נובמבר 2020

רופא/ה נכבד/ה, רוקח/ת נכבד/ה,

הנדון: **Xolair 150mg, powder and solvent for solution for injection**
זולאייר 150 מ"ג, אבקה וממס להכנת תמיסה להזרקה

אנו מבקשים להודיע על רישום התוויה Chronic rhinosinusitis with nasal polyps (CRSwNP) לתכשיר שבנדון וכן על עדכון העלון לרופא ויצירת עלון לצרכן חדש.

התכשיר רשום בישראל להתוויות הבאות:

Allergic asthma
Xolair is indicated for patients 6 to 12 years of age with severe persistent asthma and for patients 12 years of age and older with moderate to severe persistent asthma, who have a positive skin test or *in vitro* reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. Xolair has been shown to decrease the incidence of asthma exacerbations in these patients.
Limitations of use:
Xolair is not indicated for the relief of acute bronchospasm or status asthmaticus.
Xolair is not indicated for the treatment of other allergic conditions.

Chronic rhinosinusitis with nasal polyps (CRSwNP)
Xolair is indicated as an add-on therapy with intranasal corticosteroids (INC) for the treatment of adults (18 years and above) with severe CRSwNP for whom therapy with INC does not provide adequate disease control.

Chronic spontaneous urticaria (CSU)
Xolair is indicated as add-on therapy for the treatment of chronic spontaneous urticaria in adult and adolescent (12 years and above) patients with inadequate response to H1 antihistamine treatment.

המרכיב הפעיל : Omalizumab 150mg

העלון לרופא עם סימון השינויים מצורף בעמודים הבאים. העלון לצרכן החדש מצורף גם הוא למכתב זה.

העלונים לרופא ולצרכן נשלחו למאגר התרופות שבאתר משרד הבריאות, וניתן לקבלם מודפס על-ידי פניה לבעל הרישום.

בברכה,
ילנה גיטלין
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1. NAME OF THE MEDICINAL PRODUCT

XOLAIR® 150mg
Omalizumab

Powder and solvent for solution for injection

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

One vial contains 150 mg of omalizumab*.

After reconstitution one vial contains 125 mg/ml of omalizumab (150 mg in 1.2 ml).

*Omalizumab is a humanised monoclonal antibody manufactured by recombinant DNA technology in a Chinese hamster ovary (CHO) mammalian cell line.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Powder and solvent for solution for injection.

Powder: white to off-white lyophilisate
Solvent: clear and colourless solution

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Allergic asthma

Xolair is indicated for patients 6 to 12 years of age with severe persistent asthma and for patients 12 years of age and older with moderate to severe persistent asthma, who have a positive skin test or *in vitro* reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. Xolair has been shown to decrease the incidence of asthma exacerbations in these patients.

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Xolair is not indicated for the treatment of other allergic conditions.

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Xolair is indicated as an add-on therapy with intranasal corticosteroids (INC) for the treatment of adults (18 years and above) with severe CRSwNP for whom therapy with INC does not provide adequate disease control.

Chronic spontaneous urticaria (CSU)

Xolair is indicated as add-on therapy for the treatment of chronic spontaneous urticaria in adult and adolescent (12 years and above) patients with inadequate response to H1 antihistamine treatment.

4.2 Posology and method of administration

Xolair treatment should be initiated by physicians experienced in the diagnosis and treatment of moderate to severe persistent asthma, chronic rhinosinusitis with nasal polyps (CRSwNP) or chronic spontaneous urticaria.

Posology

Allergic asthma and chronic rhinosinusitis with nasal polyps (CRSwNP)

~~*Posology*~~

Dosing for allergic asthma and CRSwNP follows the same dosing principles. The appropriate dose and frequency of Xolair for these conditions is determined by baseline IgE (IU/mL), measured before the start of treatment, and body weight (kg). Prior to administration of the initial dose, patients should have their IgE level determined by any commercial serum total IgE assay for their dose assignment.
See Table 1 for a conversion chart and the dose determination tables below (Table 2, Table 3, Table 4, Table 5, ~~and~~ Table 6, Table 7 and Table 8) for appropriate dose assignment.

Allergic asthma ~~Patients~~patients with baseline IgE lower than 76 IU/ml were less likely to experience benefit (see section 5.1). Prescribing physicians should ensure that adult and adolescent patients with IgE below 76 IU/ml and children (6 to < 12 years of age) with IgE below 200 IU/ml have unequivocal in vitro reactivity (RAST) to a perennial allergen before starting therapy.

Patients whose baseline IgE levels or body weight in kilograms are outside the limits of the dose table should not be given Xolair.

The maximum recommended dose is 600 mg omalizumab every two weeks.

Table 1: Conversion from dose to number of vials, number of injections and total injection volume for each administration

Dose (mg)	Number of vials 150 mg[b]	Number of injections	Total injection volume (ml)
75	1[a]	1	0.6
150	1	1	1.2
225	2[a]	2	1.8
300	2	2	2.4
375	3[a]	3	3.0
450	3	3	3.6
525	4[a]	4	4.2
600	4	4	4.8

[a] To make up the correct injection volume use 0.6 ml from one Xolair 150 mg vial.
[b] 1.2 ml = maximum delivered volume per vial (Xolair 150 mg).

Severe Asthma -Adults and Adolescents (12 years of age and older)

Table 2: ADMINISTRATION EVERY 4 WEEKS. Xolair doses (milligrams per dose) administered by subcutaneous injection every 4 weeks for adults and adolescents (12 Years of age and older) with Severe Asthma

	Body weight (kg)									
Baseline IgE (IU/ml)	≥20-25	>25-30	>30-40	>40-50	>50-60	>60-70	>70-80	>80-90	>90-125	>125-150
≥30-100	75	75	75	150	150	150	150	150	300	300
>100-200	150	150	150	300	300	300	300	300	450	600
>200-300	150	150	225	300	300	450	450	450	600	
>300-400	225	225	300	450	450	450	600	600		
>400-500	225	300	450	450	600	600				
>500-600	300	300	450	600	600					
>600-700	300		450	600						
>700-800										
>800-900					ADMINISTRATION EVERY 2 WEEKS SEE TABLE 3					
>900-1000										
>1000-1100										

Table 3: ADMINSTRATION EVERY 2 WEEKS. Xolair doses (milligrams per dose) administered by subcutaneous injection every 2 weeks for adults and adolescents (12 Years of age and older) with Severe Asthma

	Body weight (kg)									
Baseline IgE (IU/ml)	≥20-25	>25-30	>30-40	>40-50	>50-60	>60-70	>70-80	>80-90	>90-125	>125-150
≥30-100	ADMINISTRATION EVERY 4 WEEKS SEE TABLE 2									
>100-200										
>200-300										375
>300-400									450	525
>400-500							375	375	525	600
>500-600						375	450	450	600	
>600-700		225			375	450	450	525		

>700-800	225	225	300	375	450	450	525	600
>800-900	225	225	300	375	450	525	600	
>900-1000	225	300	375	450	525	600		
>1000-1100	225	300	375	450	600			
>1100-1200	300	300	450	525	600	Insufficient data to recommend a dose~~DO NOT ADMINISTER - data is unavailable for dose recommendation~~		
>1200-1300	300	375	450	525				
>1300-1500	300	375	525	600				

Moderate Asthma - Adults and Adolescents (12 years of age and older)

Table 4: ADMINISTRATION EVERY 4 WEEKS Xolair Doses (milligrams) Administered by Subcutaneous Injection Every 4 Weeks for Adults and Adolescents (12 Years of Age and Older) with Moderate Asthma

Pre-treatment Serum IgE **Baseline IgE (IU/ml)**	Body weight (kg)			
	30-60	> 60-70	> 70-90	> 90-150
≥30-100	150	150	150	300
> 100-200	300	300	300	
> 200-300	300	**SEE TABLE 5**		
> 300-400				
> 400-500				
> 500-600				

Table 5: ADMINISTRATION EVERY 2 WEEKS Xolair Doses (milligrams) Administered by Subcutaneous Injection Every 2 Weeks for Adults and Adolescents (12 Years of Age and Older) with Moderate Asthma

Pre-treatment Serum IgE (IU/mL) **Baseline IgE (IU/ml)**	Body weight (kg)			
	30-60	> 60-70	> 70-90	> 90-150
≥30-100	**SEE TABLE 4**			
> 100-200				225
> 200-300		225	225	300
> 300-400	225	225	300	
> 400-500	300	300	375	
> 500-600	300	375	**Insufficient Data to Recommend a Dose**	
> 600-700	375			

Severe Asthma - Pediatric patients (ages of 6 to <12 years)

Pediatric patients (ages of 6 to <12 years): Initiate dosing according to Table 6.

Table 6: Subcutaneous Xolair Doses Every 2 or 4 Weeks* for Pediatric Patients (ages of 6 to <12 years) with Severe Asthma Who Begin Xolair Treatment.

Pre-treatment Serum IgE (IU/mL)	Dosing Freq.	Body Weight									
		20-25 kg	>25-30 kg	>30-40 kg	>40-50 kg	>50-60 kg	>60-70 kg	>70-80 kg	>80-90 kg	>90-125 kg	>125-150 kg
		Dose (mg)									
30-100	Every 4 weeks	75	75	75	150	150	150	150	150	300	300
>100-200		150	150	150	300	300	300	300	300	225	300
>200-300		150	150	225	300	300	225	225	225	300	375
>300-400		225	225	300	225	225	225	300	300		
>400-500		225	300	225	225	300	300	375	375		
>500-600		300	300	225	300	300	375				
>600-700		300	225	225	300	375					
>700-800	Every 2 weeks	225	225	300	375						
>800-900		225	225	300	375						
>900-1000		225	300	375							
>1000-1100		225	300	375							
>1100-1200		300	300								
>1200-1300		300	375								

Insufficient Data to Recommend a Dose

***Dosing frequency:**

- Subcutaneous doses to be administered every 4 weeks
- Subcutaneous doses to be administered every 2 weeks

Chronic rhinosinusitis with nasal polyps (CRSwNP)

Table 7: ADMINISTRATION EVERY 4 WEEKS. Xolair doses (milligrams per dose) administered by subcutaneous injection every 4 weeks for adults (18 years and above) with severe CRSwNP

	Body weight (kg)									
Baseline IgE (IU/ml)	≥20-25*	>25-30*	>30-40	>40-50	>50-60	>60-70	>70-80	>80-90	>90-125	>125-150
≥30-100	75	75	75	150	150	150	150	150	300	300
>100-200	150	150	150	300	300	300	300	300	450	600
>200-300	150	150	225	300	300	450	450	450	600	
>300-400	225	225	300	450	450	450	600	600		
>400-500	225	300	450	450	600	600				
>500-600	300	300	450	600	600					
>600-700	300		450	600						
>700-800										
>800-900					ADMINISTRATION EVERY 2 WEEKS SEE TABLE 8					
>900-1000										
>1000-1100										

*Body weights below 30 kg were not studied in the pivotal trials for CRSwNP.

