

**ANNEX I**  
**SUMMARY OF PRODUCT CHARACTERISTICS**

## 1. NAME OF THE MEDICINAL PRODUCT

Lenalidomide Krka d.d. Novo mesto 2.5 mg hard capsules  
Lenalidomide Krka d.d. Novo mesto 5 mg hard capsules  
Lenalidomide Krka d.d. Novo mesto 7.5 mg hard capsules  
Lenalidomide Krka d.d. Novo mesto 10 mg hard capsules  
Lenalidomide Krka d.d. Novo mesto 15 mg hard capsules  
Lenalidomide Krka d.d. Novo mesto 20 mg hard capsules  
Lenalidomide Krka d.d. Novo mesto 25 mg hard capsules

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each hard capsule contains lenalidomide hydrochloride monohydrate equivalent to 2.5 mg, 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg or 25 mg lenalidomide.

For the full list of excipients, see section 6.1.

## 3. PHARMACEUTICAL FORM

Hard capsule (capsule)

### Lenalidomide Krka d.d. Novo mesto 2.5 mg hard capsules

Capsule cap is green, capsule body is green with imprinted black mark 2.5. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 4, length  $14 \pm 1$  mm.

### Lenalidomide Krka d.d. Novo mesto 5 mg hard capsules

Capsule cap is blue, capsule body is blue with imprinted black mark 5. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 2, length  $18 \pm 1$  mm.

### Lenalidomide Krka d.d. Novo mesto 7.5 mg hard capsules

Capsule cap is brown, capsule body is brown with imprinted white mark 7.5. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 1, length  $19 \pm 1$  mm.

### Lenalidomide Krka d.d. Novo mesto 10 mg hard capsules

Capsule cap is green, capsule body is brown with imprinted white mark 10. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 0, length  $21 \pm 1$  mm.

### Lenalidomide Krka d.d. Novo mesto 15 mg hard capsules

Capsule cap is brown, capsule body is blue with imprinted black mark 15. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 2, length  $18 \pm 1$  mm.

### Lenalidomide Krka d.d. Novo mesto 20 mg hard capsules

Capsule cap is green, capsule body is blue with imprinted black mark 20. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 1, length  $19 \pm 1$  mm.

### Lenalidomide Krka d.d. Novo mesto 25 mg hard capsules

Capsule cap is brown, capsule body is brown with imprinted white mark 25. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 0, length  $21 \pm 1$  mm.

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

#### Multiple myeloma

Lenalidomide Krka d.d. Novo mesto as monotherapy is indicated for the maintenance treatment of adult patients with newly diagnosed multiple myeloma who have undergone autologous stem cell transplantation.

Lenalidomide Krka d.d. Novo mesto as combination therapy with dexamethasone, or bortezomib and dexamethasone, or melphalan and prednisone (see section 4.2) is indicated for the treatment of adult patients with previously untreated multiple myeloma who are not eligible for transplant.

Lenalidomide Krka d.d. Novo mesto in combination with dexamethasone is indicated for the treatment of multiple myeloma in adult patients who have received at least one prior therapy.

#### Follicular lymphoma

Lenalidomide Krka d.d. Novo mesto in combination with rituximab (anti-CD20 antibody) is indicated for the treatment of adult patients with previously treated follicular lymphoma (Grade 1 – 3a).

### 4.2 Posology and method of administration

Lenalidomide treatment should be supervised by a physician experienced in the use of anti-cancer therapies.

For all indications described below:

- Dose is modified based upon clinical and laboratory findings (see section 4.4).
- Dose adjustments, during treatment and restart of treatment, are recommended to manage Grade 3 or 4 thrombocytopenia, neutropenia, or other Grade 3 or 4 toxicity judged to be related to lenalidomide.
- In case of neutropenia, the use of growth factors in patient management should be considered.
- If less than 12 hours has elapsed since missing a dose, the patient can take the dose. If more than 12 hours has elapsed since missing a dose at the normal time, the patient should not take the dose, but take the next dose at the normal time on the following day.

#### Posology

##### *Newly diagnosed multiple myeloma (NDMM)*

##### Lenalidomide in combination with dexamethasone until disease progression in patients who are not eligible for transplant

Lenalidomide treatment must not be started if the Absolute Neutrophil Count (ANC) is  $< 1.0 \times 10^9/L$ , and/or platelet counts are  $< 50 \times 10^9/L$ .

##### *Recommended dose*

The recommended starting dose of lenalidomide is 25 mg orally once daily on days 1 to 21 of repeated 28-day cycles.

The recommended dose of dexamethasone is 40 mg orally once daily on days 1, 8, 15 and 22 of repeated 28-day cycles. Patients may continue lenalidomide and dexamethasone therapy until disease progression or intolerance.

##### Dose reduction steps

	Lenalidomide <sup>a</sup>	Dexamethasone <sup>a</sup>
Starting dose	25 mg	40 mg
Dose level -1	20 mg	20 mg
Dose level -2	15 mg	12 mg
Dose level -3	10 mg	8 mg
Dose level- 4	5 mg	4 mg
Dose level -5	2.5 mg	Not applicable

<sup>a</sup> Dose reduction for both products can be managed independently

#### *Thrombocytopenia*

When platelets	Recommended course
Fall to $< 25 \times 10^9/L$	Stop lenalidomide dosing for remainder of cycle <sup>a</sup>
Return to $\geq 50 \times 10^9/L$	Decrease by one dose level when dosing resumed at next cycle

<sup>a</sup> If Dose limiting toxicity (DLT) occurs on  $>$  day15 of a cycle, lenalidomide dosing will be interrupted for at least the remainder of the current 28-day cycle.

#### *Absolute neutrophil count (ANC) - neutropenia*

When ANC	Recommended course <sup>a</sup>
First falls to $< 0.5 \times 10^9/L$ Returns to $\geq 1 \times 10^9/L$ when neutropenia is the only observed toxicity	Interrupt lenalidomide treatment Resume lenalidomide at starting dose once daily
Returns to $\geq 0.5 \times 10^9/L$ when dose-dependent haematological toxicities other than neutropenia are observed	Resume lenalidomide at dose level - 1 once daily
For each subsequent drop below $< 0.5 \times 10^9/L$ Returns to $\geq 0.5 \times 10^9/L$	Interrupt lenalidomide treatment Resume lenalidomide at next lower dose level once daily.

<sup>a</sup> At the physician's discretion, if neutropenia is the only toxicity at any dose level, add granulocyte colony stimulating factor (G-CSF) and maintain the dose level of lenalidomide.

For hematologic toxicity the dose of lenalidomide may be re-introduced to the next higher dose level (up to the starting dose) upon improvement in bone marrow function (no hematologic toxicity for at least 2 consecutive cycles: ANC  $\geq 1.5 \times 10^9/L$  with a platelet count  $\geq 100 \times 10^9/L$  at the beginning of a new cycle).

#### Lenalidomide in combination with bortezomib and dexamethasone followed by lenalidomide and dexamethasone until disease progression in patients who are not eligible for transplant

##### *Initial treatment: Lenalidomide in combination with bortezomib and dexamethasone*

Lenalidomide in combination with bortezomib and dexamethasone must not be started if the ANC is  $< 1.0 \times 10^9/L$ , and/or platelet counts are  $< 50 \times 10^9/L$ .

The recommended starting dose is lenalidomide 25 mg orally once daily days 1-14 of each 21-day cycle in combination with bortezomib and dexamethasone. Bortezomib should be administered via subcutaneous injection ( $1.3 \text{ mg/m}^2$  body surface area) twice weekly on days 1, 4, 8 and 11 of each 21-day. For additional information on the dose, schedule and dose adjustments of medicinal products administered with lenalidomide, see Section 5.1 and the corresponding Summary of Product Characteristics.

Up to eight 21-day treatment cycles (24 weeks of initial treatment) are recommended.

##### *Continued treatment: Lenalidomide in combination with dexamethasone until progression*

Continue lenalidomide 25 mg orally once daily on days 1-21 of repeated 28-day cycles in combination with dexamethasone. Treatment should be continued until disease progression or unacceptable toxicity.

Dose reduction steps

	Lenalidomide <sup>a</sup>
Starting dose	25 mg
Dose level -1	20 mg
Dose level -2	15 mg
Dose level -3	10 mg
Dose level- 4	5 mg
Dose level -5	2.5 mg

<sup>a</sup> Dose reduction for all products can be managed independently

#### *Thrombocytopenia*

When platelets	Recommended course
Fall to $< 30 \times 10^9/L$ Return to $\geq 50 \times 10^9/L$	Interrupt lenalidomide treatment Resume lenalidomide at dose level -1 once daily
For each subsequent drop below $30 \times 10^9/L$ Return to $\geq 50 \times 10^9/L$	Interrupt lenalidomide treatment Resume lenalidomide at next lower dose level once daily

#### *Absolute neutrophil count (ANC) - neutropenia*

When ANC	Recommended course <sup>a</sup>
First falls to $< 0.5 \times 10^9/L$ Returns to $\geq 1 \times 10^9/L$ when neutropenia is the only observed toxicity	Interrupt lenalidomide treatment Resume lenalidomide at starting dose once daily
Returns to $\geq 0.5 \times 10^9/L$ when dose-dependent haematological toxicities other than neutropenia are observed	Resume lenalidomide at dose level -1 once daily
For each subsequent drop below $< 0.5 \times 10^9/L$ Returns to $\geq 0.5 \times 10^9/L$	Interrupt lenalidomide treatment Resume lenalidomide at next lower dose level once daily.

<sup>a</sup> At the physician's discretion, if neutropenia is the only toxicity at any dose level, add granulocyte colony stimulating factor (G-CSF) and maintain the dose level of lenalidomide.

#### Lenalidomide in combination with melphalan and prednisone followed by lenalidomide maintenance in patients who are not eligible for transplant

Lenalidomide treatment must not be started if the ANC is  $< 1.5 \times 10^9/L$ , and/or platelet counts are  $< 75 \times 10^9/L$ .

#### *Recommended dose*

The recommended starting dose is lenalidomide 10 mg orally once daily on days 1 to 21 of repeated 28-day cycles for up to 9 cycles, melphalan 0.18 mg/kg orally on days 1 to 4 of repeated 28-day cycles, prednisone 2 mg/kg orally on days 1 to 4 of repeated 28-day cycles. Patients who complete 9 cycles or who are unable to complete the combination therapy due to intolerance are treated with lenalidomide monotherapy as follows: 10 mg orally once daily on days 1 to 21 of repeated 28-day cycles given until disease progression.

#### Dose reduction steps

	Lenalidomide	Melphalan	Prednisone
Starting dose	10 mg <sup>a</sup>	0.18 mg/kg	2 mg/kg
Dose level -1	7.5 mg	0.14 mg/kg	1 mg/kg
Dose level -2	5 mg	0.10 mg/kg	0.5 mg/kg
Dose level -3	2.5 mg	Not applicable	0.25 mg/kg

<sup>a</sup> If neutropenia is the only toxicity at any dose level, add granulocyte colony stimulating factor (G-CSF) and maintain the dose level of lenalidomide

#### *Thrombocytopenia*

When platelets	Recommended course
First fall to $< 25 \times 10^9/L$ Return to $\geq 25 \times 10^9/L$	Interrupt lenalidomide treatment Resume lenalidomide and melphalan at dose level -1

For each subsequent drop below $30 \times 10^9/L$	Interrupt lenalidomide treatment
Return to $\geq 30 \times 10^9/L$	Resume lenalidomide at next lower dose level (dose level -2 or -3) once daily.

*Absolute neutrophil count (ANC) - neutropenia*

When ANC	Recommended course <sup>a</sup>
First falls to $< 0.5 \times 10^9/L$	Interrupt lenalidomide treatment
Returns to $\geq 0.5 \times 10^9/L$ when neutropenia is the only observed toxicity	Resume lenalidomide at starting dose once daily
Returns to $\geq 0.5 \times 10^9/L$ when dose-dependent haematological toxicities other than neutropenia are observed	Resume lenalidomide at dose level -1 once daily
For each subsequent drop below $< 0.5 \times 10^9/L$	Interrupt lenalidomide treatment
Returns to $\geq 0.5 \times 10^9/L$	Resume lenalidomide at next lower dose level once daily.

<sup>a</sup> At the physician's discretion, if neutropenia is the only toxicity at any dose level, add granulocyte colony stimulating factor (G-CSF) and maintain the dose level of lenalidomide.

Lenalidomide maintenance in patients who have undergone autologous stem cell transplantation (ASCT)

Lenalidomide maintenance should be initiated after adequate haematologic recovery following ASCT in patients without evidence of progression. Lenalidomide must not be started if the ANC is  $< 1.0 \times 10^9/L$ , and/or platelet counts are  $< 75 \times 10^9/L$ .

*Recommended dose*

The recommended starting dose is lenalidomide 10 mg orally once daily continuously (on days 1 to 28 of repeated 28-day cycles) given until disease progression or intolerance. After 3 cycles of lenalidomide maintenance, the dose can be increased to 15 mg orally once daily if tolerated.

*Dose reduction steps*

	Starting dose (10 mg)	If dose increased (15 mg) <sup>a</sup>
Dose level -1	5 mg	10 mg
Dose level -2	5 mg (days 1-21 every 28 days)	5 mg
Dose level -3	Not applicable	5 mg (days 1-21 every 28 days)
Do not dose below 5 mg (days 1-21 every 28 days)		

<sup>a</sup> After 3 cycles of lenalidomide maintenance, the dose can be increased to 15 mg orally once daily if tolerated.

*Thrombocytopenia*

When platelets	Recommended course
Fall to $< 30 \times 10^9/L$	Interrupt lenalidomide treatment
Return to $\geq 30 \times 10^9/L$	Resume lenalidomide at dose level -1 once daily
For each subsequent drop below $30 \times 10^9/L$	Interrupt lenalidomide treatment
Return to $\geq 30 \times 10^9/L$	Resume lenalidomide at next lower dose level once daily

*Absolute neutrophil count (ANC) - neutropenia*

When ANC	Recommended course <sup>a</sup>
Falls to $< 0.5 \times 10^9/L$	Interrupt lenalidomide treatment
Returns to $\geq 0.5 \times 10^9/L$	Resume lenalidomide at dose level -1 once daily
For each subsequent drop below $< 0.5 \times 10^9/L$	Interrupt lenalidomide treatment

Returns to $\geq 0.5 \times 10^9/L$	Resume lenalidomide at next lower dose level once daily
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<sup>a</sup> At the physician's discretion, if neutropenia is the only toxicity at any dose level, add granulocyte colony stimulating factor (G-CSF) and maintain the dose level of lenalidomide.

### Multiple myeloma with at least one prior therapy

Lenalidomide treatment must not be started if the ANC  $< 1.0 \times 10^9/L$ , and/or platelet counts  $< 75 \times 10^9/L$  or, dependent on bone marrow infiltration by plasma cells, platelet counts  $< 30 \times 10^9/L$ .

### *Recommended dose*

The recommended starting dose of lenalidomide is 25 mg orally once daily on days 1 to 21 of repeated 28-day cycles. The recommended dose of dexamethasone is 40 mg orally once daily on days 1 to 4, 9 to 12, and 17 to 20 of each 28-day cycle for the first 4 cycles of therapy and then 40 mg once daily on days 1 to 4 every 28 days.

Prescribing physicians should carefully evaluate which dose of dexamethasone to use, taking into account the condition and disease status of the patient.

