

HUMIRA 40 MG

1. NAME OF THE MEDICINAL PRODUCT

Humira 40 mg solution for injection in pre-filled syringe
Humira 40 mg solution for injection in pre-filled pen
Humira 40 mg/0.8 ml solution for injection in glass vial

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each 0.8 ml single dose pre-filled syringe contains 40 mg of adalimumab.

Each 0.8 ml single dose pre-filled pen contains 40 mg of adalimumab.

Each 0.8 ml single dose vial contains 40 mg of adalimumab.

Adalimumab is a recombinant human monoclonal antibody expressed in Chinese Hamster Ovary cells.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Solution for Injection.
Clear, colourless solution

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Rheumatoid arthritis

Humira in combination with methotrexate, is indicated for:

- The treatment of moderate to severe, active rheumatoid arthritis in adult patients when the response to disease-modifying anti-rheumatic drugs including methotrexate has been inadequate.
- The treatment of severe, active and progressive rheumatoid arthritis in adults not previously treated with methotrexate.

Humira can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate.

Humira has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function, when given in combination with methotrexate.

Juvenile idiopathic arthritis

Polyarticular juvenile idiopathic arthritis

Humira in combination with methotrexate is indicated for the treatment of active polyarticular juvenile idiopathic arthritis, in patients from the age of 2 years who have had an inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs). Humira can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate (for the efficacy in monotherapy see section 5.1). Humira has not been studied in patients aged less than 2 years.

Axial spondyloarthritis

Ankylosing spondylitis (AS):

Humira is indicated for the treatment of adults with severe active ankylosing spondylitis who have had an inadequate response to conventional therapy.

Axial spondyloarthritis without radiographic evidence of AS:

Humira is indicated for the treatment of adults with severe axial spondyloarthritis without radiographic evidence of AS, but with objective signs of inflammation by radiological and/or laboratory tests including MRI and serum CRP levels, who have had an inadequate response to, or are intolerant to, non-steroidal anti-inflammatory drugs.

Psoriatic arthritis

Humira is indicated for the treatment of active and progressive psoriatic arthritis in adults when the response to previous disease-modifying anti-rheumatic drug therapy has been inadequate. Humira has been shown to reduce the rate of progression of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of the disease (see Section 5.1) and to improve physical function.

Psoriasis

Humira is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or PUVA.

Paediatric plaque psoriasis

Humira is indicated for the treatment of severe chronic plaque psoriasis in children and adolescents from 4 years of age who have had an inadequate response to or are inappropriate candidates for topical therapy and phototherapies.

Hidradenitis suppurativa (HS)

Humira is indicated for the treatment of active moderate to severe hidradenitis suppurativa (acne inversa) in adult patients with an inadequate response to conventional systemic HS therapy

Crohn's disease

Humira is indicated for reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy. Humira is indicated for reducing signs and symptoms and inducing clinical remission in these patients if they have also lost response to or are intolerant to infliximab.

Paediatric Crohn's disease

Humira is indicated for the treatment of severe active Crohn's disease in paediatric patients (6-17 years of age) who have had an inadequate response to conventional therapy including primary nutrition therapy, a corticosteroid, and an immunomodulator, or who are intolerant to or have contraindications for such therapies

Ulcerative colitis

Humira is indicated for treatment of moderately to severely active ulcerative colitis in adult patients who have had an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA), or who are intolerant to or have medical contraindications for such therapies.

4.2 Posology and method of administration

Humira treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of conditions for which Humira is indicated. Patients treated with Humira should be given the special alert card.

After proper training in injection technique, patients may self-inject with Humira if their physician determines that it is appropriate and with medical follow-up as necessary.

During treatment with Humira, other concomitant therapies (e.g., corticosteroids and/or immunomodulatory agents) should be optimised.

Posology

Rheumatoid arthritis

The recommended dose of Humira for adult patients with rheumatoid arthritis is 40 mg adalimumab administered every other week as a single dose via subcutaneous injection. Methotrexate should be continued during treatment with Humira.

Glucocorticoids, salicylates, nonsteroidal anti-inflammatory drugs, or analgesics can be continued during treatment with Humira. Regarding combination with disease modifying anti-rheumatic drugs other than methotrexate see sections 4.4 and 5.1.

In monotherapy, some patients who experience a decrease in their response may benefit from an increase in dose intensity to 40 mg adalimumab every week.

Dose Interruption

There may be a need for dose interruption, for instance before surgery or if a serious infection occurs.

Available data suggest that re-introduction of Humira after discontinuation for 70 days or longer resulted in the same magnitudes of clinical response and similar safety profile as before dose interruption.

Ankylosing spondylitis, axial spondyloarthritis without radiographic evidence of AS and psoriatic arthritis

The recommended dose of Humira for patients with ankylosing spondylitis, axial spondyloarthritis without radiographic evidence of AS and for patients with psoriatic arthritis is 40 mg adalimumab administered every other week as a single dose via subcutaneous injection.

For all of the above indications, available data suggest that the clinical response is usually achieved within 12 weeks of treatment. Continued therapy should be carefully reconsidered in a patient not responding within this time period.

Psoriasis

The recommended dose of Humira for adult patients is an initial dose of 80 mg administered subcutaneously, followed by 40 mg subcutaneously given every other week starting one week after the initial dose.

Continued therapy beyond 16 weeks should be carefully reconsidered in a patient not responding within this time period.

Hidradenitis suppurativa

The recommended Humira dose regimen for adult patients with hidradenitis suppurativa (HS) is 160 mg initially at Day 1 (given as four 40 mg injections in one day or as two 40 mg injections per day for two consecutive days), followed by 80 mg two weeks later at Day 15 (given as two 40 mg injections in one day). Two weeks later (Day 29) continue with a dose of 40 mg every week. Antibiotics may be continued during treatment with Humira if necessary. It is recommended that the patient should use a topical antiseptic wash on their HS lesions on a daily basis during treatment with Humira.

Therapy beyond 12 weeks should not be continued in a patient with no response at all within this time period

Should treatment be interrupted, Humira 40 mg every week may be re-introduced (see section 5.1).

The benefit and risk of continued long-term treatment should be periodically evaluated (see section 5.1).

Crohn's disease

The recommended Humira induction dose regimen for adult patients with Crohn's disease is 160 mg at Week 0 (dose can be administered as four 40 mg injections in one day or as two 40 mg injections per day for two consecutive days), 80 mg at Week 2, followed by a maintenance dose of 40 mg every other week via subcutaneous injection beginning at Week 4.

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

Some patients who experience decrease in their response may benefit from an increase in dosing frequency to 40 mg Humira every week.

Some patients who have not responded by Week 4 may benefit from continued maintenance therapy through Week 12.

Continued therapy should be carefully reconsidered in a patient not responding within this time period.

Ulcerative colitis

The recommended Humira induction dose regimen for adult patients with moderate to severe ulcerative colitis is 160 mg at Week 0 (dose can be administered as four injections in one day or as two injections per day for two consecutive days) and 80 mg at Week 2. After induction treatment, the recommended dose is 40 mg every other week via subcutaneous injection.

During maintenance treatment, corticosteroids may be tapered in accordance with clinical practice guidelines.

Some patients who experience decrease in their response may benefit from an increase in dosing frequency to 40 mg Humira every week.

Available data suggest that clinical response is usually achieved within 2-8 weeks of treatment. Humira therapy should not be continued in patients failing to respond within this time period.

Elderly patients

No dose adjustment is required.

Impaired renal and/or hepatic function

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

Paediatric population:

Juvenile Idiopathic Arthritis

Polyarticular juvenile idiopathic arthritis from 2 to 12 years of age

The recommended dose of Humira for patients with polyarticular juvenile idiopathic arthritis, aged 2-12 years, is 24 mg/m² body surface area up to a maximum single dose of 20 mg adalimumab (for patients aged 2-<4) and up to a maximum single dose of 40 mg adalimumab (for patients aged 4-12) administered every other week via subcutaneous injection. The volume for injection is selected based on the patients' height and weight (Table 1). A 40 mg paediatric vial is available for patients who need to administer less than the full 40 mg dose.

Table 1. Humira Dose in Milliliters (ml) by Height and Weight of patients for Polyarticular Juvenile Idiopathic Arthritis

Height (cm)	Total Body Weight (kg)													
	10	15	20	25	30	35	40	45	50	55	60	65	70	
80	0.2	0.3	0.3	0.3										
90	0.2	0.3	0.3	0.4	0.4	0.4								
100	0.3	0.3	0.3	0.4	0.4	0.4	0.5	0.5						
110	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.6	0.6			
120	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7	
130		0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7	0.7	
140		0.4	0.4	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.8*	
150			0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.8*	0.8*	
160			0.5	0.5	0.6	0.6	0.7	0.7	0.7	0.8*	0.8*	0.8*	0.8*	
170				0.6	0.6	0.6	0.7	0.7	0.8*	0.8*	0.8*	0.8*	0.8*	
180					0.6	0.7	0.7	0.8*	0.8*	0.8*	0.8*	0.8*	0.8*	

*Maximum single dose is 40 mg (0.8 ml)

Polyarticular Juvenile Idiopathic Arthritis from 13 years of age

For patients from 13 years of age, a dose of 40 mg is administered every other week regardless of body surface area.

Available data suggest that clinical response is usually achieved within 12 weeks of treatment. Continued therapy should be carefully reconsidered in a patient not responding within this time period.

There is no relevant use of Humira in patients aged less than 2 years in this indication.

Paediatric plaque psoriasis

The recommended Humira dose is 0.8 mg per kg body weight (up to a maximum of 40 mg per dose) administered subcutaneously weekly for the first two doses and every other week thereafter. Continued therapy beyond 16 weeks should be carefully considered in a patient not responding within this time period.

If retreatment with Humira is indicated, the above guidance on dose and treatment duration should be followed.

The safety of Humira in paediatric patients with plaque psoriasis has been assessed for a mean of 13 months.

There is no relevant use of Humira in children aged less than 4 years in this indication.

The volume for injection is selected based on the patients' weight (Table 2).

Table 2: Humira Dose in Milliliters (mL) by Weight for Patients with Pediatric Psoriasis

Body Weight (kg)	Paediatric Psoriasis Dose
13 – 16	0.2 mL (10 mg)
17 – 22	0.3 mL (15 mg)
23 – 28	0.4 mL (20 mg)
29 – 34	0.5 mL (25 mg)

35 – 40	0.6 mL (30 mg)
41 – 46	0.7 mL (35 mg)
47+	0.8 mL (40 mg)

Paediatric Crohn's disease

Paediatric Crohn's disease patients < 40 kg:

The recommended Humira induction dose regimen for paediatric subjects with severe Crohn's disease is 40 mg at Week 0 followed by 20 mg at Week 2. In case there is a need for a more rapid response to therapy, the regimen 80 mg at Week 0 (dose can be administered as two injections in one day), 40 mg at Week 2 can be used, with the awareness that the risk for adverse events may be higher with use of the higher induction dose.

After induction treatment, the recommended dose is 20 mg every other week via subcutaneous injection. Some subjects who experience insufficient response may benefit from an increase in dosing frequency to 20 mg Humira every week.

Paediatric Crohn's disease patients ≥ 40 kg:

The recommended Humira induction dose regimen for paediatric subjects with severe Crohn's disease is 80 mg at Week 0 followed by 40 mg at Week 2. In case there is a need for a more rapid response to therapy, the regimen 160 mg at Week 0 (dose can be administered as four injections in one day or as two injections per day for two consecutive days), 80 mg at Week 2 can be used, with the awareness that the risk for adverse events may be higher with use of the higher induction dose.

After induction treatment, the recommended dose is 40 mg every other week via subcutaneous injection. Some subjects who experience insufficient response may benefit from an increase in dosing frequency to 40 mg Humira every week.

Continued therapy should be carefully considered in a subject not responding by Week 12.

There is no relevant use of Humira in children aged less than 6 years in this indication.

Paediatric hidradenitis suppurativa

The safety and efficacy of Humira in children have not yet been established for hidradenitis suppurativa. No data are available.

Paediatric ulcerative colitis

The safety and efficacy of Humira in children aged 4-17 years have not yet been established. No data are available. There is no relevant use of Humira in children aged <4 years in this indication.

Psoriatic arthritis and axial spondyloarthritis including ankylosing spondylitis

There is no relevant use of Humira in the paediatric population in the indications, ankylosing spondylitis and psoriatic arthritis.

Method of administration

Humira is administered by subcutaneous injection. Full instructions for use are provided in the package leaflet.

