

HIGHLIGHTS OF PRESCRIBING INFORMATION

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

REMICADE (infliximab)

Lyophilized Concentrate for Intravenous (IV) Injection
Initial U.S. Approval: 1998

WARNINGS:

See full prescribing information for complete boxed warning

SERIOUS INFECTIONS

- Increased risk of serious infections leading to hospitalization or death, including tuberculosis (TB), bacterial sepsis, invasive fungal infections (such as histoplasmosis) and infections due to other opportunistic pathogens.
- REMICADE should be discontinued if a patient develops a serious infection or sepsis during treatment.
- Perform test for latent TB; if positive, start treatment for TB prior to starting REMICADE.
- Monitor all patients for active TB during treatment, even if initial latent TB test is negative. (5.1)

MALIGNANCY

- Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, including REMICADE. (5.2)
- Postmarketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma, have been reported in patients treated with TNF blockers including REMICADE. All cases were reported in patients with Crohn's disease and ulcerative colitis, the majority of whom were adolescent or young adult males. This rare, aggressive T-cell lymphoma is fatal. All of these patients had received treatment with azathioprine or 6-mercaptopurine concomitantly with REMICADE at or prior to diagnosis. (5.2)

RECENT MAJOR CHANGES

Dosage and Administration (2.7)	4/2010
Warnings and Precautions: Malignancy, (Monotherapy) (5.2)	10/2010
Warnings and Precautions: Hypersensitivity (5.7)	12/2010
Warnings and Precautions: Neurologic Events (5.8)	7/2010
Warnings and Precautions: Use with Anakinra (5.9)	2/2011
Warnings and Precautions: Use with Abatacept (5.10)	2/2011
Warnings and Precautions: Switching Between Biological Disease-Modifying Antirheumatic Drugs (DMARDs) (5.11)	2/2011

INDICATIONS AND USAGE

REMICADE is a tumor necrosis factor (TNF) blocker indicated for:

Crohn's Disease (1.1):

- reducing signs and symptoms and inducing and maintaining clinical remission in adult and pediatric patients with moderately to severely active disease who have had an inadequate response to conventional therapy.
- reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing disease.

Ulcerative Colitis (1.2):

- reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

Rheumatoid Arthritis (1.3) in combination with methotrexate:

- reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active disease.

Ankylosing Spondylitis (1.4):

- reducing signs and symptoms in patients with active disease.

Psoriatic Arthritis (1.5):

- reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function.

Plaque Psoriasis (1.6):

- treatment of adult patients with chronic severe (i.e., extensive and/or disabling) plaque psoriasis who are candidates for systemic therapy and when other systemic therapies are medically less appropriate.

DOSAGE AND ADMINISTRATION

REMICADE is administered by intravenous infusion.

Crohn's Disease (2.1)

- 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. Some adult patients who initially respond to treatment may benefit from increasing the dose to 10 mg/kg if they later lose their response.

Ulcerative Colitis (2.2)

- 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

Rheumatoid Arthritis (2.3)

- In conjunction with methotrexate, 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every 4 weeks.

Ankylosing Spondylitis (2.4)

- 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks.

Psoriatic Arthritis (2.5)

- 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

Plaque Psoriasis (2.6)

- 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

DOSAGE FORMS AND STRENGTHS

100 mg of lyophilized infliximab in a 20 mL vial to be reconstituted in 10 mL of sterile water for injection. (3)

Contraindications

- REMICADE doses >5 mg/kg in moderate to severe heart failure. (4)
- Previous severe hypersensitivity reaction to REMICADE or known hypersensitivity to inactive components of REMICADE or to any murine proteins. (4)

WARNINGS AND PRECAUTIONS

- Serious infections – do not give REMICADE during an active infection. If an infection develops, monitor carefully and stop REMICADE if infection becomes serious. (5.1)
- Malignancies – seen more often than in controls. Lymphoma seen more often than in the general population; carefully assess the risks and benefits of treatment and monitor for malignancies in children and adolescents. (5.2)
- Hepatosplenic T-cell Lymphoma – carefully assess the risk/benefit especially if the patient has Crohn's disease or ulcerative colitis, is male, and is receiving azathioprine or 6-mercaptopurine treatment. (5.2)
- Hepatitis B virus reactivation – monitor HBV carriers during and several months after therapy. If reactivation occurs, stop REMICADE and begin anti-viral therapy. (5.3)
- Hepatotoxicity – rare severe hepatic reactions, some fatal or necessitating liver transplantation. Stop REMICADE in cases of jaundice and/or marked liver enzyme elevations. (5.4)
- Heart failure – closely monitor patients with heart failure and stop REMICADE if new or worsening symptoms occur. (4, 5.5)
- Cytopenias – advise patients to seek immediate medical attention if signs and symptoms develop, and consider stopping REMICADE. (5.6)
- Hypersensitivity – serious infusion reactions including anaphylaxis or serum sickness-like reactions may occur. (5.7)
- Demyelinating disease – consider stopping REMICADE if exacerbation or new onset occurs. (5.8)
- Lupus-like syndrome – stop REMICADE if syndrome develops. (5.10)

ADVERSE REACTIONS

Most common adverse reactions (>10%) – infections (e.g. upper respiratory, sinusitis, and pharyngitis), infusion-related reactions, headache, and abdominal pain. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Centocor at 1-800-457-6399 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Use with anakinra or abatacept – increased risk of serious infections (7.1)
- Live vaccines – should not be given with REMICADE. Bring pediatric Crohn's patients up to date with all vaccinations prior to initiating REMICADE. (5.13)

USE IN SPECIFIC POPULATIONS

- Pediatric Use – Although indicated for use in pediatric Crohn's disease, REMICADE has not been studied in children with Crohn's disease <6 years of age. (8.3)

See 17 for PATIENT COUNSELING INFORMATION and MEDICATION GUIDE.

Revised: February 2011

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FULL PRESCRIBING INFORMATION

WARNINGS

SERIOUS INFECTIONS

Patients treated with REMICADE[®] are at increased risk for developing serious infections that may lead to hospitalization or death [*see Warnings and Precautions (5.1) and Adverse Reactions (6.1)*] Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.

REMICADE should be discontinued if a patient develops a serious infection or sepsis.

Reported infections include:

- Active tuberculosis, including reactivation of latent tuberculosis. Patients with tuberculosis have frequently presented with disseminated or extrapulmonary disease. Patients should be tested for latent tuberculosis before REMICADE use and during therapy.^{1,2} Treatment for latent infection should be initiated prior to REMICADE use.
- Invasive fungal infections, including histoplasmosis, coccidioidomycosis, candidiasis, aspergillosis, blastomycosis, and pneumocystosis. Patients with histoplasmosis or other invasive fungal infections may present with disseminated, rather than localized, disease. Antigen and antibody testing for histoplasmosis may be negative in some patients with active infection. Empiric anti-fungal therapy should be considered in patients at risk for invasive fungal infections who develop severe systemic illness.
- Bacterial, viral and other infections due to opportunistic pathogens.

The risks and benefits of treatment with REMICADE should be carefully considered prior to initiating therapy in patients with chronic or recurrent infection.

Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with REMICADE, including the possible development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy.

MALIGNANCY

Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, including REMICADE [*see Warnings and Precautions (5.2)*].

Postmarketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma, have been reported in patients treated with TNF blockers including REMICADE. These cases have had a very aggressive disease course and have been fatal. All reported REMICADE cases have occurred in patients with Crohn's disease or ulcerative colitis and the majority were in adolescent and young adult males. All of these patients had received treatment with azathioprine or 6-mercaptopurine concomitantly with REMICADE at or prior to diagnosis.

1 INDICATIONS AND USAGE

1.1 Crohn's Disease

REMICADE is indicated for reducing signs and symptoms and inducing and maintaining clinical remission in adult and pediatric patients with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy [*see Use in Specific Populations (8.4)*].

REMICADE is indicated for reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing Crohn's disease.

1.2 Ulcerative Colitis

REMICADE is indicated for reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.

1.3 Rheumatoid Arthritis

REMICADE, in combination with methotrexate, is indicated for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active rheumatoid arthritis.

1.4 Ankylosing Spondylitis

REMICADE is indicated for reducing signs and symptoms in patients with active ankylosing spondylitis.

1.5 Psoriatic Arthritis

REMICADE is indicated for reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in patients with psoriatic arthritis.

1.6 Plaque Psoriasis

REMICADE is indicated for the treatment of adult patients with chronic severe (i.e., extensive and/or disabling) plaque psoriasis who are candidates for systemic therapy and when other systemic therapies are medically less appropriate. REMICADE should only be administered to patients who will be closely monitored and have regular follow-up visits with a physician [*see Boxed WARNINGS, Warnings and Precautions (5)*].

2 DOSAGE AND ADMINISTRATION

2.1 Crohn's Disease or Fistulizing Crohn's Disease

The recommended dose of REMICADE is 5 mg/kg given as an intravenous induction regimen at 0, 2 and 6 weeks followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter for the treatment of adults with moderately to severely active Crohn's disease or fistulizing Crohn's disease. For adult patients who respond and then lose their response, consideration may be given to treatment with 10 mg/kg. Patients who do not respond by Week 14 are unlikely to respond with continued dosing and consideration should be given to discontinue REMICADE in these patients.

The recommended dose of REMICADE for children with moderately to severely active Crohn's disease is 5 mg/kg given as an intravenous induction regimen at 0, 2 and 6 weeks followed by a maintenance regimen of 5 mg/kg every 8 weeks.

2.2 Ulcerative Colitis

The recommended dose of REMICADE is 5 mg/kg given as an intravenous induction regimen at 0, 2 and 6 weeks followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter for the treatment of moderately to severely active ulcerative colitis.

2.3 Rheumatoid Arthritis

The recommended dose of REMICADE is 3 mg/kg given as an intravenous induction regimen at 0, 2 and 6 weeks followed by a maintenance regimen of 3 mg/kg every 8 weeks thereafter for the treatment of moderately to severely active rheumatoid arthritis. REMICADE should be given in combination with methotrexate. For patients who have an incomplete response, consideration may be given to adjusting the dose up to 10 mg/kg or treating as often as every 4 weeks bearing in mind that risk of serious infections is increased at higher doses [*see Adverse Reactions (6.1)*].

2.4 Ankylosing Spondylitis

The recommended dose of REMICADE is 5 mg/kg given as an intravenous induction regimen at 0, 2 and 6 weeks followed by a maintenance regimen of 5 mg/kg every 6 weeks thereafter for the treatment of active ankylosing spondylitis.

2.5 Psoriatic Arthritis

The recommended dose of REMICADE is 5 mg/kg given as an intravenous induction regimen at 0, 2 and 6 weeks followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter for the treatment of psoriatic arthritis. REMICADE can be used with or without methotrexate.

2.6 Plaque Psoriasis

The recommended dose of REMICADE is 5 mg/kg given as an intravenous induction regimen at 0, 2 and 6 weeks followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter for the treatment of chronic severe (i.e., extensive and/or disabling) plaque psoriasis.

2.7 Monitoring to Assess Safety

Prior to initiating REMICADE and periodically during therapy, patients should be evaluated for active tuberculosis and tested for latent infection [*see Warnings and Precautions (5.1)*].

2.8 Administration Instructions Regarding Infusion Reactions

Adverse effects during administration of REMICADE have included flu-like symptoms, headache, dyspnea, hypotension, transient fever, chills, gastrointestinal symptoms, and skin rashes. Anaphylaxis might occur at any time during REMICADE infusion. Approximately 20% of REMICADE-treated patients in all clinical trials experienced an infusion reaction compared with 10% of placebo-treated patients [*see Adverse Reactions (6.1)*]. Prior to infusion with REMICADE, premedication may be administered at the physician's discretion. Premedication could include antihistamines (anti-H1 +/- anti-H2), acetaminophen and/or corticosteroids.

During infusion, mild to moderate infusion reactions may improve following slowing or suspension of the infusion, and upon resolution of the reaction, reinitiation at a lower infusion rate and/or therapeutic administration of antihistamines, acetaminophen, and/or corticosteroids. For patients that do not tolerate the infusion following these interventions, REMICADE should be discontinued.

During or following infusion, patients who have severe infusion-related hypersensitivity reactions should be discontinued from further REMICADE treatment. The management of severe infusion reactions should be dictated by the signs and symptoms of the reaction. Appropriate personnel and medication should be available to treat anaphylaxis if it occurs.

2.9 General Considerations and Instructions for Preparation and Administration

REMICADE is intended for use under the guidance and supervision of a physician. The reconstituted infusion solution should be prepared by a trained medical professional using aseptic technique by the following procedure:

1. Calculate the dose, total volume of reconstituted REMICADE solution required and the number of REMICADE vials needed. Each REMICADE vial contains 100 mg of the infliximab antibody.
2. Reconstitute each REMICADE vial with 10 mL of Sterile Water for Injection, USP, using a syringe equipped with a 21-gauge or smaller needle as follows: Remove the flip-top from the vial and wipe the top with an alcohol swab. Insert the syringe needle into the vial through the center of the rubber stopper and direct the stream of Sterile Water for Injection, USP, to the glass wall of the vial. Gently swirl the solution by rotating the vial to dissolve the lyophilized powder. Avoid prolonged or vigorous agitation. **DO NOT SHAKE.** Foaming of the solution on reconstitution is not unusual. Allow the reconstituted solution to stand for 5 minutes. The solution should be colorless to light yellow and opalescent, and the solution may develop a few translucent particles as infliximab is a protein. Do not use if the lyophilized cake has not fully dissolved or if opaque particles, discoloration, or other foreign particles are present.
3. Dilute the total volume of the reconstituted REMICADE solution dose to 250 mL with sterile 0.9% Sodium Chloride Injection, USP, by withdrawing a volume equal to the volume of reconstituted REMICADE from the 0.9% Sodium Chloride Injection, USP, 250 mL bottle or bag. Slowly add the total volume of reconstituted REMICADE solution to the 250 mL infusion bottle or bag. Gently mix. The resulting infusion concentration should range between 0.4 mg/mL and 4 mg/mL.
4. The infusion solution must be administered over a period of not less than 2 hours and must use an infusion set with an in-line, sterile, non-pyrogenic, low-protein-binding filter (pore size of 1.2 μm or less). The vials do not contain antibacterial preservatives. Therefore, any unused portion of the infusion solution should not be stored for reuse.
5. No physical biochemical compatibility studies have been conducted to evaluate the co-administration of REMICADE with other agents. REMICADE should not be infused concomitantly in the same intravenous line with other agents.
6. Parenteral drug products should be inspected visually before and after reconstitution for particulate matter and discoloration prior to administration, whenever solution and

container permit. If visibly opaque particles, discoloration or other foreign particulates are observed, the solution should not be used.

3 DOSAGE FORMS AND STRENGTHS

100 mg vial: 100 mg lyophilized infliximab in a 20 mL vial.

4 CONTRAINDICATIONS

REMICADE at doses >5 mg/kg should not be administered to patients with moderate to severe heart failure. In a randomized study evaluating REMICADE in patients with moderate to severe heart failure (New York Heart Association [NYHA] Functional Class III/IV), REMICADE treatment at 10 mg/kg was associated with an increased incidence of death and hospitalization due to worsening heart failure [*see Warnings and Precautions (5.5) and Adverse Reactions (6.1)*].

