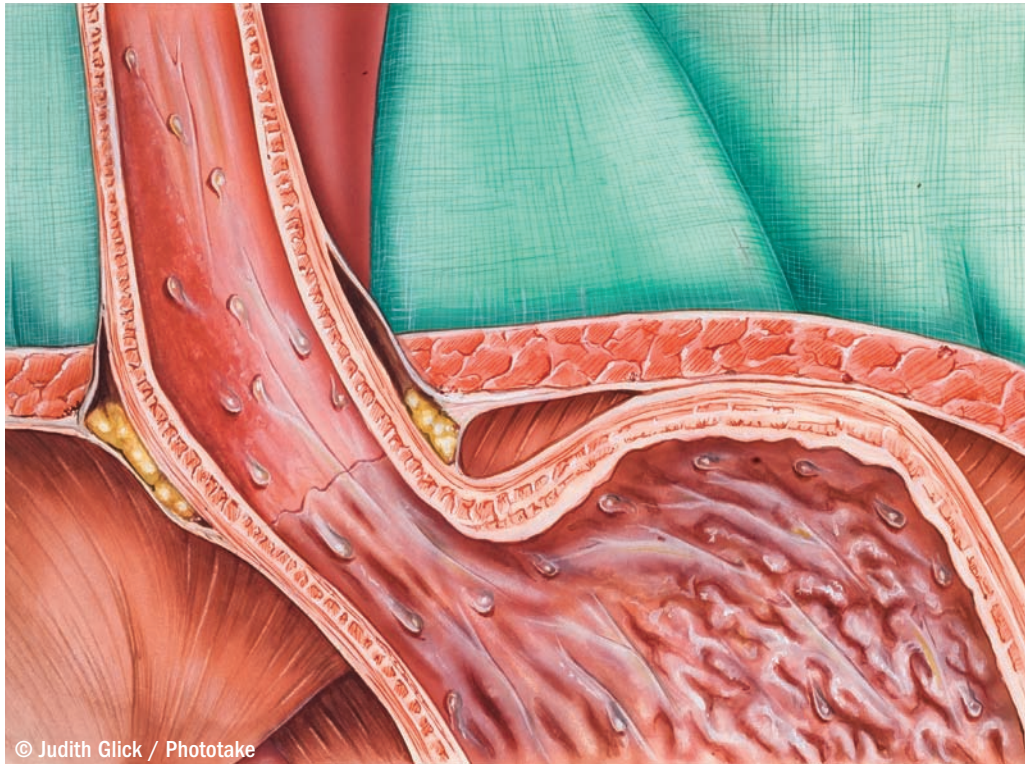




Pharmacist[®]

PRODUCT INFORMATION GUIDE



Dexilant (dexlansoprazole) Delayed Release Capsules in the Treatment of Gastroesophageal Reflux Disease (GERD)

Important Safety Information: Symptomatic response with DEXILANT does not preclude the presence of gastric malignancy. Long-term and multiple daily dose PPI therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine. Most commonly reported treatment-emergent adverse reactions: diarrhea (4.8%), abdominal pain (4.0%), nausea (2.9%), upper respiratory tract infection (1.9%), vomiting (1.6%), and flatulence (1.6%).

Please see page 6 for Important Safety Information

SPECIAL ADVERTISING SECTION

This product information guide is funded by Takeda Pharmaceuticals North America, Inc.

LPD-01614

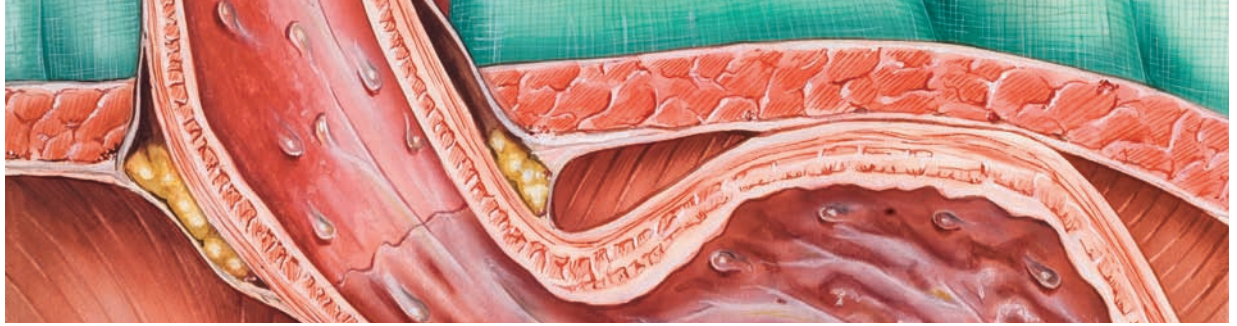
Resources on Gastroesophageal Reflux Disease and Erosive Esophagitis

American Gastroenterological Association
4930 Del Ray Avenue
Bethesda, MD 20814
Phone: 301-654-2055
Web: www.gastro.org

National Digestive Diseases Information Clearinghouse
2 Information Way
Bethesda, MD 20892
Phone: 800-891-5389
Web: www.digestive.niddk.nih.gov

American College of Gastroenterology
PO Box 342260
Bethesda, MD 20827
Phone: 301-263-9000
Web: www.acg.gi.org

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Definition

Gastroesophageal reflux disease (GERD) is a condition caused by malfunction of the body's mechanisms to protect the esophagus from abnormal reflux of stomach contents. This reflux may cause painful symptoms of heartburn and erosions, damage to the esophageal tissues known as *erosive esophagitis*.^{1,2} GERD may be diagnosed when symptoms are persistent, with or without damage to the esophagus.^{1,2}

GERD is the most common gastrointestinal (GI) condition diagnosed in ambulatory care in the United States.³ Significant health care–related costs are attributed to GERD, including the cost of nearly 65 million prescriptions and over 18 million ambulatory medical visits.³

Pathophysiology

GERD is thought to arise from a number of inter-related pathologies rather than a single mechanism. A key finding in patients with GERD is abnormal relaxation of the lower esophageal sphincter (LES), which allows stomach contents to reflux into the esophagus.¹ Hiatal hernia may be present in some patients with GERD.¹ Abnormal clearance of stomach contents after reflux may also be a mechanism for GERD symptoms.¹ Some gastroesophageal reflux is normal. GERD, however, is a complex disease process, characterized by a disruption in the body's mechanisms to protect the esophagus from reflux of acid and other gastric contents.¹

Diagnosis

GERD may be diagnosed when heartburn or acid regurgitation persists after patients change diet and lifestyle habits. Health care professionals often make a clinical diagnosis of GERD based on a set of highly specific symptoms: Heartburn and/or regurgitation that (a) occur after meals, (b) worsen with recumbancy or bending over, and (c) are relieved by antacids.⁴ To detect the presence and extent of erosive disease in GERD, upper endoscopy is the clinical standard.¹ Monitoring of esophageal pH

may also be used to determine the extent and pattern of acid reflux.⁴

Treatment

Lifestyle modification is generally the first strategy to reduce acid reflux and heartburn symptoms. The American College of Gastroenterology GERD treatment guidelines include recommendations for elevating the head of the patient's bed, reducing fat intake, quitting smoking, and not lying down for 3 hours after eating.⁴ Avoidance of certain foods, such as chocolate, alcohol, peppermint, onions, and garlic, may also reduce symptoms.⁴

Neutralization or suppression of acid to reduce acidity in the stomach is the primary pharmacologic treatment strategy for GERD. The treatment goal is to reduce symptoms and heal esophageal damage associated with reflux.⁴ Antacids (sodium bicarbonate, calcium carbonate, magnesium or aluminum hydroxide) are typically available over the counter and are widely used for rapid relief of occasional heartburn.⁴ Antacids, which work mainly by buffering acid for short periods of time, are an over-the-counter option for mild symptoms.¹

Two classes of pharmacological agents are used to suppress production of stomach acid through actions on the parietal cells: H₂-receptor antagonists (H₂RAs) and proton-pump inhibitors (PPIs). These agents are available by prescription and in over-the-counter formulations.⁴

H₂RAs (cimetidine, ranitidine, famotidine, and nizatidine) interact with the histamine-2 receptor on parietal cells, blocking one of the three pathways that lead to activation of the H⁺/K⁺-ATPase proton pump and secretion of gastric acid. H₂RAs are effective at reducing heartburn symptoms in patients with GERD.¹

PPIs (dexlansoprazole, omeprazole, esomeprazole, lansoprazole, rabeprazole, and pantoprazole) interact directly with the parietal cell proton pump and inhibit gastric acid secretion.¹ PPIs bind to proton pumps that are secreting acid at the time.¹ PPIs provide effective treatment for patients with GERD.

