

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

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

SAXENDA (liraglutide) injection, for subcutaneous use  
Initial U.S. Approval: 2010

**WARNING: RISK OF THYROID C-CELL TUMORS**  
*See full prescribing information for complete boxed warning.*

- Liraglutide causes thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Saxenda causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors has not been determined (5.1).
- Saxenda is contraindicated in patients with a personal or family history of MTC or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Counsel patients regarding the potential risk of MTC and the symptoms of thyroid tumors (4, 5.1, 13.1).

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

Indications and Usage, Limitations of Use (1).....10/2018

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

Saxenda is a glucagon-like peptide-1 (GLP-1) receptor agonist indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adult patients with an initial body mass index (BMI) of

- 30 kg/m<sup>2</sup> or greater (obese) (1) or
- 27 kg/m<sup>2</sup> or greater (overweight) in the presence of at least one weight-related comorbid condition (e.g. hypertension, type 2 diabetes mellitus, or dyslipidemia) (1).

Limitations of Use:

- Saxenda is not indicated for the treatment of type 2 diabetes (1).
- Saxenda should not be used in combination with any other GLP-1 receptor agonist (1).
- Saxenda should not be used with insulin (1, 5.4).
- The safety and efficacy of coadministration with other products for weight loss have not been established (1).

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

- Recommended dose of Saxenda is 3 mg daily. Administer at any time of day, without regard to the timing of meals (2).
- Initiate at 0.6 mg per day for one week. In weekly intervals, increase the dose until a dose of 3 mg is reached (2).
- Inject subcutaneously in the abdomen, thigh or upper arm (2).
- The injection site and timing can be changed without dose adjustment (2).

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

- Injection, pre-filled, multi-dose pen that delivers doses of 0.6 mg, 1.2 mg, 1.8 mg, 2.4 mg or 3 mg (6 mg/mL, 3 mL) (3).

-----CONTRAINDICATIONS-----

- Personal or family history of medullary thyroid carcinoma or Multiple Endocrine Neoplasia syndrome type 2 (4, 5.1).
- Hypersensitivity to liraglutide or any product components (4, 5.7).
- Pregnancy (4, 8.1).

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

- Thyroid C-cell Tumors: See Boxed Warning (5.1).
- Acute Pancreatitis: Discontinue promptly if pancreatitis is suspected. Do not restart if pancreatitis is confirmed (5.2).
- Acute Gallbladder Disease: If cholelithiasis or cholecystitis are suspected, gallbladder studies are indicated (5.3).
- Serious Hypoglycemia: Can occur when Saxenda is used with an insulin secretagogue (e.g. a sulfonylurea). Consider lowering the dose of anti-diabetic drugs to reduce the risk of hypoglycemia (2, 5.4).
- Heart Rate Increase: Monitor heart rate at regular intervals (5.5).
- Renal Impairment: Has been reported postmarketing, usually in association with nausea, vomiting, diarrhea, or dehydration which may sometimes require hemodialysis. Use caution when initiating or escalating doses of Saxenda in patients with renal impairment (5.6).
- Hypersensitivity Reactions: Postmarketing reports of serious hypersensitivity reactions (e.g., anaphylactic reactions and angioedema). Discontinue Saxenda and other suspect medications and promptly seek medical advice (5.7).
- Suicidal Behavior and Ideation: Monitor for depression or suicidal thoughts. Discontinue Saxenda if symptoms develop (5.8).

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

- Most common adverse reactions, reported in greater than or equal to 5% are: nausea, hypoglycemia, diarrhea, constipation, vomiting, headache, decreased appetite, dyspepsia, fatigue, dizziness, abdominal pain, and increased lipase (6.1).

**To report SUSPECTED ADVERSE REACTIONS, contact Novo Nordisk Inc. at 1-844-363-4448 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

-----DRUG INTERACTIONS-----

- Saxenda delays gastric emptying. May impact absorption of concomitantly administered oral medications. Use with caution (7).

-----USE IN SPECIFIC POPULATIONS-----

- Pediatric Use: Safety and effectiveness not established and use not recommended (8.4).

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised:10/2018

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**BOXED WARNING: RISK OF THYROID C-CELL TUMORS**

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## FULL PRESCRIBING INFORMATION

### WARNING: RISK OF THYROID C-CELL TUMORS

- **Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Saxenda causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors has not been determined [see Warnings and Precautions (5.1) and Nonclinical Toxicology (13.1)].**
- **Saxenda is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Counsel patients regarding the potential risk of MTC with use of Saxenda and inform them of symptoms of thyroid tumors (e.g., a mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with Saxenda [see Contraindications (4), Warnings and Precautions (5.1)].**

## 1 INDICATIONS AND USAGE

Saxenda is indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adult patients with an initial body mass index (BMI) of

- 30 kg/m<sup>2</sup> or greater (obese), or
- 27 kg/m<sup>2</sup> or greater (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, type 2 diabetes mellitus, or dyslipidemia)

### Limitations of Use

- Saxenda is not indicated for the treatment of type 2 diabetes mellitus.
- Saxenda and Victoza® both contain the same active ingredient, liraglutide, and therefore should not be used together. Saxenda should not be used in combination with any other GLP-1 receptor agonist.
- Saxenda has not been studied in patients taking insulin. Saxenda and insulin should not be used together [see Warnings and Precautions (5.4)].
- The safety and effectiveness of Saxenda in combination with other products intended for weight loss, including prescription drugs, over-the-counter drugs, and herbal preparations, have not been established.

## 2 DOSAGE AND ADMINISTRATION

The recommended dosage of Saxenda is 3 mg daily. The dose escalation schedule in Table 1 should be used to reduce the likelihood of gastrointestinal symptoms. If patients do not tolerate an increased dose during dose escalation, consider delaying dose escalation for approximately one additional week. Saxenda should be discontinued, however, if a patient cannot tolerate the 3 mg dose, as efficacy has not been established at lower doses (0.6, 1.2, 1.8, and 2.4 mg).

**Table 1. Dose Escalation Schedule**

Week	Daily Dose
1	0.6 mg
2	1.2 mg
3	1.8 mg
4	2.4 mg
5 and onward	3 mg

Saxenda should be taken once daily at any time of day, without regard to the timing of meals. Saxenda can be injected subcutaneously in the abdomen, thigh, or upper arm. The injection site and timing can be changed without dose adjustment. Saxenda must not be administered intravenously or intramuscularly.

When initiating Saxenda in patients taking insulin secretagogues (such as sulfonylureas), consider reducing the dose of the insulin secretagogue (for example, by one-half) to reduce the risk for hypoglycemia, and monitor blood glucose. Saxenda and insulin should not be used together [see *Warnings and Precautions (5.4) and Adverse Reactions (6.1)*]. Conversely, if discontinuing Saxenda in patients with type 2 diabetes, monitor for an increase in blood glucose.

Evaluate the change in body weight 16 weeks after initiating Saxenda and discontinue Saxenda if the patient has not lost at least 4% of baseline body weight, since it is unlikely that the patient will achieve and sustain clinically meaningful weight loss with continued treatment.

If a dose is missed, the once-daily regimen should be resumed as prescribed with the next scheduled dose. An extra dose or increase in dose should not be taken to make up for the missed dose. If more than 3 days have elapsed since the last Saxenda dose, patients should reinitiate Saxenda at 0.6 mg daily and follow the dose escalation schedule in Table 1, which may reduce the occurrence of gastrointestinal symptoms associated with reinitiation of treatment.

Prior to initiation of Saxenda, patients should be trained by their healthcare professional on proper injection technique. Training reduces the risk of administration errors such as needle sticks and incomplete dosing. Refer to the accompanying Instructions for Use for complete administration instructions with illustrations.

Saxenda solution should be inspected prior to each injection, and the solution should be used only if it is clear, colorless, and contains no particles.

BMI is calculated by dividing weight in (kilograms) by height (in meters) squared. A chart for determining BMI based on height and weight is provided in Table 2.

**Table 2. BMI Conversion Chart**

Weight	(lb)	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225
	(kg)	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7	100.0	102.3
Height																						
(in)	(cm)																					
58	147.3	26	27	28	29	30	31	32	34	35	36	37	38	39	40	41	42	43	44	45	46	47
59	149.9	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	43	44	45	46
60	152.4	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44
61	154.9	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44
62	157.5	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	38	39	40	41	41
63	160.0	22	23	24	25	26	27	28	28	29	30	31	32	33	34	35	36	36	37	38	39	40
64	162.6	22	22	23	24	25	26	27	28	28	29	30	31	32	33	34	34	35	36	37	38	39
65	165.1	21	22	23	23	24	25	26	27	28	28	29	30	31	32	33	33	34	35	36	37	38
66	167.6	20	21	22	23	23	24	25	26	27	27	28	29	30	31	32	32	33	34	35	36	36
67	170.2	20	20	21	22	23	24	24	25	26	27	27	28	29	30	31	31	32	33	34	35	35
68	172.7	19	20	21	21	22	23	24	24	25	26	27	27	28	29	30	30	31	32	33	34	34
69	175.3	18	19	20	21	21	22	23	24	24	25	26	27	27	28	29	30	30	31	32	33	33
70	177.8	18	19	19	20	21	22	22	23	24	24	25	26	27	27	28	29	29	30	31	32	32
71	180.3	17	18	19	20	20	21	22	22	23	24	24	25	26	27	27	28	29	29	30	31	31
72	182.9	17	18	18	19	20	20	21	22	22	23	24	24	25	26	27	27	28	29	29	30	31
73	185.4	17	17	18	19	19	20	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30
74	188.0	16	17	17	18	19	19	20	21	21	22	23	23	24	24	25	26	26	27	28	28	29
75	190.5	16	16	17	18	18	19	19	20	21	21	22	23	23	24	24	25	26	26	27	28	28
76	193.0	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	24	25	26	26	27	27

### **3 DOSAGE FORMS AND STRENGTHS**

Solution for subcutaneous injection, pre-filled, multi-dose pen that delivers doses of 0.6 mg, 1.2 mg, 1.8 mg, 2.4 mg, or 3 mg (6 mg/mL, 3 mL).

