NEW ZEALAND DATA SHEET

1. PRODUCT NAME

Ocrevus (ocrelizumab) 300 mg in 10 mL concentrate solution for intravenous infusion.

ocrelizumab (rch)

CAS: 637334-45-3

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Ocrevus is supplied in a single-dose vial containing 10 mL of preservative-free concentrate solution for infusion. Each vial contains 300 mg of ocrelizumab (30 mg/mL).

Ocrevus (ocrelizumab) is a recombinant humanised monoclonal antibody (IgG1 subtype) that selectively targets CD20-expressing B-cells.

3. PHARMACEUTICAL FORM

Concentrate solution for intravenous infusion.

Clear or slightly opalescent, and colourless to pale brown solution.

4. CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Ocrevus is indicated for the treatment of adult patients with relapsing forms of multiple sclerosis (RMS) to suppress relapses and disease progression (clinical and subclinical disease activity).

Ocrevus is indicated for the treatment of adult patients with primary progressive multiple sclerosis (PPMS) to delay disease progression and reduce deterioration in walking speed.

4.2 Dose and Method of Administration

General

Ocrevus is administered as an IV infusion through a dedicated line under the close supervision of an experienced healthcare professional with access to appropriate medical support to manage severe reactions such as serious IRRs. Ocrevus infusions should not be administered as an intravenous push or bolus. Use isotonic 0.9% sodium chloride solution as the infusion vehicle. In the event an IV infusion cannot be completed the same day, the remaining liquid in the infusion bag must be discarded (see section 6.3).

Observe the patient for at least one hour after the completion of the infusion (see section 4.4).

In order to improve traceability of biological medicinal products, the trade name and the batch number of the administered product should be clearly recorded or stated in the patient medical record.

Substitution by any other biological medicinal product approved in the indication requires the consent of the prescribing physician.

Premedication for Infusion Related Reactions (IRR)

Premedicate with 100 mg IV methylprednisolone (or an equivalent) approximately 30 minutes prior to each Ocrevus infusion (see section 4.4), and with an antihistaminic drug approximately 30-60 minutes before each infusion of Ocrevus to reduce the frequency and severity of IRRs.

The addition of an antipyretic (e.g. paracetamol) may also be considered approximately 30-60 minutes before each infusion of Ocrevus.

Dosing

Ocrevus is administered by IV infusion as a 600 mg dose every 6 months.

Initial Dose
The initial 600 mg dose is administered as two separate IV infusions; one 300 mg infusion, followed by a second 300 mg infusion two weeks later (see Table 1).

Subsequent Doses
Subsequent doses of Ocrevus thereafter are administered as a single 600 mg IV infusion every 6 months (see Table 1). A minimum interval of 5 months should be maintained between each dose of Ocrevus.

If patients did not experience a serious infusion-related reaction (IRR) with any previous OCREVUS infusion, a shorter (2-hour) infusion can be administered for subsequent doses (see Table 1, Option 2) (see sections 4.8 and 5.1).

Table 1 Dose and Schedule of Ocrevus

		Quantity of Ocrevus to be administered*	**Infusion Instructions**
Initial Dose (600 mg) divided into 2 infusions	Infusion 1	300 mg in 250 mL	• Initiate the infusion at a rate of 30 mL/hr • Thereafter the rate can be increased in 30 mL/hr increments every 30 minutes to a maximum of 180 mL/hr • Each infusion should be given over approximately 2.5 hrs
	Infusion 2 (2 weeks later)	300 mg in 250 mL	
Subsequent Doses (600 mg)** single infusion	Option 1 Infusion of approximately	600 mg in 500 mL	• Initiate the infusion at a rate of 40 mL/hr • Thereafter the rate can be increased in 40 mL/hr increments every 30 minutes to a

once every 6 months	3.5 hours duration		maximum of 200 mL/hr • Each infusion should be given over approximately 3.5 hrs
	OR		
	Option 2 Infusion of approximately 2 hours duration	600mg in 500mL	• Initiate the infusion at a rate of 100 mL/hr for the first 15 minutes • Increase the infusion rate to 200 mL/hr for the next 15 minutes • Increase the infusion rate to 250 mL/hr for the next 30 minutes • Increase the infusion rate to 300 mL/hr for the remaining 60 minutes • Each infusion should be given over approximately 2 hr

[*] Solutions of Ocrevus for IV infusion are prepared by dilution of the drug product into an infusion bag containing 0.9% sodium chloride, to a final drug concentration of approximately 1.2 mg/mL (see - *Instructions for dilution*)
[**] The first single infusion should be administered 6 months after Infusion 1 of the Initial dose

Delayed or Missed Doses

If a planned infusion of Ocrevus is missed, it should be administered as soon as possible; do not wait until the next planned dose. The treatment interval for Ocrevus should be maintained between doses.

Infusion Adjustments during Treatment

No dose reductions of Ocrevus are recommended.

In case of IRRs during any infusion, see the following adjustments below. Additional information on IRRs can be found under section 4.4.

Life-threatening IRRs
Immediately stop Ocrevus if there are signs of a life-threatening or disabling IRR during an infusion, such as acute hypersensitivity or acute respiratory distress syndrome. The patient

should receive appropriate supportive treatment. Permanently discontinue Ocrevus in these patients.

Severe IRRs
If a patient experiences a severe IRR or a complex of flushing, fever, and throat pain symptoms, the infusion should be interrupted immediately and the patient should receive symptomatic treatment. The infusion should be restarted only after all symptoms have resolved. The initial infusion rate at restart should be half the infusion rate at the time of onset of the reaction.

Mild to Moderate IRRs
If a patient experiences a mild to moderate IRR (e.g. headache), the infusion rate should be reduced to half the rate at the onset of the event. This reduced rate should be maintained for at least 30 minutes. If tolerated, the infusion rate may then be increased according to the patient's initial infusion schedule.

See section 4.4 for a full description of the symptoms associated with IRRs.

Dose Modifications in Special Populations

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

Elderly: The safety and efficacy of Ocrevus in patients ≥ 65 years of age have not been studied.

Renal Impairment: The safety and efficacy of Ocrevus in patients with renal impairment have not been formally studied. A change in dose is not expected to be required for patients with renal impairment (see section 5.2).

Hepatic Impairment: The safety and efficacy of Ocrevus in patients with hepatic impairment have not been formally studied. A change in dose is not expected to be required for patients with hepatic impairment (see section 5.2).

Instructions for Dilution

Ocrevus should be prepared by a healthcare professional using aseptic technique. A sterile needle and syringe should be used to prepare the diluted infusion solution.

Ocrevus may contain fine translucent and/or reflective particles associated with enhanced opalescence. Do not use the solution if discoloured or if the solution contains discrete foreign particulate matter.

Ocrevus must be diluted before administration. Solutions of Ocrevus for IV administration are prepared by dilution into an infusion bag containing 0.9% sodium chloride (300 mg/250 mL or 600 mg/500 mL), to a final drug concentration of approximately 1.2 mg/mL.

Instructions for Administration

The diluted infusion solution must be administered using an infusion set with a 0.2 or 0.22 micron in-line filter.

Prior to the start of the IV infusion, the content of the infusion bag should be at room temperature.

