

## **1. NAME OF THE MEDICINAL PRODUCT**

XGEVA® 120 mg solution for injection

## **2. QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each vial contains 120 mg of denosumab in 1.7 ml of solution (70 mg/ml).

Denosumab is a human monoclonal IgG2 antibody produced in a mammalian cell line (Chinese hamster ovary cells) by recombinant DNA technology.

### Excipients with known effects:

Each 1.7 ml of solution contains 78 mg sorbitol (E420).

For a full list of excipients, see section 6.1.

## **3. PHARMACEUTICAL FORM**

Solution for injection (injection).

Clear, colourless to slightly yellow solution and may contain trace amounts of translucent to white proteinaceous particles.

## **4. CLINICAL PARTICULARS**

### **4.1 Therapeutic indications**

Prevention of skeletal related events (pathological fracture, radiation to bone, spinal cord compression or surgery to bone) in patients with multiple myeloma and in patients with bone metastases from solid tumours.

Treatment of adults and skeletally mature adolescents with giant cell tumour of bone that is unresectable or where surgical resection is likely to result in severe morbidity.

### **4.2 Posology and method of administration**

XGEVA should be administered under the responsibility of a healthcare professional.

#### Posology

Supplementation of at least 500 mg calcium and 400 IU vitamin D is required in all patients, unless hypercalcaemia is present (see section 4.4).

*Skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumours*

The recommended dose of XGEVA is 120 mg administered as a single subcutaneous injection once every 4 weeks into the thigh, abdomen or upper arm.

#### *Giant cell tumour of the bone*

The recommended dose of XGEVA is 120 mg administered as a subcutaneous injection once every 4 weeks into the thigh, abdomen or upper arm, with additional 120 mg doses on days 8 and 15 of treatment of the first month of therapy.

#### *Renal impairment*

No dose adjustment is required in patients with renal impairment (see section 4.4 for recommendations relating to monitoring of calcium, 4.8 and 5.2).

In clinical studies of patients without advanced cancer with varying degrees of renal function (including severe renal impairment [creatinine clearance < 30 ml/min] or receiving dialysis) there was a greater risk of developing hypocalcaemia with increasing degree of renal impairment and in the absence of calcium supplementation. Monitoring calcium levels and adequate intake of calcium and vitamin D is important in patients with severe renal impairment or receiving dialysis (see section 4.4).

#### *Hepatic impairment*

The safety and efficacy of denosumab have not been studied in patients with hepatic impairment (see section 5.2).

#### *Elderly patients (age $\geq 65$ )*

No dose adjustment is required in elderly patients (see section 5.2).

#### *Paediatric population*

The safety and efficacy of XGEVA have not been established in paediatric patients (age < 18) other than skeletally mature adolescents (aged 13 – 17 years) with giant cell tumour of bone.

XGEVA is not recommended for use in paediatric patients other than skeletally mature adolescents (aged 13 – 17 years) with giant cell tumour of bone (see section 4.4).

XGEVA was studied in a phase II open-label trial that enrolled a subset of 28 paediatric patients (aged 13 – 17 years) with giant cell tumour of bone who had reached skeletal maturity defined by at least 1 mature long bone (e.g., closed epiphyseal growth plate of the humerus) and body weight  $\geq 45$  kg. In animal studies, inhibition of RANK/RANK ligand (RANKL) with a construct of osteoprotegerin bound to Fc (OPG-Fc) has been coupled to inhibition of bone growth and lack of tooth eruption (see section 5.3). Therefore, treatment with denosumab may impair bone growth in children with open growth plates and may inhibit eruption of dentition.

#### Method of administration

For subcutaneous use.

For instructions for use, handling and disposal see section 6.6.

### **4.3 Contraindications**

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

Severe, untreated hypocalcaemia (see section 4.4).

#### 4.4 Special warnings and precautions for use

##### Calcium and vitamin D supplementation

Supplementation with calcium and vitamin D is required in all patients unless hypercalcaemia is present (see section 4.2).

##### Hypocalcaemia

Pre-existing hypocalcaemia must be corrected prior to initiating therapy with XGEVA.

Hypocalcaemia can occur at any time during therapy with XGEVA. Monitoring of calcium levels should be conducted (i) prior to the initial dose of XGEVA, (ii) within two weeks after the initial dose, (iii) if suspected symptoms of hypocalcaemia occur (see section 4.8 for symptoms). Additional monitoring of calcium level should be considered during therapy in patients with risk factors for hypocalcaemia, or if otherwise indicated based on the clinical condition of the patient.

Patients should be encouraged to report symptoms indicative of hypocalcaemia. If hypocalcaemia occurs while receiving XGEVA, additional calcium supplementation and additional monitoring may be necessary.

In the post-marketing setting, severe symptomatic hypocalcaemia has been reported (including fatal cases) has been reported (see section 4.8), with most cases occurring in the first weeks of initiating therapy, but can occur later.

##### Renal impairment

Patients with severe renal impairment (creatinine clearance < 30 ml/min) or receiving dialysis are at greater risk of developing hypocalcaemia. The risk of developing hypocalcaemia and accompanying elevations in parathyroid hormone increases with increasing degree of renal impairment. Regular monitoring of calcium levels is especially important in these patients.

##### Osteonecrosis of the jaw (ONJ)

ONJ has been reported commonly in patients treated with XGEVA (see section 4.8).

The start of treatment/new treatment course should be delayed in patients with unhealed open soft tissue lesions in the mouth. A dental examination with preventive dentistry and an individual benefit-risk assessment is recommended prior to treatment with denosumab.

The following risk factors should be considered when evaluating a patient's risk of developing ONJ:

- potency of the medicinal product that inhibits bone resorption (higher risk for highly potent compounds), route of administration (higher risk for parenteral administration) and cumulative dose of bone resorption therapy.
- cancer, co-morbid conditions (e.g. anaemia, coagulopathies, infection), smoking.
- concomitant therapies: corticosteroids, chemotherapy, angiogenesis inhibitors, radiotherapy to head and neck.
- poor oral hygiene, periodontal disease, poorly fitting dentures, pre-existing dental disease, invasive dental procedures (e.g. tooth extractions).

All patients should be encouraged to maintain good oral hygiene, receive routine dental check-ups, and immediately report any oral symptoms such as dental mobility, pain or swelling, or non-healing of sores or discharge during treatment with denosumab. While on treatment, invasive dental procedures should be performed only after careful consideration and be avoided in close proximity to XGEVA administration.

The management plan of the patients who develop ONJ should be set up in close collaboration between the treating physician and a dentist or oral surgeon with expertise in ONJ. Temporary interruption of XGEVA treatment should be considered until the condition resolves and contributing risk factors are mitigated where possible.

#### Osteonecrosis of the external auditory canal

Osteonecrosis of the external auditory canal has been reported with denosumab. Possible risk factors for osteonecrosis of the external auditory canal include steroid use and chemotherapy and/or local risk factors such as infection or trauma. The possibility of osteonecrosis of the external auditory canal should be considered in patients receiving denosumab who present with ear symptoms including chronic ear infections.

