janssen

STELARA^â

PRODUCT INFORMATION

NAME OF THE MEDICINE

Ustekinumab (rmc). CAS Registry Number: 815610-63-0.

DESCRIPTION

STELARA (ustekinumab) is a human IgG1kappa monoclonal antibody with an approximate molecular weight of 148,600 daltons. STELARA is produced by a recombinant cell line cultured by continuous perfusion and is purified by a series of steps that includes measures to inactivate and remove viruses.
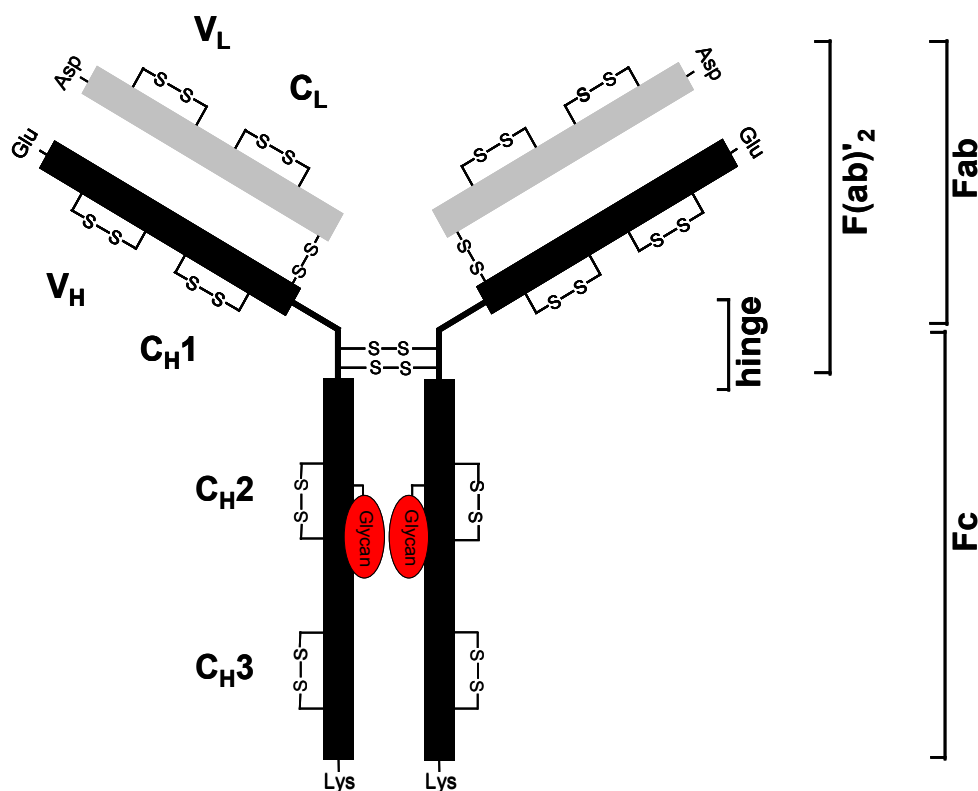

Figure 1. General structure of ustekinumab

STELARA (ustekinumab) is available in the following presentations:

Solution for injection for subcutaneous administration

Pre-filled Syringe:

·   45 mg / 0.5 mL (not currently marketed)

·   90 mg / 1.0 mL (not currently marketed)

Single-use Vial:

- · 45 mg / 0.5 mL
- · 90 mg / 1.0 mL (not currently marketed).

Each mL of STELARA solution for injection for subcutaneous administration contains 90 mg of ustekinumab, 1.0 mg histidine/histidine hydrochloride monohydrate, 76 mg sucrose, 0.04 mg polysorbate 80, and water for injection.

Solution for intravenous infusion

Single-use Vial:

- • 130 mg / 26 mL

Each mL of STELARA solution for intravenous infusion contains 5.0 mg of ustekinumab, 0.8 mg L-histidine, 1.1 mg L-histidine hydrochloride monohydrate, 85 mg sucrose, 0.40 mg polysorbate 80, 0.40 mg L-methionine, 0.02 mg disodium edetate, and water for injection.

PHARMACOLOGGY

Mechanism of action

STELARA is a human IgG1kappa monoclonal antibody that specifically binds to the shared p40 protein subunit of the human cytokines interleukin (IL)-12 and IL-23. STELARA inhibits the bioactivity of human IL-12 and IL-23 by preventing p40 from binding to the IL-12Rbeta1 receptor protein expressed on the surface of immune cells. STELARA cannot bind to IL-12 or IL-23 that is already bound to IL-12Rbeta1 cell surface receptors. Thus, STELARA is not expected to contribute to complement- or antibody-mediated cytotoxicity of cells with IL-12 and/or IL-23 receptors.

IL-12 and IL-23 are heterodimeric cytokines secreted by activated antigen presenting cells, such as macrophages and dendritic cells. IL-12 stimulates natural killer (NK) cells and drives the differentiation of CD4+ T cells toward the T helper 1 (Th1) phenotype and stimulates interferon gamma (IFNγ) production. IL-23 induces the T helper 17 (Th17) pathway and promotes secretion of IL-17A, IL-21, and IL-22. Levels of IL-12 and IL-23 are elevated in the skin and blood of patients with psoriasis, and serum IL12/23p40 distinguishes patients with psoriatic arthritis from healthy individuals, implicating IL-12 and in the pathophysiology of psoriatic inflammatory diseases. Genetic polymorphisms in IL23A, IL23R and IL-12B genes confer susceptibility to these disorders. IL-12 and IL-23 are highly expressed in lesional psoriatic skin, and IL-12-mediated induction of IFNγ correlates with psoriasis disease activity. IL-23 responsive T-cells have been found in the enthuses in a mouse model of inflammatory arthritis, where IL-23 drives entheseal inflammation. In addition, there is pre-clinical evidence implicating IL-23 and downstream pathways in bone erosion and destruction through up-regulation of receptor activator of nuclear factor κB ligand (RANKL), which activates osteoclasts.

In patients with Crohn's disease, IL-12 and IL-23 are elevated in the intestines and lymph nodes. This is accompanied by increases in serum IFNg and IL-17A levels, suggesting that IL-12 and IL-23 promote Th1 and Th17 activation in Crohn's disease. Both IL-12 and IL-23 can also stimulate TNFa production by T cells, resulting in chronic intestinal inflammation and epithelial cell injury. Significant associations have been found between Crohn's disease and genetic polymorphisms in the IL23R and IL12B genes, suggesting a potential causal role for IL-12/23 signaling in the disease. This is supported by pre-clinical data demonstrating that IL-12/23 signaling is required for intestinal injury in mouse models of inflammatory bowel disease.

By binding the shared p40 subunit of IL-12 and IL-23, STELARA may exert its clinical effects in psoriasis, psoriatic arthritis and Crohn's disease through interruption of the Th1 and Th17 cytokine pathways, which are central to the pathology of these diseases.

Pharmacodynamics

Treatment with STELARA resulted in significant improvement in histological measures of psoriasis including epidermal hyperplasia and cell proliferation. These results are consistent with the clinical efficacy observed.

In patients with psoriasis and/or psoriatic arthritis, STELARA had no apparent effect on the percentages of circulating immune cell populations including memory and naive T cell subsets or circulating cytokine levels. Systemic markers of inflammation were measurable in the serum at baseline and 4 markers (MDC, VEGF, MCSF-1 and YKL-40) showed modest differences in concentration post-treatment in STELARA-treated patients as compared to placebo.

In psoriasis and psoriatic arthritis studies, clinical response (improvement in Psoriasis Area and Severity Index [PASI] or ACR measurements, respectively) appeared to be related to serum ustekinumab levels. Patients with psoriasis with PASI response had higher median serum concentrations of ustekinumab than those with lower clinical responses. In psoriasis studies the proportion of patients with psoriasis who achieved PASI 75 response increased with increasing serum levels of ustekinumab. The proportion of patients who achieved PASI 75 response at Week 28 increased with increasing serum ustekinumab trough levels at Week 28. In psoriatic arthritis studies, patients achieving an ACR 20 response had higher median serum concentrations of ustekinumab than ACR 20 non-responders. The proportion of patients who achieved ACR 20 and ACR 50 response increased with increasing serum levels of ustekinumab.

In patients with Crohn's disease, treatment with STELARA resulted in a significant decrease in inflammatory markers including C-Reactive Protein (CRP) and fecal calprotectin. Reductions in serum IFNg and IL-17A, which are IL-12 and IL-23 regulated pro-inflammatory cytokines, were achieved and maintained in STELARA treated patients through Week 44 compared to placebo (52 weeks since the first dose of STELARA). At week 6, expression of genes such as IL-12Rb1 and IL-23 were reduced in inflamed colon tissue from Crohn's disease patients, who were responders to STELARA treatment while no significant changes were observed in placebo treated patients.

Immunisation

During the long term extension of a Phase 3 psoriasis study (PHOENIX 2), patients treated with STELARA for at least 3.5 years mounted similar antibody responses to both pneumococcal polysaccharide and tetanus vaccines as a non-systemically treated psoriasis control group. Similar proportions of patients developed protective levels of anti-pneumococcal and anti-tetanus antibodies and antibody titers were similar among STELARA-treated and control patients.

Pharmacokinetics

Absorption

The median time to reach the maximum serum concentration (t_{max}) was 8.5 days after a single 90 mg subcutaneous administration in healthy subjects. The median t_{max} values of ustekinumab following a single subcutaneous administration of either 45 mg or 90 mg in patients with psoriasis were comparable to that observed in healthy subjects.

The absolute bioavailability of ustekinumab following a single subcutaneous administration was estimated to be 57.2% in patients with psoriasis.

Distribution

Median volume of distribution during the terminal phase (V_z) following a single intravenous administration to patients with psoriasis, ranged from 57 to 83 mL/kg.

Metabolism

The exact metabolic pathway for ustekinumab is unknown.

Elimination

Median systemic clearance (CL) following a single intravenous administration to patients with psoriasis ranged from 1.99 to 2.34 mL/day/kg. Median half-life ($t_{1/2}$) of ustekinumab was approximately 3 weeks in patients with Crohn's disease, psoriasis and/or psoriatic arthritis, ranging from 15 to 32 days across all psoriasis and psoriatic arthritis studies.

Dose Linearity

The systemic exposure of ustekinumab (C_{max} and AUC) increased in an approximately dose-proportional manner after a single intravenous administration at doses ranging from 0.09 mg/kg to 4.5 mg/kg or following a single subcutaneous administration at doses ranging from approximately 24 mg to 240 mg in patients with psoriasis.

Single Dose vs. Multiple Doses

Serum concentration-time profiles of ustekinumab were generally predictable after single or multiple subcutaneous dose administrations. In patients with psoriasis, steady-state serum concentrations of ustekinumab were achieved by Week 28 after initial subcutaneous doses at Weeks 0 and 4, followed by doses every 12 weeks. The median steady-state trough concentration ranged from 0.21 microgram/mL to 0.26 microgram/mL (45 mg dose) and from 0.47 microgram/mL to 0.49 microgram/mL (90 mg dose). There was no apparent accumulation in serum ustekinumab concentration over time when given subcutaneously every 12 weeks.

In patients with Crohn's disease, following the recommended IV induction dose, median peak serum ustekinumab concentration was 126.1 µg/mL. Starting at Week 8, subcutaneous maintenance dosing of 90 mg ustekinumab was administered every 8 or 12 weeks. Steady state ustekinumab concentration was achieved by the start of the second maintenance dose. Median steady-state trough concentrations ranged from 1.97 µg/mL to 2.24 µg/mL and from 0.61 µg/mL to 0.76 µg/mL for 90 mg ustekinumab every 8 weeks or every 12 weeks respectively. The steady-state trough ustekinumab levels resulting from 90 mg ustekinumab every 8 weeks were associated with higher clinical remission rates as compared to the steady-state trough levels following 90 mg every 12 weeks.

Impact of Weight on Pharmacokinetics

Serum ustekinumab concentrations were affected by weight in patients with psoriasis and/or psoriatic arthritis. Within each dose (45 or 90 mg), patients of higher weight (> 100 kg) had lower median serum ustekinumab concentrations compared with those in patients of lower weight (≤ 100 kg). However, across doses, the median trough serum concentrations of ustekinumab in patients with higher weight (> 100 kg) in the 90 mg group were comparable to those in patients with lower weight (≤ 100 kg) in the 45 mg group.

Population Pharmacokinetic Analysis

In a population pharmacokinetic analysis using data from patients with psoriasis, the apparent clearance (CL/F) and apparent volume of distribution (V/F) were 0.465 L/d and 15.7 L, respectively, and the $t_{1/2}$ was approximately 3 weeks. The CL/F of ustekinumab was not impacted by sex, age, or race. The CL/F was impacted by body weight, with a trend toward higher CL/F in patients with higher body weight. The median CL/F in patients with weight > 100 kg was approximately 55% higher compared with patients with weight < 100 kg. The median V/F in patients with weight > 100 kg was approximately 37% higher as compared with patients with weight < 100 kg. Similar results were obtained from a confirmatory population pharmacokinetic analysis using data from patients with psoriatic arthritis.

In the population pharmacokinetic analysis using data from patients with psoriasis, the effect of comorbidities (past and current history of diabetes, hypertension, and hyperlipidaemia) on pharmacokinetics of ustekinumab was evaluated. The pharmacokinetics of ustekinumab were impacted by the comorbidity of diabetes, with a trend towards higher CL/F in patients with diabetes. The mean CL/F in patients with diabetes was approximately 29% higher compared with patients without diabetes.

No specific drug-drug interaction studies have been conducted in healthy subjects or patients with psoriasis, psoriatic arthritis or Crohn's disease.

In the population pharmacokinetic analyses, the effect of the most frequently used concomitant medications in patients with psoriasis (including paracetamol/acetaminophen, ibuprofen, acetylsalicylic acid, metformin, atorvastatin, naproxen, thyroxine, hydrochlorothiazide, and influenza vaccine) on pharmacokinetics of ustekinumab was explored and none of the concomitant medications exerted significant impact. The pharmacokinetics of ustekinumab was not impacted by the prior use of MTX, cyclosporin, or other biological therapeutics for the treatment of psoriasis. The pharmacokinetics of ustekinumab was not impacted by concomitant use of MTX, NSAIDs, oral corticosteroids, 6-MP, AZA or prior exposure to anti-TNFα agents in patients with psoriatic arthritis or Crohn's disease.

