
STELARA®

ustekinumab

NEW ZEALAND DATA SHEET

1. PRODUCT NAME

STELARA 45 mg solution for injection in vial.

STELARA 45 mg solution for injection in pre-filled syringe.

STELARA 90 mg solution for injection in pre-filled syringe.

STELARA 130 mg concentrate for solution for infusion.

STELARA 45 mg solution for injection in pre-filled pen (One-Press® patient-controlled injector) (for adult use).

STELARA 90 mg solution for injection in pre-filled pen (One-Press® patient-controlled injector) (for adult use).

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Solution for injection vial, pre-filled syringe and pre-filled pen (*for subcutaneous administration*)

Each vial contains 45 mg ustekinumab in 0.5 mL.

Each pre-filled syringe or pre-filled pen contains 45 mg ustekinumab in 0.5 mL or 90 mg ustekinumab in 1 mL.

Concentrate for solution for infusion (*for intravenous infusion as the induction dose for use in Crohn's disease and Ulcerative Colitis only*)

Each vial contains 130 mg ustekinumab in 26 mL (5 mg/mL).

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

For the full list of excipients, see **section 6.1**.

3. PHARMACEUTICAL FORM

Solution for injection vial, pre-filled syringe and pre-filled pen (*for subcutaneous administration*)

The solution is clear to slightly opalescent, colourless to light yellow with a pH of approximately 6.0.

Concentrate for solution for infusion (*for intravenous infusion*)

The solution is clear, colourless to light yellow with a pH of approximately 6.0.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Plaque Psoriasis

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

Psoriatic Arthritis (PsA)

STELARA, alone or in combination with methotrexate, is indicated for the treatment signs and symptoms, including reduction of the rate of progression of peripheral joint damage as measured by X-ray, of active psoriatic arthritis in adult patients (18 years or older).

Crohn's Disease

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

Ulcerative Colitis

STELARA is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis.

4.2 Dose and method of administration

Dosing (Adults)

Plaque Psoriasis

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

Dose Adjustment

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

Re-treatment

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

Psoriatic Arthritis

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

Crohn's Disease and Ulcerative Colitis

For the treatment of Crohn's disease and Ulcerative Colitis, the recommended treatment regimen is to initiate STELARA with a single intravenous (IV) tiered dose of STELARA based on body weight (Table 1). The infusion solution is to be composed of the number of vials of STELARA 130 mg as specified in Table 1.

Table 11. Initial IV dosing of STELARA

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

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

For some patients, the single IV dose followed by a 90 mg subcutaneous dose 8 weeks later, then every 12 weeks thereafter may be acceptable according to clinical judgment. Patients who inadequately respond to 90 mg subcutaneous dosing every 12 weeks may benefit from an increase in dosing frequency to every 8 weeks (see section 5.1).

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

If therapy in Crohn's disease or Ulcerative Colitis is interrupted, treatment may be resumed with subcutaneous dosing every 8 weeks (see section 5.1).

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

Method of Administration

Subcutaneous administration

STELARA injections are for single use in one patient only.

STELARA is intended for use under the guidance and supervision of a healthcare professional. Patient may self-inject or their caregiver may inject patients with STELARA if a physician determines that it is appropriate and with medical follow-up as necessary, after proper training in subcutaneous injection technique and disposal.

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

The needle cover on the pre-filled syringe and the needle cover inside the bottom cap of the pre-filled pen contain dry natural rubber (a derivative of latex), which may cause allergic reactions in individuals sensitive to latex (see section 4.4). Each pre-filled syringe and pre-filled pen is for single dose only. Patients may encounter resistance while injecting. It is important to instruct patients to inject the full amount to receive either 45 mg or 90 mg of STELARA.

Do not inject STELARA into areas where the skin is tender, bruised, red, hard, thick, scaly or affected by psoriasis.

Before injection, remove STELARA pre-filled pen from the refrigerator and allow STELARA to reach room temperature (30 minutes) without removing the needle cap.

Inspect STELARA visually for particulate matter and discolouration prior to administration. STELARA is a colourless to light yellow solution and may contain a few small translucent or white particles. Do not use STELARA if it is discoloured or cloudy, or if other particulate matter is present. STELARA does not contain preservatives; therefore, discard any unused product remaining in the vial, pre-filled syringe or pre-filled pen in accordance with local requirements and must never be re-used.

Intravenous infusion (Crohn's Disease and Ulcerative Colitis)

STELARA 130 mg vial is for IV infusion only. Intravenous infusion of STELARA should be administered by qualified healthcare professionals. For preparation, see section 6.6.

4.3 Contraindications

Severe hypersensitivity to ustekinumab or to any of the excipients (see sections 4.4 and 6.1).

4.4 Special warnings and precautions for use

Serious Infections

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

In clinical studies, serious bacterial, fungal, and viral infections have been observed in patients receiving STELARA. STELARA should not be given to patients with a clinically important, active infection. Caution should be exercised when considering the use of STELARA in patients with a chronic infection or a history of recurrent infection.

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

Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection they should be closely monitored and STELARA should not be administered until the infection resolves (see section 4.8).

Malignancies

STELARA is a selective immunosuppressant. Immunosuppressive agents have the potential to increase the risk of malignancy. Some patients who received STELARA in clinical studies developed cutaneous and non-cutaneous malignancies (see section 4.8).

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

All patients, in particular those greater than 60 years of age, patients with a medical history of prolonged immunosuppressant therapy or those with a history of PUVA treatment, should be monitored for the appearance of nonmelanoma skin cancer (see section 4.8).

Hypersensitivity reactions

In post-marketing experience, serious hypersensitivity reactions, including anaphylaxis and angioedema, have been reported. If an anaphylactic or other serious hypersensitivity reaction occurs, appropriate therapy should be instituted and administration of STELARA should be discontinued (see section 4.8).

Immunisations

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

Before live viral or live bacterial vaccination, treatment with STELARA should be withheld for at least 15 weeks after the last dose and can be resumed at least 2 weeks after vaccination. Prescribers should consult the Data Sheet for the specific vaccine for additional information and guidance on concomitant use of immunosuppressive agents post vaccination and considering the benefit risk of ustekinumab treatment in the patient.

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

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

Long-term treatment with STELARA does not suppress the humoral immune response to pneumococcal polysaccharide or tetanus vaccines (see section 5.1).

Infant exposure in utero

For infants exposed *in utero* to ustekinumab, a six-month waiting period following birth is recommended before the administration of live vaccines. Administration of a live vaccine prior to 6 months of age may be considered if ustekinumab dosing was limited to the first trimester of pregnancy when placental transport is minimal, or ustekinumab serum levels are undetectable in the infant, or the benefit of the vaccination clearly outweighs the theoretical risk of administration of live vaccines to the infant (see section 4.6).

Immunosuppression

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

Immunotherapy

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

Posterior Reversible Encephalopathy Syndrome (PRES)

Posterior reversible encephalopathy syndrome (PRES), also known as Reversible Posterior Leukoencephalopathy Syndrome (RPLS), is a neurological disorder, which is not caused by demyelination or a known infectious agent. Conditions with which it has been associated include preeclampsia, eclampsia, acute hypertension, cytotoxic agents and immunosuppressive therapy. Fatal outcomes have been reported in this condition.

Two cases of (PRES) were reported in clinical trials. Cases have also been reported in postmarketing experience in patients with psoriasis, psoriatic arthritis and Crohn's disease. Clinical presentation included headaches, seizures, confusion, visual disturbances, and imaging changes consistent with PRES a few days to several months after ustekinumab initiation. A few cases reported latency of a year or longer. Patients recovered with supportive care following withdrawal of ustekinumab. Monitor all patients treated with STELARA for signs and symptoms of PRES.

If PRES is suspected, promptly administer appropriate treatment and discontinue STELARA.

Serious skin conditions

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

General

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

Special Populations

Paediatric Use

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

Use in the Elderly

Of the 6710 patients exposed to STELARA, a total of 353 were 65 years or older (183 patients with psoriasis, 69 patients with psoriatic arthritis, 58 with Crohn's disease and 43 patients with ulcerative colitis). No major age-related differences in clearance or volume of distribution were observed in clinical studies. Although no overall difference in safety or efficacy were observed between older and younger patients in clinical studies in approved indications, the number of patients aged 65 and over is not sufficient to determine whether they respond differently from younger patients.

4.5 Interactions with other medicines and other forms of interactions

Live vaccines should not be given concurrently with STELARA. Recommendations for infants exposed to ustekinumab *in utero* are provided (see section 4.4).

CYP450 Substrates

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

The effects of IL-12 or IL-23 on the regulation of CYP450 enzymes were evaluated in an *in vitro* study using human hepatocytes, which showed that IL-12 and/or IL-23 at levels of 10 ng/mL did not alter human CYP450 enzyme activities (CYP1A2, 2B6, 2C9, 2C19, 2D6, or 3A4). Results from a Phase 1 study in subjects with active Crohn's disease suggest no clinically relevant drug interactions are likely. These results do not suggest the need for dose adjustments in patients who are receiving concomitant CYP450 substrate (see section 5.2).

4.6 Fertility, pregnancy and lactation

Pregnancy

Category B1.

STELARA should be given to a pregnant woman if the benefit clearly outweighs the risk.

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

Data from prospectively collected pregnancies following exposure to STELARA resulting in live birth with known outcomes, including more than 450 pregnancies exposed during the first trimester, do not indicate an increased risk of malformations in the newborn.

Overall, data from observational studies, pharmacovigilance and published case reports and cohort studies do not indicate an increase in the risk of major birth defects, pattern of major or minor anomalies, miscarriage, or adverse infant outcomes.

Breastfeeding

Limited data from published literature suggests that ustekinumab is excreted in human breast milk in very small amounts. While systemic exposure to a breastfed infant is expected to be low because ustekinumab is a large molecule and is degraded in the gastrointestinal tract, it is not known if STELARA is absorbed systemically after ingestion. Because of the potential for adverse reactions in nursing infants from STELARA, a decision should be made whether to discontinue nursing or to discontinue the drug.

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

Fertility

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

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

It is not known whether STELARA can affect reproductive potential.

4.7 Effect on ability to drive and use machines

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

4.8 Undesirable effects

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

The safety data described below reflect exposure to STELARA in 14 Phase 2 and Phase 3 studies in 6710 patients (4135 with psoriasis and/or psoriatic arthritis 1749 with Crohn's disease and 826 with ulcerative colitis in UC-1 and UC-2 clinical trials) with duration of exposure to STELARA presented in Table 2.

Table 22. Long-term exposure to STELARA in Phase 2 and Phase 3 clinical studies

Exposure	Number of patients
6 months	4577 ^a
1 year	3648 ^a
≥4 years	2194 ^a
≥5 years	1148 ^b

^a Total number of patients in the psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis studies

^b Number of patients with psoriasis, psoriatic arthritis, and Crohn's disease

The most common adverse reactions (>5%) in controlled periods of the clinical studies with STELARA among all indications were nasopharyngitis and headache. Most were considered to be mild and did not necessitate drug discontinuation. The overall safety profile of STELARA was similar for among all indications.

