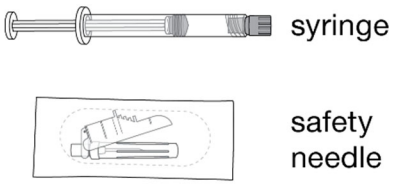
Discard the oxygen absorber pack. It is not needed.

Figure 1

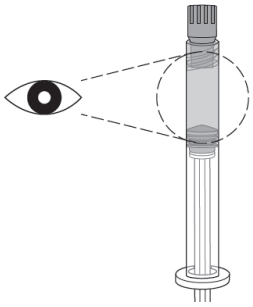


STEP 2: CHECK THE LIQUID CLARITY

Check that the medication does not contain contaminants or particles. SUBLOCADE ranges from colorless to yellow to amber. Variations of color within this range do not affect the potency of the product.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

Figure 2



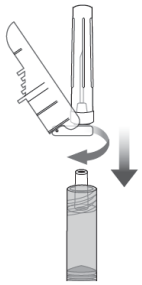
STEP 3: ATTACH THE SAFETY NEEDLE

Remove the cap from the syringe and the safety needle supplied in the carton from its sterile package.

Gently twist the needle clockwise until it is tight and firmly attached.

Do not remove the plastic cover from the needle.

Figure 3



STEP 4: PREPARE THE ABDOMINAL INJECTION SITE

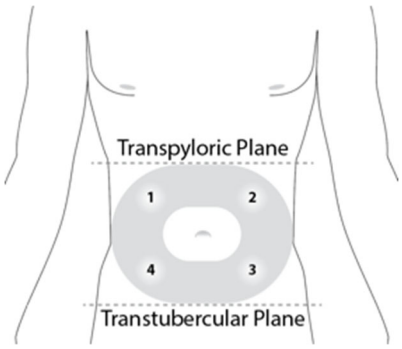
Choose an injection site on the abdomen between the transpyloric and transtubercular planes with adequate subcutaneous tissue that is free of skin conditions (e.g., nodules, lesions, excessive pigment). It is recommended that the patient is in the supine position.

Do not inject into an area where the skin is irritated, reddened, bruised, infected or scarred in any way.

Clean the injection site well with an alcohol swab.

To avoid irritation, rotate injection sites following a pattern similar to the illustration in Figure 4. Record the location of the injection to ensure that a different site is used at the time of the next injection.

Figure 4



STEP 5: REMOVE EXCESS AIR FROM SYRINGE

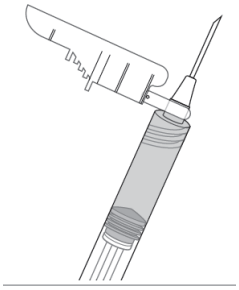
Hold the syringe upright for several seconds to allow air bubbles to rise. Due to the viscous nature of the medication, bubbles will not rise as quickly as those in an aqueous solution.

Remove needle cover and slowly depress the plunger to push out the excess air from the syringe.

- Small bubbles may remain in the medication. Large air gaps, however, can be minimized by pulling back on the plunger rod to pop air bubbles prior to expelling the air very slowly. Air should be expelled very carefully to avoid loss of medication.

If medication is seen at the needle tip, pull back slightly on the plunger to prevent medication spillage.

Figure 5



STEP 6: PINCH THE INJECTION SITE

Pinch the skin around the injection area. Be sure to pinch enough skin to accommodate the size of the needle. Lift the adipose tissue from the underlying muscle to prevent accidental intramuscular injection.

Figure 6

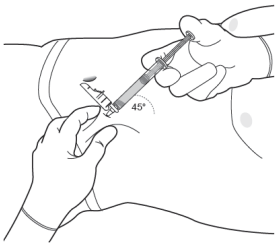
STEP 7: INJECT THE MEDICATION

SUBLOCADE is for subcutaneous injection only. Do not inject intravenously, intramuscularly, or intradermally *[see Warnings and Precautions (5.1, 5.6)]*.

Insert needle fully into the abdominal subcutaneous tissue. Actual angle of injection will depend on the amount of subcutaneous tissue.

Use a slow, steady push to inject the medication. Continue pushing until all of the medication is given.

Figure 7

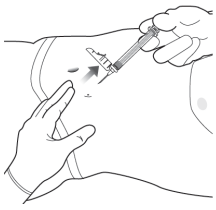


STEP 8: WITHDRAW THE NEEDLE

Withdraw the needle at the same angle used for insertion and release the pinched skin.

Do not rub the injection area after the injection. There may be a small amount of blood or fluid at the injection site; wipe with a cotton ball or gauze before applying a gauze pad or bandage using minimal pressure.

