swissmedic

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Swissmedic, Swiss Agency for Therapeutic Products

Swiss Public Assessment Report
Extension of therapeutic indication

RETSEVMO

International non-proprietary name:	selpercatinib
Pharmaceutical form:	hard capsules
Dosage strength(s):	Retsevmo 80 mg, gélules, Retsevmo 40 mg, gélules
Route(s) of administration:	oral
Marketing authorisation holder:	Eli Lilly (Suisse) SA
Marketing authorisation no.:	67862
Decision and decision date:	extension of therapeutic indication as a temporary authorisation in accordance with Art. 9a TPA approved on 21 March 2025 and extension of therapeutic indication approved on 21 March 2025

Note:

This assessment report is as adopted by Swissmedic with all information of a commercially confidential nature deleted.

SwissPARs are final documents that provide information on submissions at a particular point in time. They are not updated after publication.

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1 Terms, Definitions, Abbreviations

1L	First-line
2L	Second-line
ADA	Anti-drug antibody
ADME	Absorption, distribution, metabolism, elimination
AE	Adverse event
ALT	Alanine aminotransferase
AST	Aspartate aminotransferase
API	Active pharmaceutical ingredient
ATC	Anatomical Therapeutic Chemical Classification System
AUC	Area under the plasma concentration-time curve
$AUC_{0\text{-}24h}$	Area under the plasma concentration-time curve for the 24-hour dosing interval
BICR	Blinded independent review committee
CI	Confidence interval
C_{max}	Maximum observed plasma/serum concentration of drug
CYP	Cytochrome P450
DCO	Data cut-off
DDI	Drug-drug interaction
DOR	Duration of response
ECOG	Eastern Cooperative Oncology Group
EMA	European Medicines Agency
ERA	Environmental risk assessment
FDA	Food and Drug Administration (USA)
GLP	Good Laboratory Practice
HPLC	High-performance liquid chromatography
HR	Hazard Ratio
IC/EC_{50}	Half-maximal inhibitory/effective concentration
ICH	International Council for Harmonisation
Ig	Immunoglobulin
INN	International non-proprietary name
ITT	Intention-to-treat
LoQ	List of Questions
MAH	Marketing Authorisation Holder
Max	Maximum
Min	Minimum
MKI	Multikinase inhibitor
MTC	Medullary thyroid carcinoma
MRHD	Maximum recommended human dose
MTD	Maximum tolerated dose
N/A	Not applicable
NCCN	National Comprehensive Cancer Network
NO(A)EL	No observed (adverse) effect level
NSCLC	Non-small cell lung cancer
ORR	Overall response rate
OS	Overall survival
PBPK	Physiology-based pharmacokinetics
PD	Pharmacodynamics
PFS	Progression-free survival
PIP	Paediatric Investigation Plan (EMA)
PK	Pharmacokinetics
PopPK	Population pharmacokinetics
PSP	Pediatric study plan (US FDA)

PTC	Papillary thyroid carcinoma
RET	REarranged during Transfection
RMP	Risk management plan
SAE	Serious adverse event
SwissPAR	Swiss Public Assessment Report
TEAE	Treatment-emergent adverse event
TPA	Federal Act of 15 December 2000 on Medicinal Products and Medical Devices (SR 812.21)
TPO	Ordinance of 21 September 2018 on Therapeutic Products (SR 812.212.21)

2 Background information on the procedure

2.1 Applicant's request(s)

Extension(s) of the therapeutic indication(s)
The applicant requested the addition of a new therapeutic indication or modification of an approved one in accordance with Article 23 TPO.

Orphan drug status
The applicant requested orphan drug status in accordance with Article 4 paragraph 1 letter a^{decies} no. 2 TPA.
Orphan drug status was granted on 16 December 2021.

Authorisation as human medicinal product in accordance with Article 13 TPA
The applicant requested a reduced assessment procedure in accordance with Article 13 TPA.

