

FORTEO**teriparatide 250 mcg/ml****Solution for subcutaneous injection****FULL PRESCRIBING INFORMATION****WARNING: POTENTIAL RISK OF OSTEOSARCOMA**

In male and female rats, teriparatide caused an increase in the incidence of osteosarcoma (a malignant bone tumor) that was dependent on dose and treatment duration. The effect was observed at systemic exposures to teriparatide ranging from 3 to 60 times the exposure in humans given a 20-mcg dose. Because of the uncertain relevance of the rat osteosarcoma finding to humans, prescribe FORTEO® only for patients for whom the potential benefits are considered to outweigh the potential risk. FORTEO should not be prescribed for patients who are at increased baseline risk for osteosarcoma (including those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, pediatric and young adult patients with open epiphyses, or prior external beam or implant radiation therapy involving the skeleton) [see *Warnings and Precautions (5.1), Adverse Reactions (6.2), and Nonclinical Toxicology (13.1)*].

1 INDICATIONS AND USAGE**1.1 Treatment of Postmenopausal Women with Osteoporosis at High Risk for Fracture**

FORTEO is indicated for the treatment of postmenopausal women with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. In postmenopausal women with osteoporosis, FORTEO increases BMD reduces the risk of vertebral and nonvertebral fractures [see *Clinical Studies (14.1)*].

1.2 Increase of Bone Mass in Men with Primary or Hypogonadal Osteoporosis at High Risk for Fracture

FORTEO is indicated to increase bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy [see *Clinical Studies (14.2)*].

1.3 Treatment of Men and Women with Glucocorticoid-Induced Osteoporosis at High Risk for Fracture

FORTEO is indicated for the treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5 mg or greater of prednisone) at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy [see *Clinical Studies (14.3)*].

2 DOSAGE AND ADMINISTRATION**2.1 Treatment of Postmenopausal Women with Osteoporosis at High Risk for Fracture**

The recommended dose is 20 mcg subcutaneously once a day.

2.2 Increase of Bone Mass in Men with Primary or Hypogonadal Osteoporosis at High Risk for Fracture

The recommended dose is 20 mcg subcutaneously once a day.

2.3 Treatment of Men and Women with Glucocorticoid-Induced Osteoporosis at High Risk for Fracture

The recommended dose is 20 mcg subcutaneously once a day.

2.4 Administration

- FORTEO should be administered as a subcutaneous injection into the thigh or abdominal wall. There are no data available on the safety or efficacy of intravenous or intramuscular injection of FORTEO.
- FORTEO should be administered initially under circumstances in which the patient can sit or lie down if symptoms of orthostatic hypotension occur [see *Warnings and Precautions (5.7)*].
- Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit. FORTEO is a clear and colorless liquid. Do not use if solid particles appear or if the solution is cloudy or colored.
- Patients and caregivers who administer FORTEO should receive appropriate training and instruction on the proper use of the FORTEO delivery device from a qualified health professional.

2.5 Treatment Duration

The safety and efficacy of FORTEO have not been evaluated beyond 2 years of treatment. Consequently, use of the drug for more than 2 years during a patient's lifetime is not recommended.

3 DOSAGE FORMS AND STRENGTHS

Multi-dose prefilled delivery device (pen) for subcutaneous injection containing 28 daily doses of 20 mcg.

4 CONTRAINDICATIONS

Do not use FORTEO in patients with:

- Hypersensitivity to teriparatide or to any of its excipients. Reactions have included angioedema and anaphylaxis [*see Adverse Reactions (6.2)*].

5 WARNINGS AND PRECAUTIONS

5.1 Osteosarcoma

In male and female rats, teriparatide caused an increase in the incidence of osteosarcoma (a malignant bone tumor) that was dependent on dose and treatment duration [*see Boxed Warning and Nonclinical Toxicology (13.1)*]. FORTEO should not be prescribed for patients at increased baseline risk of osteosarcoma.

These include:

- Paget's disease of bone. Unexplained elevations of alkaline phosphatase may indicate Paget's disease of bone.
- Pediatric and young adult patients with open epiphyses.
- Prior external beam or implant radiation therapy involving the skeleton.

5.2 Treatment Duration

The safety and efficacy of FORTEO have not been evaluated beyond 2 years of treatment. Consequently, use of the drug for more than 2 years during a patients' lifetime is not recommended.

5.3 Bone Metastases and Skeletal Malignancies

Patients with bone metastases or a history of skeletal malignancies should not be treated with FORTEO.

5.4 Metabolic Bone Diseases

Patients with metabolic bone diseases other than osteoporosis should not be treated with FORTEO.

5.5 Hypercalcemia and Hypercalcemic Disorders

FORTEO has not been studied in patients with pre-existing hypercalcemia. These patients should not be treated with FORTEO because of the possibility of exacerbating hypercalcemia. Patients known to have an underlying hypercalcemic disorder, such as primary hyperparathyroidism, should not be treated with FORTEO.

5.6 Urolithiasis or Pre-existing Hypercalciuria

In clinical trials, the frequency of urolithiasis was similar in patients treated with FORTEO and placebo. However, FORTEO has not been studied in patients with active urolithiasis. If active urolithiasis or pre-existing hypercalciuria are suspected, measurement of urinary calcium excretion should be considered. FORTEO should be used with caution in patients with active or recent urolithiasis because of the potential to exacerbate this condition.

