

The data reflect the patients whose test results were considered positive or negative for neutralizing activity to BOTOX in a mouse protection assay. The results of these tests are highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of neutralizing activity to BOTOX with the incidence of antibodies to other products may be misleading.

The critical factors for neutralizing antibody formation have not been well characterized. The results from some studies suggest that BOTOX injections at more frequent intervals or at higher doses may lead to greater incidence of antibody formation. The potential for antibody formation may be minimized by injecting with the lowest effective dose given at the longest feasible intervals between injections.

6.3 Post-Marketing Experience

The following adverse reactions have been identified during post-approval use of BOTOX. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. These reactions include: abdominal pain; alopecia, including madarosis; anorexia; brachial plexopathy; denervation/muscle atrophy; diarrhea; hyperhidrosis; hypoacusis; hypoesthesia; malaise; paresthesia; peripheral neuropathy; radiculopathy; erythema multiforme, dermatitis psoriasiform, and psoriasiform eruption; strabismus; tinnitus; and visual disturbances.

There have been spontaneous reports of death, sometimes associated with dysphagia, pneumonia, and/or other significant debility or anaphylaxis, after treatment with botulinum toxin [*see Warnings and Precautions (5.3, 5.5)*].

There have also been reports of adverse events involving the cardiovascular system, including arrhythmia and myocardial infarction, some with fatal outcomes. Some of these patients had risk factors including cardiovascular disease. The exact relationship of these events to the botulinum toxin injection has not been established.

New onset or recurrent seizures have also been reported, typically in patients who are predisposed to experiencing these events. The exact relationship of these events to the botulinum toxin injection has not been established.

7 DRUG INTERACTIONS

7.1 Aminoglycosides and Other Agents Interfering with Neuromuscular Transmission

Co-administration of BOTOX and aminoglycosides or other agents interfering with neuromuscular transmission (e.g., curare-like compounds) should only be performed with caution as the effect of the toxin may be potentiated.

7.2 Anticholinergic Drugs

Use of anticholinergic drugs after administration of BOTOX may potentiate systemic anticholinergic effects.

7.3 Other Botulinum Neurotoxin Products

The effect of administering different botulinum neurotoxin products at the same time or within several months of each other is unknown. Excessive neuromuscular weakness may be exacerbated by administration of another botulinum toxin prior to the resolution of the effects of a previously administered botulinum toxin.

7.4 Muscle Relaxants

Excessive weakness may also be exaggerated by administration of a muscle relaxant before or after administration of BOTOX.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C.

There are no adequate and well-controlled studies in pregnant women. BOTOX should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

When BOTOX (4, 8, or 16 Units/kg) was administered intramuscularly to pregnant mice or rats two times during the period of organogenesis (on gestation days 5 and 13), reductions in fetal body weight and decreased fetal skeletal ossification were observed at the two highest doses. The no-effect dose for developmental toxicity in these studies (4 Units/kg) is approximately 0.7 times the average high human dose for upper limb spasticity of 360 Units on a body weight basis (Units/kg).

When BOTOX was administered intramuscularly to pregnant rats (0.125, 0.25, 0.5, 1, 4, or 8 Units/kg) or rabbits (0.063, 0.125, 0.25, or 0.5 Units/kg) daily during the period of organogenesis (total of 12 doses in rats, 13 doses in rabbits), reduced fetal body weights and decreased fetal skeletal ossification were observed at the two highest doses in rats and at the highest dose in rabbits. These doses were

also associated with significant maternal toxicity, including abortions, early deliveries, and maternal death. The developmental no-effect doses in these studies of 1 Unit/kg in rats and 0.25 Units/kg in rabbits are less than the average high human dose based on Units/kg.

When pregnant rats received single intramuscular injections (1, 4, or 16 Units/kg) at three different periods of development (prior to implantation, implantation, or organogenesis), no adverse effects on fetal development were observed. The developmental no-effect level for a single maternal dose in rats (16 Units/kg) is approximately 3 times the average high human dose based on Units/kg.

8.3 Nursing Mothers

It is not known whether BOTOX is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when BOTOX is administered to a nursing woman.

8.4 Pediatric Use

Bladder Dysfunction

Safety and effectiveness in patients below the age of 18 years have not been established.

Prophylaxis of Headaches in Chronic Migraine

Safety and effectiveness in patients below the age of 18 years have not been established.

Spasticity

Safety and effectiveness in patients below the age of 18 years have not been established.

Axillary Hyperhidrosis

Safety and effectiveness in patients below the age of 18 years have not been established.

Cervical Dystonia

Safety and effectiveness in pediatric patients below the age of 16 years have not been established.

Blepharospasm and Strabismus

Safety and effectiveness in pediatric patients below the age of 12 years have not been established.

8.5 Geriatric Use

Overall, with the exception of Overactive Bladder (see below), clinical studies of BOTOX did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. There were too few patients over the age of 75 to enable any comparisons. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

Overactive Bladder

Of 1242 overactive bladder patients in placebo-controlled clinical studies of BOTOX, 41.4% (n=514) were 65 years of age or older, and 14.7% (n=182) were 75 years of age or older. Adverse reactions of UTI and urinary retention were more common in patients 65 years of age or older in both placebo and BOTOX groups compared to younger patients (see Table 15). Otherwise, there were no overall differences in the safety profile following BOTOX treatment between patients aged 65 years and older compared to younger patients in these studies.

Table 15. Incidence of Urinary Tract Infection and Urinary Retention according to Age Group during First Placebo-controlled Treatment, Placebo-controlled Clinical Trials in Patients with OAB

Adverse Reactions	<65 Years		65 to 74 Years		≥75 Years	
	BOTOX 100 Units (N=344)	Placebo (N=348)	BOTOX 100 Units (N=169)	Placebo (N=151)	BOTOX 100 Units (N=94)	Placebo (N=86)
Urinary tract infection	73 (21%)	23 (7%)	51 (30%)	20 (13%)	36 (38%)	16 (19%)
Urinary retention	21 (6%)	2 (0.6%)	14 (8%)	0 (0%)	8 (9%)	1 (1%)

Observed effectiveness was comparable between these age groups in placebo-controlled clinical studies.

10 OVERDOSAGE

Excessive doses of BOTOX (onabotulinumtoxinA) for injection may be expected to produce neuromuscular weakness with a variety of symptoms.

Symptoms of overdose are likely not to be present immediately following injection. Should accidental injection or oral ingestion occur or overdose be suspected, the person should be medically supervised for several weeks for signs and symptoms of systemic muscular weakness which could be local, or distant from the site of injection [see *Boxed Warning and Warnings and Precautions (5.2, 5.5)*]. These patients should be considered for further medical evaluation and appropriate medical therapy immediately instituted, which may include hospitalization.

If the musculature of the oropharynx and esophagus are affected, aspiration may occur which may lead to development of aspiration pneumonia. If the respiratory muscles become paralyzed or sufficiently weakened, intubation and assisted respiration may be necessary until recovery takes place. Supportive care could involve the need for a tracheostomy and/or prolonged mechanical ventilation, in addition to other general supportive care.

In the event of overdose, antitoxin raised against botulinum toxin is available from the Centers for Disease Control and Prevention (CDC) in Atlanta, GA. However, the antitoxin will not reverse any botulinum toxin-induced effects already apparent by the time of antitoxin administration. In the event of suspected or actual cases of botulinum toxin poisoning, please contact your local or state Health Department to process a request for antitoxin through the CDC. If you do not receive a response within 30 minutes, please contact the CDC directly at 1-770-488-7100. More information can be obtained at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5232a8.htm>.

