1. PRODUCT NAME

LUCENTIS® Ranibizumab 10 mg/mL solution for injection

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Active substance
One mL contains 10 mg ranibizumab.

Vial
Each vial contains 2.3 mg of ranibizumab in 0.23 mL solution.

Pre-filled syringe
Each pre-filled syringe contains 1.65 mg of ranibizumab in 0.165 mL solution.

Ranibizumab is a humanised monoclonal antibody fragment produced in Escherichia coli cells by recombinant DNA technology.

Active moiety
Ranibizumab.

Excipients
Alpha,alpha-trehalose dihydrate
Histidine hydrochloride, monohydrate
Histidine
Polysorbate 20
Water for injections.

3. PHARMACEUTICAL FORM

Solution for injection.
Lucentis is supplied in a vial or a pre-filled syringe.

Vial
Sterile, clear, colourless to pale yellow and preservative-free aqueous solution.

Pre-filled syringe
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Sterile, clear, colourless to pale yellow and preservative-free aqueous solution.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Lucentis® is indicated for:

- the treatment of neovascular (wet) age-related macular degeneration (AMD).
- the treatment of visual impairment due to choroidal neovascularization,
- the treatment of visual impairment due to choroidal neovascularisation (CNV) secondary to pathologic myopia (PM)
- the treatment of visual impairment due to diabetic macular oedema (DME).
- the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion (branch RVO or central RVO).

4.2 Dose and method of administration

Single-use vial for intravitreal use only. Use of more than one injection from a vial can lead to product contamination and subsequent ocular infection.

Lucentis must be administered by a qualified ophthalmologist experienced in intravitreal injections.

The recommended dose for Lucentis is 0.5 mg given as a single intravitreal injection. This corresponds to an injection volume of 0.05mL. The interval between two doses injected into the same eye should not be shorter than one month.

Treatment of wet AMD, visual impairment due to DME or due to macular edema secondary to RVO, visual impairment due to CNV secondary to PM

Treatment is initiated with one injection per month until maximum visual acuity is achieved and/or there are no signs of disease activity i.e. no change in visual acuity and in other signs and symptoms of the disease under continued treatment. In patients with wet AMD, DME and RVO, initially, three or more consecutive, monthly injections may be needed.

Thereafter, monitoring and treatment intervals should be determined by the physician and should be based on disease activity as assessed by visual acuity and/or anatomic parameters.
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If, in the physician’s opinion, visual and anatomic parameters indicate that the patient is not benefiting from continued treatment, Lucentis should be discontinued.

Monitoring for disease activity may include clinical examination, functional testing or imaging techniques (e.g. optical coherence tomography or fluorescein angiography).

If patients are being treated according to a treat-and-extend regimen, once maximum visual acuity is achieved and/or there are no signs of disease activity, the treatment intervals can be extended stepwise until signs of disease activity or visual impairment recur. The treatment interval should be extended by no more than two weeks at a time for wet AMD and may be extended by up to one month at a time for DME. For RVO, treatment intervals may also be gradually extended, however there are insufficient data to conclude on the length of these intervals. If disease activity recurs, the treatment interval should be shortened accordingly.

The treatment of visual impairment due to CNV should be determined individually per patient based on disease activity. In the treatment of visual impairment due to CNV secondary to PM, many patients may only need one or two injections during the first year, while some patients may need more frequent treatment (see section 5.1, Clinical efficacy and safety).

**Lucentis and Laser Photocoagulation in DME and branch RVO:**

Lucentis can be safely administered concomitantly with laser photocoagulation as well as in patients who have received previous laser photocoagulation. When given on the same day, Lucentis should be administered at least 30 minutes after laser photocoagulation.

**Method of administration**

As with all medicinal products for parenteral use, Lucentis should be inspected visually for particulate matter and discoloration prior to administration.

The injection procedure should be carried out under aseptic conditions, which includes the use of surgical hand disinfection, sterile gloves, a sterile drape and a sterile eyelid speculum (or equivalent). Sterile paracentesis equipment should be available as a precautionary measure. The patient’s medical history for hypersensitivity reactions should be carefully evaluated prior to performing the intravitreal procedure (see section 4.3). Adequate anaesthesia and a broad-spectrum topical microbicidal to disinfect the periocular skin, eyelid and ocular surface should be administered prior to the injection.

For information on preparation of Lucentis, see section 6.6.

The injection needle should be inserted 3.5 to 4.0 mm posterior to the limbus into the vitreous cavity, avoiding the horizontal meridian and aiming towards the centre of the
globe. The injection volume of 0.05 mL is then delivered; the scleral site should be rotated for subsequent injections.

**Special populations**

**Hepatic impairment**
Lucentis has not been studied in patients with hepatic impairment. However, as systemic exposure is negligible, no special measures are considered necessary in this population.

**Renal impairment**
Dose adjustment is not needed in patients with renal impairment (see section 5.2 Pharmacokinetic properties).

**Paediatric patients**
Lucentis is not recommended for use in children and adolescents due to a lack of data on safety and efficacy in these sub-populations. Limited data on adolescent patients aged 12 to 17 years with visual impairment due to CNV is available (see section 5.1, Clinical efficacy and safety, Paediatric patients).

**Geriatric patients**
No dose adjustment is required in the elderly.

**4.3 Contraindications**

Hypersensitivity to the active substance or to any of the excipients.

Patients with active or suspected ocular or periocular infections.

Patients with active intraocular inflammation.

**4.4 Special warnings and precautions for use**

**Intravitreal injection-related reactions**

Intravitreous injections, including those with Lucentis, have been associated with endophthalmitis, intraocular inflammation, rhegmatogenous retinal detachment, retinal tear and iatrogenic traumatic cataract (see section 4.8 Undesirable effects). Proper aseptic injection techniques must always be used when administering Lucentis. In addition, patients should be monitored during the week following the injection to permit early treatment if an infection occurs. Patients should be instructed to report any symptoms suggestive of endophthalmitis or any of the above mentioned events without delay.

Transient increases in intraocular pressure (IOP) have been seen within 60 minutes of injection of Lucentis (see section 4.8 Undesirable effects). Sustained IOP increases
have also been reported. Both intraocular pressure and the perfusion of the optic nerve head must be monitored and managed appropriately.

**Arterial thromboembolic events**

There is a potential risk of arterial thromboembolic events following intravitreal use of VEGF (vascular endothelial growth factor) inhibitors. In the wet AMD Phase III studies, the overall frequency of arterial thromboembolic events was similar between ranibizumab and control. A numerically higher stroke rate was observed in patients treated with ranibizumab 0.5 mg compared to ranibizumab 0.3 mg or control, however, the differences were not statistically significant. The difference in stroke rates may be greater in patients with known risk factors for stroke, including history of prior stroke or transient ischemic attack. Therefore, these patients should be carefully evaluated by their physicians as to whether Lucentis treatment is appropriate and the benefit outweighs the potential risk.

**Immunogenicity**

As with all therapeutic proteins, there is a potential for immunogenicity with Lucentis.

**Bilateral treatment**

Available data do not suggest an increased risk of systemic adverse events with bilateral treatment.

**Patient populations with limited data**

Lucentis has not been studied in patients with active systemic infections or in patients with concurrent eye conditions such as retinal detachment or macular hole.

**4.5 Interaction with other medicines and other forms of interaction**

No formal interaction studies have been performed.

In clinical trials for treatment of visual impairment due to DME, the outcome with regards to visual acuity or central retinal thickness in patients treated with Lucentis was not affected by concomitant treatment with thiazolidinediones (see section 5.1, Clinical efficacy and safety).

For the adjunctive use of laser photocoagulation and Lucentis in DME and BRVO, see section 5.1, Clinical efficacy and safety and see section dose and method of administration.

**4.6 Fertility, pregnancy and lactation**

**Women of childbearing potential**

Women of childbearing potential should use effective contraception during treatment.
Pregnancy

For ranibizumab no clinical data on exposed pregnancies are available.