REMICADE should not be re-administered to patients who have experienced a severe hypersensitivity reaction to REMICADE. Additionally, REMICADE should not be administered to patients with known hypersensitivity to inactive components of the product or to any murine proteins.

5 WARNINGS AND PRECAUTIONS (see Boxed WARNINGS)

5.1 Serious Infections

Serious and sometimes fatal infections due to bacterial, mycobacterial, invasive fungal, viral, or other opportunistic pathogens have been reported in patients receiving TNF-blocking agents. Among opportunistic infections, tuberculosis, histoplasmosis, aspergillosis, candidiasis, coccidioidomycosis, listeriosis, and pneumocystosis were the most commonly reported. Patients have frequently presented with disseminated rather than localized disease, and are often taking concomitant immunosuppressants such as methotrexate or corticosteroids with REMICADE.

Treatment with REMICADE should not be initiated in patients with an active infection, including clinically important localized infections. The risks and benefits of treatment should be considered prior to initiating therapy in patients:

- with chronic or recurrent infection;
- who have been exposed to tuberculosis;
- who have resided or traveled in areas of endemic tuberculosis or endemic mycoses, such as histoplasmosis, coccidioidomycosis, or blastomycosis; or
- with underlying conditions that may predispose them to infection.

Cases of reactivation of tuberculosis or new tuberculosis infections have been observed in patients receiving REMICADE, including patients who have previously received treatment for latent or active tuberculosis. Patients should be evaluated for tuberculosis risk factors and tested for latent infection prior to initiating REMICADE and periodically during therapy.

Treatment of latent tuberculosis infection prior to therapy with TNF blocking agents has been shown to reduce the risk of tuberculosis reactivation during therapy. Induration of 5 mm or greater with tuberculin skin testing should be considered a positive test result when assessing if

treatment for latent tuberculosis is needed prior to initiating REMICADE, even for patients previously vaccinated with Bacille Calmette-Guerin (BCG).

Anti-tuberculosis therapy should also be considered prior to initiation of REMICADE in patients with a past history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed, and for patients with a negative test for latent tuberculosis but having risk factors for tuberculosis infection. Consultation with a physician with expertise in the treatment of tuberculosis is recommended to aid in the decision whether initiating anti-tuberculosis therapy is appropriate for an individual patient.

Tuberculosis should be strongly considered in patients who develop a new infection during REMICADE treatment, especially in patients who have previously or recently traveled to countries with a high prevalence of tuberculosis, or who have had close contact with a person with active tuberculosis.

Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with REMICADE, including the development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy. Tests for latent tuberculosis infection may also be falsely negative while on therapy with REMICADE.

REMICADE should be discontinued if a patient develops a serious infection or sepsis. A patient who develops a new infection during treatment with REMICADE should be closely monitored, undergo a prompt and complete diagnostic workup appropriate for an immunocompromised patient, and appropriate antimicrobial therapy should be initiated.

For patients who reside or travel in regions where mycoses are endemic, invasive fungal infection should be suspected if they develop a serious systemic illness. Appropriate empiric antifungal therapy should be considered while a diagnostic workup is being performed. Antigen and antibody testing for histoplasmosis may be negative in some patients with active infection. When feasible, the decision to administer empiric antifungal therapy in these patients should be made in consultation with a physician with expertise in the diagnosis and treatment of invasive fungal infections and should take into account both the risk for severe fungal infection and the risks of antifungal therapy.

5.2 Malignancies

Malignancies, some fatal, have been reported among children, adolescents and young adults who received treatment with TNF-blocking agents (initiation of therapy \leq 18 years of age), including REMICADE. Approximately half of these cases were lymphomas, including Hodgkin's and non-Hodgkin's lymphoma. The other cases represented a variety of malignancies, including rare malignancies that are usually associated with immunosuppression and malignancies that are not usually observed in children and adolescents. The malignancies occurred after a median of 30 months (range 1 to 84 months) after the first dose of TNF blocker therapy. Most of the patients were receiving concomitant immunosuppressants. These cases were reported post-marketing and are derived from a variety of sources, including registries and spontaneous postmarketing reports.

Postmarketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma, have been reported in patients treated with TNF blockers including REMICADE. These cases have had a very aggressive disease course and have been fatal. All reported REMICADE cases have occurred in patients with Crohn's disease or ulcerative colitis and the majority were in adolescent and young adult males. All of these patients had received treatment with the immunosuppressants azathioprine or 6-mercaptopurine concomitantly with REMICADE at or prior to diagnosis. It is uncertain whether the occurrence of HSTCL is related to REMICADE or REMICADE in combination with these other immunosuppressants. When treating patients with inflammatory bowel disease, particularly in adolescents and young adults, consideration of whether to use REMICADE alone or in combination with other immunosuppressants should take into account a possibility that there is a higher risk of HSTCL with combination therapy versus an observed increased risk of immunogenicity and hypersensitivity reactions with REMICADE monotherapy from the clinical trial data [*see Warnings and Precautions (5.7) and Adverse Reactions, Immunogenicity (6.1)*].

In the controlled portions of clinical trials of some TNF-blocking agents including REMICADE, more malignancies (excluding lymphoma and nonmelanoma skin cancer [NMSC]) have been observed in patients receiving those TNF-blockers compared with control patients. During the controlled portions of REMICADE trials in patients with moderately to severely active rheumatoid arthritis, Crohn's disease, psoriatic arthritis, ankylosing spondylitis, ulcerative colitis, and plaque psoriasis, 14 patients were diagnosed with malignancies (excluding lymphoma and NMSC) among 4019 REMICADE-treated patients vs. 1 among 1597 control patients (at a rate of 0.52/100 patient-years among REMICADE-treated patients vs. a rate of 0.11/100 patient-years among control patients), with median duration of follow-up 0.5 years for REMICADE-treated patients and 0.4 years for control patients. Of these, the most common malignancies were breast, colorectal, and melanoma. The rate of malignancies among REMICADE-treated patients was similar to that expected in the general population whereas the rate in control patients was lower than expected.

In the controlled portions of clinical trials of all the TNF-blocking agents, more cases of lymphoma have been observed among patients receiving a TNF blocker compared with control patients. In the controlled and open-label portions of REMICADE clinical trials, 5 patients developed lymphomas among 5707 patients treated with REMICADE (median duration of follow-up 1.0 years) vs. 0 lymphomas in 1600 control patients (median duration of follow-up 0.4 years). In rheumatoid arthritis patients, 2 lymphomas were observed for a rate of 0.08 cases per 100 patient-years of follow-up, which is approximately three-fold higher than expected in the general population. In the combined clinical trial population for rheumatoid arthritis, Crohn's disease, psoriatic arthritis, ankylosing spondylitis, ulcerative colitis, and plaque psoriasis, 5 lymphomas were observed for a rate of 0.10 cases per 100 patient-years of follow-up, which is approximately four-fold higher than expected in the general population. Patients with Crohn's disease, rheumatoid arthritis or plaque psoriasis, particularly patients with highly active disease and/or chronic exposure to immunosuppressant therapies, may be at a higher risk (up to several fold) than the general population for the development of lymphoma, even in the absence of TNF-blocking therapy. Cases of acute and chronic leukemia have been reported with postmarketing TNF-blocker use in rheumatoid arthritis and other indications. Even in the absence of TNF

blocker therapy, patients with rheumatoid arthritis may be at a higher risk (approximately 2-fold) than the general population for the development of leukemia.

In a clinical trial exploring the use of REMICADE in patients with moderate to severe chronic obstructive pulmonary disease (COPD), more malignancies, the majority of lung or head and neck origin, were reported in REMICADE-treated patients compared with control patients. All patients had a history of heavy smoking [*see Adverse Reactions (6.1)*]. Prescribers should exercise caution when considering the use of REMICADE in patients with moderate to severe COPD.

Psoriasis patients should be monitored for nonmelanoma skin cancers (NMSCs), particularly those patients who have had prior prolonged phototherapy treatment. In the maintenance portion of clinical trials for REMICADE, NMSCs were more common in patients with previous phototherapy [*see Adverse Reactions (6.1)*].

The potential role of TNF-blocking therapy in the development of malignancies is not known [*see Adverse Reactions (6.1)*]. Rates in clinical trials for REMICADE cannot be compared to rates in clinical trials of other TNF-blockers and may not predict rates observed in a broader patient population. Caution should be exercised in considering REMICADE treatment in patients with a history of malignancy or in continuing treatment in patients who develop malignancy while receiving REMICADE.

5.3 Hepatitis B Virus Reactivation

Use of TNF blockers, including REMICADE, has been associated with reactivation of hepatitis B virus (HBV) in patients who are chronic carriers of this virus. In some instances, HBV reactivation occurring in conjunction with TNF blocker therapy has been fatal. The majority of these reports have occurred in patients concomitantly receiving other medications that suppress the immune system, which may also contribute to HBV reactivation. Patients at risk for HBV infection should be evaluated for prior evidence of HBV infection before initiating TNF blocker therapy. Prescribers should exercise caution in prescribing TNF blockers, including REMICADE, for patients identified as carriers of HBV. Adequate data are not available on the safety or efficacy of treating patients who are carriers of HBV with anti-viral therapy in conjunction with TNF blocker therapy to prevent HBV reactivation. Patients who are carriers of HBV and require treatment with TNF blockers should be closely monitored for clinical and laboratory signs of active HBV infection throughout therapy and for several months following termination of therapy. In patients who develop HBV reactivation, TNF blockers should be stopped and antiviral therapy with appropriate supportive treatment should be initiated. The safety of resuming TNF blocker therapy after HBV reactivation is controlled is not known. Therefore, prescribers should exercise caution when considering resumption of TNF blocker therapy in this situation and monitor patients closely.

5.4 Hepatotoxicity

Severe hepatic reactions, including acute liver failure, jaundice, hepatitis and cholestasis, have been reported rarely in postmarketing data in patients receiving REMICADE. Autoimmune hepatitis has been diagnosed in some of these cases. Severe hepatic reactions occurred between 2 weeks to more than 1 year after initiation of REMICADE; elevations in hepatic aminotransferase

levels were not noted prior to discovery of the liver injury in many of these cases. Some of these cases were fatal or necessitated liver transplantation. Patients with symptoms or signs of liver dysfunction should be evaluated for evidence of liver injury. If jaundice and/or marked liver enzyme elevations (e.g., ≥ 5 times the upper limit of normal) develop, REMICADE should be discontinued, and a thorough investigation of the abnormality should be undertaken. In clinical trials, mild or moderate elevations of ALT and AST have been observed in patients receiving REMICADE without progression to severe hepatic injury [*see Adverse Reactions (6.1)*].

5.5 Patients with Heart Failure

REMICADE has been associated with adverse outcomes in patients with heart failure, and should be used in patients with heart failure only after consideration of other treatment options. The results of a randomized study evaluating the use of REMICADE in patients with heart failure (NYHA Functional Class III/IV) suggested higher mortality in patients who received 10 mg/kg REMICADE, and higher rates of cardiovascular adverse events at doses of 5 mg/kg and 10 mg/kg. There have been post-marketing reports of worsening heart failure, with and without identifiable precipitating factors, in patients taking REMICADE. There have also been rare post-marketing reports of new onset heart failure, including heart failure in patients without known pre-existing cardiovascular disease. Some of these patients have been under 50 years of age. If a decision is made to administer REMICADE to patients with heart failure, they should be closely monitored during therapy, and REMICADE should be discontinued if new or worsening symptoms of heart failure appear [*see Contraindications (4) and Adverse Reactions (6.1)*].

5.6 Hematologic Events

Cases of leukopenia, neutropenia, thrombocytopenia, and pancytopenia, some with a fatal outcome, have been reported in patients receiving REMICADE. The causal relationship to REMICADE therapy remains unclear. Although no high-risk group(s) has been identified, caution should be exercised in patients being treated with REMICADE who have ongoing or a history of significant hematologic abnormalities. All patients should be advised to seek immediate medical attention if they develop signs and symptoms suggestive of blood dyscrasias or infection (e.g., persistent fever) while on REMICADE. Discontinuation of REMICADE therapy should be considered in patients who develop significant hematologic abnormalities.

5.7 Hypersensitivity

REMICADE has been associated with hypersensitivity reactions that vary in their time of onset and required hospitalization in some cases. Most hypersensitivity reactions, which include urticaria, dyspnea, and/or hypotension, have occurred during or within 2 hours of REMICADE infusion.

However, in some cases, serum sickness-like reactions have been observed in patients after initial REMICADE therapy (i.e., as early as after the second dose), and when REMICADE therapy was reinstated following an extended period without REMICADE treatment. Symptoms associated with these reactions include fever, rash, headache, sore throat, myalgias, polyarthralgias, hand and facial edema and/or dysphagia. These reactions were associated with a marked increase in antibodies to infliximab, loss of detectable serum concentrations of infliximab, and possible loss of drug efficacy.

REMICADE should be discontinued for severe hypersensitivity reactions. Medications for the treatment of hypersensitivity reactions (e.g., acetaminophen, antihistamines, corticosteroids and/or epinephrine) should be available for immediate use in the event of a reaction [*see Adverse Reactions (6.1)*].

In rheumatoid arthritis, Crohn's disease and psoriasis clinical trials, re-administration of REMICADE after a period of no treatment resulted in a higher incidence of infusion reactions relative to regular maintenance treatment [*see Adverse Reactions (6.1)*]. In general, the benefit-risk of re-administration of REMICADE after a period of no-treatment, especially as a re-induction regimen given at weeks 0, 2 and 6, should be carefully considered. In the case where REMICADE maintenance therapy for psoriasis is interrupted, REMICADE should be reinitiated as a single dose followed by maintenance therapy.

5.8 Neurologic Events

REMICADE and other agents that inhibit TNF have been associated in rare cases with CNS manifestation of systemic vasculitis, seizure and new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disorders, including multiple sclerosis and optic neuritis, and peripheral demyelinating disorders, including Guillain-Barré syndrome. Prescribers should exercise caution in considering the use of REMICADE in patients with these neurologic disorders and should consider discontinuation of REMICADE if these disorders develop.

5.9 Use with Anakinra

Serious infections and neutropenia were seen in clinical studies with concurrent use of anakinra and another TNF α -blocking agent, etanercept, with no added clinical benefit compared to etanercept alone. Because of the nature of the adverse events seen with the combination of etanercept and anakinra therapy, similar toxicities may also result from the combination of anakinra and other TNF α -blocking agents. Therefore, the combination of REMICADE and anakinra is not recommended.

5.10 Use with Abatacept

In clinical studies, concurrent administration of TNF-blocking agents and abatacept have been associated with an increased risk of infections including serious infections compared with TNF-blocking agents alone, without increased clinical benefit. Therefore, the combination of REMICADE and abatacept is not recommended [*see Drug Interactions (7.1)*].

5.11 Switching between Biological Disease-Modifying Antirheumatic Drugs (DMARDs)

Care should be taken when switching from one biologic to another, since overlapping biological activity may further increase the risk of infection.