A 40 mg pen and a 40 mg prefilled syringe are available for patients to administer a full 40 mg dose.

A 40 mg paediatric vial is available for patients who need to administer less than the full 40 mg dose.

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Active tuberculosis or other severe infections such as sepsis, and opportunistic infections (see section 4.4).

- Moderate to severe heart failure (NYHA class III/IV) (see section 4.4).

4.4 Special warnings and precautions for use

In order to improve traceability of biological medicinal products, the tradename and the batch number of the administered product should be clearly recorded.

Infections

Patients taking TNF- antagonists are more susceptible to serious infections. Impaired lung function may increase the risk for developing infections. Patients must therefore be monitored closely for infections, including tuberculosis, before, during and after treatment with Humira. Because the elimination of adalimumab may take up to four months, monitoring should be continued throughout this period.

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

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

Serious infections:

Serious infections, including sepsis, due to bacterial, mycobacterial, invasive fungal, parasitic, viral, or other opportunistic infections such as listeriosis, legionellosis and pneumocystis have been reported in patients receiving Humira.

Other serious infections seen in clinical trials include pneumonia, pyelonephritis, septic arthritis and septicaemia. Hospitalisation or fatal outcomes associated with infections have been reported.

Tuberculosis:

Tuberculosis, including reactivation and new onset of tuberculosis, has been reported in patients receiving Humira. Reports included cases of pulmonary and extra-pulmonary (i.e disseminated) tuberculosis.

Before initiation of therapy with Humira, all patients must be evaluated for both active or inactive (latent) tuberculosis infection. This evaluation should include a detailed medical assessment of patient history of tuberculosis or possible previous exposure to people with active tuberculosis and previous and/or current immunosuppressive therapy. Appropriate screening tests (i.e. tuberculin skin test and chest X-ray) should be performed in all patients (local recommendations may apply). It is recommended that the conduct and results of these tests are recorded in the patient alert card. Prescribers are reminded of the risk of false negative tuberculin skin test results, especially in patients who are severely ill or immunocompromised.

If active tuberculosis is diagnosed, Humira therapy must not be initiated (see section 4.3).

In all situations described below, the benefit/risk balance of therapy should be very carefully considered.

If latent tuberculosis is suspected, a physician with expertise in the treatment of tuberculosis should be consulted.

If latent tuberculosis is diagnosed, appropriate treatment must be started with anti-tuberculosis prophylaxis treatment before the initiation of Humira, and in accordance with local recommendations.

Use of anti-tuberculosis prophylaxis treatment should also be considered before the initiation of Humira in patients with several or significant risk factors for tuberculosis despite a negative test for tuberculosis and in patients with a past history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed.

Despite prophylactic treatment for tuberculosis, cases of reactivated tuberculosis have occurred in patients treated with Humira. Some patients who have been successfully treated for active tuberculosis have redeveloped tuberculosis while being treated with Humira.

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

Other opportunistic infections:

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

For patients who develop the signs and symptoms such as fever, malaise, weight loss, sweats, cough, dyspnea, and/or pulmonary infiltrates or other serious systemic illness with or without concomitant shock an invasive fungal infection should be suspected and administration of Humira should be promptly discontinued. Diagnosis and administration of empiric antifungal therapy in these patients should be made in consultation with a physician with expertise in the care of patients with invasive fungal infections.

Hepatitis B reactivation

Reactivation of hepatitis B has occurred in patients receiving a TNF-antagonist including Humira, who are chronic carriers of this virus (i.e., surface antigen positive). Some cases have had fatal outcome. Patients should be tested for HBV infection before initiating treatment with Humira. For patients who test positive for hepatitis B infection, consultation with a physician with expertise in the treatment of hepatitis B is recommended.

Carriers of HBV who require treatment with Humira should be closely monitored for signs and symptoms of active HBV infection throughout therapy and for several months following termination of therapy. Adequate data from treating patients who are carriers of HBV with anti-viral therapy in conjunction with TNF-antagonist therapy to prevent HBV reactivation are not available. In patients who develop HBV reactivation, Humira should be stopped and effective anti-viral therapy with appropriate supportive treatment should be initiated.

Neurological events

TNF-antagonists including Humira have been associated in rare instances with new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disease including multiple sclerosis and optic neuritis, and peripheral demyelinating disease, including Guillain-Barré syndrome. Prescribers should exercise caution in considering the use of Humira in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders; discontinuation of Humira should be considered if any of these disorders develop.

Allergic reactions

Serious allergic reactions associated with Humira were rare during clinical trials. Non-serious allergic reactions associated with Humira were uncommon during clinical trials. Reports of serious allergic reactions including anaphylaxis have been received following Humira administration. If an anaphylactic reaction or other serious allergic reaction occurs, administration of Humira should be discontinued immediately and appropriate therapy initiated.

Immunosuppression

In a study of 64 patients with rheumatoid arthritis that were treated with Humira, there was no evidence of depression of delayed-type hypersensitivity, depression of immunoglobulin levels, or change in enumeration of effector T-, B-, -NK-cells, monocyte/macrophages, and neutrophils.

Malignancies and lymphoproliferative disorders

In the controlled portions of clinical trials of TNF-antagonists, more cases of malignancies including lymphoma have been observed among patients receiving a TNF-antagonist compared with control patients. However, the occurrence was rare. In the post marketing setting, cases of leukemia have been reported in patients treated with a TNF-antagonist. There is an increased background risk for lymphoma and leukemia in rheumatoid arthritis patients with long-standing highly active, inflammatory disease, which complicates the risk estimation. With the current knowledge, a possible risk for the development of lymphomas, leukemia, and other malignancies in patients treated with a TNF-antagonist cannot be excluded.

Malignancies, some fatal, have been reported among children, adolescents and young adults (up to 22 years of age) treated with TNF-antagonists (initiation of therapy \leq 18 years of age), including adalimumab in the post marketing setting. Approximately half the cases were lymphomas. The other cases represented a variety of different malignancies and included rare malignancies usually associated with immunosuppression. A risk for the development of malignancies in children and adolescents treated with TNF-antagonists cannot be excluded.

Rare postmarketing cases of hepatosplenic T-cell lymphoma have been identified in patients treated with adalimumab. This rare type of T-cell lymphoma has a very aggressive disease course and is usually fatal. Some of these hepatosplenic T-cell lymphomas with Humira have occurred in young adult patients on concomitant treatment with azathioprine or 6-mercaptopurine used for inflammatory bowel disease. The potential risk with the combination of azathioprine or 6-mercaptopurine and Humira should be carefully considered. A risk for the development of hepatosplenic T-cell lymphoma in patients treated with Humira cannot be excluded (see sections 4.8).

No studies have been conducted that include patients with a history of malignancy or in whom treatment with Humira is continued following development of malignancy. Thus additional caution should be exercised in considering Humira treatment of these patients (see section 4.8).

All patients, and in particular patients with a medical history of extensive immunosuppressant therapy or psoriasis patients with a history of PUVA treatment should be examined for the presence of non-melanoma skin cancer prior to and during treatment with Humira. Melanoma and Merkel cell carcinoma have also been reported in patients treated with TNF-antagonists including adalimumab (see section 4.8).

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

With current data it is not known if adalimumab treatment influences the risk for developing dysplasia or colon cancer. All patients with ulcerative colitis who are at increased risk for dysplasia or colon carcinoma (for example, patients with long-standing ulcerative colitis or primary sclerosing cholangitis), or who had a prior history of dysplasia or colon carcinoma should be screened for dysplasia at regular intervals before therapy and throughout their disease course. This evaluation should include colonoscopy and biopsies per local recommendations.

Haematologic reactions

Rare reports of pancytopenia including aplastic anaemia have been reported with TNF antagonists. Adverse events of the haematologic system, including medically significant cytopenia (e.g. thrombocytopenia, leucopenia) have been reported with Humira. All patients should be advised to seek immediate medical attention if they develop signs and symptoms suggestive of blood dyscrasias

(eg persistent fever, bruising, bleeding, pallor) while on Humira. Discontinuation of Humira therapy should be considered in patients with confirmed significant haematologic abnormalities.

Vaccinations

Similar antibody responses to the standard 23-valent pneumococcal vaccine and the influenza trivalent virus vaccination were observed in a study in 226 adult subjects with rheumatoid arthritis who were treated with adalimumab or placebo. No data are available on the secondary transmission of infection by live vaccines in patients receiving Humira.

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

Patients on Humira may receive concurrent vaccinations, except for live vaccines. Administration of live vaccines to infants exposed to adalimumab in utero is not recommended for 5 months following the mother's last adalimumab injection during pregnancy.

Congestive heart failure

In a clinical trial with another TNF-antagonist worsening congestive heart failure and increased mortality due to congestive heart failure have been observed. Cases of worsening congestive heart failure have also been reported in patients receiving Humira. Humira should be used with caution in patients with mild heart failure (NYHA class I/II). Humira is contraindicated in moderate to severe heart failure (see section 4.3). Treatment with Humira must be discontinued in patients who develop new or worsening symptoms of congestive heart failure.

Autoimmune processes

Treatment with Humira may result in the formation of autoimmune antibodies. The impact of long-term treatment with Humira on the development of autoimmune diseases is unknown. If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Humira and is positive for antibodies against double-stranded DNA, further treatment with Humira should not be given (see section 4.8).

Concurrent administration of biologic DMARDS or TNF-antagonists

Serious infections were seen in clinical studies with concurrent use of anakinra and another TNF-antagonist, etanercept, with no added clinical benefit compared to etanercept alone. Because of the nature of the adverse events seen with the combination of etanercept and anakinra therapy, similar toxicities may also result from the combination of anakinra and other TNF-antagonists. Therefore, the combination of adalimumab and anakinra is not recommended. (See section 4.5).

Concomitant administration of adalimumab with other biologic DMARDS (e.g, anakinra and abatacept) or other TNF-antagonists is not recommended based upon the possible increased risk for infections, including serious infections and other potential pharmacological interactions. (See section 4.5).

Surgery

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

Small bowel obstruction

Failure to respond to treatment for Crohn's disease may indicate the presence of fixed fibrotic stricture that may require surgical treatment. Available data suggest that Humira does not worsen or cause strictures.

Elderly patients

The frequency of serious infections among Humira treated subjects over 65 years of age (3.6%) was higher than for those under 65 years of age (1.4%). Some of those had a fatal outcome. Particular attention regarding the risk for infection should be paid when treating the elderly.

Paediatric population

See "Vaccinations" above.

4.5 Interaction with other medicinal products and other forms of interaction

- Humira has been studied in rheumatoid arthritis, polyarticular juvenile idiopathic arthritis and psoriatic arthritis patients taking Humira as monotherapy and those taking concomitant methotrexate. Antibody formation was lower when Humira was given together with methotrexate in comparison with use as monotherapy. Administration of Humira without methotrexate resulted in increased formation of antibodies, increased clearance and reduced efficacy of adalimumab (see section 5.1).
- The combination of Humira and anakinra is not recommended (see section 4.4 "Concurrent administration of biologic DMARDS or TNF-antagonists").
- The combination of Humira and abatacept is not recommended (see section 4.4 "Concurrent administration of biologic DMARDS or TNF-antagonists").

4.6 Fertility, Pregnancy and lactation

Women of child bearing potential/Contraception in males and females

Women of childbearing potential are strongly recommended to use adequate contraception to prevent pregnancy and continue its use for at least five months after the last Humira treatment.

Pregnancy

For Humira, limited clinical data on exposed pregnancies are available.

In a developmental toxicity study conducted in monkeys, there was no indication of maternal toxicity, embryotoxicity or teratogenicity. Preclinical data on postnatal toxicity of adalimumab are not available (see section 5.3).

Due to its inhibition of TNF α , adalimumab administered during pregnancy could affect normal immune responses in the newborn. Administration of adalimumab is not recommended during pregnancy.

Adalimumab may cross the placenta into the serum of infants born to women treated with adalimumab during pregnancy. Consequently, these infants may be at increased risk for infection. Administration of live vaccines to infants exposed to adalimumab in utero is not recommended for 5 months following the mother's last adalimumab injection during pregnancy.

Breast feeding

It is not known whether adalimumab is excreted in human milk or absorbed systemically after ingestion.

However, because human immunoglobulins are excreted in milk, women must not breast-feed for at least five months after the last Humira treatment.

Fertility

Preclinical data on fertility effects of adalimumab are not available.

4.7 Effects on ability to drive and use machines

Humira may have a minor influence on the ability to drive and use machines. Vertigo and visual impairment may occur following administration of Humira (see Section 4.8).