11 DESCRIPTION

BOTOX (onabotulinumtoxinA) for injection is a sterile, vacuum-dried purified botulinum toxin type A, produced from fermentation of Hall strain *Clostridium botulinum* type A, and intended for intramuscular, intradetrusor and intradermal use. It is purified from the culture solution by dialysis and a series of acid precipitations to a complex consisting of the neurotoxin, and several accessory proteins. The complex is dissolved in sterile sodium chloride solution containing Albumin Human and is sterile filtered (0.2 microns) prior to filling and vacuum-drying.

The primary release procedure for BOTOX uses a cell-based potency assay to determine the potency relative to a reference standard. The assay is specific to Allergan's products BOTOX and BOTOX Cosmetic. One Unit of BOTOX corresponds to the calculated median intraperitoneal lethal dose (LD₅₀) in mice. Due to specific details of this assay such as the vehicle, dilution scheme, and laboratory protocols, Units of biological activity of BOTOX cannot be compared to nor converted into Units of any other botulinum toxin or any toxin assessed with any other specific assay method. The specific activity of BOTOX is approximately 20 Units/nanogram of neurotoxin protein complex.

Each vial of BOTOX contains either 50 Units of *Clostridium botulinum* type A neurotoxin complex, 0.25 mg of Albumin Human, and 0.45 mg of sodium chloride; 100 Units of *Clostridium botulinum* type A neurotoxin complex, 0.5 mg of Albumin Human, and 0.9 mg of sodium chloride; or 200 Units of *Clostridium botulinum* type A neurotoxin complex, 1 mg of Albumin Human, and 1.8 mg of sodium chloride in a sterile, vacuum-dried form without a preservative.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

BOTOX blocks neuromuscular transmission by binding to acceptor sites on motor or sympathetic nerve terminals, entering the nerve terminals, and inhibiting the release of acetylcholine. This inhibition occurs as the neurotoxin cleaves SNAP-25, a protein integral to the successful docking and release of acetylcholine from vesicles situated within nerve endings. When injected intramuscularly at therapeutic doses, BOTOX produces partial chemical denervation of the muscle resulting in a localized reduction in muscle activity. In addition, the muscle may atrophy, axonal sprouting may occur, and extrajunctional acetylcholine receptors may develop. There is evidence that reinnervation of the muscle may occur, thus slowly reversing muscle denervation produced by BOTOX.

When injected intradermally, BOTOX produces temporary chemical denervation of the sweat gland resulting in local reduction in sweating.

Following intradetrusor injection, BOTOX affects the efferent pathways of detrusor activity via inhibition of acetylcholine release.

12.3 Pharmacokinetics

Using currently available analytical technology, it is not possible to detect BOTOX in the peripheral blood following intramuscular injection at the recommended doses.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Long term studies in animals have not been performed to evaluate the carcinogenic potential of BOTOX.

Mutagenesis

BOTOX was negative in a battery of in vitro (microbial reverse mutation assay, mammalian cell mutation assay, and chromosomal aberration assay) and in vivo (micronucleus assay) genetic toxicologic assays.

Impairment of Fertility

In fertility studies of BOTOX (4, 8, or 16 Units/kg) in which either male or female rats were injected intramuscularly prior to mating and on the day of mating (3 doses, 2 weeks apart for males, 2 doses, 2 weeks apart for females) to untreated animals, reduced fertility was observed in males at the intermediate and high doses and in females at the high dose. The no-effect doses for reproductive toxicity (4 Units/kg in males, 8 Units/kg in females) are approximately equal to the average high human dose for upper limb spasticity of 360 Units on a body weight basis (Units/kg).

13.2 Animal Toxicology

In a study to evaluate inadvertent peribladder administration, bladder stones were observed in 1 of 4 male monkeys that were injected with a total of 6.8 Units/kg divided into the prostatic urethra and proximal rectum (single administration). No bladder stones were observed in male or female monkeys following injection of up to 36 Units/kg (~12X the highest human bladder dose) directly to the bladder as either single or 4 repeat dose injections or in female rats for single injections up to 100 Units/kg (~33X the highest human bladder dose).

14 CLINICAL STUDIES

14.1 Overactive Bladder (OAB)

Two double-blind, placebo-controlled, randomized, multi-center, 24-week clinical studies were conducted in patients with OAB with symptoms of urge urinary incontinence, urgency, and frequency (Studies OAB-1 and OAB-2). Patients needed to have at least 3 urinary urgency incontinence episodes and at least 24 micturitions in 3 days to enter the studies. A total of 1105 patients, whose symptoms had not been adequately managed with anticholinergic therapy (inadequate response or intolerable side effects), were randomized to receive either 100 Units of BOTOX (n=557), or placebo (n=548). Patients received 20 injections of study drug (5 units of BOTOX or placebo) spaced approximately 1 cm apart into the detrusor muscle.

In both studies, significant improvements compared to placebo in the primary efficacy variable of change from baseline in daily frequency of urinary incontinence episodes were observed for BOTOX 100 Units at the primary time point of week 12. Significant improvements compared to placebo were also observed for the secondary efficacy variables of daily frequency of micturition episodes and volume voided per micturition. These primary and secondary variables are shown in Tables 16 and 17, and Figures 4 and 5.

Table 16: Baseline and Change from Baseline in Urinary Incontinence Episode Frequency, Micturition Episode Frequency and Volume Voided Per Micturition, Study OAB-1

	BOTOX 100 Units (N=278)	Placebo (N=272)	Treatment Difference	p-value
Daily Frequency of Urinary Incontinence Episodes^a				
Mean Baseline	5.5	5.1		
Mean Change* at Week 2	-2.6	-1.0	-1.6	
Mean Change* at Week 6	-2.8	-1.0	-1.8	
Mean Change* at Week 12**	-2.5	-0.9	-1.6 (-2.1, -1.2)	<0.001
Daily Frequency of Micturition Episodes^b				
Mean Baseline	12.0	11.2		
Mean Change† at Week 12**	-1.9	-0.9	-1.0 (-1.5, -0.6)	<0.001
Volume Voided per Micturition^b (mL)				
Mean Baseline	156	161		
Mean Change† at Week 12**	38	8	30 (17, 43)	<0.001

* Least squares (LS) mean change, treatment difference and p-value are based on an ANCOVA model with baseline value as covariate and treatment group and investigator as factors. Last observation carried forward (LOCF) values were used to analyze the primary efficacy variable.

† LS mean change, treatment difference and p-value are based on an ANCOVA model with baseline value as covariate and stratification factor, treatment group and investigator as factors.

** Primary timepoint

^a Primary variable

^b Secondary variable

Table 17: Baseline and Change from Baseline in Urinary Incontinence Episode Frequency, Micturition Episode Frequency and Volume Voided Per Micturition, Study OAB-2

	BOTOX 100 Units (N=275)	Placebo (N=269)	Treatment Difference	p-value
Daily Frequency of Urinary Incontinence Episodes^a				
Mean Baseline	5.5	5.7		
Mean Change [*] at Week 2	-2.7	-1.1	-1.6	
Mean Change [*] at Week 6	-3.1	-1.3	-1.8	
Mean Change [*] at Week 12 ^{**}	-3.0	-1.1	-1.9 (-2.5, -1.4)	<0.001
Daily Frequency of Micturition Episodes^b				
Mean Baseline	12.0	11.8		
Mean Change [†] at Week 12 ^{**}	-2.3	-0.6	-1.7 (-2.2, -1.3)	<0.001
Volume Voided per Micturition^b (mL)				
Mean Baseline	144	153		
Mean Change [†] at Week 12 ^{**}	40	10	31 (20, 41)	<0.001

* LS mean change, treatment difference and p-value are based on an ANCOVA model with baseline value as covariate and treatment group and investigator as factors. LOCF values were used to analyze the primary efficacy variable.

† LS mean change, treatment difference and p-value are based on an ANCOVA model with baseline value as covariate and stratification factor, treatment group and investigator as factors.