### **4 CONTRAINDICATIONS**

Saxenda is contraindicated in:

- Patients with a personal or family history of medullary thyroid carcinoma (MTC) or patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) [see *Warnings and Precautions (5.1)*].
- Patients with a prior serious hypersensitivity reaction to liraglutide or to any of the product components [see *Warnings and Precautions (5.7)*].
- Pregnancy [see *Use in Specific Populations (8.1)*].

### **5 WARNINGS AND PRECAUTIONS**

#### **5.1 Risk of Thyroid C-cell Tumors**

Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors (adenomas and/or carcinomas) at clinically relevant exposures in both genders of rats and mice [see *Nonclinical Toxicology (13.1)*]. Malignant thyroid C-cell carcinomas were detected in rats and mice. It is unknown whether Saxenda will cause thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors has not been determined.

Cases of MTC in patients treated with liraglutide have been reported in the postmarketing period; the data in these reports are insufficient to establish or exclude a causal relationship between MTC and liraglutide use in humans.

Saxenda is contraindicated in patients with a personal or family history of MTC or in patients with MEN 2. Counsel patients regarding the potential risk for MTC with the use of Saxenda and inform them of symptoms of thyroid tumors (e.g., a mass in the neck, dysphagia, dyspnea, persistent hoarseness).

Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with Saxenda. Such monitoring may increase the risk of unnecessary procedures, due to low test specificity for serum calcitonin and a high background incidence of thyroid disease. Significantly elevated serum calcitonin may indicate MTC, and patients with MTC usually have calcitonin values greater than 50 ng/L. If serum calcitonin is measured and found to be elevated, the patient should be further evaluated. Patients with thyroid nodules noted on physical examination or neck imaging should also be further evaluated.

#### **5.2 Acute Pancreatitis**

Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, has been observed in patients treated with liraglutide. After initiation of Saxenda, observe patients carefully for signs and symptoms of pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back and which may or may not be accompanied by vomiting). If pancreatitis is suspected, Saxenda should promptly be discontinued and appropriate management should be initiated. If pancreatitis is confirmed, Saxenda should not be restarted.

In Saxenda clinical trials, acute pancreatitis was confirmed by adjudication in 9 (0.3%) of 3291 Saxenda-treated patients and 2 (0.1%) of 1843 placebo-treated patients. In addition, there were 2 cases of acute pancreatitis in Saxenda-treated patients who prematurely withdrew from these clinical trials, occurring 74 and 124 days after the last dose. There were 2 additional cases in Saxenda-treated patients, 1 during an off-treatment follow-up period within 2 weeks of discontinuing Saxenda, and 1 that occurred in a patient who completed treatment and was off-treatment for 106 days.

Liraglutide has been studied in a limited number of patients with a history of pancreatitis. It is unknown if patients with a history of pancreatitis are at higher risk for development of pancreatitis on Saxenda.

### **5.3 Acute Gallbladder Disease**

In Saxenda clinical trials, 2.2% of Saxenda-treated patients reported adverse events of cholelithiasis versus 0.8% of placebo-treated patients. The incidence of cholecystitis was 0.8% in Saxenda-treated patients versus 0.4% in placebo-treated patients. The majority of Saxenda-treated patients with adverse events of cholelithiasis and cholecystitis required cholecystectomy. Substantial or rapid weight loss can increase the risk of cholelithiasis; however, the incidence of acute gallbladder disease was greater in Saxenda-treated patients than in placebo-treated patients even after accounting for the degree of weight loss. If cholelithiasis is suspected, gallbladder studies and appropriate clinical follow-up are indicated.

### **5.4 Risk for Hypoglycemia with Concomitant Use of Anti-Diabetic Therapy**

The risk for serious hypoglycemia is increased when Saxenda is used in combination with insulin secretagogues (for example, sulfonylureas) in patients with type 2 diabetes mellitus. Therefore, patients may require a lower dose of sulfonylurea (or other concomitantly administered insulin secretagogues) in this setting [*see Dosage and Administration (2) and Adverse Reactions (6.1)*]. Saxenda should not be used in patients taking insulin.

Saxenda can lower blood glucose [*see Clinical Pharmacology (12.2)*]. Monitor blood glucose parameters prior to starting Saxenda and during Saxenda treatment in patients with type 2 diabetes. If needed, adjust co-administered anti-diabetic drugs based on glucose monitoring results and risk of hypoglycemia.

### **5.5 Heart Rate Increase**

Mean increases in resting heart rate of 2 to 3 beats per minute (bpm) were observed with routine clinical monitoring in Saxenda-treated patients compared to placebo in clinical trials. More patients treated with Saxenda, compared with placebo, had changes from baseline at two consecutive visits of more than 10 bpm (34% versus 19%, respectively) and 20 bpm (5% versus 2%, respectively). At least one resting heart rate exceeding 100 bpm was recorded for 6% of Saxenda-treated patients compared with 4% of placebo-treated patients, with this occurring at two consecutive study visits for 0.9% and 0.3%, respectively. Tachycardia was reported as an adverse reaction in 0.6% of Saxenda-treated patients and in 0.1% of placebo-treated patients.

In a clinical pharmacology trial that monitored heart rate continuously for 24 hours, Saxenda treatment was associated with a heart rate that was 4 to 9 bpm higher than that observed with placebo.

Heart rate should be monitored at regular intervals consistent with usual clinical practice. Patients should inform health care providers of palpitations or feelings of a racing heartbeat while at rest during Saxenda treatment. For patients who experience a sustained increase in resting heart rate while taking Saxenda, Saxenda should be discontinued.

### **5.6 Renal Impairment**

In patients treated with GLP-1 receptor agonists, including Saxenda, there have been reports of acute renal failure and worsening of chronic renal failure, sometimes requiring hemodialysis [*see Adverse Reactions (6.2)*]. Some of these events were reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, or diarrhea leading to volume depletion. Some of the reported events occurred in patients receiving one or more medications known to affect renal function or volume status. Altered renal function has been reversed in many of the reported cases with supportive treatment and discontinuation of potentially causative agents, including liraglutide. Use caution when initiating or escalating doses of Saxenda in patients with renal impairment [*see Use in Specific Populations (8.6)*].

### **5.7 Hypersensitivity Reactions**

There have been reports of serious hypersensitivity reactions (e.g., anaphylactic reactions and angioedema) in patients treated with liraglutide [see *Contraindications (4) and Adverse Reactions (6.1, 6.2)*]. If a hypersensitivity reaction occurs, the patient should discontinue Saxenda and other suspect medications and promptly seek medical advice.

Anaphylaxis and angioedema have been reported with other GLP-1 receptor agonists. Use caution in a patient with a history of anaphylaxis or angioedema with another GLP-1 receptor agonist because it is unknown whether such patients will be predisposed to these reactions with Saxenda.

### **5.8 Suicidal Behavior and Ideation**

In Saxenda clinical trials, 9 (0.3%) of 3384 Saxenda-treated patients and 2 (0.1%) of the 1941 placebo-treated patients reported suicidal ideation; one of these Saxenda-treated patients attempted suicide. Patients treated with Saxenda should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior. Discontinue Saxenda in patients who experience suicidal thoughts or behaviors. Avoid Saxenda in patients with a history of suicidal attempts or active suicidal ideation.

## **6 ADVERSE REACTIONS**

The following serious adverse reactions are described below or elsewhere in the prescribing information:

- Risk of Thyroid C-Cell Tumors [see *Warnings and Precautions (5.1)*]
- Acute Pancreatitis [see *Warnings and Precautions (5.2)*]
- Acute Gallbladder Disease [see *Warnings and Precautions (5.3)*]
- Risk for Hypoglycemia with Concomitant Use of Anti-Diabetic Therapy [see *Warnings and Precautions (5.4)*]
- Heart Rate Increase [see *Warnings and Precautions (5.5)*]
- Renal Impairment [see *Warnings and Precautions (5.6)*]
- Hypersensitivity Reactions [see *Warnings and Precautions (5.7)*]
- Suicidal Behavior and Ideation [see *Warnings and Precautions (5.8)*]

### **6.1 Clinical Trials Experience**

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

Saxenda was evaluated for safety in 5 double-blind, placebo controlled trials that included 3384 overweight or obese patients treated with Saxenda for a treatment period up to 56 weeks (3 trials), 52 weeks (1 trial), and 32 weeks (1 trial). All patients received study drug in addition to diet and exercise counseling. In these trials, patients received Saxenda for a mean treatment duration of 46 weeks (median, 56 weeks). Baseline characteristics included a mean age of 47 years, 71% women, 85% white, 39% with hypertension, 15% with type 2 diabetes, 34% with dyslipidemia, 29% with a BMI greater than 40 kg/m<sup>2</sup>, and 9% with cardiovascular disease. In one of the 56-week trials, a subset of patients (with abnormal glucose measurements at randomization) [see *Clinical Studies (14)*] were enrolled for a placebo-controlled 160-week period instead, followed by a 12-week off-treatment follow-up. For those participating in this 160-week period, patients received Saxenda for a mean treatment duration of 110 weeks (median, 159 weeks). For all trials, dosing was initiated and increased weekly to reach the 3 mg dose.