### Dose reduction steps

Starting dose	25 mg
Dose level -1	15 mg
Dose level -2	10 mg
Dose level -3	5 mg

### *Thrombocytopenia*

When platelets	Recommended course
First fall to $< 30 \times 10^9/L$	Interrupt lenalidomide treatment
Return to $\geq 30 \times 10^9/L$	Resume lenalidomide at dose level -1
For each subsequent drop below $30 \times 10^9/L$	Interrupt lenalidomide treatment
Return to $\geq 30 \times 10^9/L$	Resume lenalidomide at next lower dose level (dose level -2 or -3) once daily. Do not dose below 5 mg once daily.

### *Absolute neutrophil count (ANC) - neutropenia*

When ANC	Recommended course <sup>a</sup>
First falls to $< 0.5 \times 10^9/L$	Interrupt lenalidomide treatment
Returns to $\geq 0.5 \times 10^9/L$ when neutropenia is the only observed toxicity	Resume lenalidomide at starting dose once daily
Returns to $\geq 0.5 \times 10^9/L$ when dose-dependent haematological toxicities other than neutropenia are observed	Resume lenalidomide at dose level -1 once daily
For each subsequent drop below $< 0.5 \times 10^9/L$	Interrupt lenalidomide treatment
Returns to $\geq 0.5 \times 10^9/L$	Resume lenalidomide at next lower dose level (dose level -1, -2 or -3) once daily. Do not dose below 5 mg once daily.

<sup>a</sup> At the physician's discretion, if neutropenia is the only toxicity at any dose level, add granulocyte colony stimulating factor (G-CSF) and maintain the dose level of lenalidomide.

### Follicular lymphoma (FL)

Lenalidomide treatment must not be started if the ANC is  $< 1 \times 10^9/L$ , and/or platelet count  $< 50 \times 10^9/L$ , unless secondary to lymphoma infiltration of bone marrow.

### Recommended dose

The recommended starting dose of lenalidomide is 20 mg, orally once daily on days 1 to 21 of repeated 28-day cycles for up to 12 cycles of treatment. The recommended starting dose of rituximab is 375 mg/m<sup>2</sup> intravenously (IV) every week in Cycle 1 (days 1, 8, 15, and 22) and day 1 of every 28-day cycle for cycles 2 through 5.

### Dose reduction steps

Starting dose	20 mg once daily on days 1-21, every 28 days
Dose Level -1	15 mg once daily on days 1-21, every 28 days
Dose Level -2	10 mg once daily on days 1-21, every 28 days
Dose Level -3	5 mg once daily on days 1-21, every 28 days

For dose adjustments due to toxicity with rituximab, refer to the corresponding summary of product characteristics.

### Thrombocytopenia

When platelets	Recommended course
Fall to < 50 x 10 <sup>9</sup> /L	Interrupt lenalidomide treatment and conduct CBC at least every 7 days
Return to ≥ 50 x 10 <sup>9</sup> /L	Resume at next lower dose level (dose level -1)
For each subsequent drop below 50 x 10 <sup>9</sup> /L	Interrupt lenalidomide treatment and conduct CBC at least every 7 days
Return to ≥ 50 x 10 <sup>9</sup> /L	Resume lenalidomide at next lower dose level (dose level -2, -3). Do not dose below dose level -3.

### Absolute neutrophil count (ANC) - neutropenia

When ANC	Recommended course <sup>a</sup>
Falls to < 1.0 x 10 <sup>9</sup> /L for at least 7 days or Falls to < 1.0 x 10 <sup>9</sup> /L with associated fever (body temperature ≥ 38.5°C) or Falls to < 0.5 x 10 <sup>9</sup> /L	Interrupt lenalidomide treatment and conduct CBC at least every 7 days
Returns to ≥ 1.0 x 10 <sup>9</sup> /L	Resume lenalidomide at next lower dose level (dose level -1)
For each subsequent drop below 1.0 x 10 <sup>9</sup> /L for at least 7 days or drop to < 1.0 x 10 <sup>9</sup> /L with associated fever (body temperature ≥ 38.5°C) or drop to < 0.5 x 10 <sup>9</sup> /L	Interrupt lenalidomide treatment and conduct CBC at least every 7 days
Returns to ≥ 1.0 x 10 <sup>9</sup> /L	Resume lenalidomide at next lower dose level (dose level -2, -3). Do not dose below dose level -3

<sup>a</sup> At the physician's discretion, if neutropenia is the only toxicity at any dose level, add G-CSF

### Tumour lysis syndrome (TLS)

All patients should receive TLS prophylaxis (allopurinol, rasburicase or equivalent as per institutional guidelines) and be well hydrated (orally) during the first week of the first cycle or for a longer period if clinically indicated. To monitor for TLS, patients should have a chemistry panel drawn weekly during the first cycle and as clinically indicated.

Lenalidomide may be continued (maintain dose) in patients with laboratory TLS or Grade 1 clinical TLS, or at the physician's discretion, reduce dose by one level and continue lenalidomide. Vigorous intravenous hydration should be provided and appropriate medical management according to the local standard of care, until correction of electrolyte abnormalities. Rasburicase therapy may be needed to reduce hyperuricaemia. Hospitalisation of the patient will be at physician's discretion.

In patients with Grade 2 to 4 clinical TLS, interrupt lenalidomide and obtain a chemistry panel

weekly or as clinically indicated. Vigorous intravenous hydration should be provided and appropriate medical management according to the local standard of care, until correction of electrolyte abnormalities.

Rasburicase therapy and hospitalisation will be at physician's discretion. When the TLS resolves to Grade 0, restart lenalidomide at next lower dose per physician's discretion (see section 4.4).

#### *Tumour flare reaction*

At the physician's discretion, lenalidomide may be continued in patients with Grade 1 or 2 tumour flare reaction (TFR) without interruption or modification. At the physician's discretion, therapy with non-steroidal anti-inflammatory drugs (NSAIDs), limited duration corticosteroids, and/or narcotic analgesics may be administered. In patients with Grade 3 or 4 TFR, withhold treatment with lenalidomide and initiate therapy with NSAIDs, corticosteroids and/or narcotic analgesics. When TFR resolves to  $\leq$  Grade 1, restart lenalidomide treatment at the same dose level for the rest of the cycle. Patients may be treated for management of symptoms per the guidance for treatment of Grade 1 and 2 TFR (see section 4.4).

#### All indications

For other Grade 3 or 4 toxicities judged to be related to lenalidomide, treatment should be stopped and only restarted at next lower dose level when toxicity has resolved to  $\leq$  Grade 2 depending on the physician's discretion.

Lenalidomide interruption or discontinuation should be considered for Grade 2 or 3 skin rash. Lenalidomide must be discontinued for angioedema, anaphylactic reaction, Grade 4 rash, exfoliative or bullous rash, or if Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN) or Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) is suspected, and should not be resumed following discontinuation from these reactions.

#### Special populations

##### Paediatric population

Lenalidomide should not be used in children and adolescents from birth to less than 18 years because of safety concerns (see section 5.1).

##### Elderly

Currently available pharmacokinetic data are described in section 5.2. Lenalidomide has been used in clinical trials in multiple myeloma patients up to 91 years of age (see section 5.1).

Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection and it would be prudent to monitor renal function.

##### *Newly diagnosed multiple myeloma: patients who are not eligible for transplant*

Patients with newly diagnosed multiple myeloma aged 75 years and older should be carefully assessed before treatment is considered (see section 4.4).

For patients older than 75 years of age treated with lenalidomide in combination with dexamethasone, the starting dose of dexamethasone is 20 mg once daily on days 1, 8, 15 and 22 of each 28-day treatment cycle.

No dose adjustment is proposed for patients older than 75 years who are treated with lenalidomide in combination with melphalan and prednisone.

In patients with newly diagnosed multiple myeloma aged 75 years and older who received lenalidomide, there was a higher incidence of serious adverse reactions and adverse reactions that led to treatment discontinuation.

Lenalidomide combined therapy was less tolerated in newly diagnosed multiple myeloma patients older than 75 years of age compared to the younger population. These patients discontinued at a higher rate

due to intolerance (Grade 3 or 4 adverse events and serious adverse events), when compared to patients < 75 years.

*Multiple myeloma: patients with at least one prior therapy*

The percentage of multiple myeloma patients aged 65 or over was not significantly different between the lenalidomide/dexamethasone and placebo/dexamethasone groups. No overall difference in safety or efficacy was observed between these patients and younger patients, but greater pre-disposition of older individuals cannot be ruled out.

*Follicular lymphoma*

For follicular lymphoma patients treated with lenalidomide in combination with rituximab, the overall rate of adverse events is similar for patients aged 65 years or over compared with patients under 65 years of age. No overall difference in efficacy was observed between the two age groups.

Patients with renal impairment

Lenalidomide is primarily excreted by the kidney; patients with greater degrees of renal impairment can have impaired treatment tolerance (see section 4.4). Care should be taken in dose selection and monitoring of renal function is advised.

No dose adjustments are required for patients with mild renal impairment and multiple myeloma or follicular lymphoma.

The following dose adjustments are recommended at the start of therapy and throughout treatment for patients with moderate or severe impaired renal function or end stage renal disease.

There are no phase 3 trial experiences with End Stage Renal Disease (ESRD) (CLcr < 30 mL/min, requiring dialysis).

*Multiple myeloma*

<b>Renal function (CLcr)</b>	<b>Dose adjustment</b>
Moderate renal impairment (30 ≤ CLcr < 50 mL/min)	10 mg once daily <sup>1</sup>
Severe renal impairment (CLcr < 30 mL/min, not requiring dialysis)	7.5 mg once daily <sup>2</sup> 15 mg every other day
End Stage Renal Disease (ESRD) (CLcr < 30 mL/min, requiring dialysis)	5 mg once daily. On dialysis days, the dose should be administered following dialysis.

<sup>1</sup> The dose may be escalated to 15 mg once daily after 2 cycles if patient is not responding to treatment and is tolerating the treatment.

<sup>2</sup> In countries where the 7.5 mg capsule is available.

*Follicular lymphoma*

<b>Renal function (CLcr)</b>	<b>Dose adjustment (days 1 to 21 of repeated 28-day cycles)</b>
Moderate renal impairment (30 ≤ CLcr < 60 mL/min)	10 mg once daily <sup>1,2</sup>
Severe renal impairment (CLcr < 30 mL/min, not requiring dialysis)	No data available <sup>3</sup>
End Stage Renal Disease (ESRD) (CLcr < 30 mL/min, requiring dialysis)	No data available <sup>3</sup>

<sup>1</sup> The dose may be escalated to 15 mg once daily after 2 cycles if the patient has tolerated therapy.

<sup>2</sup> For patients on a starting dose of 10 mg, in case of dose reduction to manage Grade 3 or 4 neutropenia or thrombocytopenia, or other Grade 3 or 4. Toxicity judged to be related to lenalidomide do not dose below 5 mg every other day or 2.5 mg once daily.

<sup>3</sup> Patients with severe renal impairment or ESRD were excluded from study.

After initiation of lenalidomide therapy, subsequent lenalidomide dose modification in renally impaired patients should be based on individual patient treatment tolerance, as described above.

### Patients with hepatic impairment

Lenalidomide has not formally been studied in patients with impaired hepatic function and there are no specific dose recommendations.

### Method of administration

Oral use.

Lenalidomide Krka d.d. Novo mesto capsules should be taken orally at about the same time on the scheduled days. The capsules should not be opened, broken or chewed (see section 6.6). The capsules should be swallowed whole, preferably with water, either with or without food.

Lenalidomide capsules should not be pushed through the foil in the blister pack as this could cause damage to the capsule. The capsule should be removed from the package by peeling off the foil from one separated blister cell.

### **4.3 Contraindications**

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Women who are pregnant.
- Women of childbearing potential unless all of the conditions of the Pregnancy Prevention Programme are met (see sections 4.4 and 4.6).

### **4.4 Special warnings and precautions for use**

**When lenalidomide is given in combination with other medicinal products, the corresponding Summary of Product Characteristics must be consulted prior to initiation of treatment.**

### Pregnancy warning

Lenalidomide is structurally related to thalidomide. Thalidomide is a known human teratogenic active substance that causes severe life-threatening birth defects. In monkeys lenalidomide induced malformations similar to those described with thalidomide (see sections 4.6 and 5.3). If lenalidomide is taken during pregnancy, a teratogenic effect of lenalidomide in humans is expected.

The conditions of the Pregnancy Prevention Programme must be fulfilled for all patients unless there is reliable evidence that the patient does not have childbearing potential.

### Criteria for women of non-childbearing potential

A female patient or a female partner of a male patient is considered to have childbearing potential unless she meets at least one of the following criteria:

- Age  $\geq$  50 years and naturally amenorrhoeic for  $\geq$  1 year (Amenorrhoea following cancer therapy or during breast-feeding does not rule out childbearing potential).
- Premature ovarian failure confirmed by a specialist gynaecologist.
- Previous bilateral salpingo-oophorectomy, or hysterectomy.
- XY genotype, Turner syndrome, uterine agenesis.

### Counselling

For women of childbearing potential, lenalidomide is contraindicated unless all of the following are met:

- She understands the expected teratogenic risk to the unborn child
- She understands the need for effective contraception, without interruption, at least 4 weeks before starting treatment, throughout the entire duration of treatment, and at least 4 weeks after the end of treatment
- Even if a woman of childbearing potential has amenorrhea she must follow all the advice on effective contraception

- She should be capable of complying with effective contraceptive measures
- She is informed and understands the potential consequences of pregnancy and the need to rapidly consult if there is a risk of pregnancy
- She understands the need to commence the treatment as soon as lenalidomide is dispensed following a negative pregnancy test
- She understands the need and accepts to undergo pregnancy testing at least every 4 weeks except in case of confirmed tubal sterilisation
- She acknowledges that she understands the hazards and necessary precautions associated with the use of lenalidomide.

For male patients taking lenalidomide, pharmacokinetic data has demonstrated that lenalidomide is present in human semen at extremely low levels during treatment and is undetectable in human semen 3 days after stopping the substance in the healthy subject (see section 5.2). As a precaution and taking into account special populations with prolonged elimination time such as renal impairment, all male patients taking lenalidomide must meet the following conditions:

- Understand the expected teratogenic risk if engaged in sexual activity with a pregnant woman or a woman of childbearing potential.
- Understand the need for the use of a condom if engaged in sexual activity with a pregnant woman or a woman of childbearing potential not using effective contraception (even if the man has had a vasectomy), during treatment and for at least 7 days after dose interruptions and/or cessation of treatment.
- Understand that if his female partner becomes pregnant whilst he is taking lenalidomide or shortly after he has stopped taking lenalidomide, he should inform his treating physician immediately and that it is recommended to refer the female partner to a physician specialised or experienced in teratology for evaluation and advice.

The prescriber must ensure that for women of childbearing potential:

- The patient complies with the conditions of the Pregnancy Prevention Programme, including confirmation that she has an adequate level of understanding.
- The patient has acknowledged the aforementioned conditions.

### Contraception

Women of childbearing potential must use at least one effective method of contraception for at least 4 weeks before therapy, during therapy, and until at least 4 weeks after lenalidomide therapy and even in case of dose interruption unless the patient commits to absolute and continuous abstinence confirmed on a monthly basis. If not established on effective contraception, the patient must be referred to an appropriately trained health care professional for contraceptive advice in order that contraception can be initiated.

The following can be considered to be examples of suitable methods of contraception:

- Implant
- Levonorgestrel-releasing intrauterine system (IUS)
- Medroxyprogesterone acetate depot
- Tubal sterilisation
- Sexual intercourse with a vasectomised male partner only; vasectomy must be confirmed by two negative semen analyses
- Ovulation inhibitory progesterone-only pills (i.e. desogestrel)

Because of the increased risk of venous thromboembolism in patients with multiple myeloma taking lenalidomide in combination therapy, and to a lesser extent in patients with multiple myeloma, taking lenalidomide monotherapy, combined oral contraceptive pills are not recommended (see also section 4.5). If a patient is currently using combined oral contraception the patient should switch to one of the effective methods listed above. The risk of venous thromboembolism continues for 4–6 weeks after discontinuing combined oral contraception. The efficacy of contraceptive steroids may be reduced during co-treatment with dexamethasone (see section 4.5).