**Mean plasma concentration
(in healthy subjects; day 5)⁵**

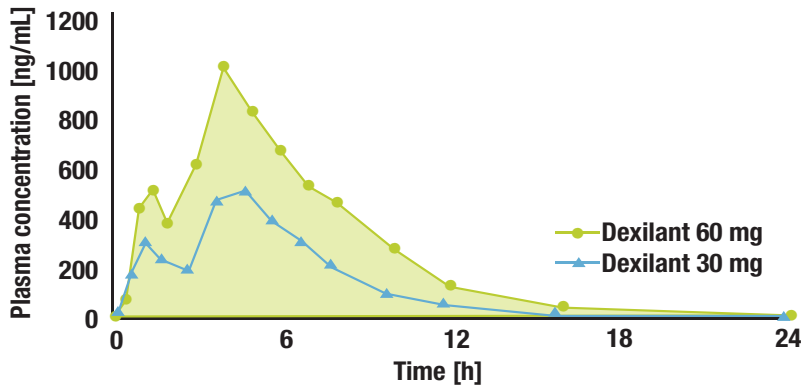


Figure 1. The Dual Delayed Release (DDR) formulation provides a second release of drug.

THE CORRELATION OF THESE DATA TO CLINICAL OUTCOMES HAS NOT BEEN DIRECTLY ESTABLISHED.

do not resolve under post-fed conditions.⁵

Clinical Pharmacology: DEXILANT (dexlansoprazole) is the R-enantiomer of lansoprazole. Lansoprazole is a racemic mixture of R- and S-enantiomers. Dexlansoprazole is an oral PPI that inhibits gastric acid secretion by specific inhibition of the H⁺/K⁺-ATPase proton pump in the parietal cells.⁵

DEXILANT has a formulation with two different enteric-coated granules that provide dual release of dexlansoprazole. DEXILANT is the first and only acid-reflux disease treat-

ment that gives two releases of drug in one pill. The clinical relevance of this statement is unknown.⁵

Focus on DEXILANT

DEXILANT is indicated for healing of all grades of erosive esophagitis, for maintaining healing of erosive esophagitis, and for treating heartburn associated with symptomatic nonerosive GERD.⁵

Dosage and Administration: DEXILANT is available as capsules in 30-mg and 60-mg strengths for adult use. The recommended treatment for symptomatic non-erosive GERD is 30 mg once daily for 4 weeks. For healing of erosive esophagitis, the recommended dosage is 60 mg once daily for up to 8 weeks. For maintenance of healing of erosive esophagitis, the recommended treatment is 30 mg once daily. Controlled studies did not extend beyond 6 months for this indication. DEXILANT 30 mg should be considered for patients with moderate hepatic impairment.⁵

DEXILANT can be taken without regard to food. DEXILANT capsules should be swallowed whole. Alternatively, capsules can be opened, sprinkled on 1 tablespoon of applesauce, and swallowed immediately. Granules should not be chewed. Do not store for later use.⁵ Some patients may benefit from administering the dose before a meal if post-meal symptoms

Pharmacokinetic and Pharmacodynamic Profile: The Dual Delayed Release formulation of DEXILANT provides two releases of drug that result in a dexlansoprazole plasma time-concentration profile with two distinct peaks. The first peak occurs 1 to 2 hours after oral administration and the second within 4 to 5 hours (FIGURE 1).⁵ After dosing of 30 or 60 mg daily, C_{max} and AUC values increase approximately dose proportionally.⁵ The correlation of these pharmacokinetic data to clinical outcomes has not been directly established.

Food-effect studies in healthy subjects showed that fed conditions increased C_{max} from 12% to 55% compared to fasting. Increases in AUC ranged from 9% to 37%, and effects on t_{max} varied from a decrease of 0.7 hours to an increase of 3 hours. No significant differences in median intragastric pH were observed.⁵

In a multiple-dose crossover clinical trial conducted in healthy subjects, treatment with 60-mg DEXILANT for 5 days resulted in maintenance of intragastric pH at >4 for 17 hours, or 71% of the 24-hour measuring period, compared with 14 hours,

Important Safety Information: Symptomatic response with DEXILANT does not preclude the presence of gastric malignancy. Long-term and multiple daily dose PPI therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine. Most commonly reported treatment-emergent adverse reactions: diarrhea (4.8%), abdominal pain (4.0%), nausea (2.9%), upper respiratory tract infection (1.9%), vomiting (1.6%), and flatulence (1.6%).

Please see additional Important Safety Information on Page 6.

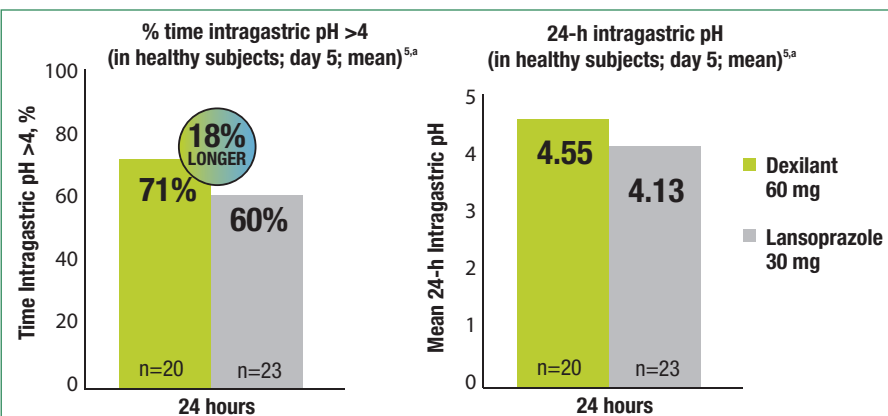


Figure 2. DEXILANT effectively maintains intragastric pH >4.

^aThe effects of Dexilant 60 mg or lansoprazole 30 mg once daily for 5 days on 24-hour intragastric pH in healthy subjects in a multiple-dose crossover study.

THE CORRELATION OF THESE DATA TO CLINICAL OUTCOMES HAS NOT BEEN DIRECTLY ESTABLISHED.

or 60%, with 30-mg lansoprazole; that is 18% longer with DEXILANT (FIGURE 2).⁵

Efficacy and Safety: A randomized, multicenter, placebo-controlled, double-blind crossover study was conducted in patients diagnosed with symptomatic, endoscopically confirmed nonerosive GERD. During the 4-week trial, patients who received 30-mg DEXILANT had significantly more symptom-free 24-hour periods than patients who received placebo ($P < .00001$).^{5,6}

In addition, more patients who received DEXILANT 30 mg experienced 24-hour relief as early as the first 3 days of treatment (on Day 3, DEXILANT [n = 291]: 38%; placebo [n = 291]: 15%), and this pattern was sustained throughout the treatment period (on Day 28, DEXILANT [n = 132]: 63%; placebo [n = 110]: 40%).^{5,6}

The efficacy of DEXILANT for healing of erosive esophagitis was evaluated in two random-

ized, multicenter, controlled studies that included more than 1,300 patients each with endoscopically confirmed erosive esophagitis. In patients with at least one post-baseline endoscopy, DEXILANT provided effective healing of erosive esophagitis in 70% and 66% of patients after 4 weeks, and in 87% and 85% of patients after 8 weeks (the primary efficacy endpoint) of treatment in the respective studies (FIGURE 3). Based on crude rate estimates,

patients who did not have endoscopically documented healed erosive esophagitis and prematurely discontinued were not considered healed. Differences between DEXILANT and lansoprazole were significant in Study 2 ($P = .004$).^{5,6}

Finally, the efficacy of DEXILANT for maintaining healing of erosive esophagitis was evaluated in