No pharmacokinetic data are available in patients with renal insufficiency. No pharmacokinetic data are available in patients with impaired hepatic function.

No specific studies have been conducted in elderly patients. The population pharmacokinetic analysis indicated there were no apparent changes in CL/F and V/F estimates in patients > 65 years.

The pharmacokinetics of ustekinumab were not impacted by the use of tobacco or alcohol.

CLINICAL TRAILS

PLAQUE PSORIASIS

The safety and efficacy of STELARA was assessed in 2 Phase 3 studies (A Phase 3 multicenter, randomised, double-blind, placebo-controlled trial evaluating the efficacy and safety of CNTO 1275 in the treatment of subjects with moderate to severe plaque-type psoriasis followed by long-term extension [PHOENIX] 1 and PHOENIX 2). A total of 1996 patients were enrolled in these studies.

The safety and efficacy of STELARA have not been established beyond 4 years.

The studies enrolled adults (≥ 18 years) with chronic (> 6 months) plaque psoriasis who had a minimum body surface area (BSA) involvement of 10%, and PASI score ≥ 12 and who were candidates for systemic therapy or phototherapy. Patients with guttate, erythrodermic, or pustular psoriasis were excluded from the studies. No concomitant anti-psoriatic therapies were allowed during the study with the exception of low-potency topical corticosteroids on the face and groin after week 12.

The Psoriasis Area and Severity Index (PASI) is a composite score that assesses the fraction of body surface area involved with psoriasis and the severity of psoriatic changes within the affected regions (plaque thickness/induration, erythema, and scaling). PASI numeric scores range from 0 to 72, with higher scores representing more severe disease.

Patients achieving ≥ 75% improvement in PASI from baseline (PASI 75) were considered PASI 75 responders. Patients originally randomised to STELARA who were PASI 75 responders at both Weeks 28 and 40 were considered long-term PASI 75 responders. Patients achieving ≥ 90% improvement in PASI from baseline (PASI 90) were considered PASI 90 responders and patients with ≥ 50% improvement in PASI from baseline (PASI 50) were considered PASI 50 responders. Patients who achieved ≥ 50% but less than 75% improvement in PASI from baseline were considered partial responders. Patients with < 50% improvement in PASI from baseline were considered non-responders.

Other key efficacy assessments included:

- The Physician's Global Assessment (PGA), a 6-category scale focusing on plaque thickness/induration, erythema, and scaling.

- The Dermatology Life Quality Index (DLQI), a dermatology-specific quality of life instrument, with a lower score indicating an improved quality of life.

- The SF-36, a health survey questionnaire consisting of multi-item scales measuring 8 health concepts (PHOENIX 1 only).

- The Nail Psoriasis Severity Index (NAPSI), a physician-assessed score that measures the severity of nail involvement (PHOENIX 1 only).
- The Hospital Anxiety and Depression Scale (HADS), a self-rating tool developed to evaluate psychological measures in patients with physical ailments (PHOENIX 2 only).
- The Work Limitations Questionnaire (WLQ), a 25-item, self-administered questionnaire that was used to measure the impact of chronic health conditions on job performance and work productivity among employed populations (PHOENIX 2 only).
- The Itch Visual Analogue Scale, (Itch VAS) used to assess the severity of itch at the time of the assessment (PHOENIX 1 only).

PHOENIX 1

PHOENIX 1 evaluated the safety and efficacy of STELARA versus placebo in 766 patients with plaque psoriasis and the efficacy of every 12 week dosing for patients who were PASI 75 responders. Patients randomised to STELARA received 45 mg or 90 mg doses at Weeks 0 and 4 followed by the same doses every 12 weeks. Patients randomised to receive placebo at Weeks 0 and 4 crossed over to receive STELARA (either 45 mg or 90 mg) at Weeks 12 and 16 followed by the same dose every 12 weeks.

Maintenance Dosing (every 12 weeks)

To evaluate the therapeutic benefit of maintenance dosing with STELARA, patients originally randomised to STELARA who were PASI 75 responders at both Weeks 28 and 40 were re-randomised to either maintenance dosing of STELARA every 12 weeks or to placebo (i.e., withdrawal of therapy). Patients who were re-randomised to placebo at Week 40 reinitiated STELARA at their original dosing regimen when they experienced at least a 50% loss of their PASI improvement obtained at Week 40.

Dose Adjustment (every 8 weeks)

At Week 28, patients who were non-responders discontinued treatment and patients who were partial responders were adjusted to every-8-week dosing. PASI 75 responders at week 28 who became partial responders or non-responders at Week 40 were adjusted to every-8-week dosing. All patients were followed for at least 52 weeks following first administration of study treatment.

PHOENIX 2

PHOENIX 2 evaluated the safety and efficacy of STELARA versus placebo in 1230 patients with plaque psoriasis. Patients randomised to STELARA received 45 mg or 90 mg doses at Weeks 0 and 4 followed by an additional dose at Week 16. Patients randomised to receive placebo at Weeks 0 and 4 crossed over to receive STELARA (either 45 mg or 90 mg) at Weeks 12 and 16. Patients were followed for 28 weeks.

Baseline Disease Characteristics: PHOENIX 1 and 2

Baseline disease characteristics across PHOENIX 1 and 2 were similar (Table 1).

Table 1. Baseline Disease Characteristics

	PHOENIX 1		PHOENIX 2	
	Placebo	STELARA	Placebo	STELARA
Patients randomised at Week 0	N = 255	N = 511	N = 410	N = 820
Median BSA	22.0	21.0	20.0	21.0
Patients with BSA $\geq$ 20%	145 (57%)	276 (54%)	217 (53%)	445 (54%)
Median PASI	17.80	17.40	16.90	17.60
PASI $\geq$ 20	91 (36%)	169 (33%)	133 (32%)	300 (37%)
PGA of marked or severe	112 (44%)	223 (44%)	160 (39%)	328 (40%)
History of psoriatic arthritis	90 (35%)	168 (33%)	105 (26%)	200 (24%)
Prior phototherapy	150 (59%)	342 (67%)	276 (67%)	553 (67%)
Prior conventional systemic therapy excluding biologics	142 (56%)	282 (55%)	241 (59%)	447 (55%)
Prior conventional systemic or biologic therapy	189 (74%)	364 (71%)	287 (70%)	536 (65%)
Failed to respond to, had contraindication for, or intolerant to $\geq$ 1 conventional therapy	139 (55%)	270 (53%)	254 (62%)	490 (60%)
Failed to respond to, had contraindication for, or intolerant to $\geq$ 3 conventional therapies	30 (12%)	54 (11%)	66 (16%)	134 (16%)

Efficacy at the Primary Endpoint, PHOENIX 1 and 2

In both the PHOENIX 1 and PHOENIX 2 studies, a significantly greater proportion of patients randomised to treatment with STELARA were PASI 75 responders compared with placebo at Week 12 (Table 2). In the PHOENIX 1 study, 67% and 66% of patients receiving STELARA 45 mg and 90 mg, respectively, achieved a PASI 75 response at Week 12 compared with 3% of patients receiving placebo. In the PHOENIX 2 study, 67% and 76% of patients receiving STELARA 45 mg and 90 mg respectively achieved a PASI 75 response at Week 12 compared with 4% of patients receiving placebo.

All 3 components of the PASI (plaque thickness/induration, erythema, and scaling) contributed comparably to the improvement in PASI.

The efficacy of STELARA was significantly superior (p<0.001) to placebo across all subgroups defined by baseline demographics, clinical disease characteristics (including patients with a history of psoriatic arthritis) and prior medication usage. While pharmacokinetic modelling suggested a trend towards higher CL/F in patients with diabetes, a consistent effect on efficacy was not observed.

Other Efficacy Measures at Week 12

In both PHOENIX 1 and PHOENIX 2, compared with placebo, significantly greater proportions of patients randomised to 45 mg or 90 mg STELARA achieved a cleared or minimal PGA score, and significantly greater proportions of patients randomised to 45 mg or 90 mg STELARA were PASI 90 and PASI 50 responders at Week 12 (Table 2). In the PHOENIX 1 study, 60% and 62% of the patients treated with 45 mg and 90 mg STELARA, respectively, achieved PGA

scores of cleared or minimal compared with 4% of placebo-treated patients. In PHOENIX 2, 68% and 73 % of patients receiving 45 mg or 90 mg STELARA, respectively, had cleared or minimal PGA scores compared with 5% of the placebo patients. In PHOENIX 1, PASI 90 was achieved by 42% and 37% of the patients treated with 45 mg and 90 mg STELARA, respectively, compared with 2% of placebo-treated patients. In PHOENIX 2, the percentage of patients achieving PASI 90 was 42% in the 45 mg STELARA group, 51% in the 90 mg STELARA group and 1% in the placebo group. The percentage of patients achieving PASI 50 in PHOENIX 1 was 84% and 86% in the 45 mg and 90 mg STELARA groups, respectively, compared with 10% in the placebo group. Similarly, 84% of patients treated with 45 mg STELARA, 89% of patients treated with 90 mg STELARA and 10% of patients treated with placebo reached PASI 50 in PHOENIX 2 (Table 2).

Table 2. Key psoriasis endpoints – PHOENIX 1 and PHOENIX 2

Response	PHOENIX 1					PHOENIX 2				
		STELARA					STELARA			
	Placebo	45 mg		90 mg		Placebo	45 mg		90 mg	
	n=255	n=255	n=250	n=256	n=243	n=410	n=409	n=397	n=411	n=400
	Week 12	Week 12	Week 28	Week 12	Week 28	Week 12	Week 12	Week 28	Week 12	Week 28
PASI response										
PASI 50 (%)	26 (10)	213 (84)[a]	228 (91)[b]	220 (86)[a]	234 (96)[b]	41 (10)	342 (84)[a]	369 (93)[b]	367 (89)[a]	380 (95)[b]
PASI 75 (%)	8 (3)	171 (67)[a]	178 (71)[b]	170 (66)[a]	191 (79)[b]	15 (4)	273 (67)[a]	276 (70)[b]	311 (76)[a]	314 (79)[b]
PASI 90 (%)	5 (2)	106 (42)[a]	123 (49)[b]	94 (37)[a]	135 (56)[b]	3 (1)	173 (42)[a]	178 (45)[b]	209 (51)[a]	217 (54)[b]
PGA Cleared or Minimal [a]	10 (4)	151 (59)[a]	146 (58)[b]	156 (61)[a]	160 (66)[b]	18 (4)	277 (68)[a]	241 (61)[b]	300 (73)[a]	279 (70)[b]
PASI 75 response by weight										
≤ 100 kg										
n	166	168	164	164	153	290	297	287	289	280
PASI 75 (%)	6 (4)	124 (74)	130 (79)	107 (65)	124 (81)	12 (4)	218 (73)	217 (76)	225 (78)	226 (81)
>100 kg										
n	89	87	86	92	90	120	112	110	121	119
PASI 75 (%)	2 (2)	47 (54)	48 (56)	63 (68)	67 (74)	3 (3)	55 (49)	59 (54)	86 (71)	88 (74)
PGA Cleared or Minimal by weight										
≤ 100 kg										
n	166	168	164	164	153	290	297	287	289	280
PGA response (%)	7 (4)	108 (64)	106 (65)	103 (63)	106 (70)	14 (5)	220 (74)	192 (67)	216 (74)	207 (74)
>100 kg										
n	89	87	86	92	90	120	112	110	121	119
PGA response (%)	3 (3)	44 (51)	40 (47)	54 (59)	54 (60)	4 (3)	59 (53)	49 (45)	85 (70)	71 (60)

[a] p < 0.001 for 45 mg or 90 mg comparison with placebo at Week 12. [b] No statistical comparisons to placebo were made at Week 28 because the original placebo group began receiving STELARA at Week 12.

Response Over Time

In PHOENIX 1, significantly greater proportions of STELARA-treated patients had PASI 50 responses (9% and 10% for the 45 mg and 90 mg groups, respectively) compared with placebo (2%) by Week 2 (p< 0.001). Significantly greater proportions of patients treated with STELARA achieved PASI 75 responses (9% and 12% for the 45 mg and 90 mg STELARA groups, respectively) compared with placebo (0.4%) by Week 4 (p< 0.001). Maximum response was

generally achieved by Week 24 in the 45 mg and 90 mg STELARA treatment groups, and response rates were generally sustained through Week 36 (Figure 2). In PHOENIX 1, PASI 75 rates at Week 24 were 76% for the 45 mg group, and 85% for the 90 mg group. Higher response rates were observed in patients receiving STELARA 90 mg than in those receiving STELARA 45 mg by Week 16 and these higher response rates were sustained through Week 36 (Figure 2). Similar results were observed in the PHOENIX 2 study through Week 28.

