HIGHLIGHTS OF PRESCRIBING INFORMATION

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

Renvela® (sevelamer carbonate) Tablet, Film Coated for Oral use
Renvela® (sevelamer carbonate) For Oral Suspension

INDICATIONS AND USAGE

Renvela® is a phosphate binder indicated for the control of serum phosphorus in adults and children 6 years of age and older with chronic kidney disease on dialysis. (1)

DOSAGE AND ADMINISTRATION

• Starting dose of Renvela is 0.8 or 1.6 grams administered orally three times per day with meals based on serum phosphorus levels for adult patients and based on body surface area (BSA) category for pediatric patients. (2.1)
• Titrate by 0.8 g per meal in two week intervals for adult patients as needed to obtain serum phosphorus target. (2.1)
• Titrate based on BSA category for pediatric patients in two week intervals for 6 weeks and then every 4 weeks as needed to obtain serum phosphorus target. (2.1)

DOSAGE FORMS AND STRENGTHS

• Tablets: 800 mg (3)
• Powder: 0.8 g and 2.4 g packet (3)

CONTRAINDICATIONS

• Bowel obstruction. (4)

WARNINGS AND PRECAUTIONS

• Known hypersensitivity to sevelamer carbonate, sevelamer hydrochloride, or to any of the excipients. (4)

ADVERSE REACTIONS

• Serious cases of dysphagia, bowel obstruction, and perforation have been associated with sevelamer use, some requiring hospitalization and surgery. (5.1)

DRUG INTERACTIONS

• For oral medication where a reduction in the bioavailability of that medication would have a clinically significant effect on its safety or efficacy, consider separation of the timing of administration and/or monitor clinical responses or blood levels of the concomitant medication. (7)
• Sevelamer did not alter the pharmacokinetics of digoxin, enalapril, iron, metoprolol and warfarin. (7)
• Sevelamer has demonstrated interaction with ciprofloxacin, mycophenolate mofetil, and therefore, these drugs should be dosed separately from Renvela. (7)

See 17 for PATIENT COUNSELING INFORMATION Revised: 06/2018

Table 2: Recommended Starting Dosage and Titration Increment Based on Pediatric Patient’s Body Surface Area (m²)

<table>
<thead>
<tr>
<th>BSA (m²)</th>
<th>Starting Dose Per Meal/ Snack</th>
<th>Titration Increases/ Decreases Per Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥0.75 to &lt;1.2</td>
<td>0.8 g</td>
<td>Titrate by 0.4 g</td>
</tr>
<tr>
<td>≥1.2</td>
<td>1.6 g</td>
<td>Titrate by 0.8 g</td>
</tr>
</tbody>
</table>

Dose Titration for Pediatric Patients Taking Renvela. Titrate the Renvela dose as needed to achieve target levels at two-week intervals based on BSA category, as shown in Table 2. Switching from Sevelamer Hydrochloride Tablets. For adult patients switching from sevelamer hydrochloride tablets to sevelamer carbonate tablets or powder, use the same dose in grams. Switching between Sevelamer Carbonate Tablets and Powder. Use the same dose in grams. Switching from Calcium Acetate. Table 3 gives recommended starting doses of Renvela based on a patient’s current calcium acetate dose.

Table 3: Starting Dose for Dialysis Patients Switching from Calcium Acetate to Renvela

<table>
<thead>
<tr>
<th>Calcium Acetate 667 mg (Tablets per meal)</th>
<th>Renvela</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 tablet</td>
<td>0.8 g</td>
</tr>
<tr>
<td>2 tablets</td>
<td>1.6 g</td>
</tr>
<tr>
<td>3 tablets</td>
<td>2.4 g</td>
</tr>
</tbody>
</table>

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*Sections or subsections omitted from the full prescribing information are not listed.
2.2 Sevelamer Carbonate Powder Preparation Instructions

Sevelamer carbonate powder is available in 0.8 or 2.4 g packets. For dose increments of 0.4 g, use one half of a 0.8 g packet. Place the sevelamer carbonate powder in a cup and suspend in the amount of water described in Table 4.