Studies in cynomolgus monkeys do not indicate direct or indirect harmful effects with respect to pregnancy or embryonal/foetal development (see section 5.3 preclinical safety data).

The systemic exposure to ranibizumab is low after ocular administration, but due to its mechanism of action, ranibizumab must be regarded as potentially teratogenic and embryo-/fetotoxic. Therefore, ranibizumab should not be used during pregnancy unless the expected benefit outweighs the potential risk to the foetus. For women who wish to become pregnant and have been treated with ranibizumab, it is recommended to wait at least 3 months after the last dose of ranibizumab before conceiving a child.

Breast-feeding

It is not known whether Lucentis is excreted in human milk. As precautionary measure, breast-feeding is not recommended during the use of Lucentis.

Fertility

There is no fertility data available.

4.7 Effects on the ability to drive and use machines

The Lucentis treatment procedure may induce temporary visual disturbances, which may affect the ability to drive or use machines (see section 4.8 Undesirable effects). Patients who experience these signs must not drive or use machines until these temporary visual disturbances subside.

4.8 Undesirable effects

Summary of the safety profile

Wet AMD population

A total of 1,315 patients constituted the safety population in the three controlled phase III studies in wet AMD (FVF2598g (MARINA), FVF2587g (ANCHOR) and FVF3192g (PIER)) with 24 months exposure to Lucentis and 440 patients were treated with the recommended dose of 0.5 mg.

Serious adverse events related to the injection procedure included endophthalmitis, rhegmatogenous retinal detachment, retinal tear and iatrogenic traumatic cataract (see Warnings and precautions).
Other serious ocular events observed among Lucentis-treated patients included intraocular inflammation and increased intraocular pressure (see section 4.4 special Warnings and precautions for use).

The adverse events listed below in Table 1 occurred at a higher rate (at least 2 percentage points) in patients receiving treatment with Lucentis 0.5 mg than in those receiving control treatment (sham injection as defined in Clinical studies, or verteporfin photodynamic therapy (PDT)) in the pooled data of the three controlled wet AMD studies. These were therefore considered potential adverse drug reactions. The safety data described below also include all adverse events suspected to be at least potentially related to the injection procedure or medicinal product in the 440 wAMD patients treated with 0.5 mg Lucentis.

**DME population**

The safety of Lucentis was studied in a one-year sham-controlled trial (RESOLVE) and in a one year laser-controlled trial (RESTORE) conducted respectively in 102 and 235 ranibizumab-treated patients with visual impairment due to DME (see section 5.1 Pharmacodynamic properties).

The event of urinary tract infection, in the common frequency category, met the criteria for the table above; otherwise ocular and non-ocular events in the RESOLVE and RESTORE trials were reported with a frequency and severity similar to those seen in the wet-AMD trials.

**RVO population**

The safety of Lucentis was studied in two 12-month trials (BRAVO and CRUISE) conducted respectively in 264 and 261 ranibizumab-treated patients with visual impairment due to macular oedema secondary to BRVO and CRVO, respectively (see section 5.1 Pharmacodynamic properties). Ocular and non-ocular events in the BRAVO and CRUISE trials were reported with a frequency and severity similar to those seen in the wet-AMD trials.

**CNV population**

The safety of Lucentis was studied in a 12-month clinical trial (MINERVA), which included 171 ranibizumab-treated patients with visual impairment due to CNV (see section 5.1, Clinical efficacy and safety). The safety profile in these patients was consistent with that seen in previous clinical trials with Lucentis.

**PM population**

The safety of Lucentis was studied in the 12-month clinical trial (RADIANCE), which included 224 ranibizumab-treated patients with visual impairment due to CNV secondary to PM (see section 5.1, Clinical efficacy and safety). Ocular and non-ocular
events in this trial were reported with a frequency and severity similar to those seen in the wet-AMD trials

Tabulated summary of adverse drug reactions from clinical trials

The adverse drug reactions from clinical trials (Table 1) are listed by MedDRA system organ class. Within each system organ class, the adverse drug reactions are ranked by frequency, with the most frequent reactions first. Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness. In addition, the corresponding frequency category for each adverse drug reaction is based on the following convention (CIOMS III): very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000).
## Table 1  Adverse drug reactions from clinical trials

<table>
<thead>
<tr>
<th>Infections and infestations</th>
<th>Very common</th>
<th>Nasopharyngitis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Common</td>
<td>Influenza, urinary tract infection*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood and lymphatic system disorders</th>
<th>Common</th>
<th>Anaemia</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Psychiatric disorders</th>
<th>Common</th>
<th>Anxiety</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Nervous system disorders</th>
<th>Very common</th>
<th>Headache</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Common</td>
<td>Stroke</td>
</tr>
</tbody>
</table>

| Eye disorders | Very common | Intraocular inflammation, vitritis, vitreous detachment, retinal haemorrhage, visual disturbance, eye pain, vitreous floaters, conjunctival haemorrhage, eye irritation, foreign body sensation in eyes, lacrimation increased, blepharitis, dry eye, ocular hyperaemia, eye pruritus. |
|              | Common      | Retinal degeneration, retinal disorder, retinal detachment, retinal tear, detachment of retinal pigment epithelium, retinal pigment epithelium tear, visual acuity reduced, vitreous haemorrhage, vitreous disorder, uveitis, iritis, iridocyclitis, cataract, cataract subcapsular, posterior capsule opacification, punctuate keratitis, corneal abrasion, anterior chamber flare, vision blurred, injection site haemorrhage, eye haemorrhage, conjunctivitis, conjunctivitis allergic, eye discharge, photopsia, photophobia, ocular discomfort, eyelid oedema, eyelid pain, conjunctival hyperaemia |
|              | Uncommon    | Blindness, endophthalmitis, hypopyon, hyphaema, keratopathy, iris adhesions, corneal deposits, corneal oedema, corneal striae, injection site pain, injection site irritation, abnormal sensation in eye, eyelid irritation |

<table>
<thead>
<tr>
<th>Respiratory, thoracic and mediastinal disorders</th>
<th>Common</th>
<th>Cough</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal disorders</th>
<th>Common</th>
<th>Nausea</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Skin and subcutaneous tissue disorders</th>
<th></th>
<th></th>
</tr>
</thead>
</table>


Common Allergic reactions (rash, urticaria, pruritus, erythema)

**Musculoskeletal and connective tissue disorders**

| Very common | Arthralgia |

**Investigations**

| Very common | Intraocular pressure increased |

*observed only in the DME population

A meta-analysis of pooled safety data from completed, randomized, double masked global studies showed a higher incidence rate of non-serious, non-ocular wound infection/inflammation in DME patients treated with ranibizumab 0.5 mg (1.85/100 patient years) compared to control (0.27/100 patient years). The relationship to ranibizumab remains unknown.

**Reporting of suspected adverse reactions**

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions [https://nzphvc.otago.ac.nz/reporting/](https://nzphvc.otago.ac.nz/reporting/)

4.9 **Overdose**

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).}

Cases of accidental overdose (injection of volumes greater than the recommended 0.05 mL Lucentis) have been reported from the clinical studies and post-marketing data. Adverse reactions most frequently associated with these reported cases were intraocular pressure increased and eye pain. If an overdose occurs, intraocular pressure should be monitored and treated, if deemed necessary by the attending physician.

In clinical trials doses up to 2 mg of ranibizumab in an injection volume of 0.05 mL to 0.10 mL have been administered to patients with wet AMD and DME. The type and frequency of ocular and systemic adverse events were consistent with those reported for the 0.5 mg (in 0.05 mL) Lucentis dose.

5. **PHARMACOLOGICAL PROPERTIES**

5.1 **Pharmacodynamic properties**

Pharmacotherapeutic group, ATC
Pharmacotherapeutic group: Antineovascularisation agents, ATC code: S01LA04

Mechanism of action (MOA)

Ranibizumab is a humanised recombinant monoclonal antibody fragment targeted against human vascular endothelial growth factor A (VEGF-A). It binds with high affinity to the VEGF-A isoforms (e.g. VEGF_{110}, VEGF_{121} and VEGF_{165}), thereby preventing binding of VEGF-A to its receptors VEGFR-1 and VEGFR-2.