Table 8: ADMINSTRATION EVERY 2 WEEKS. Xolair doses (milligrams per dose) administered by subcutaneous injection every 2 weeks for adults (18 years and above) with severe CRSwNP

	Body weight (kg)									
Baseline IgE (IU/ml)	≥20-25*	>25-30*	>30-40	>40-50	>50-60	>60-70	>70-80	>80-90	>90-125	>125-150
≥30-100	ADMINISTRATION EVERY 4 WEEKS SEE TABLE 2									
>100-200										
>200-300										375
>300-400									450	525
>400-500							375	375	525	600
>500-600						375	450	450	600	
>600-700		225			375	450	450	525		
>700-800	225	225	300	375	450	450	525	600		
>800-900	225	225	300	375	450	525	600			
>900-1000	225	300	375	450	525	600				
>1000-1100	225	300	375	450	600					
>1100-1200	300	300	450	525	600	Insufficient data to recommend a dose				
>1200-1300	300	375	450	525						
>1300-1500	300	375	525	600						

*Body weights below 30 kg were not studied in the pivotal trials for CRSwNP.

Treatment duration, monitoring and dose adjustments

Allergic asthma

Xolair is intended for long-term treatment. Clinical trials have demonstrated that it takes at least 12-16 weeks for Xolair treatment to show effectiveness. At 16 weeks after commencing Xolair therapy patients should be assessed by their physician for treatment effectiveness before further injections are administered. The decision to continue Xolair following the 16-week time point, or on subsequent occasions, should be based on whether a marked improvement in overall asthma control is seen (see section 5.1, Physician's overall assessment of treatment effectiveness).

Chronic rhinosinusitis with nasal polyps (CRSwNP)

In clinical trials for CRSwNP, changes in nasal polyps score (NPS) and nasal congestion score (NCS) were observed at 4 weeks. The need for continued therapy should be periodically reassessed based upon the patient's disease severity and level of symptom control.

Allergic asthma and chronic rhinosinusitis with nasal polyps (CRSwNP)

Discontinuation of Xolair treatment generally results in a return to elevated free IgE levels and associated symptoms.
Total IgE levels are elevated during treatment and remain elevated for up to one year after the discontinuation of treatment. Therefore, re-testing of IgE levels during Xolair treatment cannot be used as a guide for dose determination.
Dose determination after treatment interruptions lasting less than one year should be based on serum IgE levels obtained at the initial dose determination.
Total serum IgE levels may be re-tested for dose determination if treatment with Xolair has been interrupted for one year or more.

Doses should be adjusted for significant changes in body weight (see Tables 2,3,4,5 and 65).

Chronic spontaneous urticaria (CSU)

~~*Posology*~~
The recommended dose is 300 mg by subcutaneous injection every four weeks.

Prescribers are advised to periodically reassess the need for continued therapy.

Clinical trial experience of long-term treatment beyond 6 months in this indication is limited.

Special populations
Elderly (65 years of age and older)
There are limited data available on the use of Xolair in patients older than 65 years but there is no evidence that elderly patients require a different dose from younger adult patients.

Renal or hepatic impairment
There have been no studies on the effect of impaired renal or hepatic function on the pharmacokinetics of omalizumab. Because omalizumab clearance at clinical doses is dominated by the reticular endothelial system (RES) it is unlikely to be altered by renal or hepatic impairment. While no particular dose adjustment is recommended for these patients, Xolair should be administered with caution(see section 4.4).

Paediatric population
In allergic asthma, the safety and efficacy of Xolair in patients below the age of 6 years have not been established. No data are available.

In CRSwNP, the safety and efficacy of Xolair in patients below the age of 18 years have not been established.

In CSU, the safety and efficacy of Xolair in patients below the age of 12 years have not been established.

Method of administration

For subcutaneous administration only. Xolair must not be administered by the intravenous or intramuscular route.

Doses of more than 150 mg (Table 1) should be divided across two or more injection sites.

There is limited experience with self-administration of Xolair powder and solvent for solution for injection. Therefore, treatment with this formulation is intended to be administered by a healthcare provider only.

For instructions on reconstitution of the medicinal product before administration, see section 6.6 and also information for the healthcare professional section of the package leaflet.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

General

Xolair is not indicated for the treatment of acute asthma exacerbations, acute bronchospasm or status asthmaticus.

Xolair has not been studied in patients with hyperimmunoglobulin E syndrome or allergic bronchopulmonary aspergillosis or for the prevention of anaphylactic reactions, including those provoked by food allergy, atopic dermatitis, or allergic rhinitis. Xolair is not indicated for the treatment of these conditions.

Xolair therapy has not been studied in patients with autoimmune diseases, immune complex-mediated conditions, or pre-existing renal or hepatic impairment (see section 4.2). Caution should be exercised when administering Xolair in these patient populations.

Abrupt discontinuation of systemic or inhaled corticosteroids after initiation of Xolair therapy in allergic asthma or CRSwNP is not recommended. Decreases in corticosteroids should be performed under the direct supervision of a physician and may need to be performed gradually.

Immune system disorders

Allergic reactions type I
Type I local or systemic allergic reactions, including anaphylaxis and anaphylactic shock, may occur when taking omalizumab, even after a long duration of treatment. However, most of these reactions occurred within 2 hours after the first and subsequent injections of Xolair but some started beyond 2 hours and even beyond 24 hours after the injection. The majority of anaphylactic reactions occurred within the first 3 doses of Xolair. A history of anaphylaxis unrelated to omalizumab may be a risk factor for anaphylaxis following Xolair administration. Therefore medicinal products for the treatment of anaphylactic reactions should always be available for immediate use following administration of Xolair. If an anaphylactic or other serious allergic reaction occurs, administration of Xolair must be discontinued immediately, and appropriate therapy initiated. Patients should be informed that such reactions are possible, and prompt medical attention should be sought if allergic reactions occur.

Antibodies to omalizumab have been detected in a low number of patients in clinical trials (see section 4.8). The clinical relevance of anti-Xolair antibodies is not well understood.

Serum sickness

Serum sickness and serum sickness-like reactions, which are delayed allergic type III reactions, have been seen in patients treated with humanised monoclonal antibodies including omalizumab. The suggested pathophysiologic mechanism includes immune-complex formation and deposition due to development of antibodies against omalizumab. The onset has typically been 1-5 days after administration of the first or subsequent injections, also after long duration of treatment. Symptomssuggestive of serum sickness include arthritis/arthralgias, rash (urticaria or other forms), fever and lymphadenopathy. Antihistamines and corticosteroids may be useful for preventing or treating this disorder, and patients should be advised to report any suspected symptoms.

Churg-Strauss syndrome and hypereosinophilic syndrome
Patients with severe asthma may rarely present systemic hypereosinophilic syndrome or allergic eosinophilic granulomatous vasculitis (Churg-Strauss syndrome), both of which are usually treated with systemic corticosteroids.

In rare cases, patients on therapy with anti-asthma medicinal products, including omalizumab, may present or develop systemic eosinophilia and vasculitis. These events are commonly associated with the reduction of oral corticosteroid therapy.

In these patients, physicians should be alert to the development of marked eosinophilia, vasculitic rash, worsening pulmonary symptoms, paranasal sinus abnormalities, cardiac complications, and/or neuropathy.

Discontinuation of omalizumab should be considered in all severe cases with the above mentioned immune system disorders.

Parasitic (helminth) infections
IgE may be involved in the immunological response to some helminth infections. In patients at chronic high risk of helminth infection, a placebo-controlled trial in allergic patients showed a slight increase in infection rate with omalizumab, although the course, severity, and response to treatment of infection were unaltered. The helminth infection rate in the overall clinical programme, which was not designed to detect such infections, was less than 1 in 1,000 patients. However, caution may be warranted in patients at high risk of helminth infection, in particular when travelling to areas where helminthic infections are endemic. If patients do not respond to recommended anti-helminth treatment, discontinuation of Xolair should be considered.

4.5 Interaction with other medicinal products and other forms of interaction

Since IgE may be involved in the immunological response to some helminth infections, Xolair may indirectly reduce the efficacy of medicinal products for the treatment of helminthic or other parasitic infections (see section 4.4).

Cytochrome P450 enzymes, efflux pumps and protein-binding mechanisms are not involved in the clearance of omalizumab; thus, there is little potential for drug-drug interactions. Medicinal product or vaccine interaction studies have not been performed with Xolair. There is no pharmacological reason to expect that commonly prescribed medicinal products used in the treatment of asthma, CRSwNP or CSU will interact with omalizumab.

Allergic asthma

In clinical studies Xolair was commonly used in conjunction with inhaled and oral corticosteroids, inhaled short-acting and long-acting beta agonists, leukotriene modifiers, theophyllines and oral antihistamines.

There was no indication that the safety of Xolair was altered with these other commonly used anti-asthma medicinal products. Limited data are available on the use of Xolair in combination with specific immunotherapy (hypo-sensitisation therapy). In a clinical trial where Xolair was co-administered with immunotherapy, the safety and efficacy of Xolair in combination with specific immunotherapy were found to be no different to that of Xolair alone.

Chronic rhinosinusitis with nasal polyps (CRSwNP)

In clinical studies Xolair was used in conjunction with intranasal mometasone spray as per protocol. Other commonly used concomitant medicinal products included other intranasal corticosteroids, bronchodilators, antihistamines, leukotriene receptor antagonists, adrenergics/sympathomimetics and local nasal anaesthetics. There was no indication that the safety of Xolair was altered by the concomitant use of these other commonly used medicinal products.

Chronic spontaneous urticaria (CSU)

In clinical studies in CSU, Xolair was used in conjunction with antihistamines (anti-H1, anti-H2) and leukotriene receptor antagonists (LTRAs). There was no evidence that the safety of omalizumab was altered when used with these medicinal products relative to its known safety profile in allergic asthma. In addition, a population pharmacokinetic analysis showed no relevant effect of H2 antihistamines and LTRAs on omalizumab pharmacokinetics (see section 5.2).

Paediatric population

Clinical studies in CSU included some patients aged 12 to 17 years taking Xolair in conjunction with antihistamines (anti-H1, anti-H2) and LTRAs. No studies have been performed in children under 12 years.

4.6 Fertility, pregnancy and lactation

Pregnancy

A moderate amount of data on pregnant women (between 300-1,000 pregnancy outcomes) based on pregnancy registry and post-marketing spontaneous reports, indicates no malformative or foeto/neonatal toxicity. A prospective pregnancy registry study (EXPECT) in 250 pregnant women with asthma exposed to Xolair showed the prevalence of major congenital anomalies was similar (8.1% vs. 8.9%) between EXPECT and disease-matched (moderate and severe asthma) patients. The interpretation of data may be impacted due to methodological limitations of the study, including small sample size and non-randomised design.

Omalizumab crosses the placental barrier. However, animal studies do not indicate either direct or indirect harmful effects with respect to reproductive toxicity (see section 5.3).

Omalizumab has been associated with age-dependent decreases in blood platelets in non-human primates, with a greater relative sensitivity in juvenile animals (see section 5.3).

If clinically needed, the use of Xolair may be considered during pregnancy.

Breast-feeding

Immunoglobulins G (IgGs) are present in human milk and therefore it is expected that omalizumab will be present in human milk. Available data in non-human primates have shown excretion of omalizumab into milk (see section 5.3).