Table 4: Sevelamer Carbonate Powder Preparation Instructions

<table>
<thead>
<tr>
<th>Amount of Renvela Powder</th>
<th>Minimum Amount of Water for Dose Preparation (either ounces, mL, or tablespoon)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.4 g</td>
<td>1 oz. (30 mL) / 2 tablespoons</td>
</tr>
<tr>
<td>0.8 g</td>
<td>1 oz. (30 mL) / 1 tablespoon</td>
</tr>
<tr>
<td>2.4 g</td>
<td>2 oz. (60 mL) / 4 tablespoons</td>
</tr>
</tbody>
</table>

Instruct patients to stir the mixture vigorously (it does not dissolve), resuspend, if necessary, right before administration, and drink the entire preparation within 30 minutes.

As an alternative to water, the entire contents of the sachet may be pre-mixed with a small amount of food or beverage and consumed immediately (within 30 minutes) as part of the meal. Do not heat Renvela Powder (e.g., microwave) or add to heated foods or liquids.

3 DOSAGE FORMS AND STRENGTHS

Tablets: 800 mg white oval, film-coated, compressed tablets imprinted with.

<table>
<thead>
<tr>
<th>DOSAGE</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>800 mg</td>
<td>1 tablet</td>
</tr>
</tbody>
</table>

4 CONTRAINDICATIONS

Renvela is contraindicated in patients with bowel obstruction.

Renvela is contraindicated in patients with known hypersensitivity to sevelamer carbonate, sevelamer hydrochloride, or to any of the excipients.

5 WARNINGS AND PRECAUTIONS

5.1 Gastrointestinal Adverse Events

Cases of dysphagia and esophageal tablet retention have been reported in association with use of the tablet formulation of sevelamer, some requiring hospitalization and intervention. Consider using sevelamer suspension in patients with a history of swallowing disorders.

Cases of bowel obstruction and perforation have also been reported with sevelamer use.

Patients with dysphagia, swallowing disorders, severe gastrointestinal (GI) motility disorders, including severe constipation, or major GI tract surgery were not included in the Renvela clinical studies.

5.2 Reductions in Vitamins D, E, K (diluting factors) and Folic Acid Levels

In preclinical studies in rats and dogs, sevelamer hydrochloride, which contains the same active moiety as sevelamer carbonate, reduced vitamins D, E, and K (coagulation parameters) and folic acid levels at doses of 6–10 times the recommended human dose. In short-term clinical trials, there was no evidence of reduction in serum levels of vitamins. However, in a one-year clinical trial, 25-hydroxyvitamin D (normal range 10 to 55 ng/mL) fell from 39 ± 20 ng/mL to 34 ± 22 ng/mL (p<0.01) with sevelamer hydrochloride treatment. Most (approximately 75%) patients in sevelamer hydrochloride clinical trials were receiving vitamin supplements.

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

There are limited clinical trial data on the safety of Renvela. However, because it contains the same active ingredients as sevelamer hydrochloride salt, the adverse event profiles of the two salts are expected to be similar. In a cross-over study in hemodialysis patients with treatment durations of eight weeks each and no washout, and another cross-over study in hemodialysis patients with treatment durations of four weeks each and no washout between treatment periods, the adverse reactions on sevelamer carbonate powder were similar to those reported for sevelamer hydrochloride.

In a parallel design study of sevelamer hydrochloride with treatment duration of 52 weeks, adverse reactions reported for sevelamer hydrochloride (n=99) were similar to those reported for the active-comparator group (n=101). Overall adverse reactions among those treated with sevelamer hydrochloride occurring in >5% of patients included: vomiting (22%), nausea (20%), diarrhea (19%), dyspepsia (16%), abdominal pain (9%), flatulence (8%), and constipation (8%). A total of 27 patients treated with sevelamer and 10 patients treated with comparator withdrew from the study due to adverse reactions.

Based on studies of 8–52 weeks, the most common reason for withdrawal from sevelamer hydrochloride was gastrointestinal adverse reactions (3%–16%). In 143 peritoneal dialysis patients studied for 12 weeks using sevelamer hydrochloride, most common adverse reactions were similar to adverse reactions observed in hemodialysis patients. The most frequently occurring treatment emergent serious adverse reaction was portolysis (8 reactions in 6 patients [8%] in the sevelamer group and 2 reactions in 2 patients [4%] on active control). Thirteen patients (14%) in the sevelamer group and 9 patients (20%) in the active-control group discontinued mostly for gastrointestinal adverse reactions.

