NEW DRUG APPROVAL

Brand Name	Amjevita™
Generic Name	adalimumab-atto
Drug Manufacturer	Amgen Inc

New Drug Approval

FDA Approval Date: September 23, 2016

Review Designation: N/A

Type of review: Biologic License Application (BLA): 761024

Dispensing restriction: N/A

Place in Therapy

DISEASE DESCRIPTION & EPIDEMIOLOGY

Rheumatoid arthritis: Rheumatoid arthritis is a chronic autoimmune disease characterized by an inflammatory polyarthritis that preferentially affects the small joints. RA is a "multicausal" disease that most likely results from a combination of genetic predisposition and various environmental and lifestyle factors. Articular and systemic manifestations in RA can lead to poor long-term outcomes such as disability and death.

Rheumatoid arthritis is estimated to affect approximately 0.24 to 1 percent of the population and to be twice as common in women compared with men.

The worldwide prevalence of RA has been estimated as 0.24 percent based upon the Global Burden of Disease 2010 Study. Estimates of RA prevalence in the United States and northern European countries are typically higher, usually between 0.5 to 1 percent. The annual incidence of RA in the United States and northern European countries is estimated to be approximately 40 per 100,000 persons. Most epidemiologic studies of RA have been conducted in United States or northern European populations. As a result, epidemiologic estimates of RA and identification of risk factors come largely from these populations. The incidence and prevalence of RA is much greater in some populations, such as in the Pima Native Americans, where rates are up to 10 times higher than those of most population groups.

Juvenile Idiopathic Arthritis: Juvenile idiopathic arthritis is a chronic idiopathic inflammatory disorder primarily involving joints.

As per Rochester Epidemiology Program Project database, which were based on American College of Rheumatology (ACR; formerly the American Rheumatism Association [ARA]) classification criteria, the incidence of 13.9 cases of juvenile rheumatoid arthritis (JRA) per 100,000 per year was reported. A follow-up study utilizing the same database noted a decrease in incidence over a subsequent decade. In the Rochester study, the prevalence rate for JRA was 94 patients per 100,000 children on January 1, 1980 and 86 on January 1, 1990. An extrapolation to the entire United States population under 16 years of age in the year 2000 suggests that there must be 70,000 to 100,000 cases of JRA (active and inactive). However, the population in the Rochester study was predominantly White. The actual prevalence in the total United States population is probably much lower (15,000 to 36,000 in some estimates because JRA appears to be less common in African American and Asian American populations.

Psoriatic arthritis: Psoriatic arthritis is an inflammatory musculoskeletal disease associated with psoriasis that was initially considered a variant of rheumatoid arthritis, but subsequently emerged as a distinct clinical entity.

A number of studies have examined prevalence of PsA in countries all over the world. Prevalence estimates in the United States range from 0.06–0.25% with the lowest estimate derived from a paper that utilized International

Classification of Disease ninth edition (ICD-9) codes to identify cases and the highest from articles using patient self-report of diagnosis of PsA.

Psoriatic arthritis affects females and males equally, with an incidence of approximately 6 per 100,000 per year and a prevalence of approximately 1 to 2 per 1000 in the general population.

Plaque psoriasis: Plaque psoriasis is the most common form of psoriasis. About 80 to 90 percent of people living with psoriasis experience plaque psoriasis.

According to current studies, more than 8 million Americans have psoriasis. About 80 to 90 percent of people living with psoriasis experience plaque psoriasis. An estimated 30 percent of people with psoriasis also develop psoriatic arthritis.

Ankylosing Spondylitis: Ankylosing spondylitis is a chronic inflammatory disease-causing axial arthritis, frequently resulting in inflammatory low back pain early in the disease course, with eventual severe impairment of spinal mobility due to structural changes ultimately leading to spinal fusion.

Recent population estimates indicate that the prevalence of AS in the United States is approximately 0.2-0.5%. Based on data from multiple countries, the age- and sex-adjusted incidence of AS is 0.4-14 per 100,000 person-years. Prevalence of AS in the population increases to approximately 5% among patients who are HLA-B27 positive. AS occurs more frequently in men than women (2:1). Age of disease onset usually peaks in the second and third decades of life. Approximately 80% of patients with AS experience symptoms at ≤ 30 years of age, while only 5% will present with symptoms at ≥ 45 years of age.

Crohn's Disease and Ulcerative Colitis: Crohn's disease and ulcerative colitis, collectively known as inflammatory bowel disease, are characterized by chronic inflammation of the gastrointestinal tract. Inflammatory bowel disease has been associated with decreased quality of life and extensive morbidity and often results in complications requiring hospitalizations and surgical procedures. In 1999, an estimated 1.8 million (0.9%) U.S. adults had inflammatory bowel disease.

Crohn's Disease: Crohn's disease can affect any part of the GI tract, from the mouth to the anus. It most commonly affects the end of the small intestine (the ileum) where it joins the beginning of the colon. Crohn's disease may appear in "patches," affecting some areas of the GI tract while leaving other sections completely untouched. In Crohn's disease, the inflammation may extend through the entire thickness of the bowel wall.

Ulcerative Colitis: Ulcerative colitis is limited to the large intestine (colon) and the rectum. The inflammation occurs only in the innermost layer of the lining of the intestine. It usually begins in the rectum and lower colon, but may also spread continuously to involve the entire colon.

Differences in IBD prevalence among a number of sociodemographic subgroups reveal that prevalence is not uniform across the U.S. adult population. Consistent with past research that found the prevalence of both Crohn's disease and ulcerative colitis increase with age, a higher prevalence of IBD was found among adults aged ≥ 45 years in this nationally representative population. Furthermore, a significantly higher prevalence of IBD among non-Hispanic whites was found, consistent with racial/ethnic differences previously reported using 1999 NHIS data.

Efficacy

Rheumatoid Arthritis

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

in combination with methotrexate (MTX) (12.5 to 25 mg, Studies RA-I, RA-III and RA-V) or as monotherapy (Studies RA-II and RA-V) or with other disease-modifying anti-rheumatic drugs (DMARDs) (Study RA-IV).

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

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

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

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

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

Clinical Response

The percent of adalimumab treated patients achieving ACR 20, 50 and 70 responses in Studies RA-II and III are shown in Table 1.

Table 1. ACR Responses in Studies RA-II and RA-III (Percent of Patients)

	Study RA-II Monotherapy (26 weeks)			Study RA-III Methotrexate Combination (24 and 52 weeks)	
Response	**Placebo**	**Adalimumab**	**Adalimumab**	**Placebo/MTX**	**Adalimumab/MTX**
		40 mg every other week	40 mg weekly		40 mg every other week
	N = 110	N = 113	N = 103	N = 200	N = 207
ACR20					
Month 6	19%	46%*	53%*	30%	63%*
Month 12	NA	NA	NA	24%	59%*
ACR50					
Month 6	8%	22%*	35%*	10%	39%*

Table 1. ACR Responses in Studies RA-II and RA-III (Percent of Patients)					
	Study RA-II Monotherapy (26 weeks)			Study RA-III Methotrexate Combination (24 and 52 weeks)	
Response	**Placebo**	**Adalimumab**	**Adalimumab**	**Placebo/MTX**	**Adalimumab/MTX**
Month 12	NA	NA	NA	10%	42%*
ACR70					
Month 6	2%	12%*	18%*	3%	21%*
Month 12	NA	NA	NA	5%	23%*
* $p < 0.01$, adalimumab *vs.* placebo					

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

The results of the components of the ACR response criteria for Studies RA-II and RA-III are shown in Table 4. ACR response rates and improvement in all components of ACR response were maintained to week 104. Over the 2 years in Study RA-III, 20% of adalimumab patients receiving 40 mg every other week achieved a major clinical response, defined as maintenance of an ACR 70 response over a 6-month period. ACR responses were maintained in similar proportions of patients for up to 5 years with continuous adalimumab treatment in the open-label portion of Study RA-III.

