

[19] Patents Registry
The Hong Kong Special Administrative Region
香港特別行政區
專利註冊處

[11] 1176552 B
EP 2505204 B1

[12]

STANDARD PATENT SPECIFICATION
標準專利說明書

[21] Application No. 申請編號
13103556.5

[51] Int.Cl.⁸ A61K A61P

[22] Date of filing 提交日期
09.12.2010

[22] Date Lodged 交件日期
21.03.2013

[54] METHOD OF TREATING PROSTATE CANCER WITH THE GNRH ANTAGONIST DEGARELIX 使用 GNRH 拮抗劑地加瑞克治療前列腺癌的方法

[30] Priority 優先權

11.02.2008 US 27741 P

29.02.2008 EP 08250703

[43] Date of publication of application 申請發表日期

02.08.2013

[45] Publication of the grant of the patent 批予專利的發表日期

23.10.2015

EP Application No. & Date 歐洲專利申請編號及日期

EP 12165896.7 10.02.2009

EP Publication No. & Date 歐洲專利申請發表編號及日期

EP 2505204 03.10.2012

Date of Grant in Designated Patent Office 指定專利當局批予專利日期

24.12.2014

[62] Derived from Application No. 10111507.1 under section 22
of the Patents Ordinance (Chapter 514)

根據專利條例 (第 514 章) 第 22 條, 此為申請編號
10111507.1 的分開申請

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(12) **EUROPEAN PATENT SPECIFICATION**

(45) Date of publication and mention
of the grant of the patent:
24.12.2014 Bulletin 2014/52

(51) Int Cl.:
A61K 38/08 ^(2006.01) **A61K 38/09** ^(2006.01)
A61P 35/00 ^(2006.01)

(21) Application number: **12165896.7**

(22) Date of filing: **10.02.2009**

(54) **Method of treating prostate cancer with the GnRH antagonist degarelix**

Verfahren zur Behandlung von Prostatakrebs mit dem GnRH-Antagonisten Degarelix

Procédé de traitement du cancer de la prostate par le antagoniste de GnRH degarelix

(84) Designated Contracting States:
**AT BE BG CH CY CZ DE DK EE ES FI FR GB GR
HR HU IE IS IT LI LT LU LV MC MK MT NL NO PL
PT RO SE SI SK TR**

(30) Priority: **11.02.2008 US 27741 P**
29.02.2008 EP 08250703

(43) Date of publication of application:
03.10.2012 Bulletin 2012/40

(62) Document number(s) of the earlier application(s) in
accordance with Art. 76 EPC:
09709538.4 / 2 249 858

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Remarks:

The file contains technical information submitted after the application was filed and not included in this specification

Description**Background of the Invention**

[0001] Prostate cancer is a leading cause of morbidity and mortality for men in the industrialized world. The American Cancer Society estimates that during 2007 about 218,890 new cases of prostate cancer will have been diagnosed in the United States alone. Prostate cancer is the second leading cause of cancer death in American men, behind only lung cancer. However, while about 1 man in 6 will be diagnosed with prostate cancer during his lifetime, only 1 man in 35 will actually die of it. The American Cancer Society estimates that 27,050 men in the United States will die of prostate cancer in 2007. Prostate cancer accounts for about 9% of cancer-related deaths in men.

[0002] While prostate cancer incidence rates rose dramatically in the late 1980s, much of this increase is thought to reflect improvements in detection and diagnosis through widespread use of prostate-specific antigen (PSA) testing. Indeed, the incidence of prostate cancer has been declining since the early 1990s, and mortality rates for prostate cancer have also declined since the early 1990s (see SEER Program and the National Center for Health Statistics (<http://seer.cancer.gov/>). More than 9 out of 10 prostate cancers are found in the local and regional stages (local means it is still confined to the prostate; regional means it has spread from the prostate to nearby areas, but not to distant sites, such as bone). When compared to men of the same age and race who do not have cancer (relative survival), the 5-year relative survival rate for these men is nearly 100%, however the 5-year relative survival rate for men whose prostate cancers have already spread to distant parts of the body at the time of diagnosis is only about 32%. It is estimated that approximately \$8 billion is spent on prostate cancer treatment each year in the United States alone (Cancer Trends Progress Report (<http://progressreport.cancer.gov/>)).

[0003] The majority of prostate cancers are dependent on testosterone for growth, and the current medical management of advanced prostate cancer involves androgen deprivation, which may be achieved by bilateral orchiectomy or by administration of gonadotrophin releasing hormone (GnRH) receptor agonists. Removal of the testes (castration) was for many years the standard method of preventing the secretion of male hormones by the gonads as a means for reducing growth of prostate cancers. More recently, secretion of male hormones has been perturbed by chemical means by interfering with production of luteinizing hormone (LH), which regulates the synthesis of the androgens. Evidence from randomized studies strongly suggests that early endocrine therapy in non-metastatic, locally advanced disease with or without lymph node metastases is associated with a survival benefit (see Granfors et al. (1998) J. Urol. 159:2030-34; Messing et al. (1999) N. Eng. J. Med. 341:1781-88; and (1997) Br. J. Urol. 79:235-46).

[0004] Gonadotrophin releasing hormone (GnRH) is a natural hormone produced by the hypothalamus that interacts with a receptor in the pituitary to stimulate production of LH. To decrease LH production, agonists of the GnRH receptor (GnRH-R), such as leuprolide and goserelin, have been developed. Such GnRH agonists are generally analogs of GnRH, the decapeptide pyroGlu-His-Trp-Ser-Tyr-Gly-Leu-Arg-Pro-Gly-NH₂. For example, GnRH agonists having a D-isomer instead of Gly in the 6-position have greater binding affinity/strength to the receptor and greater biological potency than the native hormone; one example is the [D-Ala⁶]-GnRH (described in U.S. Pat. No. 4,072,668) having the following formula: pGlu-His-Trp-Ser-Tyr-D-Ala-Leu-Arg-Pro-Gly-NH₂. Such GnRH-R agonists initially act to stimulate LH release and only after prolonged treatment act to desensitize GnRH-R such that LH is no longer produced. The initial stimulation of LH production by the agonist leads to an initial surge in the production of male sex hormones such that the initial response to agonist therapy is aggravation, rather than amelioration, of the patient's condition (e.g., tumor growth may increase). This phenomenon, known as the "testosterone surge" or "flare reaction," can last for as long as two to four weeks. Additionally, each successive administration of the agonist can cause an additional small LH surge (known as the "acute-on chronic" phenomenon) that can further worsen the condition. The testosterone surge stimulates prostate cancer and can lead to a worsening of current symptoms or appearance of new symptoms such as spinal cord compression, bone pain and urethral obstruction (Thompson et al. (1990) J. Urol. 140:1479-80; Boccon-Gibod et al. (1986) Eur. Urol. 12: 400-402). One approach that has been taken to avoid this problem has been to combine administration of a GnRH-R agonist with an antiandrogen, such as flutamide, known as total androgen ablation therapy (AAT). Hormonal therapy with an GnRH-R agonist in combination with an antiandrogen has been used as a pre-treatment prior to radical prostatectomy known as adjuvant therapy. The use of antiandrogens, however, is associated with serious hepatic and gastrointestinal side effects.

[0005] Antagonists of the gonadotrophin releasing hormone receptor (GnRH-R) have been developed to overcome the "testosterone surge" or "flare reaction" associated with GnRH agonists. However, GnRH antagonist peptides are frequently associated with the occurrence of histamine-releasing activity. This histamine-releasing activity represents a serious obstacle to the clinical use of such antagonists because histamine release results in adverse side effects such as edema and itching.

[0006] The search for improved GnRH antagonists has resulted in the making of Antide, i.e. [Ac-D-2NaI¹, D-4CIPhe², D-3Pal³, Lys(Nic)⁵, D-Lys(Nic)⁶, ILys⁸, D-Ala¹⁰]-GnRH; and Cetorelix, i.e. [Ac-D-2NaI¹, D-4CIPhe², D-3Pal³, D-Cit⁶, D-Ala¹⁰]-GnRH. U.S. Pat. No. 5,516,887 describes GnRH antagonists which are said to be more effective than Antide in

suppressing plasma testosterone, e.g. [Ac-D-2NaI¹, D-4CIPhe², D-3Pal³, D-N⁶-carbamoyl Lys⁶, Ilys⁸, D-Ala¹⁰]-GnRH, which is referred to as Antarelix. Furthermore, U.S. Pat. No. 5,296,468 discloses the design and synthesis of a number of GnRH antagonists wherein the side chains of selected residues are reacted to create cyanoguanidino moieties, some of which subsequently spontaneously convert to a desired heterocycle, e.g. a 3-amino-1,2,4-triazole(atz). Such cyano-

5 guanidino moieties are built upon the omega-amino group in an amino acid side chain, such as lysine, ornithine, 4-amino phenylalanine (4Aph) or an extended chain version thereof, such as 4-amino homophenylalanine (4Ahp). GnRH antagonists having such significantly modified or unnatural amino acids in the 5- and 6-positions exhibit good biological potency, and those built upon Aph are generally considered to be particularly potent. One that is especially useful is Azaline B, i.e. [Ac-D-2NaI¹, D-4CIPhe², D-3Pal³, 4Aph(atz)⁵, D-4Aph(atz)⁶, ILys⁸, D-Ala¹⁰]-GnRH. U.S. Pat. No.

10 5,506,207 discloses biopotent GnRH antagonists with acylated, amino-substituted phenylalanine side chains of residues in the 5- and 6-positions; one such decapeptide is Acyline, i.e. [Ac-D-2NaI¹, D-4CIPhe², D-3Pal³, 4Aph(Ac)⁵, D-4Aph(Ac)⁶, ILys⁸, D-Ala¹⁰]-GnRH. Despite the attractive properties of this group of GnRH antagonists, the search has continued for still further improved GnRH antagonists, particularly those which exhibit long duration of biological action. It can frequently be important that a peptide analog should exhibit a long duration of activity with respect to LH secretion, a

15 property which may be enhanced by the peptide's resistance to proteolytic enzyme degradation in the body for both short-term and long-term treatment indications. In addition, to facilitate administration of these compounds to mammals, particularly humans, without significant gelling, it is considered extremely advantageous for such GnRH antagonistic decapeptides to have high solubility in water at normal physiologic pH, i.e. about pH 5 to about pH 7.4.

[0007] While the use of both GnRH agonist and antagonists in androgen deprivation therapy to treat prostate cancer has yielded promising results, there are concerns about the relative safety of the available drugs. For example, the GnRH abarelix was found to carry a risk of serious allergic reactions, including anaphylaxis with hypotension and syncope, and was also found to lose efficacy over the course of treatment in some cases. Indeed, AbarelixTM (PlenaxisTM in the U.S.) was eventually approved, but only for patients with advanced prostate cancer, and was eventually withdrawn from the market in 2005 for commercial reasons apparently related to these problems. Furthermore, while prostate cancer-

25 specific mortality has been decreasing, there has been little overall effect on mortality in this group, suggesting the possibility of an increased risk of death from nonprostate cancer related causes. In particular, it has been suggested that certain androgen deprivation therapies could adversely affect cardiovascular health (see Yannucci et al. (2006) J. Urology 176:520-525; and Etzioni et al. (1999) J. Natl. Canc. Inst. 91:1033).

[0008] Accordingly, new therapeutic regiments for prostate cancer are needed that are free of both the adverse consequences of the GnRH agonist testosterone spike, as well as the undesirable side effects of available GnRH antagonist therapies.

Summary of the Invention

[0009] Applicants have found that a relatively low dose of degarelix GnRH antagonist, delivered about once every 28 days (e.g., monthly), can safely and rapidly suppress testosterone levels to therapeutic levels in prostate cancer patients, without causing a testosterone spike and with an appreciably diminished risk of causing an undesirable side effect (other than an administration site e.g. injection site related side effect) associated with androgen deprivation therapy such as a cardiac disorder, arthralgia, and/or a urinary tract infection. Advantages of the use of degarelix for the treatment of

40 prostate cancer may include a diminished likelihood of occurrence and/or diminished severity of symptoms of adverse reactions, adverse events or side effects to organs or tissues.

[0010] According to the present invention in a first aspect there is provided a composition comprising degarelix for use in the treatment of prostate cancer in a subject identified as being at risk for cardiovascular disease. According to the present invention in a further aspect there is provided a composition comprising degarelix for use in the treatment of prostate cancer in a subject, the subject having been identified as having an increased likelihood of developing a cardiovascular disease or disorder. The composition may be for administration of degarelix at an initial dose of 160 to 320 mg; and at a maintenance dose of 60 to 160 mg, once every 20 to 36 days thereafter.

[0011] The composition may be for the treatment of a subject with a cholesterol level of greater than or equal to 4 mmol/L.

[0012] The composition comprising degarelix is for use to treat prostate cancer in a subject who is at risk for cardiovascular disease. The composition comprising degarelix is for use to treat prostate cancer in a prostate cancer subject identified as being at risk for cardiovascular disease.

[0013] The composition may be for administration at an initial dose of degarelix of 160 to 320 mg; and at a maintenance dose of 60 to 160 mg, once every 20 to 36 days thereafter. The composition may be for administration at an initial dose of degarelix of about 240 mg; and at a maintenance dose of about 80 mg degarelix once every approximately 28 days of treatment. The composition may be for use in a treatment which includes a step of identifying a suitable subject with prostate cancer and at risk for a cardiovascular disease or disorder. The cardiovascular disease or disorder may be, for example, cardiac murmur, atrioventricular blockage or myocardial ischemia.

[0014] The composition may be for treatment of a subject who possesses an indicator of increased and/or high risk

of cardiovascular disease. The indicator of increased risk for cardiovascular disease is one or more of high blood pressure, high low-density lipoprotein cholesterol, low high-density lipoprotein cholesterol, high serum glucose and habitual smoking. The composition may be for treatment of a subject with blood pressure of greater than or equal to 130 over 85 mm Hg. The composition may be for treatment of a subject who smokes cigarettes daily. The composition may be for treatment of a subject with low-density lipoprotein cholesterol of greater than or equal to about 160 mg/dL. The composition may be for treatment of a subject having a level of high-density lipoprotein cholesterol of less than 35 mg/dL. The composition may be for treatment of a subject with fasting glucose level of greater than about 120 mg/dL. The indicator of high risk for cardiovascular disease is one or more of high serum C-reactive protein (CRP), high serum homocysteine, high serum fibrinogen, and high serum lipoprotein (a) (Lp(a)). The composition may be for treatment of a subject with a level of C-reactive protein of greater than 3 mg/dL. The composition may be for the treatment of a subject with a serum homocysteine level of greater than 30 μ mol/L. The composition may be for treatment of a subject with a level of serum fibrinogen of greater than 7.0 g/L. The composition may be for treatment of a subject with a level of serum Lp(a) of greater than 30 mg/dL.

[0015] The composition may be for treatment of a subject with cholesterol level of greater than or equal to 4 mmol/L.

[0016] In particular embodiments, the subject has been identified to be at risk of a specific cardiovascular disease or disorder such as cardiac murmur, atrioventricular blockage, and/or myocardial ischemia.

[0017] In further embodiments, the subject possesses an indicator of increased risk for cardiovascular disease, e.g. high blood pressure, high low-density lipoprotein cholesterol, low high-density lipoprotein cholesterol, high serum glucose and/or a habitual smoking habit. In particular embodiments, the subject has high blood pressure of greater than or equal to 130 over 85 mm Hg. In further embodiments, the subject smokes cigarettes daily. In still further embodiments, the subject has an elevated level of low-density lipoprotein cholesterol of greater than or equal to about 160 mg/dL. In further embodiments, the subject has a low level of high-density lipoprotein cholesterol of less than 35 mg/dL. In other embodiments, the subject has an elevated fasting glucose level of greater than about 120 mg/dL.

[0018] In still other particularly useful embodiments, the subject possesses an indicator of increased risk for cardiovascular disease such as high serum C-reactive protein (CRP), high serum homocysteine, high serum fibrinogen, and/or high serum lipoprotein(a) (Lp(a)). In particular embodiments, the subject has an elevated level of C-reactive protein of greater than 3 mg/dL. In other embodiments, the subject has an elevated level of serum homocysteine of greater than 30 μ mol/L. In further embodiments, the subject has an elevated level of serum fibrinogen of greater than 7.0 g/L. In still further embodiments, the treated subject has an elevated level of serum Lp(a) of greater than 30 mg/dL.

[0019] In further embodiments, the subject has a decreased likelihood, compared to treatment with the gonadotrophin releasing hormone (GnRH) agonist leuprolide, of developing a cardiovascular side effect such as cardiac arrhythmia, coronary artery disorder, and/or a cardiac disorder. In other embodiments, the subject has a cholesterol level of greater than or equal to 4 mmol/L (155 mg/dL).

[0020] In an aspect, the invention provides a composition comprising degarelix for use in treating prostate cancer in a subject at risk for a cardiovascular disease or disorder by first identifying a suitable subject with prostate cancer that is also at risk for a cardiovascular disease or disorder. The suitable subject with cardiovascular disease risk may then be administered an initial dose of about 240 mg of degarelix, followed by a maintenance dose of about 80 mg of degarelix once every approximately 28 days thereafter, thereby treating prostate cancer in the subject at risk for a cardiovascular disease or disorder. In certain embodiments, the maintenance dose of degarelix is administered monthly.

[0021] In an aspect, the invention provides a composition comprising degarelix for use in treating prostate cancer in a subject at risk for a cardiovascular disease or disorder by first identifying a suitable subject with prostate cancer and at risk for a cardiovascular disease or disorder. The suitable subject with cardiovascular disease risk is then administered an initial dose of 160-320 mg of degarelix, followed by a maintenance dose of 60-160 mg of degarelix delivered once every approximately 28 days thereafter, thereby treating prostate cancer in the subject at risk for a cardiovascular disease or disorder. In certain embodiments, the maintenance dose of degarelix is administered monthly. In further embodiments, the subject is at risk of a cardiovascular disease or disorder, such as a cardiac murmur, an atrioventricular blockage, and/or myocardial ischemia. In still other embodiments, the subject possesses an indicator of increased risk for cardiovascular disease. In further particular embodiments, the subject possesses an indicator of increased risk for cardiovascular disease, e.g. high blood pressure, high low-density lipoprotein cholesterol, low high-density lipoprotein cholesterol, high serum glucose and/or a habitual smoking habit. In particular embodiments, the subject has high blood pressure of greater than or equal to 130 over 85 mm Hg. In further embodiments, the subject smokes cigarettes daily. In still further embodiments, the subject has an elevated level of low-density lipoprotein cholesterol of greater than or equal to about 160 mg/dL. In further embodiments, the subject has a low level of high-density lipoprotein cholesterol of less than 35 mg/dL. In other embodiments, the subject has an elevated fasting glucose level of greater than about 120 mg/dL.