In clinical trials, 9.8% of patients treated with Saxenda and 4.3% of patients treated with placebo prematurely discontinued treatment as a result of adverse reactions. The most common adverse reactions leading to discontinuation were nausea (2.9% versus 0.2% for Saxenda and placebo, respectively), vomiting (1.7% versus less than 0.1%), and diarrhea (1.4% versus 0%).

Adverse reactions reported in greater than or equal to 2% of Saxenda-treated patients and more frequently than in placebo-treated patients are shown in Table 3.

**Table 3. Adverse Reactions Reported in Greater Than or Equal to 2% of Saxenda-treated Patients and More Frequently than with Placebo\***

	<b>Placebo N = 1941 %</b>	<b>Saxenda N = 3384 %</b>
<b>Gastrointestinal Disorders</b>		
Nausea	13.8	39.3
Diarrhea	9.9	20.9
Constipation	8.5	19.4
Vomiting	3.9	15.7
Dyspepsia	2.7	9.6
Abdominal Pain	3.1	5.4
Upper Abdominal Pain	2.7	5.1
Gastroesophageal Reflux Disease	1.7	4.7
Abdominal Distension	3.0	4.5
Eructation	0.2	4.5
Flatulence	2.5	4.0
Dry Mouth	1.0	2.3
<b>Metabolism and Nutrition Disorders</b>		
Hypoglycemia in T2DM <sup>1</sup>	12.7	23.0
Decreased Appetite	2.3	10.0
<b>Nervous System Disorders</b>		
Headache	12.6	13.6
Dizziness	5.0	6.9
<b>General Disorders and Administration Site Conditions</b>		
Fatigue	4.6	7.5
Injection Site Erythema	0.2	2.5
Injection Site Reaction	0.6	2.5
Asthenia	0.8	2.1
<b>Infections and Infestations</b>		
Gastroenteritis	3.2	4.7
Urinary Tract Infection	3.1	4.3
Viral Gastroenteritis	1.6	2.8
<b>Investigations</b>		
Increased Lipase	2.2	5.3
<b>Psychiatric Disorders</b>		
Insomnia	1.7	2.4
Anxiety	1.6	2.0

<sup>1</sup> Documented symptomatic (defined as documented symptoms of hypoglycemia in combination with a plasma glucose less than or equal to 70 mg/dL) in patients with type 2 diabetes (Study 2). See text below for further information regarding hypoglycemia in patients with and without type 2 diabetes. T2DM = type 2 diabetes mellitus

\* Adverse reactions for trials with treatment period up to 56 weeks

### Hypoglycemia

Saxenda can lower blood glucose. In a clinical trial involving patients with type 2 diabetes mellitus and overweight or obesity, severe hypoglycemia (defined as requiring the assistance of another person) occurred in 3 (0.7%) of 422 Saxenda-treated patients and in none of the 212 placebo-treated patients. Each of these 3

Saxenda-treated patients was also taking a sulfonylurea. In the same trial, among patients taking a sulfonylurea, documented symptomatic hypoglycemia (defined as documented symptoms of hypoglycemia in combination with a plasma glucose less than or equal to 70 mg/dL) occurred in 48 (43.6%) of 110 Saxenda-treated patients and 15 (27.3%) of 55 placebo-treated patients. The doses of sulfonylureas were reduced by 50% at the beginning of the trial per protocol. The frequency of hypoglycemia may be higher if the dose of sulfonylurea is not reduced. Among patients not taking a sulfonylurea, documented symptomatic hypoglycemia occurred in 49 (15.7%) of 312 Saxenda-treated patients and 12 (7.6%) of 157 placebo-treated patients.

In Saxenda clinical trials involving patients without type 2 diabetes mellitus, there was no systematic capturing or reporting of hypoglycemia, as patients were not provided with blood glucose meters or hypoglycemia diaries. Spontaneously reported symptomatic episodes of unconfirmed hypoglycemia were reported by 46 (1.6%) of 2962 Saxenda-treated patients and 19 (1.1%) of 1729 placebo-treated patients. Fasting plasma glucose values obtained at routine clinic visits less than or equal to 70 mg/dL, irrespective of hypoglycemic symptoms, were reported as “hypoglycemia” in 92 (3.1%) Saxenda-treated patients and 13 (0.8%) placebo-treated patients.

### Gastrointestinal Adverse Reactions

In the clinical trials, approximately 68% of Saxenda-treated patients and 39% of placebo-treated patients reported gastrointestinal disorders; the most frequently reported was nausea (39% and 14% of patients treated with Saxenda and placebo, respectively). The percentage of patients reporting nausea declined as treatment continued. Other common adverse reactions that occurred at a higher incidence among Saxenda-treated patients included diarrhea, constipation, vomiting, dyspepsia, abdominal pain, dry mouth, gastritis, gastroesophageal reflux disease, flatulence, eructation and abdominal distension. Most episodes of gastrointestinal events were mild or moderate and did not lead to discontinuation of therapy (6.2% with Saxenda versus 0.8% with placebo discontinued treatment as a result of gastrointestinal adverse reactions). There have been reports of gastrointestinal adverse reactions, such as nausea, vomiting, and diarrhea, associated with volume depletion and renal impairment [*see Warnings and Precautions (5.6)*].

### Asthenia, Fatigue, Malaise, Dysgeusia and Dizziness

Events of asthenia, fatigue, malaise, dysgeusia and dizziness were mainly reported within the first 12 weeks of treatment with Saxenda and were often co-reported with gastrointestinal events such as nausea, vomiting, and diarrhea.

### Immunogenicity

Patients treated with Saxenda may develop anti-liraglutide antibodies. Anti-liraglutide antibodies were detected in 42 (2.8%) of 1505 Saxenda-treated patients with a post-baseline assessment. Antibodies that had a neutralizing effect on liraglutide in an *in vitro* assay occurred in 18 (1.2%) of 1505 Saxenda-treated patients. Presence of antibodies may be associated with a higher incidence of injection site reactions and reports of low blood glucose. In clinical trials, these events were usually classified as mild and resolved while patients continued on treatment.

The detection of antibody formation is 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, the incidence of antibodies to Saxenda cannot be directly compared with the incidence of antibodies of other products.

### Allergic Reactions

Urticaria was reported in 0.7% of Saxenda-treated patients and 0.5% of placebo-treated patients. Anaphylactic reactions, asthma, bronchial hyperreactivity, bronchospasm, oropharyngeal swelling, facial swelling, angioedema, pharyngeal edema, type IV hypersensitivity reactions have been reported in patients treated with liraglutide in clinical trials. Cases of anaphylactic reactions with additional symptoms such as hypotension,

palpitations, dyspnea, and edema have been reported with marketed use of liraglutide. Anaphylactic reactions may potentially be life-threatening.

### Injection Site Reactions

Injection site reactions were reported in approximately 13.9% of Saxenda-treated patients and 10.5% of placebo-treated patients. The most common reactions, each reported by 1% to 2.5% of Saxenda-treated patients and more commonly than by placebo-treated patients, included erythema, pruritus, and rash at the injection site. 0.6% of Saxenda-treated patients and 0.5% of placebo-treated patients discontinued treatment due to injection site reactions.

### Breast Cancer

In Saxenda clinical trials, breast cancer confirmed by adjudication was reported in 17 (0.7%) of 2379 Saxenda-treated women compared with 3 (0.2%) of 1300 placebo-treated women, including invasive cancer (13 Saxenda- and 2 placebo-treated women) and ductal carcinoma *in situ* (4 Saxenda- and 1 placebo-treated woman). The majority of cancers were estrogen- and progesterone-receptor positive. There were too few cases to determine whether these cases were related to Saxenda. In addition, there are insufficient data to determine whether Saxenda has an effect on pre-existing breast neoplasia.

### Papillary Thyroid Cancer

In Saxenda clinical trials, papillary thyroid carcinoma confirmed by adjudication was reported in 8 (0.2%) of 3291 Saxenda-treated patients compared with no cases among 1843 placebo-treated patients. Four of these papillary thyroid carcinomas were less than 1 cm in greatest diameter and 4 were diagnosed in surgical pathology specimens after thyroidectomy prompted by findings identified prior to treatment.

### Colorectal Neoplasms

In Saxenda clinical trials, benign colorectal neoplasms (mostly colon adenomas) confirmed by adjudication were reported in 20 (0.6%) of 3291 Saxenda-treated patients compared with 7 (0.4%) of 1843 placebo-treated patients. Six positively adjudicated cases of malignant colorectal neoplasms were reported in 5 Saxenda-treated patients (0.2%, mostly adenocarcinomas) and 1 in a placebo-treated patient (0.1%, neuroendocrine tumor of the rectum).

### Cardiac Conduction Disorders

In Saxenda clinical trials, 11 (0.3%) of 3384 Saxenda-treated patients compared with none of the 1941 placebo-treated patients had a cardiac conduction disorder, reported as first degree atrioventricular block, right bundle branch block, or left bundle branch block.

### Hypotension

Adverse reactions related to hypotension (that is, reports of hypotension, orthostatic hypotension, circulatory collapse, and decreased blood pressure) were reported more frequently with Saxenda (1.1%) compared with placebo (0.5%) in Saxenda clinical trials. Systolic blood pressure decreases to less than 80 mmHg were observed in 4 (0.1%) Saxenda-treated patients compared with no placebo-treated patients. One of the Saxenda-treated patients had hypotension associated with gastrointestinal adverse reactions and renal failure [*see Warnings and Precautions (5.6)*].