4.8 Undesirable effects

Summary of the safety profile

Humira was studied in 9,035 patients in pivotal controlled and open label trials for up to 60 months or more. These trials included rheumatoid arthritis patients with short term and long standing disease, juvenile idiopathic arthritis (polyarticular juvenile idiopathic arthritis and enthesitis-related arthritis), as well as axial spondyloarthritis (ankylosing spondylitis and axial spondyloarthritis without radiographic evidence of AS), psoriatic arthritis, Crohn's disease, ulcerative colitis, psoriasis and hidradenitis suppurativa patients. The pivotal controlled studies involved 5,839 patients receiving Humira and 3,551 patients receiving placebo or active comparator during the controlled period.

The proportion of patients who discontinued treatment due to adverse events during the double-blind, controlled portion of pivotal studies was 5.7% for patients taking Humira and 5.4% for control treated patients.

The most commonly reported adverse reactions are infections (such as nasopharyngitis, upper respiratory tract infection and sinusitis), injection site reactions (erythema, itching, haemorrhage, pain or swelling), headache and musculoskeletal pain.

Serious adverse reactions have been reported for Humira. TNF-antagonists, such as Humira affect the immune system and their use may affect the body's defense against infection and cancer.

Fatal and life-threatening infections (including sepsis, opportunistic infections and TB), HBV reactivation and various malignancies (including leukaemia, lymphoma and HSTCL) have also been reported with use of Humira.

Serious haematological, neurological and autoimmune reactions have also been reported. These include rare reports of pancytopenia, aplastic anaemia, central and peripheral demyelinating events and reports of lupus, lupus-related conditions and Stevens-Johnson syndrome.

Paediatric population

Undesirable effects in paediatric patients

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

Tabulated list of adverse reactions

The following list of adverse reactions is based on experience from clinical trials and on postmarketing experience and are displayed by system organ class and frequency in table 3 below: very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1000$ to $< 1/100$) rare ($\geq 1/10,000$ to $< 1/1000$) and not known (cannot be estimated from the available data). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness. The highest frequency seen among the various indications has been included. An asterisk (*) appears in the SOC column if further information is found elsewhere in sections 4.3, 4.4 and 4.8.

**Table 3
Undesirable Effects**

System Organ Class	Frequency	Adverse Reaction
Infections and infestations*	Very common	respiratory tract infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral)
	Common	systemic infections (including sepsis, candidiasis and influenza), intestinal infections (including gastroenteritis viral), skin and soft tissue infections (including paronychia, cellulitis, impetigo, necrotising fasciitis and herpes zoster), ear infections, oral infections (including herpes simplex, oral herpes and tooth infections), reproductive tract infections (including vulvovaginal mycotic infection), urinary tract infections (including pyelonephritis), fungal infections joint infections
	Uncommon	neurological infections (including viral meningitis), opportunistic infections and tuberculosis (including coccidioidomycosis, histoplasmosis and mycobacterium avium complex infection), eye infections, diverticulitis ¹⁾
Neoplasms benign, malignant and unspecified (including cysts and polyps)*	Common	skin cancer excluding melanoma (including basal cell carcinoma and squamous cell carcinoma) benign neoplasm
	Uncommon	lymphoma**, solid organ neoplasm (including breast cancer, lung neoplasm and thyroid neoplasm), melanoma**
	Rare	Leukaemia ¹⁾
	Not known	hepatosplenic T-cell lymphoma ¹⁾ , Merkel Cell Carcinoma (neuroendocrine carcinoma of the skin) ¹⁾
Blood and the lymphatic system disorders*	Very common	leucopaenia (including neutropaenia and agranulocytosis), anaemia
	Common	leucocytosis thrombocytopenia,

System Organ Class	Frequency	Adverse Reaction
	Uncommon	idiopathic thrombocytopaenic purpura
	Rare	pancytopaenia
Immune system disorders*	Common	hypersensitivity, allergies (including seasonal allergy)
	Uncommon	sarcoidosis ¹⁾ vasculitis
	Rare	Anaphyaxis ¹⁾
Metabolism and nutrition disorders	Very common	lipids increased
	Common	hypokalaemia, uric acid increased, blood sodium abnormal, hypocalcaemia hyperglycaemia, hypophosphataemia, dehydration
Psychiatric disorders	Common	mood alterations (including depression), anxiety insomnia
Nervous system disorders*	Very common	headache
	Common	paraesthesias (including hypoesthesia), migraine nerve root compression
	Uncommon	cerebrovascular accident ¹⁾ tremor Neuropathy
	Rare	multiple sclerosis demyelinating disorders (e.g. optic neuritis, Guillain-Barré syndrome) ¹⁾
Eye disorders	Common	visual impairment, conjunctivitis, blepharitis, eye swelling
	Uncommon	diplopia
Ear and labyrinth disorders	Common	vertigo

System Organ Class	Frequency	Adverse Reaction
	Uncommon	deafness, tinnitus
Cardiac disorders*	Common	tachycardia
	Uncommon	myocardial infarction ¹⁾ , arrhythmia, congestive heart failure
	Rare	cardiac arrest
Vascular disorders	Common	hypertension, flushing, haematoma
	Uncommon	aortic aneurysm vascular arterial occlusion, thrombophlebitis
Respiratory, thoracic and mediastinal disorders*	Common	asthma, dyspnoea cough
	Uncommon	pulmonary embolism ¹⁾ , interstitial lung disease, chronic obstructive pulmonary disease, pneumonitis pleural effusion ¹⁾
	Rare	pulmonary fibrosis ¹⁾
Gastrointestinal disorders	Very common	abdominal pain, nausea and vomiting
	Common	GI haemorrhage, dyspepsia, gastroesophageal reflux disease, sicca syndrome
	Uncommon	pancreatitis, dysphagia, face oedema
	Rare	intestinal perforation ¹⁾
Hepato-biliary disorders*	Very Common	elevated liver enzymes
	Uncommon	cholecystitis and cholelithiasis, hepatic steatosis bilirubin increased
	Rare	hepatitis reactivation of hepatitis B ¹⁾ autoimmune hepatitis ¹⁾
	Not known	Liver failure ¹⁾

System Organ Class	Frequency	Adverse Reaction
Skin and subcutaneous tissue disorders	Very Common	rash (including exfoliative rash),
	Common	worsening or new onset of psoriasis (including palmoplantar pustular psoriasis) ¹⁾ , urticaria, bruising (including purpura), dermatitis (including eczema), onychoclasia, hyperhidrosis alopecia ¹⁾ , pruritus
	Uncommon	night sweats, scar
	Rare	erythema multiforme ¹⁾ Stevens-Johnson syndrome ¹⁾ , angioedema ¹⁾ , cutaneous vasculitis ¹⁾
	Not known	Worsening of symptoms of dermatomyositis ¹⁾
Musculoskeletal and connective tissue disorders	Very common	musculoskeletal pain
	Common	muscle spasms (including blood creatine phosphokinase increased)
	Uncommon	Rhabdomyolysis systemic lupus erythematosus
	Rare	lupus-like syndrome ¹⁾
Renal and urinary disorders	Common	renal impairment haematuria
	Uncommon	nocturia
Reproductive system and breast disorders	Uncommon	erectile dysfunction
General disorders and administration site conditions*	Very Common	injection site reaction (including injection site erythema)
	Common	chest pain, oedema pyrexia ¹⁾
	Uncommon	inflammation
Investigations*	Common	coagulation and bleeding disorders (including activated partial thromboplastin time prolonged), autoantibody test positive (including double stranded DNA antibody), blood lactate dehydrogenase increased.

System Organ Class	Frequency	Adverse Reaction
injury, poisoning and procedural complications	Common	impaired healing

* further information is found elsewhere in sections 4.3, 4.4 and 4.8

** including open label extension studies

¹⁾ including spontaneous reporting data

Hidradenitis suppurativa

The safety profile for patients with HS treated with Humira weekly was consistent with the known safety profile of Humira

Description of selected adverse reactions

Injection site reactions

In the pivotal controlled trials in adults and children, 12.9% of patients treated with Humira developed injection site reactions (erythema and/or itching, haemorrhage, pain or swelling), compared to 7.1% of patients receiving placebo or active control. Injection site reactions generally did not necessitate discontinuation of the medicinal product.

Infections

In the pivotal controlled trials in adults and children, the rate of infection was 1.51 per patient year in the Humira treated patients and 1.46 per patient year in the placebo and active control-treated patients. The infections consisted primarily of nasopharyngitis, upper respiratory tract infection, sinusitis. Most patients continued on Humira after the infection resolved.

The incidence of serious infections was 0.04 per patient year in Humira treated patients and 0.03 per patient year in placebo and active control – treated patients.

In controlled and open label adult and paediatric studies with Humira, serious infections (including fatal infections, which occurred rarely) have been reported, which include reports of tuberculosis (including miliary and extra-pulmonary locations) and invasive opportunistic infections (e.g. disseminated or extrapulmonary histoplasmosis, blastomycosis, coccidioidomycosis, pneumocystis candidiasis, aspergillosis and listeriosis). Most of the cases of tuberculosis occurred within the first eight months after initiation of therapy and may reflect recrudescence of latent disease.

Malignancies and lymphoproliferative disorders

No malignancies were observed in 249 paediatric patients with an exposure of 655.6 patient years during Humira trials in patients with juvenile idiopathic arthritis (polyarticular juvenile idiopathic arthritis and enthesitis-related arthritis). In addition, no malignancies were observed in 192 paediatric patients with an exposure of 258.9 patient years during a Humira trial in paediatric patients with Crohn's disease. No malignancies were observed in 77 paediatric patients with an exposure of 80.0 patient years during a Humira trial in paediatric patients with chronic plaque psoriasis.

During the controlled portions of pivotal Humira trials in adults of at least 12 weeks in duration in patients with moderately to severely active rheumatoid arthritis, ankylosing spondylitis, axial spondyloarthritis without radiographic evidence of AS, psoriatic arthritis, psoriasis, hidradenitis suppurativa, Crohn's disease and ulcerative colitis, malignancies, other than lymphoma and non-melanoma skin cancer, were observed at a rate (95% confidence interval) of 6.1 (3.8, 9.9) per 1000 patient-years among 5,041 Humira treated patients versus a rate of 6.9 (3.7, 12.7) per 1000 patient-years among 3,194 control patients (median duration of treatment was 4.0 months for Humira and 3.9 months for control-treated patients).

The rate (95% confidence interval) of non-melanoma skin cancers was 9.0 (6.1, 13.3) per 1000 patient-years among Humira-treated patients and 3.4 (1.4, 8.2) per 1000 patient-years among control

patients. Of these skin cancers, squamous cell carcinomas occurred at rates (95% confidence interval) of 2.5 (1.2, 5.3) per 1000 patient-years among Humira-treated patients and 0.7 (0.1, 4.9) per 1000 patient-years among control patients. The rate (95% confidence interval) of lymphomas was 0.7 (0.2, 2.9) per 1000 patient-years among Humira-treated patients and 0.7 (0.1, 4.9) per 1000 patient-years among control patients.

When combining controlled portion of these trials and ongoing and completed open label extension studies with a median duration of approximately 3.4 years including 6,008 patients and over 25,446 patient-years of therapy, the observed rate of malignancies, other than lymphoma and non-melanoma skin cancers is approximately 8.5 per 1000 patient years. The observed rate of non-melanoma skin cancers is approximately 9.7 per 1000 patient years, and the observed rate of lymphomas is approximately 1.3 per 1000 patient years.

In post-marketing experience from January 2003 to December 2010, predominantly in patients with rheumatoid arthritis, the reported rate of malignancies is approximately 2.7 per 1000 patient treatment years. The reported rates for non-melanoma skin cancers and lymphomas are approximately 0.2 and 0.3 per 1000 patient treatment years, respectively (see section 4.4).

Rare post-marketing cases of hepatosplenic T-cell lymphoma have been reported in patients treated with adalimumab (see section 4.4).

Autoantibodies

Patients had serum samples tested for autoantibodies at multiple time points in rheumatoid arthritis studies I – V. In these trials, 11.9% of patients treated with Humira and 8.1% of placebo and active control – treated patients that had negative baseline anti-nuclear antibody titres reported positive titres at Week 24. Two patients out of 3,441 treated with Humira in all rheumatoid arthritis and psoriatic arthritis studies developed clinical signs suggestive of new-onset lupus-like syndrome. The patients improved following discontinuation of therapy. No patients developed lupus nephritis or central nervous system symptoms.