5.7 Orthostatic Hypotension

FORTEO should be administered initially under circumstances in which the patient can sit or lie down if symptoms of orthostatic hypotension occur. In short-term clinical pharmacology studies with teriparatide, transient episodes of symptomatic orthostatic hypotension were observed in 5% of patients. Typically, an event began within 4 hours of dosing and spontaneously resolved within a few minutes to a few hours. When transient orthostatic hypotension occurred, it happened within the first several doses, it was relieved by placing the person in a reclining position, and it did not preclude continued treatment.

5.8 Drug Interactions

Hypercalcemia may predispose patients to digitalis toxicity. Because FORTEO transiently increases serum calcium, patients receiving digoxin should use FORTEO with caution [*see Drug Interactions (7.1) and Clinical Pharmacology (12.3)*].

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice.

Treatment of Osteoporosis in Men and Postmenopausal Women

The safety of FORTEO in the treatment of osteoporosis in men and postmenopausal women was assessed in two randomized, double-blind, placebo-controlled trials of 1,382 patients (21% men, 79% women) aged 28 to 86 years (mean 67 years). The median durations of the trials were 11 months for men and 19 months for women, with 691 patients exposed to FORTEO and 691 patients to placebo. All patients received 1,000 mg of calcium plus at least 400 IU of vitamin D supplementation per day. The incidence of all cause mortality was 1% in the FORTEO group and 1% in the placebo group. The incidence of serious adverse events was 16% in FORTEO patients and 19% in placebo patients. Early discontinuation due to adverse events occurred in 7% of FORTEO patients and 6% of placebo patients.

Table 1 lists adverse events from the two principal osteoporosis trials in men and postmenopausal women that occurred in $\geq 2\%$ of FORTEO-treated and more frequently than placebo-treated patients.

Table 1. Percentage of Patients with Adverse Events Reported by at Least 2% of FORTEO-Treated Patients and in More FORTEO-Treated Patients than Placebo-Treated Patients from the Two Principal Osteoporosis Trials in Women and Men
Adverse Events are Shown Without Attribution of Causality

Event Classification	FORTEO N=691 (%)	Placebo N=691 (%)
Body as a Whole		
Pain	21.3	20.5
Headache	7.5	7.4
Asthenia	8.7	6.8
Neck pain	3.0	2.7
Cardiovascular		
Hypertension	7.1	6.8
Angina pectoris	2.5	1.6
Syncope	2.6	1.4
Digestive System		
Nausea	8.5	6.7
Constipation	5.4	4.5
Diarrhea	5.1	4.6
Dyspepsia	5.2	4.1
Vomiting	3.0	2.3
Gastrointestinal disorder	2.3	2.0
Tooth disorder	2.0	1.3
Musculoskeletal		
Arthralgia	10.1	8.4
Leg cramps	2.6	1.3
Nervous System		
Dizziness	8.0	5.4
Depression	4.1	2.7
Insomnia	4.3	3.6
Vertigo	3.8	2.7
Respiratory System		
Rhinitis	9.6	8.8
Cough increased	6.4	5.5
Pharyngitis	5.5	4.8
Dyspnea	3.6	2.6
Pneumonia	3.9	3.3
Skin and Appendages		
Rash	4.9	4.5
Sweating	2.2	1.7

Immunogenicity — In the clinical trial, antibodies that cross-reacted with teriparatide were detected in 3% of women (15/541) receiving FORTEO. Generally, antibodies were first detected following 12 months of treatment and diminished after withdrawal of therapy. There was no evidence of hypersensitivity reactions or allergic reactions among these patients. Antibody formation did not appear to have effects on serum calcium, or on bone mineral density (BMD) response.

Laboratory Findings

Serum Calcium — FORTEO transiently increased serum calcium, with the maximal effect observed at approximately 4 to 6 hours post-dose. Serum calcium measured at least 16 hours post-dose was not different from pretreatment levels. In clinical trials, the frequency of at least 1 episode of transient hypercalcemia in the 4 to 6 hours after FORTEO administration was increased from 2% of women and none of the men treated with placebo to 11% of women and 6% of men treated with FORTEO. The number of patients treated with FORTEO whose transient hypercalcemia was verified on consecutive measurements was 3% of women and 1% of men.

Urinary Calcium — FORTEO increased urinary calcium excretion, but the frequency of hypercalciuria in clinical trials was similar for patients treated with FORTEO and placebo [see *Clinical Pharmacology* (12.2)].

Serum Uric Acid — FORTEO increased serum uric acid concentrations. In clinical trials, 3% of FORTEO patients had serum uric acid concentrations above the upper limit of normal compared with 1% of placebo patients. However, the hyperuricemia did not result in an increase in gout, arthralgia, or urolithiasis.

Renal Function — No clinically important adverse renal effects were observed in clinical studies. Assessments included creatinine clearance; measurements of blood urea nitrogen (BUN), creatinine, and electrolytes in serum; urine specific gravity and pH; and examination of urine sediment.

Studies in Men and Women with Glucocorticoid-Induced Osteoporosis

The safety of FORTEO in the treatment of men and women with glucocorticoid-induced osteoporosis was assessed in a randomized, double-blind, active-controlled trial of 428 patients (19% men, 81% women) aged 22 to 89 years (mean 57 years) treated with ≥ 5 mg per day prednisone or equivalent for a minimum of 3 months. The duration of the trial was 18 months with 214 patients exposed to FORTEO and 214 patients exposed to oral daily bisphosphonate (active control). All patients received 1,000 mg of calcium plus 800 IU of vitamin D supplementation per day.