Table 3 provides a summary of Adverse Drug Reactions from the clinical studies. The frequency of these adverse reactions was based on those that occurred during the initial controlled periods

of the clinical studies. The adverse drug reactions are ranked by frequency, using the following convention:

Very common ($\geq 1/10$)

Common (frequent) ($\geq 1/100$, $< 1/10$)

Uncommon (infrequent) ($\geq 1/1,000$, $< 1/100$)

Rare ($\geq 1/10,000$, $< 1/1,000$)

Table 3. Summary of ADRs in Clinical Studies

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

Infections

In the placebo-controlled studies of patients with psoriasis, psoriatic arthritis Crohn's disease and ulcerative colitis, the rates of infection or serious infection were similar between STELARA-treated patients and those treated with placebo. In the placebo-controlled period of clinical studies of patients with psoriasis, patients with psoriatic arthritis, patients with Crohn's disease and patients with ulcerative colitis, the rate of infection was 1.36 per patient-year of follow-up in STELARA-treated patients, and 1.34 per patient-year of follow-up in placebo-treated patients. Serious infections occurred at a rate of 0.03 per patient-year of follow-up in STELARA-treated patients (30 serious infections in 930 patient-years of follow-up) and 0.03 per patient-year of follow-up in placebo-treated patients (15 serious infections in 434 patient-years of follow-up) (see section 4.4).

In the controlled and non-controlled portions of psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies representing 15227 patients-years of STELARA exposure in 6710 patients, the median follow-up was 1.2 years; 1.7 years for psoriatic disease studies, 0.6 years for Crohn's disease studies and 2.3 years for ulcerative colitis studies. The rate of infection was 0.85 per patient-year of follow-up in STELARA-treated patients. The rate of serious infections was 0.02 per patient-year of follow-up in STELARA-treated patients (289 serious infections in 15227 patient-years of follow-up) and included pneumonia, anal abscess, cellulitis, diverticulitis, osteomyelitis, viral infections, gastroenteritis, and urinary tract infections.

In clinical studies, patients with latent tuberculosis who were concurrently treated with isoniazid did not develop tuberculosis.

Malignancy

In the placebo-controlled period of the psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, the incidence of malignancies excluding non-melanoma skin cancer was 0.11 per 100 patient-years of follow-up for STELARA-treated patients (1 patient in 929 patient-years of follow-up) compared with 0.26 per 100 patient-years of follow-up for placebo-treated patients (1 patient in 434 patient-years of follow-up).

The incidence of non-melanoma skin cancer was 0.43 per 100 patient-years of follow-up for STELARA-treated patients (4 patients in 929 patient-years of follow-up) compared with 0.46 per 100 patient-years of follow-up for placebo-treated patients (2 patients in 433 patient-years of follow-up).

In the controlled and non-controlled periods of psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies representing 15205 patient-years of STELARA exposure in 6710 patients, the median follow-up was 1.2 years; 1.7 years for psoriatic disease studies, 0.6 years for Crohn's disease studies and 2.3 years for ulcerative colitis studies. Malignancies, excluding non-melanoma skin cancers were reported in 76 patients in 15205 patient-years of follow-up (incidence of 0.50 per 100 patient-years of follow-up for STELARA-treated patients). The incidence of non-melanoma skin cancer was 0.46 per 100 patient-years of follow-up for STELARA-treated patients (69 patients in 15165 patient-years of follow-up). The incidence of malignancies reported in STELARA-treated patients was comparable to the incidence expected in the general population (standardized incidence ratio = 0.94 [95% confidence interval: 0.73, 1.18], adjusted for age, gender and race). The most frequently observed malignancies, other than non-melanoma skin cancer, were prostate, colorectal, melanoma and breast. The ratio of patients with basal versus squamous cell skin cancers (3:1) is comparable with the ratio expected in the general population.

Hypersensitivity and Infusion Reactions

Subcutaneous administration

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

IV administration

In Crohn's disease and ulcerative colitis intravenous induction studies, no events of anaphylaxis or other serious infusion reactions with ustekinumab were reported. In these studies, 2.2% of 785 placebo treated patients and 1.9% of 790 patients treated with the recommended dose of STELARA reported adverse events occurring during or within an hour of the infusion.

Immunogenicity

In psoriasis and psoriatic arthritis clinical studies, up to 12.4% of patients treated with STELARA developed antibodies to ustekinumab, which were generally low-titre. In psoriasis studies, the majority of patients who were positive for antibodies to ustekinumab had neutralizing antibodies. Patients positive for antibodies to ustekinumab tended to have lower efficacy, however, antibody positivity did not preclude a clinical response.

In Crohn's disease and ulcerative colitis clinical studies, 2.9 and 4.6% respectively, developed antibodies to ustekinumab for approximately one year. No apparent association between the development of antibodies to ustekinumab and the development of injection site reactions was observed.

Adverse Events

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

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

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

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

Adverse events of depression were reported in some patients who received STELARA in psoriasis clinical trials, including rare events of suicidality. Individuals with psoriasis have higher rates of depression, and it is not known if STELARA may have contributed to these events since STELARA also resulted in improvements of the Hospital Anxiety and Depression Scale (see section 5.1 – Clinical Trials).

Post-Marketing Experience

The adverse drug reactions in Table 4 are ranked by frequency* using the following convention:

- Very common: $\geq 1/10$
- Common: $\geq 1/100$ and $< 1/10$
- Uncommon: $\geq 1/1,000$ and $< 1/100$
- Rare: $\geq 1/10,000$ and $< 1/1000$
- Very rare: $< 1/10,000$, including isolated reports

Table 4. Post-Marketing Reports

Immune system disorders	Uncommon: Hypersensitivity reactions (including rash, urticaria) Rare: Serious hypersensitivity reactions** (including anaphylaxis and angioedema)
Infections and infestations	Uncommon: Lower respiratory tract infection
Respiratory, thoracic and mediastinal disorders	Rare: Allergic alveolitis, eosinophilic pneumonia
Skin and subcutaneous tissue disorders	Uncommon: Pustular psoriasis, exfoliative dermatitis Rare: erythrodermic psoriasis; hypersensitivity vasculitis

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

**Some cases of serious hypersensitivity reactions have been reported in patients with a history of alpha-gal syndrome, allergy to mammalian meat or meat products, or anti-alpha-gal IgE in the post-marketing setting. In most of these cases the reactions occurred at the time of initial administration.

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://pophealth.my.site.com/carmreportnz/s/>

4.9 Overdose

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

For risk assessment and advice on the management of overdose, please contact the National Poisons Centre on 0800 POISON or 0800 764 766.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Immunosuppressants, interleukin inhibitors, ATC code: L04AC05.

Mechanism of action

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

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

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

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

Pharmacodynamic effects

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

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

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

Week 28 increased with increasing serum ustekinumab trough levels at Week 28. In psoriatic arthritis studies, patients achieving an ACR 20 response had higher median serum concentrations of ustekinumab than ACR 20 non-responders. The proportion of patients who achieved ACR 20 and ACR 50 response increased with increasing serum levels of ustekinumab.

In patients with Crohn's disease, treatment with STELARA resulted in a significant decrease in inflammatory markers including C-Reactive Protein (CRP) and fecal calprotectin. CRP was assessed during the study extension and the reductions observed during maintenance were generally sustained through week 252. Reductions in serum IFN γ and IL-17A, which are IL-12 and IL-23 regulated pro-inflammatory cytokines, were achieved and maintained in STELARA treated patients through Week 44 compared to placebo (52 weeks since the first dose of STELARA). At week 6, expression of genes such as IL-12R β 1 and IL-23 were reduced in inflamed colon tissue from Crohn's disease patients, who were responders to STELARA treatment while no significant changes were observed in placebo treated patients.

In patients with ulcerative colitis, treatment with STELARA resulted in a decrease in inflammatory markers including CRP and faecal calprotectin during the induction phase, which were maintained throughout the maintenance phase and study extension through week 200.

Immunisation

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

Clinical Trials

Plaque Psoriasis

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

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

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

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

Other key efficacy assessments included:

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

- The Dermatology Life Quality Index (DLQI), a dermatology-specific quality of life instrument, with a lower score indicating an improved quality of life.
- The SF-36, a health survey questionnaire consisting of multi-item scales measuring 8 health concepts (PHOENIX 1 only).
- The Nail Psoriasis Severity Index (NAPSI), a physician-assessed score that measures the severity of nail involvement (PHOENIX 1 only).
- The Hospital Anxiety and Depression Scale (HADS), a self-rating tool developed to evaluate psychological measures in patients with physical ailments (PHOENIX 2 only).
- The Work Limitations Questionnaire (WLQ), a 25-item, self-administered questionnaire that was used to measure the impact of chronic health conditions on job performance and work productivity among employed populations (PHOENIX 2 only).
- The Itch Visual Analogue Scale, (Itch VAS) used to assess the severity of itch at the time of the assessment (PHOENIX 1 only).

PHOENIX 1

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

Maintenance dosing (every 12 weeks)

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

Dose Adjustment (every 8 weeks)

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

PHOENIX 2

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

Baseline disease characteristics: PHOENIX 1 and 2

Baseline disease characteristics across PHOENIX 1 and 2 were similar (Table 5).

Table 5. Baseline Disease Characteristics

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

Efficacy at the Primary Endpoint, PHOENIX 1 and 2

In both the PHOENIX 1 and PHOENIX 2 studies, a significantly greater proportion of patients randomised to treatment with STELARA were PASI 75 responders compared with placebo at Week 12 (Table 6). In the PHOENIX 1 study, 67% and 66% of patients receiving STELARA 45 mg and 90 mg, respectively, achieved a PASI 75 response at Week 12 compared with 3% of patients receiving placebo. In the PHOENIX 2 study, 67% and 76% of patients receiving STELARA 45 mg and 90 mg respectively achieved a PASI 75 response at Week 12 compared with 4% of patients receiving placebo.

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

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

Other efficacy measures at Week 12

In both PHOENIX 1 and PHOENIX 2, compared with placebo, significantly greater proportions of patients randomised to 45 mg or 90 mg STELARA achieved a cleared or minimal PGA score, and significantly greater proportions of patients randomised to 45 mg or 90 mg STELARA were PASI 90 and PASI 50 responders at Week 12 (Table 6). In the PHOENIX 1 study, 60% and 62% of the patients treated with 45 mg and 90 mg STELARA, respectively, achieved PGA scores of cleared or minimal compared with 4% of placebo-treated patients. In PHOENIX 2, 68% and 73 % of patients receiving 45 mg or 90 mg STELARA, respectively, had cleared or minimal PGA scores compared with 5% of the placebo patients. In PHOENIX 1, PASI 90 was achieved by 42% and 37% of the patients treated with 45 mg and 90 mg STELARA, respectively, compared with 2% of placebo-treated patients. In PHOENIX 2, the percentage of patients achieving PASI 90 was 42% in the 45 mg STELARA group, 51% in the 90 mg STELARA group and 1% in the placebo group. The percentage of patients achieving PASI 50 in PHOENIX 1 was 84% and 86% in the 45 mg and 90 mg STELARA groups, respectively, compared with 10% in the placebo group. Similarly, 84% of patients treated with 45 mg STELARA, 89% of patients treated with 90 mg STELARA and 10% of patients treated with placebo reached PASI 50 in PHOENIX 2 (Table 6).

