

DATA SHEET

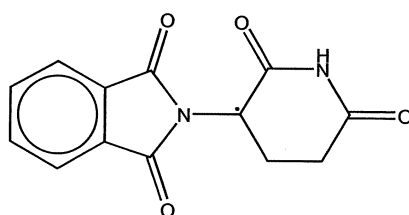
THALOMID HARD CAPSULES

Teratogenic effects:

Thalidomide has caused severe birth defects when taken during pregnancy. Thalidomide should never be used by women who are pregnant or who could become pregnant whilst taking the medicine or could become pregnant within 4 weeks after stopping the medicine. Even a single dose can cause birth defects.

NAME OF THE MEDICINE

Thalomid Hard Capsules contain thalidomide, 2-(2,6-dioxo-3-piperidiny)-1H-isoindole-1,3(2H)-dione. The Chemical Abstract Service (CAS) registry number for thalidomide is 50-35-1 and the structural formula is:



Note: • = asymmetric carbon atom

DESCRIPTION

Thalidomide has an empirical formula of $C_{13}H_{10}N_2O_4$ and a relative molecular mass of 258.23. It is a white to off-white powder. Thalidomide is practically insoluble in water, more soluble in ethanol and acetonitrile and very soluble in DMF and DMSO. It has a partition coefficient in octanol/water at room temperature of about 5.

Thalidomide contains one single asymmetric carbon atom, alpha to the phthalimido nitrogen. The molecule can, therefore, exist in either of two complementary optically active forms. Thalidomide used in the Thalomid Hard Capsules formulation is a racemic mixture containing an equal amount of the S(-) and R(+) forms and therefore has a net optical rotation of zero.

Thalomid hard capsules also contain the excipients pregelatinised starch and magnesium stearate. The capsules contain gelatin, titanium dioxide and pigments. See **PRESENTATION** for the full list of ingredients.

PHARMACOLOGY

The mechanism of action of thalidomide has not been confirmed. Several possible mechanisms have been proposed, based on *ex vivo* and *in vitro* studies.

In patients with multiple myeloma, the potential modes of thalidomide's activity include direct inhibition of myeloma cell growth and survival, anti-angiogenesis,

suppression of the production of tumour necrosis factor- α (TNF- α), inhibition of selected cell surface adhesion molecules that assist leukocyte migration, shifts in the ratio of CD4+ lymphocytes (helper T cells) to CD8+ lymphocytes (cytotoxic T cells), and effects on interleukins (IL) and interferon- γ .

The rationale for the use of thalidomide in patients with erythema nodosum leprosum (ENL) relates to its effect on TNF- α . Patients with systemic ENL demonstrate higher serum TNF- α levels which decrease significantly during thalidomide treatment. Thalidomide therapy reduces TNF- α levels in ENL patients and there is good evidence from clinical trials that thalidomide reduces the cutaneous symptoms and fever seen in ENL. However, the mechanism of action of thalidomide in this indication is not well understood and other multiple immune system mechanisms, of uncertain clinical significance, have been advanced to explain thalidomide's activity in ENL.

Thalidomide does not consistently reduce TNF- α levels in all disease states, and, in fact, thalidomide may increase TNF- α levels in some clinical indications. It should be noted that the use of thalidomide to reduce TNF- α levels in a group of patients with toxic epidermal necrolysis, resulted in an unexpected increase in TNF- α levels and considerably increased mortality compared to placebo.

Pharmacokinetics

Absorption:

Single dose studies reveal that thalidomide is slowly absorbed from the gastrointestinal tract. It exhibits linear and dose proportional pharmacokinetics over a single dose range of 50 mg to 400 mg in terms of the extent of the absorption ($AUC_{0-\infty}$) only. The effect of food on the extent of absorption is probably minimal but has not been reliably established.

The pharmacokinetic profile following multiple dosing (for 18 days) in premenopausal healthy female volunteers is similar to that following a single dose (200 mg). A C_{max} value of 2.3 $\mu\text{g/mL}$ was achieved approximately 5 hours after single or multiple dosing, with an elimination half-life of 4.1 - 4.5 hours. No evidence of accumulation or induction of metabolism was observed.

Following a single dose of 400 mg thalidomide to healthy volunteers, a peak plasma concentration of $2.82 \pm 0.80 \mu\text{g/mL}$ was measured at 4.3 ± 1.6 hours, with an elimination half-life of 7.29 ± 2.62 hours. Pharmacokinetic data in ENL patients is limited to only 6 patients, however there appears to be a higher absorption of thalidomide in ENL patients with C_{max} of $3.44 \pm 1.81 \mu\text{g/mL}$, T_{max} of 5.7 ± 1.5 hours and an elimination half-life of 6.86 ± 1.17 hours. Pharmacokinetics have not been studied in myeloma patients.

Distribution:

The exact distribution profile of thalidomide has not yet been characterised in humans.

Thalidomide has been shown to be present in the semen of male patients (see Precautions - Contraceptive requirements).

In human blood plasma, the geometric mean plasma protein binding was 55% and 65% respectively for (+) - (R) and (-) - (S) - thalidomide. The exact volume of distribution is unknown.

Metabolism:

At the present time, the exact metabolic route and fate of thalidomide is not known in humans. The drug is eliminated almost exclusively by spontaneous (non-enzymatic) hydrolysis *in vivo* with subsequent elimination of the breakdown products in the urine. There is minimal hepatic metabolism and renal excretion of thalidomide.

Elimination:

The mean elimination half-life of thalidomide was shown (in single dose studies using doses between 50 mg and 400 mg) to be between 5 and 7 hours. Less than 1% of the dose was excreted unchanged in the urine and no thalidomide was detected in urine beyond 48 hours. Less than 0.1% of the dose excreted was as the 4-OH-thalidomide metabolite which was not detected in urine after 24 hours. Apparent total clearance (Cl/F) is approximately 10.4 L/h and apparent renal clearance was found to be 0.08 L/h. The mean half-life of elimination observed in the single dose studies was not altered upon multiple dosing.

There are no data on the pharmacokinetics of thalidomide in renal or hepatic impairment.

