

DATA SHEET

HUMIRA®

Name of the Medicine

Adalimumab (rch)

Description

Humira (adalimumab) is a recombinant human immunoglobulin (IgG1) monoclonal antibody containing only human peptide sequences. Humira was created using phage display technology resulting in fully human heavy and light chain variable regions, which confer specificity to human tumour necrosis factor (TNF), and human IgG1 heavy chain and kappa light chain sequences. Humira binds with high affinity and specificity to soluble tumour necrosis factor (TNF-alpha) but not lymphotoxin (TNF-beta). Adalimumab is produced by recombinant DNA technology in a mammalian cell expression system. It consists of 1330 amino acids and has a molecular weight of approximately 148 kilodaltons.

Humira is supplied as a sterile, preservative-free solution of adalimumab for subcutaneous administration. The solution of Humira is clear and colourless with a pH of 5.2. The drug product is supplied as either a single-use pre-filled glass syringe, vial or as a single use, pre-filled pen (Humira Pen). Enclosed within the pen is a single-use, pre-filled glass syringe.

All adult presentations contain 40mg adalimumab per 0.8 mL (50 mg/mL). The paediatric presentation contains 20mg adalimumab per 0.4 mL.

Humira 40mg: Inactive ingredients include: 4.93 mg sodium chloride, 0.69 mg monobasic sodium phosphate dihydrate, 1.22 mg dibasic sodium phosphate dihydrate, 0.24 mg sodium citrate, 1.04 mg citric acid monohydrate, 9.6 mg mannitol, 0.8 mg polysorbate 80 and water for injections.

Humira 20mg: Inactive ingredients include: 2.47 mg sodium chloride, 0.34 mg monobasic sodium phosphate dihydrate, 0.61 mg dibasic sodium phosphate dihydrate, 0.12 mg sodium citrate, 0.52 mg citric acid monohydrate, 4.8 mg mannitol, 0.4 mg polysorbate 80 and water for injections.

Pharmacology

General

Adalimumab binds to TNF and neutralises the biological function of TNF by blocking its interaction with the p55 and p75 cell surface TNF receptors. TNF is a naturally occurring cytokine that is involved in normal inflammatory and immune responses. Elevated levels of TNF are found in the synovial fluid of rheumatoid arthritis (RA), including juvenile idiopathic arthritis (JIA), psoriatic arthritis (PsA) and ankylosing spondylitis (AS) patients and play an important role in both the pathologic inflammation and the joint destruction that are hallmarks of these diseases. Increased levels of TNF are also found in psoriasis (Ps) plaques, which contribute to the inflammatory response, to the proliferation and decreased maturation of keratinocytes and to the associated vascular damages that are characteristic of the disease.

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

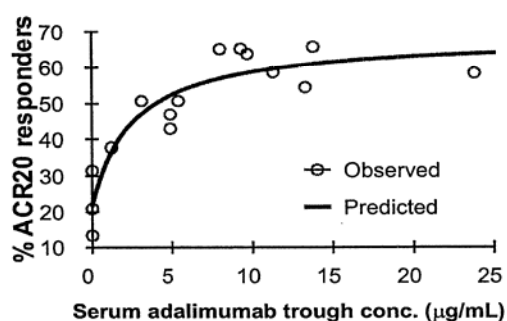
Pharmacodynamics

After treatment with Humira, a rapid decrease in levels of acute phase reactants of inflammation (C-reactive protein (CRP) and Erythrocyte Sedimentation Rate (ESR)) and serum cytokines (IL-6) was observed compared to baseline in patients with RA. In patients with Crohn's disease, a decrease in CRP levels was observed by week 1. After 12 weeks of treatment with adalimumab, subjects with CD had lower levels of expression of TNF-alpha and the inflammatory markers, human leucocyte antigen (HLA-

DR) and myeloperoxidase (MPO) in the colon but not in the ileum, compared with subjects with CD given placebo. Serum levels of matrix metalloproteinases (MMP-1 and MMP-3) that produce tissue remodelling responsible for cartilage destruction were also decreased after Humira administration. Patients treated with Humira usually experienced improvement in haematological signs of chronic inflammation. A rapid decrease in CRP levels was also observed in patients with polyarticular juvenile idiopathic arthritis.

The serum adalimumab concentration-efficacy relationship as measured by the American College of Rheumatology response criteria (ACR20) appears to follow the Hill E_{max} equation as shown below:

Figure 1: Concentration-Efficacy Relationship



EC_{50} estimates ranging from 0.8 to 1.4 µg/mL were obtained through pharmacokinetic/ pharmacodynamic modelling of swollen joint count, tender joint count and ACR20 response from patients participating in Phase II and III trials.

Pharmacokinetics

Absorption

Following a single 40 mg subcutaneous (SC) administration of Humira to 59 healthy adult subjects, absorption of adalimumab was slow, with mean peak serum concentration being reached about five days after administration. The average absolute bioavailability of adalimumab estimated from three studies following a single 40 mg subcutaneous dose was 64%. The pharmacokinetics of adalimumab was linear over the dose range of 0.5 to 10 mg/kg following a single intravenous dose.

Distribution and Elimination

The single dose pharmacokinetics of adalimumab in rheumatoid arthritis (RA) patients were determined in several studies with intravenous doses ranging from 0.25 to 10 mg/kg. The distribution volume (V_{ss}) ranged from 4.7 to 6.0 L. Adalimumab is slowly eliminated, with clearances typically under 12 mL/h. The mean terminal phase half-life was approximately two weeks, ranging from 10 to 20 days across studies. Adalimumab concentrations in the synovial fluid from several RA patients ranged from 31 to 96% of those in serum.

Steady-State

Accumulation of adalimumab was predictable based on the half-life following SC administration of 40 mg of Humira fortnightly to patients with RA, with mean steady-state trough concentrations of approximately 5 µg/mL (without concomitant methotrexate (MTX)) and 8 to 9 µg/mL (with concomitant MTX), respectively. These trough concentration levels are well above the EC_{50} estimates of 0.8 to 1.4 µg/mL and consistent with those at which ACR20 responses appear to reach a maximum (Figure 1). The serum adalimumab trough levels at steady state increased approximately proportionally with dose following 20, 40 and 80 mg fortnightly and every week SC dosing. In long-term studies with dosing for more than two years, there was no evidence of changes in clearance over time.

In patients with psoriasis, the mean steady-state trough concentration was 5 mcg/mL during adalimumab 40 mg fortnightly monotherapy treatment (after an initial loading dose of 80mg sc).

In patients with Crohn's disease, the loading dose of 160mg Humira on Week 0 followed by 80mg Humira on Week 2 achieves serum adalimumab trough concentrations of approximately 12 µg/mL at Weeks 2 and 4. The mean steady state trough concentration at Weeks 24 and 56 were 6.6 µg/mL and 7.2 µg/mL respectively. The range of trough concentrations in patients who received a maintenance dose of 40mg Humira every fortnight was 0 – 21.7 µg/mL

In subjects with polyarticular juvenile idiopathic arthritis (4 to 17 years of age), the mean steady-state trough serum adalimumab concentrations for subjects weighing <30 kg receiving 20 mg Humira subcutaneously fortnightly as monotherapy or with concomitant methotrexate were 6.8 µg/mL and 10.9 µg/mL, respectively. The mean steady-state trough serum adalimumab concentrations for subjects weighing ≥30 kg receiving 40 mg Humira subcutaneously fortnightly as monotherapy or with concomitant methotrexate were 6.6 µg/mL and 8.1 µg/mL, respectively.

Population pharmacokinetic analyses with data from over 1200 RA patients revealed a trend toward higher apparent clearance of adalimumab with increasing body weight and in patients who developed the presence of anti-adalimumab antibodies.

Minor increases in apparent clearance were predicted in RA patients receiving doses lower than the recommended dose, and in RA patients with high rheumatoid factor or CRP concentrations. These factors are not likely to be clinically important. However, there is a significant difference in mean apparent clearance in patients with Crohn's disease studied short term (4 weeks – 13.1 mL/hr) vs. long term (56 weeks – 16.8 mL/hr).

Special Populations

Pharmacokinetics in special populations were investigated using population pharmacokinetic analyses.

Geriatrics

Adalimumab's apparent clearance decreases slightly with increasing age. From the population analyses, the mean weight-adjusted clearances in patients 40 to 65 years (n=850) and ≥ 65 years (n=287) were 0.33 and 0.30 mL/h/kg, respectively.

Paediatrics

Humira has not been studied in children except for the investigation in polyarticular juvenile idiopathic arthritis.

Gender

No gender-related pharmacokinetic differences were observed after correction for a patient's body weight.

Race

No differences in immunoglobulin clearance would be expected among races. From limited data in non-Caucasians, no important kinetic differences were observed for adalimumab.

Hepatic and Renal Insufficiency

No pharmacokinetic data are available in patients with hepatic or renal impairment.

Disease States

Healthy volunteers and patients with RA displayed similar adalimumab pharmacokinetics.

Drug Interactions, Methotrexate

When Humira was administered to 21 RA patients on stable methotrexate therapy, there were no statistically significant changes in the serum methotrexate concentration profiles. In contrast, after single and multiple dosing, methotrexate reduced adalimumab's apparent clearances by 29% and 44% respectively (see **PRECAUTIONS – Drug Interactions**). This is consistent with the higher trough concentrations of adalimumab found in patients treated with concomitant methotrexate (see **Pharmacokinetics - Steady State**).

Clinical Trials for Rheumatoid Arthritis

Description of Clinical Trials

Humira was evaluated in over 3000 patients in all rheumatoid arthritis clinical trials. Some patients were treated for greater than 60 months duration. The efficacy and safety of Humira were assessed in five randomised, double-blind and well-controlled studies.

The primary efficacy endpoint in those studies was ACR20 response, equating to an at least 20% improvement from baseline in tender joint count, swollen joint count, and at least 3 of the 5 remaining ACR core set measures: Patient assessment of pain, patient global assessment of disease activity, physician global assessment of disease activity, patient self-assessed disability (HAQ), and erythrocyte sedimentation rate or CRP.

RA Study I (DE009) evaluated 271 patients with moderately to severely active RA who were ≥ 18 years old, had failed therapy with at least one but no more than four disease - modifying anti-rheumatic drugs (DMARDs) and had insufficient efficacy with methotrexate at doses of 12.5 to 25 mg (10 mg if methotrexate-intolerant) every week and whose methotrexate dose remained constant at 10 to 25 mg every week. Patients had ≥ 6 swollen joints and ≥ 9 tender joints and RA diagnosed according to ACR criteria. Doses of 20, 40 or 80 mg of Humira or placebo were given fortnightly for 24 weeks.

RA Study II (DE011) evaluated 544 patients with moderately to severely active RA who were ≥ 18 years old and had failed therapy with at least one DMARD. Patients, who were not permitted methotrexate or other DMARDs during the study, had ≥ 10 swollen joints and ≥ 12 tender joints and were also diagnosed according to ACR criteria. Doses of 20 or 40 mg of Humira were given by subcutaneous injection fortnightly with placebo on alternative weeks or every week for 26 weeks; placebo was given every week for the same duration.

RA Study III (DE019) evaluated 619 patients with moderately to severely active RA who were ≥ 18 years old, had insufficient efficacy to methotrexate at doses of 12.5 to 25 mg (10 mg if methotrexate-intolerant) every week and whose methotrexate dose remained constant at 12.5 to 25 mg every week. Patients had ≥ 6 swollen joints and ≥ 9 tender joints and RA diagnosed according to ACR criteria. There were three groups in this study. The first received placebo injections every week for 52 weeks. The second received 20 mg of Humira every week for 52 weeks. The third group received 40 mg of Humira fortnightly with placebo injections on alternate weeks. Upon completion of the first 52 weeks, 457 patients enrolled in an open-label extension phase in which 40 mg of Humira/MTX was administered fortnightly, for up to 5 years. The objectives of this open-label extension were to evaluate the long-term safety and maintenance of efficacy of Humira in subjects with RA receiving concurrent MTX. The maintenance of efficacy was assessed by evaluating the effect of Humira on the signs and symptoms of RA, physical function, structural damage, rates of clinical remission and patient-reported outcomes. Of the 457 patients who entered the open-label extension, 53/457 (11.6%) subjects discontinued the study due to adverse events, and 16/457(3.5%) subjects discontinued because of a lack of efficacy/disease progression.

RA Study IV (DE031) primarily assessed safety in 636 patients with moderately to severely active RA who were ≥ 18 years old. These patients met the ACR criteria for diagnosis of RA for at least three months and had at least 6 swollen joints and 9 tender joints. Patients were permitted to be either DMARD naïve or to remain on their pre-existing rheumatologic therapy provided that therapy was stable for a minimum of 28 days. Patients were randomised to 40 mg of Humira or placebo fortnightly for 24 weeks.