Table 2. Components of ACR Response in Studies RA-II and RA-III								
	Study RA-II				Study RA-III			
Parameter (median)	**Placebo N = 110**		**Adalimumab[a] N = 113**		**Placebo/MTX N = 200**		**Adalimumab[a]/MTX N = 207**	
	Baseline	**Wk 26**	**Baseline**	**Wk 26**	**Baseline**	**Wk 24**	**Baseline**	**Wk 24**
Number of tender joints (0-68)	35	26	31	16*	26	15	24	8*
Number of swollen joints (0-66)	19	16	18	10*	17	11	18	5*
Physician global assessment[b]	7.0	6.1	6.6	3.7*	6.3	3.5	6.5	2.0*
Patient global assessment[b]	7.5	6.3	7.5	4.5*	5.4	3.9	5.2	2.0*

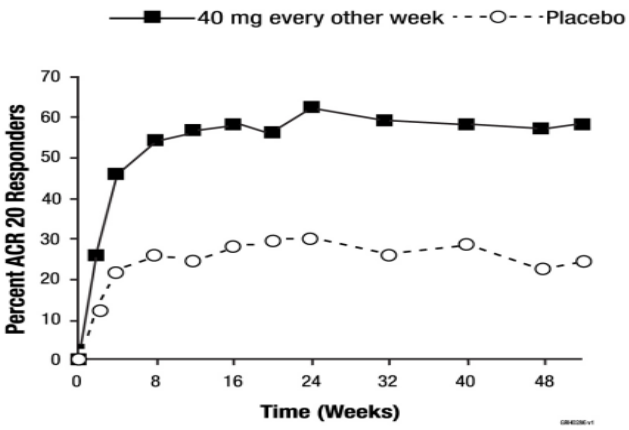
Table 2. Components of ACR Response in Studies RA-II and RA-III								
	Study RA-II				Study RA-III			
Parameter (median)	Placebo N = 110		Adalimumab[a] N = 113		Placebo/MTX N = 200		Adalimumab[a]/MTX N = 207	
Pain[b]	7.3	6.1	7.3	4.1*	6.0	3.8	5.8	2.1*
Disability index (HAQ)[c]	2.0	1.9	1.9	1.5*	1.5	1.3	1.5	0.8*
CRP (mg/dL)	3.9	4.3	4.6	1.8*	1.0	0.9	1.0	0.4*

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

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

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

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



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

In Study RA-V with MTX naïve patients with recent onset RA, the combination treatment with adalimumab plus MTX led to greater percentages of patients achieving ACR responses than either MTX monotherapy or adalimumab monotherapy at Week 52 and responses were sustained at Week 104 (See table 3).

Table 3. ACR Response in Study RA-V (Percent of Patients)			
Response	**MTX[b] N = 257**	**Adalimumab[c] N = 274**	**Adalimumab/MTX N = 268**
ACR20			
Week 52	63%	54%	73%
Week 104	56%	49%	69%
ACR50			
Week 52	46%	41%	62%
Week 104	43%	37%	59%
ACR70			
Week 52	27%	26%	46%
Week 104	28%	28%	47%
Major Clinical Response[a]	28%	25%	49%

[a] Major clinical response is defined as achieving an ACR 70 response for a continuous six-month period

[b] $p < 0.05$, Adalimumab/MTX *vs.* MTX for ACR 20
$p < 0.001$, Adalimumab/MTX *vs.* MTX for ACR 50 and 70, and Major Clinical Response

[c] $p < 0.001$, Adalimumab/MTX *vs.* Adalimumab

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

Radiographic Response

In Study RA-III, structural joint damage was assessed radiographically and expressed as change in Total Sharp Score (TSS) and its components, the erosion score and Joint Space Narrowing (JSN) score, at month 12 compared to baseline. At baseline, the median TSS was approximately 55 in the placebo and 40 mg every other week groups. The results are shown in Table 4. Adalimumab/MTX treated patients demonstrated less radiographic progression than patients receiving MTX alone at 52 weeks.

Table 4. Radiographic Mean Changes Over 12 Months in Study RA-III				
	Placebo/ MTX	**Adalimumab/ MTX 40 mg every other week**	**Placebo/MTX-Adalimumab/MTX (95% Confidence Interval*)**	**P-value****
Total Sharp score	2.7	0.1	2.6 (1.4, 3.8)	< 0.001
Erosion score	1.6	0.0	1.6 (0.9, 2.2)	< 0.001
JSN score	1.0	0.1	0.9 (0.3, 1.4)	0.002

* 95% confidence intervals for the differences in change scores between MTX and adalimumab.
** Based on rank analysis

In the open-label extension of Study RA-III, 77% of the original patients treated with any dose of adalimumab were evaluated radiographically at 2 years. Patients maintained inhibition of structural damage, as measured by the TSS. Fifty-four percent (54%) had no progression of structural damage as defined by a change in the TSS of zero or less. Fifty-five percent (55%) of patients originally treated with 40 mg adalimumab every other week have been evaluated radiographically at 5 years. Patients had continued inhibition of structural damage with 50% showing no progression of structural damage defined by a change in the TSS of zero or less.

In Study RA-V, structural joint damage was assessed as in Study RA-III. Greater inhibition of radiographic progression, as assessed by changes in TSS, erosion score and JSN was observed in the adalimumab/MTX combination group as compared to either the MTX or adalimumab monotherapy group at Week 52 as well as at Week 104 (See table 5).

Table 5. Radiographic Mean Change* in Study RA-V

		MTX[a] N = 257	Adalimumab[a,b] N = 274	Adalimumab/MTX N = 268
52 Weeks	Total Sharp score	5.7 (4.2, 7.3)	3.0 (1.7, 4.3)	1.3 (0.5, 2.1)
	Erosion score	3.7 (2.7, 4.8)	1.7 (1.0, 2.4)	0.8 (0.4, 1.2)
	JSN score	2.0 (1.2, 2.8)	1.3 (0.5, 2.1)	0.5 (0.0, 1.0)
104 Weeks	Total Sharp score	10.4 (7.7, 13.2)	5.5 (3.6, 7.4)	1.9 (0.9, 2.9)
	Erosion score	6.4 (4.6, 8.2)	3.0 (2.0, 4.0)	1.0 (0.4, 1.6)
	JSN score	4.1 (2.7, 5.4)	2.6 (1.5, 3.7)	0.9 (0.3, 1.5)

* mean (95% confidence interval)

[a] $p < 0.001$, adalimumab/MTX *vs.* MTX at 52 and 104 weeks and for adalimumab /MTX *vs.* adalimumab at 104 weeks

[b] $p < 0.01$, for adalimumab/MTX *vs.* adalimumab at 52 weeks

Physical Function Response

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

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

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

Juvenile Idiopathic Arthritis

The safety and efficacy of adalimumab was assessed in two studies (Studies JIA-I and JIA-II) in patients with active polyarticular juvenile idiopathic arthritis (JIA).