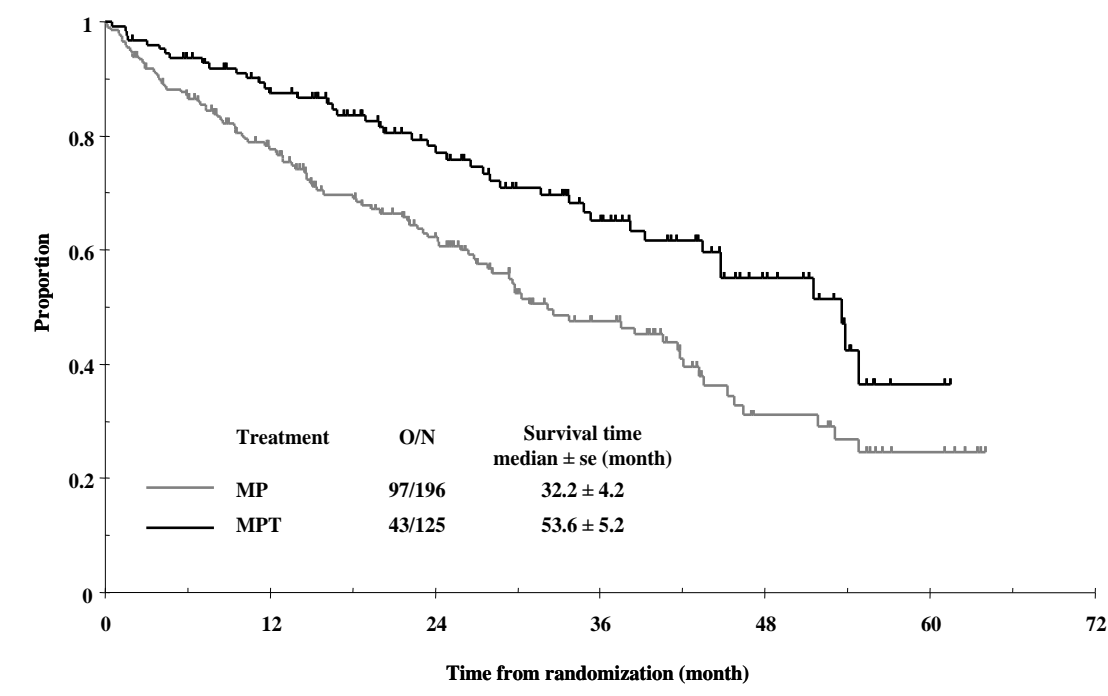
CLINICAL TRIALS

Multiple Myeloma

Untreated Multiple Myeloma: Results from IFM 99-06, a phase III, randomised, open-label, parallel group, multicentre study have demonstrated a survival advantage when thalidomide is used in combination with melphalan and prednisone (MPT) in the treatment of newly diagnosed multiple myeloma patients. In this study the age range of patients was 65 - 75 years, with 41% (183/447) of patients 70 years old or older. The median dose was 200 mg and >40% of patients received 9 cycles. Treatment with MPT was associated with improved overall survival (OS) compared to treatment with melphalan and prednisone (MP) alone (hazard ratio 0.56, 97.5% CI: 0.37 - 0.84; p = 0.0012). Median overall survival was prolonged – 53.6 months with MPT compared to 32.2 months with MP (see Figure 1).

An update to overall survival was conducted for the IFM 99-06 study providing an additional 15 months follow-up data. The OS advantage was maintained with updated median survival times of 51.6 ± 4.5 and 33.2 ± 3.2 months in the MPT and MP groups, respectively (97.5% CI: 0.42 - 0.84).

Figure 1: Overall Survival According to Treatment



Study MM-003 was a phase III randomised, parallel group, double-blind, placebo-controlled multicentre study which compared the combination of thalidomide and dexamethasone (Thal/Dex) with placebo and dexamethasone. The Thal/Dex combination was associated with a significant improvement in time to disease progression (hazard ratio 0.43, 95% CI: 0.32 – 0.58; $p < 0.0001$). Median time to progression was prolonged from 28.3 weeks with placebo/dexamethasone group to 97.7 weeks with Thal/Dex. Progression-free survival (PFS) was also significantly improved (hazard ratio 0.50, 95% CI: 0.38 – 0.64; $p < 0.0001$; median PFS 64.4 versus 28.0 weeks). Overall response rate was also significantly greater (63% vs 46%). No improvement in overall survival was demonstrated.

Study E1A00 was a phase III randomised, parallel group, open-label, multicentre study conducted by the US Eastern Co-operative Oncology Group to study the combination of Thal/Dex versus Placebo/Dex in 200 previously untreated MM patients. The primary endpoint was overall response at 4 months defined as a decrease in serum and urine M-protein of $\geq 50\%$. The response rate with Thal/Dex was significantly higher than with dexamethasone alone: 61/99 (61.6%) versus 41/101 (39.6%), respectively, ($p = 0.001$).

After Failure of Standard Therapies: Two studies of thalidomide in the treatment of refractory or relapsed multiple myeloma patients (UARK98-003, Mayo 98-80-13) were performed under an IND in the USA. These studies were non-comparative, open label studies in patients with advanced, refractory disease who had been heavily pre-treated and had limited therapeutic options available for future treatment. All response results belong to a per-protocol analysis group (events only included while patients were on thalidomide monotherapy). These studies are supported by data from other open uncontrolled trials in the published literature.

The primary efficacy variable in the studies was the serum and urine M-protein response. The results from both studies were similar. In UARK-98-003, 31.4% (53 of 169 patients) responded as judged by at least a 50% reduction in serum and/or urinary M-protein (Table 1). Overall the response was confirmed in 26.6% patients six weeks later. As expected, the least favourable response rates were found in those who had relapsed within one year of their HDT/ASCT treatment. The median time to response was 65 days, however the duration of the response was not determined.

Table 1: Tumour response (Best SWOG M-protein response) and survival rates in Study UARK 98-003

| Best SWOG M-Protein Response | Refractory pts (n=97) | Relapsed pts | | Other pts (n=22) | All pts (n=169) |
|------------------------------|--------------------------|--------------------|--------------------|---------------------|--------------------|
| | | ≤ 6 mths (n=16) | > 6 mths (n=34) | | |
| | n (%) | n (%) | n (%) | n (%) | n (%) |
| Objective response | 33 (34%) | 3 (18.8%) | 13 (38.2%) | 4 (18.2%) | 53 (31.4%) |
| Confirmed response | 29 (29.9%) | 2 (12.5%) | 12 (35.3%) | 2 (9.1%) | 45 (26.6%) |
| - complete remission* | 3 (3.1%) | 0 | 2 (5.9%) | 0 | 5 (3.0%) |
| - remission* | 17 (17.5%) | 2 (12.5%) | 7 (20.6%) | 2 (9.1%) | 28 (16.6%) |
| - partial remission* | 9 (9.3%) | 0 | 3 (8.8%) | 0 | 12 (7.1%) |
| Median Survival (mths) | 22.2 | 5.7 | 31.2 | Not reached | 23 |
| Two year Survival Rate (%) | 45.7 | 25 | 52.4 | 66 | 47.2 |

* Confirmed responders were further categorised into:

| | |
|-------------------------|---|
| Complete remission (CR) | Disappearance of serum and/or urine M-proteins by serum protein electrophoresis (SPEP), urine protein electrophoresis (UPEP) and immunofixation studies. No evidence of increasing anaemia. |
| Remission (R) | ≥ 75% to 99% reduction of serum M-protein by SPEP and /or ≥ 90% to 99% reduction of urine M-protein excretion per day by UPEP. |
| Partial remission (PR) | ≥ 50% to 74% reduction of serum M-protein by SPEP and /or ≥ 50% to 89% reduction of urine M-protein excretion per day by UPEP. |

Mayo 98-80-13 was a smaller study where 10 of the 32 patients (31%) achieved an objective response with confirmation at least six weeks later in 19%. The overall one year survival rate was 65% and the median survival time had not been reached at the time of data lock.