The incidence of all cause mortality was 4% in the FORTEO group and 6% in the active control group. The incidence of serious adverse events was 21% in FORTEO patients and 18% in active control patients, and included pneumonia (3% FORTEO, 1% active control). Early discontinuation because of adverse events occurred in 15% of FORTEO patients and 12% of active control patients, and included dizziness (2% FORTEO, 0% active control).

Adverse events reported at a higher incidence in the FORTEO group and with at least a 2% difference in FORTEO-treated patients compared with active control-treated patients were: nausea (14%, 7%), gastritis (7%, 3%), pneumonia (6%, 3%), dyspnea (6%, 3%), insomnia (5%, 1%), anxiety (4%, 1%), and herpes zoster (3%, 1%), respectively.

6.2 Postmarketing Experience

The following adverse reactions have been identified during postapproval use of FORTEO. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

- Osteosarcoma: Cases of bone tumor and osteosarcoma have been reported rarely in the postmarketing period. The causality to FORTEO use is unclear. Long term osteosarcoma surveillance studies are ongoing [see *Warnings and Precautions* (5.1)]
- Hypercalcemia: Hypercalcemia greater than 13.0 mg/dL has been reported with FORTEO use.

Adverse events reported since market introduction that were temporally (but not necessarily causally) related to FORTEO therapy include the following:

- Allergic Reactions: Anaphylactic reactions, drug hypersensitivity, angioedema, urticaria
- Investigations: Hyperuricemia
- Respiratory System: Acute dyspnea, chest pain
- Musculoskeletal: Muscle spasms of the leg or back
- Other: Injection site reactions including injection site pain, swelling and bruising; oro-facial edema

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorization 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>

7 DRUG INTERACTIONS

7.1 Digoxin

A single FORTEO dose did not alter the effect of digoxin on the systolic time interval (from electrocardiographic Q-wave onset to aortic valve closure, a measure of digoxin's calcium-mediated cardiac effect). However, because FORTEO may transiently increase serum calcium, FORTEO should be used with caution in patients taking digoxin [see *Warnings and Precaution (5.8) and Clinical Pharmacology (12.3)*].

7.2 Hydrochlorothiazide

The coadministration of hydrochlorothiazide 25 mg with teriparatide did not affect the serum calcium response to teriparatide 40 mcg. The effect of coadministration of a higher dose of hydrochlorothiazide with teriparatide on serum calcium levels has not been studied [see *Clinical Pharmacology (12.3)*].

7.3 Furosemide

Coadministration of intravenous furosemide (20 to 100 mg) with teriparatide 40 mcg in healthy people and patients with mild, moderate, or severe renal impairment (CrCl 13 to 72 mL/min) resulted in small increases in the serum calcium (2%) and 24-hour urine calcium (37%) responses to teriparatide that did not appear to be clinically important [see *Clinical Pharmacology (12.3)*].

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

There are no available data on FORTEO use in pregnant women to evaluate for drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. Consider discontinuing FORTEO when pregnancy is recognized.

In animal reproduction studies, teriparatide increased skeletal deviations and variations in mouse offspring at subcutaneous doses equivalent to more than 60 times the recommended 20 mcg human daily dose (based on body surface area, mcg/m²), and produced mild growth retardation and reduced motor activity in rat offspring at subcutaneous doses equivalent to more than 120 times the human dose.

The background risk of major birth defects and miscarriage for the indicated population is unknown. The background risk in the US general population of major birth defects is 2% to 4% and of miscarriage is 15% to 20% of clinically recognized pregnancies.

Data

Animal Data

In animal reproduction studies, pregnant mice received teriparatide during organogenesis at subcutaneous doses equivalent to 8 to 267 times the human dose (based on body surface area, mcg/m²). At subcutaneous doses ≥ 60 times the human dose, the fetuses showed an increased incidence of skeletal deviations or variations (interrupted rib, extra vertebra or rib). When pregnant rats received teriparatide during organogenesis at subcutaneous doses 16 to 540 times the human dose, the fetuses showed no abnormal findings.

In a perinatal/postnatal study in pregnant rats dosed subcutaneously from organogenesis through lactation, mild growth retardation was observed in female offspring at doses ≥ 120 times the human dose. Mild growth retardation in male offspring and reduced motor activity in both male and female offspring were observed at maternal doses of 540 times the human dose. There were no developmental or reproductive effects in mice or rats at doses 8 or 16 times the human dose, respectively.

8.2 Lactation

Risk Summary

It is not known whether teriparatide is excreted in human milk, affects human milk production, or has effects on the breastfed infant.

Because of the potential for osteosarcoma shown with teriparatide in animal studies, advise patients that breastfeeding is not recommended during treatment with FORTEO [see *Warnings and Precautions (5.1)*].

8.4 Pediatric Use

The safety and efficacy of FORTEO have not been established in any pediatric population. FORTEO should not be prescribed in patients at an increased baseline risk of osteosarcoma which include pediatric and young adult patients with open epiphyses. Therefore, FORTEO is not indicated for use in pediatric or young adult patients with open epiphyses [see *Warnings and Precautions (5.1)*].

8.5 Geriatric Use

receptors with the same affinity and have the same physiological actions on bone and kidney. Teriparatide is not expected to accumulate in bone or other tissues.