In pre-specified analyses of efficacy by body weight in PHOENIX 1 and PHOENIX 2, no consistent pattern of dose response was seen in patients ≤ 100 kg. In patients who weighed >100 kg, higher PASI 75 response rates were seen with 90 mg dosing compared with 45 mg dosing, and a higher proportion of patients receiving 90 mg dosing had PGA scores of cleared or minimal compared with patients receiving 45 mg dosing (Table 2). Figure 2 shows PASI 75 response over time in PHOENIX 1 and 2.
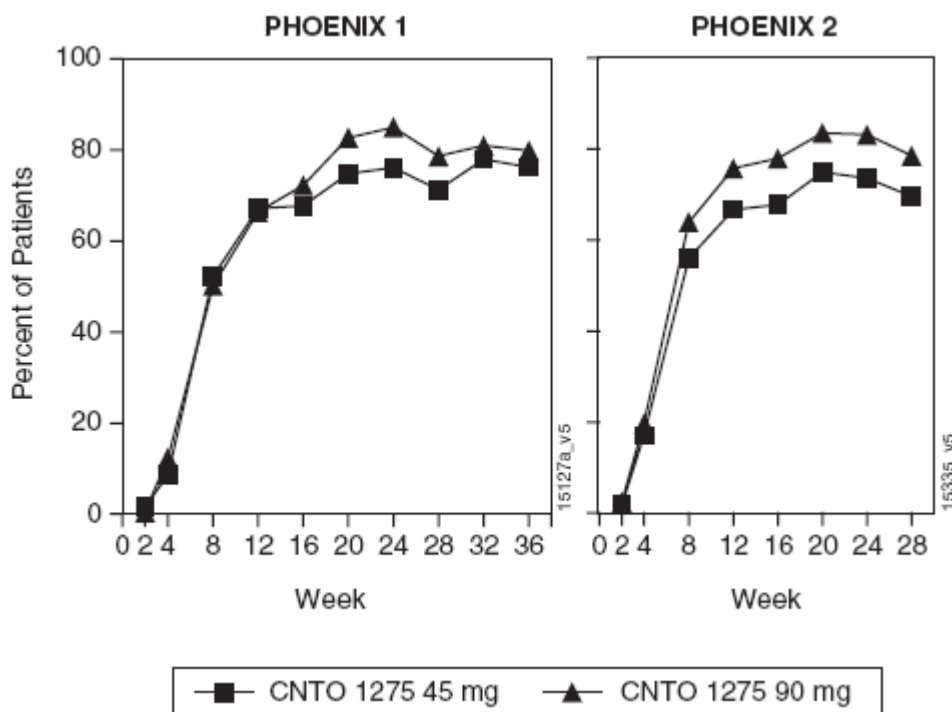

Figure 2.   PASI 75 response over time in PHOENIX 1 and 2

Therapeutic Benefit of Long-Term Continuous Use

At Week 40 in PHOENIX 1, 162 patients were randomised to receive STELARA (maintenance) and 160 were randomised to receive placebo (treatment withdrawal). Maintenance of PASI 75 was significantly superior with continuous treatment compared with treatment withdrawal (p<0.001). Similar results were seen with each dose of STELARA. At Week 52, 89% of patients re-randomised to maintenance treatment were PASI 75 responders compared with 63% of patients re-randomised to placebo (treatment withdrawal) (p<0.001).

Efficacy of Retreatment

In PHOENIX 1, after withdrawal from therapy, patients re-initiated their original STELARA treatment regimen after loss of ≥ 50% of PASI improvement. Retreatment with STELARA resulted in 76% of evaluated patients regaining PASI 75 response within 8 weeks after reinitiating therapy.

Dosing Interval Adjustment

In PHOENIX 1, Week 28 and Week 40 partial responders and Week 40 non-responders were adjusted from every 12 week to every 8 week dosing. Approximately 40%-50% of Week 28 partial responders to every 12 week dosing achieved PASI 75 response after adjustment to every 8 week dosing and this proportion of PASI 75 responders was maintained through Week 52. A similar proportion of patients who were PASI 75 responders at Week 28 and subsequently

became partial responders or non-responders at Week 40 achieved PASI 75 response following a dosing interval adjustment to every 8 weeks.

Quality of Life

In PHOENIX 1 and 2, the mean baseline DLQI scores ranged from 11 to 12. In PHOENIX 1, the mean baseline SF-36 Physical Component ranged from 47-49 and the mean baseline SF-36 Mental Component was approximately 50. Quality of life improved significantly in patients randomised to 45 mg or 90 mg ustekinumab compared with patients randomised to placebo as evaluated by DLQI in PHOENIX 1 and 2 and SF-36 in PHOENIX 1. Quality of life improvements were significant as early as 2 weeks in patients treated with ustekinumab (p<0.001) and these improvements were maintained over time with continued dosing.

In PHOENIX 1, 65% and 71% of patients treated with 45 mg and 90 mg of ustekinumab, respectively, showed a clinically meaningful reduction (5 or more points) in DLQI from baseline at week 12 compared to 18% in placebo group (p<0.001 for both groups compared with placebo). Furthermore, 33% and 34% of patients treated with 45 mg and 90 mg of ustekinumab, respectively, showed a DLQI score of 0 compared to 1% in the placebo group (p<0.001 for both groups compared with placebo), indicating no impairment in QOL from disease or treatment in these patients. In PHOENIX 2, 72% and 77% of patients treated with 45 mg and 90 mg of ustekinumab, respectively, showed a clinically meaningful reduction (5 or more points) in DLQI from baseline at Week 12 compared to 21% in placebo group (p<0.001 for both groups compared with placebo). In addition, 37% and 39% of patients treated with 45 mg and 90 mg of ustekinumab, respectively, showed a DLQI score of 0 compared to 1% in the placebo group (p<0.001 for both groups compared with placebo).

In PHOENIX 1, the median baseline NAPSI score for nail psoriasis was 4.0 and the median number of fingernails involved with psoriasis was 8.0. Nail psoriasis improved significantly in patients randomised to 45 mg or 90 mg ustekinumab compared with patients randomised to placebo when measured by the NAPSI score (p≤0.001). Improvements in physical and mental component summary scores of the SF-36 and in the Itch Visual Analogue Scale (VAS) were also significant in each ustekinumab treatment group compared with placebo (p<0.001). In PHOENIX 2, the Hospital Anxiety and Depression Scale (HADS) and Work Limitations Questionnaire (WLQ) were also significantly improved in each ustekinumab treatment group compared with placebo (p<0.001)

ACCEPT

A multicentre, randomised, single-blind, active-controlled study (ACCEPT) compared the safety and efficacy of ustekinumab and etanercept in patients 18 years of age and older with chronic (>6 months) plaque psoriasis who had a minimum BSA involvement of 10%, PASI score ≥12, Physician Global Assessment (PGA) score ≥ 3, who were candidates for phototherapy or systemic therapy, and who had had an inadequate response to, intolerance to, or contraindication to cyclosporin, methotrexate, or PUVA therapy. A total of 903 patients were enrolled in the study.

The ACCEPT trial compared the efficacy of ustekinumab to etanercept and evaluated the safety of ustekinumab and etanercept in moderate to severe psoriasis patients. The active-controlled portion of the study was from Week 0 to Week 12, during which patients were randomised to receive etanercept (50 mg twice a week) ustekinumab 45 mg at Weeks 0 and 4, or ustekinumab 90 mg at Weeks 0 and 4. This trial was powered to test the superiority of each ustekinumab dose to etanercept on the primary endpoint of the proportion of patients who achieved a PASI 75 at Week 12.

Significantly greater proportions of subjects treated with ustekinumab 45 mg (67%; p = 0.012) or 90 mg (74%; p < 0.001) were PASI 75 responders at Week 12 compared with the etanercept group (56.8%). PASI 90 response was observed in 36% and 45 % of patients in the ustekinumab 45 mg and 90 mg groups, respectively, compared with 23% of patients receiving etanercept (p<0.001 for each comparison versus etanercept). PASI 100 response was observed in 12% and 21% of patients in the ustekinumab 45 mg and 90 mg groups, respectively, compared to 6% of patients receiving etanercept. In addition, a greater proportion of patients in

the ustekinumab 45 mg and 90 mg treatment groups achieved a PGA score of "cleared" or "minimal" (65% and 71%, respectively) compared with patients in the etanercept treatment group (49%) (p<0.001 for each comparison versus etanercept).

In pre-specified analyses of efficacy by body weight in ACCEPT, minimal dose response to ustekinumab was evident in patients ≤ 100 kg. In patients who weighed >100 kg, higher PASI 75 response rates were seen with 90 mg dosing compared with 45 mg dosing, and a higher proportion of patients receiving 90 mg dosing had PGA scores of cleared or minimal compared with patients receiving 45 mg dosing (Table 3).

Table 3.   Key psoriasis endpoints at Week 12: ACCEPT

	ACCEPT		
	Etanercept (50 mg twice a week)	Ustekinumab (week 0 and week 4)	
		45 mg	90 mg
Patients randomised	347	209	347
PASI response			
PASI 50 response	286 (82%)	181 (87%)	320 (92%)[a]
PASI 75 response	197 (57%)	141 (67%)[b]	256 (74%)[a]
PASI 90 response	80 (23%)	76 (36%)[a]	155 (45%)[a]
PASI 100 response	22 (6%)	25 (12%)[c]	74 (21%)[a]
PGA of Cleared or Minimal[a]	170 (49%)	136 (65%)[a]	245 (71%)[a]
PASI 75 RESPONSE BY WEIGHT			
≤ 100 kg			
N	251	151	244
PASI 75 response	154 (61.4%)	109 (72.2%)	189 (77.5%)
>100 kg			
N	96	58	103
PASI 75 response	43 (44.8%)	32 (55.2%)	67 (65.0%)
PGA of Cleared or Minimal by weight			
≤ 100 kg			
N	251	151	244
PGA response	131 (52.2%)	110 (72.8%)	185 (75.8%)

	Etanercept (50 mg twice a week)	ACCEPT	
		Ustekinumab (week 0 and week 4)	
		45 mg	90 mg
>100 kg			
N	96	58	103
PGA response	39 (40.6%)	26 (44.8%)	60 (58.3%)
PASI 75 RESPONSE BY NUMBER OF UNSUITABLE CONVENTIONAL SYSTEMIC AGENTS [g]			
-at least one therapy			
N	347	209	346
PASI 75 Response	197 (56.8%)	141 (67.5%) [b]	256 (74.0%) [a]
-at least two therapies			
N	186	118	185
PASI 75 Response	94 (50.5%)	79 (66.9%) [d]	137 (74.1%) [a]
-at least three therapies			
N	52	31	47
PASI 75 Response	20 (38.5%)	17 (54.8%) [e]	34 (72.3%) [f]

[a] p <0.001 for ustekinumab 45 mg or 90 mg comparison with etanercept.

[b] p =0.012 for ustekinumab 45 mg comparison with etanercept.

[c] p =0.020 for ustekinumab 45 mg comparison with etanercept

[d] p=0.004 for ustekinumab 45 mg comparison with etanercept.

[e] p=0.303 for ustekinumab 45 mg comparison with etanercept.

[f] p=0.001 for ustekinumab 90 mg comparison with etanercept.

[g] Conventional systemic agents include psoralen plus ultraviolet A, methotrexate, and cyclosporin. Unsuitable conventional systemic agents are defined as those to which patients had had an inadequate response, were intolerant, or had a contraindication.

PSORIATIC ARTHRITIS (PsA)

The safety and efficacy of STELARA was assessed in two multicenter, randomised, double-blind, placebo-controlled, phase 3 studies PSUMMIT I and PSUMMIT II, in patients with active psoriatic arthritis. Patients were randomised to receive treatment with either STELARA 45 mg, 90 mg, or placebo subcutaneous injections at Weeks 0 and 4 followed by every 12 week (q12w) dosing. The primary endpoint in these studies was the reduction in the signs and symptoms of psoriatic arthritis (PsA) as measured by the percentage of ACR 20 responders at Week 24. Secondary endpoints included change from baseline in Disability Index of the Health Assessment Questionnaire (HAQ-DI), PASI 75, ACR 50, ACR 70 and change in baseline in total radiographic scores of the hands and feet, at Week 24. Efficacy data were collected and analysed through Week 52.

These studies included 927 (PSUMMIT I, n=615; PSUMMIT II, n=312) adult patients (≥18 years) who had active psoriatic arthritis (≥5 swollen joints and ≥5 tender joints, despite disease

modifying antirheumatic (DMARD) and/or nonsteroidal anti-inflammatory (NSAID) therapy). Methotrexate use was allowed during the studies but was not mandatory. Approximately 50% of patients continued on stable doses of MTX (≤25 mg/week). In PSUMMIT I and PSUMMIT II, 80% and 86% of the patients, respectively, had been previously treated with DMARDs.

In PSUMMIT I, patients who had been previously treated with anti-TNFα therapy, prior to the first study dose, were excluded. In PSUMMIT II, the majority of patients (58%, n=180) had been previously treated with one or more anti-TNFα agent(s) for at least 8 weeks (14 weeks with infliximab) or had discontinued anti-TNFα for intolerance at any time. Among the patients who had been previously treated with an anti-TNFα agent, over 70% had discontinued their anti-TNFα treatment for lack of efficacy or intolerance.

Patients with each subtype of psoriatic arthritis were enrolled, including polyarticular arthritis with no evidence of rheumatic nodules (39%, n=362), spondylitis with peripheral arthritis (28%, n=255), asymmetrical peripheral arthritis (21%, n=193), distal interphalangeal (DIP) arthritis (12%, n=112) and arthritis mutilans (0.5%, n=5). Over 70% and 40% of the patients in both studies had enthesitis and dactylitis at baseline, respectively.

In both studies, a significantly greater proportion of patients achieved ACR 20 and ACR 50 responses at Week 24 in the STELARA 45 mg and 90 mg groups compared to placebo (see Table 4. In PSUMMIT I, a significantly greater proportion of patients and in PSUMMIT II a numerically greater proportion of patients (p=NS) achieved ACR 70 responses in the STELARA 45 mg and 90 mg groups compared to placebo (see Table 4).

In both studies, the proportion of patients achieving a modified PsA response criteria (PsARC) or a Disease Activity Score 28 using C-reactive protein (DAS28-CRP) response was significantly greater in the STELARA 45 mg and 90 mg groups compared to placebo. In PSUMMIT I the proportion of patients achieving DAS28-CRP remission was significantly greater in the STELARA 45 mg and 90 mg groups compared to placebo. In PSUMMIT II, the proportion of patients who achieved DAS28-CRP remission was significantly greater in the STELARA 90 mg group compared to placebo (see Table 4). DAS28-CRP and PsARC responses were maintained through Week 52.

Table 4.   Number of patients who achieved ACR 20, ACR 50, ACR 70, PsARC, DAS28-CRP response and DAS28-CRP remission at Week 24

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo (N=206)	45 mg (N= 205)	90 mg (N= 204)	Placebo (N= 104)	45 mg (N= 103)	90 mg (N= 105)
ACR 20	47 (23%)	87 (42%) [a]	101 (50%) [a]	21 (20%)	45 (44%) [a]	46 (44%) [a]
ACR 50	18 (9%)	51 (25%) [a]	57 (28%) [a]	7 (7%)	18 (17%) [b]	24 (23%) [a]
ACR 70	5 (2%)	25 (12%) [a]	29 (14%) [a]	3 (3%)	7 (7%) [c]	9 (9%) [c]
PsARC	77 (37%)	115 (56%) [a]	132 (65%) [a]	32 (31%)	57 (55%) [a]	54 (51%) [b]
DAS28-CRP[*]	71 (34%)	135 (66%) [a]	138 (68%) [a]	31 (30%)	56 (54%) [a]	56 (53%) [a]
DAS28 Remission**	17 (8%)	42 (20%) [a]	40 (20%) [a]	4 (4%)	11 (11%) [c]	16 (15%) [b]

[a] p<0.001

[b] p<0.05

[c] p= NS

DAS28 responders include patients with moderate or good response.