RA Study V (DE013) was an active comparator trial of 2 years duration, which randomised 799 adult methotrexate (MTX)-naïve patients with early RA (mean disease duration less than 9 months) to treatment with adalimumab 40 mg fortnightly alone, methotrexate up to 20 mg/week alone, or the combination of the two, for 104 weeks. 31.5% of patients in the MTX group, 33.2% in the adalimumab group, and 32.5% in the combination group had taken previous DMARDs. The mean duration of RA was 0.8 years, 0.7 years, and 0.7 years in the MTX alone, adalimumab alone, and combination groups, respectively. The mean Tender Joint Count (TJC 68) at baseline was 32.3, 31.8 and 30.7 for the three groups, and the Erosion Score was 13.6, 11.3 and 11.0, respectively.

Results of all five trials were expressed in percentage of patients with improvement in RA using ACR response criteria. The primary endpoint in RA Studies I, II and III and the secondary endpoint in RA Study

IV was the percent of patients who achieved an ACR20 response at Week 24 or 26. The primary endpoint in RA Study V was the percent of patients who achieved an ACR50 response at Week 52. RA Studies III and V had an additional primary endpoint at 52 weeks of retardation of disease progression (as detected by X-ray results). RA Study III also had a primary endpoint of changes in quality of life.

Clinical Response

RA Studies I, II and III

The percent of Humira-treated patients achieving ACR20, 50 and 70 responses was consistent across all three trials. The results for the 40 mg fortnightly dose are summarised in Table 1.

Table 1: ACR Responses in Placebo-Controlled Trials (Percent of Patients)

Response	RA Study I ^{a*}		RA Study II ^{a*}		RA Study III ^{a, c *}	
	Placebo/ MTX N=60	Humira ^b / MTX N=63	Placebo N=110	Humira ^b *N=113	Placebo/ MTX N=200	Humira ^b / MTX N=207
ACR20						
6 months	13.3%	65.1%	19.1%	46.0%	29.5%	63.3%
12 months	NA	NA	NA	NA	24.0%	58.9%
ACR50						
6 months	6.7%	52.4%	8.2%	22.1%	9.5%	39.1%
12 months	NA	NA	NA	NA	9.5%	41.5%
ACR70						
6 months	3.3%	23.8%	1.8%	12.4%	2.5%	20.8%
12 months	NA	NA	NA	NA	4.5%	23.2%

^a RA Study I at 24 weeks, RA Study II at 26 weeks, and RA Study III at 24 and 52 weeks

^b 40 mg Humira administered fortnightly

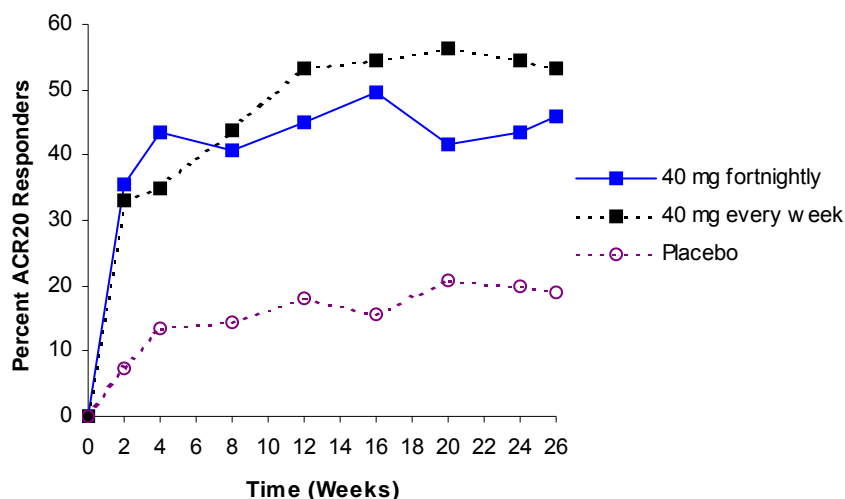
^c The 12 months placebo-controlled phase of RA Study III was followed by 12 months of open-label treatment with ACR responses at 24 months of 48.8% (ACR20), 36.2% (ACR50) and 22.7% (ACR70).

* p<0.01, Humira vs. placebo at all timepoints for ACR20, 50, 70

MTX Methotrexate

Patients receiving Humira 40 mg every week in RA Study II also achieved statistically significant ACR20, 50 and 70 response rates of 53.4%, 35.0% and 18.4%, respectively, at six months.

Figure 2: RA Study II ACR20 Responses over 26 Weeks



The results of the components of the ACR response criteria for RA Study III are shown in Table 2. ACR response rates and improvement in all ACR response criteria were maintained to Week 104. Over the 2 years in RA Study III, 20% of Humira patients achieved a major clinical response, defined as maintenance of an ACR70 response over a > 6 month period.

Table 2: Components of ACR Response in RA Study III

Parameter (median)	Placebo/MTX (N = 200)			Humira ^a /MTX (N = 207)		
	Baseline	Week 24	Week 52	Baseline	Week 24	Week 52
Number of tender joints (0 – 68)	26.0	15.0	15.0	24.0	8.0*	6.0*
Number of swollen joints (0-66)	17.0	11.0	11.0	18.0	5.0*	4.0*
Physician global assessment disease activity ^b	63.0	35.0	38.0	65.0	20.0*	16.0*
Patient global assessment disease activity ^b	53.5	39.0	43.0	52.0	20.0*	18.0*
Pain ^b	59.5	38.0	46.0	58.0	21.0*	19.0*
Disability index (HAQ) ^c	1.50	1.25	1.25	1.50	0.75*	0.75*
CRP (mg/L)	10.0	9.0	9.0	10.0	4.0*	4.0*

^a 40 mg Humira administered fortnightly

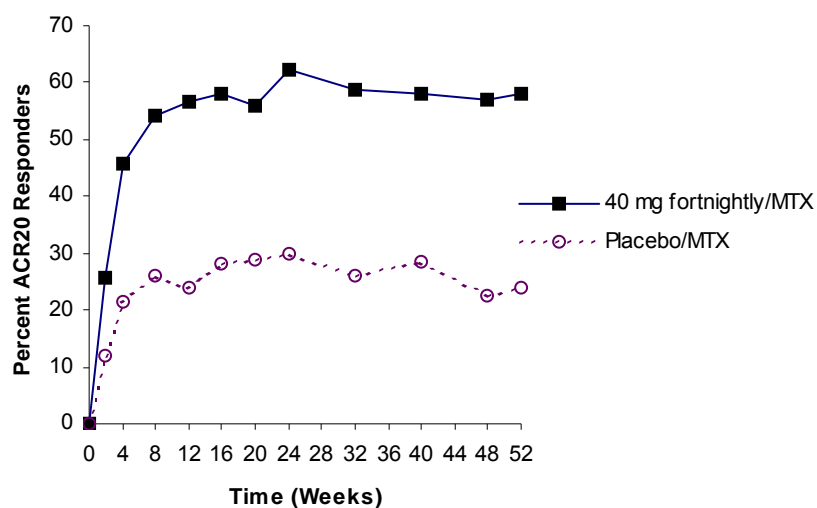
^b Visual analogue scale; 0 = best, 100 = worst

^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, Humira vs. placebo, based on mean change from baseline

In RA Study III, 84.7% of patients with ACR20 responses at Week 24 maintained the response at 52 weeks. Clinical responses were maintained for up to 5 years in the open-label portion of RA Study III. ACR responses observed at Week 52 were maintained or increased through 5 years of continuous treatment with 22% (115/534) of patients achieving major clinical response. A total of 372 (67.8%) subjects had no change in their methotrexate dose during the study, 141 (25.7%) subjects had a dose reduction and 36 (6.6%) subjects required a dose increase. A total of 149 (55.6%) subjects had no change in their corticosteroid dose during the study, 80 (29.9%) subjects had a dose reduction and 39 (14.6%) subjects required a dose increase. The following figures illustrate the durability of ACR20 responses to Humira in RA Studies III and II.

Figure 3: RA Study III ACR20 Responses over 52 Weeks



RA Study IV

The ACR20 response of patients treated with Humira plus standard of care was statistically significantly better than patients treated with placebo plus standard of care ($p < 0.001$).

In RA Studies I-IV, Humira-treated patients achieved statistically significant ACR20 and 50 responses compared to placebo as early as 1-2 weeks after initiation of treatment.

RA Study V

In RA Study V for early rheumatoid arthritis patients who were methotrexate naïve, combination therapy with Humira plus methotrexate led to significantly greater ACR responses than methotrexate monotherapy at Week 52 and responses were sustained at Week 104 (see Table 3).

At Week 52 all individual components of the ACR response criteria improved with Humira/methotrexate therapy and improvements were maintained to Week 104.

Over the two-year study, 48.5% patients who received Humira/methotrexate combination therapy achieved a major clinical response (ACR70 for > six continuous months) compared to 27.2% of patients who received methotrexate monotherapy ($p < 0.001$).

Table 3. ACR20/50/70 Response at Weeks 26, 52, 76 and 104 (All Randomised Subjects) in RA Study V

	MTX N=257	Adalimumab N=274	Adalimumab + MTX N=268		
	N (%)			p-value ^a	p-value ^b
ACR20					
Week 26	158 (61.5)	146 (53.3)	184 (68.7)	0.084	< 0.001
Week 52	161 (62.6)	149 (54.4)	195 (72.8)	0.013	< 0.001
Week 76	154 (59.9)	137 (50.0)	185 (69.0)	0.029	< 0.001
Week 104	144 (56.0)	135 (49.3)	186 (69.4)	0.002	< 0.001
ACR50					
Week 26	104 (40.5)	96 (35.0)	157 (58.6)	< 0.001	< 0.001
Week 52	118 (45.9)	113 (41.2)	165 (61.6)	< 0.001	< 0.001
Week 76	114 (44.4)	114 (41.6)	161 (60.1)	< 0.001	< 0.001
Week 104	110 (42.8)	101 (36.9)	158 (59.0)	< 0.001	< 0.001
ACR70					
Week 26	57 (22.2)	54 (19.7)	114 (42.5)	< 0.001	< 0.001
Week 52	70 (27.2)	71 (25.9)	122 (45.5)	< 0.001	< 0.001
Week 76	75 (29.2)	79 (28.8)	127 (47.4)	< 0.001	< 0.001
Week 104	73 (28.4)	77 (28.1)	125 (46.6)	< 0.001	< 0.001

Note: Subjects with missing values were counted as non-responders.

- P-value is from the pairwise comparison of MTX monotherapy and adalimumab + MTX combination therapy using Pearson's chi-square test.
- P-value is from the pairwise comparison of adalimumab monotherapy and adalimumab + MTX combination therapy using Pearson's chi-square test.

In RA Study V, Humira/methotrexate combination therapy was superior to methotrexate monotherapy in achieving clinical remission defined as Disease Activity Score (DAS28) <2.6 at Week 52 (Table 4).

Table 4: Subjects in Remission as Defined by DAS28 < 2.6 at Week 52 (All Randomised Subjects) in RA Study V

	MTX N=257	Adalimumab N=274	Adalimumab + MTX N=268		
	N (%)			p-value ^a	p-value ^b
Subjects in Remission at Week 52	53 (20.6)	64 (23.4)	115 (42.9)	< 0.001	< 0.001

- P-value is from the pairwise comparison of MTX monotherapy and adalimumab + MTX combination therapy using Pearson's chi-square test.
 - P-value is from the pairwise comparison of adalimumab monotherapy and adalimumab + MTX combination therapy using Pearson's chi-square test.
- MTX Methotrexate

Radiographic Response

In RA Study III, Humira-treated patients had a mean duration of rheumatoid arthritis for approximately 11 years and a mean + standard deviation baseline modified Total Sharp Score for the 40 mg fortnightly group of 72.1 + 60.7 and placebo group of 66.4 + 47.4. Structural joint damage was assessed radiographically and expressed as change in modified Total Sharp Score (TSS) and its components, erosion score and joint space narrowing score (JSN) at month 12 compared to baseline. Humira/methotrexate-treated patients demonstrated less radiographic progression than patients receiving placebo/methotrexate (Table 5).

In the open-label extension of RA Study III, 77% of the original patients treated with any dose of Humira were evaluated radiographically at 2 years. Patients maintained inhibition of structural damage, as measured by the TSS; 54% had no progression of structural damage as defined by a change in the TSS of zero or less.

Fifty-five percent (113/207) of patients originally treated with 40 mg Humira fortnightly have been evaluated radiographically at 5 years. Patients had continued inhibition of structural damage with approximately 50% (57/113) showing no progression of structural damage defined by a change in the TSS of zero or less.

Table 5: Radiographic Mean Changes Over 12 Months in RA Study III with Background MTX

	Placebo/ MTX N=200	Humira ^a /MTX N=207	Difference Between Humira ^a /MTX and Placebo/MTX (95% Confidence Interval*)	p-value
Total Sharp Score	2.7	0.1	2.6 (1.4, 3.8)	≤ 0.001 ^b
Erosions	1.6	0.0	1.6 (0.9, 2.2)	≤ 0.001
No New Erosions (% of Patients)	46.2	62.9	16.7	≤ 0.001
JSN Score	1.0	0.1	0.9 (0.3, 1.4)	0.002

^a 40 mg administered fortnightly

^b Based on rank analysis

MTX Methotrexate

* 95% confidence intervals for the differences in change scores between MTX and Humira

In RA Study V, Humira-treated patients had a mean duration of rheumatoid arthritis of less than 9 months and had not previously received methotrexate. Structural joint damage was assessed radiographically and expressed as change in modified Total Sharp Score. The Week 52 results are shown in Table 6. A statistically significant difference for change in modified Total Sharp Score and the erosion score was observed at Week 52 and maintained at Week 104.