[0022] In still other embodiments, the subject possesses an indicator of increased risk for cardiovascular disease such as high serum C-reactive protein (CRP), high serum homocysteine, high serum fibrinogen, and/or high serum lipoprotein(a) (Lp(a)). In particular embodiments, the subject has an elevated level of C-reactive protein of greater than 3 mg/dL. In other embodiments, the subject has an elevated level of serum homocysteine of greater than 30 μ mol/L. In further embodiments, the subject has an elevated level of serum fibrinogen of greater than 7.0 g/L. In still further embodiments,

the subject has an elevated level of serum Lp(a) of greater than 30 mg/dL. In other embodiments, the subject has a decreased likelihood, when compared to treatment with the gonadotrophin releasing hormone (GnRH) agonist leuprolide, of developing a cardiovascular side effect such as a cardiac arrhythmia, a coronary artery disorder, and/or a cardiac disorder.

Brief Description of the Figures

[0023]

Figure 1 is a depiction of the chemical structure of degarelix.

Figure 2 is a graphical representation of the effect of degarelix 240 mg/80 mg dosing on plasma testosterone from day 0 to day 364 of treatment.

Figure 3 is a graphical representation comparing the effect of degarelix 240 mg/80 mg dosing with the effect of Lupron 7.5 mg dosing on the percentage change in plasma testosterone from day 0 to day 28 of treatment.

Figure 4 is a graphical representation comparing the effect of degarelix 240 mg/160 mg and degarelix 240 mg/80 mg dosing with the effect of Lupron 7.5 mg dosing on the median levels of luteinizing hormone (LH) over time from day 0 to day 364 of treatment.

Figure 5 is a graphical representation comparing the effect of degarelix 240 mg/160 mg and degarelix 240 mg/80 mg dosing with the effect of Lupron 7.5 mg dosing on the median levels of follicle stimulating hormone (FSH) over time from day 0 to day 364 of treatment.

Figure 6 is a graphical representation comparing the effect of degarelix 240 mg/80 mg dosing with the effect of Lupron 7.5 mg dosing on prostate specific antigen (PSA) levels from day 0 to day 56 of treatment.

Detailed Description of the Invention

[0024] Particular aspects of the invention are described in greater detail below.

General

[0025] In general, the invention provides a composition comprising degarelix for use in the treatment of prostate cancer in a subject identified as being at risk for cardiovascular disease, and/or a composition comprising degarelix for use in the treatment of prostate cancer in a subject, the subject having been identified as having an increased likelihood of developing a cardiovascular disease or disorder, using a dosing regimen that results in optimal efficacy, and reduced serious side-effects e.g. cardiovascular disease, athralgia (e.g. side effects other than administration site related side effects), particularly in certain patient subgroups, compared to other androgen deprivation therapies, particularly GnRH agonist therapies such as leuprolide.

[0026] The relative efficacy and safety (including adverse side effects) of the GnRH agonist therapy leuprolide (also leuprorelin or LUPRON DEPOT) is known in the art (see e.g., Persad (2002) Int. J. Clin. Pract. 56:389-96; Wilson et al. (2007) Expert Opin. Invest. Drugs 16:1851-63; and Berges et al. (2006) Curr. Med. Res. Opin. 22:649-55). In addition, the relative efficacy and safety of the GnRH antagonist therapy abarelix (PLENAXIS) has also been reported (see, e.g., Mongiat-Artus et al. (2004) Expert Opin. Pharmacother. 5:2171-9; and Debruyne et al. (2006) Future Oncol. 2:677-96). A review of the basic methods for conducting and analyzing the type of controlled clinical studies described herein, including analyses of safety, efficacy and selective advantages to certain patient subpopulations, is available (see Spilker (1991) Guide to Clinical Trials Raven Press, New York; and Spilker (1996) Quality of Life and Pharmacoeconomics in Clinical Trials Lippincott - Raven Publishers New York).

Definitions

[0027] The singular forms "a," "an," and "the" include plural reference unless the context clearly dictates otherwise.

[0028] As used herein, the term "ADR" refers to an adverse drug reaction, and the term "AE" refers to an "adverse event."

[0029] The terms "approximately" and "about" mean to be nearly the same as a referenced number or value. As used herein, the terms "approximately" and "about" should be generally understood to encompass $\pm 10\%$ a specified amount, frequency or value.

[0030] The term "agonist" as used herein, is meant to refer to an agent that mimics or up-regulates (e.g., potentiates or supplements) the bioactivity of a protein. An agonist can be a wild-type protein or derivative thereof having at least one bioactivity of the wild-type protein.

[0031] "Antagonist" as used herein is meant to refer to an agent that down-regulates (e.g., suppresses or inhibits) at least one bioactivity of a protein.

[0032] As used herein, the term "arthralgia" refers to pain in one or more joints, which may occur as a symptom of injury, infection, illnesses -- in particular arthritis-- or an allergic reaction to medication. In distinguishing the term "arthralgia" from the term "arthritis" it should be noted that "arthralgia" specifically refers to non-inflammatory conditions, and the term "arthritis" should be used when the condition is an inflammatory condition.

[0033] The term "body mass index" (BMI) refers to a statistical measure of the weight of a person scaled according to height, which is an approximating measure of the relative percentages of fat and muscle mass in the human body. BMI is defined as the individual's body weight divided by the square of their height, and the formulas used in medicine produce a unit of measure of kg/m².

[0034] The term "CI" refers to a statistical confidence interval.

[0035] The term "cardiovascular" as used herein refers to conditions involving the heart and/or blood vessels.

[0036] The term "cardiac arrhythmia" as used herein is any of a group of conditions in which the electrical activity of the heart is irregular or is faster or slower than normal.

[0037] As used herein, the terms "coronary artery disorder" or "coronary artery disease" refers to a condition (such as sclerosis or thrombosis) that reduces the blood flow through the coronary arteries to the heart muscle.

[0038] The term "cardiac disorder" as used herein refers to any of a number of abnormal organic conditions affecting the heart including coronary heart disease, heart attack, cardiovascular disease, pulmonary heart disease and high blood pressure.

[0039] The term "deep-vein thrombosis" (also known as deep-venous thrombosis or DVT) is the formation of a blood clot ("thrombus") in a deep vein. Deep-vein thrombosis commonly affects the leg veins, such as the femoral vein or the popliteal vein or the deep veins of the pelvis. Occasionally the veins of the arm are affected (known as Paget-Schrötter disease). Thrombophlebitis is the more general class of pathologies of this kind. There is a significant risk of the thrombus embolizing and traveling to the lungs causing a pulmonary embolism.

[0040] The term "ECG" refers to an electrocardiogram.

[0041] The term "MedDRA" refers to the Medical dictionary for regulatory activities.

[0042] The term "myocardial infarction" refers to an infarction of the myocardium that results typically from coronary occlusion, that may be marked by sudden chest pain, shortness of breath, nausea, and loss of consciousness, and sometimes death. An "infarction" refers to the process of forming an infarct, which is an area of necrosis in a tissue or organ resulting from obstruction of the local circulation by a thrombus or embolus.

[0043] "Male sexual dysfunction" includes impotence, loss of libido, and erectile dysfunction. "Erectile dysfunction" is a disorder involving the failure of a male mammal to achieve erection, ejaculation, or both.

[0044] The term "prostate cancer" refers to any cancer of the prostate gland in which cells of the prostate mutate and begin to multiply out of control. The term "prostate cancer" includes early stage, localized, cancer of the prostate gland; later stage, locally advanced cancer of the prostate gland; and later stage metastatic cancer of the prostate gland (in which the cancer cells spread (metastasize) from the prostate to other parts of the body, especially the bones and lymph nodes).

[0045] The term "prostate-specific antigen" or "PSA" refers to a protein produced by the cells of the prostate gland that is present in small quantities in the serum of normal men, but is often elevated in the presence of prostate cancer and in other prostate disorders. A blood test to measure PSA is the most effective test currently available for the early detection of prostate cancer. Higher than normal levels of PSA are associated with both localized and metastatic prostate cancer (CaP).

[0046] The term "PD" refers to pharmacodynamic, and the term "PK" refers to pharmacokinetic.

[0047] The term "PT" refers to a preferred term.

[0048] The term "SAE" refers to a serious adverse event".

[0049] The term "SD" refers to standard deviation.

[0050] The term "SOC" refers to a system organ class.

[0051] The term "SUSAR" refers to a suspected, unexpected serious adverse reaction.

[0052] A "subject" or "patient" is a male mammal, more preferably a human male. Non-human male mammals include, but are not limited to, farm animals, sport animals, and pets.

[0053] A "urinary tract infection" (UTI) is a bacterial infection that affects any part of the urinary tract, which is the tract through which urine passes and includes the renal tubules and renal pelvis of the kidney, the ureters, the bladder, and the urethra. The most common type of UTI is a bladder infection which is also often called cystitis. Another kind of UTI is a kidney infection, known as pyelonephritis, which is a more serious condition.

Degarelix and Related Pharmaceutical Formulations

[0054] Degarelix is a potent GnRH antagonist that is an analog of the GnRH decapeptide (pGlu-His-Trp-Ser-Tyr-Gly-Leu-Arg-Pro-Gly -NH₂) incorporating p-ureido-phenylalanines phenylalanines at positions 5 and 6 (Jiang et al. (2001) J. Med. Chem. 44:453-67). It is indicated for treatment of patients with prostate cancer in whom androgen deprivation is warranted (including patients with rising PSA levels after having already undergone prostatectomy or radiotherapy).

[0055] Degarelix is a selective GnRH receptor antagonist (blocker) that competitively and reversibly binds to the pituitary GnRH receptors, thereby rapidly reducing the release of gonadotrophins and consequently testosterone (T). Prostate cancer is sensitive to testosterone deprivation, a mainstay principle in the treatment of hormone-sensitive prostate cancer. Unlike GnRH agonists, GnRH receptor blockers do not induce a luteinizing hormone (LH) surge with subsequent testosterone surge/tumor stimulation and potential symptomatic flare after the initiation of treatment.

[0056] The active ingredient degarelix is a synthetic linear decapeptide amide containing seven unnatural amino acids, five of which are D-amino acids. The drug substance is an acetate salt, but the active moiety of the substance is degarelix as the free base. The acetate salt of degarelix is a white to off-white amorphous powder of low density as obtained after lyophilisation. The chemical name is D-Alaninamide, N-acetyl-3-(2-naphthalenyl)-D-alanyl-4-chloro-D-phenylalanyl-3-(3-pyridinyl)-D-alanyl-L-seryl-4-[[[(4S)-hexahydro-2,6-dioxo-4-pyrimidinyl]carbonyl]amino]-L-phenylalanyl-4-[(aminocarbonyl)amino]-D-phenylalanyl-L-leucyl-N⁶-(1-methylethyl)-L-lysyl-L-prolyl. It has an empirical formula of C₈₂H₁₀₃N₁₈O₁₆Cl and a molecular weight of 1,632.3 Da.

[0057] The chemical structure of degarelix has been previously shown (EP 1003774, US5,925,730, US 6,214,798) and is shown in Figure 1. It may also be represented by the formula:

Administration and Dosing

[0058] Degarelix may be formulated for administration subcutaneously, as opposed to intravenously, generally in the abdominal region, as described in further detail below. As with other drugs administered by subcutaneous injection, the injection site may vary periodically to adapt the treatment to injection site discomfort. In general, injections should be given in areas where the patient will not be exposed to pressure, e.g. not close to waistband or belt and not close to the ribs. Administration of degarelix by subcutaneous or intramuscular injection works well, but daily injections are generally not acceptable and so a depot formulation of degarelix may be utilized as describe in further detail in WO 03/006049 and U.S. Pub. Nos. 20050245455 and 20040038903. Briefly, subcutaneous administration of degarelix may be conducted using a depot technology in which the peptide is released from a biodegradable polymer matrix over a period of (typically) one to three months. Degarelix, and related GnRH antagonist peptides as described in WO 03/006049 and U.S. Pub. Nos. 2005/0245455 and 2004/0038903, have a high affinity for the GnRH receptor and are much more soluble in water than other GnRH analogues. Degarelix and these related GnRH antagonists are capable of forming a gel after subcutaneous injection, and this gel can act as a depot from which the peptide is released over a period of weeks or even months.

[0059] A key variable for formation of an effective degarelix depot is the concentration of the solution in combination with the amount of substance administered per se. The concentration must be within a functional range. If the formulation is too dilute then no depot is formed and the long duration of action is lost, regardless of the amount of drug substance given. If the formulation is too concentrated then gel formation will occur before the drug can be administered. Effective depot-forming formulations of degarelix generally have a concentration of not less than 5 mg/mL degarelix, e.g. 5 to 40 mg/mL of degarelix.

[0060] Thus, degarelix may be provided as a powder for reconstitution (with a solvent) as a solution for injection (e.g. subcutaneous injection, e.g. to form a depot as described above). The powder may be provided as a lyophilisate containing degarelix (e.g. as acetate) and mannitol. A suitable solvent is water (e.g., water for injection, or WFI). For example, degarelix may be provided in a vial containing 120mg degarelix (acetate) for reconstitution with 3 mL WFI such that each mL of solution contains about 40 mg degarelix. In another example, degarelix may be provided in a vial containing 80mg degarelix (acetate). After reconstitution with about 4mL WFI, for example 4.2 mL WFI, each mL solution contains about 20 mg degarelix.

[0061] The composition may be for administration of degarelix at an initial dose of 160 to 320 mg; and at a maintenance dose of 60 to 160 mg, once every 20 to 36 days thereafter. For example, the composition may be for administration at an initial dose of about 240 mg ; and at a maintenance dose of about 80 mg once every approximately 28 days thereafter.

[0062] A preferred dosing regimen for treating adult males with prostate cancer is a single 240 mg starting dose of degarelix administered as two subcutaneous injections of 120 mg; and followed by monthly maintenance doses of 80 mg of degarelix administered as a single subcutaneous injection beginning approximately one month after the initial starting dose.

[0063] For example, the dosing regimen for degarelix may be administered as an initial, starting dose of 240 mg

administered as two injections of 3 mL of about 40 mg/mL degarelix formulation, followed by monthly maintenance doses of 80 mg administered as a single injection of 4 mL of about 20 mg/mL degarelix formulation. In another example, monthly maintenance doses of 160 mg may be utilized, e.g. by administering 4 mL of about 40 mg/mL degarelix every month.

[0064] The reconstituted solution should be a clear liquid, free of undissolved matter. A single dose of 240 mg degarelix, followed by a monthly maintenance dose of 80 mg, rapidly causes a decrease in the concentrations of the luteinizing hormone (LH), follicle stimulating hormone (FSH) and subsequently testosterone. The plasma concentration of dihydrotestosterone (DHT) decreases in a similar manner to testosterone.

[0065] Degarelix is effective in achieving and maintaining testosterone suppression well below medical castration level of 0.5 ng/mL. As described below in further detail, maintenance monthly dosing of 80 mg resulted in sustained testosterone suppression in 97% of patients for at least one year. In particular, the median testosterone levels after one year of treatment were 0.087 ng/mL.

[0066] The relevant pharmacokinetic parameters for degarelix evaluated in prostate cancer patients are summarized in Table 1, below. Median degarelix trough concentrations in the maintenance phase with 80 mg at a concentration of 20 mg/mL was 10.9 ng/mL.

Table 1. Degarelix pharmacokinetic parameters after subcutaneous administration of 240 mg at a concentration of 40 mg/mL

Pharmacokinetic parameter	degarelix 240 mg
C _{max} (ng/mL)	53.4
T _{max} (days)	1.4
T _{1/2} (days)	43
AUC (day·ng/mL)	1240

[0067] Following subcutaneous administration of 240 mg degarelix (6mL at a concentration of 40 mg/mL) to prostate cancer patients, degarelix is eliminated in a biphasic fashion, with a median terminal half-life of approximately 43 days. The long half-life after subcutaneous administration is a consequence of a very slow release of degarelix from the depot formed at the injection site(s). The pharmacokinetic behavior of the drug is strongly influenced by its concentration in the injection suspension.

[0068] The resulting distribution volume in healthy elderly men is approximately 1 L/kg. Plasma protein binding is estimated to be approximately 90%.

[0069] Degarelix is subject to common peptidic degradation during the passage of the hepato-biliary system and is mainly excreted as peptide fragments in the feces. No significant metabolites were detected in plasma samples after subcutaneous administration. In vitro studies have shown that degarelix is not a substrate for the human CYP450 system. Therefore, clinically significant pharmacokinetic interactions with other drugs are unlikely to occur.

[0070] In healthy men, approximately 20% of a given dose of degarelix was renally excreted, suggesting that approximately 80% is excreted via the hepato-biliary system in humans. The clearance in healthy elderly men is 35-50 mL/hr/kg.

Adverse Events (Side Effects)

[0071] Degarelix has been found to be generally well tolerated in clinical trials. The most commonly observed adverse reactions during FIRMAGON therapy were due to the expected physiological effects of testosterone suppression, mainly hot flushes and increased weight, and injection site related adverse events (injection site related side effects), mainly injection site pain and injection site erythema.

[0072] In the confirmatory active-controlled clinical trial comparing degarelix subcutaneous (s.c.) with leuprolide intramuscular (i.m.) for 12 months of treatment of patients with prostate cancer, the most frequently reported side effects were adverse events occurring at the injection site (injection site related side effects) including pain (28%), erythema (17%), swelling (6%), induration (4%) and nodule (3%). These adverse events were mostly transient, of mild to moderate intensity and occurred primarily with the starting dose and led to very few discontinuations (<1%). The majority of injection site adverse events did not require any treatment. Of the reported events 20% were ameliorated by the patients receiving treatment with over the counter (OTC) remedies such as analgesics or cold packs. In addition, there were a number of other frequent adverse events including weight increase, fatigue, chills, hot flush, hypertension, back pain, arthralgia, and urinary tract infection, as summarized in Table 2 below.

