

## HIGHLIGHTS OF PRESCRIBING INFORMATION

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

HUMIRA (adalimumab) injection, for subcutaneous use  
Initial U.S. Approval: 2002

**WARNING: SERIOUS INFECTIONS AND MALIGNANCY**  
See full prescribing information for complete boxed warning.

### SERIOUS INFECTIONS (5.1, 6.1):

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

### MALIGNANCY (5.2):

- Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers including HUMIRA.
- Post-marketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma, have occurred in adolescent and young adults with inflammatory bowel disease treated with TNF blockers including HUMIRA.

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

Indications and Usage, Ulcerative Colitis (1.6) ----- 9/2012

Dosage and Administration, Ulcerative Colitis (2.4) ----- 9/2012

Dosage and Administration, General Considerations for Administration (2.7) -  
----- 4/2013

Warnings and Precautions, Serious Infections (5.1) ----- 5/2013

Warnings and Precautions, Malignancies (5.2) ----- 5/2013

Warnings and Precautions, Hypersensitivity Reactions (5.3) ---- 5/2013

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

HUMIRA is a tumor necrosis factor (TNF) blocker indicated for treatment of:

#### Rheumatoid Arthritis (RA) (1.1):

- Reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active RA.

#### Juvenile Idiopathic Arthritis (JIA) (1.2):

- Reducing signs and symptoms of moderately to severely active polyarticular JIA in pediatric patients 4 years of age and older.

#### Psoriatic Arthritis (PsA) (1.3):

- Reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active PsA.

#### Ankylosing Spondylitis (AS) (1.4):

- Reducing signs and symptoms in adult patients with active AS.

#### Crohn's Disease (CD) (1.5):

- Reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy. Reducing signs and symptoms and inducing clinical remission in these patients if they have also lost response to or are intolerant to infliximab.

#### Ulcerative Colitis (UC) (1.6):

- Inducing and sustaining clinical remission in adult patients with moderately to severely active ulcerative colitis who have had an inadequate response to immunosuppressants such as corticosteroids, azathioprine or 6-mercaptopurine (6-MP). The effectiveness of HUMIRA has not been established in patients who have lost response to or were intolerant to TNF blockers.

#### Plaque Psoriasis (Ps) (1.7):

- The treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate.

### -----DOSAGE AND ADMINISTRATION-----

- Administered by subcutaneous injection (2)

#### Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis (2.1):

- 40 mg every other week.
  - Some patients with RA not receiving methotrexate may benefit from increasing the frequency to 40 mg every week.

#### Juvenile Idiopathic Arthritis (2.2):

- 15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg every other week
- ≥ 30 kg (66 lbs): 40 mg every other week

#### Crohn's Disease and Ulcerative Colitis (2.3, 2.4):

- Initial dose (Day 1): 160 mg (four 40 mg injections in one day or two 40 mg injections per day for two consecutive days)
- Second dose two weeks later (Day 15): 80 mg
  - Two weeks later (Day 29): Begin a maintenance dose of 40 mg every other week.
- For patients with Ulcerative Colitis only: Only continue HUMIRA in patients who have shown evidence of clinical remission by eight weeks (Day 57) of therapy.

#### Plaque Psoriasis (2.5):

- 80 mg initial dose, followed by 40 mg every other week starting one week after initial dose.

### -----DOSAGE FORMS AND STRENGTHS-----

- Injection: 40 mg/0.8 mL in a single-use prefilled pen (HUMIRA Pen) (3)
- Injection: 40 mg/0.8 mL in a single-use prefilled glass syringe (3)
- Injection: 20 mg/0.4 mL in a single-use prefilled glass syringe (3)
- Injection: 40 mg/0.8 mL in a single-use glass vial for institutional use only (3)

### -----CONTRAINDICATIONS-----

None (4)

### -----WARNINGS AND PRECAUTIONS-----

- Serious infections:* Do not start HUMIRA during an active infection. If an infection develops, monitor carefully, and stop HUMIRA if infection becomes serious (5.1)
- Invasive fungal infections:* For patients who develop a systemic illness on HUMIRA, consider empiric antifungal therapy for those who reside or travel to regions where mycoses are endemic (5.1)
- Malignancies:* Incidence of malignancies was greater in HUMIRA-treated patients than in controls (5.2)
- Anaphylaxis or serious allergic reactions* may occur (5.3)
- Hepatitis B virus reactivation:* Monitor HBV carriers during and several months after therapy. If reactivation occurs, stop HUMIRA and begin anti-viral therapy (5.4)
- Demyelinating disease:* Exacerbation or new onset, may occur (5.5)
- Cytopenias, pancytopenia:* Advise patients to seek immediate medical attention if symptoms develop, and consider stopping HUMIRA (5.6)
- Heart failure:* Worsening or new onset, may occur (5.8)
- Lupus-like syndrome:* Stop HUMIRA if syndrome develops (5.9)

### -----ADVERSE REACTIONS-----

Most common adverse reactions (incidence >10%): infections (e.g. upper respiratory, sinusitis), injection site reactions, headache and rash (6.1)  
**To report SUSPECTED ADVERSE REACTIONS, contact AbbVie Inc. at 1-800-633-9110 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch**

### -----DRUG INTERACTIONS-----

- Abatacept:* Increased risk of serious infection (5.1, 5.11, 7.2)
- Anakinra:* Increased risk of serious infection (5.1, 5.7, 7.2)
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See 17 for PATIENT COUNSELING INFORMATION and Medication Guide

Revised: 05/2013

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## FULL PRESCRIBING INFORMATION

### WARNING: SERIOUS INFECTIONS AND MALIGNANCY

#### SERIOUS INFECTIONS

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

Discontinue HUMIRA if a patient develops a serious infection or sepsis.

Reported infections include:

- Active tuberculosis (TB), including reactivation of latent TB. Patients with TB have frequently presented with disseminated or extrapulmonary disease. Test patients for latent TB before HUMIRA use and during therapy. Initiate treatment for latent TB prior to HUMIRA use.
- Invasive fungal infections, including histoplasmosis, coccidioidomycosis, candidiasis, aspergillosis, blastomycosis, and pneumocystosis. Patients with histoplasmosis or other invasive fungal infections may present with disseminated, rather than localized, disease. Antigen and antibody testing for histoplasmosis may be negative in some patients with active infection. Consider empiric anti-fungal therapy in patients at risk for invasive fungal infections who develop severe systemic illness.
- Bacterial, viral and other infections due to opportunistic pathogens, including Legionella and Listeria.

Carefully consider the risks and benefits of treatment with HUMIRA prior to initiating therapy in patients with chronic or recurrent infection.

Monitor patients closely for the development of signs and symptoms of infection during and after treatment with HUMIRA, including the possible development of TB in patients who tested negative for latent TB infection prior to initiating therapy [see *Warnings and Precautions (5.1)* and *Adverse Reactions (6.1)*].

#### MALIGNANCY

Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers including HUMIRA [see *Warnings and*

***Precautions (5.2)***. Post-marketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma, have been reported in patients treated with TNF blockers including HUMIRA. These cases have had a very aggressive disease course and have been fatal. The majority of reported TNF blocker cases have occurred in patients with Crohn's disease or ulcerative colitis and the majority were in adolescent and young adult males. Almost all these patients had received treatment with azathioprine or 6-mercaptopurine (6-MP) concomitantly with a TNF blocker at or prior to diagnosis. It is uncertain whether the occurrence of HSTCL is related to use of a TNF blocker or a TNF blocker in combination with these other immunosuppressants [*see Warnings and Precautions (5.2)*].

## **1 INDICATIONS AND USAGE**

### **1.1 Rheumatoid Arthritis**

HUMIRA is indicated for reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active rheumatoid arthritis. HUMIRA can be used alone or in combination with methotrexate or other non-biologic disease-modifying anti-rheumatic drugs (DMARDs).

### **1.2 Juvenile Idiopathic Arthritis**

HUMIRA is indicated for reducing signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in pediatric patients 4 years of age and older. HUMIRA can be used alone or in combination with methotrexate.

### **1.3 Psoriatic Arthritis**

HUMIRA is indicated for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active psoriatic arthritis. HUMIRA can be used alone or in combination with non-biologic DMARDs.

### **1.4 Ankylosing Spondylitis**

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

### **1.5 Crohn's Disease**

HUMIRA is indicated for reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active Crohn's disease who have had an

inadequate response to conventional therapy. HUMIRA is indicated for reducing signs and symptoms and inducing clinical remission in these patients if they have also lost response to or are intolerant to infliximab.

### 1.6 Ulcerative Colitis

HUMIRA is indicated for inducing and sustaining clinical remission in adult patients with moderately to severely active ulcerative colitis who have had an inadequate response to immunosuppressants such as corticosteroids, azathioprine or 6-mercaptopurine (6-MP). The effectiveness of HUMIRA has not been established in patients who have lost response to or were intolerant to TNF blockers [see *Clinical Studies (14.6)*].

### 1.7 Plaque Psoriasis

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

## 2 DOSAGE AND ADMINISTRATION

HUMIRA is administered by subcutaneous injection.

### 2.1 Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis

The recommended dose of HUMIRA for adult patients with rheumatoid arthritis (RA), psoriatic arthritis (PsA), or ankylosing spondylitis (AS) is 40 mg administered every other week. Methotrexate (MTX), other non-biologic DMARDs, glucocorticoids, nonsteroidal anti-inflammatory drugs (NSAIDs), and/or analgesics may be continued during treatment with HUMIRA. In the treatment of RA, some patients not taking concomitant MTX may derive additional benefit from increasing the dosing frequency of HUMIRA to 40 mg every week.

### 2.2 Juvenile Idiopathic Arthritis

The recommended dose of HUMIRA for pediatric patients 4 to 17 years of age with polyarticular juvenile idiopathic arthritis (JIA) is based on weight as shown below. MTX, glucocorticoids, NSAIDs, and/or analgesics may be continued during treatment with HUMIRA.

Pediatric Patients (4 to 17 years)	Dose
15 kg (33 lbs) to <30 kg (66 lbs)	20 mg every other week

	(20 mg Prefilled Syringe)
≥30 kg (66 lbs)	40 mg every other week (HUMIRA Pen or 40 mg Prefilled Syringe)

Limited data are available for HUMIRA treatment in pediatric patients with a weight below 15 kg.

### 2.3 Crohn's Disease

The recommended HUMIRA dose regimen for adult patients with Crohn's disease (CD) is 160 mg initially on Day 1 (given as four 40 mg injections in one day or as two 40 mg injections per day for two consecutive days), followed by 80 mg two weeks later (Day 15). Two weeks later (Day 29) begin a maintenance dose of 40 mg every other week. Aminosalicylates and/or corticosteroids may be continued during treatment with HUMIRA. Azathioprine, 6-mercaptopurine (6-MP) [see *Warnings and Precautions (5.2)*] or MTX may be continued during treatment with HUMIRA if necessary. The use of HUMIRA in CD beyond one year has not been evaluated in controlled clinical studies.

### 2.4 Ulcerative Colitis

The recommended HUMIRA dose regimen for adult patients with ulcerative colitis (UC) is 160 mg initially on Day 1 (given as four 40 mg injections in one day or as two 40 mg injections per day for two consecutive days), followed by 80 mg two weeks later (Day 15). Two weeks later (Day 29) continue with a dose of 40 mg every other week.

Only continue HUMIRA in patients who have shown evidence of clinical remission by eight weeks (Day 57) of therapy. Aminosalicylates and/or corticosteroids may be continued during treatment with HUMIRA. Azathioprine and 6-mercaptopurine (6-MP) [see *Warnings and Precautions (5.2)*] may be continued during treatment with HUMIRA if necessary.

### 2.5 Plaque Psoriasis

The recommended dose of HUMIRA for adult patients with plaque psoriasis (Ps) is an initial dose of 80 mg, followed by 40 mg given every other week starting one week after the initial dose. The use of HUMIRA in moderate to severe chronic Ps beyond one year has not been evaluated in controlled clinical studies.

### 2.6 Monitoring to Assess Safety

Prior to initiating HUMIRA and periodically during therapy, evaluate patients for active tuberculosis and test for latent infection [see *Warnings and Precautions (5.1)*].

## 2.7 General Considerations for Administration

HUMIRA is intended for use under the guidance and supervision of a physician. A patient may self-inject HUMIRA if a physician determines that it is appropriate, and with medical follow-up, as necessary, after proper training in subcutaneous injection technique.

Carefully inspect the solution in the HUMIRA Pen or prefilled syringe for particulate matter and discoloration prior to subcutaneous administration. If particulates and discolorations are noted, do not use the product. HUMIRA does not contain preservatives; therefore, discard unused portions of drug remaining from the syringe. NOTE: Instruct patients sensitive to latex not to handle the needle cover of the syringe because it contains dry rubber (latex).

Instruct patients using the HUMIRA Pen or prefilled syringe to inject the full amount in the syringe (0.8 mL), which provides 40 mg of HUMIRA, according to the directions provided in the Instructions for Use [see *Instructions for Use*].