Hepato-biliary events

In controlled Phase 3 trials of Humira in patients with rheumatoid arthritis and psoriatic arthritis with a control period duration ranging from 4 to 104 weeks, ALT elevations $\geq 3 \times$ ULN occurred in 3.7% of Humira-treated patients and 1.6% of control-treated patients.

In controlled Phase 3 trials of Humira in patients with polyarticular juvenile idiopathic arthritis who were 4 to 17 years and enthesitis-related arthritis who were 6 to 17 years, ALT elevations $\geq 3 \times$ ULN occurred in 6.1% of Humira-treated patients and 1.3% of control-treated patients. Most ALT elevations occurred with concomitant methotrexate use. No ALT elevations $\geq 3 \times$ ULN occurred in the Phase 3 trial of Humira in patients with polyarticular juvenile idiopathic arthritis who were 2 to <4 years.

In controlled Phase 3 trials of Humira in patients with Crohn's disease and ulcerative colitis with a control period ranging from 4 to 52 weeks. ALT elevations $\geq 3 \times$ ULN occurred in 0.9% of Humira-treated patients and 0.9% of controlled-treated patients.

In the Phase 3 trial of Humira in patients with paediatric Crohn's disease which evaluated efficacy and safety of two body weight adjusted maintenance dose regimens following body weight adjusted induction therapy up to 52 weeks of treatment, ALT elevations $\geq 3 \times$ ULN occurred in 2.6% (5/192) of patients, of whom 4 were receiving concomitant immunosuppressants at baseline.

In controlled Phase 3 trials of Humira in patients with plaque psoriasis with a control period duration ranging from 12 to 24 weeks, ALT elevations $\geq 3 \times$ ULN occurred in 1.8% of Humira-treated patients and 1.8% of control-treated patients.

No ALT elevations $\geq 3 \times$ ULN occurred in the Phase 3 trial of Humira in paediatric patients with plaque psoriasis.

In controlled trials of Humira (initial doses of 160 mg at Week 0 and 80 mg at Week 2, followed by 40 mg every week starting at Week 4), in patients with hidradenitis suppurativa with a control period duration ranging from 12 to 16 weeks, ALT elevations $\geq 3 \times$ ULN occurred in 0.3% of Humira-treated patients and 0.6% of control-treated patients.

Across all indications in clinical trials patients with raised ALT were asymptomatic and in most cases elevations were transient and resolved on continued treatment. However, there have also been post-marketing reports of liver failure as well as less severe liver disorders that may precede liver failure, such as hepatitis including autoimmune hepatitis in patients receiving adalimumab.

Concurrent treatment with azathioprine/6-mercaptopurine

In adult Crohn's disease studies, higher incidences of malignant and serious infection-related adverse events were seen with the combination of Humira and azathioprine/6-mercaptopurine compared with Humira alone.

Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form (<http://forms.gov.il/globaldata/getsequence/getsequence.aspx?formType=AdversEffectMedic@moh.health.gov.il>) or by email (adr@MOH.HEALTH.GOV.IL)

4.9 Overdose

No dose-limiting toxicity was observed during clinical trials. The highest dose level evaluated has been multiple intravenous doses of 10 mg/kg, which is approximately 15 times the recommended dose.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Immunosuppressants, Tumour Necrosis Factor alpha (TNF- α) inhibitors.
ATC code: L04AB04

Mechanism of action

Adalimumab binds specifically to TNF and neutralizes the biological function of TNF by blocking its interaction with the p55 and p75 cell surface TNF receptors.

Adalimumab also modulates biological responses that are induced or regulated by TNF, including changes in the levels of adhesion molecules responsible for leukocyte migration (ELAM-1, VCAM-1, and ICAM-1 with an IC₅₀ of 0.1-0.2 nM).

Pharmacodynamic effects

After treatment with Humira, a rapid decrease in levels of acute phase reactants of inflammation (C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR)) and serum cytokines (IL-6) was observed compared to baseline in patients with rheumatoid arthritis. Serum levels of matrix metalloproteinases (MMP-1 and MMP-3) that produce tissue remodelling responsible for cartilage destruction were also decreased after Humira administration. Patients treated with Humira usually experienced improvement in haematological signs of chronic inflammation.

A rapid decrease in CRP levels was also observed in patients with polyarticular juvenile idiopathic arthritis, Crohn's disease, ulcerative colitis and hidradenitis suppurativa after treatment with Humira. In patients with Crohn's disease, a reduction of the number of cells expressing inflammatory markers in the colon including a significant reduction of expression of TNF α was seen. Endoscopic studies in intestinal mucosa have shown evidence of mucosal healing in adalimumab treated patients.

Clinical efficacy and safety

Rheumatoid arthritis

Humira was evaluated in over 3000 patients in all rheumatoid arthritis clinical trials. The efficacy and safety of Humira were assessed in five randomised, double-blind and well-controlled studies. Some patients were treated for up to 120 months duration.

RA study I evaluated 271 patients with moderately to severely active rheumatoid arthritis who were ≥ 18 years old, had failed therapy with at least one disease-modifying, anti-rheumatic drug and had insufficient efficacy with methotrexate at doses of 12.5 to 25 mg (10 mg if methotrexate-intolerant) every week and whose methotrexate dose remained constant at 10 to 25 mg every week. Doses of 20, 40 or 80 mg of Humira or placebo were given every other week for 24 weeks.

RA study II evaluated 544 patients with moderately to severely active rheumatoid arthritis who were ≥ 18 years old and had failed therapy with at least one disease-modifying, anti-rheumatic drug. Doses of 20 or 40 mg of Humira were given by subcutaneous injection every other week with placebo on alternative weeks or every week for 26 weeks; placebo was given every week for the same duration. No other disease-modifying anti-rheumatic drugs were allowed.

RA study III evaluated 619 patients with moderately to severely active rheumatoid arthritis who were ≥ 18 years old, and who had an ineffective response to methotrexate at doses of 12.5 to 25 mg or have been intolerant to 10 mg of methotrexate every week. There were three groups in this study. The first received placebo injections every week for 52 weeks. The second received 20 mg of Humira every week for 52 weeks. The third group received 40 mg of Humira every other week with placebo injections on alternate weeks. Upon completion of the first 52 weeks, 457 patients enrolled in an open-label extension phase in which 40 mg of Humira/MTX was administered every other week up to 10 years.

RA study IV primarily assessed safety in 636 patients with moderately to severely active rheumatoid arthritis who were ≥ 18 years old. Patients were permitted to be either disease-modifying, anti-rheumatic drug-naïve or to remain on their pre-existing rheumatologic therapy provided that therapy was stable for a minimum of 28 days. These therapies include methotrexate, leflunomide, hydroxychloroquine, sulfasalazine and/or gold salts. Patients were randomised to 40 mg of Humira or placebo every other week for 24 weeks.

RA study V evaluated 799 methotrexate-naïve, adult patients with moderate to severely active early rheumatoid arthritis (mean disease duration less than 9 months). This study evaluated the efficacy of Humira 40 mg every other week/methotrexate combination therapy, Humira 40 mg every other week monotherapy and methotrexate monotherapy in reducing the signs and symptoms and rate of progression of joint damage in rheumatoid arthritis for 104 weeks.

The primary end point in RA Studies I, II and III and the secondary endpoint in RA Study IV was the percent of patients who achieved an ACR 20 response at Week 24 or 26. The primary endpoint in RA Study V was the percent of patients who achieved an ACR 50 response at Week 52. RA Studies III and V had an additional primary endpoint at 52 weeks of retardation of disease progression (as detected by X-ray results). RA Study III also had a primary endpoint of changes in quality of life.

ACR response

The percent of Humira-treated patients achieving ACR 20, 50 and 70 responses was consistent across RA studies I, II and III. The results for the 40 mg every other week dose are summarised in Table 4.

Table 4
ACR Responses in Placebo-Controlled Trials
(Percent of Patients)

Response	RA Study I ^{a**}		RA Study II ^{a**}		RA Study III ^{a**}	
	Placebo/ MTX ^c n=60	Humira ^b / MTX ^c n=63	Placebo n=110	Humira ^b n=113	Placebo/ MTX ^c n=200	Humira ^b / MTX ^c n=207
ACR 20						
6 months	13.3%	65.1%	19.1%	46.0%	29.5%	63.3%
12 months	NA	NA	NA	NA	24.0%	58.9%
ACR 50						
6 months	6.7%	52.4%	8.2%	22.1%	9.5%	39.1%
12 months	NA	NA	NA	NA	9.5%	41.5%
ACR 70						
6 months	3.3%	23.8%	1.8%	12.4%	2.5%	20.8%
12 months	NA	NA	NA	NA	4.5%	23.2%

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

^b 40 mg Humira administered every other week

^c MTX = methotrexate

**p<0.01, Humira versus placebo

In RA Studies I-IV, all individual components of the ACR response criteria (number of tender and swollen joints, physician and patient assessment of disease activity and pain, disability index (HAQ) scores and CRP (mg/dl) values) improved at 24 or 26 weeks compared to placebo. In RA study III, these improvements were maintained throughout 52 weeks.

In the open-label extension for RA study III, most patients who were ACR responders maintained response when followed for up to 10 years. Of 207 patients who were randomized to Humira 40 mg every other week, 114 patients continued on Humira 40 mg every other week for 5 years. Among those, 86 patients (75.4%) had ACR 20 responses; 72 patients (63.2%) had ACR 50 responses; and 41 patients (36%) had ACR 70 responses. Of 207 patients, 81 patients continued on Humira 40 mg every other week for 10 years. Among those, 64 patients (79.0%) had ACR 20 responses; 56 patients (69.1%) had ACR 50 responses; and 43 patients (53.1%) had ACR 70 responses.

In RA study IV, the ACR 20 response of patients treated with Humira plus standard of care was statistically significantly better than patients treated with placebo plus standard of care (p<0.001).

In RA studies I-IV, Humira-treated patients achieved statistically significant ACR 20 and 50 responses compared to placebo as early as one to two weeks after initiation of treatment.

In RA study V with early rheumatoid arthritis patients who were methotrexate naïve, combination therapy with Humira and methotrexate led to faster and significantly greater ACR responses than methotrexate monotherapy and Humira monotherapy at Week 52 and responses were sustained at Week 104 (see Table 5).

Table 5
ACR Responses in RA Study V
(percent of patients)

Response	MTX n=257	Humira n=274	Humira/MTX n=268	p-value ^a	p-value ^b	p-value ^c
ACR 20						
Week 52	62.6%	54.4%	72.8%	0.013	<0.001	0.043
Week 104	56.0%	49.3%	69.4%	0.002	<0.001	0.140
ACR 50						
Week 52	45.9%	41.2%	61.6%	<0.001	<0.001	0.317
Week 104	42.8%	36.9%	59.0%	<0.001	<0.001	0.162
ACR 70						
Week 52	27.2%	25.9%	45.5%	<0.001	<0.001	0.656
Week 104	28.4%	28.1%	46.6%	<0.001	<0.001	0.864

- a. p-value is from the pairwise comparison of methotrexate monotherapy and Humira/methotrexate combination therapy using the Mann-Whitney U test.
- b. p-value is from the pairwise comparison of Humira monotherapy and Humira/methotrexate combination therapy using the Mann-Whitney U test
- c. p-value is from the pairwise comparison of Humira monotherapy and methotrexate monotherapy using the Mann-Whitney U test

At Week 52, 42.9% of patients who received Humira/methotrexate combination therapy achieved clinical remission (DAS28 < 2.6) compared to 20.6% of patients receiving methotrexate monotherapy and 23.4% of patients receiving Humira monotherapy. Humira/methotrexate combination therapy was clinically and statistically superior to methotrexate (p<0.001) and Humira monotherapy (p<0.001) in achieving a low disease state in patients with recently diagnosed moderate to severe rheumatoid arthritis. The response for the two monotherapy arms was similar (p=0.447).

Radiographic response

In RA study III, where Humira treated patients had a mean duration of rheumatoid arthritis of approximately 11 years, structural joint damage was assessed radiographically and expressed as change in modified Total Sharp Score (TSS) and its components, the erosion score and joint space narrowing score. Humira/methotrexate patients demonstrated significantly less radiographic progression than patients receiving methotrexate alone at 6 and 12 months (see Table 6).