The EXPECT study, with 154 infants who had been exposed to Xolair during pregnancy and through breast-feeding did not indicate adverse effects on the breast-fed infant. The interpretation of data may be impacted due to methodological limitations of the study, including small sample size and non-randomised design.

Given orally, immunoglobulin G proteins undergo intestinal proteolysis and have poor bioavailability. No effects on the breast-fed newborns/infants are anticipated. Consequently, if clinically needed, the use of Xolair may be considered during breast-feeding.

Fertility

There are no human fertility data for omalizumab. In specifically-designed non-clinical fertility studies, in non-human primates including mating studies, no impairment of male or female fertility was observed following repeated dosing with omalizumab at dose levels up to 75 mg/kg. Furthermore, no genotoxic effects were observed in a separate non-clinical genotoxicity study.

4.7 Effects on ability to drive and use machines

Xolair has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

Allergic asthma and chronic rhinosinusitis with nasal polyps (CRSwNP)

Summary of safety profile

During allergic asthma clinical trials in adult and adolescent patients 12 years of age and older, the most commonly reported adverse reactions were headaches and injection site reactions, including injection site pain, swelling, erythema, and pruritus. In clinical trials in children 6 to <12 years of age, the most commonly reported adverse reactions were headache, pyrexia and upper abdominal pain. Most of the reactions were mild or moderate in severity. In clinical trials in patients ≥18 years of age in CRSwNP, the most commonly reported adverse reactions were headache, dizziness, arthralgia, abdominal pain upper and injection site reactions.

Tabulated list of adverse reactions

Table 79 lists the adverse reactions recorded in clinical studies in the total allergic asthma and CRSwNP safety population treated with Xolair by MedDRA system organ class and frequency. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. Frequency categories are defined as: very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥1/1,000 to <1/100), rare (≥1/10,000 to <1/1,000) and very rare (<1/10,000). Reactions reported in the post-marketing setting are listed with frequency not known (cannot be estimated from the available data).

Table 79: Adverse reactions in allergic asthma and CRSwNP

Infections and infestations	
Uncommon	Pharyngitis
Rare	Parasitic infection

Blood and lymphatic system disorders	
Not known	Idiopathic thrombocytopenia, including severe cases
Immune system disorders	
Rare Not known	Anaphylactic reaction, other serious allergic conditions, anti-omalizumab antibody development Serum sickness, may include fever and lymphadenopathy
Nervous system disorders	
Common Uncommon	Headache* Syncope, paraesthesia, somnolence, dizziness#
Vascular disorders	
Uncommon	Postural hypotension, flushing
Respiratory, thoracic and mediastinal disorders	
Uncommon Rare Not known	Allergic bronchospasm, coughing Laryngoedema Allergic granulomatous vasculitis (i.e. Churg-Strauss syndrome)
Gastrointestinal disorders	
Common Uncommon	Abdominal pain upper **# Dyspeptic signs and symptoms, diarrhoea, nausea
Skin and subcutaneous tissue disorders	
Uncommon Rare Not known	Photosensitivity, urticaria, rash, pruritus Angioedema Alopecia
Musculoskeletal and connective tissue disorders	
Common Rare Not known	Arthralgia† Systemic lupus erythematosus (SLE) ~~Arthralgia, myalgia~~Myalgia, joint swelling
General disorders and administration site conditions	
Very common Common Uncommon	Pyrexia** Injection site reactions such as swelling, erythema, pain, pruritus Influenza-like illness, swelling arms, weight increase, fatigue

*: Very common in children 6 to <12 years of age
**: In children 6 to <12 years of age
#: Common in nasal polyp trials
†: Unknown in allergic asthma trials

Chronic spontaneous urticaria (CSU)

Summary of safety profile

The safety and tolerability of omalizumab were investigated with doses of 75 mg, 150 mg and 300 mg every four weeks in 975 CSU patients, 242 of whom received placebo. Overall, 733 patients were treated with omalizumab for up to 12 weeks and 490 patients for up to 24 weeks. Of those, 412 patients were treated for up to 12 weeks and 333 patients were treated for up to 24 weeks at the 300 mg dose.

Tabulated list of adverse reactions

A separate table (Table ~~8~~10) shows the adverse reactions for the CSU indication resulting from differences in dosages and treatment populations (with significantly different risk factors,

comorbidities, co-medications and ages [e.g. asthma trials included children from 6-12 years of age]).

Table ~~7~~ 8 lists the adverse reactions (events occurring in ≥1% of patients in any treatment group and ≥2% more frequently in any omalizumab treatment group than with placebo (after medical review)) reported with 300 mg in the three pooled phase III studies. The adverse reactions presented are divided into two groups: those identified in the 12-week and the 24-week treatment periods.

The adverse reactions are listed by MedDRA system organ class. Within each system organ class, the adverse reactions are ranked by frequency, with the most frequent reactions listed first. The corresponding frequency category for each adverse reaction is based on the following convention: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1000); very rare (<1/10,000) and not known (cannot be estimated from the available data).

Table ~~8~~10: Adverse reactions from the pooled CSU safety database (day 1 to week 24) at 300 mg ~~Omalizumab~~omalizumab

12-Week	**Omalizumab studies 1, 2 and 3 Pooled**		**Frequency category**
	Placebo N=242	300 mg N=412	
Infections and infestations			
Sinusitis	5 (2.1%)	20 (4.9%)	Common
Nervous system disorders			
Headache	7 (2.9%)	25 (6.1%)	Common
Musculoskeletal and connective tissue disorders			
Arthralgia	1 (0.4%)	12 (2.9%)	Common
General disorder and administration site conditions			
Injection site reaction*	2 (0.8%)	11 (2.7%)	Common
24-Week	**Omalizumab studies 1 and 3 Pooled**		**Frequency category**
	Placebo N=163	300 mg N=333	
Infections and infestations			
Upper respiratory tract infection	5 (3.1%)	19 (5.7%)	Common

* Despite not showing a 2% difference to placebo, injection site reactions were included as all cases were assessed causally related to study treatment.

Description of selected adverse reactions ~~pertinent to allergic asthma and CSU indications~~

~~No relevant data was obtained in clinical studies in CSU that would require a modification of the sections below.~~

Immune system disorders
For further information, see section 4.4.

Anaphylaxis
Anaphylactic reactions were rare in clinical trials. However, post-marketing data following a cumulative search in the safety database retrieved a total of 898 anaphylaxis cases. Based on an estimated exposure of 566,923 patient treatment years, this results in a reporting rate of approximately 0.20%.

Arterial thromboembolic events (ATE)
In controlled clinical trials and during interim analyses of an observational study, a numerical imbalance of ATE was observed. The definition of the composite endpoint ATE included stroke, transient ischaemic

attack, myocardial infarction, unstable angina, and cardiovascular death (including death from unknown cause). In the final analysis of the observational study, the rate of ATE per 1,000 patient years was 7.52 (115/15,286 patient years) for Xolair-treated patients and 5.12 (51/9,963 patient years) for control patients. In a multivariate analysis controlling for available baseline cardiovascular risk factors, the hazard ratio was 1.32 (95% confidence interval 0.91-1.91). In a separate analysis of pooled clinical trials, which included all randomised double-blind, placebo-controlled clinical trials lasting 8 or more weeks, the rate of ATE per 1,000 patient years was 2.69 (5/1,856 patient years) for Xolair-treated patients and 2.38 (4/1,680 patient years) for placebo patients (rate ratio 1.13, 95% confidence interval 0.24-5.71).

Platelets
In clinical trials few patients had platelet counts below the lower limit of the normal laboratory range. None of these changes were associated with bleeding episodes or a decrease in haemoglobin. No pattern of persistent decrease in platelet counts, as observed in non-human primates (see section 5.3), has been reported in humans (patients above 6 years of age), even though isolated cases of idiopathic thrombocytopenia, including severe cases, have been reported in the post-marketing setting.

Parasitic infections
In allergic patients at chronic high risk of helminth infection, a placebo-controlled trial showed a slight numerical increase in infection rate with omalizumab that was not statistically significant. The course, severity, and response to treatment of infections were unaltered (see section 4.4).

Systemic lupus erythematosus
Clinical trial and post-marketing cases of systemic lupus erythematosus (SLE) have been reported in patients with moderate to severe asthma and CSU. The pathogenesis of SLE is not well understood.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form https://sideeffects.health.gov.il/

4.9 Overdose

Maximum tolerated dose of Xolair has not been determined. Single intravenous doses up to 4,000 mg have been administered to patients without evidence of dose-limiting toxicities. The highest cumulative dose administered to patients was 44,000 mg over a 20-week period and this dose did not result in any untoward acute effects.

If an overdose is suspected, the patient should be monitored for any abnormal signs or symptoms. Medical treatment should be sought and instituted appropriately.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Drugs for obstructive airway diseases, other systemic drugs for obstructive airway diseases, ATC code: R03DX05

Omalizumab is a recombinant DNA-derived humanised monoclonal antibody that selectively binds to

human immunoglobulin E (IgE). The antibody is an IgG1 kappa that contains human framework regions with the complementary-determining regions of a murine parent antibody that binds to IgE.

Allergic asthma and chronic rhinosinusitis with nasal polyps (CRSwNP)

Mechanism of action
Omalizumab binds to IgE and prevents binding of IgE to FcεRI (high-affinity IgE receptor) on basophils and mast cells, thereby reducing the amount of free IgE that is available to trigger the allergic cascade. Treatment of atopic subjects with omalizumab resulted in a marked down-regulation of FcεRI receptors on basophils. Treatment with Xolair inhibits IgE-mediated inflammation, as evidenced by reduced blood and tissue eosinophils and reduced inflammatory mediators, including IL-4, IL-5, and IL-13 by innate, adaptive and non-immune cells.

Pharmacodynamic effects
Allergic asthma

The *in vitro* histamine release from basophils isolated from Xolair-treated subjects was reduced by approximately 90% following stimulation with an allergen compared to pre-treatment values.

In clinical studies in allergic asthma patients, serum free IgE levels were reduced in a dose-dependent manner within one hour following the first dose and maintained between doses. One year after discontinuation of Xolair dosing, the IgE levels had returned to pre-treatment levels with no observed rebound in IgE levels after washout of the medicinal product.

Chronic rhinosinusitis with nasal polyps (CRSwNP)
In clinical studies in patients with CRSwNP, Xolair treatment led to a reduction in serum free IgE (approx. 95%) and an increase in serum total IgE levels, to a similar extent as observed in patients with allergic asthma. Total IgE levels in serum increased due to the formation of omalizumab-IgE complexes that have a slower elimination rate compared with free IgE.

Chronic spontaneous urticaria (CSU)

Mechanism of action
Omalizumab binds to IgE and lowers free IgE levels. Subsequently, IgE receptors (FcεRI) on cells down-regulate. It is not entirely understood how this results in an improvement of CSU symptoms.