Implants and levonorgestrel-releasing intrauterine systems are associated with an increased risk of infection at the time of insertion and irregular vaginal bleeding. Prophylactic antibiotics should be considered particularly in patients with neutropenia.

Copper-releasing intrauterine devices are generally not recommended due to the potential risks of infection at the time of insertion and menstrual blood loss which may compromise patients with neutropenia or thrombocytopenia.

#### Pregnancy testing

According to local practice, medically supervised pregnancy tests with a minimum sensitivity of 25 mIU/mL must be performed for women of childbearing potential as outlined below. This requirement includes women of childbearing potential who practice absolute and continuous abstinence. Ideally, pregnancy testing, issuing a prescription and dispensing should occur on the same day. Dispensing of lenalidomide to women of childbearing potential should occur within 7 days of the prescription.

#### Prior to starting treatment

A medically supervised pregnancy test should be performed during the consultation, when lenalidomide is prescribed, or in the 3 days prior to the visit to the prescriber once the patient had been using effective contraception for at least 4 weeks. The test should ensure the patient is not pregnant when she starts treatment with lenalidomide.

#### Follow-up and end of treatment

A medically supervised pregnancy test should be repeated at least every 4 weeks, including at least 4 weeks after the end of treatment, except in the case of confirmed tubal sterilisation. These pregnancy tests should be performed on the day of the prescribing visit or in the 3 days prior to the visit to the prescriber.

#### Additional precautions

Patients should be instructed never to give this medicinal product to another person and to return any unused capsules to their pharmacist at the end of treatment for safe disposal.

Patients should not donate blood during therapy or for at least 7 days following discontinuation of lenalidomide.

Healthcare professionals and caregivers should wear disposable gloves when handling the blister or capsule. Women who are pregnant or suspect they may be pregnant should not handle the blister or capsule (see section 6.6).

#### Educational materials, prescribing and dispensing restrictions

In order to assist patients in avoiding foetal exposure to lenalidomide, the marketing authorisation holder will provide educational material to health care professionals to reinforce the warnings about the expected teratogenicity of lenalidomide, to provide advice on contraception before therapy is started, and to provide guidance on the need for pregnancy testing. The prescriber must inform male and female patients about the expected teratogenic risk and the strict pregnancy prevention measures as specified in the Pregnancy Prevention Programme and provide patients with appropriate patient educational brochure, patient card and/or equivalent tool in accordance to the national implemented patient card system. A national controlled distribution system has been implemented in collaboration with each National Competent Authority. The controlled distribution system includes the use of a patient card and/or equivalent tool for prescribing and/or dispensing controls, and the collecting of detailed data relating to the indication in order to monitor closely the off-label use within the national territory. Ideally, pregnancy testing, issuing a prescription and dispensing should occur on the same day. Dispensing of lenalidomide to women of childbearing potential should occur within 7 days of the prescription and following a medically supervised negative pregnancy test result. Prescriptions for

women of childbearing potential can be for a maximum duration of treatment of 4 weeks, according to the approved indications dosing regimens (see section 4.2), and prescriptions for all other patients can be for a maximum duration of treatment of 12 weeks.

#### Other special warnings and precautions for use

##### Myocardial infarction

Myocardial infarction has been reported in patients receiving lenalidomide, particularly in those with known risk factors and within the first 12 months when used in combination with dexamethasone. Patients with known risk factors – including prior thrombosis – should be closely monitored, and action should be taken to try to minimize all modifiable risk factors (eg. smoking, hypertension, and hyperlipidaemia).

##### Venous and arterial thromboembolic events

In patients with multiple myeloma, the combination of lenalidomide with dexamethasone is associated with an increased risk of venous thromboembolism (predominantly deep vein thrombosis and pulmonary embolism). The risk of venous thromboembolism was seen to a lesser extent with lenalidomide in combination with melphalan and prednisone.

In patients with multiple myeloma, treatment with lenalidomide monotherapy was associated with a lower risk of venous thromboembolism (predominantly deep vein thrombosis and pulmonary embolism) than in patients with multiple myeloma treated with lenalidomide in combination therapy (see sections 4.5 and 4.8).

In patients with multiple myeloma, the combination of lenalidomide with dexamethasone is associated with an increased risk of arterial thromboembolism (predominantly myocardial infarction and cerebrovascular event) and was seen to a lesser extent with lenalidomide in combination with melphalan and prednisone. The risk of arterial thromboembolism is lower in patients with multiple myeloma treated with lenalidomide monotherapy than in patients with multiple myeloma treated with lenalidomide in combination therapy.

Consequently, patients with known risk factors for thromboembolism – including prior thrombosis – should be closely monitored. Action should be taken to try to minimize all modifiable risk factors (e.g. smoking, hypertension, and hyperlipidaemia). Concomitant administration of erythropoietic agents or previous history of thromboembolic events may also increase thrombotic risk in these patients. Therefore, erythropoietic agents, or other agents that may increase the risk of thrombosis, such as hormone replacement therapy, should be used with caution in multiple myeloma patients receiving lenalidomide with dexamethasone. A haemoglobin concentration above 12 g/dl should lead to discontinuation of erythropoietic agents.

Patients and physicians are advised to be observant for the signs and symptoms of thromboembolism. Patients should be instructed to seek medical care if they develop symptoms such as shortness of breath, chest pain, arm or leg swelling. Prophylactic antithrombotic medicinal products should be recommended, especially in patients with additional thrombotic risk factors. The decision to take antithrombotic prophylactic measures should be made after careful assessment of an individual patient's underlying risk factors.

If the patient experiences any thromboembolic events, treatment must be discontinued and standard anticoagulation therapy started. Once the patient has been stabilised on the anticoagulation treatment and any complications of the thromboembolic event have been managed, the lenalidomide treatment may be restarted at the original dose dependent upon a benefit risk assessment. The patient should continue anticoagulation therapy during the course of lenalidomide treatment.

##### Pulmonary hypertension

Cases of pulmonary hypertension, some fatal, have been reported in patients treated with lenalidomide. Patients should be evaluated for signs and symptoms of underlying cardiopulmonary disease prior to initiating and during lenalidomide therapy.

### Neutropenia and thrombocytopenia

The major dose limiting toxicities of lenalidomide include neutropenia and thrombocytopenia. A complete blood cell count, including white blood cell count with differential count, platelet count, haemoglobin, and haematocrit should be performed at baseline, every week for the first 8 weeks of lenalidomide treatment and monthly thereafter to monitor for cytopenias. In follicular lymphoma, the monitoring scheme should be weekly for the first 3 weeks of cycle 1 (28 days), every 2 weeks during cycles 2 through 4, and then at the start of each cycle thereafter. A dose interruption and/or a dose reduction may be required (see section 4.2).

In case of neutropenia, the physician should consider the use of growth factors in patient management. Patients should be advised to promptly report febrile episodes.

Patients and physicians are advised to be observant for signs and symptoms of bleeding, including petechiae and epistaxis, especially in patients receiving concomitant medicinal products susceptible to induce bleeding (see section 4.8, Haemorrhagic disorders).

Co-administration of lenalidomide with other myelosuppressive agents should be undertaken with caution.

### Newly diagnosed multiple myeloma: patients who have undergone ASCT treated with lenalidomide maintenance

The adverse reactions from CALGB 100104 included events reported post-high dose melphalan and ASCT (HDM/ASCT) as well as events from the maintenance treatment period. A second analysis identified events that occurred after the start of maintenance treatment. In IFM 2005-02, the adverse reactions were from the maintenance treatment period only.

Overall, Grade 4 neutropenia was observed at a higher frequency in the lenalidomide maintenance arms compared to the placebo maintenance arms in the 2 studies evaluating lenalidomide maintenance in NDMM patients who have undergone ASCT (32.1% vs 26.7% [16.1% vs 1.8% after the start of maintenance treatment] in CALGB 100104 and 16.4% vs 0.7% in IFM 2005-02, respectively). Treatment-emergent AEs of neutropenia leading to lenalidomide discontinuation were reported in 2.2% of patients in CALGB 100104 and 2.4% of patients in IFM 2005-02, respectively. Grade 4 febrile neutropenia was reported at similar frequencies in the lenalidomide maintenance arms compared to placebo maintenance arms in both studies (0.4% vs 0.5% [0.4% vs 0.5% after the start of maintenance treatment] in CALGB 100104 and 0.3% vs 0% in IFM 2005-02, respectively). Patients should be advised to promptly report febrile episodes, a treatment interruption and/or dose reduction may be required (see section 4.2).

Grade 3 or 4 thrombocytopenia was observed at a higher frequency in the lenalidomide maintenance arms compared to the placebo maintenance arms in studies evaluating lenalidomide maintenance in NDMM patients who have undergone ASCT (37.5% vs 30.3% [17.9% vs 4.1% after the start of maintenance treatment] in CALGB 100104 and 13.0% vs 2.9% in IFM 2005-02, respectively). Patients and physicians are advised to be observant for signs and symptoms of bleeding, including petechiae and epistaxes, especially in patients receiving concomitant medicinal products susceptible to induce bleeding (see section 4.8, Haemorrhagic disorders).

### Newly diagnosed multiple myeloma: patients who are not eligible for transplant treated with lenalidomide in combination with bortezomib and dexamethasone

Grade 4 neutropenia was observed at a lower frequency in the lenalidomide in combination with bortezomib and dexamethasone (RVd) arm compared to the Rd comparator arm (2.7% vs 5.9%) in the SWOG S0777 study. Grade 4 febrile neutropenia was reported at similar frequencies in the RVd arm and Rd arm (0.0% vs 0.4%). Patients should be advised to promptly report febrile episodes; a treatment interruption and/or dose reduction may be required (see section 4.2).

Grade 3 or 4 thrombocytopenia was observed at a higher frequency in the RVd arm compared to the Rd comparator arm (17.2% vs 9.4%).

### Newly diagnosed multiple myeloma: patients who are not eligible for transplant treated with lenalidomide in combination with low dose dexamethasone

Grade 4 neutropenia was observed in the lenalidomide arms in combination with dexamethasone to a lesser extent than in the comparator arm (8.5% in the Rd [continuous treatment] and Rd18 [treatment for 18 four-week cycles] compared with 15% in the melphalan/prednisone/thalidomide arm, see section 4.8). Grade 4 febrile neutropenia episodes were consistent with the comparator arm (0.6% in the Rd and Rd18 lenalidomide/dexamethasone-treated patients compared with 0.7% in the melphalan/prednisone/thalidomide arm, see section 4.8).

Grade 3 or 4 thrombocytopenia was observed to a lesser extent in the Rd and Rd18 arms than in the comparator arm (8.1% vs 11.1%, respectively).

#### Newly diagnosed multiple myeloma: patients who are not eligible for transplant treated with lenalidomide in combination with melphalan and prednisone

The combination of lenalidomide with melphalan and prednisone in clinical trials of newly diagnosed multiple myeloma patients is associated with a higher incidence of Grade 4 neutropenia (34.1% in melphalan, prednisone and lenalidomide arm followed by lenalidomide [MPR+R] and melphalan, prednisone and lenalidomide followed by placebo [MPR+p] treated patients compared with 7.8% in MPP+p-treated patients; see section 4.8). Grade 4 febrile neutropenia episodes were observed infrequently (1.7% in MPR+R/MPR+p treated patients compared to 0.0% in MPP+p treated patients; see section 4.8).

The combination of lenalidomide with melphalan and prednisone in multiple myeloma patients is associated with a higher incidence of Grade 3 and Grade 4 thrombocytopenia (40.4% in MPR+R/MPR+p treated patients, compared with 13.7% in MPP+p-treated patients; see section 4.8).

#### Multiple myeloma: patients with at least one prior therapy

The combination of lenalidomide with dexamethasone in multiple myeloma patients with at least one prior therapy is associated with a higher incidence of Grade 4 neutropenia (5.1% in lenalidomide/dexamethasone-treated patients compared with 0.6% in placebo/dexamethasone-treated patients; see section 4.8). Grade 4 febrile neutropenia episodes were observed infrequently (0.6% in lenalidomide/dexamethasone-treated patients compared to 0.0% in placebo/dexamethasone treated patients; see section 4.8).

The combination of lenalidomide with dexamethasone in multiple myeloma patients is associated with a higher incidence of Grade 3 and Grade 4 thrombocytopenia (9.9% and 1.4%, respectively, in lenalidomide/dexamethasone-treated patients compared to 2.3% and 0.0% in placebo/dexamethasone-treated patients; see section 4.8).

#### Follicular lymphoma

The combination of lenalidomide with rituximab in follicular lymphoma patients is associated with a higher incidence of Grade 3 or 4 neutropenia compared with patients on the placebo/rituximab arm. Febrile neutropenia and Grade 3 or 4 thrombocytopenia were more commonly observed in the lenalidomide/rituximab arm (see section 4.8).

#### Thyroid disorders

Cases of hypothyroidism and cases of hyperthyroidism have been reported. Optimal control of co-morbid conditions influencing thyroid function is recommended before start of treatment. Baseline and ongoing monitoring of thyroid function is recommended.

#### Peripheral neuropathy

Lenalidomide is structurally related to thalidomide, which is known to induce severe peripheral neuropathy. There was no increase in peripheral neuropathy observed with lenalidomide in combination with dexamethasone or melphalan and prednisone or lenalidomide monotherapy or with long term use of lenalidomide for the treatment of newly diagnosed multiple myeloma.

The combination of lenalidomide with intravenous bortezomib and dexamethasone in multiple myeloma patients is associated with a higher frequency of peripheral neuropathy. The frequency was lower when bortezomib was administered subcutaneously. For additional information, see Section 4.8

and the SmPC for bortezomib.

#### Tumour flare reaction and tumour lysis syndrome

Because lenalidomide has anti-neoplastic activity, the complications of tumour lysis syndrome (TLS) may occur. Cases of TLS and tumour flare reaction (TFR), including fatal cases, have been reported (see section 4.8). The patients at risk of TLS and TFR are those with high tumour burden prior to treatment. Caution should be practiced when introducing these patients to lenalidomide. These patients should be monitored closely, especially during the first cycle or dose-escalation, and appropriate precautions taken.

#### Follicular lymphoma

Careful monitoring and evaluation for TFR is recommended. Tumour flare may mimic PD. Patients who experienced Grade 1 and 2 TFR were treated with corticosteroids, NSAIDs and/or narcotic analgesics for management of TFR symptoms. The decision to take therapeutic measures for TFR should be made after careful clinical assessment of the individual patient (see sections 4.2 and 4.8).

Careful monitoring and evaluation for TLS is recommended. Patients should be well hydrated and receive TLS prophylaxis, in addition to weekly chemistry panels during the first cycle or longer, as clinically indicated (see sections 4.2 and 4.8).

#### Allergic reactions and severe skin reactions

Cases of allergic reactions including angioedema, anaphylactic reaction and severe cutaneous reactions including SJS, TEN and DRESS have been reported in patients treated with lenalidomide (see section 4.8). Patients should be advised of the signs and symptoms of these reactions by their prescribers and should be told to seek medical attention immediately if they develop these symptoms. Lenalidomide must be discontinued for angioedema, anaphylactic reaction, exfoliative or bullous rash, or if SJS, TEN or DRESS is suspected, and should not be resumed following discontinuation for these reactions. Interruption or discontinuation of lenalidomide should be considered for other forms of skin reaction depending on severity. Patients who had previous allergic reactions while treated with thalidomide should be monitored closely, as a possible cross-reaction between lenalidomide and thalidomide has been reported in the literature. Patients with a history of severe rash associated with thalidomide treatment should not receive lenalidomide.