In the open-label extension of RA Study III, the reduction in rate of progression of structural damage is maintained for 8 and 10 years in a subset of patients. At 8 years, 81 of 207 patients originally treated with 40 mg Humira every other week were evaluated radiographically. Among those, 48 patients showed no progression of structural damage defined by a change from baseline in the mTSS of 0.5 or less. At 10 years, 79 of 207 patients originally treated with 40 mg Humira every other week were evaluated radiographically. Among those, 40 patients showed no progression of structural damage defined by a change from baseline in the mTSS of 0.5 or less.

Table 6
Radiographic Mean Changes Over 12 Months in RA Study III

	Placebo/ MTX ^a	Humira /MTX 40 mg every other week	Placebo/MTX- Humira /MTX (95% Confidence Interval ^b)	p-value
Total Sharp Score	2.7	0.1	2.6 (1.4, 3.8)	<0.001 ^c
Erosion score	1.6	0.0	1.6 (0.9, 2.2)	<0.001
JSN ^d score	1.0	0.1	0.9 (0.3, 1.4)	0.002

^amethotrexate

^b95% confidence intervals for the differences in change scores between methotrexate and Humira.

^cBased on rank analysis

^dJoint Space Narrowing

In RA study V, structural joint damage was assessed radiographically and expressed as change in modified Total Sharp Score (see Table 7).

Table 7
Radiographic Mean Changes at Week 52 in RA Study V

	MTX n=257 (95% confidence interval)	Humira n=274 (95% confidence interval)	Humira/MTX n=268 (95% confidence interval)	p-value ^a	p-value ^b	p-value ^c
Total Sharp Score	5.7 (4.2-7.3)	3.0 (1.7-4.3)	1.3 (0.5-2.1)	<0.001	0.0020	<0.001
Erosion score	3.7 (2.7-4.7)	1.7 (1.0-2.4)	0.8 (0.4-1.2)	<0.001	0.0082	<0.001
JSN score	2.0 (1.2-2.8)	1.3 (0.5-2.1)	0.5 (0-1.0)	<0.001	0.0037	0.151

-
- . ^a p-value is from the pairwise comparison of methotrexate monotherapy and Humira/methotrexate combination therapy using the Mann-Whitney U test.
 - . ^b p-value is from the pairwise comparison of Humira monotherapy and Humira/methotrexate combination therapy using the Mann-Whitney U test
 - . ^c p-value is from the pairwise comparison of Humira monotherapy and methotrexate monotherapy using the Mann-Whitney U test
-

Following 52 weeks and 104 weeks of treatment, the percentage of patients without progression (change from baseline in modified Total Sharp Score ≤ 0.5) was significantly higher with Humira/methotrexate combination therapy (63.8% and 61.2% respectively) compared to methotrexate monotherapy (37.4% and 33.5% respectively, $p < 0.001$) and Humira monotherapy (50.7%, $p < 0.002$ and 44.5%, $p < 0.001$ respectively).

Quality of life and physical function

Health-related quality of life and physical function were assessed using the disability index of the Health Assessment Questionnaire (HAQ) in the four original adequate and well-controlled trials, which was a pre-specified primary endpoint at Week 52 in RA Study III. All doses/schedules of Humira in all four studies showed statistically significantly greater improvement in the disability index of the HAQ from baseline to Month 6 compared to placebo and in RA Study III the same was seen at Week 52. Results from the Short Form Health Survey (SF 36) for all doses/schedules of Humira in all four studies support these findings, with statistically significant physical component summary (PCS) scores, as well as statistically significant pain and vitality domain scores for the 40 mg every other week dose. A statistically significant decrease in fatigue as measured by functional assessment of chronic illness therapy (FACIT) scores was seen in all three studies in which it was assessed (RA studies I, III, IV).

In RA study III, most subjects who achieved improvement in physical function and continued treatment maintained improvement through Week 520 (120 months) of open-label treatment. Improvement in quality of life was measured up to Week 156 (36 months) and improvement was maintained through that time.

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

Juvenile idiopathic arthritis (JIA)

Polyarticular juvenile idiopathic arthritis (pJIA)

The safety and efficacy of Humira was assessed in two studies (pJIA I and II) in children with active polyarticular or polyarticular course juvenile idiopathic arthritis, who had a variety of JIA onset types (most frequently rheumatoid-factor negative or positive polyarthritis and extended oligoarthritis).

pJIA I

The safety and efficacy of Humira were assessed in a multicentre, randomised, double-blind, parallel – group study in 171 children (4-17 years old) with polyarticular JIA. In the open-label lead in phase (OL LI) patients were stratified into two groups, MTX (methotrexate)-treated or non- MTX-treated. Patients who were in the non-MTX stratum were either naïve to or had been withdrawn from MTX at least two weeks prior to study drug administration. Patients remained on stable doses of NSAIDs and or prednisone (≤ 0.2 mg /kg/day or 10 mg/day maximum). In the OL LI phase all patients received 24 mg/m² up to a maximum of 40 mg Humira every other week for 16 weeks. The distribution of patients by age and minimum, median and maximum dose received during the OL LI phase is presented in Table 8.

Table 8
Distribution of patients by age and adalimumab dose received during the OL LI phase

Age Group	Number of patients at Baseline n (%)	Minumum, median and maximum dose
4 to 7 years	31 (18.1)	10, 20 and 25 mg
8 to 12 years	71 (41.5)	20, 25 and 40 mg
13 to 17 years	69 (40.4)	25, 40 and 40 mg

Patients demonstrating a Pediatric ACR 30 response at week 16 were eligible to be randomised into the double blind (DB) phase and received either Humira 24 mg/m² up to a maximum of 40 mg, or placebo every other week for an additional 32 weeks or until disease flare. Disease flare criteria were defined as a worsening of $\geq 30\%$ from baseline in ≥ 3 of 6 Pediatric ACR core criteria, ≥ 2 active joints, and improvement of $> 30\%$ in no more than 1 of the 6 criteria. After 32 weeks or at disease flare, patients were eligible to enroll into the open label extension phase.

Table 9
Ped ACR 30 Responses in the JIA study

Stratum	MTX		Without MTX	
Phase				
OL-LI 16 week				
Ped ACR 30 response (n/N)	94.1% (80/85)		74.4% (64/86)	
Efficacy Outcomes				
Double Blind 32 week	Humira / MTX (N = 38)	Placebo / MTX (N = 37)	Humira (N= 30)	Placebo (N = 28)
Disease flares at the end of 32 weeks ^a (n/N)	36.8% (14/38)	64.9% (24/37) ^b	43.3% (13/30)	71.4% (20/28) ^c
Median time to disease flare	>32 weeks	20 weeks	>32 weeks	14 weeks

^a Ped ACR 30/50/70 responses week 48 significantly greater than those of placebo treated patients

^b p = 0.015

^c p = 0.031

Amongst those who responded at week 16 (n=144), the Pediatric ACR 30/50/70/90 responses were maintained for up to six years in the OLE phase in patients who received Humira throughout the study. Over all 19 subjects, of which 11 of the baseline age group 4 to 12 and 8 of the baseline age group 13 to 17 years were treated 6 years or longer.

Overall responses were generally better and, fewer patients developed antibodies when treated with the combination of Humira and MTX compared to Humira alone. Taking these results into consideration, Humira is recommended for use in combination with MTX and for use as monotherapy in patients for whom MTX use is not appropriate (see section 4.2).

pJIA II

The safety and efficacy of Humira was assessed in an open-label, multicenter study in 32 children (2 - <4 years old or aged 4 and above weighing < 15 kg) with moderately to severely active polyarticular

JIA. The patients received 24 mg/m² body surface area (BSA) of Humira up to a maximum of 20 mg every other week as a single dose via SC injection for at least 24 weeks. During the study, most subjects used concomitant MTX, with fewer reporting use of corticosteroids or NSAIDs.

At Week 12 and Week 24, PedACR30 response was 93.5% and 90.0%, respectively, using the observed data approach. The proportions of subjects with PedACR50/70/90 at Week 12 and Week 24 were 90.3%/61.3%/38.7% and 83.3%/73.3%/36.7%, respectively. Amongst those who responded (Pediatric ACR 30) at Week 24 (n=27 out of 30 patients), the Pediatric ACR 30 responses were maintained for up to 60 weeks in the OLE phase in patients who received Humira throughout this time period. Overall, 20 subjects were treated for 60 weeks or longer.

Axial Spondyloarthritis

Ankylosing spondylitis (AS)

Humira 40 mg every other week was assessed in 393 patients in two randomised, 24 week double – blind, placebo – controlled studies in patients with active ankylosing spondylitis (mean baseline score of disease activity [Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)] was 6.3 in all groups) who have had an inadequate response to conventional therapy. Seventy-nine (20.1%) patients were treated concomitantly with disease modifying anti – rheumatic drugs, and 37 (9.4 %) patients with glucocorticoids. The blinded period was followed by an open – label period during which patients received Humira 40 mg every other week subcutaneously for up to an additional 28 weeks. Subjects (n=215, 54.7%) who failed to achieve ASAS 20 at Weeks 12, or 16 or 20 received early escape open-label adalimumab 40 mg every other week subcutaneously and were subsequently treated as non-responders in the double-blind statistical analyses.

In the larger AS study I with 315 patients, results showed statistically significant improvement of the signs and symptoms of ankylosing spondylitis in patients treated with Humira compared to placebo. Significant response was first observed at Week 2 and maintained through 24 weeks (Table 10).

**Table 10 –
Efficacy Responses in Placebo-Controlled AS Study – Study I
Reduction of Signs and Symptoms**

Response	Placebo N=107	Humira N=208
ASAS ^a 20		
Week 2	16%	42%***
Week 12	21%	58%***
Week 24	19%	51%***
ASAS 50		
Week 2	3%	16%***
Week 12	10%	38%***
Week 24	11%	35%***
ASAS 70		
Week 2	0%	7%**
Week 12	5%	23%***
Week 24	8%	24%***
BASDAI ^b 50		
Week 2	4%	20%***
Week 12	16%	45%***
Week 24	15%	42%***

***, ** Statistically significant at p<0.001, <0.01 for all comparisons between Humira and placebo at Weeks 2, 12 and 24

^a Assessments in Ankylosing Spondylitis

^b Bath Ankylosing Spondylitis Disease Activity Index

Humira treated patients had significantly greater improvement at Week 12 which was maintained through Week 24 in both the SF36 and Ankylosing Spondylitis Quality of Life Questionnaire (ASQoL).

Similar trends (not all statistically significant) were seen in the smaller randomised, double – blind, placebo controlled AS study II of 82 adult patients with active ankylosing spondylitis.

Axial spondyloarthritis without radiographic evidence of AS

Humira 40mg every other week was assessed in 185 patients in one randomized, 12 week double - blind, placebo - controlled study in patients with active non-radiographic axial spondyloarthritis (mean baseline score of disease activity [Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)]) was 6.4 for patients treated with Humira and 6.5 for those on placebo) who have had an inadequate response to or intolerance to ≥ 1 NSAIDs, or a contraindication for NSAIDs.

Thirty-three (18%) of patients were treated concomitantly with disease modifying anti-rheumatic drugs, and 146 (79) patients with NSAIDs at baseline. The double-blind period was followed by an open-label period during which patients receive Humira 40 mg every other week subcutaneously for up to an additional 144 weeks. Week 12 results showed statistically significant improvement of the signs and symptoms of active non-radiographic axial spondyloarthritis in patients treated with Humira compared to placebo (Table 11).

Table 11
Efficacy Response in Placebo-Controlled Axial SpA Study -

Double-Blind Response at Week 12	Placebo N=94	Humira N=91
ASAS ^a 40	15%	36%***
ASAS 20	31%	52%**
ASAS 5/6	6%	31%***
ASAS partial remission	5%	16%***
BASDAI ^p 50	15%	35%**
ASDAS ^{c,d,e}	-0.3	-1.0***
ASDAS Inactive Disease	4%	24%***
hs-CRP ^{d,f,g}	-0.3	-4.7***
SPARCC ^h MRI Sacroiliac Joints ^{d,i}	-0.6	-3.2**
SPARCC MRI Spine ^{d,j}	-0.2	-1.8**
<p>^a Assessment of Spondyloarthritis International Society ^b Bath Ankylosing Spondylitis Disease Activity Index ^c Ankylosing Spondylitis Disease Activity Score ^d mean change from baseline ^e n=91 placebo and n=87 Humira ^f high sensitivity C-Reactive Protein (mg/L) ^g n=73 placebo and n=70 Humira ^h Spondyloarthritis Research Consortium of Canada ⁱ n=84 placebo and Humira ^j n=82 placebo and n=85 Humira ***, **, * Statistically significant at $p < 0.001$, < 0.01, and < 0.05, respectively, for all comparisons between Humira and placebo.</p>		

In the open-label extension, improvement in the signs and symptoms was maintained with Humira therapy through Week 156.