6.2 Postmarketing Experience

Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or to establish a causal relationship to drug exposure.

The following adverse reactions have been identified during postapproval use of sevelamer hydrochloride or sevelamer carbonate: hypersensitivity, pruritus, rash, abdominal pain, fecal impaction, and uncommon cases of ileus, intestinal obstruction, and intestinal perforation. Appropriate medical management should be given to patients who develop constipation or have worsening of existing constipation to avoid severe complications.

7 DRUG INTERACTIONS

There are no empirical data to avoid drug interactions between Renvela and most concomitant oral drugs. For oral medication where a reduction in the bioavailability of that medication would have a clinically significant effect on its safety or efficacy (e.g., cyclosporine, tacrolimus, levodopa/entacapone), consider separation of the timing of the administration of the two drugs [see Clinical Pharmacology (12.3)]. The duration of separation depends upon the absorption characteristics of the medication concomitantly administered, such as the time to reach peak systemic levels and whether the drug is an immediate-release or an extended-release product. Where possible consider monitoring clinical responses and/or blood levels of concomitant drugs that have a narrow therapeutic range.

Table 5: Sevelamer Drug Interactions

<table>
<thead>
<tr>
<th>Oral drugs for which sevelamer did not alter the pharmacokinetics when administered concomitantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dosing Recommendations</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
</tr>
<tr>
<td>Take at least 2 hours before or 6 hours after sevelamer</td>
</tr>
<tr>
<td>Enalapril</td>
</tr>
<tr>
<td>Iron</td>
</tr>
<tr>
<td>Metoprolol</td>
</tr>
<tr>
<td>Warfarin</td>
</tr>
<tr>
<td>Take at least 2 hours before sevelamer</td>
</tr>
</tbody>
</table>

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Sevelamer carbonate is not absorbed systemically following oral administration and maternal use is not expected to result in fetal exposure to the drug.

Clinical Considerations

Sevelamer carbonate may decrease serum levels of fat soluble vitamins and folic acid in pregnant women [see Clinical Pharmacology (12.2)]. Consider supplementation.

Data

Animal data

In pregnant rats given dietary doses of 0.5, 1.5, or 4.5 g/kg/day of sevelamer hydrochloride during organogenesis, reduced or irregular ossification of fetal bones, possibly due to a reduced absorption of fat-soluble vitamin D, occurred in mid and high-dose groups (human equivalent doses approximately equal to 3–4 times the maximum clinical trial dose of 13 g). In pregnant rabbits given oral doses of 100, 500, or 1000 mg/kg/day of sevelamer hydrochloride by gavage during organogenesis, an increase in maternal and fetal fatalities occurred in the high-dose group (human equivalent dose twice the maximum clinical trial dose).

8.2 Lactation

Risk Summary

Renvela is not absorbed systemically by the mother following oral administration, and breastfeeding is not expected to result in exposure of the child to Renvela.

Clinical Considerations

Sevelamer carbonate may decrease serum levels of fat soluble vitamins and folic acid in pregnant women [see Clinical Pharmacology (12.2)]. Consider supplementation.

8.4 Pediatric Use

The safety and efficacy of Renvela in lowering serum phosphorus levels was studied in patients 6 years of age and older with CKD. In this study, Renvela was apparently less effective in children with a low baseline serum phosphorus, which described children <13 years of age and children not on dialysis. Given its mechanism of action, Renvela is expected to be effective in lowering serum phosphorus levels in pediatric patients with CKD. Most adverse events that were reported as related, or possibly related, to sevelamer carbonate were gastrointestinal in nature. No new risks or safety signals were identified with the use of sevelamer carbonate in the trial.

Renvela has not been studied in pediatric patients below 6 years of age.

8.5 Geriatric Use

Clinical studies of Renvela did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in response between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range.

10 OVERDOSAGE

In CKD patients on dialysis, the maximum dose studied was 14 grams of sevelamer carbonate and 13 grams of sevelamer hydrochloride. There are no reports of overdose with sevelamer carbonate or sevelamer hydrochloride in patients. Since sevelamer is not absorbed, the risk of systemic toxicity is low.

11 DESCRIPTION

The active ingredient in Renvela is sevelamer carbonate, a polymeric amine that binds phosphate and is the same.