Table 6: Change in Modified Total Sharp Score from Baseline at Weeks 52 and 104 (All Randomised Subjects) in RA Study V

	MTX N=257	Adalimumab N=274	Adalimumab + MTX N=268	p-value ^a	p-value ^b
Week 52					
Baseline (mean)	21.8 ± 22.2	18.8 ± 19.0	18.1 ± 20.1		
Week 52 (mean)	27.6 ± 24.6	21.8 ± 19.7	19.4 ± 19.9		
Change at Week 52 (mean ± SD)	5.7 ± 12.7	3.0 ± 11.2	1.3 ± 6.5	< 0.001	0.002
Week 104					
Baseline (mean)	21.8 ± 22.2	18.8 ± 19.0	18.1 ± 20.1		
Week 104 (mean)	32.3 ± 30.0	24.3 ± 23.2	20.0 ± 20.5		
Change at Week 104 (mean ± SD)	10.4 ± 21.7	5.5 ± 15.8	1.9 ± 8.3	< 0.001	< 0.001

Note: Primary analysis imputation used for missing data.

- P-value is from the pairwise comparison of MTX monotherapy and adalimumab + MTX combination therapy using the Mann-Whitney U test.
- P-value is from the pairwise comparison of adalimumab monotherapy and adalimumab + MTX combination therapy using the Mann-Whitney U test.

Physical Function

Health-related quality of life and physical function was assessed using the disability index of the Stanford Health Assessment Questionnaire (HAQ), which was a pre-specified primary endpoint at Week 52 in RA Study III.

The HAQ was developed as a disease-specific outcome measure for rheumatoid arthritis and has been extensively studied in RA. HAQ has been shown to correlate with mortality, work disability, functional limitations, pain, fatigue and psychological relief. The score is based on 8 questions and normalised to a scale of 0 to 3, where higher scores indicate more disability, and lower scores indicate less disability. Studies have shown that a change in HAQ score of 0.22 or greater represents an improvement in disability that is perceptible and meaningful to the patient. All doses/schedules of Humira in RA Study III showed statistically significantly greater improvement in the disability index of the HAQ from baseline to Month 6 compared to placebo and the same was seen at Week 52.

There were 619 patients enrolled in RA Study III also known as the DE019 study. The patients were divided into three groups. The first group received placebo injections every week for 52 weeks. The second group received 20 mg of Humira every week for 52 weeks. The third group received 40 mg of Humira fortnightly with placebo injections on alternate weeks. Upon completion of the first 52 weeks, 457 patients enrolled in an open-label extension phase (DE019OLE) in which 40 mg of Humira/MTX was administered fortnightly. Maintenance of physical function was defined as maintaining a reduction in HAQ of -0.5 over the second year of active treatment.

Results

In RA Study III, the mean (95% CI) improvement in HAQ from baseline at Week 52 was -0.60 (-0.65, -0.55) for the Humira patients and -0.25 (-0.33, -0.17) for the placebo/MTX (p<0.001) patients. At Week 104, the mean improvement in HAQ from baseline was -0.70 (-0.8, -0.6) for the Humira patients.

Table 7: Percentage of Patients Achieving Improvement in Physical Function After One and Two Years of Treatment In RA Study III

Reduction in HAQ from Baseline	Proportion of patients who achieved HAQ reduction at Week 52		Proportion of patients who received adalimumab 40 mg fortnightly and who achieved HAQ reduction at Week 104	Proportion of all adalimumab-treated patients with HAQ reduction at Week 52 that was maintained at Week 104	
	Treatment arm	Adalimumab 40 mg fortnightly	Placebo	Adalimumab 40 mg fortnightly	All adalimumab
-0.22		150/207 (72.5%)	96/200 (48%)	123/207 (59.4%)	231/258 (89.5%)
-0.5		114/207 (55.1%)	56/200 (28%)	94/207 (45.4%)	167/204 (81.9%)
-0.75		82/207 (39.6%)	40/200 (20%)	71/207 (34.3%)	124/149 (83.2%)
-1.0		56/207 (27.1%)	22/200 (11%)	40/207 (19.3%)	69/103 (67.0%)

At Year 2, 94/207 (45.4%) of patients who originally entered the study achieved a –0.5 reduction in HAQ. 79.5% (115/195) of the patients who achieved a reduction in HAQ of –0.5 at the end of one year of Humira treatment maintained this response over 5 years of active treatment.

Quality of Life

Results from the Short Form Health Survey (SF-36) for all doses/schedules of Humira in all four studies support these findings, with statistically significant Physical Component Summary (PCS) scores, as well as statistically significant pain and vitality domain scores for the 40 mg fortnightly dose. A statistically significant decrease in fatigue as measured by Functional Assessment of Chronic Illness Therapy (FACIT) scores was seen in all three studies in which it was assessed (RA Studies I, III, IV). Improvement in SF-36 was measured up to Week 156 (3 years) and improvement was maintained through this time.

In RA Study V, the active-comparator controlled study in early rheumatoid arthritis, the improvement in the HAQ disability index and the physical component of the SF-36 showed greater improvement ($p < 0.001$) for Humira/methotrexate combination therapy versus methotrexate monotherapy at Week 52, which was maintained through Week 104.

Clinical Trials for Polyarticular Juvenile Idiopathic Arthritis

The safety and efficacy of Humira were assessed in a multi-centre, randomised, withdrawal, double blind, parallel-group study in 171 children (4 to 17 years of age) with polyarticular juvenile idiopathic arthritis (JIA). In the study, the patients were stratified into two groups: MTX-treated or non-MTX-treated. All subjects had to show signs of active moderate or severe disease despite previous treatment with NSAIDs, analgesics, corticosteroids, or DMARDs. Subjects 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, Humira 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) fortnightly. In the OLE-FD phase, the patients were treated with 20 mg of Humira SC fortnightly if their weight was less than 30 kg and with 40 mg of Humira SC fortnightly 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 Paediatric ACR 30 response at the end of OL-LI phase were randomized into the double blind (DB) phase of the study and received either Humira or placebo fortnightly for 32 weeks or until disease flare. Disease flare was defined as a worsening of $\geq 30\%$ from baseline in ≥ 3 of 6 Paediatric 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).

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 Paediatric ACR 30 responders. In the DB phase significantly fewer patients who received Humira experienced disease flare compared to placebo, both without MTX (43% vs. 71%) and with MTX (37% vs. 65%). More patients treated with Humira continued to show paediatric ACR 30/50/70 responses at Week 48 compared to patients treated with placebo. Overall responses were generally better and, fewer patients developed antibodies when treated with the combination of Humira and MTX compared to Humira alone.

Paediatric ACR responses were maintained for up to two years in the OLE phase in patients who received Humira throughout the study.

The long term effects of Humira on the growth and development of children have not been studied.

Clinical Trials for Psoriatic Arthritis

Humira, 40 mg fortnightly, was studied in patients with moderately to severely active psoriatic arthritis in two placebo-controlled studies, PsA Studies I (M02-518) and II (M02-570). PsA Study I with 24-week duration, treated 313 adult patients who had an inadequate response to non-steroidal anti-inflammatory drug therapy and of these, approximately 50% were taking methotrexate. PsA Study II with 12-week duration, treated 100 patients who had an inadequate response to DMARD therapy. Upon completion of both studies, 383 patients enrolled in an open-label extension study, in which 40mg Humira was administered fortnightly.

ACR and PASI response

Humira was superior to placebo in all measures of disease activity ($p < 0.001$) as shown in Table 8 and 9. Among patients with psoriatic arthritis who received Humira, the clinical responses were apparent at the time of the first visit (2 weeks), significant at 12 weeks and were maintained through 24 weeks of therapy. Patients with a psoriasis involvement of at least 3% Body Surface Areas (BSA) were evaluated for Psoriatic Area and Severity Index (PASI) response. In these patients the skin lesions of psoriasis were improved with Humira, relative to placebo, as measured by PASI. Responses were similar with and without concomitant methotrexate therapy. ACR responses were maintained in the open-label extension study for up to 136 weeks.

Table 8: ACR and PASI Response in Placebo-Controlled Psoriatic Arthritis Study (Percent of Patients)

Response*	Placebo N=162	Humira N=151
ACR20		
Week 12	14%	58%
Week 24	15%	57%
ACR50		
Week 12	4%	36%
Week 24	6%	39%
ACR70		
Week 12	1%	20%
Week 24	1%	23%
	N=69	N=69
PASI 50		
Week 12	15%	72%
Week 24	12%	75%
PASI 75		
Week 12	4%	49%
Week 24	1%	59%

* p<0.001 for all comparisons between Humira and placebo

Table 9: Components of Disease Activity in Psoriatic Arthritis

Parameter: mean (median)	Placebo N=162 ^a		Humira N=151 ^a	
	Baseline	24 Weeks	Baseline	24 Weeks
Number of tender joints ^b	25.8 (23.0)	22.3 (17.0)	23.3 (19.0)	11.8 (5.0)
Number of swollen joints ^c	14.6 (11.0)	12.1 (8.0)	13.4 (10.0)	7.6 (3.0)
Physician global assessment ^d	53.2 (53.0)	46.0 (48.0)	53.5 (54.0)	21.4 (16.0)
Patient global assessment ^d	47.2 (49.0)	47.6 (49.0)	47.5 (48.0)	24.2 (18.5)
Pain ^d	47.6 (47.5)	47.9 (49.0)	50.6 (53.0)	25.4 (19.0)
Disability index (HAQ) ^e	1.0 (1.0)	0.9 (0.8)	1.0 (0.9)	0.6 (0.4)
CRP (mg/L) ^f	13.9 (7.8)	14.3 (7.4)	14.3 (8.0)	5.5 (2.1)

^a As observed analysis presented. N at 24 weeks may be less than 162 for placebo or 151 for Humira.

^b Scale 0 – 78

^c Scale 0 – 76

^d Visual analog scale; 0 = best, 100 = worst.

^e 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.

^f Normal range: 0-2.87 mg/L.

* p< 0.001 for Humira vs. placebo comparisons based on mean changes.

Radiographic Response

Radiographic changes were assessed in the psoriatic arthritis studies. Radiographs of hands, wrists and feet were obtained at baseline and Week 24 during the double-blind period when patients were on Humira or placebo and at Week 48 when all patients were on open-label Humira. 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.

Humira-treated patients demonstrated greater inhibition of radiographic progression compared to placebo-treated patients and this effect was maintained at 48 weeks (see Table 10)

Table 10: Change in Modified Total Sharp Score in Psoriatic Arthritis

Modified Total Sharp Score*	Placebo	Adalimumab	<i>p</i> -value
Baseline to Week-24	n = 162	n = 151	
• baseline mean	19.0	22.6	
• mean change from baseline	1.6	1.0	< 0.001
	Placebo to adalimumab**		
Baseline to Week-48	n = 141	n = 133	
• baseline mean	21.2	22.2	
• mean change from baseline	0.9	0.0	
Week-48 to Week-144	n = 128	n = 115	
• Week-48 mean	22.7	22.3	
• mean change from Week-48	0.1	0.4	
Erosion Score	Placebo to adalimumab**		
Baseline to Week 48	n = 141	n = 133	
• baseline mean	11.2	11.9	
• mean change from baseline	0.6	0.1	
Week-48 to Week-144	n = 128	n = 115	
• Week-48 mean	12.1	12.1	
• Mean change from Week 48	-0.2	0.0	
Joint Space Narrowing Score	Placebo to adalimumab**		
Baseline to Week 48	n = 141	n = 133	
• baseline mean	10.0	10.4	
• mean change from baseline	0.3	-0.1	
Week-48 to Week-144	n = 128	n = 115	
• Week-48 mean	10.6	10.2	
• Mean change from Week 48	0.3	0.4	

* Baseline to Week-24 data represents ITT data and belongs to a different x-ray reading than baseline to Week-48 and Week-48 to Week-144 data.

**Patients changed over to adalimumab at Week 24

In subjects treated with Humira with no radiographic progression from baseline to Week 48 (n = 102), 84% continued to show no radiographic progression through 144 weeks of treatment.

Quality of Life and Physical Function

In PsA study VI, physical function and disability were assessed using the HAQ Disability Index (HAQ-DI) and the Short Form Health Survey (SF-36). Patients treated with 40mg of Humira 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).

Results from the Short Form Health Survey (SF-36) support these findings, with statistically significant Physical Component Summary (PCS) scores, as well as statistically significant pain and vitality domain scores. At Weeks 12 and 24, patients treated with Humira 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 and disability measures were maintained for up to 136 weeks through the open label portion of the study.