#### Atypical femoral fractures

Atypical femoral fractures have been reported in patients receiving denosumab (see section 4.8). Atypical femoral fractures may occur with little or no trauma in the subtrochanteric and diaphyseal regions of the femur and may be bilateral. Specific radiographic findings characterise these events. Atypical femoral fractures have also been reported in patients with certain co-morbid conditions (e.g., vitamin D deficiency, rheumatoid arthritis, hypophosphatasia) and with use of certain pharmaceutical agents (e.g., bisphosphonates, glucocorticoids, proton pump inhibitors). These events have also occurred without antiresorptive therapy. Similar fractures reported in association with bisphosphonates are often bilateral; therefore the contralateral femur should be examined in denosumab-treated patients who have sustained a femoral shaft fracture. Discontinuation of XGEVA therapy in patients suspected to have an atypical femur fracture should be considered pending evaluation of the patient based on an individual benefit-risk assessment. During denosumab treatment, patients should be advised to report new or unusual thigh, hip, or groin pain. Patients presenting with such symptoms should be evaluated for an incomplete femoral fracture, and the contralateral femur should also be examined.

#### Hypercalcaemia following treatment discontinuation in patients with giant cell tumour of bone and in growing skeletons

Clinically significant hypercalcaemia requiring hospitalisation and complicated by acute renal injury has been reported XGEVA-treated patients with giant cell tumour of bone weeks to months following treatment discontinuation.

After treatment is discontinued, monitor patients for signs and symptoms of hypercalcaemia, consider periodic assessment of serum calcium and re-evaluate the patient's calcium and vitamin D supplementation requirements (see section 4.8).

XGEVA is not recommended in patients with growing skeletons (see section 4.2). Clinically significant hypercalcaemia has also been reported in this patient group weeks to months following treatment discontinuation.

#### Multiple vertebral fractures (MVF) following treatment discontinuation

Multiple vertebral fractures, not due to bone metastases, may occur following discontinuation of treatment with XGEVA, particularly in patients with risk factors such as osteoporosis or prior fractures.

Advise patients not to interrupt XGEVA therapy without their physician's advice. When XGEVA treatment is discontinued, evaluate the individual patient's risk for vertebral fractures.

#### Skin infections leading to hospitalisation (predominantly cellulitis)

In clinical trials in patients with advanced malignancies involving bone, skin infections leading to hospitalisation (predominantly cellulitis) were reported (see section 4.8). Patients should be advised to seek prompt medical attention if they develop signs or symptoms of cellulitis.

#### Others

Patients being treated with XGEVA should not be treated concomitantly with other denosumab containing medicinal products (for osteoporosis indications).

Patients being treated with XGEVA should not be treated concomitantly with bisphosphonates.

#### Warnings for excipients

This medicinal product contains sorbitol. Patients with rare hereditary problems of fructose intolerance should not take this medicinal product.

This medicinal product contains less than 1 mmol sodium (23 mg) per 120 mg, i.e. essentially 'sodium free'.

### **4.5 Interaction with other medicinal products and other forms of interaction**

No interaction studies have been performed.

In clinical trials, XGEVA has been administered in combination with standard anti-cancer treatment and in subjects previously receiving bisphosphonates. There were no clinically-relevant alterations in trough serum concentration and pharmacodynamics of denosumab (creatinine adjusted urinary N-telopeptide, uNTx/Cr) by concomitant chemotherapy and/or hormone therapy or by previous intravenous bisphosphonate exposure.

### **4.6 Fertility, pregnancy and lactation**

#### Pregnancy

There are no or limited amount of data from the use of denosumab in pregnant women.

XGEVA is not recommended for use in pregnant women and women of child bearing potential not using contraception. Women should be advised not to become pregnant during and for at least 5 months after treatment with XGEVA. Any effects of XGEVA are likely to be greater during the second and third trimesters of pregnancy since monoclonal antibodies are transported across the placenta in a linear fashion as pregnancy progresses, with the largest amount transferred during the third trimester.

Animal studies showed increased stillbirths and postnatal mortality; abnormal bone growth resulting in reduced bone strength, reduced haematopoiesis and tooth malalignment; absence of peripheral lymph nodes; and decreased neonatal growth (see section 5.3).

#### Breast-feeding

It is unknown whether denosumab is excreted in human milk. A risk to the newborns/infants cannot be excluded. Knockout mouse studies suggest absence of RANKL during pregnancy may interfere with maturation of the mammary gland leading to impaired lactation post-partum (see section 5.3). A decision must be made on whether to abstain from breast-feeding or to abstain from therapy with XGEVA taking into account the benefit of breast-feeding to the newborn/infant and the benefit of therapy for the woman.

### Fertility

No data are available on the effect of denosumab on human fertility. Animal studies do not indicate direct or indirect harmful effects with respect to fertility (see section 5.3).

## **4.7 Effects on ability to drive and use machines**

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

## **4.8 Undesirable effects**

### Summary of the safety profile

Overall safety profile is consistent in all approved indications for XGEVA.

Hypocalcaemia has very commonly been reported following XGEVA administration, mostly within the first 2 weeks. Hypocalcaemia can be severe and symptomatic (see section 4.8 - description of selected adverse reactions). The decreases in serum calcium were generally appropriately managed by calcium and vitamin D supplementation. The most common adverse reactions with XGEVA are musculoskeletal pain. Cases of osteonecrosis of the jaw (see sections 4.4 and section 4.8 - description of selected adverse reactions) have been commonly observed in patients taking XGEVA.

### Tabulated list of adverse reactions

The following convention has been used for the classification of the adverse reactions based on incidence rates in four phase III, two phase II clinical studies and post-marketing experience (see Table 1): very common ( $\geq 1/10$ ), common ( $\geq 1/100$  to  $< 1/10$ ), uncommon ( $\geq 1/1,000$  to  $< 1/100$ ), rare ( $\geq 1/10,000$  to  $< 1/1,000$ ), very rare ( $< 1/10,000$ ) and not known (cannot be estimated from the available data). Within each frequency grouping and system organ class, adverse reactions are presented in order of decreasing seriousness.