Table 2. Comparison of Most Frequent Adverse Events for degarelix versus leuprolide Treatment

	degarelix 240/80mg (s.c.) N = 207	leuprolide 7.5mg (i.m.) N = 201
	%	%
Percentage of subjects with adverse events	79	78
<i>Body as a whole</i>		
Injection site adverse events**	35	<1
Weight increase*	9	12
	%	%
Fatigue	3	6
Chills	5	0
<i>Cardiovascular system</i>		
Hot flush*	26	21
Hypertension	6	4
<i>Musculoskeletal system</i>		
Back pain	6	8
Arthralgia	5	9
<i>Urogenital system</i>		
Urinary tract infection	5	9
<i>Digestive system</i>		
Constipation	5	5

[0073] There was no evidence of any clinically significant changes in liver function. Few elevations of the liver enzymes were seen, and these changes were generally mild and transient. Safety data from all clinical trials with degarelix in the treatment of prostate cancer, including patients receiving other dosing regimens, were pooled. The following adverse reactions, not already listed, were reported to be drug-related by the investigator in $\geq 1\%$ of patients: erectile dysfunction, gynaecomastia, hyperhidrosis, testicular atrophy, and diarrhea.

[0074] Decreased bone density has been reported in the medical literature in men who have had orchiectomy or who have been treated with a GnRH agonist. It can be anticipated that long periods of medical castration in men will have effects on bone density.

[0075] Advantages of the degarelix therapeutic dosing regimen for the treatment of prostate cancer include a diminished likelihood of occurrence and/or diminished severity of symptoms of adverse reactions, adverse events or side effects to other organs or tissues. An extensive panel of potential adverse events related to drug therapies have been described.

[0076] An adverse reaction dictionary allows investigators to identify the same adverse reaction with the same term and to identify different adverse reactions with different terms. A standard dictionary may be used, however specialized pharmaceutical dictionaries have been developed to define adverse reaction terms and their synonyms (see Gillum (1989) "The Merck regulatory dictionary: A pragmatically developed drug effects vocabulary" Drug Info. J. 23:217-220). The World Health Organization (WHO) Adverse Reaction Terminology is also available for delimiting the meanings of drug-induced side effects (see, e.g., Saltzman (1985) "Adverse reaction terminology standardization" Drug Info. J. 19:35-41). The Coding Symbols for a Thesaurus of Adverse Reaction Terms (COSTART) system is also known in the art (see, e.g., McNeil et al. (1982) N. Engl. J. Med. 306:1259-62; and Teal and Dimmig (1985) "Adverse drug experience management" Drug Info. J. 19:17-25). These lists are often divided by body system and certain terms are annotated with alternative classifications.

[0077] COSTART provides a basis for vocabulary control of adverse reaction reports that emanate from a variety of sources. COSTART is organized primarily by anatomy. It has a hierarchical arrangement of terms, from the broadest (body-system categories) to the narrowest (specific preferred terms or even special search categories). The COSTART dictionary is used and maintained by the Center for Drugs and Biologics at the Food and Drug Administration (FDA) for marketed medicine surveillance and has been endorsed by many senior managers in the various reviewing sections. There are four indexes in COSTART: index A, comprising three lists including a body-system search categories, and a

special search categories (e.g., neoplasia).

[0078] The WHO terminology system of adverse reactions is relatively short. A code number is assigned to each of these terms. This provides the advantage that the same code is retained when the term is translated into different languages. The WHO system uses a hierarchy of "preferred terms" to describe adverse reactions. Other commonly used terms are called "included terms," which are listed with their preferred terms.

[0079] The FDA and many pharmaceutical companies have gone through an evolution of systems in how they obtain, collect, process, and define adverse reactions. The medicine dictionary that has been used by the FDA ("The Center for Drugs and Biologics Ingredient Dictionary") is known in the art and its use in adverse event categorization has been addressed (see, e.g., Forbes et al. (1986) Drug Info. J. 20:135-45; and Turner et al. (1986) Drug Info. J. 20:147-50).

[0080] Certain advantages and disadvantages of COSTART, SNOMED and WHO Adverse Reaction Terminology are reviewed by Stephens ("The Detection of New Adverse Drug Reactions" pp. 18-124, Stockton Press, New York).

[0081] The MedDRA Medical dictionary for regulatory activities is a particularly useful source for definitions of adverse events relating to drug trials. MedDRA utilizes pragmatic, medically valid terminology with an emphasis on ease of use for data entry, retrieval, analysis, and display, as well as a suitable balance between sensitivity and specificity within the regulatory environment. It was developed by the International Conference on Harmonisation (ICH) and is owned by the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) acting as trustee for the ICH steering committee, and is readily available commercially (see, e.g., the MedDRA website at www.meddrasso.com). The MedDRA Maintenance and Support Services Organization (MSSO) holds a contract with the International Federation of Pharmaceutical Manufacturers Associations (IFPMA) to maintain and support the implementation of the terminology. MedDRA terminology applies to all phases of drug development, excluding animal toxicology, and has been utilized in the examples that follow.

[0082] As described in further detail below, a number of other adverse reactions including cardiovascular anomalies (e.g., cardiac arrhythmias, coronary artery disorders and cardiac disorders), arthralgia, and urinary tract infection unexpectedly occur at a lower frequency than prior art androgen depletion therapies such as the GnRH antagonist leuprolide.

Cardiovascular Disease

[0083] The invention provides a composition comprising degarelix for use in the treatment of prostate cancer in a subject identified as being at risk for cardiovascular disease, and/or a composition comprising degarelix for use in the treatment of prostate cancer in a subject, the subject having been identified as having an increased likelihood of developing a cardiovascular disease or disorder. This aspect of the invention is particularly significant, in light of recent findings suggesting the possibility of an increased risk of death from nonprostate cancer causes, particularly relating to adverse effects on cardiovascular health, in patients being treated with prior art androgen deprivation therapies (see Yannucci et al. (2006) J. Urol. 176:520-5).

[0084] The indicia of risk for developing cardiovascular disease have been investigated extensively and are known in the art (see, e.g., Wilson et al. (1998) Circulation 97:1837-47; Hackam (2003) JAMA 290:932-940). These cardiovascular risk factors include: high blood pressure (particularly greater than or equal to 130 over 85 mm Hg); high levels of low-density lipoprotein cholesterol (particularly greater than or equal to 160 mg/dL); low levels of high-density lipoprotein cholesterol (particularly less than 35 mg/dL); high levels of serum glucose (particularly levels of fasting glucose levels greater than about 120 mg/dL); high serum levels of C-reactive protein (CRP) (particularly levels greater than 3 mg/dL); high serum levels of homocysteine (particularly levels greater than 30 μ mol/L); high serum levels of serum fibrinogen (particularly levels greater than 7.0 g/L); and high serum levels of lipoprotein(a) (Lp(a)) (particularly levels of greater than 30 mg/dL). In addition, habitual smoking has been shown to be associated with an increased risk for cardiovascular disease.

[0085] Furthermore, the association of overall body weight, body mass index (BMI) and the presence of indicators of "metabolic syndrome" with risk for cardiovascular disease have been reported (see e.g., Behn and Ur (2006) Curr. Opin. Cardiol. 21:353-60; and Romero-Corral et al. (2006) The Lancet 368:666-78).

[0086] This invention is further illustrated by the following examples, which should not be construed as limiting.

Examples

Clinical Study of Degarelix for the Treatment of Prostate Cancer

[0087] In this example, an open-label, multi-center, randomized, parallel-group study was conducted to investigate the efficacy and safety of degarelix one month dosing regimens. Patients in two degarelix treatment groups received a degarelix starting dose of 240 mg at a concentration of about 40 mg/mL followed by either of two different once-a-month dosing regimens, 160 mg (about 40 mg/mL) and 80 mg (about 20 mg/mL). These degarelix dosing regimens were compared to LUPRON DEPOT™ at 7.5 mg in patients with prostate cancer requiring androgen ablation therapy.

[0088] The study also investigated whether degarelix is safe and effective with respect to achieving and maintaining testosterone suppression to castrate levels, evaluated as the proportion of patients with testosterone suppression ≤ 0.5 ng/mL during 12 months of treatment, and compared serum levels of testosterone and prostate-specific antigen (PSA) using a degarelix dosing regimen versus leuprolide 7.5 mg during the first 28 days of treatment. The study further compared the safety and tolerability using a degarelix dosing regimen compared to treatment with leuprolide 7.5 mg, and, further, compared testosterone, luteinizing hormone (LH), follicle-stimulating hormone (FSH), and PSA response with a degarelix dosing regimen compared to leuprolide 7.5 mg. The study further compared patient reported outcomes (quality of life factors and hot flushes) using a degarelix dosing regimen as compared to leuprolide 7.5 mg during treatment. Finally, the study evaluated the pharmacokinetics of the degarelix dosing regimens investigated.

Study Design

[0089] A total of 620 patients were randomized 1:1:1 to one of three treatment groups. Of these, 610 patients were administered Investigational Medicinal Product (IMP). Ten randomized patients withdrew from the study before dosing.

[0090] Patients in two treatment groups received a degarelix starting dose of 240 mg at a concentration of 40 mg/mL (240@40) on Day 0 administered as two equivalent subcutaneous (s.c.) injections of 120 mg each. Thereafter, patients received 12 additional single s.c. degarelix doses of either 80 mg at a concentration of 20 mg/mL (80@20: degarelix 240/80 mg group) or 160 mg at a concentration of 40 mg/mL (160@40: degarelix 240/160 mg group) administered s.c. every 28 days. In the third treatment group, patients received active treatment with leuprolide 7.5 mg on Day 0 and every 28 days administered as a single intramuscular (i.m.) injection. For patients receiving treatment with leuprolide 7.5 mg, bicalutamide could be given as clinical flare protection at the Investigator's discretion.

[0091] Patients were stratified according to geographic region (Central and Eastern Europe, Western Europe and The Americas) and body weight (<90 kg and ≥ 90 kg).

Degarelix 240/160 mg Group

[0092] This group received an initial dose of 240 mg at a concentration of 40 mg/mL (240@40) on Day 0. This starting dose was administered as two equivalent subcutaneous (s.c.) injections of 120 mg each. The group then received 12 maintenance doses of 160 mg at a concentration of 40 mg/mL (160@40) as single s.c. doses of degarelix every 28 days.

Degarelix 240/80 mg Group

[0093] This group also received an initial dose of 240 mg at a concentration of 40 mg/mL (240@40) on Day 0. This starting dose was administered as two equivalent s.c. injections of 120 mg each. The group then received 12 maintenance doses of 80 mg at a concentration of 20 mg/mL (80@20) as single s.c. doses of degarelix every 28 days.

Leuprolide 7.5 mg Group

[0094] This group received the reference therapy leuprolide 7.5 mg. This treatment was administered as a single intramuscular (i.m.) injection, once every 28 days starting at Day 0.

Table 3. Treatment Methodology

Treatment Group	Starting Dose	Maintenance Doses
Degarelix 240/160 mg	240@40 (as 2 doses on Day 0)	160@40 (as 12 single doses, one every 28 days)
Degarelix 240/80 mg	240@40 (as 2 doses on Day 0)	80@20 (as 12 single doses, one every 28 days)
Leuprolide 7.5 mg	7.5 mg administered at Day 0 and every 28 days via single intramuscular injection. Bicalutamide was given at the Investigator's discretion.	

[0095] Patients were monitored on an ongoing basis and visited the clinic at monthly intervals up to one year. Patients were observed clinically for at least 1 hour after each administration of study drug. Patients who completed the study and met appropriate criteria were offered the opportunity to receive long-term treatment and support in an extension study.

[0096] A total of 807 patients were screened and 620 patients were randomized 1:1:1 into three treatment groups,

degarelix 240/160 mg, degarelix 240/80 mg and leuprolide 7.5 mg. Of the 620 patients randomized, 610 patients actually received study medication including 202, 207 and 201 patients in the degarelix 240/160 mg, degarelix 240/80 mg and leuprolide 7.5 mg treatment groups, respectively. A total of 504 patients completed the study.

Diagnosis and Criteria for Study Inclusion

[0097] Males aged 18 years and over with histologically confirmed (Gleason graded) adenocarcinoma of the prostate (all stages), in whom androgen ablation treatment was indicated (except for neoadjuvant hormonal therapy) were eligible to participate. Signed informed consent was obtained before any study-related activity occurred. Patients were to have a baseline testosterone level >1.5 ng/mL and a PSA level of ≥ 2 ng/mL at the time of screening. Patients with rising PSA after having undergone prostatectomy or radiotherapy with curative intent could be included in the study. Patients were required to have an ECOG score of ≤ 2 and a life expectancy of at least 12 months. Previous or present hormonal management of prostate cancer (surgical castration or other hormonal manipulation, e.g. GnRH agonists, GnRH antagonists, antiandrogens, or estrogens) resulted in exclusion from the study. However, in patients having undergone prostatectomy or radiotherapy with curative intention, neoadjuvant hormonal treatment was accepted for a maximum duration of 6 months provided that this treatment had been terminated for at least 6 months prior to the screening visit. Concurrent treatment with a 5- α -reductase inhibitor also resulted in exclusion from the study. Patients who were candidates for a curative therapy (*i.e.* radical prostatectomy or radiotherapy) were excluded. Patients with histories of severe hypersensitivity reactions or clinically significant disorders (other than prostate cancer) that might affect the conclusion of the study as judged by the Investigator were not eligible to enter into the study. Patients with a marked baseline prolongation of QT/QTcF interval (>450 msec), had used concomitant medications that may prolong QT/QTcF interval or who had a history of additional risk factors for Torsade de Pointes ventricular arrhythmias were excluded. Patients who had elevated serum ALT or total bilirubin levels above upper level of normal range at the screening visit or who had known or suspected hepatic, symptomatic biliary disease were also excluded. Patients were also excluded if they had a known hypersensitivity to any component of the investigational products. In addition, patients with any form of cancer within the last five years, with the exception of prostate cancer and surgically removed basal or squamous cell carcinoma of the skin, were excluded from the study. Patients who had a mental incapacity or language barriers precluding adequate understanding or co-operation were also ineligible to participate in the study. No other investigational drug was to be administered within 28 days preceding the screening visit.

Duration of Treatment

[0098] Patients in the degarelix treatment groups received a starting dose of 240@40 on Day 0 and 12 maintenance doses of 160@40 (degarelix 240/160 mg group) or 80@20 (degarelix 240/80 mg group) every 28 days. Administration of investigational medicinal products took place on Day 0, Day 28 (± 2 days) and every 28 day (± 7 days) thereafter until the end of study visit; day 364 (± 7 days). Patients who completed the study and met appropriate criteria were offered the opportunity to receive long-term treatment and support in an extension study.

[0099] Patients in the reference therapy group received treatment with leuprolide 7.5 mg on Day 0 and every 28 days thereafter for 12 maintenance doses. Patients who completed the study received thirteen doses in total. Patients who completed the study and met appropriate criteria were offered a switch to degarelix treatment in a continuing study. These patients were randomized to degarelix treatment 240/80 mg or 240/160 mg. On Day 0 of the study, patients previously treated with leuprolide 7.5 mg in study CS21 received a 240 mg (40 mg/mL) degarelix starting dose followed by monthly maintenance doses of either 80 mg (20 mg/mL) or 160 mg (40 mg/mL).

[0100] Patients in the comparator group were treated with leuprolide 7.5 mg pre-filled, dual-chamber syringe for intramuscular (i.m.) injection. Patients received leuprolide 7.5 mg on Day 0 and every 28 days subsequently, administered as a single i.m. injection. At the investigator's discretion, bicalutamide could be given as clinical flare protection.

Criteria for Evaluation of Efficacy

[0101] The primary efficacy endpoint was the probability of testosterone levels remaining ≤ 0.5 ng/mL from day 28 through day 364.

[0102] The secondary efficacy endpoints were: the proportion of patients with testosterone surge during the first 2 weeks of treatment; the proportion of patients with testosterone level ≤ 0.5 ng/mL at day 3; the percentage change in PSA from baseline to day 28; the probability of testosterone ≤ 0.5 ng/mL from day 56 through day 364; the levels of serum testosterone, LH, FSH and PSA over time through the study; the time to PSA failure, defined as two consecutive increases of 50%, and at least 5 ng/mL as compared to nadir; degarelix concentration over the first month and trough levels at day 308 and 336; the frequency and size of testosterone increases at day 255 and/or 259 compared to the testosterone level at day 252; the quality of life on days 0, 28, 84, 168 and end of study visit; the frequency and intensity

of hot flushes experienced (scored daily from study start until end of study visit). In addition, two further secondary endpoints were added: the probability of sufficient testosterone response from day 28 through day 364 (a patient was considered to have insufficient testosterone response if he had one testosterone value >1.0 ng/mL or two consecutive testosterone values >0.5 ng/mL at day 28 onwards); and the percentage change in PSA from baseline to Day 14.

Criteria for Evaluation of Safety

[0103] The safety variables for this study were assessed on the following: the frequency and severity of adverse events (AEs); the presence of clinically significant changes in laboratory parameters (clinical chemistry, hematology and urinalysis); changes in electrocardiograms (ECGs) and vital signs; changes detected by physical examination; and body weight.

[0104] An adverse event (AE) was defined as any untoward medical occurrence in a patient or clinical investigation subject administered an investigational medical product (IMP) and which did not necessarily have a causal relationship with the study treatment. An AE was therefore any unfavorable or unintended sign (including an abnormal laboratory finding), symptom or disease temporally associated with the use of the product, whether or not related to the IMP.

[0105] This definition also included accidental injuries and reasons for changes in medication (drug and/or dose), any medical, nursing or pharmacy consultation, or admission to hospital or surgical operations. It also included AEs commonly observed and AEs anticipated based on the pharmacological effect of the IMP. Any clinically significant injection site reaction of a severity requiring active management (*i.e.* change in dose, discontinuation of study drug, more frequent follow-up or treatment of the injection site) was also considered to be an AE and was to be reported on the AE log. This definition was the minimum requirement for reporting of an AE related to injection site reactions. There may have been situations where there was no active follow-up but the reaction was still considered to be an AE.