Study JIA-I

The safety and efficacy of adalimumab were assessed in a multicenter, randomized, withdrawal, double-blind, parallel-group study in 171 patients who were 4 to 17 years of age with polyarticular JIA. In the study, the patients were stratified into two groups: MTX-treated or non-MTX-treated. All patients had to show signs of active moderate or severe disease despite previous treatment with NSAIDs, analgesics, corticosteroids, or DMARDs. Patients who received prior treatment with any biologic DMARDs were excluded from the study.

The study included four phases: an open-label lead in phase (OL-LI; 16 weeks), a double-blind randomized withdrawal phase (DB; 32 weeks), an open-label extension phase (OLE-BSA; up to 136 weeks), and an open-label fixed dose phase (OLE-FD; 16 weeks). In the first three phases of the study, adalimumab was administered based on body surface area at a dose of 24 mg/m2 up to a maximum total body dose of 40 mg subcutaneously (SC) every other week. In the OLE-FD phase, the patients were treated with 20 mg of adalimumab SC every other week if their weight was less than 30 kg and with 40 mg of adalimumab SC every other week if their weight was 30 kg or greater. Patients remained on stable doses of NSAIDs and or prednisone (≤ 0.2 mg/kg/day or 10 mg/day maximum).

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

Study JIA-I Clinical Response

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

Study JIA-II

Adalimumab was assessed in an open-label, multicenter study in 32 patients who were 2 to < 4 years of age or 4 years of age and older weighing < 15 kg with moderately to severely active polyarticular JIA. Most patients (97%) received at least 24 weeks of adalimumab treatment dosed 24 mg/m2 up to a maximum of 20 mg every other week as a single SC injection up to a maximum of 120 weeks duration. During the study, most patients used concomitant MTX, with fewer reporting use of corticosteroids or NSAIDs. The primary objective of the study was evaluation of safety.

Psoriatic Arthritis

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

Study PsA-I enrolled 313 adult patients with moderately to severely active PsA (> 3 swollen and > 3 tender joints) who had an inadequate response to NSAID therapy in one of the following forms: (1) distal interphalangeal (DIP) involvement (N = 23); (2) polyarticular arthritis (absence of rheumatoid nodules and presence of plaque psoriasis) (N = 210); (3) arthritis mutilans (N = 1); (4) asymmetric PsA (N = 77); or (5) AS-like (N = 2). Patients on MTX therapy (158 of 313 patients) at enrollment (stable dose of ≤ 30 mg/week for > 1 month) could continue MTX at the same dose. Doses of adalimumab 40 mg or placebo every other week were administered during the 24-week double-blind period of the study.

Compared to placebo, treatment with adalimumab resulted in improvements in the measures of disease activity (see Tables 8 and 9). Among patients with PsA who received adalimumab, the clinical responses were apparent in some patients at the time of the first visit (two weeks) and were maintained up to 88 weeks in the ongoing open-label study. Similar responses were seen in patients with each of the subtypes of psoriatic arthritis, although few patients were enrolled with the arthritis mutilans and ankylosing spondylitis-like subtypes. Responses were similar in patients who were or were not receiving concomitant MTX therapy at baseline.

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

Table 6. ACR Response in Study PsA-I (Percent of Patients)

	Placebo N = 162	Adalimumab* N = 151
ACR 20		
Week 12	14%	58%
Week 24	15%	57%
ACR 50		
Week 12	4%	36%
Week 24	6%	39%
ACR 70		
Week 12	1%	20%
Week 24	1%	23%
* $p < 0.001$ for all comparisons between adalimumab and placebo		

Table 7. Components of Disease Activity in Study PsA-I

	Placebo N = 162		Adalimumab* N = 151	
Parameter: median	Baseline	24 weeks	Baseline	24 weeks

Table 7. Components of Disease Activity in Study PsA-I				
	Placebo N = 162		Adalimumab* N = 151	
Number of tender joints[a]	23.0	17.0	20.0	5.0
Number of swollen joints[b]	11.0	9.0	11.0	3.0
Physician global assessment[c]	53.0	49.0	55.0	16.0
Patient global assessment[c]	49.5	49.0	48.0	20.0
Pain[c]	49.0	49.0	54.0	20.0
Disability index (HAQ)[d]	1.0	0.9	1.0	0.4
CRP (mg/dL)[e]	0.8	0.7	0.8	0.2

* $p < 0.001$ for adalimumab *vs.* placebo comparisons based on median changes
[a] Scale 0-78
[b] Scale 0-76
[c] Visual analog scale; 0 = best, 100 = worst
[d] 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
[e] Normal range: 0-0.287 mg/dL

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

Radiographic Response

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

Adalimumab-treated patients demonstrated greater inhibition of radiographic progression compared to placebo-treated patients and this effect was maintained at 48 weeks (see Table 8).

Table 8. Change in Modified Total Sharp Score in Psoriatic Arthritis			
	Placebo N = 141	Adalimumab N = 133	
	Week 24	Week 24	Week 48
Baseline mean	22.1	23.4	23.4
Mean Change ± SD	0.9 ± 3.1	-0.1 ± 1.7	* -0.2 ± 4.9

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

Physical Function Response

In Study PsA-I, physical function and disability were assessed using the HAQ Disability Index (HAQ-DI) and the SF-36 Health Survey. Patients treated with 40 mg of adalimumab every other week showed greater improvement from baseline in the HAQ-DI score (mean decreases of 47% and 49% at Weeks 12 and 24, respectively) in comparison to placebo (mean decreases of 1% and 3% at Weeks 12 and 24, respectively). At Weeks 12 and 24, patients treated with adalimumab showed greater improvement from baseline in the SF-36 Physical Component Summary score compared to patients treated with placebo, and no worsening in the SF-36 Mental Component Summary score. Improvement in physical function based on the HAQ-DI was maintained for up to 84 weeks through the open-label portion of the study.

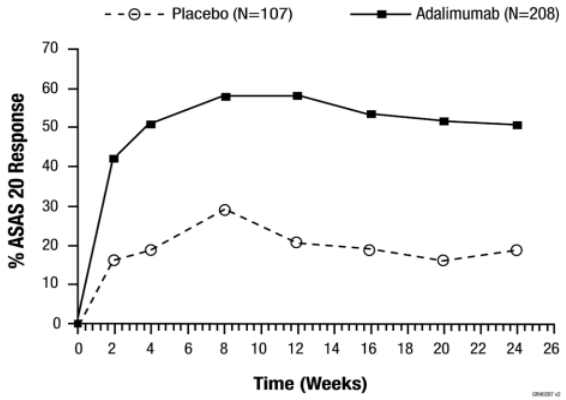
Ankylosing Spondylitis

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

Improvement in measures of disease activity was first observed at Week 2 and maintained through 24 weeks as shown in Figure 2 and Table 9.