The skeletal effects of teriparatide depend upon the pattern of systemic exposure. Once-daily administration of teriparatide stimulates new bone formation on trabecular and cortical (periosteal and/or endosteal) bone surfaces by preferential stimulation of osteoblastic activity over osteoclastic activity. In monkey studies, teriparatide improved trabecular microarchitecture and increased bone mass and strength by stimulating new bone formation in both cancellous and cortical bone. In humans, the anabolic effects of teriparatide manifest as an increase in skeletal mass, an increase in markers of bone formation and resorption, and an increase in bone strength. By contrast, continuous excess of endogenous PTH, as occurs in hyperparathyroidism, may be detrimental to the skeleton because bone resorption may be stimulated more than bone formation.

12.2 Pharmacodynamics

Pharmacodynamics in Men and Postmenopausal Women with Osteoporosis

Effects on Mineral Metabolism — Teriparatide affects calcium and phosphorus metabolism in a pattern consistent with the known actions of endogenous PTH (e.g., increases serum calcium and decreases serum phosphorus).

Serum Calcium Concentrations — When teriparatide 20 mcg is administered once daily, the serum calcium concentration increases transiently, beginning approximately 2 hours after dosing and reaching a maximum concentration between 4 and 6 hours (median increase, 0.4 mg/dL). The serum calcium concentration begins to decline approximately 6 hours after dosing and returns to baseline by 16 to 24 hours after each dose.

In a clinical study of postmenopausal women with osteoporosis, the median peak serum calcium concentration measured 4 to 6 hours after dosing with FORTEO (teriparatide 20 mcg) was 2.42 mmol/L (9.68 mg/dL) at 12 months. The peak serum calcium remained below 2.76 mmol/L (11.0 mg/dL) in >99% of women at each visit. Sustained hypercalcemia was not observed.

In this study, 11.1% of women treated with FORTEO had at least 1 serum calcium value above the upper limit of normal [2.64 mmol/L (10.6 mg/dL)] compared with 1.5% of women treated with placebo. The percentage of women treated with FORTEO whose serum calcium was above the upper limit of normal on consecutive 4- to 6-hour post-dose measurements was 3.0% compared with 0.2% of women treated with placebo. In these women, calcium supplements and/or FORTEO doses were reduced. The timing of these dose reductions was at the discretion of the investigator. FORTEO dose adjustments were made at varying intervals after the first observation of increased serum calcium (median 21 weeks). During these intervals, there was no evidence of progressive increases in serum calcium.

In a clinical study of men with either primary or hypogonadal osteoporosis, the effects on serum calcium were similar to those observed in postmenopausal women. The median peak serum calcium concentration measured 4 to 6 hours after dosing with FORTEO was 2.35 mmol/L (9.44 mg/dL) at 12 months. The peak serum calcium remained below 2.76 mmol/L (11.0 mg/dL) in 98% of men at each visit. Sustained hypercalcemia was not observed.

In this study, 6.0% of men treated with FORTEO daily had at least 1 serum calcium value above the upper limit of normal [2.64 mmol/L (10.6 mg/dL)] compared with none of the men treated with placebo. The percentage of men treated with FORTEO whose serum calcium was above the upper limit of normal on consecutive measurements was 1.3% (2 men) compared with none of the men treated with placebo. Although calcium supplements and/or FORTEO doses could have been reduced in these men, only calcium supplementation was reduced [*see Warnings and Precautions (5.5) and Adverse Reactions (6.1)*].

In a clinical study of women previously treated for 18 to 39 months with raloxifene (n=26) or alendronate (n=33), mean serum calcium >12 hours after FORTEO injection was increased by 0.09 to 0.14 mmol/L (0.36 to 0.56 mg/dL), after 1 to 6 months of FORTEO treatment compared with baseline. Of the women pretreated with raloxifene, 3 (11.5%) had a serum calcium >2.76 mmol/L (11.0 mg/dL), and of those pretreated with alendronate, 3 (9.1%) had a serum calcium >2.76 mmol/L (11.0 mg/dL). The highest serum calcium reported was 3.12 mmol/L (12.5 mg/dL). None of the women had symptoms of hypercalcemia. There were no placebo controls in this study.

In the study of patients with glucocorticoid-induced osteoporosis, the effects of FORTEO on serum calcium were similar to those observed in postmenopausal women with osteoporosis not taking glucocorticoids.

Urinary Calcium Excretion — In a clinical study of postmenopausal women with osteoporosis who received 1,000 mg of supplemental calcium and at least 400 IU of vitamin D, daily FORTEO increased urinary calcium excretion. The median urinary excretion of calcium was 4.8 mmol/day (190 mg/day) at 6 months and 4.2 mmol/day (170 mg/day) at 12 months. These levels were 0.76 mmol/day (30 mg/day) and 0.3 mmol/day (12 mg/day) higher, respectively, than in women treated with placebo. The incidence of hypercalciuria (>7.5 mmol Ca/day or 300 mg/day) was similar in the women treated with FORTEO or placebo.

In a clinical study of men with either primary or hypogonadal osteoporosis who received 1,000 mg of supplemental calcium and at least 400 IU of vitamin D, daily FORTEO had inconsistent effects on urinary calcium excretion. The median urinary excretion of calcium was 5.6 mmol/day (220 mg/day) at 1 month and 5.3 mmol/day (210 mg/day) at 6 months. These levels

were 0.5 mmol/day (20 mg/day) higher and 0.2 mmol/day (8.0 mg/day) lower, respectively, than in men treated with placebo. The incidence of hypercalciuria (>7.5 mmol Ca/day or 300 mg/day) was similar in the men treated with FORTEO or placebo. *Phosphorus and Vitamin D* — In single-dose studies, teriparatide produced transient phosphaturia and mild transient reductions in serum phosphorus concentration. However, hypophosphatemia (<0.74 mmol/L or 2.4 mg/dL) was not observed in clinical trials with FORTEO.

