

Data Sheet

ACTEMRA[®]

Tocilizumab 80 mg in 4 mL, 200 mg in 10 mL and 400 mg in 20 mL concentrate for solution for infusion

CAS 375823-41-9

Description

Tocilizumab is a recombinant humanised monoclonal antibody of the immunoglobulin (Ig) IgG1 subclass which binds to human interleukin 6 (IL-6) receptors. It is composed of two heterodimers, each of which consists of a heavy and a light polypeptide chain. The light chain contains 214 amino acids and the heavy chain 448 amino acids. The four polypeptide chains are linked intra- and inter-molecularly by disulfide bonds. Tocilizumab has a molecular weight of approximately 148,000 Daltons. Tocilizumab binds to both soluble and membrane-bound IL-6 receptors (sIL-6R and mIL-6R).

ACTEMRA is a clear to opalescent, colourless to pale yellow sterile solution for intravenous (IV) infusion. ACTEMRA is supplied in preservative-free, non-pyrogenic single-use, clear glass vials. ACTEMRA is available in 10 mL and 20 mL vials containing 4 mL, 10 mL or 20 mL of tocilizumab concentrate (20 mg/mL). ACTEMRA also contains polysorbate 80, sucrose, dibasic sodium phosphate dodecahydrate, monobasic sodium phosphate dihydrate and water for injections.

Pharmacology

Mechanism of Action

Tocilizumab is a recombinant humanised monoclonal antibody of the immunoglobulin (Ig) IgG1 subclass. Tocilizumab binds specifically to both soluble and membrane-bound IL-6 receptors, and has been shown to inhibit sIL-6R and mIL-6R-mediated signaling. IL-6 is a multi-functional cytokine, produced by a variety of cell types involved in local paracrine function as well as regulation of systemic physiological and pathological processes such as induction of immunoglobulin secretion, T-cell activation, induction of hepatic acute phase proteins and stimulation of haematopoiesis. IL-6 has been implicated in the pathogenesis of diseases including rheumatoid arthritis (RA).

The possibility exists for tocilizumab to affect host defences against infections and malignancies. The role of IL-6 receptor inhibition in the development of malignancies is not known.

Pharmacodynamics

In clinical studies with ACTEMRA, rapid decreases in C-reactive protein (CRP), erythrocyte sedimentation rate (ESR) and serum amyloid A were observed. Rapid increases in haemoglobin levels (within the first 2 weeks) were also observed, through ACTEMRA decreasing the IL-6 driven effects on hepcidin production to increase iron availability.

In healthy subjects administered ACTEMRA in doses from 2 to 28 mg/kg, absolute neutrophil counts (ANC) decreased to their lowest levels 3 to 5 days following administration. Thereafter, neutrophils recovered towards baseline in a dose dependent manner. Patients with RA demonstrated a similar pattern of absolute neutrophil counts following ACTEMRA administration (see Precautions - Haematological Abnormalities).

Pharmacokinetics

The pharmacokinetics of ACTEMRA were determined using a population pharmacokinetic analysis on a database composed of 1793 RA patients treated with a one hour infusion of 4 and 8 mg/kg every 4 weeks for 24 weeks.

The pharmacokinetic parameters of ACTEMRA did not change with time. A more than dose-proportional increase in area under the curve (AUC) and trough concentration (C_{\min}) was observed for doses of 4 and 8 mg/kg every 4 weeks. Maximum concentration (C_{\max}) increased dose-proportionally. At steady-state, predicted AUC and C_{\min} were 2.7 and 6.5 fold higher at 8 mg/kg as compared to 4 mg/kg, respectively.

The following parameters are valid for a dose of 8 mg/kg ACTEMRA given every 4 weeks. Predicted mean (\pm SD) steady-state AUC, C_{\min} and C_{\max} of ACTEMRA were $35000 \pm 15500 \cdot \mu\text{g}\cdot\text{h}/\text{mL}$, $9.74 \pm 10.5 \mu\text{g}/\text{mL}$, and $183 \pm 85.6 \mu\text{g}/\text{mL}$, respectively. The accumulation ratios for AUC and C_{\max} were small; 1.22 and 1.06, respectively. The accumulation ratio was higher for C_{\min} (2.35), which was expected based on the nonlinear clearance contribution at lower concentrations. Steady-state was reached following the first administration and after 8 and 20 weeks for C_{\max} , AUC, and C_{\min} , respectively. ACTEMRA AUC, C_{\min} and C_{\max} increased with increase of body weight. At body weight ≥ 100 kg, the predicted mean (\pm SD) steady-state AUC, C_{\min} and C_{\max} of ACTEMRA were $55500 \pm 14100 \text{ h}\cdot\mu\text{g}/\text{mL}$, $19.0 \pm 12.0 \mu\text{g}/\text{mL}$, and $269 \pm 57 \mu\text{g}/\text{mL}$, respectively, which are higher than mean exposure values for the patient population. Therefore, ACTEMRA doses exceeding 800 mg per infusion are not recommended in patients ≥ 100 kg (see Dosage and Administration).

The following parameters are valid for a dose of 4 mg/kg tocilizumab given every 4 weeks. Predicted mean (\pm SD) steady-state AUC, C_{\min} and C_{\max} of tocilizumab were $13000 \pm 5800 \cdot \mu\text{g}\cdot\text{h}/\text{mL}$, $1.49 \pm 2.13 \mu\text{g}/\text{mL}$, and $88.3 \pm 41.4 \mu\text{g}/\text{mL}$, respectively. The accumulation ratios for AUC and C_{\max} were small; 1.11 and 1.02, respectively. The accumulation ratio was higher for C_{\min} (1.96). Steady-state was reached following the first administration for both C_{\max} and AUC and from 16 weeks for C_{\min} .

Absorption and Bioavailability

Not applicable.

Distribution

Following IV dosing, ACTEMRA undergoes biphasic elimination from the circulation. In RA patients the central volume of distribution was 3.5 L and the peripheral volume of distribution was 2.9 L, resulting in a volume of distribution at steady state of 6.4 L.

Metabolism

Not applicable.

Elimination

The total clearance of ACTEMRA was concentration-dependent and is the sum of the linear clearance and the nonlinear clearance. The linear clearance was estimated as a parameter in the population

pharmacokinetic analysis and was 12.5 mL/h. The concentration-dependent nonlinear clearance plays a major role at low ACTEMRA concentrations. Once the nonlinear clearance pathway is saturated, at higher ACTEMRA concentrations, clearance is mainly determined by the linear clearance.

The half life ($t_{1/2}$) of ACTEMRA is concentration-dependent. The concentration-dependent apparent $t_{1/2}$ is up to 11 days for 4 mg/kg and 13 days for 8 mg/kg every 4 weeks at steady-state.