4.3 Contraindications

Ocrevus is contraindicated in patients with a known hypersensitivity to ocrelizumab or any of the excipients.

4.4 Special Warnings and Precautions for Use

Infusion Related Reactions (IRR)

Ocrevus is associated with IRRs, which may be related to cytokine release and/or other chemical mediators.

Symptoms of IRRs may occur during any infusion, but have been more frequently reported during the first infusion. IRRs can occur within 24 hours of the infusion (see section 4.8). These reactions may present as pruritus, rash, urticarial, erythema, throat irritation, oropharyngeal pain, dyspnoea, pharyngeal or laryngeal oedema, flushing, hypotension, pyrexia, fatigue, headache, dizziness, nausea tachycardia and anaphylaxis. Patients treated with Ocrevus should be observed for at least one hour after the completion of the infusion for any symptom of IRR. Physicians should alert patients that IRRs can occur within 24 hours of infusion.

A hypersensitivity reaction could also occur (acute allergic reaction to drug). IRRs may be clinically indistinguishable from Type 1 (IgE-mediated) acute hypersensitivity reactions (see section 4.4).

For premedication to reduce the frequency and severity of IRRs see section 4.2.

Managing IRRs
For patients experiencing life-threatening, severe or mild to moderate IRR symptoms see section 4.2.

Patients who experience severe pulmonary symptoms, such as bronchospasm or asthma exacerbation, must have their infusion interrupted immediately and permanently. After administering symptomatic treatment, monitor the patient until the pulmonary symptoms have resolved because initial improvement of clinical symptoms could be followed by deterioration.

Hypotension as a symptom of IRR may occur during Ocrevus infusions. Therefore withholding of antihypertensive treatments should be considered for 12 hours prior to and throughout each Ocrevus infusion. Patients with a history of congestive heart failure (New York Heart Association III & IV) were not studied in the controlled clinical trials.

Hypersensitivity Reactions

No hypersensitivity reactions to Ocrevus were reported in the controlled clinical trials.

Symptoms of a hypersensitivity reaction may be clinically indistinguishable from IRRs. A hypersensitivity reaction may present during any infusion, although typically would not present during the first infusion. For subsequent infusions, more severe symptoms than previously experienced, or new severe symptoms, should prompt consideration of a potential hypersensivity reaction. If a hypersensitivity reaction is suspected during infusion, the infusion must be stopped immediately and permanently. Patients with known IgE-mediated hypersensitivity to Ocrevus must not be treated (see section 4.3).

Infections

Delay Ocrevus administration in patients with an active infection until the infection is resolved.

Progressive Multifocal Leukoencephalopathy (PML)
John Cunningham (JC) virus infection resulting in PML has been observed in patients treated with anti-CD20 antibodies, including Ocrevus, and mostly associated with risk factors (e.g. patient population, polytherapy with immunosuppressants). The reporting rate with OCREVUS has been approximately 1 case per 100,000 patients.

Since a risk of PML cannot be excluded, physicians should be vigilant for early signs and symptoms of PML, which can include any new onset, or worsening of neurological signs or symptoms as these can be similar to an MS relapse.

If PML is suspected, withhold dosing with Ocrevus. Evaluation of PML, including MRI scan preferably with contrast (compared with pre-treatment MRI), confirmatory cerebrospinal fluid (CSF) testing for JC viral DNA and repeat neurological assessments, should be considered.

If PML is confirmed, discontinue treatment permanently.

Hepatitis B reactivation

Hepatitis B virus (HBV) reactivation, in some cases resulting in fulminant hepatitis, hepatic failure and death, has been reported in patients treated with anti-CD20 antibodies.

HBV screening should be performed in all patients before initiation of treatment with Ocrevus as per institutional guidelines. Patients with active HBV (i.e. an active infection confirmed by positive results for Hepatitis B surface antigen (HBsAg) and anti-HB testing) should not be treated with Ocrevus. Patients with positive serology (i.e. negative for HBsAg and positive for HB core antibody (HBcAb+)) and carriers of HBV (positive for surface antigen (HBsAg+)) should consult liver disease experts before start of treatment and should be monitored and managed according to current clinical practice.

Treatment with Immunosuppressants before, during or after Ocrevus

When initiating Ocrevus after an immunosuppressive therapy or initiating an immunosuppressive therapy after Ocrevus, the potential for overlapping pharmacodynamic effects should be taken into consideration (see section 5.1). Exercise caution when prescribing Ocrevus taking into consideration the pharmacodynamics of other disease-modifying MS therapies. Ocrevus has not been studied in combination with other disease-modifying MS therapies.

Vaccinations

The safety of immunisation with live or live-attenuated vaccines following Ocrevus therapy has not been studied and vaccination with live or live-attentuated viral vaccines is not recommended during treatment and until B-cell repletion (see section 5.1).

After treatment with Ocrevus over 2 years, the proportion of patients with positive antibody titres against *S.pneumoniae*, mumps, rubella and varicella were generally similar to the proportions at baseline.

In a randomised open-label study, patients with relapsing MS treated with Ocrevus were able to mount humoral responses, albeit decreased, to tetanus toxoid, 23-valent pneumococcal polysaccharide, keyhole limpet hemocyanin neoantigen, and seasonal influenza vaccines. For seasonal influenza vaccines, it is still recommended to vaccinate patients on Ocrevus.

Physicians should review the immunisation status of patients before starting treatment with Ocrevus. Patients should complete their vaccinations at least 6 weeks prior to initiation of Ocrevus.

Exposure in utero to ocrelizumab and vaccination of neonates and infants with live or live-attenuated vaccines

Due to the potential depletion of B-cells in neonates and infants of mothers who have been exposed to Ocrevus during pregnancy, it is recommended that vaccination with live or live-attenuated vaccines should be delayed until B-cell levels have recovered; therefore, measuring CD19-positive B-cell level, in neonates and infants, prior to vaccination is recommended.

It is recommended that all vaccinations other than live or live-attenuated should follow the local immunisation schedule and measurement of vaccine-induced response titers should be considered to check whether individuals can mount a protective immune response because the efficacy of the vaccination may be decreased.

Use in Renal Impairment

The safety and efficacy of Ocrevus in patients with renal impairment have not been formally studied. Patients with mild renal impairment were included in clinical trials. Ocrevus is a monoclonal antibody and cleared via catabolism rather than renal excretion, and a change in dose is not expected to be required for patients with renal impairment (see section 5.2).

Use in Hepatic Impairment

The safety and efficacy of Ocrevus in patients with hepatic impairment have not been formally studied. Patients with mild hepatic impairment were included in clinical trials. Ocrevus is a monoclonal antibody and cleared via catabolism rather than hepatic metabolism, and a change in dose is not expected to be required for patients with hepatic impairment (see section 5.2).

Paediatric Use

The safety and efficacy of Ocrevus in children and adolescents (< 18 years of age) have not been studied.

Use in the Elderly

The safety and efficacy of Ocrevus in patients ≥ 65 years of age have not been studied.

4.5 Interaction with Other Medicines and Other Forms of Interaction

No formal drug interaction studies have been performed as no drug interactions are expected via CYP and other metabolising enzymes or transporters.

4.6 Fertility, Pregnancy and Lactation

Pregnancy – Category C

Use of Ocrevus in women planning pregnancy should take into account the potential benefits for the mother to control peripartum disease activity (see section 5.1).