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

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



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

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

Table 9. Components of Ankylosing Spondylitis Disease Activity				
	Placebo N = 107		Adalimumab N = 208	
	Baseline mean	Week 24 mean	Baseline mean	Week 24 mean
ASAS 20 Response Criteria*				
Patient's Global Assessment of Disease Activity[a]*	65	60	63	38
Total back pain*	67	58	65	37
Inflammation[b*]	6.7	5.6	6.7	3.6
BASFI[c*]	56	51	52	34
BASDAI[d] score*	6.3	5.5	6.3	3.7
BASMI[e] score*	4.2	4.1	3.8	3.3
Tragus to wall (cm)	15.9	15.8	15.8	15.4
Lumbar flexion (cm)	4.1	4.0	4.2	4.4
Cervical rotation (degrees)	42.2	42.1	48.4	51.6
Lumbar side flexion (cm)	8.9	9.0	9.7	11.7
Intermalleolar distance (cm)	92.9	94.0	93.5	100.8
CRP[f]*	2.2	2.0	1.8	0.6

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

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

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

Adult Crohn's Disease

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

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

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

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

Induction of Clinical Remission

A greater percentage of the patients treated with 160/80 mg adalimumab achieved induction of clinical remission versus placebo at Week 4 regardless of whether the patients were TNF-blocker naïve (CD-I), or had lost response to or were intolerant to infliximab (CD-II) (See table 10)

Table 10. Induction of Clinical Remission in Studies CD-I and CD-II (Percent of Patients)

	CD-I		CD-II	
	Placebo N = 74	**Adalimumab 160/80 mg N = 76**	**Placebo N = 166**	**Adalimumab 160/80 mg N = 159**
Week 4				
Clinical remission	12%	36%*	7%	21%*
Clinical response	34%	58%**	34%	52%**

Clinical remission is CDAI score < 150; clinical response is decrease in CDAI of at least 70 points.
* $p < 0.001$ for adalimumab *vs.* placebo pairwise comparison of proportions
** $p < 0.01$ for adalimumab *vs.* placebo pairwise comparison of proportions

Maintenance of Clinical Remission

In Study CD-III at Week 4, 58% (499/854) of patients were in clinical response and were assessed in the primary analysis. At Weeks 26 and 56, greater proportions of patients who were in clinical response at Week 4 achieved clinical remission in the adalimumab 40 mg every other week maintenance group compared to patients in the placebo maintenance group (see Table 11). The group that received adalimumab therapy every week did not demonstrate significantly higher remission rates compared to the group that received adalimumab every other week.

Table 11. Maintenance of Clinical Remission in CD-III (Percent of Patients)

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

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

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

Pediatric Crohn's Disease

A randomized, double-blind, 52-week clinical study of 2 dose concentrations of adalimumab (Study PCD-I) was conducted in 192 pediatric patients (6 to 17 years of age) with moderately to severely active Crohn's disease (defined as Pediatric Crohn's Disease Activity Index (PCDAI) score > 30). Enrolled patients had over the previous two-year period an inadequate response to corticosteroids or an immunomodulator (i.e., azathioprine, 6-mercaptopurine, or methotrexate). Patients who had previously received a TNF-blocker were allowed to enroll if they had previously had loss of response or intolerance to that TNF-blocker.

Patients received open-label induction therapy at a dose based on their body weight (≥ 40 kg and < 40 kg). Patients weighing ≥ 40 kg received 160 mg (at Week 0) and 80 mg (at Week 2). Patients weighing < 40 kg received 80 mg (at Week 0) and 40 mg (at Week 2). At Week 4, patients within each body weight category (≥ 40 kg and < 40 kg) were randomized 1:1 to one of two maintenance dose regimens (high dose and low dose). The high dose was 40 mg every other week for patients weighing ≥ 40 kg and 20 mg every other week for patients weighing < 40 kg. The low dose was 20 mg every other week for patients weighing ≥ 40 kg and 10 mg every other week for patients weighing < 40 kg.

Concomitant stable dosages of corticosteroids (prednisone dosage ≤ 40 mg/day or equivalent) and immunomodulators (azathioprine, 6-mercaptopurine, or methotrexate) were permitted throughout the study.

At Week 12, patients who experienced a disease flare (increase in PCDAI of ≥ 15 from Week 4 and absolute

PCDAI > 30) or who were non-responders (did not achieve a decrease in the PCDAI of ≥ 15 from baseline for 2 consecutive visits at least 2 weeks apart) were allowed to dose-escalate (i.e., switch from blinded every other week dosing to blinded every week dosing); patients who dose-escalated were considered treatment failures.

At baseline, 38% of patients were receiving corticosteroids, and 62% of patients were receiving an immunomodulator. Forty-four percent (44%) of patients had previously lost response or were intolerant to a TNF-blocker. The median baseline PCDAI score was 40.

Of the 192 patients total, 188 patients completed the 4-week induction period, 152 patients completed 26 weeks of treatment, and 124 patients completed 52 weeks of treatment. Fifty-one percent (51%) (48/95) of patients in the low maintenance dose group dose-escalated, and 38% (35/93) of patients in the high maintenance dose group dose-escalated.

At Week 4, 28% (52/188) of patients were in clinical remission (defined as PCDAI ≤ 10).

The proportions of patients in clinical remission (defined as PCDAI ≤ 10) and clinical response (defined as reduction in PCDAI of at least 15 points from baseline) were assessed at Weeks 26 and 52.

At both Weeks 26 and 52, the proportion of patients in clinical remission and clinical response was numerically higher in the high dose group compared to the low dose group (see Table 12). The recommended maintenance regimen is 20 mg every other week for patients weighing < 40 kg and 40 mg every other week for patients weighing ≥ 40 kg. Every week dosing is not the recommended maintenance dosing regimen.

Table 12. Clinical Remission and Clinical Response in Study PCD-I

	Low Maintenance Dose† (20 or 10 mg every other week) N = 95	High Maintenance Dose# (40 or 20 mg every other week) N = 93
Week 26		
Clinical remission‡	28%	39%
Clinical response§	48%	59%
Week 52		
Clinical remission‡	23%	33%
Clinical response§	28%	42%

† The low maintenance dose was 20 mg every other week for patients weighing ≥ 40 kg and 10 mg every other week for patients weighing < 40 kg.
# The high maintenance dose was 40 mg every other week for patients weighing ≥ 40 kg and 20 mg every other week for patients weighing < 40 kg.
‡ Clinical remission defined as PCDAI ≤ 10.
§ Clinical response defined as reduction in PCDAI of at least 15 points from baseline.

Adult Ulcerative Colitis

The safety and efficacy of adalimumab were assessed in adult patients with moderately to severely active ulcerative colitis (Mayo score 6 to 12 on a 12-point scale, with an endoscopy subscore of 2 to 3 on a scale of 0 to 3) despite concurrent or prior treatment with immunosuppressants such as corticosteroids, azathioprine, or 6-MP in two randomized, double-blind, placebo-controlled clinical studies (Studies UC-I and UC-II). Both studies enrolled

TNF-blocker naïve patients, but Study UC-II also allowed entry of patients who lost response to or were intolerant to TNF-blockers. Forty percent (40%) of patients enrolled in Study UC-II had previously used another TNF-blocker.