**DAS28 remitters include patients with a DAS28 value of < 2.6 at a visit.

An ACR 20 response (Felson et al, 1995) was defined as:

1. ³ 20% improvement in swollen joint count (66 joints) and tender joint count (68 joints); and

2. ³ 20 % improvement in 3 of the following 5 assessments:

· Patient's assessment of pain [Visual Analog Scale (VAS)]

· Patient's global assessment of disease activity (VAS)

· Physician's global assessment of disease activity (VAS)

· Patient's assessment of physical function as measured by the HAQ-DI

· CRP

ACR 50 or ACR 70 are similarly defined.

The time course for ACR 20 response rates during the first 24 weeks in both studies for patients receiving STELARA or placebo are summarised in Figure 3. ACR 20 responses showed improvement at the first assessment (Week 4). ACR 20, 50 and 70 responses continued to improve or were maintained through Week 52 (see Table 5).

Figure 3.   Percent of patients achieving ACR 20 response through Week 24

PSUMMIT I

PSUMMIT II

Placebo (n=206)
STELARA 45 mg (n=205)
STELARA 90 mg (n=204)

Placebo (n=104)
STELARA 45 mg (n=103)
STELARA 90 mg (n=105)
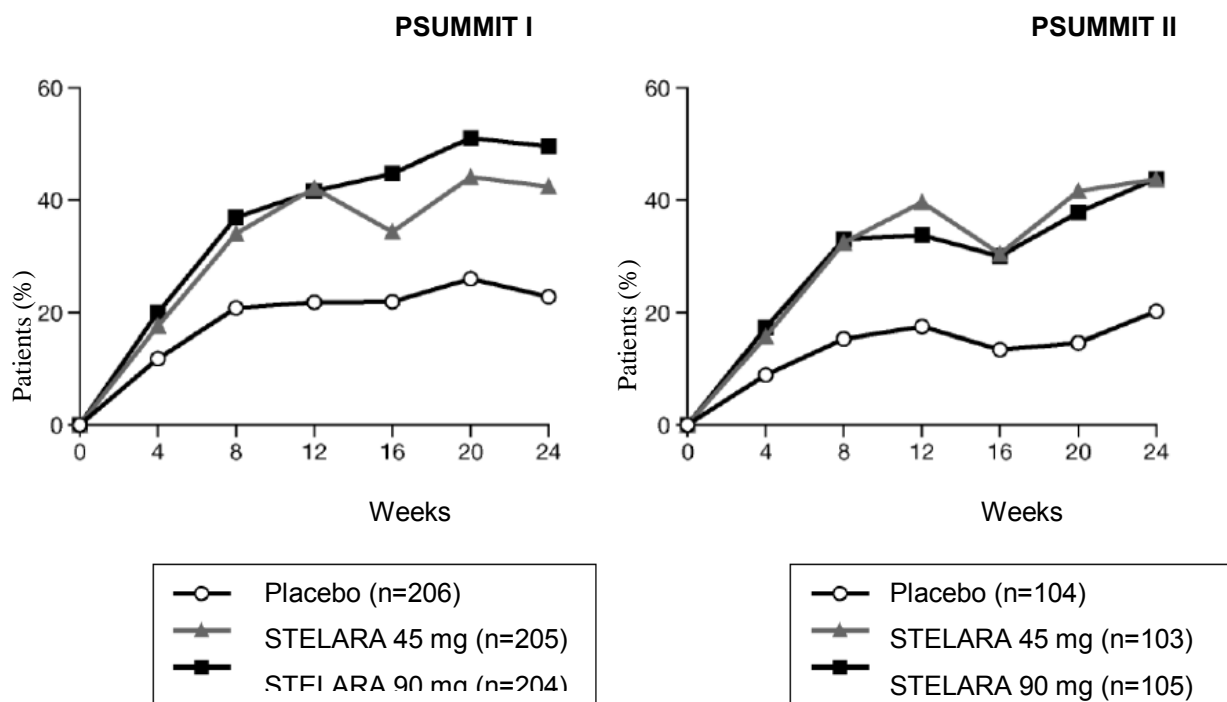
Table 5.   Proportion of patients who achieved ACR 20, ACR 50, ACR 70 response at Week 52

| | PSUMMIT I | | PSUMMIT II | |
| | STELARA | | STELARA | |
	45 mg	90 mg	45 mg	90 mg
N	194	189	94	95
ACR response				
ACR 20	55.7%	60.3%	46.8%	48.4%

	PSUMMIT I		PSUMMIT II	
	STELARA		STELARA	
	45 mg	90 mg	45 mg	90 mg
ACR 50	31.4%	37.0%	27.7%	26.3%
ACR 70	18.0%	21.2%	12.8%	17.9%

In PSUMMIT I, of 205 subjects randomised to STELARA 45 mg, 153 continued the same dose and were available for evaluation at Week 52. Among those, ACR 20, 50 and 70 responses were achieved by 99 (64.7%), 57 (37.3%) and 34 (22.2%) subjects respectively. Of 204 subjects randomised to STELARA 90 mg, 185 were available for evaluation at Week 52. Among those, ACR 20, 50 and 70 responses were achieved by 120 (64.9%), 74 (40%) and 41 (22.2%) subjects respectively.

In PSUMMIT II, of 103 subjects randomised to STELARA 45 mg, 68 continued the same dose and were available for evaluation at Week 52. Among those, ACR 20, 50 and 70 responses were achieved by 41 (60.3%), 23 (33.8%) and 11 (16.2%) subjects respectively. Of 105 subjects randomised to STELARA 90 mg, 83 were available for evaluation at Week 52. Among those, ACR 20, 50 and 70 responses were achieved by 49 (59%), 26 (31.3%) and 17 (20.5%) subjects respectively.

Additionally, within each weight group, (≤100 kg and >100 kg), ACR 20, ACR 50 and ACR 70 responses were consistently higher in the STELARA 45 mg and 90 mg groups than in the placebo group (see Table 6).

Table 6. **Number of patients who achieved ACR 20, ACR 50 and ACR 70 responses by weight through Week 24**

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo (N=206)	45 mg (N= 205)	90 mg (N= 204)	Placebo (N= 104)	45 mg (N= 103)	90 mg (N= 105)
Patients randomised with weight ≤100 kg at baseline	154	153	154	74	74	73
ACR 20	39 (25%)	67 (44%)	78 (51%)	17 (23%)	32 (43%)	34 (47%)
ACR 50	14 (9%)	38 (25%)	48 (31%)	6 (8%)	15 (20%)	21 (29%)
ACR 70	5 (3%)	20 (13%)	26 (17%)	3 (4%)	6 (8%)	8 (11%)
Patients randomised with weight >100 kg at baseline	52	52	50	30	29	31
ACR 20	8 (15%)	20 (38%)	23 (46%)	4 (13%)	13 (45%)	12 (39%)
ACR 50	4 (8%)	13 (25%)	9 (18%)	1 (3%)	3 (10%)	3 (10%)

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo (N=206)	45 mg (N= 205)	90 mg (N= 204)	Placebo (N= 104)	45 mg (N= 103)	90 mg (N= 105)
ACR 70	0	5 (10%)	3 (6%)	0	1 (3%)	1 (3%)

STELARA treatment resulted in significantly greater improvement compared with placebo for each ACR component (see Table 7).

Table 7. Summary of percent improvement from baseline in ACR components at Week 24

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo (N=206)	45 mg (N= 205)	90 mg (N= 204)	Placebo (N=104)	45 mg (N= 103)	90 mg (N= 105)
Number of swollen joints [d]						
Median	21.54	58.82 [a]	60.00 [a]	0.00	52.94 [b]	50.00 [c]
Number of tender joints [e]						
Median	13.61	45.45 [a]	51.51 [a]	0.00	33.33 [a]	35.00 [c]
Patient's assessment of pain [f]						
Median	0.00	31.33 [a]	42.58 [a]	0.00	24.19 [a]	24.29 [a]
Patient global assessment [f]						
Median	4.11	32.84 [a]	42.44 [a]	0.00	21.25 [a]	22.54 [a]
Physician global assessment [f]						
Median	17.64	48.39 [a]	55.91 [a]	0.83	36.67 [a]	36.11 [a]
Disability index (HAQ-DI)[g]						
Median	0.00	22.22 [a]	32.46 [a]	0.00	12.50 [a]	14.29 [a]
CRP (mg/dL) [h]						
Median	0.00	38.56 [a]	48.30 [a]	0.00	25.61 [c]	33.69 [a]

[a] $p<0.001$

[b] $p<0.05$

[c] $p<0.01$

[d] Number of swollen joints counted (0-66)

[e] Number of tender joints counted (0-68)

[f] Visual analogue scale; 0= best, 10=worst.

[g] Disability Index of the Health Assessment Questionnaire; 0 = best, 3 = worst, measures the patient's ability to perform the following: dress/groom, arise, eat, walk, reach, grip, maintain hygiene, and maintain daily activity.

[h] CRP: (Normal Range 0.0-1.0 mg/dL)

Methotrexate Use

The proportion of patients achieving ACR responses were consistently greater in patients treated with STELARA than those treated with placebo regardless of concomitant MTX use (see Table 8). Responses observed in the STELARA groups were similar in patients receiving or not receiving concomitant MTX. ACR responses were maintained through Week 52.

Table 8. Summary of patients achieving ACR 20, ACR 50 and ACR 70 responses through Week 24 by methotrexate usage

	PSUMMIT I					
	Receiving MTX at baseline			*Not receiving MTX at baseline*		
		STELARA			STELARA	
	Placebo (N=206)	45 mg (N= 205)	90 mg (N= 204)	Placebo (N=206)	45 mg (N= 205)	90 mg (N= 204)
Patients randomised	96	99	101	110	106	103
ACR 20	25 (26%)	43 (43%)	46 (46%)	22 (20%)	44 (42%)	55 (53%)
ACR 50	8 (8%)	23 (23%)	27 (27%)	10 (9%)	28 (26%)	30 (29%)
ACR 70	2 (2%)	11 (11%)	13 (13%)	3 (3%)	14 (13%)	16 (16%)
	PSUMMIT II					
	Receiving MTX at baseline			*Not receiving MTX at baseline*		
		STELARA			STELARA	
	Placebo (N=104)	45 mg (N= 103)	90 mg (N= 105)	Placebo (N=104)	45 mg (N= 103)	90 mg (N= 105)
Patients randomised	49	54	52	55	49	53
ACR 20	14 (29%)	27 (50%)	21 (40%)	7 (13%)	18 (37%)	25 (47%)
ACR 50	4 (8%)	10 (19%)	12 (23%)	3 (5%)	8 (16%)	12 (23%)
ACR 70	2 (4%)	4 (7%)	3 (6%)	1 (2%)	3 (6%)	6 (11%)

Prior Anti-TNFα Therapy

PSUMMIT II evaluated 180 patients who were previously treated with one or more anti-TNFα agents for at least 8 weeks (14 weeks with infliximab), or had documented intolerance of anti-TNFα therapy at any time in the past.

Among patients previously treated with anti-TNFα agents, a significantly greater proportion of STELARA-treated patients achieved an ACR 20 response at Week 24 compared to placebo (see Table 9). ACR 20, 50 and 70 responses were generally maintained through Week 52.

Table 9.   Number of patients previously treated with anti-TNFα agent(s) who achieved ACR 20, ACR 50 and ACR 70 responses through Week 24

PSUMMIT II		STELARA	
	Placebo **(N= 104)**	**45 mg** **(N= 103)**	**90 mg** **(N= 105)**
Patients randomised	62	60	58
ACR 20	9 (15%)	22 (37%)[a]	20 (34%)[b]
ACR 50	4 (6%)	9 (15%)[c]	9 (16%)[c]
ACR 70	1 (2%)	3 (5%)[c]	3 (5%)[c]

[a] $p<0.01$

[b] $p<0.05$

[c] p=NS

Enthesitis and Dactylitis

For patients with enthesitis and/or dactylitis at baseline, in PSUMMIT I, a significant improvement in enthesitis and dactylitis score was observed in the STELARA 45 mg and 90 mg groups compared to placebo. In PSUMMIT II, a significant improvement in enthesitis score and numerical improvement in dactylitis score were observed in the 90 mg group (p=NS) compared with the placebo group (see Table 10). In both studies, improvement in enthesitis score and dactylitis score were maintained at Week 52.

Table 10.   Summary of percent change in enthesitis and dactylitis scores at Week 24

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo **(N=206)**	**45 mg** **(N=205)**	**90 mg** **(N=204)**	**Placebo** **(N= 104)**	**45 mg** **(N= 103)**	**90 mg** **(N= 105)**
Enthesitis score [d]						
Patients randomised with enthesitis at baseline	145	142	154	73	72	76
N	137	140	148	68	70	70
Median	0.00	-42.86 [a]	-50.00 [b]	0.00	-33.33 [c]	-48.33[a]
Dactylitis score [e]						
Patients randomised with dactylitis at	96	101	99	38	48	41

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo (N=206)	45 mg (N=205)	90 mg (N=204)	Placebo (N= 104)	45 mg (N= 103)	90 mg (N= 105)
baseline						
N	92	99	95	33	46	38
Median	0.00	-75.00 [b]	-70.83 [b]	0.00	0.00 [c]	-64.58 [c]

[a] p<0.01
[b] p<0.001
[c] p=NS
[d] Enthesitis was assessed based on the Maastricht Ankylosing Spondylitis Enthesis Score (MASES) index modified for PSA (an instrument that counts 15 body sites).

[e] Dactylitis was assessed in both hands and feet using a scoring system from 0 to 60.