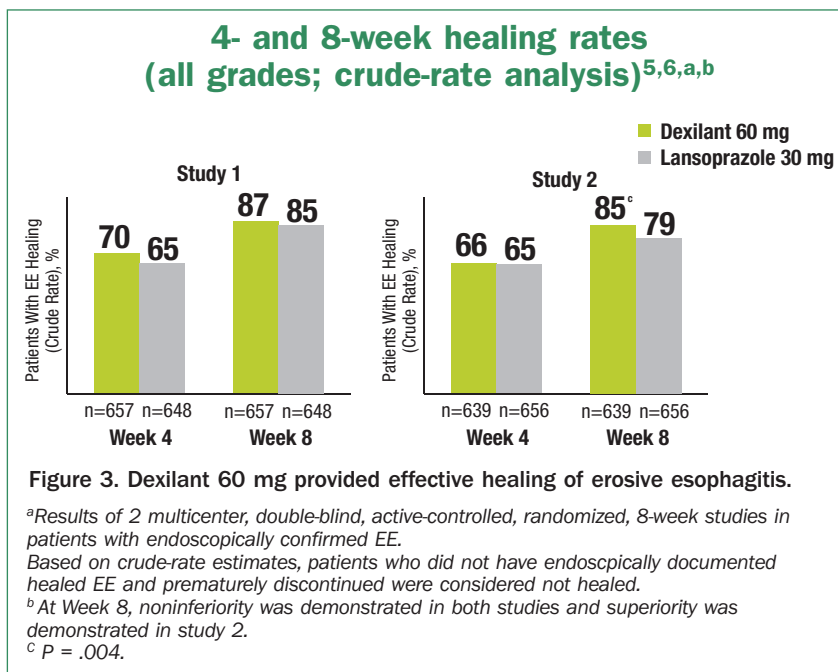


Figure 3. Dexilant 60 mg provided effective healing of erosive esophagitis.

^aResults of 2 multicenter, double-blind, active-controlled, randomized, 8-week studies in patients with endoscopically confirmed EE.

Based on crude-rate estimates, patients who did not have endoscopically documented healed EE and prematurely discontinued were considered not healed.

^bAt Week 8, noninferiority was demonstrated in both studies and superiority was demonstrated in study 2.

^c $P = .004$.

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Please see additional Important Safety Information on Page 6.

patients who had successfully completed a phase III clinical trial of erosive esophagitis and had endoscopically confirmed healing of erosive esophagitis. In a randomized, placebo-controlled, double-blind, 6-month clinical trial, patients received 30-mg DEXILANT (n = 125) or placebo (n = 119). Based on crude-rate analysis, 66% of patients who received DEXILANT had maintained healing of their esophageal erosions for 6 months, compared with 14% of those receiving placebo who were still healed ($P \leq .00001$) (FIGURE 4).^{5,6} ◆

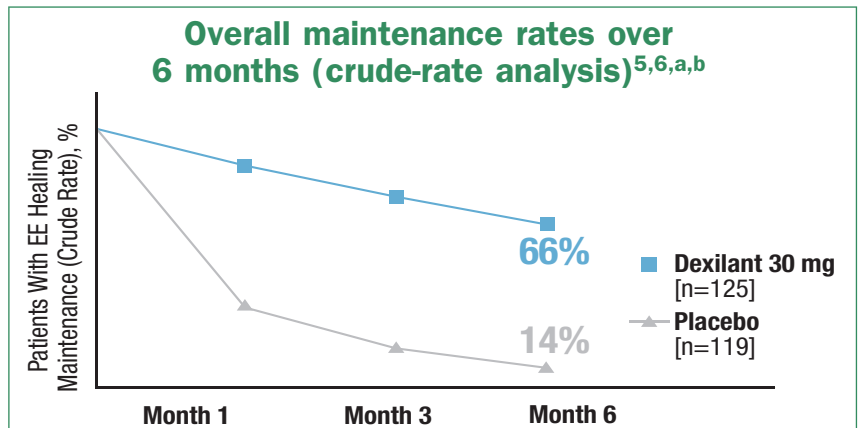


Figure 4. Two-thirds of healed patients remained healed at 6 months.

^a Results of a 6-month, multicenter, double-blind, placebo-controlled, randomized study in patients who successfully completed a phase 3 EE study and showed endoscopically confirmed healed EE. Based on crude-rate estimates, patients who did not have endoscopically documented relapse and prematurely discontinued were considered to have relapsed.
^b $P \leq .00001$.

Important Safety Information for DEXILANT (dexlansoprazole) 30 mg and 60 mg Delayed Release Capsules

The safety and tolerability profile of DEXILANT has been found to be similar to that of lansoprazole in clinical trials, which have included more than 6,000 patients.⁶

- DEXILANT is contraindicated in patients with known hypersensitivity to any component of the formulation. Hypersensitivity and anaphylaxis have been reported with DEXILANT use.
- Symptomatic response with DEXILANT does not preclude the presence of gastric malignancy.
- Long-term and multiple daily dose PPI therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine. Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated.
- Most commonly reported treatment-emergent adverse

reactions: diarrhea (4.8%), abdominal pain (4.0%), nausea (2.9%), upper respiratory tract infection (1.9%), vomiting (1.6%), and flatulence (1.6%).

- Do not co-administer atazanavir with DEXILANT because atazanavir systemic concentrations may be substantially decreased. DEXILANT may interfere with absorption of drugs for which gastric pH is important for bioavailability (e.g., ampicillin esters, digoxin, iron salts, ketoconazole). Patients taking concomitant warfarin may require monitoring for increases in international normalized ratio (INR) and prothrombin time. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Concomitant tacrolimus use may increase tacrolimus whole blood concentrations. ◆

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4. DeVault KE, Castell DO. Updated guidelines for the diagnosis and treatment of gastroesophageal reflux disease. *Am J Gastroenterol*. 2005;100:190-200.
5. DEXILANT (dexlansoprazole) prescribing information. Deerfield, IL: Takeda Pharmaceuticals America, Inc; 2010.
6. Data on file, Takeda Pharmaceuticals North America, Inc.

Important Safety Information: Symptomatic response with DEXILANT does not preclude the presence of gastric malignancy. Long-term and multiple daily dose PPI therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine. Most commonly reported treatment-emergent adverse reactions: diarrhea (4.8%), abdominal pain (4.0%), nausea (2.9%), upper respiratory tract infection (1.9%), vomiting (1.6%), and flatulence (1.6%).

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use DEXILANT safely and effectively. See full prescribing information for DEXILANT.

DEXILANT (dexlansoprazole) delayed release capsules

Initial U.S. Approval: 1995 (lansoprazole)

RECENT MAJOR CHANGES

Dosage and Administration

- Important Administration Information (2.3) 06/2010

Warnings and Precautions

- Bone Fracture (5.2) 08/2010

INDICATIONS AND USAGE

DEXILANT is a proton pump inhibitor (PPI) indicated for:

- Healing of all grades of erosive esophagitis (EE). (1.1)
- Maintaining healing of EE. (1.2)
- Treating heartburn associated with symptomatic non-erosive gastroesophageal reflux disease (GERD). (1.3)

DOSAGE AND ADMINISTRATION

- Healing of EE: 60 mg once daily for up to 8 weeks. (2.1)
- Maintenance of healed EE: 30 mg once daily for up to 6 months. (2.1)
- Symptomatic non-erosive GERD: 30 mg once daily for 4 weeks. (2.1)
- Hepatic impairment: Consider 30 mg maximum daily dose for patients with moderate hepatic impairment (Child-Pugh Class B). No studies were conducted in patients with severe hepatic impairment (Child-Pugh Class C). (2.2, 8.7)
- DEXILANT can be taken without regard to food. (2.3)
- DEXILANT should be swallowed whole. Alternatively, capsules can be opened, sprinkled on one tablespoon of applesauce, and swallowed immediately. (2.3)

DOSAGE FORMS AND STRENGTHS

Capsules: 30 mg and 60 mg. (3)

CONTRAINDICATIONS

Patients with known hypersensitivity to any component of the formulation. (4)

WARNINGS AND PRECAUTIONS

Gastric malignancy: Symptomatic response with DEXILANT does not preclude the presence of gastric malignancy. (5.1)

Bone Fracture: Long-term and multiple daily dose PPI therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist or spine. (5.2)

ADVERSE REACTIONS

Most commonly reported adverse reactions ($\geq 2\%$): diarrhea, abdominal pain, nausea, upper respiratory tract infection, vomiting, and flatulence. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Takeda Pharmaceuticals America, Inc. at 1-877-TAKEDA-7 (1-877-825-3327) or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Atazanavir: Do not co-administer with DEXILANT because atazanavir systemic concentrations may be substantially decreased. (7.1)
- Drugs with pH-dependent absorption (e.g., ampicillin esters, digoxin, iron salts, ketoconazole): DEXILANT may interfere with absorption of drugs for which gastric pH is important for bioavailability. (7.1)
- Warfarin: Patients taking concomitant warfarin may require monitoring for increases in international normalized ratio (INR) and prothrombin time. (7.2)
- Tacrolimus: Concomitant tacrolimus use may increase tacrolimus whole blood concentrations (7.3)

USE IN SPECIFIC POPULATIONS

- Nursing mothers: Discontinue drug or nursing, taking into consideration importance of drug to mother. (8.3)

See 17 for PATIENT COUNSELING INFORMATION and FDA-Approved Patient Labeling.

