HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use VELCADE safely and effectively. See full prescribing information for VELCADE.

VELCADE® (bortezomib) for Injection
For subcutaneous or intravenous use
Initial U.S. Approval: 2003

----------RECENT MAJOR CHANGES----------

Indications and Usage (1.2)	10/2014
Dosage and Administration (2)	10/2014
Warnings and Precautions, Thrombocytopenia/Neutropenia (5.7)	10/2014

----------INDICATIONS AND USAGE----------

VELCADE is a proteasome inhibitor indicated for:
- treatment of patients with multiple myeloma (1.1)
- treatment of patients with mantle cell lymphoma (1.2)

----------DOSAGE AND ADMINISTRATION----------
- For subcutaneous or intravenous use only (2.1)
- The recommended starting dose of VELCADE is 1.3 mg/m^2 administered either as a 3 to 5 second bolus intravenous injection or subcutaneous injection. (2.2, 2.4, 2.6)
- Retreatment for multiple myeloma: May retreat starting at the last tolerated dose. (2.6)
- Hepatic Impairment: Use a lower starting dose for patients with moderate or severe hepatic impairment. (2.8)
- Dose must be individualized to prevent overdose (2.10)

----------DOSAGE FORMS AND STRENGTHS----------
- Single-use vial contains 3.5 mg of bortezomib as lyophilized powder. (3)

----------CONTRAINDICATIONS----------
- Patients with hypersensitivity (not including local reactions) to bortezomib, boron, or mannitol, including anaphylactic reactions. (4)
- Contraindicated for intrathecal administration. (4)

----------WARNINGS AND PRECAUTIONS----------
- Peripheral Neuropathy: Manage with dose modification or discontinuation. (2.7) Patients with preexisting severe neuropathy should be treated with VELCADE only after careful risk-benefit assessment. (2.7, 5.1)
- Hypotension: Use caution when treating patients taking anti-hypertensives, with a history of syncope, or with dehydration. (5.2)
- Cardiac Toxicity: Worsening of and development of cardiac failure has occurred. Closely monitor patients with existing heart disease or risk factors for heart disease. (5.3)
- Pulmonary Toxicity: Acute respiratory syndromes have occurred. Monitor closely for new or worsening symptoms. (5.4)
- Posterior Reversible Encephalopathy Syndrome: Consider MRI imaging for onset of visual or neurological symptoms; discontinue VELCADE if suspected. (5.5).
- Gastrointestinal Toxicity: Nausea, diarrhea, constipation, and vomiting may require use of antiemetic and antidiarrheal medications or fluid replacement. (5.6)
- Thrombocytopenia or Neutropenia: Monitor complete blood counts regularly throughout treatment. (5.7)
- Tumor Lysis Syndrome: Closely monitor patients with high tumor burden (5.8).
- Hepatic Toxicity: Monitor hepatic enzymes during treatment.(5.9).
- Embryo-fetal Risk: Women should avoid becoming pregnant while being treated with VELCADE. Advise pregnant women of potential embryo-fetal harm. (5.10)

----------ADVERSE REACTIONS----------

Most commonly reported adverse reactions (incidence ≥ 20%) in clinical studies include nausea, diarrhea, thrombocytopenia, neutropenia, peripheral neuropathy, fatigue, neuralgia, anemia, leukopenia, constipation, vomiting, lymphopenia, rash, pyrexia, and anorexia. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Millennium Pharmaceuticals at 1-866 VELCADE or FDA at 1-800-FDA-1088 or *www.fda.gov/medwatch*.

----------DRUG INTERACTIONS----------
- Co-administration with strong CYP3A4 inhibitors can increase VELCADE exposure. Closely monitor patients receiving VELCADE in combination with strong CYP3A4 inhibitors. (7.1)
- Co-administration with strong CYP3A4 inducers can decrease VELCADE exposure. Avoid concomitant use of strong CYP3A4 inducers. (7.3)

----------USE IN SPECIFIC POPULATIONS----------
- Patients with diabetes may require close monitoring of blood glucose and adjustment of anti-diabetic medication. (8.8)

See 17 for PATIENT COUNSELING INFORMATION

Revised: 10/2014

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

1.1 Multiple Myeloma

VELCADE® (bortezomib) is indicated for the treatment of patients with multiple myeloma.

1.2 Mantle Cell Lymphoma

VELCADE is indicated for the treatment of patients with mantle cell lymphoma.

2 DOSAGE AND ADMINISTRATION

2.1 General Dosing Guidelines

The recommended starting dose of VELCADE is 1.3 mg/m^2. VELCADE may be administered intravenously at a concentration of 1 mg/mL, or subcutaneously at a concentration of 2.5 mg/mL [*see Dosage and Administration (2.10)*].

VELCADE retreatment may be considered for patients with multiple myeloma who had previously responded to treatment with VELCADE and who have relapsed at least 6 months after completing prior VELCADE treatment. Treatment may be started at the last tolerated dose [*see Dosage and Administration (2.6)*].

When administered intravenously, VELCADE is administered as a 3 to 5 second bolus intravenous injection. VELCADE is for intravenous or subcutaneous use only. VELCADE should not be administered by any other route.

Because each route of administration has a different reconstituted concentration, caution should be used when calculating the volume to be administered.

2.2 Dosage in Previously Untreated Multiple Myeloma

VELCADE is administered in combination with oral melphalan and oral prednisone for nine 6-week treatment cycles as shown in Table 1. In Cycles 1-4, VELCADE is administered twice weekly (days 1, 4, 8, 11, 22, 25, 29 and 32). In Cycles 5-9, VELCADE is administered once weekly (days 1, 8, 22 and 29). At least 72 hours should elapse between consecutive doses of VELCADE.

Table 1: Dosage Regimen for Patients with Previously Untreated Multiple Myeloma

Twice Weekly VELCADE (Cycles 1-4)												
Week	**1**				**2**		**3**	**4**		**5**		**6**
VELCADE (1.3 mg/m^2)	Day 1	--	--	Day 4	Day 8	Day 11	rest period	Day 22	Day 25	Day 29	Day 32	rest period
Melphalan(9 mg/m^2) Prednisone(60 mg/m^2)	Day 1	Day 2	Day 3	Day 4	--	--	rest period	--	--	--	--	rest period
Once Weekly VELCADE (Cycles 5-9 when used in combination with Melphalan and Prednisone)												
Week	**1**				**2**		**3**	**4**		**5**		**6**
VELCADE (1.3 mg/m^2)	Day 1	--	--		Day 8		rest period	Day 22		Day 29		rest period
Melphalan(9 mg/m^2) Prednisone(60 mg/m^2)	Day 1	Day 2	Day 3	Day 4	--	--	rest period	--	--	--	--	rest period

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2.3 Dose Modification Guidelines for VELCADE When Given in Combination with Melphalan and Prednisone

Prior to initiating any cycle of therapy with VELCADE in combination with melphalan and prednisone:

- Platelet count should be at least 70 x 10^9/L and the absolute neutrophil count (ANC) should be at least 1.0 x 10^9/L
- Non-hematological toxicities should have resolved to Grade 1 or baseline

Table 2: Dose Modifications during Cycles of Combination VELCADE, Melphalan and Prednisone Therapy

Toxicity	Dose modification or delay
Hematological toxicity during a cycle: If prolonged Grade 4 neutropenia or thrombocytopenia, or thrombocytopenia with bleeding is observed in the previous cycle	Consider reduction of the melphalan dose by 25% in the next cycle
If platelet count is not above 30 × 10^9/L or ANC is not above 0.75 x 10^9/L on a VELCADE dosing day (other than day 1)	Withhold VELCADE dose
If several VELCADE doses in consecutive cycles are withheld due to toxicity	Reduce VELCADE dose by 1 dose level (from 1.3 mg/m^2 to 1 mg/m^2, or from 1 mg/m^2 to 0.7 mg/m^2)
Grade 3 or higher non-hematological toxicities	Withhold VELCADE therapy until symptoms of toxicity have resolved to Grade 1 or baseline. Then, VELCADE may be reinitiated with one dose level reduction (from 1.3 mg/m^2 to 1 mg/m^2, or from 1 mg/m^2 to 0.7 mg/m^2). For VELCADE-related neuropathic pain and/or peripheral neuropathy, hold or modify VELCADE as outlined in Table 5.

For information concerning melphalan and prednisone, see manufacturer's prescribing information.

Dose modifications guidelines for peripheral neuropathy are provided [*see Dosage and Administration (2.7)*].

2.4 Dosage in Previously Untreated Mantle Cell Lymphoma

VELCADE (1.3 mg/m^2) is administered intravenously in combination with intravenous rituximab, cyclophosphamide, doxorubicin and oral prednisone (VcR-CAP) for six 3-week treatment cycles as shown in Table 3. VELCADE is administered first followed by rituximab. VELCADE is administered twice weekly for two weeks (Days 1, 4, 8, and 11) followed by a 10-day rest period on Days 12-21. For patients with a response first documented at cycle 6, two additional VcR-CAP cycles are recommended. At least 72 hours should elapse between consecutive doses of VELCADE.

Table 3: Dosage Regimen for Patients with Previously Untreated Mantle Cell Lymphoma

Twice Weekly VELCADE (Six 3-Week Cycles)[a]								
Week	**1**					**2**		**3**
VELCADE (1.3 mg/m^2)	Day 1	--	--	Day 4	--	Day 8	Day 11	rest period
Rituximab (375 mg/m^2) Cyclophosphamide (750 mg/m^2) Doxorubicin (50 mg/m^2)	Day 1	--	--			--	--	rest period
Prednisone (100 mg/m^2)	Day 1	Day 2	Day 3	Day 4	Day 5	--	--	rest period

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[a] Dosing may continue for 2 more cycles (for a total of 8 cycles) if response is first seen at cycle 6.

2.5 Dose Modification Guidelines for VELCADE When Given in Combination with Rituximab, Cyclophosphamide, Doxorubicin and Prednisone

Prior to the first day of each cycle (other than Cycle 1):

- Platelet count should be at least 100 x 10^9/L and absolute neutrophil count (ANC) should be at least 1.5 x 10^9/L
- Hemoglobin should be at least 8 g/dL (at least 4.96 mmol/L)
- Non-hematologic toxicity should have recovered to Grade 1 or baseline

Interrupt VELCADE treatment at the onset of any Grade 3 hematologic or non-hematological toxicities, excluding neuropathy [*see Table 5 and Warnings and Precautions (5)*]. For dose adjustments, see Table 4 below.

Table 4: Dose Modifications on Days 4, 8, and 11 during Cycles of Combination VELCADE, Rituximab, Cyclophosphamide, Doxorubicin and Prednisone Therapy

Toxicity	Dose modification or delay
Hematological toxicity	
• Grade 3 or higher neutropenia, or a platelet count not at or above 25 × 10^9/L	Withhold VELCADE therapy for up to 2 weeks until the patient has an ANC at or above 0.75 × 10^9/L and a platelet count at or above 25 × 10^9/L. • If, after VELCADE has been withheld, the toxicity does not resolve, discontinue VELCADE. • If toxicity resolves such that the patient has an ANC at or above 0.75 × 10^9/L and a platelet count at or above 25 × 10^9/L, VELCADE dose should be reduced by 1 dose level (from 1.3 mg/m^2 to 1 mg/m^2, or from 1 mg/m^2 to 0.7 mg/m^2)
Grade 3 or higher non-hematological toxicities	Withhold VELCADE therapy until symptoms of the toxicity have resolved to Grade 2 or better. Then, VELCADE may be reinitiated with one dose level reduction (from 1.3 mg/m^2 to 1 mg/m^2, or from 1 mg/m^2 to 0.7 mg/m^2). For VELCADE-related neuropathic pain and/or peripheral neuropathy, hold or modify VELCADE as outlined in Table 5.

For information concerning rituximab, cyclophosphamide, doxorubicin and prednisone, see manufacturer's prescribing information.

2.6 Dosage and Dose Modifications for Relapsed Multiple Myeloma and Relapsed Mantle Cell Lymphoma

VELCADE (1.3 mg/m^2/dose) is administered twice weekly for 2 weeks (Days 1, 4, 8, and 11) followed by a 10-day rest period (Days 12-21). For extended therapy of more than 8 cycles, VELCADE may be administered on the standard schedule or, for relapsed multiple myeloma, on a maintenance schedule of once weekly for 4 weeks (Days 1, 8, 15, and 22) followed by a 13-day rest period (Days 23 to 35) [*see Clinical Studies (14)*]. At least 72 hours should elapse between consecutive doses of VELCADE.

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Patients with multiple myeloma who have previously responded to treatment with VELCADE (either alone or in combination) and who have relapsed at least 6 months after their prior VELCADE therapy may be started on VELCADE at the last tolerated dose. Retreated patients are administered VELCADE twice weekly (Days 1, 4, 8, and 11) every three weeks for a maximum of 8 cycles. At least 72 hours should elapse between consecutive doses of VELCADE. VELCADE may be administered either as a single agent or in combination with dexamethasone [*see Clinical Studies (14.1)*].

VELCADE therapy should be withheld at the onset of any Grade 3 non-hematological or Grade 4 hematological toxicities excluding neuropathy as discussed below [*see Warnings and Precautions (5)*]. Once the symptoms of the toxicity have resolved, VELCADE therapy may be reinitiated at a 25% reduced dose (1.3 mg/m^2/dose reduced to 1 mg/m^2/dose; 1 mg/m^2/dose reduced to 0.7 mg/m^2/dose).

For dose modifications guidelines for peripheral neuropathy see section 2.7.

2.7 Dose Modifications for Peripheral Neuropathy

Starting VELCADE subcutaneously may be considered for patients with pre-existing or at high risk of peripheral neuropathy. Patients with pre-existing severe neuropathy should be treated with VELCADE only after careful risk-benefit assessment.

Patients experiencing new or worsening peripheral neuropathy during VELCADE therapy may require a decrease in the dose and/or a less dose-intense schedule.

For dose or schedule modification guidelines for patients who experience VELCADE-related neuropathic pain and/or peripheral neuropathy see Table 5.

Table 5: Recommended Dose Modification for VELCADE related Neuropathic Pain and/or Peripheral Sensory or Motor Neuropathy

Severity of Peripheral Neuropathy Signs and Symptoms*	Modification of Dose and Regimen
Grade 1 (asymptomatic; loss of deep tendon reflexes or paresthesia) without pain or loss of function	No action
Grade 1 with pain or Grade 2 (moderate symptoms; limiting instrumental Activities of Daily Living (ADL)**)	Reduce VELCADE to 1 mg/m^2
Grade 2 with pain or Grade 3 (severe symptoms; limiting self care ADL ***)	Withhold VELCADE therapy until toxicity resolves. When toxicity resolves reinitiate with a reduced dose of VELCADE at 0.7 mg/m^2 once per week.
Grade 4 (life-threatening consequences; urgent intervention indicated)	Discontinue VELCADE

*Grading based on NCI Common Terminology Criteria CTCAE v4.0

**Instrumental ADL: refers to preparing meals, shopping for groceries or clothes, using telephone, managing money etc;

***Self care ADL: refers to bathing, dressing and undressing, feeding self, using the toilet, taking medications, and not bedridden

2.8 Dosage in Patients with Hepatic Impairment

Patients with mild hepatic impairment do not require a starting dose adjustment and should be treated per the recommended VELCADE dose. Patients with moderate or severe hepatic impairment should be started on VELCADE at a reduced dose of 0.7 mg/m^2 per injection during the first cycle, and a subsequent dose escalation to 1.0 mg/m^2 or further dose reduction to 0.5 mg/m^2 may be considered based on patient tolerance (see Table 6) [*see Use in Specific Populations (8.7) and Clinical Pharmacology (12.3)*].