Table 6. Key psoriasis endpoints – PHOENIX 1 and PHOENIX 2

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

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

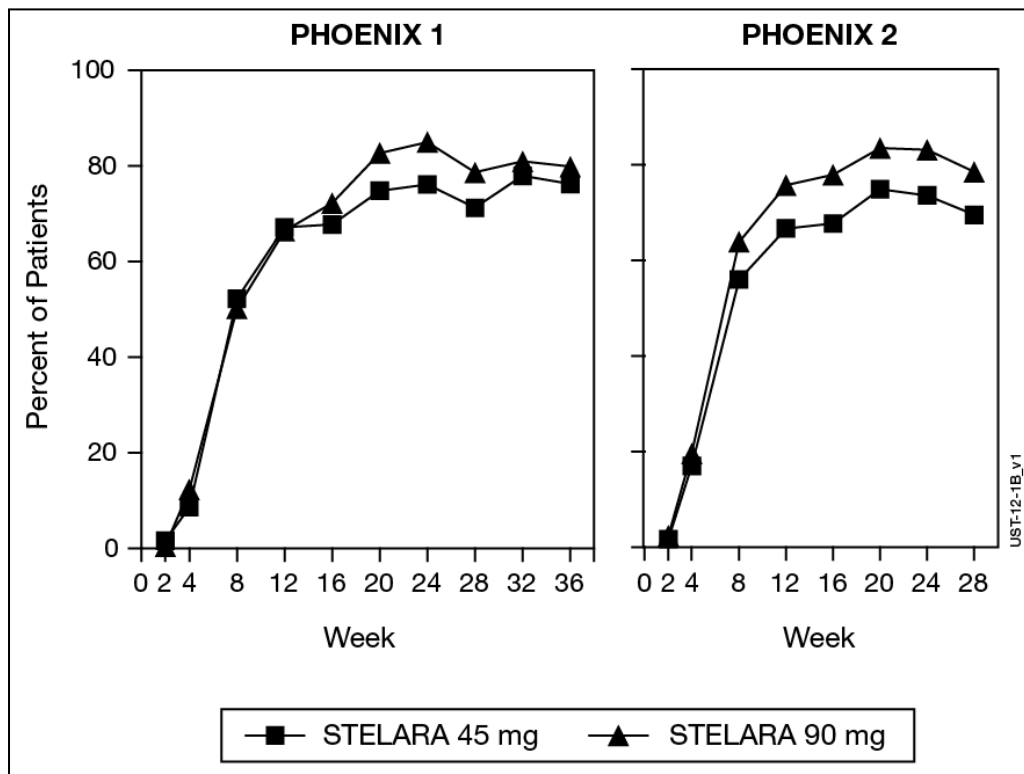
Response over time

In PHOENIX 1, significantly greater proportions of STELARA-treated patients had PASI 50 responses (9% and 10% for the 45 mg and 90 mg groups, respectively) compared with placebo (2%) by Week 2 (p < 0.001). Significantly greater proportions of patients treated with STELARA achieved PASI 75 responses (9% and 12% for the 45 mg and 90 mg STELARA groups, respectively) compared with placebo (0.4%) by Week 4 (p < 0.001). Maximum response was generally achieved by Week 24 in the 45 mg and 90 mg STELARA treatment groups, and response rates were generally sustained through Week 36 (Figure 1). In PHOENIX 1, PASI 75 rates at Week 24 were 76% for the 45 mg group, and 85% for the 90 mg group. Higher response rates were observed in patients receiving STELARA 90 mg than in those receiving STELARA 45 mg by Week 16 and these higher response rates were sustained through Week 36 (Figure 1). Similar results were observed in the PHOENIX 2 study through Week 28.

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

with patients receiving 45 mg dosing (Table 6). Figure 1 shows PASI 75 response over time in PHOENIX 1 and 2.

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



Therapeutic benefit of long-term continuous use

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

Efficacy of retreatment

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

Dosing Interval Adjustment

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

Quality of Life

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

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

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

ACCEPT

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

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

Significantly greater proportions of subjects treated with ustekinumab 45 mg (67%; $p = 0.012$) or 90 mg (74%; $p < 0.001$) were PASI 75 responders at Week 12 compared with the etanercept group (56.8%). PASI 90 response was observed in 36% and 45% of patients in the ustekinumab 45 mg and 90 mg groups, respectively, compared with 23% of patients receiving etanercept ($p < 0.001$ for each comparison versus etanercept). PASI 100 response was observed in 12% and 21% of patients in the ustekinumab 45 mg and 90 mg groups, respectively, compared to 6% of patients receiving etanercept. In addition, a greater proportion of patients in the ustekinumab 45 mg and 90 mg treatment groups achieved a PGA score of "cleared" or "minimal" (65% and 71%,

respectively) compared with patients in the etanercept treatment group (49%) (p<0.001 for each comparison versus etanercept).

In pre-specified analyses of efficacy by body weight in ACCEPT, minimal dose response to ustekinumab was evident in patients ≤ 100 kg. In patients who weighed >100 kg, higher PASI 75 response rates were seen with 90 mg dosing compared with 45 mg dosing, and a higher proportion of patients receiving 90 mg dosing had PGA scores of cleared or minimal compared with patients receiving 45 mg dosing (Table 7).

Table 7. Key psoriasis endpoints at Week 12: ACCEPT

	ACCEPT		
	Etanercept (50 mg twice a week)	Ustekinumab (week 0 and week 4)	
		45 mg	90 mg
Patients randomised	347	209	347
PASI RESPONSE			
PASI 50 response	286 (82%)	181 (87%)	320 (92%) ^a
PASI 75 response	197 (57%)	141 (67%) ^b	256 (74%) ^a
PASI 90 response	80 (23%)	76 (36%) ^a	155 (45%) ^a
PASI 100 response	22 (6%)	25 (12%) ^c	74 (21%) ^a
PGA of Cleared or Minimal^a	170 (49%)	136 (65%) ^a	245 (71%) ^a
PASI 75 RESPONSE BY WEIGHT			
< 100 kg			
N	251	151	244
PASI 75 response	154 (61.4%)	109 (72.2%)	189 (77.5%)
>100 kg			
N	96	58	103
PASI 75 response	43 (44.8%)	32 (55.2%)	67 (65.0%)
PGA of Cleared or Minimal by weight			
≤ 100 kg			
N	251	151	244
PGA response	131 (52.2%)	110 (72.8%)	185 (75.8%)
>100 kg			
N	96	58	103
PGA response	39 (40.6%)	26 (44.8%)	60 (58.3%)
PASI 75 RESPONSE BY NUMBER OF UNSUITABLE CONVENTIONAL SYSTEMIC AGENTS^g			
-at least one therapy			
N	347	209	346
PASI 75 Response	197 (56.8%)	141 (67.5%) ^b	256 (74.0%) ^a
-at least two therapies			
N	186	118	185
PASI 75 Response	94 (50.5%)	79 (66.9%) ^d	137 (74.1%) ^a
-at least three therapies			
N	52	31	47
PASI 75 Response	20 (38.5%)	17 (54.8%) ^e	34 (72.3%) ^f

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

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

^c p =0.020 for ustekinumab 45 mg comparison with etanercept

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

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

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

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

Psoriatic Arthritis (PsA)

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

These studies included 927 (PSUMMIT I, n=615; PSUMMIT II, n=312) adult patients (≥18 years) who had active psoriatic arthritis (≥5 swollen joints and ≥5 tender joints, despite disease modifying antirheumatic (DMARD) and/or nonsteroidal anti-inflammatory (NSAID) therapy). Methotrexate use was allowed during the studies but was not mandatory. Approximately 50% of patients continued on stable doses of MTX (≤25 mg/week). In PSUMMIT I and PSUMMIT II, 80% and 86% of the patients, respectively, had been previously treated with DMARDs.

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

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

In both studies, a significantly greater proportion of patients achieved ACR 20 and ACR 50 responses at Week 24 in the STELARA 45 mg and 90 mg groups compared to placebo (see Table 8). In PSUMMIT I, a significantly greater proportion of patients and in PSUMMIT II a numerically greater proportion of patients (p=NS) achieved ACR 70 responses in the STELARA 45 mg and 90 mg groups compared to placebo (see Table 8).

In both studies, the proportion of patients achieving a modified PsA response criteria (PsARC) or a Disease Activity Score 28 using C-reactive protein (DAS28-CRP) response was significantly greater in the STELARA 45 mg and 90 mg groups compared to placebo. In PSUMMIT I the proportion of patients achieving DAS28-CRP remission was significantly greater in the STELARA 45 mg and 90 mg groups compared to placebo. In PSUMMIT II, the proportion of patients who achieved DAS28-CRP remission was significantly greater in the STELARA 90 mg group compared to placebo (see Table 8). DAS28-CRP and PsARC responses were maintained through Week 52.

Table 8. Number of patients who achieved ACR 20, ACR 50, ACR 70, PsARC, DAS28-CRP response and DAS28-CRP remission at Week 24.

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

^a p<0.001

^b p<0.05

^c p= NS

* Combining tender joints (28 joints), swollen joints (28 joints), CRP, and the Patient Global Assessment of disease activity using CRP.

DAS28 responders include patients with moderate or good response.

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

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

1. ≥ 20% improvement in swollen joint count (66 joints) and tender joint count (68 joints); and
2. ≥ 20 % improvement in 3 of the following 5 assessments:
 - Patient's assessment of pain [Visual Analog Scale (VAS)]
 - Patient's global assessment of disease activity (VAS)
 - Physician's global assessment of disease activity (VAS)
 - Patient's assessment of physical function as measured by the HAQ-DI
 - CRP

ACR 50 or ACR 70 are similarly defined.

The time course for ACR 20 response rates during the first 24 weeks in both studies for patients receiving STELARA or placebo are summarised in Figure 2. ACR 20 responses showed improvement at the first assessment (Week 4). ACR 20, 50 and 70 responses continued to improve or were maintained through Week 52 (see Table 9).