Revised: 8/2010

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

1.1 Healing of Erosive Esophagitis

DEXILANT is indicated for healing of all grades of erosive esophagitis (EE) for up to 8 weeks.

1.2 Maintenance of Healed Erosive Esophagitis

DEXILANT is indicated to maintain healing of EE for up to 6 months.

1.3 Symptomatic Non-Erosive Gastroesophageal Reflux Disease

DEXILANT is indicated for the treatment of heartburn associated with symptomatic non-erosive gastroesophageal reflux disease (GERD) for 4 weeks.

2 DOSAGE AND ADMINISTRATION

2.1 Recommended Dose

DEXILANT is available as capsules in 30 mg and 60 mg strengths for adult use. Directions for use in each indication are summarized in Table 1.

Table 1: DEXILANT Dosing Recommendations

Indication	Recommended Dose	Frequency
Healing of EE	60 mg	Once daily for up to 8 weeks
Maintenance of Healed EE	30 mg	Once daily*
Symptomatic Non-Erosive GERD	30 mg	Once daily for 4 weeks

*Controlled studies did not extend beyond 6 months.

2.2 Special Populations

No adjustment for DEXILANT is necessary for patients with mild hepatic impairment (Child-Pugh Class A). Consider a maximum daily dose of 30 mg for patients with moderate hepatic impairment (Child-Pugh Class B). No studies have been conducted in patients with severe hepatic impairment (Child-Pugh Class C) [see Use in Specific Populations (8.7) and Clinical Pharmacology (12.5)].

No dosage adjustment is necessary for elderly patients or for patients with renal impairment [see Clinical Pharmacology (12.5)].

2.3 Important Administration Information

DEXILANT can be taken without regard to food.

DEXILANT should be swallowed whole.

- Alternatively, DEXILANT capsules can be opened and administered as follows:
 - Open capsule;

- Sprinkle intact granules on one tablespoon of applesauce;
- Swallow immediately. Granules should not be chewed.

3 DOSAGE FORMS AND STRENGTHS

- 30 mg capsules are opaque, blue and gray with TAP and “30” imprinted on the capsule.
- 60 mg capsules are opaque, blue with TAP and “60” imprinted on the capsule.

4 CONTRAINDICATIONS

DEXILANT is contraindicated in patients with known hypersensitivity to any component of the formulation [see Description (1.1)]. Hypersensitivity and anaphylaxis have been reported with DEXILANT use [see Adverse Reactions (6.1)].

5 WARNINGS AND PRECAUTIONS

5.1 Gastric Malignancy

Symptomatic response with DEXILANT does not preclude the presence of gastric malignancy.

5.2 Bone Fracture

Several published observational studies suggest that proton pump inhibitor (PPI) therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist or spine. The risk of fracture was increased in patients who received high-dose, defined as multiple daily doses, and long-term PPI therapy (a year or longer). Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated. Patients at risk for osteoporosis-related fractures should be managed according to established treatment guidelines [see Dosage and Administration (2) and Adverse Reactions (6)].

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

The safety of DEXILANT was evaluated in 4548 patients in controlled and uncontrolled clinical studies, including 863 patients treated for at least 6 months and 203 patients treated for one year. Patients ranged in age from 18 to 90 years (median age 48 years), with 54% female, 85% Caucasian, 8% Black, 4% Asian, and 3% other races. Six randomized controlled clinical trials were conducted for the treatment of EE, maintenance of healed EE, and symptomatic GERD, which included 896 patients on placebo, 455 patients on DEXILANT 30 mg, 2218 patients on DEXILANT 60 mg, and 1363 patients on lansoprazole 30 mg once daily.

As 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.

Most Commonly Reported Adverse Reactions

The most common adverse reactions ($\geq 2\%$) that occurred at a higher incidence for DEXILANT than placebo in the controlled studies are presented in Table 2.

Table 2: Incidence of Treatment-Emergent Adverse Reactions in Controlled Studies

Adverse Reaction	Placebo (N=896) %	DEXILANT 30 mg (N=455) %	DEXILANT 60 mg (N=2218) %	DEXILANT Total (N=2621) %	Lansoprazole 30 mg (N=1363) %
Diarrhea	2.9	5.1	4.7	4.8	3.2
Abdominal Pain	3.5	3.5	4.0	4.0	2.6
Nausea	2.6	3.3	2.8	2.9	1.8
Upper Respiratory Tract Infection	0.8	2.9	1.7	1.9	0.8
Vomiting	0.8	2.2	1.4	1.6	1.1
Flatulence	0.6	2.6	1.4	1.6	1.2

Adverse Reactions Resulting in Discontinuation

In controlled clinical studies, the most common adverse reaction leading to discontinuation from DEXILANT therapy was diarrhea (0.7%).

Other Adverse Reactions

Other adverse reactions that were reported in controlled studies at an incidence of less than 2% are listed below by body system:

Blood and Lymphatic System Disorders: anemia, lymphadenopathy

Cardiac Disorders: angina, arrhythmia, bradycardia, chest pain, edema, myocardial infarction, palpitation, tachycardia

Ear and Labyrinth Disorders: ear pain, tinnitus, vertigo

Endocrine Disorders: goiter

Eye Disorders: eye irritation, eye swelling

Gastrointestinal Disorders: abdominal discomfort, abdominal tenderness, abnormal feces, anal discomfort, Barrett's esophagus, bezoar, bowel sounds abnormal, breath odor, colitis microscopic, colonic polyp,

constipation, dry mouth, duodenitis, dyspepsia, dysphagia, enteritis, eructation, esophagitis, gastric polyp, gastritis, gastroenteritis, gastrointestinal disorders, gastrointestinal hypermotility disorders, GERD, GI ulcers and perforation, hematemesis, hematochezia, hemorrhoids, impaired gastric emptying, irritable bowel syndrome, mucus stools, nausea and vomiting, oral mucosal blistering, painful defecation, proctitis, paresthesia oral, rectal hemorrhage

General Disorders and Administration Site Conditions: adverse drug reaction, asthenia, chest pain, chills, feeling abnormal, inflammation, mucosal inflammation, nodule, pain, pyrexia

Hepatobiliary Disorders: biliary colic, cholelithiasis, hepatomegaly

Immune System Disorders: hypersensitivity

Infections and Infestations: candida infections, influenza, nasopharyngitis, oral herpes, pharyngitis, sinusitis, viral infection, vulvo-vaginal infection

Injury, Poisoning and Procedural Complications: falls, fractures, joint sprains, overdose, procedural pain, sunburn

Laboratory Investigations: ALP increased, ALT increased, AST increased, bilirubin decreased/increased, blood creatinine increased, blood gastrin increased, blood glucose increased, blood potassium increased, liver function test abnormal, platelet count decreased, total protein increased, weight increase

Metabolism and Nutrition Disorders: appetite changes, hypercalcemia, hypokalemia

Musculoskeletal and Connective Tissue Disorders: arthralgia, arthritis, muscle cramps, musculoskeletal pain, myalgia

Nervous System Disorders: altered taste, convulsion, dizziness, headaches, migraine, memory impairment, paresthesia, psychomotor hyperactivity, tremor, trigeminal neuralgia

Psychiatric Disorders: abnormal dreams, anxiety, depression, insomnia, libido changes

Renal and Urinary Disorders: dysuria, micturition urgency

Reproductive System and Breast Disorders: dysmenorrhea, dyspareunia, menorrhagia, menstrual disorder

Respiratory, Thoracic and Mediastinal Disorders: aspiration, asthma, bronchitis, cough, dyspnoea, hiccups, hyperventilation, respiratory tract congestion, sore throat

Skin and Subcutaneous Tissue Disorders: acne, dermatitis, erythema, pruritis, rash, skin lesion, urticaria

Vascular Disorders: deep vein thrombosis, hot flush, hypertension

Additional adverse reactions that were reported in a long-term uncontrolled study and were considered related to DEXILANT by the treating physician included: anaphylaxis, auditory hallucination, B-cell lymphoma, bursitis, central obesity, cholecystitis acute, decreased hemoglobin, dehydration, diabetes mellitus, dysphonia, epistaxis, folliculitis, gastrointestinal pain, gout, herpes zoster, hyperglycemia, hyperlipidemia, hypothyroidism, increased neutrophils, MCHC decrease, neutropenia, oral soft tissue disorder, rectal tenesmus, restless legs syndrome, somnolence, thrombocytopenia, tonsillitis.