PASI Response

In PSUMMIT I and PSUMMIT II, the proportion of patients with psoriasis involvement of ≥3% BSA at baseline who achieved a ≥75% improvement in the PASI assessment at Week 24 was significantly greater in the STELARA 45 mg and 90 mg groups compared with the placebo group (see Table 11). In both studies the proportion of patients achieving the PASI 75 response was maintained through Week 52 (PSUMMIT I, STELARA 45mg-70.1% and 90mg- 68.1%; PSUMMIT II, STELARA 45mg-56.5% and 90mg- 64.4%).

The proportion of patients who achieved both a PASI 75 response and an ACR 20 response was evaluated for those patients with ≥3% BSA psoriasis skin involvement at baseline. A significantly higher proportion of patients achieved the combined response in the STELARA 45 mg and 90 mg groups compared with the placebo group at Week 24 (see Table 11). In both studies the proportion of patients achieving both a PASI 75 response and an ACR20 response was maintained through Week 52 (PSUMMIT I, STELARA 45mg-44.8% and 90mg-44.3%; PSUMMIT II, STELARA 45mg-36.8% and 90mg- 43.1%).

Table 11. Number of patients who achieved PASI 75, PASI 90 and PASI 100 responses as well as a combination of skin and joint responses at Week 24

	PSUMMIT I			PSUMMIT II		
		STELARA [a]			STELARA [a]	
	Placebo (N= 206)	45 mg (N=205)	90 mg (N=204)	Placebo (N= 104)	45 mg (N=103)	90 mg (N=105)
Patients with ≥3% BSA psoriasis skin involvement at baseline	146	145	149	80	80	81
PASI 75	16 (11%)	83 (57%)	93 (62%)	4 (5%)	41 (51%)	45 (56%)
PASI 90	4 (3%)	60 (41%)	65 (44%)	3 (4%)	24 (30%)	36 (44%)
PASI 100	2 (1%)	29 (20%)	41 (28%)	1 (1%)	13 (16%)	17 (21%)

	PSUMMIT I			PSUMMIT II		
		STELARA [a]			STELARA [a]	
	Placebo (N= 206)	45 mg (N=205)	90 mg (N=204)	Placebo (N= 104)	45 mg (N=103)	90 mg (N=105)
Combination of skin and joint responses						
PASI 75 and ACR 20	8 (5%)	40 (28%)	62 (42%)	2 (3%)	24 (30%)	31 (38%)

[a] p<0.001 for 45 mg or 90 mg comparison with placebo.

Additionally, within each weight group (≤100 kg and >100 kg), PASI 75, 90 and 100 responses were consistently higher in the STELARA 45 and 90 mg groups than in the placebo group (see Table 12).

Table 12. Summary of patients who achieved PASI 75, PASI 90 and PASI 100 responses by weight through Week 24

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo (N=206)	45 mg (N= 205)	90 mg (N= 204)	Placebo (N= 104)	45 mg (N= 103)	90 mg (N= 105)
Patients randomised with weight ≤100 kg at baseline*	105	105	111	54	58	57
PASI 75	14 (13%)	64 (61%)	73 (66%)	4 (7%)	31 (53%)	32 (56%)
PASI 90	4 (4%)	46 (44%)	48 (43%)	3 (6%)	20 (34%)	27 (47%)
PASI 100	2 (2%)	21 (20%)	30 (27%)	1 (2%)	11 (19%)	13 (23%)
Patients randomised with weight >100 kg at baseline*	41	40	38	26	22	24
PASI 75	2 (5%)	19 (48%)	20 (53%)	0	10 (45%)	13 (54%)
PASI 90	0	14 (35%)	17 (45%)	0	4 (18%)	9 (38%)
PASI 100	0	8 (20%)	11 (29%)	0	2 (9%)	4 (17%)

* Patients randomised with ≥ 3% BSA psoriasis skin involvement at baseline

Methotrexate Use

In both studies, the proportion of patients who achieved a PASI 75 response at Week 24 was consistently higher in STELARA 45 mg and 90 mg groups compared with placebo regardless of concomitant MTX use. PASI 75 responses were maintained through Week 52.

Prior Anti-TNFα Therapy

In PSUMMIT II, the proportion of patients who achieved a PASI 75 response at Week 24 was significantly greater in STELARA 45 mg and 90 mg groups compared with placebo in patients previously treated with an anti-TNFα agent.

Radiographic Response

Structural damage in both hands and feet was assessed by readers unaware of treatment group and order of visits, and expressed as change in total van der Heijde-Sharp score (vdH-S score), modified for PsA by addition of hand distal interphalangeal (DIP) joints, compared to baseline. A pre-specified integrated analysis combining data from 927 subjects in both PSUMMIT I & II was performed. At Week 24, based on this integrated analysis, the STELARA 45 mg or 90 mg treatment significantly inhibited progression of structural damage, when compared to placebo (see Table 13). Beyond Week 24, STELARA treatment continued to inhibit the progression of structural damage through Week 52. The mean change from Week 24 to 52 in total modified vdH-S score (0.18 and 0.26 in the STELARA 45mg and 90 mg groups respectively) was less than the mean change from Week 0 to 24 (see Table 13).

Table 13:   Summary of change from baseline in total modified vdH-S score at Week 24 (Integrated analysis of PSUMMIT I and PSUMMIT II)

		STELARA®	
	Placebo	45mg	90mg
Total Modified vdH-S score at Baseline			
N	306	303	300
Mean ± SD	28.01 ± 55.771	30.40 ± 50.688	27.97 ± 42.137
Change from Baseline			
N	310	308	309
Mean ± SD	0.97 ± 3.852	0.40 ± 2.110[b]	0.39 ± 2.403[a]

[a] p value < 0.001 for the difference between STELARA and Placebo, Week 24 (integrated analysis)

[b] p value < 0.05

At Week 24, patients treated with STELARA demonstrated less progression of structural damage compared to placebo, irrespective of concomitant MTX use.

The effect of STELARA on progression of structural damage in patients with prior anti-TNFα experience has not been established.

Physical Function and Health-Related Quality of Life

In PSUMMIT I and PSUMMIT II, physical function and health-related quality of life were assessed using the Disability Index of the Health Assessment Questionnaire (HAQ-DI), Dermatology Life Quality Index (DLQI) and the SF-36 health survey.

Patients treated with STELARA showed significant improvement in physical function as assessed by the HAQ-DI at Week 24. The proportion of patients achieving a clinically meaningful ≥0.3 improvement in HAQ-DI score from baseline at Week 24 was also significantly greater in the STELARA groups when compared with placebo (see Table 14). Improvement was observed at the first assessment (Week 4), reached maximum at Week 12 and was maintained through Week 24. Improvement in HAQ-DI score from baseline was maintained at Week 52.

In both studies, the improvement in HAQ-DI at Week 24 was consistently greater in the STELARA 45 mg and 90 mg groups compared with placebo regardless of concomitant MTX use.

In PSUMMIT II, the improvement in HAQ-DI at Week 24 was significantly greater in the STELARA 45 mg and 90 mg groups compared with placebo in patients previously treated with anti-TNFα agents.

Table 14.   Improvement in physical function as measured by HAQ-DI at Week 24

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo (N= 206)	45 mg (N=205)	90 mg (N=204)	Placebo (N= 104)	45 mg (N=103)	90 mg (N=105)
HAQ-DI Baseline Score						
N	204	205	204	104	103	104

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo (N= 206)	45 mg (N=205)	90 mg (N=204)	Placebo (N= 104)	45 mg (N=103)	90 mg (N=105)
Mean (SD)	1.24 (0.647)	1.22 (0.610)	1.22 (0.634)	1.25 (0.723)	1.34 (0.704)	1.29 (0.666)
Median	1.25	1.25	1.25	1.25	1.38	1.25
Improvement in HAQ-DI						
N	206	205	204	104	103	105
Mean (SD)	0.10 (0.390)	0.31 (0.521)	0.40 (0.514)	0.03 (0.380)	0.21 (0.461)	0.22 (0.436)
Median	0.00	0.25 [a]	0.25 [a]	0.00	0.13 [b]	0.25 [a]
HAQ-DI Responders*	58 (28%)	98 (48%)[a]	97 (48%)[a]	17 (16%)	35 (34%)[b]	40 (38%)[a]

[a] p<0.001

[b] p<0.01

*achieving a ≥0.3 improvement from baseline

In PSUMMIT I, of 205 subjects randomised to STELARA 45 mg, 153 continued the same dose and were available for evaluation at Week 52. Among those, the HAQ-DI response was achieved by 83 (54.2%) subjects. Of 204 subjects randomised to STELARA 90 mg, 185 were available for evaluation at Week 52. Among those, HAQ-DI response was achieved by 102 (55.1%) subjects.

In PSUMMIT II, of 103 subjects randomised to STELARA 45 mg, 68 continued the same dose and were available for evaluation at Week 52. Among those, the HAQ-DI response was achieved by 29 (42.6%) subjects. Of 105 subjects randomised to STELARA 90 mg, 83 were available for evaluation at Week 52. Among those, HAQ-DI response was achieved by 44 (53%) subjects.

The DLQI was assessed by comparing the change in DLQI scores from baseline for those patients with ≥3% BSA at baseline. In both studies at Week 24, there was a significant improvement from baseline in DLQI scores in both the STELARA 45 mg and 90 mg groups as compared with placebo (see Table 15) and the improvement was maintained at Week 52.

In both PSUMMIT I and PSUMMIT II, at Week 24, the change from baseline in the SF-36 physical component summary (PCS) scores was significantly greater in the STELARA 45 mg and 90 mg groups compared with the placebo group. In both studies, the change from baseline in the SF-36 mental component summary (MCS) scores at Week 24 was greater in both STELARA groups compared with the placebo group (p<0.001 for PSUMMIT I - 90mg group, p=NS for other groups) (see Table 15). In both studies, the change from baseline in the SF-36 PCS and MCS scores was maintained at Week 52.

In PSUMMIT II, a significant change from baseline in Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F) scores was observed at Week 24 in the STELARA 45 mg and 90

mg groups compared with the placebo group (median improvement, all 3.0 vs 0.0; p<0.007). Similarly, the percentage of patients with clinically significant improvement in fatigue from baseline (4 points in FACIT-F) was significantly greater in the STELARA 45 mg (49% [p<0.001]) and 90 mg groups (49% [p<0.001]) compared with the placebo group (25.8%). The change from baseline in the FACIT-F scores was maintained at Week 52.

Table 15. **Summary of change from baseline in DLQI and SF-36 and scores at Week 24**

	PSUMMIT I			PSUMMIT II		
		STELARA			STELARA	
	Placebo (N= 206)	45 mg (N=205)	90 mg (N=204)	Placebo (N= 104)	45 mg (N=103)	90 mg (N=105)
DLQI						
Patients randomised with ≥ 3% BSA psoriasis skin involvement at baseline	146	145	149	80	80	81
Baseline						
N	145	145	149	80	80	81
Mean (SD)	11.68 (7.705)	11.02 (7.308)	10.54 (7.179)	11.93 (7.622)	12.09 (7.667)	11.98 (7.754)
Median	11.00	10.00	9.00	11.00	11.00	10.00
Change from baseline						
N	140	142	146	73	77	75
Mean (SD)	-1.40 (6.177)	-6.63 (6.776)	-7.54 (6.524)	-0.75 (5.666)	-6.95 (7.719)	-7.16 (6.748)
Median	-1.00	-6.00 [a]	-6.00 [a]	0.00	-6.00 [a]	-6.00 [a]
SF-36						
Physical component summary						
Baseline						
N	203	203	204	104	102	104
Mean (SD)	31.39 (8.785)	31.16 (8.511)	31.45 (8.152)	30.28 (9.361)	28.69 (8.501)	28.93 (8.480)

	PSUMMIT I			PSUMMIT II		
		STELARA			**STELARA**	
	Placebo **(N= 206)**	**45 mg** **(N=205)**	**90 mg** **(N=204)**	**Placebo** **(N= 104)**	**45 mg** **(N=103)**	**90 mg** **(N=105)**
Median	30.40	29.80	29.70	29.35	27.95	28.15
Change from baseline						
N	196	200	197	97	99	97
Mean (SD)	1.4(7.094)	4.89 (9.333)	6.22 (8.747)	1.09 (5.892)	4.29 (8.594)	4.67 (8.758)
Median	1.15	3.90 [a]	5.80 [a]	0.00	2.70[c]	3.50[a]
Mental component summary						
Baseline						
N	203	203	204	104	102	104
Mean (SD)	43.51 (10.848)	42.77 (10.908)	43.48 (11.608)	42.11 (12.507)	43.27 (12.911)	42.81 (11.953)
Median	43.90	42.00	41.65	41.80	43.70	41.40
Change from baseline						
N	196	200	197	97	99	97
Mean (SD)	1.53 (9.582)	3.35 (10.016)	4.79 (10.054)	0.63 (8.238)	3.01 (11.144)	3.52 (11.274)
Median	0.25	2.65[b]	4.40[a]	0.00	0.70[b]	2.20[b]

[a] p≤0.001

[b] p=NS

[c] p<0.05

CROHN'S DISEASE

The safety and efficacy of STELARA were evaluated in three randomised, double-blind, placebo-controlled clinical trials in adult patients with moderately to severely active Crohn's disease (Crohn's Disease Activity Index [CDAI] score of 220 to 450). The clinical development program consisted of two 8-week IV induction studies (UNITI-1 and UNITI-2) followed by a 44-week subcutaneous randomised withdrawal maintenance study (IM-UNITI) representing 52 weeks of therapy.

Induction of Clinical Response and Remission

UNITI-1 and UNITI-2 studies included 1409 (UNITI-1 n=769; UNITI-2 n=640) patients. In both studies, patients were permitted to concomitantly receive oral 5-ASA compounds, immunomodulators, corticosteroids, and/or antibiotics. Patients were randomised to receive a single IV administration of STELARA, designed as a tiered dose based on patient body weight (Table 21) or placebo at Week 0. The primary endpoint was clinical response (defined as a reduction in CDAI score of ≥100 points or CDAI score <150) at Week 6. Secondary endpoints included clinical remission at Week 8, clinical response at Week 8, 70-point response at Week 3, and 70-point response at Week 6. Efficacy data were collected and analyzed through Week 8 for both studies.