[0106] An adverse drug reaction (ADR) was defined as an AE evaluated by the investigator as being probably or possibly related to treatment with the IMP.

[0107] An unexpected AE was defined as an AE not identified in nature, severity, or frequency in the section "undesirable effects" in the sponsor's current investigator's summary or in the leuprolide 7.5 mg package insert.

[0108] AEs could be volunteered spontaneously by the patient, or in response to general questioning about their well-being by the investigator, or as a result of changes in systemic and local tolerability, laboratory parameters or physical examinations. All AEs were recorded. The nature of each event, time and date of onset, duration, intensity, seriousness criteria, an assessment of its cause and relationship to the study medication, the need for specific therapy and its outcome were described. The action taken because of an AE was classified according to medicinal product (no change, discontinued, other change [specified]). All medications used to treat the AE were recorded in the concomitant medication log.

[0109] All patients experiencing AEs, whether considered associated with the use of the study medication or not, were to be followed until the AE resolved, stabilized or the patient's participation in the study ended (*i.e.* until end of study visit was completed for that patient).

[0110] Any AE assessed by the investigator as serious, severe and/or possibly or probably related to the investigational product was to be followed until it had resolved or until the medical condition of the patient was stable and all relevant follow-up information had been reported to Ferring Pharmaceuticals A/S. In addition, any AE related to liver function test (LFT) was to be followed by the investigator. The outcome of an AE was classified as recovered, recovered with sequelae, not yet recovered or death.

[0111] All AEs, however minor, were documented whether or not the investigator considered the event to be related to IMP. If an AE worsened in intensity and the patient did not recover between observations, a single AE with the highest intensity was recorded. The AE reporting period was from the time the patient signed the informed consent until the end of study visit. AEs requiring therapy were treated with recognized standards of medical care to protect the health and well being of the patient. Appropriate resuscitation equipment and medicines were available to ensure the best possible treatment of an emergency situation.

[0112] AEs were graded according to the National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE). In accordance with the CTCAE criteria, AEs were rated on a five-point scale corresponding to mild, moderate, severe, life-threatening or disabling and death. For those AEs not described in the CTCAE, a separate five-point rating scale was used for rating of the intensity of AEs as follows below:

[0113] Grade 1 AEs: Mild - Minor; no specific medical intervention; asymptomatic laboratory findings only, radiographic findings only; marginal clinical relevance.

[0114] Grade 2 AEs: Moderate - minimal intervention to local intervention, or non-invasive intervention.

[0115] Grade 3: Severe - significant symptoms, requiring hospitalization or invasive intervention; transfusion; elective interventional radiological procedure; therapeutic endoscopy or operation.

[0116] Grade 4: Life-threatening or disabling - complicated by acute, life-threatening metabolic or cardiovascular complications such as circulatory failure, haemorrhage, sepsis; life-threatening physiologic consequences; need for intensive care or emergent invasive procedure; emergent interventional radiological procedure, therapeutic endoscopy

or operation.

[0117] Grade 5: Death.

[0118] Furthermore, a four-point scale was used for rating the causal relationship of the AE to the investigational product as follows.

[0119] Probable - clear-cut temporal association with improvement on cessation of test drug or reduction in dose; reappears upon re-challenge; follows a known pattern of response to test drug.

[0120] Possible - follows a reasonable temporal sequence from administration; may have been produced by the patient's clinical state or by environmental factors or other therapies administered.

[0121] Unlikely - does not follow a reasonable temporal sequence from administration. May have been produced by the subject's clinical state or by environmental factors or other therapies administered.

[0122] Unrelated - clearly and incontrovertibly due to extraneous causes, and does not meet criteria listed under unlikely, possible or probable.

[0123] Serious adverse events (SAEs) were defined as any untoward medical occurrence that at any dose resulted in death, was life-threatening, required in-patient hospitalization or prolongation of existing hospitalization, resulted in persistent or significant disability/incapacity, was an important medical event or resulted in a congenital anomaly/birth defect.

[0124] The death of a patient enrolled in this study was not considered an event per se, but rather an outcome. Any event resulting in a fatal outcome was fully documented and reported, including death, which occurred within the four weeks after treatment end, and regardless of the causality relationship to the IMP.

[0125] The term 'life-threatening' in the definition of SAEs referred to an event in which the patient was at immediate risk of death at the time of the event. It did not refer to an event, which might have caused death, if it had been more severe.

[0126] Laboratory parameters (Table 4) were recorded at screening and during the study. Details of methodology and equipment used, and the normal ranges for the various parameters are known in the art.

Table 4. Laboratory Parameters

Haematology	Clinical chemistry	Urinalysis
Haematocrit	Albumin	Haemoglobin
Haemoglobin	Alkaline phosphatase	Glucose
Mean cell haemoglobin concentration (MCHC)	Alanineaminotransferase (ALT)	Ketones
Mean cell volume (MCV)	Aspartate aminotransferase (AST)	White blood cells
Platelet count	Bicarbonate	Leucocytes
Reticulocytes	Calcium	pH
Red blood cell count (RBC)	Cholesterol	Protein
White blood cell count (WBC) with differential count (basophils, eosinophils, lymphocytes, monocytes, neutrophils)	Creatinine	Casts, granular
	Gamma-glutamyltransferase (Gamma-GT)	Casts, hyaline
	Potassium	Casts, red blood cells
	Sodium	Casts, waxy
	Total bilirubin	White blood cell casts
	Urea/Blood urea nitrogen (BUN)	Bacteria
	Uric Acid	Cholesterol
		Cystine crystals
		Leucine crystals
		Tyrosine crystals

[0127] In addition, blood samples taken pre-dose at day 0, day 168 and at the end of study visit were assessed for the presence of anti-degarelix antibodies.

[0128] Clinically significant laboratory abnormalities suggesting a disease or organ toxicity and of a severity requiring active management (*i.e.* change of dose, discontinuation of drug, more frequent follow-up or a diagnostic investigation) were to be reported as AEs.

[0129] Blood pressures and pulse were measured at Screening, before dosing at each dosing visit, and at the end of study visit. Diastolic and systolic blood pressure and pulse were measured after resting for five minutes in a sitting position. Patients were observed clinically for at least 1 hour after each administration of investigational medical product (IMP) to observe for any immediate onset hypersensitivity reaction. During the observation period, diastolic and systolic blood pressure and pulse were measured at 5, 10, 30 and 60 minutes after dosing.

[0130] A 12-lead electrocardiogram (ECG) was performed by site personnel at screening, day 0, day 3, every 12

weeks (84 days) after day 0 and at the end of study visit. ECGs were performed before dosing, if a dosing visit was scheduled. The ECGs were acquired digitally and the measurements were performed as known in the art. The ECG measurements included heart beat, PR, QRS intervals, QT and QTc, T and U wave.

[0131] Each patient also underwent a physical examination at screening, day 0, every 12 weeks thereafter and at the end of study visit. Any clinically significant abnormal findings observed at screening were recorded. Any clinically significant abnormal findings observed thereafter were recorded as AEs.

[0132] Body weight was measured at screening and the end of study visit. Height (without shoes) was measured at screening. Body mass index (BMI) is defined as the individual's body weight divided by the square of their height. The formulas universally used in medicine produce a unit of measure of kg/m². Body mass index may be accurately calculated using any of the formulas below.

Statistical Methods

[0133] All statistical analyses were performed, and summary statistics calculated, using statistical analysis software SAS™ version 9 or higher. The populations for analysis were:

The intention-to-treat (ITT) analysis set included all randomised patients who received at least one dose of investigational medicinal product (IMP).

The per protocol (PP analysis set) comprised all the ITT analysis set without any major protocol violations

The safety population was identical to the ITT analysis set, and therefore all safety analyses were performed on the ITT analysis set.

[0134] The primary efficacy endpoint was analyzed for both the ITT and PP analysis sets, with the ITT analysis set considered primary. The primary efficacy endpoint was analyzed using the Kaplan Meier method. For each of the three treatment groups, testosterone response rates with 95% confidence interval (CI) were calculated by log-log transformation of survivor function. Differences between the degarelix treatment groups and leuprolide 7.5 mg were assessed using a 97.5% CI calculated by normal approximation using pooled standard error.

[0135] To assess the efficacy of degarelix, two hypotheses were tested:

(1) The FDA criterion was to determine whether the lower bound of the 95% confidence interval (CI) for the cumulative probability of testosterone ≤ 0.5 ng/ml from Day 28 to Day 364 was no lower than 90%.

(2) The EMEA criterion was to determine whether degarelix was non-inferior to leuprolide 7.5 mg with respect to the cumulative probability of testosterone ≤ 0.5 ng/mL from Day 28 to Day 364. The non-inferiority limit for the difference between treatments (degarelix versus leuprolide 7.5 mg) was -10 percentage points.

[0136] All secondary efficacy endpoints were analysed for both the ITT and PP analysis sets, unless otherwise stated. The proportion of patients with testosterone surge during the first 2 weeks of treatment was analysed using Fisher's exact test. Fisher's exact test was also used to analyse the proportion of patients with testosterone level ≤ 0.5 ng/mL at day 3. The percentage change in PSA from baseline to day 28 endpoint was analyzed by a Wilcoxon test. For both Fisher's exact test and the Wilcoxon test, separate data presentations were made by treatment group, geographic region, weight strata (<90 kg, ≥ 90 kg) and for the leuprolide 7.5 mg subgroup.

[0137] The secondary endpoints; probability of testosterone ≤ 0.5 ng/mL from Day 56 through Day 364, time to PSA failure and probability of sufficient testosterone response from Day 28 through Day 364 were analyzed by the Kaplan-Meier method.

Efficacy Results

[0138] The primary objective of this study was to demonstrate the effectiveness of degarelix in achieving and maintaining testosterone suppression to castrate levels, evaluated as the proportion of patients with testosterone suppression ≤ 0.5 ng/mL during 12 months of treatment.

[0139] The results show that degarelix delivered at the 240/80 mg dosing regimen produced a rapid and effective suppression in testosterone levels, which remained low throughout the 364 day period of treatment (Figure 2).

[0140] Kaplan-Meier estimates of the probabilities of testosterone ≤ 0.5 ng/mL from day 28 to day 364 were 98.3%, 97.2% and 96.4% for the degarelix 240/160 mg, degarelix 240/80 mg and leuprolide 7.5 mg groups, respectively. For all three treatment groups the lower bound of the 95% CI was above the pre-specified 90% threshold. Treatment with

degarelix was demonstrated to be non-inferior to leuprolide 7.5 mg therapy with respect to the probability of testosterone ≤ 0.5 ng/mL from day 28 to day 364. For both degarelix treatment groups, the entire 97.5% CI for the difference in probability compared with the leuprolide 7.5 mg group was greater than the non-inferiority limit of -10 percentage points. Thus the study fulfilled the FDA and EMEA criteria for efficacy.

[0141] The robustness of the results for the primary efficacy endpoint was supported by an observed cases analysis, which produced similar estimates of the overall proportion of patients with testosterone ≤ 0.5 ng/mL from day 28 to day 364 for the degarelix 240/160 mg, degarelix 240/80 mg and leuprolide 7.5 mg groups of 98.2%, 97.0% and 96.0%, respectively. The findings of the primary analysis were further supported by a secondary efficacy analysis of the probability of testosterone ≤ 0.5 ng/mL from day 56 to day 364.

[0142] As expected, a significantly higher proportion of patients in the leuprolide 7.5 mg group (80.1 %) had a testosterone surge (increase $\geq 15\%$ from baseline) during the first two weeks of treatment compared with the pooled degarelix groups (0.2%: one patient) ($p < 0.0001$, Fisher's exact test). The patient treated with degarelix can be considered to be an artifact as this patient had low testosterone at baseline (0.0065 ng/mL) thus a surge from such a low baseline value was not remarkable. Conversely, 96% of patients receiving degarelix exhibited testosterone suppression on day 3 compared with no patients in the leuprolide 7.5 mg group ($p < 0.0001$, Fisher's exact test). As shown in Figure 3, the degarelix 240/ 80 mg dosing regimen rapidly and efficiently suppressed testosterone levels, while Lupron 7.5 mg acted much more gradually and only after an initial testosterone surge.

[0143] The profiles for serum levels of LH over time were similar to those observed for testosterone. Following administration of degarelix, median LH levels for the ITT analysis set decreased rapidly and were < 0.7 IU/L on day 1, a decrease of approximately 88% from baseline. For both degarelix treatment groups median LH levels remained suppressed until the end of the study on day 364. In contrast, a surge in median LH levels was observed for patients in the leuprolide 7.5 mg group, which peaked at 31.0 IU/L on day 1 ($> 400\%$ increase from baseline) before decreasing exponentially to 0.035 IU/L by day 56 and remaining at this level until day 364 (see Figure 4).

[0144] A rapid decrease in FSH levels was also observed in patients treated with degarelix. Administration of degarelix resulted in a reduction in median FSH levels to ≤ 1.5 IU/L by day 7, a $> 80\%$ decrease from baseline. For both degarelix treatment groups median FSH levels remained suppressed until the end of the study on day 364. For patients in the leuprolide 7.5 mg group there was an initial surge in FSH levels similar to that observed for LH levels which peaked at 22.5 IU/L on day 1 (146% increase from baseline) before decreasing exponentially to 2.0 IU/L by day 14. Median FSH subsequently increased around day 56 to a plateau of approximately 4.40 IU/L and stayed there until day 364 (see Figure 5).

[0145] As shown in Figure 6, the degarelix 240/ 80 mg dosing regimen also produced a more rapid and efficient reduction in PSA levels than did treatment with Lupron 7.5 mg. A rapid reduction in PSA levels was observed for patients treated with degarelix. In contrast, PSA levels in the leuprolide 7.5 mg group reached a plateau during the first week of treatment before decreasing exponentially to suppressed levels. There was a significantly greater reduction in median PSA levels from baseline that was observed on day 14 and day 28 for degarelix patients compared with leuprolide 7.5 mg patients ($p < 0.0001$, Wilcoxon test). The probability of a PSA observation from the pooled degarelix groups being less than one from the leuprolide 7.5 mg group was slightly higher on day 14 (0.82) than on day 28 (0.70). The probability of completing the study without experiencing PSA failure was highest in the degarelix 240/80 mg group (91.2%) and slightly lower ($\sim 85.8\%$) for both the degarelix 240/160 mg and leuprolide 7.5 mg groups, although this difference was not statistically significant.

[0146] Anti-androgen therapy, as per protocol, was given to 22 patients in the leuprolide 7.5 mg group at the start of treatment for flare protection. PSA data for these patients showed a greater median percentage change from baseline at day 14 (61.7% reduction) and day 28 (89.1%) compared to those patients in the leuprolide 7.5 mg group who did not receive anti-androgen therapy where the percentage reduction was 15.3 % and 61.7% at days 14 and 28, respectively. It should be noted that the median percentage change in PSA levels in the leuprolide plus antiandrogen patients was similar to those patients treated with degarelix, thereby confirming that degarelix is more effective than conventional GnRH agonist therapy at suppressing PSA at the start of treatment. Degarelix does not require additional concomitant medication as prophylaxis for flare, yet a starting dose of 240 mg has a similar effect on PSA levels as the combination of GnRH agonist plus anti-androgen.

[0147] The pharmacodynamic profile for degarelix was characteristic of a GnRH antagonist with serum levels of testosterone, LH and FSH suppressed rapidly. In contrast, for patients in the leuprolide 7.5 mg group, serum levels of testosterone, LH and FSH increased rapidly within the first week of treatment before falling to suppress levels.

Safety Results

[0148] Safety and tolerability were evaluated by observed and reported treatment-emergent AEs, including injection site reactions, haematological, clinical chemistry and urinalysis laboratory parameters, vital signs/clinical observations, and body weight measurements and physical examination, ECGs and concomitant medication.

[0149] Safety parameters were evaluated for all patients included in the ITT analysis set, comprising all 610 randomized patients who received at least one dose of study medication. All safety tables include four columns: the three treatment groups described separately, and the pooled degarelix group.

Brief Summary of Adverse Events

[0150] Adverse events were regarded as 'treatment-emergent' if they occurred in the time interval from initial dosing to end-of-study. Adverse events were considered 'pre-treatment' if they occurred between screening and the initial injections of IMP. As described above, all AEs were classified according to MedDRA (version 10.0) system organ class (SOC), sorted alphabetically, and by preferred term (PT), in decreasing frequency of occurrence. Treatment-emergent AEs were expressed in terms of intensity (using NCI CTCAE) and relationship to study drug. An overall summary of treatment-emergent AEs is presented in Table 5.

Table 5. Overall Summary of Treatment-Emergent Adverse Events

Treatment Group				
	Degarelix			Leuprolide 7.5 mg
Adverse events category	240/160 mg	240/80 mg	Total	
	N (%) E	N (%) E	N (%) E	N (%) E
ITT analysis set	202 (100%)	207 (100%)	409 (100%)	201 (100%)
All AEs	167 (83%) 941	163 (79%) 937	330 (81%) 1878	156 (78%) 777
Deaths (Grade 5)	5 (2%) 6	5 (2%) 5	10 (2%) 11	9 (4%) 10
Serious AEs	24 (12%) 41	21 (10%) 26	45 (11%) 67	28 (14%) 54
AEs leading to discontinuation	19 (9%) 19	15 (7%) 15	34 (8%) 34	12 (6%) 12
ADRs	120 (59%) 463	118 (57%) 459	238 (58%) 922	84 (42%) 146
N = number of patients with adverse events				
% = percentage of patients with adverse events				
E = number of adverse events				
ADR = AE assessed by investigator as possibly/probably related to investigational product				
Common Toxicity Criteria for Adverse Events used for intensity grading				

[0151] The overall percentages of patients experiencing treatment-emergent AEs were comparable across all three treatment groups. 167 (83%) patients in the degarelix 240/160 mg group reported treatment-emergent AEs, compared with 163 (79%) patients in the degarelix 240/80 mg group, and 156 (78%) patients in the leuprolide 7.5 mg group. In total, there were reports of ADRs in 238 (58%) pooled degarelix patients, with 120 (59%) patients in the degarelix 240/160 mg group, 118 (57%) patients in the degarelix 240/80 mg group. For the leuprolide 7.5 mg group, 42% patients reported ADRs. This difference was expected and could be accounted for entirely by injection-related AEs (injection site related side effects), which exhibited higher rates in the degarelix pooled arms. Excluding injection-site ADRs, the incidences of the remaining ADRs were similar in the three treatment groups:

88 ((44%) patients reported ADRs, excluding injections site reactions, in the degarelix 240/160 mg group

90 ((43%) patients reported ADRs, excluding injections site reactions, in the degarelix 240/80 mg group

84 ((42%) patients reported ADRs, excluding injections site reactions, in the leuprolide 7.5 mg group.