The protocols permitted maximum daily doses of 800 mg thalidomide, however the mean doses were between 400 - 500 mg. There was a trend towards achieving a greater M-protein response rate and longer progression free survival times with increasing dosage. There was a statistically significant relationship between dose and overall survival (p = 0.004).

Erythema Nodosum Leprosum

Study E-003P was a randomised single-centre, double-blind study comprising two dose regimens of thalidomide in the treatment of acute manifestations of ENL. Daily doses of 100 mg and 300 mg were studied. 23 male patients were enrolled and 22

completed the 7 day treatment period. 8 of 12 (67%) patients in the 100 mg/day and 6 of 10 (60%) patients in the 300 mg/day group showed absence of inflamed lesions at day 7. 12 of 12 patients in the 100 mg/day group and 8 of 10 in the 300 mg/day group showed complete or partial (> 50% reduction in lesion count) response. Systemic symptoms resolved in 10 of 12 patients in the 100 mg/day group and 5 of 11 patients in the 300 mg/day group. 9 of 12 patients in the 100 mg/day group who were tapered to zero mg over two weeks experienced worsening of ENL by week 7. One of 7 patients in the 300 mg/day group, who were tapered to 50 mg/day by week 7, experienced worsening of ENL.

Published studies

Iyer et al 1971: This study, co-ordinated by WHO, was a randomised, double-blind comparison in men with clearly demonstrable cutaneous manifestations of ENL. The study compared the effects of 100 mg thalidomide four times daily in the management of male patients with lepra reactions to 400 mg acetylsalicylic acid (aspirin, ASA) also given four times daily. Ninety-two male patients were included, the majority were aged between 15 and 55 years. For the first course, 42 patients received aspirin and 50 patients received thalidomide. Overall, 214 lepra reactions were observed, 116 being treated with thalidomide and 98 with ASA.

An average of 48% of patients treated with thalidomide and 21% of patients treated with ASA showed no further reaction at the end of 7 days. Temperature reduction to < 37°C was shown in the thalidomide group but not the ASA group. A difference in clearance of lepra reaction lesions was shown to favour thalidomide for skin lesions.

Sheskin and Convit 1969: This study assessed the therapeutic effects of 400 mg thalidomide daily in patients experiencing lepra reactions. This was a randomised, placebo-controlled, double-blind study assessing the effect of up to 400 mg daily in patients experiencing lepra reactions.

Fifty-two patients (37 male and 15 female) aged between 17 and 58 years participated. Forty-eight patients suffered from chronic lepra reactions, which had lasted over a year in forty patients. One-hundred-and-seventy-three treatment regimes of one week each were administered, 85 being thalidomide and 88 placebo. Twenty-five patients received four treatments, 13 received three, 13 received two and 8 were treated once. Seven patients re-entered the study and were permitted more than four courses.

78 of 85 (92%) thalidomide courses and 24 of 88 (27%) placebo courses led to overall improvement ($p < 0.01$). For the specific manifestations, erythema nodosum and erythema multiforme, 94% of those who received thalidomide and 18% of those who received placebo had some improvement.

Waters 1971: Results are reported of two studies of randomised, double-blind, cross-over design. The primary endpoint was the effect on corticosteroid requirements based on the clinical response to thalidomide 300 mg daily.

In the first study, patients were administered thalidomide 100 mg three times daily or placebo for 4 weeks in a cross-over fashion. The nine males who participated were aged between 21 - 56 years. They were receiving a mean prednisone dose of

28 mg/day. The ENL duration was between nine months to 3 years with continuous steroid treatment for twelve months. In the second study patients were administered thalidomide 100 mg three times daily or placebo for 6 weeks in a cross-over fashion. Eight patients were recruited into the second study, seven of whom had participated in the first study.

In the first 4-week assessment period, total steroid requirements fell in the order of 60% in the thalidomide treatment period compared to the previous 4 weeks. This was accompanied by improvements in the clinical and temperature scores. In the second phase of the study, there was a strong trend for steroid requirements to steadily fall over the 6 weeks of thalidomide treatment.

INDICATIONS

Multiple Myeloma

- Thalomid in combination with melphalan and prednisone is indicated for the treatment of patients with untreated multiple myeloma \geq 65 years or ineligible for high dose chemotherapy.
- Thalomid in combination with dexamethasone is indicated for induction therapy prior to high dose chemotherapy with autologous stem cell rescue, for the treatment of patients with untreated multiple myeloma.
- Thalomid, as monotherapy, is indicated for the treatment of multiple myeloma after failure of standard therapies.

Erythema Nodosum Leprosum (ENL)

- Thalomid is indicated for the acute treatment of the cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL). Thalomid is not indicated as monotherapy for such ENL treatment in the presence of moderate to severe neuritis. Thalomid is also indicated as maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence.

CONTRAINDICATIONS

Thalomid Hard Capsules are contraindicated in the following patients:

- patients with known hypersensitivity to thalidomide or to any of the excipients,
- patients below 12 years of age,
- pregnant women, or those who are breastfeeding,
- women of childbearing potential who are not using, not willing or not able to use adequate contraceptive measures to prevent pregnancy,
- women of childbearing potential where there is an alternative treatment of non-inferior efficacy available,
- males who are not able or willing to comply with adequate contraceptive measures.

PRECAUTIONS

Patients (or their legal guardians where appropriate) should give individual, written, fully informed consent for the use of thalidomide. Fully informed consent implies good understanding of the probability and the magnitude of harms that thalidomide can cause, the need to avoid pregnancy (and an understanding of appropriate choices for contraception, where needed), the limitations of thalidomide's treatment efficacy (including the potential for treatment failure) and the existence of alternative therapies. Appropriate counselling and information should be provided to the patient's sexual partner. Patients should be counselled monthly regarding risks of thalidomide and precautions to be taken when using thalidomide.

Teratogenicity (see Boxed Warning, Contraindications, Use in pregnancy)

Thalidomide can cause severe birth defects or death to an unborn baby if taken during pregnancy. Major human foetal abnormalities related to thalidomide administration during pregnancy are: amelia (absence of limbs), phocomelia (short limbs), hypoplasticity of the bones, external ear abnormalities (including anotia, micro pinna, small or absent external auditory canals), facial palsy, eye abnormalities (anophthalmos, microphthalmos), and congenital heart defects. Alimentary tract, urinary tract and genital malformations have also been documented. Mortality at or shortly after birth has been reported at or about 40%.