** Primary timepoint

^a Primary variable

^b Secondary variable

Figure 4: Mean Change from Baseline in Daily Frequency of Urinary Incontinence Episodes following intradetrusor injection in Study OAB-1

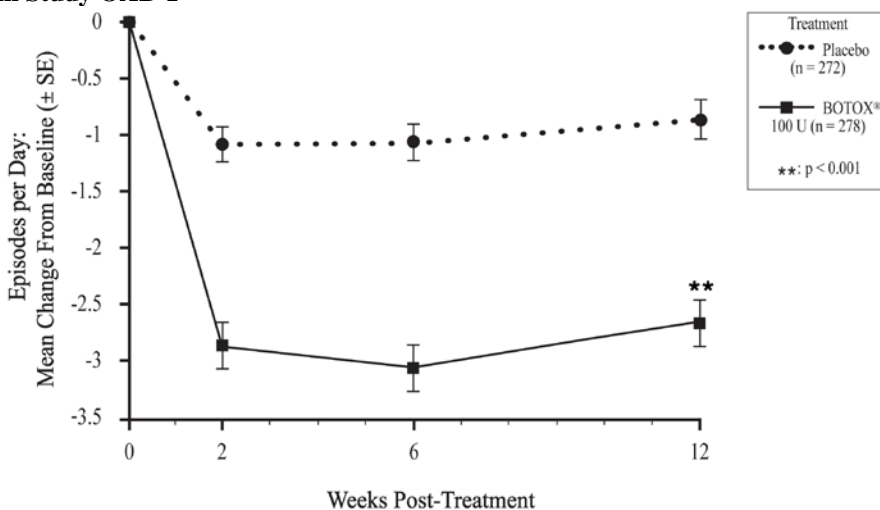


Table 18: Baseline and Change from Baseline in Weekly Urinary Incontinence Episode Frequency, Maximum Cystometric Capacity and Maximum Detrusor Pressure during First Involuntary Detrusor Contraction (cmH2O) Study NDO-1

	BOTOX 200 Units	Placebo	Treatment Difference*	p-value*
Weekly Frequency of Urinary Incontinence Episodes^a				
N	134	146		
Mean Baseline	32.3	28.3		
Mean Change* at Week 2	-15.3	-10.0	-5.3	—
Mean Change* at Week 6**	-19.9	-10.6	-9.2	p<0.001
Mean Change* at Week 12	-19.8	-8.8	(-13.1, -5.3) -11.0	—
Maximum Cystometric Capacity^b (mL)				
N	123	129		
Mean Baseline	253.8	259.1		
Mean Change* at Week 6**	135.9	12.1	123.9 (89.1, 158.7)	p<0.001
Maximum Detrusor Pressure during First Involuntary Detrusor Contraction^b (cmH₂O)				
N	41	103		
Mean Baseline	63.1	57.4		
Mean Change* at Week 6**	-28.1	-3.7	-24.4	—

* LS mean change, treatment difference and p-value are based on an analysis using an ANCOVA model with baseline weekly endpoint as covariate and treatment group, etiology at study entry (spinal cord injury or multiple sclerosis), concurrent anticholinergic therapy at screening, and investigator as factors. LOCF values were used to analyze the primary efficacy variable.

** Primary timepoint

^a Primary endpoint

^b Secondary endpoint

Table 19: Baseline and Change from Baseline in Weekly Urinary Incontinence Episode Frequency, Maximum Cystometric Capacity and Maximum Detrusor Pressure during First Involuntary Detrusor Contraction (cmH2O) in Study NDO-2

	BOTOX 200 Units	Placebo	Treatment Difference*	p-value*
Weekly Frequency of Urinary Incontinence Episodes^a				
N	91	91		
Mean Baseline	32.7	36.8		
Mean Change* at Week 2	-18.0	-7.9	-10.1	—
Mean Change* at Week 6**	-19.6	-10.8	-8.8	p=0.003
Mean Change* at Week 12	-19.6	-10.7	(-14.5, -3.0) -8.9	—
Maximum Cystometric Capacity^b (mL)				
N	88	85		
Mean Baseline	239.6	253.8		
Mean Change* at Week 6**	150.8	2.8	148.0 (101.8, 194.2)	p<0.001
Maximum Detrusor Pressure during First Involuntary Detrusor Contraction^b (cmH₂O)				
N	29	68		
Mean Baseline	65.6	43.7		
Mean Change* at Week 6**	-28.7	2.1	-30.7	—

* LS mean change, treatment difference and p-value are based on an analysis using an ANCOVA model with baseline weekly endpoint as covariate and treatment group, etiology at study entry (spinal cord injury or multiple sclerosis), concurrent anticholinergic therapy at screening, and investigator as factors. LOCF values were used to analyze the primary efficacy variable.

** Primary timepoint

^a Primary endpoint

^b Secondary endpoint

Figure 6: Mean Change from Baseline in Weekly Frequency of Urinary Incontinence Episodes During Treatment Cycle 1 in Study NDO-1

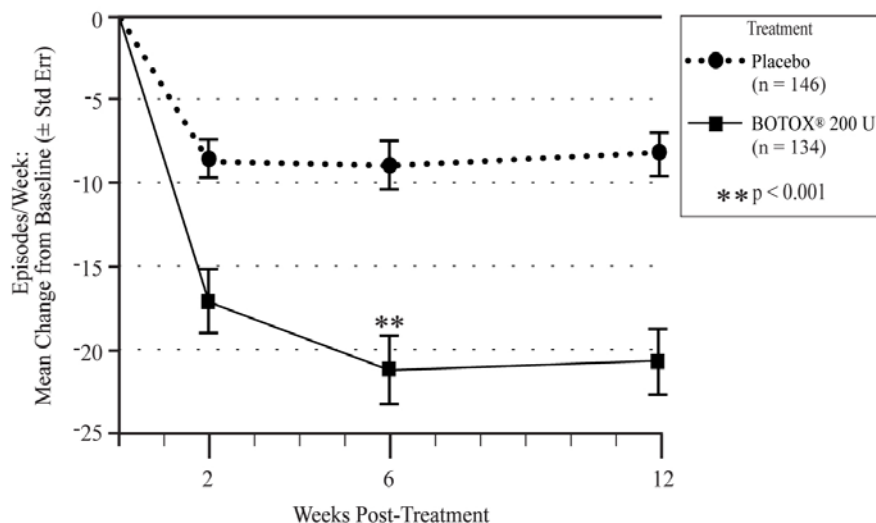
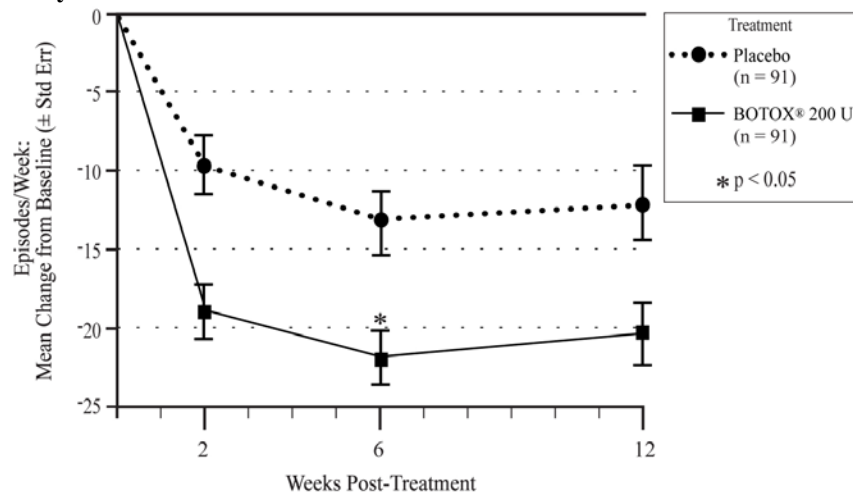


Figure 7: Mean Change from Baseline in Weekly Frequency of Urinary Incontinence Episodes During Treatment Cycle 1 in Study NDO-2



The median duration of response in study NDO-1 and NDO-2, based on patient qualification for re-treatment was 295-337 days (42-48 weeks) for the 200 Units dose group compared to 96-127 days (13-18 weeks) for placebo. Re-treatment was based on loss of effect on incontinence episode frequency (50% of effect in Study NDO-1; 70% of effect in Study NDO-2).