Other adverse reactions not observed with DEXILANT, but occurring with the racemate lansoprazole can be found in the lansoprazole package insert, ADVERSE REACTIONS section.

6.2 Postmarketing Experience

Adverse reactions have been identified during post-approval of DEXILANT. As 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 drug exposure.

Eye Disorders: blurred vision

Gastrointestinal Disorders: oral edema

General Disorders and Administration Site Conditions: facial edema

Immune System Disorders: anaphylactic shock (requiring emergency intervention), Stevens-Johnsons syndrome, toxic epidermal necrolysis (some fatal)

Musculoskeletal System Disorders: bone fracture

Respiratory, Thoracic and Mediastinal Disorders: pharyngeal edema, throat tightness

Skin and Subcutaneous Tissue Disorders: generalized rash, leukocytoclastic vasculitis

7 DRUG INTERACTIONS

7.1 Drugs with pH-Dependent Absorption Pharmacokinetics

DEXILANT causes inhibition of gastric acid secretion. DEXILANT is likely to substantially decrease the systemic concentrations of the HIV protease inhibitor atazanavir, which is dependent upon the presence of gastric acid for absorption, and may result in a loss of therapeutic effect of atazanavir and the development of HIV resistance. Therefore, DEXILANT should not be co-administered with atazanavir.

It is theoretically possible that DEXILANT may interfere with the absorption of other drugs where gastric pH is an important determinant of oral bioavailability (e.g., ampicillin esters, digoxin, iron salts, ketoconazole).

7.2 Warfarin

Co-administration of DEXILANT 90 mg and warfarin 25 mg did not affect the pharmacokinetics of warfarin or INR [see *Clinical Pharmacology* (12.6)]. However, there have been reports of increased INR and prothrombin time in patients receiving PPIs and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Patients treated with DEXILANT and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

7.3 Tacrolimus

Concomitant administration of dexlansoprazole and tacrolimus may increase whole blood levels of tacrolimus, especially in transplant patients who are intermediate or poor metabolizers of CYP2C19.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Teratogenic Effects

Pregnancy Category B. There are no adequate and well-controlled studies with dexlansoprazole in pregnant women. There were no adverse fetal effects in animal reproduction studies of dexlansoprazole in rabbits. Because animal reproduction studies are not always predictive of human response, DEXILANT should be used during pregnancy only if clearly needed.

A reproduction study conducted in rabbits at oral dexlansoprazole doses up to approximately 9 times the maximum recommended human dexlansoprazole dose (60 mg per day) revealed no evidence of impaired fertility or harm to the fetus due to dexlansoprazole. In addition, reproduction studies performed in pregnant rats with oral lansoprazole at doses up to 40 times the recommended human lansoprazole dose and in pregnant rabbits at oral lansoprazole doses up to 16 times the recommended human lansoprazole dose revealed no evidence of impaired fertility or harm to the fetus due to lansoprazole [see *Nonclinical Toxicology* (13.2)].

8.3 Nursing Mothers

It is not known whether dexlansoprazole is excreted in human milk. However, lansoprazole and its metabolites are present in rat milk following the administration of lansoprazole. As many drugs are excreted in human milk, and because of the potential for tumorigenicity shown for lansoprazole in rat carcinogenicity studies [see *Carcinogenesis, Mutagenesis, Impairment of Fertility* (13.1)], a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

Safety and effectiveness of DEXILANT in pediatric patients (less than 18 years of age) have not been established.

8.5 Geriatric Use

In clinical studies of DEXILANT, 11% of patients were aged 65 years and over. No overall differences in safety or effectiveness were observed between these patients and younger patients, and other reported clinical experience has not identified significant differences in responses between geriatric and younger patients, but greater sensitivity of some older individuals cannot be ruled out [see *Clinical Pharmacology* (12.5)].

8.6 Renal Impairment

No dosage adjustment of DEXILANT is necessary in patients with renal impairment. The pharmacokinetics of dexlansoprazole in patients with renal impairment are not expected to be altered since dexlansoprazole is extensively metabolized in the liver to inactive metabolites, and no parent drug is recovered in the urine following an oral dose of dexlansoprazole [see *Clinical Pharmacology* (12.5)].

8.7 Hepatic Impairment

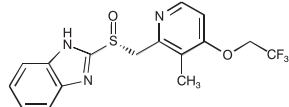
No dosage adjustment for DEXILANT is necessary for patients with mild hepatic impairment (Child-Pugh Class A). DEXILANT 30 mg should be considered for patients with moderate hepatic impairment (Child-Pugh Class B). No studies have been conducted in patients with severe hepatic impairment (Child-Pugh Class C) [see *Clinical Pharmacology* (12.5)].

10 OVERDOSAGE

There have been no reports of significant overdose of DEXILANT. Multiple doses of DEXILANT 120 mg and a single dose of DEXILANT 300 mg did not result in death or other severe adverse events. Dexlansoprazole is not expected to be removed from the circulation by hemodialysis. If an overdose occurs, treatment should be symptomatic and supportive.

11 DESCRIPTION

The active ingredient in DEXILANT (dexlansoprazole) delayed release capsules is (+)-2-[(*R*)-{[3-methyl-4-(2,2,2-trifluoroethoxy)pyridin-2-yl]methyl} sulfinyl]-1*H*-benzimidazole, a compound that inhibits gastric acid secretion. Dexlansoprazole is the *R*-enantiomer of lansoprazole (a racemic mixture of the *R*- and *S*-enantiomers). Its empirical formula is: C₁₆H₁₄F₃N₃O₂S, with a molecular weight of 369.36. The structural formula is:



Dexlansoprazole is a white to nearly white crystalline powder which melts with decomposition at 140°C. Dexlansoprazole is freely soluble

in dimethylformamide, methanol, dichloromethane, ethanol, and ethyl acetate; and soluble in acetonitrile; slightly soluble in ether; and very slightly soluble in water; and practically insoluble in hexane.

Dexlansoprazole is stable when exposed to light. Dexlansoprazole is more stable in neutral and alkaline conditions than acidic conditions.

DEXILANT is supplied as a dual delayed release formulation in capsules for oral administration. The capsules contain dexlansoprazole in a mixture of two types of enteric-coated granules with different pH-dependent dissolution profiles [see *Clinical Pharmacology* (12.3)].

DEXILANT is available in two dosage strengths: 30 mg and 60 mg, per capsule. Each capsule contains enteric-coated granules consisting of dexlansoprazole (active ingredient) and the following inactive ingredients: sugar spheres, magnesium carbonate, sucrose, low-substituted hydroxypropyl cellulose, titanium dioxide, hydroxypropyl cellulose, hypromellose 2910, talc, methacrylic acid copolymers, polyethylene glycol 8000, triethyl citrate, polysorbate 80, and colloidal silicon dioxide. The components of the capsule shell include the following inactive ingredients: hypromellose, carrageenan and potassium chloride. Based on the capsule shell color, blue contains FD&C Blue No. 2 and aluminum lake; gray contains ferric oxide and aluminum lake; and both contain titanium dioxide.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Dexlansoprazole is a PPI that suppresses gastric acid secretion by specific inhibition of the (H⁺,K⁺)-ATPase in the gastric parietal cell. By acting specifically on the proton pump, dexlansoprazole blocks the final step of acid production.

12.2 Pharmacodynamics

Antisecretory Activity

The effects of DEXILANT 60 mg (n=20) or lansoprazole 30 mg (n=23) once daily for five days on 24-hour intragastric pH were assessed in healthy subjects in a multiple-dose crossover study. The results are summarized in Table 3.

Table 3: Effect on 24-hour Intragastric pH on Day 5 After Administration of DEXILANT or Lansoprazole

DEXILANT 60 mg	Lansoprazole 30 mg
Mean Intragastric pH	
4.55	4.13
% Time Intragastric pH > 4 (hours)	
71 (17 hours)	60 (14 hours)

Serum Gastrin Effects

The effect of DEXILANT on serum gastrin concentrations was evaluated in approximately 3460 patients in clinical trials up to 8 weeks and in 1023 patients for up to 6 to 12 months. The mean fasting gastrin concentrations increased from baseline during treatment with DEXILANT 30 mg and 60 mg doses. In patients treated for more than 6 months, mean serum gastrin levels increased during approximately the first 3 months of treatment and were stable for the remainder of treatment. Mean serum gastrin levels returned to pre-treatment levels within one month of discontinuation of treatment.