Prospective data collected from over 1100 pregnancies with known outcomes have been reviewed from clinical trials, a prospective pregnancy registry, literature, and post-marketing experience. More than 500 prospectively collected pregnancies with in utero exposure (Ocrevus administered within the last 3 months prior to the last menstrual period and/or during pregnancy), including more than 150 pregnancies with Ocrevus administered during the first trimester, indicate no malformative or feto-neonatal toxicity.

Ocrevus should be avoided during the second and third trimester of pregnancy unless the potential benefit to the mother outweighs the potential risk to the fetus. Ocrevus should be used during the first trimester of pregnancy only if clearly needed. Ocrevus is a humanised monoclonal antibody and immunoglobulins are known to cross the placental barrier. Placental transfer of human IgG is known to be significant after the first trimester and data with second or third trimester administration is limited.

There are no adequate and well-controlled data from studies in pregnant women, however transient peripheral B-cell depletion and lymphocytopenia have been reported in infants born to mothers exposed to other anti-CD20 antibodies during pregnancy.

Postponing vaccination with live or live-attenuated vaccines should be considered for neonates and infants born to mothers who have been exposed to Ocrevus during pregnancy. B-cell levels in neonates and infants following maternal exposure to Ocrevus have not been studied in clinical trials and the potential duration of B-cell depletion in neonates and infants is unknown (see section 4.4).

Labour and Delivery

The safe use of Ocrevus during labour and delivery has not been established.

Breast-feeding

Human IgGs are known to be excreted in breast milk during the first few days after birth (colostrum period), which decrease to low concentrations soon afterwards.

In a prospective clinical study, data from 29 lactating women given Ocrevus at a median of 4.3 months (range 0.1-36 months) postpartum indicated minimal transfer and low Ocrevus concentrations in milk (relative infant dose of 0.1%). Follow-up of 30 breastfed infants describe normal growth and development up to 1 year.

If clinically needed, Ocrevus can be used during breastfeeding starting a few days after birth.

Fertility

Preclinical data reveal no special hazards for humans based on studies of male and female fertility in cynomolgus monkeys.

4.7 Effects on Ability to Drive and Use Machines

Ocrevus has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable Effects

The safety of Ocrevus has been established in 1311 patients across MS clinical studies, which includes 825 patients in active-controlled RMS clinical trials and 486 patients in a placebo-controlled PPMS trial. Table 2 summarises the adverse drug reactions (ADRs) that have been reported in association with the use of Ocrevus in the controlled period of the pivotal clinical trials. The most frequently reported ADRs were IRRs and respiratory tract infections.

A total of 2376 patients were included in the controlled period of the pivotal clinical trials; of these patients, 1852 entered the Open-Label Extension (OLE) phase. All patients switched to Ocrevus 600 mg during the OLE phase. 1155 patients completed the OLE phase, resulting in approximately 10 years of continuous Ocrevus treatment (15,515 patient-years of exposure) across the controlled period and OLE phase. The overall safety profile observed during the controlled period and OLE phase remains consistent with that observed during the controlled period.

RMS

The ADRs described in this section were identified based on data from two identical active-controlled studies (WA21092 and WA21093) evaluating the efficacy and safety of Ocrevus in adults with RMS. In the two studies, patients (n=825) were given Ocrevus 600 mg, every 6 months (with the first dose administered as two 300 mg IV infusions separated by two weeks and all subsequent doses as a single, 600 mg infusion), or interferon beta-1a (IFN) 44 mcg (n=826) s.c. three times per week. The controlled period of the study was 96 weeks (four doses of Ocrevus).

PPMS

The ADRs described in this section were identified based on data from a placebo-controlled study (WA25046) evaluating the efficacy and safety of Ocrevus in adults with PPMS. Patients were given Ocrevus 600 mg (n=486) or placebo (n=239) every 6 months (administered as two 300 mg infusions separated by two weeks during the entire study).

Frequencies are defined as very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1000 to < 1/100), rare (≥ 1/10,000 to < 1/1000) and very rare (< 1/10,000). Adverse reactions are presented in order of decreasing frequency.

Table 2 Summary of ADRs associated with Ocrevus **(RMS or PPMS) with an incidence of ≥ 2% and higher than the comparator[1]**

ADR (MedDRA)	**RMS Pooled WA21092 & WA21093**		**PPMS WA25046[2]**		**Frequency category for O**crevus
	Ocrevus (n=825)	Interferon beta-1a (n=826)	Ocrevus (n=486)	Placebo (n=239)	
Injury, Poisoning and Procedural Complications					
Infusion-related reactions[3]	283 (34.3%)	82 (9.9%)	195 (40.1%)	61 (25.5%)	Very common

Infections and Infestations					
Upper respiratory tract infection	125 (15.2%)	88 (10.7%)	59 (12.1%)	14 (5.9%)	Very common
Nasopharyngitis	123 (14.9%)	84 (10.2%)	117 (24.1%)	67 (28.0%)	Very common
Sinusitis	46 (5.6%)	45 (5.4%)	19 (3.9%)	7 (2.9%)	Common
Bronchitis	42 (5.1%)	29 (3.5%)	31 (6.4%)	15 (6.3%)	Common
Influenza	38 (4.6%)	39 (4.7%)	57 (11.7%)	20 (8.4%)	Very common
Gastroenteritis	25 (3.0%)	19 (2.3%)	22 (4.5%)	12 (5.0%)	Common
Oral herpes	25 (3.0%)	18 (2.2%)	13 (2.7%)	2 (0.8%)	Common
Respiratory tract infection	19 (2.3%)	17 (2.1%)	13 (2.7%)	2 (0.8%)	Common
Viral infection	18 (2.2%)	23 (2.8%)	15 (3.1%)	4 (1.7%)	Common
Herpes zoster	17 (2.1%)	8 (1.0%)	8 (1.6%)	4 (1.7%)	Common
Conjunctivitis	9 (1.1%)	5 (0.6%)	10 (2.1%)	1 (0.4%)	Common
Cellulitis	7 (0.8%)	5 (0.6%)	11 (2.3%)	1 (0.4%)	Common
Respiratory, Thoracic and Mediastinal Disorders					
Cough	25 (3.0%)	12 (1.5%)	34 (7.0%)	8 (3.3%)	Common
Catarrh	0	0	10 (2.1%)	2 (0.8%)	Common

[1] Interferon beta-1a 44 mcg s.c. or placebo
[2] PPMS patients were randomised 2:1 (Ocrevus:placebo)
[3] Symptoms reported as IRRs within 24 hours of infusion are described below under *Infusion Related Reactions*

Description of selected adverse drug reactions from clinical trials

Infusion Related Reactions
Across the RMS and PPMS trials, symptoms associated with IRRs included, but are not limited to, pruritus, rash, urticarial, erythema, flushing, hypotension, pyrexia, fatigue, headache, dizziness, throat irritation, oropharyngeal pain, dyspnoea, pharyngeal or laryngeal oedema, nausea and tachycardia. In the controlled clinical trials there were no fatal IRRs.