### Laboratory Abnormalities

#### Liver Enzymes

Increases in alanine aminotransferase (ALT) greater than or equal to 10 times the upper limit of normal were observed in 5 (0.15%) Saxenda-treated patients (two of whom had ALT greater than 20 and 40 times the upper limit of normal) compared with 1 (0.05%) placebo-treated patient during the Saxenda clinical trials. Because clinical evaluation to exclude alternative causes of ALT and aspartate aminotransferase (AST) increases was not done in most cases, the relationship to Saxenda is uncertain. Some increases in ALT and AST were associated with other confounding factors (such as gallstones).

### *Serum Calcitonin*

Calcitonin, a biological marker of MTC, was measured throughout the clinical development program [see *Warnings and Precautions (5.1)*]. More patients treated with Saxenda in the clinical trials were observed to have high calcitonin values during treatment, compared with placebo. The proportion of patients with calcitonin greater than or equal to 2 times the upper limit of normal at the end of the trial was 1.2% in Saxenda-treated patients and 0.6% in placebo-treated patients. Calcitonin values greater than 20 ng/L at the end of the trial occurred in 0.5% of Saxenda-treated patients and 0.2% of placebo-treated patients; among patients with pre-treatment serum calcitonin less than 20 ng/L, none had calcitonin elevations to greater than 50 ng/L at the end of the trial.

### *Serum Lipase and Amylase*

Serum lipase and amylase were routinely measured in the Saxenda clinical trials. Among Saxenda-treated patients, 2.1% had a lipase value at anytime during treatment of greater than or equal to 3 times the upper limit of normal compared with 1.0% of placebo-treated patients. 0.1% of Saxenda-treated patients had an amylase value at anytime in the trial of greater than or equal to 3 times the upper limit of normal versus 0.1% of placebo-treated patients. The clinical significance of elevations in lipase or amylase with Saxenda is unknown in the absence of other signs and symptoms of pancreatitis [see *Warnings and Precautions (5.2)*].

## **6.2 Post-Marketing Experience**

The following adverse reactions have been reported during post-approval use of liraglutide, the active ingredient of Saxenda. 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.

### *Neoplasms*

Medullary thyroid carcinoma [see *Warnings and Precautions (5.1)*]

### *Gastrointestinal Disorders*

Acute pancreatitis, hemorrhagic and necrotizing pancreatitis, sometimes resulting in death [see *Warnings and Precautions (5.2)*]

### *Metabolism and Nutrition Disorders*

Dehydration resulting from nausea, vomiting and diarrhea [see *Adverse Reactions (6.1)*]

### *Renal and Urinary Disorders*

Increased serum creatinine, acute renal failure or worsening of chronic renal failure, sometimes requiring hemodialysis [see *Warnings and Precautions (5.6)*]

### *General Disorders and Administration Site Conditions*

Allergic reactions: rash and pruritus [see *Adverse Reactions (6.1)*]

### *Immune System Disorders*

Angioedema and anaphylactic reactions [see *Warnings and Precautions (5.7)*]

### *Hepatobiliary Disorders*

Elevations of liver enzymes, hyperbilirubinemia, cholestasis and hepatitis [see *Adverse Reactions (6.1)*]

## **7 DRUG INTERACTIONS**

### **7.1 Oral Medications**

Saxenda causes a delay of gastric emptying, and thereby has the potential to impact the absorption of concomitantly administered oral medications. In clinical pharmacology trials, liraglutide did not affect the absorption of the tested orally administered medications to any clinically relevant degree. Nonetheless, monitor for potential consequences of delayed absorption of oral medications concomitantly administered with Saxenda.

## **8 USE IN SPECIFIC POPULATIONS**

### **8.1 Pregnancy**

### Risk Summary

Saxenda is contraindicated during pregnancy because weight loss offers no potential benefit to a pregnant woman and may result in fetal harm [see *Clinical Considerations*]. There are no available data with liraglutide in pregnant women to inform a drug associated risk for major birth defects and miscarriage. Saxenda should not be used during pregnancy. If a patient wishes to become pregnant, or pregnancy occurs, treatment with Saxenda should be discontinued.

Animal reproduction studies identified increased adverse embryofetal developmental outcomes from exposure during pregnancy. Liraglutide exposure was associated with early embryonic deaths and an imbalance in some fetal abnormalities in pregnant rats administered liraglutide during organogenesis at doses that approximate clinical exposures at the maximum recommended human dose (MRHD) of 3 mg/day. In pregnant rabbits administered liraglutide during organogenesis, decreased fetal weight and an increased incidence of major fetal abnormalities were seen at exposures below the human exposures at the MRHD [see *Animal Data*].

The estimated background risk of major birth defects and miscarriage for the indicated populations is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage of clinically recognized pregnancies is 2-4% and 15-20%, respectively.

### Clinical Considerations

#### *Disease-associated maternal and/or embryofetal risk*

A minimum weight gain, and no weight loss, is recommended for all pregnant women, including those who are already overweight or obese, due to the necessary weight gain that occurs in maternal tissues during pregnancy.

### Animal Data

Liraglutide has been shown to be teratogenic in rats at or above 0.8-times systemic exposures in obese humans resulting from the maximum recommended human dose (MRHD) of 3 mg/day based on plasma area under the time-concentration curve (AUC) comparison. Liraglutide has been shown to cause reduced growth and increased total major abnormalities in rabbits at systemic exposures below exposure in obese humans at the MRHD based on plasma AUC comparison.

Female rats given subcutaneous doses of 0.1, 0.25 and 1 mg/kg/day liraglutide beginning 2 weeks before mating through gestation day 17 had estimated systemic exposures 0.8-, 3-, and 11-times the exposure in obese humans at the MRHD based on plasma AUC comparison. The number of early embryonic deaths in the 1 mg/kg/day group increased slightly. Fetal abnormalities and variations in kidneys and blood vessels, irregular ossification of the skull, and a more complete state of ossification occurred at all doses. Mottled liver and minimally kinked ribs occurred at the highest dose. The incidence of fetal malformations in liraglutide-treated groups exceeding concurrent and historical controls were misshapen oropharynx and/or narrowed opening into larynx at 0.1 mg/kg/day and umbilical hernia at 0.1 and 0.25 mg/kg/day.

Pregnant rabbits given subcutaneous doses of 0.01, 0.025 and 0.05 mg/kg/day liraglutide from gestation day 6 through day 18 inclusive, had estimated systemic exposures less than the exposure in obese humans at the MRHD of 3 mg/day at all doses, based on plasma AUC comparison. Liraglutide decreased fetal weight and dose-dependently increased the incidence of total major fetal abnormalities at all doses. The incidence of malformations exceeded concurrent and historical controls at 0.01 mg/kg/day (kidneys, scapula), greater than or equal to 0.01 mg/kg/day (eyes, forelimb), 0.025 mg/kg/day (brain, tail and sacral vertebrae, major blood vessels and heart, umbilicus), greater than or equal to 0.025 mg/kg/day (sternum) and at 0.05 mg/kg/day (parietal bones, major blood vessels). Irregular ossification and/or skeletal abnormalities occurred in the skull and jaw, vertebrae and ribs, sternum, pelvis, tail, and scapula; and dose-dependent minor skeletal variations were observed. Visceral abnormalities occurred in blood vessels, lung, liver, and esophagus. Bilobed or bifurcated gallbladder was seen in all treatment groups, but not in the control group.

In pregnant female rats given subcutaneous doses of 0.1, 0.25 and 1 mg/kg/day liraglutide from gestation day 6 through weaning or termination of nursing on lactation day 24, estimated systemic exposures were 0.8-, 3-, and

11-times exposure in obese humans at the MRHD of 3 mg/day, based on plasma AUC comparison. A slight delay in parturition was observed in the majority of treated rats. Group mean body weight of neonatal rats from liraglutide-treated dams was lower than neonatal rats from control group dams. Bloody scabs and agitated behavior occurred in male rats descended from dams treated with 1 mg/kg/day liraglutide. Group mean body weight from birth to postpartum day 14 trended lower in F<sub>2</sub> generation rats descended from liraglutide-treated rats compared to F<sub>2</sub> generation rats descended from controls, but differences did not reach statistical significance for any group.

## 8.2 Lactation

### Risk Summary

There are no data on the presence of liraglutide in human milk, the effects on the breastfed infant, or effects on milk production. Liraglutide was present in the milk of lactating rats (see *Data*).

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Saxenda and any potential adverse effects on the breastfed infant from Saxenda or from the underlying maternal condition.

### Data

In lactating rats, liraglutide was present unchanged in milk at concentrations approximately 50% of maternal plasma concentrations.

## 8.4 Pediatric Use

Safety and effectiveness of Saxenda have not been established in pediatric patients. Saxenda is not recommended for use in pediatric patients.

## 8.5 Geriatric Use

In the Saxenda clinical trials, 232 (6.9%) of the Saxenda-treated patients were 65 years of age and over, and 17 (0.5%) of the Saxenda-treated patients were 75 years of age and over. No overall differences in safety or effectiveness were observed between these patients and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

## 8.6 Renal Impairment

There is limited experience with Saxenda in patients with mild, moderate, and severe renal impairment, including end-stage renal disease. However, there have been postmarketing reports of acute renal failure and worsening of chronic renal failure with liraglutide, which may sometimes require hemodialysis [*see Warnings and Precautions (5.6) and Adverse Reactions (6.2)*]. Saxenda should be used with caution in this patient population [*see Clinical Pharmacology (12.3)*].

## 8.7 Hepatic Impairment

There is limited experience in patients with mild, moderate, or severe hepatic impairment. Therefore, Saxenda should be used with caution in this patient population [*see Clinical Pharmacology (12.3)*].