Clinical Trials for Ankylosing Spondylitis

The safety and efficacy of Humira 40 mg fortnightly was assessed in 393 adult patients in two randomised, 24-week double-blind, placebo-controlled studies in patients with active ankylosing spondylitis (AS). The larger study (AS Study I or M03-607) enrolled 315 adult patients with active AS (defined as fulfilling 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, (3) morning stiffness ≥ 1 hour), who had an inadequate response to conventional therapy. Seventy-nine (20.1%) patients were treated concomitantly with disease modifying anti-rheumatic drugs, and 37 (9.4%) patients with glucocorticoids. The blinded period was followed by an open-label period. Subjects (N=215, 54.7%) who failed to achieve ASAS 20 at Weeks 12, or 16 or 20 received early escape open-label adalimumab 40mg fortnightly SC and were subsequently treated as non-responders in double-blind statistical analyses.

Results showed statistically significant improvement of signs and symptoms of AS in patients treated with Humira compared to placebo. Significant improvement in measures of disease activity was first observed at Week 2 and maintained through 24 weeks as shown in Figure 4 and Table 11.

Patients with total spinal ankylosis were included in the larger study (n=11). Responses of these patients were similar to those without total ankylosis.

Figure 4. ASAS 20 Response By Visit, AS Study I

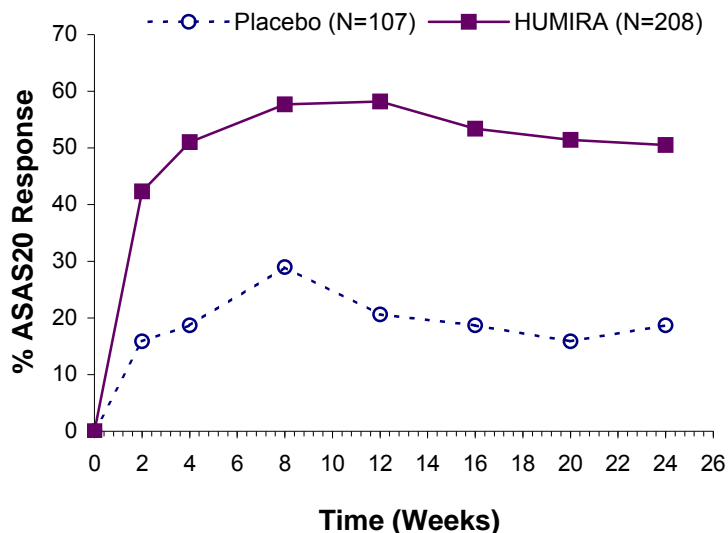


Table 11. ASAS^a Responses in Placebo-Controlled AS Study

Response	Placebo N=107	Humira N=208
ASAS 20		
Week 12	21%	58%*
Week 24	19%	51%*
ASAS 50		
Week 12	10%	38%*
Week 24	11%	35%*
ASAS 70		
Week 12	5%	23%*
Week 24	8%	24%*

* Statistically significant at p<0.001 for all comparisons between Humira and placebo at Weeks 12 and 24

^a Assessments in Ankylosing Spondylitis

A low level of disease activity (defined as a value <20 [on a scale of 0-100mm] in each of the four ASAS response parameters) was achieved at 24 weeks in 22% of Humira-treated patients vs. 6% in placebo-treated patients (p<0.001).

Table 12. Components of Ankylosing Spondylitis Disease Activity

	Placebo N=107		Humira 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
CRP ^e	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 C-Reactive Protein (mg/dL)

* Statistically significant as p<0.001 for all comparisons between Humira and placebo at Week 24

Results of this study were similar to those seen in the second randomised trial (AS Study II or M03-606), a multicenter, double-blind, placebo-controlled study of 82 patients with ankylosing spondylitis. Patient Reported Outcomes were assessed in both ankylosing spondylitis studies using the generic health status questionnaire SF-36 and the disease specific Ankylosing Spondylitis Quality of Life Questionnaire (ASQoL). The Humira-treated patients had significantly greater improvement in SF-36 Physical Component Score (mean change: 6.93) compared to placebo-treated patients (mean change: 1.55; p<0.001) at Week 12, which was maintained through Week 24.

Results from the ASQoL support these findings demonstrating improvement in overall quality of life. The Humira-treated patients had statistically significant improvement (mean change: - 3.15) compared to placebo-treated patients (mean change: - 0.95; $p < 0.001$) at Week 12, which was maintained through Week 24.

Clinical Trials for Crohn's Disease

The safety and efficacy of multiple doses of Humira were assessed in over 1500 patients with moderately to severely active Crohn's disease (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 80% of patients continued to receive at least one of these medications.

Induction of clinical remission (defined as CDAI < 150) was evaluated in two studies, CD Study I (M02-403) and CD Study II (M04-691). In CD Study I, 299 TNF-antagonist naïve patients were randomised to one of four treatment groups; the placebo group received placebo at Weeks 0 to 2, the 160/80 group received 160mg Humira at Week 0 and 80mg at Week 2, the 80/40 group received 80mg at Week 0 and 40mg at Week 2, and the 40/20 group received 40mg at Week 0 and 20mg at Week 2. In CD Study II, 325 patients who had lost response or were intolerant to infliximab were randomised to receive either 160mg Humira at Week 0 and 80mg at Week 2, or placebo at Weeks 0 and 2.

Maintenance of clinical remission was evaluated in a third study, CD Study III (M02-404). In CD Study III, 854 patients received open-label 80 mg Humira at Week 0 and 40 mg Humira at Week 2. Patients were then randomised at Week 4 to 40 mg Humira fortnightly, 40 mg Humira every week or placebo with a total study duration of 56 weeks. Patients in clinical response (decrease in CDAI ≥ 70) at Week 4 were stratified and analysed separately from those not in clinical response at Week 4. Corticosteroid taper was permitted after Week 8. Fistula healing was an important pre-determined secondary endpoint for this study.

Clinical Results

CD Study I / CD Study II

A statistically significantly greater percentage of the groups treated with 160/80mg Humira achieved induction of clinical remission versus placebo at Week 4 regardless of whether the patients were TNF antagonist naïve (CD Study I) or had been previously exposed to infliximab (CD Study II) (see table 13)

**Table 13: Induction of Clinical Remission and Response
(Percent of Patients)**

	CD Study I		CD Study II	
	Placebo N=74	HUMIRA 160/80 mg N=76	Placebo N=166	HUMIRA 160/80 mg N=159
Week 4				
Clinical remission	12%	36%*	7%	21%*
Clinical response (CR-100)	24%	49%**	25%	38%**
Clinical response (CR-70)	34%	58%**	34%	52%**

Clinical remission is CDAI score < 150 ; clinical response (CR-100) is decrease in CDAI ≥ 100 points; clinical response (CR-70) is decrease in CDAI ≥ 70 points

All p-values are pairwise comparisons of proportions for Humira vs. placebo

* $p < 0.001$

** $p < 0.01$

CD Study III (M02-404)

At Week 4, 58% (499/854) patients were in clinical response (decrease in CDAI ≥ 70 points) and were assessed in the primary analysis. Of those in clinical response at Week 4, 48% had been previously exposed to other anti-TNF therapy. At Weeks 26 and 56, statistically significantly greater proportions of patients who were in clinical response at Week 4 achieved clinical remission in the Humira maintenance groups compared to patients in the placebo maintenance group. Additionally, statistically significantly

greater proportions of patients receiving concomitant corticosteroids at baseline were in clinical remission and were able to discontinue corticosteroid use for at least 90 days in the Humira maintenance groups compared to patients in the placebo maintenance group at Weeks 26 and 56 (see table 15).

Disease-related hospitalisations and surgeries were statistically significantly reduced with adalimumab compared with placebo at Week 56 (See table 14).

Table 14: Hospitalisations to Week 56 (ITT population)

	Placebo	40 mg HUMIRA fortnightly	40 mg HUMIRA every week	Combined HUMIRA
	N=261	N=260	N=257	N= 517
	n (%)	n (%)	n (%)	n (%)
All-cause Hospitalisation	47 (18)	25 (9.6) *	29 (11.3) *	54 (10.4) *
CD – Related Hospitalisation	31 (11.9)	16 (6.2) *	18 (7.0)*	34 (6.6) *
Major Surgery	11 (4.2)	1 (0.4) *	2 (0.8) *	3 (0.6) *

* p ≤0.05

Clinical remission results presented in Table 15 remained relatively constant irrespective of previous TNF antagonist exposure.

Of those in response at Week 4 who attained remission during the study, patients in Humira maintenance groups maintained remission for a significantly longer time that patients in the placebo maintenance group (see Figure 5). Among patients who were not in response by Week 12, therapy continued beyond 12 weeks did not result in significantly more responses. The group that received Humira every week did not show significantly higher remission rates than the group that received Humira fortnightly.

Table 15: Maintenance of Clinical Remission and Response (Percent of Patients)

	Placebo	40 mg HUMIRA fortnightly	40 mg HUMIRA every week
Week 26	N=170	N=172	N=157
Clinical remission	17%	40%*	47%*
Clinical response (CR-100)	27%	52%*	52%*
Clinical response (CR-70)	28%	54%*	56%*
Patients in steroid-free remission for ≥ 90 days ^a	3% (2/66)	19% (11/58)**	15% (11/74)**
Week 56	N=170	N=172	N=157
Clinical remission	12%	36%*	41%*
Clinical response (CR-100)	17%	41%*	48%*
Clinical response (CR-70)	18%	43%*	49%*
Patients in steroid-free remission for ≥ 90 days ^a	5% (3/66)	29% (17/58)*	20% (15/74)**

Clinical remission is CDAl score <150; clinical response (CR-100) is decrease in CDAl ≥ 100 points; clinical response (CR-70) is decrease in CDAl ≥ 70 points

* p<0.001 for Humira vs. placebo pairwise comparisons of proportions

** p<0.02 for Humira vs. placebo pairwise comparisons of proportions

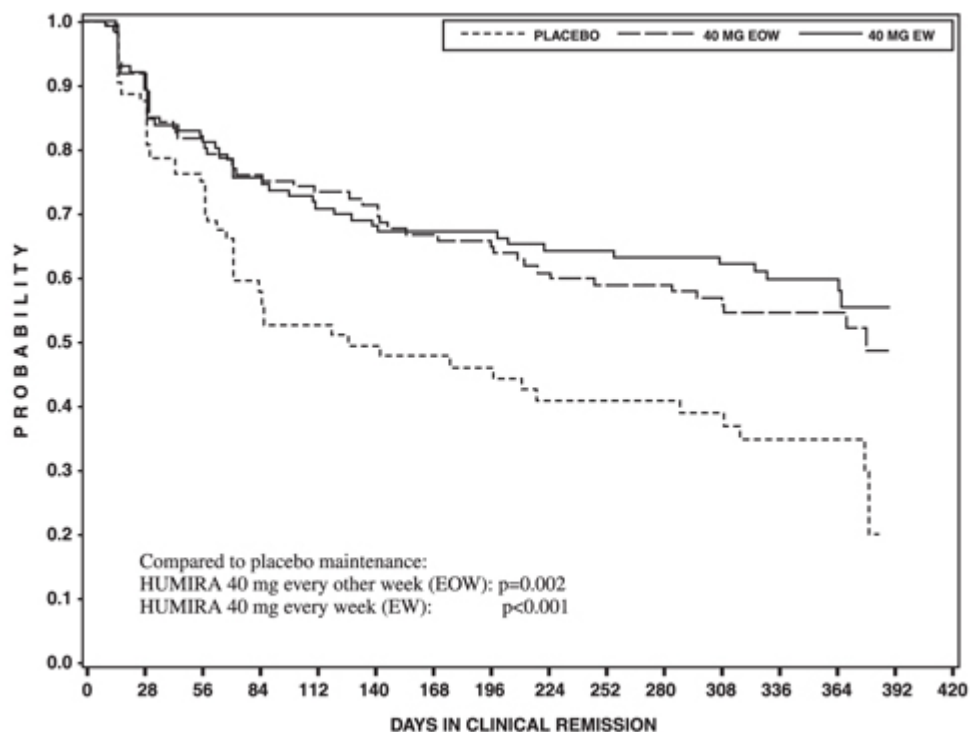
^a Of those receiving corticosteroids at baseline

117/854 patients had draining fistulas both at screening and at baseline. For the assessment of fistula healing, the data for both doses of adalimumab used in the study were pooled. The proportion of subjects (IIT population) with fistula healing at Week 26 was statistically significantly greater in patients treated with adalimumab [21/70 (30.0%)] compared to placebo [6/47 (12.8%)]. Complete fistula healing was maintained through Week 56 in 23/70 (32.9%) and 6/47 (12.8%) patients (ITT population) in the adalimumab and placebo groups, respectively

117/276 patients from CD study I and 272/777 patients from CD studies II and III were followed through at least 3 years of open-label adalimumab therapy. 88 (75.2%) and 189 (69.5%) patients, respectively, continued to be in clinical remission. Clinical response (CR-100) was maintained in 102 (87.2%) and 233 (85.7%) patients, respectively.

An endoscopy study (n=135) assessed rates of mucosal healing in patients with moderate to severe Crohn's Disease given either adalimumab or placebo. After 8 weeks of randomised treatment (Week 12 of study) there was a trend towards higher levels of mucosal healing in subjects given adalimumab compared with subjects given placebo but the differences were not statistically significant (healing in 27.4% (17/62) adalimumab vs 13.1% (8/61) given placebo; p = 0.056). Subjects who continued randomised adalimumab for 52 weeks (n=135) were more likely to experience mucosal healing relative to placebo (healing in 24.2% [15/62] adalimumab vs 0% [0/61] given placebo; p<0.001).