Pharmacodynamic effect
In clinical studies in CSU patients, maximum suppression of free IgE was observed 3 days after the first subcutaneous dose. After repeated dosing once every 4 weeks, pre-dose serum free IgE levels remained stable between 12 and 24 weeks of treatment. After discontinuation of Xolair, free IgE levels increased towards pre-treatment levels over a 16-week treatment-free follow-up period

Clinical efficacy and safety ~~in allergic asthma~~

Allergic asthma

Adults and adolescents ≥12 years of age
The efficacy and safety of Xolair were demonstrated in a 28-week double-blind placebo-controlled study (study 1) involving 419 severe allergic asthmatics, ages 12-79 years, who had reduced lung function

(FEV_1 40-80% predicted) and poor asthma symptom control despite receiving high dose inhaled corticosteroids and a long-acting beta2-agonist. Eligible patients had experienced multiple asthma exacerbations requiring systemic corticosteroid treatment or had been hospitalised or attended an emergency room due to a severe asthma exacerbation in the past year despite continuous treatment with high-dose inhaled corticosteroids and a long-acting beta2-agonist. Subcutaneous Xolair or placebo were administered as add-on therapy to >1,000 micrograms beclomethasone dipropionate (or equivalent) plus a long-acting beta2-agonist. Oral corticosteroid, theophylline and leukotriene-modifier maintenance therapies were allowed (22%, 27%, and 35% of patients, respectively).

The rate of asthma exacerbations requiring treatment with bursts of systemic corticosteroids was the primary endpoint. Omalizumab reduced the rate of asthma exacerbations by 19% (p = 0.153). Further evaluations which did show statistical significance (p<0.05) in favour of Xolair included reductions in severe exacerbations (where patient's lung function was reduced to below 60% of personal best and requiring systemic corticosteroids) and asthma-related emergency visits (comprised of hospitalisations, emergency room, and unscheduled doctor visits), and improvements in Physician's overall assessment of treatment effectiveness, Asthma-related Quality of Life (AQL), asthma symptoms and lung function.

In a subgroup analysis, patients with pre-treatment total IgE ≥76 IU/ml were more likely to experience clinically meaningful benefit to Xolair. In these patients in study 1 Xolair reduced the rate of asthma exacerbations by 40% (p = 0.002). In addition more patients had clinically meaningful responses in the total IgE ≥76 IU/ml population across the Xolair severe asthma programme. Table ~~8~~ 911 includes results in the study 1 population.

Table ~~9~~11: Results of study 1

	Whole study 1 population	
	Xolair N=209	Placebo N=210
Asthma exacerbations		
Rate per 28-week period	0.74	0.92
% reduction, p-value for rate ratio	19.4%, p = 0.153	
Severe asthma exacerbations		
Rate per 28-week period	0.24	0.48
% reduction, p-value for rate ratio	50.1%, p = 0.002	
Emergency visits		
Rate per 28-week period	0.24	0.43
% reduction, p-value for rate ratio	43.9%, p = 0.038	
Physician's overall assessment		
% responders*	60.5%	42.8%
p-value**	<0.001	
AQL improvement		
% of patients ≥0.5 improvement	60.8%	47.8%
p-value	0.008	

* marked improvement or complete control
** p-value for overall distribution of assessment

Study 2 assessed the efficacy and safety of Xolair in a population of 312 severe allergic asthmatics which matched the population in study 1. Treatment with Xolair in this open label study led to a 61% reduction in clinically significant asthma exacerbation rate compared to current asthma therapy alone.

Four additional large placebo-controlled supportive studies of 28 to 52 weeks duration in 1,722 adults and adolescents (studies 3, 4, 5, 6) assessed the efficacy and safety of Xolair in patients with severe persistent asthma. Most patients were inadequately controlled but were receiving less concomitant asthma therapy than patients in studies 1 or 2. Studies 3-5 used exacerbation as primary endpoint, whereas study 6 primarily evaluated inhaled corticosteroid sparing.

In studies 3, 4 and 5 patients treated with Xolair had respective reductions in asthma exacerbation rates of 37.5% ($p = 0.027$), 40.3% ($p<0.001$) and 57.6% ($p<0.001$) compared to placebo.

In study 6, significantly more severe allergic asthma patients on Xolair were able to reduce their fluticasone dose to ≤500 micrograms/day without deterioration of asthma control (60.3%) compared to the placebo group (45.8%, $p<0.05$).

Quality of life scores were measured using the Juniper Asthma-related Quality of Life Questionnaire. For all six studies there was a statistically significant improvement from baseline in quality of life scores for Xolair patients versus the placebo or control group.

Physician's overall assessment of treatment effectiveness:
Physician's overall assessment was performed in five of the above studies as a broad measure of asthma control performed by the treating physician. The physician was able to take into account PEF (peak expiratory flow), day and night time symptoms, rescue medication use, spirometry and exacerbations. In all five studies a significantly greater proportion of Xolair treated patients were judged to have achieved either a marked improvement or complete control of their asthma compared to placebo patients.

Children 6 to <12 years of age
The primary support for safety and efficacy of Xolair in the group aged 6 to <12 years comes from one randomised, double-blind, placebo-controlled, multi-centre trial (study 7).

Study 7 was a placebo-controlled trial which included a specific subgroup (n=235) of patients as defined in the present indication, who were treated with high-dose inhaled corticosteroids (≥500 μg/day fluticasone equivalent) plus long-acting beta agonist.

A clinically significant exacerbation was defined as a worsening of asthma symptoms as judged clinically by the investigator, requiring doubling of the baseline inhaled corticosteroid dose for at least 3 days and/or treatment with rescue systemic (oral or intravenous) corticosteroids for at least 3 days.

In the specific subgroup of patients on high dose inhaled corticosteroids, the omalizumab group had a statistically significantly lower rate of clinically significant asthma exacerbations than the placebo group. At 24 weeks, the difference in rates between treatment groups represented a 34% (rate ratio 0.662, $p = 0.047$) decrease relative to placebo for omalizumab patients. In the second double-blind 28- week treatment period the difference in rates between treatment groups represented a 63% (rate ratio 0.37, $p<0.001$) decrease relative to placebo for omalizumab patients.

During the 52-week double-blind treatment period (including the 24-week fixed-dose steroid phase and the 28-week steroid adjustment phase) the difference in rates between treatment groups represented a 50% (rate ratio 0.504, $p<0.001$) relative decrease in exacerbations for omalizumab patients.

The omalizumab group showed greater decreases in beta-agonist rescue medication use than the placebo group at the end of the 52-week treatment period, although the difference between treatment groups was not statistically significant. For the global evaluation of treatment effectiveness at the end of the 52-week double-blind treatment period in the subgroup of severe patients on high-dose inhaled corticosteroids plus long-acting beta agonists, the proportion of patients rated as having 'excellent' treatment effectiveness was higher, and the proportions having 'moderate' or 'poor' treatment effectiveness lower in the omalizumab group compared to the placebo group; the difference between groups was statistically significant ($p<0.001$), while there were no differences between the omalizumab and placebo groups for patients' subjective Quality of Life ratings.

Chronic rhinosinusitis with nasal polyps (CRSwNP)

The safety and efficacy of Xolair were evaluated in two randomised, double-blind, placebo-controlled trials in patients with CRSwNP (Table 11). Patients received Xolair or placebo subcutaneously every 2 or 4 weeks (see section 4.2). All patients received background intranasal mometasone therapy throughout the study. Prior sino-nasal surgery or prior systemic corticosteroid usage were not required for inclusion in the studies. Patients received Xolair or placebo for 24 weeks followed by a 4-week follow-up period. Demographics and baseline characteristics, including allergic comorbidities, are described in Table 12.

Table 12: Demographics and baseline characteristics of nasal polyp studies

Parameter	**Nasal polyp study 1 N=138**	**Nasal polyp study 2 N=127**
Mean age (years) (SD)	51.0 (13.2)	50.1 (11.9)
% Male	63.8	65.4
Patients with systemic corticosteroid use in the previous year (%)	18.8	26.0
Bilateral endoscopic nasal polyp score (NPS): mean (SD), range 0-8	6.2 (1.0)	6.3 (0.9)
Nasal congestion score (NCS): mean (SD), range 0-3	2.4 (0.6)	2.3 (0.7)
Sense of smell score: mean (SD), range 0-3	2.7 (0.7)	2.7 (0.7)
SNOT-22 total score: mean (SD), range 0-110	60.1 (17.7)	59.5 (19.3)
Blood eosinophils (cells/µl): mean (SD)	346.1 (284.1)	334.6 (187.6)
Total IgE IU/ml: mean (SD)	160.9 (139.6)	190.2 (200.5)
Asthma (%)	53.6	60.6
Mild (%)	37.8	32.5
Moderate (%)	58.1	58.4
Severe (%)	4.1	9.1
Aspirin exacerbated respiratory disease (%)	19.6	35.4
Allergic rhinitis	43.5	42.5

SD = standard deviation; SNOT-22 = Sino-Nasal Outcome Test 22 Questionnaire; IgE = Immunoglobulin E; IU = international units. For NPS, NCS, and SNOT-22 higher scores indicate greater disease severity.

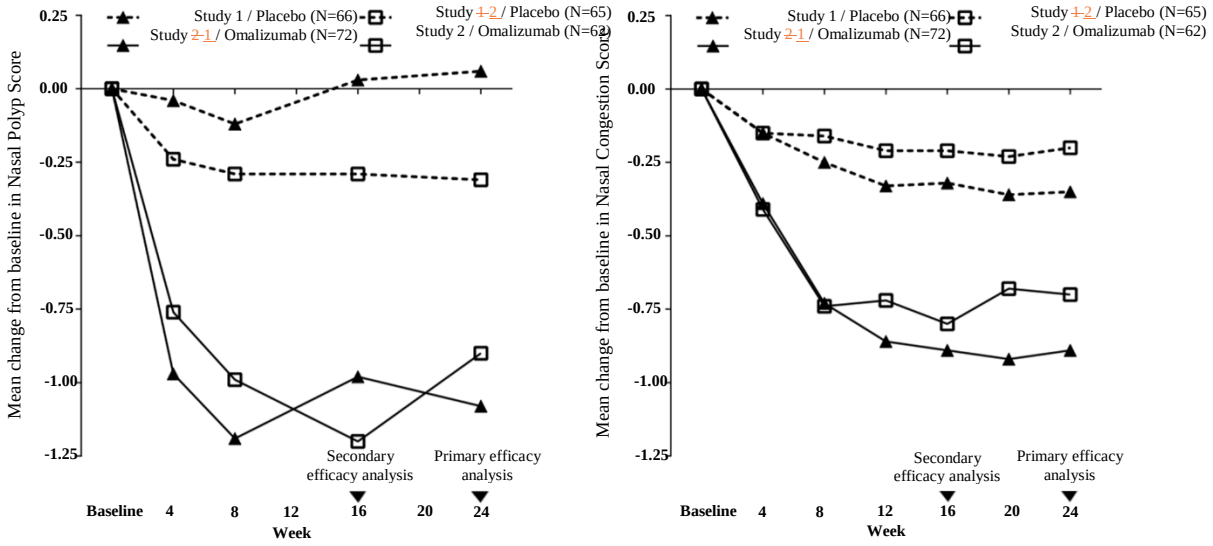
The co-primary endpoints were bilateral nasal polyps score (NPS) and average daily nasal congestion score (NCS) at Week 24. In both nasal polyp studies 1 and 2, patients who received Xolair had a statistically significant greater improvements from baseline at Week 24 in NPS and weekly average NCS than patients who received placebo. Results from nasal polyp studies 1 and 2 are shown in Table 13.