Temporary authorisation for human medicinal products
The applicant requested temporary authorisation in accordance with Article 9*a* TPA.

2.2 Indication and dosage

2.2.1 Requested indication

Indications subject to temporary authorisation

Retsevmo as monotherapy is indicated for the treatment of adults with advanced RET fusion-positive non-small cell lung cancer (NSCLC) not previously treated with a RET inhibitor.

Retsevmo as monotherapy is indicated for the treatment of adults and adolescents 12 years and older with advanced RET-mutant medullary thyroid cancer (MTC).

2.2.2 Approved indication

Indications subject to ordinary authorisation

Retsevmo as monotherapy is indicated

- For the treatment of adults and adolescents of 12 years and older with advanced RET-mutant medullary thyroid cancer (MTC) (see "Warnings and precautions" and "Clinical efficacy")

Indications subject to temporary authorisation

Retsevmo as monotherapy is indicated for the first-line treatment of adults with metastatic RET fusion-positive non-small cell lung cancer (NSCLC) *(see* "Properties/effects").

The efficacy and safety of Retsevmo in patients with additional oncogenic driver mutations have not been evaluated (see "Warnings and precautions").

Since the documentation was incomplete at the time the application was assessed, this indication is approved for a limited period (Art. 9a of the Therapeutic Products Act). This temporary authorisation is contingent on the timely fulfilment of conditions. After these have been met, the temporary approval can be converted into an approval without special conditions.

2.2.3 Requested dosage

Summary of the requested standard dosage:

No change to the dosage recommendation was requested with the application for extension of indication.

2.2.4 Approved dosage

(See appendix)

2.3 Regulatory history (milestones)

Application	25 April 2023
List of Questions (LoQ)	10 August 2023
Response to LoQ	29 October 2023
Second LoQ	11 December 2023
Response to second LoQ	29 February 2024
Preliminary decision	28 May 2024
Response to preliminary decision	16 August 2024
Labelling corrections and/or other aspects	07 October 2024
Response to labelling corrections and/or other aspects	07 November 2024
Second labelling corrections and/or other aspects	19 December 2024
Labelling meeting	16 January 2025
Response to second labelling corrections and/or other aspects	03 February 2025
Final decision	21 March 2025
Decision	approval (temporary authorisation in accordance with Art. 9a TPA)

Swissmedic has only assessed parts of the primary data submitted with this application. As regards the remaining data, Swissmedic relies for its decision on the assessment of the foreign reference authority EMA. This SwissPAR relates to the publicly available assessment reports for Retsevmo, published on 22 April 2022, Procedure No. EMEA/H/C/005375/II/0011, and 22 July 2022, Procedure No. EMEA/H/C/005375/II/0014/G, issued by EMA.

3 Medical context

RET (REarranged during Transfection) is a receptor tyrosine kinase (RTK) involved in the development and maintenance of neural crest-derived cells, including components of the neural and neuroendocrine systems, as well as in kidney development, hematopoiesis, and spermatogenesis. Alterations in the RET gene, such as activating point mutations or gene rearrangements, can lead to constitutive activation of the kinase, promoting uncontrolled cell growth. Selpercatinib is a selective inhibitor of RET.

RET fusion-positive non–small cell lung cancer (NSCLC)
Lung cancer is the leading cause of cancer-related mortality globally. NSCLC accounts for 85% of all lung cancers, with adenocarcinoma being the most common histological subtype (1). The estimated five-year survival rate in metastatic NSCLC is around 9% (2)
RET rearrangements occur in 1%–2% of all NSCLCs, predominantly among younger, non-smoking patients with adenocarcinoma histology (1).
Patients with RET-driven NSCLC are currently treated with the current standard of care for first-line NSCLC (chemotherapy, immune checkpoint inhibitors) regardless of the presence of RET mutation.