Pharmacokinetics in Special Populations

Hepatic Impairment: No formal study of the effect of hepatic impairment on the pharmacokinetics of ACTEMRA was conducted.

Renal Impairment: No formal study of the effect of renal impairment on the pharmacokinetics of ACTEMRA was conducted.

Most of the patients in the population pharmacokinetic analysis had normal renal function or mild renal impairment. Mild renal impairment (creatinine clearance based on Cockcroft-Gault < 80 mL/min and ≥ 50 mL/min) did not impact the pharmacokinetics of ACTEMRA. ACTEMRA has not been studied in patients with moderate to severe renal impairment. (See Clinical Trials and Dosage and Administration).

Other special populations: Population pharmacokinetics in adult rheumatoid arthritis patients showed that age, gender and race did not affect the pharmacokinetics of ACTEMRA. No dose adjustment is necessary for these demographic factors.

Clinical Trials

The efficacy of ACTEMRA in alleviating the signs and symptoms of RA was assessed in five randomised, double-blind, multicentre studies. Studies I-V required patients \geq age 18 with active RA diagnosed according to American College of Rheumatology (ACR) criteria who had at least 8 tender and 6 swollen joints at baseline.

ACTEMRA was administered intravenously every 4 weeks as monotherapy (Study I), in combination with methotrexate (MTX) (Studies II, III, V) or with other disease-modifying anti-rheumatic drugs (DMARDs) (Study IV).

Study I (AMBITION) evaluated 673 patients who had not been treated with MTX within 6 months prior to randomisation, and who had not discontinued previous MTX treatment as a result of clinically important toxic effects or lack of response. The majority (67%) of patients were MTX naïve. Doses of 8 mg/kg of ACTEMRA were given every four weeks as monotherapy. The comparator group was weekly MTX (dose titrated from 7.5 to a maximum of 20 mg weekly over an 8 week period). The primary endpoint was the proportion of patients who achieved an ACR20 response at week 24. Inclusion criteria included discontinuation of etanercept for ≥ 2 weeks, infliximab or adalimumab for ≥ 8 weeks, anakinra for ≥ 1 week, leflunomide for ≥ 12 weeks (or ≥ 4 weeks after 11 days of standard cholestyramine washout) prior to randomisation, had received MTX for at least 12 weeks immediately prior to baseline (including a stable dose between 10-25 mg/week for the last 8 weeks prior to baseline), all DMARDs withdrawn prior to baseline, SJC (Swollen Joint Count) of ≥ 6 (66 joint count) and TJC (Tender Joint Count) of ≥ 8 (68 joint count) at screening and baseline, oral corticosteroids (≤ 10 mg/day prednisone or equivalent) and NSAIDs (up to the maximum recommended dose) were

permitted if the dose was stable for at least 6 weeks prior to baseline. Exclusion criteria included treatment with MTX within 6 months prior to randomisation, discontinuation of previous MTX treatment due to clinically important toxicity or lack of response (determined by investigator), unsuccessful treatment with an anti-TNF agent due to significant safety issues or lack of efficacy, known active current or history of recurrent bacterial, viral, fungal, mycobacterial or other infections, absolute neutrophil count $<2 \times 10^9/L$. (Not all inclusion or exclusion criteria are listed.)

Study II (LITHE), a 2 year study with a planned interim analysis at week 24 and week 52, evaluated 1196 patients who had an inadequate clinical response to MTX. Doses of 4 or 8 mg/kg of ACTEMRA or placebo were given every four weeks as blinded therapy for 52 weeks, in combination with stable MTX (10 – 25 mg weekly). The primary endpoint at week 24 was the proportion of patients who achieved ACR20 response criteria. At week 52 the co-primary endpoints were prevention of joint damage and improvement in physical function. Inclusion criteria for Study II were the same as the criteria listed above for Study I with the exception that all DMARDs other than MTX were withdrawn prior to baseline. In addition radiographic evidence of at least one joint with definite erosion attributable to RA was required (all relevant joints were considered with the exception of the distal inter-phalangeal joints of the hands). Exclusion criteria included unsuccessful treatment with an anti-TNF agent due to significant safety issues or lack of efficacy, known active current or history of recurrent bacterial, viral, fungal, mycobacterial or other infections, absolute neutrophil count $<2 \times 10^9/L$. (Not all inclusion or exclusion criteria are listed.)

Study III (OPTION) evaluated 623 patients who had an inadequate clinical response to MTX. Doses of 4 or 8 mg/kg of ACTEMRA or placebo were given every four weeks, in combination with stable MTX (10 – 25 mg weekly). The primary endpoint was the proportion of patients who achieved an ACR20 response at week 24. Inclusion criteria for Study III were the same as the criteria listed above for Study I with the exception that all DMARDs other than MTX were withdrawn prior to baseline. Exclusion criteria included unsuccessful treatment with an anti-TNF agent due to significant safety issues or lack of efficacy, known active current or history of recurrent bacterial, viral, fungal, mycobacterial or other infections, absolute neutrophil count $<2 \times 10^9/L$. (Not all inclusion or exclusion criteria are listed.)

Study IV (TOWARD) evaluated 1220 patients who had an inadequate response to their existing rheumatologic therapy, including one or more DMARDs. Doses of 8 mg/kg ACTEMRA or placebo were given every four weeks, in combination with the stable DMARD. The primary endpoint was the proportion of patients who achieved an ACR20 response at week 24. Inclusion criteria for Study IV included discontinuation of etanercept for ≥ 2 weeks, infliximab or adalimumab for ≥ 8 weeks, anakinra for ≥ 1 week prior to randomisation, has received permitted DMARDs at a stable dose for at least 8 weeks prior to baseline, SJC (66 joint count) of ≥ 6 and TJC (68 joint count) of ≥ 8 at screening and baseline, oral corticosteroids (≤ 10 mg/day prednisone or equivalent) and NSAIDs (up to the maximum recommended dose) were permitted if the dose was stable for at least 6 weeks prior to baseline. Exclusion criteria included unsuccessful treatment with an anti-TNF agent due to significant safety issues or lack of efficacy, known active current or history of recurrent bacterial, viral, fungal, mycobacterial or other infections, absolute neutrophil count $<2 \times 10^9/L$. (Not all inclusion or exclusion criteria are listed.)