Table 13: Change from baseline at Week 24 in clinical scores from nasal polyp study 1, nasal polyp study 2, and pooled data

	Nasal polyp study 1		Nasal polyp study 2		Nasal polyp pooled results	
	Placebo	Xolair	Placebo	Xolair	Placebo	Xolair
N	66	72	65	62	131	134
Nasal polyp score						
Baseline mean	6.32	6.19	6.09	6.44	6.21	6.31
LS mean change at Week 24	0.06	-1.08	-0.31	-0.90	-0.13	-0.99
Difference (95%) CI	-1.14 (-1.59, -0.69)		-0.59 (-1.05, -0.12)		-0.86 (-1.18, -0.54)	
p-value	<0.0001		0.0140		<0.0001	
7-day average of daily nasal congestion score						
Baseline mean	2.46	2.40	2.29	2.26	2.38	2.34
LS mean change at Week 24	-0.35	-0.89	-0.20	-0.70	-0.28	-0.80
Difference (95%) CI	-0.55 (-0.84, -0.25)		-0.50 (-0.80, -0.19)		-0.52 (-0.73, -0.31)	
p-value	0.0004		0.0017		<0.0001	
TNSS						
Baseline mean	9.33	8.56	8.73	8.37	9.03	8.47
LS mean change at Week 24	-1.06	-2.97	-0.44	-2.53	-0.77	-2.75
Difference (95%)	-1.91 (-2.85, -0.96)		-2.09 (-3.00, -1.18)		-1.98 (-2.63, -1.33)	
p-value	0.0001		<0.0001		<0.0001	
SNOT-22						
Baseline mean	60.26	59.82	59.80	59.21	60.03	59.54
LS mean change at Week 24	-8.58	-24.70	-6.55	-21.59	-7.73	-23.10
Difference (95%)	-16.12 (-21.86, -10.38)		-15.04 (-21.26, -8.82)		-15.36 (-19.57, -11.16)	
p-value	<0.0001		<0.0001		<0.0001	
(MID = 8.9)						
UPSIT						
Baseline mean	13.56	12.78	13.27	12.87	13.41	12.82
LS mean change at Week 24	0.63	4.44	0.44	4.31	0.54	4.38
Difference (95%)	3.81 (1.38, 6.24)		3.86 (1.57, 6.15)		3.84 (2.17, 5.51)	
p-value	0.0024		0.0011		<0.0001	

LS=least-square; CI = confidence interval; TNSS = Total nasal symptom score; SNOT-22 = Sino-Nasal Outcome Test 22 Questionnaire; UPSIT = University of Pennsylvania Smell Identification Test; MID = minimal important difference.

Figure 1 Mean change from baseline in nasal congestion score and mean change from baseline in nasal polyp score by treatment group in nasal polyp study 1 and study 2



In a pre-specified pooled analysis of rescue treatment (systemic corticosteroids for ≥3 consecutive days or nasal polypectomy) during the 24-week treatment period, the proportion of patients requiring rescue treatment was lower in Xolair compared to placebo (2.3% versus 6.2%, respectively). The odds-ratio of having taken rescue treatment in Xolair compared to placebo was 0.38 (95% CI: 0.10, 1.49). There were no sino-nasal surgeries reported in either study.

~~Clinical efficacy and safety in chronic~~ Chronic spontaneous urticaria (CSU)

The efficacy and safety of Xolair were demonstrated in two randomised, placebo-controlled phase III studies (study 1 and 2) in patients with CSU who remained symptomatic despite H1 antihistamine therapy at the approved dose. A third study (study 3) primarily evaluated the safety of Xolair in patients with CSU who remained symptomatic despite treatment with H1 antihistamines at up to four times the approved dose and H2 antihistamine and/or LTRA treatment. The three studies enrolled 975 patients aged between 12 and 75 years (mean age 42.3 years; 39 patients 12-17 years, 54 patients ≥65 years; 259 males and 716 females). All patients were required to have inadequate symptom control, as assessed by a weekly urticaria activity score (UAS7, range 0-42) of ≥16, and a weekly itch severity score (which is a component of the UAS7; range 0-21) of ≥8 for the 7 days prior to randomisation, despite having used an antihistamine for at least 2 weeks beforehand.

In studies 1 and 2, patients had a mean weekly itch severity score of between 13.7 and 14.5 at baseline and a mean UAS7 score of 29.5 and 31.7 respectively. Patients in safety study 3 had a mean weekly itch severity score of 13.8 and a mean UAS7 score of 31.2 at baseline. Across all three studies, patients reported receiving on average 4 to 6 medications (including H1 antihistamines) for CSU symptoms prior to study enrollment. Patients received Xolair at 75 mg, 150 mg or 300 mg or placebo by subcutaneous injection every 4 weeks for 24 and 12 weeks in studies 1 and 2, respectively, and 300 mg or placebo by subcutaneous injection every 4 weeks for 24 weeks in study 3. All studies had a 16-week treatment-free follow-up period.

The primary endpoint was the change from baseline to week 12 in weekly itch severity score. Omalizumab at 300 mg reduced the weekly itch severity score by 8.55 to 9.77 (p <0.0001) compared to a reduction of 3.63 to 5.14 for placebo (see Table ~~910~~14). Statistically significant results were further observed in the responder rates for UAS7≤6 (at week 12) which were higher for the 300 mg treatment groups, ranging from 52-66% (p<0.0001) compared to 11-19% for the placebo groups, and complete response (UAS7=0) was achieved by 34-44% (p<0.0001) of patients treated with 300 mg compared to 5-9% of patients in the placebo groups. Patients in the 300 mg treatment groups achieved the highest mean proportion of angioedema-free days from week 4 to week 12, (91.0-96.1%; p<0.001) compared to the placebo groups (88.1-89.2%). Mean change from baseline to week 12 in the overall DLQI for the 300 mg treatment groups was greater (p<0.001) than for placebo showing an improvement ranging from 9.7-10.3 points compared to 5.1-6.1 points for the corresponding placebo groups.

Table ~~10~~14: Change from baseline to week 12 in weekly itch severity score, studies 1, 2 and 3 (mITT population*)

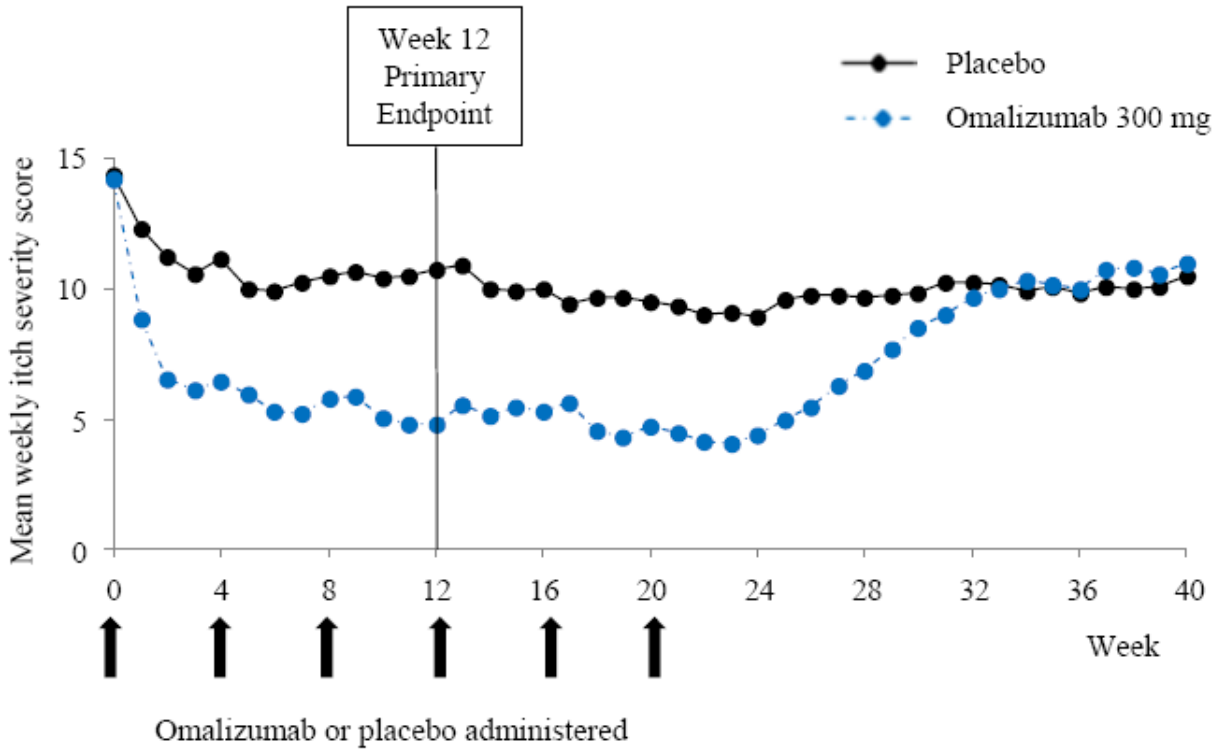
	Placebo	Omalizumab 300 mg
Study 1		
N	80	81
Mean (SD)	−3.63 (5.22)	−9.40 (5.73)
Difference in LS means vs. placebo[1]	-	−5.80
95% CI for difference	-	−7.49,−4.10
P-value vs. placebo[2]	-	<0.0001
Study 2		
N	79	79
Mean (SD)	−5.14 (5.58)	−9.77 (5.95)
Difference in LS means vs. placebo[1]	-	−4.81
95% CI for difference	-	−6.49,−3.13
P-value vs. placebo[2]	-	<0.0001
Study 3		
N	83	252
Mean (SD)	−4.01 (5.87)	−8.55 (6.01)
Difference in LS means vs. placebo[1]	-	-4.52
95% CI for difference	-	−5.97, −3.08
P-value vs. placebo[2]	-	<0.0001

*Modified intent-to-treat (mITT) population: included all patients who were randomised and received at least one dose of study medication.
BOCF (Baseline Observation Carried Forward) was used to impute missing data.
[1] The LS mean was estimated using an ANCOVA model. The strata were baseline weekly itch severity score (<13 vs. ≥13) and baseline weight (<80 kg vs. ≥80 kg).
[2] p-value is derived from ANCOVA t-test.

Figure ~~1~~2 shows the mean weekly itch severity score over time in study 1. The mean weekly itch severity scores significantly decreased with a maximum effect around week 12 that was sustained over the 24-week treatment period. The results were similar in study 3.

In all three studies the mean weekly itch severity score increased gradually during the 16-week treatment-free follow-up period, consistent with symptom re-occurrence. Mean values at the end of the follow-up period were similar to the placebo group, but lower than respective mean baseline values.