14.3 Chronic Migraine

BOTOX was evaluated in two randomized, multi-center, 24-week, 2 injection cycle, placebo-controlled double-blind studies. Study 1 and Study 2 included chronic migraine adults who were not using any concurrent headache prophylaxis, and during a 28-day baseline period had ≥ 15 headache days lasting 4 hours or more, with $\geq 50\%$ being migraine/probable migraine. In both studies, patients were randomized to receive placebo or 155 Units to 195 Units BOTOX injections every 12 weeks for the 2-cycle, double-blind phase. Patients were allowed to use acute headache treatments during the study. BOTOX treatment demonstrated statistically significant and clinically meaningful improvements from baseline compared to placebo for key efficacy variables (see Table 20).

Table 20: Week 24 Key Efficacy Variables for Study 1 and Study 2

Efficacy per 28 days	Study 1		Study 2	
	BOTOX (N=341)	Placebo (N=338)	BOTOX (N=347)	Placebo (N=358)
Change from baseline in frequency of headache days	-7.8*	-6.4	-9.2*	-6.9
Change from baseline in total cumulative hours of headache on headache days	-107*	-70	-134*	-95

*Significantly different from placebo ($p \leq 0.05$)

Patients treated with BOTOX had a significantly greater mean decrease from baseline in the frequency of headache days at most timepoints from Week 4 to Week 24 in Study 1 (Figure 8), and all timepoints from Week 4 to Week 24 in Study 2 (Figure 9), compared to placebo-treated patients.

Figure 8: Mean Change from Baseline in Number of Headache Days for Study 1

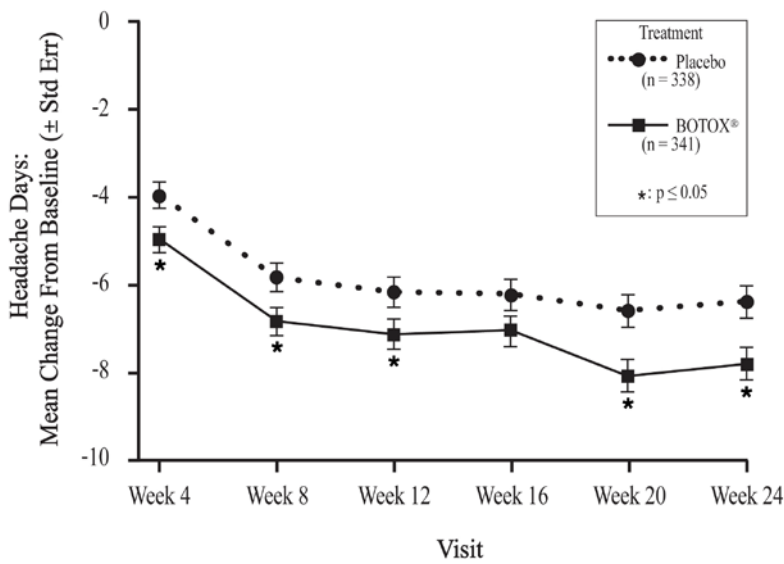
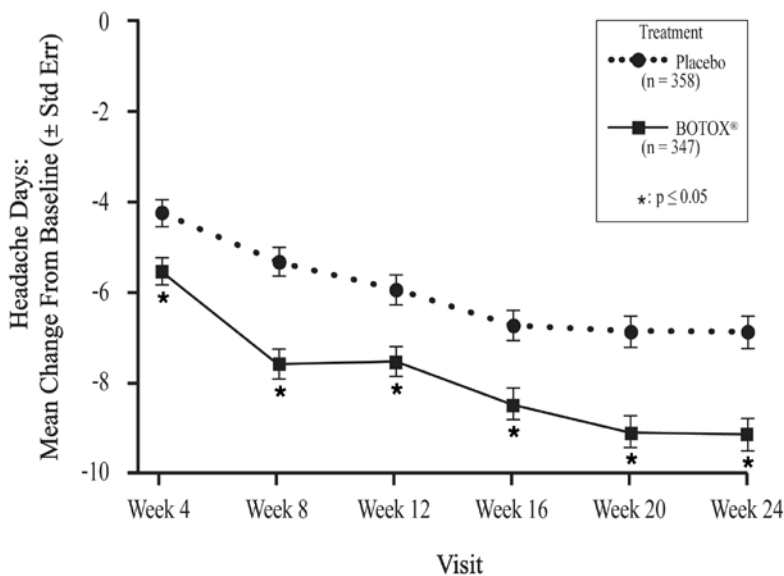


Figure 9: Mean Change from Baseline in Number of Headache Days for Study 2



14.4 Upper Limb Spasticity

The efficacy of BOTOX for the treatment of upper limb spasticity was evaluated in three randomized, multi-center, double-blind, placebo-controlled studies (Studies 1, 2, and 3). Two additional randomized, multi-center, double-blind, placebo-controlled studies for upper limb spasticity in adults also included the evaluation of the efficacy of BOTOX for the treatment of thumb spasticity (Studies 4 and 5).

Study 1 included 126 patients (64 BOTOX and 62 placebo) with upper limb spasticity (Ashworth score of at least 3 for wrist flexor tone and at least 2 for finger flexor tone) who were at least 6 months post-stroke. BOTOX (a total dose of 200 Units to 240 Units) and placebo were injected intramuscularly (IM) into the flexor digitorum profundus, flexor digitorum sublimis, flexor carpi radialis, flexor carpi ulnaris, and if necessary into the adductor pollicis and flexor pollicis longus (see Table 21). Use of an EMG/nerve stimulator was recommended to assist in proper muscle localization for injection. Patients were followed for 12 weeks.

Table 21: Study Medication Dose and Injection Sites in Study 1

Muscles Injected	Volume (mL)	BOTOX (Units)	Number of Injection Sites
Wrist			
Flexor Carpi Radialis	1	50	1
Flexor Carpi Ulnaris	1	50	1
Finger			1
Flexor Digitorum Profundus	1	50	
Flexor Digitorum Sublimis	1	50	1
Thumb			
Adductor Pollicis ^a	0.4	20	1
Flexor Pollicis Longus ^a	0.4	20	1

^a injected only if spasticity is present in this muscle

The primary efficacy variable was wrist flexors muscle tone at week 6, as measured by the Ashworth score. The Ashworth Scale is a clinical measure of the force required to move an extremity around a joint, with a reduction in score clinically representing a reduction in the force needed to move a joint (i.e., improvement in spasticity).

Possible scores range from 0 to 4:

0 = No increase in muscle tone (none)

1 = Slight increase in muscle tone, giving a 'catch' when the limb was moved in flexion or extension (mild)

2 = More marked increase in muscle tone but affected limb is easily flexed (moderate)

3 = Considerable increase in muscle tone - passive movement difficult (severe)

4 = Limb rigid in flexion or extension (very severe).

Key secondary endpoints included Physician Global Assessment, finger flexors muscle tone, and thumb flexors tone at Week 6. The Physician Global Assessment evaluated the response to treatment in terms of how the patient was doing in his/her life using a scale from -4 = very marked worsening to +4 = very marked improvement. Study 1 results on the primary endpoint and the key secondary endpoints are shown in Table 22.