Study V (RADIATE) evaluated 499 patients who had an inadequate clinical response or were intolerant to one or more anti-tumour necrosis factor (TNF) therapies. The anti-TNF agent was discontinued prior to randomisation. Doses of 4 or 8 mg/kg of ACTEMRA or placebo were given every four weeks, in combination with stable MTX (10 – 25 mg weekly). The primary endpoint was the proportion of patients who achieved an ACR20 response at week 24. Inclusion criteria for Study V were the same as the criteria listed for Study I above with the exception that all DMARDs other than

MTX were withdrawn prior to baseline, and that within 1 year prior to randomisation the patient experienced an inadequate response to treatment with etanercept, infliximab, or adalimumab due to toxicity or inadequate efficacy. Exclusion criteria included known active current or history of recurrent bacterial, viral, fungal, mycobacterial or other infections, absolute neutrophil count $<2 \times 10^9/L$. (Not all inclusion or exclusion criteria are listed.)

The percent of patients achieving ACR 20, 50 and 70 responses in Studies I to V are shown in Table 1.

Table 1 ACR Responses in MTX/Placebo-Controlled Trials (Percent of Patients)

Response Rate	Study I MTX-Naive		Study II Inadequate Response to MTX		Study III Inadequate Response to MTX		Study IV Inadequate Response to DMARD		Study V Inadequate Response to anti- TNF Agent	
	ACT 8 mg/kg n=286	MTX n=284	ACT 8 mg/kg +MTX n=398	Placebo + MTX n=393	ACT 8 mg/kg +MTX n=205	Placebo + MTX n=204	ACT 8mg/kg + DMARD n=803	Placebo + DMARD n=413	ACT 8 mg/kg +MTX n=170	Placebo + MTX n=158
ACR 20										
Week 24	70%***	52%	56%***	27%	59%***	26%	61%***	24%	50%***	10%
Week 52 [^]			56%***	25%						
ACR 50										
Week 24	44%**	33%	32%***	10%	44%***	11%	38%***	9%	29%***	4%
Week 52 [^]			36%***	10%						
ACR 70										
Week 24	28%**	15%	13%***	2%	22%***	2%	21%***	3%	12%**	1%
Week 52 [^]			20%***	4%						
MCR† by Week 52 [^]			7%	1%						

ACT = ACTEMRA

* $p < 0.05$, ACTEMRA vs. placebo+MTX/DMARD

** $p < 0.01$, ACTEMRA vs. placebo+MTX/DMARD

*** $p < 0.0001$, ACTEMRA vs. placebo+MTX/DMARD

† MCR = major clinical response, defined as an ACR70 response maintained for any 24 consecutive weeks or more. Note: the comparison for MCR occurred after the break in the hierarchical ordered testing sequence, so no significance claims can be made. Secondary efficacy endpoints were tested in a fixed sequence approach in order to control for the rate of false positive conclusions.

[^] based on a protocol-specified interim analysis

In all studies, 8 mg/kg ACTEMRA-treated patients had statistically significant higher ACR20, 50, 70 response rates at 6 months compared to placebo. The treatment effect was similar in patients independent of rheumatoid factor status, age, gender, race, number of prior treatments or disease status. Time to onset was rapid (as early as week 2) and the magnitude of response continued to improve with duration of treatment. Continued durable responses were seen for over 3 years in the on going open label extension studies of studies I -V.

In the 8 mg/kg ACTEMRA-treated patients significant improvements were noted on all individual components of the ACR response: tender and swollen joint counts; pain assessment and CRP normalisation; disability index scores; patients and physician global assessment, compared to patients receiving placebo + MTX/DMARDS in all studies.

ACTEMRA 8 mg/kg treated patients had a statistically significant greater reduction in disease activity score (DAS28) than patients treated with placebo + DMARD. The rate of remission (defined as DAS < 2.6) for patients treated with ACTEMRA ranged from 27.5% to 33.6%. ACTEMRA treated patients had a statistically significant greater rate of remission than patients treated with placebo + DMARD. A good to moderate EULAR response was achieved by significantly more ACTEMRA treated patients compared to patients treated with placebo + DMARD (Table 2).

Table 2 Cross-Study Comparison of DAS and EULAR Responses at Week 24

	Study I MTX-Naïve		Study II Inadequate Response to MTX		Study III Inadequate Response to MTX		Study IV Inadequate Response to DMARD		Study V Inadequate Response to anti-TNF Agent	
	ACT 8 mg/kg n=286	MTX n=284	ACT 8 mg/kg + MTX n=398	Placebo + MTX n=393	ACT 8 mg/kg + MTX n=205	Placebo + MTX n=204	ACT 8 mg/kg + DMARD n=803	Placebo + DMARD n=413	ACT 8 mg/kg + MTX n=170	Placebo + MTX n=158
Change in DAS28 [mean (Adjusted mean (SE))]										
Week 24	-3.31 (0.12)	-2.05 (0.12)	-3.11 (0.09)***	-1.45 (0.11)	-3.43 (0.12)***	-1.55 (0.15)	-3.17 (0.07)***	-1.16 (0.09)	-3.16 (0.14) ***	-0.95 (0.22)
DAS<2.6 response (%)										
Week 24	33.6%	12.1%	≠33.3% ***	^3.8%	27.5%***	0.8%	30.2%***	3.4%	30.1% ***	1.6%
EULAR response (%)										
None	18%	35%	26%	65%	20%	65%	20%	62%	32%	84%
Moderate	42%	48%	34%	29%	41%	32%	40%	33%	31%	15%
Good†	40%	17%	41%***	6%	38%***	3%	40%***	4%	37%***	2%

ACT = ACTEMRA

†The p value compares across all the EULAR categories

* $p < 0.05$, ACTEMRA vs. placebo+MTX/DMARD

** $p < 0.01$, ACTEMRA vs. placebo+MTX/DMARD

*** $p < 0.0001$, ACTEMRA vs. placebo+MTX/DMARD

≠ In study II, 47% of patients achieved a DAS28 < 2.6 at 52 weeks compared to 33% of patients at week 24.

^ In study II, 8% of patients achieved a DAS28 < 2.6 at 52 weeks compared to 4% of patients at week 24.

Major Clinical Response

After 2 years of treatment with ACTEMRA + MTX, 14% of patients achieved a major clinical response (maintenance of an ACR70 response for 24 weeks or more)

Radiographic response

In study II (LITHE), in patients with an inadequate response to MTX, inhibition of structural joint damage was assessed radiographically and expressed as change in modified Sharp score and its components, the erosion score and joint space narrowing (JSN) score. Missing week 52 radiographic data was imputed using linear extrapolation. This was performed for any patient who had a baseline assessment and at least one post-baseline radiographic assessment. The change from baseline was then calculated using the extrapolated score. Inhibition of structural joint damage was shown with significantly less radiographic progression in patients receiving ACTEMRA compared to control (Table 3).