Figure 2. Percent of patients achieving ACR 20 response through Week 24

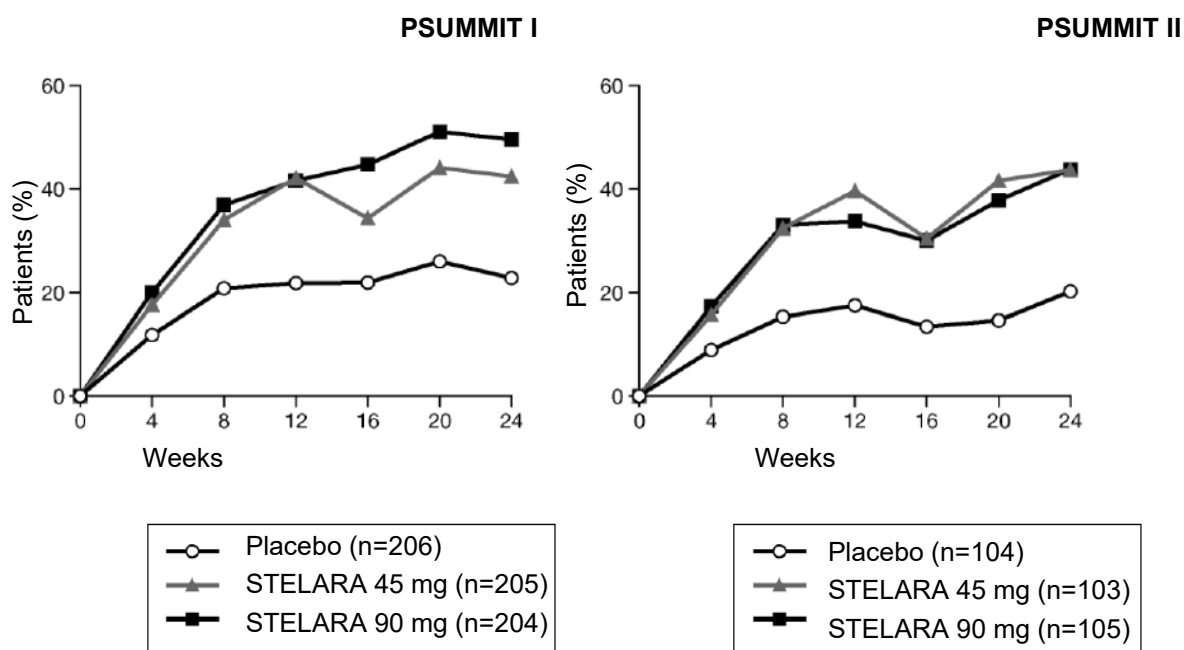


Table 9. Proportion of patients who achieved ACR 20, ACR 50, ACR 70 response at Week 52.

	PSUMMIT I		PSUMMIT II	
	STELARA		STELARA	
	45 mg	90 mg	45 mg	90 mg
N	194	189	94	95
ACR response				
ACR 20	55.7%	60.3%	46.8%	48.4%
ACR 50	31.4%	37.0%	27.7%	26.3%
ACR 70	18.0%	21.2%	12.8%	17.9%

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

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

Additionally, within each weight group, (≤ 100 kg and > 100 kg), ACR 20, ACR 50 and ACR 70 responses were consistently higher in the STELARA 45 mg and 90 mg groups than in the placebo group (see Table 10).

Table 10. Number of patients who achieved ACR 20, ACR 50 and ACR 70 responses by weight through Week 24

	PSUMMIT I			PSUMMIT II		
	STELARA			STELARA		
	Placebo (N=206)	45 mg (N= 205)	90 mg (N= 204)	Placebo (N= 104)	45 mg (N= 103)	90 mg (N= 105)
Patients randomised with weight ≤100 kg at baseline	154	153	154	74	74	73
ACR 20	39 (25%)	67 (44%)	78 (51%)	17 (23%)	32 (43%)	34 (47%)
ACR 50	14 (9%)	38 (25%)	48 (31%)	6 (8%)	15 (20%)	21 (29%)
ACR 70	5 (3%)	20 (13%)	26 (17%)	3 (4%)	6 (8%)	8 (11%)
Patients randomised with weight >100 kg at baseline	52	52	50	30	29	31
ACR 20	8 (15%)	20 (38%)	23 (46%)	4 (13%)	13 (45%)	12 (39%)
ACR 50	4 (8%)	13 (25%)	9 (18%)	1 (3%)	3 (10%)	3 (10%)
ACR 70	0	5 (10%)	3 (6%)	0	1 (3%)	1 (3%)

STELARA treatment resulted in significantly greater improvement compared with placebo for each ACR component (see Table 11).

Table 11. Summary of percent improvement from baseline in ACR components at Week 24

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

^a p<0.001

^b p<0.05

^c p<0.01

^d Number of swollen joints counted (0-66)

^e Number of tender joints counted (0-68)

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

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

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

Methotrexate use

The proportion of patients achieving ACR responses were consistently greater in patients treated with STELARA than those treated with placebo regardless of concomitant MTX use (see Table 12). Responses observed in the STELARA groups were similar in patients receiving or not receiving concomitant MTX. ACR responses were maintained through Week 52.

Table 12. Summary of patients achieving ACR 20, ACR 50 and ACR 70 responses through Week 24 by methotrexate usage

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

Prior Anti-TNF α Therapy

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

Among patients previously treated with anti-TNF α agents, a significantly greater proportion of STELARA-treated patients achieved an ACR 20 response at Week 24 compared to placebo (see Table 13). ACR 20, 50 and 70 responses were generally maintained through Week 52.

Table 13. Number of patients previously treated with anti-TNF α agent(s) who achieved ACR 20, ACR 50 and ACR 70 responses through Week 24

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

^a p<0.01

^b p<0.05

^c p=NS

Enthesitis and Dactylitis

For patients with enthesitis and/or dactylitis at baseline, in PSUMMIT I, a significant improvement in enthesitis and dactylitis score was observed in the STELARA 45 mg and 90 mg groups compared to placebo. In PSUMMIT II, a significant improvement in enthesitis score and numerical improvement in dactylitis score were observed in the 90 mg group (p=NS) compared with the placebo group (see Table 14). In both studies, improvement in enthesitis score and dactylitis score were maintained at Week 52.

Table 14. Summary of percent change in enthesitis and dactylitis scores at Week 24

	PSUMMIT I			PSUMMIT II		
	Placebo (N=206)	STELARA		Placebo (N= 104)	STELARA	
		45 mg (N=205)	90 mg (N=204)		45 mg (N= 103)	90 mg (N= 105)
Enthesitis score^d						
Patients randomised with enthesitis at baseline	145	142	154	73	72	76
N	137	140	148	68	70	70
Median	0.00	-42.86 ^a	-50.00 ^b	0.00	-33.33 ^c	-48.33 ^a
Dactylitis score^e						
Patients randomised with dactylitis at baseline	96	101	99	38	48	41
N	92	99	95	33	46	38
Median	0.00	-75.00 ^b	-70.83 ^b	0.00	0.00 ^c	-64.58 ^c

^ap<0.01

^bp<0.001

^cp=NS

^d Enthesitis was assessed based on the Maastricht Ankylosing Spondylitis Enthesis Score (MASES) index modified for PSA (an instrument that counts 15 body sites).

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

A higher proportion of patients treated with STELARA, that have spondylitis with peripheral arthritis as their primary presentation, demonstrated Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) 50 and 70 percent improvement in BASDAI scores at Week 24 compared with placebo (see Table 15).

Table 15. Number of patients who achieved improvement from baseline in BASDAI at Week 24

	PSUMMIT I			PSUMMIT II		
	Placebo (N= 206)	STELARA		Placebo (N= 104)	STELARA	
		45 mg (N=205)	90 mg (N=204)		45 mg (N=103)	90 mg (N=105)
Patients randomised with spondylitis and peripheral joint involvement at baseline	70	52	64	22	26	22
N	61	51	60	18	25	21
BASDAI 20	16 (26%)	25 (49%) ^a	35 (58%) ^b	10 (56%)	15 (60%) ^c	11 (52%) ^c
BASDAI 50	8 (13%)	12 (24%) ^c	19 (32%) ^a	1 (6%)	7 (28%) ^c	8 (38%) ^a
BASDAI 70	0	7 (14%) ^d	9 (15%) ^d	0	3 (12%)*	5 (24%)*

^a p≤0.05

^b p<0.001

^c p=NS

^d p≤0.01

*p value not calculated

PASI Response

In PSUMMIT I and PSUMMIT II, the proportion of patients with psoriasis involvement of $\geq 3\%$ BSA at baseline who achieved a $\geq 75\%$ improvement in the PASI assessment at Week 24 was significantly greater in the STELARA 45 mg and 90 mg groups compared with the placebo group (see Table 16). In both studies the proportion of patients achieving the PASI 75 response was maintained through Week 52 (PSUMMIT I, STELARA 45mg-70.1% and 90mg- 68.1%; PSUMMIT II, STELARA 45mg-56.5% and 90mg- 64.4%).

The proportion of patients who achieved both a PASI 75 response and an ACR 20 response was evaluated for those patients with $\geq 3\%$ BSA psoriasis skin involvement at baseline. A significantly higher proportion of patients achieved the combined response in the STELARA 45 mg and 90 mg groups compared with the placebo group at Week 24 (see Table 16). In both studies the proportion of patients achieving both a PASI 75 response and an ACR20 response was maintained through Week 52 (PSUMMIT I, STELARA 45mg-44.8% and 90mg-44.3%; PSUMMIT II, STELARA 45mg-36.8% and 90mg- 43.1%).

Table 16. Number of patients who achieved PASI 75, PASI 90 and PASI 100 responses as well as a combination of skin and joint responses at Week 24

	PSUMMIT I			PSUMMIT II		
	Placebo (N= 206)	STELARA ^a		Placebo (N= 104)	STELARA ^a	
		45 mg (N=205)	90 mg (N=204)		45 mg (N=103)	90 mg (N=105)
Patients with $\geq 3\%$ BSA psoriasis skin involvement at baseline	146	145	149	80	80	81
PASI 75	16 (11%)	83 (57%)	93 (62%)	4 (5%)	41 (51%)	45 (56%)
PASI 90	4 (3%)	60 (41%)	65 (44%)	3 (4%)	24 (30%)	36 (44%)
PASI 100	2 (1%)	29 (20%)	41 (28%)	1 (1%)	13 (16%)	17 (21%)
Combination of skin and joint responses						
PASI 75 and ACR 20	8 (5%)	40 (28%)	62 (42%)	2 (3%)	24 (30%)	31 (38%)

^a $p < 0.001$ for 45 mg or 90 mg comparison with placebo.

Additionally, within each weight group (≤ 100 kg and > 100 kg), PASI 75, 90 and 100 responses were consistently higher in the STELARA 45 and 90 mg groups than in the placebo group (see Table 17).

Table 17. Summary of patients who achieved PASI 75, PASI 90 and PASI 100 responses by weight through Week 24

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

* Patients randomised with $\geq 3\%$ BSA psoriasis skin involvement at baseline

Methotrexate Use

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

Prior Anti-TNF α Therapy

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

Radiographic Response

Structural damage in both hands and feet was assessed by readers unaware of treatment group and order of visits and expressed as change in total van der Heijde-Sharp score (vdH-S score), modified for PsA by addition of hand distal interphalangeal (DIP) joints, compared to baseline. A pre-specified integrated analysis combining data from 927 subjects in both PSUMMIT I & II was performed. At Week 24, based on this integrated analysis, the STELARA 45 mg or 90 mg treatment significantly inhibited progression of structural damage, when compared to placebo (see Table 18). Beyond Week 24, STELARA treatment continued to inhibit the progression of structural damage through Week 52. The mean change from Week 24 to 52 in total modified vdH-S score (0.18 and 0.26 in the STELARA 45mg and 90 mg groups respectively) was less than the mean change from Week 0 to 24 (see Table 18).