**Table 1. Adverse reactions reported in patients with advanced malignancies involving bone, multiple myeloma, or with giant cell tumour of bone**

MedDRA system organ class	Frequency category	Adverse Reaction
Neoplasms benign, malignant and unspecified (including cysts and polyps)	Common	New primary malignancy <sup>1</sup>
Infections and infestations	Uncommon	Cellulitis <sup>1,3</sup>
Immune system disorder	Rare	Drug hypersensitivity <sup>1</sup>
	Rare	Anaphylactic reaction <sup>1</sup>
Metabolism and nutrition disorders	Very common	Hypocalcaemia <sup>1,3</sup>
	Common	Hypophosphataemia
	Uncommon	Hypercalcaemia following treatment discontinuation in patients with giant cell tumour of bone <sup>3</sup>
Respiratory, thoracic and mediastinal disorders	Very common	Dyspnoea
Gastrointestinal disorders	Very common	Diarrhoea
	Common	Tooth extraction

MedDRA system organ class	Frequency category	Adverse Reaction
Skin and subcutaneous tissues disorders	Common	Hyperhidrosis
	Common	Alopecia
	Uncommon	Lichenoid drug eruptions <sup>1</sup>
Musculoskeletal and connective tissue disorders	Very common	Musculoskeletal pain <sup>1</sup>
	Common	Osteonecrosis of the jaw <sup>1,3</sup>
	Uncommon	Atypical femoral fracture <sup>1</sup>
	Rare	Multiple vertebral fractures following treatment discontinuation <sup>3</sup>
	Not known	Osteonecrosis of the external auditory canal <sup>3,4</sup>

<sup>1</sup> See Description of selected adverse reactions

<sup>2</sup> See section Other special populations

<sup>3</sup> See section 4.4

<sup>4</sup> Class effect

### Description of selected adverse reactions

#### *Hypocalcaemia*

A higher incidence of hypocalcaemia among subjects treated with denosumab compared to zoledronic acid has been observed in SRE prevention clinical trials.

The highest incidence of hypocalcaemia was observed in a phase III trial in patients with multiple myeloma. Hypocalcaemia was reported in 16.9% of patients treated with XGEVA and 12.4% of patients treated with zoledronic acid. A grade 3 decrease in serum calcium levels was experienced in 1.4% of patients treated with XGEVA and 0.6% of patients treated with zoledronic acid. A grade 4 decrease in serum calcium levels was experienced in 0.4% of patients treated with XGEVA and 0.1% of patients treated with zoledronic acid.

In three phase III active-controlled clinical trials in patients with advanced malignancies involving bone, hypocalcaemia was reported in 9.6% of patients treated with XGEVA and 5.0% of patients treated with zoledronic acid.

A grade 3 decrease in serum calcium levels was experienced in 2.5% of patients treated with XGEVA and 1.2% of patients treated with zoledronic acid. A grade 4 decrease in serum calcium levels was experienced in 0.6% of patients treated with XGEVA and 0.2% of patients treated with zoledronic acid (see section 4.4).

In two phase II single-arm clinical trials in patients with giant cell tumour of bone, hypocalcaemia was reported in 5.7% of patients. None of the adverse events was considered serious.

In the post-marketing setting, severe symptomatic hypocalcaemia (including fatal cases) has been reported, with most cases occurring in the first weeks of initiating therapy. Examples of clinical manifestations of severe symptomatic hypocalcaemia have included QT interval prolongation, tetany, seizures and altered mental status (including coma) (see section 4.4). Symptoms of hypocalcaemia in clinical studies included paraesthesias or muscle stiffness, twitching, spasms and muscle cramps.

### *Osteonecrosis of the jaw (ONJ)*

In clinical trials, the incidence of ONJ was higher with longer duration of exposure; ONJ has also been diagnosed after stopping treatment with XGEVA with the majority of cases occurring within 5 months after the last dose. Patients with prior history of ONJ or osteomyelitis of the jaw, an active dental or jaw condition requiring oral surgery, non-healed dental/oral surgery, or any planned invasive dental procedure were excluded from the clinical trials.

A higher incidence of ONJ among subjects treated with denosumab compared to zoledronic acid has been observed in SRE prevention clinical trials. The highest incidence of ONJ was observed in a phase III trial in patients with multiple myeloma. In the double-blind treatment phase of this trial, ONJ was confirmed in 5.9% of patients treated with XGEVA (median exposure of 19.4 months; range 1 - 52) and in 3.2% of patients treated with zoledronic acid. At the completion of the double-blind treatment phase of this trial, the patient-year adjusted incidence of confirmed ONJ in the XGEVA group (median exposure of 19.4 months; range 1 - 52), was 2.0 per 100 patient-years during the first year of treatment, 5.0 in the second year, and 4.5 thereafter. The median time to ONJ was 18.7 months (range: 1 - 44).

In the primary treatment phases of three phase III active-controlled clinical trials in patients with advanced malignancies involving bone, ONJ was confirmed in 1.8% of patients treated with XGEVA (median exposure of 12.0 months; range 0.1 – 40.5) and 1.3% of patients treated with zoledronic acid. Clinical characteristics of these cases were similar between treatment groups. Among subjects with confirmed ONJ, most (81% in both treatment groups) had a history of tooth extraction, poor oral hygiene, and/or use of a dental appliance. Most subjects were receiving or had received chemotherapy.

The trials in patients with breast or prostate cancer included an XGEVA extension treatment phase (median overall exposure of 14.9 months; range 0.1 – 67.2). ONJ was confirmed in 6.9% of patients with breast cancer and prostate cancer during the extension treatment phase.

The patient-year adjusted incidence of confirmed ONJ was 1.1 per 100 patient-years during the first year of treatment, 3.7 in the second year, and 4.6 thereafter. The median time to ONJ was 20.6 months (range: 4 – 53).

In a phase III trial in patients with non-metastatic prostate cancer (a patient population for which XGEVA is not indicated), with longer treatment exposure of up to 7 years, the patient-year adjusted incidence of confirmed ONJ was 1.1 per 100 patient-years during the first year of treatment, 3.0 in the second year, and 7.1 thereafter.

In a long-term phase II open-label clinical trial in patients with giant cell tumour of bone (Study 6, see section 5.1), ONJ was confirmed in 6.8% of patients, including one adolescent (median number of 34 doses; range 4 – 116). At the completion of the trial, median time on trial including safety follow-up phase was 60.9 months (range: 0 – 112.6). The patient year adjusted incidence of confirmed ONJ was 1.5 per 100 patient years overall (0.2 per 100 patient years during the first year of treatment, 1.5 in the second year, 1.8 in the third year, 2.1 in the fourth year, 1.4 in the fifth year, and 2.2 thereafter). The median time to ONJ was 41 months (range: 11 - 96).

### *Drug related hypersensitivity reactions*

In the post-marketing setting, events of hypersensitivity, including rare events of anaphylactic reactions, have been reported in patients receiving XGEVA.



#### *Atypical femoral fractures*

In the clinical trial programme, atypical femoral fractures have been reported uncommonly in patients treated with XGEVA and the risk increased with longer duration of treatment. Events have occurred during treatment and up to 9 months after treatment was discontinued (see section 4.4).

#### *Skin infections (predominantly cellulitis) leading to hospitalisation*

In three phase III active-controlled clinical trials in patients with advanced malignancies involving bone, skin infections leading to hospitalisation (predominantly cellulitis) were reported more frequently in patients receiving XGEVA (0.9%) compared with zoledronic acid (0.7%).

In postmenopausal women with osteoporosis, skin infections leading to hospitalisation were reported for 0.4% women receiving Prolia (denosumab 60 mg every 6 months) and for 0.1% women receiving placebo (see section 4.4).