In the open-label extension of study II further improvement in the inhibition of progression of structural damage in ACTEMRA + MTX-treated patients was observed in the second year of treatment. Study II did not investigate the effect of ACTEMRA monotherapy on radiographic endpoints.

Table 3 Radiographic mean changes at 52 and 104 weeks in study II (LITHE)

	Placebo + MTX (+ option of ACT from week 16) [n=393]	ACT 8 mg/kg + MTX [n=398]
Changes from baseline to week 52		
n	294	353
Total Sharp-Genant score	1.17	0.25
Erosion score	0.76	0.15
JSN score	0.41	0.10
Change from week 52 to week 104		
n	294	353
Total Sharp-Genant score	0.79	0.12
Erosion score	0.48	0.07
JSN score	0.31	0.05

ACT = ACTEMRA

JSN = joint space narrowing

The data presented consists of the evaluations of the baseline, week 24, week 52, week 80, week 104 and early withdrawal or escape therapy readings taken up to the week 104 visit.

Following 1 year of treatment with ACTEMRA + MTX, 83% of patients had no progression of structural damage, as defined by a change in the Total Sharp Score of zero or less, compared with 67% of placebo + MTX-treated patients. This remained consistent following 2 years of treatment (83%). Ninety three percent (93%) of patients had no progression between week 52 and week 104.

Quality of Life Outcomes

Clinically significant improvements in disability index (HAQ-DI, Health Assessment Questionnaire Disability Index), fatigue (FACIT-F, Functional Assessment of Chronic Illness Therapy Fatigue) and improvement in both the physical (PCS, Physical Component Summary) and mental health (MCS, Mental Component Summary) domains of the SF-36 (Short Form 36) were observed in patients treated with 8 mg/kg ACTEMRA (monotherapy or combination with DMARDs) compared to patients treated with MTX/DMARDs.

At week 24, the proportion of 8 mg/kg ACTEMRA treated patients showing a clinically relevant improvement in HAQ-DI (defined as an individual total score decrease of > 0.25), was significantly

higher than among patients receiving placebo + MTX/DMARDs in all studies. During the open-label period of study II the improvement in physical function has been maintained for up to 2 years.

At week 52, the mean change in HAQ-DI was -0.58 in the ACTEMRA 8 mg/kg + MTX group compared with -0.39 in the placebo + MTX group. The mean change in HAQ-DI was maintained at week 104 in the ACTEMRA 8 mg/kg + MTX group (-0.61). The percentage of ACTEMRA-treated patients showing a clinically relevant improvement in HAQ-DI (≥ 0.3 units) at weeks 52 & 104 were 63% and 62%, respectively.

Laboratory Evaluations

Treatment with 8 mg/kg ACTEMRA in combination with DMARD/MTX or as monotherapy resulted in a statistically significant improvement in haemoglobin levels compared with placebo + MTX/DMARD ($p < 0.0001$) at week 24. The greatest improvement was observed in patients with chronic anaemia associated with RA; mean haemoglobin levels increased by week 2 and remained within normal range through week 24.

A marked decrease in mean levels of acute phase reactants, CRP, ESR, and serum amyloid A occurred rapidly after ACTEMRA administration. Consistent with the effect on acute phase reactants, treatment with ACTEMRA was associated with reduction in platelet count within the normal range.

Indications

ACTEMRA is indicated for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients:

- in combination with methotrexate (MTX) or other non-biological disease-modifying anti-rheumatic drugs (DMARDs) in case of either an inadequate response or intolerance to previous therapy with one or more DMARDs; or
- as monotherapy in case of intolerance to MTX or where continued treatment with MTX is inappropriate.

ACTEMRA has been shown to inhibit the progression of joint damage, as measured by X-ray, when given in combination with methotrexate.

Contraindications

ACTEMRA is contraindicated in patients with:

- known hypersensitivity to any component of the product or with a history of any reaction consistent with hypersensitivity to any component of the product, Chinese hamster ovary cell products or other recombinant human or humanised antibodies
- active, severe infections (see Precautions – Infections)

Precautions

Infections

Serious and sometimes fatal infections have been reported in patients receiving immunosuppressive agents including ACTEMRA (see Adverse Effects). ACTEMRA treatment should not be initiated in patients with active infections (see Contraindications). If a patient develops a serious infection, administration of ACTEMRA should be interrupted until the infection is controlled. Physicians should exercise caution when considering the use of ACTEMRA in patients with a history of recurring or chronic infection, or with underlying conditions (e.g. diverticulitis, diabetes) which may predispose patients to infections.

Vigilance for the timely detection of serious infection is recommended for patients receiving biologic treatments for moderate to severe RA as signs and symptoms of acute inflammation may be lessened, associated with suppression of the acute phase reaction. The effects of ACTEMRA on C-reactive protein (CRP), neutrophils and signs and symptoms of infection should be considered when evaluating a patient for a potential infection. Patients should be instructed to contact a physician immediately when any symptoms suggesting infection appear, in order to assure rapid evaluation and appropriate treatment.

The use of ACTEMRA is not recommended in patients with HIV, positive core antibody for hepatitis B, prior HCV infection, or symptomatic EBV infection. Viral reactivation (e.g. hepatitis B) has been reported with biologic therapies for RA. In clinical studies with ACTEMRA, patients who screened positive for hepatitis were excluded.

In the long term exposure population, the overall rate of serious infections (bacterial, viral and fungal) was 4.7 events per 100 patient years. Reported serious infections, some with fatal outcome, included active tuberculosis, which may present with intrapulmonary or extrapulmonary disease, invasive pulmonary infections, including candidiasis, aspergillosis, coccidioidomycosis and pneumocystis jirovecii, pneumonia, cellulitis, herpes zoster, gastroenteritis, diverticulitis, sepsis and bacterial arthritis. Cases of opportunistic infections have been reported.

Complications of Diverticulitis

Events of diverticular perforation as complications of diverticulitis have been reported. ACTEMRA should be used with caution in patients with previous history of intestinal ulceration or diverticulitis. Patients presenting with symptoms potentially indicative of complicated diverticulitis, such as abdominal pain, should be evaluated promptly for early identification of gastrointestinal perforation.

Tuberculosis

As recommended for other biological treatments in RA, patients should be screened for latent tuberculosis (TB) infection prior to starting ACTEMRA therapy. Patients with latent TB should be treated with standard anti-mycobacterial therapy before initiating ACTEMRA.

Vaccinations

Live and live attenuated vaccines should not be given concurrently with ACTEMRA as clinical safety has not been established.

No data are available on the secondary transmission of infection from persons receiving live vaccines to patients receiving ACTEMRA.