5.12 Autoimmunity

Treatment with REMICADE may result in the formation of autoantibodies and, rarely, in the development of a lupus-like syndrome. If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with REMICADE, treatment should be discontinued [*see Adverse Reactions (6.1)*].

5.13 Vaccinations

No data are available on the response to vaccination with live vaccines or on the secondary transmission of infection by live vaccines in patients receiving anti-TNF therapy. It is recommended that live vaccines not be given concurrently.

It is recommended that all pediatric Crohn's disease patients be brought up to date with all vaccinations prior to initiating REMICADE therapy. The interval between vaccination and initiation of REMICADE therapy should be in accordance with current vaccination guidelines.

6 ADVERSE REACTIONS

6.1 Clinical Studies Experience

The data described herein reflect exposure to REMICADE in 4779 adult patients (1304 patients with rheumatoid arthritis, 1106 patients with Crohn's disease, 202 with ankylosing spondylitis, 293 with psoriatic arthritis, 484 with ulcerative colitis, 1373 with plaque psoriasis, and 17 patients with other conditions), including 2625 patients exposed beyond 30 weeks and 374 exposed beyond 1 year. *[For information on adverse reactions in pediatric patients see Adverse Reactions (6.1).]* One of the most-common reasons for discontinuation of treatment was infusion-related reactions (e.g., dyspnea, flushing, headache and rash). Adverse events have been reported in a higher proportion of rheumatoid arthritis patients receiving the 10 mg/kg dose than the 3 mg/kg dose, however, no differences were observed in the frequency of adverse events between the 5 mg/kg dose and 10 mg/kg dose in patients with Crohn's disease.

Infusion-related Reactions

An infusion reaction was defined in clinical trials as any adverse event occurring during an infusion or within 1 to 2 hours after an infusion. Approximately 20% of REMICADE-treated patients in all clinical studies experienced an infusion reaction compared to approximately 10% of placebo-treated patients. Among all REMICADE infusions, 3% were accompanied by nonspecific symptoms such as fever or chills, 1% were accompanied by cardiopulmonary reactions (primarily chest pain, hypotension, hypertension or dyspnea), and <1% were accompanied by pruritus, urticaria, or the combined symptoms of pruritus/urticaria and cardiopulmonary reactions. Serious infusion reactions occurred in <1% of patients and included anaphylaxis, convulsions, erythematous rash and hypotension. Approximately 3% of patients discontinued REMICADE because of infusion reactions, and all patients recovered with treatment and/or discontinuation of the infusion. REMICADE infusions beyond the initial infusion were not associated with a higher incidence of reactions. The infusion reaction rates remained stable in psoriasis through 1 year in psoriasis Study I. In psoriasis Study II, the rates were variable over time and somewhat higher following the final infusion than after the initial infusion. Across the 3 psoriasis studies, the percent of total infusions resulting in infusion reactions (i.e., an adverse event occurring within 1 to 2 hours) was 7% in the 3 mg/kg group, 4% in the 5 mg/kg group, and 1% in the placebo group.

Patients who became positive for antibodies to infliximab were more likely (approximately two- to three-fold) to have an infusion reaction than were those who were negative. Use of concomitant immunosuppressant agents appeared to reduce the frequency of both antibodies to infliximab and infusion reactions *[see Adverse Reactions (6.1) and Drug Interactions (7.3)]*.

Infusion reactions following re-administration

In a clinical trial of patients with moderate to severe psoriasis designed to assess the efficacy of long-term maintenance therapy versus re-treatment with an induction regimen of REMICADE following disease flare, 4% (8/219) of patients in the re-treatment therapy arm experienced serious infusion reactions versus < 1% (1/222) in the maintenance therapy arm. Patients enrolled in this trial did not receive any concomitant immunosuppressant therapy. In this study, the majority of serious infusion reactions occurred during the second infusion at Week 2. Symptoms included, but were not limited to, dyspnea, urticaria, facial edema, and hypotension. In all cases, REMICADE treatment was discontinued and/or other treatment instituted with complete resolution of signs and symptoms.

Delayed Reactions/Reactions Following Re-administration

Plaque Psoriasis

In psoriasis studies, approximately 1% of REMICADE-treated patients experienced a possible delayed hypersensitivity reaction, generally reported as serum sickness or a combination of arthralgia and/or myalgia with fever and/or rash. These reactions generally occurred within 2 weeks after repeat infusion.

Crohn's disease

In a study where 37 of 41 patients with Crohn's disease were retreated with infliximab following a 2- to 4-year period without infliximab treatment, 10 patients experienced adverse events manifesting 3 to 12 days following infusion of which 6 were considered serious. Signs and symptoms included myalgia and/or arthralgia with fever and/or rash, with some patients also experiencing pruritus, facial, hand or lip edema, dysphagia, urticaria, sore throat, and headache. Patients experiencing these adverse events had not experienced infusion-related adverse events associated with their initial infliximab therapy. These adverse events occurred in 39% (9/23) of patients who had received liquid formulation which is no longer in use and 7% (1/14) of patients who received lyophilized formulation. The clinical data are not adequate to determine if occurrence of these reactions is due to differences in formulation. Patients' signs and symptoms improved substantially or resolved with treatment in all cases. There are insufficient data on the incidence of these events after drug-free intervals of 1 to 2 years. These events have been observed only infrequently in clinical studies and post-marketing surveillance with retreatment intervals up to 1 year.

Infections

In REMICADE clinical studies, treated infections were reported in 36% of REMICADE-treated patients (average of 51 weeks of follow-up) and in 25% of placebo-treated patients (average of 37 weeks of follow-up). The infections most frequently reported were respiratory tract infections (including sinusitis, pharyngitis, and bronchitis) and urinary tract infections. Among REMICADE-treated patients, serious infections included pneumonia, cellulitis, abscess, skin ulceration, sepsis, and bacterial infection. In clinical trials, 7 opportunistic infections were reported; 2 cases each of coccidioidomycosis (1 case was fatal) and histoplasmosis (1 case was fatal), and 1 case each of pneumocystosis, nocardiosis and cytomegalovirus. Tuberculosis was reported in 14 patients, 4 of whom died due to miliary tuberculosis. Other cases of tuberculosis, including disseminated tuberculosis, also have been reported post-marketing. Most of these cases of tuberculosis occurred within the first 2 months after initiation of therapy with REMICADE

and may reflect recrudescence of latent disease [see *Warnings and Precautions (5.1)*]. In the 1-year placebo-controlled studies RA I and RA II, 5.3% of patients receiving REMICADE every 8 weeks with MTX developed serious infections as compared to 3.4% of placebo patients receiving MTX. Of 924 patients receiving REMICADE, 1.7% developed pneumonia and 0.4% developed TB, when compared to 0.3% and 0.0% in the placebo arm respectively. In a shorter (22-week) placebo-controlled study of 1082 RA patients randomized to receive placebo, 3 mg/kg or 10 mg/kg REMICADE infusions at 0, 2, and 6 weeks, followed by every 8 weeks with MTX, serious infections were more frequent in the 10 mg/kg REMICADE group (5.3%) than the 3 mg/kg or placebo groups (1.7% in both). During the 54-week Crohn's II Study, 15% of patients with fistulizing Crohn's disease developed a new fistula-related abscess.

In REMICADE clinical studies in patients with ulcerative colitis, infections treated with antimicrobials were reported in 27% of REMICADE-treated patients (average of 41 weeks of follow-up) and in 18% of placebo-treated patients (average 32 weeks of follow-up). The types of infections, including serious infections, reported in patients with ulcerative colitis were similar to those reported in other clinical studies.

In post-marketing experience in the various indications, infections have been observed with various pathogens including viral, bacterial, fungal, and protozoal organisms. Infections have been noted in all organ systems and have been reported in patients receiving REMICADE alone or in combination with immunosuppressive agents.

The onset of serious infections may be preceded by constitutional symptoms such as fever, chills, weight loss, and fatigue. The majority of serious infections, however, may also be preceded by signs or symptoms localized to the site of the infection.

Autoantibodies/Lupus-like Syndrome

Approximately half of REMICADE-treated patients in clinical trials who were antinuclear antibody (ANA) negative at baseline developed a positive ANA during the trial compared with approximately one-fifth of placebo-treated patients. Anti-dsDNA antibodies were newly detected in approximately one-fifth of REMICADE-treated patients compared with 0% of placebo-treated patients. Reports of lupus and lupus-like syndromes, however, remain uncommon.

Malignancies

In controlled trials, more REMICADE-treated patients developed malignancies than placebo-treated patients [see *Warnings and Precautions (5.2)*].

In a randomized controlled clinical trial exploring the use of REMICADE in patients with moderate to severe COPD who were either current smokers or ex-smokers, 157 patients were treated with REMICADE at doses similar to those used in rheumatoid arthritis and Crohn's disease. Of these REMICADE-treated patients, 9 developed a malignancy, including 1 lymphoma, for a rate of 7.67 cases per 100 patient-years of follow-up (median duration of follow-up 0.8 years; 95% CI 3.51 - 14.56). There was 1 reported malignancy among 77 control patients for a rate of 1.63 cases per 100 patient-years of follow-up (median duration of follow-up 0.8 years; 95% CI 0.04 - 9.10). The majority of the malignancies developed in the lung or head and neck.

Malignancies, including non-Hodgkin's lymphoma and Hodgkin's disease, have also been reported in patients receiving REMICADE during post-approval use.

Patients with Heart Failure

In a randomized study evaluating REMICADE in moderate to severe heart failure (NYHA Class III/IV; left ventricular ejection fraction $\leq 35\%$), 150 patients were randomized to receive treatment with 3 infusions of REMICADE 10 mg/kg, 5 mg/kg, or placebo, at 0, 2, and 6 weeks. Higher incidences of mortality and hospitalization due to worsening heart failure were observed in patients receiving the 10 mg/kg REMICADE dose. At 1 year, 8 patients in the 10 mg/kg REMICADE group had died compared with 4 deaths each in the 5 mg/kg REMICADE and the placebo groups. There were trends toward increased dyspnea, hypotension, angina, and dizziness in both the 10 mg/kg and 5 mg/kg REMICADE treatment groups, versus placebo. REMICADE has not been studied in patients with mild heart failure (NYHA Class I/II) [*see Contraindications (4) and Warnings and Precautions (5.5)*].

Immunogenicity

Treatment with REMICADE can be associated with the development of antibodies to infliximab. The incidence of antibodies to infliximab in patients given a 3-dose induction regimen followed by maintenance dosing was approximately 10% as assessed through 1 to 2 years of REMICADE treatment. A higher incidence of antibodies to infliximab was observed in Crohn's disease patients receiving REMICADE after drug-free intervals >16 weeks. In a study of psoriatic arthritis in which 191 patients received 5 mg/kg with or without MTX, antibodies to infliximab occurred in 15% of patients. The majority of antibody-positive patients had low titers. Patients who were antibody-positive were more likely to have higher rates of clearance, reduced efficacy and to experience an infusion reaction [*see Adverse Reactions (6.1)*] than were patients who were antibody negative. Antibody development was lower among rheumatoid arthritis and Crohn's disease patients receiving immunosuppressant therapies such as 6-MP/AZA or MTX.

In the psoriasis Study II, which included both the 5 mg/kg and 3 mg/kg doses, antibodies were observed in 36% of patients treated with 5 mg/kg every 8 weeks for 1 year, and in 51% of patients treated with 3 mg/kg every 8 weeks for 1 year. In the psoriasis Study III, which also included both the 5 mg/kg and 3 mg/kg doses, antibodies were observed in 20% of patients treated with 5 mg/kg induction (weeks 0, 2 and 6), and in 27% of patients treated with 3 mg/kg induction. Despite the increase in antibody formation, the infusion reaction rates in Studies I and II in patients treated with 5 mg/kg induction followed by every 8 week maintenance for 1 year and in Study III in patients treated with 5 mg/kg induction (14.1%-23.0%) and serious infusion reaction rates ($<1\%$) were similar to those observed in other study populations. The clinical significance of apparent increased immunogenicity on efficacy and infusion reactions in psoriasis patients as compared to patients with other diseases treated with REMICADE over the long term is not known.

The data reflect the percentage of patients whose test results were positive for antibodies to infliximab in an ELISA assay, and they are highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody positivity in an assay may be influenced by several factors including sample handling, timing of sample collection, concomitant medication, and underlying disease. For these reasons, comparison of the incidence of antibodies to infliximab with the incidence of antibodies to other products may be misleading.

Hepatotoxicity

Severe liver injury, including acute liver failure and autoimmune hepatitis, has been reported rarely in patients receiving REMICADE [see *Warnings and Precautions (5.4)*]. Reactivation of hepatitis B virus has occurred in patients receiving TNF-blocking agents, including REMICADE, who are chronic carriers of this virus [see *Warnings and Precautions (5.3)*].

In clinical trials in rheumatoid arthritis, Crohn’s disease, ulcerative colitis, ankylosing spondylitis, plaque psoriasis, and psoriatic arthritis, elevations of aminotransferases were observed (ALT more common than AST) in a greater proportion of patients receiving REMICADE than in controls (Table 1), both when REMICADE was given as monotherapy and when it was used in combination with other immunosuppressive agents. In general, patients who developed ALT and AST elevations were asymptomatic, and the abnormalities decreased or resolved with either continuation or discontinuation of REMICADE, or modification of concomitant medications.

Table 1 Proportion of patients with elevated ALT in clinical trials

	Proportion of patients with elevated ALT					
	>1 to <3 x ULN		≥3 x ULN		≥5 x ULN	
	Placebo	REMICADE	Placebo	REMICADE	Placebo	REMICADE
Rheumatoid arthritis ^a	24%	34%	3%	4%	<1%	<1%
Crohn’s disease ^b	34%	39%	4%	5%	0%	2%
Ulcerative colitis ^c	12%	17%	1%	2%	<1%	<1%
Ankylosing spondylitis ^d	15%	51%	0%	10%	0%	4%
Psoriatic arthritis ^e	16%	50%	0%	7%	0%	2%
Plaque psoriasis ^f	24%	49%	<1%	8%	0%	3%

^aPlacebo patients received methotrexate while REMICADE patients received both REMICADE and methotrexate. Median follow-up was 58 weeks.

^bPlacebo patients in the 2 Phase 3 trials in Crohn’s disease received an initial dose of 5 mg/kg REMICADE at study start and were on placebo in the maintenance phase. Patients who were randomized to the placebo maintenance group and then later crossed over to REMICADE are included in the REMICADE group in ALT analysis. Median follow-up was 54 weeks.

^cMedian follow-up was 30 weeks. Specifically, the median duration of follow-up was 30 weeks for placebo and 31 weeks for REMICADE.

^dMedian follow-up was 24 weeks for the placebo group and 102 weeks for the REMICADE group.

^eMedian follow-up was 39 weeks for the REMICADE group and 18 weeks for the placebo group.

^fALT values are obtained in 2 Phase 3 psoriasis studies with median follow-up of 50 weeks for REMICADE and 16 weeks for placebo.