RET-mutant Medullary Thyroid Carcinoma (MTC)
MTC is a rare subtype of thyroid cancer, comprising approximately 3% to 5% of all thyroid cancers. A significant proportion of cases are diagnosed at an advanced stage, and the estimated five-year survival rate is approximately 86%, while the ten-year survival rate ranges from 50% to 65% (3).
Activating mutations in the RET gene are the main driver mutation in MTC. Approximately 50% of sporadic forms carry a somatic RET mutation, and familial cases have an identifiable germline mutation in at least 90% of cases (1). RET mutations confer a poor prognosis in MTC (4).
Complete surgical resection remains the only curative approach for locoregional MTC. In cases of recurrent or metastatic disease, treatment options may include surgical resection, external beam radiation therapy, locally directed therapies, or systemic therapies (5).
There are no RET-specific inhibitors authorised for the treatment of first-line RET-mutant MTC. The multikinase inhibitor vandetanib is approved for the treatment of adult patients with unresectable, locally advanced, or metastatic MTC harboring RET mutations.

1) Hoe HJ, Solomon BJ. Treatment of non–small cell lung cancer with RET rearrangements. Cancer. 2025; e35779. doi:10.1002/cncr.35779.
2) Wang Y, Kondrat K, Adhikari J, Nguyen Q, Yu Q, Uprety D. Survival trends among patients with metastatic non-small cell lung cancer before and after the approval of immunotherapy in the United States: A Surveillance, Epidemiology, and End Results database-based study. Cancer. 2025 Jan 1;131(1):e35476. doi:10.1002/cncr.35476. PMID: 38985895.
3) Viola D, Elisei R. Management of medullary thyroid cancer. Endocrinol Metab Clin North Am. 2019 Mar;48(1):285–301. doi:10.1016/j.ecl.2018.11.006. PMID: 30717909.
4) Elisei R, Cosci B, Romei C, Bottici V, Renzini G, Molinaro E, Agate L, Vivaldi A, Faviana P, Basolo F, Miccoli P, Berti P, Pacini F, Pinchera A. Prognostic significance of somatic RET oncogene mutations in sporadic medullary thyroid cancer: a 10-year follow-up study. J Clin Endocrinol Metab. 2008 Mar;93(3):682–7. doi:10.1210/jc.2007-1714. PMID: 18073307.
5) Kim M, Kim BH. Current guidelines for management of medullary thyroid carcinoma. Endocrinol Metab (Seoul). 2021 Jun;36(3):514–524. doi:10.3803/EnM.2021.1082. PMID: 34154310; PMCID: PMC8258323

4 Nonclinical aspects

Swissmedic has not assessed the primary data relating to nonclinical aspects submitted with this application and relies on the assessment of the foreign reference authority EMA. The nonclinical aspects in this SwissPAR refer to the publicly available assessment reports for Retsevmo, published on 22 April 2022, Procedure No. EMEA/H/C/005375/II/0011, and 22 July 2022, Procedure No. EMEA/H/C/005375/II/0014/G, issued by EMA.

5 Clinical aspects

5.1 Clinical pharmacology

The evaluation of the clinical pharmacology data for this application relied on previous regulatory decisions by EMA and the US FDA. The available assessment reports and the Summary of Product Characteristics from EMA and the Prescribing Information from the US FDA were used as a basis for evaluating clinical pharmacology. For further details on clinical pharmacology, please see section 8 of this report.

5.2 Dose finding and dose recommendation

No new dose-finding outcomes have been submitted. The proposed dosage aligns with the currently approved regimen for both adults and adolescent patients aged 12 years and older.

5.3 Efficacy

Swissmedic has only assessed parts of the primary data submitted with this application. As regards the remaining data, Swissmedic relies for its decision on the assessment of the foreign reference authority EMA. This SwissPAR relates to the publicly available assessment reports Retsevmo Procedure No. EMEA/H/C/005375/0011 (dated 22 April 2022) and Retsevmo Procedure No. EMEA/H/C/0053I75/II/0014/G (dated 21 July 2022), issued by EMA.
The clinical evaluation focused on the evaluation of the new phase 3 studies LIBRETTO-431 and LIBRETTO-531. Additional results from LIBRETTO-001 are supportive.