Figure ~~1~~2: Mean weekly itch severity score over time, study 1 (mITT population)



BOCF=baseline observation carried forward; mITT=modified intention-to-treat population

Efficacy after 24 weeks of treatment
The magnitude of the efficacy outcomes observed at week 24 of treatment was comparable to that observed at week 12:
For 300 mg, in studies 1 and 3, the mean decrease from baseline in weekly itch severity score was 9.8 and 8.6, the proportion of patients with UAS7≤6 was 61.7% and 55.6%, and the proportion of patients with complete response (UAS7=0) was 48.1% and 42.5%, respectively, (all p<0.0001, when compared to placebo).

There is limited clinical experience in re-treatment of patients with omalizumab.

Clinical trial data on adolescents (12 to 17 years) included a total of 39 patients, of whom 11 received the 300 mg dose. Results for the 300 mg are available for 9 patients at week 12 and 6 patients at week 24, and show a similar magnitude of response to omalizumab treatment compared to the adult population. Mean change from baseline in weekly itch severity score showed a reduction of 8.25 at week 12 and of 8.95 at week 24. The responder rates were: 33% at week 12 and 67% at week 24 for UAS7=0, and 56% at week 12 and 67% at week 24 for UAS7≤6.

5.2 Pharmacokinetic properties

The pharmacokinetics of omalizumab have been studied in adult and adolescent patients with allergic asthma as well as in adult patients with CRSwNP, and adult and adolescent patients with CSU. The general pharmacokinetic characteristics of omalizumab are similar in these patient populations.

Absorption

After subcutaneous administration, omalizumab is absorbed with an average absolute bioavailability of 62%. Following a single subcutaneous dose in adult and adolescent patients with asthma or CSU, omalizumab was absorbed slowly, reaching peak serum concentrations after an average of 6-8 days. In patients with asthma, following multiple doses of omalizumab, areas under the serum concentration-time curve from Day 0 to Day 14 at steady state were up to 6-fold of those after the first dose.

The pharmacokinetics of omalizumab are linear at doses greater than 0.5 mg/kg. Following doses of 75 mg, 150 mg or 300 mg every 4 weeks in patients with CSU, trough serum concentrations of omalizumab increased proportionally with the dose level.

Distribution

In vitro, omalizumab forms complexes of limited size with IgE. Precipitating complexes and complexes larger than one million Daltons in molecular weight are not observed *in vitro* or *in vivo*.
Based on population pharmacokinetics, distribution of omalizumab was similar in patients with allergic asthma and patients with CSU. The apparent volume of distribution in patients with asthma following subcutaneous administration was 78 ± 32 ml/kg.

Elimination

Clearance of omalizumab involves IgG clearance processes as well as clearance via specific binding and complex formation with its target ligand, IgE. Liver elimination of IgG includes degradation in the reticuloendothelial system and endothelial cells. Intact IgG is also excreted in bile. In asthma patients the omalizumab serum elimination half-life averaged 26 days, with apparent clearance averaging 2.4 ± 1.1 ml/kg/day. Doubling of body weight approximately doubled apparent clearance.
In CSU patients, based on population pharmacokinetic simulations, omalizumab serum elimination half-life at steady state averaged 24 days and apparent clearance at steady state for a patient of 80 kg weight was 3.0 ml/kg/day.

Characteristics in patient populations

Age, Race/Ethnicity, Gender, Body Mass Index
Patients with allergic asthma and chronic rhinosinusitis with nasal polyps (CRSwNP)
~~*Patients with asthma*~~
The population pharmacokinetics of omalizumab were analysed to evaluate the effects of demographic characteristics. Analyses of these limited data suggest that no dose adjustments are necessary ~~in patients with asthma~~ for age (6-76 years for patients with allergic asthma; 18 to 75 years for patients with CRSwNP), race/ethnicity, gender or body mass index (see section 4.2).

Patients with CSU
The effects of demographic characteristics and other factors on omalizumab exposure were evaluated based on population pharmacokinetics. In addition, covariate effects were evaluated by analysing the relationship between omalizumab concentrations and clinical responses.
These analyses suggest that no dose adjustments are necessary in patients with CSU for age (12-75 years), race/ethnicity, gender, body weight, body mass index, baseline IgE, anti-FcεRI autoantibodies or concomitant use of H2 antihistamines or LTRAs.

Renal and hepatic impairment

There are no pharmacokinetic or pharmacodynamic data in allergic asthma or CSU patients with renal or hepatic impairment (see sections 4.2 and 4.4).

5.3 Preclinical safety data

The safety of omalizumab has been studied in the cynomolgus monkey, since omalizumab binds to cynomolgus and human IgE with similar affinity. Antibodies to omalizumab were detected in some monkeys following repeated subcutaneous or intravenous administration. However, no apparent toxicity, such as immune complex-mediated disease or complement-dependent cytotoxicity, was seen.
There was no evidence of an anaphylactic response due to mast-cell degranulation in cynomolgus monkeys.

Chronic administration of omalizumab at dose levels of up to 250 mg/kg (at least 14 times the highest recommended clinical dose in mg/kg according to the recommended dosing table) was well tolerated in non human primates (both adult and juvenile animals), with the exception of a dose related and age-dependent decrease in blood platelets, with a greater sensitivity in juvenile animals. The serum concentration required to attain a 50% drop in platelets from baseline in adult cynomolgus monkeys was roughly 4- to 20-fold higher than anticipated maximum clinical serum concentrations. In addition, acute haemorrhage and inflammation were observed at injection sites in cynomolgus monkeys.

Formal carcinogenicity studies have not been conducted with omalizumab.

In reproduction studies in cynomolgus monkeys, subcutaneous doses up to 75 mg/kg per week (at least 8 times the highest recommended clinical dose in mg/kg over a 4 week period) did not elicit maternal toxicity, embryotoxicity or teratogenicity when administered throughout organogenesis and did not elicit adverse effects on foetal or neonatal growth when administered throughout late gestation, delivery and nursing.

Omalizumab is excreted in breast milk in cynomolgus monkeys. Milk levels of omalizumab were 0.15% of the maternal serum concentration.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Powder
Sucrose 108mg/1.2mL
L-histidine hydrochloride monohydrate
L-histidine
Polysorbate 20

Solvent
Water for injections

6.2 Incompatibilities
This medicinal product must not be mixed with other medicinal products except those mentioned in section 6.6.

6.3 Shelf life

The expiry date of the product is printed on the package materials.

After reconstitution:
The chemical and physical stability of the reconstituted medicinal product have been demonstrated for 8 hours at 2°C to 8°C.

From a microbiological point of view, the medicinal product should be used immediately after reconstitution. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 8 hours at 2°C to 8°C or 2 hours at 25°C.

6.4 Special precautions for storage

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

For storage conditions after reconstitution of the medicinal product, see section 6.3.

6.5 Nature and contents of container

Powder vial: Clear, colourless type I glass vial with a chlorobutyl rubber stopper and blue flip-off seal.

Solvent ampoule: Clear, colourless type I glass ampoule containing 2 ml water for injections.

Packs containing 1 vial of powder and 1 ampoule of water for injections, respectively.

6.6 Special precautions for disposal and other handling

Xolair 150 mg powder for solution for injection is supplied in a single-use vial.

From a microbiological point of view, the medicinal product should be used immediately after reconstitution (see section 6.3).

The lyophilised medicinal product takes 15-20 minutes to dissolve, although in some cases it may take longer. The fully reconstituted medicinal product will appear clear to slightly opalescent, colorless to pale brownish-yellow and may have a few small bubbles or foam around the edge of the vial. Because of the viscosity of the reconstituted medicinal product care must be taken to withdraw all of the medicinal product from the vial before expelling any air or excess solution from the syringe in order to obtain the 1.2 ml.

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

~~**7. Manufacturer :**~~
~~Novartis Pharma Stein AG, Stein,~~
~~Switzerland~~

~~For: Novartis Pharma AG, Basel, Switzerland.~~

~~8~~7**. Registration number:** 132 61 31124.

~~9~~8. Registration Holder and Importer:
Novartis Israel Ltd.,
P.O.B 7126, Tel Aviv

Revised in ~~August 2020~~ November 2020

INFORMATION FOR THE HEALTHCARE PROFESSIONAL

The following information is intended for healthcare professionals only:

The lyophilised medicinal product takes 15-20 minutes to dissolve, although in some cases it may take longer. The fully reconstituted medicinal product will appear clear to slightly opalescent, colourless to pale brownish-yellow and may have a few small bubbles or foam around the edge of the vial. Because of the viscosity of the reconstituted medicinal product care must be taken to withdraw all of the medicinal product from the vial before expelling any air or excess solution from the syringe in order to obtain the 1.2 ml.

To prepare Xolair 150 mg vials for subcutaneous administration, please adhere to the following instructions:

1. Draw 1.4 ml of water for injections from the ampoule into a 3 ml syringe equipped with a large-bore 18-gauge needle.

2. With the vial placed upright on a flat surface, insert the needle and transfer the water for injections into the vial containing the lyophilised powder using standard aseptic techniques, directing the water for injections directly onto the powder.

3. Keeping the vial in an upright position, vigorously swirl it (do not shake) for approximately 1 minute to evenly wet the powder.

4. To aid in dissolution after completing step 3, gently swirl the vial for 5-10 seconds approximately every 5 minutes in order to dissolve any remaining solids.

Note that in some cases it may take longer than 20 minutes for the powder to dissolve completely. If this is the case, repeat step 4 until there are no visible gel-like particles in the solution.

When the medicinal product is fully dissolved, there should be no visible gel-like particles in the solution. Small bubbles or foam around the edge of the vial are common. The reconstituted medicinal product will appear clear to lightly opalescent, colourless to pale brownish-yellow. Do not use if solid particles are present.

5. Invert the vial for at least 15 seconds in order to allow the solution to drain towards the stopper. Using a new 3-ml syringe equipped with large-bore, 18-gauge needle, insert the needle into the inverted vial. Keeping the vial inverted position the needle tip at the very bottom of the solution in the vial when drawing the solution into the syringe. Before removing the needle from the vial, pull the plunger all the way back to the end of the syringe barrel in order to remove all of the solution from the inverted vial.

6. Replace the 18-gauge needle with a 25-gauge needle for subcutaneous injection.

7. Expel air, large bubbles, and any excess solution in order to obtain the required 1.2 ml dose. A thin layer of small bubbles may remain at the top of the solution in the syringe. Because the solution is slightly viscous, it may take 5-10 seconds to administer the solution by subcutaneous injection.

The vial delivers 1.2 ml (150 mg) of Xolair. For a 75 mg dose, draw up 0.6 ml into the syringe and discard the remaining solution.

8. The injections are administered subcutaneously in the deltoid region of the arm, the lower abdomen (but not the area 5 centimetres around the navel), or the thigh.

<u>עלון לצרכן לפי תקנות הרוקחים (תכשירים) התשמ"ו- 1986</u>

התרופה משווקת על פי מרשם רופא בלבד.

<u>זולאייר® 150 מ"ג, אבקה וממס עבור תמיסה להזרקה</u>

חומר פעיל:

אומליזומאב 150 מ"ג **Omalizumab 150 mg**

חומרים בלתי פעילים ואלרגניים: ראה פרק 6 "מידע נוסף".