In the active-controlled RMS clinical trials, IRRs were the most common adverse event in patients treated with Ocrevus 600 mg with an overall incidence of 34.3% compared with an incidence of 9.9% in the interferon beta-1a treatment group (placebo infusion). The incidence of IRRs was highest during Dose 1, infusion 1 (27.5%) and decreased over time to <10% at Dose 4. The majority of IRRs in both treatment groups were mild to moderate.

In the placebo-controlled PPMS clinical trial, the incidence of IRRs was highest during Dose 1, infusion 1 (27.4%) and decreased with subsequent doses to < 10% at Dose 4. A greater proportion of patients in each group experienced IRRs with the first infusion of each dose compared with the second infusion of that dose. The majority of IRRs were mild to moderate.

Over the controlled period and OLE phase of RMS and PPMS clinical trials, patients were given approximately 20 doses of Ocrevus 600 mg. Incidence of IRRs decreased to <4% by Dose 4 of the OLE phase in RMS patients and to <5% by Dose 5 of the OLE phase in PPMS patients.

With subsequent doses administered during the OLE phase, the incidence of IRR remained low. The majority of IRRs were mild during the OLE phase (see section 4.4).

Alternative Shorter Infusion of Subsequent Doses
In a study (MA30143 Shorter Infusion Substudy) designed to characterize the safety profile of shorter (2-hour) Ocrevus infusions in patients with Relapsing-Remitting Multiple Sclerosis, the incidence, intensity, and types of symptoms of IRRs were consistent with those of infusions administered over 3.5 hours (see section 5.1).

Infection
There was no increase in serious infections (SIs) associated with Ocrevus treatment. In RMS patients the rate of serious infections was lower than for interferon beta-1a, and in PPMS patients the rate was similar to placebo.

In the active-controlled RMS and placebo-controlled PPMS clinical trials, respiratory tract infections and herpes infections (both predominantly mild to moderate) were more frequently reported in the Ocrevus treatment arm.

Over the OLE phase in RMS and PPMS patients, the rate of SIs did not increase from that observed during the controlled period. Throughout the controlled period and OLE phase, the rate of SIs in PPMS patients remained higher than that observed in RMS patients.

In line with the previous analysis of risk factors for SIs in autoimmune conditions other than MS, a multivariate analysis of risk factors for SIs was conducted in the approximately 10 years of cumulative exposure data from the controlled period and OLE phase of the Ocrevus pivotal MS clinical studies. Risk factors for SIs in RMS patients include having at least 1 comorbidity, recent clinical relapse, and EDSS ≥6.0. Risk factors for SIs in PPMS patients include body mass index greater than 25 kg/m^2, having at least 2 comorbidities, EDSS ≥6.0, and IgM <LLN. Comorbidities included, but were not limited to, cardiovascular, renal and urinary tract conditions, previous infections, and depression.

Respiratory Tract Infections
The proportion of respiratory tract infections was higher in the Ocrevus treated patients compared to interferon and placebo. The infections were predominantly mild to moderate and consisted mostly of upper respiratory tract infections (including nasopharyngitis) and bronchitis (see Table 2).

Herpes
In the active-controlled RMS clinical trials, herpes infections were reported more frequently in Ocrevus treated patients than interferon beta-1a treated patients including herpes zoster (2.1% vs 1.0%), herpes simplex (0.7% vs 0.1%) and oral herpes (3.0% vs 2.2%), genital herpes (0.1% vs 0%), herpes virus infection (0.1% vs 0%). Infections were predominantly mild to moderate in severity and patients recovered with treatment by standard therapies. There were no reports of disseminated herpes.

In the placebo-controlled PPMS clinical trial, a higher proportion of patients with oral herpes (2.7% vs 0.8%) were observed in the Ocrevus treatment arm.

Serious Infections (SIs) from Clinical Trials in Autoimmune Conditions other than MS

Ocrevus in combination with concomitant immunosuppressive medications (e.g. chronic steroids, non-biologic and biologic disease-modifying antirheumatic drugs (DMARDs), mycopheolate mofetil, cyclophosphamide and azathioprine) has been studied in other autoimmune conditions.

The majority of available data is from studies in patients with rheumatoid arthritis (RA), where an imbalance in SIswas observed including, but not limited to, atypical pneumonia and pneumocystis jirovecii pneumonia, varicella pneumonia, tuberculosis, histoplasmosis in the Ocrevus-immunosuppressant group. In rare cases some of these infections were fatal. SIs were reported more frequently in the 1000 mg dose group compared to the 400 mg dose group or immunosuppressant-placebo group.

Risk factors for SIs in these trials included other comorbidities, chronic use of immunosuppressants/steroids, and patients from Asia.

Laboratory Abnormalities

Immunoglobulins

Treatment with Ocrevus resulted in a decrease in total immunoglobulins over the controlled period of the studies, mainly driven by reduction in IgM.

In the active-controlled RMS clinical trials, the proportion of patients at baseline reporting IgG, IgA and IgM < lower limit of normal (LLN) in the Ocrevus treatment arm was 0.5%, 1.5% and 0.1%, respectively. Following treatment, the proportion of Ocrevus-treated patients reporting IgG, IgA and IgM < LLN at 96 weeks was 1.5%, 2.4% and 16.5%, respectively.

In the placebo-controlled PPMS clinical trial, the proportion of patients at baseline reporting IgG, IgA and IgM < LLN in the Ocrevus treatment arm was 0.0%, 0.2% and 0.2%, respectively. Following treatment, the proportion of Ocrevus-treated patients reporting IgG, IgA and IgM < LLN at 120 weeks was 1.1%, 0.5% and 15.5%, respectively.

The pooled data of the Ocrevuspivotal clinical studies (RMS and PPMS) and their open-label extensions (approximately 10 years of exposure) have shown an apparent association between decreased levels of immunoglobulins and increased rate of SIs, and was most apparent for IgG (2.1% of RMS patients had a SI during a period with IgG < LLN and 2.3% of PPMS patients had a SI during a period with IgG < LLN). The difference in the rate of SIs between patients with IgG < LLN compared to patients with IgG ≥ LLN did not increase over time. The type, severity, latency, duration, and outcome of SIs observed during episodes of immunoglobulins below LLN were consistent with the overall SIs observed in patients treated with Ocrevus during the controlled period and OLE phase. Throughout the 10 years of continuous Ocrevus treatment, mean IgG levels of RMS and PPMS patients remained above LLN.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions https://pophealth.my.site.com/carmreportnz/s/

Neutrophils

In the active-controlled treatment period of the RMS clinical trials, decreased neutrophils were observed in 14.7% of Ocrevus patients as compared to 40.9% of patients treated with interferon beta-1a. In the placebo-controlled PPMS clinical trial, the proportion of Ocrevus patients presenting decreased neutrophils was slightly higher (12.9%) than placebo patients (10.0%).

In the majority of cases decreased neutrophils were transient (only observed once for a given patient treated with Ocrevus) and were Grade 1 and 2 in severity.

Overall, approximately 1% of the patients in the Ocrevus group had Grade 3 or 4 neutropenia. These were not temporally associated with an infection.

4.9 Overdose

There is limited clinical trial experience with doses higher than the approved IV dose of Ocrevus. The highest dose tested to date in MS patients is 2000 mg, administered as two 1000 mg IV infusions separated by two weeks (Phase II dose finding study in RRMS). The ADRs were consistent with the safety profile for Ocrevus in the pivotal clinical studies.