#### Second primary malignancies

An increase of second primary malignancies (SPM) has been observed in clinical trials in previously treated myeloma patients receiving lenalidomide/dexamethasone (3.98 per 100 person-years) compared to controls (1.38 per 100 person-years). Non-invasive SPM comprise basal cell or squamous cell skin cancers. Most of the invasive SPMs were solid tumour malignancies.

In clinical trials of newly diagnosed multiple myeloma patients not eligible for transplant, a 4.9-fold increase in incidence rate of hematologic SPM (cases of AML, MDS) has been observed in patients receiving lenalidomide in combination with melphalan and prednisone until progression (1.75 per 100 person-years) compared with melphalan in combination with prednisone (0.36 per 100 person-years).

A 2.12-fold increase in incidence rate of solid tumour SPM has been observed in patients receiving lenalidomide (9 cycles) in combination with melphalan and prednisone (1.57 per 100 person-years) compared with melphalan in combination with prednisone (0.74 per 100 person-years).

In patients receiving lenalidomide in combination with dexamethasone until progression or for 18 months, the hematologic SPM incidence rate (0.16 per 100 person-years) was not increased as compared to thalidomide in combination with melphalan and prednisone (0.79 per 100 person-years).

A 1.3-fold increase in incidence rate of solid tumour SPM has been observed in patients receiving lenalidomide in combination with dexamethasone until progression or for 18 months (1.58 per 100 person-years) compared to thalidomide in combination with melphalan and prednisone (1.19 per 100 person-years).

In newly diagnosed multiple myeloma patients receiving lenalidomide in combination with bortezomib and dexamethasone, the hematologic SPM incidence rate was 0.00 – 0.16 per 100 person-years and the incidence rate of solid tumour SPM was 0.21 – 1.04 per 100 person-years.

The increased risk of secondary primary malignancies associated with lenalidomide is relevant also in the context of NDMM after stem cell transplantation. Though this risk is not yet fully characterized, it should be kept in mind when considering and using lenalidomide in this setting.

The incidence rate of hematologic malignancies, most notably AML, MDS and B-cell malignancies (including Hodgkin's lymphoma), was 1.31 per 100 person-years for the lenalidomide arms and 0.58 per 100 person-years for the placebo arms (1.02 per 100 person-years for patients exposed to lenalidomide after ASCT and 0.60 per 100 person-years for patients not-exposed to lenalidomide after ASCT). The incidence rate of solid tumour SPMs was 1.36 per 100 person-years for the lenalidomide arms and 1.05 per 100 person-years for the placebo arms (1.26 per 100 person-years for patients exposed to lenalidomide after ASCT and 0.60 per 100 person-years for patients not-exposed to lenalidomide after ASCT).

The risk of occurrence of hematologic SPM must be taken into account before initiating treatment with lenalidomide either in combination with melphalan or immediately following high-dose melphalan and ASCT. Physicians should carefully evaluate patients before and during treatment using standard cancer screening for occurrence of SPM and institute treatment as indicated.

#### Second primary malignancies in follicular lymphoma

In a relapsed/refractory iNHL study which included follicular lymphoma patients, no increased risk of SPMs in the lenalidomide/rituximab arm, compared to the placebo/rituximab arm, was observed. Hematologic SPM of AML occurred in 0.29 per 100 person-years in the lenalidomide/rituximab arm compared with 0.29 per 100 person-years in patients receiving placebo/rituximab. The incidence rate of hematologic plus solid tumour SPMs (excluding non-melanoma skin cancers) was 0.87 per 100 person-years in the lenalidomide/rituximab arm, compared to 1.17 per 100 person-years in patients receiving placebo/rituximab with a median follow-up of 30.59 months (range 0.6 to 50.9 months).

Non-melanoma skin cancers are identified risks and comprise squamous cell carcinomas of skin or basal cell carcinomas.

Physicians should monitor patients for the development of SPMs. Both the potential benefit of lenalidomide and the risk of SPMs should be considered when considering treatment with lenalidomide.

#### Hepatic disorders

Hepatic failure, including fatal cases, has been reported in patients treated with lenalidomide in combination therapy: acute hepatic failure, toxic hepatitis, cytolytic hepatitis, cholestatic hepatitis, and mixed cytolytic/cholestatic hepatitis have been reported. The mechanisms of severe drug-induced hepatotoxicity remain unknown although, in some cases, pre-existing viral liver disease, elevated baseline liver enzymes, and possibly treatment with antibiotics might be risk factors.

Abnormal liver function tests were commonly reported and were generally asymptomatic and reversible upon dosing interruption. Once parameters have returned to baseline, treatment at a lower dose may be considered.

Lenalidomide is excreted by the kidneys. It is important to dose adjust patients with renal impairment in order to avoid plasma levels which may increase the risk for higher haematological adverse reactions or hepatotoxicity. Monitoring of liver function is recommended, particularly when there is a history of or concurrent viral liver infection or when lenalidomide is combined with medicinal products known to be associated with liver dysfunction.

#### Infection with or without neutropenia

Patients with multiple myeloma are prone to develop infections including pneumonia. A higher rate of infections was observed with lenalidomide in combination with dexamethasone than with MPT in

patients with NDMM who are not eligible for transplant, and with lenalidomide maintenance compared to placebo in patients with NDMM who had undergone ASCT. Grade  $\geq 3$  infections occurred within the context of neutropenia in less than one-third of the patients. Patients with known risk factors for infections should be closely monitored. All patients should be advised to seek medical attention promptly at the first sign of infection (eg, cough, fever, etc) thereby allowing for early management to reduce severity.

#### Viral reactivation

Cases of viral reactivation have been reported in patients receiving lenalidomide, including serious cases of herpes zoster or hepatitis B virus (HBV) reactivation.

Some of the cases of viral reactivation had a fatal outcome.

Some of the cases of herpes zoster reactivation resulted in disseminated herpes zoster, meningitis herpes zoster or ophthalmic herpes zoster requiring a temporary hold or permanent discontinuation of the treatment with lenalidomide and adequate antiviral treatment.

Reactivation of hepatitis B has been reported rarely in patients receiving lenalidomide who have previously been infected with the hepatitis B virus (HBV). Some of these cases have progressed to acute hepatic failure resulting in discontinuation of lenalidomide and adequate antiviral treatment. Hepatitis B virus status should be established before initiating treatment with lenalidomide. For patients who test positive for HBV infection, consultation with a physician with expertise in the treatment of hepatitis B is recommended. Caution should be exercised when lenalidomide is used in patients previously infected with HBV, including patients who are anti-HBc positive but HBsAg negative. These patients should be closely monitored for signs and symptoms of active HBV infection throughout therapy.

#### Progressive multifocal leukoencephalopathy

Cases of progressive multifocal leukoencephalopathy (PML), including fatal cases, have been reported with lenalidomide. PML was reported several months to several years after starting the treatment with lenalidomide. Cases have generally been reported in patients taking concomitant dexamethasone or prior treatment with other immunosuppressive chemotherapy. Physicians should monitor patients at regular intervals and should consider PML in the differential diagnosis in patients with new or worsening neurological symptoms, cognitive or behavioural signs or symptoms. Patients should also be advised to inform their partner or caregivers about their treatment, since they may notice symptoms that the patient is not aware of.

The evaluation for PML should be based on neurological examination, magnetic resonance imaging of the brain, and cerebrospinal fluid analysis for JC virus (JCV) DNA by polymerase chain reaction (PCR) or a brain biopsy with testing for JCV. A negative JCV PCR does not exclude PML. Additional follow-up and evaluation may be warranted if no alternative diagnosis can be established.

If PML is suspected, further dosing must be suspended until PML has been excluded. If PML is confirmed, lenalidomide must be permanently discontinued.

#### Newly diagnosed multiple myeloma patients

There was a higher rate of intolerance (Grade 3 or 4 adverse events, serious adverse events, discontinuation) in patients with age  $> 75$  years, ISS stage III, ECOG PS $\geq 2$  or CLcr $<60$  mL/min when lenalidomide is given in combination. Patients should be carefully assessed for their ability to tolerate lenalidomide in combination, with consideration to age, ISS stage III, ECOG PS $\geq 2$  or CLcr $<60$  mL/min (see sections 4.2 and 4.8).

#### Cataract

Cataract has been reported with a higher frequency in patients receiving lenalidomide in combination with dexamethasone particularly when used for a prolonged time. Regular monitoring of visual ability is recommended.

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

Erythropoietic agents, or other agents that may increase the risk of thrombosis, such as hormone replacement therapy, should be used with caution in multiple myeloma patients receiving lenalidomide with dexamethasone (see sections 4.4 and 4.8).

##### Oral contraceptives

No interaction study has been performed with oral contraceptives. Lenalidomide is not an enzyme inducer. In an *in vitro* study with human hepatocytes, lenalidomide, at various concentrations tested did not induce CYP1A2, CYP2B6, CYP2C9, CYP2C19 and CYP3A4/5. Therefore, induction leading to reduced efficacy of medicinal products, including hormonal contraceptives, is not expected if lenalidomide is administered alone. However, dexamethasone is known to be a weak to moderate inducer of CYP3A4 and is likely to also affect other enzymes as well as transporters. It may not be excluded that the efficacy of oral contraceptives may be reduced during treatment. Effective measures to avoid pregnancy must be taken (see sections 4.4 and 4.6).

##### Warfarin

Co-administration of multiple 10 mg doses of lenalidomide had no effect on the single dose pharmacokinetics of R- and S- warfarin. Co-administration of a single 25 mg dose of warfarin had no effect on the pharmacokinetics of lenalidomide. However, it is not known whether there is an interaction during clinical use (concomitant treatment with dexamethasone). Dexamethasone is a weak to moderate enzyme inducer and its effect on warfarin is unknown. Close monitoring of warfarin concentration is advised during the treatment.

##### Digoxin

Concomitant administration with lenalidomide 10 mg once daily increased the plasma exposure of digoxin (0.5 mg, single dose) by 14% with a 90% CI (confidence interval) [0.52%-28.2%]. It is not known whether the effect will be different in the clinical use (higher lenalidomide doses and concomitant treatment with dexamethasone). Therefore, monitoring of the digoxin concentration is advised during lenalidomide treatment.

##### Statins

There is an increased risk of rhabdomyolysis when statins are administered with lenalidomide, which may be simply additive. Enhanced clinical and laboratory monitoring is warranted notably during the first weeks of treatment.

##### Dexamethasone

Co-administration of single or multiple doses of dexamethasone (40 mg once daily) has no clinically relevant effect on the multiple dose pharmacokinetics of lenalidomide (25 mg once daily).

##### Interactions with P-glycoprotein (P-gp) inhibitors

*In vitro*, lenalidomide is a substrate of P-gp, but is not a P-gp inhibitor. Co-administration of multiple doses of the strong P-gp inhibitor quinidine (600 mg, twice daily) or the moderate P-gp inhibitor/substrate temsirolimus (25 mg) has no clinically relevant effect on the pharmacokinetics of lenalidomide (25 mg). Co-administration of lenalidomide does not alter the pharmacokinetics of temsirolimus.

#### 4.6 Fertility, pregnancy and lactation

Due to the teratogenic potential, lenalidomide must be prescribed under a Pregnancy Prevention Programme (see section 4.4) unless there is reliable evidence that the patient does not have childbearing

potential.

#### Women of childbearing potential / Contraception in males and females

Women of childbearing potential should use effective method of contraception. If pregnancy occurs in a woman treated with lenalidomide, treatment must be stopped and the patient should be referred to a physician specialised or experienced in teratology for evaluation and advice. If pregnancy occurs in a partner of a male patient taking lenalidomide, it is recommended to refer the female partner to a physician specialised or experienced in teratology for evaluation and advice.

Lenalidomide is present in human semen at extremely low levels during treatment and is undetectable in human semen 3 days after stopping the substance in the healthy subject (see section 5.2). As a precaution, and taking into account special populations with prolonged elimination time such as renal impairment, all male patients taking lenalidomide should use condoms throughout treatment duration, during dose interruption and for 1 week after cessation of treatment if their partner is pregnant or of childbearing potential and has no contraception.

#### Pregnancy

Lenalidomide is structurally related to thalidomide. Thalidomide is a known human teratogenic active substance that causes severe life-threatening birth defects.

In monkeys lenalidomide induced malformations similar to those described with thalidomide (see section 5.3). Therefore, a teratogenic effect of lenalidomide is expected and lenalidomide is contraindicated during pregnancy (see section 4.3).

#### Breast-feeding

It is not known whether lenalidomide is excreted in breast milk. Therefore, breast-feeding should be discontinued during therapy with lenalidomide.

#### Fertility

A fertility study in rats with lenalidomide doses up to 500 mg/kg (approximately 200 to 500 times the human doses of 25 mg and 10 mg, respectively, based on body surface area) produced no adverse effects on fertility and no parental toxicity.

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

Lenalidomide has minor or moderate influence on the ability to drive and use machines. Fatigue, dizziness, somnolence, vertigo and blurred vision have been reported with the use of lenalidomide. Therefore, caution is recommended when driving or operating machines.

### **4.8 Undesirable effects**

#### Summary of the safety profile

##### *Newly diagnosed multiple myeloma: patients who have undergone ASCT treated with lenalidomide maintenance*

A conservative approach was applied to determine the adverse reactions from CALGB 100104. The adverse reactions described in Table 1 included events reported post-HDM/ASCT as well as events from the maintenance treatment period. A second analysis that identified events that occurred after the start of maintenance treatment suggests that the frequencies described in Table 1 may be higher than actually observed during the maintenance treatment period. In IFM 2005-02, the adverse reactions were from the maintenance treatment period only.

The serious adverse reactions observed more frequently ( $\geq 5\%$ ) with lenalidomide maintenance than

placebo were:

- Pneumonia (10.6%; combined term) from IFM 2005-02
- Lung infection (9.4% [9.4% after the start of maintenance treatment]) from CALGB 100104

In the IFM 2005-02 study, the adverse reactions observed more frequently with lenalidomide maintenance than placebo were neutropenia (60.8%), bronchitis (47.4%), diarrhoea (38.9%), nasopharyngitis (34.8%), muscle spasms (33.4%), leucopenia (31.7%), asthenia (29.7%), cough (27.3%), thrombocytopenia (23.5%), gastroenteritis (22.5%) and pyrexia (20.5%).

In the CALGB 100104 study, the adverse reactions observed more frequently with lenalidomide maintenance than placebo were neutropenia (79.0% [71.9% after the start of maintenance treatment]), thrombocytopenia (72.3% [61.6%]), diarrhoea (54.5% [46.4%]), rash (31.7% [25.0%]), upper respiratory tract infection (26.8% [26.8%]), fatigue (22.8% [17.9%]), leucopenia (22.8% [18.8%]) and anaemia (21.0% [13.8%]).

*Newly diagnosed multiple myeloma patients who are not eligible for transplant receiving lenalidomide in combination with bortezomib and dexamethasone*

In the SWOG S0777 study, the serious adverse reactions observed more frequently ( $\geq 5\%$ ) with lenalidomide in combination with intravenous bortezomib and dexamethasone than with lenalidomide in combination with dexamethasone were:

- Hypotension (6.5%), lung infection (5.7%), dehydration (5.0%)

The adverse reactions observed more frequently with lenalidomide in combination with bortezomib and dexamethasone than with lenalidomide in combination with dexamethasone were: Fatigue (73.7%), peripheral neuropathy (71.8%), thrombocytopenia (57.6%), constipation (56.1%), hypocalcaemia (50.0%).