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Table 6: Recommended Starting Dose Modification for VELCADE in Patients with Hepatic Impairment

	Bilirubin Level	SGOT (AST) Levels	Modification of Starting Dose
Mild	Less than or equal to 1.0x ULN	More than ULN	None
	More than 1.0x–1.5x ULN	Any	None
Moderate	More than 1.5x–3x ULN	Any	Reduce VELCADE to 0.7 mg/m^2 in the first cycle. Consider dose escalation to 1.0 mg/m^2 or further dose reduction to 0.5 mg/m^2 in subsequent cycles based on patient tolerability.
Severe	More than 3x ULN	Any	

Abbreviations: SGOT = serum glutamic oxaloacetic transaminase;
AST = aspartate aminotransferase; ULN = upper limit of the normal range.

2.9 Administration Precautions

The drug quantity contained in one vial (3.5 mg) may exceed the usual dose required. Caution should be used in calculating the dose to prevent overdose [*see Dosage and Administration (2.10)*].

When administered subcutaneously, sites for each injection (thigh or abdomen) should be rotated. New injections should be given at least one inch from an old site and never into areas where the site is tender, bruised, erythematous, or indurated.

If local injection site reactions occur following VELCADE administration subcutaneously, a less concentrated VELCADE solution (1 mg/mL instead of 2.5 mg/mL) may be administered subcutaneously [*see Dosage and Administration (2.10)*]. Alternatively, the intravenous route of administration should be considered [*see Dosage and Administration (2.10)*].

VELCADE is an antineoplastic. Procedures for proper handling and disposal should be considered [*see How Supplied/Storage and Handling (16)*].

2.10 Reconstitution/Preparation for Intravenous and Subcutaneous Administration

Proper aseptic technique should be used. Reconstitute **only with 0.9% sodium chloride**. The reconstituted product should be a clear and colorless solution.

Different volumes of 0.9% sodium chloride are used to reconstitute the product for the different routes of administration. The reconstituted concentration of bortezomib for subcutaneous administration (2.5 mg/mL) is greater than the reconstituted concentration of bortezomib for intravenous administration (1 mg/mL). **Because each route of administration has a different reconstituted concentration, caution should be used when calculating the volume to be administered** [*see Dosage and Administration (2.9)*].

For each 3.5 mg single-use vial of bortezomib reconstitute with the following volume of 0.9% sodium chloride based on route of administration (Table 7):

Table 7: Reconstitution Volumes and Final Concentration for Intravenous and Subcutaneous Administration

Route of administration	Bortezomib (mg/vial)	Diluent (0.9% Sodium Chloride)	Final Bortezomib concentration (mg/mL)
Intravenous	3.5 mg	3.5 mL	1 mg/mL
Subcutaneous	3.5 mg	1.4 mL	2.5 mg/mL

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Dose must be individualized to prevent overdosage. After determining patient body surface area (BSA) in square meters, use the following equations to calculate the total volume (mL) of reconstituted VELCADE to be administered:

- **Intravenous Administration [1 mg/mL concentration**]

$$\frac{\text{VELCADE dose (mg/m}^2\text{) x patient BSA (m}^2\text{)}}{\text{1 mg/mL}} = \text{Total VELCADE volume (mL) to be administered}$$

- **Subcutaneous Administration [2.5 mg/mL concentration]**

$$\frac{\text{VELCADE dose (mg/m}^2\text{) x patient BSA (m}^2\text{)}}{\text{2.5 mg/mL}} = \text{Total VELCADE volume (mL) to be administered}$$

Stickers that indicate the route of administration are provided with each VELCADE vial. These stickers should be placed directly on the syringe of VELCADE once VELCADE is prepared to help alert practitioners of the correct route of administration for VELCADE.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit. If any discoloration or particulate matter is observed, the reconstituted product should not be used.

Stability: Unopened vials of VELCADE are stable until the date indicated on the package when stored in the original package protected from light.

VELCADE contains no antimicrobial preservative. Reconstituted VELCADE should be administered within 8 hours of preparation. When reconstituted as directed, VELCADE may be stored at 25ºC (77ºF). The reconstituted material may be stored in the original vial and/or the syringe prior to administration. The product may be stored for up to 8 hours in a syringe; however, total storage time for the reconstituted material must not exceed 8 hours when exposed to normal indoor lighting.

3 DOSAGE FORMS AND STRENGTHS

Each single-use vial of VELCADE contains 3.5 mg of bortezomib as a sterile lyophilized white to off-white powder.

4 CONTRAINDICATIONS

VELCADE is contraindicated in patients with hypersensitivity (not including local reactions) to bortezomib, boron, or mannitol. Reactions have included anaphylactic reactions [*see Adverse Reactions (6.1)*].

VELCADE is contraindicated for intrathecal administration. Fatal events have occurred with intrathecal administration of VELCADE.

5 WARNINGS AND PRECAUTIONS

5.1 Peripheral Neuropathy

VELCADE treatment causes a peripheral neuropathy that is predominantly sensory; however, cases of severe sensory and motor peripheral neuropathy have been reported. Patients with pre-existing symptoms (numbness, pain or a burning feeling in the feet or hands) and/or signs of peripheral neuropathy may experience worsening peripheral neuropathy (including ≥ Grade 3) during treatment with VELCADE. Patients should be monitored for symptoms of neuropathy, such as a burning sensation, hyperesthesia, hypoesthesia, paresthesia, discomfort, neuropathic pain or weakness. In the Phase 3 relapsed multiple myeloma trial comparing VELCADE subcutaneous versus intravenous the incidence of Grade ≥ 2 peripheral neuropathy was 24% for subcutaneous and 39% for intravenous. Grade ≥ 3 peripheral neuropathy occurred in 6% of patients in the subcutaneous treatment group, compared with 15% in the intravenous treatment group. Starting VELCADE subcutaneously may be considered for patients with pre-existing or at high risk of peripheral neuropathy.

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Patients experiencing new or worsening peripheral neuropathy during VELCADE therapy may require a decrease in the dose and/or a less dose-intense schedule [*see Dosage and Administration (2.7)*]. In the VELCADE versus dexamethasone phase 3 relapsed multiple myeloma study, improvement in or resolution of peripheral neuropathy was reported in 48% of patients with ≥ Grade 2 peripheral neuropathy following dose adjustment or interruption. Improvement in or resolution of peripheral neuropathy was reported in 73% of patients who discontinued due to Grade 2 neuropathy or who had ≥ Grade 3 peripheral neuropathy in the phase 2 multiple myeloma studies [*see Adverse Reactions (6.1)*]. The long-term outcome of peripheral neuropathy has not been studied in mantle cell lymphoma.

5.2 Hypotension

The incidence of hypotension (postural, orthostatic, and hypotension NOS) was 8%. These events are observed throughout therapy. Caution should be used when treating patients with a history of syncope, patients receiving medications known to be associated with hypotension, and patients who are dehydrated. Management of orthostatic/postural hypotension may include adjustment of antihypertensive medications, hydration, and administration of mineralocorticoids and/or sympathomimetics [*see Adverse Reactions (6.1)*].

5.3 Cardiac Toxicity

Acute development or exacerbation of congestive heart failure and new onset of decreased left ventricular ejection fraction have occurred during VELCADE therapy, including reports in patients with no risk factors for decreased left ventricular ejection fraction. Patients with risk factors for, or existing heart disease should be closely monitored. In the relapsed multiple myeloma study of VELCADE versus dexamethasone, the incidence of any treatment-related cardiac disorder was 8% and 5% in the VELCADE and dexamethasone groups, respectively. The incidence of adverse reactions suggestive of heart failure (acute pulmonary edema, pulmonary edema, cardiac failure, congestive cardiac failure, cardiogenic shock) was ≤ 1% for each individual reaction in the VELCADE group. In the dexamethasone group the incidence was ≤ 1% for cardiac failure and congestive cardiac failure; there were no reported reactions of acute pulmonary edema, pulmonary edema, or cardiogenic shock. There have been isolated cases of QT-interval prolongation in clinical studies; causality has not been established.

5.4 Pulmonary Toxicity

Acute Respiratory Distress Syndrome (ARDS) and acute diffuse infiltrative pulmonary disease of unknown etiology such as pneumonitis, interstitial pneumonia, lung infiltration have occurred in patients receiving VELCADE. Some of these events have been fatal.

In a clinical trial, the first two patients given high-dose cytarabine (2g/m^2 per day) by continuous infusion with daunorubicin and VELCADE for relapsed acute myelogenous leukemia died of ARDS early in the course of therapy.

There have been reports of pulmonary hypertension associated with VELCADE administration in the absence of left heart failure or significant pulmonary disease.

In the event of new or worsening cardiopulmonary symptoms, consider interrupting VELCADE until a prompt and comprehensive diagnostic evaluation is conducted.

5.5 Posterior Reversible Encephalopathy Syndrome (PRES)

Posterior Reversible Encephalopathy Syndrome (PRES; formerly termed Reversible Posterior Leukoencephalopathy Syndrome (RPLS)) has occurred in patients receiving VELCADE. PRES is a rare, reversible, neurological disorder which can present with seizure, hypertension, headache, lethargy, confusion, blindness, and other visual and neurological disturbances. Brain imaging, preferably MRI (Magnetic Resonance Imaging), is used to confirm the diagnosis. In patients developing PRES, discontinue VELCADE. The safety of reinitiating VELCADE therapy in patients previously experiencing PRES is not known.

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5.6 Gastrointestinal Toxicity

VELCADE treatment can cause nausea, diarrhea, constipation, and vomiting [*see Adverse Reactions (6.1)]* sometimes requiring use of antiemetic and antidiarrheal medications. Ileus can occur. Fluid and electrolyte replacement should be administered to prevent dehydration. Interrupt VELCADE for severe symptoms.

5.7 Thrombocytopenia/Neutropenia

VELCADE is associated with thrombocytopenia and neutropenia that follow a cyclical pattern with nadirs occurring following the last dose of each cycle and typically recovering prior to initiation of the subsequent cycle. The cyclical pattern of platelet and neutrophil decreases and recovery remain consistent in the studies of multiple myeloma and mantle cell lymphoma, with no evidence of cumulative thrombocytopenia or neutropenia in the treatment regimens studied.

Monitor complete blood counts (CBC) frequently during treatment with VELCADE. Measure platelet counts prior to each dose of VELCADE. Adjust dose/schedule for thrombocytopenia [*see Tables 2 and 4 and Dosage and Administration (2.6)*]. Gastrointestinal and intracerebral hemorrhage has occurred during thrombocytopenia in association with VELCADE. Support with transfusions and supportive care, according to published guidelines.

In the single-agent, relapsed multiple myeloma study of VELCADE versus dexamethasone, the mean platelet count nadir measured was approximately 40% of baseline. The severity of thrombocytopenia related to pretreatment platelet count is shown in Table 8. The incidence of bleeding (≥ Grade 3) was 2% on the VELCADE arm and was < 1% in the dexamethasone arm.

Table 8: Severity of Thrombocytopenia Related to Pretreatment Platelet Count in the Relapsed Multiple Myeloma Study of VELCADE versus Dexamethasone

Pretreatment Platelet Count*	Number of Patients (N=331)**	Number (%) of Patients with Platelet Count < 10,000/µL	Number (%) of Patients with Platelet Count 10,000-25,000/µL
≥ 75,000/µL	309	8 (3%)	36 (12%)
≥ 50,000/µL-< 75,000/µL	14	2 (14%)	11 (79%)
≥ 10,000/µL-< 50,000/µL	7	1 (14%)	5 (71%)

* A baseline platelet count of 50,000/µL was required for study eligibility
** Data were missing at baseline for 1 patient

In the combination study of VELCADE with rituximab, cyclophosphamide, doxorubicin and prednisone (VcR-CAP) in previously untreated mantle cell lymphoma patients, the incidence of thrombocytopenia (≥ Grade 4) was 32% versus 1% for the rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone (R-CHOP) arm as shown in Table 12. The incidence of bleeding events (≥ Grade 3) was 1% in the VcR-CAP arm (3 patients) and was < 1% in the R-CHOP arm (1 patient).

Platelet transfusions were given to 23% of the patients in the VcR-CAP arm and 3% of the patients in the R-CHOP arm.

The incidence of neutropenia (≥ Grade 4) was 70% in the VcR-CAP arm and was 52% in the R-CHOP arm. The incidence of febrile neutropenia (≥ Grade 4) was 5% in the VcR-CAP arm and was 6% in the R-CHOP arm. Myeloid growth factor support was provided at a rate of 78% in the VcR-CAP arm and 61% in the R-CHOP arm.

5.8 Tumor Lysis Syndrome

Tumor lysis syndrome has been reported with VELCADE therapy. Patients at risk of tumor lysis syndrome are those with high tumor burden prior to treatment. Monitor patients closely and take appropriate precautions.

5.9 Hepatic Toxicity

Cases of acute liver failure have been reported in patients receiving multiple concomitant medications and with serious underlying medical conditions. Other reported hepatic reactions include hepatitis, increases in liver enzymes, and hyperbilirubinemia. Interrupt VELCADE therapy to assess reversibility. There is limited re-challenge information in these patients.

5.10 Embryo-fetal Risk

Women of reproductive potential should avoid becoming pregnant while being treated with VELCADE. Bortezomib administered to rabbits during organogenesis at a dose approximately 0.5 times the clinical dose of 1.3 mg/m^2 based on body surface area caused post-implantation loss and a decreased number of live fetuses [*see Use in Specific Populations (8.1)*].

6 ADVERSE REACTIONS

The following adverse reactions are also discussed in other sections of the labeling:

- Peripheral Neuropathy [*see Warnings and Precautions (5.1)*]
- Hypotension [*see Warnings and Precautions (5.2)*]
- Cardiac Toxicity[*see Warnings and Precautions (5.3)*]
- Pulmonary Toxicity [*see Warnings and Precautions (5.4)*]
- Posterior Reversible Encephalopathy Syndrome (PRES) [*see Warnings and Precautions (5.5)*]
- Gastrointestinal Toxicity [*see Warnings and Precautions (5.6)*]
- Thrombocytopenia/Neutropenia [*see Warnings and Precautions (5.7)*]
- Tumor Lysis Syndrome [*see Warnings and Precautions (5.8)*]
- Hepatic Toxicity [*see Warnings and Precautions (5.9)*]

6.1 Clinical Trials Safety Experience

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

Summary of Clinical Trial in Patients with Previously Untreated Multiple Myeloma

Table 9 describes safety data from 340 patients with previously untreated multiple myeloma who received VELCADE (1.3 mg/m^2) administered intravenously in combination with melphalan (9 mg/m^2) and prednisone (60 mg/m^2) in a prospective randomized study.