Table 22: Primary and Key Secondary Endpoints by Muscle Group at Week 6 in Study 1

	BOTOX (N=64)	Placebo (N=62)
Median Change from Baseline in Wrist Flexor Muscle Tone on the Ashworth Scale^{†a}	-2.0*	0.0
Median Change from Baseline in Finger Flexor Muscle Tone on the Ashworth Scale^{††b}	-1.0*	0.0
Median Change from Baseline in Thumb Flexor Muscle Tone on the Ashworth Scale^{††c}	-1.0	-1.0
Median Physician Global Assessment of Response to Treatment^{††}	2.0*	0.0

† Primary endpoint at Week 6

†† Secondary endpoints at Week 6

* Significantly different from placebo ($p \leq 0.05$)

^a BOTOX injected into both the flexor carpi radialis and ulnaris muscles

^b BOTOX injected into the flexor digitorum profundus and flexor digitorum sublimis muscles

^c BOTOX injected into the adductor pollicis and flexor pollicis longus muscles

Study 2 compared 3 doses of BOTOX with placebo and included 91 patients [BOTOX 360 Units (N=21), BOTOX 180 Units (N=23), BOTOX 90 Units (N=21), and placebo (N=26)] with upper limb spasticity (expanded Ashworth score of at least 2 for elbow flexor tone and at least 3 for wrist flexor tone) who were at least 6 weeks post-stroke. BOTOX and placebo were injected with EMG guidance into the flexor digitorum profundus, flexor digitorum sublimis, flexor carpi radialis, flexor carpi ulnaris, and biceps brachii (see Table 23).

Table 23: Study Medication Dose and Injection Sites in Study 2 and Study 3

Muscles Injected	Total Dose			Volume (mL) per site	Injection Sites (n)
	BOTOX low dose (90 Units)	BOTOX mid dose (180 Units)	BOTOX high dose (360 Units)		
Wrist Flexor Carpi Ulnaris	10 Units	20 Units	40 Units	0.4	1
Flexor Carpi Radialis	15 Units	30 Units	60 Units	0.6	1
Finger Flexor Digitorum Profundus	7.5 Units	15 Units	30 Units	0.3	1
Flexor Digitorum Sublimis	7.5 Units	15 Units	30 Units	0.3	1
Elbow Biceps Brachii	50 Units	100 Units	200 Units	0.5	4

The primary efficacy variable in Study 2 was the wrist flexor tone at Week 6 as measured by the expanded Ashworth Scale. The expanded Ashworth Scale uses the same scoring system as the Ashworth Scale, but allows for half-point increments.

Key secondary endpoints in Study 2 included Physician Global Assessment, finger flexors muscle tone, and elbow flexors muscle tone at Week 6. Study 2 results on the primary endpoint and the key secondary endpoints at Week 6 are shown in Table 24.

Table 24: Primary and Key Secondary Endpoints by Muscle Group and BOTOX Dose at Week 6 in Study 2

	BOTOX low dose (90 Units) (N=21)	BOTOX mid dose (180 Units) (N=23)	BOTOX high dose (360 Units) (N=21)	Placebo (N=26)
Median Change from Baseline in Wrist Flexor Muscle Tone on the Ashworth Scale^{†b}	-1.5*	-1.0*	-1.5*	-1.0
Median Change from Baseline in				

Finger Flexor Muscle Tone on the Ashworth Scale^{††c}	-0.5	-0.5	-1.0	-0.5
Median Change from Baseline in Elbow Flexor Muscle Tone on the Ashworth Scale^{††d}	-0.5	-1.0*	-0.5 ^a	-0.5
Median Physician Global Assessment of Response to Treatment	1.0*	1.0*	1.0*	0.0

[†] Primary endpoint at Week 6

^{††} Secondary endpoints at Week 6

* Significantly different from placebo ($p \leq 0.05$)

^a $p=0.053$

^b Total dose of BOTOX injected into both the flexor carpi radialis and ulnaris muscles

^c Total dose of BOTOX injected into the flexor digitorum profundus and flexor digitorum sublimis muscles

^d Dose of BOTOX injected into biceps brachii muscle

Study 3 compared 3 doses of BOTOX with placebo and enrolled 88 patients [BOTOX 360 Units (N=23), BOTOX 180 Units (N=23), BOTOX 90 Units (N=23), and placebo (N=19)] with upper limb spasticity (expanded Ashworth score of at least 2 for elbow flexor tone and at least 3 for wrist flexor tone and/or finger flexor tone) who were at least 6 weeks post-stroke. BOTOX and placebo were injected with EMG guidance into the flexor digitorum profundus, flexor digitorum sublimis, flexor carpi radialis, flexor carpi ulnaris, and biceps brachii (see Table 23).

The primary efficacy variable in Study 3 was wrist and elbow flexor tone as measured by the expanded Ashworth score. A key secondary endpoint was assessment of finger flexors muscle tone. Study 3 results on the primary endpoint at Week 4 are shown in Table 25.

Table 25: Primary and Key Secondary Endpoints by Muscle Group and BOTOX Dose at Week 4 in Study 3

	BOTOX low dose (90 Units) (N=23)	BOTOX mid dose (180 Units) (N=21)	BOTOX high dose (360 Units) (N=22)	Placebo (N=19)
Median Change from Baseline in Wrist Flexor Muscle Tone on the Ashworth Scale^{†b}	-1.0	-1.0	-1.5*	-0.5
Median Change from Baseline in Finger Flexor Muscle Tone on the Ashworth Scale^{††c}	-1.0	-1.0	-1.0*	-0.5
Median Change from Baseline in Elbow Flexor Muscle Tone on the Ashworth Scale^{†d}	-0.5	-0.5	-1.0*	-0.5

[†] Primary endpoint at Week 4

^{††} Secondary endpoints at Week 4

* Significantly different from placebo ($p \leq 0.05$)

^b Total dose of BOTOX injected into both the flexor carpi radialis and ulnaris muscles

^c Total dose of BOTOX injected into the flexor digitorum profundus and flexor digitorum sublimis muscles

^d Dose of BOTOX injected into biceps brachii muscle

Study 4 included 170 patients (87 BOTOX and 83 placebo) with upper limb spasticity who were at least 6 months post-stroke. In Study 4, patients received 20 Units of BOTOX into the adductor pollicis and flexor pollicis longus (total BOTOX dose =40 Units in thumb muscles) or placebo (see Table 26). Study 5 included 109 patients with upper limb spasticity who were at least 6 months post-stroke. In Study 5, patients received 15 Units (low dose) or 20 Units (high dose) of BOTOX into the adductor pollicis and flexor pollicis longus under EMG guidance (total BOTOX low dose =30 Units, total BOTOX high dose =40 Units), or placebo (see Table 26). The duration of follow-up in Study 4 and Study 5 was 12 weeks.

Table 26: Study Medication Dose and Injection Sites in Studies 4 and 5

Muscles Injected	Study 4		Study 5				Number of Injection Sites for Studies 4 and 5
	BOTOX (Units)	Volume (mL)	BOTOX low dose (Units)	BOTOX high dose (Units)	Volume low dose (mL)	Volume high dose (mL)	
Thumb							
Adductor Pollicis	20	0.4	15	20	0.3	0.4	1
Flexor Pollicis Longus	20	0.4	15	20	0.3	0.4	1

The results of Study 4 for the change from Baseline to Week 6 in thumb flexor tone measured by modified Ashworth Scale and overall treatment response by Physician Global Assessment at week 6 are presented in Table 27.