Instruct patients (15 kg to <30 kg) using the pediatric pre-filled syringe, or their caregivers, to inject the full amount in the syringe (0.4 mL), which provides 20 mg of HUMIRA, according to the directions provided in the Instructions for Use.

Rotate injection sites and do not give injections into areas where the skin is tender, bruised, red or hard.

The HUMIRA institutional use vial is for use and administration within an institutional setting only, such as a hospital, physician's office or clinic. Withdraw the dose using a sterile needle and syringe and administer promptly by a healthcare provider within an institutional setting. Only administer one dose per vial. The vial does not contain preservatives; therefore, discard unused portions.

## 3 DOSAGE FORMS AND STRENGTHS

- **Pen**

Injection: A single-use pen (HUMIRA Pen), containing a 1 mL prefilled glass syringe with a fixed 27 gauge ½ inch needle, providing 40 mg (0.8 mL) of HUMIRA.

- **Prefilled Syringe**

Injection: A single-use, 1 mL prefilled glass syringe with a fixed 27 gauge ½ inch needle, providing 40 mg (0.8 mL) of HUMIRA.

Injection: A single-use, 1 mL prefilled glass syringe with a fixed 27 gauge ½ inch needle, providing 20 mg (0.4 mL) of HUMIRA.

- **Institutional Use Vial**

Injection: A single-use, glass vial, providing 40 mg (0.8 mL) of HUMIRA for institutional use only.

## 4 CONTRAINDICATIONS

None.

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Serious Infections

Patients treated with HUMIRA are at increased risk for developing serious infections involving various organ systems and sites that may lead to hospitalization or death [see *Boxed Warning*]. Opportunistic infections due to bacterial, mycobacterial, invasive fungal, viral, parasitic, or other opportunistic pathogens including aspergillosis, blastomycosis, candidiasis, coccidioidomycosis, histoplasmosis, legionellosis, listeriosis, pneumocystosis and tuberculosis have been reported with TNF blockers. Patients have frequently presented with disseminated rather than localized disease.

The concomitant use of a TNF blocker and abatacept or anakinra was associated with a higher risk of serious infections in patients with rheumatoid arthritis (RA); therefore, the concomitant use of HUMIRA and these biologic products is not recommended in the treatment of patients with RA [see *Warnings and Precautions (5.7, 5.11) and Drug Interactions (7.2)*].

Treatment with HUMIRA should not be initiated in patients with an active infection, including localized infections. Patients greater than 65 years of age, patients with co-morbid conditions and/or patients taking concomitant immunosuppressants (such as corticosteroids or methotrexate), may be at greater risk of infection. Consider the risks and benefits of treatment prior to initiating therapy in patients:

- with chronic or recurrent infection;
- who have been exposed to tuberculosis;
- with a history of an opportunistic infection;
- who have resided or traveled in areas of endemic tuberculosis or endemic mycoses, such as histoplasmosis, coccidioidomycosis, or blastomycosis; or



- with underlying conditions that may predispose them to infection.

### ***Tuberculosis***

Cases of reactivation of tuberculosis and new onset tuberculosis infections have been reported in patients receiving HUMIRA, including patients who have previously received treatment for latent or active tuberculosis. Reports included cases of pulmonary and extrapulmonary (i.e., disseminated) tuberculosis. Evaluate patients for tuberculosis risk factors and test for latent infection prior to initiating HUMIRA and periodically during therapy.

Treatment of latent tuberculosis infection prior to therapy with TNF blocking agents has been shown to reduce the risk of tuberculosis reactivation during therapy. Prior to initiating HUMIRA, assess if treatment for latent tuberculosis is needed; and consider an induration of  $\geq 5$  mm a positive tuberculin skin test result, even for patients previously vaccinated with Bacille Calmette-Guerin (BCG).

Consider anti-tuberculosis therapy prior to initiation of HUMIRA in patients with a past history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed, and for patients with a negative test for latent tuberculosis but having risk factors for tuberculosis infection. Despite prophylactic treatment for tuberculosis, cases of reactivated tuberculosis have occurred in patients treated with HUMIRA. Consultation with a physician with expertise in the treatment of tuberculosis is recommended to aid in the decision whether initiating anti-tuberculosis therapy is appropriate for an individual patient.

Strongly consider tuberculosis in the differential diagnosis in patients who develop a new infection during HUMIRA treatment, especially in patients who have previously or recently traveled to countries with a high prevalence of tuberculosis, or who have had close contact with a person with active tuberculosis.

### ***Monitoring***

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

Discontinue HUMIRA if a patient develops a serious infection or sepsis. For a patient who develops a new infection during treatment with HUMIRA, closely monitor them, perform a prompt and complete diagnostic workup appropriate for an immunocompromised patient, and initiate appropriate antimicrobial therapy.

## ***Invasive Fungal Infections***

If patients develop a serious systemic illness and they reside or travel in regions where mycoses are endemic, consider invasive fungal infection in the differential diagnosis. Antigen and antibody testing for histoplasmosis may be negative in some patients with active infection. Consider appropriate empiric antifungal therapy, taking into account both the risk for severe fungal infection and the risks of antifungal therapy, while a diagnostic workup is being performed. To aid in the management of such patients, consider consultation with a physician with expertise in the diagnosis and treatment of invasive fungal infections.

## **5.2 Malignancies**

Consider the risks and benefits of TNF-blocker treatment including HUMIRA prior to initiating therapy in patients with a known malignancy other than a successfully treated non-melanoma skin cancer (NMSC) or when considering continuing a TNF blocker in patients who develop a malignancy.

### **Malignancies in Adults**

In the controlled portions of clinical trials of some TNF-blockers, including HUMIRA, more cases of malignancies have been observed among TNF-blocker-treated adult patients compared to control-treated adult patients. During the controlled portions of 34 global HUMIRA clinical trials in adult patients with rheumatoid arthritis (RA), psoriatic arthritis (PsA), ankylosing spondylitis (AS), Crohn's disease (CD), ulcerative colitis (UC) and plaque psoriasis (Ps), malignancies, other than non-melanoma (basal cell and squamous cell) skin cancer, were observed at a rate (95% confidence interval) of 0.6 (0.38, 0.91) per 100 patient-years among 7304 HUMIRA-treated patients versus a rate of 0.6 (0.30, 1.03) per 100 patient-years among 4232 control-treated patients (median duration of treatment of 4 months for HUMIRA-treated patients and 4 months for control-treated patients). In 47 global controlled and uncontrolled clinical trials of HUMIRA in adult patients with RA, PsA, AS, CD, UC, and Ps, the most frequently observed malignancies, other than lymphoma and NMSC, were breast, colon, prostate, lung, and melanoma. The malignancies in HUMIRA-treated patients in the controlled and uncontrolled portions of the studies were similar in type and number to what would be expected in the general U.S. population according to the SEER database (adjusted for age, gender, and race).<sup>1</sup>

In controlled trials of other TNF blockers in adult patients at higher risk for malignancies (i.e., patients with COPD with a significant smoking history and cyclophosphamide-treated patients

with Wegener's granulomatosis), a greater portion of malignancies occurred in the TNF blocker group compared to the control group.

### ***Non-Melanoma Skin Cancer***

During the controlled portions of 34 global HUMIRA clinical trials in adult patients with RA, PsA, AS, CD, UC, and Ps, the rate (95% confidence interval) of NMSC was 0.7 (0.49, 1.08) per 100 patient-years among HUMIRA-treated patients and 0.2 (0.08, 0.59) per 100 patient-years among control-treated patients. Examine all patients, and in particular patients with a medical history of prior prolonged immunosuppressant therapy or psoriasis patients with a history of PUVA treatment for the presence of NMSC prior to and during treatment with HUMIRA.

### ***Lymphoma and Leukemia***

In the controlled portions of clinical trials of all the TNF-blockers in adults, more cases of lymphoma have been observed among TNF-blocker-treated patients compared to control-treated patients. In the controlled portions of 34 global HUMIRA clinical trials in adult patients with RA, PsA, AS, CD, UC and Ps, 3 lymphomas occurred among 7304 HUMIRA-treated patients versus 1 among 4232 control-treated patients. In 47 global controlled and uncontrolled clinical trials of HUMIRA in adult patients with RA, PsA, AS, CD, UC and Ps with a median duration of approximately 0.6 years, including 23,036 patients and over 34,000 patient-years of HUMIRA, the observed rate of lymphomas was approximately 0.11 per 100 patient-years. This is approximately 3-fold higher than expected in the general U.S. population according to the SEER database (adjusted for age, gender, and race).<sup>1</sup> Rates of lymphoma in clinical trials of HUMIRA cannot be compared to rates of lymphoma in clinical trials of other TNF blockers and may not predict the rates observed in a broader patient population. Patients with RA and other chronic inflammatory diseases, particularly those with highly active disease and/or chronic exposure to immunosuppressant therapies, may be at a higher risk (up to several fold) than the general population for the development of lymphoma, even in the absence of TNF blockers. Post-marketing cases of acute and chronic leukemia have been reported in association with TNF-blocker use in RA and other indications. Even in the absence of TNF-blocker therapy, patients with RA may be at a higher risk (approximately 2-fold) than the general population for the development of leukemia.

### **Malignancies in Pediatric Patients and Young Adults**

Malignancies, some fatal, have been reported among children, adolescents, and young adults who received treatment with TNF-blockers (initiation of therapy  $\leq$  18 years of age), of which HUMIRA is a member [see *Boxed Warning*]. Approximately half the cases were lymphomas,

including Hodgkin's and non-Hodgkin's lymphoma. The other cases represented a variety of different malignancies and included rare malignancies usually associated with immunosuppression and malignancies that are not usually observed in children and adolescents. The malignancies occurred after a median of 30 months of therapy (range 1 to 84 months). Most of the patients were receiving concomitant immunosuppressants. These cases were reported post-marketing and are derived from a variety of sources including registries and spontaneous postmarketing reports.

Postmarketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma, have been reported in patients treated with TNF blockers including HUMIRA [*see Boxed Warning*]. These cases have had a very aggressive disease course and have been fatal. The majority of reported TNF blocker cases have occurred in patients with Crohn's disease or ulcerative colitis and the majority were in adolescent and young adult males. Almost all of these patients had received treatment with the immunosuppressants azathioprine or 6-mercaptopurine (6-MP) concomitantly with a TNF blocker at or prior to diagnosis. It is uncertain whether the occurrence of HSTCL is related to use of a TNF blocker or a TNF blocker in combination with these other immunosuppressants. The potential risk with the combination of azathioprine or 6-mercaptopurine and HUMIRA should be carefully considered.

### **5.3 Hypersensitivity Reactions**

Anaphylaxis and angioneurotic edema have been reported following HUMIRA administration. If an anaphylactic or other serious allergic reaction occurs, immediately discontinue administration of HUMIRA and institute appropriate therapy. In clinical trials of HUMIRA in adults, allergic reactions (e.g., allergic rash, anaphylactoid reaction, fixed drug reaction, non-specified drug reaction, urticaria) have been observed.

### **5.4 Hepatitis B Virus Reactivation**

Use of TNF blockers, including HUMIRA, may increase the risk of reactivation of hepatitis B virus (HBV) in patients who are chronic carriers of this virus. In some instances, HBV reactivation occurring in conjunction with TNF blocker therapy has been fatal. The majority of these reports have occurred in patients concomitantly receiving other medications that suppress the immune system, which may also contribute to HBV reactivation. Evaluate patients at risk for HBV infection for prior evidence of HBV infection before initiating TNF blocker therapy. Exercise caution in prescribing TNF blockers for patients identified as carriers of HBV. Adequate data are not available on the safety or efficacy of treating patients who are carriers of HBV with anti-viral therapy in conjunction with TNF blocker therapy to prevent HBV reactivation. For patients who are carriers of HBV and require treatment with TNF blockers,

closely monitor such patients for clinical and laboratory signs of active HBV infection throughout therapy and for several months following termination of therapy. In patients who develop HBV reactivation, stop HUMIRA and initiate effective anti-viral therapy with appropriate supportive treatment. The safety of resuming TNF blocker therapy after HBV reactivation is controlled is not known. Therefore, exercise caution when considering resumption of HUMIRA therapy in this situation and monitor patients closely.

### **5.5 Neurologic Reactions**

Use of TNF blocking agents, including HUMIRA, has been associated with rare cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disease, including multiple sclerosis (MS) and optic neuritis, and peripheral demyelinating disease, including Guillain-Barré syndrome. Exercise caution in considering the use of HUMIRA in patients with preexisting or recent-onset central or peripheral nervous system demyelinating disorders.

### **5.6 Hematological Reactions**

Rare reports of pancytopenia including aplastic anemia have been reported with TNF blocking agents. Adverse reactions of the hematologic system, including medically significant cytopenia (e.g., thrombocytopenia, leukopenia) have been infrequently reported with HUMIRA. The causal relationship of these reports to HUMIRA remains unclear. Advise all patients to seek immediate medical attention if they develop signs and symptoms suggestive of blood dyscrasias or infection (e.g., persistent fever, bruising, bleeding, pallor) while on HUMIRA. Consider discontinuation of HUMIRA therapy in patients with confirmed significant hematologic abnormalities.