## 8.8 Gastroparesis

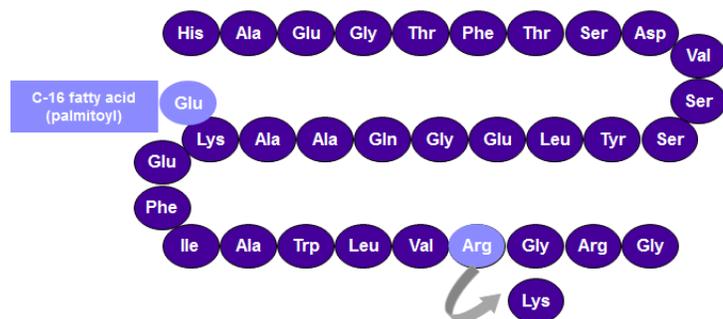
Saxenda slows gastric emptying. Saxenda has not been studied in patients with pre-existing gastroparesis.

## 10 OVERDOSAGE

Overdoses have been reported in clinical trials and post-marketing use of liraglutide. Effects have included severe nausea and severe vomiting. In the event of overdosage, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms.

## 11 DESCRIPTION

Saxenda contains liraglutide, an analog of human GLP-1 and acts as a GLP-1 receptor agonist. The peptide precursor of liraglutide, produced by a process that includes expression of recombinant DNA in *Saccharomyces cerevisiae*, has been engineered to be 97% homologous to native human GLP-1 by substituting arginine for lysine at position 34. Liraglutide is made by attaching a C-16 fatty acid (palmitic acid) with a glutamic acid spacer on the remaining lysine residue at position 26 of the peptide precursor. The molecular formula of liraglutide is  $C_{172}H_{265}N_{43}O_{51}$  and the molecular weight is 3751.2 Daltons. The structural formula (Figure 1) is:



**Figure 1. Structural Formula of liraglutide**

Saxenda is a clear, colorless solution. Each 1 mL of Saxenda solution contains 6 mg of liraglutide and the following inactive ingredients: disodium phosphate dihydrate, 1.42 mg; propylene glycol, 14 mg; phenol, 5.5 mg; and water for injection. Each pre-filled pen contains a 3 mL solution of Saxenda equivalent to 18 mg liraglutide (free-base, anhydrous).

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Liraglutide is an acylated human glucagon-like peptide-1 (GLP-1) receptor agonist with 97% amino acid sequence homology to endogenous human GLP-1(7-37). Like endogenous GLP-1, liraglutide binds to and activates the GLP-1 receptor, a cell-surface receptor coupled to adenylyl cyclase activation through the stimulatory G-protein, Gs. Endogenous GLP-1 has a half-life of 1.5-2 minutes due to degradation by the ubiquitous endogenous enzymes, dipeptidyl peptidase 4 (DPP-4) and neutral endopeptidases (NEP). Unlike native GLP-1, liraglutide is stable against metabolic degradation by both peptidases and has a plasma half-life of 13 hours after subcutaneous administration. The pharmacokinetic profile of liraglutide, which makes it suitable for once-daily administration, is a result of self-association that delays absorption, plasma protein binding, and stability against metabolic degradation by DPP-4 and NEP.

GLP-1 is a physiological regulator of appetite and calorie intake, and the GLP-1 receptor is present in several areas of the brain involved in appetite regulation. In animal studies, peripheral administration of liraglutide resulted in the presence of liraglutide in specific brain regions regulating appetite, including the hypothalamus. Although liraglutide activated neurons in brain regions known to regulate appetite, specific brain regions mediating the effects of liraglutide on appetite were not identified in rats.

### 12.2 Pharmacodynamics

Liraglutide lowers body weight through decreased calorie intake. Liraglutide does not increase 24-hour energy expenditure.

As with other GLP-1 receptor agonists, liraglutide stimulates insulin secretion and reduces glucagon secretion in a glucose-dependent manner. These effects can lead to a reduction of blood glucose.

#### *Cardiac Electrophysiology (QTc) in healthy volunteers*

The effect of liraglutide on cardiac repolarization was tested in a QTc study. Liraglutide at steady-state concentrations after daily doses up to 1.8 mg did not produce QTc prolongation. The maximum liraglutide

plasma concentration ( $C_{max}$ ) in overweight and obese subjects treated with liraglutide 3 mg is similar to the  $C_{max}$  observed in the liraglutide QTc study in healthy volunteers.

### 12.3 Pharmacokinetics

**Absorption** - Following subcutaneous administration, maximum concentrations of liraglutide are achieved at 11 hours post dosing. The average liraglutide steady state concentration ( $AUC_{\tau/24}$ ) reached approximately 116 ng/mL in obese (BMI 30-40 kg/m<sup>2</sup>) subjects following administration of Saxenda. Liraglutide exposure increased proportionally in the dose range of 0.6 mg to 3 mg. The intra-subject coefficient of variation for liraglutide AUC was 11% following single dose administration. Liraglutide exposures were considered similar among three subcutaneous injection sites (upper arm, abdomen, and thigh). Absolute bioavailability of liraglutide following subcutaneous administration is approximately 55%.

**Distribution** - The mean apparent volume of distribution after subcutaneous administration of liraglutide 3 mg is 20-25 L (for a person weighing approximately 100 kg). The mean volume of distribution after intravenous administration of liraglutide is 0.07 L/kg. Liraglutide is extensively bound to plasma protein (greater than 98%).

**Metabolism** - During the initial 24 hours following administration of a single [3H]-liraglutide dose to healthy subjects, the major component in plasma was intact liraglutide. Liraglutide is endogenously metabolized in a similar manner to large proteins without a specific organ as a major route of elimination.

**Elimination** - Following a [3H]-liraglutide dose, intact liraglutide was not detected in urine or feces. Only a minor part of the administered radioactivity was excreted as liraglutide-related metabolites in urine or feces (6% and 5%, respectively). The majority of urine and feces radioactivity was excreted during the first 6-8 days. The mean apparent clearance following subcutaneous administration of a single dose of liraglutide is approximately 0.9-1.4 L/h with an elimination half-life of approximately 13 hours, making liraglutide suitable for once daily administration.

#### Specific Populations

**Elderly** - No dosage adjustment is required based on age. Age had no effect on the pharmacokinetics of liraglutide based on a pharmacokinetic study in healthy elderly subjects (65 to 83 years) and population pharmacokinetic analyses of data from overweight and obese patients 18 to 82 years of age [*see Use in Specific Populations (8.5)*].

**Gender** - Based on the results of population pharmacokinetic analyses, females have 24% lower weight adjusted clearance of Saxenda compared to males. Based on the exposure response data, no dose adjustment is necessary based on gender.

**Race and Ethnicity** - Race and ethnicity had no effect on the pharmacokinetics of liraglutide based on the results of population pharmacokinetic analyses that included overweight and obese patients of Caucasian, Black, Asian and Hispanic/Non-Hispanic groups.

**Body Weight** - Body weight significantly affects the pharmacokinetics of liraglutide based on results of population pharmacokinetic analyses conducted in patients with body weight range of 60-234 kg. The exposure of liraglutide decreases as baseline body weight increases.

**Pediatric** - Saxenda has not been studied in pediatric patients [*see Use in Specific Populations (8.4)*].

**Renal Impairment** - The single-dose pharmacokinetics of liraglutide were evaluated in subjects with varying degrees of renal impairment. Subjects with mild (estimated creatinine clearance 50-80 mL/min) to severe (estimated creatinine clearance less than 30 mL/min) renal impairment and subjects with end-stage renal disease requiring dialysis were included in the trial. Compared to healthy subjects, liraglutide AUC in mild, moderate,

and severe renal impairment and in end-stage renal disease was on average 35%, 19%, 29% and 30% lower, respectively [see Use in Specific Populations (8.6)].

**Hepatic Impairment** - The single-dose pharmacokinetics of liraglutide were evaluated in subjects with varying degrees of hepatic impairment. Subjects with mild (Child Pugh score 5-6) to severe (Child Pugh score greater than 9) hepatic impairment were included in the trial. Compared to healthy subjects, liraglutide AUC in subjects with mild, moderate and severe hepatic impairment was on average 11%, 14% and 42% lower, respectively [see Use in Specific Populations (8.7)].

### *Drug Interactions*

#### *In vitro assessment of drug–drug interactions*

Liraglutide has low potential for pharmacokinetic drug-drug interactions related to cytochrome P450 (CYP) and plasma protein binding.

#### *In vivo assessment of drug–drug interactions*

The drug-drug interaction studies were performed at steady state with liraglutide 1.8 mg/day. The effect on rate of gastric emptying was equivalent between liraglutide 1.8 mg and 3 mg (acetaminophen AUC<sub>0-300min</sub>). Administration of the interacting drugs was timed so that C<sub>max</sub> of liraglutide (8-12 h) would coincide with the absorption peak of the co-administered drugs.

### **Oral Contraceptives**

A single dose of an oral contraceptive combination product containing 0.03 mg ethinylestradiol and 0.15 mg levonorgestrel was administered under fed conditions and 7 hours after the dose of liraglutide at steady state. Liraglutide lowered ethinylestradiol and levonorgestrel C<sub>max</sub> by 12% and 13%, respectively. There was no effect of liraglutide on the overall exposure (AUC) of ethinylestradiol. Liraglutide increased the levonorgestrel AUC<sub>0-∞</sub> by 18%. Liraglutide delayed T<sub>max</sub> for both ethinylestradiol and levonorgestrel by 1.5 h.