The active ingredient in Renvela is sevelamer carbonate, a polymeric amine that binds phosphate and is the same.
12.1 Mechanism of Action
Renova contains sevelamer carbonate, a non-absorbed phosphate binding cross-linked polymer, free of metal and calcium. It contains multiple amines separated by one carbon from the polymer backbone. These amines exist in a protonated form in the intestine and interact with phosphate molecules through ionic and hydrogen bonding. By binding phosphate in the gastrointestinal tract and decreasing absorption, sevelamer carbonate lowers the phosphate concentration in the serum (serum phosphorus).

12.2 Pharmacodynamics
In addition to effects on serum phosphorus levels, sevelamer hydrochloride has been shown to bind bile acids in vitro and in vivo in experimental animal models. Because sevelamer binds bile acids, it may interfere with normal fat absorption and thus may reduce absorption of fat soluble vitamins such as A, D, and K. In clinical trials of sevelamer hydrochloride, both the mean total and LDL cholesterol declined by 15%–31%; the clinical significance of this finding, which was observed after 2 weeks, is unclear. Triglycerides, HDL cholesterol, and albumin did not change.

12.3 Pharmacokinetics
A mass balance study using 13C-sevelamer hydrochloride, in 16 healthy male and female volunteers showed that sevelamer hydrochloride is not systemically absorbed. No absorption studies have been performed in patients with renal disease.

Drug Interactions
In vivo
Sevelamer carbonate has been studied in human drug-drug interaction studies (9.6 grams once daily with a meal) with warfarin and digoxin. Sevelamer hydrochloride, which contains the same active moiety as sevelamer carbonate, has been studied in human drug-drug interaction studies (2.4–2.8 grams single dose or three times daily with meals or two times daily without meals) with ciprofloxacin, digoxin, enalapril, iron, metropil, mycophenolate mofetil, and warfarin.

Coadministered single dose of 2.8 grams of sevelamer hydrochloride in fasted state decreased the bioavailability of ciprofloxacin by 50% in healthy subjects. Concentration of cyclosporine and tacrolimus leading to dose increases has also been reported in patients coadministered sevelamer hydrochloride and levothyroxine. Reduction in concentrations of cyclosporine and tacrolimus leading to dose increases has also been reported in transplant patients when coadministered with sevelamer hydrochloride without any clinical consequences (for example, graft rejection). The possibility of an interaction cannot be excluded with these drugs.

13 NONCLINICAL TOXICOLOGY
13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility
Standard lifetime carcinogenicity bioassays were conducted in mice and rats. Rats were given sevelamer hydrochloride by diet at 0.3, 1, or 3 g/kg/day. There was an increased incidence of urinary bladder transitional cell papilloma in male rats of the high dose group (human equivalent dose twice the maximum clinical trial dose of 13 g). Mice received dietary administration of sevelamer hydrochloride at doses of up to 9 g/kg/day (human equivalent dose 3 times the maximum clinical trial dose). There was no increased incidence of tumors observed in mice.

In an in vitro mammalian cytogenetic test with metabolite activation, sevelamer hydrochloride caused a statistically significant increase in the number of structural chromosome aberrations. Sevelamer hydrochloride was not mutagenic in the Ames bacterial mutation assay.

Sevelamer hydrochloride did not impair the fertility of male or female rats in a dietary administration study in which the females were treated from 14 days prior to mating through gestation and the males were treated for 28 days prior to mating. The highest dose in this study was 4.5 g/kg/day (human equivalent dose 3 times the maximum clinical trial dose of 13 g).

14 CLINICAL STUDIES
The ability of sevelamer to control serum phosphorus in CKD patients on dialysis was predominantly determined from the effects of the hydrochloride salt to bind phosphate. Six clinical trials used sevelamer hydrochloride and three clinical trials used sevelamer carbonate. The sevelamer hydrochloride studies include one double-blind, placebo-controlled 2-week study (sevelamer N=24); two open-label, uncontrolled, 8-week studies (sevelamer N=220); and three active-controlled open-label studies with treatment durations of 8 to 52 weeks (sevelamer N=256). The sevelamer carbonate studies include one double-blind, active-controlled, cross-over study with two 8-week treatment periods using sevelamer carbonate tablets (N=73); one open-label, active-controlled, cross-over study with two 4-week treatment periods using sevelamer carbonate powder (N=31); and one randomized, parallel, open-label study using sevelamer carbonate powder (N=144) dosed once daily or sevelamer hydrochloride tablets (N=73) dosed three times daily for 24 weeks. Six of the active-controlled studies are described here (the sevelamer hydrochloride studies).