In clinical trials of daily FORTEO, the median serum concentration of 1,25-dihydroxyvitamin D was increased at 12 months by 19% in women and 14% in men, compared with baseline. In the placebo group, this concentration decreased by 2% in women and increased by 5% in men. The median serum 25-hydroxyvitamin D concentration at 12 months was decreased by 19% in women and 10% in men compared with baseline. In the placebo group, this concentration was unchanged in women and increased by 1% in men.

In the study of patients with glucocorticoid-induced osteoporosis, the effects of FORTEO on serum phosphorus were similar to those observed in postmenopausal women with osteoporosis not taking glucocorticoids.

Effects on Markers of Bone Turnover — Daily administration of FORTEO to men and postmenopausal women with osteoporosis in clinical studies stimulated bone formation, as shown by increases in the formation markers serum bone-specific alkaline phosphatase (BSAP) and procollagen I carboxy-terminal propeptide (PICP). Data on biochemical markers of bone turnover were available for the first 12 months of treatment. Peak concentrations of PICP at 1 month of treatment were approximately 41% above baseline, followed by a decline to near-baseline values by 12 months. BSAP concentrations increased by 1 month of treatment and continued to rise more slowly from 6 through 12 months. The maximum increases of BSAP were 45% above baseline in women and 23% in men. After discontinuation of therapy, BSAP concentrations returned toward baseline. The increases in formation markers were accompanied by secondary increases in the markers of bone resorption: urinary N-telopeptide (NTX) and urinary deoxypyridinoline (DPD), consistent with the physiological coupling of bone formation and resorption in skeletal remodeling. Changes in BSAP, NTX, and DPD were lower in men than in women, possibly because of lower systemic exposure to teriparatide in men.

In the study of patients with glucocorticoid-induced osteoporosis, the effects of FORTEO on serum markers of bone turnover were similar to those observed in postmenopausal women with osteoporosis not taking glucocorticoids.

12.3 Pharmacokinetics

Absorption — Teriparatide is absorbed after subcutaneous injection; the absolute bioavailability is approximately 95% based on pooled data from 20-, 40-, and 80- mcg doses. The rates of absorption and elimination are rapid. The peptide reaches peak serum concentrations about 30 minutes after subcutaneous injection of a 20-mcg dose and declines to non-quantifiable concentrations within 3 hours.

Distribution — Systemic clearance of teriparatide (approximately 62 L/hr in women and 94 L/hr in men) exceeds the rate of normal liver plasma flow, consistent with both hepatic and extra-hepatic clearance. Volume of distribution, following intravenous injection, is approximately 0.12 L/kg. Intersubject variability in systemic clearance and volume of distribution is 25% to 50%. The half-life of teriparatide in serum is 5 minutes when administered by intravenous injection and approximately 1 hour when administered by subcutaneous injection. The longer half-life following subcutaneous administration reflects the time required for absorption from the injection site.

Metabolism and Excretion — No metabolism or excretion studies have been performed with teriparatide. However, the mechanisms of metabolism and elimination of PTH(1-34) and intact PTH have been extensively described in published literature. Peripheral metabolism of PTH is believed to occur by non-specific enzymatic mechanisms in the liver followed by excretion via the kidneys.

Pediatric Patients — Pharmacokinetic data in pediatric patients are not available [see *Warnings and Precautions (5.1)*].

Geriatric Patients — No age-related differences in teriparatide pharmacokinetics were detected (range 31 to 85 years).

Gender — Although systemic exposure to teriparatide was approximately 20% to 30% lower in men than women, the recommended dose for both genders is 20 mcg/day.

Race — The populations included in the pharmacokinetic analyses were 98.5% Caucasian. The influence of race has not been determined.

Renal Impairment — No pharmacokinetic differences were identified in 11 patients with mild or moderate renal impairment [creatinine clearance (CrCl) 30 to 72 mL/min] administered a single dose of teriparatide. In 5 patients with severe renal impairment (CrCl<30 mL/min), the AUC and T_{1/2} of teriparatide were increased by 73% and 77%, respectively. Maximum serum concentration of teriparatide was not increased. No studies have been performed in patients undergoing dialysis for chronic renal failure [see *Use in Specific Populations (8.7)*].

Hepatic Impairment — No studies have been performed in patients with hepatic impairment. Non-specific proteolytic enzymes in the liver (possibly Kupffer cells) cleave PTH(1-34) and PTH(1-84) into fragments that are cleared from the circulation mainly by the kidney [see *Use in Specific Populations (8.6)*].

Drug Interactions

Digoxin — In a study of 15 healthy people administered digoxin daily to steady state, a single FORTEO dose did not alter the effect of digoxin on the systolic time interval (from electrocardiographic Q-wave onset to aortic valve closure, a measure of

digoxin's calcium-mediated cardiac effect). However, sporadic case reports have suggested that hypercalcemia may predispose patients to digitalis toxicity. Because FORTEO may transiently increase serum calcium, FORTEO should be used with caution in patients taking digoxin [see *Drug Interactions (7.1)*].