In UNITI-1, patients had failed or were intolerant to prior anti-TNFα therapy. At baseline, approximately 46% (n=340) patients were receiving corticosteroids (including budesonide) and 31.4% of patients were receiving immunomodulators. Approximately 48% had failed 1 prior anti-TNFα therapy and 52% had failed 2 or 3 prior anti-TNFα therapies (40.8% and 10.4%, respectively). In this study, 29.1% patients had an inadequate initial response (primary non-responders), 69.4% responded but subsequently lost response (secondary non-responders), and 36.4% were intolerant to anti-TNF α therapies.

Patients in UNITI-2 had failed at least one conventional therapy (corticosteroids or immunomodulators) and were either anti-TNFα naïve (68.6%) or had previously received but not failed anti-TNFα therapy (31.4%). At baseline, approximately 40% patients were receiving corticosteroids (including budesonide) and 35% patients were receiving immunomodulators.

In these induction studies, efficacy was higher and better sustained in the tiered dose (based on weight ranges) group compared to the 130 mg dose group. In both UNITI-1 and UNITI-2, a significantly greater proportion of patients were in clinical response and remission in the group treated with STELARA, compared to placebo (Table 16, Figure 4). Clinical response and remission were significant as early as Week 3 in STELARA treated patients and continued to improve through Week 8 (Figure 4).

Table 16.   Induction of Clinical Response and Remission in UNITI-1* and UNITI 2**

	UNITI-1		UNITI-2	
	Placebo N=247	Recommended dose of ustekinumab N=249	Placebo N=209	Recommended dose of ustekinumab N=209
Clinical Response (100 point), Week 6	53 (21.5%)	84 (33.7%)[a]	60 (28.7%)	116 (55.5%)[b]
Clinical Response (100 point), Week 8	50 (20.2%)	94 (37.8%)[b]	67 (32.1%)	121 (57.9%)[b]
70 Point Response, Week 3	67 (27.1%)	101 (40.6%)[a]	66 (31.6%)	106 (50.7%)[b]
70 Point Response, Week 6	75 (30.4%)	109 (43.8%)[a]	81 (38.8%)	135 (64.6%)[b]
Clinical Remission, Week 8	18 (7.3%)	52 (20.9%)[b]	41	84 (40.2%)[b]

			(19.6%)	

Clinical remission is defined as CDAI score < 150; Clinical response is defined as reduction in CDAI score by at least 100 points or being in clinical remission

70 point response is defined as reduction in CDAI score by at least 70 points

* Anti-TNFα failures

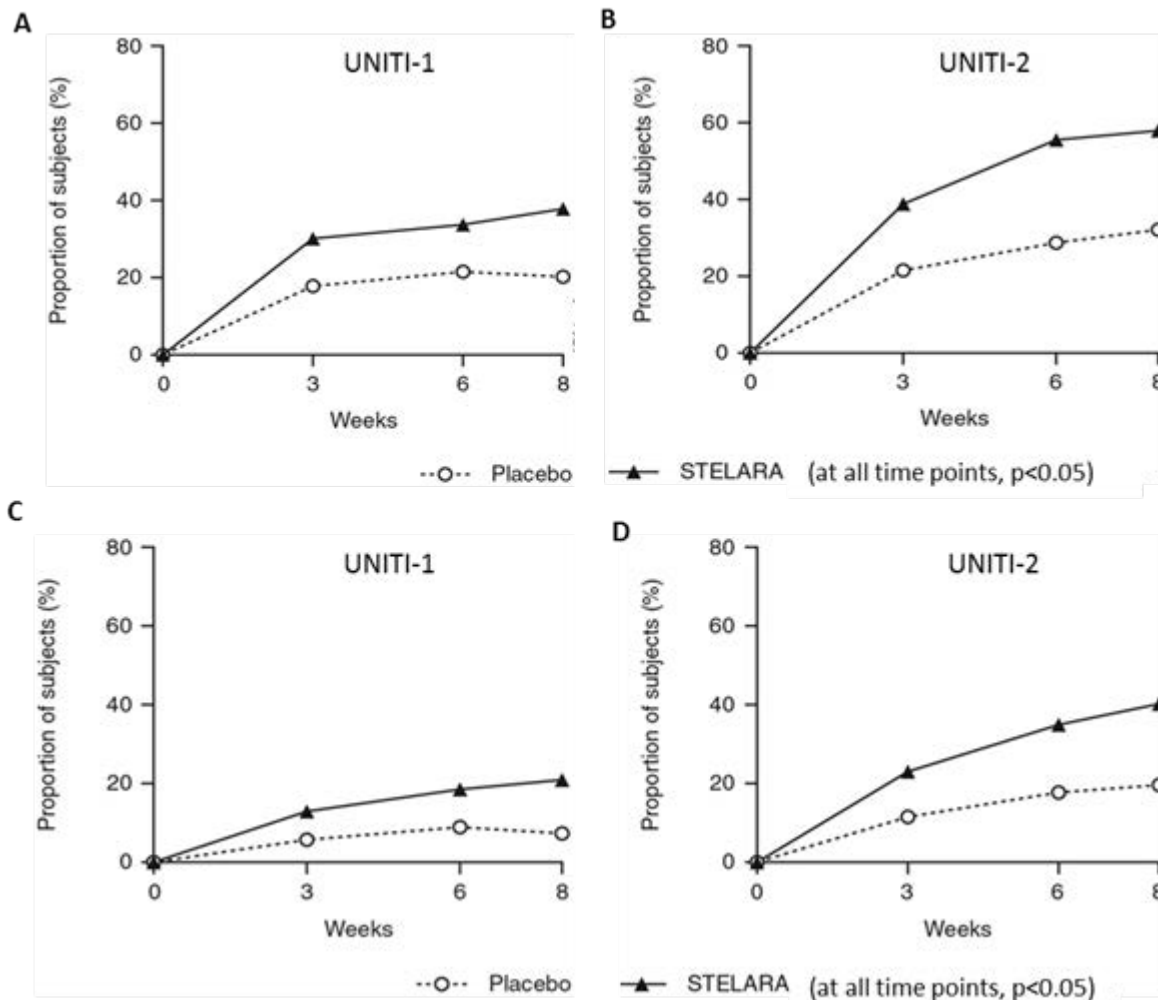** Conventional therapy failures

[a] $p < 0.01$

[b] $p < 0.001$

Figure 4.   Proportion of STELARA treated patients in clinical response (A, B) and remission (C, D) through Week 8 in UNITI-1 and UNITI-2 studies

Maintenance of Response and Remission

The maintenance study (IM-UNITI) evaluated 388 patients who achieved clinical response (≥100 point reduction in CDAI score) at Week 8 of induction with STELARA in UNITI-1 or UNITI-2. Of those, approximately 60% of the patients entered the maintenance study in remission. Patients were randomised to receive a subcutaneous maintenance regimen of either 90 mg STELARA every 8 weeks, 90 mg STELARA every 12 weeks or placebo for 44 weeks.

Concomitant doses of oral 5-ASA compounds, immunomodulators corticosteroids and antibiotics were permitted. Corticosteroids were tapered at the start of the maintenance trial. The primary endpoint was clinical remission (CDAI < 150) at Week 44. Secondary endpoints assessed at Week 44 included clinical response, clinical remission among STELARA treated

patients in clinical remission after induction, corticosteroid-free remission, and clinical remission in the subset of patients who were refractory or intolerant to anti-TNFα treatment.

Significantly higher proportions of patients maintained clinical remission and response in the STELARA treated groups as compared to placebo at Week 44 (Table 17, Figure 5). A higher proportion of STELARA treated patients compared to placebo achieved sustained clinical remission (clinical remission at Week 36, 40 and 44). Clinical remission was achieved in patients who had failed conventional therapy (anti-TNFα naïve) and in patients who had prior treatment experience with an anti-TNFα. A higher rate of clinical remission was observed in the anti-TNFα naïve patients compared to the anti-TNFα refractory/intolerant patients, but the overall treatment effect was consistent in both anti-TNFα refractory/intolerant patients and anti-TNFα naïve patients (Table 17).

Table 17.   Maintenance of Clinical Response and Remission in IM-UNITI (Week 44; 52 weeks from initiation of the induction dose)

	Placebo* N=131[†]	90 mg STELARA every 8 weeks N=128[†]	90 mg STELARA every 12 weeks N=129[†]
Clinical Remission	36%	53%[a]	49%[b]
Clinical Response	44%	59%[b]	58%[b]
Corticosteroid-Free Clinical Remission	30%	47%[a]	43%[c]
Sustained Clinical Remission‡	26%	46%[c]	40%[c]
Clinical Remission in patients:			
in remission at the start of maintenance therapy	46% (36/79)	67% (52/78)[a]	56% (44/78)
who are Anti-TNFα refractory/intolerant	26% (16/61)	41% (23/56)	39% (22/57)
who failed conventional therapy but not anti-TNFα therapy	44% (31/70)	63% (45/72)[c]	57% (41/72)
who are Anti-TNFα naïve	49% (25/51)	65% (34/52)[c]	57% (30/53)

Clinical remission is defined as CDAI score < 150; Clinical response is defined as reduction in CDAI of at least 100 points or being in clinical remission

*The placebo group consisted of patients who were in response to STELARA and were randomised to receive placebo at the start of maintenance therapy.

† Patients who achieved a clinical response to STELARA at start of maintenance therapy

‡ Defined as clinical remission at Week 36, 40 and 44.

[a]p < 0.01

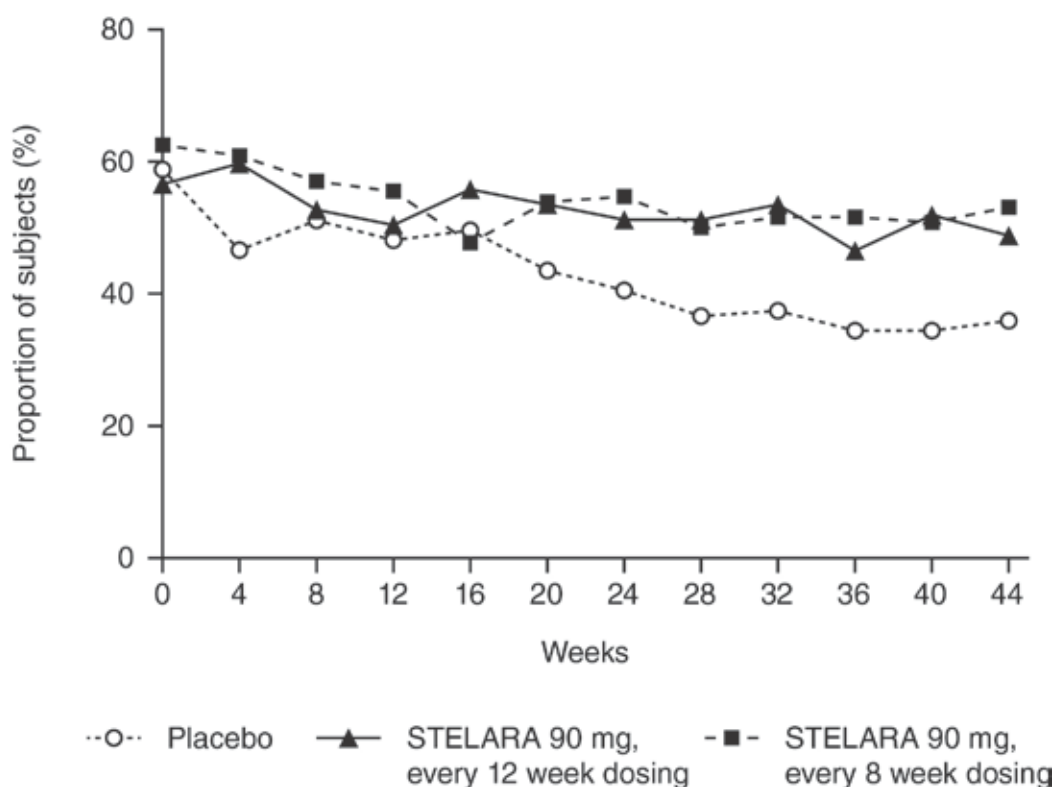[b]p < 0.05

[c]nominally significant (p<0.05)

Figure 5. **Proportion of patients in clinical remission at each visit through Week 44**

Delayed Response

Patients who were not in clinical response to STELARA induction (n=467) received a 90 mg subcutaneous injection of STELARA at week 8 upon entry into the maintenance study. Eight weeks later, 50.5% of the patients achieved clinical response and continued to receive maintenance dosing every 8 weeks; among these patients with continued maintenance dosing, a majority achieved levels of response (68.1%) and remission (50.2%) similar to the patients who initially responded to STELARA induction.

Dosing in Patients with a Lower Inflammatory Burden

In patients with a lower inflammatory burden as reflected by CRP ≤ 10 mg/L at initiation of induction or initiation of maintenance therapy, the efficacy of the every 12 week dosing regimen was similar to that of the every 8 week dosing regimen.

Dosing Frequency Adjustment

In IM-UNITI, 29 of 129 patients (22%) did not maintain response to STELARA when treated every 12 weeks and were allowed to increase the frequency of dosing and receive STELARA every 8 weeks. In these patients, clinical remission was achieved in 41.4% of patients 16 weeks after dosing frequency adjustment.

Resumption of Treatment

Of 131 patients that responded to STELARA induction and who were randomised to the placebo group at the start of the maintenance study, 51 subsequently lost response and received 90 mg STELARA subcutaneously every 8 weeks. Of these 51 patients, 70.6% achieved clinical response and 39.2% achieved clinical remission 16 weeks after receiving the first subcutaneous dose of STELARA.

Corticosteroid Use in Maintenance

In patients that were in clinical response to STELARA induction therapy, a greater proportion of patients in the STELARA treated group were in remission and corticosteroid-free compared to

the placebo group after 44 weeks of maintenance treatment (Table 17). In addition, a higher proportion of patients were in clinical response and not receiving corticosteroids in the STELARA treated group compared to placebo.