The safety profile of VELCADE in combination with melphalan/prednisone is consistent with the known safety profiles of both VELCADE and melphalan/prednisone.

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Table 9: Most Commonly Reported Adverse Reactions (≥ 10% in the VELCADE, Melphalan and Prednisone arm) with Grades 3 and ≥ 4 Intensity in the Previously Untreated Multiple Myeloma Study

	VELCADE, Melphalan and Prednisone (n=340)			Melphalan and Prednisone (n=337)		
System Organ Class	Total	Toxicity Grade, n (%)		Total	Toxicity Grade, n (%)	
Preferred Term	n (%)	3	≥ 4	n (%)	3	≥ 4
Blood and lymphatic system disorders						
Thrombocytopenia	164 (48)	60 (18)	57 (17)	140 (42)	48 (14)	39 (12)
Neutropenia	160 (47)	101 (30)	33 (10)	143 (42)	77 (23)	42 (12)
Anemia	109 (32)	41 (12)	4 (1)	156 (46)	61 (18)	18 (5)
Leukopenia	108 (32)	64 (19)	8 (2)	93 (28)	53 (16)	11 (3)
Lymphopenia	78 (23)	46 (14)	17 (5)	51 (15)	26 (8)	7 (2)
Gastrointestinal disorders						
Nausea	134 (39)	10 (3)	0	70 (21)	1 (< 1)	0
Diarrhea	119 (35)	19 (6)	2 (1)	20 (6)	1 (< 1)	0
Vomiting	87 (26)	13 (4)	0	41 (12)	2 (1)	0
Constipation	77 (23)	2 (1)	0	14 (4)	0	0
Abdominal Pain Upper	34 (10)	1 (< 1)	0	20 (6)	0	0
Nervous system disorders						
Peripheral Neuropathy[a]	156 (46)	42 (12)	2 (1)	4 (1)	0	0
Neuralgia	117 (34)	27 (8)	2 (1)	1 (< 1)	0	0
Paresthesia	42 (12)	6 (2)	0	4 (1)	0	0
General disorders and administration site conditions						
Fatigue	85 (25)	19 (6)	2 (1)	48 (14)	4 (1)	0
Asthenia	54 (16)	18 (5)	0	23 (7)	3 (1)	0
Pyrexia	53 (16)	4 (1)	0	19 (6)	1 (< 1)	1 (< 1)
Infections and infestations						
Herpes Zoster	39 (11)	11 (3)	0	9 (3)	4 (1)	0
Metabolism and nutrition disorders						
Anorexia	64 (19)	6 (2)	0	19 (6)	0	0
Skin and subcutaneous tissue disorders						
Rash	38 (11)	2 (1)	0	7 (2)	0	0
Psychiatric disorders						
Insomnia	35 (10)	1 (< 1)	0	21 (6)	0	0

[a] Represents High Level Term Peripheral Neuropathies NEC

Relapsed Multiple Myeloma Randomized Study of VELCADE versus Dexamethasone

The safety data described below and in Table 10 reflect exposure to either VELCADE (n=331) or dexamethasone (n=332) in a study of patients with relapsed multiple myeloma. VELCADE was administered intravenously at doses of 1.3 mg/m^2 twice weekly for 2 out of 3 weeks (21-day cycle). After eight 21-day cycles patients continued therapy for three 35-day cycles on a weekly schedule. Duration of treatment was up to 11 cycles (9 months) with a median duration of 6 cycles (4.1 months). For inclusion in the trial, patients must have had measurable disease and 1 to 3 prior therapies. There was no upper age limit for entry. Creatinine clearance could be as low as 20 mL/min and bilirubin levels as high as 1.5 times the upper limit of normal. The overall frequency of adverse reactions was similar in men and women, and in patients < 65 and ≥ 65 years of age. Most patients were Caucasian [*see Clinical Studies (14.1)*].

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Among the 331 VELCADE-treated patients, the most commonly reported (> 20%) adverse reactions overall were nausea (52%), diarrhea (52%), fatigue (39%), peripheral neuropathies (35%), thrombocytopenia (33%), constipation (30%), vomiting (29%), and anorexia (21%). The most commonly reported (> 20%) adverse reaction reported among the 332 patients in the dexamethasone group was fatigue (25%). Eight percent (8%) of patients in the VELCADE-treated arm experienced a Grade 4 adverse reaction; the most common reactions were thrombocytopenia (4%) and neutropenia (2%). Nine percent (9%) of dexamethasone-treated patients experienced a Grade 4 adverse reaction. All individual dexamethasone-related Grade 4 adverse reactions were less than 1%.

Serious Adverse Reactions and Adverse Reactions Leading to Treatment Discontinuation in the Relapsed Multiple Myeloma Study of VELCADE versus Dexamethasone

Serious adverse reactions are defined as any reaction that results in death, is life-threatening, requires hospitalization or prolongs a current hospitalization, results in a significant disability, or is deemed to be an important medical event. A total of 80 (24%) patients from the VELCADE treatment arm experienced a serious adverse reaction during the study, as did 83 (25%) dexamethasone-treated patients. The most commonly reported serious adverse reactions in the VELCADE treatment arm were diarrhea (3%), dehydration, herpes zoster, pyrexia, nausea, vomiting, dyspnea, and thrombocytopenia (2% each). In the dexamethasone treatment group, the most commonly reported serious adverse reactions were pneumonia (4%), hyperglycemia (3%), pyrexia, and psychotic disorder (2% each).

A total of 145 patients, including 84 (25%) of 331 patients in the VELCADE treatment group and 61 (18%) of 332 patients in the dexamethasone treatment group were discontinued from treatment due to adverse reactions. Among the 331 VELCADE treated patients, the most commonly reported adverse reaction leading to discontinuation was peripheral neuropathy (8%). Among the 332 patients in the dexamethasone group, the most commonly reported adverse reactions leading to treatment discontinuation were psychotic disorder and hyperglycemia (2% each).

Four deaths were considered to be VELCADE-related in this relapsed multiple myeloma study: 1 case each of cardiogenic shock, respiratory insufficiency, congestive heart failure and cardiac arrest. Four deaths were considered dexamethasone-related: 2 cases of sepsis, 1 case of bacterial meningitis, and 1 case of sudden death at home.

Most Commonly Reported Adverse Reactions in the Relapsed Multiple Myeloma Study of VELCADE versus Dexamethasone

The most common adverse reactions from the relapsed multiple myeloma study are shown in Table 10. All adverse reactions with incidence ≥ 10% in the VELCADE arm are included.

Table 10: Most Commonly Reported Adverse Reactions (≥ 10% in VELCADE arm), with Grades 3 and 4 Intensity in the Relapsed Multiple Myeloma Study of VELCADE versus Dexamethasone (N=663)

	VELCADE N=331			Dexamethasone N=332		
Preferred Term	All	Grade 3	Grade 4	All	Grade 3	Grade 4
Adverse Reactions	324 (98)	193 (58)	28 (8)	297 (89)	110 (33)	29 (9)
Nausea	172 (52)	8 (2)	0	31 (9)	0	0
Diarrhea NOS	171 (52)	22 (7)	0	36 (11)	2 (< 1)	0
Fatigue	130 (39)	15 (5)	0	82 (25)	8 (2)	0
Peripheral neuropathies[a]	115 (35)	23 (7)	2 (< 1)	14 (4)	0	1 (< 1)
Thrombocytopenia	109 (33)	80 (24)	12 (4)	11 (3)	5 (2)	1 (< 1)
Constipation	99 (30)	6 (2)	0	27 (8)	1 (< 1)	0
Vomiting NOS	96 (29)	8 (2)	0	10 (3)	1 (< 1)	0
Anorexia	68 (21)	8 (2)	0	8 (2)	1 (< 1)	0
Pyrexia	66 (20)	2 (< 1)	0	21 (6)	3 (< 1)	1 (< 1)
Paresthesia	64 (19)	5 (2)	0	24 (7)	0	0
Anemia NOS	63 (19)	20 (6)	1 (< 1)	21 (6)	8 (2)	0
Headache NOS	62 (19)	3 (< 1)	0	23 (7)	1 (< 1)	0

Preferred Term	VELCADE N=331 All	Grade 3	Grade 4	Dexamethasone N=332 All	Grade 3	Grade 4
Neutropenia	58 (18)	37 (11)	8 (2)	1 (< 1)	1 (< 1)	0
Rash NOS	43 (13)	3 (< 1)	0	7 (2)	0	0
Appetite decreased NOS	36 (11)	0	0	12 (4)	0	0
Dyspnea NOS	35 (11)	11 (3)	1 (< 1)	37 (11)	7 (2)	1 (< 1)
Abdominal pain NOS	35 (11)	5 (2)	0	7 (2)	0	0
Weakness	34 (10)	10 (3)	0	28 (8)	8 (2)	0

[a] Represents High Level Term Peripheral Neuropathies NEC

Safety Experience from the Phase 2 Open-Label Extension Study in Relapsed Multiple Myeloma

In the phase 2 extension study of 63 patients, no new cumulative or new long-term toxicities were observed with prolonged VELCADE treatment. These patients were treated for a total of 5.3 to 23 months, including time on VELCADE in the prior VELCADE study [*see Clinical Studies (14.1)*].

Safety Experience from the Phase 3 Open-Label Study of VELCADE Subcutaneous versus Intravenous in Relapsed Multiple Myeloma

The safety and efficacy of VELCADE administered subcutaneously were evaluated in one Phase 3 study at the recommended dose of 1.3 mg/m^2. This was a randomized, comparative study of VELCADE subcutaneous versus intravenous in 222 patients with relapsed multiple myeloma. The safety data described below and in Table 11 reflect exposure to either VELCADE subcutaneous (n=147) or VELCADE intravenous (n=74) [*see Clinical Studies (14.1)*].

Table 11: Most Commonly Reported Adverse Reactions (≥ 10%), with Grade 3 and ≥ 4 Intensity in the Relapsed Multiple Myeloma Study (N=221) of VELCADE Subcutaneous versus Intravenous

System Organ Class Preferred Term	Subcutaneous (N=147) Total n (%)	Toxicity Grade, n (%) 3	≥ 4	Intravenous (N=74) Total n (%)	Toxicity Grade, n (%) 3	≥ 4
Blood and lymphatic system disorders						
Anemia	28 (19)	8 (5)	0	17 (23)	3 (4)	0
Leukopenia	26 (18)	8 (5)	0	15 (20)	4 (5)	1 (1)
Neutropenia	34 (23)	15 (10)	4 (3)	20 (27)	10 (14)	3 (4)
Thrombocytopenia	44 (30)	7 (5)	5 (3)	25 (34)	7 (9)	5 (7)
Gastrointestinal disorders						
Diarrhea	28 (19)	1 (1)	0	21 (28)	3 (4)	0
Nausea	24 (16)	0	0	10 (14)	0	0
Vomiting	13 (9)	3 (2)	0	8 (11)	0	0
General disorders and administration site conditions						
Asthenia	10 (7)	1 (1)	0	12 (16)	4 (5)	0
Fatigue	11 (7)	3 (2)	0	11 (15)	3 (4)	0
Pyrexia	18 (12)	0	0	6 (8)	0	0
Nervous system disorders						
Neuralgia	34 (23)	5 (3)	0	17 (23)	7 (9)	0
Peripheral neuropathies[a]	55 (37)	8 (5)	1 (1)	37 (50)	10 (14)	1 (1)

Note: Safety population: 147 patients in the subcutaneous treatment group and 74 patients in the intravenous treatment group who received at least 1 dose of study medication

[a] Represents High Level Term Peripheral Neuropathies NEC

In general, safety data were similar for the subcutaneous and intravenous treatment groups. Differences were observed in the rates of some Grade ≥ 3 adverse reactions. Differences of ≥ 5% were reported in neuralgia (3% subcutaneous versus 9% intravenous), peripheral neuropathies (6% subcutaneous versus 15% intravenous),

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neutropenia (13% subcutaneous versus 18% intravenous), and thrombocytopenia (8% subcutaneous versus 16% intravenous).

A local reaction was reported in 6% of patients in the subcutaneous group, mostly redness. Only 2 (1%) patients were reported as having severe reactions, 1 case of pruritus and 1 case of redness. Local reactions led to reduction in injection concentration in one patient and drug discontinuation in one patient. Local reactions resolved in a median of 6 days.

Dose reductions occurred due to adverse reactions in 31% of patients in the subcutaneous treatment group compared with 43% of the intravenously-treated patients. The most common adverse reactions leading to a dose reduction included peripheral sensory neuropathy (17% in the subcutaneous treatment group compared with 31% in the intravenous treatment group); and neuralgia (11% in the subcutaneous treatment group compared with 19% in the intravenous treatment group).

Serious Adverse Reactions and Adverse Reactions Leading to Treatment Discontinuation in the Relapsed Multiple Myeloma Study of VELCADE Subcutaneous versus Intravenous

The incidence of serious adverse reactions was similar for the subcutaneous treatment group (20%) and the intravenous treatment group (19%). The most commonly reported serious adverse reactions in the subcutaneous treatment arm were pneumonia and pyrexia (2% each). In the intravenous treatment group, the most commonly reported serious adverse reactions were pneumonia, diarrhea, and peripheral sensory neuropathy (3% each).

In the subcutaneous treatment group, 27 patients (18%) discontinued study treatment due to an adverse reaction compared with 17 patients (23%) in the intravenous treatment group. Among the 147 subcutaneously-treated patients, the most commonly reported adverse reactions leading to discontinuation were peripheral sensory neuropathy (5%) and neuralgia (5%). Among the 74 patients in the intravenous treatment group, the most commonly reported adverse reactions leading to treatment discontinuation were peripheral sensory neuropathy (9%) and neuralgia (9%).

Two patients (1%) in the subcutaneous treatment group and 1 (1%) patient in the intravenous treatment group died due to an adverse reaction during treatment. In the subcutaneous group the causes of death were one case of pneumonia and one case of sudden death. In the intravenous group the cause of death was coronary artery insufficiency.

Safety Experience from the Clinical Trial in Patients with Previously Untreated Mantle Cell Lymphoma

Table 12 describes safety data from 240 patients with previously untreated mantle cell lymphoma who received VELCADE (1.3 mg/m^2) administered intravenously in combination with rituximab (375 mg/m^2), cyclophosphamide (750 mg/m^2), doxorubicin (50 mg/m^2), and prednisone (100 mg/m^2) (VcR-CAP) in a prospective randomized study.