Concomitant stable doses of aminosalicylates and immunosuppressants were permitted. In Studies UC-I and II, patients were receiving aminosalicylates (69%), corticosteroids (59%) and/or azathioprine or 6-MP (37%) at baseline. In both studies, 92% of patients received at least one of these medications.

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

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

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

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

Table 13. Induction of Clinical Remission in Studies UC-I and UC-II and Sustained Clinical Remission in Study UC-II (Percent of Patients)

	Study UC-I			Study UC-II		
	Placebo N = 130	**Adalimumab 160/80 mg N = 130**	**Treatment Difference (95% CI)**	**Placebo N = 246**	**Adalimumab 160/80 mg N = 248**	**Treatment Difference (95% CI)**
Induction of Clinical Remission (Clinical Remission at Week 8)	9.2%	18.5%	9.3%* (0.9%, 17.6%)	9.3%	16.5%	7.2%* (1.2%, 12.9%)
Sustained Clinical Remission (Clinical Remission at both Weeks 8 and 52)	N/A	N/A	N/A	4.1%	8.5%	4.4%* (0.1%, 8.6%)

Clinical remission is defined as Mayo score ≤ 2 with no individual subscores > 1.
CI = Confidence interval
* $p < 0.05$ for adalimumab *vs.* placebo pairwise comparison of proportions

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

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

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

Plaque Psoriasis

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

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

Study Ps-II evaluated 99 subjects randomized to adalimumab and 48 subjects randomized to placebo with chronic plaque psoriasis with ≥ 10% BSA involvement and PASI ≥ 12. Subjects received placebo, or an initial dose of 80 mg adalimumab at Week 0 followed by 40 mg every other week starting at Week 1 for 16 weeks. Across all treatment groups the mean baseline PASI score was 21 and the baseline PGA score ranged from "moderate" (41%) to "severe" (51%) to "very severe" (8%).

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

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

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

	Adalimumab 40 mg every other week	Placebo
	N = 814	**N = 398**
PGA: Clear or minimal*	506 (62%)	17 (4%)

PASI 75	578 (71%)	26 (7%)
* Clear = no plaque elevation, no scale, plus or minus hyperpigmentation or diffuse pink or red coloration Minimal = possible but difficult to ascertain whether there is slight elevation of plaque above normal skin, plus or minus surface dryness with some white coloration, plus or minus up to red coloration		

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

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

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

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

A randomized, double-blind study (Study Ps-III) compared the efficacy and safety of adalimumab versus placebo in 217 adult subjects. Subjects in the study had to have chronic plaque psoriasis of at least moderate severity on the PGA scale, fingernail involvement of at least moderate severity on a 5-point Physician's Global Assessment of Fingernail Psoriasis (PGA-F) scale, a Modified Nail Psoriasis Severity Index (mNAPSI) score for the target-fingernail of ≥ 8, and either a BSA involvement of at least 10% or a BSA involvement of at least 5% with a total mNAPSI score for all fingernails of ≥ 20. Subjects received an initial dose of 80 mg adalimumab followed by 40 mg every other week (starting one week after the initial dose) or placebo for 26 weeks followed by open-label adalimumab treatment for an additional 26 weeks. This study evaluated the proportion of subjects who achieved "clear" or "minimal" assessment with at least a 2-grade improvement on the PGA-F scale and the proportion of subjects who achieved at least a 75% improvement from baseline in the mNAPSI score (mNAPSI 75) at Week 26.

At Week 26, a higher proportion of subjects in the adalimumab group than in the placebo group achieved the PGA-F endpoint. Furthermore, a higher proportion of subjects in the adalimumab group than in the placebo group achieved mNAPSI 75 at Week 26 (see Table 16).

Table 16. Efficacy Results at 26 Weeks

Endpoint	Adalimumab 40 mg every other week* N = 109	Placebo N = 108
PGA-F: ≥ 2-grade improvement and clear or minimal	49%	7%
mNAPSI 75	47%	3%
* Subjects received 80 mg of adalimumab at Week 0, followed by 40 mg every other week starting at Week 1.		

Nail pain was also evaluated and improvement in nail pain was observed in Study Ps-III.

Most common adverse reactions (> 10%): infections (e.g., upper respiratory, sinusitis), injection site reactions, headache and rash.

Safety

ADVERSE EVENTS

The most common adverse reaction with adalimumab was injection site reactions. In placebo- controlled trials, 20% of patients treated with adalimumab developed injection site reactions (erythema and/or itching, hemorrhage, pain or swelling), compared to 14% of patients receiving placebo. Most injection site reactions were described as mild and generally did not necessitate drug discontinuation. The proportion of patients who discontinued treatment due to adverse reactions during the double-blind, placebo-controlled portion of studies in patients with RA (i.e., Studies RA-I, RA- II, RA-III and RA-IV) was 7% for patients taking adalimumab and 4% for placebo-treated patients. The most common adverse reactions leading to discontinuation of adalimumab in these RA studies were clinical flare reaction (0.7%), rash (0.3%) and pneumonia (0.3%).

Infections: In the controlled portions of the 39 global adalimumab clinical trials in adult patients with RA, PsA, AS, CD, UC, Ps, and other indications the rate of serious infections was 4.3 per 100 patient years in 7973 adalimumab-treated patients versus a rate of 2.9 per 100 patient-years in 4848 control-treated patients. Serious infections observed included pneumonia, septic arthritis, prosthetic and post- surgical infections, erysipelas, cellulitis, diverticulitis, and pyelonephritis.

Tuberculosis and Opportunistic Infections: In 52 global controlled and uncontrolled clinical trials in RA, PsA, AS, CD, UC, Ps, and other indications that included 24,605 adalimumab-treated patients, the rate of reported active tuberculosis was 0.20 per 100 patient-years and the rate of positive PPD conversion was 0.09 per 100 patient-years. In a subgroup of 10,113 U.S. and Canadian adalimumab-treated patients, the rate of reported active TB was 0.05 per 100 patient-years and the rate of positive PPD conversion was 0.07 per 100 patient-years. These trials included reports of miliary, lymphatic, peritoneal, and pulmonary TB. Most of the TB cases occurred within the first eight months after initiation of therapy and may reflect recrudescence of latent disease. In these global clinical trials, cases of serious opportunistic infections have been reported at an overall rate of 0.05 per 100 patient-years. Some cases of serious opportunistic infections and TB have been fatal.

Autoantibodies: In the rheumatoid arthritis-controlled trials, 12% of patients treated with adalimumab and 7% of placebo-treated patients that had negative baseline ANA titers developed positive titers at week 24. The impact of long-term treatment with adalimumab products on the development of autoimmune diseases is unknown.

Liver Enzyme Elevations: There have been reports of severe hepatic reactions including acute liver failure in patients receiving TNF-blockers. In controlled Phase 3 trials of adalimumab (40 mg subcutaneously every other week) in patients with RA, PsA, and AS with control period duration ranging from 4 to 104 weeks, ALT elevations ≥ 3 x ULN occurred in 3.5% of adalimumab-treated patients and 1.5% of control- treated patients. Since many of these patients in these trials were also taking medications that cause liver enzyme elevations (e.g., NSAIDS, MTX), the relationship between adalimumab and the liver enzyme elevations is not clear. In a controlled Phase 3 trial of

adalimumab in patients with polyarticular JIA who were 4 to 17 years, ALT elevations ≥ 3 x ULN occurred in 4.4% of adalimumab-treated patients and 1.5% of control-treated patients (ALT more common than AST); liver enzyme test elevations were more frequent among those treated with the combination of adalimumab and MTX than those treated with adalimumab alone. In general, these elevations did not lead to discontinuation of adalimumab treatment. No ALT elevations ≥ 3 x ULN occurred in the open-label study of adalimumab in patients with polyarticular JIA who were 2 to <4 years.