*Newly diagnosed multiple myeloma: patients who are not eligible for transplant treated with lenalidomide in combination with low dose dexamethasone*

The serious adverse reactions observed more frequently ( $\geq 5\%$ ) with lenalidomide in combination with low dose dexamethasone (Rd and Rd18) than with melphalan, prednisone and thalidomide (MPT) were:

- Pneumonia (9.8%)
- Renal failure (including acute) (6.3%)

The adverse reactions observed more frequently with Rd or Rd18 than MPT were: diarrhoea (45.5%), fatigue (32.8%), back pain (32.0%), asthenia (28.2%), insomnia (27.6%), rash (24.3%), decreased appetite (23.1%), cough (22.7%), pyrexia (21.4%), and muscle spasms (20.5%).

*Newly diagnosed multiple myeloma: patients who are not eligible for transplant treated with lenalidomide in combination with melphalan and prednisone*

The serious adverse reactions observed more frequently ( $\geq 5\%$ ) with melphalan, prednisone and lenalidomide followed by lenalidomide maintenance (MPR+R) or melphalan, prednisone and lenalidomide followed by placebo (MPR+p) than melphalan, prednisone and placebo followed by placebo (MPp+p) were:

- Febrile neutropenia (6.0%)
- Anaemia (5.3%)

The adverse reactions observed more frequently with MPR+R or MPR+p than MPp+p were: neutropenia (83.3%), anaemia (70.7%), thrombocytopenia (70.0%), leucopenia (38.8%), constipation (34.0%), diarrhoea (33.3%), rash (28.9%), pyrexia (27.0%), peripheral oedema (25.0%), cough (24.0%), decreased appetite (23.7%), and asthenia (22.0%).

*Multiple myeloma: patients with at least one prior therapy*

In two phase 3 placebo-controlled studies, 353 patients with multiple myeloma were exposed to the lenalidomide/dexamethasone combination and 351 to the placebo/dexamethasone combination.

The most serious adverse reactions observed more frequently in lenalidomide/dexamethasone than placebo/dexamethasone combination were:

- Venous thromboembolism (deep vein thrombosis, pulmonary embolism) (see section 4.4)
- Grade 4 neutropenia (see section 4.4).

The observed adverse reactions which occurred more frequently with lenalidomide and dexamethasone than placebo and dexamethasone in pooled multiple myeloma clinical trials (MM-009 and MM-010) were fatigue (43.9%), neutropenia (42.2%), constipation (40.5%), diarrhoea (38.5%), muscle cramp (33.4%), anaemia (31.4%), thrombocytopenia (21.5%), and rash (21.2%).

#### Follicular lymphoma

The overall safety profile of lenalidomide in combination with rituximab in patients with previously treated follicular lymphoma is based on data from 294 patients from a Phase 3 randomised, controlled study NHL-007. Additionally, adverse drug reactions from supportive study NHL-008 have been included in Table 3.

The serious adverse reactions observed most frequently (with a difference of at least 1 percentage point) in study NHL-007 in the lenalidomide/rituximab arm compared with the placebo/rituximab arm were:

- Febrile neutropenia (2.7%)
- Pulmonary embolism (2.7%)
- Pneumonia (2.7%)

In the NHL-007 study the adverse reactions observed more frequently in the lenalidomide/rituximab arm compared with the placebo/rituximab arm (with at least 2% higher frequency between arms) were neutropenia (58.2%), diarrhoea (30.8%), leucopenia (28.8%), constipation (21.9%), cough (21.9%) and fatigue (21.9%).

#### Tabulated list of adverse reactions

The adverse reactions observed in patients treated with lenalidomide are listed below by system organ class and frequency. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. Frequencies are defined as: 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 ( $< 1/10,000$ ), not known (cannot be estimated from the available data).

Adverse reactions have been included under the appropriate category in the table below according to the highest frequency observed in any of the main clinical trials.

#### Tabulated summary for monotherapy in MM

The following table is derived from data gathered during NDMM studies in patients who have undergone ASCT treated with lenalidomide maintenance. The data were not adjusted according to the longer duration of treatment in the lenalidomide-containing arms continued until disease progression versus the placebo arms in the pivotal multiple myeloma studies (see section 5.1).

**Table 1. ADRs reported in clinical trials in patients with multiple myeloma treated with lenalidomide maintenance therapy**

System Organ Class/Preferred Term	All ADRs/Frequency	Grade 3-4 ADRs/Frequency
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<b>Infections and Infestations</b>	<p><u>Very common</u> Pneumonia<sup>◊,a</sup>, Upper respiratory tract infection, Neutropenic infection, Bronchitis<sup>◊</sup>, Influenza<sup>◊</sup>, Gastroenteritis<sup>◊</sup>, Sinusitis, Nasopharyngitis, Rhinitis</p> <p><u>Common</u> Infection<sup>◊</sup>, Urinary tract infection<sup>◊,*</sup>, Lower respiratory tract infection, Lung infection<sup>◊</sup></p>	<p><u>Very common</u> Pneumonia<sup>◊,a</sup>, Neutropenic infection</p> <p><u>Common</u> Sepsis<sup>◊,b</sup>, Bacteraemia, Lung infection<sup>◊</sup>, Lower respiratory tract infection bacterial, Bronchitis<sup>◊</sup>, Influenza<sup>◊</sup>, Gastroenteritis<sup>◊</sup>, Herpes zoster<sup>◊</sup>, Infection<sup>◊</sup></p>
<b>Neoplasms Benign, Malignant and Unspecified (incl cysts and polyps)</b>	<p><u>Common</u> Myelodysplastic syndrome<sup>◊,*</sup></p>	
<b>Blood and Lymphatic System Disorders</b>	<p><u>Very common</u> Neutropenia<sup>^,◊</sup>, Febrile neutropenia<sup>^,◊</sup>, Thrombocytopenia<sup>^,◊</sup>, Anaemia, Leucopenia<sup>◊</sup>, Lymphopenia</p>	<p><u>Very common</u> Neutropenia<sup>^,◊</sup>, Febrile neutropenia<sup>^,◊</sup>, Thrombocytopenia<sup>^,◊</sup>, Anaemia, Leucopenia<sup>◊</sup>, Lymphopenia</p> <p><u>Common</u> Pancytopenia<sup>◊</sup></p>
<b>Metabolism and Nutrition Disorders</b>	<p><u>Very common</u> Hypokalaemia</p>	<p><u>Common</u> Hypokalaemia, Dehydration</p>
<b>Nervous System Disorders</b>	<p><u>Very common</u> Paraesthesia</p> <p><u>Common</u> Peripheral neuropathy<sup>c</sup></p>	<p><u>Common</u> Headache</p>
<b>Vascular Disorders</b>	<p><u>Common</u> Pulmonary embolism<sup>◊,*</sup></p>	<p><u>Common</u> Deep vein thrombosis<sup>^,◊,d</sup></p>
<b>Respiratory, Thoracic and Mediastinal Disorders</b>	<p><u>Very common</u> Cough</p> <p><u>Common</u> Dyspnoea<sup>◊</sup>, Rhinorrhoea</p>	<p><u>Common</u> Dyspnoea<sup>◊</sup></p>
<b>Gastrointestinal Disorders</b>	<p><u>Very common</u> Diarrhoea, Constipation, Abdominal pain, Nausea</p> <p><u>Common</u> Vomiting, Abdominal pain upper</p>	<p><u>Common</u> Diarrhoea, Vomiting, Nausea</p>
<b>Hepatobiliary Disorders</b>	<p><u>Very common</u> Abnormal liver function tests</p>	<p><u>Common</u> Abnormal liver function tests</p>
<b>Skin and Subcutaneous Tissue Disorders</b>	<p><u>Very common</u> Rash, Dry skin</p>	<p><u>Common</u> Rash, Pruritus</p>
<b>Musculoskeletal and Connective Tissue Disorders</b>	<p><u>Very common</u> Muscle spasms</p> <p><u>Common</u> Myalgia, Musculoskeletal pain</p>	

<b>General Disorders and Administration Site Conditions</b>	<u>Very common</u> Fatigue, Asthenia, Pyrexia	<u>Common</u> Fatigue, Asthenia
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<sup>◇</sup> Adverse reactions reported as serious in clinical trials in patients with NDMM who had undergone ASCT

<sup>\*</sup> Applies to serious adverse drug reactions only

<sup>^</sup> See section 4.8 description of selected adverse reactions

<sup>a</sup> “Pneumonia” combined AE term includes the following PTs: Bronchopneumonia, Lobar pneumonia, Pneumocystis jiroveci pneumonia, Pneumonia, Pneumonia klebsiella, Pneumonia legionella, Pneumonia mycoplasmal, Pneumonia pneumococcal, Pneumonia streptococcal, Pneumonia viral, Lung disorder, Pneumonitis

<sup>b</sup> “Sepsis” combined AE term includes the following PTs: Bacterial sepsis, Pneumococcal sepsis, Septic shock, Staphylococcal sepsis <sup>c</sup> “Peripheral neuropathy” combined AE term includes the following preferred terms (PTs): Neuropathy peripheral, Peripheral sensory neuropathy, Polyneuropathy

<sup>d</sup> “Deep vein thrombosis” combined AE term includes the following PTs: Deep vein thrombosis, Thrombosis, Venous thrombosis

### Tabulated summary for combination therapy in MM

The following table is derived from data gathered during the multiple myeloma studies with combination therapy. The data were not adjusted according to the longer duration of treatment in the lenalidomide-containing arms continued until disease progression versus the comparator arms in the pivotal multiple myeloma studies (see section 5.1).

**Table 2. ADRs reported in clinical studies in patients with multiple myeloma treated with lenalidomide in combination with bortezomib and dexamethasone, dexamethasone, or melphalan and prednisone**

<b>System Organ Class / Preferred Term</b>	<b>All ADRs/Frequency</b>	<b>Grade 3–4 ADRs/Frequency</b>
<b>Infections and Infestations</b>	<p><u>Very common</u> Pneumonia<sup>◇,◇◇</sup>, Upper respiratory tract infection<sup>◇</sup>, Bacterial, viral and fungal infections (including opportunistic infections)<sup>◇</sup>, Nasopharyngitis, Pharyngitis, Bronchitis<sup>◇</sup>, Rhinitis</p> <p><u>Common</u> Sepsis<sup>◇,◇◇</sup>, Lung infection<sup>◇◇</sup>, Urinary tract infection<sup>◇◇</sup>, Sinusitis<sup>◇</sup></p>	<p><u>Common</u> Pneumonia<sup>◇,◇◇</sup>, Bacterial, viral and fungal infections (including opportunistic infections)<sup>◇</sup>, Cellulitis<sup>◇</sup>, Sepsis<sup>◇,◇◇</sup>, Lung infection<sup>◇◇</sup>, Bronchitis<sup>◇</sup>, Respiratory tract infection<sup>◇◇</sup>, Urinary tract infection<sup>◇◇</sup>, Enterocolitis infectious</p>
<b>Neoplasms Benign, Malignant and Unspecified (incl cysts and polyps)</b>	<p><u>Uncommon</u> Basal cell carcinoma<sup>^,◇</sup>, Squamous skin cancer<sup>^,◇,*</sup></p>	<p><u>Common</u> Acute myeloid leukaemia<sup>◇</sup>, Myelodysplastic syndrome<sup>◇</sup>, Squamous cell carcinoma of skin<sup>^,◇,**</sup></p> <p><u>Uncommon</u> T-cell type acute leukaemia<sup>◇</sup>, Basal cell carcinoma<sup>^,◇</sup>, Tumour lysis syndrome</p>
<b>Blood and Lymphatic System Disorders</b>	<p><u>Very common</u> Neutropenia<sup>^,◇,◇◇</sup>, Thrombocytopenia<sup>^,◇,◇◇</sup>, Anemia<sup>◇</sup>, Haemorrhagic disorder<sup>^</sup>, Leucopenia, Lymphopenia</p> <p><u>Common</u> Febrile neutropenia<sup>^,◇</sup>, Pancytopenia<sup>◇</sup></p> <p><u>Uncommon</u> Haemolysis, Autoimmune haemolytic anaemia, Haemolytic anaemia</p>	<p><u>Very common</u> Neutropenia<sup>^,◇,◇◇</sup>, Thrombocytopenia<sup>^,◇,◇◇</sup>, Anemia<sup>◇</sup>, Leucopenia, Lymphopenia</p> <p><u>Common</u> Febrile neutropenia<sup>^,◇</sup>, Pancytopenia<sup>◇</sup>, Haemolytic anemia</p> <p><u>Uncommon</u> Hypercoagulation, Coagulopathy</p>

<b>Immune System Disorders</b>	<u>Uncommon</u> Hypersensitivity <sup>^</sup>	
<b>Endocrine Disorders</b>	<u>Common</u> Hypothyroidism	
<b>Metabolism and Nutrition Disorders</b>	<u>Very common</u> Hypokalaemia <sup>◊,◊◊</sup> , Hyperglycaemia, Hypoglycaemia, Hypocalcaemia <sup>◊</sup> , Hyponatraemia <sup>◊</sup> , Dehydration <sup>◊◊</sup> , Decreased appetite <sup>◊◊</sup> , Weight decreased  <u>Common</u> Hypomagnesaemia, Hyperuricaemia, Hypercalcaemia <sup>+</sup>	<u>Common</u> Hypokalaemia <sup>◊,◊◊</sup> , Hyperglycaemia, Hypocalcaemia <sup>◊</sup> , Diabetes mellitus <sup>◊</sup> , Hypophosphataemia, Hyponatraemia <sup>◊</sup> , Hyperuricaemia, Gout, Dehydration <sup>◊◊</sup> , Decreased appetite <sup>◊◊</sup> , Weight decreased
<b>Psychiatric Disorders</b>	<u>Very common</u> Depression, Insomnia  <u>Uncommon</u> Loss of libido	<u>Common</u> Depression, Insomnia
<b>Nervous System Disorders</b>	<u>Very common</u> Peripheral neuropathies <sup>◊◊</sup> , Paraesthesia, Dizziness <sup>◊◊</sup> , Tremor, Dysgeusia, Headache  <u>Common</u> Ataxia, Balance impaired, Syncope <sup>◊◊</sup> , Neuralgia, Dysaesthesia	<u>Very common</u> Peripheral neuropathies <sup>◊◊</sup>  <u>Common</u> Cerebrovascular accident <sup>◊</sup> , Dizziness <sup>◊◊</sup> , Syncope <sup>◊◊</sup> , Neuralgia  <u>Uncommon</u> Intracranial haemorrhage <sup>^</sup> , Transient ischaemic attack, Cerebral ischemia
<b>Eye Disorders</b>	<u>Very common</u> Cataracts, Blurred vision  <u>Common</u> Reduced visual acuity	<u>Common</u> Cataract  <u>Uncommon</u> Blindness
<b>Ear and Labyrinth Disorders</b>	<u>Common</u> Deafness (Including Hypoacusis), Tinnitus	
<b>Cardiac Disorders</b>	<u>Common</u> Atrial fibrillation <sup>◊,◊◊</sup> , Bradycardia  <u>Uncommon</u> Arrhythmia, QT prolongation, Atrial flutter, Ventricular extrasystoles	<u>Common</u> Myocardial infarction (including acute) <sup>^,◊</sup> , Atrial fibrillation <sup>◊,◊◊</sup> , Congestive cardiac failure <sup>◊</sup> , Tachycardia, Cardiac failure <sup>◊,◊◊</sup> , Myocardial ischemia <sup>◊</sup>
<b>Vascular Disorders</b>	<u>Very common</u> Venous thromboembolic events <sup>^</sup> , predominantly deep vein thrombosis and pulmonary embolism <sup>^,◊,◊◊</sup> , Hypotension <sup>◊◊</sup>  <u>Common</u> Hypertension, Ecchymosis <sup>^</sup>	<u>Very common</u> Venous thromboembolic events <sup>^</sup> , predominantly deep vein thrombosis and pulmonary embolism <sup>^,◊,◊◊</sup>  <u>Common</u> Vasculitis, Hypotension <sup>◊◊</sup> , Hypertension  <u>Uncommon</u> Ischemia, Peripheral ischemia, Intracranial venous sinus