Figure 8

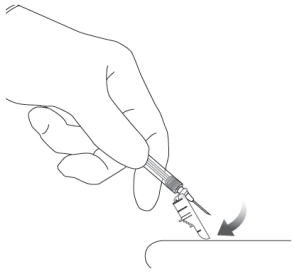


STEP 9: LOCK THE NEEDLE GUARD AND DISCARD THE SYRINGE

Lock the needle guard into place by pushing it against a hard surface such as a table (Figure 9).

Dispose of all syringe components in a secure sharps disposal container.

Figure 9



STEP 10: INSTRUCT THE PATIENT

Advise the patient that they may have a lump for several weeks that will decrease in size over time. Instruct the patient not to rub or massage the injection site and to be aware of the placement of any belts or clothing waistbands.

2.6 Limits on Distribution

SUBLOCADE is subject to a risk evaluation and mitigation strategy (REMS) program that includes, among other elements, a restricted distribution system. The purpose of the restricted distribution system is to ensure that SUBLOCADE is only administered by a health care provider *[see Warnings and Precautions (5.2)]*.

2.7 Removal of the Depot

In the event the depot must be removed, it can be surgically excised under local anesthesia within 14 days of injection. Only the most recently-injected depot can be removed.

The removed depot should be handled with adequate security, accountability, and proper disposal, per facility procedure for a Schedule III drug product and pharmaceutical biohazardous waste, and per applicable federal, state, and local regulations.

The residual plasma concentrations from previous injections will decrease gradually over subsequent

months *[see Clinical Pharmacology (12.3)]*.

Patients who have the depot removed should be monitored for signs and symptoms of withdrawal and treated appropriately *[see Warnings and Precautions (5.9)]*.

3 DOSAGE FORMS AND STRENGTHS

SUBLOCADE is available in dosage strengths of 100 mg/0.5 mL and 300 mg/1.5 mL buprenorphine. Each dose is a clear, colorless to yellow to amber solution provided in a prefilled syringe with a 19 gauge 5/8-inch needle.

4 CONTRAINDICATIONS

SUBLOCADE should not be administered to patients who have been shown to be hypersensitive to buprenorphine or any component of the ATRIGEL® delivery system *[see Warnings and Precautions (5.11)]*.

5 WARNINGS AND PRECAUTIONS

5.1 Risk of Serious Harm or Death With Intravenous Administration

Intravenous injection presents significant risk of serious harm or death as SUBLOCADE forms a solid mass upon contact with body fluids. Occlusion, local tissue damage, and thrombo-embolic events, including life threatening pulmonary emboli, could result if administered intravenously *[see Warnings and Precautions (5.2), Drug Abuse and Dependence (9.2)]*. Do not administer intravenously, intramuscularly, or intradermally *[see Warnings and Precautions (5.6)]*.

5.2 SUBLOCADE Risk Evaluation and Mitigation Strategy (REMS) Program

SUBLOCADE is available only through a restricted program called the SUBLOCADE REMS Program because of the risk of serious harm or death that could result from intravenous self-administration. The goal of the REMS is to mitigate serious harm or death that could result from intravenous self-administration by ensuring that healthcare settings and pharmacies are certified and only dispense SUBLOCADE directly to a healthcare provider for administration by a healthcare provider.

Notable requirements of the SUBLOCADE REMS Program include the following:

- Healthcare Settings and Pharmacies that order and dispense SUBLOCADE must be certified in the SUBLOCADE REMS Program.
- Certified Healthcare Settings and Pharmacies must establish processes and procedures to verify SUBLOCADE is provided directly to a healthcare provider for administration by a healthcare provider, and the drug is not dispensed to the patient.
- Certified Healthcare Settings and Pharmacies must not distribute, transfer, loan, or sell SUBLOCADE.

Further information is available at www.SublocadeREMS.com or call 1-866-258-3905.

5.3 Addiction, Abuse, and Misuse

SUBLOCADE contains buprenorphine, a Schedule III controlled substance that can be abused in a manner similar to other opioids. Buprenorphine is sought by people with opioid use disorder and is

subject to criminal diversion. Monitor all patients for progression of opioid use disorder and addictive behaviors *[see Drug Abuse and Dependence (9.2)]*.

5.4 Risk of Life-Threatening Respiratory and Central Nervous System (CNS) Depression

Buprenorphine has been associated with life-threatening respiratory depression and death. Many, but not all, postmarketing reports regarding coma and death involved misuse by self-injection or were associated with the concomitant use of buprenorphine and benzodiazepines or other CNS depressants, including alcohol. Warn patients of the potential danger of self-administration of benzodiazepines or other CNS depressants while under treatment with SUBLOCADE *[see Warnings and Precautions (5.5), Drug Interactions (7), Patient Counseling Information (17)].*

Use SUBLOCADE with caution in patients with compromised respiratory function (e.g., chronic obstructive pulmonary disease, cor pulmonale, decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression).