### **5.7 Use with Anakinra**

Concurrent use of anakinra (an interleukin-1 antagonist) and another TNF-blocker, was associated with a greater proportion of serious infections and neutropenia and no added benefit compared with the TNF-blocker alone in patients with RA. Therefore, the combination of HUMIRA and anakinra is not recommended [*see Drug Interactions (7.2)*].

### **5.8 Heart Failure**

Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers. Cases of worsening CHF have also been observed with HUMIRA. HUMIRA has not been formally studied in patients with CHF; however, in clinical trials of another TNF blocker, a higher rate of serious CHF-related adverse reactions was observed. Exercise caution when using HUMIRA in patients who have heart failure and monitor them carefully.

## 5.9 Autoimmunity

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

## 5.10 Immunizations

In a placebo-controlled clinical trial of patients with RA, no difference was detected in anti-pneumococcal antibody response between HUMIRA and placebo treatment groups when the pneumococcal polysaccharide vaccine and influenza vaccine were administered concurrently with HUMIRA. Similar proportions of patients developed protective levels of anti-influenza antibodies between HUMIRA and placebo treatment groups; however, titers in aggregate to influenza antigens were moderately lower in patients receiving HUMIRA. The clinical significance of this is unknown. Patients on HUMIRA may receive concurrent vaccinations, except for live vaccines. No data are available on the secondary transmission of infection by live vaccines in patients receiving HUMIRA.

It is recommended that JIA patients, if possible, be brought up to date with all immunizations in agreement with current immunization guidelines prior to initiating HUMIRA therapy. Patients on HUMIRA may receive concurrent vaccinations, except for live vaccines.

## 5.11 Use with Abatacept

In controlled trials, the concurrent administration of TNF-blockers and abatacept was associated with a greater proportion of serious infections than the use of a TNF-blocker alone; the combination therapy, compared to the use of a TNF-blocker alone, has not demonstrated improved clinical benefit in the treatment of RA. Therefore, the combination of abatacept with TNF-blockers including HUMIRA is not recommended [*see Drug Interactions (7.2)*].

## 6 ADVERSE REACTIONS

The most serious adverse reactions described elsewhere in the labeling include the following:

- Serious Infections [*see Warnings and Precautions (5.1)*]
- Malignancies [*see Warnings and Precautions (5.2)*]

## 6.1 Clinical Trials Experience

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

The most common adverse reaction with HUMIRA was injection site reactions. In placebo-controlled trials, 20% of patients treated with HUMIRA developed injection site reactions (erythema and/or itching, hemorrhage, pain or swelling), compared to 14% of patients receiving placebo. Most injection site reactions were described as mild and generally did not necessitate drug discontinuation.

The proportion of patients who discontinued treatment due to adverse reactions during the double-blind, placebo-controlled portion of studies in patients with RA (i.e., Studies RA-I, RA-II, RA-III and RA-IV) was 7% for patients taking HUMIRA and 4% for placebo-treated patients. The most common adverse reactions leading to discontinuation of HUMIRA in these RA studies were clinical flare reaction (0.7%), rash (0.3%) and pneumonia (0.3%).

### Infections

In the controlled portions of the 34 global HUMIRA clinical trials in adult patients with RA, PsA, AS, CD, UC and Ps, the rate of serious infections was 4.6 per 100 patient-years in 7304 HUMIRA-treated patients versus a rate of 3.1 per 100 patient-years in 4232 control-treated patients. Serious infections observed included pneumonia, septic arthritis, prosthetic and post-surgical infections, erysipelas, cellulitis, diverticulitis, and pyelonephritis [*see Warnings and Precautions (5.1)*].

### Tuberculosis and Opportunistic Infections

In 47 global controlled and uncontrolled clinical trials in RA, PsA, AS, CD, UC and Ps that included 23,036 HUMIRA-treated patients, the rate of reported active tuberculosis was 0.22 per 100 patient-years and the rate of positive PPD conversion was 0.08 per 100 patient-years. In a subgroup of 9396 U.S. and Canadian HUMIRA-treated patients, the rate of reported active TB was 0.07 per 100 patient-years and the rate of positive PPD conversion was 0.08 per 100 patient-years. These trials included reports of miliary, lymphatic, peritoneal, and pulmonary TB. Most of the TB cases occurred within the first eight months after initiation of therapy and may reflect recrudescence of latent disease. In these global clinical trials, cases of serious opportunistic infections have been reported at an overall rate of 0.08 per 100 patient-years. Some cases of serious opportunistic infections and TB have been fatal [*see Warnings and Precautions (5.1)*].

### Autoantibodies

In the rheumatoid arthritis controlled trials, 12% of patients treated with HUMIRA and 7% of placebo-treated patients that had negative baseline ANA titers developed positive titers at week 24. Two patients out of 3046 treated with HUMIRA developed clinical signs suggestive of new-onset lupus-like syndrome. The patients improved following discontinuation of therapy. No patients developed lupus nephritis or central nervous system symptoms. The impact of long-term treatment with HUMIRA on the development of autoimmune diseases is unknown.

### Liver Enzyme Elevations

There have been reports of severe hepatic reactions including acute liver failure in patients receiving TNF-blockers. In controlled Phase 3 trials of HUMIRA (40 mg SC every other week) in patients with RA, PsA, and AS with control period duration ranging from 4 to 104 weeks, ALT elevations  $\geq 3 \times$  ULN occurred in 3.5% of HUMIRA-treated patients and 1.5% of control-treated patients. Since many of these patients in these trials were also taking medications that cause liver enzyme elevations (e.g., NSAIDs, MTX), the relationship between HUMIRA and the liver enzyme elevations is not clear. In controlled Phase 3 trials of HUMIRA (initial doses of 160 mg and 80 mg, or 80 mg and 40 mg on Days 1 and 15, respectively, followed by 40 mg every other week) in patients with CD with control period duration ranging from 4 to 52 weeks, ALT elevations  $\geq 3 \times$  ULN occurred in 0.9% of HUMIRA-treated patients and 0.9% of control-treated patients. In controlled Phase 3 trials of HUMIRA (initial doses of 160 mg and 80 mg on Days 1 and 15 respectively, followed by 40 mg every other week) in patients with UC with control period duration ranging from 1 to 52 weeks, ALT elevations  $\geq 3 \times$  ULN occurred in 1.5% of HUMIRA-treated patients and 1.0% of control-treated patients. In controlled Phase 3 trials of HUMIRA (initial dose of 80 mg then 40 mg every other week) in patients with Ps with control period duration ranging from 12 to 24 weeks, ALT elevations  $\geq 3 \times$  ULN occurred in 1.8% of HUMIRA-treated patients and 1.8% of control-treated patients.

### Immunogenicity

Patients in Studies RA-I, RA-II, and RA-III were tested at multiple time points for antibodies to adalimumab during the 6- to 12-month period. Approximately 5% (58 of 1062) of adult RA patients receiving HUMIRA developed low-titer antibodies to adalimumab at least once during treatment, which were neutralizing *in vitro*. Patients treated with concomitant methotrexate (MTX) had a lower rate of antibody development than patients on HUMIRA monotherapy (1% versus 12%). No apparent correlation of antibody development to adverse reactions was observed. With monotherapy, patients receiving every other week dosing may develop antibodies more frequently than those receiving weekly dosing. In patients receiving the



recommended dosage of 40 mg every other week as monotherapy, the ACR 20 response was lower among antibody-positive patients than among antibody-negative patients. The long-term immunogenicity of HUMIRA is unknown.

In patients with JIA, adalimumab antibodies were identified in 16% of HUMIRA-treated patients. In patients receiving concomitant MTX, the incidence was 6% compared to 26% with HUMIRA monotherapy.

In patients with AS, the rate of development of antibodies to adalimumab in HUMIRA-treated patients was comparable to patients with RA.

In patients with PsA, the rate of antibody development in patients receiving HUMIRA monotherapy was comparable to patients with RA; however, in patients receiving concomitant MTX the rate was 7% compared to 1% in RA.

In patients with CD, the rate of antibody development was 3%.

In patients with moderately to severely active UC, the rate of antibody development in patients receiving HUMIRA was 5%. However, due to the limitation of the assay conditions, antibodies to adalimumab could be detected only when serum adalimumab levels were < 2 ug/ml. Among the patients whose serum adalimumab levels were < 2 ug/ml (approximately 25% of total patients studied), the immunogenicity rate was 20.7%.

In patients with Ps, the rate of antibody development with HUMIRA monotherapy was 8%. However, due to the limitation of the assay conditions, antibodies to adalimumab could be detected only when serum adalimumab levels were < 2 ug/ml. Among the patients whose serum adalimumab levels were < 2 ug/ml (approximately 40% of total patients studied), the immunogenicity rate was 20.7%. In Ps patients who were on HUMIRA monotherapy and subsequently withdrawn from the treatment, the rate of antibodies to adalimumab after retreatment was similar to the rate observed prior to withdrawal.

The data reflect the percentage of patients whose test results were considered positive for antibodies to adalimumab in an ELISA assay, and are highly dependent on the sensitivity and specificity of the assay. The observed incidence of antibody (including neutralizing antibody) positivity in an assay is highly dependent on several factors including assay sensitivity and specificity, assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies to adalimumab with the incidence of antibodies to other products may be misleading.

#### Other Adverse Reactions

*Rheumatoid Arthritis Clinical Studies*

The data described below reflect exposure to HUMIRA in 2468 patients, including 2073 exposed for 6 months, 1497 exposed for greater than one year and 1380 in adequate and well-controlled studies (Studies RA-I, RA-II, RA-III, and RA-IV). HUMIRA was studied primarily in placebo-controlled trials and in long-term follow up studies for up to 36 months duration. The population had a mean age of 54 years, 77% were female, 91% were Caucasian and had moderately to severely active rheumatoid arthritis. Most patients received 40 mg HUMIRA every other week.

Table 1 summarizes reactions reported at a rate of at least 5% in patients treated with HUMIRA 40 mg every other week compared to placebo and with an incidence higher than placebo. In Study RA-III, the types and frequencies of adverse reactions in the second year open-label extension were similar to those observed in the one-year double-blind portion.

**Table 1. Adverse Reactions Reported by  $\geq$ 5% of Patients Treated with HUMIRA During Placebo-Controlled Period of Pooled RA Studies (Studies RA-I, RA-II, RA-III, and RA-IV)**

	HUMIRA 40 mg subcutaneous Every Other Week	Placebo
	(N=705)	(N=690)
Adverse Reaction (Preferred Term)		
<b>Respiratory</b>		
Upper respiratory infection	17%	13%
Sinusitis	11%	9%
Flu syndrome	7%	6%
<b>Gastrointestinal</b>		
Nausea	9%	8%
Abdominal pain	7%	4%
<b>Laboratory Tests*</b>		
Laboratory test abnormal	8%	7%
Hypercholesterolemia	6%	4%
Hyperlipidemia	7%	5%
Hematuria	5%	4%
Alkaline phosphatase increased	5%	3%
<b>Other</b>		
Headache	12%	8%
Rash	12%	6%
Accidental injury	10%	8%
Injection site reaction **	8%	1%
Back pain	6%	4%
Urinary tract infection	8%	5%
Hypertension	5%	3%

<p>* Laboratory test abnormalities were reported as adverse reactions in European trials ** Does not include injection site erythema, itching, hemorrhage, pain or swelling</p>
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### Less Common Adverse Reactions in Rheumatoid Arthritis Clinical Studies

Other infrequent serious adverse reactions that do not appear in the Warnings and Precautions or Adverse Reaction sections that occurred at an incidence of less than 5% in HUMIRA-treated patients in RA studies were:

*Body As A Whole:* Pain in extremity, pelvic pain, surgery, thorax pain

*Cardiovascular System:* Arrhythmia, atrial fibrillation, chest pain, coronary artery disorder, heart arrest, hypertensive encephalopathy, myocardial infarct, palpitation, pericardial effusion, pericarditis, syncope, tachycardia

*Digestive System:* Cholecystitis, cholelithiasis, esophagitis, gastroenteritis, gastrointestinal hemorrhage, hepatic necrosis, vomiting

*Endocrine System:* Parathyroid disorder

*Hemic And Lymphatic System:* Agranulocytosis, polycythemia

*Metabolic And Nutritional Disorders:* Dehydration, healing abnormal, ketosis, paraproteinemia, peripheral edema

*Musculo-Skeletal System:* Arthritis, bone disorder, bone fracture (not spontaneous), bone necrosis, joint disorder, muscle cramps, myasthenia, pyogenic arthritis, synovitis, tendon disorder

*Neoplasia:* Adenoma

*Nervous System:* Confusion, paresthesia, subdural hematoma, tremor

*Respiratory System:* Asthma, bronchospasm, dyspnea, lung function decreased, pleural effusion

*Special Senses:* Cataract

*Thrombosis:* Thrombosis leg

*Urogenital System:* Cystitis, kidney calculus, menstrual disorder

### Juvenile Idiopathic Arthritis Clinical Studies

In general, the adverse reactions in the HUMIRA-treated pediatric patients in the juvenile idiopathic arthritis (JIA) trial were similar in frequency and type to those seen in adult patients [see *Warnings and Precautions (5)*, *Adverse Reactions (6)*]. Important findings and differences from adults are discussed in the following paragraphs.