Pharmacodynamic effects

Binding of VEGF A to its receptors leads to endothelial cell proliferation and neovascularisation, as well as vascular leakage, which are thought to contribute to the progression of the neovascular form of age-related macular degeneration, to the development of CNV, including CNV secondary to PM or to the macular oedema causing visual impairment in diabetes and retinal vein occlusion.

Clinical efficacy and safety

Treatment of wet AMD

In wet AMD, the clinical safety and efficacy of Lucentis have been assessed in three randomised, double-masked, sham*- or active-controlled studies in patients with neovascular AMD (FVF2598g (MARINA), FVF2587g (ANCHOR) and FVF3192g (PIER)). A total of 1,323 patients (879 active and 444 control) were enrolled in these studies.

*The sham Lucentis injection control procedure involved anesthetising the eye in a manner identical to a Lucentis intravitreal injection. The tip of a needleless syringe was then pressed against the conjunctiva and the plunger of the needleless syringe depressed.
Key outcomes are summarised in Tables 2, 3 and Figure 1.

### Table 2  Outcomes at Month 12 and Month 24 in study FVF2598g (MARINA)

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Month</th>
<th>Sham (n=238)</th>
<th>Lucentis 0.5 mg (n=240)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of &lt;15 letters in visual acuity (%)&lt;sup&gt;a&lt;/sup&gt; (Maintenance of vision)</td>
<td>Month 12</td>
<td>62%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Month 24</td>
<td>53%</td>
<td>90%</td>
</tr>
<tr>
<td>Gain of ≥15 letters in visual acuity (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Month 12</td>
<td>5%</td>
<td>34%</td>
</tr>
<tr>
<td></td>
<td>Month 24</td>
<td>4%</td>
<td>33%</td>
</tr>
<tr>
<td>Mean change in visual acuity (letters) (SD)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Month 12</td>
<td>-10.5 (16.6)</td>
<td>+7.2 (14.4)</td>
</tr>
<tr>
<td></td>
<td>Month 24</td>
<td>-14.9 (18.7)</td>
<td>+6.6 (16.5)</td>
</tr>
</tbody>
</table>

<sup>a</sup> *p* < 0.01.

### Table 3  Outcomes at Month 12 and 24 in study FVF2587g (ANCHOR)

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Month</th>
<th>Verteporfin PDT (n=143)</th>
<th>Lucentis 0.5 mg (n=140)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of &lt;15 letters in visual acuity (%)&lt;sup&gt;a&lt;/sup&gt; (Maintenance of vision)</td>
<td>Month 12</td>
<td>64%</td>
<td>96%</td>
</tr>
<tr>
<td></td>
<td>Month 24</td>
<td>66%</td>
<td>90%</td>
</tr>
<tr>
<td>Gain of ≥15 letters in visual acuity (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Month 12</td>
<td>6%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Month 24</td>
<td>6%</td>
<td>41%</td>
</tr>
<tr>
<td>Mean change in visual acuity (letters) (SD)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Month 12</td>
<td>-9.5 (16.4)</td>
<td>+11.3 (14.6)</td>
</tr>
<tr>
<td></td>
<td>Month 24</td>
<td>-9.8 (17.6)</td>
<td>+10.7 (16.5)</td>
</tr>
</tbody>
</table>

<sup>a</sup> *p* < 0.01.
Patients in the group treated with Lucentis had minimal observable CNV lesion growth, on average. At Month 12, the mean change in the total area of the CNV lesion was 0.1 to 0.3 DA for Lucentis versus 2.3 to 2.6 DA for the control arms.

Results from both trials indicated that continued ranibizumab-treatment may be of benefit also in patients who lost ≥15 letters of best-corrected visual acuity (BCVA) in the first year of treatment.

In both the MARINA and ANCHOR studies, the improvement in visual acuity seen with Lucentis 0.5 mg at 12 months was accompanied by patient-reported benefits as
measured by the National Eye Institute Visual Function Questionnaire (VFQ-25) scores. The differences between Lucentis 0.5 mg and the two control groups were assessed with p-values ranging from 0.009 to <0.0001.

Study FVF3192g (PIER)

Study FVF3192g (PIER) was a randomised, double-masked, sham-controlled, two-year study designed to assess the safety and efficacy of Lucentis in 184 patients with neovascular AMD (with or without a classic CNV component). Patients received Lucentis 0.3 mg or 0.5 mg intravitreal injections or sham injections once a month for 3 consecutive doses, followed by a dose administered once every 3 months. From Month 14 of the study, sham-treated patients were allowed to cross over to receive ranibizumab and from Month 19, more frequent treatments were possible. Patients treated with Lucentis in PIER received a mean of 10 treatments during the study. The primary efficacy endpoint was mean change in visual acuity at month 12 compared with baseline (see Figure 2). After an initial increase in visual acuity (following monthly dosing), on average, patients dosed once every three months with Lucentis lost visual acuity, returning to baseline at month 12. In PIER, almost all Lucentis-treated patients (90%) maintained their visual acuity at month 12. This effect was maintained in most Lucentis-treated patients (82%) at Month 24. Data from a limited number of subjects that crossed over to receive ranibizumab after more than a year of sham-treatment suggested that early initiation of treatment may be associated with a better preservation of visual acuity.

Study FVF3689g (SAILOR)

Study FVF3689g (SAILOR) was a Phase IIIb, single-masked, one-year multicenter study in naïve and previously treated subjects with CNV secondary to AMD. The primary study objective was to estimate the incidence of ocular and non-ocular serious adverse events in subjects treated for 12 months. Overall 2,378 patients were randomized in a 1:1 ratio to receive one intravitreal injection of 0.3 mg or 0.5 mg ranibizumab every month for three consecutive months followed by re-treatment as needed not more often than monthly.

Overall, no imbalances between the two dose groups were observed in the frequency of ocular and non-ocular adverse events. There was a statistically non significant trend towards a higher stroke rate in the 0.5 mg group compared to the 0.3 mg group. The respective 95% CIs for the overall stroke rate were wide (0.3% to 1.3% for the 0.3 mg group vs. 0.7% to 2.0% for the 0.5 mg group). The number of strokes was small in both dose groups, and there is not sufficient evidence to conclude (or rule out) that there is a true difference in stroke rates among the treatment groups. The difference in stroke rates may be greater in patients with known risk factors for stroke, including history of prior stroke and transient ischemic attack.

Treatment of visual impairment due to DME
The efficacy and safety of Lucentis have been assessed in two randomized, double-masked, sham- or active controlled studies of 12 months duration in patients with visual impairment due to diabetic macular oedema (Study D2301 (RESTORE) and D2201 (RESOLVE)). A total of 496 patients (336 active and 160 control) were enrolled in these studies, the majority had type II diabetes, 28 patients treated with ranibizumab had type I diabetes.

**Study D2301 (RESTORE)**

In study D2301 (RESTORE), a total of 345 patients with visual impairment due to macular edema was randomised to receive either initial intravitreal injection of ranibizumab 0.5 mg as monotherapy and sham laser photocoagulation (n=116), combined ranibizumab 0.5 mg and laser photocoagulation (n=118), or sham injection and laser photocoagulation monotherapy (n=111). Treatment with ranibizumab was started with monthly intravitreal injections and continued until visual acuity was stable for at least three consecutive monthly assessments. The treatment was reinitiated when there was a reduction in best corrected visual acuity (BCVA) due to DME progression. Laser photocoagulation was administered at baseline on the same day, at least 30 minutes before injection of ranibizumab, and then as needed based on ETDRS (Early Treatment Diabetic Retinopathy Study) criteria. Key outcomes are summarised in Table 4 and Figure 2.