		thrombosis
<b>Respiratory, Thoracic and Mediastinal Disorders</b>	<p><u>Very common</u> Dyspnoea<sup>◊,◊◊</sup>, Epistaxis<sup>^</sup>, Cough</p> <p><u>Common</u> Dysphonia</p>	<p><u>Common</u> Respiratory distress<sup>◊</sup>, Dyspnoea<sup>◊,◊◊</sup>, Pleuritic pain<sup>◊◊</sup>, Hypoxia<sup>◊◊</sup></p>
<b>Gastrointestinal Disorders</b>	<p><u>Very common</u> Diarrhoea<sup>◊,◊◊</sup>, Constipation<sup>◊</sup>, Abdominal pain<sup>◊◊</sup>, Nausea, Vomiting<sup>◊◊</sup>, Dyspepsia, Dry mouth, Stomatitis</p> <p><u>Common</u> Gastrointestinal haemorrhage (including rectal haemorrhage, haemorrhoidal haemorrhage, peptic ulcer haemorrhage and gingival bleeding)<sup>^,◊◊</sup>, Dysphagia</p> <p><u>Uncommon</u> Colitis, Caecitis</p>	<p><u>Common</u> Gastrointestinal haemorrhage<sup>^,◊,◊◊</sup>, Small intestinal obstruction<sup>◊◊</sup>, Diarrhoea<sup>◊◊</sup>, Constipation<sup>◊</sup>, Abdominal pain<sup>◊◊</sup>, Nausea, Vomiting<sup>◊◊</sup></p>
<b>Hepatobiliary Disorders</b>	<p><u>Very common</u> Alanine aminotransferase increased, Aspartate aminotransferase increased</p> <p><u>Common</u> Hepatocellular injury<sup>◊◊</sup>, Abnormal liver function tests<sup>◊</sup>, Hyperbilirubinaemia</p> <p><u>Uncommon</u> Hepatic failure<sup>^</sup></p>	<p><u>Common</u> Cholestasis<sup>◊</sup>, Hepatotoxicity, Hepatocellular injury<sup>◊◊</sup>, Alanine aminotransferase increased, Abnormal liver function tests<sup>◊</sup></p> <p><u>Uncommon</u> Hepatic failure<sup>^</sup></p>
<b>Skin and Subcutaneous Tissue Disorders</b>	<p><u>Very common</u> Rashes<sup>◊◊</sup>, Pruritus</p> <p><u>Common</u> Urticaria, Hyperhidrosis, Dry skin, Skin hyperpigmentation, Eczema, Erythema</p> <p><u>Uncommon</u> Drug rash with eosinophilia and systemic symptoms<sup>◊◊</sup>, Skin discolouration, Photosensitivity reaction</p>	<p><u>Common</u> Rashes<sup>◊◊</sup></p> <p><u>Uncommon</u> Drug rash with eosinophilia and systemic symptoms<sup>◊◊</sup></p>
<b>Musculoskeletal and Connective Tissue Disorders</b>	<p><u>Very common</u> Muscular weakness<sup>◊◊</sup>, Muscle spasms, Bone pain<sup>◊</sup>, Musculoskeletal and connective tissue pain and discomfort (including back pain<sup>◊,◊◊</sup>), Pain in extremity, Myalgia, Arthralgia<sup>◊</sup></p> <p><u>Common</u> Joint swelling</p>	<p><u>Common</u> Muscular weakness<sup>◊◊</sup>, Bone pain<sup>◊</sup>, Musculoskeletal and connective tissue pain and discomfort (including back pain<sup>◊,◊◊</sup>)</p> <p><u>Uncommon</u> Joint swelling</p>

<b>Renal and Urinary Disorders</b>	<u>Very common</u> Renal failure (including acute) <sup>◊,◊◊</sup>  <u>Common</u> Haematuria <sup>^</sup> , Urinary retention, Urinary incontinence  <u>Uncommon</u> Acquired Fanconi syndrome	<u>Uncommon</u> Renal tubular necrosis
<b>Reproductive System and Breast Disorders</b>	<u>Common</u> Erectile dysfunction	
<b>General Disorders and Administration Site Conditions</b>	<u>Very common</u> Fatigue <sup>◊,◊◊</sup> , Oedema (including peripheral oedema), Pyrexia <sup>◊,◊◊</sup> , Asthenia, Influenza like illness syndrome (including pyrexia, cough, myalgia, musculoskeletal pain, headache and rigors)  <u>Common</u> Chest pain <sup>◊,◊◊</sup> , Lethargy	<u>Very common</u> Fatigue <sup>◊,◊◊</sup>  <u>Common</u> Oedema peripheral, Pyrexia <sup>◊,◊◊</sup> , Asthenia
<b>Investigations</b>	<u>Very common</u> Blood alkaline phosphatase increased  <u>Common</u> C-reactive protein increased	
<b>Injury, Poisoning and Procedural Complications</b>	<u>Common</u> Fall, Contusion <sup>^</sup>	

<sup>◊◊</sup> Adverse reactions reported as serious in clinical trials in patients with NDMM who had received lenalidomide in combination with bortezomib and dexamethasone

<sup>^</sup> See section 4.8 description of selected adverse reactions

<sup>†</sup> Adverse reactions reported as serious in clinical trials in patients with multiple myeloma treated with lenalidomide in combination with dexamethasone, or with melphalan and prednisone

<sup>+</sup> Applies to serious adverse drug reactions only

<sup>\*</sup> Squamous skin cancer was reported in clinical trials in previously treated myeloma patients with lenalidomide/dexamethasone compared to controls

<sup>\*\*</sup> Squamous cell carcinoma of skin was reported in a clinical trial in newly diagnosed myeloma patients with lenalidomide/dexamethasone compared to controls

#### *Tabulated summary for combination therapy in FL*

The following table is derived from data gathered during the main studies (NHL-007 and NHL-008) using lenalidomide in combination with rituximab for patients with follicular lymphoma.

**Table 3: ADRs reported in clinical trials in patients with follicular lymphoma treated with lenalidomide in combination with rituximab**

<b>System Organ Class / Preferred Term</b>	<b>All ADRs/Frequency</b>	<b>Grade 3–4 ADRs/Frequency</b>
<b>Infections and Infestations</b>	<u>Very common</u> Upper respiratory tract infection  <u>Common</u> Pneumonia <sup>◊</sup> , Influenza, Bronchitis, Sinusitis, Urinary tract infection	<u>Common</u> Pneumonia <sup>◊</sup> , Sepsis <sup>◊</sup> , Lung infection, Bronchitis, Gastroenteritis, Sinusitis, Urinary tract infection, Cellulitis <sup>◊</sup>

<b>Neoplasms Benign, Malignant and Unspecified (incl cysts and polyps)</b>	<u>Very common</u> Tumour flare <sup>^</sup>  <u>Common</u> Squamous Cell Carcinoma of Skin <sup>◊.^.+</sup>	<u>Common</u> Basal cell carcinoma <sup>^.◊</sup>
<b>Blood and Lymphatic System Disorders</b>	<u>Very common</u> Neutropenia <sup>^◊</sup> , Anaemia <sup>◊</sup> , Thrombocytopenia <sup>^</sup> , Leucopenia <sup>**</sup> Lymphopenia <sup>***</sup>	<u>Very common</u> Neutropenia <sup>^◊</sup>  <u>Common</u> Anaemia <sup>◊</sup> , Thrombocytopenia <sup>^</sup> , Febrile neutropenia <sup>◊</sup> , Pancytopenia, Leucopenia <sup>**</sup> , Lymphopenia <sup>***</sup>
<b>Metabolism and Nutrition Disorders</b>	<u>Very common</u> Decreased appetite, Hypokalaemia  <u>Common</u> Hypophosphataemia, Dehydration	<u>Common</u> Dehydration, Hypercalcaemia <sup>◊</sup> , Hypokalaemia, Hypophosphataemia, Hyperuricaemia
<b>Psychiatric Disorders</b>	<u>Common</u> Depression, Insomnia	
<b>Nervous System Disorders</b>	<u>Very common</u> Headache, Dizziness  <u>Common</u> Peripheral sensory neuropathy, Dysgeusia	<u>Common</u> Syncope
<b>Cardiac Disorders</b>	<u>Uncommon</u> Arrhythmia <sup>◊</sup>	
<b>Vascular Disorders</b>	<u>Common</u> Hypotension	<u>Common</u> Pulmonary embolism <sup>^◊</sup> , Hypotension
<b>Respiratory, Thoracic and Mediastinal Disorders</b>	<u>Very common</u> Dyspnoea <sup>◊</sup> , Cough  <u>Common</u> Oropharyngeal pain, Dysphonia	<u>Common</u> Dyspnoea <sup>◊</sup>
<b>Gastrointestinal Disorders</b>	<u>Very common</u> Abdominal pain <sup>◊</sup> , Diarrhoea, Constipation, Nausea, Vomiting, Dyspepsia  <u>Common</u> Upper abdominal pain, Stomatitis, Dry mouth	<u>Common</u> Abdominal pain <sup>◊</sup> , Diarrhoea, Constipation, Stomatitis
<b>Skin and Subcutaneous Tissue Disorders</b>	<u>Very common</u> Rash <sup>*</sup> , Pruritus  <u>Common</u> Dry skin, Night sweats, Erythema	<u>Common</u> Rash <sup>*</sup> , Pruritus

<b>Musculoskeletal and Connective Tissue Disorders</b>	<u>Very common</u> Muscle spasms, Back pain, Arthralgia  <u>Common</u> Pain in extremity, Muscular weakness, Musculoskeletal pain, Myalgia, Neck pain	<u>Common</u> Muscular weakness, Neck pain
<b>Renal and Urinary Disorders</b>		<u>Common</u> Acute kidney injury <sup>◇</sup>
<b>General Disorders and Administration Site Conditions</b>	<u>Very common</u> Pyrexia, Fatigue, Asthenia, Peripheral oedema  <u>Common</u> Malaise, Chills	<u>Common</u> Fatigue, Asthenia
<b>Investigations</b>	<u>Very common</u> Alanine aminotransferase increased  <u>Common</u> Weight decreased, Blood Bilirubin increased	

<sup>^</sup>see section 4.8 description of selected adverse reactions

Algorithm applied for follicular lymphoma:

Controlled- Phase 3 trial:

- NHL-007 ADRs- All treatment-emergent AEs with  $\geq 5.0\%$  of subjects in lenalidomide/rituximab arm and at least 2.0% higher frequency (%) in Len arm compared to control arm - (Safety population)
- NHL-007 Gr 3/4 ADRs- All Grades 3 or Grade 4 treatment-emergent AEs with at least 1.0% subjects in lenalidomide/rituximab arm and at least 1.0% higher frequency in lenalidomide arm compared to control arm - (safety population)
- NHL-007 Serious ADRs- All serious treatment-emergent AEs with at least 1.0% subjects in lenalidomide/rituximab arm and at least 1.0% higher frequency in lenalidomide/rituximab arm compared to control arm - (safety population)

FL single arm - phase 3 trial:

- NHL-008 ADRs- All treatment-emergent adverse events with  $\geq 5.0\%$  of subjects
- NHL-008 Gr 3/4 ADRs- All Grade 3/4 treatment-emergent adverse events reported in  $\geq 1.0\%$  of subjects
- NHL-008 Serious ADRs- All serious treatment-emergent adverse events reported in  $\geq 1.0\%$  of subjects

<sup>◇</sup>Adverse events reported as serious in follicular lymphoma clinical trials

<sup>+</sup> Applies to serious adverse drug reactions only

<sup>\*</sup> Rash includes PT of rash and rash maculo-papular

<sup>\*\*</sup>Leucopenia includes PT leucopenia and white blood cell count decreased

<sup>\*\*\*</sup>Lymphopenia includes PT lymphopenia and lymphocyte count decreased

#### Tabulated summary of post-marketing adverse reactions

In addition to the above adverse reactions identified from the pivotal clinical trials, the following table is derived from data gathered from post-marketing data.

**Table 4. ADRs reported in post-marketing use in patients treated with lenalidomide**

<b>System Organ Class / Preferred Term</b>	<b>All ADRs/Frequency</b>	<b>Grade 3–4 ADRs/Frequency</b>
<b>Infections and Infestations</b>	<u>Not known</u> Viral infections, including herpes zoster and hepatitis B virus reactivation	<u>Not known</u> Viral infections, including herpes zoster and hepatitis B virus reactivation
<b>Neoplasms Benign, Malignant and Unspecified (incl cysts and polyps)</b>		<u>Rare</u> Tumour lysis syndrome
<b>Blood and Lymphatic System Disorders</b>	<u>Not known</u> Acquired haemophilia	

<b>Immune System Disorders</b>	<u>Rare</u> Anaphylactic reaction^  <u>Not known</u> Solid organ transplant rejection	<u>Rare</u> Anaphylactic reaction^
<b>Endocrine Disorders</b>	<u>Common</u> Hyperthyroidism	
<b>Respiratory, Thoracic and Mediastinal Disorders</b>	<u>Uncommon</u> Pulmonary hypertension	<u>Rare</u> Pulmonary hypertension  <u>Not known</u> Interstitial pneumonitis
<b>Gastrointestinal Disorders</b>		<u>Not known</u> Pancreatitis, Gastrointestinal perforation (including diverticular, intestinal and large intestine perforations)^
<b>Hepatobiliary Disorders</b>	<u>Not known</u> Acute hepatic failure^, Hepatitis toxic^, Cytolytic hepatitis^, Cholestatic hepatitis^, Mixed cytolytic/cholestatic hepatitis^	<u>Not known</u> Acute hepatic failure^, Hepatitis toxic^
<b>Skin and Subcutaneous Tissue Disorders</b>		<u>Uncommon</u> Angioedema  <u>Rare</u> Stevens-Johnson Syndrome^, Toxic epidermal necrolysis^  <u>Not known</u> Leukocytoclastic vasculitis, Drug Reaction with Eosinophilia and Systemic Symptoms^

^see section 4.8 description of selected adverse reactions

#### Description of selected adverse reactions

##### Teratogenicity

Lenalidomide is structurally related to thalidomide. Thalidomide is a known human teratogenic active substance that causes severe life-threatening birth defects. In monkeys, lenalidomide induced malformations similar to those described with thalidomide (see sections 4.6 and 5.3). If lenalidomide is taken during pregnancy, a teratogenic effect of lenalidomide in humans is expected.

##### Neutropenia and thrombocytopenia

##### Newly diagnosed multiple myeloma: patients who have undergone ASCT treated with lenalidomide maintenance

Lenalidomide maintenance after ASCT is associated with a higher frequency of Grade 4 neutropenia compared to placebo maintenance (32.1% vs 26.7% [16.1% vs 1.8% after the start of maintenance treatment] in CALGB 100104 and 16.4% vs 0.7% in IFM 2005-02, respectively). Treatment-emergent AEs of neutropenia leading to lenalidomide discontinuation were reported in 2.2% of patients in CALGB 100104 and 2.4% of patients in IFM 2005-02, respectively. Grade 4 febrile neutropenia was reported at similar frequencies in the lenalidomide maintenance arms compared to placebo maintenance arms in both studies (0.4% vs 0.5% [0.4% vs 0.5% after the start of maintenance treatment] in CALGB 100104 and 0.3% vs 0% in IFM 2005-02, respectively).