Table 18. Summary of change from baseline in total modified vdH-S score at Week 24 (Integrated analysis of PSUMMIT I and PSUMMIT II)

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

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

^b p value < 0.05

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

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

Physical Function and Health-Related Quality of Life

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

Patients treated with STELARA showed significant improvement in physical function as assessed by the HAQ-DI at Week 24. The proportion of patients achieving a clinically meaningful ≥ 0.3 improvement in HAQ-DI score from baseline at Week 24 was also significantly greater in the STELARA groups when compared with placebo (see Table 19). Improvement was observed at the first assessment (Week 4), reached maximum at Week 12 and was maintained through Week 24. Improvement in HAQ-DI score from baseline was maintained at Week 52.

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

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

Table 19. Improvement in physical function as measured by HAQ-DI at Week 24

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

^a p<0.001^b p<0.01*achieving a ≥ 0.3 improvement from baseline

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

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

The DLQI was assessed by comparing the change in DLQI scores from baseline for those patients with $\geq 3\%$ BSA at baseline. In both studies at Week 24, there was a significant improvement from baseline in DLQI scores in both the STELARA 45 mg and 90 mg groups as compared with placebo (see Table 20) and the improvement was maintained at Week 52.

In both PSUMMIT I and PSUMMIT II, at Week 24, the change from baseline in the SF-36 physical component summary (PCS) scores was significantly greater in the STELARA 45 mg and 90 mg groups compared with the placebo group. In both studies, the change from baseline in the SF-36 mental component summary (MCS) scores at Week 24 was greater in both STELARA groups compared with the placebo group (p<0.001 for PSUMMIT I - 90mg group, p=NS for other groups) (see Table 20). In both studies, the change from baseline in the SF-36 PCS and MCS scores was maintained at Week 52.

In PSUMMIT II, a significant change from baseline in Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F) scores was observed at Week 24 in the STELARA 45 mg and 90 mg groups compared with the placebo group (median improvement, all 3.0 vs 0.0; p<0.007). Similarly, the percentage of patients with clinically significant improvement in fatigue from baseline (4 points in FACIT-F) was significantly greater in the STELARA 45 mg (49% [p<0.001]) and 90 mg groups (49% [p<0.001]) compared with the placebo group (25.8%). The change from baseline in the FACIT-F scores was maintained at Week 52.

Table 20. Summary of change from baseline in DLQI and SF-36 and scores at Week 24

	PSUMMIT I			PSUMMIT II		
	Placebo (N= 206)	STELARA		Placebo (N= 104)	STELARA	
		45 mg (N=205)	90 mg (N=204)		45 mg (N=103)	90 mg (N=105)
DLQI						
Patients randomised with ≥ 3% BSA psoriasis skin involvement at baseline	146	145	149	80	80	81
Baseline						
N	145	145	149	80	80	81
Mean (SD)	11.68 (7.705)	11.02 (7.308)	10.54 (7.179)	11.93 (7.622)	12.09 (7.667)	11.98 (7.754)
Median	11.00	10.00	9.00	11.00	11.00	10.00
Change from baseline						
N	140	142	146	73	77	75
Mean (SD)	-1.40 (6.177)	-6.63 (6.776)	-7.54 (6.524)	-0.75 (5.666)	-6.95 (7.719)	-7.16 (6.748)
Median	-1.00	-6.00 ^a	-6.00 ^a	0.00	-6.00 ^a	-6.00 ^a
SF-36						
Physical component summary						
Baseline						
N	203	203	204	104	102	104
Mean (SD)	31.39 (8.785)	31.16 (8.511)	31.45 (8.152)	30.28 (9.361)	28.69 (8.501)	28.93 (8.480)
Median	30.40	29.80	29.70	29.35	27.95	28.15
Change from baseline						
N	196	200	197	97	99	97
Mean (SD)	1.4(7.094)	4.89 (9.333)	6.22 (8.747)	1.09 (5.892)	4.29 (8.594)	4.67 (8.758)
Median	1.15	3.90 ^a	5.80 ^a	0.00	2.70 ^c	3.50 ^a
Mental component summary						
Baseline						
N	203	203	204	104	102	104
Mean (SD)	43.51 (10.848)	42.77 (10.908)	43.48 (11.608)	42.11 (12.507)	43.27 (12.911)	42.81 (11.953)
Median	43.90	42.00	41.65	41.80	43.70	41.40
Change from baseline						
N	196	200	197	97	99	97
Mean (SD)	1.53 (9.582)	3.35 (10.016)	4.79 (10.054)	0.63 (8.238)	3.01 (11.144)	3.52 (11.274)

	PSUMMIT I			PSUMMIT II		
	Placebo (N= 206)	STELARA		Placebo (N= 104)	STELARA	
		45 mg (N=205)	90 mg (N=204)		45 mg (N=103)	90 mg (N=105)
Median	0.25	2.65 ^b	4.40 ^a	0.00	0.70 ^b	2.20 ^b

^a p<0.001

^b p=NS

^c p<0.05

Health Economics

Health economics data on time lost from work, employability, and daily productivity at work, school, or home were collected through questionnaires at baseline and Week 24. To assess productivity, patients were asked to indicate how much their disease affected their productivity at work, school or at home in the past 4 weeks, using a 10 cm Visual Analogue Scale (VAS) (not at all affected [0] to affected very much [10]).

The improvement in self-reported productivity was significantly greater in the STELARA 45 mg and 90 mg groups compared to placebo at Week 24.

Crohn's Disease

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

Induction of Clinical Response and Remission

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

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

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

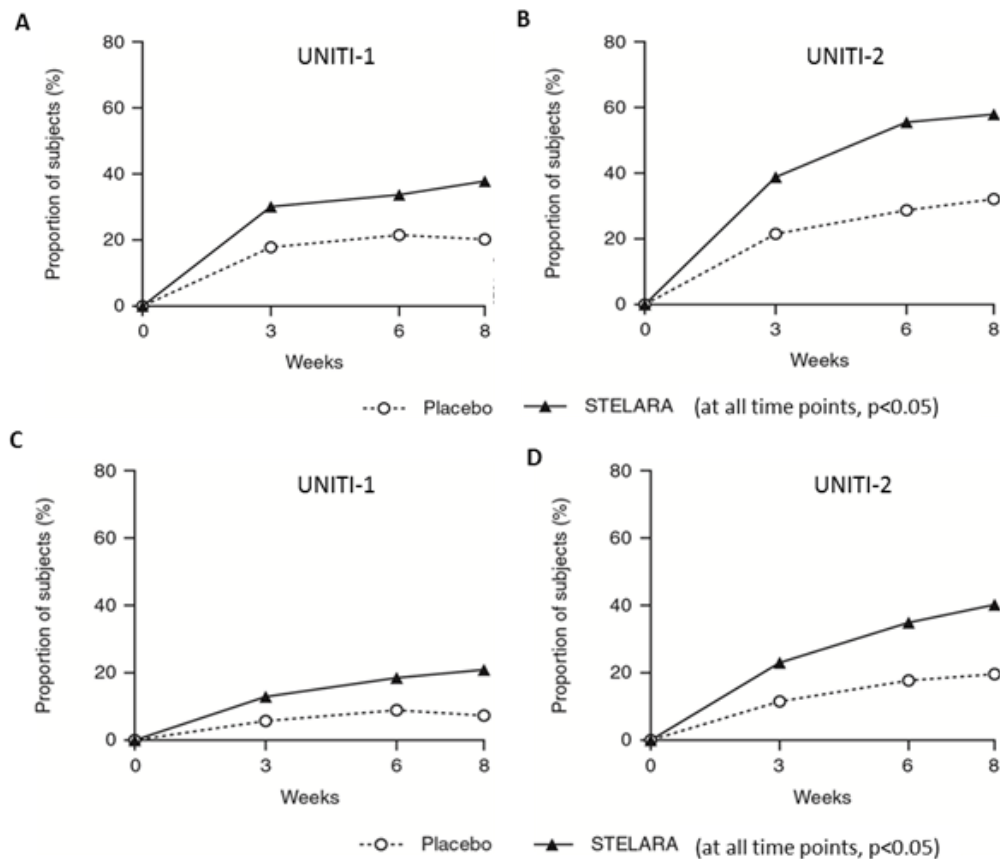
In these induction studies, efficacy was higher and better sustained in the tiered dose (based on weight ranges) group compared to the 130 mg dose group. In both UNITI-1 and UNITI-2, a significantly greater proportion of patients were in clinical response and remission in the group treated with STELARA, compared to placebo (Table 21, Figure 3). Clinical response and remission were significant as early as Week 3 in STELARA treated patients and continued to improve through Week 8 (Figure 3).

Table 21. Induction of Clinical Response and Remission in UNITI-1* and UNITI 2**

	UNITI-1		UNITI-2	
	Placebo N=247	Recommended dose of ustekinumab N=249	Placebo N=209	Recommended dose of ustekinumab N=209
Clinical Response (100 point), Week 6	53 (21.5%)	84 (33.7%) ^a	60 (28.7%)	116 (55.5%) ^b
Clinical Response (100 point), Week 8	50 (20.2%)	94 (37.8%) ^b	67 (32.1%)	121 (57.9%) ^b
70 Point Response, Week 3	67 (27.1%)	101 (40.6%) ^a	66 (31.6%)	106 (50.7%) ^b
70 Point Response, Week 6	75 (30.4%)	109 (43.8%) ^a	81 (38.8%)	135 (64.6%) ^b
Clinical Remission, Week 8	18 (7.3%)	52 (20.9%) ^b	41 (19.6%)	84 (40.2%) ^b

Clinical remission is defined as CDAI score < 150; Clinical response is defined as reduction in CDAI score by at least 100 points or being in clinical remission
 70 point response is defined as reduction in CDAI score by at least 70 points
 * Anti-TNF α failures
 ** Conventional therapy failures
^a p < 0.01
^b p < 0.001

Figure 3. Proportion of STELARA treated patients in clinical response (A, B) and remission (C, D) through Week 8 in UNITI-1 and UNITI-2 studies