Infections were reported for 31% of patients in the VcR-CAP arm and 23% of the patients in the comparator (rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone [R-CHOP]) arm, including the predominant preferred term of pneumonia (VcR-CAP 8% versus R-CHOP 5%).

Table 12: Most Commonly Reported Adverse Reactions (≥ 5%) with Grades 3 and ≥ 4 Intensity in the Previously Untreated Mantle Cell Lymphoma Study

	VcR-CAP n=240			R-CHOP n=242		
System Organ Class Preferred Term	All n (%)	Toxicity Grade 3 n (%)	Toxicity Grade ≥4 n (%)	All n (%)	Toxicity Grade 3 n (%)	Toxicity Grade ≥4 n (%)
Blood and lymphatic system disorders						
Neutropenia	209 (87)	32 (13)	168 (70)	172 (71)	31 (13)	125 (52)
Leukopenia	116 (48)	34 (14)	69 (29)	87 (36)	39 (16)	27 (11)
Anemia	106 (44)	27 (11)	4 (2)	71 (29)	23 (10)	4 (2)

	VcR-CAP n=240			R-CHOP n=242		
System Organ Class Preferred Term	All n (%)	Toxicity Grade 3 n (%)	Toxicity Grade ≥4 n (%)	All n (%)	Toxicity Grade 3 n (%)	Toxicity Grade ≥4 n (%)
Thrombocytopenia	172 (72)	59 (25)	76 (32)	42 (17)	9 (4)	3 (1)
Febrile neutropenia	41 (17)	24 (10)	12 (5)	33 (14)	17 (7)	15 (6)
Lymphopenia	68 (28)	25 (10)	36 (15)	28 (12)	15 (6)	2 (1)
Nervous system disorders						
Peripheral neuropathy[a]	71 (30)	17 (7)	1 (< 1)	65 (27)	10 (4)	0
Hypoesthesia	14 (6)	3 (1)	0	13 (5)	0	0
Paresthesia	14 (6)	2 (1)	0	11 (5)	0	0
Neuralgia	25 (10)	9 (4)	0	1 (< 1)	0	0
General disorders and administration site conditions						
Fatigue	43 (18)	11 (5)	1 (< 1)	38 (16)	5 (2)	0
Pyrexia	48 (20)	7 (3)	0	23 (10)	5 (2)	0
Asthenia	29 (12)	4 (2)	1 (< 1)	18 (7)	1 (< 1)	0
Edema peripheral	16 (7)	1 (< 1)	0	13 (5)	0	0
Gastrointestinal disorders						
Nausea	54 (23)	1 (< 1)	0	28 (12)	0	0
Constipation	42 (18)	1 (< 1)	0	22 (9)	2 (1)	0
Stomatitis	20 (8)	2 (1)	0	19 (8)	0	1 (< 1)
Diarrhea	59 (25)	11 (5)	0	11 (5)	3 (1)	1 (< 1)
Vomiting	24 (10)	1 (< 1)	0	8 (3)	0	0
Abdominal distension	13 (5)	0	0	4 (2)	0	0
Infections and infestations						
Pneumonia	20 (8)	8 (3)	5 (2)	11 (5)	5 (2)	3 (1)
Skin and subcutaneous tissue disorders						
Alopecia	31 (13)	1 (< 1)	1 (< 1)	33 (14)	4 (2)	0
Metabolism and nutrition disorders						
Hyperglycemia	10 (4)	1 (< 1)	0	17 (7)	10 (4)	0
Decreased appetite	36 (15)	2 (1)	0	15 (6)	1 (< 1)	0
Vascular disorders						
Hypertension	15 (6)	1 (< 1)	0	3 (1)	0	0
Psychiatric disorders						
Insomnia	16 (7)	1 (< 1)	0	8 (3)	0	0

Key: R-CHOP=rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone;
VcR-CAP=VELCADE, rituximab, cyclophosphamide, doxorubicin, and prednisone.

[a] Represents High Level Term Peripheral Neuropathies NEC

The incidence of herpes zoster reactivation was 4.6% in the VcR-CAP arm and 0.8% in the R-CHOP arm. Antiviral prophylaxis was mandated by protocol amendment.

The incidences of Grade ≥ 3 bleeding events were similar between the 2 arms (3 patients in the VcR-CAP arm and 1 patient in the R-CHOP arm). All of the Grade ≥ 3 bleeding events resolved without sequelae in the VcR-CAP arm.

Adverse reactions leading to discontinuation occurred in 8% of patients in VcR-CAP group and 6% of patients in R-CHOP group. In the VcR-CAP group, the most commonly reported adverse reaction leading to discontinuation was peripheral sensory neuropathy (1%; 3 patients). The most commonly reported adverse reaction leading to discontinuation in the R-CHOP group was febrile neutropenia (< 1%; 2 patients).

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Integrated Summary of Safety (Relapsed Multiple Myeloma and Relapsed Mantle Cell Lymphoma)

Safety data from phase 2 and 3 studies of single agent VELCADE 1.3 mg/m^2/dose twice weekly for 2 weeks followed by a 10-day rest period in 1163 patients with previously-treated multiple myeloma (N=1008) and previously-treated mantle cell lymphoma (N=155) were integrated and tabulated. This analysis does not include data from the Phase 3 Open-Label Study of VELCADE subcutaneous versus intravenous in relapsed multiple myeloma. In the integrated studies, the safety profile of VELCADE was similar in patients with multiple myeloma and mantle cell lymphoma.

In the integrated analysis, the most commonly reported (> 20%) adverse reactions were nausea (49%), diarrhea (46%), asthenic conditions including fatigue (41%) and weakness (11%), peripheral neuropathies (38%), thrombocytopenia (32%), vomiting (28%), constipation (25%), and pyrexia (21%). Eleven percent (11%) of patients experienced at least 1 episode of ≥ Grade 4 toxicity, most commonly thrombocytopenia (4%) and neutropenia (2%).

In the Phase 2 relapsed multiple myeloma clinical trials of VELCADE administered intravenously, local skin irritation was reported in 5% of patients, but extravasation of VELCADE was not associated with tissue damage.

Serious Adverse Reactions and Adverse Reactions Leading to Treatment Discontinuation in the Integrated Summary of Safety

A total of 26% of patients experienced a serious adverse reaction during the studies. The most commonly reported serious adverse reactions included diarrhea, vomiting and pyrexia (3% each), nausea, dehydration, and thrombocytopenia (2% each) and pneumonia, dyspnea, peripheral neuropathies, and herpes zoster (1% each).

Adverse reactions leading to discontinuation occurred in 22% of patients. The reasons for discontinuation included peripheral neuropathy (8%), and fatigue, thrombocytopenia, and diarrhea (2% each).

In total, 2% of the patients died and the cause of death was considered by the investigator to be possibly related to study drug: including reports of cardiac arrest, congestive heart failure, respiratory failure, renal failure, pneumonia and sepsis.

Most Commonly Reported Adverse Reactions in the Integrated Summary of Safety

The most common adverse reactions are shown in Table 13. All adverse reactions occurring at ≥ 10% are included. In the absence of a randomized comparator arm, it is often not possible to distinguish between adverse events that are drug-caused and those that reflect the patient's underlying disease. Please see the discussion of specific adverse reactions that follows.

Table 13: Most Commonly Reported (≥ 10% Overall) Adverse Reactions in Integrated Analyses of Relapsed Multiple Myeloma and Relapsed Mantle Cell Lymphoma Studies using the 1.3 mg/m^2 Dose (N=1163)

	All Patients N=1163		Multiple Myeloma N=1008		Mantle Cell Lymphoma N=155	
Preferred Term	All	≥ Grade 3	All	≥ Grade 3	All	≥ Grade 3
Nausea	567 (49)	36 (3)	511 (51)	32 (3)	56 (36)	4 (3)
Diarrhea NOS	530 (46)	83 (7)	470 (47)	72 (7)	60 (39)	11 (7)
Fatigue	477 (41)	86 (7)	396 (39)	71 (7)	81 (52)	15 (10)
Peripheral neuropathies[a]	443 (38)	129 (11)	359 (36)	110 (11)	84 (54)	19 (12)
Thrombocytopenia	369 (32)	295 (25)	344 (34)	283 (28)	25 (16)	12 (8)
Vomiting NOS	321 (28)	44 (4)	286 (28)	40 (4)	35 (23)	4 (3)
Constipation	296 (25)	17 (1)	244 (24)	14 (1)	52 (34)	3 (2)
Pyrexia	249 (21)	16 (1)	233 (23)	15 (1)	16 (10)	1 (< 1)
Anorexia	227 (20)	19 (2)	205 (20)	16 (2)	22 (14)	3 (2)
Anemia NOS	209 (18)	65 (6)	190 (19)	63 (6)	19 (12)	2 (1)
Headache NOS	175 (15)	8 (< 1)	160 (16)	8 (< 1)	15 (10)	0
Neutropenia	172 (15)	121 (10)	164 (16)	117 (12)	8 (5)	4 (3)

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	All Patients N=1163		Multiple Myeloma N=1008		Mantle Cell Lymphoma N=155	
Preferred Term	All	≥ Grade 3	All	≥ Grade 3	All	≥ Grade 3
Rash NOS	156 (13)	8 (< 1)	120 (12)	4 (< 1)	36 (23)	4 (3)
Paresthesia	147 (13)	9 (< 1)	136 (13)	8 (< 1)	11 (7)	1 (< 1)
Dizziness (excl vertigo)	129 (11)	13 (1)	101 (10)	9 (< 1)	28 (18)	4 (3)
Weakness	124 (11)	31 (3)	106 (11)	28 (3)	18 (12)	3 (2)

[a] Represents High Level Term Peripheral Neuropathies NEC

Description of Selected Adverse Reactions from the Integrated Phase 2 and 3 Relapsed Multiple Myeloma and Phase 2 Relapsed Mantle Cell Lymphoma Studies

Gastrointestinal Toxicity

A total of 75% of patients experienced at least one gastrointestinal disorder. The most common gastrointestinal disorders included nausea, diarrhea, constipation, vomiting, and appetite decreased. Other gastrointestinal disorders included dyspepsia and dysgeusia. Grade 3 adverse reactions occurred in 14% of patients; ≥ Grade 4 adverse reactions were ≤ 1%. Gastrointestinal adverse reactions were considered serious in 7% of patients. Four percent (4%) of patients discontinued due to a gastrointestinal adverse reaction. Nausea was reported more often in patients with multiple myeloma (51%) compared to patients with mantle cell lymphoma (36%).

Thrombocytopenia

Across the studies, VELCADE-associated thrombocytopenia was characterized by a decrease in platelet count during the dosing period (days 1 to 11) and a return toward baseline during the 10-day rest period during each treatment cycle. Overall, thrombocytopenia was reported in 32% of patients. Thrombocytopenia was Grade 3 in 22%, ≥ Grade 4 in 4%, and serious in 2% of patients, and the reaction resulted in VELCADE discontinuation in 2% of patients [*see Warnings and Precautions (5.7)*]. Thrombocytopenia was reported more often in patients with multiple myeloma (34%) compared to patients with mantle cell lymphoma (16%). The incidence of ≥ Grade 3 thrombocytopenia also was higher in patients with multiple myeloma (28%) compared to patients with mantle cell lymphoma (8%).

Peripheral Neuropathy

Overall, peripheral neuropathies occurred in 38% of patients. Peripheral neuropathy was Grade 3 for 11% of patients and ≥ Grade 4 for < 1% of patients. Eight percent (8%) of patients discontinued VELCADE due to peripheral neuropathy. The incidence of peripheral neuropathy was higher among patients with mantle cell lymphoma (54%) compared to patients with multiple myeloma (36%).

In the VELCADE versus dexamethasone phase 3 relapsed multiple myeloma study, among the 62 VELCADE-treated patients who experienced ≥ Grade 2 peripheral neuropathy and had dose adjustments, 48% had improved or resolved with a median of 3.8 months from first onset.

In the phase 2 relapsed multiple myeloma studies, among the 30 patients who experienced Grade 2 peripheral neuropathy resulting in discontinuation or who experienced ≥ Grade 3 peripheral neuropathy, 73% reported improvement or resolution with a median time of 47 days to improvement of one Grade or more from the last dose of VELCADE.

Hypotension

The incidence of hypotension (postural, orthostatic and hypotension NOS) was 8% in patients treated with VELCADE. Hypotension was Grade 1 or 2 in the majority of patients and Grade 3 in 2% and ≥ Grade 4 in < 1%. Two percent (2%) of patients had hypotension reported as a serious adverse reaction, and 1% discontinued due to hypotension. The incidence of hypotension was similar in patients with multiple myeloma (8%) and those with mantle cell lymphoma (9%). In addition, < 1% of patients experienced hypotension associated with a syncopal reaction.

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Neutropenia
Neutrophil counts decreased during the VELCADE dosing period (days 1 to 11) and returned toward baseline during the 10-day rest period during each treatment cycle. Overall, neutropenia occurred in 15% of patients and was Grade 3 in 8% of patients and ≥ Grade 4 in 2%. Neutropenia was reported as a serious adverse reaction in < 1% of patients and < 1% of patients discontinued due to neutropenia. The incidence of neutropenia was higher in patients with multiple myeloma (16%) compared to patients with mantle cell lymphoma (5%). The incidence of ≥ Grade 3 neutropenia also was higher in patients with multiple myeloma (12%) compared to patients with mantle cell lymphoma (3%).

Asthenic conditions (Fatigue, Malaise, Weakness, Asthenia)
Asthenic conditions were reported in 54% of patients. Fatigue was reported as Grade 3 in 7% and ≥ Grade 4 in < 1% of patients. Asthenia was reported as Grade 3 in 2% and ≥ Grade 4 in < 1% of patients. Two percent (2%) of patients discontinued treatment due to fatigue and < 1% due to weakness and asthenia. Asthenic conditions were reported in 53% of patients with multiple myeloma and 59% of patients with mantle cell lymphoma.

Pyrexia
Pyrexia (> 38ºC) was reported as an adverse reaction for 21% of patients. The reaction was Grade 3 in 1% and ≥ Grade 4 in < 1%. Pyrexia was reported as a serious adverse reaction in 3% of patients and led to VELCADE discontinuation in < 1% of patients. The incidence of pyrexia was higher among patients with multiple myeloma (23%) compared to patients with mantle cell lymphoma (10%). The incidence of ≥ Grade 3 pyrexia was 1% in patients with multiple myeloma and < 1% in patients with mantle cell lymphoma.

Herpes Virus Infection
Consider using antiviral prophylaxis in subjects being treated with VELCADE. In the randomized studies in previously untreated and relapsed multiple myeloma, herpes zoster reactivation was more common in subjects treated with VELCADE (ranging between 6-11%) than in the control groups (3-4%). Herpes simplex was seen in 1-3% in subjects treated with VELCADE and 1-3% in the control groups. In the previously untreated multiple myeloma study, herpes zoster virus reactivation in the VELCADE, melphalan and prednisone arm was less common in subjects receiving prophylactic antiviral therapy (3%) than in subjects who did not receive prophylactic antiviral therapy (17%).