Inhibition of inflammation

Significant improvement of signs of inflammation as measured by hs-CRP and MRI of both Sacroiliac Joints and the Spine was maintained in Humira-treated patients through Week 156 and Week 104, respectively.

Quality of life and physical function

Health-related quality of life and physical function were assessed using the HAQ-S and the SF-36 questionnaires. Humira showed statistically significantly greater improvement in the HAQ-S total score and the SF-36 Physical Component Score (PCS) from baseline to week 12 compared to placebo. Improvement in health-related quality of life and physical function was maintained during the open-label extension through Week 156.

Psoriatic arthritis

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

There is insufficient evidence of the efficacy of Humira in patients with ankylosing spondylitis-like psoriatic arthropathy due to the small number of patients studied.

Table 12
ACR Response in Placebo-Controlled Psoriatic Arthritis Studies
(Percent of Patients)

Response	PsA Study I		PsA Study II	
	Placebo N=162	Humira N=151	Placebo N=49	Humira N=51
ACR 20				
Week 12	14%	58% ^{***}	16%	39% [*]
Week 24	15%	57% ^{***}	N/A	N/A
ACR 50				
Week 12	4%	36% ^{***}	2%	25% ^{***}
Week 24	6%	39% ^{***}	N/A	N/A
ACR 70				
Week 12	1%	20% ^{***}	0%	14% [*]
Week 24	1%	23% ^{***}	N/A	N/A

*** p<0.001 for all comparisons between Humira and placebo

* p<0.05 for all comparisons between Humira and placebo

N/A not applicable

ACR responses in PsA study I were similar with and without concomitant methotrexate therapy. ACR responses were maintained in the open-label extension study for up to 136 weeks.

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

Humira treatment reduced the rate of progression of peripheral joint damage compared with placebo treatment as measured by change from baseline in mTSS (mean ± SD) 0.8 ± 2.5 in the placebo group (at week 24) compared with 0.0 ± 1.9 (p< 0.001) in the Humira group (at week 48).

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

Humira treated patients demonstrated statistically significant improvement in physical function as assessed by HAQ and Short Form Health Survey (SF 36) compared to placebo at week 24. Improved physical function continued during the open label extension up to week 136.

Psoriasis

The safety and efficacy of Humira were studied in adult patients with chronic plaque psoriasis ($\geq 10\%$ BSA involvement and Psoriasis Area and Severity Index (PASI) ≥ 12 or ≥ 10) who were candidates for systemic therapy or phototherapy in randomised, double-blind studies. 73% of patients enrolled in Psoriasis Studies I and II had received prior systemic therapy or phototherapy. The safety and efficacy of Humira were also studied in adult patients with moderate to severe chronic plaque psoriasis with concomitant hand and/or foot psoriasis who were candidates for systemic therapy in a randomized double-blind study (Psoriasis Study III).

Psoriasis Study I (REVEAL) evaluated 1,212 patients within three treatment periods. In period A, patients received placebo or Humira at an initial dose of 80 mg followed by 40 mg every other week starting one week after the initial dose. After 16 weeks of therapy, patients who achieved at least a PASI 75 response (PASI score improvement of at least 75% relative to baseline), entered period B and received open-label 40 mg Humira every other week. Patients who maintained \geq PASI 75 response at Week 33 and were originally randomised to active therapy in Period A, were re-randomised in period C to receive 40 mg Humira every other week or placebo for an additional 19 weeks. Across all treatment groups, the mean baseline PASI score was 18.9 and the baseline Physician's Global Assessment (PGA) score ranged from "moderate" (53% of subjects included) to "severe" (41%) to "very severe" (6%).

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

Patients participating in all Phase 2 and Phase 3 psoriasis studies were eligible to enroll into an open-label extension trial, where Humira was given for at least an additional 108 weeks.

In Psoriasis Studies I and II, a primary endpoint was the proportion of patients who achieved a PASI 75 response from baseline at Week 16 (see Tables 13 and 14).

Table 13
Ps Study I (REVEAL) - Efficacy Results at 16 Weeks

	Placebo N=398 n (%)	Humira 40 mg eow N=814 n (%)
\geq PASI 75 ^a	26 (6.5)	578 (70.9) ^b
PASI 100	3 (0.8)	163 (20.0) ^b
PGA: Clear/minimal	17 (4.3)	506 (62.2) ^b
^a Percent of patients achieving PASI75 response was calculated as center-adjusted rate		
^b p<0.001, Humira vs. placebo		

Table 14
Ps Study II (CHAMPION) Efficacy Results at 16 Weeks

	Placebo N=53 n (%)	MTX N=110 n (%)	Humira 40 mg eow N=108 n (%)
\geq PASI 75	10 (18.9)	39 (35.5)	86 (79.6) ^{a, b}
PASI 100	1 (1.9)	8 (7.3)	18 (16.7) ^{c, d}
PGA: Clear/minimal	6 (11.3)	33 (30.0)	79 (73.1) ^{a, b}
^a p<0.001 Humira vs. placebo			
^b p<0.001 Humira vs. methotrexate			
^c p<0.01 Humira vs. placebo			
^d p<0.05 Humira vs. methotrexate			

In Psoriasis Study I, 28% of patients who were PASI 75 responders and were re-randomised to placebo at Week 33 compared to 5% continuing on Humira, $p < 0.001$, experienced “loss of adequate response” (PASI score after Week 33 and on or before Week 52 that resulted in a $< \text{PASI } 50$ response relative to baseline with a minimum of a 6-point increase in PASI score relative to Week 33). Of the patients who lost adequate response after re-randomization to placebo who then enrolled into the open-label extension trial, 38% (25/66) and 55% (36/66) regained PASI 75 response after 12 and 24 weeks of re-treatment, respectively.

A total of 233 PASI 75 responders at Week 16 and Week 33 received continuous Humira therapy for 52 weeks in Psoriasis Study I, and continued Humira in the open-label extension trial. PASI 75 and PGA of clear or minimal response rates in these patients were 74.7% and 59.0%, respectively, after an additional 108 weeks of open-label therapy (total of 160 weeks). In an analysis in which all patients who dropped out of the study for adverse events or lack of efficacy, or who dose-escalated, were considered non-responders, PASI 75 and PGA clear or minimal response rates in these patients were 69.6% and 55.7%, respectively, after an additional 108 weeks of open-label therapy (total of 160 weeks).

A total of 347 stable responders participated in a withdrawal and retreatment evaluation in an open-label extension study. During the withdrawal period, symptoms of psoriasis returned over time with a median time to relapse (decline to PGA “moderate” or worse) was approximately 5 months. None of these patients experienced rebound during the withdrawal period. A total of 76.5% (218/285) of patients who entered the retreatment period had a response of PGA “clear” or “minimal” after 16 weeks of retreatment, irrespective of whether they relapsed during withdrawal (69.1% [123/178] and 88.8% [95/107] for patients who relapsed and who did not relapse during the withdrawal period, respectively). A similar safety profile was observed during retreatment as before withdrawal.

Significant improvements at Week 16 from baseline compared to placebo (Studies I and II) and MTX (Study II) were demonstrated in the DLQI (Dermatology Life Quality Index). In Study I, improvements in the physical and mental component summary scores of the SF-36 were also significant compared to placebo.

In an open-label extension study, for patients who dose escalated from 40 mg every other week to 40 mg weekly due to a PASI response below 50% and were evaluated at 12 weeks after dose escalation, 93/349 (26.6%) of patients achieved PASI 75 response.

Psoriasis Study III (REACH) compared the efficacy and safety of Humira *versus* placebo in 71 patients with moderate to severe chronic plaque psoriasis and hand and/or foot psoriasis. Patients received an initial dose of 80 mg Humira followed by 40 mg every other week (starting one week after the initial dose) or placebo for 16 weeks. At Week 16, a statistically significantly greater proportion of patients who received Humira achieved PGA of 'clear' or 'almost clear' for the hands and/or feet compared to patients who received placebo (30.6% versus 4.3%, respectively [$P = 0.014$]).

Paediatric plaque psoriasis

The efficacy of Humira was assessed in a randomised, double-blind, controlled study of 114 paediatric patients from 4 years of age with severe chronic plaque psoriasis (as defined by a $\text{PGA} \geq 4$ or $> 20\%$ BSA involvement or $> 10\%$ BSA involvement with very thick lesions or $\text{PASI} \geq 20$ or ≥ 10 with clinically relevant facial, genital, or hand/ foot involvement) who were inadequately controlled with topical therapy and heliotherapy or phototherapy.

Patients received Humira 0.8mg/kg eow (up to 40 mg), 0.4 mg/kg eow (up to 20 mg), or methotrexate 0.1 – 0.4 mg/kg weekly (up to 25 mg). At week 16, more patients randomised to Humira 0.8 mg/kg had positive efficacy responses (e.g., PASI 75) than those randomised to 0.4mg/kg eow or MTX.

Table 15: Paediatric Plaque Psoriasis Efficacy Results at 16 Weeks

	MTX ^a N=37	Humira 0.8mg/kg eow N=38
PASI 75 ^b	12 (32.4%)	22 (57.9%)
PGA: Clear/minimal ^c	15 (40.5%)	23 (60.5%)

^a MTX = methotrexate ^b P=0.027, Humira 0.8 mg/kg versus MTX ^c P=0.083, Humira 0.8 mg/kg versus MTX

Patients who achieved PASI 75 and PGA clear or minimal were withdrawn from treatment for up to 36 weeks and monitored for loss of disease control (i.e. a worsening of PGA by at least 2 grades). Patients were then re-treated with adalimumab 0.8 mg/kg eow for an additional 16 weeks and response rates observed during retreatment were similar to the previous double-blind period: PASI 75 response of 78.9% (15 of 19 subjects) and PGA clear or minimal of 52.6% (10 of 19 subjects).

In the open label period of the study, PASI 75 and PGA clear or minimal responses were maintained for up to an additional 52 weeks with no new safety findings.

Hidradenitis suppurativa

The safety and efficacy of Humira were assessed in randomised, double-blind, placebo-controlled studies and an open-label extension study in adult patients with moderate to severe hidradenitis suppurativa (HS) who were intolerant, had a contraindication or an inadequate response to at least a 3-month trial of systemic antibiotic therapy. The patients in HS-I and HS-II had Hurley Stage II or III disease with at least 3 abscesses or inflammatory nodules.

Study HS-I (PIONEER I) evaluated 307 patients with 2 treatment periods. In Period A, patients received placebo or Humira at an initial dose of 160 mg at Week 0, 80 mg at Week 2, and 40 mg every week starting at Week 4 to Week 11. Concomitant antibiotic use was not allowed during the study. After 12 weeks of therapy, patients who had received Humira in Period A were re-randomised in Period B to 1 of 3 treatment groups (Humira 40 mg every week, Humira 40 mg every other week, or placebo from Week 12 to Week 35). Patients who had been randomised to placebo in Period A were assigned to receive Humira 40 mg every week in Period B.

Study HS-II (PIONEER II) evaluated 326 patients with 2 treatment periods. In Period A, patients received placebo or Humira at an initial dose of 160 mg at Week 0 and 80 mg at Week 2 and 40 mg every week starting at Week 4 to Week 11. 19.3% of patients had continued baseline oral antibiotic therapy during the study. After 12 weeks of therapy, patients who had received Humira in Period A were re-randomised in Period B to 1 of 3 treatment groups (Humira 40 mg every week, Humira 40 mg every other week, or placebo from Week 12 to Week 35). Patients who had been randomised to placebo in Period A were assigned to receive placebo in Period B.

Patients participating in Studies HS-I and HS-II were eligible to enroll into an open-label extension study in which Humira 40mg was administered every week. Throughout all 3 studies patients used topical antiseptic wash daily.

Clinical Response

Reduction of inflammatory lesions and prevention of worsening of abscesses and draining fistulas was assessed using Hidradenitis Suppurativa Clinical Response (HiSCR; 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count relative to Baseline). Reduction in HS-related skin pain was assessed using a Numeric Rating Scale in patients who entered the study with an initial baseline score of 3 or greater on a 11 point scale.

At Week 12, a significantly higher proportion of patients treated with Humira versus placebo achieved HiSCR. At Week 12, a significantly higher proportion of patients in Study HS-II experienced a clinically relevant decrease in HS-related skin pain (see Table 16). Patients treated with Humira had significantly reduced risk of disease flare during the initial 12 weeks of treatment.