In controlled Phase 3 trials of adalimumab (initial doses of 160 mg and 80 mg, or 80 mg and 40 mg on Days 1 and 15, respectively, followed by 40 mg every other week) in adult patients with Crohn's Disease with a control period duration ranging from 4 to 52 weeks, ALT elevations ≥ 3 x ULN occurred in 0.9% of adalimumab-treated patients and 0.9% of control-treated patients. In the Phase 3 trial of adalimumab in pediatric patients with Crohn's disease which evaluated efficacy and safety of two body weight-based maintenance dose regimens following body weight based induction therapy up to 52 weeks of treatment, ALT elevations ≥ 3 x ULN occurred in 2.6% (5/192) of patients, of whom 4 were receiving concomitant immunosuppressants at baseline; none of these patients discontinued due to abnormalities in ALT tests. In controlled Phase 3 trials of adalimumab (initial doses of 160 mg and 80 mg on Days 1 and 15 respectively, followed by 40 mg every other week) in adult patients with UC with control period duration ranging from 1 to 52 weeks, ALT elevations ≥3 x ULN occurred in 1.5% of adalimumab-treated patients and 1.0% of control-treated patients. In controlled Phase 3 trials of adalimumab (initial dose of 80 mg then 40 mg every other week) in patients with Ps with control period duration ranging from 12 to 24 weeks, ALT elevations ≥ 3 x ULN occurred in 1.8% of adalimumab-treated patients and 1.8% of control-treated patients.

Other Adverse Reactions

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

Table 17 summarizes reactions reported at a rate of at least 5% in patients treated with adalimumab 40 mg every other week compared to placebo and with an incidence higher than placebo. In Study RA-III, the types and frequencies of adverse reactions in the second year open-label extension were similar to those observed in the one-year double-blind portion

Table 17. Adverse Reactions Reported by ≥5% of Patients Treated with Adalimumab during Placebo-Controlled Period of Pooled RA Studies (Studies RA-I, RA-II, RA-III, and RA-IV)

	Adalimumab 40 mg subcutaneously Every Other Week	Placebo
	(N=705)	(N=690)
Adverse Reaction (Preferred Term)		
Respiratory		
Upper respiratory infection	17%	13%
Sinusitis	11%	9%

Flu syndrome	7%	6%
Gastrointestinal		
Nausea	9%	8%
Abdominal pain	7%	4%
Laboratory Tests*		
Laboratory test abnormal	8%	7%
Hypercholesterolemia	6%	4%
Hyperlipidemia	7%	5%
Hematuria	5%	4%
Alkaline phosphatase increased	5%	3%
Other		
Headache	12%	8%
Rash	12%	6%
Accidental injury	10%	8%
Injection site reaction **	8%	1%
Back pain	6%	4%
Urinary tract infection	8%	5%
Hypertension	5%	3%

* Laboratory test abnormalities were reported as adverse reactions in European trials

** Does not include injection site erythema, itching, hemorrhage, pain or swelling

Less Common Adverse Reactions in Rheumatoid Arthritis Clinical Studies

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

- Body as a whole: Pain in extremity, pelvic pain, surgery, thorax pain.
- Cardiovascular System: Arrhythmia, atrial fibrillation, chest pain, coronary artery disorder, heart arrest, hypertensive encephalopathy, myocardial infarct, palpitation, pericardial effusion, pericarditis, syncope, tachycardia.
- Digestive System: Cholecystitis, cholelithiasis, esophagitis, gastroenteritis, gastrointestinal hemorrhage, hepatic necrosis, vomiting.
- Endocrine System: Parathyroid disorder.
- Hemic and Lymphatic System: Agranulocytosis, polycythemia.
- Metabolic And Nutritional Disorders: Dehydration, healing abnormal, ketosis, paraproteinemia, peripheral edema.

- Musculo-Skeletal System: Arthritis, bone disorder, bone fracture (not spontaneous), bone necrosis, joint disorder, muscle cramps, myasthenia, pyogenic arthritis, synovitis, tendon disorder.
- Neoplasia: Adenoma.
- Nervous System: Confusion, paresthesia, subdural hematoma, tremor.
- Respiratory System: Asthma, bronchospasm, dyspnea, lung function decreased, pleural effusion Special.
- Senses: Cataract.
- Thrombosis: Thrombosis leg.
- Urogenital System: Cystitis, kidney calculus, menstrual disorder.

Juvenile Idiopathic Arthritis Clinical Studies

In general, the adverse reactions in the adalimumab-treated patients in the polyarticular juvenile idiopathic arthritis (JIA) trials (Studies JIA-I and JIA-II) were similar in frequency and type to those seen in adult patients. Important findings and differences from adults are discussed in the following paragraphs.

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

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

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

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

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

In Study JIA-II, adalimumab was studied in 32 patients who were 2 to <4 years of age or 4 years of age and older weighing <15 kg with polyarticular JIA. The safety profile for this patient population was similar to the safety profile seen in patients 4 to 17 years of age with polyarticular JIA.

In Study JIA-II, 78% of patients experienced an infection while receiving adalimumab. These included nasopharyngitis, bronchitis, upper respiratory tract infection, otitis media, and were mostly mild to moderate in severity. Serious infections were observed in 9% of patients receiving adalimumab in the study and included dental caries, rotavirus gastroenteritis, and varicella.

In Study JIA-II, non-serious allergic reactions were observed in 6% of patients and included intermittent urticaria and rash, which were all mild in severity.

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

Crohn's Disease Clinical Studies

Adults: The safety profile of adalimumab in 1478 adult patients with Crohn's disease from four placebo-controlled and two open-label extension studies was similar to the safety profile seen in patients with RA.

Pediatric Patients 6 Years to 17 Years: The safety profile of adalimumab in 192 pediatric patients from one double-blind study (Study PCD-I) and one open-label extension study was similar to the safety profile seen in adult patients with Crohn's disease.

During the 4-week open label induction phase of Study PCD-I, the most common adverse reactions occurring in the pediatric population treated with adalimumab were injection site pain and injection site reaction (6% and 5%, respectively).

A total of 67% of children experienced an infection while receiving adalimumab in Study PCD-I. These included upper respiratory tract infection and nasopharyngitis. A total of 5% of children experienced a serious infection while receiving adalimumab in Study PCD-I. These included viral infection, device related sepsis (catheter), gastroenteritis, H1N1 influenza, and disseminated histoplasmosis.

In Study PCD-I, allergic reactions were observed in 5% of children which were all non-serious and were primarily localized reactions.

Ulcerative Colitis Clinical Studies

Adults: The safety profile of adalimumab in 1010 adult patients with ulcerative colitis (UC) from two placebo-controlled studies and one open-label extension study was similar to the safety profile seen in patients with RA.