HUMIRA was studied in 171 pediatric patients, 4 to 17 years of age, with polyarticular JIA. Severe adverse reactions reported in the study included neutropenia, streptococcal pharyngitis, increased aminotransferases, herpes zoster, myositis, metrorrhagia, appendicitis. Serious infections were observed in 4% of patients within approximately 2 years of initiation of treatment with HUMIRA and included cases of herpes simplex, pneumonia, urinary tract infection, pharyngitis, and herpes zoster.

A total of 45% of children experienced an infection while receiving HUMIRA with or without concomitant MTX in the first 16 weeks of treatment. The types of infections reported in HUMIRA-treated patients were generally similar to those commonly seen in JIA patients who are not treated with TNF blockers. Upon initiation of treatment, the most common adverse reactions occurring in the pediatric population treated with HUMIRA were injection site pain and injection site reaction (19% and 16%, respectively). A less commonly reported adverse event in children receiving HUMIRA was granuloma annulare which did not lead to discontinuation of HUMIRA treatment.

In the first 48 weeks of treatment, non-serious hypersensitivity reactions were seen in approximately 6% of children and included primarily localized allergic hypersensitivity reactions and allergic rash.

Isolated mild to moderate elevations of liver aminotransferases (ALT more common than AST) were observed in children with JIA exposed to HUMIRA alone; liver enzyme test elevations were more frequent among those treated with the combination of HUMIRA and MTX than those treated with HUMIRA alone. In general, these elevations did not lead to discontinuation of HUMIRA treatment.

In the JIA trial, 10% of patients treated with HUMIRA who had negative baseline anti-dsDNA antibodies developed positive titers after 48 weeks of treatment. No patient developed clinical signs of autoimmunity during the clinical trial.

Approximately 15% of children treated with HUMIRA developed mild-to-moderate elevations of creatine phosphokinase (CPK). Elevations exceeding 5 times the upper limit of normal were observed in several patients. CPK levels decreased or returned to normal in all patients. Most patients were able to continue HUMIRA without interruption.

### Psoriatic Arthritis and Ankylosing Spondylitis Clinical Studies

HUMIRA has been studied in 395 patients with psoriatic arthritis (PsA) in two placebo-controlled trials and in an open label study and in 393 patients with ankylosing spondylitis (AS) in two placebo-controlled studies. The safety profile for patients with PsA and AS treated with HUMIRA 40 mg every other week was similar to the safety profile seen in patients with RA, HUMIRA Studies RA-I through IV.

### Crohn's Disease Clinical Studies

HUMIRA has been studied in 1478 patients with Crohn's disease (CD) in four placebo-controlled and two open-label extension studies. The safety profile for patients with CD treated with HUMIRA was similar to the safety profile seen in patients with RA.

### Ulcerative Colitis Clinical Studies

HUMIRA has been studied in 1010 patients with ulcerative colitis (UC) in two placebo-controlled studies and one open-label extension study. The safety profile for patients with UC treated with HUMIRA was similar to the safety profile seen in patients with RA.

### Plaque Psoriasis Clinical Studies

HUMIRA has been studied in 1696 patients with plaque psoriasis (Ps) in placebo-controlled and open-label extension studies. The safety profile for patients with Ps treated with HUMIRA was similar to the safety profile seen in patients with RA with the following exceptions. In the placebo-controlled portions of the clinical trials in Ps patients, HUMIRA-treated patients had a higher incidence of arthralgia when compared to controls (3% vs. 1%).

## **6.2 Postmarketing Experience**

The following adverse reactions have been identified during post-approval use of HUMIRA. 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 HUMIRA exposure.

Gastrointestinal disorders: Diverticulitis, large bowel perforations including perforations associated with diverticulitis and appendiceal perforations associated with appendicitis, pancreatitis

General disorders and administration site conditions: Pyrexia

Hepato-biliary disorders: Liver failure

Immune system disorders: Sarcoidosis

Neoplasms benign, malignant and unspecified (incl cysts and polyps): Merkel Cell Carcinoma (neuroendocrine carcinoma of the skin)

Nervous system disorders: Demyelinating disorders (e.g., optic neuritis, Guillain-Barré syndrome), cerebrovascular accident

Respiratory disorders: Interstitial lung disease, including pulmonary fibrosis, pulmonary embolism

Skin reactions: Stevens Johnson Syndrome, cutaneous vasculitis, erythema multiforme, new or worsening psoriasis (all sub-types including pustular and palmoplantar), alopecia

Vascular disorders: Systemic vasculitis, deep vein thrombosis

## **7 DRUG INTERACTIONS**

### **7.1 Methotrexate**

HUMIRA has been studied in rheumatoid arthritis (RA) patients taking concomitant methotrexate (MTX). Although MTX reduced the apparent adalimumab clearance, the data do not suggest the need for dose adjustment of either HUMIRA or MTX [*see Clinical Pharmacology (12.3)*].

### **7.2 Biological Products**

In clinical studies in patients with RA, an increased risk of serious infections has been seen with the combination of TNF blockers with anakinra or abatacept, with no added benefit; therefore, use of HUMIRA with abatacept or anakinra is not recommended in patients with RA [*see Warnings and Precautions (5.7 and 5.11)*]. A higher rate of serious infections has also been observed in patients with RA treated with rituximab who received subsequent treatment with a TNF blocker. There is insufficient information regarding the concomitant use of HUMIRA and other biologic products for the treatment of RA, PsA, AS, CD, UC, and Ps. Concomitant administration of HUMIRA with other biologic DMARDs (e.g., anakinra and abatacept) or other TNF blockers is not recommended based upon the possible increased risk for infections and other potential pharmacological interactions.

### 7.3 Live Vaccines

Avoid the use of live vaccines with HUMIRA [see *Warnings and Precautions (5.10)*].

### 7.4 Cytochrome P450 Substrates

The formation of CYP450 enzymes may be suppressed by increased levels of cytokines (e.g., TNF $\alpha$ , IL-6) during chronic inflammation. It is possible for a molecule that antagonizes cytokine activity, such as adalimumab, to influence the formation of CYP450 enzymes. Upon initiation or discontinuation of HUMIRA in patients being treated with CYP450 substrates with a narrow therapeutic index, monitoring of the effect (e.g., warfarin) or drug concentration (e.g., cyclosporine or theophylline) is recommended and the individual dose of the drug product may be adjusted as needed.

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

Pregnancy Category B

#### *Risk Summary*

Adequate and well controlled studies with HUMIRA have not been conducted in pregnant women. Adalimumab is an IgG1 monoclonal antibody and IgG1 is actively transferred across the placenta during the third trimester of pregnancy. Adalimumab serum levels were obtained from ten women treated with HUMIRA during pregnancy and eight newborn infants suggest active placental transfer of adalimumab. No fetal harm was observed in reproductive studies performed in cynomolgus monkeys. Because animal reproductive studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

#### *Clinical Considerations*

In general, monoclonal antibodies are transported across the placenta in a linear fashion as pregnancy progresses, with the largest amount transferred during the third trimester.

#### *Human Data*

In an independent clinical study conducted in ten pregnant women with inflammatory bowel disease treated with HUMIRA, adalimumab concentrations were measured in maternal blood as well as in cord (n=10) and infant blood (n=8) on the day of birth. The last dose of HUMIRA was given between 1 and 56 days prior to delivery. Adalimumab concentrations were 0.16-19.7  $\mu\text{g/mL}$  in cord blood, 4.28-17.7  $\mu\text{g/mL}$  in infant blood, and 0-16.1  $\mu\text{g/mL}$  in maternal blood. In

all but one case, the cord blood level of adalimumab was higher than the maternal level, suggesting adalimumab actively crosses the placenta. In addition, one infant had levels at each of the following: 6 weeks (1.94 µg/mL), 7 weeks (1.31 µg/mL), 8 weeks (0.93 µg/mL), and 11 weeks (0.53 µg/mL), suggesting adalimumab can be detected in the serum of infants exposed in utero for at least 3 months from birth.

#### *Animal Data*

An embryo-fetal perinatal developmental toxicity study has been performed in cynomolgus monkeys at dosages up to 100 mg/kg (266 times human AUC when given 40 mg subcutaneously with methotrexate every week or 373 times human AUC when given 40 mg subcutaneously without methotrexate) and has revealed no evidence of harm to the fetuses due to adalimumab.

### **8.3 Nursing Mothers**

Limited data from published literature indicate that adalimumab is present in low levels in human milk and is not likely to be absorbed by a breastfed infant. However, no data is available on the absorption of adalimumab from breastmilk in newborn or preterm infants. Caution should be exercised when HUMIRA is administered to a nursing woman.

### **8.4 Pediatric Use**

Safety and efficacy of HUMIRA in pediatric patients for uses other than juvenile idiopathic arthritis (JIA) have not been established. Due to its inhibition of TNF $\alpha$ , HUMIRA administered during pregnancy could affect immune response in the *in utero*-exposed newborn and infant. Data from eight infants exposed to HUMIRA *in utero*, suggest adalimumab crosses the placenta [see *Use in Specific Populations (8.1)*]. The clinical significance of elevated adalimumab levels in infants is unknown. The safety of administering live or live-attenuated vaccines in exposed infants is unknown. Risks and benefits should be considered prior to vaccinating (live or live-attenuated) exposed infants.

#### *Juvenile Idiopathic Arthritis*

In the JIA trial, HUMIRA was shown to reduce signs and symptoms of active polyarticular JIA in patients 4 to 17 years of age [see *Clinical Studies (14.2)*]. HUMIRA has not been studied in children less than 4 years of age, and there are limited data on HUMIRA treatment in children with weight <15 kg.

The safety of HUMIRA in pediatric patients in the JIA trial was generally similar to that observed in adults with certain exceptions [see *Adverse Reactions (6.1)*].



Post-marketing cases of malignancies, some fatal, have been reported among children, adolescents, and young adults who received treatment with TNF-blockers including HUMIRA [see *Warnings and Precautions (5.2)*].

### **8.5 Geriatric Use**

A total of 519 RA patients 65 years of age and older, including 107 patients 75 years of age and older, received HUMIRA in clinical studies RA-I through IV. No overall difference in effectiveness was observed between these subjects and younger subjects. The frequency of serious infection and malignancy among HUMIRA treated subjects over 65 years of age was higher than for those under 65 years of age. Because there is a higher incidence of infections and malignancies in the elderly population, use caution when treating the elderly.

### **10 OVERDOSAGE**

Doses up to 10 mg/kg have been administered to patients in clinical trials without evidence of dose-limiting toxicities. In case of overdosage, it is recommended that the patient be monitored for any signs or symptoms of adverse reactions or effects and appropriate symptomatic treatment instituted immediately.

### **11 DESCRIPTION**

HUMIRA (adalimumab) is a recombinant human IgG1 monoclonal antibody specific for human tumor necrosis factor (TNF). HUMIRA was created using phage display technology resulting in an antibody with human derived heavy and light chain variable regions and human IgG1:k constant regions. Adalimumab is produced by recombinant DNA technology in a mammalian cell expression system and is purified by a process that includes specific viral inactivation and removal steps. It consists of 1330 amino acids and has a molecular weight of approximately 148 kilodaltons.

HUMIRA is supplied as a sterile, preservative-free solution of adalimumab for subcutaneous administration. The drug product is supplied as either a single-use, prefilled pen (HUMIRA Pen) or as a single-use, 1 mL prefilled glass syringe. Enclosed within the pen is a single-use, 1 mL prefilled glass syringe. The solution of HUMIRA is clear and colorless, with a pH of about 5.2.

Each prefilled syringe delivers 0.8 mL (40 mg) of drug product. Each 0.8 mL of HUMIRA contains 40 mg adalimumab, 4.93 mg sodium chloride, 0.69 mg monobasic sodium phosphate dihydrate, 1.22 mg dibasic sodium phosphate dihydrate, 0.24 mg sodium citrate, 1.04 mg citric acid monohydrate, 9.6 mg mannitol, 0.8 mg polysorbate 80, and Water for Injection, USP. Sodium hydroxide added as necessary to adjust pH.