### **Digoxin**

A single dose of digoxin 1 mg was administered 7 hours after the dose of liraglutide at steady state. The concomitant administration with liraglutide resulted in a reduction of digoxin AUC by 16%; C<sub>max</sub> decreased by 31%. Digoxin median time to maximal concentration (T<sub>max</sub>) was delayed from 1 h to 1.5 h.

### **Lisinopril**

A single dose of lisinopril 20 mg was administered 5 minutes after the dose of liraglutide at steady state. The co-administration with liraglutide resulted in a reduction of lisinopril AUC by 15%; C<sub>max</sub> decreased by 27%. Lisinopril median T<sub>max</sub> was delayed from 6 h to 8 h with liraglutide.

### **Atorvastatin**

Liraglutide did not change the overall exposure (AUC) of atorvastatin following a single dose of atorvastatin 40 mg, administered 5 hours after the dose of liraglutide at steady state. Atorvastatin C<sub>max</sub> was decreased by 38% and median T<sub>max</sub> was delayed from 1 h to 3 h with liraglutide.

### **Acetaminophen**

Liraglutide did not change the overall exposure (AUC) of acetaminophen following a single dose of acetaminophen 1000 mg, administered 8 hours after the dose of liraglutide at steady state. Acetaminophen C<sub>max</sub> was decreased by 31% and median T<sub>max</sub> was delayed up to 15 minutes.

### **Griseofulvin**

Liraglutide did not change the overall exposure (AUC) of griseofulvin following co-administration of a single dose of griseofulvin 500 mg with liraglutide at steady state. Griseofulvin C<sub>max</sub> increased by 37% while median T<sub>max</sub> did not change.

## Insulin Detemir

No pharmacokinetic interaction was observed between liraglutide and insulin detemir when separate subcutaneous injections of insulin detemir 0.5 Unit/kg (single-dose) and liraglutide 1.8 mg (steady state) were administered to patients with type 2 diabetes mellitus.

## 13 NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

A 104-week carcinogenicity study was conducted in male and female CD-1 mice at doses of 0.03, 0.2, 1, and 3 mg/kg/day liraglutide administered by bolus subcutaneous injection yielding systemic exposures 0.2-, 2-, 10- and 43-times the exposure in obese humans, respectively, at the maximum recommended human dose (MRHD) of 3 mg/day based on plasma AUC comparison. A dose-related increase in benign thyroid C-cell adenomas was seen in the 1 and the 3 mg/kg/day groups with incidences of 13% and 19% in males and 6% and 20% in females, respectively. C-cell adenomas did not occur in control groups or 0.03 and 0.2 mg/kg/day groups. Treatment-related malignant C-cell carcinomas occurred in 3% of females in the 3 mg/kg/day group. Thyroid C-cell tumors are rare findings during carcinogenicity testing in mice. A treatment-related increase in fibrosarcomas was seen on the dorsal skin and subcutis, the body surface used for drug injection, in males in the 3 mg/kg/day group. These fibrosarcomas were attributed to the high local concentration of drug near the injection site. The liraglutide concentration in the clinical formulation (6 mg/mL) is 10-times higher than the concentration in the formulation used to administer 3 mg/kg/day liraglutide to mice in the carcinogenicity study (0.6 mg/mL).

A 104-week carcinogenicity study was conducted in male and female Sprague Dawley rats at doses of 0.075, 0.25 and 0.75 mg/kg/day liraglutide administered by bolus subcutaneous injection with exposures 0.5-, 2- and 7-times the exposure in obese humans, respectively, resulting from the MRHD based on plasma AUC comparison. A treatment-related increase in benign thyroid C-cell adenomas was seen in males in 0.25 and 0.75 mg/kg/day liraglutide groups with incidences of 12%, 16%, 42%, and 46% and in all female liraglutide-treated groups with incidences of 10%, 27%, 33%, and 56% in 0 (control), 0.075, 0.25, and 0.75 mg/kg/day groups, respectively. A treatment-related increase in malignant thyroid C-cell carcinomas was observed in all male liraglutide-treated groups with incidences of 2%, 8%, 6%, and 14% and in females at 0.25 and 0.75 mg/kg/day with incidences of 0%, 0%, 4%, and 6% in 0 (control), 0.075, 0.25, and 0.75 mg/kg/day groups, respectively. Thyroid C-cell carcinomas are rare findings during carcinogenicity testing in rats.

Studies in mice demonstrated that liraglutide-induced C-cell proliferation was dependent on the GLP-1 receptor and that liraglutide did not cause activation of the REarranged during Transfection (RET) proto-oncogene in thyroid C-cells.

Human relevance of thyroid C-cell tumors in mice and rats is unknown and has not been determined by clinical studies or nonclinical studies [*see Boxed Warning and Warnings and Precautions (5.1)*].

Liraglutide was negative with and without metabolic activation in the Ames test for mutagenicity and in a human peripheral blood lymphocyte chromosome aberration test for clastogenicity. Liraglutide was negative in repeat-dose *in vivo* micronucleus tests in rats.

In rat fertility studies using subcutaneous doses of 0.1, 0.25 and 1 mg/kg/day liraglutide, males were treated for 4 weeks prior to and throughout mating and females were treated 2 weeks prior to and throughout mating until gestation day 17. No direct adverse effects on male fertility was observed at doses up to 1 mg/kg/day, a high dose yielding an estimated systemic exposure 11-times the exposure in obese humans at the MRHD, based on plasma AUC comparison. In female rats, an increase in early embryonic deaths occurred at 1 mg/kg/day. Reduced body weight gain and food consumption were observed in females at the 1 mg/kg/day dose.

## 14 CLINICAL STUDIES

The safety and efficacy of Saxenda for chronic weight management in conjunction with reduced caloric intake and increased physical activity were studied in three 56-week, randomized, double-blind, placebo-controlled trials. In all studies, Saxenda was titrated to 3 mg daily during a 4-week period. All patients received instruction for a reduced calorie diet (approximately 500 kcal/day deficit) and exercise counseling (recommended increase in physical activity of minimum 150 mins/week) that began with the first dose of study medication or placebo and continued throughout the trial.

Study 1 enrolled 3731 patients with obesity (BMI greater than or equal to 30 kg/m<sup>2</sup>) or with overweight (BMI 27-29.9 kg/m<sup>2</sup>) and at least one weight-related comorbid condition such as treated or untreated dyslipidemia or hypertension; patients with type 2 diabetes mellitus were excluded. Patients were randomized in a 2:1 ratio to either Saxenda or placebo. Patients were stratified based on the presence or absence of abnormal blood glucose measurements at randomization. All patients were treated for up to 56 weeks. Those patients with abnormal glucose measurements at randomization (2254 of the 3731 patients) were treated for a total of 160 weeks. At baseline, mean age was 45 years (range 18-78), 79% were women, 85% were Caucasian, 10% were African American, and 11% were Hispanic/Latino. Mean baseline body weight was 106.3 kg and mean BMI was 38.3 kg/m<sup>2</sup>.

Study 2 was a 56-week trial that enrolled 635 patients with type 2 diabetes and with either overweight or obesity (as defined above). Patients were to have an HbA<sub>1c</sub> of 7-10% and be treated with metformin, a sulfonylurea, or a glitazone as single agent or in any combination, or with diet and exercise alone. Patients were randomized in a 2:1 ratio to receive either Saxenda or placebo. The mean age was 55 years (range 18-82), 50% were women, 83% were Caucasian, 12% were African American, and 10% were Hispanic/Latino. Mean baseline body weight was 105.9 kg and mean BMI was 37.1 kg/m<sup>2</sup>.

Study 3 was a 56-week trial that enrolled 422 patients with obesity (BMI greater than or equal to 30 kg/m<sup>2</sup>) or with overweight (BMI 27-29.9 kg/m<sup>2</sup>) and at least one weight-related comorbid condition such as treated or untreated dyslipidemia or hypertension; patients with type 2 diabetes mellitus were excluded. All patients were first treated with a low-calorie diet (total energy intake 1200-1400 kcal/day) in a run-in period lasting up to 12 weeks. Patients who lost at least 5% of their screening body weight after 4 to 12 weeks during the run-in were then randomized, with equal allocation, to receive either Saxenda or placebo for 56 weeks. The mean age was 46 years (range 18-73), 81% were women, 84% were Caucasian, 13% were African American, and 7% were Hispanic/Latino. Mean baseline body weight was 99.6 kg and mean BMI was 35.6 kg/m<sup>2</sup>.

The proportions of patients who discontinued study drug in the 56-week trials were 27% for the Saxenda-treated group and 35% for the placebo-treated group, and in the 160-week trial the proportions of patients who discontinued were 47% and 55%, respectively. In the 56-week trials, approximately 10% of patients treated with Saxenda and 4% of patients treated with placebo discontinued treatment due to an adverse reaction [*see Adverse Reactions (6.1)*]. The majority of patients who discontinued Saxenda due to adverse reactions did so during the first few months of treatment. In the 160-week trial the proportions of patients who discontinued due to an adverse reaction was 13% and 6% for Saxenda- and placebo-treated patients, respectively.

### **Effect of Saxenda on Body Weight in 56-week Trials**

For Study 1 and Study 2, the primary efficacy parameters were mean percent change in body weight and the percentages of patients achieving greater than or equal to 5% and 10% weight loss from baseline to week 56. For Study 3, the primary efficacy parameters were mean percent change in body weight from randomization to week 56, the percentage of patients not gaining more than 0.5% body weight from randomization (i.e., after run-in) to week 56, and the percentage of patients achieving greater than or equal to 5% weight loss from randomization to week 56. Because losing at least 5% of fasting body weight through lifestyle intervention during the 4- to 12-week run-in was a condition for their continued participation in the randomized treatment period, the results may not reflect those expected in the general population.