Lenalidomide maintenance after ASCT is associated with a higher frequency of Grade 3 or 4 thrombocytopenia compared to placebo maintenance (37.5% vs 30.3% [17.9% vs 4.1% after the start of maintenance treatment] in CALGB 100104 and 13.0% vs 2.9% in IFM 2005-02, respectively).

Newly diagnosed multiple myeloma patients who are not eligible for transplant receiving lenalidomide in combination with bortezomib and dexamethasone

Grade 4 neutropenia was observed in the RVd arm to a lesser extent than in the Rd comparator arm (2.7% vs 5.9%) in the SWOG S0777 study. Grade 4 febrile neutropenia was reported at similar frequencies in the RVd arm compared to the Rd arm (0.0% vs 0.4%).

Grade 3 or 4 thrombocytopenia was observed in the RVd arm to a greater extent than in the Rd comparator arm (17.2 % vs 9.4%).

Newly diagnosed multiple myeloma: patients who are not eligible for transplant treated with lenalidomide in combination with dexamethasone

The combination of lenalidomide with dexamethasone in newly diagnosed multiple myeloma patients is associated with a lower frequency of Grade 4 neutropenia (8.5% in Rd and Rd18, compared with MPT (15%). Grade 4 febrile neutropenia was observed infrequently (0.6% in Rd and Rd18 compared with 0.7% in MPT).

The combination of lenalidomide with dexamethasone in newly diagnosed multiple myeloma patients is associated with a lower frequency of Grade 3 and 4 thrombocytopenia (8.1% in Rd and Rd18) compared with MPT (11.1%).

Newly diagnosed multiple myeloma: patients who are not eligible for transplant treated with lenalidomide in combination with melphalan and prednisone

The combination of lenalidomide with melphalan and prednisone in newly diagnosed multiple myeloma patients is associated with a higher frequency of Grade 4 neutropenia (34.1% in MPR+R/MPR+p) compared with MPp+p (7.8%). There was a higher frequency of Grade 4 febrile neutropenia observed (1.7% in MPR+R/MPR+p compared to 0.0% in MPp+p).

The combination of lenalidomide with melphalan and prednisone in newly diagnosed multiple myeloma patients is associated with a higher frequency of Grade 3 and Grade 4 thrombocytopenia (40.4% in MPR+R/MPR+p) compared with MPp+p (13.7%).

Multiple myeloma: patients with at least one prior therapy

The combination of lenalidomide with dexamethasone in multiple myeloma patients is associated with a higher incidence of Grade 4 neutropenia (5.1% in lenalidomide/dexamethasone-treated patients compared with 0.6% in placebo/dexamethasone-treated patients). Grade 4 febrile neutropenia episodes were observed infrequently (0.6% in lenalidomide/dexamethasone-treated patients compared to 0.0% in placebo/dexamethasone treated patients).

The combination of lenalidomide with dexamethasone in multiple myeloma patients is associated with a higher incidence of Grade 3 and Grade 4 thrombocytopenia (9.9% and 1.4%, respectively, in lenalidomide/dexamethasone-treated patients compared to 2.3% and 0.0% in placebo/dexamethasone-treated patients).

Follicular lymphoma patients

The combination of lenalidomide with rituximab in follicular lymphoma is associated with a higher rate of Grade 3 or Grade 4 neutropenia (50.7% in lenalidomide/rituximab treated patients compared with 12.2% in placebo/rituximab treated patients). All Grade 3 or 4 neutropenia were reversible through dose interruption, reduction and/or supportive care with growth factors. Additionally, febrile neutropenia was observed infrequently (2.7% in lenalidomide/rituximab treated patients compared with 0.7% in placebo/rituximab treated patients).

Lenalidomide in combination with rituximab is also associated with a higher incidence of Grade 3

or 4 thrombocytopenia (1.4% in lenalidomide/rituximab treated patients compared to 0% in placebo/rituximab patients).

#### Venous thromboembolism

An increased risk of DVT and PE is associated with the use of the combination of lenalidomide with dexamethasone in patients with multiple myeloma, and to a lesser extent in patients treated with lenalidomide in combination with melphalan and prednisone or in patients with multiple myeloma, treated with lenalidomide monotherapy (see section 4.5).

Concomitant administration of erythropoietic agents or previous history of DVT may also increase thrombotic risk in these patients.

#### Myocardial infarction

Myocardial infarction has been reported in patients receiving lenalidomide, particularly in those with known risk factors.

#### Haemorrhagic disorders

Haemorrhagic disorders are listed under several system organ classes: Blood and lymphatic system disorders; nervous system disorders (intracranial haemorrhage); respiratory, thoracic and mediastinal disorders (epistaxis); gastrointestinal disorders (gingival bleeding, haemorrhoidal haemorrhage, rectal haemorrhage); renal and urinary disorders (haematuria); injury, poisoning and procedural complications (contusion) and vascular disorders (ecchymosis).

#### Allergic reactions and severe skin reactions

Cases of allergic reactions including angioedema, anaphylactic reaction and severe cutaneous reactions including SJS, TEN and DRESS have been reported with the use of lenalidomide. A possible cross-reaction between lenalidomide and thalidomide has been reported in the literature.

Patients with a history of severe rash associated with thalidomide treatment should not receive lenalidomide (see section 4.4).

#### Second primary malignancies

In clinical trials in previously treated myeloma patients with lenalidomide/dexamethasone compared to controls, mainly comprising of basal cell or squamous cell skin cancers.

#### Acute myeloid leukaemia

##### Multiple myeloma

Cases of AML have been observed in clinical trials of newly diagnosed multiple myeloma in patients taking lenalidomide treatment in combination with melphalan or immediately following HDM/ASCT (see section 4.4). This increase was not observed in clinical trials of newly diagnosed multiple myeloma in patients taking lenalidomide in combination with dexamethasone compared to thalidomide in combination with melphalan and prednisone.

#### Hepatic disorders

The following post-marketing adverse reactions have been reported (frequency unknown): acute hepatic failure and cholestasis (both potentially fatal), toxic hepatitis, cytolytic hepatitis, mixed cytolytic/cholestatic hepatitis.

#### Rhabdomyolysis

Rare cases of rhabdomyolysis have been observed, some of them when lenalidomide is administered with a statin.

#### Thyroid disorders

Cases of hypothyroidism and cases of hyperthyroidism have been reported (see section 4.4 Thyroid disorders).

#### Tumour flare reaction and tumour lysis syndrome

In study NHL-007, TFR was reported in 19/146 (13.0%) of patients in the lenalidomide/rituximab

arm versus 1/148 (0.7%) patients in the placebo/rituximab arm. Most TFRs (18 out of 19) reported in the lenalidomide/rituximab arm occurred during first two cycles of treatment. One FL patient in the lenalidomide/rituximab arm experienced a Grade 3 TFR event versus no patients in the placebo/rituximab arm. In study NHL-008, 7/177 (4.0%) of FL patients experienced TFR; (3 reports were Grade 1 and 4 reports were Grade 2 severity); while 1 report was considered serious. In study NHL-007, TLS occurred in 2 FL patients (1.4%) in the lenalidomide/rituximab arm and no FL patients in the placebo/rituximab arm; neither patient had a Grade 3 or 4 event. TLS occurred in 1 FL patient (0.6%) in study NHL-008. This single event was identified as a serious, Grade 3 adverse reaction. For study NHL-007 no patients had to discontinue lenalidomide/rituximab therapy due to TFR or TLS.

#### Gastrointestinal disorders

Gastrointestinal perforations have been reported during treatment with lenalidomide. Gastrointestinal perforations may lead to septic complications and may be associated with fatal outcome.

#### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via **the national reporting system** listed in [Appendix V](#).

### **4.9 Overdose**

There is no specific experience in the management of lenalidomide overdose in patients, although in dose-ranging studies some patients were exposed to up to 150 mg, and in single-dose studies, some patients were exposed to up to 400 mg. The dose limiting toxicity in these studies was essentially haematological. In the event of overdose, supportive care is advised.

## **5. PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Other immunosuppressants, ATC code: L04AX04.

#### Mechanism of action

Lenalidomide binds directly to cereblon, a component of a cullin ring E3 ubiquitin ligase enzyme complex that includes deoxyribonucleic acid (DNA) damage-binding protein 1 (DDB1), cullin 4 (CUL4), and regulator of cullins 1 (Roc1). In haematopoietic cells, lenalidomide binding to cereblon recruits substrate proteins Aiolos and Ikaros, lymphoid transcriptional factors, leading to their ubiquitination and subsequent degradation resulting in direct cytotoxic and immunomodulatory effects.

Specifically, lenalidomide inhibits proliferation and enhances apoptosis of certain haematopoietic tumour cells (including MM plasma tumour cells, follicular lymphoma tumour cells and those with deletions of chromosome 5), enhances T cell- and Natural Killer (NK) cell-mediated immunity and increases the number of NK, T and NK T cells.

The combination of lenalidomide and rituximab increases ADCC and direct tumor apoptosis in follicular lymphoma cells.

The lenalidomide mechanism of action also includes additional activities such as anti-angiogenic and pro-erythropoietic properties. Lenalidomide inhibits angiogenesis by blocking the migration and adhesion of endothelial cells and the formation of microvessels, augments foetal haemoglobin production by CD34+ haematopoietic stem cells, and inhibits production of pro-inflammatory cytokines (e.g., TNF- $\alpha$  and IL-6) by monocytes.

#### Clinical efficacy and safety

Lenalidomide efficacy and safety have been evaluated in six phase 3 studies in newly diagnosed multiple myeloma, two phase 3 studies in relapsed refractory multiple myeloma and one phase 3 and one phase 3b study in iNHL, as described below.

### Newly diagnosed multiple myeloma

#### Lenalidomide maintenance in patients who have undergone ASCT

The efficacy and safety of lenalidomide maintenance was assessed in two phase 3 multicentre, randomised, double-blind 2-arm, parallel group, placebo-controlled studies: CALGB 100104 and IFM 2005-02.

#### *CALGB 100104*

Patients between 18 and 70 years of age with active MM requiring treatment and without prior progression after initial treatment were eligible.

Patients were randomised 1:1 within 90-100 days after ASCT to receive either lenalidomide or placebo maintenance. The maintenance dose was 10 mg once daily on days 1-28 of repeated 28-day cycles (increased up to 15 mg once daily after 3 months in the absence of dose-limiting toxicity), and treatment was continued until disease progression.

The primary efficacy endpoint in the study was progression free survival (PFS) from randomisation to the date of progression or death, whichever occurred first; the study was not powered for the overall survival endpoint. In total 460 patients were randomised: 231 patients to lenalidomide and 229 patients to placebo. The demographic and disease-related characteristics were balanced across both arms.

The study was unblinded upon the recommendations of the data monitoring committee after surpassing the threshold for a preplanned interim analysis of PFS. After unblinding, patients in the placebo arm were allowed to cross over to receive lenalidomide before disease progression.

The results of PFS at unblinding, following a preplanned interim analysis, using a cut-off of 17 December 2009 (15.5 months follow up) showed a 62% reduction in risk of disease progression or death favouring lenalidomide (HR = 0.38; 95% CI 0.27, 0.54; p <0.001). The median overall PFS was 33.9 months (95% CI NE, NE) in the lenalidomide arm versus 19.0 months (95% CI 16.2, 25.6) in the placebo arm.

The PFS benefit was observed both in the subgroup of patients with CR and in the subgroup of patients who had not achieved a CR.

The results for the study, using a cut-off of 1 February 2016, are presented in Table 5.

**Table 5. Summary of overall efficacy data**

	Lenalidomide (N = 231)	Placebo (N = 229)
<b>Investigator-assessed PFS</b>		
Median <sup>a</sup> PFS time, months (95% CI) <sup>b</sup>	<b>56.9</b> (41.9, 71.7)	<b>29.4</b> (20.7, 35.5)
HR [95% CI] <sup>c</sup> ; p-value <sup>d</sup>	<b>0.61</b> (0.48, 0.76); <0.001	
<b>PFS2<sup>c</sup></b>		
Median <sup>a</sup> PFS2 time, months (95% CI) <sup>b</sup>	<b>80.2</b> (63.3, 101.8)	<b>52.8</b> (41.3, 64.0)
HR [95% CI] <sup>c</sup> ; p-value <sup>d</sup>	<b>0.61</b> (0.48, 0.78); <0.001	
<b>Overall survival</b>		
Median <sup>a</sup> OS time, months (95% CI) <sup>b</sup>	<b>111.0</b> (101.8, NE)	<b>84.2</b> (71.0, 102.7)
8-year survival rate, % (SE)	60.9 (3.78)	44.6 (3.98)
HR [95% CI] <sup>c</sup> ; p-value <sup>d</sup>	<b>0.61</b> (0.46, 0.81); <0.001	
<b>Follow-up</b>		
Median <sup>f</sup> (min, max), months: all surviving patients	<b>81.9</b> (0.0, 119.8)	<b>81.0</b> (4.1, 119.5)

CI = confidence interval; HR = hazard ratio; max = maximum; min = minimum; NE = not estimable; OS = overall survival; PFS = progression-free survival;

<sup>a</sup> The median is based on the Kaplan-Meier estimate.

<sup>b</sup> The 95% CI about the median.

<sup>c</sup> Based on Cox proportional hazards model comparing the hazard functions associated with the indicated treatment arms.

<sup>d</sup> The p-value is based on the unstratified log-rank test of Kaplan-Meier curve differences between the indicated treatment arms.

<sup>e</sup> Exploratory endpoint (PFS2). Lenalidomide received by subjects in the placebo arm who crossed over prior to PD upon study unblinding was not considered as a second-line therapy.

<sup>f</sup> Median follow-up post-ASCT for all surviving subjects.

**Data cuts:** 17 Dec 2009 and 01 Feb 2016

### *IFM 2005-02*

Patients aged < 65 years at diagnosis who had undergone ASCT and had achieved at least a stable disease response at the time of hematologic recovery were eligible. Patients were randomised 1:1 to receive either lenalidomide or placebo maintenance (10 mg once daily on days 1-28 of repeated 28-day cycles increased up to 15 mg once daily after 3 months in the absence of dose-limiting toxicity) following 2 courses of lenalidomide consolidation (25 mg/day, days 1-21 of a 28-day cycle). Treatment was to be continued until disease progression.

The primary endpoint was PFS defined from randomisation to the date of progression or death, whichever occurred first; the study was not powered for the overall survival endpoint. In total 614 patients were randomised: 307 patients to lenalidomide and 307 patients to placebo.

The study was unblinded upon the recommendations of the data monitoring committee after surpassing the threshold for a preplanned interim analysis of PFS. After unblinding, patients receiving placebo were not crossed over to lenalidomide therapy prior to progressive disease. The lenalidomide arm was discontinued, as a proactive safety measure, after observing an imbalance of SPMs (see Section 4.4).

The results of PFS at unblinding, following a preplanned interim analysis, using a cut-off of 7 July 2010 (31.4 months follow up) showed a 48% reduction in risk of disease progression or death favouring lenalidomide (HR = 0.52; 95% CI 0.41, 0.66; p < 0.001). The median overall PFS was 40.1 months (95% CI 35.7, 42.4) in the lenalidomide arm versus 22.8 months (95% CI 20.7, 27.4) in the placebo arm.

The PFS benefit was less in the subgroup of patients with CR than in the subgroup of patients who had not achieved a CR.