Table 16: Efficacy Results at 12 Weeks, HS Studies I and II

	HS Study I		HS Study II	
	Placebo	Humira 40 mg Weekly	Placebo	Humira 40 mg Weekly
Hidradenitis Suppurativa Clinical Response (HiSCR) ^a	N = 154 40 (26.0%)	N = 153 64 (41.8%) *	N=163 45 (27.6%)	N=163 96 (58.9%) ***

≥30% Reduction in Skin Pain ^b	N = 109 27 (24.8%)	N = 122 34 (27.9%)	N=111 23 (20.7%)	N=105 48 (45.7%) ***
<p>* $P < 0.05$, ***$P < 0.001$, Humira versus placebo</p> <p>a. Among all randomised patients.</p> <p>b. Among patients with baseline HS-related skin pain assessment ≥ 3, based on Numeric Rating Scale 0 – 10; 0 = no skin pain, 10 = skin pain as bad as you can imagine.</p>				

Treatment with Humira 40 mg every week significantly reduced the risk of worsening of abscesses and draining fistulas. Approximately twice the proportion of patients in the placebo group in the first 12 weeks of Studies HS-I and HS-II, compared with those in the Humira group experienced worsening of abscesses (23.0% vs 11.4%, respectively) and draining fistulas (30.0% vs 13.9%, respectively).

Greater improvements at Week 12 from baseline compared to placebo were demonstrated in skin-specific health-related quality of life, as measured by the Dermatology Life Quality Index (DLQI; Studies HS-I and HS-II), patient global satisfaction with medication treatment as measured by the Treatment Satisfaction Questionnaire - medication (TSQM; Studies HS-I and HS-II), and physical health as measured by the physical component summary score of the SF-36 (Study HS-I).

In patients with at least a partial response to Humira 40 mg weekly at Week 12, the HiSCR rate at Week 36 was higher in patients who continued weekly Humira than in patients in whom dosing frequency was reduced to every other week, or in whom treatment was withdrawn (see Table 17).

Table 17: Proportion of Patients^a Achieving HiSCR^b at Weeks 24 and 36 After

Treatment Reassignment from Weekly Humira at Week 12	Placebo (treatment withdrawal) N = 73	Humira 40 mg every other week N = 70	Humira 40 mg weekly N = 70
Week 24	24 (32.9%)	36 (51.4%)	40 (57.1%)
Week 36	22 (30.1%)	28 (40.0%)	39 (55.7%)
<p>^a Patients with at least a partial response to Humira 40 mg weekly after 12 weeks of treatment.</p> <p>^b Patients meeting protocol-specified criteria for loss of response or no improvement were required to discontinue from the studies and were counted as nonresponders.</p>			

Among patients who were at least partial responders at Week 12, and who received continuous weekly Humira therapy, the HiSCR rate at Week 48 was 64.3%.

Among patients whose Humira treatment was withdrawn at Week 12 in Studies HS-I and HS-II, the HiSCR rate 12 weeks after re-introduction of Humira 40 mg weekly returned to levels similar to that observed before withdrawal (56.0 %).

Crohn's disease

The safety and efficacy of Humira were assessed in over 1500 patients with moderately to severely active Crohn's disease (Crohn's Disease Activity Index (CDAI) ≥ 220 and ≤ 450) in randomised, double-blind, placebo-controlled studies. Concomitant stable doses of aminosaliclates, corticosteroids, and/or immunomodulatory agents were permitted and 80% of patients continued to receive at least one of these medications.

Induction of clinical remission (defined as CDAI < 150) was evaluated in two studies, CD Study I (CLASSIC I) and CD Study II (GAIN). In CD Study I, 299 TNF-antagonist naive patients were randomised to one of four treatment groups; placebo at Weeks 0 and 2, 160 mg Humira at Week 0 and 80 mg at Week 2, 80 mg at Week 0 and 40 mg at Week 2, and 40 mg at Week 0 and 20 mg at Week 2. In CD Study II, 325 patients who had lost response or were intolerant to infliximab were randomised to receive either 160 mg Humira at Week 0 and 80 mg at Week 2 or placebo at Weeks 0 and 2. The primary non-responders were excluded from the studies and therefore these patients were not further evaluated.

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

CD study I and CD study II induction of remission and response rates are presented in Table 18.

Table 18
Induction of Clinical Remission and Response
(Percent of Patients)

	CD Study I: Infliximab Naive Patients			CD Study II : Infliximab Experienced Patients	
	Placebo N=74	Humira 80/40 mg N=75	Humira 160/80 mg N=76	Placebo N=166	Humira 160/80 mg N=159
Week 4					
Clinical remission	12%	24%	36%*	7%	21%*
Clinical response (CR-100)	24%	37%	49%***	25%	38%***

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

* p<0.001

** p<0.01

Similar remission rates were observed for the 160/80 mg and 80/40 mg induction regimens by Week 8 and adverse events were more frequently noted in the 160/80 mg group.

In CD study III, at Week 4, 58% (499/854) patients were in clinical response and were assessed in the primary analysis. Of those in clinical response at Week 4, 48% had been previously exposed to other -TNF antagonists. Maintenance of remission and response rates are presented in Table 19. Clinical remission results remained relatively constant irrespective of previous TNF antagonist exposure.

Disease-related hospitalisation and surgeries were statistically significantly reduced with adalimumab compared with placebo at Week 56.

Table 19
Maintenance of Clinical Remission and Response
(Percent of Patients)

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

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

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

^a Of those receiving corticosteroids at baseline

Among patients who were not in response at Week 4, 43% of Humira maintenance patients responded by Week 12 compared to 30% of placebo maintenance patients. These results suggest that some patients who have not responded by Week 4 benefit from continued maintenance therapy through Week 12. Therapy continued beyond 12 Weeks did not result in significantly more responses (see section 4.2)

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

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

Quality of Life

In CD Study I and CD Study II, statistically significant improvement in the disease-specific inflammatory bowel disease questionnaire (IBDQ) total score was achieved at Week 4 in patients randomised to Humira 80/40 mg and 160/80 mg compared to placebo and was seen at Weeks 26 and 56 in CD Study III as well among the adalimumab treatment groups compared to the placebo group.

Paediatric Crohn's disease

Humira was assessed in a multicenter, randomized, double-blind clinical trial designed to evaluate the efficacy and safety of induction and maintenance treatment with doses dependent on body weight (< 40 kg or ≥ 40 kg) in 192 paediatric subjects between the ages of 6 and 17 (inclusive) years, with moderate to severe Crohn's disease (CD) defined as Paediatric Crohn's Disease Activity Index (PCDAI) score > 30. Subjects had to have failed conventional therapy (including a corticosteroid and/or an immunomodulator) for CD. Subjects may also have previously lost response or been intolerant to infliximab.

All subjects received open-label induction therapy at a dose based on their Baseline body weight: 160 mg at Week 0 and 80 mg at Week 2 for subjects ≥ 40 kg, and 80 mg and 40 mg, respectively, for subjects < 40 kg.

At Week 4, subjects were randomized 1:1 based on their body weight at the time to either the Low Dose or Standard Dose maintenance regimens as shown in Table 20.

Patient Weight	Low dose	Standard dose
< 40 kg	10 mg eow	20 mg eow
≥ 40 kg	20 mg eow	40 mg eow

Efficacy Results

The primary endpoint of the study was clinical remission at Week 26, defined as PCDAI score ≤10. Clinical remission and clinical response (defined as reduction in PCDAI score of at least 15 points from Baseline) rates are presented in Table 21. Rates of discontinuation of corticosteroids or immunomodulators are presented in Table 22.

	Standard Dose 40/20 mg eow N = 93	Low Dose 20/10 mg eow N = 95	P value*
Week 26			
Clinical remission	38.7%	28.4%	0.075
Clinical response	59.1%	48.4%	0.073
Week 52			
Clinical remission	33.3%	23.2%	0.100
Clinical response	41.9%	28.4%	0.038
* p value for Standard Dose <i>versus</i> Low Dose comparison.			

	Standard Dose 40/20 mg eow	Low Dose 20/10 mg eow	P value¹
Discontinued corticosteroids	N= 33	N=38	
Week 26	84.8%	65.8%	0.066
Week 52	69.7%	60.5%	0.420
Discontinuation of Immunomodulators²	N=60	N=57	
Week 52	30.0%	29.8%	0.983
Fistula remission³	N=15	N=21	
Week 26	46.7%	38.1%	0.608
Week 52	40.0%	23.8%	0.303

¹ p value for Standard Dose *versus* Low Dose comparison.

² Immunosuppressant therapy could only be discontinued at or after Week 26 at the investigator's discretion if the subject met the clinical response criterion

³ defined as a closure of all fistulas that were draining at Baseline for at least 2 consecutive post-Baseline visits.

Statistically significant increases (improvement) from Baseline to Week 26 and 52 in Body Mass Index and height velocity were observed for both treatment groups.

Statistically and clinically significant improvements from Baseline were also observed in both treatment groups for quality of life parameters (including IMPACT III).

Ulcerative Colitis

The safety and efficacy of multiple doses of Humira were assessed in adult patients with moderately to severely active ulcerative colitis (Mayo score 6 to 12 with endoscopy subscore of 2 to 3) in randomised, double-blind, placebo-controlled studies.

In study UC-I, 390 TNF-antagonist naïve patients were randomised to receive either placebo at Weeks 0 and 2, 160 mg Humira at Week 0 followed by 80 mg at Week 2, or 80 mg Humira at Week 0 followed by 40 mg at Week 2. After Week 2, patients in both adalimumab arms received 40 mg eow. Clinical remission (defined as Mayo score \leq 2 with no subscore $>$ 1) was assessed at Week 8.

In study UC-II, 248 patients received 160 mg of Humira at Week 0, 80 mg at Week 2 and 40 mg eow thereafter, and 246 patients received placebo. Clinical results were assessed for induction of remission at Week 8 and for maintenance of remission at Week 52.

Patients induced with 160/80 mg Humira achieved clinical remission versus placebo at Week 8 in statistically significantly greater percentages in study UC-I (18% vs. 9% respectively, p=0.031) and study UC-II (17% vs. 9% respectively, p=0.019). In study UC-II, among those treated with Humira who were in remission at Week 8, 21/41 (51%) were in remission at Week 52.

Results from the overall UC-II study population are shown in Table 23.

Table 23
Response, Remission and Mucosal Healing in Study UC-II

	(Percent of Patients)	
	Placebo	Humira 40 mg eow
Week 52	N=246	N=248
Clinical Response	18%	30%*
Clinical Remission	9%	17%*
Mucosal Healing	15%	25%*
Steroid-free remission for ≥ 90 days ^a	6%	13%*
	(N=140)	(N=150)
Week 8 and 52		
Sustained Response	12%	24%**
Sustained Remission	4%	8%*
Sustained Mucosal Healing	11%	19%*

Clinical remission is Mayo score ≤ 2 with no subscore > 1 ;

Clinical response is decrease from baseline in Mayo score ≥ 3 points and $\geq 30\%$ plus a decrease in the rectal bleeding subscore [RBS] ≥ 1 or an absolute RBS of 0 or 1;

*p<0.05 for Humira vs. placebo pairwise comparison of proportions

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

^a Of those receiving corticosteroids at baseline

Of those patients who had a response at Week 8, 47% were in response, 29% were in remission, 41% had mucosal healing, and 20% were in steroid-free remission for ≥ 90 days at Week 52.

Approximately 40% of patients in study UC-II had failed prior anti-TNF treatment with infliximab. The efficacy of adalimumab in those patients was reduced compared to that in anti-TNF naïve patients. Among patients who had failed prior anti-TNF treatment, Week 52 remission was achieved by 3% on placebo and 10% on adalimumab.

Patients from UC studies UC I and UC II had the option to roll over into an open-label long-term extension study (UC III). Following 3 years of adalimumab therapy, 75% (301/402) continued to be in clinical remission per partial Mayo score.

Hospitalisation rates

During 52 weeks of studies UC-I and UC-II, lower rates of all-cause hospitalisations and UC-related hospitalisations were observed for the adalimumab-treated arm compared to the placebo arm. The number of all cause hospitalisations in the adalimumab treatment group was 0.18 per patient year vs. 0.26 per patient year in the placebo group and the corresponding figures for UC-related hospitalisations were 0.12 per patient year vs. 0.22 per patient year.