Hypersensitivity Reactions

Serious hypersensitivity reactions, including anaphylaxis with fatal outcome, have been reported in association with infusion of ACTEMRA (see Adverse Effects – Infusion Reactions). In the post-marketing setting, events of serious hypersensitivity and anaphylaxis, including in some cases with a fatal outcome, have occurred in patients treated with a range of doses of ACTEMRA, with or without concomitant arthritis therapies, premedication and/or a previous hypersensitivity reaction. These events have occurred as early as the first infusion of ACTEMRA (see Contraindications and Post-Marketing Experience). Appropriate treatment should be available for immediate use in the event of an anaphylactic reaction during treatment with ACTEMRA. If an anaphylactic reaction or other serious hypersensitivity reaction occurs, administration of ACTEMRA should be stopped immediately and ACTEMRA should be permanently discontinued.

Patients with a history of any reaction consistent with hypersensitivity to any component of the product must not be re-challenged with ACTEMRA (see Contraindications).

Viral Reactivation

Viral reactivation (e.g. hepatitis B virus) has been reported with biologic therapies for RA. In clinical studies with ACTEMRA, patients who screened positive for hepatitis were excluded.

Active Hepatic Disease and Hepatic Impairment

Treatment with ACTEMRA particularly when administered concomitantly with MTX, may be associated with elevations in hepatic transaminases therefore caution should be exercised when considering treatment of patients with active hepatic disease or hepatic impairment (see Adverse Effects – Laboratory Abnormalities and Dosage and Administration – Special Patient Groups).

Viral reactivation (e.g. hepatitis B) has been reported with biologic therapies for RA. In clinical studies with ACTEMRA, patients who screened positive for hepatitis were excluded.

Hepatic Transaminase and Laboratory Effects

In clinical trials, transient or intermittent mild and moderate elevations of hepatic transaminases and bilirubin have been reported with ACTEMRA treatment, without progression to hepatic injury (see Adverse Effects). An increased frequency of these elevations was observed when potentially hepatotoxic drugs (e.g. MTX) were used in combination with ACTEMRA. There is a potential risk of hepatotoxicity with use of ACTEMRA.

Particular caution should be exercised when considering initiation of ACTEMRA treatment in patients with elevated ALT or AST $> 1.5 \times \text{ULN}$. In patients with baseline ALT or AST $> 5 \times \text{ULN}$, treatment with ACTEMRA is not recommended.

ALT and AST levels should be monitored every 4 to 8 weeks for the first 6 months of treatment followed by every 12 weeks thereafter. For recommended modifications based on transaminases see Dosage and Administration. For ALT or AST elevations > 3 to $5 \times \text{ULN}$, confirmed by repeat testing, ACTEMRA treatment should be interrupted. Once the patient's hepatic transaminases are below $3 \times \text{ULN}$, treatment with ACTEMRA may recommence at 4 or 8 mg/kg.

Haematological Abnormalities

Decreases in neutrophil and platelet counts have occurred following treatment with ACTEMRA 8 mg/kg in combination with MTX (see section Adverse Effects – Laboratory Abnormalities). There may

be an increased risk of neutropenia in patients who have previously been treated with a TNF antagonist.

Caution should be exercised when considering initiation of ACTEMRA treatment in patients with a low neutrophil or platelet count (i.e. ANC < $2 \times 10^9/L$ or platelet count < $100 \times 10^9/L$). In patients with an ANC < $0.5 \times 10^9/L$ or a platelet count < $50 \times 10^9/L$ treatment is not recommended (see Precautions - Effects of Laboratory Tests).

Severe neutropenia may be associated with an increased risk of serious infections, although there has been no clear association between decreases in neutrophils and the occurrence of serious infections in clinical trials with ACTEMRA to date.

Neutrophils and platelets should be monitored 4 to 8 weeks after start of therapy and thereafter according to standard clinical practice. For recommended dose modifications based on ANC and platelet counts, see Dosage and Administration.

Lipid Parameters

Elevations in lipid parameters including total cholesterol, low density lipoprotein (LDL), high density lipoprotein (HDL) and triglycerides were observed in patients treated with ACTEMRA (see Adverse Effects – *Elevations in Lipid Parameters*). In the majority of patients, there was no increase in atherogenic indices, and elevations in total cholesterol responded to treatment with lipid lowering agents.

Assessment of lipid parameters should be performed 4 to 8 weeks following initiation of ACTEMRA therapy. Patients should be managed according to local clinical guidelines for management of hyperlipidaemia.

Demyelinating Disorders

Physicians should be vigilant for symptoms potentially indicative of new-onset central demyelinating disorders. The potential for central demyelination with ACTEMRA is currently unknown.

Malignancy

The risk of malignancy is increased in patients with RA. Immunomodulatory medicinal products may increase the risk of malignancy.

Infusion Reactions

Infusion reactions have been observed during and within 24 hours of treatment with ACTEMRA (see Adverse Effects – Infusion Reactions).

Cardiovascular Risk

RA patients have an increased risk for cardiovascular disorders and should have risk factors (e.g. hypertension, hyperlipidaemia) managed as part of usual standard of care (see Precautions – Lipid Parameters). Elevations in LDL and HDL lipids have been observed, with no clinical consequences identified. No data are available concerning cardiovascular outcomes with long-term use of ACTEMRA.

Combination with TNF Antagonists and/or other Biological Therapies

There is no experience with the use of ACTEMRA with TNF antagonists or other biological treatments for RA. ACTEMRA is not recommended for use with other biologic agents including TNF antagonists, anakinra, rituximab and abatacept.

Sodium

This medicinal product contains 1.17 mmol (26.55 mg) of sodium per maximum dose of 1200 mg. This should be taken into consideration by patients on a controlled sodium diet. Doses below 1025 mg of ACTEMRA contain less than 1 mmol of sodium (23 mg) and can essentially be considered 'sodium free'.

Effects on Fertility

Preclinical data do not suggest an effect on fertility under treatment with a murine analogue of ACTEMRA. Effects on endocrine active organs or on organs of the reproductive system were not seen in a chronic cynomolgus monkey toxicity study, nor was the reproductive performance affected in IL-6 deficient male and female mice.

Use in Pregnancy – Category C

ACTEMRA should not be used during pregnancy unless clearly necessary. There are no adequate data from the use of ACTEMRA in pregnant women. The potential risk for humans is unknown. Women of childbearing potential should be advised to use adequate contraception during and for several months after therapy with ACTEMRA.