Retreatment in Relapsed Multiple Myeloma

A single-arm trial was conducted in 130 patients with relapsed multiple myeloma to determine the efficacy and safety of retreatment with intravenous VELCADE. The safety profile of patients in this trial is consistent with the known safety profile of VELCADE-treated patients with relapsed multiple myeloma as demonstrated in Tables 10, 11, and 13; no cumulative toxicities were observed upon retreatment. The most common adverse drug reaction was thrombocytopenia which occurred in 52% of the patients. The incidence of ≥ Grade 3 thrombocytopenia was 24%. Peripheral neuropathy occurred in 28% of patients, with the incidence of ≥ Grade 3 peripheral neuropathy reported at 6%. The incidence of serious adverse reactions was 12.3%. The most commonly reported serious adverse reactions were thrombocytopenia (3.8%), diarrhea (2.3%), and herpes zoster and pneumonia (1.5% each).

Adverse reactions leading to discontinuation occurred in 13% of patients. The reasons for discontinuation included peripheral neuropathy (5%) and diarrhea (3%).

Two deaths considered to be VELCADE-related occurred within 30 days of the last VELCADE dose; one in a patient with cerebrovascular accident and one in a patient with sepsis.

Additional Adverse Reactions from Clinical Studies

The following clinically important serious adverse reactions that are not described above have been reported in clinical trials in patients treated with VELCADE administered as monotherapy or in combination with other

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chemotherapeutics. These studies were conducted in patients with hematological malignancies and in solid tumors.

Blood and lymphatic system disorders: Anemia, disseminated intravascular coagulation, febrile neutropenia, lymphopenia, leukopenia

Cardiac disorders: Angina pectoris, atrial fibrillation aggravated, atrial flutter, bradycardia, sinus arrest, cardiac amyloidosis, complete atrioventricular block, myocardial ischemia, myocardial infarction, pericarditis, pericardial effusion, *Torsades de pointes*, ventricular tachycardia

Ear and labyrinth disorders: Hearing impaired, vertigo

Eye disorders: Diplopia and blurred vision, conjunctival infection, irritation

Gastrointestinal disorders: Abdominal pain, ascites, dysphagia, fecal impaction, gastroenteritis, gastritis hemorrhagic, hematemesis, hemorrhagic duodenitis, ileus paralytic, large intestinal obstruction, paralytic intestinal obstruction, peritonitis, small intestinal obstruction, large intestinal perforation, stomatitis, melena, pancreatitis acute, oral mucosal petechiae, gastroesophageal reflux

General disorders and administration site conditions: Chills, edema, edema peripheral, injection site erythema, neuralgia, injection site pain, irritation, malaise, phlebitis

Hepatobiliary disorders: Cholestasis, hepatic hemorrhage, hyperbilirubinemia, portal vein thrombosis, hepatitis, liver failure

Immune system disorders: Anaphylactic reaction, drug hypersensitivity, immune complex mediated hypersensitivity, angioedema, laryngeal edema

Infections and infestations: Aspergillosis, bacteremia, bronchitis, urinary tract infection, herpes viral infection, listeriosis, nasopharyngitis, pneumonia, respiratory tract infection, septic shock, toxoplasmosis, oral candidiasis, sinusitis, catheter related infection

Injury, poisoning and procedural complications: Catheter related complication, skeletal fracture, subdural hematoma

Investigations: Weight decreased

Metabolism and nutrition disorders: Dehydration, hypocalcemia, hyperuricemia, hypokalemia, hyperkalemia, hyponatremia, hypernatremia

Musculoskeletal and connective tissue disorders: Arthralgia, back pain, bone pain, myalgia, pain in extremity

Nervous system disorders*:* Ataxia, coma, dizziness, dysarthria, dysesthesia, dysautonomia, encephalopathy, cranial palsy, grand mal convulsion, headache, hemorrhagic stroke, motor dysfunction, neuralgia, spinal cord compression, paralysis, postherpetic neuralgia, transient ischemic attack

Psychiatric disorders*:* Agitation, anxiety, confusion, insomnia, mental status change, psychotic disorder, suicidal ideation

Renal and urinary disorders: Calculus renal, bilateral hydronephrosis, bladder spasm, hematuria, hemorrhagic cystitis, urinary incontinence, urinary retention, renal failure (acute and chronic), glomerular nephritis proliferative

Respiratory, thoracic and mediastinal disorders: Acute respiratory distress syndrome, aspiration pneumonia, atelectasis, chronic obstructive airways disease exacerbated, cough, dysphagia, dyspnea, dyspnea exertional, epistaxis, hemoptysis, hypoxia, lung infiltration, pleural effusion, pneumonitis, respiratory distress, pulmonary hypertension

Skin and subcutaneous tissue disorders*:* Urticaria, face edema, rash (which may be pruritic), leukocytoclastic vasculitis, pruritus.

Vascular disorders: Cerebrovascular accident, cerebral hemorrhage, deep venous thrombosis, hypertension, peripheral embolism, pulmonary embolism, pulmonary hypertension

6.2 Postmarketing Experience

The following adverse reactions have been identified from the worldwide postmarketing experience with VELCADE. Because these reactions 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 drug exposure: atrioventricular block complete, cardiac tamponade, ischemic colitis, encephalopathy, dysautonomia, deafness bilateral, disseminated intravascular coagulation, hepatitis, acute pancreatitis, progressive multifocal leukoencephalopathy (PML), acute diffuse infiltrative pulmonary disease, PRES (formerly RPLS), toxic epidermal necrolysis, acute febrile neutrophilic dermatosis (Sweet's syndrome), herpes meningoencephalitis, optic neuropathy, blindness and ophthalmic herpes.

7 DRUG INTERACTIONS

Bortezomib is a substrate of cytochrome P450 enzyme 3A4, 2C19 and 1A2.

7.1 CYP3A4 inhibitors

Co-administration of ketoconazole, a strong CYP3A4 inhibitor, increased the exposure of bortezomib by 35% in 12 patients. Monitor patients for signs of bortezomib toxicity and consider a bortezomib dose reduction if bortezomib must be given in combination with strong CYP3A4 inhibitors (e.g. ketoconazole, ritonavir).

7.2 CYP2C19 inhibitors

Co-administration of omeprazole, a strong inhibitor of CYP2C19, had no effect on the exposure of bortezomib in 17 patients.

7.3 CYP3A4 inducers

Co-administration of rifampin, a strong CYP3A4 inducer, is expected to decrease the exposure of bortezomib by at least 45%. Because the drug interaction study (n=6) was not designed to exert the maximum effect of rifampin on bortezomib PK, decreases greater than 45% may occur.

Efficacy may be reduced when VELCADE is used in combination with strong CYP3A4 inducers; therefore, concomitant use of strong CYP3A4 inducers is not recommended in patients receiving VELCADE.

St. John's Wort (*Hypericum perforatum*) may decrease bortezomib exposure unpredictably and should be avoided.

7.4 Dexamethasone

Co-administration of dexamethasone, a weak CYP3A4 inducer, had no effect on the exposure of bortezomib in 7 patients.

7.5 Melphalan-Prednisone

Co-administration of melphalan-prednisone increased the exposure of bortezomib by 17% in 21 patients. However, this increase is unlikely to be clinically relevant.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category D [*see Warnings and Precautions (5.10)*].

Risk Summary

VELCADE may cause fetal harm when administered to a pregnant woman. There are no adequate and well-controlled studies in pregnant women. If VELCADE is used during pregnancy, or if the patient becomes pregnant while receiving this drug, the patient should be apprised of the potential hazard to the fetus. Bortezomib caused embryo-fetal lethality in rabbits at doses lower than the clinical dose.

Animal Data

Bortezomib was not teratogenic in nonclinical developmental toxicity studies in rats and rabbits at the highest dose tested (0.075 mg/kg; 0.5 mg/m^2 in the rat and 0.05 mg/kg; 0.6 mg/m^2 in the rabbit) when administered during organogenesis. These dosages are approximately 0.5 times the clinical dose of 1.3 mg/m^2 based on body surface area.

Pregnant rabbits given bortezomib during organogenesis at a dose of 0.05 mg/kg (0.6 mg/m^2) experienced significant post-implantation loss and decreased number of live fetuses. Live fetuses from these litters also showed significant decreases in fetal weight. The dose is approximately 0.5 times the clinical dose of 1.3 mg/m^2 based on body surface area.

8.3 Nursing Mothers

It is not known whether bortezomib is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VELCADE, 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

The safety and effectiveness of VELCADE in children have not been established.

8.5 Geriatric Use

Of the 669 patients enrolled in the relapsed multiple myeloma study, 245 (37%) were 65 years of age or older: 125 (38%) on the VELCADE arm and 120 (36%) on the dexamethasone arm. Median time to progression and median duration of response for patients ≥ 65 were longer on VELCADE compared to dexamethasone [5.5 mo versus 4.3 mo, and 8.0 mo versus 4.9 mo, respectively]. On the VELCADE arm, 40% (n=46) of evaluable patients aged ≥ 65 experienced response (CR+PR) versus 18% (n=21) on the dexamethasone arm. The incidence of Grade 3 and 4 events was 64%, 78% and 75% for VELCADE patients ≤ 50, 51-64 and ≥ 65 years old, respectively [*see Adverse Reactions (6.1); Clinical Studies (14.1)*].

No overall differences in safety or effectiveness were observed between patients ≥ age 65 and younger patients receiving VELCADE; but greater sensitivity of some older individuals cannot be ruled out.

8.6 Patients with Renal Impairment

The pharmacokinetics of VELCADE are not influenced by the degree of renal impairment. Therefore, dosing adjustments of VELCADE are not necessary for patients with renal insufficiency. Since dialysis may reduce VELCADE concentrations, VELCADE should be administered after the dialysis procedure [*see Clinical Pharmacology (12.3)*].

8.7 Patients with Hepatic Impairment

The exposure of bortezomib is increased in patients with moderate (bilirubin ≥ 1.5 – 3x ULN) and severe (bilirubin > 3 x ULN) hepatic impairment. Starting dose should be reduced in those patients [*see Dosage and Administration (2.8), Clinical Pharmacology (12.3)*].

8.8 Patients with Diabetes

During clinical trials, hypoglycemia and hyperglycemia were reported in diabetic patients receiving oral hypoglycemics. Patients on oral anti-diabetic agents receiving VELCADE treatment may require close monitoring of their blood glucose levels and adjustment of the dose of their anti-diabetic medication.

10 OVERDOSAGE

There is no known specific antidote for VELCADE overdosage. In humans, fatal outcomes following the administration of more than twice the recommended therapeutic dose have been reported, which were

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associated with the acute onset of symptomatic hypotension (5.2) and thrombocytopenia (5.7). In the event of an overdosage, the patient's vital signs should be monitored and appropriate supportive care given.

Studies in monkeys and dogs showed that intravenous bortezomib doses as low as 2 times the recommended clinical dose on a mg/m^2 basis were associated with increases in heart rate, decreases in contractility, hypotension, and death. In dog studies, a slight increase in the corrected QT interval was observed at doses resulting in death. In monkeys, doses of 3.0 mg/m^2 and greater (approximately twice the recommended clinical dose) resulted in hypotension starting at 1 hour post-administration, with progression to death in 12 to 14 hours following drug administration.

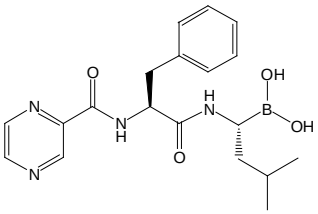
11 DESCRIPTION

VELCADE® (bortezomib) for Injection is an antineoplastic agent available for intravenous injection or subcutaneous use. Each single use vial contains 3.5 mg of bortezomib as a sterile lyophilized powder. Inactive ingredient: 35 mg mannitol, USP.

Bortezomib is a modified dipeptidyl boronic acid. The product is provided as a mannitol boronic ester which, in reconstituted form, consists of the mannitol ester in equilibrium with its hydrolysis product, the monomeric boronic acid. The drug substance exists in its cyclic anhydride form as a trimeric boroxine.

The chemical name for bortezomib, the monomeric boronic acid, is [(1R)-3-methyl-1-[[(2S)-1-oxo-3-phenyl-2-[(pyrazinylcarbonyl) amino]propyl]amino]butyl] boronic acid.

Bortezomib has the following chemical structure:



The molecular weight is 384.24. The molecular formula is $C_{19}H_{25}BN_4O_4$. The solubility of bortezomib, as the monomeric boronic acid, in water is 3.3 to 3.8 mg/mL in a pH range of 2 to 6.5.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Bortezomib is a reversible inhibitor of the chymotrypsin-like activity of the 26S proteasome in mammalian cells. The 26S proteasome is a large protein complex that degrades ubiquitinated proteins. The ubiquitin-proteasome pathway plays an essential role in regulating the intracellular concentration of specific proteins, thereby maintaining homeostasis within cells. Inhibition of the 26S proteasome prevents this targeted proteolysis, which can affect multiple signaling cascades within the cell. This disruption of normal homeostatic mechanisms can lead to cell death. Experiments have demonstrated that bortezomib is cytotoxic to a variety of cancer cell types *in vitro*. Bortezomib causes a delay in tumor growth *in vivo* in nonclinical tumor models, including multiple myeloma.

12.2 Pharmacodynamics

Following twice weekly administration of 1 mg/m^2 and 1.3 mg/m^2 bortezomib doses (n=12 per each dose level), the maximum inhibition of 20S proteasome activity (relative to baseline) in whole blood was observed 5 minutes after drug administration. Comparable maximum inhibition of 20S proteasome activity was observed between 1 and 1.3 mg/m^2 doses. Maximal inhibition ranged from 70% to 84% and from 73% to 83% for the 1 mg/m^2 and 1.3 mg/m^2 dose regimens, respectively.

12.3 Pharmacokinetics

Following intravenous administration of 1 mg/m^2 and 1.3 mg/m^2 doses to 24 patients with multiple myeloma (n=12, per each dose level), the mean maximum plasma concentrations of bortezomib (C_{max}) after the first dose

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(Day 1) were 57 and 112 ng/mL, respectively. In subsequent doses, when administered twice weekly, the mean maximum observed plasma concentrations ranged from 67 to 106 ng/mL for the 1 mg/m^2 dose and 89 to 120 ng/mL for the 1.3 mg/m^2 dose. The mean elimination half-life of bortezomib upon multiple dosing ranged from 40 to 193 hours after the 1 mg/m^2 dose and 76 to 108 hours after the 1.3mg/m^2 dose. The mean total body clearances was 102 and 112 L/h following the first dose for doses of 1 mg/m^2 and 1.3 mg/m^2, respectively, and ranged from 15 to 32 L/h following subsequent doses for doses of 1 and 1.3 mg/m^2, respectively.