There is no specific antidote in the event of an overdose. Interrupt the infusion immediately and observe the patient for IRRs (see section 4.4).

Treatment of overdose should consist of general supportive measures.

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic Properties

Pharmacotherapeutic group: Immunosuppressants, Monoclonal antibodies. ATC code: L04AG08

Ocrelizumab is a recombinant humanised monoclonal antibody that selectively targets CD20-expressing B-cells. CD20 is a cell surface antigen found on pre-B-cells, mature and memory B-cells but not expressed on lymphoid stem cells and plasma cells.
The precise mechanisms through which ocrelizumab exerts its therapeutic clinical effects in multiple sclerosis (MS) are not fully elucidated but is presumed to involve immunomodulation through the reduction in the number and function of CD20-expressing B-cells. Following cell surface binding, ocrelizumab selectively depletes CD20-expressing B-cells through antibody-dependent cellular phagocytosis, antibody-dependent cellular cytotoxicity, complement-dependent cytotoxicity, and apoptosis. The capacity of B-cell reconstitution and pre-existing humoural immunity are preserved. In addition, innate immunity and total T-cell numbers are not affected.

Pharmacodynamic effects

Treatment with Ocrevus leads to rapid depletion of CD19+ B-cells in blood by 14 days post-treatment (first time-point of assessment) as an expected pharmacologic effect. This was sustained throughout the treatment period. For the B-cell counts, CD19 is used as the presence of Ocrevus interferes with the detection of CD20 by the assay.

In the Phase III studies, between each dose of Ocrevus, up to 5% of patients showed B-cell repletion (> lower limit of normal (LLN) or baseline) at least at one time point. The extent and duration of B-cell depletion was consistent in the primary progressive MS (PPMS) and relapsing forms of MS (RMS) trials.

The longest follow up time after the last Ocrevus infusion (Phase II WA21493, n=51) indicates that the median time to B-cell repletion (return to baseline/LLN, whichever occurred first) was 72 weeks (range 27-175 weeks). Ninety percent of all patients had their B-cells repleted to LLN or baseline by approximately two and a half years after the last infusion.

Clinical Trials

Relapsing forms of MS (RMS)

The efficacy and safety of Ocrevus were evaluated in two randomised, double-blind, double-dummy, active comparator-controlled clinical trials with identical design in patients with RMS (in accordance with McDonald criteria 2010). Study design and baseline characteristics of the study population are summarised in Table 3.

Demographic and baseline characteristics were well balanced across the two treatment groups. Patients receiving Ocrevus (Group A) were given 600 mg every 6 months (Dose 1 - two x 300 mg IV infusions, administered two weeks apart), and subsequent doses were administered as a single 600 mg IV infusion. Patients in Group B were administered interferon beta-1a (Rebif®) 44 mcg subcutaneous (s.c.) injection three times per week.

Key clinical and magnetic resonance imaging (MRI) efficacy results are presented in Table 4 and Figure 1.

Table 3 Study design and demographic characteristics for studies WA21092 and WA21093 (RMS)

	Study 1		**Study 2**	
Study name	**WA21092 (OPERA I) (n=821)**		**WA21093 (OPERA II) (n=835)**	
Study Design				
Population	• Patients with relapsing forms of MS			
Disease history at screening	• At least two relapses within the prior two years or one relapse within the prior year • EDSS between 0 and 5.5, inclusive			
Study duration	• Two years (96 weeks)			
Treatment groups	• Group A: Ocrevus 600 mg • Group B: interferon beta-1a (Rebif®), 44 mcg s.c. (IFN)			
Baseline Characteristics	Ocrevus 600 mg (n=410)	IFN 44 mcg (n=411)	Ocrevus 600 mg (n=417)	IFN 44 mcg (n=418)
Mean age (years)	37.1	36.9	37.2	37.4
Gender distribution (% male/% female)	34.1 / 65.9	33.8 / 66.2	35.0 / 65.0	33.0 / 67.0

Mean/Median duration since onset of MS symptoms (years)	6.74 / 4.88	6.25 / 4.62	6.72 / 5.16	6.68 / 5.07
Mean/Median disease duration since diagnosis (years)	3.82 / 1.53	3.71 / 1.57	4.15 / 2.10	4.13 / 1.84
Mean number of relapses in the last year	1.31	1.33	1.32	1.34
Mean Gd-enhancing T1 lesion count	1.69	1.87	1.82	1.95
Mean T2 lesion count	51.04	51.06	49.26	51.01

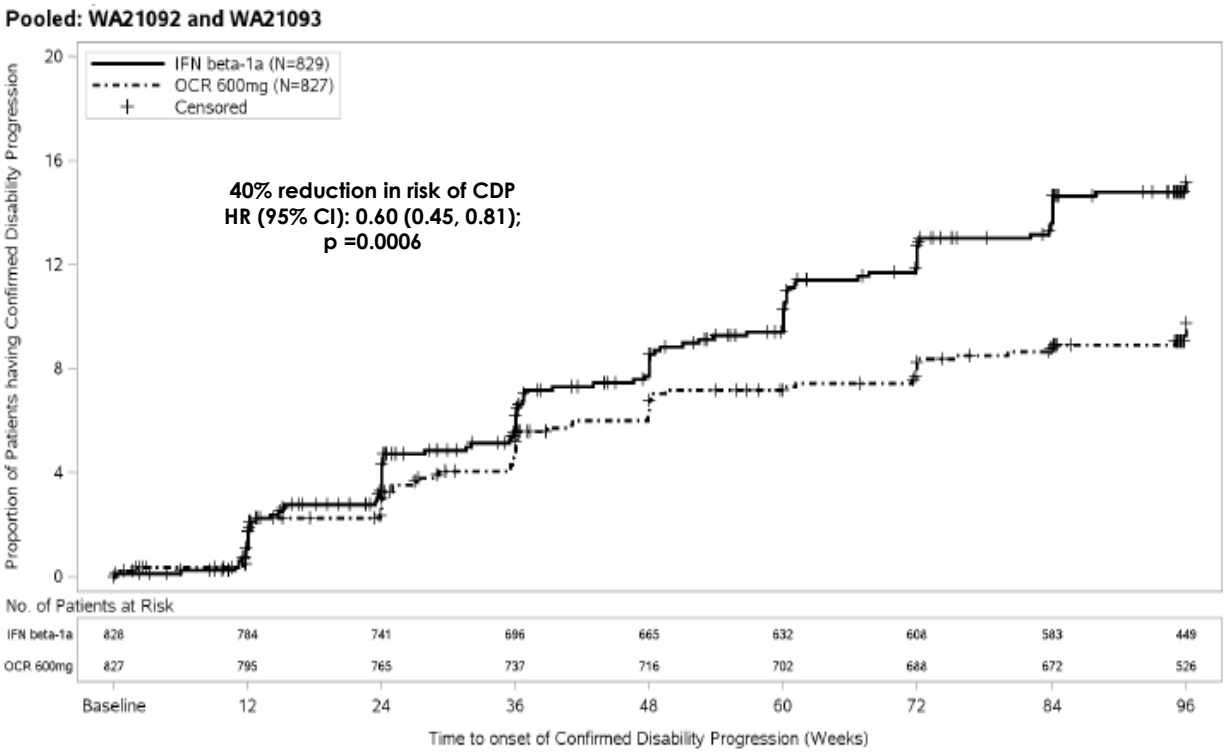
Table 4 Key clinical and MRI endpoints from studies WA21092 and WA21093