[0152] Such results suggest that both the degarelix maintenance doses (80@20 mg/mL or 160@40 mg/ml) resulted in a similar incidence of ADRs.

[0153] A total of 45 (11%) pooled degarelix patients reported 67 serious AEs, including ten deaths. Overall, 24 (12%)

patients in the degarelix 240/160 mg group reported serious AEs, compared with 21 (10%) patients in the degarelix 240/80 mg group, and 28 (14%) patients, including 9 deaths, in the leuprolide 7.5 mg group. All deaths were assessed to be unrelated or unlikely to be related to study treatment. Such results should also be interpreted in the knowledge that this is an elderly patient population (mean age 72 years) with both prostate cancer and other underlying health issues.

[0154] Thirty-four (8%) pooled degarelix patients were reported as being withdrawn due to AEs (including both fatal and non-fatal AEs); 19 (9%) patients in the degarelix 240/160 mg group and 15 (7%) patients in the degarelix 240/80 mg group, and there were 12 (6%) patients withdrawn in the leuprolide 7.5 mg group. Of the pooled degarelix patients, there were reports for 17 patients of SAEs that led to withdrawal.

Detailed Analysis of Adverse Events

[0155] While the overall occurrence of adverse events was similar in the two degarelix treatment groups and the leuprolide control group, a large majority of such events for the degarelix treatment groups were mere injection site reactions related to the subcutaneous/depot delivery system employed for degarelix. In comparison, leuprolide intramuscular injection was not associated with such a high rate of injection site reactions even though the overall rate of adverse occurrence was similar. Accordingly, a detailed analysis of the precise type of adverse events occurring in each study group was undertaken to characterize the types of adverse events, other than injection site reactions (injection site related side effects), that must be occurring in the leuprolide treatment group to account for the overall similar adverse event occurrence rates.

[0156] Table 6 shows a summary of the number of patients reporting treatment-emergent AEs, presented by SOC. All treatment-emergent AEs are presented by system organ class and Med-DRA preferred term.

Table 6. Treatment-Emergent Adverse Events by System Organ Class

	Treatment Group			
	Degarelix			Leuprolide 7.5 mg
MedDRA System Organ Class	240/160 mg	240/80 mg	Total	
	N (%)	N (%)	N (%)	N (%)
ITT analysis set	202 (100%)	207 (100%)	409 (100%)	201 (100%)
Treatment-emergent adverse events	167 (83%)	163 (79%)	330 (81%)	156 (78%)
BLOOD & LYMPHATIC SYSTEM DISORDERS	11 (5%)	5 (2%)	16 (4%)	12 (6%)
CARDIAC DISORDERS	19 (9%)	17 (8%)	36 (9%)	27 (13%)
CONGENITAL, FAMILIAL & GENETIC DISORDERS				1 (<1%)
EAR & LABYRINTH DISORDERS	3 (1%)	6 (3%)	9 (2%)	3 (1%)
ENDOCRINE DISORDERS	2 (<1%)		2 (<1%)	3 (1%)
EYE DISORDERS	4 (2%)	6 (3%)	10 (2%)	5 (2%)
GASTROINTESTINAL DISORDERS	33 (16%)	38 (18%)	71 (17%)	39 (19%)
GENERAL DISORDERS & ADMINISTRATION SITE CONDITIONS	102 (50%)	92 (44%)	194 (47%)	36 (18%)
HEPATOBIILIARYDISORDERS	2 (<1%)	2 (<1%)	4 (<1%)	3 (1%)
IMMUNE SYSTEM DISORDERS	1 (<1%)	1 (<1%)	2 (<1%)	2 (<1%)
INFECTIONS & INFESTATIONS	38 (19%)	45 (22%)	83 (20%)	49 (24%)
INJURY, POISONING & PROCEDURAL COMPLICATIONS	11 (5%)	10 (5%)	21 (5%)	17 (8%)
INVESTIGATIONS	58 (29%)	54 (26%)	112 (27%)	62 (31%)
METABOLISM & NUTRITION DISORDERS	26 (13%)	14 (7%)	40 (10%)	15 (7%)

(continued)

	Treatment Group			
	Degarelix			Leuprolide 7.5 mg
MedDRA System Organ Class	240/160 mg	240/80 mg	Total	
MUSCULOSKELETAL & CONNECTIVE TISSUE DISORDERS	37 (18%)	31 (15%)	68 (17%)	53 (26%)
NEOPLASMS BENIGN, MALIGNANT & UNSPECIFIED (INCL CYSTS AND POLYPS)	12 (6%)	10 (5%)	22 (5%)	16 (8%)
NERVOUS SYSTEM DISORDERS	27 (13%)	24 (12%)	51 (12%)	23 (11%)
PSYCHIATRIC DISORDERS	16 (8%)	16 (8%)	32 (8%)	21 (10%)
RENAL & URINARY DISORDERS	26 (13%)	28 (14%)	54 (13%)	39 (19%)
REPRODUCTIVE SYSTEM & BREAST DISORDERS	13 (6%)	9 (4%)	22 (5%)	21 (10%)
RESPIRATORY, THORACIC & MEDIASTINAL DISORDERS	17 (8%)	25 (12%)	42(10%)	18 (9%)
SKIN & SUBCUTANEOUS TISSUE DISORDERS	21 (10%)	18 (9%)	39 (10%)	10 (5%)
SURGICAL & MEDICAL PROCEDURES	2 (<1%)		2 (<1%)	
VASCULAR DISORDERS	65 (32%)	71 (34%)	136 (33%)	60 (30%)
N = number of patients with adverse events				
% = percentage of patients with adverse events				

[0157] Treatment-emergent AEs were reported for a comparable percentage of patients across all three treatment groups: 83%, 79% and 78% of patients in the degarelix 240/160 mg, degarelix 240/80 mg and leuprolide 7.5 mg groups, respectively. As shown in Table 6 above, there were no marked differences between the SOC's affected for the two degarelix treatment groups. The predominant system-organ class affected for degarelix patients in both treatment groups was 'General Disorders and Administration Site Conditions', reported for 47% pooled degarelix patients, and 18% leuprolide 7.5 mg patients. The majority of these AEs were injection site pain, which occurred in 29% of pooled degarelix patients. In addition, 'vascular disorders' were reported for 33% degarelix patients, and 30% leuprolide 7.5 mg patients, primarily hot flushes. Other SOC's affected in ≥15% patients were: 'investigations' in 27% degarelix patients and 31 % leuprolide 7.5 mg patients, 'infections and infestations' in 20% and 24% patients, respectively, 'musculoskeletal and connective tissue disorders' in 17% and 26% patients, respectively, and 'gastrointestinal disorders' in 17% and 19% patients, respectively. The most frequent musculoskeletal and connective tissue disorders were back pain, reported by 6% of degarelix patients and 8% of leuprolide 7.5 mg patients, and arthralgia reported for 4% of degarelix patients and 9% of leuprolide 7.5 mg patients.

[0158] In examining the SOC's of AEs associated with degarelix treatment as compared to leuprolide, several areas of increased risk for leuprolide as compared to degarelix emerged. For example, 'musculoskeletal and connective tissue disorders' occurred in 26% of leuprolide patients, as compared to only 17% of degarelix patients overall (and even lower, 15% in the degarelix 240/80 mg treatment group). Furthermore, 'renal and urinary disorders' occurred in 19% of leuprolide patients, but only 13% of degarelix patients, while 'reproductive system and breast disorders' occurred in 10% of leuprolide patients, but only 5% of degarelix patients. Furthermore, 'cardiac disorders' occurred at a slightly increased overall frequency for leuprolide treatment (13%) than for degarelix (9% overall between the two treatment groups). This may be of particular interest, since, as addressed above, there is some concern in the art that certain androgen deprivation therapies adversely affect cardiovascular health (see Yannucci et al. (2006) J. Urology 176:520-525; and Etzioni et al. (1999) J. Natl. Canc. Inst. 91:1033). Accordingly, androgen deprivation therapies that minimize the risk of cardiovascular side effects are particularly desirable.

[0159] The increased risk for cardiac disorders, musculoskeletal and connective tissue disorders, renal and urinary disorders, and reproductive system disorders for leuprolide as compared to degarelix likely account for the overall similarity in adverse events between leuprolide and degarelix, despite the fact that most of the adverse events seen with degarelix were mere injection site reactions related to the mode of subcutaneous delivery and not to adverse systemic effects on other organ systems.

[0160] As shown in Table 7, the most frequently reported treatment-emergent AEs for patients treated with degarelix were injections site reactions (particularly injection site pain and erythema). The most frequently reported AE for both degarelix and leuprolide patients during the study were flushing events: overall, 52 (26%) patients in the degarelix 240/160 mg group reported hot flushes, compared to 53 (26%) patients in the degarelix 240/80 mg group, and 43 (21%) patients in the leuprolide 7.5 mg group.

Table 7. Adverse Events by System Organ Class and Preferred Term Occurring in $\geq 5\%$ of any Treatment Group

MedDRA System Organ Class/ Preferred Term	Treatment Group			
	Degarelix			Leuprolide 7.5 mg
	240/160 mg	240/80 mg	Total	
	N (%)	N (%)	N (%)	N (%)
ITT analysis set	202 (100%)	207 (100%)	409 (100%)	201 (100%)
Treatment-emergent adverse events	167 (83%)	163 (79%)	330 (81%)	156 (78%)
GASTROINTESTINAL DISORDERS	33 (16%)	38 (18%)	71 (17%)	39 (19%)
Nausea	11 (5%)	9 (4%)	20 (5%)	8 (4%)
Constipation	6 (3%)	11 (5%)	17 (4%)	10 (5%)
GENERAL DISORDERS AND ADMINISTRATION SITE CONDITIONS	102 (50%)	92 (44%)	194 (47%)	36 (18%)
Injection site pain	61 (30%)	58 (28%)	119 (29%)	1 (<1%)
Injection site erythema	48 (24%)	36 (17%)	84 (21%)	
Injection site swelling	14 (7%)	13 (6%)	27 (7%)	
Fatigue	13 (6%)	7 (3%)	20 (5%)	13 (6%)
Injection site induration	11 (5%)	8 (4%)	19 (5%)	
Injection site nodule	13 (6%)	6 (3%)	19 (5%)	
Chills	7 (3%)	11 (5%)	18 (4%)	
INFECTIONS AND INFESTATIONS	38 (19%)	45 (22%)	83 (20%)	49 (24%)
Urinary tract infection	3 (1%)	10 (5%)	13 (3%)	18 (9%)
INVESTIGATIONS	58 (29%)	54 (26%)	112 (27%)	62 (31%)
Weight increased	22 (11%)	18 (9%)	40 (10%)	24 (12%)
Alanine aminotransferase increased	17 (8%)	20 (10%)	37 (9%)	11 (5%)
Aspartate aminotransferase increased	10 (5%)	11 (5%)	21 (5%)	6 (3%)
METABOLISM AND NUTRITION DISORDERS	26 (13%)	14 (7%)	40 (10%)	15 (7%)
Hypercholesterolaemia	12 (6%)	7 (3%)	19 (5%)	5 (2%)
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	37 (18%)	31 (15%)	68 (17%)	53 (26%)
Back pain	12 (6%)	12 (6%)	24 (6%)	17 (8%)
Arthralgia	6 (3%)	11 (5%)	17 (4%)	18 (9%)
VASCULAR DISORDERS	65 (32%)	71 (34%)	136 (33%)	60 (30%)
Hot flush	52 (26%)	53 (26%)	105 (26%)	43 (21%)
Hypertension	14 (7%)	12 (6%)	26 (6%)	8 (4%)
N = number of patients with adverse events				
% = percentage of patients with adverse events				

[0161] Long-term treatment with degarelix and leuprolide 7.5 mg was anticipated to result in adverse reactions asso-

ciated with testosterone suppression such as hot flushes, loss of libido, impotence and infertility, and increased sweating. It was therefore to be expected that flushing events would be relatively common and largely considered possibly or probably related to treatment. However, very few AEs related to sexual dysfunction or sweating were reported. In total, there were reports for 22 (5%) pooled degarelix patients and 21 (10%) leuprolide patients with reproductive system/breast disorders and approximately 1 % patients treated with degarelix with sweating disorders (skin and subcutaneous tissues SOC): six (1%) of patients reported erectile dysfunction, six (1%) of patients reported night sweats, four (<1%) of patients experienced testicular pain, three (<1%) of patients reported pelvic pain, three (<1%) of patients reported hyperhidrosis, two (2%) of patients each experienced gynaecomastia, prostatitis or testicular atrophy, and all other reproductive system/breast disorders were reported by one (<1%) of patients, and no other sweating disorders were reported.

[0162] An analysis of these SOC/preferred term data further support the finding discussed above for diminished musculoskeletal disorders, and renal and urinary disorders for degarelix as compared to leuprolide treatments. For example, 9% of leuprolide patients experienced urinary tract infections during the course of treatment as compared to only 3% of all degarelix-treated patients. Similarly, 9% of leuprolide patients experienced arthralgia (joint pain) during the course of treatment while only 4% of all degarelix-treated patients experienced arthralgia.

[0163] To summarize, the incidence of treatment-emergent AEs was similar for patients treated with degarelix and leuprolide 7.5 mg. Treatment-emergent AEs were reported by 330 (81%) patients in the pooled degarelix treatment groups and by 156 (78%) patients in the leuprolide 7.5 mg group. The majority of AEs were of mild or moderate intensity.

[0164] There were 58% of patients treated with degarelix with reported AEs considered to be possibly/probably related to IMP by the Investigator (ADR) and those treated with leuprolide 7.5 mg had 42% ADRs. However the majority of treatment-emergent ADRs were general disorders and administration site conditions including injection-site reactions which occurred in 173 (42%) patients in the pooled degarelix group. For patients treated with degarelix, the overall incidence of treatment-emergent injection site reactions was 4.4 per 100 injections. Most injection site reactions occurred after the first dose of degarelix where two injections were administered and injection site reactions were decreased over time. Among MedDRA preferred terms, the highest incidences were injection site pain (2.9 per 100 injections) and injection site erythema (1.9 per 100 injections) for the pooled degarelix group. All other preferred terms had an incidence rate of 0.5 per 100 injections or less. None of the injection-related ADRs were considered to be serious, and there were no immediate onset hypersensitivity reactions. Five (1.2%) patients reported degarelix-related injection site reactions, which led to withdrawal. Other commonly reported ADRs were hot flushes which were an expected adverse reaction associated with testosterone suppression. In total, hot flushes were reported by 104 (25%) patients treated with degarelix and 42 (21 %) treated with leuprolide 7.5 mg. One patient treated with degarelix reported a hot flush ADR, which led to withdrawal. Notably, although AEs related to sexual dysfunction would be anticipated to result from testosterone suppression, very few were actually reported.

[0165] There were 121 serious adverse events SAEs reported by 73 (12%) patients, with relatively equal incidence across the treatment groups. The most common SAEs were cardiac disorders, which occurred in ten (2%) patients in the pooled degarelix group and ten (5%) patients in the leuprolide 7.5 mg group; and renal and urinary disorders, which occurred in 10 (2%) patients in the pooled degarelix group and six (3%) patients in the leuprolide 7.5 mg group.

[0166] Weight increase is a known effect of androgen deprivation and markedly abnormal increases in weight of $\geq 7\%$ from baseline were observed in 10% patients treated with degarelix and 13% patients treated with leuprolide 7.5 mg. The incidence of other markedly abnormal changes in vital signs was consistent with a group of elderly patients many of whom had a medical history of cardiac disease or hypertension.

[0167] Therefore, while degarelix treatment resulted in a significant number of subjects experiencing minor injection site reactions, these adverse effects were remarkably less serious than many of those associated with the GnRH agonist leuprolide. Notably, these minor injection site reactions were also much less serious than the potentially life-threatening effects associated with another GnRH antagonist, Abarelix (Plenaxis in the U.S.) (see www.fda.gov/cder/drug/infopage/plenaxis). Indeed Abarelix/Plenaxis has been associated with serious allergic reactions (e.g., swelling of the tongue/throat, asthma, wheezing and serious breathing problems), and therefore is only available through a special "user safety program" to ensure that it is safely used by doctors with the right skills to administer and monitor the drug.

Further Statistical Analyses of Subgroup Populations

[0168] Further statistical analysis of the CS21 clinical study results was undertaken in order to determine whether any of the advantages in superior efficacy and/or diminished side effects of degarelix over leuprolide treatment were particularly pronounced in certain patient subgroups. Particular attention was paid to whether particular patient subgroups were responsible for any of the diminished cardiac, arthralgic and/or urinary tract infection side effects seen with degarelix treatment as compared to leuprolide treatment.

[0169] Using the results from the summary of clinical efficacy (SCE) and summary of clinical safety (SCS) findings, different patient subgroups were analyzed. Subgroup distinguishers included race (white, black, and other), age (<65 years, ≥ 65 years to < 70 years, and ≥ 75 years), weight (<70 kg, ≥ 70 - <90 kg, and ≥ 90 kg), body mass index (BMI) (\leq

20, > 20 to 30, and > 30 kg/m²), region (North-America, Western Europe, Central and Eastern Europe and Other), and stage of prostate cancer (e.g., localized, locally advanced, and metastatic).

[0170] The SCS summarizes both crude incidences (n/N) as well as incidence rates of adverse events (number of patients with at least one adverse event investigated per 1,000 person years) including exact 95 % CI based on the Poisson model and presented per MedDRA Preferred term (and grouped by SOC) for all study-groups, including the CS21 trial (the trial comprising the controlled phase 3 study group) and for all sub-groups. Briefly, the Poisson model

provides exact 1- α lower (LL) and upper (UL) confidence limits are $LL = \chi^2_{2x; \alpha/2} / (2T)$ and

$UL = \chi^2_{2(x+1); 1-\alpha/2} / (2T)$, respectively, where T is the number of 1,000 person years and x= number of

subjects at least once having reported the adverse event under investigation (see Gerlinger et al. (2003) Eur. J. Contracept. Reprod. Health Care 8:87-92).