Maintenance of Response and Remission

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

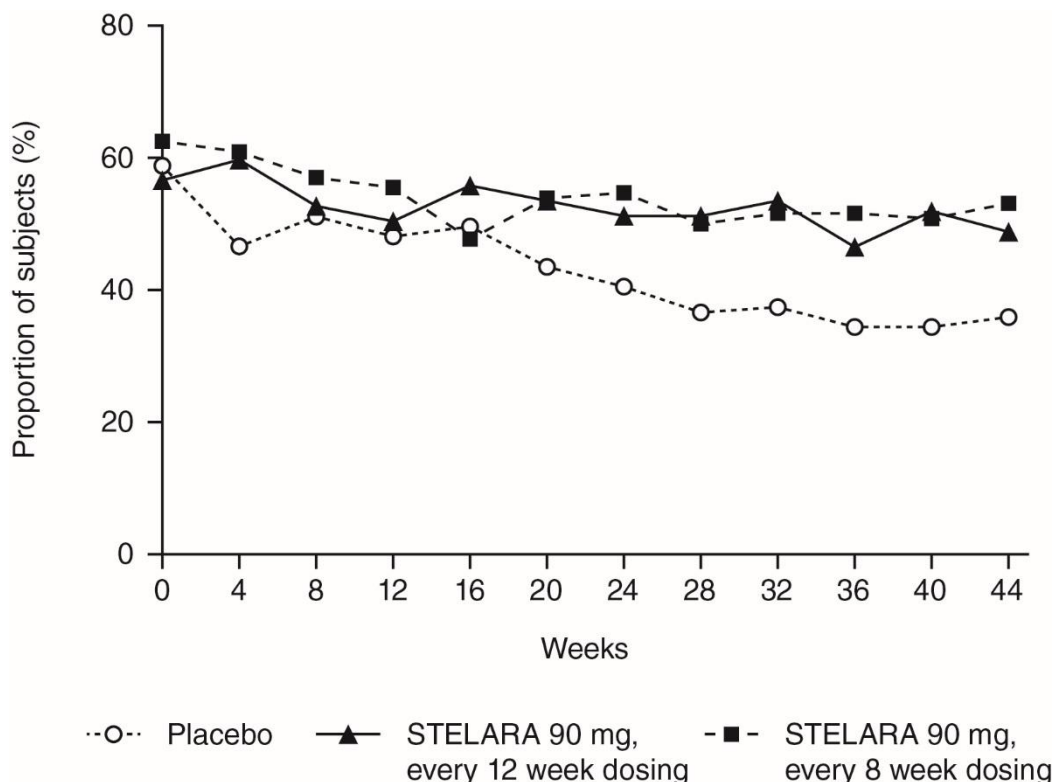
Concomitant doses of oral 5-ASA compounds, immunomodulators corticosteroids and antibiotics were permitted. Corticosteroids were tapered at the start of the maintenance trial. The primary endpoint was clinical remission (CDAI < 150) at Week 44. Secondary endpoints assessed at Week 44 included clinical response, clinical remission among STELARA treated patients in clinical remission after induction, corticosteroid-free remission, and clinical remission in the subset of patients who were refractory or intolerant to anti-TNF α treatment.

Significantly higher proportions of patients maintained clinical remission and response in the STELARA treated groups as compared to placebo at Week 44 (Table 22, Figure 4). A higher proportion of STELARA treated patients compared to placebo achieved sustained clinical remission (clinical remission at Week 36, 40 and 44). Clinical remission was achieved in patients who had failed conventional therapy (anti-TNF α naïve) and in patients who had prior treatment experience with an anti-TNF α . A higher rate of clinical remission was observed in the anti-TNF α naïve patients compared to the anti-TNF α refractory/intolerant patients, but the overall treatment effect was consistent in both anti-TNF α refractory/intolerant patients and anti-TNF α naïve patients (Table 22).

Table 22. Maintenance of Clinical Response and Remission in IM-UNITI (Week 44; 52 weeks from initiation of the induction dose)

	Placebo* N=131†	90 mg STELARA every 8 weeks N=128†	90 mg STELARA every 12 weeks N=129†
Clinical Remission	36%	53% ^a	49% ^b
Clinical Response	44%	59% ^b	58% ^b
Corticosteroid-Free Clinical Remission	30%	47% ^a	43% ^c
Sustained Clinical Remission‡	26%	46% ^c	40% ^c
Clinical Remission in patients:			
in remission at the start of maintenance therapy	46% (36/79)	67% (52/78) ^a	56% (44/78)
who are Anti-TNF α refractory/intolerant	26% (16/61)	41% (23/56)	39% (22/57)
who failed conventional therapy but not anti-TNF α therapy	44% (31/70)	63% (45/72) ^c	57% (41/72)
who are Anti-TNF α naïve	49% (25/51)	65% (34/52) ^c	57% (30/53)
Clinical remission is defined as CDAI score <150; Clinical response is defined as reduction in CDAI of at least 100 points or being in clinical remission			
*The placebo group consisted of patients who were in response to STELARA and were randomised to receive placebo at the start of maintenance therapy.			
† Patients who achieved a clinical response to STELARA at start of maintenance therapy			
‡ Defined as clinical remission at Week 36, 40 and 44.			
^a p < 0.01			
^b p < 0.05			
^c nominally significant (p<0.05)			

Figure 4. Proportion of patients in clinical remission at each visit through Week 44.



Delayed response

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

Dosing in patients with a lower inflammatory burden

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

Dosing frequency adjustment

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

Resumption of treatment

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

Long-Term Maintenance

In IM-UNITI, patients who completed the study through week 44 were eligible to continue treatment in a study extension. Among patients who entered the study extension, clinical remission and response were generally maintained through week 252. Results were consistent between patients who failed TNF-therapies versus those who did not.

No new safety concerns were identified in this study extension with up to 5 years of treatment in patients with Crohn's Disease.

Corticosteroid use in maintenance

In patients that were in clinical response to STELARA induction therapy, a greater proportion of patients in the STELARA treated group were in remission and corticosteroid-free compared to the placebo group after 44 weeks of maintenance treatment (Table 22). In addition, a higher proportion of patients were in clinical response and not receiving corticosteroids in the STELARA treated group compared to placebo.

Endoscopic Healing of the Mucosa

Endoscopic healing of the mucosa was evaluated in 252 patients with baseline endoscopic disease activity in a substudy. At Week 8, after a single IV induction dose, reduction in mucosal inflammation, as measured by the Simplified Endoscopic Activity Score for Crohn's Disease (SES-CD), was greater in patients treated with STELARA (n=83) compared with patients treated with placebo (n=97) (-2.8 vs -0.7, p=0.0012). Similar reductions in histologic inflammation were also observed.

Fistula Response

In patients with draining fistulas at baseline (8.8%), a numerically greater proportion of STELARA treated patients achieved a fistula response (defined as $\geq 50\%$ reduction from baseline of the induction study in the number of draining fistulas) compared with placebo over 44 weeks. The proportion of patients in fistula response at Week 44 was 45.5% (5/11) for placebo group, 71.4% (5/7) for STELARA 90 mg every 12 week dosing group (p=0.782, not statistically significant), and 87.5% (7/8) for STELARA 90 mg every 8 week dosing group (p=0.886, not statistically significant).

Health-Related Quality of Life Measures

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

SF-36

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

IBDQ

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

Long-term maintenance of health-related quality of life measures

Improvement in health-related quality of life as measured by IBDQ and SF-36 was generally maintained during the extension through week 252.

Ulcerative colitis

The safety and efficacy of STELARA was assessed in two randomised, double-blind, placebo-controlled, multicentre studies in adult patients with moderately to severely active ulcerative colitis (Mayo score 6 to 12; Endoscopy subscore ≥ 2 based on central review of the endoscopy). The clinical development program consisted of one intravenous induction study (referred to as UNIFI-induction) with treatment of up to 16 weeks followed by a 44-week subcutaneous randomised withdrawal maintenance study (referred to as UNIFI-maintenance) representing at least 52 weeks of therapy.

Efficacy results presented for UNIFI-induction and UNIFI-maintenance were based on central review of endoscopies.

UNIFI-induction included 961 patients. The primary endpoint for the induction study was the proportion of patients in clinical remission (defined as a Mayo score ≤ 2 points, with no individual subscore > 1) at Week 8. Patients were randomised to receive a single intravenous administration of either the recommended tiered dose of approximately 6 mg/kg (see Table 1; Initial IV dosing of STELARA^a), a fixed dose of 130 mg ustekinumab, or placebo at Week 0.

Concomitant use of oral corticosteroids, immunomodulators, and aminosalicylates were permitted and 90% of patients continued to receive at least one of these medications. Enrolled patients had to have failed conventional therapy (corticosteroids or immunomodulators) or at least one biologic (a TNF α antagonist and/or vedolizumab). 49% of patients had failed conventional therapy, but not a biologic (of which 94% were biological-naïve). 51% of patients had failed or were intolerant to a biologic. Approximately 50% of the patients had failed at least 1 prior anti-TNF α therapy (of which 48% were primary non-responders) and 17% had failed at least 1 anti-TNF α therapy and vedolizumab.

In UNIFI-induction a significantly greater proportion of patients were in clinical response and remission in the STELARA treated group compared to placebo (Table 23). As early as Week 2, the earliest scheduled study visit, and at each visit thereafter, a higher proportion of STELARA patients had no rectal bleeding or achieved normal stool frequency (defined as a stool frequency subscore of 0 or 1) as compared with placebo patients. Significant differences in partial Mayo score and symptomatic remission were observed between STELARA and placebo as early as Week 2. Efficacy was higher in the tiered dose group (6 mg/kg) compared to the 130 mg dose group in select endpoints, and tiered dosing is therefore the recommended intravenous induction dose.

Table 23: Summary of Key Efficacy Measures in UNIFI-Induction (Week 8)

Endpoint	Placebo N = 319		Ustekinumab [†] N = 322	
	N	%	N	%
Clinical Remission[*]	17	5%	50	16% ^a
<i>Biologic-naïve[‡]</i>	15/151	10%	27/147	18%
<i>Not biologic failure</i>	15/158	9%	29/156	19%
<i>Prior biological failure</i>	2/161	1%	21/166	13%
Clinical Response[§]	100	31%	199	62% ^a
<i>Biologic-naïve[‡]</i>	54/151	36%	98/147	67%
<i>Not biologic failure</i>	56/158	35%	104/156	67%
<i>Prior biological failure</i>	44/161	27%	95/166	57%
Endoscopic Healing[¶]	44	14%	87	27% ^a
<i>Biologic-naïve[‡]</i>	32/151	21%	49/147	33%
<i>Not biologic failure</i>	33/158	21%	52/156	33%
<i>Prior biological failure</i>	11/161	7%	35/166	21%
Histo-Endoscopic Mucosal Healing[‡]	28/316	9%	58/315	18% ^a
<i>Biologic-naïve[‡]</i>	21/148	14%	33/140	24%
<i>Not biologic failure</i>	22/155	14%	36/149	24%
<i>Prior biological failure</i>	6/161	4%	22/166	13%
Symptomatic Remission[¶]	72	23%	144	45% ^b

Combined Symptomatic Remission and Endoscopic Healing[†]	25	8%	67	21% ^b
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[†] Infusion dose of ustekinumab using the weight-based dosage regimen specified in Table 1.
[‡] An additional 7 patients on placebo and 9 patients on ustekinumab (6mg/kg) had been exposed to, but had not failed, biologics
^{*} Clinical remission is defined as Mayo score ≤ 2 points, with no individual subscore > 1 .
[§] Clinical response is defined as a decrease from baseline in the Mayo score by $\geq 30\%$ and ≥ 3 points, with either a decrease from baseline in the rectal bleeding subscore ≥ 1 or a rectal bleeding subscore of 0 or 1.
[€] Endoscopic healing is defined as a Mayo endoscopic subscore of 0 or 1 determined by central review of the endoscopy.
[‡] Histo-endoscopic mucosal healing is defined as combined endoscopic healing (Mayo endoscopy subscore of 0 or 1) and histologic healing of the colon tissue (neutrophil infiltration in $< 5\%$ of crypts, no crypt destruction, and no erosions, ulcerations, or granulation tissue).
[£] Symptomatic remission is defined as a stool frequency subscore of 0 or 1 and a rectal bleeding subscore of 0.
[†] Combined symptomatic remission and endoscopic healing is defined as remission based on a stool frequency subscore of 0 or 1, a rectal bleeding subscore of 0, and an endoscopy subscore of 0 or 1.
^a $p < 0.001$
^b Nominally significant ($p < 0.001$)

UNIFI-maintenance evaluated 523 patients who achieved clinical response with a single IV administration of STELARA in UNIFI-induction. Patients were randomised to receive a subcutaneous maintenance regimen of either 90 mg STELARA every 8 weeks, 90 mg STELARA every 12 weeks or placebo for 44 weeks.