Figure 5: Days in Clinical Remission for Patients Who Achieved Clinical Remission in CD Study III



Patient Reported Outcomes

In CD Study I and CD Study II, statistically significant improvement in disease-specific inflammatory bowel disease questionnaire (IBDQ) total score was achieved at Week 4 in patients randomised to Humira 160/80 mg compared to placebo. Statistically significant improvement from baseline in IBDQ scores was seen at Weeks 26 and 56 in CD Study III among the adalimumab treatment groups compared to the placebo group.

Clinical Trials for Psoriasis

The safety and efficacy of Humira were assessed in over 1,600 patients 18 years of age or older with moderate to severe chronic plaque psoriasis who were candidates for systemic therapy or phototherapy in randomized, double-blind, well-controlled studies.

Ps Study I (M03-656) evaluated 1212 patients with chronic plaque psoriasis with $\geq 10\%$ BSA involvement and Psoriasis Area and Severity Index (PASI) ≥ 12 within three treatment periods. In period A, patients received placebo or Humira subcutaneously at an initial dose of 80 mg at Week 0 followed by a dose of 40 mg fortnightly starting at Week 1. After 16 weeks of therapy, patients 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 Humira fortnightly. After 17 weeks of open label therapy, patients 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 Humira fortnightly or placebo for an additional 19 weeks. Across all treatment groups the mean baseline PASI score was 18.9 and the baseline Physician's Global Assessment (PGA) score ranged from "moderate" (52.6%) to "severe" (41.3%) to "very severe" (6.1%).

Ps Study II (M04-716) compared the efficacy and safety of Humira versus methotrexate and placebo in 271 patients with 10% BSA involvement and PASI ≥ 10 . Patients received placebo, an initial dose of MTX 7.5 mg and thereafter dose increases up to Week 12, with a maximum dose of 25 mg or an initial dose of 80 mg Humira followed by 40 mg fortnightly (starting one week after the initial dose) for 16 weeks. There are no data available comparing Humira and MTX beyond 16 weeks of therapy. Patients receiving MTX who achieved a \geq PASI 50 response at Week 8 and/or 12 did not receive further dose increases. Across all treatment groups, the mean baseline PASI score was 19.7 and the baseline PGA score ranged from "mild" (<1%) to "moderate" (48%) to "severe" (46%) to "very severe" (6%).

Ps Study III (M02-528) evaluated 148 patients with chronic plaque psoriasis with $\geq 5\%$ BSA involvement for at least 1 year. Patients received placebo or Humira subcutaneously at a dose of 40 mg fortnightly starting at Week 1 after an initial dose of 80 mg at Week 0 or Humira at an initial dose of 80 mg at Week 0 followed by a dose of 40 mg weekly.

Patients participating in all Phase 2 and Phase 3 psoriasis studies were eligible to enrol into an open-label extension trial (M03-658) where Humira was given for at least an additional 108 weeks at 40mg fortnightly, with the option to dose-escalate to 40 mg weekly if response was sub-optimal.

Clinical Results

In Ps Studies I, II and III, the primary endpoint was the proportion of patients who achieved a reduction in PASI score of at least 75% (PASI 75) from baseline at Week 16 for Ps Studies I and II and Week 12 for Ps Study III. Other evaluated outcomes in Ps Studies I, II, and III included the PGA and other PASI measures. Ps Study I had an additional primary endpoint of loss of adequate response after Week 33 and on or before Week 52. Loss of adequate response is defined as a PASI score after Week 33 and on or before Week 52 that resulted in a <PASI 50 response relative to baseline with a minimum of a 6-point increase in PASI score relative to Week 33. In Ps Studies I and II, more patients randomized to Humira than to placebo achieved at least a 75% reduction from baseline of PASI score at Week 16. Other relevant clinical parameters including PASI 100 (i.e. complete clearance of psoriasis skin signs) and PGA of "clear or minimal" were also improved over placebo. Patients with \geq PASI 75 response continued to Week 33. In Ps Study I, patients who were PASI 75 responders and were re-randomised to continue Humira therapy at Week 33 were less likely to experience a loss of adequate response on or before Week 52 than the PASI 75 responders who were re-randomised to placebo at Week 33 (4.9% versus 28.4%, $p < 0.001$). In Ps Study II, superior results were achieved for PASI 75, PASI 100 and PGA of "clear or minimal" in patients randomized to the Humira treatment group versus those randomized to receive methotrexate (see Tables 16 and 17).

Table 16: Ps Study I (M03-656)

	Period A		Period B	Period C	
	Efficacy Results at 16 Weeks (Percent of Patients)		Efficacy Results at 33 Weeks (Percent of Patients)	Among PASI 75 Responders at Week 33, Efficacy Results at 52 Weeks (Percent of Patients)	
	Placebo N=398	Humira 40 mg eow N=814	Humira 40 mg eow N=580	Placebo N=240	Humira 40 mg eow N=250
≥PASI 75	6.5	70.9 ^a	84.5	42.5	79.2
PASI 100	0.8	20.0 ^a	30.3	7.5	32.0
PGA: Clear/minimal	4.3	62.2 ^a	73.3	27.9	68.0

^a p<0.001, Humira vs. placebo

Table 17: Ps Study II (M04-716)
Efficacy Results at 16 Weeks (Percent of Patients)

	Placebo N=53	MTX N=110	Humira 40 mg eow N=108
≥PASI 75	18.9	35.5	79.6 ^{a, b}
PASI 100	1.9	7.3	16.7 ^{c, d}
PGA: Clear/minimal	11.3	30.0	73.1 ^{a, b}

^a p<0.001, Humira vs. placebo
^b p<0.001 Humira vs. methotrexate
^c p< 0.01 Humira vs. placebo
^d p< 0.05 Humira vs. methotrexate

Two of the continuous treatment populations entering trial M03-658 were those from Period C of Study I and those from Study II.

250 subjects in the Humira group in Period C of Study I achieved PASI 75 at Weeks 16 and 33 and received continuous Humira therapy at 40 mg fortnightly for up to 52 weeks. Of these, 233 entered the extension trial M03-658 and the proportion of patients with PGA of “clear or minimal” response was 70.0% at entry to the extension trial (52 weeks Humira treatment), 73.4% after 76 weeks treatment, and 59.0% after 160 weeks treatment. The corresponding percentages for PASI 75 were 83.7% at entry, 86.5% after 76 weeks treatment, and 74.7% after 160 weeks treatment.

108 subjects in the Humira group of Study II received continuous Humira therapy at 40 mg fortnightly for 16 weeks. Of these, 94 entered the extension trial M03-658, and the proportion of these patients with PGA of “clear or minimal” response was 68.1% at entry to the extension trial (16 weeks Humira treatment) and 46.2% after 124 weeks treatment. The corresponding percentages for PASI 75 were 74.5% at entry and 58.1% after 124 weeks treatment.

There was a withdrawal and retreatment evaluation in the extension trial (M03-658) after subjects had received at least 2 years of treatment with Humira. A pre-specified evaluable population of stable responders to Humira was assessed after withdrawal of Humira. This population consisted of subjects with stable psoriasis defined as PGA clear or minimal at the last 2 visits at least 12 weeks apart and receiving Humira 40 mg fortnightly during the last 12 weeks. If subjects relapsed (PGA became moderate or worse) during the withdrawal period, Humira was recommenced at an initial dose of 80 mg and then, from the following week, at 40 mg fortnightly. After 178 subjects had relapsed and recommenced Humira, the remaining subjects who had not relapsed were also eligible for retreatment with Humira.

Of 347 stable responders withdrawn from Humira, 339 had at least one post-baseline evaluation. Approximately half (55.5%) of these subjects relapsed. The median time to relapse was approximately 5 months. None of the subjects experienced rebound of disease (PASI ≥ 125% or new generalised erythrodermic or pustular psoriasis within 3 months of withdrawal of Humira). The number of retreated subjects was 285, of whom 178 had relapsed during the withdrawal period. At week 16 of retreatment,

PGA “clear or minimal” increased from 0% to 69.1% in relapsed subjects and from 59.8% to 88.8% in non-relapsed subjects. Therefore, after withdrawal of Humira and relapse, most subjects responded to retreatment within 16 weeks.

Quality of Life

Patient Reported Outcomes (PRO) were evaluated by several measures. Quality of Life was assessed using the disease-specific Dermatology Life Quality Index (DLQI) in Ps Study I and Ps Study II. In Ps Study I, patients receiving Humira demonstrated clinically meaningful improvement in the DLQI total score, disease severity, pain, and pruritus compared to the placebo group at both Weeks 4 & 16. The DLQI result was maintained at Week 52. In Ps Study II, patients receiving Humira demonstrated clinically meaningful improvement in the DLQI total score, disease severity, and pruritus compared to the placebo and methotrexate groups at Week 16, and clinically meaningful improvement in pain compared to the placebo group at Week 16.

The Short Form Health Survey (SF-36) was used to assess general health-related quality of life in Ps Study I. The Humira-treated patients had significantly greater improvement in the SF-36 Physical Component Summary (PCS) and Mental Component Summary (MCS) scores.

IMMUNOGENICITY

Patients in RA Studies I, II, and III were tested at multiple time points for antibodies to adalimumab during the 6- to 12-month period. Approximately 5.5% (58 of 1,062) of adult rheumatoid arthritis patients receiving Humira developed low-titer antibodies to adalimumab at least once during treatment, which were neutralizing *in vitro*. Patients treated with concomitant MTX had a lower rate of antibody development than patients on Humira monotherapy (1% versus 12%). No apparent correlation of antibody development to adverse events was observed. With monotherapy, patients receiving fortnightly dosing may develop antibodies more frequently than those receiving weekly dosing. In patients receiving the recommended dosage of 40 mg fortnightly as monotherapy, the ACR 20 response was lower among antibody-positive patients than among antibody-negative patients. The long-term immunogenicity of Humira is unknown.

In the polyarticular juvenile idiopathic arthritis trial a greater percentage of patients developed antibodies to Humira compared to adult rheumatoid arthritis patients. Antibody formation was lower when Humira was given together with methotrexate in comparison with use as monotherapy. There was no apparent correlation between the presence of antibodies and adverse events. In patients with polyarticular juvenile idiopathic arthritis, adalimumab antibodies were identified in 27/171 subjects (15.8%) treated with adalimumab. In patients not given concomitant methotrexate, the incidence was 22/86 (25.6%), compared to 5/85 (5.9%) when adalimumab was used as add-on to methotrexate.

In patients with ankylosing spondylitis, the rate of development of antibodies to adalimumab in Humira-treated patients was comparable to patients with rheumatoid arthritis. In patients with psoriatic arthritis, the rate of antibody development in patients receiving Humira monotherapy was comparable to patients with rheumatoid arthritis; however, in patients receiving concomitant methotrexate the rate was 7% compared to 1% in rheumatoid arthritis. The immunogenicity rate was 8% for psoriasis patients who were treated with Humira monotherapy.

In plaque psoriasis patients on long term adalimumab monotherapy who participated in a withdrawal and retreatment study, the rate of antibodies to adalimumab after retreatment was similar to the rate observed prior to withdrawal.

The data reflect the percentage of patients whose test results were considered positive for antibodies to adalimumab in an ELISA assay, and are highly dependent on the sensitivity and specificity of the assay. For these reasons, comparison of the incidence of antibodies to adalimumab with the incidence of antibodies to other products may be misleading.

Indications

Rheumatoid Arthritis

Humira is indicated for reducing signs and symptoms, as well as inhibiting the progression of structural damage in adult patients with moderate to severely active rheumatoid arthritis. This includes the treatment of patients with recently diagnosed moderate to severely active disease who have not received methotrexate.

Humira can be used alone or in combination with methotrexate.

Polyarticular juvenile idiopathic arthritis

Humira in combination with methotrexate is indicated for reducing the signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in patients aged 4 years of age and older. Humira can be given as monotherapy in case of intolerance or when continued treatment with methotrexate is inappropriate.

Psoriatic Arthritis

Humira is indicated for the treatment of signs and symptoms, as well as inhibiting the progression of structural damage, of moderate to severely active psoriatic arthritis in adult patients where response to previous DMARDs has been inadequate.

Ankylosing Spondylitis

Humira is indicated for reducing signs and symptoms in patients with active ankylosing spondylitis.

Crohn's Disease

Humira is indicated for the treatment of moderate to severe Crohn's disease in adults to reduce the signs and symptoms of the disease and to induce and maintain clinical remission in patients who have had an inadequate response to conventional therapies, or who have lost response to or are intolerant of infliximab.

Psoriasis

Humira is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

Contraindications

Humira should not be administered to patients with known hypersensitivity to Humira or any of its excipients.

Humira is contraindicated in severe infections including sepsis, active tuberculosis and opportunistic infections (see **PRECAUTIONS**).