קרא בעיון את העלון עד סופו בטרם תשתמש בתרופה. עלון זה מכיל מידע תמציתי על התרופה. אם יש לך שאלות נוספות, פנה אל הרופא או אל הרוקח .

תרופה זו נרשמה לטיפול במחלתך. אל תעביר אותה לאחרים. היא עלולה להזיק להם אפילו אם נראה לך כי מחלתם דומה.

1. <u>למה מיועדת התרופה?</u>

אסתמה אלרגית:

זולאייר מותווית למטופלים בגילאי 12-6 שנים עם אסתמה עיקשת חמורה ובמטופלים בני 12 שנים ומעלה עם אסתמה עיקשת בינונית עד חמורה, אשר יש להם תבחין עור חיובי או תגובה מעבדתית לאלרגן נשימתי רב שנתי ואשר התסמינים שלהם אינם נשלטים כראוי עם קורטיקוסטרואידים בשאיפה. זולאייר הראתה ירידה בשכיחות של התלקחויות של אסתמה בחולים אלו.

הגבלות שימוש:

זולאייר אינה מותווית להקלה בכיווץ סימפונות חריף או בסטטוס אסתמטיקוס (התקף אסתמה שנמשך יותר מ-24 שעות).
זולאייר אינה מותווית לטיפול במצבים אלרגיים אחרים.

רינוסינוסיטיס כרונית (דלקת באף ובסינוסים) עם פוליפים באף:

זולאייר מותווית בשילוב עם קורטיקוסטרואידים הניתנים דרך האף, לטיפול במבוגרים (בני 18 שנים ומעלה) עם רינוסינוסיטיס כרונית חמורה עם פוליפים באף, שעבורם הטיפול בקורטיקוסטרואידים הניתנים דרך האף לא מביא לשליטה מספקת במחלה.

אורטיקריה כרונית ספונטנית:

זולאייר מותווית כטיפול נוסף לטיפול באורטיקריה כרונית ספונטנית במטופלים מבוגרים ובמתבגרים (בני 12 שנים ומעלה) עם תגובה לא מספקת לטיפול באנטיהיסטמין H1.

קבוצה תרפויטית: תרופות למחלות חסימתיות של דרכי הנשימה, תרופות סיסטמיות אחרות למחלות חסימתיות של דרכי הנשימה.

זולאייר פועלת על ידי חסימת חומר הנקרא אימונוגלובולין E (IgE) אשר מיוצר בגוף. IgE תורם לסוג של דלקת לה תפקיד מפתח בגרימת אסתמה אלרגית, רינוסינוסיטיס כרונית עם פוליפים באף ואורטיקריה כרונית ספונטנית.

פוליפים באף הינם בליטות קטנות על רירית האף. זולאייר מסייעת בהקטנת גודלם ומשפרת תסמינים כולל גודש באף, איבוד חוש ריח, נזלת אחורית (בצד האחורי של הגרון) ואף נוזל.

2. <u>לפני שימוש בתרופה</u>

אין להשתמש בתרופה אם:

- אתה רגיש (אלרגי) לחומר הפעיל אומליזומאב או לכל אחד מהמרכיבים הנוספים אשר מכילה

התרופה (מופיעים בפרק 6).
אם אתה חושב שאתה עלול להיות אלרגי לאחד מן המרכיבים, ספר על כך לרופא שלך מאחר ואין לתת לך זולאייר.

אזהרות מיוחדות הנוגעות לשימוש בתרופה

לפני הטיפול בזולאייר, ספר לרופא:

- אם יש לך בעיות בכליות או בכבד.
- אם יש לך הפרעה שבה מערכת החיסון שלך תוקפת חלקים מהגוף שלך (מחלה אוטואימונית).
- אם אתה מטייל לאזור שבו זיהומים הנגרמים על ידי טפילים הינם נפוצים, מאחר שזולאייר עלולה להחליש את העמידות שלך בפני זיהומים כאלו.
- אם הייתה לך בעבר תגובה אלרגית חמורה (אנפילקסיס) שנגרמה לדוגמא מתרופה, עקיצת חרקים או מזון.

זולאייר אינה מטפלת בתסמיני אסתמה חריפה, כגון התקף אסתמה פתאומי. לכן, זולאייר אינה צריכה לשמש לטיפול בתסמינים כאלו.

זולאייר אינה מיועדת למנוע או לטפל במצבים של סוגי אלרגיה אחרים, כגון תגובות אלרגיות פתאומית, תסמונת של היפר אימונוגלובולין E (תסמונת איוב, תסמונת חיסונית מולדת), אספרגילוסיס (מחלת ריאות הקשורה לפטרת), אלרגיה למזון, אקזמה או קדחת השחת, מאחר שזולאייר לא נבדקה במצבים אלו.

שים לב לסימנים של תגובות אלרגיות ותופעות לוואי רציניות אחרות
זולאייר עלולה לגרום לתופעות לוואי רציניות. עליך לשים לב לסימנים של מצבים אלה בזמן השימוש בזולאייר. יש לפנות מיד לקבלת טיפול רפואי אם אתה מבחין בסימנים המעידים על תופעות לוואי רציניות אפשריות. סימנים אלה מפורטים תחת " תופעות לוואי רציניות " בפרק 4. מרבית התגובות האלרגיות החמורות מתרחשות ב 3 המנות הראשונות של זולאייר.

ילדים ומתבגרים:
<u>אסתמה אלרגית</u>
זולאייר אינה מיועדת לילדים מתחת לגיל 6 שנים. השימוש בתרופה בילדים מתחת לגיל 6 שנים לא נבדק.

<u>רינוסינוסיטיס כרונית עם פוליפים באף</u>
זולאייר אינה מיועדת לילדים ומתבגרים מתחת לגיל 18 שנים. השימוש בתרופה במטופלים מתחת לגיל 18 שנים לא נבדק.

<u>אורטיקריה כרונית ספונטנית</u>
זולאייר אינה מיועדת לילדים מתחת לגיל 12 שנים. השימוש בתרופה בילדים בני פחות 12 שנים לא נבדק.

אינטראקציות/תגובות בין תרופתיות:

אם אתה לוקח , או אם לקחת לאחרונה, או אם אתה עשוי לקחת תרופות אחרות כולל תרופות ללא מרשם ותוספי תזונה, ספר על כך לרופא, אחות או לרוקח. במיוחד אם אתה לוקח:

- תרופות לטיפול בזיהום הנגרם על ידי טפיל, מאחר שזולאייר עלולה להפחית את ההשפעה של התרופות שלך,
- קורטיקוסטרואידים בשאיפה ותרופות אחרות לאסתמה אלרגית.

הריון, הנקה ופוריות:

אם את בהריון, חושבת שאת עשויה להיות בהריון או מתכננת להיכנס להריון, ספרי על כך לרופא שלך לפני תחילת השימוש בזולאייר. הרופא שלך ידון איתך על היתרונות ועל הסיכונים האפשריים של קבלת תרופה זו במהלך הריון.

אם תיכנסי להריון בזמן השימוש בתרופה, ספרי על כך מיד לרופא שלך.

זולאייר יכולה לעבור לחלב אם. אם את מניקה או מתכננת להניק, ספרי על כך לרופא שלך לפני השימוש בזולאייר.

נהיגה ושימוש במכונות:

לא סביר כי זולאייר תשפיע על יכולתך לנהוג ולהפעיל מכונות.

3. כיצד תשתמש בתרופה?

יש להשתמש בתכשיר תמיד בהתאם להוראות הרופא.

עליך לבדוק עם הרופא או הרוקח אם אינך בטוח בנוגע למינון ולאופן הטיפול בתכשיר.

המינון ואופן הטיפול יקבעו על ידי הרופא בלבד. המינון המקובל בדרך כלל הוא:

<u>אסתמה אלרגית וריניוסינוסיטיס כרונית עם פוליפים באף</u>

הרופא שלך יחליט מה המינון של זולאייר שאתה צריך ומה התדירות בה התרופה תינתן לך. הדבר תלוי במשקל הגוף שלך ובתוצאות בדיקות הדם למדידת רמת IgE בדם שלך שבוצעו לפני תחילת השימוש.

אתה תקבל בין אחת לארבע זריקות בכל פעם, בתדירות של פעם בשבועיים או פעם בארבעה שבועות.

יש להמשיך ליטול את התרופה הנוכחית שלך לאסתמה ו/או לרינוסינוסיטיס כרונית עם פוליפים באף במהלך הטיפול בזולאייר.אל תפסיק ליטול שום תרופה אחרת לאסתמה או לרינוסינוסיטיס כרונית עם פוליפים באף בלי לשוחח על כך עם הרופא שלך.

אתה עשוי שלא לראות שיפור מידי לאחר התחלת הטיפול בזולאייר. במטופלים עם רינוסינוסיטיס כרונית עם פוליפים באף ההשפעה נראתה לאחר 4 שבועות מתחילת הטיפול. במטופלים עם אסתמה לוקח בדרך כלל בין 12 ל 16 שבועות עד לקבלת השפעה מלאה.

<u>אורטיקריה כרונית ספונטנית</u>

אתה תקבל שתי זריקות של 150 מ״ג בכל פעם, כל ארבעה שבועות.

המשך ליטול את התרופה הנוכחית שלך לטיפול באורטיקריה כרונית ספונטנית במהלך הטיפול בזולאייר. אל תפסיק ליטול שום תרופה בלי לשוחח על כך קודם עם הרופא שלך.

שימוש בילדים ובמתבגרים

<u>אסתמה אלרגית</u>

ניתן לתת זולאייר לילדים ומתבגרים בני 6 שנים ומעלה, אשר מקבלים כבר תרופות לאסתמה, אך תסמיני האסתמה אינם נשלטים היטב על ידי תרופות כגון משאפים עם מינון גבוה של סטרואידים ומשאפים עם בטא אגוניסטים. הרופא יחשב מה המינון של זולאייר שילדך צריך ומה התדירות בה צריך לתת אותו. הדבר יהיה תלוי במשקל הגוף של ילדך ובתוצאות בדיקות הדם למדידת רמת IgE בדם שלו שבוצעו לפני תחילת השימוש.

<u>ריניוסינוסיטיס כרונית עם פוליפים באף</u>

אין לתת זולאייר לילדים ומתבגרים מתחת לגיל 18 שנים.

<u>אורטיקריה כרונית ספונטנית</u>

ניתן לתת זולאייר למתבגרים בני 12 שנים ומעלה, אשר מקבלים כבר אנטיהיסטמינים, אך תסמיני אורטיקריה כרונית ספונטנית שלהם אינם נשלטים היטב על ידי תרופות אלו. המינון למתבגרים בני 12 שנים ומעלה זהה לזה של מבוגרים.

אין לעבור על המנה המומלצת.

צורת נטילה

הוראות לגבי אופן השימוש בזולאייר מצוינות באנגלית בהמשך העלון בפרק ״מידע לצוות הרפואי״.

זולאייר תינתן לך על ידי רופא או אחות כזריקה מתחת לעור (תת עורית).

עקוב בקפדנות אחרי כל ההוראות שיינתנו לך על ידי הרופא שלך או האחות.