In an embryo-foetal toxicity study conducted in cynomolgus monkeys, a slight increase of abortion/embryo-foetal death was observed with high systemic cumulative exposure in the 10 mg/kg/day mid-dose group (> 35 times human exposure) and in the 50 mg/kg/day high-dose group (> 100 times human exposure) compared to vehicle control and low-dose groups. It cannot be excluded that this finding is related to ACTEMRA treatment. Placental transfer of both tocilizumab and anti-tocilizumab antibodies to the foetus was seen in cynomolgus monkeys.

Use in Lactation

It is unknown whether ACTEMRA is excreted in human breast milk and its efficacy and safety in lactating women has not been established. However, it is known that endogenous immunoglobulins of the IgG isotype are excreted into human milk. A decision on whether to continue/discontinue breast-feeding or to continue/discontinue therapy with ACTEMRA should be made taking into account the benefit of breast-feeding to the child and the benefit of ACTEMRA therapy to the woman.

Transfer of a murine analogue of tocilizumab into the milk of lactating mice has been observed.

Use in Children

The safety and efficacy of ACTEMRA in children have not been established.

Use in the Elderly

Population analyses evaluated the potential effects of demographic characteristics on the pharmacokinetics of ACTEMRA in adult RA patients. Results of these analyses showed that no adjustment of the dose is necessary for age, gender, or race.

No dose adjustment is required in elderly patients.

Carcinogenicity

A carcinogenicity study of ACTEMRA has not been conducted. Proliferating lesions were not observed in a chronic cynomolgus monkey 6-month toxicity study.

Genotoxicity

Standard genotoxicity studies with ACTEMRA in both prokaryotic and eukaryotic cells were negative.

Interactions with Other Medicines

Population pharmacokinetic analyses did not detect any effect of MTX, non-steroidal anti-inflammatory drugs or corticosteroids on tocilizumab clearance.

Concomitant administration of a single dose of 10 mg/kg ACTEMRA with 10-25 mg MTX once weekly had no clinically significant effect on MTX exposure.

ACTEMRA has not been studied in combination with other biological DMARDs.

The expression of hepatic CYP450 enzymes is suppressed by cytokines that stimulate chronic inflammation, such as IL-6. Thus suppression of CYP450 expression may be reversed when potent cytokine inhibitory therapy, such as tocilizumab, is introduced.

In vitro studies with cultured human hepatocytes demonstrated that IL-6 caused a reduction in CYP3A4 and to a lesser extent CYP1A2, CYP2C9 and CYP2C19 enzyme messenger RNA (mRNA) expression. Tocilizumab was shown to normalise expression of the mRNA for these enzymes.

This is clinically relevant for CYP450 substrates with a narrow therapeutic index, and/or where the dose is individually adjusted.

In a study in RA patients, levels of simvastatin and its acid metabolite (CYP3A4 substrates) were decreased by 57% and 39%, respectively, one week following a single dose of tocilizumab, to a level similar or slightly higher than those observed (in other studies) in healthy subjects.

When starting or stopping therapy with ACTEMRA, patients taking medicinal products which are individually adjusted and are metabolised via CYP450 3A4, 1A2, 2C9 or 2C19 (e.g. atorvastatin, dextromethorphan, omeprazole, calcium channel blockers, theophylline, warfarin, phenytoin, cyclosporine or benzodiazepines) should be monitored as doses may need adjustment to maintain therapeutic effect. The degree of dose up-titration upon initiation of therapy or dose down-titration when stopping therapy with ACTEMRA should be based on the therapeutic response and/or adverse effects of the patient to the individual medicine. Given a relatively long elimination half-life ($t_{1/2}$), the effect of ACTEMRA on CYP450 activity may persist for several weeks after stopping therapy.

Effects on Laboratory Tests

Caution should be exercised when considering initiation of ACTEMRA treatment in patients with a low neutrophil count. Decreases in neutrophil counts below $1 \times 10^9/L$ occurred in 3.4%, with counts $< 0.5 \times 10^9/L$ occurring in 0.3%, of patients on ACTEMRA 8 mg/kg + DMARD without clear association with serious infection (see Precautions – Haematological Abnormalities; Adverse Effects - Laboratory Abnormalities). In patients with an absolute neutrophil count $< 0.5 \times 10^9/L$ treatment is not recommended.

Ability to Drive and Use Machines

No studies on the effects on the ability to drive and use machines have been performed. However, there is no evidence from the available data that ACTEMRA treatment affects the ability to drive and use machines.

Adverse Effects

The safety of ACTEMRA has been studied in 5 phase III, double-blind controlled trials and their extension periods.

The *all control* population includes all patients who received at least one dose of ACTEMRA in the double-blind controlled period of the 5 studies. The control period in 4 of the studies was 6 months and in 1 study was up to 2 years. In the double-blind controlled studies 774 patients received ACTEMRA 4 mg/kg in combination with MTX, 1870 patients received ACTEMRA 8 mg/kg in combination with MTX/other DMARDs and 288 patients received ACTEMRA 8 mg/kg monotherapy.

The *all exposure* population includes all patients who received at least one dose of ACTEMRA either in the double-blind control period or open label extension phase in studies. Of the 4009 patients in this population, 3577 received treatment for at least 6 months, 3296 for at least one year; 2806 received treatment for at least 2 years and 1222 for 3 years. The mean duration of exposure to ACTEMRA in the *all exposure* population was 2.14 years.

The most commonly reported AEs in controlled studies up to 2 years (occurring in $\geq 5\%$ of patients treated with ACTEMRA monotherapy or in combination with DMARDs) were upper respiratory tract infections, nasopharyngitis, headache, hypertension, increased ALT and bronchitis. In study II the rate of AEs (including deaths, serious AEs and AEs leading to treatment withdrawal or dose modification) after 2 years, calculated as a function of exposure (i.e. events per 100 patient years), had not increased in comparison with the AE profile observed after 1 year of study II.