#### *Musculoskeletal pain*

In the post-marketing setting, musculoskeletal pain, including severe cases, has been reported in patients receiving XGEVA. In clinical trials, musculoskeletal pain was very common in both the denosumab and zoledronic acid treatment groups. Musculoskeletal pain leading to discontinuation of study treatment was uncommon.

#### *New primary malignancy*

In the primary double-blind treatment phases of four phase III active-controlled clinical trials in patients with advanced malignancies involving bone, new primary malignancy was reported in 54/3691 (1.5%) of patients treated with XGEVA (median exposure of 13.8 months; range: 1.0–51.7) and 33/3688 (0.9%) of patients treated with zoledronic acid (median exposure of 12.9 months; range: 1.0–50.8).

The cumulative incidence at one year was 1.1 % for denosumab and 0.6 % for zoledronic acid, respectively.

No treatment-related pattern in individual cancers or cancer groupings was apparent.

#### *Lichenoid drug eruptions*

Lichenoid drug eruptions (e.g. lichen planus-like reactions), have been reported in patients in the post-marketing setting.

#### Paediatric population

XGEVA was studied in an open label trial that enrolled 28 skeletally mature adolescents with giant cell tumour of bone. Based on these limited data, the adverse event profile appeared to be similar to adults.

Clinically significant hypercalcaemia after treatment discontinuation has been reported in the post-marketing setting in paediatric patients (see section 4.4).

#### Other special populations

##### *Renal impairment*

In a clinical study of patients without advanced cancer with severe renal impairment (creatinine clearance < 30 ml/min) or receiving dialysis, there was a greater risk of developing hypocalcaemia in the absence of calcium supplementation. The risk of developing hypocalcaemia during XGEVA treatment is greater with increasing degree of renal impairment. In a clinical study in patients without advanced cancer, 19% of patients with severe renal impairment (creatinine clearance < 30 ml/min) and 63% of patients receiving

dialysis developed hypocalcaemia despite calcium supplementation. The overall incidence of clinically significant hypocalcaemia was 9%.

Accompanying increases in parathyroid hormone have also been observed in patients receiving XGEVA with severe renal impairment or receiving dialysis. Monitoring of calcium levels and adequate intake of calcium and vitamin D is especially important in patients with renal impairment (see section 4.4).

## **4.9 Overdose**

There is no experience with overdose in clinical studies. XGEVA has been administered in clinical studies using doses up to 180 mg every 4 weeks and 120 mg weekly for 3 weeks.

# **5. PHARMACOLOGICAL PROPERTIES**

## **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Drugs for the treatment of bone diseases – other drugs affecting bone structure and mineralisation, ATC code: M05BX04

### Mechanism of action

RANKL exists as a transmembrane or soluble protein. RANKL is essential for the formation, function and survival of osteoclasts, the sole cell type responsible for bone resorption. Increased osteoclast activity, stimulated by RANKL, is a key mediator of bone destruction in metastatic bone disease and multiple myeloma. Denosumab is a human monoclonal antibody (IgG2) that targets and binds with high affinity and specificity to RANKL, preventing the RANKL/RANK interaction from occurring and resulting in reduced osteoclast numbers and function, thereby decreasing bone resorption and cancer-induced bone destruction.

Giant cell tumours of bone are characterised by stromal cells expressing RANK ligand and osteoclast-like giant cells expressing RANK. In patients with giant cell tumour of bone, denosumab binds to RANK ligand, significantly reducing or eliminating osteoclast-like giant cells. Consequently, osteolysis is reduced and proliferative tumour stroma is replaced with non-proliferative, differentiated, densely woven new bone.

### Pharmacodynamic effects

In phase II clinical studies of patients with advanced malignancies involving bone, subcutaneous (SC) dosing of XGEVA administered either every 4 weeks (Q4W) or every 12 weeks resulted in a rapid reduction in markers of bone resorption (uNTx/Cr, serum CTx), with median reductions of approximately 80% for uNTx/Cr occurring within 1 week regardless of prior bisphosphonate therapy or baseline uNTx/Cr level. In phase III clinical trials of patients with advanced malignancies involving bone, median uNTx/Cr reductions of approximately 80% were maintained through 49 weeks of XGEVA treatment (120 mg every Q4W).

Similarly, in patients with advanced cancer and bone metastases (including subjects with multiple myeloma and bone disease) who were receiving IV bisphosphonate therapy, yet had uNTx/Cr levels > 50 nM/mM, multiple SC dosing of XGEVA administered either every 4 weeks or every 12 weeks caused an approximate 80% reduction in uNTx/creatinine from baseline after 3 and 6 months of treatment. Overall, 97% of patients in the XGEVA groups had at least 1 uNTx/Cr value < 50 nM/mM up to week 25 of the study.

In a phase II study of patients with giant cell tumour of bone who received SC doses of XGEVA 120 mg every 4 weeks (Q4W) with loading doses on days 8 and 15, median reductions in uNTx/Cr and sCTx of approximately 80% were observed by week 9. Reductions in bone turnover markers were maintained, with median reductions of 77% to 87% for uNTx/Cr and 78% to 83% for sCTx from weeks 5 to 25 of continued 120 mg Q4W dosing.

#### Immunogenicity

In clinical studies, neutralising antibodies have not been observed for denosumab in advanced cancer patients or giant cell tumour of bone patients. Using a sensitive immunoassay < 1% of patients treated with denosumab for up to 3 years tested positive for non-neutralising binding antibodies with no evidence of altered pharmacokinetics, toxicity, or clinical response.

#### Clinical efficacy and safety in patients with bone metastases from solid tumours

Efficacy and safety of 120 mg XGEVA SC every 4 weeks or 4 mg zoledronic acid (dose-adjusted for reduced renal function) IV every 4 weeks were compared in three randomised, double-blind, active-controlled studies, in IV-bisphosphonate naïve patients with advanced malignancies involving bone: adults with breast cancer (study 1), other solid tumours or multiple myeloma (study 2), and castrate-resistant prostate cancer (study 3). Within these active-controlled clinical trials, safety was evaluated in 5,931 patients. Patients with prior history of ONJ or osteomyelitis of the jaw, an active dental or jaw condition requiring oral surgery, non-healed dental/oral surgery, or any planned invasive dental procedure, were not eligible for inclusion in these studies. The primary and secondary endpoints evaluated the occurrence of one or more skeletal related events (SREs). In studies demonstrating superiority of XGEVA to zoledronic acid, patients were offered open-label XGEVA in a pre-specified 2-year extension treatment phase. An SRE was defined as any of the following: pathologic fracture (vertebral or non-vertebral), radiation therapy to bone (including the use of radioisotopes), surgery to bone, or spinal cord compression.

The median duration of exposure to XGEVA was 12 months (range: 0.1 – 41) and median duration on-study was 13 months (range: 0.1 – 41).

XGEVA reduced the risk of developing a SRE, and developing multiple SREs (first and subsequent) in patients with bone metastases from solid tumours (see Table 2).