Endoscopic Healing of the Mucosa

Endoscopic healing of the mucosa was evaluated in 252 patients with baseline endoscopic disease activity in a substudy. At Week 8, after a single IV induction dose, reduction in mucosal inflammation, as measured by the Simplified Endoscopic Activity Score for Crohn's Disease (SES-CD), was greater in patients treated with STELARA (n=83) compared with patients treated with placebo (n=97) (-2.8 vs -0.7, p=0.012). Similar reductions in histologic inflammation were also observed.

Fistula Response

In patients with draining fistulas at baseline (8.8%), a numerically greater proportion of STELARA treated patients achieved a fistula response (defined as ≥ 50% reduction from baseline of the induction study in the number of draining fistulas) compared with placebo over 44 weeks (p=NS). The proportion of patients in fistula response at Week 44 was 45.5% (5/11) for placebo group, 71.4% (5/7) for STELARA 90 mg every 12 week dosing group, and 87.5% (7/8) for STELARA 90 mg every 8 week dosing group.

Health-Related Quality of Life Measures

Improvement in general and disease specific health-related quality of life was assessed using the SF-36 and Inflammatory Bowel Disease Questionnaire (IBDQ) respectively.

SF-36

A higher proportion of patients treated with STELARA showed clinically meaningful improvements in SF-36 Physical Component Summary (PCS) and Mental Component Summary (MCS) scores, and these improvements were significantly greater at week 8 compared with the placebo group in UNITI-1 (MCS) and UNITI-2 (PCS, MCS and all subscores). These improvements in the PCS and MCS scores were maintained in STELARA treated patients in the IM-UNITI maintenance study through Week 44.

IBDQ

At Week 8 in UNITI-1 and UNITI-2, significant improvement from baseline in the inflammatory bowel disease questionnaire (IBDQ) total score and all subscales, was observed in the patients treated with STELARA compared to placebo. In both studies, a higher proportion of patients with clinically meaningful improvement in IBDQ total scores were observed in patients treated with STELARA compared to placebo. These improvements in the IBDQ total scores were maintained in STELARA treated patients in the IM-UNITI maintenance study through Week 44.

INDICATIONS

Plaque Psoriasis

STELARA is indicated for the treatment of adult patients (18 years or older) with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

Psoriatic Arthritis (PsA)

STELARA, alone or in combination with methotrexate, is indicated for the treatment of signs and symptoms of active psoriatic arthritis in adult patients (18 years and older) where response to previous non-biological DMARD therapy has been inadequate.

Crohn's Disease

STELARA is indicated for the treatment of adult patients with moderately to severely active Crohn's disease who have had an inadequate response, lost response, or were intolerant to either conventional therapy or a TNFα antagonist or have medical contraindications to such therapies.

CONTRAINDICATIONS

Severe hypersensitivity to ustekinumab or to any of the excipients (see PRECAUTIONS).

STELARA should not be given to patients with a clinically important, active infection.

PRECAUTIONS

Serious Infections

STELARA is a selective immunosuppressant and may have the potential to increase the risk of infections and reactivate latent infections.

In clinical studies, serious bacterial, fungal, and viral infections have been observed in patients receiving STELARA. Caution should be exercised when considering the use of STELARA in patients with a chronic infection or a history of recurrent infection.

Prior to initiating treatment with STELARA, patients should be evaluated for tuberculosis infection. STELARA should not be given to patients with active tuberculosis. Treatment of latent tuberculosis infection should be initiated prior to administering STELARA. Anti-tuberculosis therapy should also be considered prior to initiation of STELARA in patients with a past history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed. Patients receiving STELARA should be monitored closely for signs and symptoms of active tuberculosis during and after treatment.

Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection they should be closely monitored and STELARA should not be administered until the infection resolves (see ADVERSE EFFECTS).

Malignancies

STELARA is a selective immunosuppressant. Immunosuppressive agents have the potential to increase the risk of malignancy. Some patients who received STELARA in clinical studies developed cutaneous and non-cutaneous malignancies (see ADVERSE EFFECTS).

STELARA has not been studied in patients with a history of malignancy. Caution should be exercised when considering the use of STELARA in patients with a history of malignancy or when considering continuing treatment in patients who develop a malignancy.

All patients, in particular those greater than 60 years of age, patients with a medical history of prolonged immunosuppressant therapy or those with a history of PUVA treatment, should be monitored for the appearance of non-melanoma skin cancer (see ADVERSE EFFECTS).

Hypersensitivity reactions

In post-marketing experience, serious hypersensitivity reactions, including anaphylaxis and angioedema, have been reported. If an anaphylactic or other serious hypersensitivity reaction occurs, appropriate therapy should be instituted and administration of STELARA should be discontinued immediately (see ADVERSE EFFECTS).

Immunisations

It is recommended that live viral or live bacterial vaccines (such as Bacillus of Calmette and Guérin [BCG]) not be given concurrently with STELARA.

Before live viral or live bacterial vaccination, treatment with STELARA should be withheld for at least 15 weeks after the last dose and can be resumed at least 2 weeks after vaccination. Prescribers should consult the Product Information for the specific vaccine for additional

information and guidance on concomitant use of immunosuppressive agents post vaccination and considering the benefit risk of ustekinumab treatment in the patient.

No data are available on the secondary transmission of infection by live vaccines in patients receiving STELARA. Caution is advised when administering some live vaccines to household contacts of patients receiving STELARA because of the potential risk for shedding from the household contact and transmission to the patient.

Patients receiving STELARA may receive concurrent inactivated or non-live vaccinations.

Long term treatment with STELARA does not suppress the humoral immune response to pneumococcal polysaccharide or tetanus vaccines (see Pharmacodynamics).

Immunosuppression

In psoriasis studies, the safety and efficacy of STELARA in combination with immunosuppressive agents or phototherapy have not been evaluated. In psoriatic arthritis studies, concomitant MTX use did not appear to influence the safety or efficacy of STELARA. In Crohn's disease studies, concomitant use of immunomodulators (6-mercaptopurine (6-MP), azathioprine (AZA), MTX) or corticosteroids did not appear to influence the safety or efficacy of STELARA. Caution should be exercised when considering concomitant use of immunosuppressive agents and STELARA or when transitioning from other biologic agents.

Immunotherapy

STELARA has not been evaluated in patients who have undergone allergy immunotherapy. STELARA may affect allergy immunotherapy. Caution should be exercised in patients receiving or who have received allergy immunotherapy particularly for anaphylaxis.

Reversible Posterior Leukoencephalopathy Syndrome

One case of reversible posterior leukoencephalopathy syndrome (RPLS) was observed during the clinical development program which included 3523 STELARA-treated subjects. The subject, who had received 12 doses of STELARA over approximately two years, presented with headache, seizures and confusion. No additional STELARA injections were administered and the subject fully recovered with appropriate treatment. A causal relationship to STELARA is uncertain.

RPLS is a neurological disorder, which is not caused by demyelination or a known infectious agent. RPLS can present with headache, seizures, confusion and visual disturbances. Conditions with which it has been associated include preeclampsia, eclampsia, acute hypertension, cytotoxic agents and immunosuppressive therapy. Fatal outcomes have been reported in this condition.

If RPLS is suspected, STELARA should be discontinued and appropriate treatment administered.

Serious skin conditions

In patients with psoriasis, exfoliative dermatitis has been reported following ustekinumab treatment. Patients with plaque psoriasis may develop erythrodermic psoriasis, with symptoms that may be clinically indistinguishable from exfoliative dermatitis, as part of the natural course of their disease. As part of the monitoring of the patient's psoriasis, physicians should be alert for symptoms of erythrodermic psoriasis or exfoliative dermatitis. If these symptoms occur, appropriate therapy should be instituted. STELARA should be discontinued if a drug reaction is suspected.

General

The needle cover on the pre-filled syringe contains dry natural rubber (a derivative of latex), which may cause allergic reactions in individuals sensitive to latex.

Effects on fertility

In a male fertility study in cynomolgus monkeys, no ustekinumab-related effects on mating behaviour, sperm parameters, or serum concentrations of male hormones were observed following twice weekly subcutaneous administration of ustekinumab at doses up to 45 mg/kg.

The effect of STELARA on female fertility has not been evaluated. A female fertility toxicity study was conducted in mice using an analogous antibody that binds to and inhibits IL-12 and IL-23 activity in mice. Twice weekly subcutaneous administration of the anti-mouse IL-12/23 antibody was well tolerated at doses up to 50 mg/kg and no adverse effects on female fertility parameters were observed.

Use in Pregnancy

Category B1.

It is not known whether STELARA can cause foetal harm when administered to a pregnant woman or can affect reproduction capacity. STELARA should be given to a pregnant woman only if the benefit clearly outweighs the risk.

Women of childbearing potential should use effective methods of contraception during treatment and for at least 15 weeks after treatment.

Developmental toxicity studies of STELARA were conducted in cynomolgus monkeys. No evidence of maternal toxicity, embryotoxicity or teratogenicity was observed at doses up to 45 mg/kg following weekly or twice weekly administration via the IV or SC routes, respectively, during the period of organogenesis. However, animal reproductive and developmental studies are not always predictive of human response.

Use in Lactation

Ustekinumab is excreted in the milk of lactating monkeys administered ustekinumab. It is not known if STELARA is absorbed systemically after ingestion. Because of the potential for adverse reactions in nursing infants from ustekinumab, a decision on whether to discontinue breast-feeding during treatment and up to 15 weeks after treatment or to discontinue therapy with STELARA must be made, taking into account the benefit of breast-feeding to the child and the benefit of STELARA therapy to the woman.

Maternal treatment of monkeys with STELARA at doses up to 45 mg/kg twice weekly SC from gestation Day 20 to post-partum Day 33 had no adverse effects on offspring development. However, animal reproductive and developmental studies are not always predictive of human response.

Paediatric Use

Specific studies of STELARA in paediatric patients have not been conducted. There are no safety or efficacy data in children or adolescents < 18 years of age.

Use in the Elderly

Of the 5884 patients exposed to STELARA, a total of 310 were 65 years or older (183 patients with psoriasis, 69 patients with psoriatic arthritis and 58 with Crohn's disease). No major age-related differences in clearance or volume of distribution were observed in clinical studies. Although no differences in efficacy or safety were observed between older and younger patients, the number of patients aged 65 and over is not sufficient to determine whether they respond differently from younger patients.

Carcinogenicity

STELARA has not been evaluated for carcinogenic potential, due to the lack of appropriate models for an antibody with no cross-reactivity to rodent IL-12/23 p40. STELARA is a selective immunosuppressant agent. Immunosuppressive agents have the potential to increase the risk of malignancy (see PRECAUTIONS – Malignancies).

Genotoxicity

STELARA has not been evaluated for genotoxic potential.

Interactions with Other Medicines

Specific drug interaction studies have not been conducted with STELARA (See PHARMACOLOGY - Pharmacokinetics).

Live vaccines should not be given concurrently with STELARA (see PRECAUTIONS).

CYP450 Substrates

The formation of CYP450 enzymes can be altered by increased levels of certain cytokines (eg, IL-1, IL-6, IL-10, TNFα, IFN) during chronic inflammation. Thus, STELARA, an antagonist of IL-12 and IL-23, could normalize the formation of CYP450 enzymes. Upon initiation of STELARA in patients who are receiving concomitant CYP450 substrates, particularly those with a narrow therapeutic index, monitoring for therapeutic effect (e.g. for warfarin) or drug concentration (e.g. for cyclosporine) should be considered and the individual dose of the drug adjusted as needed.

The effects of IL-12 or IL-23 on the regulation of CYP450 enzymes were evaluated in an in vitro study using human hepatocytes, which showed that IL-12 and/or IL-23 at levels of 10 ng/mL did not alter human CYP450 enzyme activities (CYP1A2, 2B6, 2C9, 2C19, 2D6, or 3A4). However, the clinical relevance of this in vitro data has not been established.

Effect on Ability to Drive and Operate Machinery

No studies on the effects on the ability to drive and use machines have been performed.

ADVERSE EFFECTS

Clinical Studies Experience in Patients with Psoriasis, Psoriatic Arthritis and Crohn's Disease

The safety data described below in table 18 reflect exposure to STELARA in 12 Phase 2 and Phase 3 studies in 5884 patients (4135 with psoriasis and/or psoriatic arthritis and 1749 for Cro

Table 18.   Long term exposure to STELARA in Phase 2 and Phase 3 clinical studies

Exposure	Number of patients
6 months	4105[a]
1 year	2846[a]
≥4 years	1482[b]
≥5 years	838[b]

[a] Total number of patients in the psoriasis, psoriatic arthritis and Crohn's disease studies
[b] Number of patients with psoriasis

The most common adverse reactions (>5%) in controlled periods of the psoriasis, psoriatic arthritis and Crohn's Disease clinical studies with STELARA were nasopharyngitis and headache. Most were considered to be mild and did not necessitate drug discontinuation. The overall safety profile of STELARA was similar for patients with psoriasis, psoriatic arthritis and Crohn's disease.

Table 19 provides a summary of Adverse Drug Reactions from psoriasis, psoriatic arthritis and Crohn's Disease clinical studies. The frequency of these adverse reactions was based on those that occurred during the initial controlled periods of the clinical studies. The adverse drug reactions are ranked by frequency, using the following convention:

Very common (≥1/10)

Common (frequent) (≥1/100, <1/10)

Uncommon (infrequent) (≥1/1,000, <1/100)

Rare (≥1/10,000, <1/1,000)

Table 19.   Summary of ADRs in Clinical Studies

Infections and infestations	Common: Upper respiratory tract infection, nasopharyngitis
	Uncommon: Herpes zoster, cellulitis, dental infections, viral upper respiratory tract infection, vulvovaginal mycotic infection
Psychiatric disorders	Uncommon: Depression
Nervous system disorders	Common: Dizziness, headache
Respiratory, thoracic and mediastinal disorders	Common: Oropharyngeal pain
	Uncommon: Nasal congestion
Gastrointestinal disorders	Common: Diarrhoea, nausea, vomiting
Skin and subcutaneous tissue disorders	Common: Pruritus
	Uncommon: Acne
Musculoskeletal and connective tissue disorders	Common: Back pain, myalgia, arthralgia
General disorders and administration site conditions	Common: Fatigue, injection site erythema, injection site pain
	Uncommon: Injection site reactions (including haemorrhage, haematoma, induration, swelling and pruritus), asthenia

Infections

In the placebo-controlled studies of patients with psoriasis, psoriatic arthritis and Crohn's disease, the rates of infection or serious infection were similar between STELARA-treated patients and those treated with placebo. In the placebo-controlled period of clinical studies of patients with psoriasis, patients with psoriatic arthritis and patients with Crohn's disease, the rate of infection was 1.38 per patient-year of follow-up in STELARA-treated patients, and 1.35 per patient-year of follow-up in placebo-treated patients. Serious infections occurred at a rate of 0.03 per patient-year of follow-up in STELARA-treated patients (27 serious infections in 829 patient-years of follow-up) and 0.03 per patient-year of follow-up in placebo-treated patients (11 serious infections in 385 patient-years of follow-up) (see PRECAUTIONS).