Concurrent administration of Humira and anakinra (interleukin-1 receptor antagonist) is contraindicated (see **PRECAUTIONS**).

Moderate to severe heart failure (NYHA class III/IV).

Precautions

Infections

Serious infections, due to bacterial, mycobacterial, invasive fungal (disseminated or extrapulmonary histoplasmosis, aspergillosis, coccidioidomycosis), viral, parasitic or other opportunistic infections such as listeriosis, legionellosis and pneumocystis have been reported in patients receiving TNF-blocking agents, including Humira. Sepsis, rare cases of tuberculosis and candidiasis have also been reported with the use of TNF antagonists, including Humira. Other serious infections seen in clinical trials include pneumonia, pyelonephritis, septic arthritis and septicaemia. Hospitalisation or fatal outcomes associated with infections have been reported. Many of the serious infections have occurred in patients on concomitant immunosuppressive therapy that, in addition to their underlying disease could predispose them to infections.

Treatment with Humira should not be initiated in patients with active infections including chronic or localised infections until infections are controlled. In patients who have been exposed to tuberculosis, and patients who have travelled in areas of high risk of tuberculosis or endemic mycoses, such as histoplasmosis, coccidioidomycosis, or blastomycosis, the risk and benefits of treatment with Humira should be considered prior to initiating therapy (see **Other Opportunistic Infections**).

Patients should be monitored closely for infections – including tuberculosis before, during and after treatment with Humira.

Patients who develop a new infection while undergoing treatment with Humira should be monitored closely and undergo a complete diagnostic evaluation. Administration of Humira should be discontinued if a patient develops a new serious infection or sepsis, and appropriate antimicrobial or antifungal therapy should be initiated. Physicians should exercise caution when considering the use of Humira in patients with a history of recurring infection or with underlying conditions, which may predispose patients to infections.

Hepatitis B Virus

Use of TNF blockers, including Humira, has been associated with 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. Patients at risk for HBV infection should be evaluated for evidence of prior HBV infection before initiating TNF blocker therapy. Prescribers should exercise caution in prescribing TNF blockers for patients identified as carriers of HBV. Patients who are carriers of HBV and require treatment with TNF blockers should be closely monitored for signs and symptoms of active HBV infection throughout therapy and for several months following termination of therapy. 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. In patients who develop HBV reactivation, Humira should be stopped and effective anti-viral therapy with appropriate supportive treatment should be initiated.

Tuberculosis

As observed with other TNF-antagonists, tuberculosis associated with administration of Humira in clinical trials has been reported.

While cases were observed at all doses, the incidence of tuberculosis reactivations was particularly increased at doses of Humira that were higher than the recommended dose.

Before initiation of therapy with Humira, all patients should be evaluated for both active or inactive (latent) tuberculosis infection. This evaluation should include a detailed medical history with possible previous exposure to patients with active tuberculosis and previous and/or current immunosuppressive therapy. Appropriate screening tests (e.g., chest X-ray or tuberculin test) should be performed in accordance with local recommendations. Treatment of latent tuberculosis infections should be initiated prior to therapy with Humira. When tuberculin skin testing is performed for latent tuberculosis infection, an induration size of

5mm or greater should be considered positive, even if vaccinated previously with Bacille Calmette-Guerin (BCG).

The possibility of undetected latent tuberculosis should be considered especially in patients who have immigrated from or travelled to countries with a high prevalence of tuberculosis or who had close contact with a person with active tuberculosis.

If active tuberculosis is diagnosed, Humira therapy must not be initiated.

If latent tuberculosis is diagnosed, appropriate anti-tuberculosis prophylaxis in accordance with local recommendations should be initiated before starting treatment with Humira. Anti-tuberculosis therapy prior initiating Humira should also be considered in patients who have a negative test for latent tuberculosis but have risk factors for TB infection. The decision to initiate anti-tuberculosis therapy in these patients should only be made after taking into account both the risk for latent tuberculosis infection and the risks of anti-tuberculosis therapy. If necessary, consultation should occur with a physician with expertise in the treatment of tuberculosis. The benefit/risk balance of therapy with Humira should be very carefully considered.

Anti-tuberculosis treatment of patients with latent tuberculosis infection reduces the risk of reactivation in patients receiving treatment with Humira. However, active tuberculosis has developed in patients receiving Humira whose screening for latent tuberculosis infection was negative, and some patients who have previously received treatment for latent or active tuberculosis have developed active tuberculosis while being treated with TNF blocking agents.

Patients receiving Humira should be monitored for signs and symptoms of active tuberculosis, particularly because tests for latent tuberculosis infection may be falsely negative. The risk of false negative tuberculin skin test results should be considered especially in patients who are severely ill or immunocompromised.

Patients should be instructed to seek medical advice if signs/symptoms (e.g., persistent cough, wasting/weight loss, low grade fever) suggestive of a tuberculosis infection occur.

Other Opportunistic Infections

Opportunistic infections, including invasive fungal infections, have been observed in patients receiving Humira. These infections are not consistently recognised in patients taking TNF blockers and this has resulted in delays in appropriate treatment, sometimes resulting in fatal outcomes.

Patients taking TNF blockers are more susceptible to serious fungal infections such as histoplasmosis, coccidioidomycosis, blastomycosis, aspergillosis, candidiasis, and other opportunistic infections. Those who develop fever, malaise, weight loss, sweats, cough, dyspnoea, and/or pulmonary infiltrates, or other serious systemic illness with or without concomitant shock should promptly seek medical attention for a diagnostic evaluation.

For patients who reside or travel in regions where mycoses are endemic, invasive fungal infections should be suspected if they develop the signs and symptoms of possible systemic fungal infection. Patients are at risk of histoplasmosis and other invasive fungal infections and hence clinicians should consider empiric antifungal treatment until the pathogen(s) are identified. Antigen and antibody testing for histoplasmosis may be negative in some patients with active infection. When feasible, the decision to administer empiric antifungal therapy in these patients should be made in consultation with a physician with expertise in the diagnosis and treatment of invasive fungal infections and should take into account both the risk for severe fungal infection and the risks of antifungal therapy. Patients who develop a severe fungal infection are also advised to stop the TNF blocker until infections are controlled.

Neurologic Events

Humira has been associated in rare cases with new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disease, including multiple sclerosis and peripheral demyelinating disease, including Guillain Barré syndrome. Prescribers should exercise caution in considering the use of Humira in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders.

Hypersensitivity Reactions

Serious allergic reactions associated with Humira were rare during clinical trials. Allergic reactions overall (e.g., allergic rash, anaphylactoid reaction, fixed-drug reaction, non-specific drug reaction, urticaria) have been observed in approximately 1% of patients. In post-marketing, serious allergic reactions including anaphylaxis have been reported rarely following Humira administration. If an anaphylactic reaction or other serious allergic reaction occurs, administration of Humira should be discontinued immediately and appropriate therapy initiated.

The needle cover of the syringe contains natural rubber (latex). This may cause severe allergic reactions in patients sensitive to latex.

Haematologic Events

Rare reports of pancytopenia including aplastic anaemia have been reported with TNF blocking agents. Adverse events of the haematologic system, including medically significant cytopenia (e.g., thrombocytopenia, leukopenia) have been infrequently reported with Humira (see **ADVERSE EFFECTS**). The causal relationship of these reports to Humira remains unclear. All patients should be advised 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 Humira. Discontinuation of Humira therapy should be considered in patients with confirmed significant haematologic abnormalities.

Immunosuppression

The possibility exists for TNF blocking agents, including Humira, to affect host defenses against infections and malignancies since TNF mediates inflammation and modulates cellular immune responses. In a study of 64 patients with rheumatoid arthritis treated with Humira, there was no evidence of depression of delayed-type hypersensitivity, depression of immunoglobulin levels, or change in enumeration of effector T- and B-cells and NK-cells, monocyte/macrophages, and neutrophils. The impact of treatment with Humira on the development and course of malignancies, as well as active and/or chronic infections is not fully understood. The safety and efficacy of Humira in patients with immunosuppression have not been evaluated. See **PRECAUTIONS - Infections** and **ADVERSE EFFECTS - Infections and Malignancies**.

Vaccinations

In a randomised, double-blind, placebo-controlled study in 226 adult rheumatoid arthritis patients treated with Humira, antibody responses to concomitant pneumococcal and influenza vaccines were assessed. Protective antibody levels to the pneumococcal antigens were achieved by 86% of patients in the Humira group compared to 82% in the placebo group. A total of 37% of Humira-treated subjects and 40% of placebo-treated subjects achieved at least a 2-fold increase in at least 3 out of 5 pneumococcal antigens. In the same study 98% of patients in the Humira group and 95% in the placebo group achieved protective antibody levels to the influenza antigens. A total of 52% of Humira-treated subjects and 63% of placebo-treated subjects achieved at least a 4-fold increase in at least 2 out of 3 influenza antigens.

Patients on Humira may receive concurrent vaccinations, except for live vaccines. No data are available on the secondary transmission of infection by live vaccines in patients receiving Humira.

It is recommended that polyarticular juvenile idiopathic arthritis patients, if possible, be brought up to date with all immunisations in agreement with current immunisation guidelines prior to initiating Humira therapy.

Congestive Heart Failure

In a clinical trial with another TNF antagonist worsening congestive heart failure and increased mortality due to congestive heart failure have been observed. Cases of worsening congestive heart failure have been reported in patients receiving Humira. Humira should be used with caution in patients with mild heart failure (NYHA class I/II). Humira is contraindicated in moderate or severe heart failure. Treatment

with Humira must be discontinued in patients who develop new or worsening symptoms of congestive heart failure.

Malignancies

In the controlled portions of clinical trials of TNF-antagonists, more cases of malignancies including lymphoma have been observed among patients receiving a TNF-antagonist, including Humira, compared with control patients (see **ADVERSE EFFECTS – Malignancies**). However, the occurrence was rare. Furthermore, there is an increased background lymphoma risk in rheumatoid arthritis patients with long-standing, highly active inflammatory disease, which complicates the risk estimation.

Very rare postmarketing reports of hepatosplenic T-cell lymphoma (HSTCL), a rare aggressive lymphoma that is often fatal, have been identified in patients treated with adalimumab. Most of the patients had prior infliximab therapy as well as concomitant azathioprine or 6-mercaptopurine use for inflammatory bowel disease. The potential risk with the combination of azathioprine or 6-mercaptopurine and Humira should be carefully considered. The causal association of HSTCL with adalimumab is not clear.

With the current knowledge, a possible risk for the development of lymphomas or other malignancies in patients treated with a TNF-antagonist cannot be excluded.

Malignancies, some fatal, have been reported among children and adolescents who received treatment with TNF-blocking agents. 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. The malignancies occurred after a median of 30 months of therapy. 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 postmarketing reports.

No studies have been conducted that include patients with a history of malignancy or that continue treatment in patients who develop malignancy while receiving Humira. Thus, additional caution should be exercised in considering Humira treatment of these patients.

In an exploratory clinical trial evaluating the use of another anti-TNF agent, infliximab, in patients with moderate to severe chronic obstructive pulmonary disease (COPD), more malignancies, mostly in the lung or head and neck, were reported in infliximab-treated patients compared with control patients. All patients had a history of heavy smoking. Therefore, caution should be exercised when using any TNF-antagonist in COPD patients, as well as in patients with an increased risk for malignancy due to heavy smoking.

All patients, and in particular patients with a medical history of extensive immunosuppressant therapy or psoriasis patients with a history of PUVA treatment should be examined for the presence of non-melanoma skin cancer prior to and during treatment with Humira.

Cases of acute and chronic leukaemia have been reported in association with postmarketing TNF blocker use in rheumatoid arthritis and other indications. Patients with rheumatoid arthritis may be at a higher risk (up to 2-fold) than the general population for the development of leukaemia, even in the absence of TNF-blocking therapy.

Autoimmune Processes

Treatment with Humira may result in the formation of autoantibodies and rarely in the development of a lupus-like syndrome. The impact of long-term treatment with Humira on the development of autoimmune disease is unknown. If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Humira, treatment should be discontinued (see **ADVERSE EFFECTS – Autoantibodies**).

Concurrent Administration of TNF-alpha Inhibitor and Anakinra

Concurrent administration of etanercept and anakinra has been associated with an increased risk of serious infections, an increased risk of neutropenia and no additional benefit compared to these medicinal

products alone. The safety and efficacy of anakinra used in combination with adalimumab has not been established. Therefore, combination of adalimumab and anakinra is contraindicated.

Concurrent Administration of TNF-alpha Inhibitor and Abatacept

Concurrent administration of TNF antagonists and abatacept has been associated with an increased risk of infections including serious infections compared to TNF antagonists alone. This combination has not demonstrated increased clinical benefit. Thus, the combined use of TNF antagonists and abatacept is not recommended.

Use in Psoriasis

The safety and efficacy of adalimumab in combination with other systemic agents used in psoriasis or with phototherapy have not been studied. Adalimumab should not be used in combination with such agents.

Renal and Hepatic Impairment

Humira has not been studied in these patient populations. No dose recommendations can be made.