14.1 Cross-Over Study of Sevelamer Carbonate (Renvela®) 800 mg Tablets and Sevelamer Hydrochloride (Renagel®) 800 mg Tablets
Stage 5 CKD patients on hemodialysis were entered into a five-week sevelamer hydrochloride run-in period and 79 patients received, in random order, sevelamer carbonate 800 mg tablets and sevelamer hydrochloride tablets for four weeks each with no intervening washout. Study dose during the cross-over period was determined based on the sevelamer hydrochloride dose during the run-in period on a gram-per-gram basis. The phosphorus levels at the end of each of the two cross-over periods were similar. Average actual daily dose was 6.4 g/day divided among meals for both treatments. Thirty-nine of those completing the cross-over portion of the study were entered into a two-week washout period during which patients were instructed not to take any phosphate binders; this confirmed the activity of sevelamer in this study.

14.2 Cross-Over Study of Sevelamer Carbonate (Renvela®) Powder and Sevelamer Hydrochloride (Renagel®) Tablets
Stage 5 CKD patients on hemodialysis were entered into a four-week sevelamer hydrochloride run-in period and 31 patients received, in random order, sevelamer carbonate powder and sevelamer hydrochloride tablets for four weeks each with no intervening washout. Study dose during the cross-over period was determined based on the sevelamer hydrochloride dose during the run-in period on a gram-per-gram basis. The phosphorus levels at the end of each of the two cross-over periods were similar. Average actual daily dose was 6.0 g/day divided among meals for sevelamer carbonate powder and 6.4 g/day divided among meals for sevelamer hydrochloride tablets.

14.3 Clinical Study of Sevelamer Carbonate (Renvela®) Powder and Tablets in Pediatric Patients
A clinical study with sevelamer carbonate was conducted in 101 patients 6 to 18 years of age with chronic kidney disease. This study included a washout period for patients on a phosphate binder, a 2-week, double-blind, fixed-dose period (FDA) in which patients were randomized to sevelamer carbonate (N=50) or placebo (N=51), and a 26-week, open-label, sevelamer carbonate dose titration period (DT). Most patients were 13 to 18 years of age (73%) and had a BSA ≥2 m² (84%). Approximately 78% of patients were CKD patients on dialysis.

Sevelamer carbonate significantly reduced serum phosphorous through Week 2 (primary endpoint) by an LS Mean difference of -0.90 (SE 0.27) mg/dL compared to placebo (p=0.001). A similar treatment response was observed in patients who received sevelamer carbonate during the 6-month open-label DT. Approximately 30% of subjects reached their target serum phosphorus. The median prescribed dose was 7.0 g per day during the titration period.

The results of the primary efficacy endpoint were consistent by BSA subgroup. In contrast, a treatment effect was not observed in subjects with a baseline serum phosphorus below 7 mg/dL, many of whom were the subjects 6 to <13 years of age or the subjects not on dialysis (Figure 2).

Figure 2: Change in Serum Phosphorus (mg/dL) from Baseline to Week 2 by Subgroup

Note: LS Mean difference of Sevelamer Carbonate – Placebo, based on ANCOVA within subgroup and with treatment as fixed effect and screening BSA and baseline serum phosphorus as covariates.

14.4 Sevelamer Hydrochloride versus Active-Control, Cross-Over Study in Hemodialysis Patients
Eighty-four CKD patients on hemodialysis who were hyperphosphatemic (serum phosphorus >6.0 mg/dL) following a two-week phosphate binder washout period were randomized in a cross-over design to receive in random order sevelamer hydrochloride and active control for eight weeks each. Treatment periods were separated by a two-week phosphate binder washout period. Patients started on treatment three times per day with meals. Over each eight-week treatment period, at three separate time points the dose of sevelamer hydrochloride could be titrated up to control serum phosphorus, the dose of active control could also be altered to control serum phosphorus. Both treatments significantly decreased mean serum phosphorus by about 2 mg/dL (Table 6).