Following an intravenous bolus or subcutaneous injection of a 1.3 mg/m^2 dose to patients (n = 14 for intravenous, n = 17 for subcutaneous) with multiple myeloma, the total systemic exposure after repeat dose administration (AUC_{last}) was equivalent for subcutaneous and intravenous administration. The C_{max} after subcutaneous administration (20.4 ng/mL) was lower than intravenous (223 ng/mL). The AUC_{last} geometric mean ratio was 0.99 and 90% confidence intervals were 80.18% - 122.80%.

Distribution: The mean distribution volume of bortezomib ranged from approximately 498 to 1884 L/m^2 following single- or repeat-dose administration of 1 mg/m^2 or 1.3mg/m^2 to patients with multiple myeloma. This suggests bortezomib distributes widely to peripheral tissues. The binding of bortezomib to human plasma proteins averaged 83% over the concentration range of 100 to 1000 ng/mL.

Metabolism: *In vitro* studies with human liver microsomes and human cDNA-expressed cytochrome P450 isozymes indicate that bortezomib is primarily oxidatively metabolized via cytochrome P450 enzymes 3A4, 2C19, and 1A2. Bortezomib metabolism by CYP 2D6 and 2C9 enzymes is minor. The major metabolic pathway is deboronation to form 2 deboronated metabolites that subsequently undergo hydroxylation to several metabolites. Deboronated bortezomib metabolites are inactive as 26S proteasome inhibitors. Pooled plasma data from 8 patients at 10 min and 30 min after dosing indicate that the plasma levels of metabolites are low compared to the parent drug.

Elimination: The pathways of elimination of bortezomib have not been characterized in humans.

Age: Analyses of data after the first dose of Cycle 1 (Day 1) in 39 multiple myeloma patients who had received intravenous doses of 1 mg/m^2 and 1.3 mg/m^2 showed that both dose-normalized AUC and C_{max} tend to be less in younger patients. Patients < 65 years of age (n=26) had about 25% lower mean dose-normalized AUC and C_{max} than those ≥ 65 years of age (n=13).

Gender: Mean dose-normalized AUC and C_{max} values were comparable between male (n=22) and female (n=17) patients after the first dose of Cycle 1 for the 1 and 1.3 mg/m^2 doses.

Race: The effect of race on exposure to bortezomib could not be assessed as most of the patients were Caucasian.

Hepatic Impairment: The effect of hepatic impairment (see Table 6 for definition of hepatic impairment) on the pharmacokinetics of bortezomib was assessed in 60 patients with cancer at bortezomib doses ranging from 0.5 to 1.3 mg/m^2. When compared to patients with normal hepatic function, mild hepatic impairment did not alter dose-normalized bortezomib AUC. However, the dose-normalized mean AUC values were increased by approximately 60% in patients with moderate or severe hepatic impairment. A lower starting dose is recommended in patients with moderate or severe hepatic impairment, and those patients should be monitored closely [*see Dosage and Administration (2.8) and Use in Specific Populations (8.7)*].

Renal Impairment: A pharmacokinetic study was conducted in patients with various degrees of renal impairment who were classified according to their creatinine clearance values (CrCl) into the following groups: Normal (CrCl ≥60 mL/min/1.73 m^2, N=12), Mild (CrCl=40-59 mL/min/1.73 m^2, N=10), Moderate (CrCl=20-39 mL/min/1.73 m^2, N=9), and Severe (CrCl < 20 mL/min/1.73 m^2, N=3). A group of dialysis patients who were dosed after dialysis was also included in the study (N=8). Patients were administered intravenous doses of 0.7 to 1.3 mg/m^2 of bortezomib twice weekly. Exposure of bortezomib (dose-normalized AUC and C_{max}) was comparable among all the groups [*see Use in Specific Populations (8.6)*].

Pediatric: There are no pharmacokinetic data in pediatric patients.

Cytochrome P450: Bortezomib is a poor inhibitor of human liver microsome cytochrome P450 1A2, 2C9, 2D6, and 3A4, with IC_{50} values of > 30µM (> 11.5µg/mL). Bortezomib may inhibit 2C19 activity (IC_{50} = 18 µM, 6.9 µg/mL) and increase exposure to drugs that are substrates for this enzyme. Bortezomib did not induce the activities of cytochrome P450 3A4 and 1A2 in primary cultured human hepatocytes.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenicity studies have not been conducted with bortezomib.

Bortezomib showed clastogenic activity (structural chromosomal aberrations) in the in vitro chromosomal aberration assay using Chinese hamster ovary cells. Bortezomib was not genotoxic when tested in the in vitro mutagenicity assay (Ames test) and in vivo micronucleus assay in mice.

Fertility studies with bortezomib were not performed but evaluation of reproductive tissues has been performed in the general toxicity studies. In the 6-month rat toxicity study, degenerative effects in the ovary were observed at doses ≥ 0.3 mg/m^2 (one-fourth of the recommended clinical dose), and degenerative changes in the testes occurred at 1.2 mg/m^2. VELCADE could have a potential effect on either male or female fertility.

13.2 Animal Toxicology and/or Pharmacology

Cardiovascular Toxicity: Studies in monkeys showed that administration of dosages approximately twice the recommended clinical dose resulted in heart rate elevations, followed by profound progressive hypotension, bradycardia, and death 12 to 14 hours post dose. Doses ≥ 1.2 mg/m^2 induced dose-proportional changes in cardiac parameters. Bortezomib has been shown to distribute to most tissues in the body, including the myocardium. In a repeated dosing toxicity study in the monkey, myocardial hemorrhage, inflammation, and necrosis were also observed.

Chronic Administration: In animal studies at a dose and schedule similar to that recommended for patients (twice weekly dosing for 2 weeks followed by 1-week rest), toxicities observed included severe anemia and thrombocytopenia, and gastrointestinal, neurological and lymphoid system toxicities. Neurotoxic effects of bortezomib in animal studies included axonal swelling and degeneration in peripheral nerves, dorsal spinal roots, and tracts of the spinal cord. Additionally, multifocal hemorrhage and necrosis in the brain, eye, and heart were observed.

14 CLINICAL STUDIES

14.1 Multiple Myeloma

Randomized, Open-Label Clinical Study in Patients with Previously Untreated Multiple Myeloma:
A prospective, international, randomized (1:1), open-label clinical study of 682 patients was conducted to determine whether VELCADE administered intravenously (1.3 mg/m^2) in combination with melphalan (9 mg/m^2) and prednisone (60 mg/m^2) resulted in improvement in time to progression (TTP) when compared to melphalan (9 mg/m^2) and prednisone (60 mg/m^2) in patients with previously untreated multiple myeloma. Treatment was administered for a maximum of 9 cycles (approximately 54 weeks) and was discontinued early for disease progression or unacceptable toxicity. Antiviral prophylaxis was recommended for patients on the VELCADE study arm.

The median age of the patients in the study was 71 years (48;91), 50% were male, 88% were Caucasian and the median Karnofsky performance status score for the patients was 80 (60;100). Patients had IgG/IgA/Light chain myeloma in 63%/25%/8% instances, a median hemoglobin of 105 g/L (64;165), and a median platelet count of 221,500 /microliter (33,000;587,000).

Efficacy results for the trial are presented in Table 14. At a pre-specified interim analysis (with median follow-up of 16.3 months), the combination of VELCADE, melphalan and prednisone therapy resulted in significantly superior results for time to progression, progression-free survival, overall survival and response rate. Further enrollment was halted, and patients receiving melphalan and prednisone were offered VELCADE in addition.

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A later, pre-specified analysis of overall survival (with median follow-up of 36.7 months with a hazard ratio of 0.65, 95% CI: 0.51, 0.84) resulted in a statistically significant survival benefit for the VELCADE, melphalan and prednisone treatment arm despite subsequent therapies including VELCADE based regimens. In an updated analysis of overall survival based on 387 deaths (median follow-up 60.1 months), the median overall survival for the VELCADE, melphalan and prednisone treatment arm was 56.4 months and for the melphalan and prednisone treatment arm was 43.1 months, with a hazard ratio of 0.695 (95% CI: 0.57, 0.85).

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Table 14: Summary of Efficacy Analyses in the Previously Untreated Multiple Myeloma Study

Efficacy Endpoint	VELCADE, Melphalan and Prednisone n=344	Melphalan and Prednisone n=338
Time to Progression		
Events n (%)	101 (29)	152 (45)
Median[a] (months)	20.7	15.0
(95% CI)	(17.6, 24.7)	(14.1, 17.9)
Hazard ratio[b]	0.54	
(95% CI)	(0.42, 0.70)	
p-value[c]	0.000002	
Progression-free Survival		
Events n (%)	135 (39)	190 (56)
Median[a] (months)	18.3	14.0
(95% CI)	(16.6, 21.7)	(11.1, 15.0)
Hazard ratio[b]	0.61	
(95% CI)	(0.49, 0.76)	
p-value[c]	0.00001	
Response Rate		
CR[d] n (%)	102 (30)	12 (4)
PR[d] n (%)	136 (40)	103 (30)
nCR n (%)	5 (1)	0
CR + PR[d] n (%)	238 (69)	115 (34)
p-value[e]	$<10^{-10}$	
Overall Survival at median follow up of 36.7 months		
Events (deaths) n (%)	109 (32)	148 (44)
Median[a] (months)	Not Reached	43.1
(95% CI)	(46.2, NR)	(34.8, NR)
Hazard ratio[b]	0.65	
(95% CI)	(0.51, 0.84)	
p-value[c]	0.00084	

Note: All results are based on the analysis performed at a median follow-up duration of 16.3 months except for the overall survival analysis.

[a] Kaplan-Meier estimate

[b] Hazard ratio estimate is based on a Cox proportional-hazard model adjusted for stratification factors: beta2-microglobulin, albumin, and region. A hazard ratio less than 1 indicates an advantage for VELCADE, melphalan and prednisone

[c] p-value based on the stratified log-rank test adjusted for stratification factors: beta2-microglobulin, albumin, and region

[d] EBMT criteria

[e] p-value for Response Rate (CR + PR) from the Cochran-Mantel-Haenszel chi-square test adjusted for the stratification factors

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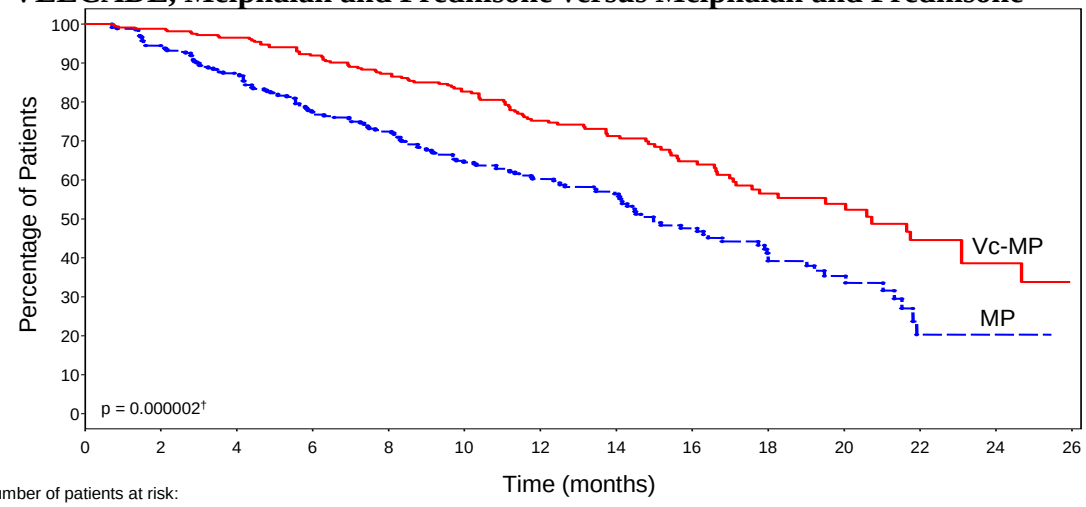
TTP was statistically significantly longer on the VELCADE, melphalan and prednisone arm (see Figure 1). (median follow-up 16.3 months)

Figure 1: Time to Progression
VELCADE, Melphalan and Prednisone versus Melphalan and Prednisone



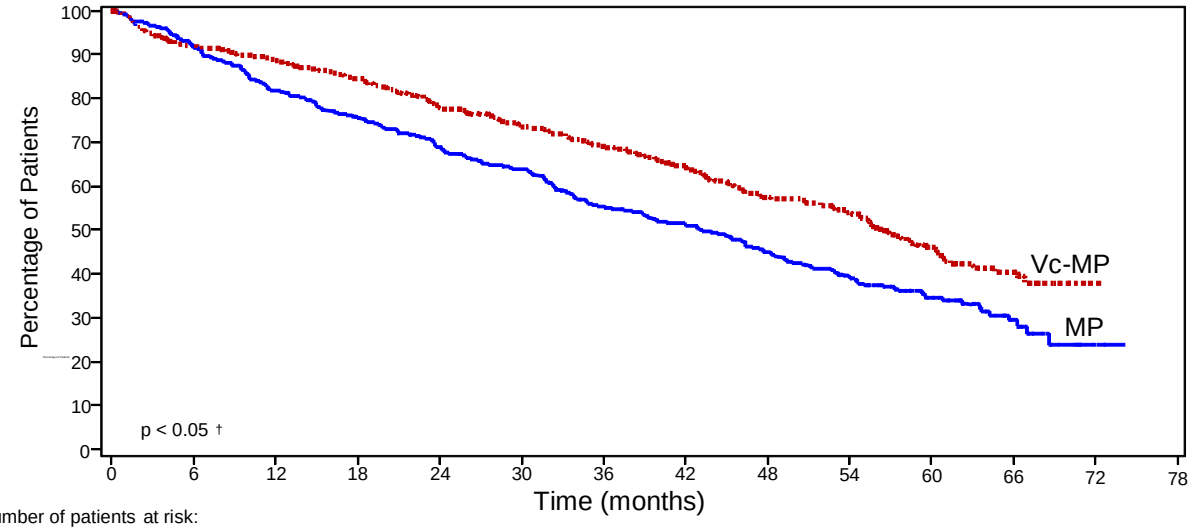
Number of patients at risk:

Vc-MP (n*)	344	309	280	258	240	200	159	114	81	53	35	20	13
MP (n*)	338	298	264	218	200	160	128	90	61	41	20	6	3

* Patients remaining after the indicated timepoint
† p-value from log-rank test

Overall survival was statistically significantly longer on the VELCADE, melphalan and prednisone arm (see Figure 2). (median follow-up 60.1 months)

Figure 2: Overall Survival
VELCADE, Melphalan and Prednisone versus Melphalan and Prednisone



Number of patients at risk:

Vc-MP (n*):	344	300	288	270	246	232	216	199	176	158	78	34	1	0
MP (n*):	338	301	262	240	216	196	168	153	133	112	61	24	3	0

* Patients remaining after the indicated timepoint
† p-value from log-rank test

Randomized, Clinical Study in Relapsed Multiple Myeloma of VELCADE versus Dexamethasone
A prospective phase 3, international, randomized (1:1), stratified, open-label clinical study enrolling 669 patients was designed to determine whether VELCADE resulted in improvement in time to progression (TTP) compared to high-dose dexamethasone in patients with progressive multiple myeloma following 1 to 3 prior therapies. Patients considered to be refractory to prior high-dose dexamethasone were excluded as were those with baseline Grade ≥ 2 peripheral neuropathy or platelet counts < 50,000/µL. A total of 627 patients were evaluable for response.