Surgery

There is limited safety experience of surgical procedures in patients treated with Humira. The long half-life of adalimumab should be taken into consideration if a surgical procedure is planned. A patient who requires surgery while on Humira should be closely monitored for infections, and appropriate actions should be taken. There is limited safety experience in patients undergoing arthroplasty while receiving Humira.

Effects on Fertility

The effect of adalimumab on fertility has not been investigated.

Use in Pregnancy (Category C)

Results obtained with a very high intravenous adalimumab dose (100 mg/kg/week) in an embryofetal toxicity study in cynomolgus monkeys were inconclusive. No developmental toxicity was observed with an intravenous dose of 30 mg/kg/week, which resulted in a serum drug concentration greater than 100-fold higher than the maximum value expected during therapy during 40 mg fortnightly. Parturition was unaffected by both doses.

There are no clinical data for pregnant women being treated with Humira. Because animal studies are not always predictive of human responses, the use of Humira during pregnancy is not recommended. Women of child bearing potential should be advised to use adequate contraception during Humira therapy. The long half-life of Humira should also be considered when discontinuing therapy.

Use in Lactation

It is not known whether adalimumab is excreted in animal or human milk or whether it would be absorbed by neonates after ingestion.

Because many drugs and immunoglobulins are excreted in human milk, and because of the potential for serious adverse reactions in breastfeeding infants from Humira, a decision should be made whether to discontinue breastfeeding or to discontinue the drug, taking into account the importance of the drug to the mother. The long half-life of Humira should also be considered when discontinuing therapy.

Paediatric Use

The safety and efficacy of Humira has not been established in other forms of JIA such as systemic JIA or oligoarticular JIA. The long term effects of Humira on the growth and development of children have not been studied.

Use in the Elderly

A total of 519 RA patients 65 years of age and older, including 107 patients 75 years and older, received Humira in clinical RA studies I-IV. No overall difference in effectiveness was observed between these subjects and younger subjects. The frequency of serious infection and malignancy among Humira-treated subjects over age 65 was higher than for those under age 65. Because there is a higher incidence of infections and malignancies in the elderly population in general, caution should be used when treating the elderly.

Carcinogenicity

Long-term animal studies have not been conducted to evaluate the carcinogenic potential of adalimumab.

Genotoxicity

No genotoxicity was observed in an *in-vitro* test for bacterial gene mutation or in an *in-vivo* mouse micronucleus test for clastogenicity.

Interactions with other Medicines

Humira has been studied in RA patients taking concomitant methotrexate (see **CLINICAL STUDIES** and **Pharmacokinetics – Steady State**). The data do not suggest the need for dose adjustment of either Humira or methotrexate. Interactions between Humira and drugs other than methotrexate have not been evaluated in formal pharmacokinetic studies. Concurrent administration of TNF-alpha inhibitors with anakinra or abatacept has been associated with an increased risk of serious infections (see **PRECAUTIONS** above)

Effects on Ability to Drive and Use Machines

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

Effects on Laboratory Tests

There is no known interference between Humira and laboratory tests.

Adverse Effects

Clinical Trials

Humira was studied in 6,728 patients in controlled and open label trials.

These trials included rheumatoid arthritis patients with short term and long standing disease, polyarticular juvenile idiopathic arthritis as well as psoriatic arthritis, ankylosing spondylitis, Crohn's disease and psoriasis patients. The data in Table 18 is based on the pivotal controlled Studies involving 4,419 patients receiving Humira and 2,552 patients receiving placebo or active comparator during the controlled period.

The proportion of patients who discontinued treatment due to adverse events during the double-blind, controlled portion of pivotal studies across all indications was 4.5% for patients taking Humira and 4.5% for control treated patients. The proportion of patients who discontinued treatment due to adverse events during the double-blind, placebo-controlled portion of RA Studies I, II, III and IV was 6.6% for patients taking Humira and 4.2% for placebo-treated patients.

Approximately 15% of patients can be expected to experience injection site reactions, based on the most common adverse event with adalimumab in controlled clinical studies.

Undesirable effects in paediatric patients with polyarticular juvenile idiopathic arthritis:

In general, the adverse events in paediatric patients were similar in frequency and type to those seen in adult patients.

Adverse events at least possibly causally-related to adalimumab for clinical studies, both clinical and laboratory, are displayed by system organ class and frequency (very common $\geq 1/10$; common $\geq 1/100$ to $< 1/10$; uncommon $\geq 1/1000$ to $< 1/100$); and rare $\geq 1/10000$ to $< 1/1000$ in Table 18 below.

The highest frequency seen among the various indications has been included.

Table 18: Adverse Drug Reactions in Clinical Studies

System Organ Class ^{a)}	Frequency	Adverse Reaction ^{a)}
Infections and infestations	Very common	respiratory tract infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral)
	Common	systemic infections (including sepsis, candidiasis and influenza), intestinal infections (including gastroenteritis viral), skin and soft tissue infections (including paronychia, cellulitis, impetigo, necrotising fasciitis and herpes zoster), ear infections, oral infections (including herpes simplex, oral herpes and tooth infections), reproductive tract infections (including vulvovaginal mycotic infection), urinary tract infections (including pyelonephritis), fungal infections
	Uncommon	opportunistic infections and tuberculosis (including coccidioidomycosis, histoplasmosis and mycobacterium avum complex infection), neurological infections (including viral meningitis), eye infections, bacterial infections, joint infections
Neoplasms benign, malignant and unspecified (including cysts and polyps)	Common	benign neoplasm, skin cancer excluding melanoma (including basal cell carcinoma and squamous cell carcinoma)
	Uncommon	lymphoma*, solid organ neoplasm (including breast cancer, lung neoplasm and thyroid neoplasm), melanoma*
Blood and the lymphatic system disorders	Very common	leucopaenia (including neutropaenia and agranulocytosis), anaemia

System Organ Class^{a)}	Frequency	Adverse Reaction^{a)}
	Common	thrombocytopaenia, leucocytosis
	Uncommon	idiopathic thrombocytopaenic purpura
	Rare	pancytopaenia
Immune system disorders	Common	hypersensitivity, allergies (including seasonal allergy)
Metabolism and nutrition disorders	Very common	lipids increased
	Common	hypokalaemia, uric acid increased, blood sodium abnormal, hypocalcaemia hyperglycemia, hypophosphotemia, dehydration
Psychiatric disorders	Common	mood alterations (including depression), anxiety, insomnia
Nervous system disorders	Very common	headache
	Common	paraesthesias (including hypoaesthesia), migraine, sciatica
	Uncommon	tremor, neuropathy
	Rare	multiple sclerosis
Eye disorders	Common	visual impairment, conjunctivitis
	Uncommon	blepharitis, eye swelling, diplopia
Ear and labyrinth disorders	Common	vertigo
	Uncommon	deafness, tinnitus
Cardiac disorders	Common	tachycardia
	Uncommon	arrhythmia, congestive heart failure
	Rare	cardiac arrest

System Organ Class^{a)}	Frequency	Adverse Reaction^{a)}
Vascular disorders	Common	hypertension, flushing, haematoma
	Uncommon	vascular arterial occlusion, thrombophlebitis, aortic aneurysm
Respiratory, thoracic and mediastinal disorders	Common	cough, asthma, dyspnoea
	Uncommon	chronic obstructive pulmonary disease, interstitial lung disease, pneumonitis
Gastrointestinal disorders	Very common	abdominal pain, nausea and vomiting
	Common	GI haemorrhage, dyspepsia, gastroesophageal reflux disease, sicca syndrome
	Uncommon	pancreatitis, dysphagia, face oedema
Hepato-biliary disorders	Very common	liver enzymes elevated
	Uncommon	cholecystitis and cholelithiasis, bilirubin increased, hepatic steatosis
Skin and subcutaneous tissue disorders	Very Common	rash (including exfoliative rash),
	Common	pruritus, urticaria, bruising (including purpura), dermatitis (including eczema), onychoclasia (e.g. nail disorders), hyperhidrosis
	Uncommon	night sweats, scar
Musculoskeletal, connective tissue and bone disorders	Very common	musculoskeletal pain
	Common	muscle spasms (including blood creatine phosphokinase increased)

System Organ Class ^{a)}	Frequency	Adverse Reaction ^{a)}
	Uncommon	rhabdomyolysis systemic lupus erythematosus
Renal and urinary disorders	Common	haematuria, renal impairment
	Uncommon	nocturia
Reproductive system and breast disorders	Uncommon	erectile dysfunction
General disorders and administration site conditions	Very Common	injection site reaction (including injection site erythema)
	Common	chest pain, oedema
	Uncommon	inflammation
Investigations	Common	coagulation and bleeding disorders (including activated partial thromboplastin time prolonged), autoantibody test positive (including double stranded DNA antibody), blood lactate dehydrogenase increased
Injury and poisoning	Common	impaired healing

* including open label extension studies

^{a)} MedDRA

Table 18 contains adverse reactions (ADRs), which in some cases represent groups of related Preferred Terms to represent a medical concept. The ADRs presented in the table were included based on criteria including statistical significance, doubling in rate in adalimumab treated patients compared to placebo treated patients, a rate greater than 1% for adalimumab treated patients and medical importance assessment.

Table 19 contains adverse reactions reported in at least 1% of RA patients with higher incidence ($\geq 1\%$) in patients treated with adalimumab compared to control in 4 placebo-controlled RA trials (RA study I-IV). In general, the adverse reactions across all indications were similar to those seen in RA patients

Table 19. Adverse Reactions reported by Patients Treated with HUMIRA during Placebo-Controlled Period of Rheumatoid Arthritis Studies

System Organ Class ^{a)}	Adverse Reaction ^{a)}	Adalimumab (N = 1380) (%)	Control (N = 690) (%)
Infections and infestations	respiratory tract infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral)	39	33
	oral infections (including herpes simplex, oral herpes and tooth infections)	7	5
	reproductive tract infections (including vulvovaginal mycotic infection)	3	1

System Organ Class^{a)}	Adverse Reaction^{a)}	Adalimumab (N = 1380) (%)	Control (N =690) (%)
Blood and the lymphatic system disorders	anaemia	13	8
	leucopaenia (including neutropaenia and agranulocytosis)	14	8
	leucocytosis	1	0
	thrombocytopenia	1	0
Metabolism and nutrition disorders	lipids increased	17	8
	uric acid increased	6	3
	blood sodium abnormal	10	3
	hypokalaemia	3	2
	hypophosphotaemia	2	1
	blood potassium increased	3	1
Nervous system disorders	headache	14	8
Vascular disorders	hypertension	6	3
	flushing	2	1
Respiratory, thoracic and mediastinal disorders	cough	7	6
Gastrointestinal disorders	nausea and vomiting	12	11
	abdominal pain	10	6
	sicca syndrome	3	2
	GI haemorrhage	2	1
Hepato-biliary disorders	liver enzymes elevated	12	8
Skin and subcutaneous tissue disorders	rash (including exfoliative rash)	14	7
	pruritus	5	1
	dermatitis (including eczema)	3	1
	bruising (including purpura)	2	0
Musculoskeletal, connective tissue and bone disorders	musculoskeletal pain	14	9
	muscle spasms (including blood creatine phosphokinase increased)	5	4
Renal and urinary disorders	haematuria	9	4
	renal impairment	8	4
General disorders and administration	injection site reaction (including injection site erythema)	20	13

System Organ Class^{a)}	Adverse Reaction^{a)}	Adalimumab (N = 1380) (%)	Control (N =690) (%)
site conditions	oedema	5	4
Investigations	coagulation and bleeding disorders (including activated partial thromboplastin time prolonged)	9	4
	blood lactate dehydrogenase increased	2	1

^{a)} MedDRA

Injection Site Reactions

In the pivotal controlled trials, 15% of patients treated with Humira developed injection site reactions (erythema and/or itching, haemorrhage, pain or swelling), compared to 9% of patients receiving control treatments. Most injection site reactions were described as mild and generally did not necessitate drug discontinuation.

Infections

In pivotal controlled trials, the rate of infection was 1.50 per patient year in the Humira-treated patients and 1.42 per patient year in the control treated patients. The infections consisted primarily of upper respiratory tract infections, bronchitis and urinary tract infections. Most patients continued on Humira after the infection resolved. The incidence of serious infections was 0.03 per patient year in Humira-treated patients and 0.03 per patient year in control treated patients. In the controlled and open label studies with Humira, serious infections (including fatal infections, which occurred rarely) have been reported, which include reports of tuberculosis (including miliary and extrapulmonary locations) and invasive opportunistic infections (e.g. disseminated histoplasmosis, pneumocystis carinii pneumonia, aspergillosis and listeriosis).

Most, but not all of the cases of tuberculosis occurred within the first eight months after initiation of therapy and may reflect recrudescence of latent disease.