<u>RET fusion-positive NSCLC</u>
The Applicant submitted the results of study LIBRETTO-431, a multicentre, randomised, open-label phase 3 trial in patients with RET fusion-positive NSCLC. Adult patients with histologically confirmed, unresectable, locally advanced or metastatic NSCLC who had not received prior systemic therapy for metastatic disease were eligible. Patients with previous neoadjuvant or adjuvant systemic therapy were included if treatment had been completed at least six months prior to randomisation. Patients with squamous histology or significant cardiovascular disease were excluded.

Patients were randomised to receive either selpercatinib at a starting dose of 160 mg twice daily or platinum-based chemotherapy with pemetrexed, with or without pembrolizumab, based on the investigator's intent (Intention to Treat (ITT) population). After 4 cycles of chemotherapy without progressive disease, patients randomly assigned to the control arm received maintenance therapy with pemetrexed with or without pembrolizumab. For details of dosing please refer to the attached Information for healthcare professionals.
Patients assigned to the selpercatinib arm whose disease progressed were allowed to continue treatment with selpercatinib if they were deriving clinical benefit, as determined by the investigator and if approved by the sponsor.
Patients randomly assigned to the control arm were allowed to cross over to selpercatinib treatment upon confirmation of disease progression by a blinded independent review committee (BICR) if they met the eligibility criteria for crossover.
RET fusion status was confirmed prospectively using next-generation sequencing or polymerase chain reaction.
Stratification was based on geographic region, presence of central nervous system metastases at baseline and investigator intent to use pembrolizumab.

The primary endpoints were progression free survival (PFS) as determined by BICR with selpercatinib in the ITT pembrolizumab population and in the ITT population. If statistical significance was reached for both primary endpoints, overall survival (OS) in the ITT population was planned to be tested as secondary endpoint.

A total of 261 patients were included in the ITT population. The median age was 62.5 years, and 54.8% of patients were female. Most patients were of Asian (57.4%) or white (40.2%) ethnicity, and 67.4% were never-smokers. At study entry, 93.5% of patients had metastatic disease, 6.5% were in stage III (17 patients) and 19.5% had CNS metastases. Most patients (96.9%) had an ECOG performance status (PS) of 0 or 1, while 3.1% had a PS of 2.
Of the 261 patients in the ITT population, 212 were included in the ITT pembrolizumab population based on pre-randomisation intent to use pembrolizumab. In this subgroup, 129 patients received selpercatinib, while 83 patients received chemotherapy with pemetrexed and pembrolizumab. Please refer to the attached Information for healthcare professionals for more details regarding the baseline characteristics of the ITT pembrolizumab population.

At the prespecified interim analysis (IA1) for PFS with data cut-off (DCO) date of 1 May 2023, median PFS in the ITT pembrolizumab population was 24.84 months (95% CI: 16.89 to not estimable [NE]) for selpercatinib versus 11.17 months (95% CI: 8.77 to 16.76) for the control arm, with a hazard ratio (HR) for disease progression or death of 0.465 (95% CI: 0.309 to 0.699; p = 0.0002) (statistically significant).
In the ITT population, median PFS was 24.84 months (95% CI: 17.31 to NE) for selpercatinib versus 11.17 months (95% CI: 8.77 to 16.76) for the control arm, with an HR of 0.482 (95% CI: 0.331 to 0.700; p = 0.0001) (statistically significant). In both the ITT and ITT pembrolizumab populations, the Kaplan-Meier curves for selpercatinib and the control arm diverge early and remain consistently separated throughout the entire follow-up period.