Each pediatric prefilled syringe delivers 0.4 mL (20 mg) of drug product. Each 0.4 mL of HUMIRA contains 20 mg adalimumab, 2.47 mg sodium chloride, 0.34 mg monobasic sodium phosphate dihydrate, 0.61 mg dibasic sodium phosphate dihydrate, 0.12 mg sodium citrate, 0.52 mg citric acid monohydrate, 4.8 mg mannitol, 0.4 mg polysorbate 80, and Water for Injection, USP. Sodium hydroxide added as necessary to adjust pH.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Adalimumab binds specifically to TNF-alpha and blocks its interaction with the p55 and p75 cell surface TNF receptors. Adalimumab also lyses surface TNF expressing cells *in vitro* in the presence of complement. Adalimumab does not bind or inactivate lymphotoxin (TNF-beta). TNF is a naturally occurring cytokine that is involved in normal inflammatory and immune responses. Elevated levels of TNF are found in the synovial fluid of patients with RA, JIA, PsA, and AS and play an important role in both the pathologic inflammation and the joint destruction that are hallmarks of these diseases. Increased levels of TNF are also found in psoriasis plaques. In Ps, treatment with HUMIRA may reduce the epidermal thickness and infiltration of inflammatory cells. The relationship between these pharmacodynamic activities and the mechanism(s) by which HUMIRA exerts its clinical effects is unknown.

Adalimumab also modulates biological responses that are induced or regulated by TNF, including changes in the levels of adhesion molecules responsible for leukocyte migration (ELAM-1, VCAM-1, and ICAM-1 with an  $IC_{50}$  of  $1-2 \times 10^{-10}M$ ).

### 12.2 Pharmacodynamics

After treatment with HUMIRA, a decrease in levels of acute phase reactants of inflammation (C-reactive protein [CRP] and erythrocyte sedimentation rate [ESR]) and serum cytokines (IL-6) was observed compared to baseline in patients with rheumatoid arthritis. A decrease in CRP levels was also observed in patients with Crohn's disease and ulcerative colitis. Serum levels of matrix metalloproteinases (MMP-1 and MMP-3) that produce tissue remodeling responsible for cartilage destruction were also decreased after HUMIRA administration.

### 12.3 Pharmacokinetics

The maximum serum concentration ( $C_{max}$ ) and the time to reach the maximum concentration ( $T_{max}$ ) were  $4.7 \pm 1.6 \mu g/mL$  and  $131 \pm 56$  hours respectively, following a single 40 mg subcutaneous administration of HUMIRA to healthy adult subjects. The average absolute bioavailability of adalimumab estimated from three studies following a single 40 mg

subcutaneous dose was 64%. The pharmacokinetics of adalimumab were linear over the dose range of 0.5 to 10.0 mg/kg following a single intravenous dose.

The single dose pharmacokinetics of adalimumab in RA patients were determined in several studies with intravenous doses ranging from 0.25 to 10 mg/kg. The distribution volume ( $V_{ss}$ ) ranged from 4.7 to 6.0 L. The systemic clearance of adalimumab is approximately 12 mL/hr. The mean terminal half-life was approximately 2 weeks, ranging from 10 to 20 days across studies. Adalimumab concentrations in the synovial fluid from five rheumatoid arthritis patients ranged from 31 to 96% of those in serum.

In RA patients receiving 40 mg HUMIRA every other week, adalimumab mean steady-state trough concentrations of approximately 5  $\mu\text{g/mL}$  and 8 to 9  $\mu\text{g/mL}$ , were observed without and with methotrexate (MTX), respectively. MTX reduced adalimumab apparent clearance after single and multiple dosing by 29% and 44% respectively, in patients with RA. Mean serum adalimumab trough levels at steady state increased approximately proportionally with dose following 20, 40, and 80 mg every other week and every week subcutaneous dosing. In long-term studies with dosing more than two years, there was no evidence of changes in clearance over time.

Adalimumab mean steady-state trough concentrations were slightly higher in psoriatic arthritis patients treated with 40 mg HUMIRA every other week (6 to 10  $\mu\text{g/mL}$  and 8.5 to 12  $\mu\text{g/mL}$ , without and with MTX, respectively) compared to the concentrations in RA patients treated with the same dose.

The pharmacokinetics of adalimumab in patients with AS were similar to those in patients with RA.

In patients with CD, the loading dose of 160 mg HUMIRA on Week 0 followed by 80 mg HUMIRA on Week 2 achieves mean serum adalimumab trough levels of approximately 12  $\mu\text{g/mL}$  at Week 2 and Week 4. Mean steady-state trough levels of approximately 7  $\mu\text{g/mL}$  were observed at Week 24 and Week 56 in CD patients after receiving a maintenance dose of 40 mg HUMIRA every other week.

In patients with UC, the loading dose of 160 mg HUMIRA on Week 0 followed by 80 mg HUMIRA on Week 2 achieves mean serum adalimumab trough levels of approximately 12  $\mu\text{g/mL}$  at Week 2 and Week 4. Mean steady-state trough level of approximately 8  $\mu\text{g/mL}$  was observed at Week 52 in UC patients after receiving a dose of 40 mg HUMIRA every other week, and approximately 15  $\mu\text{g/mL}$  at Week 52 in UC patients who increased to a dose of 40 mg HUMIRA every week.

In patients with Ps, the mean steady-state trough concentration was approximately 5 to 6 µg/mL during HUMIRA 40 mg every other week monotherapy treatment.

Population pharmacokinetic analyses in patients with RA revealed that there was a trend toward higher apparent clearance of adalimumab in the presence of anti-adalimumab antibodies, and lower clearance with increasing age in patients aged 40 to >75 years.

Minor increases in apparent clearance were also predicted in RA patients receiving doses lower than the recommended dose and in RA patients with high rheumatoid factor or CRP concentrations. These increases are not likely to be clinically important.

No gender-related pharmacokinetic differences were observed after correction for a patient's body weight. Healthy volunteers and patients with rheumatoid arthritis displayed similar adalimumab pharmacokinetics.

No pharmacokinetic data are available in patients with hepatic or renal impairment.

In subjects with JIA (4 to 17 years of age), the mean steady-state trough serum adalimumab concentrations for subjects weighing <30 kg receiving 20 mg HUMIRA subcutaneously every other week as monotherapy or with concomitant methotrexate were 6.8 µg/mL and 10.9 µg/mL, respectively. The mean steady-state trough serum adalimumab concentrations for subjects weighing ≥30 kg receiving 40 mg HUMIRA subcutaneously every other week as monotherapy or with concomitant methotrexate were 6.6 µg/mL and 8.1 µg/mL, respectively.

## **13 NONCLINICAL TOXICOLOGY**

### **13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility**

Long-term animal studies of HUMIRA have not been conducted to evaluate the carcinogenic potential or its effect on fertility. No clastogenic or mutagenic effects of HUMIRA were observed in the *in vivo* mouse micronucleus test or the *Salmonella-Escherichia coli* (Ames) assay, respectively.

## **14 CLINICAL STUDIES**

### **14.1 Rheumatoid Arthritis**

The efficacy and safety of HUMIRA were assessed in five randomized, double-blind studies in patients ≥18 years of age with active rheumatoid arthritis (RA) diagnosed according to American College of Rheumatology (ACR) criteria. Patients had at least 6 swollen and 9 tender joints. HUMIRA was administered subcutaneously in combination with methotrexate (MTX) (12.5 to

25 mg, Studies RA-I, RA-III and RA-V) or as monotherapy (Studies RA-II and RA-V) or with other disease-modifying anti-rheumatic drugs (DMARDs) (Study RA-IV).

Study RA-I evaluated 271 patients who had failed therapy with at least one but no more than four DMARDs and had inadequate response to MTX. Doses of 20, 40 or 80 mg of HUMIRA or placebo were given every other week for 24 weeks.

Study RA-II evaluated 544 patients who had failed therapy with at least one DMARD. Doses of placebo, 20 or 40 mg of HUMIRA were given as monotherapy every other week or weekly for 26 weeks.

Study RA-III evaluated 619 patients who had an inadequate response to MTX. Patients received placebo, 40 mg of HUMIRA every other week with placebo injections on alternate weeks, or 20 mg of HUMIRA weekly for up to 52 weeks. Study RA-III had an additional primary endpoint at 52 weeks of inhibition of disease progression (as detected by X-ray results). Upon completion of the first 52 weeks, 457 patients enrolled in an open-label extension phase in which 40 mg of HUMIRA was administered every other week for up to 5 years.

Study RA-IV assessed safety in 636 patients who were either DMARD-naïve or were permitted to remain on their pre-existing rheumatologic therapy provided that therapy was stable for a minimum of 28 days. Patients were randomized to 40 mg of HUMIRA or placebo every other week for 24 weeks.

Study RA-V evaluated 799 patients with moderately to severely active RA of less than 3 years duration who were  $\geq 18$  years old and MTX naïve. Patients were randomized to receive either MTX (optimized to 20 mg/week by week 8), HUMIRA 40 mg every other week or HUMIRA/MTX combination therapy for 104 weeks. Patients were evaluated for signs and symptoms, and for radiographic progression of joint damage. The median disease duration among patients enrolled in the study was 5 months. The median MTX dose achieved was 20 mg.

### Clinical Response

The percent of HUMIRA treated patients achieving ACR 20, 50 and 70 responses in Studies RA-II and III are shown in Table 2.

**Table 2. ACR Responses in Studies RA-II and RA-III (Percent of Patients)**

	Study RA-II Monotherapy (26 weeks)		Study RA-III Methotrexate Combination (24 and 52 weeks)		
Response	Placebo	HUMIRA 40 mg every	HUMIRA 40 mg weekly	Placebo/MTX	HUMIRA/MTX 40 mg every

		other week			other week
	N=110	N=113	N=103	N=200	N=207
<b>ACR20</b>					
Month 6	19%	46%*	53%*	30%	63%*
Month 12	NA	NA	NA	24%	59%*
<b>ACR50</b>					
Month 6	8%	22%*	35%*	10%	39%*
Month 12	NA	NA	NA	10%	42%*
<b>ACR70</b>					
Month 6	2%	12%*	18%*	3%	21%*
Month 12	NA	NA	NA	5%	23%*

\* p<0.01, HUMIRA vs. placebo

The results of Study RA-I were similar to Study RA-III; patients receiving HUMIRA 40 mg every other week in Study RA-I also achieved ACR 20, 50 and 70 response rates of 65%, 52% and 24%, respectively, compared to placebo responses of 13%, 7% and 3% respectively, at 6 months (p<0.01).

The results of the components of the ACR response criteria for Studies RA-II and RA-III are shown in Table 3. ACR response rates and improvement in all components of ACR response were maintained to week 104. Over the 2 years in Study RA-III, 20% of HUMIRA patients receiving 40 mg every other week (EOW) achieved a major clinical response, defined as maintenance of an ACR 70 response over a 6-month period. ACR responses were maintained in similar proportions of patients for up to 5 years with continuous HUMIRA treatment in the open-label portion of Study RA-III.

**Table 3. Components of ACR Response in Studies RA-II and RA-III**

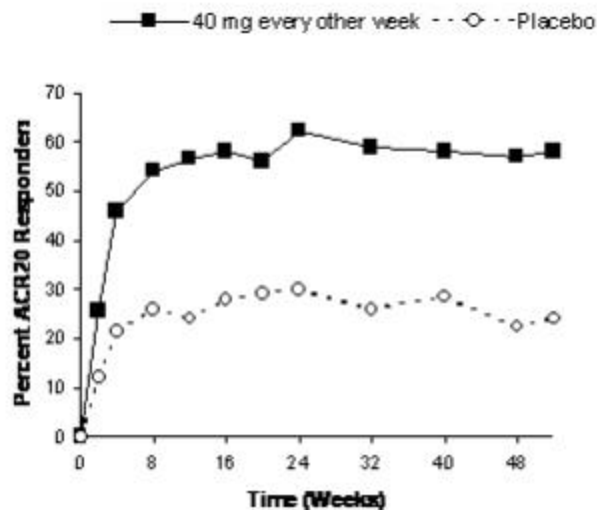
Parameter (median)	Study RA-II				Study RA-III			
	Placebo N=110		HUMIRA <sup>a</sup> N=113		Placebo/MTX N=200		HUMIRA <sup>a</sup> /MTX N=207	
	Baseline	Wk 26	Baseline	Wk 26	Baseline	Wk 24	Baseline	Wk 24
Number of tender joints (0-68)	35	26	31	16*	26	15	24	8*
Number of swollen joints (0-66)	19	16	18	10*	17	11	18	5*
Physician global assessment <sup>b</sup>	7.0	6.1	6.6	3.7*	6.3	3.5	6.5	2.0*
Patient global assessment <sup>b</sup>	7.5	6.3	7.5	4.5*	5.4	3.9	5.2	2.0*
Pain <sup>b</sup>	7.3	6.1	7.3	4.1*	6.0	3.8	5.8	2.1*
Disability index (HAQ) <sup>c</sup>	2.0	1.9	1.9	1.5*	1.5	1.3	1.5	0.8*
CRP (mg/dL)	3.9	4.3	4.6	1.8*	1.0	0.9	1.0	0.4*

<sup>a</sup> 40 mg HUMIRA administered every other week  
<sup>b</sup> Visual analogue scale; 0 = best, 10 = worst  
<sup>c</sup> Disability Index of the Health Assessment Questionnaire; 0 = best, 3 = worst, measures the patient's ability to perform the following: dress/groom, arise, eat, walk, reach, grip, maintain hygiene, and maintain daily activity  
\* p<0.001, HUMIRA vs. placebo, based on mean change from baseline

The time course of ACR 20 response for Study RA-III is shown in Figure 1.