Patients should be instructed to take thalidomide only as prescribed and not to share thalidomide with anyone else.

Special Prescribing Requirements for Thalomid

Thalomid is available under a restricted distribution program. This program is known as the "*i-access*[®]" risk management program.

Treatment must be initiated and monitored under the supervision of a specialist in oncology or haematology experienced in the management of haematological malignancies, or under the supervision of a specialist in the management of leprosy experienced in the treatment of ENL.

Procedure for prescribing Thalomid Hard Capsules:

Thalidomide is a known human teratogen, therefore Celgene will only supply thalidomide if the prescriber, patient and dispensing pharmacist agree to participate in the risk management program designed to ensure that pregnant women are not exposed to the medicine. A prescriber wishing to obtain access to thalidomide for a patient must contact Celgene for further detailed information on the *i-access*[®] program.

Criteria for women of non-childbearing potential

A female patient, or a female partner of a male patient, is considered to have childbearing potential unless she meets at least one of the following criteria:

- Age \geq 50 years and naturally amenorrhoeic for \geq 1 year*
- Premature ovarian failure confirmed by a specialist gynaecologist

- Previous bilateral salpingo-oophorectomy, or hysterectomy
- XY genotype, Turner syndrome, uterine agenesis.

*Amenorrhoea following cancer therapy does not rule out childbearing potential.

The following requirements concerning pregnancy testing, contraception and, for male patients, condom use, must be followed:

Pregnancy testing:

Medically supervised pregnancy tests with a minimum sensitivity of 25 mIU/mL must be performed for women of childbearing potential as outlined below. This requirement includes women of childbearing potential who practice absolute and continuous abstinence. Ideally, pregnancy testing, issuing a prescription and dispensing should occur on the same day. For women of childbearing potential, dispensing of thalidomide should occur within a maximum of 7 days from the date of the pregnancy test.

Prior to starting treatment

A medically supervised pregnancy test should be performed when thalidomide is prescribed. The test should occur either at the time of consultation, or in the 3 days prior to the visit to the prescriber and at a point where the patient has been using effective contraception for at least 4 weeks. The test should ensure the patient is not pregnant when she starts treatment with thalidomide. This requirement includes women of childbearing potential who practice absolute and continuous abstinence.

Follow-up and end of treatment

A medically supervised pregnancy test should be repeated every 4 weeks, including 4 weeks after the end of treatment, except in the case of confirmed tubal sterilisation. These pregnancy tests should be performed on the day of the prescribing visit or in the 3 days prior to the visit to the prescriber. This requirement includes women of childbearing potential who practice absolute and continuous abstinence.

In female patients in whom the time of the next menstrual bleeding can reasonably be determined (i.e. who are having regular cycles), thalidomide should be initiated on day 2 or 3 of the menstrual cycle.

It is strongly recommended that pregnancy testing be carried out weekly in the first month of treatment, then monthly in women with regular menstrual cycles or fortnightly in women with irregular menstrual cycles.

Contraception requirements:

Females of non-childbearing potential

In a female patient, or a female partner of a male patient, who is confirmed as being of non-childbearing potential, the physician must evaluate the risks of these patients still becoming pregnant and give advice on use of contraceptive methods.

Females of childbearing potential

A female patient, or a female partner of a male patient, who is of childbearing potential must use at least one reliable contraceptive method for at least 4 weeks before starting thalidomide treatment, during this treatment, and for 4 weeks following termination of this treatment. Reliable contraception in these patients means that she uses at least one highly effective method of contraception (intra-uterine device, hormonal contraception via oral, injection or implant routes (except in concomitant use of cytochrome P450 inducing agents such as glucocorticoids), tubal ligation or partner's vasectomy) and preferably at least one additional effective method (diaphragm, cervical cap or latex/polyurethane condom by her male partner) (also see "Oral contraceptives").

If a female patient, or female partner of a male patient, misses or is suspected to have missed her period, or there is any abnormality in menstrual bleeding, or suspects she is pregnant, then a pregnancy test and counselling should be performed.

If pregnancy occurs in a patient, or female partner of a male patient, during thalidomide treatment, thalidomide should be discontinued **immediately** by the female patient. The female patient or pregnant partner should be referred to an obstetrician or gynaecologist experienced in reproductive toxicity for further evaluation and counselling (also see "Use in Pregnancy").

Male patients

Thalidomide is present in semen, therefore males receiving thalidomide must always use a latex or polyurethane condom when engaging in sexual activity with women of childbearing potential (women who have not undergone hysterectomy or who have not been post-menopausal for at least 1 year). Condom use should continue for 4 weeks after cessation of thalidomide treatment. In the case of a male patient with an allergy to latex or polyurethane, at least one highly efficacious method should be used by any female sexual partner. Contraception should be started in this partner at least 4 weeks prior to the start of a sexual relationship with the patient, and continued throughout thalidomide treatment and for an additional 4 weeks following cessation of treatment.

Male patients must not donate sperm whilst taking thalidomide and for 4 weeks after cessation of treatment.

Drowsiness, somnolence and sedation:

Thalidomide frequently causes drowsiness, somnolence and sedation. Patients should be instructed to avoid situations where drowsiness may be a problem and not to take other medications that may cause drowsiness without adequate medical advice. Dose reduction may be required. Thalidomide may potentiate the drowsiness caused by alcohol. As with any sedative medication, the potential for impaired consciousness may increase the risk for aspiration of food, vomitus and oral secretions.

Patients should be advised as to the possible impairment of mental and/or physical abilities required for the performance of hazardous tasks.

Peripheral neuropathy:

Peripheral neuropathy is a very common, potentially severe, side-effect of treatment with thalidomide that may be irreversible. Peripheral neuropathy generally occurs following chronic use over a period of months, however, reports following relatively short-term use also exist. Incidence of neuropathy events leading to discontinuation, dose reduction or interruption increases with cumulative dose and duration of therapy. Symptoms may occur some time after thalidomide treatment has been stopped and may resolve slowly or not at all. If thalidomide is contemplated for long-term use, baseline and 6-monthly sensory nerve action potential (SNAP) data should be collected. Where such monitoring is not feasible, regular clinical assessment is required.

Patients should be advised to report prickling, numbness and paraesthesia. Patients should be questioned monthly, and clinically evaluated for signs or symptoms of peripheral neuropathy such as numbness, tingling or pain in the hands and feet. Should symptoms of peripheral neuropathy be observed, SNAP data should be collected.