Adverse Reactions in Pediatric Crohn's Disease

There were some differences in the adverse reactions observed in the pediatric patients receiving REMICADE compared to those observed in adults with Crohn's disease. These differences are discussed in the following paragraphs.

The following adverse events were reported more commonly in 103 randomized pediatric Crohn's disease patients administered 5 mg/kg REMICADE through 54 weeks than in 385 adult Crohn's disease patients receiving a similar treatment regimen: anemia (11%), blood in stool (10%), leukopenia (9%), flushing (9%), viral infection (8%), neutropenia (7%), bone fracture (7%), bacterial infection (6%), and respiratory tract allergic reaction (6%).

Infections were reported in 56% of randomized pediatric patients in Study Peds Crohn's and in 50% of adult patients in Study Crohn's I. In Study Peds Crohn's, infections were reported more frequently for patients who received every 8-week as opposed to every 12-week infusions (74% and 38%, respectively), while serious infections were reported for 3 patients in the every 8-week and 4 patients in the every 12-week maintenance treatment group. The most commonly reported infections were upper respiratory tract infection and pharyngitis, and the most commonly reported serious infection was abscess. Pneumonia was reported for 3 patients, (2 in the every 8-week and 1 in the every 12-week maintenance treatment groups). Herpes zoster was reported for 2 patients in the every 8-week maintenance treatment group.

In Study Peds Crohn's, 18% of randomized patients experienced 1 or more infusion reactions, with no notable difference between treatment groups. Of the 112 patients in Study Peds Crohn's, there were no serious infusion reactions, and 2 patients had non-serious anaphylactoid reactions.

In Study Peds Crohn's, in which all patients received stable doses of 6-MP, AZA, or MTX, 3% (3/105) of patients developed antibodies to REMICADE.

Elevations of ALT up to 3 times the upper limit of normal (ULN) were seen in 18% of pediatric patients in Crohn's disease clinical trials; 4% had ALT elevations ≥ 3 x ULN, and 1% had elevations ≥ 5 x ULN. (Median follow-up was 53 weeks.)

Adverse Reactions in Psoriasis Studies

During the placebo-controlled portion across the 3 clinical trials up to week 16, the proportion of patients who experienced at least 1 SAE (defined as resulting in death, life threatening, requires hospitalization, or persistent or significant disability/incapacity) was 1.7% in the 3 mg/kg REMICADE group, 3.2% in the placebo group, and 3.9% in the 5 mg/kg REMICADE group.

Among patients in the 2 Phase 3 studies, 12.4% of patients receiving REMICADE 5 mg/kg every 8 weeks through 1 year of maintenance treatment experienced at least 1 SAE in Study I. In Study II, 4.1% and 4.7% of patients receiving REMICADE 3 mg/kg and 5 mg/kg every 8 weeks, respectively, through 1 year of maintenance treatment experienced at least 1 SAE.

One death due to bacterial sepsis occurred 25 days after the second infusion of 5 mg/kg REMICADE. Serious infections included sepsis, and abscesses. In Study I, 2.7% of patients receiving REMICADE 5 mg/kg every 8 weeks through 1 year of maintenance treatment

experienced at least 1 serious infection. In Study II, 1.0% and 1.3% of patients receiving REMICADE 3 mg/kg and 5 mg/kg, respectively, through 1 year of treatment experienced at least 1 serious infection. The most common serious infection (requiring hospitalization) was abscess (skin, throat, and peri-rectal) reported by 5 (0.7%) patients in the 5 mg/kg REMICADE group. Two active cases of tuberculosis were reported: 6 weeks and 34 weeks after starting REMICADE.

In the placebo-controlled portion of the psoriasis studies, 7 of 1123 patients who received REMICADE at any dose were diagnosed with at least one NMSC compared to 0 of 334 patients who received placebo.

In the psoriasis studies, 1% (15/1373) of patients experienced serum sickness or a combination of arthralgia and/or myalgia with fever, and/or rash, usually early in the treatment course. Of these patients, 6 required hospitalization due to fever, severe myalgia, arthralgia, swollen joints, and immobility.

Other Adverse Reactions

Safety data are available from 4779 REMICADE-treated adult patients, including 1304 with rheumatoid arthritis, 1106 with Crohn's disease, 484 with ulcerative colitis, 202 with ankylosing spondylitis, 293 with psoriatic arthritis, 1373 with plaque psoriasis and 17 with other conditions. *[For information on other adverse reactions in pediatric patients, see Adverse Reactions (6.1)].* Adverse events reported in $\geq 5\%$ of all patients with rheumatoid arthritis receiving 4 or more infusions are in Table 2. The types and frequencies of adverse reactions observed were similar in REMICADE-treated rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis, plaque psoriasis and Crohn's disease patients except for abdominal pain, which occurred in 26% of REMICADE-treated patients with Crohn's disease. In the Crohn's disease studies, there were insufficient numbers and duration of follow-up for patients who never received REMICADE to provide meaningful comparisons.

Table 2 Adverse reactions occurring in 5% or more of patients receiving 4 or more infusions for rheumatoid arthritis

	Placebo (n=350)	REMICADE (n=1129)
Average weeks of follow-up	59	66
Gastrointestinal		
Nausea	20%	21%
Abdominal pain	8%	12%
Diarrhea	12%	12%
Dyspepsia	7%	10%
Respiratory		
Upper respiratory tract infection	25%	32%
Sinusitis	8%	14%
Pharyngitis	8%	12%
Coughing	8%	12%
Bronchitis	9%	10%
Skin and appendages disorders		
Rash	5%	10%
Pruritus	2%	7%
Body as a whole-general disorders		
Fatigue	7%	9%
Pain	7%	8%
Resistance mechanism disorders		
Fever	4%	7%
Moniliasis	3%	5%
Central and peripheral nervous system disorders		
Headache	14%	18%
Musculoskeletal system disorders		
Arthralgia	7%	8%
Urinary system disorders		
Urinary tract infection	6%	8%
Cardiovascular disorders, general		
Hypertension	5%	7%

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

The most common serious adverse reactions observed in clinical trials were infections [see *Adverse Reactions (6.1)*]. Other serious, medically relevant adverse reactions $\geq 0.2\%$ or clinically significant adverse reactions by body system were as follows:

Body as a whole: allergic reaction, edema
Blood: pancytopenia
Cardiovascular: hypotension
Gastrointestinal: constipation, intestinal obstruction
Central and Peripheral Nervous: dizziness
Heart Rate and Rhythm: bradycardia
Liver and Biliary: hepatitis
Metabolic and Nutritional: dehydration
Platelet, Bleeding and Clotting: thrombocytopenia
Neoplasms: lymphoma
Red Blood Cell: anemia, hemolytic anemia
Resistance Mechanism: cellulitis, sepsis, serum sickness
Respiratory: lower respiratory tract infection (including pneumonia), pleurisy, pulmonary edema
Skin and Appendages: increased sweating
Vascular (Extracardiac): thrombophlebitis
White Cell and Reticuloendothelial: leukopenia, lymphadenopathy

6.2 Post-marketing Experience

Adverse reactions have been reported during post approval use of REMICADE in adult and pediatric patients. Because these events are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to REMICADE exposure.

The following adverse reactions, some with fatal outcome, have been reported during post-approval use of REMICADE: neutropenia [*see Warnings and Precautions (5.6)*], interstitial lung disease (including pulmonary fibrosis/interstitial pneumonitis and very rare rapidly progressive disease), idiopathic thrombocytopenic purpura, thrombotic thrombocytopenic purpura, pericardial effusion, systemic and cutaneous vasculitis, erythema multiforme, Stevens-Johnson Syndrome, toxic epidermal necrolysis, peripheral demyelinating disorders (such as Guillain-Barré syndrome, chronic inflammatory demyelinating polyneuropathy, and multifocal motor neuropathy), new onset and worsening psoriasis (all subtypes including pustular, primarily palmoplantar), transverse myelitis, and neuropathies (additional neurologic events have also been observed) [*see Warnings and Precautions (5.8)*] and acute liver failure, jaundice, hepatitis, and cholestasis [*see Warnings and Precautions (5.4)*].

Infusion-related Reactions

In post-marketing experience, cases of anaphylactic-like reactions, including laryngeal/pharyngeal edema and severe bronchospasm, and seizure have been associated with REMICADE administration.

Cases of myocardial ischemia/infarction and transient visual loss have also been rarely reported in association with REMICADE during or within 2 hours of infusion.

Adverse Reactions in Pediatric Patients

The following serious adverse reactions have been reported in the post-marketing experience in children: infections (some fatal) including opportunistic infections and tuberculosis, infusion reactions, and hypersensitivity reactions.

Serious adverse reactions in the post-marketing experience with REMICADE in the pediatric population have also included malignancies, including hepatosplenic T-cell lymphomas [*see Boxed WARNINGS and Warnings and Precautions (5.2)*], transient hepatic enzyme abnormalities, lupus-like syndromes, and the development of autoantibodies.

7 DRUG INTERACTIONS

7.1 Use with Anakinra or Abatacept

An increased risk of serious infections was seen in clinical studies of other TNF α -blocking agents used in combination with anakinra or abatacept, with no added clinical benefit. Because of the nature of the adverse events seen with these combinations with TNF-blocker therapy, similar toxicities may also result from the combination of anakinra or abatacept with other TNF α -blocking agents. Therefore, the combination of REMICADE and anakinra or abatacept is not recommended [*see Warnings and Precautions (5.9 and 5.10)*].

7.2 Use with Tocilizumab

The use of tocilizumab in combination with biological DMARDs such as TNF antagonists, including REMICADE, should be avoided because of the possibility of increased immunosuppression and increased risk of infection.

7.3 Methotrexate (MTX) and Other Concomitant Medications

Specific drug interaction studies, including interactions with MTX, have not been conducted. The majority of patients in rheumatoid arthritis or Crohn's disease clinical studies received one or more concomitant medications. In rheumatoid arthritis, concomitant medications besides MTX were nonsteroidal anti-inflammatory agents (NSAIDs), folic acid, corticosteroids and/or narcotics. Concomitant Crohn's disease medications were antibiotics, antivirals, corticosteroids, 6-MP/AZA and aminosalicylates. In psoriatic arthritis clinical trials, concomitant medications included MTX in approximately half of the patients as well as NSAIDs, folic acid and corticosteroids. Concomitant MTX use may decrease the incidence of anti-infliximab antibody production and increase infliximab concentrations.

7.4 Immunosuppressants

Patients with Crohn's disease who received immunosuppressants tended to experience fewer infusion reactions compared to patients on no immunosuppressants [*see Adverse Reactions (6.1)*]. Serum infliximab concentrations appeared to be unaffected by baseline use of medications for the treatment of Crohn's disease including corticosteroids, antibiotics (metronidazole or ciprofloxacin) and aminosalicylates.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category B. It is not known whether REMICADE can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. REMICADE should be

given to a pregnant woman only if clearly needed. Because infliximab does not cross-react with TNF α in species other than humans and chimpanzees, animal reproduction studies have not been conducted with REMICADE. No evidence of maternal toxicity, embryotoxicity or teratogenicity was observed in a developmental toxicity study conducted in mice using an analogous antibody that selectively inhibits the functional activity of mouse TNF α . Doses of 10 to 15 mg/kg in pharmacodynamic animal models with the anti-TNF analogous antibody produced maximal pharmacologic effectiveness. Doses up to 40 mg/kg were shown to produce no adverse effects in animal reproduction studies.

8.3 Nursing Mothers

It is not known whether REMICADE is excreted in human milk or absorbed systemically after ingestion. Because many drugs and immunoglobulins are excreted in human milk, and because of the potential for adverse reactions in nursing infants from REMICADE, women should not breast-feed their infants while taking REMICADE. A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

REMICADE is indicated for reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy [*see Boxed WARNINGS, Warnings and Precautions (5), Indications and Usage (1.1), Dosage and Administration (2.1), Clinical Studies (14.1) and Adverse Reactions (6.1)*].

Remicade has been studied only in combination with conventional immunosuppressive therapy in children with Crohn's disease. REMICADE has not been studied in children with Crohn's disease <6 years of age. Use of REMICADE in the absence of other immunosuppressants may increase the likelihood of infliximab-specific antibody formation and increase the risk of developing hypersensitivity reactions [*see Warnings and Precautions (5.7) and Adverse Reactions, Immunogenicity (6.1)*]. The longer term (greater than 1 year) safety and effectiveness of REMICADE in pediatric Crohn's disease patients have not been established in clinical trials.

Safety and effectiveness of REMICADE in pediatric patients with ulcerative colitis and plaque psoriasis have not been established.

The safety and efficacy of REMICADE in patients with juvenile rheumatoid arthritis (JRA) were evaluated in a multicenter, randomized, placebo-controlled, double-blind study for 14 weeks, followed by a double-blind, all-active treatment extension, for a maximum of 44 weeks. Patients with active JRA between the ages of 4 and 17 years who had been treated with MTX for at least 3 months were enrolled. Concurrent use of folic acid, oral corticosteroids (≤ 0.2 mg/kg/day of prednisone or equivalent), NSAIDs, and/or disease modifying antirheumatic drugs (DMARDs) was permitted.

Doses of 3 mg/kg REMICADE or placebo were administered intravenously at Weeks 0, 2 and 6. Patients randomized to placebo crossed-over to receive 6 mg/kg REMICADE at Weeks 14, 16,

and 20, and then every 8 weeks through Week 44. Patients who completed the study continued to receive open-label treatment with REMICADE for up to 2 years in a companion extension study.

The study failed to establish the efficacy of REMICADE in the treatment of JRA. Key observations in the study included a high placebo response rate and a higher rate of immunogenicity than what has been observed in adults. Additionally, a higher rate of clearance of infliximab was observed than had been observed in adults [see *Clinical Pharmacology (12.3)*].

A total of 60 patients with JRA were treated with doses of 3 mg/kg and 57 patients were treated with doses of 6 mg/kg. The proportion of patients with infusion reactions who received 3 mg/kg REMICADE was 35% (21/60) over 52 weeks compared with 18% (10/57) in patients who received 6 mg/kg over 38 weeks. The most common infusion reactions reported were vomiting, fever, headache, and hypotension. In the 3 mg/kg REMICADE group, 4 patients had a serious infusion reaction and 3 patients reported a possible anaphylactic reaction (2 of which were among the serious infusion reactions). In the 6 mg/kg REMICADE group, 2 patients had a serious infusion reaction, 1 of whom had a possible anaphylactic reaction. Two of the 6 patients who experienced serious infusion reactions received REMICADE by rapid infusion (duration of less than 2 hours). Antibodies to infliximab developed in 38% (20/53) of patients who received 3 mg/kg REMICADE compared with 12% (6/49) of patients who received 6 mg/kg.

A total of 68% (41/60) of patients who received 3 mg/kg REMICADE in combination with MTX experienced an infection over 52 weeks compared with 65% (37/57) of patients who received 6 mg/kg REMICADE in combination with MTX over 38 weeks. The most commonly reported infections were upper respiratory tract infection and pharyngitis, and the most commonly reported serious infection was pneumonia. Other notable infections included primary varicella infection in 1 patient and herpes zoster in 1 patient.