Table 4 Adverse Events occurring in at least 2% or more of patients on 8 mg/kg ACTEMRA + DMARD and at least 1% greater than that observed in patients on placebo + DMARD

All Control Study Population					
	ACTEMRA 8 mg/kg monotherapy	MTX	ACTEMRA 4 mg/kg + MTX	ACTEMRA 8 mg/kg + DMARDs	Placebo + DMARDs
	n=288 (%)	n=284 (%)	n=774 (%)	n=1870 (%)	n=1555 (%)
Preferred Term					
Upper Respiratory Tract Infection	7	5	9	9	7
Nasopharyngitis	7	6	5	7	5
Headache	7	2	6	6	4
Hypertension	6	2	6	5	3
Cough	3	0	3	3	2
ALT increased	6	4	3	3	1
Diarrhoea	5	5	5	4	4
Back Pain	2	1	3	4	3

Peripheral Oedema	2	0	2	3	1
Dizziness	3	1	2	3	2
Bronchitis	3	2	4	3	3
Rash	2	1	4	3	1
Mouth Ulceration	2	2	1	2	1
Abdominal Pain Upper	2	2	3	3	2
Gastritis	1	2	2	2	1
Transaminase increased	1	5	3	3	1

Other infrequent and medically relevant adverse events occurring at an incidence of less than 2% in RA patients treated with ACTEMRA in controlled trials were:

Infections and infestations: cellulitis, oral herpes simplex, herpes zoster, diverticulitis

Gastrointestinal disorders: stomatitis, gastric ulcer

Skin and subcutaneous tissue disorders: pruritus, urticaria

Investigations: weight increased, total bilirubin increased

Blood and lymphatic system disorders: leucopenia, neutropenia

Metabolism and nutrition disorders: hypercholesterolaemia, hypertriglyceridaemia

General disorders and administration site conditions: hypersensitivity reaction

Respiratory, thoracic and mediastinal disorders: dyspnoea

Eye disorders: conjunctivitis

Renal disorders: nephrolithiasis

Endocrine disorders: hypothyroidism

Infections

In the 6 month controlled clinical trials, the rate of all infections reported with ACTEMRA 8 mg/kg + DMARD treatment was 127 events per 100 patient (pt) years compared to 112 events per 100 pt years in the placebo + DMARD group. In the *all exposure* population long-term the overall rate of infections with ACTEMRA was 108 events per 100 pt years exposure.

In the 6 month controlled clinical trials, the rate of serious infections (bacterial, viral and fungal) with ACTEMRA 8 mg/kg + DMARD was 5.3 events per 100 pt years exposure compared to 3.9 events per 100 pt years exposure in the placebo + DMARD group. In the monotherapy study the rate of serious infections was 3.6 events per 100 pt years of exposure in the ACTEMRA group and 1.5 events per 100 pt years of exposure in the MTX group.

In the *all exposure* population the overall rate of serious infections was 4.7 events per 100 pt years. Reported serious infections, some with fatal outcome, included pneumonia, cellulitis, herpes zoster, gastroenteritis, diverticulitis, sepsis and bacterial arthritis. Cases of opportunistic infections have also been reported.

Gastrointestinal Perforation

During the 6 month controlled clinical trials, the overall rate of gastrointestinal (GI) perforation was 0.26 events per 100 pt years with ACTEMRA therapy. In the *all exposure* population the overall rate of GI perforation was 0.28 events per 100 pt years. Reports of GI perforation were primarily reported as complications of diverticulitis including generalised purulent peritonitis, lower GI perforation, fistula and abscess.

Infusion Reactions

In the 6 month controlled trials adverse events associated with infusion (selected events occurring during or within 24 hours of infusion) were reported by 6.9% of patients in the ACTEMRA 8 mg/kg + DMARD and 5.1% of patients in the placebo + DMARD group. Events reported during the infusion were primarily episodes of hypertension. Events reported within 24 hours of finishing an infusion were headache and skin reactions (rash, urticaria). These events were not treatment limiting.

In the 6 month controlled clinical trials, the rate of anaphylactic reactions in those receiving the lower dose of 4 mg/kg was 3/744 (0.4%) and in the higher dose of 8 mg/kg was 3/1870 (0.2%). As anaphylactic reactions tend to occur early in the course of treatment, the overall rate of anaphylaxis cumulatively in the long term extensions remained at 6/3778 or 0.2%.

Clinically significant hypersensitivity reactions associated with ACTEMRA and requiring treatment discontinuation, were reported in a total of 13 out of 3778 patients (0.3%) treated with ACTEMRA during the controlled and open label clinical trials. These reactions were generally observed during the second to fifth infusions of ACTEMRA (see Precautions – Hypersensitivity Reactions).

Immunogenicity

A total of 2876 patients have been tested for anti-tocilizumab antibodies in the 6 month controlled clinical trials. Forty six patients (1.6%) developed positive anti-tocilizumab antibodies of whom 5 had an associated medically significant hypersensitivity reaction leading to withdrawal. Thirty patients (1.1%) developed neutralising antibodies.

Laboratory Abnormalities

Haematology Abnormalities

Neutrophils

In the 6 month controlled trials decreases in neutrophil counts below $1 \times 10^9/L$ occurred in 3.4% of patients on ACTEMRA 8 mg/kg + DMARD compared to < 0.1% of patients on placebo + DMARD. Approximately half of the patients who developed an ANC < $1 \times 10^9/L$ did so within 8 weeks after starting therapy. Decreases below $0.5 \times 10^9/L$ were reported in 0.3% patients receiving ACTEMRA 8 mg/kg + DMARD (see Precautions – Effects on Laboratory Tests).

There was no clear relationship between decreases in neutrophils below $1 \times 10^9/L$ and the occurrence of serious infections.

In the *all control* and *all exposure* population, the pattern and incidence of decreases in neutrophil counts remained consistent with what was seen in the 6 month controlled clinical trials.

Platelets

In the 6 month controlled trials decreases in platelet counts below $100 \times 10^9/L$ occurred in 1.7% of patients on ACTEMRA 8 mg/kg + DMARDs compared to < 1% on placebo + DMARDs. These decreases occurred without associated bleeding events. (See Dosage and Administration and Precautions – Haematological Abnormalities.)

In the *all control* and *all exposure population*, the pattern and incidence of decreases in platelet counts remained consistent with what was seen in the 6 month controlled clinical trials.

Liver Enzyme Elevations

During the 6 month controlled trials transient elevations in ALT (alanine transaminase)/AST (aspartate transaminase) > 3 x ULN (Upper Limit of Normal) were observed in 2.1% of patients on ACTEMRA 8

mg/kg compared to 4.9% of patients on MTX, and in 6.5% of patients who received ACTEMRA 8 mg/kg + DMARD compared to 1.5% of patients on placebo + DMARD. The addition of potentially hepatotoxic drugs (for example MTX) to ACTEMRA monotherapy resulted in increased frequency of these elevations. Elevations of ALT/AST > 5 x ULN were observed in 0.7% of ACTEMRA monotherapy patients and 1.4% of ACTEMRA + DMARD patients, the majority of whom were discontinued from ACTEMRA treatment. These elevations were not associated with any clinically relevant increases in direct bilirubin, nor were they associated with clinical evidence of hepatitis or hepatic insufficiency. During routine laboratory monitoring, the incidence of indirect bilirubin > ULN is 6.2% in patients treated with 8 mg/kg ACTEMRA + DMARD in the *all control* population.

In the *all control* and *all exposure* population, the pattern and incidence of elevations in ALT/AST remained consistent with what was seen in the 6 month controlled clinical trials.