If medicine-induced neuropathy is confirmed, discontinuation of thalidomide is necessary to limit further damage. With use of thalidomide in combination, continue to monitor the patient and when the patient reaches Grade 1 neuropathy, the treatment may be restarted at a 50% reduction. Medications known to be associated with neuropathy should be used with caution in patients receiving thalidomide (e.g. zalcitabine, vincristine and didanosine).

Thrombogenicity:

Use of thalidomide in patients with malignant neoplastic disease, including multiple myeloma, has been associated with an increased risk of deep vein thrombosis (DVT) and pulmonary embolus (PE).

This risk increases significantly when thalidomide is used in combination with standard chemotherapeutic agents including melphalan, prednisone or dexamethasone. In one controlled trial, the rate of venous thromboembolic events was 22.5% in patients receiving thalidomide in combination with dexamethasone compared to 4.9% in patients receiving dexamethasone alone ($p = 0.002$). Patients and physicians are advised to be observant for the signs and symptoms of thromboembolism. Patients should be instructed to seek medical care if they develop symptoms such as shortness of breath, chest pain, arm or leg swelling. (See also "Oral contraceptives").

Preliminary data suggest that patients who are appropriate candidates may benefit from concurrent prophylactic anticoagulation or aspirin treatment.

Seizures:

Although very rare, seizures, including generalised clonic/tonic convulsions, have been reported during use of thalidomide. Most of the patients had disorders that may have predisposed to seizure activity, and it is not currently known whether thalidomide has any epileptogenic influence. During therapy with thalidomide, patients with a history of seizures or with other risk factors for the development of

seizures should be monitored closely for clinical changes that could precipitate acute seizure activity.

Dizziness and orthostatic hypotension:

Patients should be advised that thalidomide may cause dizziness and orthostatic hypotension and that, therefore, they should sit upright for a few minutes prior to standing up from a recumbent position.

Syncope and bradycardia:

Patients receiving thalidomide should be monitored for syncope and bradycardia and dose reduction or discontinuation may be required.

Neutropenia:

Decreased white blood cell counts, including neutropenia, have been reported in association with some clinical use of thalidomide. For thalidomide in combination with dexamethasone and as monotherapy, treatment should be initiated with caution in patients with neutropenia, in accordance with oncology guidelines. White blood cell count and differential count should be monitored on an on-going basis, especially in patients who may be more prone to neutropenia, such as those with myeloma or those who are HIV-seropositive. If ANC decreases to below $750/\text{mm}^3$ ($0.75 \times 10^9/\text{L}$) while on treatment, the patient's medication regimen should be re-evaluated and consideration should be given to withholding thalidomide if clinically appropriate.

Dermatological reactions:

Serious dermatological reactions including Stevens-Johnson syndrome, which may be fatal, have been reported. Thalidomide should be discontinued if a skin rash occurs. Rechallenge in some treatment populations e.g. HIV patients, has produced a severe and immediate reaction associated with fever, tachycardia, hypotension and rash. If a rash associated with thalidomide is exfoliative, purpuric or bullous, or if Stevens-Johnson syndrome or toxic epidermal necrolysis is suspected, or angioedema occurs, the use of thalidomide should not be resumed.

Impaired wound healing:

It has been suggested that thalidomide's anti-angiogenic properties may interfere with wound healing. Thalidomide should not be used within 7 days of surgery where wound healing may be problematic.

Tumour lysis syndrome:

The patients at risk of tumour lysis syndrome are those with a high tumour burden prior to treatment. These patients should be monitored closely and appropriate precautions taken.

Erythema Nodosum Leprosum (ENL):

Thalidomide is known to cause neuritis which may be irreversible. The medicine potentially aggravates existing neuritis and should therefore not be used in such patients unless the clinical benefits outweigh the risks.

Other warnings:

Thyroid activity should be monitored during ongoing treatment with thalidomide as cases of hypothyroidism have been reported.

Patients should be instructed to take Thalomid Hard Capsules only as prescribed and not to share it with anyone else.

Patients must not donate blood or semen during treatment or within 4 weeks of stopping treatment with Thalomid Hard Capsules.

Interaction with other medicines

Interactions between Thalomid Hard Capsules and other medicines have not been extensively studied.

Increase of sedative effects of other medicines:

Thalidomide has been reported to enhance the sedative activity of barbiturates, alcohol, chlorpromazine, and reserpine. Thalidomide increases the effects of morphine derivatives, benzodiazepines, other anxiolytics, hypnotics, sedative antidepressants, neuroleptics, sedative H₁ antihistamines, central antihypertensives, and baclofen.

Bradycardic effect:

Due to thalidomide's potential to induce bradycardia, caution should be exercised with medicinal products having the same pharmacodynamic effect such as beta blockers, anticholinesterase agents, or active substances known to induce torsade de pointes.

Medications known to cause peripheral neuropathy:

Medications known to be associated with peripheral neuropathy should be used with caution in patients receiving thalidomide (e.g. zalcitabine, vincristine, and didanosine).

Cytotoxic medicines:

An increased risk for thrombosis and thromboembolic events has been reported in association with the use of thalidomide in combination with cytotoxic medicines e.g. doxorubicin and melphalan (see Precautions).

Oral contraceptives:

Thalidomide does not interact with oral contraceptives. In 10 healthy women, the pharmacokinetic profiles of norethindrone and ethinyl estradiol following administration of a single dose containing 1.0 mg of norethindrone acetate and 0.75 mg of ethinyl estradiol were studied. The results were similar with and without co-administration of thalidomide 200 mg/day to steady-state levels. However, caution should be exercised when combined hormonal contraceptives are used during treatment with thalidomide due to the increased risk of venous thromboembolic disease (see also "Thrombogenicity").

Warfarin:

Thalidomide does not interact with warfarin. In 18 healthy male volunteers, multiple dose administration of 200 mg thalidomide had no effect on the single dose pharmacokinetics of warfarin (both S-warfarin and R-warfarin), and had no effect on the international normalized ratio (INR). In addition, single dose administration of 25 mg warfarin had no effect on thalidomide pharmacokinetics.

Digoxin:

Thalidomide does not interact with digoxin. In 18 healthy male volunteers, multiple dose administration of 200 mg thalidomide had no apparent effect on the single dose pharmacokinetics of digoxin. In addition, single dose administration of 0.5 mg digoxin had no apparent effect on thalidomide pharmacokinetics.

Important non-thalidomide medicine interactions - medicines that interfere with hormonal contraceptives:

Concomitant use of glucocorticoids (including dexamethasone and prednisone), HIV-protease inhibitors, griseofulvin, rifampin, rifabutin, phenytoin, or carbamazepine with hormonal contraceptive agents, may reduce the effectiveness of the contraception. Therefore, women of childbearing potential requiring treatment with one or more of these medicines must use two other effective methods of contraception.

Use in children

It is not recommended to use thalidomide in patients below 12 years of age as safety and efficacy have not been established. There is only limited evidence of efficacy and safety of thalidomide in children 12 - 17 years of age.