Stratification factors were based on the number of lines of prior therapy the patient had previously received (1 previous line versus more than 1 line of therapy), time of progression relative to prior treatment (progression during or within 6 months of stopping their most recent therapy versus relapse > 6 months after receiving their most recent therapy), and screening β_2-microglobulin levels (≤ 2.5 mg/L versus > 2.5 mg/L).

Baseline patient and disease characteristics are summarized in Table 15.

Table 15: Summary of Baseline Patient and Disease Characteristics in the Relapsed Multiple Myeloma Study

Patient Characteristics	**VELCADE N=333**	**Dexamethasone N=336**
Median age in years (range)	62.0 (33, 84)	61.0 (27, 86)
Gender: Male/female	56% / 44%	60% / 40%
Race: Caucasian/black/other	90% / 6% / 4%	88% / 7% / 5%
Karnofsky performance status score ≤70	13%	17%
Hemoglobin <100 g/L	32%	28%
Platelet count <75 x 10^9/L	6%	4%
Disease Characteristics		
Type of myeloma (%): IgG/IgA/Light chain	60% / 23% / 12%	59% / 24% / 13%
Median β_2-microglobulin (mg/L)	3.7	3.6
Median albumin (g/L)	39.0	39.0
Creatinine clearance ≤30 mL/min [n (%)]	17 (5%)	11 (3%)
Median Duration of Multiple Myeloma Since Diagnosis (Years)	3.5	3.1
Number of Prior Therapeutic Lines of Treatment		
Median	2	2
1 prior line	40%	35%
>1 prior line	60%	65%
Previous Therapy		
Any prior steroids, e.g., dexamethasone, VAD	98%	99%
Any prior anthracyclines, e.g., VAD, mitoxantrone	77%	76%
Any prior alkylating agents, e.g., MP, VBMCP	91%	92%
Any prior thalidomide therapy	48%	50%
Vinca alkaloids	74%	72%
Prior stem cell transplant/other high-dose therapy	67%	68%
Prior experimental or other types of therapy	3%	2%

Patients in the VELCADE treatment group were to receive eight 3-week treatment cycles followed by three 5-week treatment cycles of VELCADE. Patients achieving a CR were treated for 4 cycles beyond first evidence of CR. Within each 3-week treatment cycle, VELCADE 1.3 mg/m^2/dose alone was administered by intravenous bolus twice weekly for 2 weeks on Days 1, 4, 8, and 11 followed by a 10-day rest period (Days 12 to 21). Within each 5-week treatment cycle, VELCADE 1.3 mg/m^2/dose alone was administered by intravenous bolus

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once weekly for 4 weeks on Days 1, 8, 15, and 22 followed by a 13-day rest period (Days 23 to 35) [*see Dosage and Administration (2.2)*].

Patients in the dexamethasone treatment group were to receive four 5-week treatment cycles followed by five 4-week treatment cycles. Within each 5-week treatment cycle, dexamethasone 40 mg/day PO was administered once daily on Days 1 to 4, 9 to 12, and 17 to 20 followed by a 15-day rest period (Days 21-35). Within each 4-week treatment cycle, dexamethasone 40 mg/day PO was administered once daily on Days 1 to 4 followed by a 24-day rest period (Days 5 to 28). Patients with documented progressive disease on dexamethasone were offered VELCADE at a standard dose and schedule on a companion study. Following a preplanned interim analysis of time to progression, the dexamethasone arm was halted and all patients randomized to dexamethasone were offered VELCADE, regardless of disease status.

In the VELCADE arm, 34% of patients received at least one VELCADE dose in all 8 of the 3-week cycles of therapy, and 13% received at least one dose in all 11 cycles. The average number of VELCADE doses during the study was 22, with a range of 1 to 44. In the dexamethasone arm, 40% of patients received at least one dose in all 4 of the 5-week treatment cycles of therapy, and 6% received at least one dose in all 9 cycles.

The time to event analyses and response rates from the relapsed multiple myeloma study are presented in Table 16. Response and progression were assessed using the European Group for Blood and Marrow Transplantation (EBMT) criteria. Complete response (CR) required < 5% plasma cells in the marrow, 100% reduction in M-protein, and a negative immunofixation test (IF^-). Partial response (PR) requires ≥ 50% reduction in serum myeloma protein and ≥ 90% reduction of urine myeloma protein on at least 2 occasions for a minimum of at least 6 weeks along with stable bone disease and normal calcium. Near complete response (nCR) was defined as meeting all the criteria for complete response including 100% reduction in M-protein by protein electrophoresis; however, M-protein was still detectable by immunofixation (IF^+).

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Table 16: Summary of Efficacy Analyses in the Relapsed Multiple Myeloma Study

	All Patients		1 Prior Line of Therapy		> 1 Prior Line of Therapy	
	VELCADE	**Dex**	**VELCADE**	**Dex**	**VELCADE**	**Dex**
Efficacy Endpoint	**n=333**	**n=336**	**n=132**	**n=119**	**n=200**	**n=217**
Time to Progression						
Events n (%)	147 (44)	196 (58)	55 (42)	64 (54)	92 (46)	132 (61)
Median [a] (95% CI)	6.2 mo (4.9, 6.9)	3.5 mo (2.9, 4.2)	7.0 mo (6.2, 8.8)	5.6 mo (3.4, 6.3)	4.9 mo (4.2, 6.3)	2.9 mo (2.8, 3.5)
Hazard ratio [b] (95% CI)	0.55 (0.44, 0.69)		0.55 (0.38, 0.81)		0.54 (0.41, 0.72)	
p-value [c]	<0.0001		0.0019		<0.0001	
Overall Survival						
Events (deaths) n (%)	51 (15)	84 (25)	12 (9)	24 (20)	39 (20)	60 (28)
Hazard ratio [b] (95% CI)	0.57 (0.40, 0.81)		0.39 (0.19, 0.81)		0.65 (0.43, 0.97)	
p-value [c,d]	<0.05		<0.05		<0.05	
Response Rate						
Population [e] n = 627	n=315	n=312	n=128	n=110	n=187	n=202
CR [f] n (%)	20 (6)	2 (<1)	8 (6)	2 (2)	12 (6)	0 (0)
PR [f] n(%)	101 (32)	54 (17)	49 (38)	27 (25)	52 (28)	27 (13)
nCR [f,g] n(%)	21 (7)	3 (<1)	8 (6)	2 (2)	13 (7)	1 (<1)
CR + PR [f] n (%)	121 (38)	56 (18)	57 (45)	29 (26)	64 (34)	27 (13)
p-value [h]	<0.0001		0.0035		<0.0001	

[a] Kaplan-Meier estimate

[b] Hazard ratio is based on Cox proportional-hazard model with the treatment as single independent variable. A hazard ratio less than 1 indicates an advantage for VELCADE

[c] p-value based on the stratified log-rank test including randomization stratification factors

[d] Precise p-value cannot be rendered

[e] Response population includes patients who had measurable disease at baseline and received at least 1 dose of study drug

[f] EBMT criteria; nCR meets all EBMT criteria for CR but has positive IF. Under EBMT criteria nCR is in the PR category

[g] In 2 patients, the IF was unknown

[h] p-value for Response Rate (CR + PR) from the Cochran-Mantel-Haenszel chi-square test adjusted for the stratification factors

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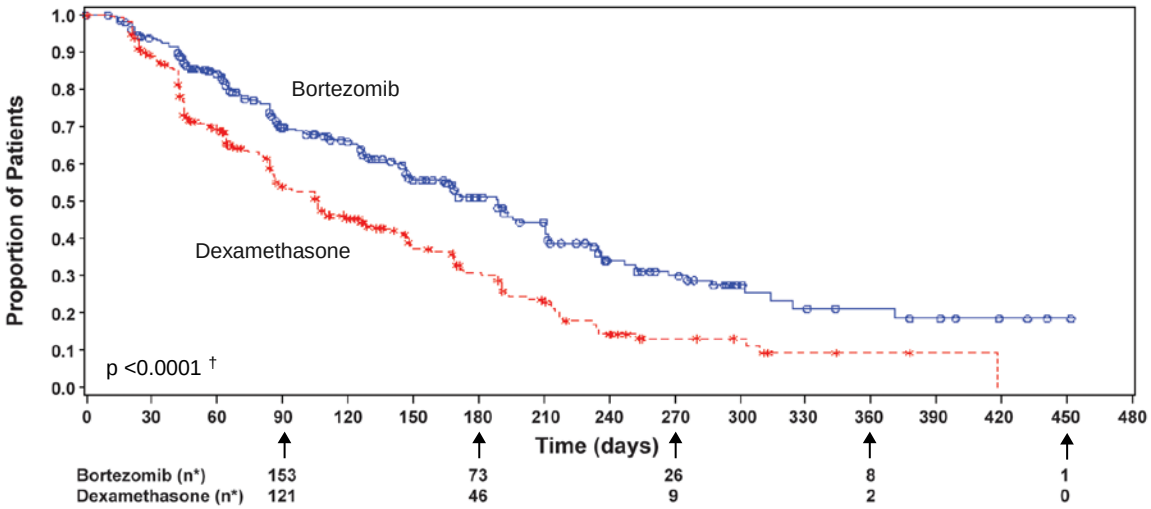
TTP was statistically significantly longer on the VELCADE arm (see Figure 3).

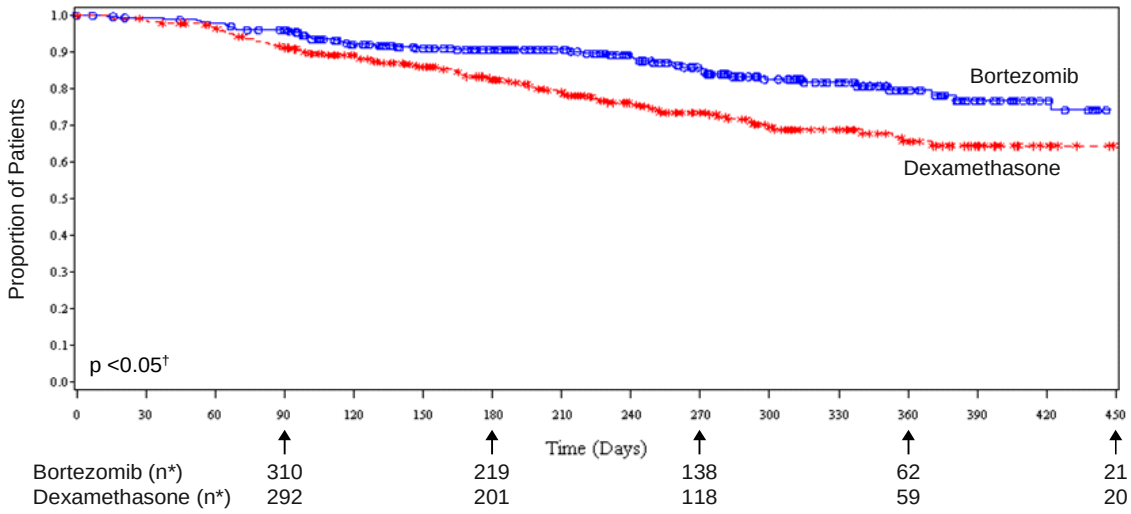
Figure 3: Time to Progression
Bortezomib versus Dexamethasone (relapsed multiple myeloma study)



* Patients remaining after the indicated timepoint
† p-value from log-rank test

As shown in Figure 4 VELCADE had a significant survival advantage relative to dexamethasone ($p < 0.05$). The median follow-up was 8.3 months.

Figure 4: Overall Survival
Bortezomib versus Dexamethasone (relapsed multiple myeloma study)



* Patients remaining after the indicated timepoint
† p-value from log-rank test

For the 121 patients achieving a response (CR or PR) on the VELCADE arm, the median duration was 8.0 months (95% CI: 6.9, 11.5 months) compared to 5.6 months (95% CI: 4.8, 9.2 months) for the 56 responders on the dexamethasone arm. The response rate was significantly higher on the VELCADE arm regardless of β_2-microglobulin levels at baseline.

Randomized, Open-Label Clinical Study of VELCADE Subcutaneous versus Intravenous in Relapsed Multiple Myeloma

An open-label, randomized, phase 3 non-inferiority study compared the efficacy and safety of the subcutaneous administration of VELCADE versus the intravenous administration. This study included 222 bortezomib naïve patients with relapsed multiple myeloma, who were randomized in a 2:1 ratio to receive 1.3 mg/m^2 of VELCADE by either the subcutaneous (n=148) or intravenous (n=74) route for 8 cycles. Patients who did not obtain an optimal response (less than Complete Response (CR)) to therapy with VELCADE alone after 4 cycles were allowed to receive oral dexamethasone 20 mg daily on the day of and after VELCADE administration (82 patients in subcutaneous treatment group and 39 patients in the intravenous treatment group). Patients with baseline Grade ≥ 2 peripheral neuropathy or neuropathic pain, or platelet counts < 50,000/µL were excluded. A total of 218 patients were evaluable for response.

Stratification factors were based on the number of lines of prior therapy the patient had received (1 previous line versus more than 1 line of therapy), and international staging system (ISS) stage (incorporating beta$_2$-microglobulin and albumin levels; Stages I, II, or III).

The baseline demographic and others characteristics of the two treatment groups are summarized as follows: the median age of the patient population was approximately 64 years of age (range 38-88 years), primarily male (subcutaneous: 50%, intravenous: 64%); the primary type of myeloma is IgG (subcutaneous: 65% IgG, 26% IgA, 8% light chain; intravenous: 72% IgG, 19% IgA, 8% light chain), ISS staging I/II/III (%) was 27, 41, 32 for both subcutaneous and intravenous, Karnofsky performance status score was ≤ 70% in 22% of subcutaneous and 16% of intravenous, creatinine clearance was 67.5 mL/min in subcutaneous and 73 mL/min in intravenous, the median years from diagnosis was 2.68 and 2.93 in subcutaneous and intravenous respectively and the proportion of patients with more than one prior line of therapy was 38% in subcutaneous and 35% in intravenous.

This study met its primary (non-inferiority) objective that single agent subcutaneous VELCADE retains at least 60% of the overall response rate after 4 cycles relative to single agent intravenous VELCADE. The results are provided in Table 17.