Significantly greater proportions of patients were in clinical remission at Week 44 and maintained clinical response through Week 44 in both STELARA treated groups compared to the placebo group (see Table 24).

Table 24: Summary of Key Efficacy Measures in UNIFI-Maintenance (Week 44; 52 weeks from initiation of the induction dose)

	Placebo[*] N = 175	Ustekinumab 90 mg every 8 Weeks N = 176	Ustekinumab 90 mg every 12 Weeks N = 172
Clinical Remission^{**}	24%	44% ^a	38% ^b
<i>Biologic-naïve[‡]</i>	32% (27/84)	51% (40/79)	47% (45/95)
<i>Not biologic failure</i>	31% (27/87)	48% (41/85)	49% (50/102)
<i>Prior biologic failure</i>	17% (15/88)	40% (36/91)	23% (16/70)
Maintenance of Clinical Response through Week 44[§]	45%	71% ^a	68% ^a
<i>Biologic-naïve[‡]</i>	52% (44/84)	77% (61/79)	77% (73/95)
<i>Not biologic failure</i>	51% (44/87)	78% (66/85)	76% (78/102)
<i>Prior biologic failure</i>	39% (34/88)	65% (59/91)	56% (39/70)
Corticosteroids Free Clinical Remission[‡]	23%	42% ^a	38% ^b
<i>Biologic-naïve[‡]</i>	32% (27/84)	49% (39/79)	46% (44/95)
<i>Not biologic failure</i>	31% (27/87)	47% (40/85)	48% (49/102)
<i>Prior biologic failure</i>	16% (14/88)	37% (34/91)	23% (16/70)
Endoscopic Healing at Week 44[†]	29%	51% ^a	44% ^b
<i>Biologic-naïve</i>	36% (30/84)	58% (46/79)	55% (52/95)
<i>Not biologic failure</i>	34% (30/87)	58% (49/85)	56% (57/102)

	Placebo* N = 175	Ustekinumab 90 mg every 8 Weeks N = 176	Ustekinumab 90 mg every 12 Weeks N = 172
<i>Prior biologic failure</i>	23% (20/88)	45% (41/91)	26% (18/70)
Maintenance of Clinical Remission through Week 44[£]	38%	58%	65% ^b
<i>Biologic-naïve[†]</i>	36% (9/25)	75% (12/16)	70% (21/30)
<i>Not biologic failure</i>	36% (9/25)	67% (12/18)	72% (23/32)
<i>Prior biologic failure</i>	40% (8/20)	50% (10/20)	38% (3/8)
Durable Partial Mayo Remission through Week 44	35%	57% ^c	48% ^c
Symptomatic Remission at Week 44[£]	45%	68% ^c	62% ^c
Combined Symptomatic Remission and Endoscopic Healing at Week 44[€]	28%	48% ^c	41% ^c
<p>* The placebo group consisted of patients who were in response to ustekinumab IV and were randomised to receive placebo at the start of maintenance therapy.</p> <p>**Clinical remission is defined as Mayo score ≤ 2 points, with no individual subscore > 1.</p> <p>§ Clinical response is defined as a decrease from baseline in the Mayo score by $\geq 30\%$ and ≥ 3 points, with either a decrease from baseline in the rectal bleeding subscore ≥ 1 or a rectal bleeding subscore of 0 or 1.</p> <p>[†] An additional 3 patients on placebo and 6 patients on Q8W, 7 patients on Q12W ustekinumab had been exposed to, but had not failed, biologics</p> <p>[†] Endoscopic healing is defined as a Mayo endoscopic subscore of 0 or 1 determined by central review of the endoscopy</p> <p>[‡] Corticosteroid-free clinical remission is defined as patients in clinical remission and not receiving corticosteroids at Week 44.</p> <p>[£] Maintenance of clinical remission is defined as patients in clinical remission at maintenance baseline through Week 44 among patients in clinical remission at maintenance baseline.</p> <p> Durable partial Mayo remission is defined as partial Mayo remission (i.e. a partial Mayo score of ≤ 2) at $\geq 80\%$ of all visits prior to Week 44 and in partial Mayo remission at last visit (Week 44).</p> <p>[£] Symptomatic remission is defined as a stool frequency subscore of 0 or 1 and a rectal bleeding subscore of 0.</p> <p>[€] Combined symptomatic remission and endoscopic healing is defined as a stool frequency subscore of 0 or 1, a rectal bleeding subscore of 0, and an endoscopy subscore of 0 or 1.</p> <p>^a $p < 0.001$</p> <p>^b $p < 0.05$</p> <p>^c Nominally significant ($p < 0.05$)</p>			

The beneficial effect of STELARA on clinical response, mucosal healing and clinical remission was observed in induction and in maintenance both in patients who failed conventional therapy but not a biologic therapy, as well as in those who had failed at least one prior TNF α antagonist therapy, and/or vedolizumab including in patients with a primary non-response to TNF α antagonist therapy.

Delayed Responders to STELARA Induction

STELARA treated patients who were not in response at Week 8 of UNIFI-induction received an administration of 90 mg SC STELARA at Week 8 (36% of patients). Of those patients, 9% of patients who were initially randomised to the recommended induction dose achieved clinical remission and 58% achieved clinical response at Week 16. When combining the delayed responders with the initial responders, 80% of subjects randomised to the recommended induction dose in UNIFI-I achieved clinical response and 18% achieved clinical remission within 16 weeks after initiating treatment with ustekinumab.

Patients who were not in clinical response to STELARA induction at Week 8 of the UNIFI-induction study but were in response at Week 16 (157 patients) entered in the non-randomised portion of UNIFI-maintenance and continued to receive maintenance dosing every 8 weeks; among these patients, a majority (62%) maintained response and 30% achieved remission at Week 44.

Long-Term Maintenance

In UNIFI (UCO3001), patients who completed the study through week 44 were eligible to continue treatment in a study extension.

Among 400 patients who entered in the study extension and were treated with ustekinumab, symptomatic remission was generally maintained through week 200 for patients who failed conventional therapy (but not a biologic therapy) and those who failed biologic therapy, including those who failed both anti-TNF and vedolizumab. Of those patients who were assessed using the full Mayo score at week 200, mucosal healing and clinical remission were generally maintained.

The safety analysis including 457 patients (1289.9 person-years) followed up to 220 weeks showed a safety profile between week 44 and 220 that was comparable with that observed up to week 44.

No new safety concerns were identified in this study extension with up to 4 years of treatment in patients with ulcerative colitis.

Endoscopic Normalisation

Normalisation of endoscopic appearance of the mucosa was defined as a Mayo endoscopic subscore of 0 and was observed as early as Week 8 of UNIFI-induction. At Week 44 of UNIFI-maintenance, it was achieved in 24% and 29% of patients treated with STELARA every 12 or 8 weeks, respectively, as compared to 18% of patients in the placebo group.

Histologic & Histo-Endoscopic Mucosal Healing

Histologic healing (defined as neutrophil infiltration in <5% of crypts, no crypt destruction, and no erosions, ulcerations, or granulation tissue) was assessed at Week 8 of UNIFI-induction and Week 44 of UNIFI-maintenance. At Week 8, after a single intravenous induction dose, significantly greater proportions of patients in the recommended dose group achieved histologic healing (36%) compared with patients in the placebo group (22%). At Week 44 maintenance of this effect was maintained with significantly more patients in histologic healing in every 12 week (54%) and every 8 week (59%) STELARA groups as compared to placebo (33%).

A combined endpoint of histo-endoscopic mucosal healing defined as subjects having both mucosal healing and histologic healing was evaluated at week 8 of UNIFI-induction and Week 44 of UNIFI-maintenance. Patients receiving STELARA at the recommended dose showed significant improvements on the histo-endoscopic mucosal healing endpoint at Week 8 in the STELARA group (18%) as compared to the placebo group (9%). At Week 44, maintenance of this effect was observed with significantly more patients in histo-endoscopic mucosal healing in every 12 week (39%) and every 8 week (46%) STELARA groups as compared to placebo (24%).

Health-related quality of life

Health-related quality of life was assessed by Inflammatory Bowel Disease Questionnaire (IBDQ), SF-36 and EuroQoL-5D (EQ-5D) questionnaires. At Week 8 of UNIFI-induction, patients receiving STELARA showed significantly greater and clinically meaningful improvements on IBDQ total score, EQ-5D and EQ-5D VAS, and SF-36 Mental Component Summary Score and SF-36 Physical Component Summary Score when compared to placebo. These improvements were maintained in ustekinumab-treated patients in UNIFI-maintenance through Week 44.

Patients receiving STELARA experienced significantly more improvements in work productivity as assessed by greater reductions in overall work impairment and in activity impairment as assessed by the WPAI-GH questionnaire than patients receiving placebo.

Long-term maintenance of health-related quality of life measures

Improvement in health related quality of life as measured by IBDQ and SF-36 was generally maintained during the extension through week 200.

Hospitalisations and Ulcerative Colitis related surgeries

Through Week 8 of UNIFI-induction, the proportions of subjects with ulcerative colitis disease related hospitalizations were significantly lower for subjects in the STELARA recommended dose group (1.6%, 5/322) compared with subjects in the placebo group (4.4%, 14/319) and no subjects underwent ulcerative colitis disease related surgeries in subjects receiving STELARA at the recommended induction dose compared to 0.6% (2/319) subjects in the placebo group.

Through Week 44 of UNIFI-maintenance, a significantly lower number of ulcerative colitis disease related hospitalizations was observed in subjects in the combined STELARA group (2.0%, 7/348) as compared with subjects in the placebo group (5.7%, 10/175). A numerically lower number of subjects in the STELARA group (0.6%, 2/348) underwent ulcerative colitis disease related surgeries compared with subjects in the placebo group (1.7%, 3/175) through Week 44.

5.2 Pharmacokinetic properties

Absorption

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

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

Following the recommended intravenous induction dose, median peak serum ustekinumab concentration was 126.1 mcg/mL in patients with Crohn's disease, and 127.0 mcg/mL in patients with ulcerative colitis.