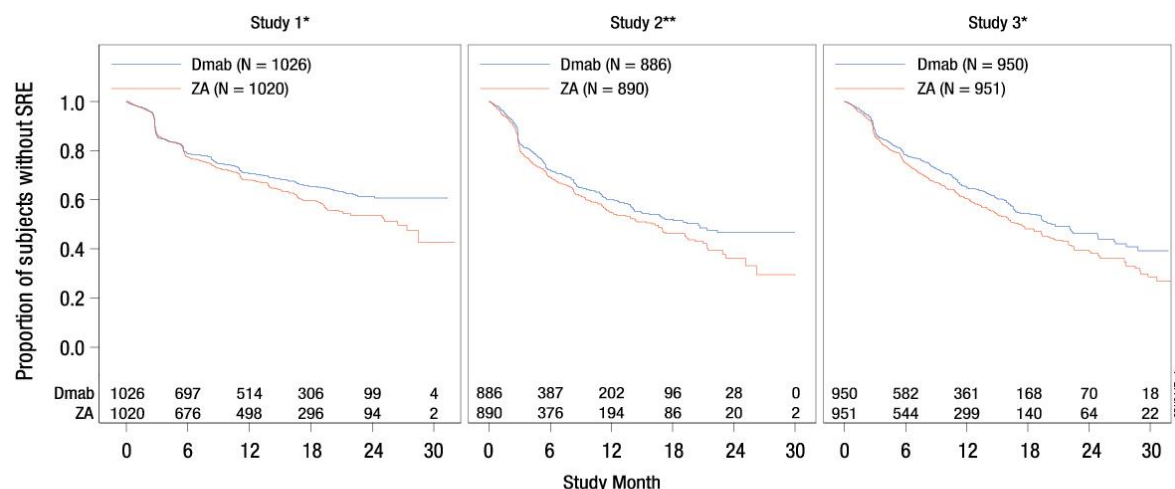
**Table 2. Efficacy results in patients with advanced malignancies involving bone**

	Study 1 breast cancer		Study 2 other solid tumours** or multiple myeloma		Study 3 prostate cancer		Combined advanced cancer	
	XGEVA	zoledronic acid	XGEVA	zoledronic acid	XGEVA	zoledronic acid	XGEVA	zoledronic acid
N	1026	1020	886	890	950	951	2862	2861
First SRE								
Median time (months)	NR	26.4	20.6	16.3	20.7	17.1	27.6	19.4
Difference in median time (months)	NA		4.2		3.5		8.2	
Hazard ratio (95% CI)/RRR (%)	0.82 (0.71, 0.95) / 18		0.84 (0.71, 0.98) / 16		0.82 (0.71, 0.95) / 18		0.83 (0.76, 0.90) / 17	
Non-inferiority/Superiority p-values	< 0.0001 <sup>†</sup> / 0.0101 <sup>†</sup>		0.0007 <sup>†</sup> / 0.0619 <sup>†</sup>		0.0002 <sup>†</sup> / 0.0085 <sup>†</sup>		< 0.0001 / < 0.0001	
Proportion of subjects (%)	30.7	36.5	31.4	36.3	35.9	40.6	32.6	37.8
First and subsequent SRE*								
Mean number/patient	0.46	0.60	0.44	0.49	0.52	0.61	0.48	0.57
Rate ratio (95% CI)/RRR (%)	0.77 (0.66, 0.89) / 23		0.90 (0.77, 1.04) / 10		0.82 (0.71, 0.94) / 18		0.82 (0.75, 0.89) / 18	
Superiority p-value	0.0012 <sup>†</sup>		0.1447 <sup>†</sup>		0.0085 <sup>†</sup>		< 0.0001	
SMR per year	0.45	0.58	0.86	1.04	0.79	0.83	0.69	0.81
First SRE or HCM								
Median time (months)	NR	25.2	19.0	14.4	20.3	17.1	26.6	19.4
HR (95% CI)/RRR (%)	0.82 (0.70, 0.95) / 18		0.83 (0.71, 0.97) / 17		0.83 (0.72, 0.96) / 17		0.83 (0.76, 0.90) / 17	
Superiority p-value	0.0074		0.0215		0.0134		< 0.0001	
First Radiation to Bone								
Median time (months)	NR	NR	NR	NR	NR	28.6	NR	33.2
HR (95% CI)/RRR (%)	0.74 (0.59, 0.94) / 26		0.78 (0.63, 0.97) / 22		0.78 (0.66 , 0.94) / 22		0.77 (0.69 , 0.87) / 23	
Superiority p-value	0.0121		0.0256		0.0071		< 0.0001	

NR = not reached; NA = not available; HCM = hypercalcaemia of malignancy; SMR = skeletal morbidity rate; HR = Hazard Ratio; RRR = Relative Risk Reduction <sup>†</sup>Adjusted p-values are presented for Studies 1, 2 and 3 (first SRE and first and subsequent SRE endpoints); \*Accounts for all skeletal events over time; only events occurring  $\geq 21$  days after the previous event are counted.

\*\* Including NSCLC, renal cell cancer, colorectal cancer, small cell lung cancer, bladder cancer, head and neck cancer, GI/genitourinary cancer and others, excluding breast and prostate cancer.

**Figure 1. Kaplan-Meier plots of time to first on-study SRE**



Dmab = Denosumab 120 mg Q4W

ZA = Zoledronic Acid 4 mg Q4W

N = Number of subjects randomised

\* = Statistically significant for superiority; \*\* = Statistically significant for non-inferiority

### Disease progression and overall survival with bone metastases from solid tumours

Disease progression was similar between XGEVA and zoledronic acid in all three studies and in the pre-specified analysis of all three studies combined.

In studies 1, 2 and 3, overall survival was balanced between XGEVA and zoledronic acid in patients with advanced malignancies involving bone: patients with breast cancer (hazard ratio and 95% CI was 0.95 [0.81, 1.11]), patients with prostate cancer (hazard ratio and 95% CI was 1.03 [0.91, 1.17]), and patients with other solid tumours or multiple myeloma (hazard ratio and 95% CI was 0.95 [0.83, 1.08]). A post-hoc analysis in study 2 (patients with other solid tumours or multiple myeloma) examined overall survival for the 3 tumour types used for stratification (non-small cell lung cancer, multiple myeloma, and other). Overall survival was longer for XGEVA in non-small cell lung cancer (hazard ratio [95% CI] of 0.79 [0.65, 0.95]; n = 702) and longer for zoledronic acid in multiple myeloma (hazard ratio [95% CI] of 2.26 [1.13, 4.50]; n = 180) and similar between XGEVA and zoledronic acid in other tumour types (hazard ratio [95% CI] of 1.08 (0.90, 1.30); n = 894). This study did not control for prognostic factors and anti-neoplastic treatments for multiple myeloma. In a combined pre-specified analysis from studies 1, 2 and 3, overall survival was similar between XGEVA and zoledronic acid (hazard ratio and 95% CI 0.99 [0.91, 1.07]).