**Table 4 Outcomes at Month 12 in study D2301 (RESTORE)**

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Ranibizumab 0.5 mg (n=115)</th>
<th>Ranibizumab 0.5 mg + Laser (n=118)</th>
<th>Laser (n=110)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean average change in BCVA from month 1 to month 12 compared to baseline (letters) b (SD)</td>
<td>6.1 (6.43)</td>
<td>5.9 (7.92)</td>
<td>0.8 (8.56)</td>
</tr>
<tr>
<td>Mean change in BCVA at month 12 compared to baseline (letters) (SD) b</td>
<td>6.8 (8.25)b</td>
<td>6.4 (11.77)c</td>
<td>0.9 (11.44)</td>
</tr>
<tr>
<td>Gain of ≥10 letters in BCVA (% of patients) at month 12</td>
<td>37.4d</td>
<td>43.2b</td>
<td>15.5</td>
</tr>
<tr>
<td>Gain of ≥15 letters in BCVA (% of patients) at month 12</td>
<td>22.6e</td>
<td>22.9f</td>
<td>8.2</td>
</tr>
</tbody>
</table>
^b p<0.0001, ^c p=0.0004, ^d p=0.0001, ^e p=0.0032, ^f p=0.0021
Study D2301E1 (RESTORE Extension)

Study D2301E1 (RESTORE Extension) was an open-label, multi-center, 24-month extension study. 240 patients who had completed the 12-month core study entered the extension study and were treated with ranibizumab 0.5 mg pro re nata (PRN) in the same eye that was selected as the study eye in the core study. Treatment was administered monthly upon a decrease in BCVA due to DME until stable BCVA was reached. In addition, laser treatment was administered, if deemed necessary by the investigator, and based on ETDRS guidelines.

On average, 6.4 ranibizumab injections were administered per patient in the 24-month extension period in patients who were treated with ranibizumab in the core study. Of the 74 patients from the core study laser treatment arm, 59 (79%) patients received ranibizumab at some point during the extension phase. On average, these 59 patients received 8.1 ranibizumab injections per patient over the 24 months of the extension study. The proportions of patients who did not require any ranibizumab treatment during the extension phase were 19%, 25% and 20% in the prior ranibizumab, prior ranibizumab + laser, and prior laser group, respectively.

Key outcome measures are summarized in Table 5.
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#### Table 5  Outcomes at Month 36 in study D2301E1 (RESTORE Extension)

<table>
<thead>
<tr>
<th>Outcome measure compared to core baseline</th>
<th>Prior ranibizumab 0.5 mg n=83</th>
<th>Prior ranibizumab 0.5 mg + Laser n=83</th>
<th>Prior laser n=74*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean change in BCVA from baseline in the core study at Month 36 (SD)</td>
<td>8.0 (10.09)</td>
<td>6.7 (9.59)</td>
<td>6.0 (9.35)</td>
</tr>
<tr>
<td>Gain of ≥10 letters from core baseline or BCVA ≥84 (%) at Month 36</td>
<td>39 (47.0)</td>
<td>37 (44.6)</td>
<td>31 (41.9)</td>
</tr>
<tr>
<td>Gain of ≥15 letters from core baseline or BCVA ≥84 (%) at Month 36</td>
<td>23 (27.7)</td>
<td>25 (30.1)</td>
<td>16 (21.6)</td>
</tr>
</tbody>
</table>

n The number of patients with a value both at core baseline (Month 0) and at the Month 36 visit.

* Of the 74 patients with prior laser treatment, 59 (79%) patients received ranibizumab in the extension study.

VFQ-25 scores in patients who were previously treated with ranibizumab PRN in the core study stabilized during the extension phase. Those treated with laser in the core study control group, and then switched to ranibizumab PRN treatment in the extension phase, demonstrated an improvement in VFQ-25 scores.

The long-term safety profile of ranibizumab observed in this 24-month extension study is consistent with the known Lucentis safety profile.

**Study D2201 (RESOLVE)**

In study D2201 (RESOLVE), a total of 151 patients with macular center involvement causing visual impairment were treated with ranibizumab (6 mg/mL, n=51, 10 mg/mL, n=51) or sham (n=49) by monthly intravitreal injections until pre-defined treatment stopping criteria were met. The initial ranibizumab dose (0.3 mg or 0.5 mg) could be doubled at any time during the study after the first injection if the investigator evaluated that response to treatment was not sufficiently achieved. Laser photocoagulation rescue treatment was allowed from month 3 in both treatment arms.

The study comprised two parts: an exploratory part (the first 42 patients analysed at month 6), and a confirmatory part (of the remaining 109 patients analysed at month 12).

Key outcomes from the confirmatory part of the study (2/3 of the patients) are summarised in Table 6 and Figure 3.

#### Table 6  12-month outcomes in Group A+B of study D2201 (RESOLVE)
New Zealand Data Sheet

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Ranibizumab pooled (n=102)</th>
<th>Sham (n=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean average change in BCVA from month 1 to month 12 compared to baseline (letters) (SD)(^b)</td>
<td>+7.8 (7.72)</td>
<td>-0.1 (9.77)</td>
</tr>
<tr>
<td>Mean change in BCVA at month 12 compared to baseline (letters) (SD)</td>
<td>+10.3 (9.14)</td>
<td>-1.4 (14.16)</td>
</tr>
<tr>
<td>Gain of ≥10 letters in BCVA (% patients) at month 12(^b)</td>
<td>60.8</td>
<td>18.4</td>
</tr>
<tr>
<td>Gain of ≥15 letters in BCVA (% patients) at month 12(^g)</td>
<td>32.4</td>
<td>10.2</td>
</tr>
</tbody>
</table>

\(^b\) p<0.0001, \(^g\) p=0.0043

Figure 3 Mean change in visual acuity from baseline over time in study D2201 (RESOLVE) (overall population)
Patients treated with ranibizumab experienced a continuous reduction in central retina thickness (CRT). At month 12, the mean CRT change from baseline was -194 micrometres for ranibizumab versus -48 micrometres for sham control.

Overall, ocular and non-ocular safety findings in DME patients of both studies D2201 and D2301 were comparable with the previously known safety profile observed in wet AMD patients.

**Study D2304 (RETAI)**

In the phase IIIb study D2304 (RETAI), 372 patients with visual impairment due to DME were randomized to receive either intravitreal injection of

- ranibizumab 0.5 mg with concomitant laser photocoagulation on a treat-and-extend (TE) regimen (n=121),
- ranibizumab 0.5 mg monotherapy on a TE regimen (n=128), or
- ranibizumab 0.5 mg monotherapy on a pro re nata (PRN) regimen (n=123).

In all groups, treatment with ranibizumab was initiated with monthly intravitreal injections and continued until BCVA was stable for at least three consecutive monthly assessments. Laser photocoagulation was administered at baseline on the same day as the first ranibizumab injection and then as needed based on ETDRS criteria. On TE regimen, ranibizumab was administered, at scheduled treatment at intervals of 2-3 months. On PRN regimen, BCVA was assessed monthly and ranibizumab was then administered during the same visit, if needed. In all groups, monthly treatment was re-initiated upon a decrease in BCVA due to DME progression and continued until stable BCVA was reached again. The duration of the study was 24 months.

In the RETAIN study the number of scheduled treatment visits required by the TE regimen was 40% lower than the number of monthly visits required by the PRN regimen. With both regimens, more than 70% of patients were able to maintain their BCVA with a visit frequency of ≥ 2 months.

Key outcome measures are summarised in Table 7.