8.5 Geriatric Use

In rheumatoid arthritis and plaque psoriasis clinical trials, no overall differences were observed in effectiveness or safety in 181 patients with rheumatoid arthritis and 75 patients with plaque psoriasis, aged 65 or older who received REMICADE, compared to younger patients - although the incidence of serious adverse events in patients aged 65 or older was higher in both REMICADE and control groups compared to younger patients. In Crohn's disease, ulcerative colitis, ankylosing spondylitis and psoriatic arthritis studies, there were insufficient numbers of patients aged 65 and over to determine whether they respond differently from patients aged 18 to 65. Because there is a higher incidence of infections in the elderly population in general, caution should be used in treating the elderly [see *Adverse Reactions (6.1)*].

10 OVERDOSAGE

Single doses up to 20 mg/kg have been administered without any direct toxic effect. In case of overdosage, it is recommended that the patient be monitored for any signs or symptoms of adverse reactions or effects and appropriate symptomatic treatment instituted immediately.

11 DESCRIPTION

Infliximab, the active ingredient in REMICADE, is a chimeric IgG1 κ monoclonal antibody (composed of human constant and murine variable regions) specific for human tumor necrosis factor-alpha (TNF α). It has a molecular weight of approximately 149.1 kilodaltons. Infliximab is produced by a recombinant cell line cultured by continuous perfusion and is purified by a series of steps that includes measures to inactivate and remove viruses.

REMICADE is supplied as a sterile, white, lyophilized powder for intravenous infusion. Following reconstitution with 10 mL of Sterile Water for Injection, USP, the resulting pH is approximately 7.2. Each single-use vial contains 100 mg infliximab, 500 mg sucrose, 0.5 mg polysorbate 80, 2.2 mg monobasic sodium phosphate, monohydrate, and 6.1 mg dibasic sodium phosphate, dihydrate. No preservatives are present.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Infliximab neutralizes the biological activity of TNF α by binding with high affinity to the soluble and transmembrane forms of TNF α and inhibits binding of TNF α with its receptors. Infliximab does not neutralize TNF β (lymphotoxin- α), a related cytokine that utilizes the same receptors as TNF α . Biological activities attributed to TNF α include: induction of pro-inflammatory cytokines such as interleukins (IL) 1 and 6, enhancement of leukocyte migration by increasing endothelial layer permeability and expression of adhesion molecules by endothelial cells and leukocytes, activation of neutrophil and eosinophil functional activity, induction of acute phase reactants and other liver proteins, as well as tissue degrading enzymes produced by synoviocytes and/or chondrocytes. Cells expressing transmembrane TNF α bound by infliximab can be lysed *in vitro* or *in vivo*. Infliximab inhibits the functional activity of TNF α in a wide variety of *in vitro* bioassays utilizing human fibroblasts, endothelial cells, neutrophils, B and T-lymphocytes and epithelial cells. The relationship of these biological response markers to the mechanism(s) by which REMICADE exerts its clinical effects is unknown. Anti-TNF α antibodies reduce disease activity in the cotton-top tamarin colitis model, and decrease synovitis and joint erosions in a murine model of collagen-induced arthritis. Infliximab prevents disease in transgenic mice that develop polyarthritis as a result of constitutive expression of human TNF α , and when administered after disease onset, allows eroded joints to heal.

12.2 Pharmacodynamics

Elevated concentrations of TNF α have been found in involved tissues and fluids of patients with rheumatoid arthritis, Crohn's disease, ulcerative colitis, ankylosing spondylitis, psoriatic arthritis and plaque psoriasis. In rheumatoid arthritis, treatment with REMICADE reduced infiltration of inflammatory cells into inflamed areas of the joint as well as expression of molecules mediating cellular adhesion [E-selectin, intercellular adhesion molecule-1 (ICAM-1) and vascular cell adhesion molecule-1 (VCAM-1)], chemoattraction [IL-8 and monocyte chemoattractant protein (MCP-1)] and tissue degradation [matrix metalloproteinase (MMP) 1 and 3]. In Crohn's disease, treatment with REMICADE reduced infiltration of inflammatory cells and TNF α production in inflamed areas of the intestine, and reduced the proportion of mononuclear cells from the lamina propria able to express TNF α and interferon. After treatment with REMICADE, patients with

rheumatoid arthritis or Crohn's disease exhibited decreased levels of serum IL-6 and C-reactive protein (CRP) compared to baseline. Peripheral blood lymphocytes from REMICADE-treated patients showed no significant decrease in number or in proliferative responses to *in vitro* mitogenic stimulation when compared to cells from untreated patients. In psoriatic arthritis, treatment with REMICADE resulted in a reduction in the number of T-cells and blood vessels in the synovium and psoriatic skin lesions as well as a reduction of macrophages in the synovium. In plaque psoriasis, REMICADE treatment may reduce the epidermal thickness and infiltration of inflammatory cells. The relationship between these pharmacodynamic activities and the mechanism(s) by which REMICADE exerts its clinical effects is unknown.

12.3 Pharmacokinetics

In adults, single intravenous (IV) infusions of 3 mg/kg to 20 mg/kg showed a linear relationship between the dose administered and the maximum serum concentration. The volume of distribution at steady state was independent of dose and indicated that infliximab was distributed primarily within the vascular compartment. Pharmacokinetic results for single doses of 3 mg/kg to 10 mg/kg in rheumatoid arthritis, 5 mg/kg in Crohn's disease, and 3 mg/kg to 5 mg/kg in plaque psoriasis indicate that the median terminal half-life of infliximab is 7.7 to 9.5 days.

Following an initial dose of REMICADE, repeated infusions at 2 and 6 weeks resulted in predictable concentration-time profiles following each treatment. No systemic accumulation of infliximab occurred upon continued repeated treatment with 3 mg/kg or 10 mg/kg at 4- or 8-week intervals. Development of antibodies to infliximab increased infliximab clearance. At 8 weeks after a maintenance dose of 3 to 10 mg/kg of REMICADE, median infliximab serum concentrations ranged from approximately 0.5 to 6 mcg/mL; however, infliximab concentrations were not detectable (<0.1 mcg/mL) in patients who became positive for antibodies to infliximab. No major differences in clearance or volume of distribution were observed in patient subgroups defined by age, weight, or gender. It is not known if there are differences in clearance or volume of distribution in patients with marked impairment of hepatic or renal function.

Infliximab peak and trough concentrations were similar in pediatric (aged 6 to 17 years old) and adult patients with Crohn's disease following the administration of the recommended regimen [*see Dosage and Administration (2.1)*].

Population pharmacokinetic analysis showed that in children with juvenile rheumatoid arthritis (JRA) with a body weight of up to 35 kg receiving 6 mg/kg REMICADE and children with JRA with body weight greater than 35 kg up to adult body weight receiving 3mg/kg REMICADE, the steady state area under the concentration curve (AUC_{ss}) was similar to that observed in adults receiving 3 mg/kg of REMICADE.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

The significance of the results of nonclinical studies for human risk is unknown. A repeat dose toxicity study was conducted with mice given cV1q anti-mouse TNF α to evaluate tumorigenicity. CV1q is an analogous antibody that inhibits the function of TNF α in mice. Animals were assigned to 1 of 3 dose groups: control, 10 mg/kg or 40 mg/kg cV1q given weekly for 6 months. The weekly doses of 10 mg/kg and 40 mg/kg are 2 and 8 times, respectively, the

human dose of 5 mg/kg for Crohn's disease. Results indicated that cV1q did not cause tumorigenicity in mice. No clastogenic or mutagenic effects of infliximab were observed in the *in vivo* mouse micronucleus test or the *Salmonella-Escherichia coli* (Ames) assay, respectively. Chromosomal aberrations were not observed in an assay performed using human lymphocytes. It is not known whether infliximab can impair fertility in humans. No impairment of fertility was observed in a fertility and general reproduction toxicity study with the analogous mouse antibody used in the 6-month chronic toxicity study.

14 CLINICAL STUDIES

14.1 Crohn's Disease

Active Crohn's Disease

The safety and efficacy of single and multiple doses of REMICADE were assessed in 2 randomized, double-blind, placebo-controlled clinical studies in 653 patients with moderate to severely active Crohn's disease [Crohn's Disease Activity Index (CDAI) ≥ 220 and ≤ 400] with an inadequate response to prior conventional therapies. Concomitant stable doses of aminosalicylates, corticosteroids and/or immunomodulatory agents were permitted and 92% of patients continued to receive at least one of these medications.

In the single-dose trial of 108 patients, 16% (4/25) of placebo patients achieved a clinical response (decrease in CDAI ≥ 70 points) at Week 4 vs. 81% (22/27) of patients receiving 5 mg/kg REMICADE ($p < 0.001$, two-sided, Fisher's Exact test). Additionally, 4% (1/25) of placebo patients and 48% (13/27) of patients receiving 5 mg/kg REMICADE achieved clinical remission (CDAI < 150) at Week 4.

In a multidose trial (ACCENT I [Study Crohn's I]), 545 patients received 5 mg/kg at Week 0 and were then randomized to one of three treatment groups; the placebo maintenance group received placebo at Weeks 2 and 6, and then every 8 weeks; the 5 mg/kg maintenance group received 5 mg/kg at Weeks 2 and 6, and then every 8 weeks; and the 10 mg/kg maintenance group received 5 mg/kg at Weeks 2 and 6, and then 10 mg/kg every 8 weeks. Patients in response at Week 2 were randomized and analyzed separately from those not in response at Week 2. Corticosteroid taper was permitted after Week 6.

At Week 2, 57% (311/545) of patients were in clinical response. At Week 30, a significantly greater proportion of these patients in the 5 mg/kg and 10 mg/kg maintenance groups achieved clinical remission compared to patients in the placebo maintenance group (Table 3).

Additionally, a significantly greater proportion of patients in the 5 mg/kg and 10 mg/kg REMICADE maintenance groups were in clinical remission and were able to discontinue corticosteroid use compared to patients in the placebo maintenance group at Week 54 (Table 3).

Table 3 Clinical remission and steroid withdrawal

	Single 5-mg/kg Dose ^a	Three-Dose Induction ^b	
	Placebo Maintenance	REMICADE Maintenance q 8 wks 5 mg/kg	10 mg/kg
Week 30	25/102	41/104	48/105
Clinical remission	25%	39%	46%
<i>P</i> -value ^c		0.022	0.001
Week 54			
Patients in remission able to discontinue corticosteroid use ^d	6/54 11%	14/56 25%	18/53 34%
<i>P</i> -value ^c		0.059	0.005

^aREMICADE at Week 0

^bREMICADE 5 mg/kg administered at Weeks 0, 2 and 6

^c*P*-values represent pairwise comparisons to placebo

^dOf those receiving corticosteroids at baseline

Patients in the REMICADE maintenance groups (5 mg/kg and 10 mg/kg) had a longer time to loss of response than patients in the placebo maintenance group (Figure 1). At Weeks 30 and 54, significant improvement from baseline was seen among the 5 mg/kg and 10 mg/kg REMICADE-treated groups compared to the placebo group in the disease-specific inflammatory bowel disease questionnaire (IBDQ), particularly the bowel and systemic components, and in the physical component summary score of the general health-related quality of life questionnaire SF-36.

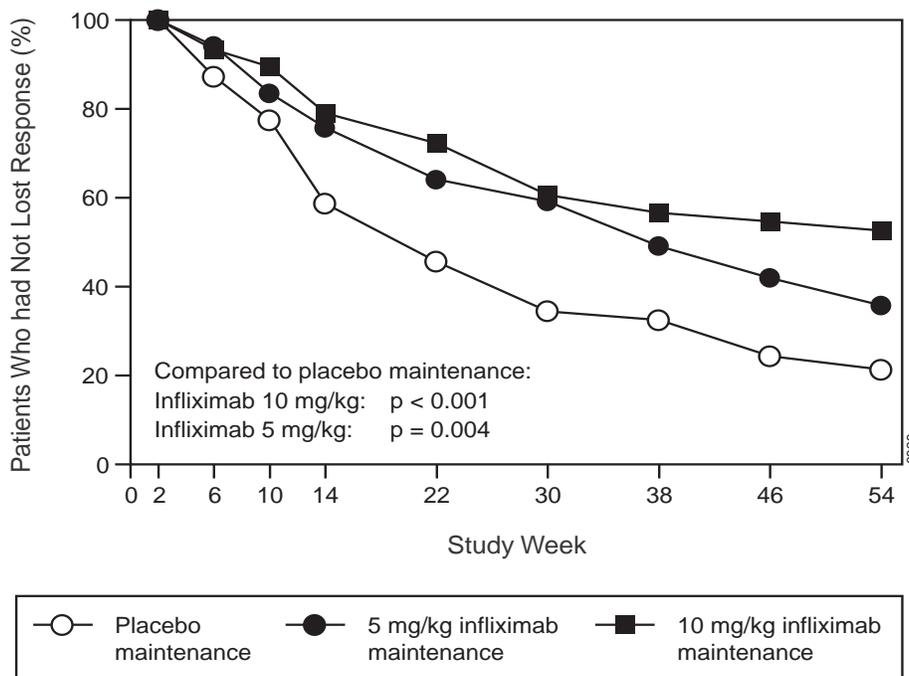


Figure 1 Kaplan-Meier estimate of the proportion of patients who had not lost response through Week 54

In a subset of 78 patients who had mucosal ulceration at baseline and who participated in an endoscopic substudy, 13 of 43 patients in the REMICADE maintenance group had endoscopic evidence of mucosal healing compared to 1 of 28 patients in the placebo group at Week 10. Of the REMICADE-treated patients showing mucosal healing at Week 10, 9 of 12 patients also showed mucosal healing at Week 54.

Patients who achieved a response and subsequently lost response were eligible to receive REMICADE on an episodic basis at a dose that was 5 mg/kg higher than the dose to which they were randomized. The majority of such patients responded to the higher dose. Among patients who were not in response at Week 2, 59% (92/157) of REMICADE maintenance patients responded by Week 14 compared to 51% (39/77) of placebo maintenance patients. Among patients who did not respond by Week 14, additional therapy did not result in significantly more responses [see *Dosage and Administration (2)*].

Fistulizing Crohn's Disease

The safety and efficacy of REMICADE were assessed in 2 randomized, double-blind, placebo-controlled studies in patients with fistulizing Crohn's disease with fistula(s) that were of at least 3 months duration. Concurrent use of stable doses of corticosteroids, 5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine (6-MP) and/or azathioprine (AZA) was permitted.

In the first trial, 94 patients received 3 doses of either placebo or REMICADE at Weeks 0, 2 and 6. Fistula response ($\geq 50\%$ reduction in number of enterocutaneous fistulas draining upon gentle compression on at least 2 consecutive visits without an increase in medication or surgery for Crohn's disease) was seen in 68% (21/31) of patients in the 5 mg/kg REMICADE group ($P=0.002$) and 56% (18/32) of patients in the 10 mg/kg REMICADE group ($P=0.021$) vs. 26% (8/31) of patients in the placebo arm. The median time to onset of response and median duration of response in REMICADE-treated patients was 2 and 12 weeks, respectively. Closure of all fistulas was achieved in 52% of REMICADE-treated patients compared with 13% of placebo-treated patients ($P<0.001$).