### Effect on pain

The time to pain improvement (i.e.,  $\geq 2$ -point decrease from baseline in BPI-SF worst pain score) was similar for denosumab and zoledronic acid in each study and the integrated analyses. In a post-hoc analysis of the combined dataset, the median time to worsening pain ( $> 4$ -point worst pain score) in patients with mild or no pain at baseline was delayed for XGEVA compared to zoledronic acid (198 versus 143 days) (p = 0.0002).

### Clinical efficacy in patients with multiple myeloma

XGEVA was evaluated in an international, randomised (1:1), double-blind, active-controlled study comparing XGEVA with zoledronic acid in patients with newly diagnosed multiple myeloma, Study 4.

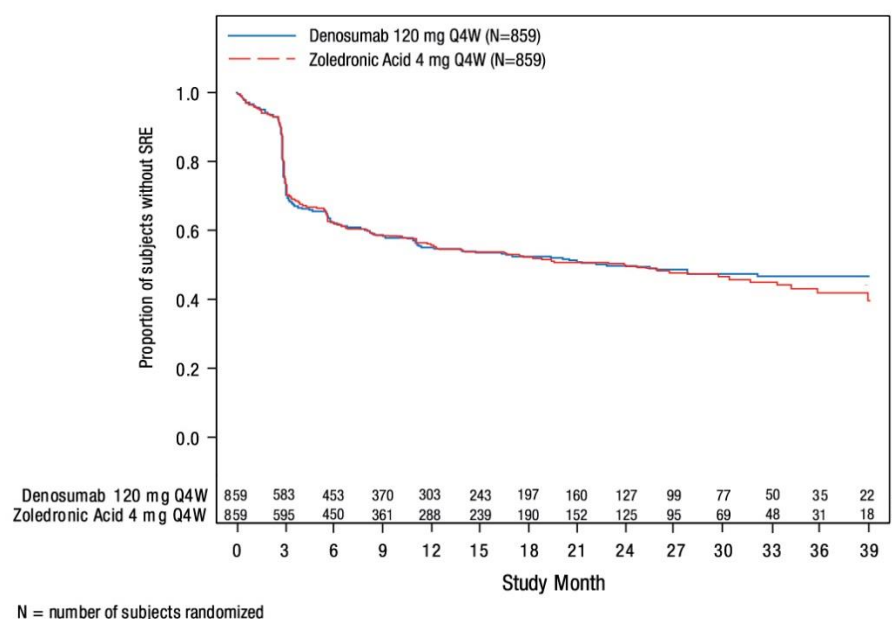
In this study, 1,718 multiple myeloma patients with at least one bone lesion were randomised to receive 120 mg XGEVA subcutaneously every 4 weeks (Q4W) or 4 mg zoledronic acid intravenously (IV) every 4 weeks (dose-adjusted for renal function). The primary outcome measure was demonstration of non-inferiority of time to first on study skeletal related event (SRE) as compared to zoledronic acid. Secondary outcome measures included superiority of time to first SRE, superiority of time to first and subsequent SRE, and overall survival. An SRE was defined as any of the following: pathologic fracture (vertebral or non-vertebral), radiation therapy to bone (including the use of radioisotopes), surgery to bone, or spinal cord compression.

Across both study arms, 54.5% of patients intended to undergo autologous PBSC transplantation, 95.8% patients utilised/planned to utilise a novel anti-myeloma agent (novel therapies include bortezomib, lenalidomide, or thalidomide) in first-line therapy, and 60.7% of patients had a previous SRE. The number of patients across both study arms with ISS stage I, stage II, and stage III at diagnosis were 32.4%, 38.2%, and 29.3%, respectively.

The median number of doses administered was 16 for XGEVA and 15 for zoledronic acid.

Efficacy results from Study 4 are presented in Figure 2 and Table 3.

**Figure 2. Kaplan-Meier plot for time to first on-study SRE in patients with newly diagnosed multiple myeloma**



**Table 3. Efficacy results for XGEVA compared to zoledronic acid in patients with newly diagnosed multiple myeloma**

Multiple myeloma		
	XGEVA (N = 859)	Zoledronic Acid (N = 859)
First SRE		
Number of patients who had SREs (%)	376 (43.8)	383 (44.6)
Median time to SRE (months)	22.8 (14.7, NE)	23.98 (16.56, 33.31)
Hazard ratio (95% CI)	0.98 (0.85, 1.14)	
First and subsequent SRE		
Mean number of events/patient	0.66	0.66
Rate ratio (95% CI)	1.01 (0.89, 1.15)	
Skeletal morbidity rate per year	0.61	0.62
First SRE or HCM		
Median time (months)	22.14 (14.26, NE)	21.32 (13.86, 29.7)
Hazard ratio (95% CI)	0.98 (0.85, 1.12)	
First radiation to bone		
Hazard ratio (95% CI)	0.78 (0.53, 1.14)	
Overall survival		
Hazard ratio (95% CI)	0.90 (0.70, 1.16)	

NE = not estimable

HCM = hypercalcaemia of malignancy

#### Clinical efficacy and safety in adults and skeletally mature adolescents with giant cell tumour of bone

The safety and efficacy of XGEVA was studied in two phase II open-label, single arm trials (Studies 5 and 6) that enrolled 554 patients with giant cell tumour of bone that was either unresectable or for which surgery would be associated with severe morbidity. Patients received 120 mg XGEVA subcutaneously every 4 weeks with a loading dose of 120 mg on days 8 and 15. Patients who discontinued XGEVA then entered the safety follow-up phase for a minimum of 60 months. Retreatment with XGEVA while in safety follow-up was allowed for subjects who initially demonstrated a response to XGEVA (e.g. in the case of recurrent disease).

Study 5 enrolled 37 adult patients with histologically confirmed unresectable or recurrent giant cell tumour of bone. The main outcome measure of the trial was response rate, defined as either at least 90% elimination of giant cells relative to baseline (or complete elimination of giant cells in cases where giant cells represent < 5% of tumour cells), or a lack of progression of the target lesion by radiographic measurements in cases where histopathology was not available. Of the 35 patients included in the efficacy analysis, 85.7% (95% CI: 69.7, 95.2) had a treatment response to XGEVA. All 20 patients (100%) with histology assessments met response criteria. Of the remaining 15 patients, 10 (67%) met response criteria based on radiology data.

Study 6 enrolled 535 adult or skeletally mature adolescents with giant cell tumour of bone. Of these patients, 28 were aged 13 – 17 years. Patients were assigned to one of three cohorts: Cohort 1 included patients with surgically unsalvageable disease (e.g., sacral, spinal, or multiple lesions, including pulmonary metastases); Cohort 2 included patients with surgically salvageable disease whose planned

surgery was associated with severe morbidity (e.g., joint resection, limb amputation, or hemipelvectomy); Cohort 3 included patients previously participating in Study 5 and rolled over into this study. The outcome measures of the study were time to disease progression (based on investigator assessment) for Cohort 1 and proportion of patients without any surgery at month 6 for Cohort 2. Pain outcomes and clinical benefit were also assessed.