	Study 1: WA21092 (OPERA I)		**Study 2: WA21093 (OPERA II)**	
	Ocrevus 600 mg (n=410)	**IFN 44 mcg (n=411)**	**Ocrevus 600 mg (n=417)**	**IFN 44 mcg (n=418)**
Clinical Endpoints				
Primary efficacy endpoint Annualised Relapse Rate	0.156	0.292	0.155	0.290
Relative Reduction	46% (p < 0.0001)		47% (p < 0.0001)	
Proportion of patients with 12-week Confirmed Disability Progression[3]	9.8% Ocrevus vs 15.2% IFN			
Risk Reduction (Pooled Analysis[1])	40% (p=0.0006)			
Risk Reduction (Individual Studies[2])	43% (p=0.0139)		37% (p=0.0169)	
Proportion of patients with 24-week Confirmed Disability Progression[3]	7.6% Ocrevus vs 12.0% IFN			
Risk Reduction (Pooled Analysis[1])	40% (p=0.0025)			
Risk Reduction (Individual Studies[2])	43% (p=0.0278)		37% (p=0.0370)	
Proportion of patients with at least 12-week Confirmed Disability Improvement[4] (Pooled)	20.7% Ocrevus vs 15.6% IFN			
Relative Increase (Pooled Analysis[1])	33% (p=0.0194)			
Relative Increase (Individual Studies[2])	61% (p=0.0106)		14% (p=0.4019)	
Mean change from baseline in Multiple Sclerosis Functional Composite (MSFC)	0.213	0.174	0.276	0.169
Difference	0.039		0.107	

	(p=0.3261)		(p=0.0040)	
Proportion of patients with No Evidence of Disease Activity (NEDA)[5]	48%	29%	48%	25%
Relative Increase[2]	64% (p<0.0001)		89% (p<0.0001)	
MRI Endpoints				
Mean number of T1 Gd-enhancing lesions per MRI scan	0.016	0.286	0.021	0.416
Relative Reduction	94% (p<0.0001)		95% (p<0.0001)	
Mean number of new and/or enlarging T2 hyperintense lesions per MRI scan	0.323	1.413	0.325	1.904
Relative Reduction	77% (p<0.0001)		83% (p<0.0001)	
Mean number of new T1-hypo-intense lesions (chronic black holes) per MRI scan	0.420	0.982	0.449	1.255
Relative reduction	57% (p<0.0001)		64% (p<0.0001)	
Percentage change in brain volume from week 24 to week 96	-0.572	-0.741	-0.638	-0.750
Relative reduction in brain volume loss	22.8% (p=0.0042)[6]		14.9% (p=0.0900)	
Quality of Life				
Mean change from baseline in SF-36 Physical Component Summary	0.036	-0.657	0.326	-0.833
Difference	0.693 (p=0.2193)		1.159 (p=0.0404)[6]	

[1] Data prospectively pooled from Study 1 & 2
[2] Non-confirmatory p-value; analysis not part of the pre-specified testing hierarchy
[3] Defined as an increase of ≥ 1.0 point from the baseline Expanded Disability Status Scale (EDSS) score for patients with baseline EDSS score of 5.5 or less, or ≥ 0.5 when the baseline score is > 5.5; Kaplan-Meier estimates at Week 96
[4] Defined as decrease of ≥ 1.0 point from the baseline EDSS score for patients with baseline EDSS score of ≥ 2 and ≤ 5.5, or ≥ 0.5 when the baseline score is > 5.5. Patients with baseline score < 2 were not included in analysis
[5] NEDA defined as absence of protocol defined relapses, Confirmed Disability Progression and any MRI activity (either Gd-enhancing T1 lesions, or new or enlarging T2 lesions) during the whole 96 week treatment period. Exploratory result based on complete ITT population
[6] Non-confirmatory p-value; hierarchical testing procedure terminated before reaching endpoint

Figure 1 Kaplan-Meier plot of time to onset of confirmed disability progression sustained for at least 12 weeks with the initial event of neurological worsening occurring during the double-blind treatment period (pooled ITT population)*



*Pre-specified pooled analysis of OPERA I & II

Results of the pre-specified pooled analyses of time to CDP sustained for at least 12 weeks (40% risk reduction for Ocrevus compared to interferon beta-1a, p=0.0006) were highly consistent with the results sustained for at least 24 weeks (40% risk reduction for Ocrevus compared to interferon beta-1a, p=0.0025).

Shorter Infusion Substudy

The safety of the shorter (2-hour) Ocrevus infusion was evaluated in a prospective, multicenter, randomized, double-blind, controlled, parallel arm substudy to Study MA30143 (Ensemble) in patients with Relapsing-Remitting Multiple Sclerosis that were naïve to other disease modifying treatments. The first dose of Ocrevus was administered as two 300 mg infusions (600 mg total) separated by 14 days. Patients were randomized from their second dose or onwards (Dose 2 to 6) in a 1:1 ratio to either the conventional infusion group with Ocrevus infused over approximately 3.5 hours every 24 weeks, or the shorter infusion group with Ocrevus infused over approximately 2 hours every 24 weeks. The randomization was stratified by region and the dose at which patients were first randomized.

The primary endpoint was the proportion of patients with IRRs occurring during or within 24 hours following the first randomized infusion of Ocrevus. The primary analysis was performed when 580 patients were randomized. The proportion of patients with IRRs occurring during or within 24 hours following the first randomized infusion was 24.6% in the shorter infusion group compared to 23.1% in the conventional infusion group. The stratified group difference was similar. Overall, in all randomized doses, the majority of the IRRs were mild or moderate and only two IRRs were severe in intensity, with one severe IRR in each group. There were no life-threatening, fatal, or serious IRRs.

Primary Progressive MS (PPMS)

The efficacy and safety of Ocrevus were evaluated in a randomised, double-blind, placebo-controlled clinical trial in patients with PPMS (Study WA25046). Study design and baseline characteristics of the study population are presented in Table 5. Demographic and baseline characteristics were well balanced across the two treatment groups.

Throughout the treatment period patients receiving Ocrevus (Group A) were given 600 mg every 6 months (as two x 300 mg IV infusions, administered two weeks apart). Patients in Group B were administered placebo. The 600 mg infusions in RMS and the two x 300 mg infusions in PPMS demonstrated consistent PK/PD profiles. Infusion related reactions (IRRs) profiles per infusion were also similar, independent of whether the 600 mg dose was administered as a single 600 mg infusion or as two x 300 mg infusions two weeks apart (see sections 4.8 and 5.1), but due to overall more infusions with the two x 300 mg regimen, the total number of IRRs were higher. Therefore, after Dose 1 it is recommended to administer Ocrevus in a single 600 mg infusion (see Table 1) to reduce the total number of infusions (and concurrent exposure to prophylactic methylprednisolone) and IRRs.