**Table 7 Outcomes in study D2304 (RETAI)**

<table>
<thead>
<tr>
<th>Outcome measure compared to baseline</th>
<th>TE Ranibizumab 0.5 mg + Laser n=117</th>
<th>TE Ranibizumab 0.5 mg n=125</th>
<th>PRN Ranibizumab 0.5 mg n=117</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean average change in BCVA from Month 1 to Month 12 (SD)</td>
<td>5.9 (5.5)b</td>
<td>6.1 (5.7)b</td>
<td>6.2 (6.0)</td>
</tr>
</tbody>
</table>
New Zealand Data Sheet

<table>
<thead>
<tr>
<th>Mean average change in BCVA from Month 1 to Month 24 (SD)</th>
<th>6.8 (6.0)</th>
<th>6.6 (7.1)</th>
<th>7.0 (6.4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean change in BCVA at Month 24 (SD)</td>
<td>8.3 (8.1)</td>
<td>6.5 (10.9)</td>
<td>8.1 (8.5)</td>
</tr>
<tr>
<td>Gain of ≥10 letters or BCVA ≥84 (%) at Month 24</td>
<td>43.6</td>
<td>40.8</td>
<td>45.3</td>
</tr>
<tr>
<td>Gain of ≥15 letters or BCVA ≥84 (%) at Month 24</td>
<td>25.6</td>
<td>28.0</td>
<td>30.8</td>
</tr>
</tbody>
</table>

bp<0.0001

In DME studies, the improvement in BCVA was accompanied by a reduction over time in mean CRT in all the treatment groups.

There was no difference in the BCVA or CRT outcomes of patients in RETAIN study who received or did not receive concomitant thiazolidinediones.

**Study D2303 (REVEAL)**

The study D2303 (REVEAL), was a 12 month, randomized, double-masked Phase IIIb trial conducted in Asian patients. Similar to the RESTORE 12 month core study in trial design and inclusion/exclusion criteria, 390 patients with visual impairment due to macular edema were randomized to receive either ranibizumab 0.5 mg injection as monotherapy and sham laser photocoagulation (n=133), ranibizumab 0.5 mg injection and laser photocoagulation (n=129), or sham injection and laser photocoagulation (n=128). Mean change in visual acuity at Month 12 compared to baseline were +6.6 letters in the ranibizumab monotherapy group, +6.4 letters in the ranibizumab plus laser group and +1.8 letters in the laser group. Overall, the efficacy and safety results of the REVEAL study in Asian DME patients are consistent with those of the RESTORE study in Caucasian DME patients.

**Treatment of visual impairment due to macular oedema secondary to RVO**

**Study FVF4165g (BRAVO) and study FVF4166g CRUISE**

The clinical safety and efficacy of Lucentis in patients with visual impairment due to macular oedema secondary to RVO have been assessed in the randomised, double-masked, controlled studies BRAVO and CRUISE that recruited subjects with BRVO (n=397) and CRVO (n=392), respectively. In both studies, subjects received either 0.3 mg or 0.5 mg intravitreal ranibizumab or sham** injections. After 6 months, patients in the sham-control arms were crossed over to 0.5 mg ranibizumab. In BRAVO, laser photocoagulation as rescue was allowed in all arms from Month 3.
New Zealand Data Sheet

Key outcomes from BRAVO and CRUISE are summarised in Tables 8 and 9, and Figures 4 and 5.

**Table 8  Outcomes at Month 6 and 12 (BRAVO)**

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Sham/Lucentis 0.5 mg (n=132)</th>
<th>Lucentis 0.5 mg (n=131)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean change in visual acuity from baseline at Month 6^b (letters) (primary endpoint)</td>
<td>+7.3</td>
<td>+18.3</td>
</tr>
<tr>
<td>Mean change in visual acuity from baseline at Month 12 (letters)</td>
<td>+12.1</td>
<td>+18.3</td>
</tr>
<tr>
<td>Proportion of patients gained ≥15 letters in BCVA from baseline at Month 6^b</td>
<td>28.8 %</td>
<td>61.1 %</td>
</tr>
<tr>
<td>Proportion of patients gained ≥15 letters in BCVA from baseline at Month 12</td>
<td>43.9 %</td>
<td>60.3 %</td>
</tr>
<tr>
<td>Proportion of patients receiving laser rescue over 12 months</td>
<td>61.4 %</td>
<td>34.4 %</td>
</tr>
</tbody>
</table>

^b: p<0.0001
Figure 4  Mean Change from Baseline BCVA over time to Month 6 and Month 12 (BRAVO)

BL=baseline; SE=standard error of mean
Table 9  Outcomes at Month 6 and 12 (CRUISE)

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Sham/Lucentis 0.5 mg (n=130)</th>
<th>Lucentis 0.5 mg (n=130)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean change in visual acuity from baseline at Month 6(^b) (letters)</td>
<td>+0.8</td>
<td>+14.9</td>
</tr>
<tr>
<td>Mean change in visual acuity from baseline at Month 12 (letters)</td>
<td>+7.3</td>
<td>+13.9</td>
</tr>
<tr>
<td>Proportion of patients gained ≥ 15 letters in BCVA from baseline at Month 6(^b)</td>
<td>16.9 %</td>
<td>47.7 %</td>
</tr>
<tr>
<td>Proportion of patients gained &gt; 15 letters in BCVA from baseline at Month 12</td>
<td>33.1 %</td>
<td>50.8 %</td>
</tr>
</tbody>
</table>

\(^b\): p<0.0001

Figure 5  Mean Change from Baseline BCVA over time to Month 6 and Month 12 (CRUISE)
In both studies, the improvement of vision was accompanied by a continuous decrease in the macular oedema as measured by central retinal thickness.

The improvement in visual acuity seen with ranibizumab treatment at 6 and 12 months was accompanied by patient-reported benefits as measured by the National Eye Institute Visual Function Questionnaire (VFQ-25) sub-scales related to near and distance activity, a pre-specified secondary efficacy endpoint. The difference between Lucentis 0.5 mg and the control group was assessed at Month 6 with p-values of 0.02 to 0.0002.

Study E2401 (CRYSTAL) and study E2402 (BRIGHTER)

The long term (24 month) clinical safety and efficacy of Lucentis in patients with visual impairment due to macular edema secondary to RVO were assessed in the BRIGHTER and CRYSTAL studies, which recruited subjects with BRVO (n=455) and CRVO (n=357), respectively. In both studies, subjects received a 0.5 mg ranibizumab PRN dosing regimen driven by individualized stabilization criteria. BRIGHTER was a 3-arm, randomized, active-controlled study that compared 0.5 mg ranibizumab given as monotherapy or in combination with adjunctive laser photocoagulation, to laser photocoagulation alone. After 6 months, subjects in the laser monotherapy arm could receive 0.5 mg ranibizumab. CRYSTAL was a single-arm study with 0.5 mg ranibizumab monotherapy.

Key outcome measures from BRIGHTER and CRYSTAL are shown in Table 10 and Figures 6 and 7.

Table 10 Outcomes at Month 6 (BRIGHTER) and Month 24 (BRIGHTER and CRYSTAL)

<table>
<thead>
<tr>
<th></th>
<th>BRIGHTER</th>
<th>CRYSTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lucentis 0.5 mg</td>
<td>Lucentis 0.5 mg</td>
</tr>
<tr>
<td></td>
<td>N=180</td>
<td>+ Laser</td>
</tr>
<tr>
<td></td>
<td>Mean change in BCVA at Month 6&lt;sup&gt;b&lt;/sup&gt; (letters) (SD)</td>
<td>N=178</td>
</tr>
<tr>
<td></td>
<td>+14.8 (10.7)</td>
<td>+14.8 (11.13)</td>
</tr>
<tr>
<td></td>
<td>Mean change in BCVA at Month 24&lt;sup&gt;b&lt;/sup&gt; (letters) (SD)</td>
<td>+6.0 (14.27)</td>
</tr>
<tr>
<td></td>
<td>+15.5 (13.91)</td>
<td>+12.0 (13.95)</td>
</tr>
<tr>
<td></td>
<td>Mean change in BCVA at Month 6&lt;sup&gt;b&lt;/sup&gt; (letters) (SD)</td>
<td>+12.1 (18.60)</td>
</tr>
</tbody>
</table>

* Represents Laser Photocoagulation
### New Zealand Data Sheet

<table>
<thead>
<tr>
<th>Proportion of patients gained ≥15 letters in BCVA at Month 24</th>
<th>52.8 %</th>
<th>59.6 %</th>
<th>43.3 %</th>
<th>49.2 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean number of injections (SD) (Months 0-23)</td>
<td>11.4 (5.81)</td>
<td>11.3 (6.02)</td>
<td>NA</td>
<td>13.1 (6.39)</td>
</tr>
</tbody>
</table>

*a* Starting at Month 6 treatment with ranibizumab 0.5 mg was allowed (24 patients were treated with laser only).

b:*p<0.0001* for both comparisons in BRIGHTER at Month 6: Lucentis 0.5 mg vs Laser and Lucentis 0.5 mg + Laser vs Laser.

bp:*p<0.0001* for null hypothesis in CRYSTAL that the mean change at Month 24 from baseline is zero.
In BRIGHTER, 0.5 mg ranibizumab with adjunctive laser therapy demonstrated non-inferiority to ranibizumab monotherapy from baseline to Month 24 as assessed by the mean average change in BCVA. There was no difference between the two groups in the number of ranibizumab injections administered over this period.