Quality of Life

In study UC-II, treatment with adalimumab resulted in improvements in the Inflammatory Bowel Disease Questionnaire (IBDQ) score

Immunogenicity

Formation of anti-adalimumab antibodies is associated with increased clearance and reduced efficacy of adalimumab. There is no apparent correlation between the presence of anti-adalimumab antibodies and the occurrence of adverse events.

Patients in rheumatoid arthritis Studies I, II and III were tested at multiple time points for anti-adalimumab antibodies during the 6 to 12 month period. In the pivotal trials, anti-adalimumab antibodies were identified in 5.5 % (58/1053) patients treated with adalimumab, compared to 0.5% (2/370) on placebo. In patients not given concomitant methotrexate, the incidence was 12.4%, compared to 0.6% when adalimumab was used as add-on to methotrexate.

In patients with polyarticular juvenile idiopathic arthritis who were 4 to 17 years, anti adalimumab antibodies were identified in 15.8% (27/171) of patients treated with adalimumab. In patients not given concomitant methotrexate, the incidence was 25.6 (22/86), compared to 5.9% (5/85) when adalimumab was used as add-on to methotrexate. In patients with polyarticular juvenile idiopathic arthritis who were 2 to <4 years old or aged 4 and above weighing <15 kg, anti-adalimumab antibodies were identified in 7% (1/15) of patients, and the one patient was receiving concomitant methotrexate.

In patients with enthesitis-related arthritis, anti-adalimumab antibodies were identified in 10.9% (5/46) of patients treated with adalimumab. In patients not given concomitant methotrexate, the incidence was 13.6% (3/22), compared to 8.3% (2/24) when adalimumab was used as add-on to methotrexate.

In patients with psoriatic arthritis, anti-adalimumab antibodies were identified in 38/376 subjects (10%) treated with adalimumab. In patients not given concomitant methotrexate, the incidence was 13.5 % (24/178 subjects), compared to 7 % (14 of 198 subjects) when adalimumab was used as add-on to methotrexate.

In patients with ankylosing spondylitis anti-adalimumab antibodies were identified in 17/204 subjects (8.3%) treated with adalimumab. In patients not given concomitant methotrexate, the incidence was 16/185 (8.6%), compared to 1/19 (5.3%) when adalimumab was used as add-on to methotrexate.

In patients with Crohn's disease, anti-adalimumab antibodies were identified in 7/269 subjects (2.6 %) and in 19/487 subjects (3.9%) with ulcerative colitis.

In adult patients with psoriasis, anti-adalimumab antibodies were identified in 77/920 subjects (8.4%) treated with adalimumab monotherapy.

In adult plaque psoriasis patients on long term adalimumab monotherapy who participated in a withdrawal and retreatment study, the rate of antibodies to adalimumab after retreatment (11 of 482 subjects, 2.3%) was similar to the rate observed prior to withdrawal (11 of 590 subjects, 1.9%).

In patients with paediatric psoriasis, anti-adalimumab antibodies were identified in 5/38 subjects (13%) treated with 0.8mg/kg adalimumab monotherapy

In patients with moderate to severe hidradenitis suppurativa, anti-adalimumab antibodies were identified in 10/99 subjects (10.1%) treated with adalimumab.

Because immunogenicity analyses are product-specific, comparison of antibody rates with those from other products is not appropriate.

Paediatric population

The European Medicines Agency has waived the obligation to submit the results of studies with Humira in all subjects of the paediatric population in rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis, see section 4.2 for information on paediatric use.

The European Medicines Agency has deferred the obligation to submit the results of the studies with Humira in one or more subsets of the paediatric population in ulcerative colitis and hidradenitis suppurativa, see section 4.2 for information on paediatric use.

5.2 Pharmacokinetic properties

Absorption and distribution

After subcutaneous administration of a single 40 mg dose, absorption and distribution of adalimumab was slow, with peak serum concentrations being reached about 5 days after administration. The average absolute bioavailability of adalimumab estimated from three studies following a single 40 mg subcutaneous dose was 64%. After single intravenous doses ranging from 0.25 to 10 mg/kg,

concentrations were dose proportional. After doses of 0.5 mg/kg (~40 mg), clearances ranged from 11 to 15 ml/hour, the distribution volume (V_{ss}) ranged from 5 to 6 litres and the mean terminal phase half-life was approximately two weeks. Adalimumab concentrations in the synovial fluid from several rheumatoid arthritis patients ranged from 31-96% of those in serum.

Following subcutaneous administration of 40 mg of adalimumab every other week in adult rheumatoid arthritis (RA) patients the mean steady-state trough concentrations were approximately 5 µg/ml (without concomitant methotrexate) and 8 to 9 µg/ml (with concomitant methotrexate), respectively. The serum adalimumab trough levels at steady-state increased roughly proportionally with dose following 20, 40 and 80 mg subcutaneous dosing every other week and every week.

Following the administration of 24 mg/m² (up to a maximum of 40 mg) subcutaneously every other week to patients with polyarticular juvenile idiopathic arthritis (JIA) who were 4 to 17 years, the mean trough steady-state (values measured from Week 20 to 48) serum adalimumab concentration was 5.6 ± 5.6 µg/mL (102 %CV) for adalimumab without concomitant methotrexate and 10.9 ± 5.2 µg/mL (47.7% CV) with concomitant methotrexate.

In patients with polyarticular JIA who were 2 to <4 years old or aged 4 and above weighing <15 kg dosed with adalimumab 24 mg/m², the mean trough steady-state serum adalimumab concentrations was 6.0 ± 6.1 µg/ml (101% CV) for adalimumab without concomitant methotrexate and 7.9 ± 5.6 µg/ml (71.2% CV) with concomitant methotrexate.

In adult patients with psoriasis, the mean steady-state trough concentration was 5 µg/mL during adalimumab 40 mg every other week monotherapy treatment.

Following the administration of 0.8 mg/kg (up to a maximum of 40 mg) subcutaneously every other week to paediatric patients with chronic plaque psoriasis, the mean ± SD steady-state adalimumab trough concentration was approximately 7.4 ± 5.8 µg/mL (79% CV).

In patients with hidradenitis suppurativa, a dose of 160 mg Humira on Week 0 followed by 80 mg on Week 2 achieved serum adalimumab trough concentrations of approximately 7 to 8 µg/mL at Week 2 and Week 4. The mean steady-state trough concentration at Week 12 through Week 36 were approximately 8 to 10 µg/mL during adalimumab 40 mg every week treatment.

In patients with Crohn's disease, the loading dose of 80 mg Humira on Week 0 followed by 40 mg Humira on Week 2 achieves serum adalimumab trough concentrations of approximately 5.5 µg/ml during the induction period. A loading dose of 160 mg Humira on Week 0 followed by 80 mg Humira on Week 2 achieves serum adalimumab trough concentrations of approximately 12 µg/ml during the induction period. Mean steady-state trough levels of approximately 7 µg/ml were observed in Crohn's disease patients who received a maintenance dose of 40 mg Humira every other week.

In paediatric patients with moderate to severe CD, the open-label adalimumab induction dose was 160/80 mg or 80/40 mg at Weeks 0 and 2, respectively, dependent on a body weight cut-off of 40 kg. At Week 4, subjects were randomized 1:1 to either the Standard Dose (40/20 mg eow) or Low Dose (20/10 mg eow) maintenance treatment groups based on their body weight. The mean (±SD) serum adalimumab trough concentrations achieved at Week 4 were 15.7±6.6 µg/mL for subjects ≥ 40 kg (160/80 mg) and 10.6 ±6.1 µg/mL for subjects < 40 kg (80/40 mg).

For patients who stayed on their randomized therapy, the mean (±SD) adalimumab trough concentrations at Week 52 were 9.5±5.6 µg/mL for the Standard Dose group and 3.5±2.2 µg/mL for the Low Dose group. The mean trough concentrations were maintained in subjects who continued to receive adalimumab treatment eow for 52 weeks. For patients who dose escalated from eow to weekly regimen, the mean (±SD) serum concentrations of adalimumab at Week 52 were 15.3±11.4 µg/mL (40/20 mg, weekly) and 6.7±3.5 µg/mL (20/10 mg, weekly).

In patients with ulcerative colitis, a loading dose of 160 mg Humira on Week 0 followed by 80 mg Humira on Week 2 achieves serum adalimumab trough concentrations of approximately 12 µg/ml during the induction period. Mean steady-state trough levels of approximately 8 µg/ml were observed in ulcerative colitis patients who received a maintenance dose of 40 mg Humira every other week

Elimination

Population pharmacokinetic analyses with data from over 1,300 RA patients revealed a trend toward higher apparent clearance of adalimumab with increasing body weight. After adjustment for weight differences, gender and age appeared to have a minimal effect on adalimumab clearance. The serum levels of free adalimumab (not bound to anti-adalimumab antibodies, AAA) were observed to be lower in patients with measurable AAA.

Hepatic or renal impairment

Humira has not been studied in patients with hepatic or renal impairment.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on studies of single dose toxicity, repeated dose toxicity, and genotoxicity.

An embryo-foetal developmental toxicity/perinatal developmental study has been performed in cynomolgous monkeys at 0, 30 and 100 mg/kg (9-17 monkeys/group) and has revealed no evidence of harm to the fetuses due to adalimumab. Neither carcinogenicity studies, nor a standard assessment of fertility and postnatal toxicity, were performed with adalimumab due to the lack of appropriate models for an antibody with limited cross-reactivity to rodent TNF and to the development of neutralizing antibodies in rodents.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Mannitol
Citric acid monohydrate
Sodium citrate
Sodium dihydrogen phosphate dihydrate
Disodium phosphate dihydrate
Sodium chloride
Polysorbate 80
Sodium hydroxide
Water for injections.

6.2 Incompatibilities

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

6.3 Shelf life

24 months

6.4 Special precautions for storage

Pre-filled syringe:

Store in a refrigerator (2°C – 8°C). Do not freeze. Keep the syringe in the outer carton in order to protect from light. .

A single Humira pre-filled syringe may be stored at temperatures below 25°C for a period of up to 14 days. The syringe must be protected from light, and discarded if not used within the 14-day period.

Pre-filled pen:

Store in a refrigerator (2°C – 8°C). Do not freeze.

Keep the pre-filled pen in the outer carton in order to protect from light. .

A single Humira pen may be stored at temperatures below 25°C for a period of up to 14 days.

The pen must be protected from light, and discarded if not used within the 14-day period.

Humira 40 mg solution for injection glass vial:

Store in a refrigerator (2°C – 8°C). Keep the vial in the outer carton in order to protect from light. Do not freeze.

6.5 Nature and contents of container

Pre-filled syringe:

Humira 40 mg solution for injection in single-use pre-filled syringe (type I glass) with a plunger stopper (bromobutyl rubber) and a needle with a needle shield (thermoplastic elastomer) for patient use:

Packs of:

- 1 pre-filled syringe (0.8 ml sterile solution) with 1 alcohol pad in a blister.
- 2 pre-filled syringes (0.8 ml sterile solution), each with 1 alcohol pad, in a blister.
- 4 pre-filled syringes (0.8 ml sterile solution), each with 1 alcohol pad, in a blister.
- 6 pre-filled syringes (0.8 ml sterile solution), each with 1 alcohol pad, in a blister.

Not all pack sizes may be marketed.

Pre-filled pen:

Humira 40 mg solution for injection in single-use pre-filled pen for patient use containing a pre-filled syringe. The syringe inside the pen is made from type 1 glass with a plunger stopper (bromobutyl rubber) and a needle with a needle shield (thermoplastic elastomer).

Packs of:

- 1 pre-filled pen with 2 alcohol pad in a blister.
- 2 pre-filled pen, each with 1 alcohol pad, in a blister.
- 4 pre-filled pen, each with 1 alcohol pad, in a blister.
- 6 pre-filled pen, each with 1 alcohol pad, in a blister.

Not all pack sizes may be marketed.

Humira 40 mg solution for injection in single-use vial (type I glass), fitted with rubber stoppers, aluminium crimps and flip-off seals:

1 Pack of 2 boxes each containing:

1 vial (0.8 ml sterile solution), 1 empty sterile injection syringe, 1 needle, 1 vial adapter and 2 alcohol pads.

6.6 Special precautions for disposal

Humira does not contain preservatives; Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. Manufacturer:

AbbVie Ltd., Maidenhead, UK

8. MARKETING AUTHORISATION HOLDER : ABBVIE BIOPHARMACEUTICALS LTD ., ISRAEL

9. MARKETING AUTHORISATION NUMBER: 131 41 30990 00

The format of this leaflet was determined by the Ministry of Health and its content was checked and approved.