Table 5 Study design and baseline characteristics for study WA25046

Study name	**WA25046 (ORATORIO) (n=732)**	
Study Design		
Population	• Patients with primary progressive MS	
Disease history at screening	• Age 18 – 55 years • EDSS between 3.0 and 6.5	
Study duration	• Event-driven (minimum 120 weeks and 253 confirmed disability progression events) • Median follow-up time – Ocrevus 3.0 years, placebo 2.8 years	
Treatment groups	• Group A: Ocrevus 600 mg • Group B: placebo, 2:1 randomisation	
Baseline Characteristics	OCREVUS 600 mg (n=488)	Placebo (n=244)
Mean age (years)	44.7	44.4
Gender distribution (% male/% female)	51.4 / 48.6	49.2 / 50.8
Mean/Median duration since onset of MS symptoms (years)	6.7 / 6.0	6.1 / 5.5
Mean/Median disease duration since diagnosis (years)	2.9 / 1.6	2.8 / 1.3
Mean EDSS	4.7	4.7

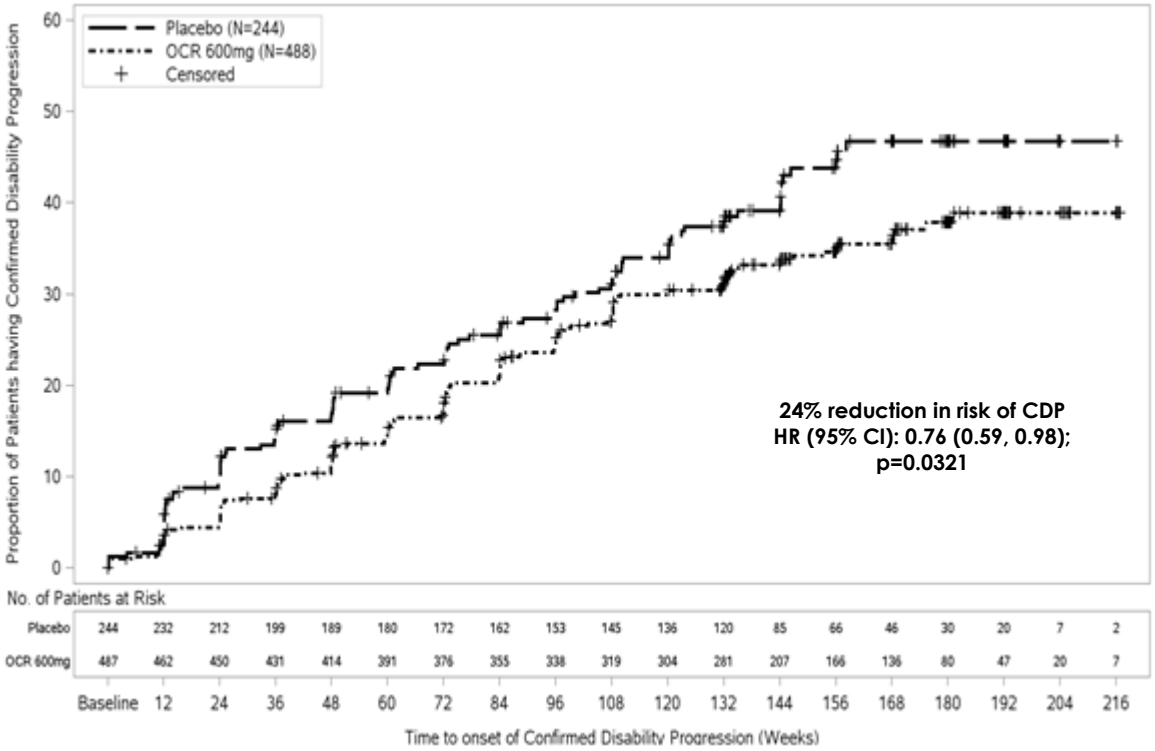
Key clinical and MRI efficacy results are presented in Table 6 and Figure 2.

Table 6 Key clinical and MRI endpoints from study WA25046 (PPMS)

	Study 3: WA25046 (ORATORIO)	
	Ocrevus 600 mg (n=488)	**Placebo (n=244)**
Clinical Endpoints		
Primary efficacy endpoint Proportion of patients with 12 weeks Confirmed Disability Progression[1]	30.2%	34.0%
Risk Reduction	24% (p=0.0321)	
Proportion of patients with 24 weeks Confirmed Disability Progression[1]	28.3%	32.7%
Risk Reduction	25% (p=0.0365)	
Percentage change in timed 25-foot walk from baseline to week 120	38.9	55.1
Relative reduction in progression rate of walking time	29.4% (p=0.0404)	
MRI Endpoints		
Percentage change in T2 hyperintense lesion volume, from baseline to week 120	-3.4	7.4
	p<0.0001	
Percentage change brain volume from week 24 to week 120	-0.902	-1.093
Relative reduction in rate of brain volume loss	17.5% (p=0.0206)	
Quality of Life		
Mean change from baseline in SF-36 Physical Component Summary	-0.731	-1.108
Difference	0.377 (p=0.6034)	

[1]Defined as an increase of ≥ 1.0 point from the baseline EDSS score for patients with baseline score of ≤ 5.5, or ≥ 0.5 when the baseline score is > 5.5; Kaplan-Meier estimates at week 120

Figure 2 Kaplan-Meier plot of time to onset of confirmed disability progression sustained for at least 12 weeks with the initial event of neurological worsening occurring during the double-blind treatment period (ITT population)*



*All patients in this analysis had a minimum of 120 weeks of follow-up. The primary analysis is based on all events accrued

Post-hoc analyses were performed in the Extended Controlled Period (ECP), which includes double-blinded treatment and approximately 9 additional months of controlled follow-up before continuing into the Open-Label Extension (OLE) or until withdrawal from study treatment. The proportion of patients with 24 week Confirmed Disability Progression of EDSS≥7.0 (24W-CDP of EDSS≥7.0, time to wheelchair) was 9.1% in the placebo group compared to 4.8% in the Ocrevus group at Week 144, resulting in a 47% risk reduction of the time to wheelchair (HR 0.53, [0.31, 0.92]) during the ECP. These results were exploratory in nature and included data after unblinding.

Immunogenicity

Patients in the MS trials (WA21092, WA21093 and WA25046) were tested at multiple time points (baseline and every 6 months post treatment for the duration of the trial) for anti-drug antibodies (ADAs). Out of 1311 patients treated with ocrelizumab, 12 (~1%) tested positive for treatment-emergent ADAs, of which two patients tested positive for neutralising antibodies. The impact of treatment-emergent ADAs on safety and efficacy cannot be assessed given the low incidence of ADA associated with Ocrevus.

Immunogenicity data are highly dependent on the sensitivity and specificity of the test methods used. Additionally, the observed incidence of a positive result in a test method may be influenced by several factors, including sample handling, timing of sample collection, drug interference, concomitant medication and the underlying disease. Therefore comparison of the incidence of antibodies to Ocrevus with the incidence of antibodies to other products may be misleading.