Plaque Psoriasis Clinical Studies

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

Immunogenicity

As with all therapeutic proteins, there is potential for immunogenicity. The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies in the studies described below with the incidence of antibodies in other studies or to other adalimumab products may be misleading. There are two assays that have been used to measure anti-adalimumab antibodies. With the ELISA, antibodies to adalimumab could be detected only when serum adalimumab concentrations were < 2 mcg/mL. The ECL assay can detect anti-adalimumab antibody titers independent of adalimumab concentrations in the serum samples. The incidence of anti-adalimumab antibody (AAA) development in patients treated with adalimumab are presented in following table.

Table 18. Anti-Adalimumab Antibody Development Determined by ELISA and ECL Assay in Patients Treated with adalimumab

Indications		Study Duration	Anti-Adalimumab Antibody Incidence by ELISA (n/N)		Anti-Adalimumab Antibody Incidence by ECL Assay (n/N)
			In all patients who received adalimumab	In patients with serum adalimumab concentrations < 2 mcg/mL	
Rheumatoid Arthritis[a]		6 to 12 months	5% (58/1062)	NR	NA
Juvenile Idiopathic Arthritis (JIA)	4 to 17 years of age[b]	48 weeks	16% (27/171)	NR	NA
	2 to 4 years of age or ≥ 4 years of age and weighing < 15 kg	24 weeks	7% (1/15)[c]	NR	NA
Psoriatic Arthritis[d]		48 weeks[e]	13% (24/178)	NR	NA
Ankylosing Spondylitis		24 weeks	9% (16/185)	NR	NA
Adult Crohn's Disease		56 weeks	3% (7/269)	8% (7/86)	NA
Pediatric Crohn's Disease		52 weeks	3% (6/182)	10% (6/58)	NA
Adult Ulcerative Colitis		52 weeks	5% (19/360)	21% (19/92)	NA
Plaque Psoriasis[f]		Up to 52 weeks[g]	8% (77/920)	21% (77/372)	NA

n: number of patients with anti-adalimumab antibody; NR: not reported; NA: Not applicable (not performed)

[a] In patients receiving concomitant methotrexate (MTX), the incidence of anti-adalimumab antibody was 1% compared to 12% with adalimumab monotherapy

[b] In patients receiving concomitant MTX, the incidence of anti-adalimumab antibody was 6% compared to 26% with adalimumab monotherapy

[c] This patient received concomitant MTX

[d] In patients receiving concomitant MTX, the incidence of antibody development was 7% compared to 1% in RA

[e] Subjects enrolled after completing 2 previous studies of 24 weeks or 12 weeks of treatments.

[f] In plaque psoriasis patients who were on adalimumab monotherapy and subsequently withdrawn from the treatment, the rate of antibodies to adalimumab after retreatment was similar to the rate observed prior to withdrawal

[g] One 12-week Phase 2 study and one 52-week Phase 3 study

Rheumatoid Arthritis and Psoriatic Arthritis: Patients in Studies RA-I, RA-II, and RA-III were tested at multiple time points for antibodies to adalimumab using the ELISA during the 6- to 12- month period. No apparent correlation of antibody development to adverse reactions was observed. With monotherapy, patients receiving every other week dosing may develop antibodies more frequently than those receiving weekly dosing. In patients receiving the recommended dosage of 40 mg every other week as monotherapy, the ACR 20 response was lower among antibody-positive patients than among antibody-negative patients. The long-term immunogenicity of adalimumab products is unknown.

WARNINGS & PRECAUTIONS

Serious Infections

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

The concomitant use of a TNF-blocker and abatacept or anakinra was associated with a higher risk of serious infections in patients with rheumatoid arthritis (RA); therefore, the concomitant use of Amjevita™and these biologic products is not recommended in the treatment of patients with RA.

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

- with chronic or recurrent infection.
- who have been exposed to tuberculosis.
- with a history of an opportunistic infection.
- who have resided or travelled in areas of endemic tuberculosis or endemic mycoses, such as histoplasmosis, coccidioidomycosis, or blastomycosis; or
- With underlying conditions that may predispose them to infection.

Tuberculosis

Cases of reactivation of tuberculosis and new onset tuberculosis infections have been reported in patients receiving adalimumab products, including patients who have previously received treatment for latent or active tuberculosis. Reports included cases of pulmonary and extrapulmonary (i.e., disseminated) tuberculosis.

Evaluate patients for tuberculosis risk factors and test for latent infection prior to initiating Amjevita™ and periodically during therapy.

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

Consider anti-tuberculosis therapy prior to initiation of Amjevita™ in patients with a past history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed, and for patients with a negative test for latent tuberculosis but having risk factors for tuberculosis infection. Despite prophylactic treatment for

tuberculosis, cases of reactivated tuberculosis have occurred in patients treated with adalimumab products. Consultation with a physician with expertise in the treatment of tuberculosis is recommended to aid in the decision whether initiating anti-tuberculosis therapy is appropriate for an individual patient.

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

Monitoring

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

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

Invasive Fungal Infections

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

Malignancies

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

Malignancies in Adults

In the controlled portions of clinical trials of some TNF-blockers, including adalimumab products, more cases of malignancies have been observed among TNF-blocker-treated adult patients compared to control-treated adult patients. During the controlled portions of 39 global adalimumab clinical trials in adult patients with rheumatoid arthritis (RA), psoriatic arthritis (PsA), ankylosing spondylitis (AS), Crohn's disease (CD), ulcerative colitis (UC), plaque psoriasis (Ps) and other indications, malignancies, other than non-melanoma (basal cell and squamous cell) skin cancer, were observed at a rate (95% confidence interval) of 0.7 (0.48, 1.03) per 100 patient-years among 7973 adalimumab-treated patients versus a rate of 0.7 (0.41, 1.17) per 100 patient-years among 4848 control-treated patients (median duration of treatment of 4 months for adalimumab-treated patients and 4 months for control-treated patients). In 52 global controlled and uncontrolled clinical trials of adalimumab in adult patients with RA, PsA, AS, CD, UC, Ps and other indications, the most frequently observed malignancies, other than lymphoma and NMSC, were breast, colon, prostate, lung, and melanoma. The malignancies in adalimumab-treated patients in the controlled and uncontrolled portions of the studies were similar in type and number to what would be expected in the general U.S. population according to the SEER database (adjusted for age, gender, and race).[1]

In controlled trials of other TNF-blockers in adult patients at higher risk for malignancies (i.e., patients with COPD with a significant smoking history and cyclophosphamide-treated patients with Wegener's granulomatosis), a greater portion of malignancies occurred in the TNF-blocker group compared to the control group.

Non-Melanoma Skin Cancer

During the controlled portions of 39 global adalimumab clinical trials in adult patients with RA, PsA, AS, CD, UC, Ps and other indications, the rate (95% confidence interval) of NMSC was 0.8 (0.52, 1.09) per 100 patient-years among adalimumab-treated patients and 0.2 (0.10, 0.59) per 100 patient-years among control-treated patients. Examine all patients, and in particular patients with a medical history of prior prolonged immunosuppressant therapy or psoriasis patients with a history of PUVA treatment for the presence of NMSC prior to and during treatment with Amjevita™.