In the controlled and non-controlled portions of psoriasis, psoriatic arthritis and Crohn's disease clinical studies representing 10953 patient-years of exposure in 5884 patients, the median follow-up was 0.99 years; 3.2 years for psoriasis studies, 1.0 year for psoriatic arthritis studies and 0.6 year for Crohn's disease studies. The rate of infection was 0.91 per patient-year of follow-up in STELARA-treated patients. The incidence of serious infections was 0.02 per patient-year of follow-up in STELARA-treated patients (178 serious infections in 10953 patient-years of follow-up) and included anal abscess, cellulitis, pneumonia, diverticulitis, osteomyelitis, viral infections, gastroenteritis, and urinary tract infections.

In clinical studies, patients with latent tuberculosis who were concurrently treated with isoniazid did not develop tuberculosis. One case of tuberculosis reactivation occurred in a subject with abnormal baseline chest X-Ray and without treatment for latent TB while on ustekinumab therapy. The subject fully recovered with appropriate treatment.

Malignancy

In the placebo-controlled period of the psoriasis, psoriatic arthritis and Crohn's disease clinical studies, the incidence of malignancies excluding non-melanoma skin cancer was 0.12 per 100 patient-years of follow-up for STELARA-treated patients (1 patient in 615 patient-years of follow-up) compared with 0.26 per 100 patient-years of follow-up for placebo-treated patients (1 patient in 385 patient-years of follow-up).

The incidence of non-melanoma skin cancer was 0.48 per 100 patient-years of follow-up for STELARA-treated patients (4 patients in 829 patient-years of follow-up) compared with 0.52 per 100 patient-years of follow-up for placebo-treated patients (2 patients in 385 patient-years of follow-up).

In the controlled and non-controlled periods of psoriasis, psoriatic arthritis and Crohn's disease clinical studies representing 10935 patient-years of exposure in 5884 patients, the median follow-up was 1.0 years; 3.2 years for psoriasis studies, 1.0 year for psoriatic arthritis studies and 0.6 years for Crohn's disease studies. Malignancies excluding non-melanoma skin cancers were reported in 58 patients in 10935 patient-years of follow-up (incidence of 0.53 per 100 patient-years of follow-up for STELARA-treated patients). The rate of malignancies reported in STELARA-treated patients was comparable to the rate expected in the general population (standardized incidence ratio = 0.87 [95% confidence interval:0.66,1.14]). The most frequently observed malignancies, other than non-melanoma skin cancer, were prostate, colorectal, melanoma *in situ* and breast. The incidence of non-melanoma skin cancer was 0.49 per 100 patient-years of follow-up for STELARA-treated patients (53 patients in 10919 patient-years of follow-up). The ratio of patients with basal versus squamous cell skin cancers (4:1) is comparable with the ratio expected in the general population (see WARNINGS AND PRECAUTIONS).

Hypersensitivity and Infusion Reactions

Subcutaneous administration

During the controlled periods of the psoriasis and psoriatic arthritis clinical studies of STELARA, rash and urticaria have each been observed in <1% of patients.

IV administration

In Crohn's disease induction studies, no events of anaphylaxis or other serious infusion reactions were reported. In these studies, 2.4% of 466 placebo treated patients and 2.6% of 470 patients treated with the recommended dose of STELARA reported adverse events occurring during or within an hour of the infusion.

Immunogenicity

In psoriasis and psoriatic arthritis clinical studies, less than 8% of patients treated with STELARA in psoriasis and psoriatic arthritis clinical studies developed antibodies to ustekinumab. In Crohn's disease clinical studies, less than 3% of patients treated with STELARA developed antibodies to ustekinumab. No apparent association between the development of antibodies to ustekinumab and the development of injection site reactions was observed. Patients positive for antibodies to ustekinumab tended to have lower efficacy, however, antibody positivity did not preclude a clinical response. In psoriasis studies, the majority of patients who were positive for antibodies to ustekinumab had neutralising antibodies.

Adverse Events

The following adverse events have been reported in patients treated with STELARA. A causal relationship to STELARA is uncertain.

In psoriasis clinical trials of STELARA, serious cardiovascular events, including cardiovascular death, myocardial infarction, and stroke, were reported in 0.3% of patients who received STELARA compared with 0% of patients treated with placebo, during the placebo-controlled period. Individuals with chronic inflammatory diseases, such as psoriasis, have higher rates of

cardiovascular risk factors and cardiovascular events. Rates of myocardial infarction and stroke reported in STELARA-treated patients were comparable to rates expected in the general population.

In clinical trials for Crohn's disease, there is no consistent evidence that ustekinumab increases cardiovascular risk in patients treated with STELARA through approximately 1 year of treatment. Results from the Crohn's disease studies, up to 1 year, did not change the previous assessment of the impact of ustekinumab on serious major adverse cardiovascular event (MACE).

Adverse events of depression were reported in some patients who received STELARA in psoriasis clinical trials, including rare events of suicidality. Individuals with psoriasis have higher rates of depression, and it is not known if STELARA may have contributed to these events since STELARA also resulted in improvements of the Hospital Anxiety and Depression Scale (see CLINICAL TRIALS).

Post Marketing Experience

The adverse drug reactions in Table 20 are ranked by frequency* using the following convention:

Very common: ≥1/10

Common: ≥1/100 and <1/10

Uncommon: ≥1/1,000 and <1/100

Rare: ≥1/10,000 and <1/1000

Very rare: <1/10,000, including isolated reports

Table 20.   Post-Marketing Reports

Immune system disorders	Uncommon: Hypersensitivity reactions (including rash, urticaria)
	Rare: Serious hypersensitivity reactions (including anaphylaxis and angioedema)
Skin and subcutaneous tissue disorders	Uncommon: Pustular psoriasis, exfoliative dermatitis
	Rare: erythrodermic psoriasis

*Post-marketing adverse reaction frequency is derived from clinical trials if the adverse reaction was observed during trials, or is estimated to be lower than a certain frequency given the exposure in adequately designed clinical trials where the adverse reaction was not observed.

There have been reports of rapidly growing and/or multiple squamous cell carcinomas of the skin in patients receiving STELARA who had multiple pre-existing risk factors for developing non-melanoma skin cancer. A causal relationship of these adverse events to STELARA is uncertain.

DOSAGE AND ADMINSTRATION

Dosing (Adults)

Plaque Psoriasis

For the treatment of plaque psoriasis, STELARA is administered by subcutaneous injection. The recommended dose of STELARA is 45 mg administered at Weeks 0 and 4, then every 12 weeks thereafter. Alternatively, 90 mg administered over Weeks 0 and 4, then every 12 weeks thereafter may be used in patients with a body weight greater than 100 kg.

Dose Adjustment

For patients who inadequately respond to dosing every 12 weeks, consideration may be given to treating as often as every 8 weeks. Treatment should be discontinued in patients who have shown no response after 28 weeks of treatment.

Re-treatment

After interruption of therapy, re-treatment with a dosing regimen of Weeks 0 and 4, then every 12 weeks thereafter has been shown to be safe and effective.

<u>Psoriatic Arthritis</u>

For the treatment of psoriatic arthritis, STELARA is administered by subcutaneous injection. The recommended dose of STELARA is 45 mg administered at Weeks 0 and 4, then every 12 weeks thereafter. Some patients with a body weight greater than 100 kg received a 90 mg dose in clinical trials and observed a clinical benefit.

Treatment should be discontinued in patients who have shown no response after 28 weeks of treatment.

<u>Crohn's Disease</u>

For the treatment of Crohn's disease, the recommended treatment regimen is to initiate STELARA with a single intravenous (IV) tiered dose based on body weight (Table 21). The infusion solution is to be composed of the number of vials of STELARA 130 mg as specified in Table 21.

Table 21.   Initial IV dosing of STELARA

Body Weight of Patient at the time of dosing	Dose	Number of 130 mg STELARA Vials
≤ 55 kg	260 mg	2
> 55 kg to ≤ 85 kg	390 mg	3
> 85 kg	520 mg	4

After the initial IV dose, STELARA should then be administered subcutaneously. The first subcutaneous dose of 90 mg STELARA should be administered 8 weeks after the initial intravenous dose, then every 8 weeks thereafter.

For some patients, the single IV dose followed by a 90 mg subcutaneous dose 8 weeks later, then every 12 weeks thereafter may be acceptable according to clinical judgment. Patients who inadequately respond to 90 mg subcutaneous dosing every 12 weeks may benefit from an increase in dosing frequency to every 8 weeks (see CLINICAL TRIALS).

Immunomodulators and/or corticosteroids may be continued during treatment with STELARA. In patients who have responded to treatment with STELARA corticosteroids may be reduced or discontinued in accordance with standard of care.

If therapy is interrupted, treatment may be resumed with subcutaneous dosing every 8 weeks (see CLINICAL TRIALS).

Consideration should be given to discontinuing treatment in patients who show no evidence of therapeutic benefit by week 16.

Use in patients with hepatic or renal impairment

STELARA has not been studied in these patient populations. No dose recommendations can be made (see PHARMACOKINETICS – Population Pharmacokinetic Analysis).

<u>Administration</u>

Subcutaneous administration

STELARA injections are for single use in one patient only.

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

Comprehensive instructions for the subcutaneous administration of STELARA are given in the Consumer Medicine Information. Patients should be instructed to inject the full amount of STELARA according to the directions provided in the Consumer Medicine Information. When using the single-use vial, a 27 gauge, ½ inch needle is recommended.

Following administration of STELARA, the syringe should be disposed of in accordance with accepted medical practices for used syringes.

Intravenous infusion (Crohn's Disease)

STELARA 130 mg vial is for IV infusion only.

Instructions for dilution and intravenous infusion of STELARA 130 mg for IV infusion (Crohn's disease)

STELARA 130 mg solution must be diluted and prepared for IV infusion by a healthcare professional using aseptic technique. The IV infusion should be administered by qualified healthcare professionals.

1. Calculate the dose and the number of STELARA vials needed based on patient's body weight (see Table 21). Each 26 ml vial of STELARA contains 130 mg of ustekinumab.

2. Withdraw and then discard a volume of the 0.9% w/v sodium chloride solution from the 250 ml infusion bag equal to the volume of STELARA to be added. (Discard 26 mL sodium chloride for each vial of STELARA needed, for 2 vials-discard 52 mL, for 3 vials- discard 78 mL, for 4 vials- discard 104 mL.)

3. Withdraw 26 mL of STELARA from each vial needed and add it to the 250 ml infusion bag. The final volume in the infusion bag should be 250 ml. Gently invert or swirl the bag to mix the solution. Do not shake.

4. Once diluted, the infusion solution may be stored for up to four hours prior to infusion.

5. Visually inspect the diluted solution before administration. Do not use if visibly opaque particles, discoloration or foreign particles are observed.

6. Administer the diluted solution over a period of at least one hour.

7. Use only an infusion set with an in-line, sterile, non-pyrogenic, low protein-binding filter (pore size 0.2 micrometer).

8. Do not infuse STELARA concomitantly in the same intravenous line with other agents.

9. Each vial is for single use only and any unused medicinal product should be disposed of in accordance with local requirements.

OVERDOSAGE

Single doses up to 6 mg/kg intravenously have been administered in clinical studies without dose-limiting toxicity. In case of overdosage, it is recommended that the patient be monitored for any signs or symptoms of adverse reactions or effects and appropriate symptomatic treatment be instituted immediately. Contact the Poisons Information Centre on 13 11 26 for advice on management of overdose.

PRESENTATION AND ATORAGE CONDITIONS

For subcutaneous administration

STELARA is supplied as a sterile solution in a single-use (Type 1) glass vial. The vial is stoppered with a coated stopper.

STELARA is also supplied as a single-use, sterile solution in a Type 1 glass syringe with a fixed 27G, half-inch needle and needle cover. The needle cover is manufactured using a dry natural rubber containing latex (see PRECAUTIONS). The syringe is fitted with a passive safety guard.

The solution is clear to slightly opalescent, colourless to light yellow with a pH of approximately 6.0. STELARA does not contain preservatives.

There are two strengths of STELARA available: 45 mg of ustekinumab (rmc) in 0.5 mL, or 90 mg of ustekinumab (rmc) in 1.0 mL (the 90 mg vial, 45 mg pre-filled syringe and 90 mg pre-filled syringe are not currently marketed).

STELARA is available in packs of:

- · 1 single use vial (45 mg)

Store at 2°C to 8°C. Refrigerate. Do not freeze.

Protect from light by storing in original carton until time of use. Do not shake.

For intravenous infusion only

STELARA 130 mg vial is supplied as a sterile solution in a single-use (Type 1) glass vial. The vial is stoppered with a coated stopper.

The solution is clear, colorless to light yellow with a pH of approximately 6.0. STELARA does not contain preservatives.

STELARA is available for intravenous infusion in one strength, 130 mg in 26 mL, and packaged as 1 single use vial. Product is for single use in one patient only. Discard any residue.

Store at 2°C to 8°C. Refrigerate. Do not freeze.

Protect from light by storing in original carton until time of use. Do not shake.

If necessary, the diluted infusion solution may be stored for up to four hours at room temperature. Do not freeze. Discard any unused portion of the infusion solution.

NAME AND ADDRESS OF THE SPONSOR

Janssen-Cilag Pty Ltd,

1-5 Khartoum Road,

Macquarie Park NSW 2113.

POISON SCHEDULE OF THE MEDICINE

Prescription Only Medicine

DATE OF APPROVAL

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