A European regulatory perspective

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The views expressed in this presentation are mine and may not represent those of either EMA, the PKWP, or MPA
Guideline on the investigation of drug interactions

Adopted
Coming into effect

June 2012
January 2013
Transporter highlights in the guideline

• Recommend identifying transporters important for absorption and elimination in vivo and performing relevant DDI studies.

• Published a living list of transporters for which inhibition should be screened

• and cut-offs for in vivo relevance of in vitro inhibition signals based on available data (Pgp) or estimations from the enzyme experience

• Provide recommendations on in vitro study design
Initial issues in applications

- Transporters not identified although there was significant metabolism (OATPs) or biliary excretion
- Problems interpreting mass-balance data and worst-case thinking (without iv data)
- Lack of in vivo DDI or PGx studies
- Lack of justification of chosen in vitro system and probe drug / inhibitor
- Too high concentrations in substrate assays
- DDI risk/study with inducer in vivo not considered
- Stability, adsorption in assays
- Controls in in vitro study (inhibitors, untransfected cells, etc)
Initial issues

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The applications have markedly improved!
The guideline was applied more flexibly in the beginning.

We are also learning with the applications.
Missing information in today´s applications

- Caco-2 cell studies with inhibited/saturated transporters, controls
- Double systems for inhibition of Pgp
- Justify in vitro system and probe drug / inhibitor
- Justify using EC\textsubscript{50} (time and conc. independent)
- DDI risk/study with inducer in vivo not considered
- Use dabigatran etexilate instead of digoxin for intestinal Pgp inhibition
- i.v data (bioavailability) supporting estimation of biliary excretion from mass-balance data
- PGx, stratified studies
Additional knowledge: rate limiting step

- The uptake to the hepatocyte may be rate limiting for the elimination
- Inhibition of a major metabolism pathway may not affect drug exposure, only metabolite exposure – parent drug may be misleading in elimination investigations.
- **Useful to check metabolites!**
- **In vitro metabolite formation data important.**
- (The effect of inhibition of uptake transport is not influenced by these considerations. Inhibition will always have an effect on elimination ruled by its contribution as compared to passive permeation.)
Illustrative data in recent submissions

Time for more data and less text

Reality is merely an illusion, albeit a very persistent one.

- Albert Einstein
Discussed last week - Importance of i.v. data

Drug H

Is biliary excretion important?
Is M2 formation major pathway?
Possible contribution 31 or 50%

\[ \sum M_n \]

7% feces

M5

8% feces

M2

22% feces

M4

5% feces

M3

4% feces

Drug H

40% faeces
Supportive data

Food interaction (other formulation) rather high on other formulation indicating a quite low Fabs.
Dabigatran vs digoxin

Drug X/Y, Pgp/BCRP inhibitor in intestine

Dabigatran
- Cmax 105%↑
- 150 mg, caps
- fed
- AUC 138%↑
- t1/2 9.9 to 13 hrs

Digoxin
- Cmax 72%↑
- 0.5 mg, tablet
- fed
- AUC 48%↑
- t1/2 37 to 42 hrs
- CLR ↔

CLR

Why making a (sensitive) in vivo study?
Support labelling of intestinal Pgp substrates: dabigatran, sofosbuvir, tenofovir alafenamide, coming NCEs (digoxin TDM)
Remember DDIs with inducers on drugs with significant intestinal Pgp/BCRP transport

AUC ↓ by 74%
Cmax ↓ by 77%
(t₁/₂ unchanged)

7 days OK here
Other examples: Inducers on intestinal Pgp

- Dabigatran - RIF: AUC↓ by 67%.
- Drug X - RIF: Cmax ↓ by 79%, AUC ↓ by 87%
- TAF – efavirenz: Cmax ↓ by 22%, AUC ↓ by 14%
  (No RIF study, labelled “Not recommended”)

- (Digoxin - RIF staggered Cmax ↓ by 22%, AUC ↓ by 19%, CLR ↔ (other transporter inhibited))

Kirby et al DMD 2012
Assessment time

Some recent questions
Why is the half-life sometimes unchanged by OATP1B1/3 inhibition?

We look a lot on the half-lives in DDI studies trying to get information on the site of the DDI (intestine or liver).
OATP inhibition and $t_{1/2}$

Rifampicin single dose on drug Y (OATP1B1/3, BCRP/Pgp substrate, fu 2.7%, Vd?)

AUC 8.55-fold $\uparrow$

$t_{1/2}$ $\downarrow$ from 5.70 to 3.80 hrs

Effect also on Vd?

CyA gave AUC 8.5-fold $\uparrow$ and $t_{1/2}$ $\uparrow$ fr. 5.5 to 11.4 hrs and

Darunavir/r 800/100 qd gave AUC 5-fold $\uparrow$ and $C_{\text{trough}}$ $\uparrow$ 8-fold

Lopinavir/r 400/100 bid gave AUC 4.4-fold $\uparrow$ and $C_{\text{trough}}$ $\uparrow$ 19-fold

Atazanavir/r 300/100 qd gave AUC 6.5-fold $\uparrow$ and $C_{\text{trough}}$ $\uparrow$ 14-fold
Effect by OATP1B1/3, Pgp and BCRP inhibitory combination

**Losartan**
50% biliary elimination, OATP1B1/3 substrate, Vd 17L, low fu

**Valsartan**
biliary excretion main pathway, OATP substrate, Vd 34L, low fu

Losartan
AUC 1.56, t1/2 2.1 to 0.9hrs

Valsartan
AUC 1.31, t1/2 8.9 to 5.9

Filled = with inhibitor
How are the hepatocyte concentrations affected?

By induction?

By inhibition of the efflux transporters?

Can we do anything to know more? (Post-marketing follow up, KO, etc)

ITC paper 2010
Up, down, tox or what?

- Difficult to extrapolate DDI effects to other scenarios when multiple transporters involved.

Identified for HIV drugs in the DDI guideline:

... most drug-drug interaction can be predicted. However, it is acknowledged that there are remaining scientific uncertainties. In the area of HIV there have been cases of unexpected interactions. When developing a drug in such an area, *in vivo* interaction studies should be considered with commonly combined drugs having a relatively narrow therapeutic window while more knowledge is gained on the mechanism behind the unsuspected interactions in the field.

This can be applied to other fields/situations with complex DDI mechanisms, especially involving transporters.
Time for a guideline update

**PKWP workplan 2017**

**EU Guidelines under revision**

Guideline on the investigation of drug interactions, EMEA/CHMP/EWP/147013/2004

**Target date**

Concept paper to be released for public consultation **Q1 2017**

Under preparation for publication.
Not a major update but
Proposed changes includes

- Specific recommendations for in vitro studies on
  - Transport
  - TDI
  - Induction
- Update of transporter list (for inhibition screening)
- Update on cut-offs for transporter inhibition
- Transport as rate limiting step
- Clarifications of guideline text
- Discussion of DDI study requirement with contraceptive steroids
Public consultation

- Q1 2017 – aimed for publication at 1st of April
- 3 months consultation period
Thank you for listening!

Are there any clarifying questions?