[0171] For the phase 3 controlled study (CS21), crude incidences in the degarelix arms were compared to those in the leuprolide 7.5 mg arm using two-sided Fisher exact test and corresponding P-value as a flagging device. These P values were presented as * (0.01 < P ≤ 0.05), ** (0.001 < P ≤ 0.01), and *** (P ≤ 0.001). Similarly, incidence rates were compared using P values associated with the Poisson model-based UMPU test. Briefly, assuming $x_i \sim \text{Poisson}(\lambda_i T_i)$, where x_i = the number of subjects with the event, T_i = total number of 1,000 person years in arm i and λ_i = incidence rate in arm i ($i=1,2$), then the P value = 2 min (P(S ≥ 1), P(S ≤ x_1), 0.5), where $S \sim \text{Binomial}(x_1 + x_2, T_1 / (T_1 + T_2))$ (see, e.g. Lehmann (1986) Testing Statistical Hypotheses, 2nd edition, Springer-Verlag, New York).

[0172] Based on these results all adverse events (on SOC or PT level) that demonstrated a statistically significantly (P ≤ 0.05) or borderline significantly (0.05 < P < 0.2) lower incidence or incidence rate in the degarelix arm as compared to leuprolide 7.5 mg were identified.

[0173] In the SCS, cardiovascular events were more specifically investigated on more aggregated MedDRA levels, i.e. the incidence, and incidence rates of subject with AEs in the following High Level Group Terms were tabulated by study group and treatment:

HLGT = Central nervous system vascular disorders

HLGT = Cardiac arrhythmias

HLGT = Coronary artery disorders

HLGT = Heart failures

[0174] To further substantiate apparent, but potentially isolated evidence on a detailed Preferred Term level that degarelix shows lower incidence rates than leuprolide with regard to specific cardiac disorders, the incidence rates with regard to the above-mentioned HLGTs, as well as the SOC=Cardiac Disorders these HLGTs belong to, were tested with regard to subgroups based on possible risk-factor (cholesterol, BMI, body weight, systolic/diastolic blood pressure, medical history of cardiac disorder, age, pulse). These subgroup analyses were not pre-planned as part of the SCS. By testing statistical significance of risk-factor by treatment (degarelix/leuprolide 7.5 mg) interaction in a time to event analyses (Cox Proportional hazard model) these covariates were screened for potential subgroup effects. Body mass index and to a lesser extent cholesterol were identified accordingly. Next, BMI subgroups (<25, 25 to <30, and ≥ 30 kg/m²) and low /normal cholesterol subgroups (≤ 4 mmol/L and > 4 mmol/L, respectively) were used to test and quantify differences in incidence rates between degarelix and leuprolide, along using the Poisson model mentioned above. Statistically significant lower incidence rate as compared to leuprolide were noted in patients with BMI < 25 kg/m² with regard to SOC=Cardiac Disorders (P=0.0045), HLGT=Coronary artery disorders (P=0.005), and HLGT=Cardiac Arrhythmias (borderline, P=0.056), with Relative risks of respectively 0.242 (95% CI: 0.08 - 0.67), 0.0 (95% CI: 0.0 - 0.47), and 0.312 (95% CI: 0.09 - 1.03). Statistically significantly lower incidence rate as compared to leuprolide were noted in patients with Cholesterol greater than or equal to 4 mmol/L with regard to HLGT=Cardiac Arrhythmias (P=0.035), with relative risks of respectively 0.41 (95% CI: 0.18 - 0.94).

[0175] See Tables 8-10 for efficacy findings in subgroups from the SCE, Tables 11-19 for subgroup findings from the SCS, and Tables 20-23 for the explorative substantiating subgroup findings on cardiovascular risk. In summary, notable findings include:

[0176] Time to testosterone escape during Days 28, 56, ..., 364 in the age < 65 subgroup is significantly superior to LUPRON DEPOT® 7.5 mg for both degarelix dosing regimens (see Table 8 below).

Table 8. One year efficacy results for the testosterone endpoints for Controlled Study CS21 in the age < 65 subgroup

Dosing regimen	Probability of testosterone ≤ 0.5 ng/ml from Day 28 through Day 364			Probability of testosterone ≤ 0.5 ng/ml from Day 56 trough Day 364			Probability of sufficient testosterone response*		
	(%)	95% CI	N	(%)	95% CI	N	(%)	95% CI	N
Degarelix 240/40/80@20	97.4%	82.8;99.6%	43	97.4%	82.8;99.6%	43	97.4%	82.8;99.6%	43
Degarelix 240/160@40	96.7%	78.6;99.5%	37	96.7%	78.6;99.5%	37	96.7%	78.6;99.5%	37
LUPRON DEPOT@ 7.5 mg	89.5%	74.3;95.9%	38	89.5%	74.3;95.9%	38	92.1%	77.5;97.4%	38
Log-rank test:									
Degarelix 240/40/80@20 vs. LUPRON DEPOT® 7.5 mg	p=0.1318			p=0.1318			p=0.2588		
Degarelix 240/160@40 vs. LUPRON DEPOT® 7.5 mg	p=0.1851			p=0.1851			p=0.3373		
Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg), * 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).									

[0177] Time to PSA failure is significantly ($P=0.03$) superior in the degarelix 240/80 mg group as compared to LUPRON DEPOT® 7.5 mg in the age > 75 year group, and also ($P=0.06$) significantly better in the <65 age group (see Table 9 below).

Table 9. One year efficacy results for the PSA endpoints for Controlled Study CS21 - by age subgroups

Age (years) =<65			
Dosing regimen	Probability of no PSA failure*		
	(%)	95% CI	N
Degarelix 240@40/80@20	85.2%	70.0;93.1%	43
Degarelix 240/160@40	71.6%	53.6;83.6%	37
LUPRON DEPOT® 7.5 mg	68.2%	50.9;80.6%	38
	Log-rank test:		
Degarelix 240@40/80@20 vs. LUPRON DEPOT® 7.5 mg	p=0.0679		
Degarelix 240/160@40 vs. LUPRON DEPOT® 7.5 mg	p=0.7273		
Age (years) = >=75			
Dosing regimen	Probability of no PSA failure*		
	(%)	95% CI	N
Degarelix 240@40/80@20	96.6%	87.0;99.1%	78
Deqarelix 240/160@40	94.5%	85.9;97.9%	82
LUPRON DEPOT® 7.5 mg	86.8%	77.4;92.5%	92
	Log-rank test:		
Degarelix 240@40/80@20 vs. LUPRON DEPOT® 7.5 mg	p=0.0376		
Degarelix 240/160@40 vs. LUPRON DEPOT® 7.5 mg	p=0.1125		
Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg),			
* = 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).			

[0178] PSA percent change from baseline is more pronounced in the patient with metastatic stage prostate cancer (See Table 10 below). All subgroups are statistically significantly better than LUPRON DEPOT® 7.5 mg.

Table 10. Effect of starting dose on PSA during first month of treatment for Controlled Study CS21 - by stage of prostate cancer subgroups

PCA = Localized						
Day 0 dose	Day 14 percentage change in PSA			Day 28 percentage change in PSA		
	Median %	InterQuartile Range	N	Median %	InterQuartile Range	N
Degarelix 240@40	-50.6%	-65.0;-30.4%	128	-75.0%	-85.2;-60.5%	128
LUPRON DEPOT® 7.5 mg	-13.2%	-29.3;-0.518%	63	-55.7%	-66.7;-33.8%	63
Wilcoxon rank sum test:						
Degarelix 240@40 vs. LUPRON DEPOT® 7.5 mg	p=<.0001			p=<.0001		

EP 2 505 204 B1

(continued)

PCA - Locally advanced						
	Median %	InterQuartile Range	N	Median %	InterQuartile Range	N
Degarelix 240@40	-66.6%	-75.9;-49.6%	126	-84.1%	-91.8;-75.0%	126
LUPRON DEPOT® 7.5 mg	-21.3%	-36.2;-9.20%	52	-73.2%	-84.0;-50.0%	52
	Wilcoxon rank sum test:					
Degarelix 240@40 vs. LUPRON DEPOT® 7.5 mg	p=<.0001			p=<.0001		
PCA = Metastatic						
	Median %	InterQuartile Range	N	Median %	InterQuartile Range	N
Degarelix 240@40	-77.9%	-85.3;-62.3%	78	-89.9%	-95.6;-83.1%	78
LUPRON DEPOT® 7.5 mg	-25.3%	-53.2;-0.943%	47	-79.7%	-90.6;-70.7%	47
	Wilcoxon rank sum test:					
Degarelix 240@40 vs. LUPRON DEPOT® 7.5 mg	p=<.0001			p=0.0003		
Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg), * = 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).						

[0179] Notable statistically significant findings in the total trial population are (See Table 11):

Myocardial Infarction (PT): 0.5 % (2/409, degarelix combined) versus 2.5% (5/201, LUPRON DEPOT ® 7.5 mg),

Oedema peripheral (PT) 2% (8/409, degarelix combined) versus 5% (10/201, LUPRON DEPOT ® 7.5 mg),

Chest pain: 0.5% (2/409, degarelix combined) versus 3% (6/201, LUPRON DEPOT ® 7.5 mg),

Urinary Tract infection (PT) 3 % (13/409, degarelix combined) versus 9% (18/201, LUPRON DEPOT ® 7.5 mg),

Cardiac murmur (PT): 0 % (0/409, degarelix combined) versus 1.5% (3/201, LUPRON DEPOT ® 7.5 mg),

Musculoskeletal and connective tissue disorders (SOC): 17 % (68/409, degarelix combined) versus 26% (53/201, LUPRON DEPOT ® 7.5 mg),

Arthralgia (PT within Musculoskeletal and CTD SOC): 4.2% (17/409, degarelix combined) versus 9% (18/201, LUPRON DEPOT ® 7.5 mg),

Musculoskeletal stiffness (PT within Musculoskeletal and CTD SOC): 0% (0/409, degarelix combined) versus 1% (3/201, LUPRON DEPOT ® 7.5 mg),

Libido decreased: 0% (0/409, degarelix combined) versus 1.5% (3/201, LUPRON DEPOT ® 7.5 mg),

Urinary retention: 1.2% (5/409, degarelix combined) versus 4.5% (9/201, LUPRON DEPOT ® 7.5 mg),

Cystitis noninfective: 0% (0/409, degarelix combined) versus 2% (4/201, LUPRON DEPOT ® 7.5 mg),

Erectile dysfunction: 1.5% (6/409, degarelix combined) versus 4.5% (9/201, LUPRON DEPOT ® 7.5 mg),

DVT: 0% (0/409, degarelix combined) versus 1.5% (3/201, LUPRON DEPOT ® 7.5 mg).

[0180] Particularly notable statistically significant findings in and across subgroups are indicated.

Table 11. Crude Incidence of Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term

MedDRA System Organ Class/ Preferred Term	One-Month Controlled	
	Degarelix	LUPRON DEPORT® 7.5 mg
	N (%)	N (%)
Exposed Subjects	409 (100%)	201 (100%)
Total No. of Subjects with Adverse Events	330 (81%)	156 (78%)
BLOOD AND LYMPHATIC SYSTEM DISORDERS	16 (4%)	12 (6%)
Myocardial ischaemia	2 (<1%)*	5 (2%)*
GENERAL DISORDERS AND ADMINISTRATION SITE CONDITIONS		
Oedema peripheral	8 (2%)*	10 (5%)*
Chest pain	2 (<1%)*	6 (3%)*
INFECTIONS AND INFESTATIONS		
Urinary tract infection	13 (3%)**	18 (9%)**
INVESTIGATIONS	113 (28%)	62 (31%)
Cardiac murmur		3 (1%)*
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	68 (17%)**	53 (26%)**
Arthralgia	17 (4%)*	18 (9%)*
Musculoskeletal stiffness		3 (1%)*
PSYCHIATRIC DISORDERS		
Libido decreased	0	3 (1%)*
RENAL AND URINARY DISORDERS		
Urinary retention	5 (1%)*	9 (4%)*
Cystitis noninfective		4 (2%)*
REPRODUCTIVE SYSTEM AND BREAST DISORDERS	22 (5%)*	21 (10%)*
Erectile dysfunction	6 (1%)*	9 (4%)*
VASCULAR DISORDERS		
Deep vein thrombosis	0	3 (1%)*
Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg), * 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).		

[0181] Musculoskeletal and connective tissue disorders (SOC) and Arthralgia superiority is not just confined to the metastatic, but in all disease stage subgroup (see Table 12). Arthralgia is statistically significant in locally advanced patients.

EP 2 505 204 B1

Table 12. Crude Incidence of Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term - by Stage of Prostate Cancer

PCA = Localised		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Exposed Subjects	128 (100%)	63 (100%)
Total No. of Subjects with Adverse Events	104 (81%)	48 (76%)
GENERAL DISORDERS AND ADMINISTRATION SITE CONDITIONS		
Oedema peripheral	2 (2%)*	6 (10%)*
INFECTIONS AND INFESTATIONS	22 (17%)	14 (22%)
Urinary tract infection	2 (2%)*	5 (8%)*
Upper respiratory tract infection	4 (3%)	6 (10%)
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	20 (16%)	16 (25%)
NEOPLASMS BENIGN, MALIGNANT AND UNSPECIFIED (INCL CYSTS AND POLYPS)	4 (3%)	6 (10%)
PSYCHIATRIC DISORDERS	11 (9%)	9 (14%)
Depression	1 (<1%)*	4 (6%)*
Libido decreased		2 (3%)
REPRODUCTIVE SYSTEM AND BREAST DISORDERS	5 (4%)	7 (11%)
Gynaecomastia	1 (<1%)	2 (3%)
Erectile dysfunction	1 (<1%)*	4 (6%)*
PCA = Locally advanced		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Exposed Subjects	126 (100%)	52 (100%)
Total No. of Subjects with Adverse Events	93 (74%)	37 (71%)
CARDIAC DISORDERS	4 (3%)	5 (10%)

EP 2 505 204 B1

(continued)

PCA = Locally advanced		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Atrioventricular block first degree		3 (6%)*
GASTROINTESTINAL DISORDERS	16 (13%)	11 (21%)
Diarrhoea	1 (<1%)*	4 (8%)*
INFECTIONS AND INFESTATIONS	16 (13%)	11 (21%)
Urinary tract infection	1 (<1%)**	5 (10%)**
INJURY, POISONING AND PROCEDURAL COMPLICATIONS	2 (2%)**	6 (12%)**
PCA = Locally advanced (con't.)		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
	N (%)	N (%)
Fall	1 (<1%)	1 (2%)
Excoriation		2 (4%)
Muscle strain	1 (<1%)	
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	13 (10%)	10 (19%)
Back pain	6 (5%)	4 (8%)
Arthralgia	2 (2%)**	7 (13%)**
RESPIRATORY, THORACIC AND MEDIASTINAL DISORDERS	9 (7%)	5 (10%)
Dyspnoea	0	3 (6%)*
PCA = Metastatic		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Exposed Subjects	78 (100%)	47 (100%)
Total No. of Subjects with Adverse Events	63 (81%)	39 (83%)
GASTROINTESTINAL DISORDERS	12 (15%)	12 (26%)
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	16 (21%)	17 (36%)
Back pain	4 (5%)	6 (13%)

(continued)

PCA = Metastatic		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Arthralgia	4 (5%)	6 (13%)
Pain in extremity	1 (1%)	4 (9%)
Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg), * = 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).		

[0182] Renal And Urinary Disorders and Musculoskeletal and Connective Tissue disorders in Age <65 group (see Table 13)

Table 13. Crude Incidence of Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term - in the age < 65 subgroup

Age (years) = <65		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Exposed Subjects	80 (100%)	38 (100%)
Total No. of Subjects with Adverse Events	60 (75%)	31 (82%)
GASTROINTESTINAL DISORDERS	7 (9%)*	9 (24%)*
INFECTIONS AND INFESTATIONS	13 (16%)	10 (26%)
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	7 (9%)**	13 (34%)**
Arthralgia		5 (13%)**
RENAL AND URINARY DISORDERS	8 (10%)*	11 (29%)*
Urinary retention	1 (1%)*	5 (13%)*
Note: No findings in the other age-categories		
Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg), * = 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).		

[0183] See Table 14 and Table 15 for further subgroup findings.

Table 14. Crude Incidence of Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term - by Body Weight categories

Weight (kg) = <70		
	One-Month Controlled	
	Degarelix	LUPRONDEPOT®7.5 mg
MedDRA System Organ Class/Preferred Term		
	N (%)	N (%)
Exposed Subjects	102 (100%)	39 (100%)
Total No. of Subjects with Adverse Events	80 (78%)	30 (77%)
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	17 (17%)*	14 (36%)*
Arthralgia	3 (3%)**	7 (18%)**
REPRODUCTIVE SYSTEM AND BREAST DISORDERS	4 (4%)*	7 (18%)*
Pelvic pain	0	3 (8%)*
Weight (kg) = 70-<90		
	One-Month Controlled	
	Degarelix	LUPRONDEPOT®7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Exposed Subjects	227 (100%)	125 (100%)
Total No. of Subjects with Adverse Events	183 (81%)	95 (76%)
CARDIAC DISORDERS	12 (5%)*	16 (13%)*
NERVOUS SYSTEM DISORDERS	27 (12%)	13 (10%)
Syncope		3 (2%)*
REPRODUCTIVE SYSTEM AND BREAST DISORDERS	11 (5%)	10 (8%)
Erectile dysfunction	2 (<1%)*	7 (6%)*
Weight (kg) = >=90		
	One-Month Controlled	
	Degarelix	LUPRONDEPOT®7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Exposed Subjects	80 (100%)	37 (100%)
Total No. of Subjects with Adverse Events	67 (84%)	31 (84%)
INFECTIONS AND INFESTATIONS	21 (26%)	12 (32%)
Urinary tract infection	2 (3%)*	5 (14%)*
Bronchitis		3 (8%)*
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	12 (15%)*	12 (32%)*

EP 2 505 204 B1

(continued)

Weight (kg) = >=90		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Arthralgia	4 (5%)	4 (11%)
Back pain	4 (5%)*	7 (19%)*
NEOPLASMS BENIGN, MALIGNANT AND UNSPECIFIED (INCL CYSTS AND POLYPS)	1 (1%)*	4 (11%)*
Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg), * = 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).		