In both studies, a rapid and significant decrease from baseline in central retinal subfield thickness was observed at Month 1. This effect was maintained up to Month 24.

The beneficial effect of ranibizumab treatment was similar irrespective of the presence of retinal ischemia. In BRIGHTER, patients with retinal ischemia present (N=87) or absent (N=35) and treated with ranibizumab monotherapy had a mean change from
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baseline of +15.4 and +12.9 letters respectively, at Month 24. In CRYSTAL, patients with retinal ischemia present (N=107) or absent (N=109), treated with ranibizumab monotherapy had a mean change from baseline of +11.1 and +12.94 letters, respectively.

The beneficial effect in terms of visual improvement was observed in all patients treated with 0.5 mg ranibizumab monotherapy regardless of their disease duration in both BRIGHTER and CRYSTAL. In patients with <3 months disease duration an increase in visual acuity of 13.3 and 10.0 letters was seen at Month 1; and 17.7 and 13.2 letters at Month 24 in BRIGHTER and CRYSTAL, respectively. Treatment initiation at the time of diagnosis should be considered.

The long term safety profile of ranibizumab observed in these 24-month studies is consistent with the known Lucentis safety profile.

Treatment of visual impairment due to CNV

Study G2301 (MINERVA) [76,77]

The clinical safety and efficacy of Lucentis in patients with visual impairment due to CNV secondary to etiologies other than nAMD and PM have been assessed based on the 12-month data of the randomized, double-masked, sham controlled pivotal study G2301 (MINERVA). Due to the multiple baseline etiologies involved, five subgroups (angioid streaks, post-inflammatory retinochoroidopathy, central serous chorioretinopathy, idiopathic chorioretinopathy, and miscellaneous etiology) were pre-defined for analysis. In this study, 178 patients were randomized in a 2:1 ratio to one of the following arms:

- ranibizumab 0.5 mg at baseline followed by an individualized dosing regimen driven by disease activity.
- sham injection at baseline followed by an individualized treatment regimen driven by disease activity.

Starting at Month 2, all patients received open-label treatment with ranibizumab as needed. The primary endpoint was assessed by the best corrected visual acuity (BCVA) change from baseline to Month 2.

Key outcomes from MINERVA are summarized in Tables 10 and 11 and Figure 7.

Table 10 Outcomes at Month 2 (MINERVA)

<table>
<thead>
<tr>
<th></th>
<th>Ranibizumab 0.5 mg (n=119)</th>
<th>Sham (n=59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean BCVA change from baseline to Month 2 (letters) (Least Squares Mean) a</td>
<td>+9.5</td>
<td>-0.4</td>
</tr>
</tbody>
</table>

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New Zealand Data Sheet

<table>
<thead>
<tr>
<th>Ranibizumab 0.5 mg (n=119)</th>
<th>Sham (n=59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients who gained ≥10 letters from baseline or reached 84 letters at Month 2</td>
<td>42.4%</td>
</tr>
<tr>
<td>Proportion of patients not losing &gt;10 letters from baseline at Month 2</td>
<td>99.2%</td>
</tr>
<tr>
<td>Reduction in CSFT from baseline to Month 2 (Least Squares Mean) (^a)</td>
<td>77 µm</td>
</tr>
</tbody>
</table>

CSFT=central subfield thickness

\(^a\): One sided p<0.001 comparison with sham control

Figure 7  Mean BCVA change from baseline over time to Month 12 (MINERVA)

When comparing ranibizumab versus sham control at Month 2, a consistent treatment effect both overall and across baseline etiology subgroups was observed.
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Table 11 Overall treatment effect and treatment effect across baseline etiology subgroups for primary variable at Month 2 (MINERVA)

<table>
<thead>
<tr>
<th>Overall and per baseline etiology</th>
<th>Treatment over sham (letters)</th>
<th>Patient numbers (n) (treatment + sham)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>9.9</td>
<td>175*</td>
</tr>
<tr>
<td>Angioid streaks</td>
<td>14.6</td>
<td>27</td>
</tr>
<tr>
<td>Post-inflammatory retinochoroidopathy</td>
<td>6.5</td>
<td>27</td>
</tr>
<tr>
<td>Central serous chorioretinopathy</td>
<td>5.0</td>
<td>23</td>
</tr>
<tr>
<td>Idiopathic chorioretinopathy</td>
<td>11.4</td>
<td>62</td>
</tr>
<tr>
<td>Miscellaneous etiologies\a</td>
<td>10.6</td>
<td>36</td>
</tr>
</tbody>
</table>

\a comprises CNV etiologies which do not fall under the other subgroups

* number of patients with data available in the analysis

The improvement of vision was accompanied by a reduction in central subfield thickness over the 12-month period.

The mean number of ranibizumab injections given in the study eye over 12 months was 5.8 in the ranibizumab arm versus 5.4 in those patients in the sham with ranibizumab group. In the sham arm, 7 out of 59 patients did not receive any treatment with ranibizumab in the study eye during the 12-month period.

A trend in patient-reported benefits, as measured by the NEI VFQ-25 composite score, was observed from baseline to Month 2 for patients receiving ranibizumab treatment versus the sham control group. This trend was maintained to Month 12.

**Paediatric patients**

Five adolescent patients aged 12 to 17 years with visual impairment secondary to CNV received open-label treatment with ranibizumab 0.5 mg at baseline followed by an individualized treatment regimen based on evidence of disease activity (e.g. VA impairment, intra/sub-retinal fluid, hemorrhage or leakage). BCVA change from baseline to Month 12 improved in all five patients, ranging from +5 to +38 letters (mean of 16.6 letters). The improvement of vision was accompanied by a stabilization or reduction in central subfield thickness over the 12-month period. The mean number of ranibizumab injections given in the study eye over 12 months was three.

**Treatment of visual impairment due to CNV secondary to PM**

*Study F2301 (RADIANCE)*
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The clinical safety and efficacy of Lucentis in patients with visual impairment due to CNV in PM have been assessed based on the 12-month data of the randomized, double-masked, controlled pivotal study F2301 (RADIANCE) which was designed to evaluate two different dosing regimens of 0.5 mg ranibizumab given as intravitreal injection in comparison to verteporfin PDT (vPDT, Visudyne photodynamic therapy).

The 277 patients were randomized to one of the following arms:

- Group I (ranibizumab 0.5mg, dosing regimen driven by “stability” criteria defined as no change in BCVA compared to two preceding monthly evaluations)
- Group II (ranibizumab 0.5mg, dosing regimen driven by “disease activity” criteria defined as vision impairment attributable to intra-or-subretinal fluid or active leakage due to the CNV lesion as assessed by OCT and/or FA)
- Group III (vPDT - patients were allowed to receive ranibizumab treatment as of Month 3)

Over the 12 months of the study patients received on average 4.6 injections (range 1-11) in Group I and 3.5 injections (range 1-12) in Group II. In Group II (in which patients received the recommended treatment regimen based on disease activity, see section 4.2 Dose and method of Administration), 50.9% of patients required 1 or 2 injections, 34.5% required 3 to 5 injections and 14.7% required 6 to 12 injections over the 12-month study period. In group II, 62.9% of patients did not require injections in the second 6 months of study.

Key outcomes from RADIANCE are summarised in Table 11 and Figure 8.