Use in elderly

Analysis of pharmacokinetic data in healthy volunteers does not reveal any age-related changes.

Impaired renal or hepatic function

Specific dose recommendations in patients with renal or hepatic disease have not been established.

Since renal insufficiency is common among patients with multiple myeloma as a complication of their disease, the recommended dosage in adults has been established in populations of patients including patients with reduced renal function. Patients with severe renal impairment should be carefully monitored for adverse reactions. In general, doses in patients with renal or hepatic disease should be titrated against observed tolerance and toxicity and the highest tolerated dose should be selected.

Carcinogenesis, mutagenesis, impairment of fertility

Thalidomide showed no evidence of carcinogenicity in 104-week oral gavage studies in mice administered 0, 100, 1000 or 3000 mg/kg/day (respective systemic exposures up to approximately 4 times the estimated clinical AUC at the maximum dose of 800 mg/day), male rats administered 0, 20, 160 or 300 mg/kg/day (respective

exposures up to approximately 4 times the estimated clinical AUC at the maximum dose) or female rats administered 0, 30, 300 or 3000 mg/kg/day (respective exposures up to approximately 11 times the estimated clinical AUC at the maximum dose).

Thalidomide was negative in tests for mutagenicity in *Salmonella typhimurium*, *Escherichia coli* and Chinese hamster ovary cells *in vitro*, and did not induce micronuclei in the bone marrow of mice.

The potential effects of thalidomide on fertility and early embryonic development were investigated in an oral gavage study in New Zealand White rabbits. Female rabbits were administered thalidomide 0, 10, 50 or 100 mg/kg/day for 14 days prior to mating (with untreated males) through to gestation day 7, and underwent Caesarean section on gestation day 29. Estimated female systemic exposures at the respective doses were approximately 0.4, 1.8 or 2.7 times the estimated clinical AUC at the maximum dose of 800 mg/day. Mating and pregnancy parameters were unaffected, but the mean numbers of early resorptions and percentages of resorbed foetuses per litter were increased at all doses, and at 100 mg/kg/day, the mean number of corpora lutea, implantations, litter sizes and does with viable or live foetuses were decreased, and the mean numbers of does with any resorptions or all conceptuses resorbed were increased. There were no drug-related foetal gross external malformations or variations.

Male rabbits were treated with 0, 30, 150 or 500 mg/kg/day for at least 56 days, starting 14 days prior to mating with untreated females, which underwent Caesarean section on gestation day 29. Estimated male systemic exposures at the respective doses were approximately 0.6, 2.9 and 4.5 times the estimated clinical AUC at the maximum dose of 800 mg/day. Testes weights were reduced at all doses and the incidences and severity of testicular germinal epithelium degeneration and loss of round and elongating spermatids were increased at 150 and 500 mg/kg/day. Thalidomide was detected in semen at all doses, but sperm motility, count and concentration were unaffected. Untreated females mated with the treated males showed no effects on fertility and pregnancy indices or litter parameters, and there were no drug-related foetal malformations.

Use in pregnancy – (Category X)

Category X is defined as medicines which have such a high risk of causing permanent damage to the foetus that they should not be used in pregnancy or when there is a possibility of pregnancy.

Thalidomide is a known human teratogen and should not, under any circumstances, be administered during pregnancy, or to women of childbearing potential, unless they are using at least one effective means of contraception. A single dose taken by pregnant women can cause birth defects. Thalidomide has been found in the semen of men taking the medicine; therefore male patients with female partners of childbearing potential must use adequate contraceptive methods.

Contraception must continue for 4 weeks after stopping thalidomide treatment.

If a female patient, or female partner of a male patient, misses or is suspected to have missed her period or there is any abnormality in menstrual bleeding, or suspects she is pregnant then a pregnancy test and counselling should be performed.

If pregnancy occurs in a patient during thalidomide treatment, thalidomide should be discontinued immediately.

The patient or pregnant partner should be referred to an obstetrician or gynaecologist experienced in reproductive toxicity for further evaluation and counselling.

Use in lactation

It is not known whether thalidomide is excreted in human milk. Thalidomide has been detected in the milk of lactating rabbits given thalidomide by oral gavage, at concentrations up to 3.6 times maternal plasma levels. Women who are taking thalidomide should not breast feed.

Effects on ability to drive and use machines

Thalidomide may cause sedation, drowsiness, somnolence and orthostatic hypotension. If affected, patients should be instructed not to drive cars, use machinery or perform hazardous tasks while being treated with Thalomid Hard Capsules.

ADVERSE EFFECTS

Nearly all patients can be expected to experience adverse reactions. The most commonly observed adverse reactions associated with the use of thalidomide in combination with dexamethasone or melphalan and prednisone are: deep vein thrombosis, constipation, peripheral oedema, tremor, dizziness, fatigue, somnolence, peripheral neuropathy, neutropenia, lymphopenia, leukopenia, anaemia, thrombocytopenia, paraesthesia, and dysaesthesia.

Untreated Multiple Myeloma in Combination Therapy

The clinically important adverse reactions associated with the use of thalidomide in combination include: deep vein thrombosis and pulmonary embolism, peripheral neuropathy, bradycardia, orthostatic hypotension, dizziness, syncope, and severe skin reactions including Stevens-Johnson syndrome and toxic epidermal necrolysis (see Precautions).

The table below contains only the adverse events for which a causal relationship with medicine treatment could reasonably be established. Frequencies given are based on the observations during pivotal comparative clinical studies investigating the effect of thalidomide in combination with dexamethasone and with melphalan and prednisone in previously untreated multiple myeloma patients (Table 2 and Table 3, respectively). Additional adverse events related to thalidomide and not seen in either pivotal study are based on post-marketing experience with the medicine (see data stated after tables).