Enterochromaffin-Like Cell (ECL) Effects

There were no reports of ECL cell hyperplasia in gastric biopsy specimens obtained from 653 patients treated with DEXILANT 30 mg, 60 mg or 90 mg for up to 12 months.

During lifetime exposure of rats dosed daily with up to 150 mg per kg per day of lansoprazole, marked hypergastrinemia was observed followed by ECL cell proliferation and formation of carcinoid tumors, especially in female rats [see *Nonclinical Toxicology* (13.1)].

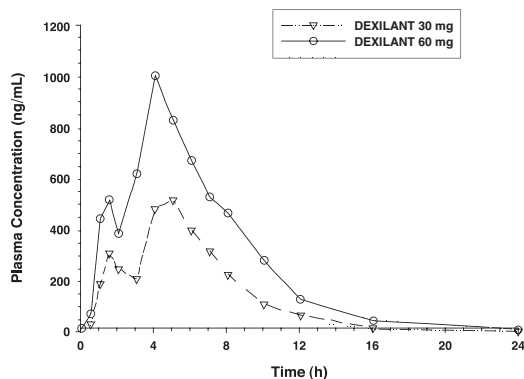
Effect on Cardiac Repolarization

A study was conducted to assess the potential of DEXILANT to prolong the QT/QT_c interval in healthy adult subjects. DEXILANT doses of 90 mg or 300 mg did not delay cardiac repolarization compared to placebo. The positive control (moxifloxacin) produced statistically significantly greater mean maximum and time-averaged QT/QT_c intervals compared to placebo.

12.3 Pharmacokinetics

The dual delayed release formulation of DEXILANT results in a dexlansoprazole plasma concentration-time profile with two distinct peaks; the first peak occurs 1 to 2 hours after administration, followed by a second peak within 4 to 5 hours (see Figure 1). Dexlansoprazole is eliminated with a half-life of approximately 1 to 2 hours in healthy subjects and in patients with symptomatic GERD. No accumulation of dexlansoprazole occurs after multiple, once daily doses of DEXILANT 30 mg or 60 mg, although mean AUC_t and C_{max} values of dexlansoprazole were slightly higher (less than 10%) on day 5 than on day 1.

Figure 1: Mean Plasma Dexlansoprazole Concentration – Time Profile Following Oral Administration of 30 or 60 mg DEXILANT Once Daily for 5 Days in Healthy Subjects



The pharmacokinetics of dexlansoprazole are highly variable, with percent coefficient of variation (CV%) values for C_{max} , AUC, and CL/F of greater than 30% (see Table 4).

Table 4: Mean (CV%) Pharmacokinetic Parameters for Subjects on Day 5 After Administration of DEXILANT

Dose (mg)	C_{max} (ng/mL)	AUC ₂₄ (ng·h/mL)	CL/F (L/h)
30	658 (40%) (N=44)	3275 (47%) (N=43)	11.4 (48%) (N=43)
60	1397 (51%) (N=79)	6529 (60%) (N=73)	11.6 (46%) (N=41)

Absorption

After oral administration of DEXILANT 30 mg or 60 mg to healthy subjects and symptomatic GERD patients, mean C_{max} and AUC values of dexlansoprazole increased approximately dose proportionally (see Figure 1).

Distribution

Plasma protein binding of dexlansoprazole ranged from 96.1% to 98.8% in healthy subjects and was independent of concentration from 0.01 to 20 mcg per mL. The apparent volume of distribution (V_z/F) after multiple doses in symptomatic GERD patients was 40.3 L.

Metabolism

Dexlansoprazole is extensively metabolized in the liver by oxidation, reduction, and subsequent formation of sulfate, glucuronide and glutathione conjugates to inactive metabolites. Oxidative metabolites are formed by the cytochrome P450 (CYP) enzyme system including hydroxylation mainly by CYP2C19, and oxidation to the sulfone by CYP3A4.

CYP2C19 is a polymorphic liver enzyme which exhibits three phenotypes in the metabolism of CYP2C19 substrates; extensive metabolizers (*1/*1), intermediate metabolizers (*1/mutant) and poor metabolizers (mutant/mutant). Dexlansoprazole is the major circulating component in plasma regardless of CYP2C19 metabolizer status. In CYP2C19 intermediate and extensive metabolizers, the major plasma metabolites are 5-hydroxy dexlansoprazole and its glucuronide conjugate, while in CYP2C19 poor metabolizers dexlansoprazole sulfone is the major plasma metabolite.

Elimination

Following the administration of DEXILANT, no unchanged dexlansoprazole is excreted in urine. Following the administration of [¹⁴C]dexlansoprazole to 6 healthy male subjects, approximately 50.7% (standard deviation (SD): 9.0%) of the administered radioactivity was excreted in urine and 47.6% (SD: 7.3%) in the feces. Apparent clearance (CL/F) in healthy subjects was 11.4 to 11.6 L/h, respectively, after 5-days of 30 or 60 mg once daily administration.

Effect of CYP2C19 Polymorphism on Systemic Exposure of Dexlansoprazole

Systemic exposure of dexlansoprazole is generally higher in intermediate and poor metabolizers. In male Japanese subjects who received a single dose of DEXILANT 30 mg or 60 mg (N=2 to 6 subjects/group), mean dexlansoprazole C_{max} and AUC values were up to 2 times higher in intermediate compared to extensive metabolizers; in poor metabolizers, mean C_{max} was up to 4 times higher and mean AUC was up to 12 times higher compared to extensive metabolizers. Though such study was not conducted in Caucasians and African Americans, it is expected dexlansoprazole exposure in these races will be affected by CYP2C19 phenotypes as well.

12.4 Effect of Food on Pharmacokinetics and Pharmacodynamics

In food-effect studies in healthy subjects receiving DEXILANT under various fed conditions compared to fasting, increases in C_{max} ranged from 12% to 55%, increases in AUC ranged from 9% to 37%, and t_{max}

varied (ranging from a decrease of 0.7 hours to an increase of 3 hours). No significant differences in mean intragastric pH were observed between fasted and various fed conditions. However, the percentage of time intragastric pH exceeded 4 over the 24-hour dosing interval decreased slightly when DEXILANT was administered after a meal (57%) relative to fasting (64%), primarily due to a decreased response in intragastric pH during the first 4 hours after dosing. Because of this, while DEXILANT can be taken without regard to food, some patients may benefit from administering the dose prior to a meal if post-meal symptoms do not resolve under post-fed conditions.

12.5 Special Populations

Pediatric Use

The pharmacokinetics of dexlansoprazole in patients under the age of 18 years have not been studied.

Geriatric Use

The terminal elimination half-life of dexlansoprazole is significantly increased in geriatric subjects compared to younger subjects (2.23 and 1.5 hours, respectively); this difference is not clinically relevant. Dexlansoprazole exhibited higher systemic exposure (AUC) in geriatric subjects (34.5% higher) than younger subjects. No dosage adjustment is needed in geriatric patients [see Use in Specific Populations (8.5)].

Renal Impairment

Dexlansoprazole is extensively metabolized in the liver to inactive metabolites, and no parent drug is recovered in the urine following an oral dose of dexlansoprazole. Therefore, the pharmacokinetics of dexlansoprazole are not expected to be altered in patients with renal impairment, and no studies were conducted in subjects with renal impairment [see Use in Specific Populations (8.6)]. In addition, the pharmacokinetics of lansoprazole were studied in patients with mild, moderate or severe renal impairment; results demonstrated no need for a dose adjustment for this patient population.

Hepatic Impairment

In a study of 12 patients with moderately impaired hepatic function who received a single oral dose of DEXILANT 60 mg, plasma exposure (AUC) of bound and unbound dexlansoprazole in the hepatic impairment group was approximately 2 times greater compared to subjects with normal hepatic function. This difference in exposure was not due to a difference in protein binding between the two liver function groups. No adjustment for DEXILANT is necessary for patients with mild hepatic impairment (Child-Pugh Class A). DEXILANT 30 mg should be considered for patients with moderate hepatic impairment (Child-Pugh Class B). No studies have been conducted in patients with severe hepatic impairment (Child-Pugh Class C) [see Use in Specific Populations (8.7)].