Hydrochlorothiazide — In a study of 20 healthy people, the coadministration of hydrochlorothiazide 25 mg with teriparatide did not affect the serum calcium response to teriparatide 40 mcg. The 24-hour urine excretion of calcium was reduced by a clinically unimportant amount (15%). The effect of coadministration of a higher dose of hydrochlorothiazide with teriparatide on serum calcium levels has not been studied [see *Drug Interactions (7.2)*].

Furosemide — In a study of 9 healthy people and 17 patients with mild, moderate, or severe renal impairment (CrCl 13 to 72 mL/min), coadministration of intravenous furosemide (20 to 100 mg) with teriparatide 40 mcg resulted in small increases in the serum calcium (2%) and 24-hour urine calcium (37%) responses to teriparatide that did not appear to be clinically important [see *Drug Interactions (7.3)*].

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis — Two carcinogenicity bioassays were conducted in Fischer 344 rats. In the first study, male and female rats were given daily subcutaneous teriparatide injections of 5, 30, or 75 mcg/kg/day for 24 months from 2 months of age. These doses resulted in systemic exposures that were, respectively, 3, 20, and 60 times higher than the systemic exposure observed in humans following a subcutaneous dose of 20 mcg (based on AUC comparison). Teriparatide treatment resulted in a marked dose-related increase in the incidence of osteosarcoma, a rare malignant bone tumor, in both male and female rats. Osteosarcomas were observed at all doses and the incidence reached 40% to 50% in the high-dose groups. Teriparatide also caused a dose-related increase in osteoblastoma and osteoma in both sexes. No osteosarcomas, osteoblastomas or osteomas were observed in untreated control rats. The bone tumors in rats occurred in association with a large increase in bone mass and focal osteoblast hyperplasia.

The second 2-year study was carried out in order to determine the effect of treatment duration and animal age on the development of bone tumors. Female rats were treated for different periods between 2 and 26 months of age with subcutaneous doses of 5 and 30 mcg/kg (equivalent to 3 and 20 times the human exposure at the 20-mcg dose, based on AUC comparison). The study showed that the occurrence of osteosarcoma, osteoblastoma and osteoma was dependent upon dose and duration of exposure. Bone tumors were observed when immature 2-month old rats were treated with 30 mcg/kg/day for 24 months or with 5 or 30 mcg/kg/day for 6 months. Bone tumors were also observed when mature 6-month old rats were treated with 30 mcg/kg/day for 6 or 20 months. Tumors were not detected when mature 6-month old rats were treated with 5 mcg/kg/day for 6 or 20 months. The results did not demonstrate a difference in susceptibility to bone tumor formation, associated with teriparatide treatment, between mature and immature rats.

The relevance of these animal findings to humans is uncertain.

Mutagenesis — Teriparatide was not genotoxic in any of the following test systems: the Ames test for bacterial mutagenesis; the mouse lymphoma assay for mammalian cell mutation; the chromosomal aberration assay in Chinese hamster ovary cells, with and without metabolic activation; and the in vivo micronucleus test in mice.

Impairment of Fertility — No effects on fertility were observed in male and female rats given subcutaneous teriparatide doses of 30, 100, or 300 mcg/kg/day prior to mating and in females continuing through gestation Day 6 (16 to 160 times the human dose of 20 mcg based on surface area, mcg/m²).

13.2 Animal Toxicology

In single-dose rodent studies using subcutaneous injection of teriparatide, no mortality was seen in rats given doses of 1,000 mcg/kg (540 times the human dose based on surface area, mcg/m²) or in mice given 10,000 mcg/kg (2,700 times the human dose based on surface area, mcg/m²).

In a long-term study, skeletally mature ovariectomized female monkeys (N=30 per treatment group) were given either daily subcutaneous teriparatide injections of 5 mcg/kg or vehicle. Following the 18-month treatment period, the monkeys were removed from teriparatide treatment and were observed for an additional 3 years. The 5 mcg/kg dose resulted in systemic exposures that were approximately 6 times higher than the systemic exposure observed in humans following a subcutaneous dose of 20 mcg (based on AUC comparison). Bone tumors were not detected by radiographic or histologic evaluation in any monkey in the study.

14 CLINICAL STUDIES

14.1 Treatment of Osteoporosis in Postmenopausal Women

The safety and efficacy of once-daily FORTEO, median exposure of 19 months, were examined in a double-blind, multicenter, placebo-controlled clinical study of 1,637 postmenopausal women with osteoporosis (FORTEO 20 mcg, n=541). All women received 1,000 mg of calcium and at least 400 IU of vitamin D per day. Baseline and endpoint spinal radiographs were evaluated using the semiquantitative scoring. Ninety percent of the women in the study had 1 or more radiographically diagnosed vertebral fractures at baseline. The primary efficacy endpoint was the occurrence of new radiographically

diagnosed vertebral fractures defined as changes in the height of previously undeformed vertebrae. Such fractures are not necessarily symptomatic.

Effect on Fracture Incidence

New Vertebral Fractures — FORTEO, when taken with calcium and vitamin D and compared with calcium and vitamin D alone, reduced the risk of 1 or more new vertebral fractures from 14.3% of women in the placebo group to 5.0% in the FORTEO group. This difference was statistically significant ($p < 0.001$); the absolute reduction in risk was 9.3% and the relative reduction was 65%. FORTEO was effective in reducing the risk for vertebral fractures regardless of age, baseline rate of bone turnover, or baseline BMD (see Table 2).