Table 15. Crude Incidence of Treatment-Emergent Adverse Events by MedDRA System Organ Class and Preferred Term- by Race

Race = White		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Exposed Subjects	339 (100%)	172 (100%)
Total No. of Subjects with Adverse Events	267 (79%)	131 (76%)
CARDIAC DISORDERS	33 (10%)	25 (15%)
Myocardial ischaemia	2 (<1%)*	5 (3%)*
GENERAL DISORDERS AND ADMINISTRATION SITE CONDITIONS		
Oedema peripheral	5 (1%)*	10 (6%)*
Chest pain	2 (<1%)*	5 (3%)*
INFECTIONS AND INFESTATIONS	64 (19%)	39 (23%)
Upper respiratory tract infection	3 (<1%)*	7 (4%)*
INVESTIGATIONS	88 (26%)	52 (30%)
Cardiac murmur		3 (2%)*
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	52 (15%)**	44 (26%)**
Musculoskeletal stiffness	0	3 (2%)*
RENAL AND URINARY DISORDERS	46 (14%)	34 (20%)
Urinary retention	4 (1%)*	7 (4%)*
RENAL AND URINARY DISORDERS (cont.)		
Cystitis noninfective	0	4 (2%)*
VASCULAR DISORDERS	106 (31%)	52 (30%)

EP 2 505 204 B1

(continued)

Race = White		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Orthostatic hypotension	0	3 (2%)*
Deep vein thrombosis	0	3 (2%)*
Race = Other		
	One-Month Controlled	
	Degarelix	LUPRON DEPOT® 7.5 mg
MedDRA System Organ Class/ Preferred Term		
	N (%)	N (%)
Exposed Subjects	42 (100%)	19 (100%)
Total No. of Subjects with Adverse Events	40 (95%)	16 (84%)
INFECTIONS AND INFESTATIONS	14 (33%)	7 (37%)
Urinary tract infection	2 (5%)*	5 (26%)*
REPRODUCTIVE SYSTEM AND BREAST DISORDERS	4 (10%)	5 (26%)
Erectile dysfunction	1 (2%)*	4 (21%)*
Note : no findings in Blacks Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg), * = 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).		

[0184] These results shown in Tables 16 and 17 below demonstrate that treated subjects had a significantly reduced risk of developing coronary artery disease, heart failure, myocardial infarction, cardiac arrhythmia, coronary artery disease or heart failure when receiving androgen depletion therapy with degarelix as compared to Lupron.

Table 16: Incidence Rate (in 1,000 py) of Cardiovascular Events compared to Background Incidence Rates

	Degarelix				LUPRON DEPOT® 7.5 mg			
	N (%)	PY	Incidence Rate	95% CI	N (%)	PY	Incidence Rate	95% CI
CV Event type								
Stroke	3 (<1%)	0.354	8.49	[1.75;24.8]	1 (<1%)	0.178	5.63	10.142;31.41
Coronary artery disease	12 (3%)	0.351	34.2	[17.7;59.7]	11 (5%)	0.174	63.4	[31.6;113]
Heart failure	5 (1%)	0.354	14.1	[4.59;33.0]	5 (2%)	0.176	28.4	[9.21;66.2]
MI	2 (<1%)	0.354	5.64	[0.683;20.4]	4 (2%)	0.177	22.6	[6.15;57.8]
Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg), * = 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).								

Table 17. Incidence Rate of Cardiovascular Events defined by High Level Group Terms

	Degarelix				LUPRON DEPOT® 7.5 mg			
	N (%)	PY	Incidence Rate	95% CI	N (%)	PY	Incidence Rate	95% CI
MedDRA HLGT								
Central nervous system vascular disorders	5 (1%)	0.353	14.2	[4.60;33.1]	1 (<1%)	0.178	5.63	[0.142;31.4]
Cardiac arrhythmias	20 (5%)	0.347	57.7	[35.3;89.1]	17 (8%)	0.170	100	[58.2;160]
Coronary artery disorders	12 (3%)	0.351	34.2	[17.7;59.7]	11 (5%)	0.174	63.4	[31.6;113]
Heart failures	5 (1%)	0.354	14.1	[4.59;33.0]	5 (2%)	0.176	28.4	[9.21;66.2]
Note: P values as flagging device used only in the Phase 3 study (head to head comparison to LUPRON DEPOT 7.5 mg), * = 0.01 < P ≤ 0.05, ** = 0.001 < P ≤ 0.01, *** = P ≤ 0.001 (Fisher exact, two-sided).								

EP 2 505 204 B1

[0185] Mortality Subgroups with statistically (pre-planned as part of the ISS) significant findings

Table 18. Mortality by Treatment group

Age (years) = >=65-<75						
					Mortality per 1,000 PY	
Treatment Group	N	No. of Deaths	Crude Mortality	PY of Exposure	Estimate	95% CI
Degarelix	169	3	(2%)	0.148	20.2	[4.17;59.1]
LUPRON DEPOT® 7.5 mq	71	6	(8%)	0.061	99.0	[36.3;216]
Test for homogeneity of mortality rates:	P=0.0426					

Table 19. Mortality by Treatment group

PCA = Localized						
					Mortality per 1,000 PY	
Treatment Group	N	No. of Deaths	Crude Mortality	PY of Exposure	Estimate	95% CI
Degarelix	128	0	(0%)	0.113	0	[0, 32.6]
LUPRON DEPOT® 7.5 mg	63	4	(6%)	0.057	70.3	[19.2;180]
Test for homogeneity of mortality rates:	P=0.0251					

Table 20. Incidence rates ratios by BMI of Cardiac Arrhythmias in CS21 - Degarelix vs Luprolide

	Degarelix		Lupron		Relative Risk		
Body Mass Index Category	Incidence Rate	95% CI	Incidence Rate	95% CI	RR	95% CI	P value (a)
1: < 25 kg/m2	46.58	(17.1-101)	149.3	(64.4-294)	0.312	(0.09-1.03)	.0556
2: 25 - <30 kg/m2	52.66	(24.1-100)	93.09	(40.2-183)	0.566	(0.19-1.68)	.3495
3: >= 30 kg/m2	84.50	(27.4-197)	26.73	(0.68-149)	3.161	(0.35- 150)	.5069
(a) P value for for homogeneity of incidence rates PY in 1,000 person years							

EP 2 505 204 B1

[0186] These results show that treated subjects with BMIs of less than 30 kg/m² (e.g. less than 25 kg/m² e.g. 20-25 kg/m²) had a significantly reduced risk of developing a cardiac arrhythmia when receiving androgen depletion therapy with degarelix as compared to Lupron.

Table 21. Incidence rates ratios by BMI of Coronary Artery Disorders in CS21 - Degarelix vs Luprolide

Body Mass Index Category	Degarelix		Lupron		Relative Risk		
	Incidence Rate	95% CI	Incidence Rate	95% CI	RR	95% CI	P value (a)
1: < 25 kg/m ²	0.00	(0.00-28.0)	87.96	(28.6- 205)	0.000	(0.00-0.47)	0.0050
2: 25 - <30 kg/m ²	46.88	(20.2-92.4)	46.27	(12.6-118)	1.013	(0.27-4.60)	1.000
3: ≥ 30 kg/m ²	65.16	(17.8- 167)	53.53	(6.48- 193)	1.217	(0.17-13.5)	1.000
(a) P value for for homogeneity of incidence rates PY in 1,000 person years							

[0187] These results show that treated subjects with BMIs of less than 25 kg/m² e.g. 20-25 kg/m² had a significantly reduced risk of developing a coronary artery disorder when receiving androgen depletion therapy with degarelix as compared to Lupron.

Table 22. Incidence rates ratios by BMI of Cardiac Disorders (SOC) in CS21 - Degarelix vs Luprolide

Body Mass Index Category	Degarelix		Lupron		Relative Risk		
	Incidence Rate	95% CI	Incidence Rate	95% CI	RR	95% CI	P value (a)
1: < 25 kg/m ²	54.32	(21.8- 112)	224.9	(116- 393)	0.242	(0.08-0.67)	.0045
2: 25 - <30 kg/m ²	101.5	(59.1- 62)	132.6	(66.2- 237)	0.765	(0.34-1.81)	.6106
3: ≥ 30 kg/m ²	209.6	(108-366)	107.7	(29.4- 276)	1.946	(0.59-8.28)	.3606
(a) P value for for homogeneity of incidence rates PY in 1,000 person years							

[0188] These results show that treated subjects with BMIs of less than 30 kg/m² (e.g. less than 25 kg/m² e.g. 20-25 kg/m²) had a significantly reduced risk of developing a cardiac disorder when receiving androgen depletion therapy with degarelix as compared to Lupron.

Table 23. Incidence rates ratios by Cholesterol of Cardiac Arrhythmias in CS21 - Degarelix vs Luprolide

Cholesterol Category	Degarelix		Lupron		Relative Risk		
	Incidence Rate	95% CI	Incidence Rate	95% CI	RR	95% CI	P value (a)
1: < 4 mmol/L	156.1	(62.8- 322)	79.12	(16.3- 231)	1.973	(0.45-11.8)	.4981
2: ≥ 4 mmol/L	41.39	(22.0-70.8)	100.7	(55.1- 169)	0.411	(0.18-0.94)	.0350
(a) P value for for homogeneity of incidence rates PY in 1,000 person years							

[0189] These results show that treated subjects with cholesterol levels of greater than or equal to 4 mmol/L had a significantly reduced risk of developing a cardiac arrhythmia when receiving androgen depletion therapy with degarelix as compared to GnRH antagonist therapy with Lupron.

Claims

1. A composition comprising degarelix for use in the treatment of prostate cancer in a subject identified as being at risk for cardiovascular disease.
2. A composition comprising degarelix for use in the treatment of prostate cancer in a subject, the subject having been identified as having an increased likelihood of developing a cardiovascular disease or disorder.
3. A composition for use according to claim 1 or 2 for administration at an initial dose of degarelix of 160 to 320 mg; and at a maintenance dose of 60 to 160 mg, once every 20 to 36 days thereafter.
4. A composition for use according to any preceding claim for administration at an initial dose of degarelix of about 240 mg; and at a maintenance dose of about 80 mg degarelix once every approximately 28 days of treatment.
5. A composition for use according to any preceding claim for treatment of a subject with cholesterol level of greater than or equal to 4 mmol/L.
6. A composition for use according to any preceding claim for treatment of a subject who possesses an indicator of increased and/or high risk of cardiovascular disease.
7. A composition for use according to claim 6 wherein the indicator of increased risk for cardiovascular disease is one or more of high blood pressure, high low-density lipoprotein cholesterol, low high-density lipoprotein cholesterol, high serum glucose and habitual smoking.
8. A composition for use according to any preceding claim for treatment of a subject with blood pressure of greater than or equal to 130 over 85 mm Hg.
9. A composition for use according to any preceding claim for treatment of a subject who smokes cigarettes daily.
10. A composition for use according to any preceding claim for treatment of a subject with low-density lipoprotein cholesterol of greater than or equal to about 160 mg/dL and/or a level of high-density lipoprotein cholesterol of less than 35 mg/dL.
11. A composition for use according to any preceding claim for treatment of a subject with fasting glucose level of greater than about 120 mg/dL.
12. A composition for use according to claim 6 wherein the indicator of high risk for cardiovascular disease is one or more of high serum C-reactive protein (CRP), high serum homocysteine, high serum fibrinogen, and high serum lipoprotein (a) (Lp(a)).
13. A composition for use according to claim 12 for treatment of a subject with one or more of: a level of C-reactive protein of greater than 3 mg/dL; a serum homocysteine level of greater than 30 μ mol/L; a level of serum fibrinogen of greater than 7.0 g/L; and a level of serum Lp(a) of greater than 30 mg/dL.
14. A composition for use according to any preceding claim wherein the cardiovascular disease or disorder is cardiac murmur, atrioventricular blockage or myocardial ischemia.

Patentansprüche

1. Zusammensetzung, die Degarelix beinhaltet, zur Verwendung bei der Behandlung von Prostatakrebs bei einem Subjekt, bei dem ein Risiko für eine Herz-Kreislauf-Erkrankung identifiziert wurde.

2. Zusammensetzung, die Degarelix beinhaltet, zur Verwendung bei der Behandlung von Prostatakrebs bei einem Subjekt, bei dem eine erhöhte Wahrscheinlichkeit der Entwicklung einer Herz-Kreislauf-Erkrankung oder -störung identifiziert wurde.
- 5 3. Zusammensetzung zur Verwendung nach Anspruch 1 oder 2 zur Verabreichung einer Anfangsdosis von Degarelix von 160 bis 320 mg und einer Erhaltungsdosis von 60 bis 160 mg einmal alle 20 bis 36 Tage danach.
- 10 4. Zusammensetzung zur Verwendung nach einem vorherigen Anspruch zur Verabreichung einer Anfangsdosis von Degarelix von etwa 240 mg und einer Erhaltungsdosis von etwa 80 mg Degarelix einmal etwa alle 28 Behandlungstage.
- 5 5. Zusammensetzung zur Verwendung nach einem vorherigen Anspruch zur Behandlung eines Subjekts mit einem Cholesterinwert von gleich oder mehr als 4 mmol/l.
- 15 6. Zusammensetzung zur Verwendung nach einem vorherigen Anspruch zur Behandlung eines Subjekts mit einem Indikator für ein erhöhtes und/oder hohes Risiko für eine Herz-Kreislauf-Erkrankung.
- 20 7. Zusammensetzung zur Verwendung nach Anspruch 6, wobei der Indikator ein erhöhtes Risiko für eine Herz-Kreislauf-Erkrankung hoher Blutdruck, hohes (Lipoprotein geringer Dichte)-Cholesterin, niedriges (Lipoprotein hoher Dichte)-Cholesterin, hohe Serumglukose und/oder gewohnheitsmäßiges Rauchen anzeigt.
- 25 8. Zusammensetzung zur Verwendung nach einem vorherigen Anspruch zur Behandlung eines Subjekts mit einem Blutdruck von mehr als oder gleich 130 zu 85 mmHg.
- 30 9. Zusammensetzung zur Verwendung nach einem vorherigen Anspruch zur Behandlung eines Subjekts, das täglich Zigaretten raucht.
10. Zusammensetzung zur Verwendung nach einem vorherigen Anspruch zur Behandlung eines Subjekts mit einem (Lipoprotein geringer Dichte)-Cholesterinwert von mehr als oder gleich etwa 160 mg/dl und/oder einem (Lipoprotein hoher Dichte)-Cholesterinwert von weniger als 35 mg/dl.
- 35 11. Zusammensetzung zur Verwendung nach einem vorherigen Anspruch zur Behandlung eines Subjekts mit einem Nüchternglukosewert von mehr als etwa 120 mg/dl.
- 40 12. Zusammensetzung zur Verwendung nach Anspruch 6, wobei der Indikator ein hohes Herz-Kreislauf-Erkrankungsrisiko hohes Serum-CRP (C-reaktives Protein), hohes Serum-Homocystein, hohes Serum-Fibrinogen und/oder hohes Serum-Lipoprotein (a)(Lp(a)) anzeigt.
- 45 13. Zusammensetzung zur Verwendung nach Anspruch 12 zur Behandlung eines Subjekts mit einem oder mehreren aus: einem C-reaktiven Proteinwert von mehr als 3 mg/dl; einem Serum-Homocysteinwert von mehr als 30 µmol/l; einem Serum-Fibrinogenwert von mehr als 7,0 g/l; und einem Serum-Lp(a)-Wert von mehr als 30 mg/dl.
14. Zusammensetzung zur Verwendung nach einem der vorherigen Ansprüche, wobei die Herz-Kreislauf-Erkrankung oder -störung Herzgeräusche, atrioventrikuläre Blockierung oder myokardiale Ischämie ist.

Revendications

- 50 1. Composition comprenant du dégarélix à utiliser dans le traitement du cancer de la prostate chez un sujet identifié comme étant à risque de maladie cardiovasculaire.
- 55 2. Composition comprenant du dégarélix à utiliser dans le traitement du cancer de la prostate chez un sujet, le sujet ayant été identifié comme présentant une probabilité accrue de développer une maladie ou un trouble cardiovasculaire.
3. Composition à utiliser selon la revendication 1 ou 2, pour administration à une dose initiale de dégarélix de 160 à 320 mg et à une dose de maintien de 60 à 160 mg une fois tous les 20 à 36 jours par la suite.

EP 2 505 204 B1

4. Composition à utiliser selon l'une quelconque des revendications précédentes, pour administration à une dose initiale de dégarélix d'environ 240 mg et à une dose de maintien d'environ 80 mg de dégarélix une fois tous les 28 jours de traitement approximativement.
5. Composition à utiliser selon l'une quelconque des revendications précédentes, dans le traitement d'un sujet ayant un taux de cholestérol supérieur ou égal à 4 mmol/l.
6. Composition à utiliser selon l'une quelconque des revendications précédentes, dans le traitement d'un sujet qui possède un indicateur de risque accru et/ou élevé de maladie cardiovasculaire.
7. Composition à utiliser selon la revendication 6, où l'indicateur de risque accru de maladie cardiovasculaire est l'un ou plusieurs d'entre hypertension, taux élevé de cholestérol à lipoprotéines de basse densité, taux faible de cholestérol à lipoprotéines de haute densité, taux élevé de glucose sérique et fumeur habituel.
8. Composition à utiliser selon l'une quelconque des revendications précédentes, dans le traitement d'un sujet ayant une tension artérielle supérieure ou égale à 130/85 mmHg.
9. Composition à utiliser selon l'une quelconque des revendications précédentes, dans le traitement d'un sujet qui fume des cigarettes tous les jours.
10. Composition à utiliser selon l'une quelconque des revendications précédentes, dans le traitement d'un sujet ayant un taux de cholestérol à lipoprotéines de basse densité supérieur ou égal à environ 160 mg/dl et/ou un taux de cholestérol à lipoprotéines de haute densité inférieur à 35 mg/dl.
11. Composition à utiliser selon l'une quelconque des revendications précédentes, dans le traitement d'un sujet ayant un taux de glucose à jeun supérieur à environ 120 mg/dl.
12. Composition à utiliser selon la revendication 6, où l'indicateur de risque élevé de maladie cardiovasculaire est l'un ou plusieurs d'entre taux élevé de protéine C réactive (CRP) sérique, taux sérique élevé d'homocystéine, taux élevé de fibrinogène sérique et taux élevé de lipoprotéines (a) sériques (Lp(a)).
13. Composition à utiliser selon la revendication 12, dans le traitement d'un sujet ayant un ou plusieurs d'entre : un taux de protéine C réactive supérieur à 3 mg/dl; un taux sérique d'homocystéine supérieur à 30 μ mol/l; un taux de fibrinogène sérique supérieur à 7,0 g/l et un taux de Lp(a) sériques supérieur à 30 mg/dl.
14. Composition à utiliser selon l'une quelconque des revendications précédentes, où la maladie ou trouble cardiovasculaire est un murmure cardiaque, un blocage auriculo-ventriculaire ou une ischémie myocardique.