In the second trial (ACCENT II [Study Crohn's II]), patients who were enrolled had to have at least 1 draining enterocutaneous (perianal, abdominal) fistula. All patients received 5 mg/kg REMICADE at Weeks 0, 2 and 6. Patients were randomized to placebo or 5 mg/kg REMICADE maintenance at Week 14. Patients received maintenance doses at Week 14 and then every 8 weeks through Week 46. Patients who were in fistula response (fistula response was defined the same as in the first trial) at both Weeks 10 and 14 were randomized separately from those not in response. The primary endpoint was time from randomization to loss of response among those patients who were in fistula response.

Among the randomized patients (273 of the 296 initially enrolled), 87% had perianal fistulas and 14% had abdominal fistulas. Eight percent also had rectovaginal fistulas. Greater than 90% of the patients had received previous immunosuppressive and antibiotic therapy.

At Week 14, 65% (177/273) of patients were in fistula response. Patients randomized to REMICADE maintenance had a longer time to loss of fistula response compared to the placebo maintenance group (Figure 2). At Week 54, 38% (33/87) of REMICADE-treated patients had no

draining fistulas compared with 22% (20/90) of placebo-treated patients ($P=0.02$). Compared to placebo maintenance, patients on REMICADE maintenance had a trend toward fewer hospitalizations.

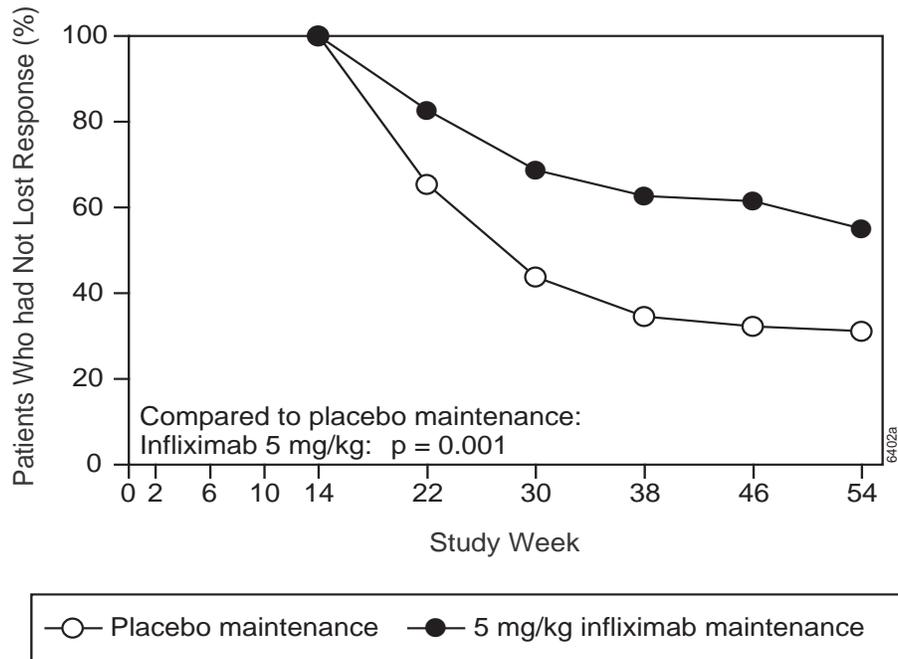


Figure 2 Life table estimates of the proportion of patients who had not lost fistula response through Week 54

Patients who achieved a fistula response and subsequently lost response were eligible to receive REMICADE maintenance therapy at a dose that was 5 mg/kg higher than the dose to which they were randomized. Of the placebo maintenance patients, 66% (25/38) responded to 5 mg/kg REMICADE, and 57% (12/21) of REMICADE maintenance patients responded to 10 mg/kg.

Patients who had not achieved a response by Week 14 were unlikely to respond to additional doses of REMICADE.

Similar proportions of patients in either group developed new fistulas (17% overall) and similar numbers developed abscesses (15% overall).

Active Crohn's Disease in Pediatric Patients

The safety and efficacy of REMICADE were assessed in a randomized, open-label study (Study Peds Crohn's) in 112 pediatric patients aged 6 to 17 years old with moderately to severely active Crohn's disease and an inadequate response to conventional therapies. The median age was 13 years and the median Pediatric Crohn's Disease Activity Index (PCDAI) was 40 (on a scale of 0 to 100). All patients were required to be on a stable dose of 6-MP, AZA, or MTX; 35% were also receiving corticosteroids at baseline.

All patients received induction dosing of 5 mg/kg REMICADE at Weeks 0, 2, and 6. At Week 10, 103 patients were randomized to a maintenance regimen of 5 mg/kg REMICADE given either every 8 weeks or every 12 weeks.

At Week 10, 88% of patients were in clinical response (defined as a decrease from baseline in the PCDAI score of ≥ 15 points and total PCDAI score of ≤ 30 points), and 59% were in clinical remission (defined as PCDAI score of ≤ 10 points).

The proportion of pediatric patients achieving clinical response at Week 10 compared favorably with the proportion of adults achieving a clinical response in Study Crohn's I. The study definition of clinical response in Study Peds Crohn's was based on the PCDAI score, whereas the CDAI score was used in the adult Study Crohn's I.

At both Week 30 and Week 54, the proportion of patients in clinical response was greater in the every 8-week treatment group than in the every 12-week treatment group (73% vs. 47% at Week 30, and 64% vs. 33% at Week 54). At both Week 30 and Week 54, the proportion of patients in clinical remission was also greater in the every 8-week treatment group than in the every 12-week treatment group (60% vs. 35% at Week 30, and 56% vs. 24% at Week 54), (Table 4).

For patients in Study Peds Crohn's receiving corticosteroids at baseline, the proportion of patients able to discontinue corticosteroids while in remission at Week 30 was 46% for the every 8-week maintenance group and 33% for the every 12-week maintenance group. At Week 54, the proportion of patients able to discontinue corticosteroids while in remission was 46% for the every 8-week maintenance group and 17% for the every 12-week maintenance group.

Table 4 Response and remission in study peds Crohn's

	5 mg/kg REMICADE	
	Every 8 Week	Every 12 Week
	Treatment Group	Treatment Group
Patients randomized	52	51
Clinical Response ^a		
Week 30	73% ^d	47%
Week 54	64% ^d	33%
Clinical Remission ^b		
Week 30	60% ^c	35%
Week 54	56% ^d	24%

^aDefined as a decrease from baseline in the PCDAI score of ≥ 15 points and total score of ≤ 30 points.

^bDefined as a PCDAI score of ≤ 10 points.

^c *P*-value <0.05

^d *P*-value <0.01

14.2 Ulcerative Colitis

The safety and efficacy of REMICADE were assessed in 2 randomized, double-blind, placebo-controlled clinical studies in 728 patients with moderately to severely active ulcerative colitis (UC) (Mayo score⁵ 6 to 12 [of possible range 0 to 12], Endoscopy subscore ≥ 2) with an inadequate response to conventional oral therapies (Studies UC I and UC II). Concomitant treatment with stable doses of aminosalicylates, corticosteroids and/or immunomodulatory agents was permitted. Corticosteroid taper was permitted after Week 8. Patients were randomized at week 0 to receive either placebo, 5 mg/kg REMICADE or 10 mg/kg REMICADE at Weeks 0, 2, 6, and every 8 weeks thereafter through Week 46 in Study UC I, and at Weeks 0, 2, 6, and every 8 weeks thereafter through Week 22 in Study UC II. In Study UC II, patients were allowed to continue blinded therapy to Week 46 at the investigator's discretion.

Patients in Study UC I had failed to respond or were intolerant to oral corticosteroids, 6-MP, or AZA. Patients in Study UC II had failed to respond or were intolerant to the above treatments and/or aminosalicylates. Similar proportions of patients in Studies UC I and UC II were receiving corticosteroids (61% and 51%, respectively), 6-MP/AZA (49% and 43%) and aminosalicylates (70% and 75%) at baseline. More patients in Study UC II than UC I were taking solely aminosalicylates for UC (26% vs. 11%, respectively). Clinical response was defined as a decrease from baseline in the Mayo score by $\geq 30\%$ and ≥ 3 points, accompanied by a decrease in the rectal bleeding subscore of ≥ 1 or a rectal bleeding subscore of 0 or 1.

Clinical Response, Clinical Remission, and Mucosal Healing

In both Study UC I and Study UC II, greater percentages of patients in both REMICADE groups achieved clinical response, clinical remission and mucosal healing than in the placebo group. Each of these effects was maintained through the end of each trial (Week 54 in Study UC I, and Week 30 in Study UC II). In addition, a greater proportion of patients in REMICADE groups demonstrated sustained response and sustained remission than in the placebo groups (Table 5).

Of patients on corticosteroids at baseline, greater proportions of patients in the REMICADE treatment groups were in clinical remission and able to discontinue corticosteroids at Week 30 compared with the patients in the placebo treatment groups (22% in REMICADE treatment groups vs. 10% in placebo group in Study UC I; 23% in REMICADE treatment groups vs. 3% in placebo group in Study UC II). In Study UC I, this effect was maintained through Week 54 (21% in REMICADE treatment groups vs. 9% in placebo group). The REMICADE-associated response was generally similar in the 5 mg/kg and 10 mg/kg dose groups.

Table 5 Response, remission and mucosal healing in ulcerative colitis studies

	Study UC I			Study UC II		
	Placebo	5 mg/kg REMICADE	10 mg/kg REMICADE	Placebo	5 mg/kg REMICADE	10 mg/kg REMICADE
Patients randomized	121	121	122	123	121	120
Clinical Response^{a, d}						
Week 8	37%	69%*	62%*	29%	65%*	69%*
Week 30	30%	52%*	51%**	26%	47%*	60%*
Week 54	20%	45%*	44%*	NA	NA	NA
Sustained Response^d						
(Clinical response at both Week 8 and 30)	23%	49%*	46%*	15%	41%*	53%*
(Clinical response at Weeks 8, 30, and 54)	14%	39%*	37%*	NA	NA	NA
Clinical Remission^{b, d}						
Week 8	15%	39%*	32%**	6%	34%*	28%*
Week 30	16%	34%**	37%*	11%	26%**	36%*
Week 54	17%	35%**	34%**	NA	NA	NA
Sustained Remission^d						
(Clinical remission at both Week 8 and 30)	8%	23%**	26%*	2%	15%*	23%*
(Clinical remission at Weeks 8, 30 and 54)	7%	20%**	20%**	NA	NA	NA
Mucosal Healing^{c, d}						
Week 8	34%	62%*	59%*	31%	60%*	62%*
Week 30	25%	50%*	49%*	30%	46%**	57%*
Week 54	18%	45%*	47%*	NA	NA	NA

* $P < 0.001$, ** $P < 0.01$ ^a Defined as a decrease from baseline in the Mayo score by $\geq 30\%$ and ≥ 3 points, accompanied by a decrease in the rectal bleeding subscore of ≥ 1 or a rectal bleeding subscore of 0 or 1. (The Mayo score consists of the sum of four subscores: stool frequency, rectal bleeding, physician's global assessment and endoscopy findings.)^b Defined as a Mayo score ≤ 2 points, no individual subscore > 1 .^c Defined as a 0 or 1 on the endoscopy subscore of the Mayo score.^d Patients who had a prohibited change in medication, had an ostomy or colectomy, or discontinued study infusions due to lack of efficacy are considered to not be in clinical response, clinical remission or mucosal healing from the time of the event onward.

The improvement with REMICADE was consistent across all Mayo subscores through Week 54 (Study UC I shown in Table 6; Study UC II through Week 30 was similar).

Table 6 Proportion of patients in Study UC I with Mayo subscores indicating inactive or mild disease through Week 54

	Study UC I		
	Placebo (n=121)	REMICADE	
		5 mg/kg (n=121)	10 mg/kg (n=122)
Stool frequency			
Baseline	17%	17%	10%
Week 8	35%	60%	58%
Week 30	35%	51%	53%
Week 54	31%	52%	51%
Rectal bleeding			
Baseline	54%	40%	48%
Week 8	74%	86%	80%
Week 30	65%	74%	71%
Week 54	62%	69%	67%
Physician's Global Assessment			
Baseline	4%	6%	3%
Week 8	44%	74%	64%
Week 30	36%	57%	55%
Week 54	26%	53%	53%
Endoscopy findings			
Baseline	0%	0%	0%
Week 8	34%	62%	59%
Week 30	26%	51%	52%
Week 54	21%	50%	51%

14.3 Rheumatoid Arthritis

The safety and efficacy of REMICADE were assessed in 2 multicenter, randomized, double-blind, pivotal trials: ATTRACT (Study RA I) and ASPIRE (Study RA II). Concurrent use of stable doses of folic acid, oral corticosteroids (≤ 10 mg/day) and/or non-steroidal anti-inflammatory drugs (NSAIDs) was permitted.

Study RA I was a placebo-controlled study of 428 patients with active rheumatoid arthritis despite treatment with MTX. Patients enrolled had a median age of 54 years, median disease duration of 8.4 years, median swollen and tender joint count of 20 and 31 respectively, and were on a median dose of 15 mg/wk of MTX. Patients received either placebo + MTX or one of 4 doses/schedules of REMICADE + MTX: 3 mg/kg or 10 mg/kg of REMICADE by IV infusion at Weeks 0, 2 and 6 followed by additional infusions every 4 or 8 weeks in combination with MTX.

Study RA II was a placebo-controlled study of 3 active treatment arms in 1004 MTX naive patients of 3 or fewer years' duration active rheumatoid arthritis. Patients enrolled had a median age of 51 years with a median disease duration of 0.6 years, median swollen and tender joint count of 19 and 31, respectively, and >80% of patients had baseline joint erosions. At

randomization, all patients received MTX (optimized to 20 mg/wk by Week 8) and either placebo, 3 mg/kg or 6 mg/kg REMICADE at Weeks 0, 2, and 6 and every 8 weeks thereafter.

Data on use of REMICADE without concurrent MTX are limited [*see Adverse Reactions (6.1)*].

Clinical response

In Study RA I, all doses/schedules of REMICADE + MTX resulted in improvement in signs and symptoms as measured by the American College of Rheumatology response criteria (ACR 20) with a higher percentage of patients achieving an ACR 20, 50 and 70 compared to placebo + MTX (Table 7). This improvement was observed at Week 2 and maintained through Week 102. Greater effects on each component of the ACR 20 were observed in all patients treated with REMICADE + MTX compared to placebo + MTX (Table 8). More patients treated with REMICADE reached a major clinical response than placebo-treated patients (Table 7).

In Study RA II, after 54 weeks of treatment, both doses of REMICADE + MTX resulted in statistically significantly greater response in signs and symptoms compared to MTX alone as measured by the proportion of patients achieving ACR 20, 50 and 70 responses (Table 7). More patients treated with REMICADE reached a major clinical response than placebo-treated patients (Table 7).