Due to its extended-release characteristics, if SUBLOCADE is discontinued as a result of compromised respiratory function, monitor patients for ongoing buprenorphine effects for several months.

Educate patients and caregivers on how to recognize respiratory depression and emphasize the importance of calling 911 or getting emergency medical help right away in the event of a known or suspected overdose *[see Patient Counseling Information (17)]*.

Opioids can cause sleep-related breathing disorders including central sleep apnea (CSA) and sleep-related hypoxemia. Opioid use increases the risk of CSA in a dose-dependent fashion. In patients who present with CSA, consider decreasing the opioid dosage using best practices for opioid taper *[see Dosage and Administration (2.7)]*.

Patient Access to Naloxone for the Emergency Treatment of Opioid Overdose

Discuss the availability of naloxone for the emergency treatment of opioid overdose with the patient and caregiver.

Because patients being treated for opioid use disorder have the potential for relapse, putting them at risk for opioid overdose, strongly consider prescribing naloxone for the emergency treatment of opioid overdose, both when initiating and renewing treatment with SUBLOCADE. Also consider prescribing naloxone if the patient has household members (including children) or other close contacts at risk for accidental ingestion or opioid overdose *[see Dosage and Administration (2.2)].*

Advise patients and caregivers that naloxone may also be administered for a known or suspected overdose with buprenorphine itself. Higher than normal doses and repeated administration of naloxone may be necessary due to the long duration of action of buprenorphine and its affinity for the mu-opioid receptor *[see Overdosage (10)]*.

Inform patients and caregivers of their options for obtaining naloxone as permitted by individual state naloxone dispensing and prescribing requirements or guidelines (e.g., by prescription, directly from a pharmacist, or as part of a community-based program).

Educate patients and caregivers on how to recognize respiratory depression and, if naloxone is prescribed, how to treat with naloxone. Emphasize the importance of calling 911 or getting emergency medical help, even if naloxone is administered *[see Patient Counseling Information (17)].*

5.5 Managing Risks From Concomitant Use of Benzodiazepines Or Other CNS Depressants With Buprenorphine

Concomitant use of buprenorphine and benzodiazepines or other CNS depressants increases the risk of adverse reactions including overdose, respiratory depression, and death. Medication-assisted treatment of opioid use disorder, however, should not be categorically denied to patients taking these drugs. Prohibiting or creating barriers to treatment can pose an even greater risk of morbidity and mortality due to the opioid use disorder alone.

As a routine part of orientation to buprenorphine treatment, educate patients about the risks of concomitant use of benzodiazepines, sedatives, opioid analgesics, and alcohol.

Develop strategies to manage use of prescribed or illicit benzodiazepines or other CNS depressants at initiation of buprenorphine treatment, or if it emerges as a concern during treatment. Adjustments to induction procedures and additional monitoring may be required. There is no evidence to support dose limitations or arbitrary caps of buprenorphine as a strategy to address benzodiazepine use in buprenorphine-treated patients. However, if a patient is sedated at the time of buprenorphine dosing, delay or omit the buprenorphine dose if appropriate.

Cessation of benzodiazepines or other CNS depressants is preferred in most cases of concomitant use with buprenorphine. In some cases, monitoring in a higher level of care for taper may be appropriate. In others, gradually tapering a patient off of a prescribed benzodiazepine or other CNS depressant or decreasing to the lowest effective dose may be appropriate.

For patients in buprenorphine treatment, benzodiazepines are not the treatment of choice for anxiety or insomnia. Before co-prescribing benzodiazepines, ensure that patients are appropriately diagnosed and consider alternative medications and non-pharmacologic treatments to address anxiety or insomnia. Ensure that other healthcare providers prescribing benzodiazepines or other CNS depressants are aware of the patient's buprenorphine treatment and coordinate care to minimize the risks associated with concomitant use.

If concomitant use is warranted, strongly consider prescribing naloxone for the emergency treatment of opioid overdose, as is recommended for all patients in buprenorphine treatment for opioid use disorder *[see Warnings and Precautions (5.4)].*

In addition, take measures to confirm that patients are taking their medications as prescribed and are not diverting or supplementing with illicit drugs. Toxicology screening should test for prescribed and illicit benzodiazepines *[see Drug Interactions (7)]*.

5.6 Risk of Serious Injection Site Reactions

Injection site reactions are most commonly manifested by pain, erythema and pruritus. In some post-marketing case reports injection site reactions have involved abscess, ulceration, and necrosis. Some cases resulted in surgical depot removal, debridement, antibiotic administration, and SUBLOCADE