אם שכחת ליטול את הרופה
צור קשר עם הרופא שלך או עם המרפאה/מרכז רפואי בהקדם האפשרי כדי לקבוע לך מועד חדש.
יש להתמיד בטיפול כפי שהומלץ על ידי הרופא.

אם אתה מפסיק את נטילת התרופה

אל תפסיק את הטיפול בזולאייר אלא אם הרופא שלך אומר לך לעשות זאת. קטיעה או הפסקה של הטיפול בזולאייר עלולה לגרום לתסמינים שלך לחזור.

יחד עם זאת, אם אתה מטופל עבור אורטיקריה כרונית ספונטנית, הרופא שלך עשוי להפסיק את הטיפול בזולאייר מידי פעם כדי שניתן יהיה להעריך את התסמינים שלך. מלא אחר הוראות הרופא שלך.

אין ליטול תרופות בחושך !בדוק התווית והמנה בכל פעם שהנך נוטל תרופה .הרכב משקפיים אם הנך זקוק להם.

אם יש לך שאלות נוספות בנוגע לשימוש בתרופה, היוועץ ברופא, ברוקח או באחות .

4. <u>תופעות לוואי</u>

כמו בכל תרופה, השימוש בזולאייר עלול לגרום לתופעות לוואי בחלק מהמשתמשים. אל תיבהל למקרא רשימת תופעות הלוואי. יתכן ולא תסבול מאף אחת מהן. תופעות הלוואי הנגרמות על ידי זולאייר הן בדרך כלל קלות עד בינוניות אבל לעיתים עלולות להיות רציניות.

<u>תופעות לוואי רציניות:</u>

יש לפנות לקבלת טיפול רפואי מיד אם אתה מבחין בסימנים כלשהם של תופעות הלוואי הבאות:

תופעות לוואי נדירות (rare) -תופעות שמופיעות ב 1-10 משתמשים מתוך 10,000

- תגובות אלרגיות חמורות (כולל אנפילקסיס). תסמינים עשויים לכלול פריחה, גירוד או חרלת על העור, נפיחות של הפנים, שפתיים, לשון, תיבת הקול, קנה הנשימה או חלקים אחרים של הגוף, דפיקות לב מהירות, סחרחורת ותחושת סיחרור, בילבול, קוצר נשימה, צפצופים או קושי בנשימה, הכחלה של העור או השפתיים, התמוטטות ואבדן הכרה.

  אם יש לך עבר של תגובות אלרגיות חמורות (אנפילקסיס) אשר אינן קשורות לזולאייר, אתה עשוי להיות בסיכון רב יותר לפתח תגובה אלרגית חמורה בעקבות השימוש בזולאייר.

- זאבת אדמנתית מערכתית (SLE). תסמינים עשויים לכלול כאבי שרירים, כאבים ונפיחות במפרקים, פריחה, חום, ירידה במשקל ועייפות.

תופעות לוואי ששכיחותן אינה ידועה (תופעות ששכיחותן טרם נקבעה)

- תסמונת צ'רג שטראוס או תסמונת היפר אאוזינופילית. התסמינים עשויים לכלול אחד או יותר מהתסמינים הבאים: נפיחות, כאב או פריחה סביב כלי דם או דרכי לימפה, רמה גבוהה של תאי דם לבנים מסוג מסוים (ריבוי אאזנופילים), החרפת בעיות נשימה, גודש באף, בעיות לב, כאב, חוסר תחושה, עקצוצים בזרועות וברגליים.
- ספירת טסיות דם נמוכה עם תסמינים כגון דימום או הופעת חבורות בקלות רבה יותר מהרגיל.
- מחלת נסיוב זר. התסמינים עשויים לכלול אחד או יותר מהתסמינים הבאים: כאב מפרקים עם או ללא נפיחות או קשיון, פריחה, חום, בלוטות לימפה נפוחות, כאבי שרירים.

<u>תופעות לוואי נוספות כוללות:</u>

תופעות לוואי שכיחות מאוד (very common) - תופעות שמופיעות ביותר ממשתמש אחד מעשרה

- חום (בילדים)

תופעות לוואי שכיחות (common)- תופעות שמופיעות ב 1-10 משתמשים מתוך 100

- תגובות באזור ההזרקה כולל כאב, נפיחות, גרוד ואדמומיות
- כאב בחלק העליון של הבטן
- כאב ראש (שכיח מאוד בילדים)
- זיהומים של דרכי הנשימה העליונות, כגון דלקת של הלוע והצטננות
- תחושת לחץ או כאב בלחיים ובמצח (סינוסיטיס, כאבי ראש שמקורם בסינוסים)

- כאב מפרקים
- תחושת סחרחורת

תופעות לוואי שאינן שכיחות (uncommon) - תופעות שמופיעות ב 1-10 משתמשים מתוך 1,000

- תחושת ישנוניות או עייפות
- עקצוץ או חוסר תחושה של בידיים או כפות הרגליים
- עילפון, לחץ דם נמוך בזמן ישיבה או עמידה (תת לחץ דם בעמידה), הסמקה
- כאב גרון, שיעול, בעיות נשימה חריפות
- בחילה, שלשול, קלקול קיבה
- גרוד, חרלת, פריחה, רגישות מוגברת של העור לשמש
- עליה במשקל
- תסמינים דמויי שפעת
- זרועות נפוחות

תופעות לוואי נדירות (rare) תופעות שמופיעות ב 1-10 משתמשים מתוך 10,000

- זיהום טפילי

תופעות לוואי ששכיחותן אינה ידועה (תופעות ששכיחותן טרם נקבעה)

- כאבי שרירים ונפיחות מפרקים
- נשירת שיער

אם הופיעה תופעת לוואי, אם אחת מתופעות הלוואי מחמירה, או כאשר אתה סובל מתופעת לוואי שלא צוינה בעלון, עליך להתייעץ עם הרופא.

ניתן לדווח על תופעות לוואי למשרד הבריאות באמצעות לחיצה על הקישור" דיווח על תופעות לוואי עקב טיפול תרופתי " שנמצא בדף הבית של אתר משרד הבריאות (www.health.gov.il) המפנה לטופס המקוון לדיווח על תופעות לוואי, או ע"י כניסה לקישור: https://sideeffects.health.gov.il/

5. איך לאחסן את התרופה?

- מנע הרעלה! תרופה זו וכל תרופה אחרת יש לשמור במקום סגור מחוץ להישג ידם וטווח ראייתם של ילדים ו/או תינוקות ועל ידי כך תמנע הרעלה. אל תגרום להקאה ללא הוראה מפורשת מהרופא.
- אין להשתמש בתרופה אחרי תאריך התפוגה (exp. date) המופיע על גבי האריזה. תאריך התפוגה מתייחס ליום האחרון של אותו חודש.
- **תנאי אחסון:**
  אחסן בקירור (2°C-8° C). אין להקפיא.
- תנאי אחסון לאחר שחזור על ידי הצוות המטפל: בקירור (2°C-8° C) עד 8 שעות.

6. מידע נוסף

נוסף על המרכיב הפעיל התרופה מכילה גם:
בקבוקון עם אבקה:

Sucrose, L-Histidine HCl monohydrate, L-Histidine, Polysorbate 20.

אמפולה עם ממס:

Water for injection

כיצד נראית התרופה ומה תוכן האריזה:

אבקה: אבקה בצבע לבן עד קרמי ארוזה בבקבוקון זכוכית.
ממס: נוזל שקוף ללא צבע (מים להזרקה) באמפולת זכוכית בנפח 2 מ״ל.
האבקה משוחזרת במים לפני שהיא מוזרקת על ידי רופא או אחות.
התמיסה המשוחזרת מכילה אומליזומאב 125 מ״ג/מ״ל (150 מ״ג ב 1.2 מ״ל).
התמיסה המשוחזרת הינה בצבע שקוף עד חום-צהוב חיוור, צלולה עד מעט חלבית.
כל אריזה מכילה בקבוקון אחד עם אבקה ואמפולה אחת של ממס.

שם בעל הרישום והיבואן וכתובתו: נוברטיס ישראל בע״מ, ת.ד. 7126, תל אביב.

מספר רישום התרופה בפנקס התרופות הממלכתי במשרד הבריאות: 132-61-31124

לשם הפשטות ולהקלת הקריאה, עלון זה נוסח בלשון זכר. על אף זאת, התרופה מיועדת לבני שני המינים.

נערך בנובמבר 2020

מידע לצוות הרפואי
INFORMATION FOR THE HEALTHCARE PROFESSIONAL

The following information is intended for healthcare professionals only:

The lyophilised medicinal product takes 15-20 minutes to dissolve, although in some cases it may take longer. The fully reconstituted medicinal product will appear clear to slightly opalescent, colourless to pale brownish-yellow and may have a few small bubbles or foam around the edge of the vial. Because of the viscosity of the reconstituted medicinal product care must be taken to withdraw all of the medicinal product from the vial before expelling any air or excess solution from the syringe in order to obtain the 1.2 ml.

To prepare Xolair 150 mg vials for subcutaneous administration, please adhere to the following instructions:

1. Draw 1.4 ml of water for injections from the ampoule into a 3 ml syringe equipped with a large-bore 18-gauge needle.

2. With the vial placed upright on a flat surface, insert the needle and transfer the water for injections into the vial containing the lyophilised powder using standard aseptic techniques, directing the water for injections directly onto the powder.

3. Keeping the vial in an upright position, vigorously swirl it (do not shake) for approximately 1 minute to evenly wet the powder.

4. To aid in dissolution after completing step 3, gently swirl the vial for 5-10 seconds approximately every 5 minutes in order to dissolve any remaining solids.

   Note that in some cases it may take longer than 20 minutes for the powder to dissolve completely. If this is the case, repeat step 4 until there are no visible gel-like particles in the solution.

When the medicinal product is fully dissolved, there should be no visible gel-like particles in the solution. Small bubbles or foam around the edge of the vial are common. The reconstituted medicinal product will appear clear to lightly opalescent, colourless to pale brownish-yellow. Do not use if solid particles are present.

5. Invert the vial for at least 15 seconds in order to allow the solution to drain towards the stopper.Using a new 3-ml syringe equipped with large-bore, 18-gauge needle, insert the needle into the inverted vial. Keeping the vial inverted position the needle tip at the very bottom of the solution in the vial when drawing the solution into the syringe. Before removing the needle from the vial, pull the plunger all the way back to the end of the syringe barrel in order to remove all of the solution from the inverted vial.

6. Replace the 18-gauge needle with a 25-gauge needle for subcutaneous injection.

7. Expel air, large bubbles, and any excess solution in order to obtain the required 1.2 ml dose. A thin layer of small bubbles may remain at the top of the solution in the syringe. Because the solution is slightly viscous, it may take 5-10 seconds to administer the solution by subcutaneous injection.

   The vial delivers 1.2 ml (150 mg) of Xolair. For a 75 mg dose, draw up 0.6 ml into the syringe and discard the remaining solution.

8. The injections are administered subcutaneously in the deltoid region of the arm, the lower abdomen (but not the area 5 centimetre$_S$ around the navel), or the thigh.