Table 4 presents the results for the changes in weight observed in Studies 1, 2, and 3. After 56 weeks, treatment with Saxenda resulted in a statistically significant reduction in weight compared with placebo. Statistically significantly greater proportions of patients treated with Saxenda achieved 5% and 10% weight loss than those treated with placebo. In Study 3, statistically significantly more patients randomized to Saxenda than placebo had not gained more than 0.5% of body weight from randomization to week 56.

**Table 4. Changes in Weight at Week 56 for Studies 1, 2, and 3**

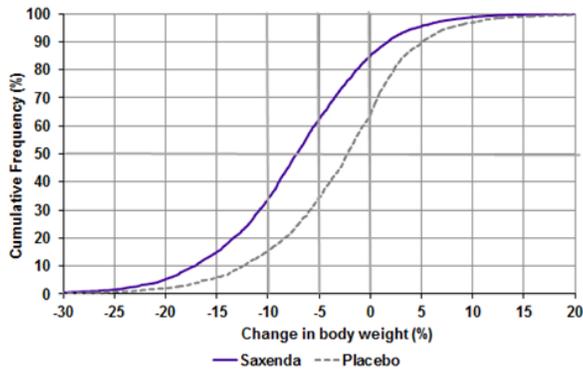
	Study 1 (Obesity or overweight with comorbidity)		Study 2 (Type 2 diabetes with obesity or overweight)		Study 3 (Obesity or overweight with comorbidity following at least 5% weight loss with diet)	
	Saxenda N=2487	Placebo N=1244	Saxenda N=423	Placebo N=212	Saxenda N=212	Placebo N=210
<b>Weight</b>						
Baseline mean (SD) (kg)	106.2 (21.2)	106.2 (21.7)	105.7 (21.9)	106.5 (21.3)	100.4 (20.8)	98.7 (21.2)
Percent change from baseline (LSMean)	-7.4	-3.0	-5.4	-1.7	-4.9	0.3
Difference from placebo (LSMean) (95% CI)	-4.5* (-5.2;-3.8)		-3.7* (-4.7;-2.7)		-5.2* (-6.8;-3.5)	
<b>% of Patients losing greater than or equal to 5% body weight</b>	62.3%	34.4%	49.0%	16.4%	44.2%	21.7%
Difference from placebo (LSMean) (95% CI)	27.9* (23.9;31.9)		32.6* (25.1;40.1)		22.6* (13.9;31.3)	
<b>% of Patients losing greater than 10% body weight</b>	33.9%	15.4%	22.4%	5.5%	25.4%	6.9%
Difference from placebo (LSMean) (95% CI)	18.5* (15.2;21.7)		16.9* (11.7;22.1)		18.5* (11.7;25.3)	

SD = Standard Deviation; CI = Confidence Interval

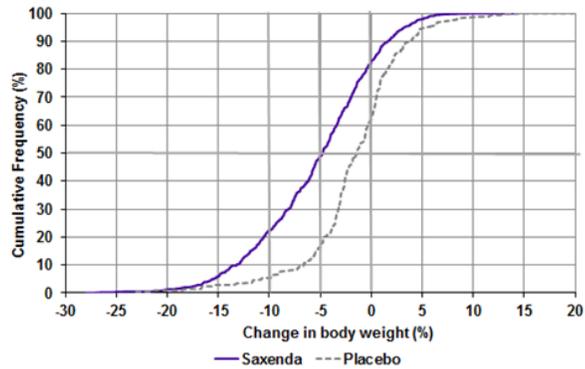
\* p < 0.0001 compared to placebo. Type 1 error was controlled across the three endpoints.

Includes all randomized subjects who had a baseline body weight measurement. All available body weight data during the 56 week treatment period are included in the analysis. In Studies 1 and 2 missing values for week 56 were handled using multiple imputations analysis. In Study 3 missing values for week 56 were handled using weighted regression analysis.

The cumulative frequency distributions of change in body weight from baseline to week 56 are shown in Figure 2 for Studies 1 and 2. One way to interpret this figure is to select a change in body weight of interest on the horizontal axis and note the corresponding proportions of patients (vertical axis) in each treatment group who achieved at least that degree of weight loss. For example, note that the vertical line arising from -10% in Study 1 intersects the Saxenda and placebo curves at approximately 34% and 15%, respectively, which correspond to the values shown in Table 4.



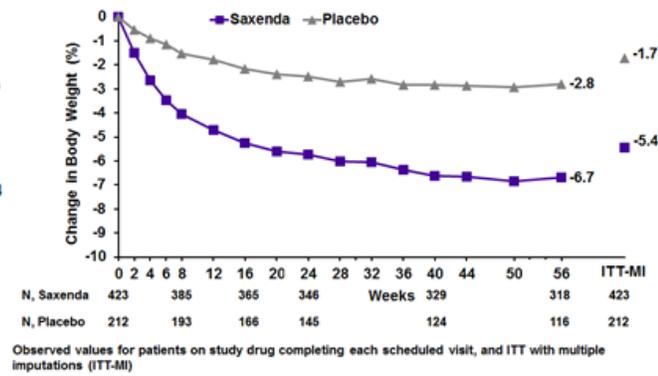
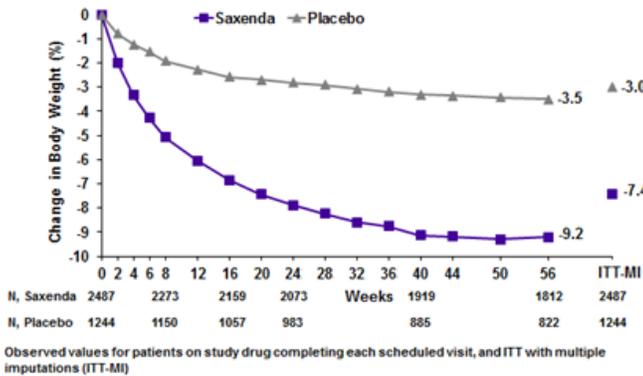
ITT, multiple imputations (MI)



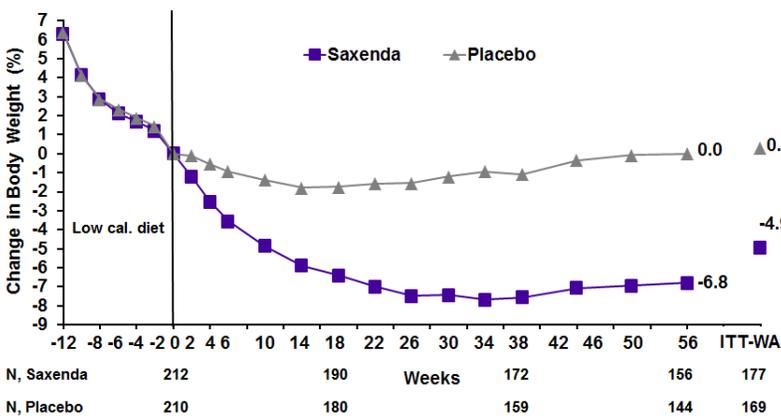
ITT, multiple imputations (MI)

**Figure 2.** Change in body weight (%) from baseline to week 56 (Study 1 on left and Study 2 on right)

The time courses of weight loss with Saxenda and placebo from baseline through week 56 are depicted in Figures 3 and 4.



**Figure 3.** Change from baseline (%) in body weight (Study 1 on left and Study 2 on right)



Observed values for patients on study drug completing each scheduled visit, and ITT with weighted average (ITT-WA)

**Figure 4.** Change from baseline (%) in body weight during Study 3

**Effect of Saxenda on Body Weight in a 160-week Trial (Study 1, Subset of Patients with Abnormal Blood Glucose at Randomization)**

The numbers and percentages of patients known to have lost greater than or equal to 5% body weight at week 56 and/or week 160 in Study 1 (patients with abnormal glucose at randomization only) are summarized in Table 5 for descriptive purposes.

**Table 5. Changes in Weight at Week 56 and Week 160 for Study 1 (Subset of Patients with Abnormal Blood Glucose at Randomization)**

	<b>Saxenda N=1505</b>	<b>Placebo N=749</b>
Baseline mean body weight (SD) (kg)	107.5 (21.6)	107.9 (21.8)
Number (%) of patients known to lose greater than or equal to 5% body weight at 56 weeks	817 (56%)	182 (25%)
Number (%) of patients known to lose greater than or equal to 5% body weight at 160 weeks	424 (28%)	102 (14%)
Number (%) of patients known to lose greater than or equal to 5% body weight at both 56 weeks and 160 weeks	391 (26%)	74 (10%)
Number (%) of patients with weight assessment at 160 weeks	747 (50%)	322 (43%)

SD = Standard Deviation

Includes all randomized subjects who had a baseline body weight measurement. All available body weight data at 56 and 160 weeks are included in the analysis.

**Effect of Saxenda on Anthropometry and Cardiometabolic Parameters in 56-week Trials**

Changes in waist circumference and cardiometabolic parameters with Saxenda are shown in Table 6 for Study 1 (patients without diabetes mellitus) and Table 7 for Study 2 (patients with type 2 diabetes). Results from Study 3, which also enrolled patients without diabetes mellitus, were similar to Study 1.