In Study RA-III, 85% of patients with ACR 20 responses at week 24 maintained the response at 52 weeks. The time course of ACR 20 response for Study RA-I and Study RA-II were similar.

**Figure 1. Study RA-III ACR 20 Responses over 52 Weeks**



In Study RA-IV, 53% of patients treated with HUMIRA 40 mg every other week plus standard of care had an ACR 20 response at week 24 compared to 35% on placebo plus standard of care ( $p < 0.001$ ). No unique adverse reactions related to the combination of HUMIRA (adalimumab) and other DMARDs were observed.

In Study RA-V with MTX naïve patients with recent onset RA, the combination treatment with HUMIRA plus MTX led to greater percentages of patients achieving ACR responses than either MTX monotherapy or HUMIRA monotherapy at Week 52 and responses were sustained at Week 104 (see Table 4).

**Table 4. ACR Response in Study RA-V (Percent of Patients)**

Response	MTX <sup>b</sup> N=257	HUMIRA <sup>c</sup> N=274	HUMIRA/MTX N=268
<b>ACR20</b>			
Week 52	63%	54%	73%
Week 104	56%	49%	69%
<b>ACR50</b>			
Week 52	46%	41%	62%
Week 104	43%	37%	59%
<b>ACR70</b>			

Week 52	27%	26%	46%
Week 104	28%	28%	47%
Major Clinical Response <sup>a</sup>	28%	25%	49%
<sup>a</sup> Major clinical response is defined as achieving an ACR70 response for a continuous six month period			
<sup>b</sup> p<0.05, HUMIRA/MTX vs. MTX for ACR 20			
<sup>c</sup> p<0.001, HUMIRA/MTX vs. MTX for ACR 50 and 70, and Major Clinical Response			
<sup>c</sup> p<0.001, HUMIRA/MTX vs. HUMIRA			

At Week 52, all individual components of the ACR response criteria for Study RA-V improved in the HUMIRA/MTX group and improvements were maintained to Week 104.

### Radiographic Response

In Study RA-III, structural joint damage was assessed radiographically and expressed as change in Total Sharp Score (TSS) and its components, the erosion score and Joint Space Narrowing (JSN) score, at month 12 compared to baseline. At baseline, the median TSS was approximately 55 in the placebo and 40 mg every other week groups. The results are shown in Table 5. HUMIRA/MTX treated patients demonstrated less radiographic progression than patients receiving MTX alone at 52 weeks.

**Table 5. Radiographic Mean Changes Over 12 Months in Study RA-III**

	Placebo/MTX	HUMIRA/MTX 40 mg every other week	Placebo/MTX- HUMIRA/MTX (95% Confidence Interval*)	P-value**
Total Sharp score	2.7	0.1	2.6 (1.4, 3.8)	<0.001
Erosion score	1.6	0.0	1.6 (0.9, 2.2)	<0.001
JSN score	1.0	0.1	0.9 (0.3, 1.4)	0.002
*95% confidence intervals for the differences in change scores between MTX and HUMIRA.				
**Based on rank analysis				

In the open-label extension of Study RA-III, 77% of the original patients treated with any dose of HUMIRA were evaluated radiographically at 2 years. Patients maintained inhibition of structural damage, as measured by the TSS. Fifty-four percent had no progression of structural damage as defined by a change in the TSS of zero or less. Fifty-five percent (55%) of patients originally treated with 40 mg HUMIRA every other week have been evaluated radiographically at 5 years. Patients had continued inhibition of structural damage with 50% showing no progression of structural damage defined by a change in the TSS of zero or less.

In Study RA-V, structural joint damage was assessed as in Study RA-III. Greater inhibition of radiographic progression, as assessed by changes in TSS, erosion score and JSN was observed in the HUMIRA/MTX combination group as compared to either the MTX or HUMIRA monotherapy group at Week 52 as well as at Week 104 (see Table 6).

**Table 6. Radiographic Mean Change\* in Study RA-V**



		<b>MTX<sup>a</sup></b> <b>N=257</b>	<b>HUMIRA<sup>a,b</sup></b> <b>N=274</b>	<b>HUMIRA/MTX</b> <b>N=268</b>
52 Weeks	Total Sharp score	5.7 (4.2, 7.3)	3.0 (1.7, 4.3)	1.3 (0.5, 2.1)
	Erosion score	3.7 (2.7, 4.8)	1.7 (1.0, 2.4)	0.8 (0.4, 1.2)
	JSN score	2.0 (1.2, 2.8)	1.3 (0.5, 2.1)	0.5 (0.0, 1.0)
104 Weeks	Total Sharp score	10.4 (7.7, 13.2)	5.5 (3.6, 7.4)	1.9 (0.9, 2.9)
	Erosion score	6.4 (4.6, 8.2)	3.0 (2.0, 4.0)	1.0 (0.4, 1.6)
	JSN score	4.1 (2.7, 5.4)	2.6 (1.5, 3.7)	0.9 (0.3, 1.5)
* mean (95% confidence interval)				
<sup>a</sup> p<0.001, HUMIRA/MTX vs. MTX at 52 and 104 weeks and for HUMIRA/MTX vs. HUMIRA at 104 weeks				
<sup>b</sup> p<0.01, for HUMIRA/MTX vs. HUMIRA at 52 weeks				

### Physical Function Response

In studies RA-I through IV, HUMIRA showed significantly greater improvement than placebo in the disability index of Health Assessment Questionnaire (HAQ-DI) from baseline to the end of study, and significantly greater improvement than placebo in the health-outcomes as assessed by The Short Form Health Survey (SF 36). Improvement was seen in both the Physical Component Summary (PCS) and the Mental Component Summary (MCS).

In Study RA-III, the mean (95% CI) improvement in HAQ-DI from baseline at week 52 was 0.60 (0.55, 0.65) for the HUMIRA patients and 0.25 (0.17, 0.33) for placebo/MTX (p<0.001) patients. Sixty-three percent of HUMIRA-treated patients achieved a 0.5 or greater improvement in HAQ-DI at week 52 in the double-blind portion of the study. Eighty-two percent of these patients maintained that improvement through week 104 and a similar proportion of patients maintained this response through week 260 (5 years) of open-label treatment. Mean improvement in the SF-36 was maintained through the end of measurement at week 156 (3 years).

In Study RA-V, the HAQ-DI and the physical component of the SF-36 showed greater improvement (p<0.001) for the HUMIRA/MTX combination therapy group versus either the MTX monotherapy or the HUMIRA monotherapy group at Week 52, which was maintained through Week 104.

## **14.2 Juvenile Idiopathic Arthritis**

The safety and efficacy of HUMIRA were assessed in a multicenter, randomized, withdrawal, double-blind, parallel-group study in 171 children (4 to 17 years of age) with polyarticular juvenile idiopathic arthritis (JIA). In the study, the patients were stratified into two groups: MTX-treated or non-MTX-treated. All subjects had to show signs of active moderate or severe disease despite previous treatment with NSAIDs, analgesics, corticosteroids, or DMARDs.

Subjects who received prior treatment with any biologic DMARDs were excluded from the study.

The study included four phases: an open-label lead in phase (OL-LI; 16 weeks), a double-blind randomized withdrawal phase (DB; 32 weeks), an open-label extension phase (OLE-BSA; up to 136 weeks), and an open-label fixed dose phase (OLE-FD; 16 weeks). In the first three phases of the study, HUMIRA was administered based on body surface area at a dose of 24 mg/m<sup>2</sup> up to a maximum total body dose of 40 mg subcutaneously (SC) every other week. In the OLE-FD phase, the patients were treated with 20 mg of HUMIRA SC every other week if their weight was less than 30 kg and with 40 mg of HUMIRA SC every other week if their weight was 30 kg or greater. Patients remained on stable doses of NSAIDs and or prednisone ( $\leq 0.2$  mg/kg/day or 10 mg/day maximum).

Patients demonstrating a Pediatric ACR 30 response at the end of OL-LI phase were randomized into the double blind (DB) phase of the study and received either HUMIRA or placebo every other week for 32 weeks or until disease flare. Disease flare was defined as a worsening of  $\geq 30\%$  from baseline in  $\geq 3$  of 6 Pediatric ACR core criteria,  $\geq 2$  active joints, and improvement of  $>30\%$  in no more than 1 of the 6 criteria. After 32 weeks or at the time of disease flare during the DB phase, patients were treated in the open-label extension phase based on the BSA regimen (OLE-BSA), before converting to a fixed dose regimen based on body weight (OLE-FD phase).

### Clinical Response

At the end of the 16-week OL-LI phase, 94% of the patients in the MTX stratum and 74% of the patients in the non-MTX stratum were Pediatric ACR 30 responders. In the DB phase significantly fewer patients who received HUMIRA experienced disease flare compared to placebo, both without MTX (43% vs. 71%) and with MTX (37% vs. 65%). More patients treated with HUMIRA continued to show pediatric ACR 30/50/70 responses at Week 48 compared to patients treated with placebo. Pediatric ACR responses were maintained for up to two years in the OLE phase in patients who received HUMIRA throughout the study.

### **14.3 Psoriatic Arthritis**

The safety and efficacy of HUMIRA was assessed in two randomized, double-blind, placebo controlled studies in 413 patients with psoriatic arthritis (PsA). Upon completion of both studies, 383 patients enrolled in an open-label extension study, in which 40 mg HUMIRA was administered every other week.

Study PsA-I enrolled 313 adult patients with moderately to severely active PsA ( $>3$  swollen and  $>3$  tender joints) who had an inadequate response to NSAID therapy in one of the following

forms: (1) distal interphalangeal (DIP) involvement (N=23); (2) polyarticular arthritis (absence of rheumatoid nodules and presence of plaque psoriasis) (N=210); (3) arthritis mutilans (N=1); (4) asymmetric PsA (N=77); or (5) AS-like (N=2). Patients on MTX therapy (158 of 313 patients) at enrollment (stable dose of  $\leq 30$  mg/week for  $>1$  month) could continue MTX at the same dose. Doses of HUMIRA 40 mg or placebo every other week were administered during the 24-week double-blind period of the study.

Compared to placebo, treatment with HUMIRA resulted in improvements in the measures of disease activity (see Tables 7 and 8). Among patients with PsA who received HUMIRA, the clinical responses were apparent in some patients at the time of the first visit (two weeks) and were maintained up to 88 weeks in the ongoing open-label study. Similar responses were seen in patients with each of the subtypes of psoriatic arthritis, although few patients were enrolled with the arthritis mutilans and ankylosing spondylitis-like subtypes. Responses were similar in patients who were or were not receiving concomitant MTX therapy at baseline.

Patients with psoriatic involvement of at least three percent body surface area (BSA) were evaluated for Psoriatic Area and Severity Index (PASI) responses. At 24 weeks, the proportions of patients achieving a 75% or 90% improvement in the PASI were 59% and 42% respectively, in the HUMIRA group (N=69), compared to 1% and 0% respectively, in the placebo group (N=69) ( $p < 0.001$ ). PASI responses were apparent in some patients at the time of the first visit (two weeks). Responses were similar in patients who were or were not receiving concomitant MTX therapy at baseline.

**Table 7. ACR Response in Study PsA-I (Percent of Patients)**

	Placebo N=162	HUMIRA* N=151
<b>ACR20</b>		
Week 12	14%	58%
Week 24	15%	57%
<b>ACR50</b>		
Week 12	4%	36%
Week 24	6%	39%
<b>ACR70</b>		
Week 12	1%	20%
Week 24	1%	23%
* $p < 0.001$ for all comparisons between HUMIRA and placebo		

**Table 8. Components of Disease Activity in Study PsA-I**

Parameter: median	Placebo N=162		HUMIRA* N=151	
	Baseline	24 weeks	Baseline	24 weeks
Number of tender joints <sup>a</sup>	23.0	17.0	20.0	5.0
Number of swollen joints <sup>b</sup>	11.0	9.0	11.0	3.0
Physician global assessment <sup>c</sup>	53.0	49.0	55.0	16.0

Patient global assessment <sup>c</sup>	49.5	49.0	48.0	20.0
Pain <sup>c</sup>	49.0	49.0	54.0	20.0
Disability index (HAQ) <sup>d</sup>	1.0	0.9	1.0	0.4
CRP (mg/dL) <sup>c</sup>	0.8	0.7	0.8	0.2
* p<0.001 for HUMIRA vs. placebo comparisons based on median changes				
<sup>a</sup> Scale 0-78				
<sup>b</sup> Scale 0-76				
<sup>c</sup> Visual analog scale; 0=best, 100=worst				
<sup>d</sup> Disability Index of the Health Assessment Questionnaire; 0=best, 3=worst; measures the patient's ability to perform the following: dress/groom, arise, eat, walk, reach, grip, maintain hygiene, and maintain daily activity.				
<sup>e</sup> Normal range: 0-0.287 mg/dL				

Similar results were seen in an additional, 12-week study in 100 patients with moderate to severe psoriatic arthritis who had suboptimal response to DMARD therapy as manifested by  $\geq 3$  tender joints and  $\geq 3$  swollen joints at enrollment.