Table 7 ACR response (percent of patients)

Response	Study RA I					Study RA II		
	Placebo + MTX (n=88)	REMICADE + MTX				Placebo + MTX (n=274)	REMICADE + MTX	
		3 mg/kg		10 mg/kg			3 mg/kg	6 mg/kg
		q 8 wks (n=86)	q 4 wks (n=86)	q 8 wks (n=87)	q 4 wks (n=81)	q 8 wks (n=351)	q 8 wks (n=355)	
ACR 20								
Week 30	20%	50% ^a	50% ^a	52% ^a	58% ^a	N/A	N/A	N/A
Week 54	17%	42% ^a	48% ^a	59% ^a	59% ^a	54%	62% ^c	66% ^a
ACR 50								
Week 30	5%	27% ^a	29% ^a	31% ^a	26% ^a	N/A	N/A	N/A
Week 54	9%	21% ^c	34% ^a	40% ^a	38% ^a	32%	46% ^a	50% ^a
ACR 70								
Week 30	0%	8% ^b	11% ^b	18% ^a	11% ^a	N/A	N/A	N/A
Week 54	2%	11% ^c	18% ^a	26% ^a	19% ^a	21%	33% ^b	37% ^a
Major clinical response [#]	0%	7% ^c	8% ^b	15% ^a	6% ^c	8%	12%	17% ^a

A major clinical response was defined as a 70% ACR response for 6 consecutive months (consecutive visits spanning at least 26 weeks) through week 102 for Study RA I and week 54 for Study RA II.

^a $P \leq 0.001$

^b $P < 0.01$

^c $P < 0.05$

Table 8 Components of ACR 20 at baseline and 54 weeks (Study RA I)

<u>Parameter (medians)</u>	<u>Placebo + MTX</u>		<u>REMICADE + MTX^a</u>	
	<u>(n=88)</u>		<u>(n=340)</u>	
	<u>Baseline</u>	<u>Week 54</u>	<u>Baseline</u>	<u>Week 54</u>
No. of Tender Joints	24	16	32	8
No. of Swollen Joints	19	13	20	7
Pain ^b	6.7	6.1	6.8	3.3
Physician's Global Assessment ^b	6.5	5.2	6.2	2.1
Patient's Global Assessment ^b	6.2	6.2	6.3	3.2
Disability Index (HAQ-DI) ^c	1.8	1.5	1.8	1.3
CRP (mg/dL)	3.0	2.3	2.4	0.6

^aAll doses/schedules of REMICADE + MTX

^bVisual Analog Scale (0=best, 10=worst)

^cHealth Assessment Questionnaire, measurement of 8 categories: dressing and grooming, arising, eating, walking, hygiene, reach, grip, and activities (0=best, 3=worst)

Radiographic response

Structural damage in both hands and feet was assessed radiographically at Week 54 by the change from baseline in the van der Heijde-modified Sharp (vdH-S) score, a composite score of structural damage that measures the number and size of joint erosions and the degree of joint space narrowing in hands/wrists and feet.³

In Study RA I, approximately 80% of patients had paired X-ray data at 54 weeks and approximately 70% at 102 weeks. The inhibition of progression of structural damage was observed at 54 weeks (Table 9) and maintained through 102 weeks.

In Study RA II, >90% of patients had at least 2 evaluable X-rays. Inhibition of progression of structural damage was observed at Weeks 30 and 54 (Table 9) in the REMICADE + MTX groups compared to MTX alone. Patients treated with REMICADE + MTX demonstrated less progression of structural damage compared to MTX alone, whether baseline acute-phase reactants (ESR and CRP) were normal or elevated: patients with elevated baseline acute-phase reactants treated with MTX alone demonstrated a mean progression in vdH-S score of 4.2 units compared to patients treated with REMICADE + MTX who demonstrated 0.5 units of progression; patients with normal baseline acute phase reactants treated with MTX alone demonstrated a mean progression in vdH-S score of 1.8 units compared to REMICADE + MTX who demonstrated 0.2 units of progression. Of patients receiving REMICADE + MTX, 59% had no progression (vdH-S score \leq 0 unit) of structural damage compared to 45% of patients receiving MTX alone. In a subset of patients who began the study without erosions, REMICADE + MTX maintained an erosion-free state at 1 year in a greater proportion of patients than MTX alone, 79% (77/98) vs. 58% (23/40), respectively ($P<0.01$). Fewer patients in the REMICADE + MTX groups (47%) developed erosions in uninvolved joints compared to MTX alone (59%).

Table 9 Radiographic change from baseline to Week 54

	Study RA I			Study RA II		
	Placebo + MTX	REMICADE + MTX		Placebo + MTX	REMICADE + MTX	
		3 mg/kg q 8 wks	10 mg/kg q 8 wks		3 mg/kg q 8 wks	6 mg/kg q 8 wks
	(n=64)	(n=71)	(n=77)	(n=282)	(n=359)	(n=363)
<i>Total Score</i>						
Baseline						
Mean	79	78	65	11.3	11.6	11.2
Median	55	57	56	5.1	5.2	5.3
Change from baseline						
Mean	6.9	1.3 ^a	0.2 ^a	3.7	0.4 ^a	0.5 ^a
Median	4.0	0.5	0.5	0.4	0.0	0.0
<i>Erosion Score</i>						
Baseline						
Mean	44	44	33	8.3	8.8	8.3
Median	25	29	22	3.0	3.8	3.8
Change from baseline						
Mean	4.1	0.2 ^a	0.2 ^a	3.0	0.3 ^a	0.1 ^a
Median	2.0	0.0	0.5	0.3	0.0	0.0
<i>JSN Score</i>						
Baseline						
Mean	36	34	31	3.0	2.9	2.9
Median	26	29	24	1.0	1.0	1.0
Change from baseline						
Mean	2.9	1.1 ^a	0.0 ^a	0.6	0.1 ^a	0.2
Median	1.5	0.0	0.0	0.0	0.0	0.0

^a $P < 0.001$ for each outcome against placebo.

Physical function response

Physical function and disability were assessed using the Health Assessment Questionnaire (HAQ-DI) and the general health-related quality of life questionnaire SF-36.

In Study RA I, all doses/schedules of REMICADE + MTX showed significantly greater improvement from baseline in HAQ-DI and SF-36 physical component summary score averaged over time through Week 54 compared to placebo + MTX, and no worsening in the SF-36 mental component summary score. The median (interquartile range) improvement from baseline to Week 54 in HAQ-DI was 0.1 (-0.1, 0.5) for the placebo + MTX group and 0.4 (0.1, 0.9) for REMICADE + MTX ($p < 0.001$). Both HAQ-DI and SF-36 effects were maintained through

Week 102. Approximately 80% of patients in all doses/schedules of REMICADE + MTX remained in the trial through 102 weeks.

In Study RA II, both REMICADE treatment groups showed greater improvement in HAQ-DI from baseline averaged over time through Week 54 compared to MTX alone; 0.7 for REMICADE + MTX vs. 0.6 for MTX alone ($P \leq 0.001$). No worsening in the SF-36 mental component summary score was observed.

14.4 Ankylosing Spondylitis

The safety and efficacy of REMICADE were assessed in a randomized, multicenter, double-blind, placebo-controlled study in 279 patients with active ankylosing spondylitis. Patients were between 18 and 74 years of age, and had ankylosing spondylitis as defined by the modified New York criteria for Ankylosing Spondylitis.⁴ Patients were to have had active disease as evidenced by both a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score >4 (possible range 0-10) and spinal pain >4 (on a Visual Analog Scale [VAS] of 0-10). Patients with complete ankylosis of the spine were excluded from study participation, and the use of Disease Modifying Anti-Rheumatic Drugs (DMARDs) and systemic corticosteroids were prohibited. Doses of REMICADE 5 mg/kg or placebo were administered intravenously at Weeks 0, 2, 6, 12 and 18.

At 24 weeks, improvement in the signs and symptoms of ankylosing spondylitis, as measured by the proportion of patients achieving a 20% improvement in ASAS response criteria (ASAS 20), was seen in 60% of patients in the REMICADE-treated group vs. 18% of patients in the placebo group ($p < 0.001$). Improvement was observed at Week 2 and maintained through Week 24 (Figure 3 and Table 10).

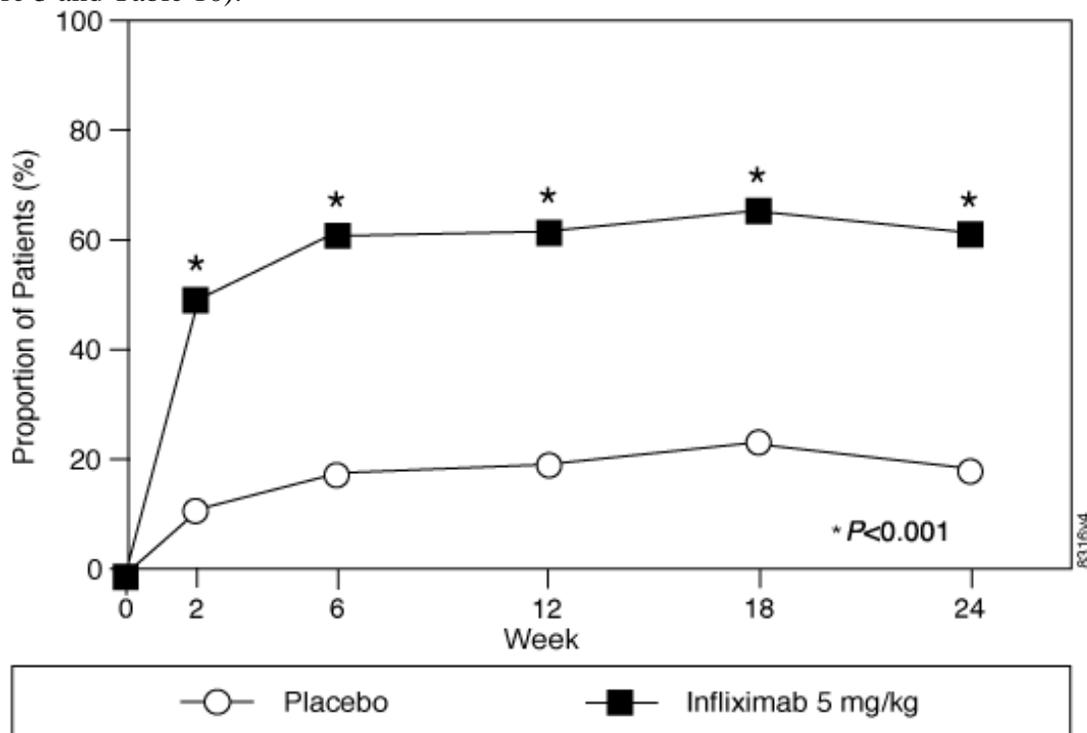


Figure 3 Proportion of patients achieving ASAS 20 response

At 24 weeks, the proportions of patients achieving a 50% and a 70% improvement in the signs and symptoms of ankylosing spondylitis, as measured by ASAS response criteria (ASAS 50 and ASAS 70, respectively), were 44% and 28%, respectively, for patients receiving REMICADE, compared to 9% and 4%, respectively, for patients receiving placebo ($P<0.001$, REMICADE vs. placebo). A low level of disease activity (defined as a value <20 [on a scale of 0-100 mm] in each of the 4 ASAS response parameters) was achieved in 22% of REMICADE-treated patients vs. 1% in placebo-treated patients ($P<0.001$).

Table 10 Components of ankylosing spondylitis disease activity

	<u>Placebo</u> (n=78)		<u>REMICADE 5mg/kg</u> (n=201)		<u>P-value</u>
	<u>Baseline</u>	<u>24 Weeks</u>	<u>Baseline</u>	<u>24 Weeks</u>	
ASAS 20 response Criteria (Mean)					
Patient Global Assessment ^a	6.6	6.0	6.8	3.8	<0.001
Spinal pain ^a	7.3	6.5	7.6	4.0	<0.001
BASFI ^b	5.8	5.6	5.7	3.6	<0.001
Inflammation ^c	6.9	5.8	6.9	3.4	<0.001
Acute Phase Reactants					
Median CRP ^d (mg/dL)	1.7	1.5	1.5	0.4	<0.001
Spinal Mobility (cm, Mean)					
Modified Schober's test ^e	4.0	5.0	4.3	4.4	0.75
Chest expansion ^e	3.6	3.7	3.3	3.9	0.04
Tragus to wall ^e	17.3	17.4	16.9	15.7	0.02
Lateral spinal flexion ^e	10.6	11.0	11.4	12.9	0.03

^a Measured on a VAS with 0="none" and 10="severe"

^b Bath Ankylosing Spondylitis Functional Index (BASFI), average of 10 questions

^c Inflammation, average of last 2 questions on the 6-question BASDAI

^d CRP normal range 0-1.0 mg/dL

^e Spinal mobility normal values: modified Schober's test: >4 cm; chest expansion: >6 cm; tragus to wall: <15 cm; lateral spinal flexion: >10 cm

The median improvement from baseline in the general health-related quality-of-life questionnaire SF-36 physical component summary score at Week 24 was 10.2 for the REMICADE group vs. 0.8 for the placebo group ($P<0.001$). There was no change in the SF-36 mental component summary score in either the REMICADE group or the placebo group.

Results of this study were similar to those seen in a multicenter double-blind, placebo-controlled study of 70 patients with ankylosing spondylitis.

14.5 Psoriatic Arthritis

Safety and efficacy of REMICADE were assessed in a multicenter, double-blind, placebo-controlled study in 200 adult patients with active psoriatic arthritis despite DMARD or NSAID therapy (≥ 5 swollen joints and ≥ 5 tender joints) with 1 or more of the following subtypes:

arthritis involving DIP joints (n=49), arthritis mutilans (n=3), asymmetric peripheral arthritis (n=40), polyarticular arthritis (n=100), and spondylitis with peripheral arthritis (n=8). Patients also had plaque psoriasis with a qualifying target lesion ≥ 2 cm in diameter. Forty-six percent of patients continued on stable doses of methotrexate (≤ 25 mg/week). During the 24-week double-blind phase, patients received either 5 mg/kg REMICADE or placebo at Weeks 0, 2, 6, 14, and 22 (100 patients in each group). At Week 16, placebo patients with $<10\%$ improvement from baseline in both swollen and tender joint counts were switched to REMICADE induction (early escape). At Week 24, all placebo-treated patients crossed over to REMICADE induction. Dosing continued for all patients through Week 46.

Clinical response

Treatment with REMICADE resulted in improvement in signs and symptoms, as assessed by the ACR criteria, with 58% of REMICADE-treated patients achieving ACR 20 at Week 14, compared with 11% of placebo-treated patients ($P < 0.001$). The response was similar regardless of concomitant use of methotrexate. Improvement was observed as early as Week 2. At 6 months, the ACR 20/50/70 responses were achieved by 54%, 41%, and 27%, respectively, of patients receiving REMICADE compared to 16%, 4%, and 2%, respectively, of patients receiving placebo. Similar responses were seen in patients with each of the subtypes of psoriatic arthritis, although few patients were enrolled with the arthritis mutilans and spondylitis with peripheral arthritis subtypes.

Compared to placebo, treatment with REMICADE resulted in improvements in the components of the ACR response criteria, as well as in dactylitis and enthesopathy (Table 11). The clinical response was maintained through Week 54. Similar ACR responses were observed in an earlier randomized, placebo-controlled study of 104 psoriatic arthritis patients, and the responses were maintained through 98 weeks in an open-label extension phase.