Frequencies are defined as:

| | |
|-------------|--|
| very common | > 1/10; |
| common | > 1/100, < 1/10; |
| uncommon | > 1/1000, < 1/100; |
| rare | > 1/10,000, < 1/1000; |
| very rare | < 1/10,000 including isolated reports. |

Table 2: Thalidomide in Combination with Melphalan and Prednisone

| System Organ Class | Very Common | Common |
|--|--|--|
| Infections and infestations | | Pneumonia |
| Blood and lymphatic system disorders | Neutropenia, Leukopenia, Anaemia, Lymphopenia, Thrombocytopenia | |
| Psychiatric disorders | | Depression, Confusional state |
| Nervous system disorders | Peripheral neuropathy*, Tremor, Dizziness, Somnolence, Paraesthesia, Dysaesthesia | Abnormal coordination |
| Cardiac disorders | | Cardiac failure, Bradycardia |
| Vascular disorders | Deep vein thrombosis* | |
| Respiratory, thoracic and mediastinal disorders | | Pulmonary embolism, Dyspnoea, Bronchopneumopathy, Interstitial lung disease |
| Gastrointestinal disorders | Constipation | Vomiting, Dry mouth |
| Skin and subcutaneous tissue disorders | | Toxic skin eruption, Dry skin, Rash |
| General disorders and administration site conditions | Peripheral oedema | Pyrexia, Asthenia, Malaise |

* - See detailed section below

Table 3: Thalidomide in Combination with Dexamethasone

| System Organ Class | Very Common | Common | Uncommon |
|---|---|--|--------------------------|
| Infections and infestations | | Pneumonia, | |
| Psychiatric disorders | | Mood alteration, Depression, Anxiety, Confusional state | |
| Nervous system disorders | Peripheral neuropathy*, Tremor, Dizziness | Transient ischaemic event, Ataxia, Syncope, Paraesthesia, Somnolence | Cerebrovascular accident |
| Eye disorders | | Blurred vision | |
| Ear and labyrinth disorders | | Vertigo | |
| Cardiac disorders | | Bradycardia | |
| Vascular disorders | Deep vein thrombosis* | Hypotension | Orthostatic hypotension |
| Respiratory, thoracic and mediastinal disorders | | Pulmonary embolism | Bronchitis |
| Gastrointestinal disorders | Constipation | Vomiting, | Peritonitis, |

| | | | |
|---|-------------------------------|------------------------------------|--------------------------|
| | | Nausea, Dyspepsia, Dry mouth | Diverticular perforation |
| Skin and subcutaneous tissue disorders | | Rash | |
| Musculoskeletal, connective tissue and bone disorders | | Muscle cramps | |
| General disorders and administration site conditions | Peripheral oedema, Fatigue | Pyrexia, Asthenia | |

* - See detailed section below

Additional adverse events related to thalidomide and not seen in either pivotal study include: toxic epidermal necrolysis, hypothyroidism, bowel obstruction, tumour lysis syndrome, gastrointestinal perforation, febrile neutropenia, pancytopenia, myocardial infarction, menstrual disorders including amenorrhea, allergic reactions (hypersensitivity, angioedema/urticaria), convulsions, severe infections (e.g. fatal sepsis including septic shock), and sexual dysfunction.

Blood and the Lymphatic System Disorders

Adverse reactions for haematological disorders are provided compared to the comparator arm as the comparator has a significant effect on these disorders (Table 4).

Table 4: Comparison of Grade 3 and 4* haematological disorders for MP and MPT combinations and the Thal/Dex and Placebo/Dex combinations

| Study | IFM 99-06 | | THAL-MM-003 | |
|-------------------------|-------------------|-------------|---------------------|------------------|
| | n (% of patients) | | | |
| Treatment Arm | MP (n=193) | MPT (n=124) | Placebo/Dex (n=232) | Thal/Dex (n=234) |
| Neutropenia | 57 (29.5) | 53 (42.7) | 3 (1.3) | 7 (3.0) |
| Leukopenia | 32 (16.6) | 32 (25.8) | 1 (0.4) | 4 (1.7) |
| Anaemia | 28 (14.5) | 17 (13.7) | 1 (0.4) | 0 |
| Lymphopenia | 14 (7.3) | 15 (12.1) | 0 | 0 |
| Thrombocytopenia | 19 (9.8) | 14 (11.3) | 0 | 0 |

* NCI-CTC criteria

Treatment of Multiple Myeloma after Failure of Standard Therapies and Treatment of Erythema Nodosum Leprosum

The most commonly observed adverse reactions associated with the use of thalidomide are somnolence and sensory peripheral neuropathy.

The other clinically most important adverse reactions associated with the use of thalidomide include constipation, orthostatic hypotension, asthenia, neutropenia, severe skin reactions including Stevens-Johnson syndrome and toxic epidermal necrolysis, headache, rash, eosinophilia, peripheral oedema, dyspnoea, dizziness, hypotension, bradycardia, symptomatic hypothyroidism, increase or decrease in platelet count, anaemia and, in HIV patients, an increase in HIV viral load.

Table 5 contains frequencies for those adverse events for which a causal relationship with medicine treatment could reasonably be established during investigational studies

and post-marketing experience with the medicine in the US. Frequencies are as previously defined.

Table 5: Thalidomide as monotherapy

| System Organ Class | Very Common | Common | Uncommon | Rare | Very Rare |
|--|---|--|-----------------|--|---|
| Blood and lymphatic system disorders | | Leukopenia, Neutropenia | | | Eosinophilia, Thrombocytopenia, Anaemia |
| Metabolism and nutrition disorders | | | | Increased appetite | |
| Endocrine disorders | | | | | Hypothyroidism |
| Psychiatric disorders | | Mood changes | | | Libido decreased, Confusion |
| Nervous system disorders | Somnolence, Peripheral sensory neuropathy | Drowsiness, Dizziness, Paraesthesia, Headache | Tremor | | Seizures |
| Cardiac disorders | | | | Bradycardia, Tachycardia, Cardiac arrhythmia | |
| Vascular disorders | | | | Deep vein thrombosis | Orthostatic hypotension, Thromboembolic events |
| Respiratory, thoracic and mediastinal disorders | | | Dyspnoea | | Bronchospasm |
| Gastro-intestinal disorders | | Constipation, Nausea, Dry mouth | | | Intestinal obstruction |
| Skin and subcutaneous system disorders | | Rash, Urticaria | | | Pruritus, Serious bullous skin reactions including Stevens-Johnson syndrome and toxic epidermal necrolysis, Dry skin, Facial oedema, Photosensitivity |
| Reproductive system and breast disorders | | | | | 'Menstruation abnormalities' |
| General disorders and administration site disorders | | Asthenia, Peripheral oedema, Weakness, Fatigue, Lethargy | | Malaise | |

Teratogenicity (see Precautions)

The most serious toxicity associated with thalidomide is teratogenicity. The risk of severe birth defects, primarily phocomelia or death to the foetus, is extremely high during the critical period of pregnancy. The critical period is estimated to range from 35 to 50 days after the last menstrual period. The risk of other potentially severe birth defects outside this critical period is unknown, but may be significant. Thalidomide must not be used at any time during pregnancy.

Thromboembolic Events (see Precaution)

An increased risk of deep venous thrombosis (DVT) and pulmonary embolus (PE) has been reported in patients treated with thalidomide in combination with other therapies including doxorubicin, melphalan and prednisone or dexamethasone.

Peripheral neuropathy (see Precautions)

Peripheral neuropathy is a very common, potentially severe, adverse effect of treatment with thalidomide that may result in irreversible damage (see Precautions). Peripheral neuropathy generally occurs following chronic use over a period of months, however, reports following relatively short-term use also exist. The correlation with cumulative dose is unclear. Symptoms may occur some time after thalidomide treatment has been stopped and may resolve slowly or not at all.