At the time of the IA1, OS data were not mature; the analysis did not meet the boundaries for statistical significance. A descriptive IA2 was conducted on 1 May 2024, when 43% of the planned OS events had occurred in the ITT population, reported 75 events across both treatment arms: 49 events (31% of the ITT population) in the selpercatinib arm and 26 events (25%) in the control arm. The estimated OS HR was 1.259 (95% CI: 0.777 to 2.040). As regards post-progression treatments, of the 68 patients in the control arm who experienced disease progression, 74% (n = 50) crossed over to receive selpercatinib. Among the 71 patients in the selpercatinib arm with disease progression, 23% (n = 16) received chemotherapy or immune checkpoint inhibitors, and 62% (n = 44) continued selpercatinib therapy beyond progression. Please refer to the attached Information for healthcare professionals for the OS Kaplan Meier curve.

RET-mutant MTC
The applicant submitted the results of the LIBRETTO-531 trial, a multicentre, randomised, open-label, phase 3 study.

Eligible participants included adult and adolescent patients older than 12 years with histologically confirmed, unresectable, locally advanced or metastatic MTC who had not previously received treatment with a kinase inhibitor for advanced/metastatic disease.
Although the inclusion criteria only required no prior treatment with kinase inhibitors, the extension to the first-line treatment as reported in the requested indication is acceptable as kinase inhibitors are the standard of care in the first-line setting for MTC.
At screening, patients were required to have radiologic disease progression as determined by comparison with an imaging scan taken within the previous 14 months. Patients with significant cardiovascular disease were excluded.

Patients received either 160 mg selpercatinib twice daily or, at the investigator's discretion, 140 mg cabozantinib once daily or 300 mg vandetanib once daily.
Paediatric patients (between 12 and 18 years old) received either 92 mg/m2 selpercatinib twice daily or, at the investigator's discretion, 40 mg/m2 cabozantinib once daily or vandetanib per dosing guide. For details on dosing please refer to the attached Information for healthcare professionals.

In the event of disease progression, patients assigned to selpercatinib were allowed to continue treatment if they were deriving clinical benefit from selpercatinib, as determined by the investigator and if approved by the sponsor.
Patients randomly assigned to the control arm were allowed to cross over to selpercatinib treatment upon confirmation of disease progression by BICR.

RET mutations were prospectively confirmed using next-generation sequencing or polymerase chain reaction. Patients were stratified by RET mutation type, and by intended treatment within the control arm.
The primary efficacy endpoint was PFS as assessed by BICR. Key secondary efficacy endpoints included treatment-failure-free survival (TFFS) and tolerability. OS was also assessed as a secondary endpoint, but was not powered and not under family-wise type I error.

A total of 291 patients were enrolled and randomised in the ITT population: 193 to the selpercatinib arm and 98 to the control arm. Of those in the control arm, 73 were assigned to cabozantinib and 25 to vandetanib. The median age in the ITT population was 55 years. The study included 37.1% female patients. Overall, 69.4% of patients were white, 27.7% Asian, and 2.9% black. ECOG PS was 0–1 in 98.3% of patients and 2 in 1. For details please refer to the attached Information for healthcare professionals.

At the time of the preplanned IA1 with a DCO date of 22 May 2023, the study met its primary endpoint, demonstrating a significant improvement in PFS in the ITT population. At a median follow-up of 12 months, median PFS with selpercatinib had not yet been reached, compared to 16.8 months (95% CI: 12.22 to 25.10) in the control group. The PFS HR was 0.280 (95% CI: 0.165 to 0.475; p<0.0001).

Median TFFS with selpercatinib was also not reached, compared to 13.9 months in the control group. There were 27 TFFS events in the selpercatinib arm and 37 in the control arm, with a HR of 0.254 (95% CI: 0.153 to 0.423; p<0.0001).