Gender

In a study of 12 male and 12 female healthy subjects who received a single oral dose of DEXILANT 60 mg, females had higher systemic exposure (AUC) (42.8% higher) than males. No dosage adjustment is necessary in patients based on gender.

12.6 Drug-Drug Interactions

Warfarin

In a study of 20 healthy subjects, co-administration of DEXILANT 90 mg once daily for 11 days with a single 25 mg oral dose of warfarin on day 6 did not result in any significant differences in the pharmacokinetics of warfarin or INR compared to administration of warfarin with placebo. However, there have been reports of increased INR and prothrombin time in patients receiving PPIs and warfarin concomitantly [see Drug Interactions (7.2)].

Cytochrome P 450 Interactions

Dexlansoprazole is metabolized, in part, by CYP2C19 and CYP3A4 [see Clinical Pharmacology (12.3)].

In vitro studies have shown that DEXILANT is not likely to inhibit CYP isoforms 1A1, 1A2, 2A6, 2B6, 2C8, 2C9, 2C19, 2D6, 2E1 or 3A4. As such, no clinically relevant interactions with drugs metabolized by these CYP enzymes would be expected. Furthermore, clinical drug-drug interaction studies in mainly CYP2C19 extensive and intermediate metabolizers have shown that DEXILANT does not affect the pharmacokinetics of diazepam, phenytoin, or theophylline. The subjects' CYP1A2 genotypes in the drug-drug interaction study with theophylline were not determined.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

The carcinogenic potential of dexlansoprazole was assessed using lansoprazole studies. In two 24-month carcinogenicity studies, Sprague-Dawley rats were treated orally with lansoprazole at doses of 5 to 150 mg per kg per day, about 1 to 40 times the exposure on a body surface (mg/m²) basis of a 50 kg person of average height [1.46 m² body surface area (BSA)] given the recommended human dose of lansoprazole 30 mg per day.

Lansoprazole produced dose-related gastric ECL cell hyperplasia and ECL cell carcinoids in both male and female rats [see Clinical Pharmacology (12.2)].

In rats, lansoprazole also increased the incidence of intestinal metaplasia of the gastric epithelium in both sexes. In male rats, lansoprazole

produced a dose-related increase of testicular interstitial cell adenomas. The incidence of these adenomas in rats receiving doses of 15 to 150 mg per kg per day (4 to 40 times the recommended human lansoprazole dose based on BSA) exceeded the low background incidence (range = 1.4 to 10%) for this strain of rat.

In a 24-month carcinogenicity study, CD-1 mice were treated orally with lansoprazole doses of 15 mg to 600 mg per kg per day, 2 to 80 times the recommended human lansoprazole dose based on BSA. Lansoprazole produced a dose-related increased incidence of gastric ECL cell hyperplasia. It also produced an increased incidence of liver tumors (hepatocellular adenoma plus carcinoma). The tumor incidences in male mice treated with 300 mg and 600 mg lansoprazole per kg per day (40 to 80 times the recommended human lansoprazole dose based on BSA) and female mice treated with 150 mg to 600 mg lansoprazole per kg per day (20 to 80 times the recommended human lansoprazole dose based on BSA) exceeded the ranges of background incidences in historical controls for this strain of mice. Lansoprazole treatment produced adenoma of rete testis in male mice receiving 75 to 600 mg per kg per day (10 to 80 times the recommended human lansoprazole dose based on BSA).

A 26-week p53 (+/-) transgenic mouse carcinogenicity study of lansoprazole was not positive.

Lansoprazole was negative in the Ames test, the *ex vivo* rat hepatocyte unscheduled DNA synthesis (UDS) test, the *in vivo* mouse micronucleus test and the rat bone marrow cell chromosomal aberration test. Lansoprazole was positive in *in vitro* human lymphocyte chromosomal aberration tests.

Dexlansoprazole was positive in the Ames test and in the *in vitro* chromosome aberration test using Chinese hamster lung cells. Dexlansoprazole was negative in the *in vivo* mouse micronucleus test.

The potential effects of dexlansoprazole on fertility and reproductive performance were assessed using lansoprazole studies. Lansoprazole at oral doses up to 150 mg per kg per day (40 times the recommended human lansoprazole dose based on BSA) was found to have no effect on fertility and reproductive performance of male and female rats.

13.2 Animal Toxicology and/or Pharmacology

Reproductive Toxicology Studies

A reproduction study conducted in rabbits at oral dexlansoprazole doses up to 30 mg per kg per day (approximately 9 times the maximum recommended human dexlansoprazole dose [60 mg per day] based on BSA) revealed no evidence of impaired fertility or harm to the fetus due to dexlansoprazole. In addition, reproduction studies performed in pregnant rats with oral lansoprazole at doses up to 150 mg per kg per day (40 times the recommended human lansoprazole dose based on BSA) and in pregnant rabbits at oral lansoprazole doses up to 30 mg per kg per day (16 times the recommended human lansoprazole dose based on BSA) revealed no evidence of impaired fertility or harm to the fetus due to lansoprazole.

14 CLINICAL STUDIES

14.1 Healing of Erosive Esophagitis

Two multi-center, double-blind, active-controlled, randomized, 8-week studies were conducted in patients with endoscopically confirmed EE. Severity of the disease was classified based on the Los Angeles Classification Grading System (Grades A-D). Patients were randomized to one of the following three treatment groups: DEXILANT 60 mg daily, DEXILANT 90 mg daily or lansoprazole 30 mg daily. Patients who were *H. pylori* positive or who had Barrett's Esophagus and/or definite dysplastic changes at baseline were excluded from these studies. A total of 4092 patients were enrolled and ranged in age from 18 to 90 years (median age 48 years) with 54% male. Race was distributed as follows: 87% Caucasian, 5% Black and 8% other. Based on the Los Angeles Classification, 71% of patients had mild EE (Grades A and B) and 29% of patients had moderate to severe EE (Grades C and D) before treatment.

The studies were designed to test non-inferiority. If non-inferiority was demonstrated then superiority would be tested. Although non-inferiority was demonstrated in both studies, the finding of superiority in one study was not replicated in the other.

The proportion of patients with healed EE at week 4 or 8 is presented below in Table 5.

Table 5: EE Healing Rates^a : All Grades

Study	Number of Patients (N) ^b	Treatment Group (daily)	Week 4 % Healed	Week 8 ^c % Healed	(95% CI) for the Treatment Difference (DEXILANT - Lansoprazole) by Week 8
1	657	DEXILANT 60 mg	70	87	(-1.5, 6.1) ^d
	648	Lansoprazole 30 mg	65	85	
2	639	DEXILANT 60 mg	66	85	(2.2, 10.5) ^d
	656	Lansoprazole 30 mg	65	79	

CI = Confidence interval

^a Based on crude rate estimates, patients who did not have endoscopically documented healed EE and prematurely discontinued were considered not healed.

^b Patients with at least one post baseline endoscopy

^c Primary efficacy endpoint

^d Demonstrated non-inferiority to lansoprazole

DEXILANT 90 mg was studied and did not provide additional clinical benefit over DEXILANT 60 mg.

14.2 Maintenance of Healed Erosive Esophagitis

A multi-center, double-blind, placebo-controlled, randomized study was conducted in patients who successfully completed an EE study and showed endoscopically confirmed healed EE. Maintenance of healing and symptom resolution over a six-month period were evaluated with DEXILANT 30 mg or 60 mg once daily compared to placebo. A total of 445 patients were enrolled and ranged in age from 18 to 85 years (median age 49 years), with 52% female. Race was distributed as follows: 90% Caucasian, 5% Black and 5% other.

Sixty-six percent of patients treated with 30 mg of DEXILANT remained healed over the six-month time period as confirmed by endoscopy (see Table 6).

Table 6: Maintenance Rates^a of Healed EE at Month 6

Number of Patients (N) ^b	Treatment Group (daily)	Maintenance Rate (%)
125	DEXILANT 30 mg	66.4 ^c
119	Placebo	14.3

^a Based on crude rate estimates, patients who did not have endoscopically documented relapse and prematurely discontinued were considered to have relapsed.

^b Patients with at least one post baseline endoscopy

^c Statistically significant vs placebo

DEXILANT 60 mg was studied and did not provide additional clinical benefit over DEXILANT 30 mg.

DEXILANT 30 mg demonstrated a higher median percent of 24-hour heartburn-free days compared to placebo over the 6-month treatment period.