**Table 6. Mean Changes in Anthropometry and Cardiometabolic Parameters in Study 1 (Patients without Diabetes)**

	<b>Saxenda N = 2487</b>		<b>Placebo N = 1244</b>		<b>Saxenda minus Placebo (LSMean)</b>
	<b>Baseline</b>	<b>Change from Baseline (LSMean<sup>1</sup>)</b>	<b>Baseline</b>	<b>Change from Baseline (LSMean<sup>1</sup>)</b>	
Waist Circumference (cm)	115.0	-8.2	114.5	-4.0	-4.2
Systolic Blood Pressure (mmHg)	123.0	-4.3	123.3	-1.5	-2.8
Diastolic Blood Pressure (mmHg)	78.7	-2.7	78.9	-1.8	-0.9
Heart Rate (bpm)	71.4	2.6	71.3	0.1	2.5
	<b>Baseline</b>	<b>% Change from Baseline</b>	<b>Baseline</b>	<b>% Change from Baseline</b>	<b>Relative Difference of Saxenda to Placebo</b>

		(LSMean <sup>1</sup> )		(LSMean <sup>1</sup> )	(LSMean)
Total Cholesterol (mg/dL)*	193.8	-3.2	194.4	-0.9	-2.3
LDL Cholesterol (mg/dL)*	111.8	-3.1	112.3	-0.7	-2.4
HDL Cholesterol (mg/dL)*	51.4	2.3	50.9	0.5	1.9
Triglycerides (mg/dL)†	125.7	-13.0	128.3	-4.1	-7.1

Based on last observation carried forward method while on study drug

<sup>1</sup>Least squares mean adjusted for treatment, country, sex, pre-diabetes status at screening, baseline BMI stratum and an interaction between pre-diabetes status at screening and BMI stratum as fixed factors, and the baseline value as covariate.

\* Baseline value is the geometric mean

†Values are baseline median, median % change, and the Hodges-Lehmann estimate of the median treatment difference.

**Table 7. Mean Changes in Anthropometry and Cardiometabolic Parameters in Study 2 (Patients with Diabetes Mellitus)**

	Saxenda N = 423		Placebo N = 212		Saxenda minus Placebo (LSMean)
	Baseline	Change from Baseline (LSMean <sup>1</sup> )	Baseline	Change from Baseline (LSMean <sup>1</sup> )	
Waist Circumference (cm)	118.1	-6.0	117.3	-2.8	-3.2
Systolic Blood Pressure (mmHg)	128.9	-3.0	129.2	-0.4	-2.6
Diastolic Blood Pressure (mmHg)	79.0	-1.0	79.3	-0.6	-0.4
Heart Rate (bpm)	74.0	2.0	74.0	-1.5	3.4
	Baseline	% Change from Baseline (LSMean <sup>1</sup> )	Baseline	% Change from Baseline (LSMean <sup>1</sup> )	Relative Difference of Saxenda to Placebo (LSMean)
Total Cholesterol (mg/dL)*	171.0	-1.4	169.4	2.4	-3.7
LDL Cholesterol (mg/dL)*	86.4	0.9	85.2	3.3	-2.3
HDL Cholesterol (mg/dL)*	45.2	4.8	45.4	1.9	2.9
Triglycerides (mg/dL)†	156.2	-14.5	155.8	-0.7	-13.5

Based on last observation carried forward method while on study drug

<sup>1</sup>Least squares mean adjusted for treatment, country, sex, background treatment, baseline HbA<sub>1c</sub> stratum and an interaction between background treatment and HbA<sub>1c</sub> stratum as fixed factors, and the baseline value as covariate.

\* Baseline value is the geometric mean

†Values are baseline median, median % change, and the Hodges-Lehmann estimate of the median treatment difference.

### **Cardiovascular Outcomes Trial of Liraglutide 1.8 mg in Patients with Type 2 Diabetes and Cardiovascular Disease**

Liraglutide 1.8 mg (Victoza) is used in the treatment of type 2 diabetes mellitus in adults. The efficacy of liraglutide at doses below 3 mg daily has not been established for chronic weight management.

The LEADER trial (NCT01179048) randomized 9340 patients with inadequately controlled type 2 diabetes and cardiovascular disease to liraglutide 1.8 mg or placebo in addition to standard of care treatments for type 2 diabetes for a median duration of 3.5 years. Patients either were 50 years of age or older with established, stable cardiovascular, cerebrovascular, peripheral vascular disease, chronic renal failure or chronic heart failure (80% of patients), or were 60 years of age or older and had other specified risk factors of vascular disease (20%

of patients). The population was 64% male, 78% Caucasian, 10% Asian and 8% Black; 12% of the population was Hispanic or Latino.

In total, 96.8% of the patients completed the trial; vital status was known at the end of the trial for 99.7%. The primary endpoint was the time from randomization to first occurrence of a major adverse cardiovascular event (MACE) defined as: cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke. No increased risk for MACE was observed with liraglutide 1.8 mg. The total number of primary component MACE endpoints was 1302 (608 [13.0%] with liraglutide 1.8 mg and 694 [14.9%] with placebo).

## 16 HOW SUPPLIED/STORAGE AND HANDLING

### 16.1 How Supplied

Saxenda is available in the following package sizes containing disposable, pre-filled, multi-dose pens. Each individual pen delivers doses of 0.6 mg, 1.2 mg, 1.8 mg, 2.4 mg or 3 mg (6 mg/mL, 3 mL).

3 x Saxenda pen NDC 0169-2800-13

5 x Saxenda pen NDC 0169-2800-15

Each Saxenda pen is for use by a single patient. A Saxenda pen should never be shared between patients, even if the needle is changed.

### 16.2 Recommended Storage

Prior to first use, Saxenda should be stored in a refrigerator between 36°F to 46°F (2°C to 8°C) (Table 8). Do not store in the freezer or directly adjacent to the refrigerator cooling element. Do not freeze Saxenda and do not use Saxenda if it has been frozen.

After initial use of the Saxenda pen, the pen can be stored for 30 days at controlled room temperature (59°F to 86°F; 15°C to 30°C) or in a refrigerator (36°F to 46°F; 2°C to 8°C). Keep the pen cap on when not in use. Saxenda should be protected from excessive heat and sunlight. Always remove and safely discard the needle after each injection and store the Saxenda pen without an injection needle attached. This will reduce the potential for contamination, infection, and leakage while also ensuring dosing accuracy.

**Table 8. Recommended Storage Conditions for Saxenda**

Prior to first use	After first use	
Refrigerated 36°F to 46°F (2°C to 8°C)	Room Temperature 59°F to 86°F (15°C to 30°C)	Refrigerated 36°F to 46°F (2°C to 8°C)
Until expiration date	30 days	

## 17 PATIENT COUNSELING INFORMATION

### FDA-Approved Medication Guide

Advise the patient to read the FDA-approved patient labeling (Medication Guide and Instructions for Use).

### Instructions

Advise patients to take Saxenda exactly as prescribed. Instruct patients to follow the dose escalation schedule and to not take more than the recommended dose.

Instruct patients to discontinue Saxenda if they have not achieved 4% weight loss by 16 weeks of treatment.

### Risk of Thyroid C-cell Tumors

Inform patients that liraglutide causes benign and malignant thyroid C-cell tumors in mice and rats and that the human relevance of this finding has not been determined. Counsel patients to report symptoms of thyroid tumors (e.g., a lump in the neck, hoarseness, dysphagia or dyspnea) to their health care provider [*see Boxed Warning and Warnings and Precautions (5.1)*].

### **Acute Pancreatitis**

Inform patients of the potential risk for acute pancreatitis. Explain that persistent severe abdominal pain that may radiate to the back which may or may not be accompanied by vomiting is the hallmark symptom of acute pancreatitis. Instruct patients to discontinue Saxenda promptly and contact their health care provider if persistent severe abdominal pain occurs.

### **Acute Gallbladder Disease**

Inform patients of the risk of acute gallbladder disease. Advise patients that substantial or rapid weight loss can increase the risk of gallbladder disease, but that gallbladder disease may also occur in the absence of substantial or rapid weight loss. Instruct patients to contact their healthcare provider for appropriate clinical follow-up if gallbladder disease is suspected.

### **Hypoglycemia in Patients with Type 2 Diabetes Mellitus on Anti-Diabetic Therapy**

Educate patients on the signs and symptoms of hypoglycemia. Advise patients with type 2 diabetes mellitus on glycemic lowering therapy to report signs and/or symptoms of hypoglycemia to their healthcare provider.

### **Heart Rate Increase**

Inform patients to report symptoms of sustained periods of heart pounding or racing while at rest to their healthcare provider. Discontinue Saxenda in patients who experience a sustained increase in resting heart rate.

### **Dehydration and Renal Impairment**

Advise patients of the risk of dehydration due to gastrointestinal adverse reactions and to take precautions to avoid fluid depletion. Inform patients of the potential risk for worsening renal function, which in some cases may require dialysis.

### **Hypersensitivity Reactions**

Inform patients that serious hypersensitivity reactions have been reported during postmarketing use of Saxenda. Advise patients on the symptoms of hypersensitivity reactions and instruct them to stop taking Saxenda and seek medical advice promptly if such symptoms occur [*see Warnings and Precautions (5.7)*].

### **Suicidal Behavior and Ideation**

Advise patients to report emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior. Inform patients that if they experience suicidal thoughts or behaviors, they should stop taking Saxenda.

### **Jaundice and Hepatitis**

Inform patients that jaundice and hepatitis have been reported during postmarketing use of liraglutide. Instruct patients to contact their healthcare provider if they develop jaundice.

### **Never Share a Saxenda Pen Between Patients**

Inform patients that they should never share a Saxenda pen with another person, even if the needle is changed. Sharing of the pen between patients may pose a risk of transmission of infection.

Version: 5

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**PATENT Information:** <http://novonordisk-us.com/patients/products/product-patents.html>

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