### Radiographic Response

Radiographic changes were assessed in the PsA studies. Radiographs of hands, wrists, and feet were obtained at baseline and Week 24 during the double-blind period when patients were on HUMIRA or placebo and at Week 48 when all patients were on open-label HUMIRA. A modified Total Sharp Score (mTSS), which included distal interphalangeal joints (i.e., not identical to the TSS used for rheumatoid arthritis), was used by readers blinded to treatment group to assess the radiographs.

HUMIRA-treated patients demonstrated greater inhibition of radiographic progression compared to placebo-treated patients and this effect was maintained at 48 weeks (see Table 9).

**Table 9. Change in Modified Total Sharp Score in Psoriatic Arthritis**

	Placebo N=141	HUMIRA N=133	
	Week 24	Week 24	Week 48
Baseline mean	22.1	23.4	23.4
Mean Change $\pm$ SD	0.9 $\pm$ 3.1	-0.1 $\pm$ 1.7	-0.2 $\pm$ 4.9*

\* <0.001 for the difference between HUMIRA, Week 48 and Placebo, Week 24 (primary analysis)

### Physical Function Response

In Study PsA-I, physical function and disability were assessed using the HAQ Disability Index (HAQ-DI) and the SF-36 Health Survey. Patients treated with 40 mg of HUMIRA every other week showed greater improvement from baseline in the HAQ-DI score (mean decreases of 47% and 49% at Weeks 12 and 24 respectively) in comparison to placebo (mean decreases of 1% and 3% at Weeks 12 and 24 respectively). At Weeks 12 and 24, patients treated with HUMIRA showed greater improvement from baseline in the SF-36 Physical Component Summary score

compared to patients treated with placebo, and no worsening in the SF-36 Mental Component Summary score. Improvement in physical function based on the HAQ-DI was maintained for up to 84 weeks through the open-label portion of the study.

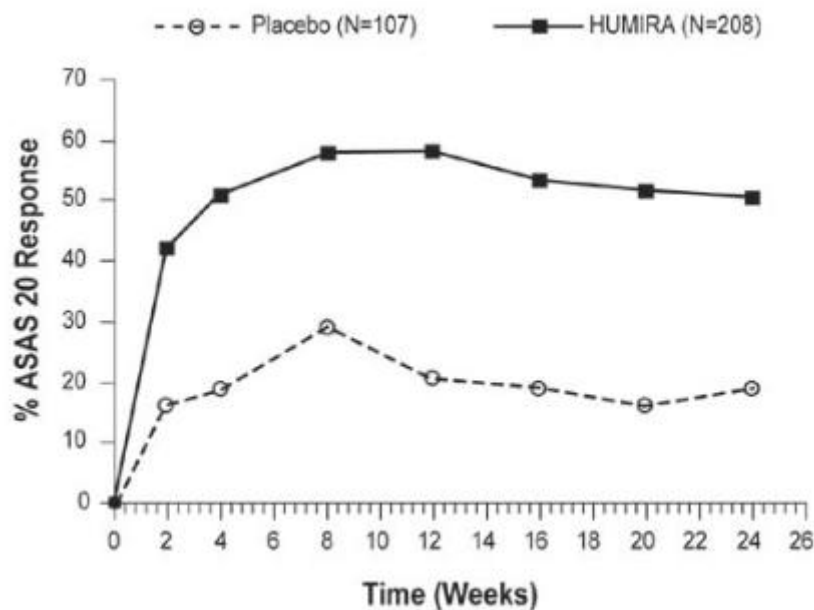
#### 14.4 Ankylosing Spondylitis

The safety and efficacy of HUMIRA 40 mg every other week was assessed in 315 adult patients in a randomized, 24 week double-blind, placebo-controlled study in patients with active ankylosing spondylitis (AS) who had an inadequate response to glucocorticoids, NSAIDs, analgesics, methotrexate or sulfasalazine. Active AS was defined as patients who fulfilled at least two of the following three criteria: (1) a Bath AS disease activity index (BASDAI) score  $\geq 4$  cm, (2) a visual analog score (VAS) for total back pain  $\geq 40$  mm, and (3) morning stiffness  $\geq 1$  hour. The blinded period was followed by an open-label period during which patients received HUMIRA 40 mg every other week subcutaneously for up to an additional 28 weeks.

Improvement in measures of disease activity was first observed at Week 2 and maintained through 24 weeks as shown in Figure 2 and Table 10.

Responses of patients with total spinal ankylosis (n=11) were similar to those without total ankylosis.

**Figure 2. ASAS 20 Response By Visit, Study AS-I**



At 12 weeks, the ASAS 20/50/70 responses were achieved by 58%, 38%, and 23%, respectively, of patients receiving HUMIRA, compared to 21%, 10%, and 5% respectively, of patients receiving placebo (p <0.001). Similar responses were seen at Week 24 and were sustained in patients receiving open-label HUMIRA for up to 52 weeks.

A greater proportion of patients treated with HUMIRA (22%) achieved a low level of disease activity at 24 weeks (defined as a value <20 [on a scale of 0 to 100 mm] in each of the four ASAS response parameters) compared to patients treated with placebo (6%).

**Table 10. Components of Ankylosing Spondylitis Disease Activity**

	Placebo N=107		HUMIRA N=208	
	Baseline mean	Week 24 mean	Baseline mean	Week 24 mean
ASAS 20 Response Criteria*				
Patient's Global Assessment of Disease Activity <sup>a*</sup>	65	60	63	38
Total back pain*	67	58	65	37
Inflammation <sup>b*</sup>	6.7	5.6	6.7	3.6
BASFI <sup>c*</sup>	56	51	52	34
BASDAI <sup>d</sup> score*	6.3	5.5	6.3	3.7
BASMI <sup>e</sup> score*	4.2	4.1	3.8	3.3
Tragus to wall (cm)	15.9	15.8	15.8	15.4
Lumbar flexion (cm)	4.1	4.0	4.2	4.4
Cervical rotation (degrees)	42.2	42.1	48.4	51.6
Lumbar side flexion (cm)	8.9	9.0	9.7	11.7
Intermalleolar distance (cm)	92.9	94.0	93.5	100.8
CRP <sup>f*</sup>	2.2	2.0	1.8	0.6

<sup>a</sup> Percent of subjects with at least a 20% and 10-unit improvement measured on a Visual Analog Scale (VAS) with 0 = "none" and 100 = "severe"  
<sup>b</sup> mean of questions 5 and 6 of BASDAI (defined in 'd')  
<sup>c</sup> Bath Ankylosing Spondylitis Functional Index  
<sup>d</sup> Bath Ankylosing Spondylitis Disease Activity Index  
<sup>e</sup> Bath Ankylosing Spondylitis Metrology Index  
<sup>f</sup> C-Reactive Protein (mg/dL)  
\* statistically significant for comparisons between HUMIRA and placebo at Week 24

A second randomized, multicenter, double-blind, placebo-controlled study of 82 patients with ankylosing spondylitis showed similar results.

Patients treated with HUMIRA achieved improvement from baseline in the Ankylosing Spondylitis Quality of Life Questionnaire (ASQoL) score (-3.6 vs. -1.1) and in the Short Form Health Survey (SF-36) Physical Component Summary (PCS) score (7.4 vs. 1.9) compared to placebo-treated patients at Week 24.

## 14.5 Crohn's Disease

The safety and efficacy of multiple doses of HUMIRA were assessed in adult patients with moderately to severely active Crohn's disease, CD, (Crohn's Disease Activity Index (CDAI)  $\geq$  220 and  $\leq$  450) in randomized, double-blind, placebo-controlled studies. Concomitant stable doses of aminosalicylates, corticosteroids, and/or immunomodulatory agents were permitted, and 79% of patients continued to receive at least one of these medications.

Induction of clinical remission (defined as CDAI < 150) was evaluated in two studies. In Study CD-I, 299 TNF-blocker naïve patients were randomized to one of four treatment groups: the placebo group received placebo at Weeks 0 and 2, the 160/80 group received 160 mg HUMIRA at Week 0 and 80 mg at Week 2, the 80/40 group received 80 mg at Week 0 and 40 mg at Week 2, and the 40/20 group received 40 mg at Week 0 and 20 mg at Week 2. Clinical results were assessed at Week 4.

In the second induction study, Study CD-II, 325 patients who had lost response to, or were intolerant to, previous infliximab therapy were randomized to receive either 160 mg HUMIRA at Week 0 and 80 mg at Week 2, or placebo at Weeks 0 and 2. Clinical results were assessed at Week 4.

Maintenance of clinical remission was evaluated in Study CD-III. In this study, 854 patients with active disease received open-label HUMIRA, 80 mg at week 0 and 40 mg at Week 2. Patients were then randomized at Week 4 to 40 mg HUMIRA every other week, 40 mg HUMIRA every week, or placebo. The total study duration was 56 weeks. Patients in clinical response (decrease in CDAI  $\geq$  70) at Week 4 were stratified and analyzed separately from those not in clinical response at Week 4.

### Induction of Clinical Remission

A greater percentage of the patients treated with 160/80 mg HUMIRA achieved induction of clinical remission versus placebo at Week 4 regardless of whether the patients were TNF blocker naïve (CD-I), or had lost response to or were intolerant to infliximab (CD-II) (see Table 11).

**Table 11. Induction of Clinical Remission in Studies CD-I and CD-II (Percent of Patients)**

	CD-I		CD-II	
	Placebo N=74	HUMIRA 160/80 mg N=76	Placebo N=166	HUMIRA 160/80 mg N=159
Week 4				
Clinical remission	12%	36%*	7%	21%*
Clinical response	34%	58%**	34%	52%**
Clinical remission is CDAI score < 150; clinical response is decrease in CDAI of at least 70 points.				

\* p<0.001 for HUMIRA vs. placebo pairwise comparison of proportions  
 \*\* p<0.01 for HUMIRA vs. placebo pairwise comparison of proportions

### Maintenance of Clinical Remission

In Study CD-III at Week 4, 58% (499/854) of patients were in clinical response and were assessed in the primary analysis. At Weeks 26 and 56, greater proportions of patients who were in clinical response at Week 4 achieved clinical remission in the HUMIRA 40 mg every other week maintenance group compared to patients in the placebo maintenance group (see Table 12). The group that received HUMIRA therapy every week did not demonstrate significantly higher remission rates compared to the group that received HUMIRA every other week.

**Table 12. Maintenance of Clinical Remission in CD-III (Percent of Patients)**

	Placebo	40 mg HUMIRA every other week
	N=170	N=172
<b>Week 26</b>		
Clinical remission	17%	40%*
Clinical response	28%	54%*
<b>Week 56</b>		
Clinical remission	12%	36%*
Clinical response	18%	43%*

Clinical remission is CDAI score < 150; clinical response is decrease in CDAI of at least 70 points.  
 \*p<0.001 for HUMIRA vs. placebo pairwise comparisons of proportions

Of those in response at Week 4 who attained remission during the study, patients in the HUMIRA every other week group maintained remission for a longer time than patients in the placebo maintenance group. Among patients who were not in response by Week 12, therapy continued beyond 12 weeks did not result in significantly more responses.

### **14.6 Ulcerative Colitis**

The safety and efficacy of HUMIRA were assessed in adult patients with moderately to severely active ulcerative colitis (Mayo score 6 to 12 on a 12 point scale, with an endoscopy subscore of 2 to 3 on a scale of 0 to 3) despite concurrent or prior treatment with immunosuppressants such as corticosteroids, azathioprine, or 6-MP in two randomized, double-blind, placebo-controlled clinical studies (Studies UC-I and UC-II). Both studies enrolled TNF-blocker naïve patients, but Study UC-II also allowed entry of patients who lost response to or were intolerant to TNF-blockers. Forty percent (40%) of patients enrolled in Study UC-II had previously used another TNF-blocker.

Concomitant stable doses of aminosaliculates and immunosuppressants were permitted. In Studies UC-I and II, patients were receiving aminosaliculates (69%), corticosteroids (59%)



and/or azathioprine or 6-MP (37%) at baseline. In both studies, 92% of patients received at least one of these medications.

Induction of clinical remission (defined as Mayo score  $\leq 2$  with no individual subscores  $> 1$ ) at Week 8 was evaluated in both studies. Clinical remission at Week 52 and sustained clinical remission (defined as clinical remission at both Weeks 8 and 52) were evaluated in Study UC-II.

In Study UC-I, 390 TNF-blocker naïve patients were randomized to one of three treatment groups for the primary efficacy analysis. The placebo group received placebo at Weeks 0, 2, 4 and 6. The 160/80 group received 160 mg HUMIRA at Week 0 and 80 mg at Week 2, and the 80/40 group received 80 mg HUMIRA at Week 0 and 40 mg at Week 2. After Week 2, patients in both HUMIRA treatment groups received 40 mg every other week (eow).