14.3 Symptomatic Non-Erosive GERD

A multi-center, double-blind, placebo-controlled, randomized, 4-week study was conducted in patients with a diagnosis of symptomatic non-erosive GERD made primarily by presentation of symptoms. These patients who identified heartburn as their primary symptom, had a history of heartburn for 6 months or longer, had heartburn on at least 4 of 7 days immediately prior to randomization and had no esophageal erosions as confirmed by endoscopy. However, patients with symptoms which were not acid-related may not have been excluded using these inclusion criteria. Patients were randomized to one of the following treatment groups: DEXILANT 30 mg daily, 60 mg daily, or placebo. A total of 947 patients were enrolled and ranged in age from 18 to 86 years (median age 48 years) with 71% female. Race was distributed as follows: 82% Caucasian, 14% Black and 4% other.

DEXILANT 30 mg provided statistically significantly greater percent of days with heartburn-free 24-hour periods over placebo as assessed by daily diary over 4 weeks (see Table 7). DEXILANT 60 mg was studied and provided no additional clinical benefit over DEXILANT 30 mg.

Table 7: Median Percentages of 24-Hour Heartburn-Free Periods During the 4 Week Treatment Period of the Symptomatic Non-Erosive GERD Study

N	Treatment Group (daily)	Heartburn-Free 24-hour Periods (%)
312	DEXILANT 30 mg	54.9 ^a
310	Placebo	18.5

^a Statistically significant vs placebo

A higher percentage of patients on DEXILANT 30 mg had heartburn-free 24-hour periods compared to placebo as early as the first three days of treatment and this was sustained throughout the treatment period (percentage of patients on Day 3: DEXILANT 38% versus placebo 15%; on Day 28: DEXILANT 63% versus placebo 40%).

16 HOW SUPPLIED/STORAGE AND HANDLING

DEXILANT delayed release capsules, 30 mg, are opaque, blue and gray with TAP and "30" imprinted on the capsule and supplied as:

NDC Number	Size
64764-171-11	Unit dose package of 100
64764-171-30	Bottle of 30
64764-171-90	Bottle of 90
64764-171-19	Bottle of 1000

DEXILANT delayed release capsules, 60 mg, are opaque, blue with TAP and "60" imprinted on the capsule and supplied as:

NDC Number	Size
64764-175-11	Unit dose package of 100
64764-175-30	Bottle of 30
64764-175-90	Bottle of 90
64764-175-19	Bottle of 1000

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

17 PATIENT COUNSELING INFORMATION

To ensure the safe and effective use of DEXILANT, this information and instructions provided in the FDA-approved Patient Information Leaflet should be discussed with the patient. Inform patients of the following:

Tell your patients to watch for signs of an allergic reaction as these could be serious and may require that DEXILANT be discontinued. Advise your patients to tell you if they take atazanavir, tacrolimus, warfarin and drugs that are affected by gastric pH changes [see *Drug Interactions (7)*].

Advise patients to follow the dosing instructions in the Patient Information Leaflet.

DEXILANT is available as a delayed release capsule.

DEXILANT may be taken without regard to food.

DEXILANT should be swallowed whole.

- Alternatively, DEXILANT capsules can be opened and administered as follows:
 - Open capsule;
 - Sprinkle intact granules on one tablespoon of applesauce;
 - Swallow immediately. Granules should not be chewed.
 - Do not store for later use.

FDA-Approved Patient Labeling

Patient Information

DEXILANT (decks-ì-launt) (dexlansoprazole) delayed release capsules

Read the information that comes with DEXILANT before you start taking it and each time you get a refill. There may be new information. This information does not take the place of talking with your doctor about your medical condition or your treatment.

What is DEXILANT?

DEXILANT is a prescription medicine called a proton pump inhibitor (PPI). DEXILANT reduces the amount of acid in your stomach.

DEXILANT is used in adults:

- for 4 weeks to treat heartburn related to gastroesophageal reflux disease (GERD).
- for up to 8 weeks to heal acid-related damage to the lining of the esophagus (called erosive esophagitis or EE).
- for up to 6 months to stop erosive esophagitis from coming back.

GERD happens when acid from your stomach enters the tube (esophagus) that connects your mouth to your stomach. This may cause a burning feeling in your chest or throat, sour taste or burping.

In some cases, acid can damage the lining of your esophagus. This damage is called erosive esophagitis or EE.

DEXILANT may help your acid-related symptoms, but you could still have serious stomach problems. Talk with your doctor.

It is not known if DEXILANT is safe and effective in children under 18 years of age.

Who should not take DEXILANT?

Do not take DEXILANT if you are allergic to DEXILANT or any of its ingredients. See the end of this leaflet for a complete list of ingredients in DEXILANT.

What should I tell my doctor before taking DEXILANT?

Before you take DEXILANT, tell your doctor if you:

- have liver problems
- have any other medical conditions
- are pregnant or plan to become pregnant. It is not known if DEXILANT will harm your unborn baby. Talk to your doctor if you are pregnant or plan to become pregnant.
- are breast-feeding or planning to breast-feed. You and your doctor should decide if you will take DEXILANT or breast-feed. You should not do both without first talking with your doctor.

Tell your doctor about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. DEXILANT may affect how other medicines work, and other medicines may affect how DEXILANT works. Especially tell your doctor if you take:

- ampicillin sodium (Unasyn) or ampicillin trihydrate (Principen)
- atazanavir (Reyataz)
- digoxin (Lanoxicaps, Lanoxin)
- a product that contains iron
- ketoconazole (Nizoral)
- warfarin (Coumadin, Jantoven)
- tacrolimus (Prograf)

Ask your doctor or pharmacist if you are not sure if your medicine is listed above.

How should I take DEXILANT?

- Take DEXILANT exactly as prescribed by your doctor.
- Do not change your dose or stop taking DEXILANT without talking to your doctor first.
- You can take DEXILANT with or without food.
- Swallow DEXILANT capsules whole.
- If you have trouble swallowing DEXILANT capsules whole, you can open the capsules and sprinkle the contents on a tablespoon of applesauce. Be sure to swallow the applesauce mixture right away. Do not chew the mixture. Do not store for later use.
- If you miss a dose, take it as soon as you remember. If it is almost time for your next dose, skip the missed dose. Just take the next dose at your regular time. Do not take 2 doses at the same time. If you are not sure about dosing, call your doctor.
- If you take too much DEXILANT, call your doctor right away.

What are the possible side effects of DEXILANT?

Serious allergic reactions. Tell your doctor if you get any of the following symptoms with DEXILANT.

- rash
- face swelling
- throat tightness
- difficulty breathing

Your doctor may stop DEXILANT if these symptoms happen.

The most common side effects of DEXILANT include:

- diarrhea
- stomach pain
- nausea
- common cold
- vomiting
- gas

People who are taking multiple daily doses of proton pump inhibitor medicines for a long period of time may have an increased risk of fractures of the hip, wrist or spine.

Tell your doctor if you have any side effect that bothers you or that does not go away. These are not all the possible side effects of DEXILANT. For more information, ask your doctor or pharmacist. Call your doctor for medical advice about side effects. You may report side effects to the FDA at 1-800-FDA-1088.

How should I store DEXILANT?

- Store DEXILANT at room temperature between 59° to 86°F (15° to 30°C).

Keep DEXILANT and all medicines out of the reach of children.

General information about DEXILANT

Medicines are sometimes prescribed for conditions other than those listed in a Patient Information Leaflet. Do not use DEXILANT for conditions for which it was not prescribed. Do not give DEXILANT to other people, even if they have the same symptoms you have. It may harm them.

This Patient Information Leaflet provides a summary of the most important information about DEXILANT. For more information, ask your doctor. You can ask your doctor or pharmacist for information that is written for healthcare professionals. For more information, go to www.DEXILANT.com or call 1-877-825-3327.

What is in DEXILANT?

Active ingredient: dexlansoprazole.

Inactive ingredients: sugar spheres, magnesium carbonate, sucrose, low-substituted hydroxypropyl cellulose, titanium dioxide, hydroxypropyl cellulose, hypromellose 2910, talc, methacrylic acid copolymers, polyethylene glycol 8000, triethyl citrate, polysorbate 80, and colloidal silicon dioxide. The capsule shell is made of hypromellose, carrageenan and potassium chloride. Based on the capsule shell color, blue contains FD&C Blue No. 2 and aluminum lake; gray contains ferric oxide and aluminum lake; and both contain titanium dioxide.

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