Table 27: Efficacy Endpoints for Thumb Flexors at Week 6 in Study 4

	BOTOX (N=66)	Placebo (N=57)
Median Change from Baseline in Thumb Flexor Muscle Tone on the modified Ashworth Scale^{††a}	-1.0*	0.0
Median Physician Global Assessment of Response to Treatment^{††}	2.0*	0.0

^{††} Secondary endpoints at Week 6

* Significantly different from placebo ($p \leq 0.001$)

^a BOTOX injected into the adductor pollicis and flexor pollicis longus muscles

In Study 5, the results of the change from Baseline to Week 6 in thumb flexor tone measured by modified Ashworth Scale and Clinical Global Impression (CGI) of functional assessment scale assessed by the physician using an 11-point Numeric Rating Scale [-5 worst possible function to +5 best possible function]) are presented in Table 28.

Table 28: Efficacy Endpoints for Thumb Flexors at Week 6 in Study 5

	BOTOX low dose (30 Units) (N=14)	Placebo low dose (N=9)	BOTOX high dose (40 Units) (N=43)	Placebo high dose (N=23)
Median Change from Baseline in Thumb Flexor Muscle Tone on the modified Ashworth Scale^{†††a}	-1.0	-1.0	-0.5*	0.0
Median change from Baseline in Clinical Global Impression Score by Physician^{††}	1.0	0.0	2.0*	0.0

^{††} Secondary endpoint at Week 6

^{†††} Other endpoint at Week 6

* Significantly different from placebo ($p \leq 0.010$)

^a BOTOX injected into the adductor pollicis and flexor pollicis longus muscles

14.5 Cervical Dystonia

A randomized, multi-center, double-blind, placebo-controlled study of the treatment of cervical dystonia was conducted. This study enrolled adult patients with cervical dystonia and a history of having received BOTOX in an open label manner with perceived good response and tolerable side effects. Patients were excluded if they had previously received surgical or other denervation treatment for their symptoms or had a known history of neuromuscular disorder. Subjects participated in an open label enrichment period where they received their previously employed dose of BOTOX. Only patients who were again perceived as showing a response were advanced to the randomized evaluation period. The muscles in which the blinded study agent injections were to be administered were determined on an individual patient basis.

There were 214 subjects evaluated for the open label period, of which 170 progressed into the randomized, blinded treatment period (88 in the BOTOX group, 82 in the placebo group). Patient evaluations continued for at least 10 weeks post-injection. The primary outcome for the study was a dual endpoint, requiring evidence of both a change in the Cervical Dystonia Severity Scale (CDSS) and an increase in the percentage of patients showing any improvement on the Physician Global Assessment Scale at 6 weeks after the injection session. The CDSS quantifies the severity of abnormal head positioning and was newly devised for this study. CDSS allots 1 point for each 5 degrees (or part thereof) of head deviation in each of the three planes of head movement (range of scores up to theoretical maximum of 54). The Physician Global Assessment Scale is a 9 category scale scoring the physician's evaluation of the patients' status compared to baseline, ranging from -4 to +4 (very marked worsening to complete improvement), with 0 indicating no

change from baseline and +1 slight improvement. Pain is also an important symptom of cervical dystonia and was evaluated by separate assessments of pain frequency and severity on scales of 0 (no pain) to 4 (constant in frequency or extremely severe in intensity). Study results on the primary endpoints and the pain-related secondary endpoints are shown in Table 29.

Table 29: Efficacy Outcomes of the Phase 3 Cervical Dystonia Study (Group Means)

	Placebo (N=82)	BOTOX (N=88)	95% CI on Difference
Baseline CDSS	9.3	9.2	
Change in CDSS at Week 6	-0.3	-1.3	(-2.3, 0.3) ^[a,b]
% Patients with Any Improvement on Physician Global Assessment	31%	51%	(5%, 34%) ^[a]
Pain Intensity Baseline	1.8	1.8	
Change in Pain Intensity at Week 6	-0.1	-0.4	(-0.7, -0.2) ^[c]
Pain Frequency Baseline	1.9	1.8	
Change in Pain Frequency at Week 6	-0.0	-0.3	(-0.5, -0.0) ^[c]

^[a] Confidence intervals are constructed from the analysis of covariance table with treatment and investigational site as main effects, and baseline CDSS as a covariate.

^[b] These values represent the prospectively planned method for missing data imputation and statistical test. Sensitivity analyses indicated that the 95% confidence interval excluded the value of no difference between groups and the p-value was less than 0.05. These analyses included several alternative missing data imputation methods and non-parametric statistical tests.

^[c] Confidence intervals are based on the t-distribution.

Exploratory analyses of this study suggested that the majority of patients who had shown a beneficial response by week 6 had returned to their baseline status by 3 months after treatment. Exploratory analyses of subsets by patient sex and age suggest that both sexes receive benefit, although female patients may receive somewhat greater amounts than male patients. There is a consistent treatment-associated effect between subsets greater than and less than age 65. There were too few non-Caucasian patients enrolled to draw any conclusions regarding relative efficacy in racial subsets.

In this study the median total BOTOX dose in patients randomized to receive BOTOX (N=88) was 236 Units, with 25th to 75th percentile ranges of 198 Units to 300 Units. Of these 88 patients, most received injections to 3 or 4 muscles; 38 received injections to 3 muscles, 28 to 4 muscles, 5 to 5 muscles, and 5 to 2 muscles. The dose was divided amongst the affected muscles in quantities shown in Table 30. The total dose and muscles selected were tailored to meet individual patient needs.

Table 30: Number of Patients Treated per Muscle and Fraction of Total Dose Injected into Involved Muscles

Muscle	Number of Patients Treated in this Muscle (N=88)	Mean % Dose per Muscle	Mid-Range of % Dose per Muscle*
Splenius capitis/cervicis	83	38	25-50
Sternocleidomastoid	77	25	17-31
Levator scapulae	52	20	16-25
Trapezius	49	29	18-33
Semispinalis	16	21	13-25
Scalene	15	15	6-21
Longissimus	8	29	17-41

* The mid-range of dose is calculated as the 25th to 75th percentiles.

There were several randomized studies conducted prior to the double-blind, placebo-controlled study, which were supportive but not adequately designed to assess or quantitatively estimate the efficacy of BOTOX.

14.6 Primary Axillary Hyperhidrosis

The efficacy and safety of BOTOX for the treatment of primary axillary hyperhidrosis were evaluated in two randomized, multi-center, double-blind, placebo-controlled studies. Study 1 included adult patients with persistent primary axillary hyperhidrosis who

scored 3 or 4 on a Hyperhidrosis Disease Severity Scale (HDSS) and who produced at least 50 mg of sweat in each axilla at rest over 5 minutes. HDSS is a 4-point scale with 1 = “underarm sweating is never noticeable and never interferes with my daily activities”; to 4 = “underarm sweating is intolerable and always interferes with my daily activities”. A total of 322 patients were randomized in a 1:1:1 ratio to treatment in both axillae with either 50 Units of BOTOX, 75 Units of BOTOX, or placebo. Patients were evaluated at 4-week intervals. Patients who responded to the first injection were re-injected when they reported a re-increase in HDSS score to 3 or 4 and produced at least 50 mg sweat in each axilla by gravimetric measurement, but no sooner than 8 weeks after the initial injection.

Study responders were defined as patients who showed at least a 2-grade improvement from baseline value on the HDSS 4 weeks after both of the first two treatment sessions or had a sustained response after their first treatment session and did not receive re-treatment during the study. Spontaneous resting axillary sweat production was assessed by weighing a filter paper held in the axilla over a period of 5 minutes (gravimetric measurement). Sweat production responders were those patients who demonstrated a reduction in axillary sweating from baseline of at least 50% at week 4.

In the three study groups the percentage of patients with baseline HDSS score of 3 ranged from 50% to 54% and from 46% to 50% for a score of 4. The median amount of sweat production (averaged for each axilla) was 102 mg, 123 mg, and 114 mg for the placebo, 50 Units and 75 Units groups respectively.