In an additional OS analysis with a DCO date of 11 March 2024, with median follow-up of 25 months, 26 OS events had occurred, with 10 (5.2%) events in the selpercatinib arm and 16 (16.3%) in the control arm; the OS results are still immature. The OS HR was 0.275 (95% CI: 0.124 to 0.608).
The updated PFS HR at this time point was 0.202 (95% CI: 0.128 to 0.320).
Adolescent population

The evidence for the efficacy of selpercatinib in the adolescent population is limited. Only one patient under the age of 18 with treatment-naïve MTC was enrolled in the LIBRETTO-531 study. Additionally, results are available from a total of three patients in the phase 1 /2 LIBRETTO-001 study, of whom two had treatment-naïve MTC. Furthermore, data from a total of 14 paediatric patients with MTC are included from the phase 1/2 study LIBRETTO-121. The overall response rate (ORR) for patients with MTC in LIBRETTO-121 was 42.9% (95% CI: 17.7%–71.1%) in the RET-mutant MTC population.

It is noteworthy that a dosage of 92 mg/kg was administered to paediatric patients aged between 12 and 18 in the pivotal study LIBRETTO-531 and in LIBRETTO-121. Although the currently approved dosage in the paediatric population is acceptable, the Information for healthcare professionals has been amended to reflect the fact that the evidence on paediatric patients was limited and based on a dosage of 92 mg/m2.

5.4 Safety

RET fusion-positive NSCLC
Safety was assessed in the safety-overall population of LIBRETTO-531, which included all patients who received at least one dose of study treatment (158 in the selpercatinib arm; 98 in the control arm).

The most frequently reported any-grade treatment emergent adverse events (TEAEs) in the selpercatinib arm included increased AST and ALT hypertension, diarrhoea, oedema, dry mouth, increased bilirubin, rash, fatigue, thrombocytopenia, abdominal pain, leukopenia, increased blood creatinine, neutropenia, constipation and ECG QT prolongation.
Grade ≥3 TEAEs were observed in 72.8% of patients in the selpercatinib arm and 58.2% in the control arm. The most frequent grade ≥3 TEAEs were increased ALT, hypertension, increased AST and prolonged ECG QT.
Serious Adverse Events (SAEs) were reported in 38.9% of patients in the selpercatinib arm vs 24.5% in the control arm. The most frequently reported SAEs (≥2%) in the selpercatinib arm included pleural effusion and hepatic function abnormalities.
A total of 12 grade 5 TEAEs were observed and 9 grade 5 TEAEs occurred in patients treated with selpercatinib on treatment or within 30 days of discontinuation (2 patients died due to myocardial infarction, 1 due to acute respiratory failure, 1 due to cardiac arrest, 1 due to malnutrition, 1 due to sudden death, 1 due to respiratory failure, 1 due to suicide, 1 “death”), 2 occurred during crossover to selpercatinib (1 due to respiratory failure, 1 due to sudden death), and 1 in the control arm. The rate of fatal TEAEs in the control arm was 1.0%.

RET-mutant MTC
At the DCO date of the IA1 in study LIBRETTO-531, TEAEs were reported in 96.4% of patients treated with selpercatinib and 99.0% of patients in the control arm. The most common TEAEs in the selpercatinib arm included hypertension, diarrhoea, increased ALT, increased AST, dry mouth, headache, fatigue and constipation.
Grade ≥3 TEAEs occurred in 52.8% of patients in the selpercatinib arm and 76.3% in the control arm. The most common grade ≥3 TEAEs in the selpercatinib arm included hypertension, increased ALT, fatigue, and diarrhoea.
SAEs were reported in 21.8% of patients in the selpercatinib arm and 26.8% in the control arm. TEAEs leading to permanent treatment discontinuation occurred in 4.7% of patients in the selpercatinib arm compared to 26.8% in the control arm. On-treatment grade 5 TEAEs occurred in 4 patients (2.1%) in the selpercatinib arm and in 2 patients (2.1%) in the control arm. The causes of the grade 5 TEAEs in the selpercatinib arm were diabetic ketoacidosis, COVID-19, multiple organ dysfunction syndrome and sudden death.

At the DCO date of the IA2, a new signal for erectile dysfunction was identified, which was reported in 15.7% of patients in the selpercatinib arm and 0% in the control arm and has been included in the Information for healthcare professionals.