Distribution

Median volume of distribution during the terminal phase (V_z) following a single intravenous administration to patients with psoriasis, ranged from 57 to 83 mL/kg. In a population pharmacokinetic analysis of ustekinumab, the volume of distribution at steady-state was 4.62 L in patients with Crohn's disease and 4.44 L in patients with ulcerative colitis.

Metabolism

The exact metabolic pathway for ustekinumab is unknown.

Elimination

Median systemic clearance (CL) following a single intravenous administration to patients with psoriasis ranged from 1.99 to 2.34 mL/day/kg. Median half-life ($t_{1/2}$) of ustekinumab was approximately 3 weeks in patients with Crohn's disease, ulcerative colitis, psoriasis and/or psoriatic arthritis, ranging from 15 to 32 days across all psoriasis and psoriatic arthritis studies. In a population pharmacokinetic analysis of ustekinumab, the clearance was 0.19 L/day while the half-life was approximately 19 days in patients with Crohn's disease and ulcerative colitis.

Dose Linearity

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

Single Dose vs. Multiple Doses

Serum concentration-time profiles of ustekinumab were generally predictable after single or multiple subcutaneous dose administrations. In patients with psoriasis, steady-state serum concentrations of ustekinumab were achieved by Week 28 after initial subcutaneous doses at Weeks 0 and 4, followed by doses every 12 weeks. The median steady-state trough concentration ranged from 0.21 microgram/mL to 0.26 microgram/mL (45 mg dose) and from 0.47 microgram/mL to 0.49 microgram/mL (90 mg dose).

Following the recommended IV induction dose, median peak serum ustekinumab concentration was 126.1 µg/mL in patients with Crohn's disease and 127.0 mcg/mL in patients with ulcerative colitis. Starting at Week 8, subcutaneous maintenance dosing of 90 mg ustekinumab was administered every 8 or 12 weeks. Steady state ustekinumab concentration was achieved by the start of the second maintenance dose. There was no apparent accumulation in serum ustekinumab concentration over time when given subcutaneously every 12 weeks.

Following subcutaneous maintenance dosing of 90 mg ustekinumab every 8 weeks, median steady-state trough concentrations ranged from 1.97 µg/mL to 2.24 µg/mL in patients with Crohn's disease and 2.69 mcg/mL to 3.09 mcg/mL in patients with ulcerative colitis. Following subcutaneous maintenance dosing of 90 mg ustekinumab every 12 weeks, median steady state trough concentrations ranged from 0.61 µg/mL to 0.76 µg/mL in patients with Crohn's disease and 0.92 mcg/mL to 1.19 mcg/mL in patients with ulcerative colitis. The steady-state trough ustekinumab levels resulting from 90 mg ustekinumab every 8 weeks were associated with higher clinical remission rates as compared to the steady-state trough levels following 90 mg every 12 weeks.

Dosing Frequency Adjustment

In patients with Crohn's disease and ulcerative colitis, based on observed data and population PK analyses, randomised subjects who lost response to treatment had lower serum ustekinumab concentrations over time compared with subjects who did not lose response. In Crohn's disease, dose adjustment from 90 mg every 12 weeks to 90 mg every 8 weeks was associated with an increase in trough serum ustekinumab concentrations and an accompanying increase in efficacy. In ulcerative colitis, population PK model based simulations demonstrated that adjusting dosing from 90 mg every 12 weeks to every 8 weeks would be expected to result in a 3-fold increase in steady-state trough ustekinumab concentrations. Additionally, on the basis of clinical trial data in patients with ulcerative colitis, a positive exposure-response relationship was established between trough concentrations and clinical response, clinical remission, and mucosal healing.

Impact of Weight on Pharmacokinetics

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

Population Pharmacokinetic Analysis

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

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

In the population pharmacokinetic analyses, the effect of the most frequently used concomitant medications in patients with psoriasis (including paracetamol/acetaminophen, ibuprofen, acetylsalicylic acid, metformin, atorvastatin, naproxen, thyroxine, hydrochlorothiazide, and influenza vaccine) on pharmacokinetics of ustekinumab was explored and none of the

concomitant medications exerted significant impact. The pharmacokinetics of ustekinumab was not impacted by the prior use of MTX, cyclosporin, or other biological therapeutics for the treatment of psoriasis. The pharmacokinetics of ustekinumab was not impacted by concomitant use of NSAIDs or prior exposure to anti-TNF α agents in patients with psoriatic arthritis; or by the use of MTX, oral corticosteroids, 6-MP, AZA in patients with psoriatic arthritis, Crohn's disease or by prior exposure to biologics (i.e. anti-TNF α agents and/or vedolizumab) in patients with ulcerative colitis.

The effects of IL-12 or IL-23 on the regulation of CYP450 enzymes were evaluated in an *in vitro* study using human hepatocytes, which showed that IL-12 and/or IL-23 at levels of 10 ng/mL did not alter human CYP450 enzyme activities (CYP1A2, 2B6, 2C9, 2C19, 2D6, or 3A4 (see section 4.5).

No clinically significant changes in exposure of caffeine (CYP1A2 substrate), warfarin (CYP2C9 substrate), omeprazole (CYP2C19 substrate), dextromethorphan (CYP2D6 substrate), or midazolam (CYP3A substrate) were observed when used concomitantly with ustekinumab at the approved recommended dosing in subjects with Crohn's disease (the same dose as ulcerative colitis and higher than approved recommended dosing for plaque psoriasis and psoriatic arthritis) (see Section 4.5 Interactions with other medicines and other forms of interactions).

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

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

The pharmacokinetics of ustekinumab were generally comparable between Asian and non-Asian patients with psoriasis.

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

5.3 Preclinical safety data

Carcinogenicity

STELARA has not been evaluated for carcinogenic potential, due to the lack of appropriate models for an antibody with no cross-reactivity to rodent IL-12/23 p40. STELARA is a selective immunosuppressant agent. Immunosuppressive agents have the potential to increase the risk of malignancy (see section 4.4 - Malignancies).

Genotoxicity

STELARA has not been evaluated for genotoxic potential.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

45 mg Solution for injection vial, pre-filled syringe and pre-filled pen or 90 mg pre-filled syringe and pre-filled pen (for subcutaneous injection)

Histidine

Histidine monohydrochloride monohydrate

Polysorbate 80

Sucrose

Water for injection

130 mg vial Concentrate for solution for infusion (for intravenous infusion)

EDTA disodium salt dehydrate

Histidine

Histidine hydrochloride monohydrate
Methionine
Polysorbate 80
Sucrose
Water for injection

6.2 Incompatibilities

Solution for injection vial, pre-filled syringe and pre-filled pen (*for subcutaneous injection*)

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

Concentrate for solution for infusion (*for intravenous infusion*)

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

STELARA should only be diluted with 0.9% w/v sodium chloride solution.

STELARA should not be administered concomitantly in the same intravenous line with other medicinal products.

6.3 Shelf life

- 45 mg solution for injection vial: 24 months.
- 45 mg or 90 mg solution for injection in pre-filled syringe: 36 months
- 45 mg or 90 mg solution for injection in pre-filled pen: 36 months
- 130 mg vial Concentrate for solution for infusion: 36 months.

6.4 Special precautions for storage

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

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

STELARA does not contain preservatives.

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

STELARA pre-filled syringe and pre-filled pen – Room temperature storage (excluding vials)

If needed, STELARA pre-filled syringes and pre-filled pen may be stored at room temperature up to a maximum of 30°C for a single period of up to 30 days in the original carton protected from light. Record the date when the pre-filled syringe and pre-filled pen is first removed from the refrigerator on the carton in the spaces provided. The new expiry date must not exceed the original expiry date printed on the carton. Once a syringe has been stored at room temperature, it should not be returned to the refrigerator. Discard the syringe if not used within 30 days at room temperature storage.

6.5 Nature and contents of container

Solution for injection vial, pre-filled syringe and pre-filled pen (*for subcutaneous injection*)

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

STELARA is also supplied as a single-use, sterile solution in a Type 1 glass pre-filled syringe with a fixed 27G, half-inch needle and needle cover. The needle cover is manufactured using a dry natural rubber (a derivative of latex) (see section 4.4). The syringe is fitted with a passive safety

guard. The STELARA pre-filled syringe is also supplied as a pre-filled pen (One-Press patient-controlled injector) for adult use

There are two strengths of STELARA available: 45 mg of ustekinumab (rmc) in 0.5 mL, or 90 mg of ustekinumab (rmc) in 1.0 mL.

STELARA is available in the following packaging presentations:

- 1 single-use vial (45 mg)
- 1 single-use pre-filled syringe (45 mg and 90 mg)
- 1 single-use pre-filled pen (45 mg and 90 mg)

The vial for subcutaneous injection is not currently marketed in New Zealand.

Concentrate for solution for infusion (for intravenous infusion only)

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

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

6.6 Special precautions for disposal and other handling

The solution in the STELARA vial, pre-filled syringe or pre-filled pen should not be shaken. The solution should be visually inspected for particulate matter or discolouration prior to subcutaneous administration. The solution may contain a few small translucent or white particles of protein. This appearance is not unusual for proteinaceous solutions. The medicinal product should not be used if the solution is discoloured or cloudy, or if foreign particulate matter is present. Before administration, STELARA should be allowed to reach room temperature (approximately half an hour).

STELARA does not contain preservatives; therefore, any unused medicinal product remaining in the vial, the syringe and the pre-filled pen should not be used. STELARA is supplied as a sterile, single-use vial, single-use pre-filled syringe or the single-use pre-filled pen. The syringe, needle and vial must never be re-used. Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

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

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

1. Calculate the dose and the number of STELARA vials needed based on patient's body weight (see Table 1). Each 26 mL vial of STELARA contains 130 mg of ustekinumab.
2. Withdraw and then discard a volume of the 0.9% w/v sodium chloride solution from the 250 mL infusion bag equal to the volume of STELARA to be added (discard 26 mL sodium chloride for each vial of STELARA needed, for 2 vials-discard 52 mL, for 3 vials- discard 78 mL, for 4 vials- discard 104 mL).
3. Withdraw 26 mL of STELARA from each vial needed and add it to the 250 mL infusion bag. The final volume in the infusion bag should be 250 mL. Gently invert or swirl the bag to mix the solution. Do not shake.
4. Once diluted, the infusion solution may be stored for up to eight hours prior to infusion.
5. Visually inspect the diluted solution before administration. Do not use if visibly opaque particles, discolouration or foreign particles are observed.
6. Administer the diluted solution over a period of at least one hour.
7. Use only an infusion set with an in-line, sterile, non-pyrogenic, low protein-binding filter (pore size 0.2 micrometre).
8. Do not infuse STELARA concomitantly in the same intravenous line with other agents.

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

7. MEDICINE CLASSIFICATION

Prescription Only Medicine

8. SPONSOR

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9. DATE OF FIRST APPROVAL

45 mg or 90 mg solution for injection: 30 September 2010
5 mg/ mL concentrate for infusion: 01 February 2018

10. DATE OF PREPARATION

02 April 2026

Summary table of changes

Section changes	Summary of new information
4.8	Update regarding alpha-gal sensitisation associated with hypersensitivity
4.9	Addition of the risk assessment text in line with the data sheet template