Table 11 Components of ACR 20 and percentage of patients with 1 or more joints with dactylitis and percentage of patients with enthesopathy at baseline and Week 24

Patients Randomized	Placebo (n=100)		REMICADE 5mg/kg ^a (n=100)	
	Baseline	Week 24	Baseline	Week 24
Parameter (medians)				
No. of Tender Joints ^b	24	20	20	6
No. of Swollen Joints ^c	12	9	12	3
Pain ^d	6.4	5.6	5.9	2.6
Physician's Global Assessment ^d	6.0	4.5	5.6	1.5
Patient's Global Assessment ^d	6.1	5.0	5.9	2.5
Disability Index (HAQ-DI) ^e	1.1	1.1	1.1	0.5
CRP (mg/dL) ^f	1.2	0.9	1.0	0.4
% Patients with 1 or more digits with dactylitis	41	33	40	15
% Patients with enthesopathy	35	36	42	22

^a $P < 0.001$ for percent change from baseline in all components of ACR 20 at Week 24, $P < 0.05$ for % of patients with dactylitis, and $P = 0.004$ for % of patients with enthesopathy at Week 24

^b Scale 0-68

^c Scale 0-66

^d Visual Analog Scale (0=best, 10=worst)

^e Health Assessment Questionnaire, measurement of 8 categories: dressing and grooming, arising, eating, walking, hygiene, reach, grip, and activities (0=best, 3=worst)

^f Normal range 0-0.6 mg/dL

Improvement in Psoriasis Area and Severity Index (PASI) in psoriatic arthritis patients with baseline body surface area (BSA) $\geq 3\%$ (n=87 placebo, n=83 REMICADE) was achieved at Week 14, regardless of concomitant methotrexate use, with 64% of REMICADE-treated patients achieving at least 75% improvement from baseline vs. 2% of placebo-treated patients; improvement was observed in some patients as early as Week 2. At 6 months, the PASI 75 and PASI 90 responses were achieved by 60% and 39%, respectively, of patients receiving REMICADE compared to 1% and 0%, respectively, of patients receiving placebo. The PASI response was generally maintained through Week 54. [See also *Clinical Studies (14.6)*].

Radiographic response

Structural damage in both hands and feet was assessed radiographically by the change from baseline in the van der Heijde-Sharp (vdH-S) score, modified by the addition of hand DIP joints. The total modified vdH-S score is a composite score of structural damage that measures the number and size of joint erosions and the degree of joint space narrowing (JSN) in the hands and

feet. At Week 24, REMICADE-treated patients had less radiographic progression than placebo-treated patients (mean change of -0.70 vs. 0.82, $P < 0.001$). REMICADE-treated patients also had less progression in their erosion scores (-0.56 vs 0.51) and JSN scores (-0.14 vs 0.31). The patients in the REMICADE group demonstrated continued inhibition of structural damage at Week 54. Most patients showed little or no change in the vdH-S score during this 12-month study (median change of 0 in both patients who initially received REMICADE or placebo). More patients in the placebo group (12%) had readily apparent radiographic progression compared with the REMICADE group (3%).

Physical function

Physical function status was assessed using the HAQ Disability Index (HAQ-DI) and the SF-36 Health Survey. REMICADE-treated patients demonstrated significant improvement in physical function as assessed by HAQ-DI (median percent improvement in HAQ-DI score from baseline to Week 14 and 24 of 43% for REMICADE-treated patients vs 0% for placebo-treated patients).

During the placebo-controlled portion of the trial (24 weeks), 54% of REMICADE-treated patients achieved a clinically meaningful improvement in HAQ-DI (≥ 0.3 unit decrease) compared to 22% of placebo-treated patients. REMICADE-treated patients also demonstrated greater improvement in the SF-36 physical and mental component summary scores than placebo-treated patients. The responses were maintained for up to 2 years in an open-label extension study.

14.6 Plaque Psoriasis

The safety and efficacy of REMICADE were assessed in 3 randomized, double-blind, placebo-controlled studies in patients 18 years of age and older with chronic, stable plaque psoriasis involving $\geq 10\%$ BSA, a minimum PASI score of 12, and who were candidates for systemic therapy or phototherapy. Patients with guttate, pustular, or erythrodermic psoriasis were excluded from these studies. No concomitant anti-psoriatic therapies were allowed during the study, with the exception of low-potency topical corticosteroids on the face and groin after Week 10 of study initiation.

Study I (EXPRESS) evaluated 378 patients who received placebo or REMICADE at a dose of 5 mg/kg at Weeks 0, 2, and 6 (induction therapy), followed by maintenance therapy every 8 weeks. At Week 24, the placebo group crossed over to REMICADE induction therapy (5 mg/kg), followed by maintenance therapy every 8 weeks. Patients originally randomized to REMICADE continued to receive REMICADE 5 mg/kg every 8 weeks through Week 46. Across all treatment groups, the median baseline PASI score was 21 and the baseline Static Physician Global Assessment (sPGA) score ranged from moderate (52% of patients) to marked (36%) to severe (2%). In addition, 75% of patients had a BSA $> 20\%$. Seventy-one percent of patients previously received systemic therapy, and 82% received phototherapy.

Study II (EXPRESS II) evaluated 835 patients who received placebo or REMICADE at doses of 3 mg/kg or 5 mg/kg at Weeks 0, 2, and 6 (induction therapy). At Week 14, within each REMICADE dose group, patients were randomized to either scheduled (every 8 weeks) or as needed (PRN) maintenance treatment through Week 46. At Week 16, the placebo group crossed over to REMICADE induction therapy (5 mg/kg), followed by maintenance therapy every 8

weeks. Across all treatment groups, the median baseline PASI score was 18, and 63% of patients had a BSA >20%. Fifty-five percent of patients previously received systemic therapy, and 64% received a phototherapy.

Study III (SPIRIT) evaluated 249 patients who had previously received either psoralen plus ultraviolet A treatment (PUVA) or other systemic therapy for their psoriasis. These patients were randomized to receive either placebo or REMICADE at doses of 3 mg/kg or 5 mg/kg at Weeks 0, 2, and 6. At Week 26, patients with a sPGA score of moderate or worse (greater than or equal to 3 on a scale of 0 to 5) received an additional dose of the randomized treatment. Across all treatment groups, the median baseline PASI score was 19, and the baseline sPGA score ranged from moderate (62% of patients) to marked (22%) to severe (3%). In addition, 75% of patients had a BSA >20%. Of the enrolled patients, 114 (46%) received the Week 26 additional dose.

In Studies I, II and III, the primary endpoint was the proportion of patients who achieved a reduction in score of at least 75% from baseline at Week 10 by the PASI (PASI 75). In Study I and Study III, another evaluated outcome included the proportion of patients who achieved a score of “cleared” or “minimal” by the sPGA. The sPGA is a 6-category scale ranging from “5 = severe” to “0 = cleared” indicating the physician’s overall assessment of the psoriasis severity focusing on induration, erythema, and scaling. Treatment success, defined as “cleared” or “minimal,” consisted of none or minimal elevation in plaque, up to faint red coloration in erythema, and none or minimal fine scale over <5% of the plaque.

Study II also evaluated the proportion of patients who achieved a score of “clear” or “excellent” by the relative Physician’s Global Assessment (rPGA). The rPGA is a 6-category scale ranging from “6 = worse” to “1 = clear” that was assessed relative to baseline. Overall lesions were graded with consideration to the percent of body involvement as well as overall induration, scaling, and erythema. Treatment success, defined as “clear” or “excellent,” consisted of some residual pinkness or pigmentation to marked improvement (nearly normal skin texture; some erythema may be present). The results of these studies are presented in Table 12.

Table 12 Psoriasis studies I, II, and III, Week 10 percentage of patients who achieved PASI 75 and percentage who achieved treatment “success” with Physician’s Global Assessment

	Placebo	REMICADE	
		3 mg/kg	5 mg/kg
Psoriasis Study I - patients randomized ^a	77	---	301
PASI 75	2 (3%)	---	242 (80%)*
sPGA	3 (4%)	---	242 (80%)*
Psoriasis Study II - patients randomized ^a	208	313	314
PASI 75	4 (2%)	220 (70%)*	237 (75%)*
rPGA	2 (1%)	217 (69%)*	234 (75%)*
Psoriasis Study III - patients randomized ^b	51	99	99
PASI 75	3 (6%)	71 (72%)*	87 (88%)*
sPGA	5 (10%)	71 (72%)*	89 (90%)*

* $P < 0.001$ compared with placebo

^a Patients with missing data at Week 10 were considered as nonresponders.

^b Patients with missing data at Week 10 were imputed by last observation.

In Study I, in the subgroup of patients with more extensive psoriasis who had previously received phototherapy, 85% of patients on 5 mg/kg REMICADE achieved a PASI 75 at Week 10 compared with 4% of patients on placebo.

In Study II, in the subgroup of patients with more extensive psoriasis who had previously received phototherapy, 72% and 77% of patients on 3 mg/kg and 5 mg/kg REMICADE achieved a PASI 75 at Week 10 respectively compared with 1% on placebo. In Study II, among patients with more extensive psoriasis who had failed or were intolerant to phototherapy, 70% and 78% of patients on 3 mg/kg and 5 mg/kg REMICADE achieved a PASI 75 at Week 10 respectively, compared with 2% on placebo.

Maintenance of response was studied in a subset of 292 and 297 REMICADE-treated patients in the 3 mg/kg and 5 mg/kg groups; respectively, in Study II. Stratified by PASI response at Week 10 and investigational site, patients in the active treatment groups were re-randomized to either a scheduled or as needed maintenance (PRN) therapy, beginning on Week 14.

The groups that received a maintenance dose every 8 weeks appear to have a greater percentage of patients maintaining a PASI 75 through week 50 as compared to patients who received the as-needed or PRN doses, and the best response was maintained with the 5 mg/kg every 8-week dose. These results are shown in Figure 4. At Week 46, when REMICADE serum concentrations were at trough level, in the every 8-week dose group, 54% of patients in the 5 mg/kg group compared to 36% in the 3 mg/kg group achieved PASI 75. The lower percentage of PASI 75 responders in the 3 mg/kg every 8-week dose group compared to the 5 mg/kg group was associated with a lower percentage of patients with detectable trough serum infliximab levels.

This may be related in part to higher antibody rates [see *Adverse Reactions (6.1)*]. In addition, in a subset of patients who had achieved a response at Week 10, maintenance of response appears to be greater in patients who received REMICADE every 8 weeks at the 5 mg/kg dose. Regardless of whether the maintenance doses are PRN or every 8 weeks, there is a decline in response in a subpopulation of patients in each group over time. The results of Study I through Week 50 in the 5 mg/kg every 8 weeks maintenance dose group were similar to the results from Study II.

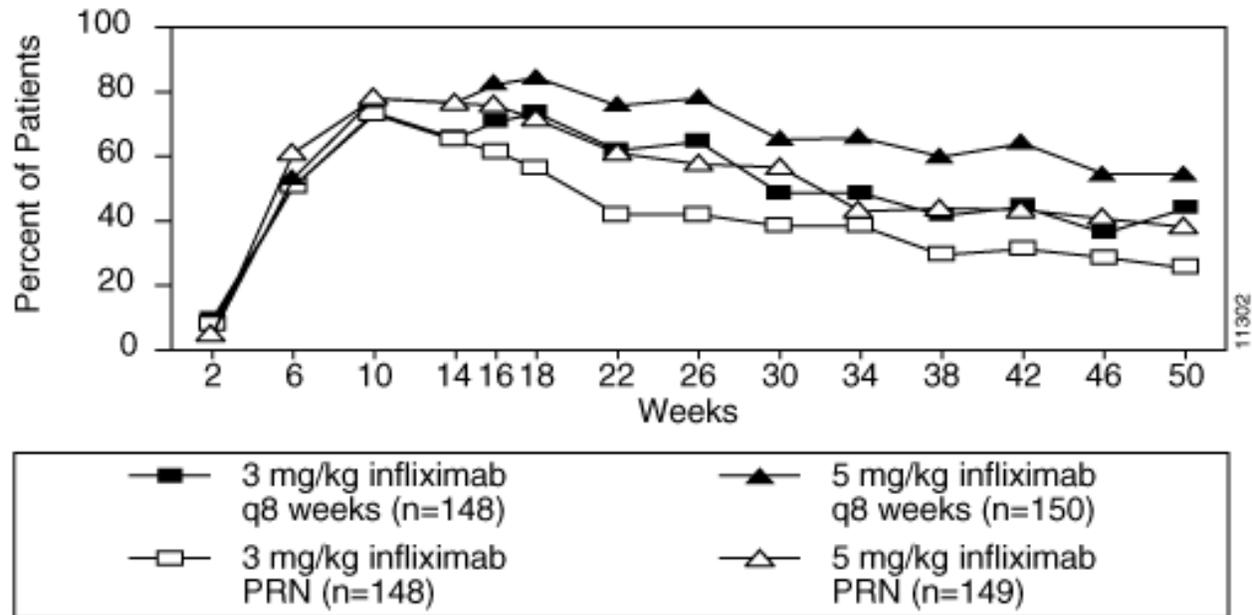


Figure 4 Proportion of patients achieving $\geq 75\%$ improvement in PASI from baseline through Week 50; patients randomized at Week 14

Efficacy and safety of REMICADE treatment beyond 50 weeks have not been evaluated in patients with plaque psoriasis.

15 REFERENCES

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16 HOW SUPPLIED/STORAGE AND HANDLING

Each REMICADE 20 mL vial is individually packaged in a carton. REMICADE is supplied in an accumulator carton containing 10 vials.

NDC 57894-030-01 100 mg vial

Each single dose vial contains 100 mg of infliximab for final reconstitution volume of 10 mL.

Storage and Stability

REMICADE must be refrigerated at 2°C to 8°C (36°F to 46°F). Do not use REMICADE beyond the expiration date (Exp) located on the carton and the vial. This product contains no preservative.

17 PATIENT COUNSELING INFORMATION

See FDA-Approved Patient Labeling (Medication Guide)

17.1 Patient Counseling

Patients or their caregivers should be advised of the potential benefits and risks of REMICADE. Physicians should instruct their patients to read the Medication Guide before starting REMICADE therapy and to reread it each time they receive an infusion. It is important that the patient's overall health be assessed at each treatment visit and that any questions resulting from the patient's or their caregiver's reading of the Medication Guide be discussed.

- **Immunosuppression**
Inform patients that REMICADE may lower the ability of their immune system to fight infections. Instruct patients of the importance of contacting their doctors if they develop any symptoms of an infection, including tuberculosis and reactivation of hepatitis B virus infections. Patients should be counseled about the risk of lymphoma and other malignancies while receiving REMICADE.
- **Other Medical Conditions**
Advise patients to report any signs of new or worsening medical conditions such as heart disease, neurological disease, or autoimmune disorders. Advise patients to report any symptoms of a cytopenia such as bruising, bleeding or persistent fever.

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Malvern, PA 19355
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