In Study UC-II, 518 patients were randomized to receive either HUMIRA 160 mg at Week 0, 80 mg at Week 2, and 40 mg eow starting at Week 4 through Week 50, or placebo starting at Week 0 and eow through Week 50. Corticosteroid taper was permitted starting at Week 8.

In both Studies UC-I and UC-II, a greater percentage of the patients treated with 160/80 mg of HUMIRA compared to patients treated with placebo achieved induction of clinical remission. In Study UC-II, a greater percentage of the patients treated with 160/80 mg of HUMIRA compared to patients treated with placebo achieved sustained clinical remission (clinical remission at both Weeks 8 and 52) (Table 13).

<b>Table 13. Induction of Clinical Remission in Studies UC-I and UC-II and Sustained Clinical Remission in Study UC-II (Percent of Patients)</b>						
	<b>Study UC-I</b>			<b>Study UC-II</b>		
	<b>Placebo N=130</b>	<b>HUMIRA 160/80 mg N=130</b>	<b>Treatment Difference (95% CI)</b>	<b>Placebo N=246</b>	<b>HUMIRA 160/80 mg N=248</b>	<b>Treatment Difference (95% CI)</b>
Induction of Clinical Remission (Clinical Remission at Week 8)	9.2%	18.5%	9.3%* (0.9%, 17.6%)	9.3%	16.5%	7.2%* (1.2%, 12.9%)
Sustained Clinical Remission (Clinical Remission at both Weeks 8 and 52)	N/A	N/A	N/A	4.1%	8.5%	4.4%* (0.1%, 8.6%)
Clinical remission is defined as Mayo score $\leq 2$ with no individual subscores $> 1$ . CI=Confidence interval * $p < 0.05$ for HUMIRA vs. placebo pairwise comparison of proportions						

In Study UC-I, there was no statistically significant difference in clinical remission observed between the HUMIRA 80/40 mg group and the placebo group at Week 8.

In Study UC-II, 17.3% (43/248) in the HUMIRA group were in clinical remission at Week 52 compared to 8.5% (21/246) in the placebo group (treatment difference: 8.8%; 95% confidence interval (CI): [2.8%, 14.5%];  $p < 0.05$ ).

In the subgroup of patients in Study UC-II with prior TNF-blocker use, the treatment difference for induction of clinical remission appeared to be lower than that seen in the whole study population, and the treatment differences for sustained clinical remission and clinical remission at Week 52 appeared to be similar to those seen in the whole study population. The subgroup of patients with prior TNF-blocker use achieved induction of clinical remission at 9% (9/98) in the HUMIRA group versus 7% (7/101) in the placebo group, and sustained clinical remission at 5% (5/98) in the HUMIRA group versus 1% (1/101) in the placebo group. In the subgroup of patients with prior TNF-blocker use, 10% (10/98) were in clinical remission at Week 52 in the HUMIRA group versus 3% (3/101) in the placebo group.

#### **14.7 Plaque Psoriasis**

The safety and efficacy of HUMIRA were assessed in randomized, double-blind, placebo-controlled studies in 1696 adult patients with moderate to severe chronic plaque psoriasis (Ps) who were candidates for systemic therapy or phototherapy.

Study Ps-I evaluated 1212 patients with chronic Ps with  $\geq 10\%$  body surface area (BSA) involvement, Physician's Global Assessment (PGA) of at least moderate disease severity, and Psoriasis Area and Severity Index (PASI)  $\geq 12$  within three treatment periods. In period A, patients received placebo or HUMIRA at an initial dose of 80 mg at Week 0 followed by a dose of 40 mg every other week starting at Week 1. After 16 weeks of therapy, patients who achieved at least a PASI 75 response at Week 16, defined as a PASI score improvement of at least 75% relative to baseline, entered period B and received open-label 40 mg HUMIRA every other week. After 17 weeks of open label therapy, patients who maintained at least a PASI 75 response at Week 33 and were originally randomized to active therapy in period A were re-randomized in period C to receive 40 mg HUMIRA every other week or placebo for an additional 19 weeks. Across all treatment groups the mean baseline PASI score was 19 and the baseline Physician's Global Assessment score ranged from "moderate" (53%) to "severe" (41%) to "very severe" (6%).

Study Ps-II evaluated 99 patients randomized to HUMIRA and 48 patients randomized to placebo with chronic plaque psoriasis with  $\geq 10\%$  BSA involvement and PASI  $\geq 12$ . Patients received placebo, or an initial dose of 80 mg HUMIRA at Week 0 followed by 40 mg every other week starting at Week 1 for 16 weeks. Across all treatment groups the mean baseline PASI

score was 21 and the baseline PGA score ranged from “moderate” (41%) to “severe” (51%) to “very severe” (8%).

Studies Ps-I and II evaluated the proportion of patients who achieved “clear” or “minimal” disease on the 6-point PGA scale and the proportion of patients who achieved a reduction in PASI score of at least 75% (PASI 75) from baseline at Week 16 (see Table 14 and 15).

Additionally, Study Ps-I evaluated the proportion of subjects who maintained a PGA of “clear” or “minimal” disease or a PASI 75 response after Week 33 and on or before Week 52.

**Table 14. Efficacy Results at 16 Weeks in Study Ps-I Number of Patients (%)**

	HUMIRA 40 mg every other week	Placebo
	N = 814	N = 398
PGA: Clear or minimal*	506 (62%)	17 (4%)
PASI 75	578 (71%)	26 (7%)
* Clear = no plaque elevation, no scale, plus or minus hyperpigmentation or diffuse pink or red coloration Minimal = possible but difficult to ascertain whether there is slight elevation of plaque above normal skin, plus or minus surface dryness with some white coloration, plus or minus up to red coloration		

**Table 15. Efficacy Results at 16 Weeks in Study Ps-II Number of Patients (%)**

	HUMIRA 40 mg every other week	Placebo
	N = 99	N = 48
PGA: Clear or minimal*	70 (71%)	5 (10%)
PASI 75	77 (78%)	9 (19%)
* Clear = no plaque elevation, no scale, plus or minus hyperpigmentation or diffuse pink or red coloration Minimal = possible but difficult to ascertain whether there is slight elevation of plaque above normal skin, plus or minus surface dryness with some white coloration, plus or minus up to red coloration		

Additionally, in Study Ps-I, subjects on HUMIRA who maintained a PASI 75 were re-randomized to HUMIRA (N = 250) or placebo (N = 240) at Week 33. After 52 weeks of treatment with HUMIRA, more patients on HUMIRA maintained efficacy when compared to subjects who were re-randomized to placebo based on maintenance of PGA of “clear” or “minimal” disease (68% vs. 28%) or a PASI 75 (79% vs. 43%).

A total of 347 stable responders participated in a withdrawal and retreatment evaluation in an open-label extension study. Median time to relapse (decline to PGA “moderate” or worse) was approximately 5 months. During the withdrawal period, no subject experienced transformation to either pustular or erythrodermic psoriasis. A total of 178 subjects who relapsed re-initiated treatment with 80 mg of HUMIRA, then 40 mg eow beginning at week 1. At week 16, 69% (123/178) of subjects had a response of PGA “clear” or “minimal”.

## 15 REFERENCES

1. National Cancer Institute. Surveillance, Epidemiology, and End Results Database (SEER) Program. SEER Incidence Crude Rates, 11 Registries, 1993-2001.

## 16 HOW SUPPLIED/STORAGE AND HANDLING

HUMIRA<sup>®</sup> (adalimumab) is supplied as a preservative-free, sterile solution for subcutaneous administration. The following packaging configurations are available.

- **HUMIRA Pen Carton**

HUMIRA is dispensed in a carton containing two alcohol preps and two dose trays. Each dose tray consists of a single-use pen, containing a 1 mL prefilled glass syringe with a fixed 27 gauge ½ inch needle, providing 40 mg (0.8 mL) of HUMIRA. The NDC number is 0074-4339-02.

- **HUMIRA Pen – Crohn's Disease/Ulcerative Colitis Starter Package**

HUMIRA is dispensed in a carton containing 6 alcohol preps and 6 dose trays (Crohn's Disease/Ulcerative Colitis Starter Package). Each dose tray consists of a single-use pen, containing a 1 mL prefilled glass syringe with a fixed 27 gauge ½ inch needle, providing 40 mg (0.8 mL) of HUMIRA. The NDC number is 0074-4339-06.

- **HUMIRA Pen – Psoriasis Starter Package**

HUMIRA is dispensed in a carton containing 4 alcohol preps and 4 dose trays (Psoriasis Starter Package). Each dose tray consists of a single-use pen, containing a 1 mL prefilled glass syringe with a fixed 27 gauge ½ inch needle, providing 40 mg (0.8 mL) of HUMIRA. The NDC number is 0074-4339-07.

- **Prefilled Syringe Carton – 40 mg**

HUMIRA is dispensed in a carton containing two alcohol preps and two dose trays. Each dose tray consists of a single-use, 1 mL prefilled glass syringe with a fixed 27 gauge ½ inch needle, providing 40 mg (0.8 mL) of HUMIRA. The NDC number is 0074-3799-02.

- **Pediatric Prefilled Syringe Carton – 20 mg**

HUMIRA is supplied for pediatric use only in a carton containing two alcohol preps and two dose trays. Each dose tray consists of a single-use, 1 mL pre-filled glass syringe with a fixed 27

gauge ½ inch needle, providing 20 mg (0.4 mL) of HUMIRA. The NDC number is 0074-9374-02.

- **Institutional Use Vial Carton – 40 mg**

HUMIRA is supplied for institutional use only in a carton containing a single-use, glass vial, providing 40 mg (0.8 mL) of HUMIRA. The NDC number is 0074-3797-01.

*Storage and Stability*

Do not use beyond the expiration date on the container. HUMIRA must be refrigerated at 36°F to 46°F (2°C to 8°C). DO NOT FREEZE. Do not use if frozen even if it has been thawed. When traveling, store HUMIRA in a cool carrier with an ice pack. Protect the prefilled syringe from exposure to light. Store in original carton until time of administration.

## **17 PATIENT COUNSELING INFORMATION**

See FDA-approved patient labeling (Medication Guide and Instructions for Use).

### **17.1 Patient Counseling**

Provide the HUMIRA “Medication Guide” to patients or their caregivers, and provide them an opportunity to read it and ask questions prior to initiation of therapy and prior to each time the prescription is renewed. If patients develop signs and symptoms of infection, instruct them to seek medical evaluation immediately.

Advise patients of the potential benefits and risks of HUMIRA.

- **Infections**

Inform patients that HUMIRA may lower the ability of their immune system to fight infections. Instruct patients of the importance of contacting their doctor if they develop any symptoms of infection, including tuberculosis, invasive fungal infections, and reactivation of hepatitis B virus infections.

- **Malignancies**

Counsel patients about the risk of malignancies while receiving HUMIRA.

- **Allergic Reactions**

Advise patients to seek immediate medical attention if they experience any symptoms of severe allergic reactions. Advise latex-sensitive patients that the needle cap of the prefilled syringe contains latex.

- **Other Medical Conditions**

Advise patients to report any signs of new or worsening medical conditions such as congestive heart failure, neurological disease, autoimmune disorders, or cytopenias. Advise patients to report any symptoms suggestive of a cytopenia such as bruising, bleeding, or persistent fever.

## **17.2 Instruction on Injection Technique**

Inform patients that the first injection is to be performed under the supervision of a qualified health care professional. If a patient or caregiver is to administer HUMIRA, instruct them in injection techniques and assess their ability to inject subcutaneously to ensure the proper administration of HUMIRA [see *Instructions for Use*].

For patients who will use the HUMIRA Pen, tell them that they:

- Will hear a **loud ‘click’** when the plum-colored activator button is pressed. The loud click means the **start** of the injection.
- Must keep holding the HUMIRA Pen against their squeezed, raised skin until all of the medicine is injected. This can take up to 10 seconds.
- Will know that the injection has finished when the yellow marker fully appears in the window view and stops moving.

Instruct patients to dispose of their used needles and syringes or used Pen in a FDA-cleared sharps disposal container immediately after use. **Instruct patients not to dispose of loose needles and syringes or Pen in their household trash.** Instruct patients that if they do not have a FDA-cleared sharps disposal container, they may use a household container that is made of a heavy-duty plastic, can be closed with a tight-fitting and puncture-resistant lid without sharps being able to come out, upright and stable during use, leak-resistant, and properly labeled to warn of hazardous waste inside the container.

Instruct patients that when their sharps disposal container is almost full, they will need to follow their community guidelines for the correct way to dispose of their sharps disposal container. Instruct patients that there may be state or local laws regarding disposal of used needles and syringes. Refer patients to the FDA’s website at <http://www.fda.gov/safesharpsdisposal> for more information about safe sharps disposal, and for specific information about sharps disposal in the state that they live in.