The percentage of responders based on at least a 2-grade decrease from baseline in HDSS or based on a >50% decrease from baseline in axillary sweat production was greater in both BOTOX groups than in the placebo group (p<0.001), but was not significantly different between the two BOTOX doses (see Table 31).

Duration of response was calculated as the number of days between injection and the date of the first visit at which patients returned to 3 or 4 on the HDSS scale. The median duration of response following the first treatment in BOTOX treated patients with either dose was 201 days. Among those who received a second BOTOX injection, the median duration of response was similar to that observed after the first treatment.

In study 2, 320 adults with bilateral axillary primary hyperhidrosis were randomized to receive either 50 Units of BOTOX (n=242) or placebo (n=78). Treatment responders were defined as subjects showing at least a 50% reduction from baseline in axillary sweating measured by gravimetric measurement at 4 weeks. At week 4 post-injection, the percentages of responders were 91% (219/242) in the BOTOX group and 36% (28/78) in the placebo group, p<0.001. The difference in percentage of responders between BOTOX and placebo was 55% (95% CI=43.3, 65.9).

Table 31: Study 1 - Study Outcomes

Treatment Response	BOTOX 50 Units (N=104)	BOTOX 75 Units (N=110)	Placebo (N=108)	BOTOX 50-placebo (95% CI)	BOTOX 75-placebo (95% CI)
HDSS Score change ≥ 2 (n)^a	55% (57)	49% (54)	6% (6)	49.3% (38.8, 59.7)	43% (33.2, 53.8)
>50% decrease in axillary sweat production % (n)	81% (84)	86% (94)	41% (44)	40% (28.1, 52.0)	45% (33.3, 56.1)

^a Patients who showed at least a 2-grade improvement from baseline value on the HDSS 4 weeks after both of the first two treatment sessions or had a sustained response after their first treatment session and did not receive re-treatment during the study.

14.7 Blepharospasm

Botulinum toxin has been investigated for use in patients with blepharospasm in several studies. In an open label, historically controlled study, 27 patients with essential blepharospasm were injected with 2 Units of BOTOX at each of six sites on each side. Twenty-five of the 27 patients treated with botulinum toxin reported improvement within 48 hours. One patient was controlled with a higher dosage at 13 weeks post initial injection and one patient reported mild improvement but remained functionally impaired.

In another study, 12 patients with blepharospasm were evaluated in a double-blind, placebo-controlled study. Patients receiving botulinum toxin (n=8) improved compared with the placebo group (n=4). The effects of the treatment lasted a mean of 12 weeks.

One thousand six hundred eighty-four patients with blepharospasm who were evaluated in an open label trial showed clinical improvement as evaluated by measured eyelid force and clinically observed intensity of lid spasm, lasting an average of 12 weeks prior to the need for re-treatment.

14.8 Strabismus

Six hundred seventy-seven patients with strabismus treated with one or more injections of BOTOX were evaluated in an open label trial. Fifty-five percent of these patients improved to an alignment of 10 prism diopters or less when evaluated six months or more following injection.

16 HOW SUPPLIED/STORAGE AND HANDLING

BOTOX is supplied in a single-use vial in the following sizes:

50 Units NDC 0023-3920-50
100 Units NDC 0023-1145-01
200 Units NDC 0023-3921-02

Vials of BOTOX have a holographic film on the vial label that contains the name “Allergan” within horizontal lines of rainbow color. In order to see the hologram, rotate the vial back and forth between your fingers under a desk lamp or fluorescent light source. (Note: the holographic film on the label is absent in the date/lot area.) If you do not see the lines of rainbow color or the name “Allergan”, do not use the product and contact Allergan for additional information at 1-800-890-4345 from 7:00 AM to 3:00 PM Pacific Time.

Storage

Unopened vials of BOTOX should be stored in a refrigerator (2° to 8°C) for up to 36 months for the 50 Units and 100 Units vials or up to 24 months for the 200 Units vial. Do not use after the expiration date on the vial. Administer BOTOX within 24 hours of reconstitution; during this period reconstituted BOTOX should be stored in a refrigerator (2° to 8°C). Reconstituted BOTOX should be clear, colorless, and free of particulate matter.

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide)

Swallowing, Speaking or Breathing Difficulties, or Other Unusual Symptoms

Advise patients to inform their doctor or pharmacist if they develop any unusual symptoms (including difficulty with swallowing, speaking, or breathing), or if any existing symptom worsens [*see Boxed Warning and Warnings and Precautions (5.2, 5.5)*].

Ability to Operate Machinery or Vehicles

Advise patients that if loss of strength, muscle weakness, blurred vision, or drooping eyelids occur, they should avoid driving a car or engaging in other potentially hazardous activities.

Voiding Symptoms after Bladder Injections

After bladder injections for urinary incontinence, advise patients to contact their physician if they experience difficulties in voiding or burning sensation upon voiding.

MEDICATION GUIDE
BOTOX[®]
BOTOX[®] Cosmetic
(Boe-tox)
(onabotulinumtoxinA)
for Injection

Read the Medication Guide that comes with **BOTOX** or **BOTOX Cosmetic** before you start using it and each time it is given to you. There may be new information. This information does not take the place of talking with your doctor about your medical condition or your treatment. You should share this information with your family members and caregivers.

What is the most important information I should know about BOTOX and BOTOX Cosmetic?

BOTOX and BOTOX Cosmetic may cause serious side effects that can be life threatening, including:

- **Problems breathing or swallowing**
- **Spread of toxin effects**

These problems can happen hours, days, to weeks after an injection of BOTOX or BOTOX Cosmetic. Call your doctor or get medical help right away if you have any of these problems after treatment with BOTOX or BOTOX Cosmetic:

1. Problems swallowing, speaking, or breathing. These problems can happen hours, days, to weeks after an injection of BOTOX or BOTOX Cosmetic usually because the muscles that you use to breathe and swallow can become weak after the injection. Death can happen as a complication if you have severe problems with swallowing or breathing after treatment with **BOTOX** or **BOTOX Cosmetic**.

- People with certain breathing problems may need to use muscles in their neck to help them breathe. These people may be at greater risk for serious breathing problems with **BOTOX** or **BOTOX Cosmetic**.
- Swallowing problems may last for several months. People who cannot swallow well may need a feeding tube to receive food and water. If swallowing problems are severe, food or liquids may go into your lungs. People who already have swallowing or breathing problems before receiving **BOTOX** or **BOTOX Cosmetic** have the highest risk of getting these problems.

2. Spread of toxin effects. In some cases, the effect of botulinum toxin may affect areas of the body away from the injection site and cause symptoms of a serious condition called botulism. The symptoms of botulism include:

- loss of strength and muscle weakness all over the body
- double vision
- blurred vision and drooping eyelids
- hoarseness or change or loss of voice (dysphonia)
- trouble saying words clearly (dysarthria)
- loss of bladder control
- trouble breathing
- trouble swallowing

These symptoms can happen hours, days, to weeks after you receive an injection of **BOTOX** or **BOTOX Cosmetic**.

These problems could make it unsafe for you to drive a car or do other dangerous activities. See "What should I avoid while receiving **BOTOX** or **BOTOX Cosmetic**?"

There has not been a confirmed serious case of spread of toxin effect away from the injection site when **BOTOX** has been used at the recommended dose to treat chronic migraine, severe underarm sweating, blepharospasm, or strabismus, or when **BOTOX Cosmetic** has been used at the recommended dose to treat frown lines and/or crow's feet lines.

What are BOTOX and BOTOX Cosmetic?