Table 2. Effect of FORTEO on Risk of Vertebral Fractures in Postmenopausal Women with Osteoporosis

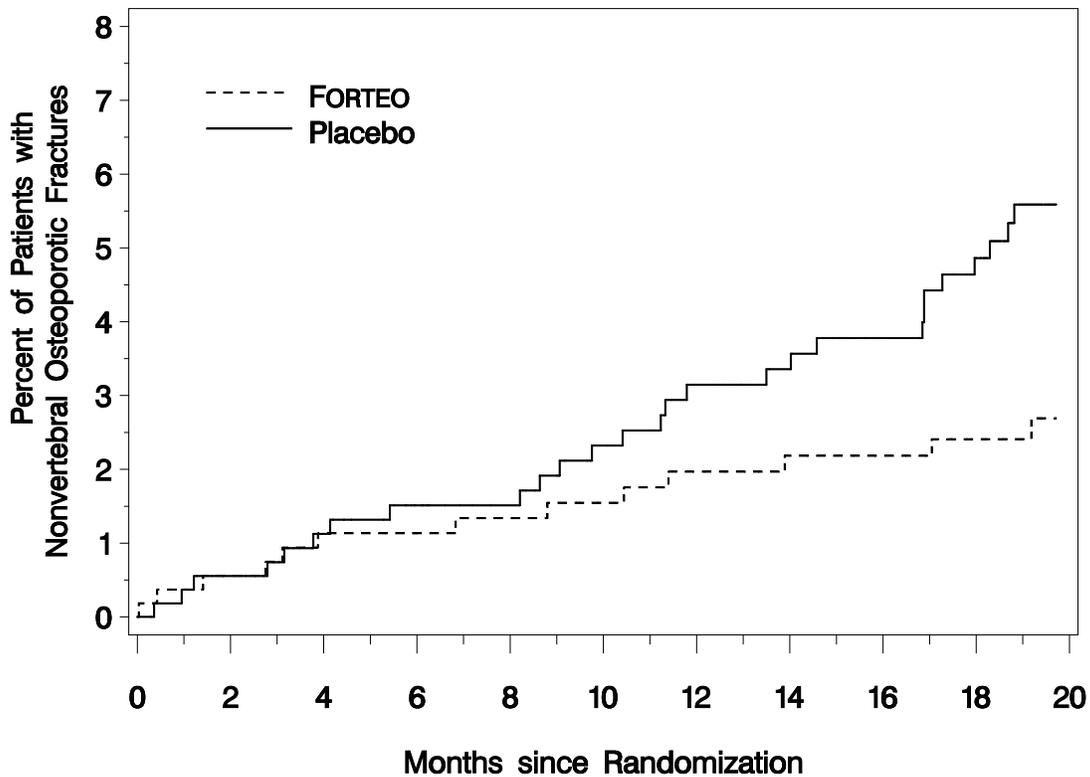
	Percent of Women With Fracture			
	FORTEO (N=444)	Placebo (N=448)	Absolute Risk Reduction (%, 95% CI)	Relative Risk Reduction (%, 95% CI)
New fracture (≥ 1)	5.0 ^a	14.3	9.3 (5.5-13.1)	65 (45-78)
1 fracture	3.8	9.4		
2 fractures	0.9	2.9		
≥ 3 fractures	0.2	2.0		

^a $p \leq 0.001$ compared with placebo.

New Nonvertebral Osteoporotic Fractures — FORTEO significantly reduced the risk of any nonvertebral fracture from 5.5% in the placebo group to 2.6% in the FORTEO group ($p < 0.05$). The absolute reduction in risk was 2.9% and the relative reduction was 53%. The incidence of new nonvertebral fractures in the FORTEO group compared with the placebo group was ankle/foot (0.2%, 0.7%), hip (0.2%, 0.7%), humerus (0.4%, 0.4%), pelvis (0%, 0.6%), ribs (0.6%, 0.9%), wrist (0.4%, 1.3%), and other sites (1.1%, 1.5%), respectively.

The cumulative percentage of postmenopausal women with osteoporosis who sustained new nonvertebral fractures was lower in women treated with FORTEO than in women treated with placebo (see Figure 1).

Figure 1. Cumulative Percentage of Postmenopausal Women with Osteoporosis Sustaining New Nonvertebral Osteoporotic Fractures



Effect on Bone Mineral Density (BMD)

FORTEO increased lumbar spine BMD in postmenopausal women with osteoporosis. Statistically significant increases were seen at 3 months and continued throughout the treatment period. Postmenopausal women with osteoporosis who were treated with FORTEO had statistically significant increases in BMD from baseline to endpoint at the lumbar spine, femoral neck, total hip, and total body (see Table 3).

Table 3. Mean Percent Change in BMD from Baseline to Endpoint^a in Postmenopausal Women with Osteoporosis, Treated with FORTEO or Placebo for a Median of 19 Months

	FORTEO N=541	Placebo N=544
Lumbar spine BMD	9.7 ^b	1.1
Femoral neck BMD	2.8 ^c	-0.7
Total hip BMD	2.6 ^c	-1.0
Trochanter BMD	3.5 ^c	-0.2
Intertrochanter BMD	2.6 ^c	-1.3
Ward's triangle BMD	4.2 ^c	-0.8
Total body BMD	0.6 ^c	-0.5
Distal 1/3 radius BMD	-2.1	-1.3
Ultradistal radius BMD	-0.1	-1.6

^a Intent-to-treat analysis, last observation carried forward.