Lymphoma and Leukemia

In the controlled portions of clinical trials of all the TNF-blockers in adults, more cases of lymphoma have been observed among TNF-blocker-treated patients compared to control-treated patients. In the controlled portions of 39 global adalimumab clinical trials in adult patients with RA, PsA, AS, CD, UC, Ps and other indications, 2 lymphomas occurred among 7973 adalimumab treated patients versus 1 among 4848 control-treated patients. In 52 global controlled and uncontrolled clinical trials of adalimumab in adult patients with RA, PsA, AS, CD, UC, Ps and other indications, with a median duration of approximately 0.7 years, including 24,605 patients and over 40,215 patient-years of adalimumab, the observed rate of lymphomas was approximately 0.11 per 100 patient-years. This is approximately 3-fold higher than expected in the general U.S. population according to the SEER database (adjusted for age, gender, and race).1 Rates of lymphoma in clinical trials of adalimumab cannot be compared to rates of lymphoma in clinical trials of other TNF-blockers and may not predict the rates observed in a broader patient population. Patients with RA and other chronic inflammatory diseases, particularly those with highly active disease and/or chronic exposure to immunosuppressant therapies, may be at a higher risk (up to several fold) than the general population for the development of lymphoma, even in the absence of TNF-blockers. Post-marketing cases of acute and chronic leukemia have been reported in association with TNF-blocker use in RA and other indications. Even in the absence of TNF-blocker therapy, patients with RA may be at a higher risk (approximately 2-fold) than the general population for the development of leukemia.

Malignancies in Pediatric Patients and Young Adults

Malignancies, some fatal, have been reported among children, adolescents, and young adults who received treatment with TNF-blockers (initiation of therapy ≤ 18 years of age), of which Amjevita™ is a member. Approximately half the cases were lymphomas, including Hodgkin's and non-Hodgkin's lymphoma. The other cases represented a variety of different malignancies and included rare malignancies usually associated with immunosuppression and malignancies that are not usually observed in children and adolescents. The malignancies occurred after a median of 30 months of therapy (range 1 to 84 months). Most of the patients were receiving concomitant immunosuppressants. These cases were reported post-marketing and are derived from a variety of sources including registries and spontaneous post-marketing reports.

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

Hypersensitivity Reactions

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

Hepatitis B Virus Reactivation

Use of TNF-blockers, including Amjevita™, may increase the risk of reactivation of hepatitis B virus (HBV) in patients who are chronic carriers of this virus. In some instances, HBV reactivation occurring in conjunction with TNF-blocker therapy has been fatal. The majority of these reports have occurred in patients concomitantly receiving other medications that suppress the immune system, which may also contribute to HBV reactivation. Evaluate patients at risk for HBV infection for prior evidence of HBV infection before initiating TNF-blocker therapy. Exercise caution in prescribing TNF-blockers for patients identified as carriers of HBV. Adequate data are not available on the safety or efficacy of treating patients who are carriers of HBV with anti-viral therapy in conjunction with TNF-blocker therapy to prevent HBV reactivation. For patients who are carriers of HBV and require treatment with TNF-blockers, closely monitor such patients for clinical and laboratory signs of active HBV infection throughout therapy and for several months following termination of therapy. In patients who develop HBV reactivation, stop Amjevita™ and initiate effective anti-viral therapy with appropriate supportive treatment. The safety of resuming TNF-blocker therapy after HBV reactivation is controlled is not known. Therefore, exercise caution when considering resumption of Amjevita™ therapy in this situation and monitor patients closely.

Neurologic Reactions

Use of TNF blocking agents, including adalimumab products, has been associated with rare cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disease, including multiple sclerosis (MS) and optic neuritis, and peripheral demyelinating disease, including Guillain-Barré syndrome. Exercise caution in considering the use of Amjevita™ in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders; discontinuation of Amjevita™ should be considered if any of these disorders develop.

Hematological Reactions

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

Increased Risk of Infection When Used with Anakinra

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

Heart Failure

Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF-blockers. Cases of worsening CHF have also been observed with adalimumab products. Adalimumab products have not been formally studied in patients with CHF; however, in clinical trials of another TNF-blocker, a higher rate of

serious CHF-related adverse reactions was observed. Exercise caution when using Amjevita™ in patients who have heart failure and monitor them carefully.

Autoimmunity

Treatment with adalimumab products may result in the formation of autoantibodies and, rarely, in the development of a lupus-like syndrome. If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Amjevita™, discontinue treatment.

Immunizations

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

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

The safety of administering live or live-attenuated vaccines in infants exposed to adalimumab products in utero is unknown. Risks and benefits should be considered prior to vaccinating (live or live attenuated) exposed infants.

Increased Risk of Infection

When Used with Abatacept In controlled trials, the concurrent administration of TNF-blockers and abatacept was associated with a greater proportion of serious infections than the use of a TNF-blocker alone; the combination therapy, compared to the use of a TNF-blocker alone, has not demonstrated improved clinical benefit in the treatment of RA. Therefore, the combination of abatacept with TNF-blockers including Amjevita™ is not recommended.

CONTRAINDICATIONS

None reported.

Clinical Pharmacology

MECHANISMS OF ACTION

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

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

Dose & Administration

ADULTS

Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis:

- Adults: 40 mg administered by subcutaneous injection every other week.
- Some patients with RA not receiving methotrexate may benefit from increasing the dosage to 40 mg every week or 80 mg every other week.

Ulcerative Colitis:

- Adults: 160 mg on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15 and 40 mg every other week starting on Day 29. Discontinue in patients without evidence of clinical remission by eight weeks (Day 57).

Plaque Psoriasis:

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

Crohn's Disease:

- Adults: 160 mg on Day 1 (given in one day or split over two consecutive days); 80 mg on Day 15; and 40 mg every other week starting on Day 29.

PEDIATRICS

Juvenile Idiopathic Arthritis:

Table 19: Juvenile Idiopathic Arthritis

Pediatric Weight 2 Years of Age and Older	Recommended Dosage
15 kg (33 lbs) to less than 30 kg (66 lbs)	20 mg every other week
30 kg (66 lbs) and greater	40 mg every other week

Crohn's Disease: Pediatric Patients 6 Years of Age and Older dose mentioned below:

Table 20: Pediatric Patients 6 Years of Age and Older

Pediatric Weight	Recommended Dosage	
	Days 1 and 15	Starting on Day 29
17 kg (37 lbs) to less than 40 kg (88 lbs)	Day 1: 80 mg Day 15: 40 mg	20 mg every other week
40 kg (88 lbs) and greater	Day 1: 160 mg (single-dose or split over two consecutive days) Day 15: 80 mg	40 mg every other week

GERIATRICS

Refer to adult dosing.

RENAL IMPAIRMENT

None

HEPATIC IMPAIRMENT

None

Product Availability

DOSAGE FORM(S) & STRENGTH(S)

- Prefilled SureClick Autoinjector
  - Injection: 40 mg/0.8 mL in a single-dose prefilled SureClick autoinjector.
- Prefilled Syringe
  - Injection: 40 mg/0.8 mL in a single-dose prefilled glass syringe.
  - Injection: 20 mg/0.4 mL in a single-dose prefilled glass syringe.