BOTOX is a prescription medicine that is injected into muscles and used:

- to treat overactive bladder symptoms such as a strong need to urinate with leaking or wetting accidents (urge urinary incontinence), a strong need to urinate right away (urgency), and urinating often (frequency) in adults when another type of medicine (anticholinergic) does not work well enough or cannot be taken.
- to treat leakage of urine (incontinence) in adults with overactive bladder due to neurologic disease when another type of medicine (anticholinergic) does not work well enough or cannot be taken.
- to prevent headaches in adults with chronic migraine who have 15 or more days each month with headache lasting 4 or more hours each day.
- to treat increased muscle stiffness in elbow, wrist, and finger muscles in adults with upper limb spasticity.

- to treat the abnormal head position and neck pain that happens with cervical dystonia (CD) in adults.
- to treat certain types of eye muscle problems (strabismus) or abnormal spasm of the eyelids (blepharospasm) in people 12 years and older.

BOTOX is also injected into the skin to treat the symptoms of severe underarm sweating (severe primary axillary hyperhidrosis) when medicines used on the skin (topical) do not work well enough.

BOTOX Cosmetic is a prescription medicine that is injected into muscles and used to improve the look of moderate to severe frown lines between the eyebrows (glabellar lines) in adults for a short period of time (temporary).

BOTOX Cosmetic is a prescription medicine that is injected into the area around the side of the eyes to improve the look of crow's feet lines in adults for a short period of time (temporary).

You may receive treatment for frown lines and crow's feet lines at the same time.

It is not known whether **BOTOX** is safe or effective in people younger than:

- 18 years of age for treatment of urinary incontinence
- 18 years of age for treatment of chronic migraine
- 18 years of age for treatment of spasticity
- 16 years of age for treatment of cervical dystonia
- 18 years of age for treatment of hyperhidrosis
- 12 years of age for treatment of strabismus or blepharospasm

BOTOX Cosmetic is not recommended for use in children younger than 18 years of age.

It is not known whether **BOTOX** and **BOTOX Cosmetic** are safe or effective to prevent headaches in people with migraine who have 14 or fewer headache days each month (episodic migraine).

It is not known whether **BOTOX** and **BOTOX Cosmetic** are safe or effective for other types of muscle spasms or for severe sweating anywhere other than your armpits.

Who should not take BOTOX or BOTOX Cosmetic?

Do not take **BOTOX** or **BOTOX Cosmetic** if you:

- are allergic to any of the ingredients in **BOTOX** or **BOTOX Cosmetic**. See the end of this Medication Guide for a list of ingredients in **BOTOX** and **BOTOX Cosmetic**.
- had an allergic reaction to any other botulinum toxin product such as *Myobloc*[®], *Dysport*[®], or *Xeomin*[®]
- have a skin infection at the planned injection site
- are being treated for urinary incontinence and have a urinary tract infection (UTI)
- are being treated for urinary incontinence and find that you cannot empty your bladder on your own (only applies to people who are not routinely catheterizing)

What should I tell my doctor before taking BOTOX or BOTOX Cosmetic?

Tell your doctor about all your medical conditions, including if you:

- have a disease that affects your muscles and nerves (such as amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease], myasthenia gravis or Lambert-Eaton syndrome). See "What is the most important information I should know about **BOTOX** and **BOTOX Cosmetic**?"
- have allergies to any botulinum toxin product
- had any side effect from any botulinum toxin product in the past
- have or have had a breathing problem, such as asthma or emphysema
- have or have had swallowing problems
- have or have had bleeding problems
- have plans to have surgery
- had surgery on your face
- have weakness of your forehead muscles, such as trouble raising your eyebrows
- have drooping eyelids
- have any other change in the way your face normally looks
- have symptoms of a urinary tract infection (UTI) and are being treated for urinary incontinence. Symptoms of a urinary tract infection may include pain or burning with urination, frequent urination, or fever.
- have problems emptying your bladder on your own and are being treated for urinary incontinence

- are pregnant or plan to become pregnant. It is not known if **BOTOX** or **BOTOX Cosmetic** can harm your unborn baby.
- are breast-feeding or plan to breastfeed. It is not known if **BOTOX** or **BOTOX Cosmetic** passes into breast milk.

Tell your doctor about all the medicines you take, including prescription and nonprescription medicines, vitamins and herbal products. Using **BOTOX** or **BOTOX Cosmetic** with certain other medicines may cause serious side effects. **Do not start any new medicines until you have told your doctor that you have received BOTOX or BOTOX Cosmetic in the past.**

Especially tell your doctor if you:

- have received any other botulinum toxin product in the last four months
- have received injections of botulinum toxin, such as *Myobloc*[®] (rimabotulinumtoxinB), *Dysport*[®] (abobotulinumtoxinA), or *Xeomin*[®] (incobotulinumtoxinA) in the past. Be sure your doctor knows exactly which product you received.
- have recently received an antibiotic by injection
- take muscle relaxants
- take an allergy or cold medicine
- take a sleep medicine
- take anti-platelets (aspirin-like products) and/or anti-coagulants (blood thinners)

Ask your doctor if you are not sure if your medicine is one that is listed above.

Know the medicines you take. Keep a list of your medicines with you to show your doctor and pharmacist each time you get a new medicine.

How should I take BOTOX or BOTOX Cosmetic?

- **BOTOX** or **BOTOX Cosmetic** is an injection that your doctor will give you.
- **BOTOX** is injected into your affected muscles, skin, or bladder.
- **BOTOX Cosmetic** is injected into your affected muscles.
- Your doctor may change your dose of **BOTOX** or **BOTOX Cosmetic**, until you and your doctor find the best dose for you.
- **Your doctor will tell you how often you will receive your dose of BOTOX or BOTOX Cosmetic injections.**

What should I avoid while taking BOTOX or BOTOX Cosmetic?

BOTOX and **BOTOX Cosmetic** may cause loss of strength or general muscle weakness, or vision problems within hours to weeks of taking **BOTOX** or **BOTOX Cosmetic**. **If this happens, do not drive a car, operate machinery, or do other dangerous activities.** See "What is the most important information I should know about **BOTOX** and **BOTOX Cosmetic**?"

What are the possible side effects of BOTOX and BOTOX Cosmetic?

BOTOX and **BOTOX Cosmetic** can cause serious side effects. See "What is the most important information I should know about **BOTOX** and **BOTOX Cosmetic**?"

Other side effects of BOTOX and BOTOX Cosmetic include:

- dry mouth
- discomfort or pain at the injection site
- tiredness
- headache
- neck pain
- eye problems: double vision, blurred vision, decreased eyesight, drooping eyelids, swelling of your eyelids, and dry eyes.
- urinary tract infection in people being treated for urinary incontinence
- painful urination in people being treated for urinary incontinence
- inability to empty your bladder on your own and are being treated for urinary incontinence. If you have difficulty fully emptying your bladder after getting **BOTOX**, you may need to use disposable self-catheters to empty your bladder up to a few times each day until your bladder is able to start emptying again.
- allergic reactions. Symptoms of an allergic reaction to **BOTOX** or **BOTOX Cosmetic** may include: itching, rash, red itchy welts, wheezing, asthma symptoms, or dizziness or feeling faint. Tell your doctor or get medical help right away if you are wheezing or have asthma symptoms, or if you become dizzy or faint.

Tell your doctor if you have any side effect that bothers you or that does not go away.

These are not all the possible side effects of **BOTOX** and **BOTOX Cosmetic**. For more information, ask your doctor or pharmacist.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

General information about BOTOX and BOTOX Cosmetic:

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide.

This Medication Guide summarizes the most important information about **BOTOX** and **BOTOX Cosmetic**. If you would like more information, talk with your doctor. You can ask your doctor or pharmacist for information about **BOTOX** and **BOTOX Cosmetic** that is written for healthcare professionals.

What are the ingredients in BOTOX and BOTOX Cosmetic?

Active ingredient: botulinum toxin type A

Inactive ingredients: human albumin and sodium chloride

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