^b p<0.001 compared with placebo.

^c p<0.05 compared with placebo.

FORTEO treatment increased lumbar spine BMD from baseline in 96% of postmenopausal women treated. Seventy-two percent of patients treated with FORTEO achieved at least a 5% increase in spine BMD, and 44% gained 10% or more.

Both treatment groups lost height during the trial. The mean decreases were 3.61 and 2.81 mm in the placebo and FORTEO groups, respectively.

Bone Histology

The effects of teriparatide on bone histology were evaluated in iliac crest biopsies of 35 postmenopausal women treated for 12 to 24 months with calcium and vitamin D and teriparatide 20 or 40 mcg/day. Normal mineralization was observed with no evidence of cellular toxicity. The new bone formed with teriparatide was of normal quality (as evidenced by the absence of woven bone and marrow fibrosis).

14.2 Treatment to Increase Bone Mass in Men with Primary or Hypogonadal Osteoporosis

The safety and efficacy of once-daily FORTEO, median exposure of 10 months, were examined in a double-blind, multicenter, placebo-controlled clinical study of 437 men with either primary (idiopathic) or hypogonadal osteoporosis (FORTEO 20 mcg, n=151). All men received 1000 mg of calcium and at least 400 IU of vitamin D per day. The primary efficacy endpoint was change in lumbar spine BMD.

FORTEO increased lumbar spine BMD in men with primary or hypogonadal osteoporosis. Statistically significant increases were seen at 3 months and continued throughout the treatment period. FORTEO was effective in increasing lumbar spine BMD regardless of age, baseline rate of bone turnover, and baseline BMD. The effects of FORTEO at additional skeletal sites are shown in Table 4.

FORTEO treatment for a median of 10 months increased lumbar spine BMD from baseline in 94% of men treated.

Fifty-three percent of patients treated with FORTEO achieved at least a 5% increase in spine BMD, and 14% gained 10% or more.

Table 4. Mean Percent Change in BMD from Baseline to Endpoint^a in Men with Primary or Hypogonadal Osteoporosis, Treated with FORTEO or Placebo for a Median of 10 Months

	FORTEO N=151	Placebo N=147
Lumbar spine BMD	5.9 ^b	0.5
Femoral neck BMD	1.5 ^c	0.3
Total hip BMD	1.2	0.5
Trochanter BMD	1.3	1.1
Intertrochanter BMD	1.2	0.6
Ward's triangle BMD	2.8	1.1
Total body BMD	0.4	-0.4
Distal 1/3 radius BMD	-0.5	-0.2
Ultradistal radius BMD	-0.5	-0.3

^a Intent-to-treat analysis, last observation carried forward.

^b p<0.001 compared with placebo.

^c p<0.05 compared with placebo.

14.3 Treatment of Men and Women with Glucocorticoid-Induced Osteoporosis

The efficacy of FORTEO for treating glucocorticoid-induced osteoporosis was assessed in a randomized, double-blind, active-controlled trial of 428 patients (19% men, 81% women) aged 22 to 89 years (mean 57 years) treated with ≥ 5 mg/day prednisone or equivalent for a minimum of 3 months. The duration of the trial was 18 months with 214 patients exposed to FORTEO. In the FORTEO group, the baseline median glucocorticoid dose was 7.5 mg/day and the median duration of glucocorticoid use was 1.5 years. The mean (SD) baseline lumbar spine BMD was 0.85 ± 0.13 g/cm² and lumbar spine BMD T-score was -2.5 ± 1 (number of standard deviations below the mean BMD value for healthy adults). A total of 30% of patients had prevalent vertebral fracture(s) and 43% had prior non-vertebral fracture(s). The patients had chronic rheumatologic, respiratory or other diseases that required sustained glucocorticoid therapy. All patients received 1,000 mg of calcium plus 800 IU of vitamin D supplementation per day.

Because of differences in mechanism of action (anabolic vs. anti-resorptive) and lack of clarity regarding differences in BMD as an adequate predictor of fracture efficacy, data on the active comparator are not presented.

Effect on Bone Mineral Density (BMD)

In patients with glucocorticoid-induced osteoporosis, FORTEO increased lumbar spine BMD compared with baseline at 3 months through 18 months of treatment. In patients treated with FORTEO, the mean percent change in BMD from baseline to endpoint was 7.2% at the lumbar spine, 3.6% at the total hip, and 3.7% at the femoral neck (p<0.001 all sites). The relative treatment effects of FORTEO were consistent in subgroups defined by gender, age, geographic region, body mass index, underlying disease, prevalent vertebral fracture, baseline glucocorticoid dose, prior bisphosphonate use, and glucocorticoid discontinuation during trial.

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

The FORTEO delivery device (pen) is available in the following package size:

- 2.4 mL prefilled delivery device.

16.2 Storage and Handling

- The FORTEO delivery device should be stored under refrigeration at 2° to 8°C at all times.
- Recap the delivery device when not in use to protect the cartridge from physical damage and light.
- During the use period, time out of the refrigerator should be minimized; the dose may be delivered immediately following removal from the refrigerator.
- Do not freeze. Do not use FORTEO if it has been frozen.

Manufacturer

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License Holder

Eli Lilly Israel Ltd., 4 HaSheizaf St., P.O.Box 4246, Ra'anana 4366411

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