A retrospective interim analysis included an independent review of radiographic imaging data for patients enrolled in Studies 5 and 6. Of the 305 patients at the time of the interim analysis enrolled in Studies 5 and 6, 190 had at least 1 evaluable time point response and were included in the analysis (see Table 4).

**Table 4. Objective Treatment Response in Patients with Giant Cell Tumour of Bone**

	<b>Number of patients evaluable for the endpoint</b>	<b>Number of patients with the endpoint</b>	<b>Proportion (%) (95% CI)<sup>a</sup></b>	<b>KM estimate of median (95% CI) (Months)</b>
<b>Proportion of patients with an objective tumour response (CR, PR)</b>				
Based on best response	190	136	71.6 (64.6, 77.9)	-
RECIST 1.1	187	47	25.1 (19.1, 32.0)	-
EORTC	26	25	96.2 (80.4, 99.9)	-
Density/Size	176	134	76.1 (69.1, 82.2)	-
<b>Duration of objective tumour response (time to PD from the first objective tumour response)</b>				
Based on best response	136	1	0.7	NE (NE, NE) <sup>1</sup>
RECIST 1.1	47	3	6.4	NE (19.94, NE)
EORTC	25	0	0.0	NE (NE, NE)
Density/Size	134	1	0.7	NE (NE, NE)
<b>Time to first objective tumour response</b>				
Based on best response	190	136	71.6	3.1 (2.89, 3.65)
RECIST 1.1	187	47	25.1	NE (20.93, NE)
EORTC	26	25	96.2	2.7 (1.64, 2.79)
Density/Size	176	134	76.1	3.0 (2.79, 3.48)

<sup>a</sup> Exact Confidence Interval

<sup>1</sup> NE = Not Estimable

Patients were evaluated by the following response criteria to determine objective tumour response:

- Modified Response Evaluation Criteria in Solid Tumours (RECIST 1.1) to evaluate tumour burden based on computed tomography (CT)/magnetic resonance imaging (MRI).
- Modified European Organisation for Research and Treatment of Cancer (EORTC) criteria to evaluate metabolic response using fluorodeoxyglucose positron emission tomography (FDG-PET).
- Modified Inverse Choi criteria to evaluate tumour size and density using Hounsfield units based on CT/MRI (Density/Size).

Overall in this retrospective interim analysis, XGEVA achieved objective tumour responses in 71.6% (95% CI: 64.6, 77.9) of patients (Table 5). The median time to response was 3.1 months (95% CI:



2.89, 3.65). The median duration of response was not estimable, as few patients experienced disease progression, with a median follow-up of 13.4 months. Efficacy results in skeletally mature adolescents appeared to be similar to those observed in adults.

In the final analysis, across Cohorts 1 and 2 combined, 500 of 501 evaluable subjects (99.8%) (i.e., those who had a post-baseline disease status evaluation) had an investigator-reported best response of stable disease or better (CR in 195 subjects [38.9%], PR in 161 subjects [32.1%], and stable disease in 144 subjects [28.7%]).

In Cohort 1 at the final analysis, median time to disease progression was not reached, as only 28 of the 260 treated patients (10.8%) had disease progression. In Cohort 2, XGEVA prolonged the time to surgery, reduced the morbidity of planned surgery, and reduced the proportion of patients undergoing surgery. 219 of the 238 (92.0%; 95% CI: 87.8%, 95.1%) evaluable patients treated with XGEVA had not undergone surgery by month 6. Of the 239 subjects in Cohort 2 with baseline target lesion location or on-study location not in lungs or soft tissue, a total of 82 subjects (34.3%) were able to avoid on-study surgery. Of the 157 subjects who received on-study GCTB surgery, 106 (67.5%) underwent a less morbid procedure from that planned at baseline. (see Table 5).

**Table 5. Distribution of Planned Versus Actual Surgery in Patients with Giant Cell Tumour of Bone (Cohort 2)**

<b>Surgical Procedure, n</b>	<b>Baseline Planned (N = 239)</b>	<b>Actual Total (N = 239)</b>
Total number of surgeries	239	157
Major surgeries	109	18
Hemipelvectomy	11	1
Amputation	36	2
Joint/prosthesis replacement	27	11
Joint resection	35	4
Marginal excision, en bloc excision, or en bloc resection	95	42
Curettage	29	95
Other	6	2
No surgery	0	82

#### Effect on pain

In the final analysis Cohorts 1 and 2 combined, a clinically meaningful reduction in worst pain (i.e.  $\geq 2$ -point decrease from baseline) was reported for 30.8% of patients at risk (i.e. those who had a worst pain score of  $\geq 2$  at baseline) within 1 week of treatment, and  $\geq 50\%$  at week 5. These pain improvements were maintained at all subsequent evaluations.

#### Paediatric population

The European Medicines Agency has waived the obligation to submit the results of studies with XGEVA in all subsets of the paediatric population in the prevention of skeletal related events in patients with bone metastases and subsets of the paediatric population below the age of 12 in the treatment of giant cell tumour of bone (see section 4.2 for information on paediatric use).

In Study 6, XGEVA has been evaluated in a subset of 28 adolescent patients (aged 13 – 17 years) with giant cell tumour of bone who had reached skeletal maturity defined by at least 1 mature long bone (e.g. closed epiphyseal growth plate of the humerus) and body weight  $\geq 45$  kg. One adolescent subject with surgically unsalvageable disease (N=14) had disease recurrence during initial treatment. Thirteen of the 14 subjects with surgically salvageable disease whose planned surgery was associated with severe morbidity had not undergone surgery by month 6.

## **5.2 Pharmacokinetic properties**

### Absorption

Following subcutaneous administration, bioavailability was 62%.

### Biotransformation

Denosumab is composed solely of amino acids and carbohydrates as native immunoglobulin and is unlikely to be eliminated via hepatic metabolic mechanisms. Its metabolism and elimination are expected to follow the immunoglobulin clearance pathways, resulting in degradation to small peptides and individual amino acids.

### Elimination

In patients with advanced cancer who received multiple doses of 120 mg every 4 weeks an approximate 2-fold accumulation in serum denosumab concentrations was observed and steady-state was achieved by 6 months, consistent with time-independent pharmacokinetics. In subjects with multiple myeloma who received 120 mg every 4 weeks, median trough levels varied by less than 8% between months 6 and 12. In subjects with giant cell tumour of bone who received 120 mg every 4 weeks with a loading dose on days 8 and 15, steady-state levels were achieved within the first month of treatment. Between weeks 9 and 49, median trough levels varied by less than 9%. At steady-state, the mean serum trough concentration was 20.6 mcg/ml (range: 0.456 to 56.9 mcg/ml). In subjects who discontinued 120 mg every 4 weeks, the mean half-life was 28 days (range 14 to 55 days).