Elevations in Lipid Parameters

During routine laboratory monitoring in the 6 month controlled trials, increases of lipid parameters such as total cholesterol, triglycerides, LDL (low-density lipoprotein) cholesterol, and/or HDL (high-density lipoprotein) cholesterol have been commonly reported. Approximately 24% of patients receiving ACTEMRA in clinical trials experienced sustained elevations in total cholesterol > 6.2 mmol/L (240 mg/dL), with 15% experiencing a sustained increase in LDL to \geq 4.1 mmol/L (160 mg/dL). Elevations in lipid parameters responded to treatment with lipid-lowering agents.

In the *all control* and *all exposure* population, the pattern and incidence of elevations in lipid parameters remained consistent with what was seen in the 6 month controlled clinical trials.

Malignancies

The clinical data are insufficient to assess the potential incidence of malignancy following exposure to ACTEMRA. Long-term safety evaluations are ongoing.

Post-Marketing Experience

The safety profile in post-marketing experience is consistent with clinical trial data with the exception of reports of fatal anaphylaxis during ACTEMRA treatment (see Contraindications and Precautions – Hypersensitivity Reactions).

Dosage and Administration

Treatment should be initiated by healthcare professionals experienced not only in the diagnosis and treatment of RA but also in the use of biological therapies for this condition.

The recommended dose of ACTEMRA for adult patients is 8 mg/kg given once every 4 weeks as an IV infusion.

For individuals whose body weight is more than 100 kg, doses exceeding 800 mg per infusion are not recommended (see Pharmacology – Pharmacokinetics).

The calculated dose of ACTEMRA should be diluted to 100 mL and administered as an IV infusion over a period of 1 hour.

ACTEMRA can be used alone or in combination with MTX and/or other non-biological DMARDs.

During IV infusion with ACTEMRA the patient must be closely monitored at all times for any signs or symptoms of a hypersensitivity reaction. Should any such reaction occur then appropriate urgent responses and treatments are to be initiated. The necessary equipment, treatments and protocols sufficient to initiate the management of acute anaphylaxis are to be in place along with the availability of appropriately trained personnel. There must be continued education and training of the health care professionals who administer the infusions. As part of the informed consent process patients should be made aware of the risk of anaphylaxis and the equipment, treatments and protocols in place to manage this risk.

Dose Modification Recommendations

- Liver enzyme abnormalities

Lab Value	Action
> 1 to 3 x ULN	Dose modify concomitant DMARDs if appropriate For persistent increases in this range, reduce ACTEMRA dose to 4 mg/kg or interrupt ACTEMRA until ALT/AST have normalised Restart with 4 mg/kg or 8 mg/kg, as clinically appropriate
> 3 to 5 x ULN (confirmed by repeat testing, see Precautions - Hepatic Transaminase Elevations)	Interrupt ACTEMRA dosing until < 3 x ULN and follow recommendations above for > 1 to 3 x ULN For persistent increases > 3 x ULN, discontinue ACTEMRA
> 5 x ULN	Discontinue ACTEMRA

- Low absolute neutrophil count (ANC)

Lab Value (cells x 10 ⁹ /L)	Action
ANC > 1	Maintain dose
ANC 0.5 to 1	Interrupt ACTEMRA dosing When ANC > 1 x 10 ⁹ /L resume ACTEMRA at 4 mg/kg and increase to 8 mg/kg as clinically appropriate
ANC < 0.5	Discontinue ACTEMRA

- Low platelet count

Lab Value (cells x 10 ⁹ /L)	Action
50 to 100	Interrupt ACTEMRA dosing When platelet count is > 100 x 10 ⁹ /L resume ACTEMRA at 4 mg/kg and increase to 8 mg/kg as clinically appropriate
< 50	Discontinue ACTEMRA

Special Patient Groups

Children: The safety and efficacy of ACTEMRA in children below 18 years of age have not been established.

Elderly: No dose adjustment is required in elderly patients aged 65 years and older.

Renal Impairment: No dose adjustment is required in patients with mild renal impairment (see Pharmacology – Pharmacokinetics in Special Populations). ACTEMRA has not been studied in patients with moderate to severe renal impairment.

Hepatic Impairment: The safety and efficacy of ACTEMRA has not been studied in patients with hepatic impairment (see Precautions – Active Hepatic Disease and Hepatic Impairment) and therefore no dose recommendations can be made.

Preparing the Infusion

Parenteral medications should be inspected visually for particulate matter or discoloration prior to administration.

Only solutions which are clear to opalescent, colourless to pale yellow and free of visible particles must be infused.

From a 100 mL infusion bag, withdraw a volume of 0.9% sodium chloride solution equal to the volume of the ACTEMRA solution required for the patient's dose, and discard. Withdraw the required amount of ACTEMRA (0.4 mL per kg of the patient's body weight) under aseptic conditions and add to the infusion bag. To mix the solution, gently invert the bag to avoid foaming.

Overdosage

There are limited data available on overdosage with ACTEMRA. One case of accidental overdose was reported in which a patient with multiple myeloma received a single dose of 40 mg/kg. No adverse drug reactions were observed. No serious adverse drug reactions were observed in healthy volunteers who received a single dose up to 28 mg/kg, although dose-limiting neutropenia was observed.

Treatment of overdose should consist of general supportive measures.

Contact the Poisons Information Centre for advice on management of overdosage.

Presentation and Storage

ACTEMRA is available as:

*(not marketed)

- Single use vial containing 80 mg of ACTEMRA in 4 mL (20 mg/mL). Packs of 1 and 4* vials.
- Single use vial containing 200 mg of ACTEMRA in 10 mL (20 mg/mL). Packs of 1 and 4* vials.
- Single use vial containing 400 mg of ACTEMRA in 20 mL (20 mg/mL). Packs of 1* and 4* vials.

Store vials at 2°C – 8°C. (Refrigerate. Do not freeze.) Keep the container in the outer carton in order to protect from light.



ACTEMRA does not contain any antimicrobial agent; therefore care must be taken to ensure the sterility of the prepared solution. Product is for single use in one patient only. Discard any residue.

The prepared infusion solution of ACTEMRA is physically and chemically stable in 0.9% w/v sodium chloride solution at 30°C for 24 hours. To reduce microbiological hazard, the prepared infusion should be used immediately. If storage is necessary, hold at 2°C – 8°C for not more than 24 hours.

Do not use after the expiry date (EXP) shown on the pack.

Disposal of Medicines

The release of medicines into the environment should be minimised. Medicines should not be disposed of via wastewater and disposal through household waste should be avoided. Unused or expired medicine should be returned to a pharmacy for disposal.

Medicine Classification

Prescription Medicine

Name and Address

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