Monitoring during thalidomide treatment should include regular SNAP assessments.

DOSAGE AND ADMINISTRATION

To reduce central nervous system effects (e.g. drowsiness, somnolence, sedation) during the day, Thalomid is normally taken as a single dose in the evening. Thalomid Hard Capsules should be taken at least one hour after food.

Multiple Myeloma (dosage in adults and adolescents):

The required total duration of treatment should be individually determined for each patient depending on tolerability and disease progression.

Patients with Untreated Multiple Myeloma

- In combination with Melphalan and Prednisone: The Thalomid recommended oral dose is 200 mg per day. A maximum number of 12 cycles of 6 weeks should be used.
- In combination with Dexamethasone: The Thalomid recommended oral dose is 200 mg per day. For induction, 4 cycles of 4 weeks of thalidomide/dexamethasone is recommended.

For elderly patients of poor performance, tolerability may be improved by starting the patient on 50 mg per day and increasing this dose to 200 mg per day over a 4-week period.

After Failure of Standard Therapies

- Dosing should be initiated at 200 mg daily orally and increased by 100 mg at weekly intervals to a maximum dose of 400 mg daily according to tolerance and toxicity.

Depending on tolerance and observed toxicity, lower maintenance doses can be used.

Erythema Nodosum Leprosum (adult dosage):

Dosing should be initiated at 100 mg daily orally and, only where symptoms remain uncontrolled, increased by 100 mg at weekly intervals according to tolerance and toxicity (see Clinical Trials section for results of Study E-003P). The maximum recommended dose is 400 mg daily. Depending on tolerance and observed toxicity, lower maintenance doses can be used than those used to control the active reaction.

In patients with moderate to severe neuritis (due to leprosy) or other serious complications (e.g. uveitis), corticosteroids and other appropriate therapy may be started concomitantly and tapered/discontinued when neuritis etc has improved.

There have been no well-controlled studies of thalidomide as maintenance therapy to prevent ENL relapse, to provide maintenance dosing recommendations. In study E - 003P, only 1 of 23 patients was tapered from treatment successfully using a 3 - 7 week tapering regimen. Given the risks associated with ongoing thalidomide treatment, it is suggested that tapering (with the aim of discontinuation) be attempted every 3 - 6 months, in decrements of 50 mg every 2 to 4 weeks.

Dosage adjustments during treatment:

Dosage delay or reduction, dependent upon grade of toxicity, may be necessary.

Thromboembolic Events

If the patient experiences any thromboembolic events during treatment with thalidomide in combination, discontinue treatment and start standard anticoagulation therapy. Once the patient has been stabilised on the anticoagulation treatment and any complications of the thromboembolic event have been managed, the thalidomide treatment may be restarted at the original dose dependent upon a risk-benefit assessment. The patient should continue anticoagulation therapy during the course of thalidomide treatment.

Peripheral Neuropathy

If the patient experiences peripheral neuropathy during treatment with thalidomide in combination, treatment should be discontinued. Continue to monitor the patient and when the patient reaches Grade 1 neuropathy, the treatment may be restarted at a 50% reduction. If at anytime the patient experiences Grade 3 or 4 neuropathy, the treatment should be discontinued permanently.

Elderly

No specific dose adjustments are recommended for the elderly.

Patients with renal or hepatic impairment

No specific studies have been conducted in patients with renal or hepatic impairment.

OVERDOSAGE

Eighteen cases of overdose have been reported in the literature concerning doses up to 14.4 g. No fatalities have been reported and all overdose patients recovered without sequelae. There is no specific antidote for a thalidomide overdose. In the event of an overdose, the patient's vital signs should be monitored and appropriate supportive care given to maintain blood pressure and respiratory status. In Australia contact the Poisons Advisory Centre on 13 11 26, and in New Zealand call the National Poison Centre on 0800 POISON or 0800 764 766 for advice on management.

PRESENTATION AND STORAGE CONDITIONS

Presentation

Thalomid is produced as 50 mg, 100 mg, 150 mg or 200 mg hard capsules in blister packs containing 28 capsules. Not all of these presentations may be available.

Thalomid capsules contain thalidomide as the active ingredient, and the excipients pregelatinised starch and magnesium stearate.

Thalomid 50 mg hard capsules

White, opaque capsule shells imprinted with "Celgene 50 mg" with a "Do not get pregnant" symbol in black ink (SW-9008/SW-9009). The capsule shell contains gelatin and titanium dioxide (E171).

Thalomid 100 mg hard capsules

Tan, opaque capsule shells imprinted with "Celgene 100 mg" with a "Do not get pregnant" symbol in black ink (SW-9008/SW-9009). The capsule shell contains gelatin, titanium dioxide (E171) and colourants black iron oxide and yellow iron oxide.

Thalomid 150 mg hard capsules

Tan, opaque body capsule shells imprinted with "Celgene 150 mg" in black ink (SW-9008/SW-9009), and a blue, opaque cap with a "Do not get pregnant" symbol in white ink (S-1-7085). The capsule shell contains gelatin, titanium dioxide (E171) and colourants blue#2, black iron oxide and yellow iron oxide.

Thalomid 200 mg hard capsules

Blue, opaque capsule shells imprinted with "Celgene 200 mg" with a "Do not get pregnant" symbol in white ink (S-1-7085). The capsule shell contains gelatin, titanium dioxide (E171) and colourant blue#2.

Thalomid hard capsules are packed in PVC/PCTFE blisters with push-through foil containing a paper backing. Each blister strip contains 28 capsules and is enclosed in a cardboard carton.

Storage conditions

Store below 25°C. Store in the original package in order to protect from light.

NAME AND ADDRESS OF THE SPONSOR

In Australia:

Celgene Pty Limited
Level 7, 607 St Kilda Road,
Melbourne, VIC 3004, Australia.

In New Zealand:

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Wellington, New Zealand
Phone: (04) 474 0755
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Thalomid is distributed in New Zealand by:

Douglas Pharmaceuticals Ltd
Central Park Drive, Lincoln
PO Box 45 027
Auckland 0651
Phone: (09) 835 0660
Fax: (09) 835 0665.

FURTHER INFORMATION

Thalomid may only be prescribed by registered medical practitioners as defined in the Health Practitioners Competence Assurance Act 2003 and who are certified as competent by the Medical Council of New Zealand in the scope of practice of internal medicine.

Celgene Limited will manage the risk management program relating to the distribution and use of Thalomid.

The consent to distribute Thalomid is valid following renewal every two years from the 25th of November 2010.

MEDICINE CLASSIFICATION

Prescription medicine

DATE OF PREPARATION

09 November 2011

Thalomid (thalidomide) Hard Capsules: New Zealand Data Sheet