### Table 11 Outcomes at Month 3 and Month 12 (RADIANCE)

<table>
<thead>
<tr>
<th>Group I Ranibizumab 0.5mg “visual acuity stability” (n=105)</th>
<th>Group II Ranibizumab 0.5mg “disease activity” (n=116)</th>
<th>Group III vPDT* (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean average BCVA change from Month 1 to Month 3 compared to baselinea (letters)</td>
<td>+10.5</td>
<td>+10.6</td>
</tr>
<tr>
<td>Proportion of patients who gained</td>
<td>61.9 %</td>
<td>65.5 %</td>
</tr>
</tbody>
</table>

Note: a. BCVA = Best Corrected Visual Acuity
New Zealand Data Sheet

<table>
<thead>
<tr>
<th></th>
<th>Group I Ranibizumab 0.5mg “visual acuity stability” (n=105)</th>
<th>Group II Ranibizumab 0.5mg “disease activity” (n=116)</th>
<th>Group III vPDT* (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 10 letters, or reached ≥ 84 letters in BCVA</td>
<td>38.1 %</td>
<td>43.1 %</td>
<td>14.5 %</td>
</tr>
<tr>
<td>≥ 15 letters, or reached ≥ 84 letters in BCVA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Month 12**

Number of injections up to Month 12:

<table>
<thead>
<tr>
<th></th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>4.6</td>
<td>3.5</td>
<td>N/A</td>
</tr>
<tr>
<td>Median</td>
<td>4.0</td>
<td>2.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Mean average BCVA change from Month 1 to Month 12 compared to baseline (letters)</td>
<td>+12.8</td>
<td>+12.5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Proportion of patients who gained

<table>
<thead>
<tr>
<th></th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 10 letters, or reached ≥ 84 letters in BCVA</td>
<td>69.5 %</td>
<td>69.0 %</td>
<td>N/A</td>
</tr>
<tr>
<td>≥ 15 letters, or reached ≥ 84 letters in BCVA</td>
<td>53.3 %</td>
<td>51.7 %</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Comparative control up to Month 3. Patients randomized to vPDT were allowed to receive ranibizumab treatment as of Month 3 (in Group III, 38 patients received ranibizumab from Month 3 onwards)

*: p<0.00001 comparison with vPDT control
Figure 8  Mean change from baseline BCVA over time up to Month 12 (RADIANCE)

BL = baseline; SE = standard error of the mean.
Patients randomized to vPDT were allowed to receive ranibizumab from Month 3 onwards.
The improvement of vision was accompanied by a reduction in central retinal thickness.
Patient-reported benefits were observed with both ranibizumab treatment arms over vPDT (p-value <0.05) in terms of improvement in the composite score and several subscales (general vision, near activities, mental health and dependency) of the VFQ-25.

5.2 Pharmacokinetic properties

Absorption
Following monthly intravitreal administration of Lucentis to patients with neovascular AMD, serum concentrations of ranibizumab were generally low, with maximum levels ($C_{\text{max}}$) generally below the ranibizumab concentration necessary to inhibit the
biological activity of VEGF by 50% (11 to 27 ng/mL, as assessed in an in vitro cellular proliferation assay). C\text{max} was dose proportional over the dose range of 0.05 to 1.0 mg/eye. Upon monthly intravitreal administration of Lucentis 0.5 mg/eye, serum ranibizumab C\text{max}, attained approximately 1 day after dosing, is predicted to generally range between 0.79 and 2.90 ng/mL, and C\text{min} is predicted to generally range between 0.07 and 0.49 ng/mL. Serum ranibizumab concentrations in RVO patients were similar to those observed in neovascular AMD patients.

**Distribution and elimination**

Based on analysis of population pharmacokinetics and disappearance of ranibizumab from serum for patients with neovascular AMD treated with the 0.5 mg dose, the average vitreous elimination half-life of ranibizumab is approximately 9 days. Serum ranibizumab exposure is predicted to be approximately 90,000-fold lower than vitreal ranibizumab exposure.

**Special populations**

Renal impairment: No formal studies have been conducted to examine the pharmacokinetics of Lucentis in patients with renal impairment. In a population pharmacokinetic analysis of neovascular AMD patients, 68% percent (136 of 200) of patients in a population pharmacokinetic analysis had renal impairment (46.5% mild [50 to 80 mL/min], 20% moderate [30 to 50 mL/min] and 1.5% severe [<30 mL/min]). In RVO patients, 48.2% (253 of 525) had renal impairment (36.4% mild, 9.5% moderate and 2.3% severe). Systemic clearance was slightly lower, but this was not clinically significant.

Hepatic impairment: No formal studies have been conducted to examine the pharmacokinetics of Lucentis in patients with hepatic impairment.

**5.3 Preclinical safety data**

Bilateral intravitreal administration of ranibizumab to cynomolgus monkeys at doses between 0.25 mg/eye and 2.0 mg/eye once every 2 weeks for up to 26 weeks resulted in dose-dependent ocular effects.

Intraocularly, there were dose-dependent increases in anterior chamber flare and cells with a peak 2 days after injection. The severity of the inflammatory response generally diminished with subsequent injections or during recovery. In the posterior segment, there were vitreal cell infiltration and floaters, which also tended to be dose-dependent and generally persisted to the end of the treatment period. In the 26-week study, the severity of the vitreous inflammation increased with the number of injections. However, evidence of reversibility was observed after recovery. The nature and timing of the posterior segment inflammation is suggestive of an immune-mediated antibody response, which may be clinically irrelevant. Cataract formation was observed in some animals after a relatively long period of intense inflammation, suggesting that the lens
changes were secondary to severe inflammation. A transient increase in post-dose intraocular pressure was observed following intravitreal injections, irrespective of dose.

Microscopic ocular changes were related to inflammation and did not indicate degenerative processes. Granulomatous inflammatory changes were noted in the optic disc of some eyes. These posterior segment changes diminished, and in some instances resolved, during the recovery period. Following intravitreal administration, no signs of systemic toxicity were detected. Serum and vitreous antibodies to ranibizumab were found in a subset of treated animals.

No carcinogenicity and mutagenicity are available.

In pregnant monkeys, IVT ranibizumab treatment did not elicit developmental toxicity or teratogenicity, and had no effect on weight or structure of the placenta, although, based on its pharmacological effect ranibizumab should be regarded as potentially teratogenic and embryo-foetotoxic.

However, due to restrictions dictated by the intravitreal route of administration the feasible doses used in this study did not reach maternal toxicity but only a multiple with respect to human systemic exposure. The absence of ranibizumab-mediated effects on the embryo-foetal development is plausibly related mainly to the inability of the Fab fragment to cross the placenta.

Nevertheless, a case was described with high maternal ranibizumab serum levels and presence of ranibizumab in foetal serum, suggesting that the anti-ranibizumab antibody acted as a (Fc region containing) carrier protein for ranibizumab, thereby decreasing its maternal serum clearance and enabling its placental transfer. The embryo-foetal development investigations were performed in healthy pregnant animals and disease (such as diabetes) may modify the permeability of the placenta towards a Fab fragment (see recommendations in section 4.6 fertility, pregnancy and lactation).

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Alpha, alpha-trehalose dihydrate
Histidine hydrochloride, monohydrate
Histidine
Polysorbate 20
Water for injections.

6.2 Incompatibilities

In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products.
New Zealand Data Sheet

6.3 Shelf life

Vial
36 months.

Pre-filled syringe
36 months.

6.4 Special precautions for storage

Vial
Store in a refrigerator (2°C to 8°C).
Do not freeze.
Keep the vial in the outer carton in order to protect from light.
Prior to usage, the unopened tray may be kept at room temperature (25°C) for up to 24 hours.

Pre-filled syringe
Store in a refrigerator (2°C to 8°C).
Do not freeze.
Keep the pre-filled syringe in its sealed tray in the carton in order to protect from light.
Prior to usage, the unopened tray may be kept at room temperature (25°C) for up to 24 hours.
Lucentis must be kept out of the reach and sight of children.