Malignancies

During the controlled portions of pivotal Humira trials at least 12 weeks in duration in patients with moderately to severely active rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease and psoriasis, malignancies, other than lymphoma and non-melanoma skin cancer, were observed at a rate (95% confidence interval) of 6.6 (4.0, 10.8) per 1000 patients years among 3917 Humira treated patients versus a rate of 4.2 (1.8, 10.1) per 1000 patient years among 2247 control patients (median duration of treatment was 5.6 months for Humira and 4.0 months for control treated patients). The rate (95% confidence interval) of non-melanoma (basal cell and squamous cell) skin cancers was 9.9 (6.6, 14.8) per 1000 patient years among Humira treated patients and 2.5 (0.8, 7.9) per 1000 patient years among control patients. Of these skin cancers, squamous cell carcinomas occurred at rates (95% confidence interval) of 2.5 (1.1, 5.5) per 1000 patient years among Humira treated patients and 0.8 (0.1, 6.0) per 1000 patient years among control patients. The rate (95% confidence interval) of lymphomas was 0.8 (0.2, 3.3) per 1000 patient years among Humira treated patients and 0.8 (0.1, 6.0) per 1000 patient years among control patients.

When combining controlled portions of these trials and ongoing open label extension studies with a median duration of approximately 3.4 years including 4954 patients and over 21021 patient years of therapy, the observed rate of malignancies, other than lymphoma and non-melanoma skin cancers is approximately 9.1 per 1000 patient years. The observed rate of non-melanoma skin cancers is approximately 10.1 per 1000 patient years and the observed rate of lymphomas is approximately 1.1 per 1000 patient years.

In post-marketing experience from January 2003, predominantly in patients with rheumatoid arthritis, the reported rate of malignancies other than lymphomas and non-melanoma skin cancers is approximately

1.7 per 1000 patient years. The reported rates for non-melanoma skins cancers and lymphomas are approximately 0.2 and 0.4 per 1000 patient years, respectively.

Rare post-marketing cases of hepatosplenic T-cell lymphoma have been reported in patients treated with adalimumab (See **PRECAUTIONS**)

Autoantibodies

Patients had serum samples tested for autoantibodies at multiple time points in rheumatoid arthritis studies I – V. In these adequate and well-controlled trials, 11.9% of patients treated with Humira and 8.1% of placebo and active control treated patients that had negative baseline antinuclear antibody titres reported positive titres at Week 24. Two patients out of 3989 treated with Humira in all rheumatoid and psoriatic arthritis, and ankylosing spondylitis studies developed clinical signs suggestive of new-onset lupus-like syndrome. The patients improved following discontinuation of therapy. No patients developed lupus nephritis or central nervous system symptoms. The impact of long-term treatment with Humira on the development of autoimmune diseases is unknown.

Psoriasis: New-onset and Worsening

Cases of new onset psoriasis, including pustular psoriasis and palmoplantar psoriasis, and cases of worsening of pre-existing psoriasis have been reported with the use of TNF blockers, including HUMIRA. Many of these patients were taking concomitant immunosuppressants (e.g., MTX, corticosteroids). Some of these patients required hospitalisation. Most patients had improvement of their psoriasis following discontinuation of their TNF blocker. Some patients have had recurrences of the psoriasis when they were re-challenged with a different TNF blocker. Discontinuation of HUMIRA should be considered for severe cases and those that do not improve or that worsen despite topical treatments.

Liver Enzyme Elevations

In controlled Phase 3 trials of Humira (40 mg SC every other week), in patients with RA and PsA with a control period duration ranging from 4 to 104 weeks, ALT elevations $\geq 3 \times$ ULN occurred in 3.7% of Humira-treated patients and 1.6% of control-treated patients. Since many of the patients in these trials were also taking medications that cause liver enzyme elevations (e.g., NSAIDS, MTX), the relationship between HUMIRA and the liver enzyme elevations is not clear.

In controlled Phase 3 trials of Humira (initial doses of 160 mg and 80 mg, or 80 mg and 40mg on Days 1 and 15, respectively, followed by 40 mg every other week), in patients with Crohn's disease with a control period duration ranging from 4 to 52 weeks, ALT elevations $\geq 3 \times$ ULN occurred in 0.9% of Humira-treated patients and 0.9% of control-treated patients.

In controlled Phase 3 trials of Humira (initial dose of 80 mg then 40 mg every other week), in patients with plaque psoriasis with control a period duration ranging from 12 to 24 weeks, ALT elevations $\geq 3 \times$ ULN occurred in 1.8% of Humira-treated patients and 1.8% of control-treated patients.

In controlled Phase 3 trials of Humira (40 mg every other week), in patients with ankylosing spondylitis with a control period of 12 to 24 weeks, ALT elevations $\geq 3 \times$ ULN occurred in 2.44% of Humira-treated patients and 0.66% of control-treated patients.

In the JIA trial, the few transaminases elevations were small and similar in the placebo and adalimumab exposed patients and mostly occurred in combination with methotrexate

Across all indications in clinical trials ,patients with raised ALT were asymptomatic and in most cases elevations were transient and resolved on continued treatment. However, there have been very rare postmarketing reports of severe hepatic reactions including liver failure in patients receiving TNF blockers, including adalimumab. The causal relationship to adalimumab treatment remains unclear

Polyarticular Juvenile Idiopathic Arthritis Clinical Trial

In general, the adverse reactions in paediatric patients were similar in frequency and type to those seen in adult patients. Important findings and differences from adults are discussed in the following paragraphs.

Humira has been studied in 171 paediatric patients, 4 to 17 years of age, with polyarticular juvenile idiopathic arthritis. Severe adverse reactions reported in the study included neutropenia, streptococcal pharyngitis, increased aminotransferases, herpes zoster, myositis, metrorrhagia, appendicitis. Serious infections were observed in 4% of patients within approximately 2 years of initiation of treatment with Humira and included cases of herpes simplex, pneumonia, urinary tract infection, pharyngitis, and herpes zoster.

A total of 45% of children experienced an infection while receiving Humira with or without concomitant methotrexate in the first 16 weeks of treatment. The types of infections reported in polyarticular juvenile idiopathic arthritis (JIA) patients were generally similar to those commonly seen in outpatient JIA populations. Upon initiation of treatment, the most common adverse reactions occurring in the paediatric population treated with Humira were injection site pain and injection site reaction (19% and 16%, respectively). A less commonly reported adverse event in children receiving Humira was granuloma annulare which did not lead to discontinuation of Humira treatment.

In the first 48 weeks of treatment, non-serious hypersensitivity reactions were seen in approximately 6% of children and included primarily localised allergic hypersensitivity reactions and allergic rash. Isolated mild to moderate elevations of liver aminotransferases (ALT more common than AST) were observed in children with polyarticular JIA exposed to Humira alone; liver function tests (LFT) elevations were more frequent among those treated with the combination of Humira and methotrexate. In general, these elevations did not lead to discontinuation of Humira treatment.

In the polyarticular JIA trial, 10% of patients treated with Humira 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 children treated with Humira developed mild-to-moderate elevations of creatine phosphokinase (CPK). Elevations exceeding 5 times the upper limit of normal were observed in several patients. CPK levels decreased or returned to normal in all patients. Most patients were able to continue Humira without interruption.

Additional Adverse Reactions from Postmarketing Surveillance or Phase IV Clinical Trials

Adverse events have been reported during post-approval use of Humira. Because these events are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to Humira exposure.

Table 20: Additional Adverse Reactions from Postmarketing Surveillance or Phase IV Clinical Trials

Body System	Adverse Reaction
Infections and infestations	diverticulitis
Neoplasms benign, malignant and unspecified (including cysts and polyps)	Hepatosplenic T-cell lymphoma, leukaemia
Immune system disorders	Anaphylaxis, sarcoidosis
Nervous System Disorders	Cerebrovascular accident, demyelinating disorders (e.g. optic neuritis, Guillain-Barré syndrome)
Cardiac disorders	Myocardial infarction
Respiratory, thoracic and mediastinal disorders	Pulmonary embolism, pulmonary fibrosis; pleural effusion
Gastrointestinal Disorders	Intestinal perforation
Hepato-biliary disorders	Reactivation of hepatitis B, liver failure
Skin and subcutaneous tissue disorders	Alopecia, angioedema, cutaneous vasculitis, new onset or worsening of psoriasis (including palmoplantar pustular psoriasis), erythema multiforme, Stevens Johnson Syndrome
Musculoskeletal and connective tissue disorders	Lupus-like syndrome

Dosage and Administration

Humira is administered by subcutaneous injection.

This product is for one dose in one patient only.

Rheumatoid Arthritis

The recommended dose of Humira for adult patients with rheumatoid arthritis is 40 mg administered fortnightly as a single dose. Methotrexate, glucocorticoids, salicylates, nonsteroidal anti-inflammatory drugs or analgesics may be continued during treatment with Humira.

Some patients not taking concomitant methotrexate may derive additional benefit from increasing the dosing frequency of Humira to 40 mg every week.

Polyarticular Juvenile Idiopathic Arthritis

The recommended dose of Humira for patients 4 to 17 years of age with polyarticular juvenile idiopathic arthritis is based on weight as shown below. Methotrexate, glucocorticoids, salicylates, NSAIDs or analgesics may be continued during treatment with Humira.

Paediatric Patients (4 to 17 years)	Dose
15 kg to <30 kg	20 mg fortnightly (20 mg Pre-filled Syringe)
≥ 30 kg	40 mg fortnightly (Humira 40mg Pen or 40 mg Pre-filled Syringe)

Limited data are available for Humira treatment in paediatric patients with a weight below 15 kg.

Psoriatic Arthritis

The recommended dose of Humira for patients with psoriatic arthritis is 40 mg adalimumab administered fortnightly as a single dose.

Glucocorticoids, salicylates, nonsteroidal anti-inflammatory drugs, analgesics or disease-modifying anti-rheumatic drugs can be continued during treatment with Humira.

Ankylosing Spondylitis

The recommended dose of Humira for patients with ankylosing spondylitis is 40 mg adalimumab administered every fortnight as a single dose.

Glucocorticoids, salicylates, nonsteroidal anti-inflammatory drugs, analgesics or disease-modifying anti-rheumatic drugs can be continued during treatment with Humira.

Crohn's Disease

	Dose	Frequency
Induction	160 mg	Initial Dose (Day 0) as four injections OR as two injections on Day 0 and two injections on Day 1
	80mg	Second Dose (Day 14) as two injections
Maintenance	40mg	Starting Day 28 & continuing fortnightly

Aminosalicylates, corticosteroids, and/or immunomodulatory agents (e.g., 6-mercaptopurine and azathioprine) may be continued during treatment with Humira.

Patients usually respond within the induction phase. However, if a patient does not show any response, available data do not sufficiently support further Humira treatment.

Psoriasis

The recommended dose of Humira for adult patients is an initial dose of 80 mg, followed by 40 mg fortnightly, starting one week after the initial dose.

Preparation of Humira

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

Sites for self-injection include thigh or abdomen. Injection sites should be rotated. New injections should never be given into areas where the skin is tender, bruised, red or hard.

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

Humira should not be mixed in the same syringe or vial with any other medicine. Any unused product or waste material should be disposed of in accordance with local requirements.

Humira contains no antimicrobial agent. Discard any residue.

Overdosage

The maximum tolerated dose of Humira has not been established in humans. No dose-limiting toxicities have been observed during clinical trials with Humira. Multiple doses up to 10 mg/kg have been administered to patients in clinical trials without evidence of dose-limiting toxicities. 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 instituted immediately.

For advice on the management of overdose please contact the Poisons Information Centre. In Australia please call 13 11 26 and in New Zealand 0800 764 766.

Presentation and Storage Conditions

Humira (adalimumab) solution for injection for paediatric use is supplied as a sterile solution of 20 mg adalimumab dissolved in 0.4 mL sterile solution for subcutaneous administration in the following packaging configurations:

Humira 20 mg solution for injection in single-use pre-filled syringe:

- Carton containing 2 blisters, each containing 1 pre-filled syringe and 1 alcohol pad

Humira (adalimumab) solution for injection is supplied as a sterile solution of 40 mg adalimumab dissolved in 0.8 mL sterile solution for subcutaneous administration in the following packaging configurations:

Humira 40 mg solution for injection in single-use pre-filled syringe or pre-filled pen (for **patient use**):

- Carton containing 1 blister with 1 pre-filled syringe or pre-filled pen and 1 alcohol pad*
- Carton containing 2 blisters, each containing 1 pre-filled syringe or pre-filled pen and 1 alcohol pad.
- Carton containing 3 blisters, each containing 1 pre-filled syringe or pre-filled pen and 1 alcohol pad*
- Carton containing 4 blisters, each containing 1 pre-filled pen and 1 alcohol pad*
- Carton containing 6 blisters, each containing 1 pre-filled syringe or pre-filled pen and 1 alcohol pad.

Humira 40 mg solution for injection in single-use vial.

- Carton containing 1 blister with 1 vial, 1 empty sterile injection syringe in pouch and 2 alcohol pads *
The vial is fitted with rubber stoppers, aluminium crimps and flip-off seals.

Store at 2° C to 8° C (in a refrigerator) and store the syringe or vial in the outer carton. Do not freeze. Do not use beyond the expiration date.

* Not currently marketed New Zealand

Humira is a prescription only medicine.

Name and Address of the Sponsor

Abbott Laboratories (NZ) Ltd
4 Pacific Rise
Mt Wellington
Auckland
New Zealand

Poison Schedule of the Medicine

Prescription Only Medicine

Date of Preparation

15 December 2011

Version 23