FIGURE 1

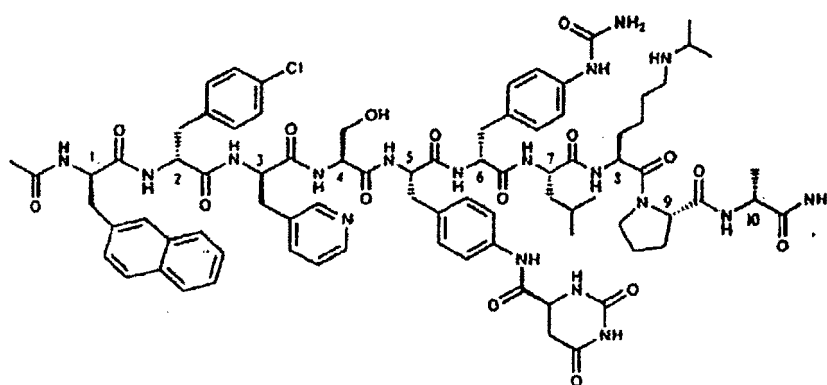


FIG. 2

Testosterone from Day 0 to 364 for degarelix 240/80mg

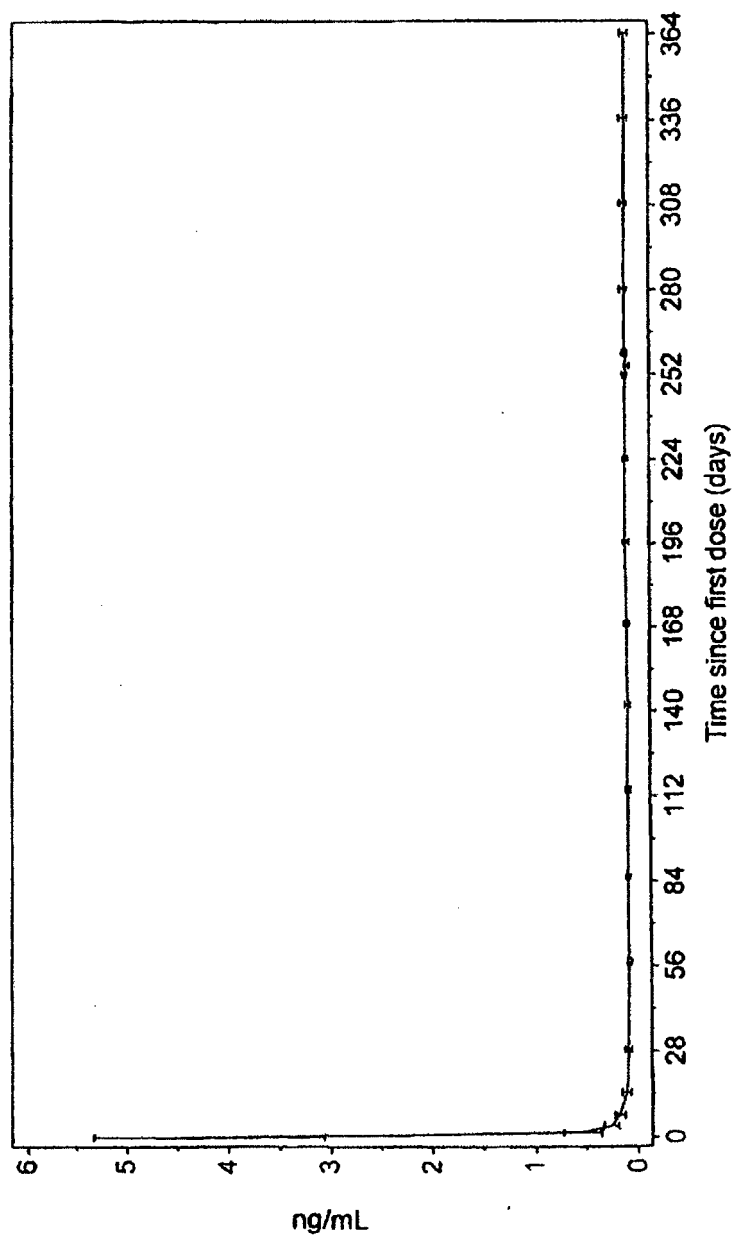


FIG. 3

Percentage change in testosterone from Day 0 to 28

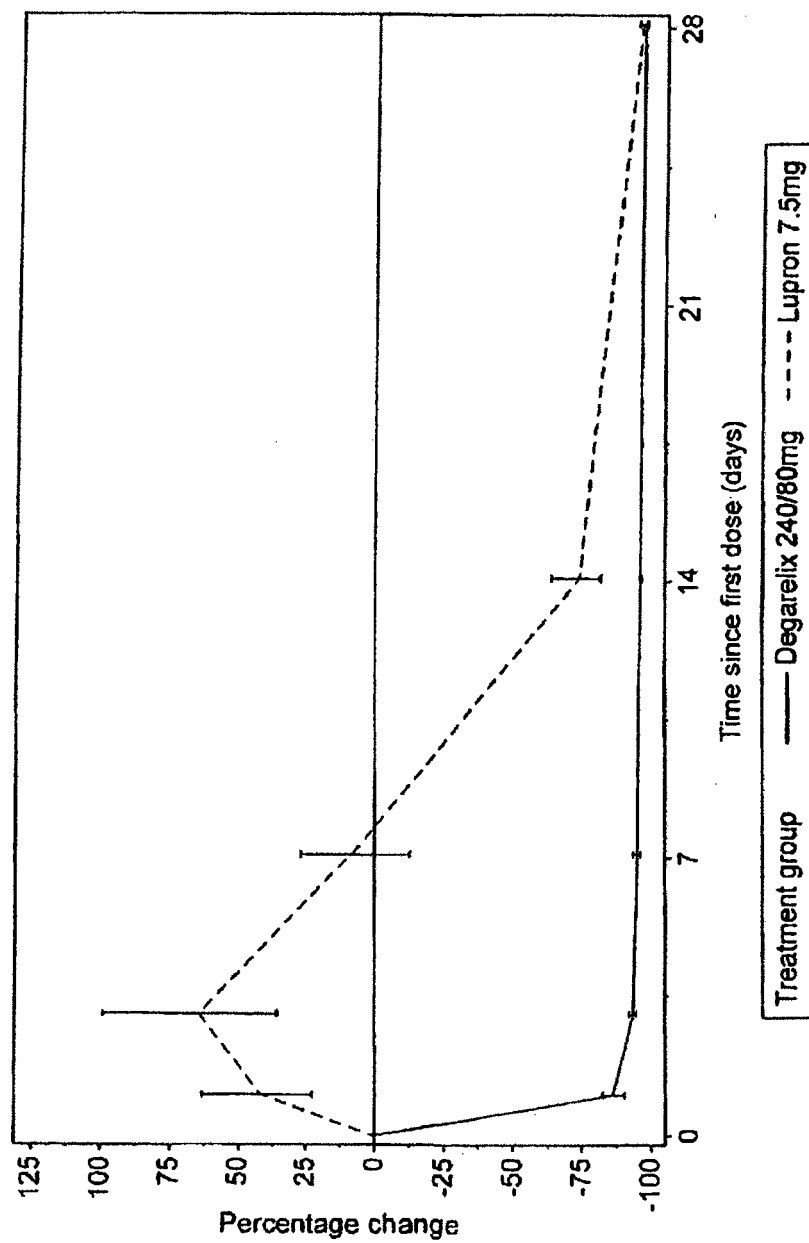


FIG. 4

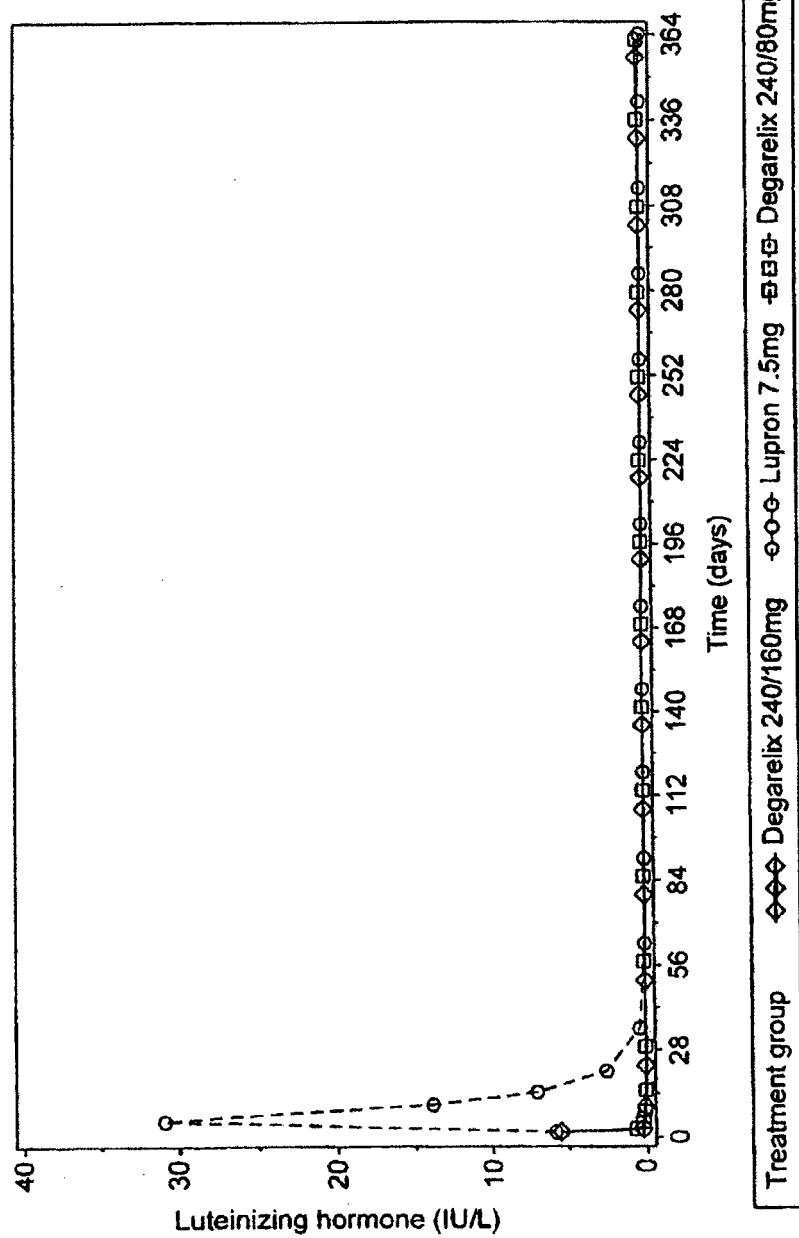


FIG. 5

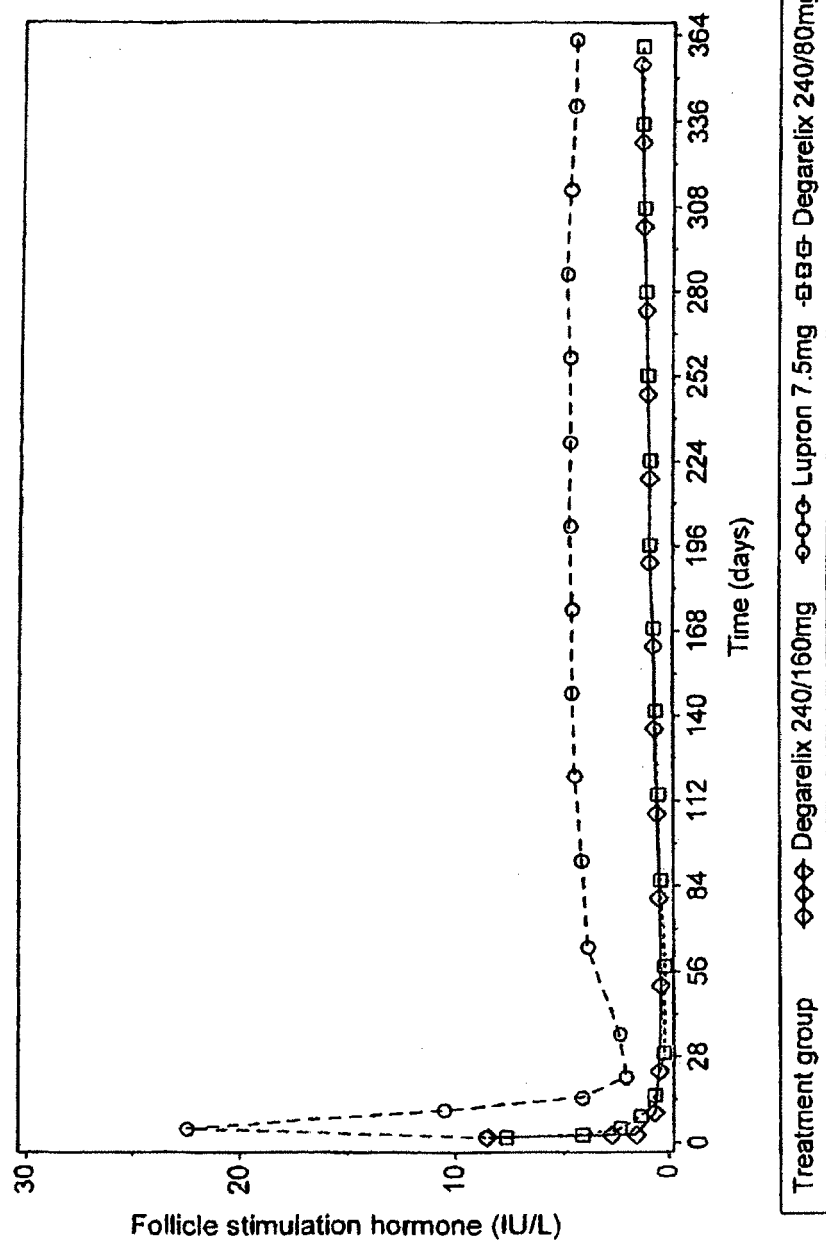
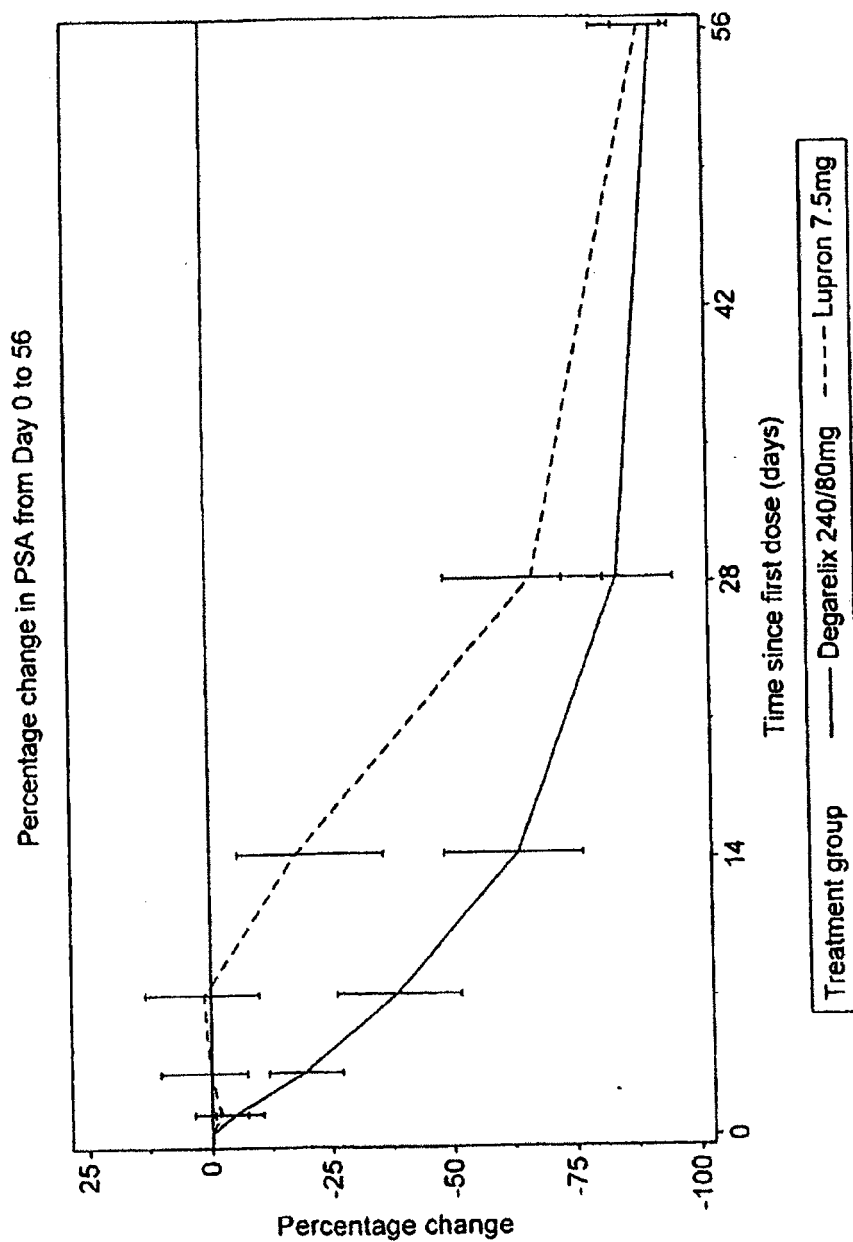


FIG. 6



REFERENCES CITED IN THE DESCRIPTION

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