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Table 17: Summary of Efficacy Analyses in the Relapsed Multiple Myeloma Study of VELCADE Subcutaneous versus Intravenous

	Subcutaneous VELCADE	Intravenous VELCADE
Intent to Treat Population	**n=148**	**n=74**
Primary Endpoint		
Response Rate at 4 cycles		
ORR (CR+PR) n(%)	63 (43)	31 (42)
Ratio of Response Rates (95% CI)	1.01 (0.73, 1.40)	
CR n (%)	11 (7)	6 (8)
PR n (%)	52 (35)	25 (34)
nCR n (%)	9 (6)	4 (5)
Secondary Endpoints		
Response Rate at 8 cycles		
ORR (CR+PR)	78 (53)	38 (51)
CR n (%)	17 (11)	9 (12)
PR n (%)	61 (41)	29 (39)
nCR n (%)	14 (9)	7 (9)
Median Time to Progression, months	10.4	9.4
Median Progression Free Survival, months	10.2	8.0
1-year Overall Survival (%)[a]	72.6	76.7

[a] Median duration of follow up is 11.8 months

A Randomized Phase 2 Dose-Response Study in Relapsed Multiple Myeloma

An open-label, multicenter study randomized 54 patients with multiple myeloma who had progressed or relapsed on or after front-line therapy to receive VELCADE 1 mg/m^2 or 1.3 mg/m^2 intravenous bolus twice weekly for 2 weeks on Days 1, 4, 8, and 11 followed by a 10-day rest period (Days 12 to 21). The median duration of time between diagnosis of multiple myeloma and first dose of VELCADE on this trial was 2.0 years, and patients had received a median of 1 prior line of treatment (median of 3 prior therapies). A single complete response was seen at each dose. The overall response rates (CR + PR) were 30% (8/27) at 1 mg/m^2 and 38% (10/26) at 1.3 mg/m^2.

A Phase 2 Open-Label Extension Study in Relapsed Multiple Myeloma

Patients from the two phase 2 studies, who in the investigators' opinion would experience additional clinical benefit, continued to receive VELCADE beyond 8 cycles on an extension study. Sixty-three (63) patients from the phase 2 multiple myeloma studies were enrolled and received a median of 7 additional cycles of VELCADE therapy for a total median of 14 cycles (range 7 to 32). The overall median dosing intensity was the same in both the parent protocol and extension study. Sixty-seven percent (67%) of patients initiated the extension study at the same or higher dose intensity at which they completed the parent protocol, and 89% of patients maintained the standard 3-week dosing schedule during the extension study. No new cumulative or new long-term toxicities were observed with prolonged VELCADE treatment [*see Adverse Reactions (6.1)*].

A Single-Arm Trial of Retreatment in Relapsed Multiple Myeloma

A single arm, open-label trial was conducted to determine the efficacy and safety of retreatment with VELCADE. One hundred and thirty patients (≥ 18 years of age) with multiple myeloma who previously had at least partial response on a VELCADE-containing regimen (median of 2 prior lines of therapy [range 1-7]) were retreated upon progression with VELCADE administered intravenously. Patients were excluded from trial participation if they had peripheral neuropathy or neuropathic pain of Grade ≥2. At least 6 months after prior VELCADE therapy, VELCADE was restarted at the last tolerated dose of 1.3 mg/m^2 (n=93) or ≤ 1.0 mg/m^2

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(n=37) and given on days 1, 4, 8 and 11 every 3 weeks for maximum of 8 cycles either as single agent or in combination with dexamethasone in accordance with the standard of care. Dexamethasone was administered in combination with VELCADE to 83 patients in Cycle 1 with an additional 11 patients receiving dexamethasone during the course of VELCADE retreatment cycles.

The primary endpoint was best confirmed response to retreatment as assessed by European Group for Blood and Marrow Transplantation (EBMT) criteria. Fifty of the 130 patients achieved a best confirmed response of Partial Response or better for an overall response rate of 38.5% (95% CI: 30.1, 47.4). One patient achieved a Complete Response and 49 achieved Partial Response. In the 50 responding patients, the median duration of response was 6.5 months and the range was 0.6 to 19.3 months.

14.2 Mantle Cell Lymphoma

A Randomized, Open-Label Clinical Study in Patients with Previously Untreated Mantle Cell Lymphoma

A randomized, open-label, Phase 3 study was conducted in 487 adult patients with previously untreated mantle cell lymphoma (Stage II, III or IV) who were ineligible or not considered for bone marrow transplantation to determine whether VELCADE administered in combination with rituximab, cyclophosphamide, doxorubicin, and prednisone (VcR-CAP) resulted in improvement in progression free survival (PFS) when compared to the combination of rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone (R-CHOP). This clinical study utilized independent pathology confirmation and independent radiologic response assessment.

Patients in the VcR-CAP treatment arm received VELCADE (1.3 mg/m^2) administered intravenously on days 1, 4, 8, and 11 (rest period days 12-21); rituximab (375 mg/m^2) on Day 1; cyclophosphamide (750 mg/m^2) on Day 1; doxorubicin (50 mg/m^2) on Day 1; and prednisone (100 mg/m^2) on Day 1 through Day 5 of the the 21-day treatment cycle. For patients with a response first documented at cycle 6, two additional treatment cycles were allowed.

Median patient age was 66 years, 74% were male, 66% were Caucasian and 32% were Asian. 69% of patients had a positive bone marrow aspirate and/or a positive bone marrow biopsy for MCL, 54% of patients had an International Prognostic Index (IPI) score of 3 (high-intermediate) or higher and 76% had Stage IV disease.

The majority of the patients in both groups received 6 or more cycles of treatment, 84% in the VcR-CAP group and 83% in the R-CHOP group. Median number of cycles received by patients in both treatment arms was 6 with 17% of patients in the R-CHOP group and 14% of subjects in the VcR-CAP group receiving up to 2 additional cycles.

The efficacy results of the study with a median follow-up of 40 months are presented in Table 18. The response criteria used to assess efficacy were based on the International Workshop to Standardize Response Criteria for Non-Hodgkin's Lymphoma (IWRC). The combination of VcR-CAP resulted in statistically significant prolongation of PFS compared with R-CHOP (see Table 18 and Figure 5).

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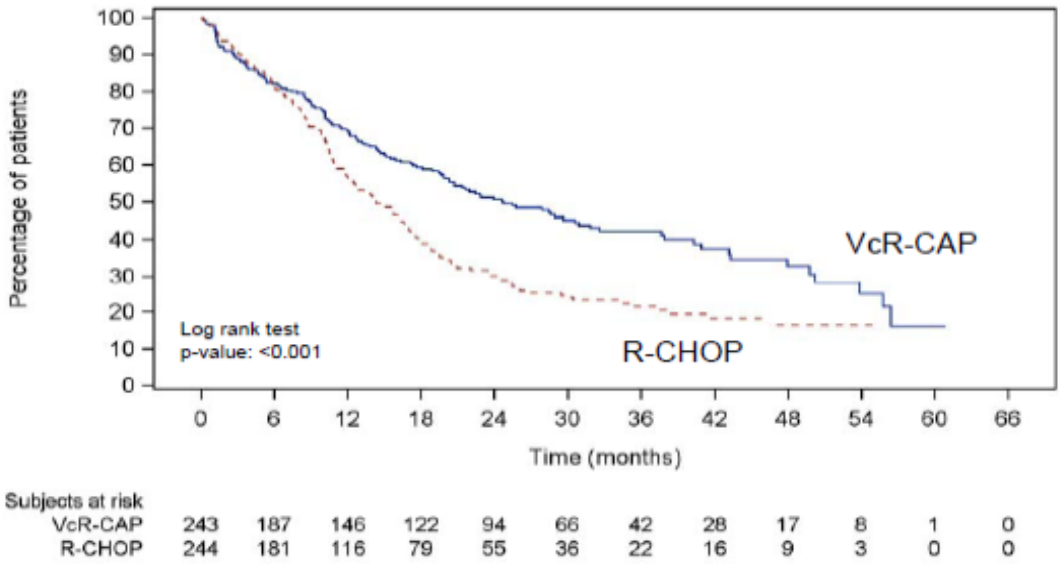
Table 18: Summary of Efficacy Analyses in the Previously Untreated Mantle Cell Lymphoma Study

Efficacy endpoint **n: Intent to Treat patients**	**VcR-CAP** **n=243**	**R-CHOP** **n=244**
Progression-free Survival (by independent radiographic assessment)		
Events n (%)	133 (55)	165 (68)
Median[a] (months)	25	14
(95% CI)	(20, 32)	(12, 17)
Hazard ratio[b]	0.63	
(95% CI)	(0.50, 0.79)	
p-value [c]	<0.001	
Complete Response Rate (CR)[d]		
n (%)	108 (44)	82 (34)
(95% CI)	(38, 51)	(28, 40)
Overall Response Rate (CR+CRu+PR)[e]		
n (%)	214 (88)	208 (85)
(95% CI)	(83, 92)	(80, 89)

[a] Based on Kaplan-Meier product limit estimates.
[b] Hazard ratio estimate is based on a Cox's model stratified by IPI risk and stage of disease. A hazard ratio < 1 indicates an advantage for VcR-CAP.
[c] Based on Log rank test stratified with IPI risk and stage of disease.
[d] Includes CR by independent radiographic assessment, bone marrow, and LDH using ITT population.
[e] Includes CR+ CRu+PR by independent radiographic assessment, regardless of the verification by bone marrow and LDH, using ITT population.
CI=Confidence Interval; IPI= International Prognostic Index; LDH=Lactate dehydrogenase

Figure 5: Progression Free Survival
VcR-CAP versus R-CHOP (previously untreated mantle cell lymphoma study)



Key: R-CHOP=rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone;
VcR-CAP=VELCADE, rituximab, cyclophosphamide, doxorubicin, and prednisone.

A Phase 2 Single-arm Clinical Study in Relapsed Mantle Cell Lymphoma After Prior Therapy

The safety and efficacy of VELCADE in relapsed or refractory mantle cell lymphoma were evaluated in an open-label, single-arm, multicenter study of 155 patients with progressive disease who had received at least 1

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prior therapy. The median age of the patients was 65 years (42, 89), 81% were male, and 92% were Caucasian. Of the total, 75% had one or more extra-nodal sites of disease, and 77% were stage 4. In 91% of the patients, prior therapy included all of the following: an anthracycline or mitoxantrone, cyclophosphamide, and rituximab. A total of thirty seven percent (37%) of patients were refractory to their last prior therapy. An intravenous bolus injection of VELCADE 1.3 mg/m^2/dose was administered twice weekly for 2 weeks on Days 1, 4, 8, and 11 followed by a 10-day rest period (Days 12 to 21) for a maximum of 17 treatment cycles. Patients achieving a CR or CRu were treated for 4 cycles beyond first evidence of CR or CRu. The study employed dose modifications for toxicity [*see Dosage and Administration (2.6, 2.7)*].

Responses to VELCADE are shown in Table 19. Response rates to VELCADE were determined according to the International Workshop Response Criteria (IWRC) based on independent radiologic review of CT scans. The median number of cycles administered across all patients was 4; in responding patients the median number of cycles was 8. The median time to response was 40 days (range 31 to 204 days). The median duration of follow-up was more than 13 months.

Table 19: Response Outcomes in a Phase 2 Relapsed Mantle Cell Lymphoma Study

Response Analyses (N = 155)	**N (%)**	**95% CI**
Overall Response Rate (IWRC) (CR + CRu + PR)	48 (31)	(24, 39)
Complete Response (CR + CRu)	12 (8)	(4, 13)
CR	10 (6)	(3, 12)
CRu	2 (1)	(0, 5)
Partial Response (PR)	36 (23)	(17, 31)
Duration of Response	**Median**	**95% CI**
CR + CRu + PR (N = 48)	9.3 months	(5.4, 13.8)
CR + CRu (N = 12)	15.4 months	(13.4, 15.4)
PR (N=36)	6.1 months	(4.2, 9.3)

15 REFERENCES

1. “OSHA Hazardous Drugs” (refer to antineoplastic weblinks including OSHA Technical Manual). *OSHA.* http://www.osha.gov/SLTC/hazardousdrugs/index.html

16 HOW SUPPLIED/STORAGE AND HANDLING

VELCADE® (bortezomib) for Injection is supplied as individually cartoned 10 mL vials containing 3.5 mg of bortezomib as a white to off-white cake or powder.

NDC 63020-049-01
3.5 mg single use vial

Unopened vials may be stored at controlled room temperature 25ºC (77ºF); excursions permitted from 15 to 30ºC (59 to 86ºF) [see USP Controlled Room Temperature]. Retain in original package to protect from light.

Follow guidelines for handling and disposal for cytotoxic drugs, including the use of gloves and other protective clothing to prevent skin contact[1].

17 PATIENT COUNSELING INFORMATION

Discuss the following with patients prior to treatment with VELCADE:

Ability to Drive or Operate Machinery or Impairment of Mental Ability: VELCADE may cause fatigue, dizziness, syncope, orthostatic/postural hypotension. Advise patients not to drive or operate machinery if they experience any of these symptoms.

Dehydration/Hypotension: Patients receiving VELCADE therapy may experience vomiting and/or diarrhea. Advise patients how to avoid dehydration. Instruct patients to seek medical advice if they experience symptoms of dizziness, light headedness or fainting spells, or muscle cramps.

Pregnancy/Nursing: Advise patients to use effective contraceptive measures to prevent pregnancy during treatment with VELCADE. Instruct patients to report pregnancy to their physicians immediately. Advise patients that they should not receive VELCADE while pregnant or breast-feeding. If a patient wishes to restart breastfeeding after treatment, she should be advised to discuss the appropriate timing with her physician.

Concomitant Medications: Advise patients to speak with their physicians about any other medication they are currently taking.

Diabetic Patients: Advise patients to check their blood sugar frequently if using an oral antidiabetic medication and to notify their physicians of any changes in blood sugar level.

Peripheral Neuropathy and Nervous System: Advise patients to contact their physicians if they experience new or worsening symptoms of peripheral neuropathy such as tingling, numbness, pain, a burning feeling in the feet or hands, or weakness in the arms or legs. Advise patients to contact their physicians if they experience symptoms possibly indicative of PRES [*see Warnings and Precautions (5.5)*] or PML, such as convulsion, persistent headache, reduced eyesight, blurred vision, confusion, lethargy, altered ability to think, or difficulty walking.

Cardiac: Advise patients to contact their physicians if they experience swelling of the feet, ankles, or legs or other heart-related problems [*see Warnings and Precautions (5.3)*].

Respiratory: Advise patients to contact their physicians if they experience shortness of breath, cough, or other lung problems [see *Warnings and Precautions (5.4)*].

Hepatic: Advise patients to contact their physicians if they experience jaundice or right upper quadrant abdominal pain [*see Warnings and Precautions (5.9)*].

Dermal: Advise patients to contact their physicians if they experience rash, severe injection site reactions [*see Dosage and Administration (2.9)*], or skin pain. Discuss with patients the option for antiviral prophylaxis for herpes virus infection [*see Clinical Trials Safety Experience (6.1)*].

Other: Instruct patients to contact their physicians if they develop an increase in blood pressure, bleeding, fever, constipation, or decreased appetite.

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