A population pharmacokinetic analysis did not indicate clinically significant changes in the systemic exposure of denosumab at steady state with respect to age (18 to 87 years), race/ethnicity (Blacks, Hispanics, Asians and Caucasians explored), gender or solid tumour types, patients with multiple myeloma, and giant cell tumour of the bone. Increasing body weight was associated with decreases in systemic exposure, and vice versa. The alterations were not considered clinically-relevant, since pharmacodynamic effects based on bone turnover markers were consistent across a wide range of body weight.

### Linearity/non-linearity

Denosumab displayed non-linear pharmacokinetics with dose over a wide dose range, but approximately dose-proportional increases in exposure for doses of 60 mg (or 1 mg/kg) and higher. The non-linearity is likely due to a saturable target-mediated elimination pathway of importance at low concentrations.

### Renal impairment

In studies of denosumab (60 mg, N = 55 and 120 mg, N = 32) involving patients without advanced cancer, but with varying degrees of renal function, including patients on dialysis, the degree of renal impairment had no effect on the pharmacokinetics and pharmacodynamics of denosumab; thus dose adjustment for renal impairment is not necessary. There is no need for renal monitoring with XGEVA dosing.

### Hepatic impairment

No specific study in patients with hepatic impairment was performed. In general, monoclonal antibodies are not eliminated via hepatic metabolic mechanisms. The pharmacokinetics of denosumab is not expected to be affected by hepatic impairment.

### Elderly

No overall differences in safety or efficacy were observed between geriatric patients and younger patients. Controlled clinical studies of XGEVA in patients with advanced malignancies involving bone over age 65 revealed similar efficacy and safety in older and younger patients. No dose adjustment is required in elderly patients.

### Paediatric population

In skeletally-mature adolescents (13 - 17 years of age) with giant cell tumour of bone who received 120 mg every 4 weeks with a loading dose on days 8 and 15, the pharmacokinetics of denosumab were similar to those observed in adult subjects with GCTB.

## **5.3 Preclinical safety data**

Since the biological activity of denosumab in animals is specific to non-human primates, evaluation of genetically engineered (knockout) mice or use of other biological inhibitors of the RANK/RANKL pathway, such as OPG-Fc and RANK-Fc, were used to evaluate the pharmacodynamic properties of denosumab in rodent models.

In mouse bone metastasis models of oestrogen receptor positive and negative human breast cancer, prostate cancer and non-small cell lung cancer, OPG-Fc reduced osteolytic, osteoblastic, and osteolytic/osteoblastic lesions, delayed formation of *de novo* bone metastases, and reduced skeletal tumour growth. When OPG-Fc was combined with hormonal therapy (tamoxifen) or chemotherapy (docetaxel) in these models, there was additive inhibition of skeletal tumour growth in breast, and prostate or lung cancer respectively. In a mouse model of mammary tumour induction, RANK-Fc reduced hormone-induced proliferation in mammary epithelium and delayed tumour formation.

Standard tests to investigate the genotoxicity potential of denosumab have not been evaluated, since such tests are not relevant for this molecule. However, due to its character it is unlikely that denosumab has any potential for genotoxicity.

The carcinogenic potential of denosumab has not been evaluated in long-term animal studies.

In a study of cynomolgus monkeys dosed with denosumab throughout pregnancy at AUC exposures 12-fold higher than the human dose (120 mg every 4 weeks), there were increased stillbirths and postnatal mortality; abnormal bone growth resulting in reduced bone strength, reduced haematopoiesis, and tooth malalignment; absence of peripheral lymph nodes; and decreased neonatal growth. There was no evidence of maternal harm prior to labour. Following a recovery period from birth to 6 months of age, the effects on bone returned to normal; there were no adverse effects on tooth eruption; and minimal to moderate mineralisation in multiple tissues was seen in one recovery animal. Adverse maternal effects occurred infrequently during labour. Maternal mammary gland development was normal.

At AUC exposures up to 16-fold higher than the human exposure (120 mg once every 4 weeks), denosumab showed no evidence of impaired fertility in female cynomolgus monkeys.

In a study of cynomolgus monkeys dosed with denosumab during the period equivalent to the first trimester at AUC exposures up to 10-fold higher than the human dose (120 mg every 4 weeks), there was no evidence of maternal or foetal harm. In this study, foetal lymph nodes were not examined.

In preclinical bone quality studies in monkeys on long-term denosumab treatment, decreases in bone turnover were associated with improvement in bone strength and normal bone histology.

In male mice genetically engineered to express huRANKL (knock-in mice), which were subjected to a transcortical fracture, denosumab delayed the removal of cartilage and remodelling of the fracture callus compared to control, but biomechanical strength was not adversely affected.

In preclinical studies knockout mice lacking RANK or RANKL had an absence of lactation due to inhibition of mammary gland maturation (lobulo-alveolar gland development during pregnancy) and exhibited impairment of lymph node formation. Neonatal RANK/RANKL knockout mice exhibited decreased body weight, reduced bone growth, altered growth plates and lack of tooth eruption. Reduced bone growth, altered growth plates and impaired tooth eruption were also seen in studies of neonatal rats administered RANKL inhibitors, and these changes were partially reversible when dosing of RANKL inhibitor was discontinued. Adolescent primates dosed with denosumab at 2.7 and 15 times (10 and 50 mg/kg dose) the clinical exposure had abnormal growth plates. Therefore, treatment with denosumab may impair bone growth in children with open growth plates and may inhibit eruption of dentition.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Acetic acid, glacial\*

Sodium hydroxide (for pH adjustment)\*

Sorbitol (E420)

Polysorbate 20

Water for injections

\* Acetate buffer is formed by mixing acetic acid with sodium hydroxide

### **6.2 Incompatibilities**

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

### **6.3 Shelf life**

The expiry date is indicated on the packaging.

Once removed from the refrigerator, XGEVA may be stored at room temperature (up to 25°C) for up to 30 days in the original container. It must be used within this 30 days period.

### **6.4 Special precautions for storage**

Store in a refrigerator (2°C – 8°C).

Do not freeze.

Keep the vial in the outer carton in order to protect from light.

### **6.5 Nature and contents of container**

1.7 ml solution in a single use vial (type I glass) with stopper (fluoropolymer coated elastomeric) and seal (aluminium) with flip-off cap.

Pack size of one or four.

Not all pack sizes may be marketed.

### **6.6 Special precautions for disposal and other handling**

- Before administration, the XGEVA solution should be inspected visually. The solution may contain trace amounts of translucent to white proteinaceous particles. Do not inject the solution if it is cloudy or discoloured.
- Do not shake.
- To avoid discomfort at the site of injection, allow the vial to reach room temperature (up to 25°C) before injecting and inject slowly.
- The entire contents of the vial should be injected.
- A 27 gauge needle is recommended for the administration of denosumab.
- The vial should not be re-entered.

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

**Date of revision:** March 2021

Manufactured by: Amgen Manufacturing Limited, State Road 31, Kilometer 24.6, Juncos, Puerto Rico 00777, USA

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