Adolescent population

The evidence for the safety of selpercatinib in the adolescent population is limited. Safety data in the adolescent population are available from the LIBRETTO-001, LIBRETTO-121 and LIBRETTO-531 studies. The most common TEAEs in LIBRETTO-121 study were diarrhoea, pyrexia nausea, abdominal pain, headache, increased AST levels, increased ALT levels, coronavirus infection, cough, epistaxis and vomiting. Grade ≥3 TEAEs occurred in 57.6% of patients. The most common grade ≥3 TEAEs were weight gain, vomiting, increased ALT, constipation, hypokalaemia and decreased neutrophil count. SAEs occurred in 42.4% of patients. The most common SAE was vomiting. No fatal events were reported.

A safety signal for slipped upper femoral epiphysis was reported in association with selpercatinib in paediatric patients (1 patient in LIBRETTO-121 study, 1 patient in LIBRETTO-531 study, and 1 patient from expanded access). A specific warning regarding this risk was included in the Information for healthcare professionals.

5.5 Final clinical benefit risk assessment

RET fusion-positive NSCLC
The LIBRETTO-431 trial demonstrated a statistically significant and clinically meaningful PFS benefit for selpercatinib compared to the standard of care in NSCLC. However, in first-line treatment, PFS must be interpreted in conjunction with the clinically relevant endpoint OS. At the most recent IA2, OS data were immature, and no statistically significant OS benefit was observed. In addition, the OS HR was >1 with multiple crossing of the curve. In addition, selpercatinib treatment was associated with higher toxicity than the current standard of care. Therefore, on the basis of the data at hand, the benefit was regarded as negative for authorisation without special conditions.

Taking into account the high rate of crossover and the absence of an alternative targeted therapy in this setting, the benefit risk was regarded as positive for a temporary authorisation “ex-officio” according to Art. 18 TPLO. Additional follow-up data and safety analyses from LIBRETTO-431 study were accepted as a condition and must be submitted within the timeframe of temporary authorisation.

RET-mutant MTC
The LIBRETTO-531 study met its primary endpoint, demonstrating a statistically significant and clinically meaningful improvement in PFS, as assessed by BICR, for selpercatinib compared to cabozantinib or vandetanib. OS data are immature and interpretation is limited due to the high censoring rate. However, no detriment was shown for selpercatinib.
Selpercatinib was associated with a lower rate of ≥grade 3 TEAEs, SAEs, grade 5 TEAEs and TEAEs leading to discontinuation compared to cabozantinib or vandetanib.

The efficacy and safety data in the adolescent population are limited. However, taking into account the high unmet medical need in this population and the fact that the limited data are adequately reflected in the Information for healthcare professionals, authorisation in this population was accepted.

Taken together, the overall benefit-risk profile is positive for selpercatinib in the first-line treatment of RET-mutant MTC for patients 12 years and older.

6 Risk management plan summary

The RMP summaries contain information on the medicinal products′ safety profiles and explain the measures that are taken to further investigate and monitor the risks, as well as to prevent or minimise them.
The RMP summaries are published separately on the Swissmedic website. It is the responsibility of the marketing authorisation holder to ensure that the content of the published RMP summaries is accurate and correct. As the RMPs are international documents, their summaries might differ from the content in the Information for healthcare professionals / product information approved and published in Switzerland, e.g. by mentioning risks that occur in populations or indications not included in the Swiss authorisations.

7 Appendix

Approved Information for healthcare professionals

Please be aware that the following version of the Information for healthcare professionals for Retsevmo was approved with the submission described in the SwissPAR. This Information for healthcare professionals may have been updated since the SwissPAR was published.

Please note that the valid and relevant reference document for the effective and safe use of medicinal products in Switzerland is the Information for healthcare professionals currently authorised by Swissmedic (see www.swissmedicinfo.ch).

Note:
The following Information for healthcare professionals has been translated by the MAH. It is the responsibility of the authorisation holder to ensure the translation is correct. The only binding and legally valid text is the Information for healthcare professionals approved in one of the official Swiss languages.