6.5 Nature and contents of container

Vial*
0.23 mL Lucentis solution for injection in a glass vial (colourless type I glass) with a bromobutyl rubber stopper. One pack contains one vial.

Vial kit
0.23 mL Lucentis solution for injection in a glass vial (colourless type I glass) with chlorobutyl rubber stopper. One pack contains one vial, one filter needle for withdrawal of the vial content, one needle for intravitreal injection, one syringe for withdrawal of the vial contents and for intravitreal injection.

Vial and filter needle*
0.23 mL Lucentis solution for injection in a glass vial (colourless type I glass) with chlorobutyl rubber stopper. One pack contains one vial and one filter needle for withdrawal of the vial content.

**Pre-filled syringe***

0.165 mL sterile solution in a pre-filled syringe (type I glass) with a bromobutyl rubber plunger stopper and a syringe cap consisting of a white, tamper-evident rigid seal with a grey bromobutyl rubber tip cap and a Luer Lock adapter. The pre-filled syringe has a plunger rod and a finger grip, and is packed in a sealed tray. One pack contains one pre-filled syringe.

6.6 Special precautions for disposal and other handling

**Vial**

Vials are for single use only (see section dose and method of administration).

The vial is sterile. Do not use the vial if the packaging is damaged. The sterility of the vial cannot be guaranteed unless the packaging seal remains intact. Do not use the vial if the solution is discoloured, cloudy, or contains particulates.

For preparation and intravitreal injection, the following single use medical devices are needed:

- a 5 micrometer filter needle (18G)
- a 1 mL sterile syringe
- an injection needle (30G x ½ inch)

These medical devices are not supplied in the Lucentis pack that contains only the vial. The sterile syringe and injection needle are not supplied with the vial + filter needle presentation. To prepare Lucentis for intravitreal administration, please adhere to the following instructions:

<table>
<thead>
<tr>
<th>A.</th>
<th>1. Before withdrawal, the outer part of the rubber stopper of the vial should be disinfected.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Attach a 5 micrometer filter needle (18 G) onto the 1 mL syringe using aseptic technique. Push the blunt filter needle into the centre of the vial stopper until the needle touches the bottom edge of the vial.</td>
</tr>
<tr>
<td></td>
<td>3. Withdraw all the liquid from the vial, keeping the vial in an upright position, slightly inclined to ease complete withdrawal</td>
</tr>
</tbody>
</table>
New Zealand Data Sheet

| B. | 4. Ensure that the plunger rod is drawn back sufficiently when emptying the vial in order to completely empty the filter needle.  
5. Leave the blunt filter needle in the vial and disconnect the syringe from the blunt filter needle. The filter needle should be discarded after withdrawal of the vial contents and should not be used for the intravitreal injection. |
| C. | 6. Aseptically and firmly attach an injection needle (30G x ½ inch) onto the syringe.  
7. Carefully remove the cap from the injection needle without disconnecting the injection needle from the syringe.  
Note: Grip at the yellow hub of the injection needle while removing the cap. |
| D. | 8. Carefully expel the air from the syringe and adjust the dose to the 0.05 ml mark on the syringe. The syringe is ready for injection.  
Note: Do not wipe the injection needle. Do not pull back on the plunger. |

Any unused product or waste material should be disposed of in accordance with local requirements.

**Pre-filled syringe**

The pre-filled syringe is for single use only (see section dose and method of administration).

The pre-filled syringe is sterile. Do not use the pre-filled syringe if the packaging is damaged. The sterility of the pre-filled syringe cannot be guaranteed unless the tray remains sealed. Do not use the pre-filled syringe if the solution is discoloured, cloudy, or contains particulates.
For the intravitreal injection, a 30G x 1/2 inch injection needle should be used.

To prepare Lucentis for intravitreal administration, please adhere to the instructions for use:

<table>
<thead>
<tr>
<th>Heading</th>
<th>Instructions</th>
<th>Diagram/Image</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read all the instructions carefully before using the prefilled syringe. The prefilled syringe is for single use only. The pre-filled syringe is sterile. Do not use the product if the packaging is damaged. The opening of the sealed tray and all subsequent steps should be done under aseptic conditions. Note: The dose must be set to 0.05 mL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-filled syringe</td>
<td></td>
<td>Figure 1</td>
</tr>
</tbody>
</table>
| Prepare           | 1. Make sure that your pack contains:  
  • a sterile pre-filled syringe in a sealed tray.  
  2. Peel the lid off the syringe tray and, using aseptic technique, carefully remove the syringe.                                                                                                                                                                         |                        |
| Check syringe     | 3. Check that:                                                                                                                                                                                                                                                                                                                              |                        |
## New Zealand Data Sheet

<table>
<thead>
<tr>
<th>Remove syringe cap</th>
<th>Attach needle</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. If any of the above is not true, discard the pre-filled syringe and use a new one.</td>
<td>5. Snap off (do not turn or twist) the syringe cap (see Figure 2).</td>
</tr>
<tr>
<td>6. Dispose of the syringe cap (see Figure 3).</td>
<td>7. Attach a 30G x 1/2 inch sterile injection needle firmly onto the syringe by screwing it tightly onto the Luer Lock (see Figure 4).</td>
</tr>
<tr>
<td>Note: Do not wipe the needle at any time.</td>
<td>8. Carefully remove the needle cap by pulling it straight off (see Figure 5).</td>
</tr>
</tbody>
</table>
### New Zealand Data Sheet

<table>
<thead>
<tr>
<th>Dislodge air bubbles</th>
<th>9. Hold the syringe upright.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10. If there are any air bubbles, gently tap the syringe with your finger until the bubbles rise to the top (see Figure 6).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Set dose</th>
<th>11. Hold the syringe at eye level and carefully push the plunger until the edge below the dome of the rubber stopper is aligned with the dose mark (see Figure 7).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ This will expel the air and the excess solution and set the dose to 0.05 mL.</td>
</tr>
<tr>
<td></td>
<td><strong>Note: the plunger rod is not attached to the rubber stopper – this is to prevent air being drawn into the syringe.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inject</th>
<th>The injection procedure should be carried out under aseptic conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12. The injection needle should be inserted 3.5 - 4.0 mm posterior to the limbus into the vitreous cavity, avoiding the horizontal meridian and aiming towards the center of the globe.</td>
</tr>
<tr>
<td></td>
<td>13. Inject slowly until the rubber stopper reaches the bottom of the syringe to deliver the volume of 0.05 mL.</td>
</tr>
<tr>
<td></td>
<td>14. A different scleral site should be used for subsequent injections.</td>
</tr>
</tbody>
</table>
15. After injection, do not recap the needle or detach it from the syringe. Dispose of the used syringe together with the needle in a sharps disposal container or in accordance with local requirements.

7. MEDICINE SCHEDULE

Prescription Medicine

8. SPONSOR

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109 Carlton Gore Road
Newmarket
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Auckland 1149

Telephone: 0800 354 335

9. DATE OF FIRST APPROVAL

21 June 2007

10. DATE OF REVISION OF THE TEXT

12 July 2018

Summary table of changes
### New Zealand Data Sheet

<table>
<thead>
<tr>
<th>Section changed</th>
<th>Summary of new information</th>
</tr>
</thead>
<tbody>
<tr>
<td>All sections</td>
<td>Data Sheet updated to SmPC style format</td>
</tr>
<tr>
<td>4.1</td>
<td>Addition of therapeutic indication</td>
</tr>
<tr>
<td>4.2</td>
<td>Clarification around dosing for new indication</td>
</tr>
<tr>
<td>4.8</td>
<td>Addition of safety information for CNV population</td>
</tr>
<tr>
<td>5.1</td>
<td>Addition of clinical safety and efficacy information from MINERVA study to support new indication</td>
</tr>
<tr>
<td>6.3</td>
<td>Addition of shelf life information to harmonise with SmPC format</td>
</tr>
</tbody>
</table>

(Internal Ref: luc220618iNZ based on CDS 5 Aug 2016)

*Not all presentations may be marketed*