Table 6: Mean Serum Phosphorus (mg/dL) at Baseline and Endpoint

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Baseline</th>
<th>LS Mean at Week 2 (mg/dL)</th>
<th>Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sevelamer Hydrochloride (N=81)</td>
<td>6.0</td>
<td>4.4</td>
<td>-1.6</td>
</tr>
<tr>
<td>Active Control (N=83)</td>
<td>6.0</td>
<td>5.6</td>
<td>-0.4</td>
</tr>
</tbody>
</table>
Two hundred CKD patients on hemodialysis who were hyperphosphatemic (serum phosphorus >5.5 mg/dL) following a two-week phosphate-binder washout period were randomized to receive either sevelamer carbonate powder once daily (N=144) or sevelamer hydrochloride as a tablet with the dose divided three times per day (N=73) for 24 weeks. The initial dose for the two groups was 4.8 g/day. At the end of the study, the total daily dose was 6.2 g/day of sevelamer carbonate powder once daily and 6.7 g/day of sevelamer hydrochloride tablets three times per day. A greater percentage of subjects on the once-daily dose than three times per day regimen discontinued therapy prematurely, 35% versus 15%. The reasons for discontinuation were largely driven by adverse events and withdrawal of consent in the once-daily dosing regimen. Serum phosphate levels and calcium-phosphate product were better controlled on the three times per day regimen than on the once-daily regimen. Mean serum phosphorus decreased 2.0 mg/dL for sevelamer carbonate powder once daily and 2.9 mg/dL for sevelamer hydrochloride tablets three times per day.

**16. HOW SUPPLIED/STORAGE AND HANDLING**

Tablets: Renvela® 800 mg Tablets are supplied as white oval, film-coated, compressed tablets, imprinted with “RENVELA 800,” containing 800 mg of sevelamer carbonate on an anhydrous basis, microcrystalline cellulose, hypromellose, dioctylated monoglycerides, sodium chloride, and zinc stearate.

1 Bottle of 270 ct 800 mg Tablets (NDC 58468-0130-1)
1 Box (NDC 58468-0131-2) of 90 ct 2.4 g packets (NDC 58468-0131-1)
1 Box (NDC 58468-0132-2) of 90 ct 0.8 g packets (NDC 58468-0132-1)

Storage: Store at 25°C (77°F); excursions permitted to 15°C–30°C (59°F–86°F). [See USP controlled room temperature]

Protect from moisture.

**17. PATIENT COUNSELING INFORMATION**

Inform patients to take Renvela with meals and adhere to their prescribed diets. For patients using an oral medication where a reduction in the bioavailability of that medication would have a clinically significant effect on its safety or efficacy, advise the patient to take the oral medication at least one hour before or three hours after Renvela.

For Renvela powder, brief the patient on preparation of the powder in water. Advise patients to report new onset or worsening of existing constipation promptly to their physician.

Manufactured by: Genzyme Ireland Ltd.
For: Genzyme Corporation Cambridge, MA 02142

Renvela is a registered trademark of Genzyme Corporation.

SEVC-FPLR-SL-JUN18 Rx Only

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**Table 6: Mean Serum Phosphorus (mg/dL) at Baseline and Endpoint (continued)**

<table>
<thead>
<tr>
<th></th>
<th>Sevelamer Hydrochloride (N=81)</th>
<th>Active Control (N=83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(95% Confidence Interval)</td>
<td>(-2.5, -1.5)</td>
<td>(-2.6, -1.7)</td>
</tr>
</tbody>
</table>

*p<0.0001, within treatment group comparison*

The distribution of responses is shown in Figure 3. The distributions are similar for sevelamer hydrochloride and active control. The median response is a reduction of about 2 mg/dL in both groups. About 50% of subjects have reductions between 1 and 3 mg/dL. About 50% of subjects have reductions between 1 and 3 mg/dL. The distribution of responses is shown in Figure 3. The distributions are similar for sevelamer hydrochloride and active control. The median response is a reduction of about 2 mg/dL in both groups. About 50% of subjects have reductions between 1 and 3 mg/dL. About 50% of subjects have reductions between 1 and 3 mg/dL.