Peripartum disease activity
Peripartum disease activity was evaluated in 99 women receiving Ocrevus across 13 interventional clinical trials, who experienced at least one pregnancy resulting in live birth. The median time of the last Ocrevus administration was 4.3 [interquartile range (IQR): 2.3-5.5] months prior to the last menstrual period. A total of 15 women received Ocrevus during pregnancy at 3.9 [3.0-4.1] gestational weeks and 28 women resumed Ocrevus postpartum at 3.8 [1.9-7.0] months. The annualised relapse rate remained low in the pre-pregnancy year (0.07 [95% confidence interval (CI): 0.02, 0.14]), during pregnancy (0.03 [95% CI: 0.00-0.10]) and up to 1 year postpartum (0.04 [95% CI: 0.01, 0.16]).

These results are consistent with an analysis of 73 women receiving Ocrevus from an international MS registry. The median time of last Ocrevus administration was 1.9 [IQR: 0-4.8] months prior to conception. The annualised relapse rate remained low in the pre-pregnancy year (0.15 [95% CI: 0.07, 0.29]), during pregnancy (0 [95% CI: 0, 0.07]) and up to 6 months postpartum (0.09 [95% CI: 0.02, 0.27]).

5.2 Pharmacokinetic Properties

Pharmacokinetics of ocrelizumab in the MS studies were described by a two compartment model with time-dependent clearance, and with pharmacokinetic (PK) parameters typical for an IgG1 monoclonal antibody. Clearance and central volume were estimated at 0.17 L/day and 2.78 L, peripheral volume and inter-compartment clearance at 2.68 L and 0.294 L/day, and initial time-dependent clearance at 0.0489 L/day which declined with a half-life of 33 weeks. The overall exposure (area under curve (AUC) over the 24 week dosing intervals) was identical in the 2 x 300 mg PPMS study and the 1 x 600 mg RMS studies, as expected given an identical dose was administered. AUCτ after the fourth dose of 600 mg OCREVUS was 3510 µg/mL•day, and mean maximum concentration (C_{max}) was 212 µg/mL in RMS (600 mg infusion) and 141 µg/mL in PPMS (300 mg infusions). Terminal half-life was 26 days.

Absorption

Ocrelizumab is administered intravenously. There have been no clinical studies performed with other routes of administration.

Distribution

The population PK estimate of the central volume of distribution was 2.78 L. Peripheral volume and inter-compartment clearance were estimated at 2.68 L and 0.294 L/day.

Metabolism

The metabolism of ocrelizumab has not been directly studied, as antibodies are cleared principally by catabolism.

Excretion

Constant clearance was estimated at 0.17 L/day, and initial time-dependent clearance at 0.0489 L/day which declined with a half-life of 33 weeks. The terminal elimination half-life was 26 days.

<u>Pharmacokinetics in Special Populations</u>

Elderly Patients

No studies have been conducted to investigate the PK of ocrelizumab in patients ≥ 65 years.

Paediatric Patients

No studies have been conducted to investigate the PK of ocrelizumab in children and adolescents (< 18 years of age).

Renal Impairment

No formal PK study has been conducted. Patients with mild renal impairment were included in clinical trials and no change in the PK of ocrelizumab was observed in those patients.

Hepatic Impairment

No formal PK study has been conducted. Patients with mild hepatic impairment were included in clinical trials and no change in the PK of ocrelizumab was observed in those patients.

5.3 Preclinical Safety Data

Genotoxicity

No studies have been performed to assess the mutagenic potential of Ocrevus. As an antibody Ocrevus is not expected to interact with DNA or other chromosomal material.

Carcinogenicity

No carcinogenicity studies have been performed as no appropriate animal or in vitro models are available to assess the carcinogenic potential of Ocrevus.

Reproductive Toxicity

It is not known whether Ocrevus can cause harm to the foetus when administered to pregnant women or whether it affects reproductive capacity. In an embryo-foetal developmental study in cynomolgus monkeys, there was no evidence of maternal toxicity, teratogenicity or embryotoxicity following Ocrevus administration at 75 mg/kg (loading dose) or 100 mg/kg (study dose). As IgG molecules are known to cross the placental barrier Ocrevus causes depletion of B-cells in the foetuses of treated cynomolgus monkeys.

In a pre- and post-natal development study in cynomolgus monkeys, administration of Ocrevus 15/20 and 75/100 mg/kg loading/study doses (which correspond to human equivalent doses of approximately 3,000 mg (approximately 5 x clinical dose) and 15,000 mg (approximately 25 x clinical dose), respectively) were associated with glomerulopathy (7/24 animals), and lymphoplasmacytic inflammation in the kidney (2/24 animals). Testicular weights of the neonates were significantly reduced in the 75/100 mg/kg group compared with controls. There were two cases of moribundity on study (2/24), one attributed to weakness due to premature birth accompanied by opportunistic infection and the other to an infective meningoencephalitis involving the cerebellum of the offspring from a maternal dam with an active infection (mastitis). The course of both neonatal infections could have potentially been impacted by B-cell depletion. Newborn offspring of maternal animals exposed to Ocrevus were noted to have depleted B-cell populations during the post-natal phase. Measurable levels of ocrelizumab were detected in milk (approximately 0.2% of steady state trough serum levels) during the lactation period (see section 4.6).

Other

Preclinical data reveal no special hazards for humans based on conventional studies of safety pharmacology, acute and repeated dose toxicity.

6. PHARMACEUTICAL PARTICULARS

6.1 List of Excipients

Sodium acetate 20mM, Trehalose dehydrate 106mM, Glacial acetic acid 0.02% (w/v) Polysorbate 20 and Water for injections.

6.2 Incompatibilities

No incompatibilities between Ocrevus and polyvinyl chloride or polyolefine bags, and IV administration sets have been observed. Do not use diluents other than 0.9% sodium chloride to dilute Ocrevus since use has not been tested.

6.3 Shelf-life

24 months

Shelf-life of reconstituted solution
OCREVUS does not contain any anti-microbial preservative; 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.

To reduce microbiological hazard, the prepared infusion solution should be used immediately. If storage is necessary, hold at 2°C - 8°C (Refrigerate, do not freeze) for not more than 24 hours and 8 hours stored at or below 30^0C.

In the event an IV infusion cannot be completed the same day, the remaining solution should be discarded.

6.4 Special Precautions for Storage

Store vial in a refrigerator at 2°C to 8°C. Do not freeze.
Keep vial in the outer carton in order to protect from light.
Do not shake.
Do not use after the expiry date (EXP) shown on the pack.

6.5 Nature and Contents of Container

Single-use 15 mL-sized glass vial containing 10 mL of solution at pH 5.3.

6.6 Special Precautions for Disposal

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.

The following should be strictly adhered to regarding the use and disposal of syringes and other medicinal sharps:

- Needles and syringes should never be reused

- Place all used needles and syringes into a sharps container (puncture-proof disposable container)

7. MEDICINE SCHEDULE

Prescription Medicine.

8. SPONSOR

Distributed in New Zealand by:
Roche Products (New Zealand) Limited
PO Box 109113, Newmarket, Auckland 1149
NEW ZEALAND
Medical enquiries: 0800 276 243

9. DATE OF FIRST APPROVAL

21 December 2017

10. DATE OF REVISION OF THE TEXT

12 DECEMBER 2024SUMMARY OF CHANGES TABLE

Section Changed	Summary of new information
Section 4.6	Updated pregnancy and lactation recommendations based on new prospective data
Section 4.8	Updated information based on 10 year exposure data from open-label extension phase of pivotal clinical trials
Section 5.1	Addition of Peripartum disease activity data