**Figure 3: Percentage of Patients (Y-axis) Attaining a Phosphorus Reduction from Baseline (mg/dL) at Least as Great as the Value of the X-axis.**

The distribution of responses is shown in Figure 3. The distributions are similar for sevelamer hydrochloride and active control. The median response is a reduction of about 2 mg/dL in both groups. About 50% of subjects have reductions between 1 and 3 mg/dL. The distribution of responses is shown in Figure 3. The distributions are similar for sevelamer hydrochloride and active control. The median response is a reduction of about 2 mg/dL in both groups. About 50% of subjects have reductions between 1 and 3 mg/dL. About 50% of subjects have reductions between 1 and 3 mg/dL.

Average daily sevelamer hydrochloride dose at the end of treatment was 4.9 g (range of 0.0 to 12.6 g).

14.5 Sevelamer Hydrochloride versus Active Control in Hemodialysis Patients

Two hundred CKD patients on hemodialysis who were hyperphosphatemic (serum phosphorus >5.5 mg/dL) following a two-week phosphate-binder washout period were randomized to receive sevelamer hydrochloride 320 mg tablets (N=89) or an active control (N=101). At week 52, using last observation carried forward, sevelamer and active control both significantly decreased mean serum phosphorus (Table 7).

**Table 7: Mean Serum Phosphorus (mg/dL) and Ion Product at Baseline and Change from Baseline to End of Treatment**

<table>
<thead>
<tr>
<th></th>
<th>Sevelamer HCl (N=94)</th>
<th>Active Control (N=98)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phosphorus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>7.5</td>
<td>7.3</td>
</tr>
<tr>
<td>Change from Baseline to Endpoint</td>
<td>-2.1</td>
<td>-1.8</td>
</tr>
<tr>
<td>Ca × Phosphorus Ion Product</td>
<td>70.5</td>
<td>68.4</td>
</tr>
<tr>
<td>Baseline</td>
<td>70.5</td>
<td>68.4</td>
</tr>
<tr>
<td>Change from Baseline to Endpoint</td>
<td>-19.4</td>
<td>-14.2</td>
</tr>
</tbody>
</table>

Sixty-one percent of sevelamer hydrochloride patients and 73% of the control patients completed the full 52 weeks of treatment.

Figure 4, a plot of the phosphorus change from baseline for the completers, illustrates the durability of response for patients who are able to remain on treatment.

**Figure 4: Mean Phosphorus Change from Baseline for Patients who Completed 52 Weeks of Treatment**

Average daily sevelamer hydrochloride dose at the end of treatment was 6.5 g (range of 0.8 to 13.6 g).

14.6 Sevelamer Hydrochloride versus Active Control in Peritoneal Dialysis Patients

One hundred and forty-three patients on peritoneal dialysis who were hyperphosphatemic (serum phosphorus >5.5 mg/dL) following a two-week phosphate binder washout period were randomized to receive sevelamer hydrochloride (N=97) or active control (N=46) open label for 12 weeks. Average daily sevelamer hydrochloride dose at the end of treatment was 6.7 g (range of 0.0 to 13.6 g). Thirteen patients (14%) in the sevelamer group and 5 patients (20%) in the active-control group discontinued, mostly for gastrointestinal adverse reactions. There were statistically significant changes in serum phosphorus (p<0.001) for sevelamer hydrochloride (-1.6 mg/dL from baseline) of 7.5 mg/dL), similar to the active control.

14.7 Once a Day versus Three Times a Day Dosing

Stage 5 CKD patients on hemodialysis with a serum phosphate level of >5.5 mg/dL, after washout from baseline therapies were randomized in a 2:1 ratio to receive either sevelamer carbonate powder once daily (N=144) or sevelamer hydrochloride as a tablet with the dose divided three times per day (N=73) for 24 weeks. The initial dose for the two groups was 4.8 g/day. At the end of the study, the total daily dose was 6.2 g/day of sevelamer carbonate powder once daily and 6.7 g/day of sevelamer hydrochloride tablets three times per day. A greater percentage of subjects on the once-daily dose than three times per day regimen discontinued therapy prematurely, 35% versus 15%. The reasons for discontinuation were largely driven by adverse events and withdrawal of consent in the once-daily dosing regimen. Serum phosphate levels and calcium-phosphate product were better controlled on the three times per day regimen than on the once-daily regimen. Mean serum phosphorus decreased 2.0 mg/dL for sevelamer carbonate powder once daily and 2.9 mg/dL for sevelamer hydrochloride tablets three times per day.