The updated PFS, using a cut-off of 1 February 2016 (96.7 months follow up) continues to show a PFS advantage: HR = 0.57 (95% CI 0.47, 0.68; p < 0.001). The median overall PFS was 44.4 months (39.6, 52.0) in the lenalidomide arm versus 23.8 months (95% CI 21.2, 27.3) in the placebo arm. For PFS2, the observed HR was 0.80 (95% CI 0.66, 0.98; p = 0.026) for lenalidomide versus placebo. The median overall PFS2 was 69.9 months (95% CI 58.1, 80.0) in the lenalidomide arm versus 58.4 months (95% CI 51.1, 65.0) in the placebo arm. For OS, the observed HR was 0.90: (95% CI 0.72, 1.13; p = 0.355) for lenalidomide versus placebo. The median overall survival time was 105.9 months (95% CI 88.8, NE) in the lenalidomide arm versus 88.1 months (95% CI 80.7, 108.4) in the placebo arm.

### Lenalidomide in combination with bortezomib and dexamethasone in patients who are not eligible for stem cell transplantation

The SWOG S0777 study evaluated the addition of bortezomib to a foundation of lenalidomide and dexamethasone, as initial treatment, followed by continued Rd until disease progression, in patients with previously untreated multiple myeloma who are either ineligible for transplant or eligible for transplant with no plan to undertake immediate transplant.

Patients in the lenalidomide, bortezomib and dexamethasone (RVd) arm received lenalidomide 25 mg/day orally on days 1-14, intravenous bortezomib 1.3 mg/m<sup>2</sup> on days 1, 4, 8, and 11, and dexamethasone 20 mg/day orally on days 1, 2, 4, 5, 8, 9, 11, and 12 of repeated 21-day cycles for up to eight 21-day cycles (24 weeks). Patients in the lenalidomide and dexamethasone (Rd) arm received lenalidomide 25 mg/day orally on days 1-21, and dexamethasone 40 mg/day orally on days 1, 8, 15,

and 22 of repeated 28-day cycles for up to six 28-day cycles (24 weeks). Patients in both arms took continued Rd: lenalidomide 25 mg/day orally on days 1-21 and dexamethasone 40 mg/day orally on days 1, 8, 15, and 22 of repeated 28-day cycles.

Treatment was to be continued until disease progression.

The primary efficacy endpoint in the study was progression free survival (PFS). In total 523 patients were enrolled into the study, with 263 patients randomised to RVd and 260 patients randomised to Rd. The demographics and disease-related baseline characteristics of the patients were well balanced between arms.

The results of PFS, as assessed by IRAC, at the time of the primary analysis, using a cut-off of 05 November 2015 (50.6 months follow up) showed a 24% reduction in risk of disease progression or death favouring RVd (HR = 0.76; 95% CI 0.61, 0.94; p = 0.010). The median overall PFS was 42.5 months (95% CI 34.0, 54.8) in the RVd arm versus 29.9 months (95% CI 25.6, 38.2) in the Rd arm. The benefit was observed regardless of eligibility for stem cell transplant.

The results for the study, using a cut-off of 01 December 2016, where the median follow-up time for all surviving subjects was 69.0 months, are presented in Table 6. The benefit favouring RVd was observed regardless of eligibility for stem cell transplant.

**Table 6. Summary of overall efficacy data**

	Initial treatment	
	RVd (3-week cycles x 8) (N = 263)	Rd (4-week cycles x 6) (N = 260)
<b>IRAC-assessed PFS (months)</b>		
Median <sup>a</sup> PFS time, months (95% CI) <sup>b</sup>	41.7 (33.1, 51.5)	29.7 (24.2, 37.8)
HR [95% CI] <sup>c</sup> ; p-value <sup>d</sup>	0.76 (0.62, 0.94); 0.010	
<b>Overall survival (months)</b>		
Median <sup>a</sup> OS time, months (95% CI) <sup>b</sup>	89.1 (76.1, NE)	67.2 (58.4, 90.8)
HR [95% CI] <sup>c</sup> ; p-value <sup>d</sup>	0.72 (0.56, 0.94); 0.013	
<b>Response – n (%)</b>		
Overall response: CR, VGPR, or PR	199 (75.7)	170 (65.4)
≥ VGPR	153 (58.2)	83 (31.9)
<b>Follow-up (months)</b>		
Median <sup>c</sup> (min, max): all patients	61.6 (0.2, 99.4)	59.4 (0.4, 99.1)

CI = confidence interval; HR = hazard ratio; max = maximum; min = minimum; NE = not estimable; OS = overall survival; PFS = progression-free survival.

<sup>a</sup> The median is based on Kaplan-Meier estimate.

<sup>b</sup> Two-sided 95% CI about the median time.

<sup>c</sup> Based on unstratified Cox proportional hazards model comparing hazard functions associated with treatment arms (RVd:Rd).

<sup>d</sup> The p-value is based on unstratified log-rank test.

<sup>e</sup> Median follow-up was calculated from the date of randomization.

Data cutoff date = 01 Dec 2016.

Updated OS results, using a cut-off of 01 May 2018 (84.2 months median follow-up for surviving subjects) continue to show an OS advantage favouring RVd: HR = 0.73 (95% CI 0.57, 0.94; p=0.014). The proportion of subjects alive after 7 years was 54.7% in the RVd arm versus 44.7% in the Rd arm.

#### Lenalidomide in combination with dexamethasone in patients who are not eligible for stem cell transplantation

The safety and efficacy of lenalidomide was assessed in a phase 3, multicentre, randomised, open-label, 3-arm study (MM-020) of patients who were at least 65 years of age or older or, if younger than 65 years of age, were not candidates for stem cell transplantation because they declined to undergo stem cell transplantation or stem cell transplantation is not available to the patient due to cost or other reason. The study (MM-020) compared lenalidomide and dexamethasone (Rd) given for 2 different durations of time (i.e., until progressive disease [Arm Rd] or for up to eighteen 28-day cycles [72

weeks, Arm Rd18]) to melphalan, prednisone and thalidomide (MPT) for a maximum of twelve 42-day cycles (72 weeks). Patients were randomised (1:1:1) to 1 of 3 treatment arms. Patients were stratified at randomisation by age ( $\leq 75$  versus  $>75$  years), stage (ISS Stages I and II versus Stage III), and country.

Patients in the Rd and Rd18 arms took lenalidomide 25 mg once daily on days 1 to 21 of 28-day cycles according to protocol arm. Dexamethasone 40 mg was dosed once daily on days 1, 8, 15, and 22 of each 28-day cycle. Initial dose and regimen for Rd and Rd18 were adjusted according to age and renal function (see section 4.2). Patients  $>75$  years received a dexamethasone dose of 20 mg once daily on days 1, 8, 15, and 22 of each 28-day cycle. All patients received prophylactic anticoagulation (low molecular weight heparin, warfarin, heparin, low-dose aspirin) during the study.

The primary efficacy endpoint in the study was progression free survival (PFS). In total 1623 patients were enrolled into the study, with 535 patients randomised to Rd, 541 patients randomised to Rd18 and 547 patients randomised to MPT. The demographics and disease-related baseline characteristics of the patients were well balanced in all 3 arms. In general, study subjects had advanced-stage disease: of the total study population, 41% had ISS stage III, 9% had severe renal insufficiency (creatinine clearance [CLCr]  $< 30$  mL/min). The median age was 73 in the 3 arms.

In an updated analysis of PFS, PFS2 and OS using a cut off of 3 March 2014 where the median follow-up time for all surviving subjects was 45.5 months, the results of the study are presented in Table 7:

**Table 7. Summary of overall efficacy data**

	<b>Rd (N = 535)</b>	<b>Rd18 (N = 541)</b>	<b>MPT (N = 547)</b>
<b>Investigator-assessed PFS - (months)</b>			
Median <sup>a</sup> PFS time, months (95% CI) <sup>b</sup>	26.0 (20.7, 29.7)	21.0 (19.7, 22.4)	21.9 (19.8, 23.9)
HR [95% CI] <sup>c</sup> ; p-value <sup>d</sup>			
Rd vs MPT	0.69 (0.59, 0.80); $<0.001$		
Rd vs Rd18	0.71 (0.61, 0.83); $<0.001$		
Rd18 vs MPT	0.99 (0.86, 1.14); 0.866		
<b>PFS2<sup>e</sup> - (months)</b>			
Median <sup>a</sup> PFS2 time, months (95% CI) <sup>b</sup>	42.9 (38.1, 47.4)	40.0 (36.2, 44.2)	35.0 (30.4, 37.8)
HR [95% CI] <sup>c</sup> ; p-value <sup>d</sup>			
Rd vs MPT	0.74 (0.63, 0.86); $<0.001$		
Rd vs Rd18	0.92 (0.78, 1.08); 0.316		
Rd18 vs MPT	0.80 (0.69, 0.93); 0.004		
<b>Overall survival (months)</b>			
Median <sup>a</sup> OS time, months (95% CI) <sup>b</sup>	58.9 (56.0, NE)	56.7 (50.1, NE)	48.5 (44.2, 52.0)
HR [95% CI] <sup>c</sup> ; p-value <sup>d</sup>			
Rd vs MPT	0.75 (0.62, 0.90); 0.002		
Rd vs Rd18	0.91 (0.75, 1.09); 0.305		
Rd18 vs MPT	0.83 (0.69, 0.99); 0.034		
<b>Follow-up (months)</b>			
Median <sup>f</sup> (min, max): all patients	40.8 (0.0, 65.9)	40.1 (0.4, 65.7)	38.7 (0.0, 64.2)
<b>Myeloma response<sup>g</sup> n (%)</b>			
CR	81 (15.1)	77 (14.2)	51 (9.3)
VGPR	152 (28.4)	154 (28.5)	103 (18.8)
PR	169 (31.6)	166 (30.7)	187 (34.2)
Overall response: CR, VGPR, or PR	402 (75.1)	397 (73.4)	341 (62.3)
<b>Duration of response - (months)<sup>h</sup></b>			
Median <sup>a</sup> (95% CI) <sup>b</sup>	35.0 (27.9, 43.4)	22.1 (20.3, 24.0)	22.3 (20.2, 24.9)

AMT = antimyeloma therapy; CI = confidence interval; CR = complete response; d = low-dose dexamethasone; HR = hazard ratio; IMWG = International Myeloma Working Group; IRAC = Independent Response Adjudication Committee; M = melphalan; max = maximum; min = minimum; NE = not estimable; OS = overall survival; P = prednisone; PFS = progression-free survival; PR = partial response; R = lenalidomide; Rd = Rd given until documentation of progressive disease; Rd18 = Rd given for  $\leq 18$  cycles; SE = standard error; T = thalidomide; VGPR = very good partial response; vs = versus.

<sup>a</sup> The median is based on the Kaplan-Meier estimate.

<sup>b</sup> The 95% CI about the median.

<sup>c</sup> Based on Cox proportional hazards model comparing the hazard functions associated with the indicated treatment arms.

<sup>d</sup> The p-value is based on the unstratified log-rank test of Kaplan-Meier curve differences between the indicated treatment arms.

<sup>e</sup> Exploratory endpoint (PFS2)

<sup>f</sup> The median is the univariate statistic without adjusting for censoring.

<sup>g</sup> Best assessment of adjudicated response during the treatment phase of the study (for definitions of each response category, Data cut-off date = 24 May 2013).

<sup>h</sup> data cut = 24 May 2013

### Lenalidomide in combination with melphalan and prednisone followed by maintenance therapy in patients who are not eligible for transplant

The safety and efficacy of lenalidomide was assessed in a phase 3 multicentre, randomised double blind 3 arm study (MM-015) of patients who were 65 years or older and had a serum creatinine <2.5 mg/dL. The study compared lenalidomide in combination with melphalan and prednisone (MPR) with or without lenalidomide maintenance therapy until disease progression, to that of melphalan and prednisone for a maximum of 9 cycles. Patients were randomised in a 1:1:1 ratio to one of 3 treatment arms. Patients were stratified at randomisation by age ( $\leq 75$  vs.  $> 75$  years) and stage (ISS; Stages I and II vs. stage III).

This study investigated the use of combination therapy of MPR (melphalan 0.18 mg/kg orally on days 1 to 4 of repeated 28-day cycles; prednisone 2 mg/kg orally on days 1 to 4 of repeated 28-day cycles; and lenalidomide 10 mg/day orally on days 1 to 21 of repeated 28-day cycles) for induction therapy, up to 9 cycles. Patients who completed 9 cycles or who were unable to complete 9 cycles due to intolerance proceeded to maintenance therapy starting with lenalidomide 10 mg orally on days 1 to 21 of repeated 28-day cycles until disease progression.

The primary efficacy endpoint in the study was progression free survival (PFS). In total 459 patients were enrolled into the study, with 152 patients randomised to MPR+R, 153 patients randomised to MPR+p and 154 patients randomised to MPp+p. The demographics and disease-related baseline characteristics of the patients were well balanced in all 3 arms; notably, approximately 50% of the patients enrolled in each arm had the following characteristics; ISS Stage III, and creatinine clearance < 60 mL/min. The median age was 71 in the MPR+R and MPR+p arms and 72 in the MPp+p arm.

In an analysis of PFS, PFS2, OS using a cut-off of April 2013 where the median follow up time for all surviving subjects was 62.4 months, the results of the study are presented in Table 8:

**Table 8. Summary of overall efficacy data**

	<b>MPR+R (N = 152)</b>	<b>MPR+p (N = 153)</b>	<b>MPp +p (N = 154)</b>
<b>Investigator-assessed PFS - (months)</b>			
Median <sup>a</sup> PFS time, months (95% CI)	27.4 (21.3, 35.0)	14.3 (13.2, 15.7)	13.1 (12.0, 14.8)
HR [95% CI]; p-value			
MPR+R vs MPp+p	0.37 (0.27, 0.50); <0.001		
MPR+R vs MPR+p	0.47 (0.35, 0.65); <0.001		
MPR+p vs MPp +p	0.78 (0.60, 1.01); 0.059		
<b>PFS2- (months)</b> <sup>e</sup>			
Median <sup>a</sup> PFS2 time, months (95% CI)	39.7 (29.2, 48.4)	27.8 (23.1, 33.1)	28.8 (24.3, 33.8)
HR [95% CI]; p-value			
MPR+R vs MPp+p	0.70 (0.54, 0.92); 0.009		
MPR+R vs MPR+p	0.77 (0.59, 1.02); 0.065		
MPR+p vs MPp +p	0.92 (0.71, 1.19); 0.051		
<b>Overall survival (months)</b>			
Median <sup>a</sup> OS time, months (95% CI)	55.9 (49.1, 67.5)	51.9 (43.1, 60.6)	53.9 (47.3, 64.2)
HR [95% CI]; p-value			
MPR+R vs MPp+p	0.95 (0.70, 1.29); 0.736		

MPR+R vs MPR+p	0.88 (0.65, 1.20); 0.43		
MPR+p vs MPp +p	1.07 (0.79, 1.45); 0.67		
Follow-up (months)			
Median (min, max): all patients	48.4 (0.8, 73.8)	46.3 (0.5, 71.9)	50.4 (0.5, 73.3)
<b>Investigator-assessed Myeloma response n (%)</b>			
CR	30 (19.7)	17 (11.1)	9 (5.8)
PR	90 (59.2)	99 (64.7)	75 (48.7)
Stable Disease (SD)	24 (15.8)	31 (20.3)	63 (40.9)
Response Not Evaluable (NE)	8 (5.3)	4 (2.6)	7 (4.5)
<b>Investigator-assessed Duration of response (CR+PR) - (months)</b>			
Median <sup>a</sup> (95% CI)	26.5 (19.4, 35.8)	12.4 (11.2, 13.9)	12.0 (9.4, 14.5)

CI = confidence interval; CR = complete response; HR = Hazard Rate; M = melphalan; NE = not estimable; OS = overall survival; p = placebo; P = prednisone; PD = progressive disease; PR = partial response; R = lenalidomide; SD = stable disease; VGPR = very good partial response.

<sup>a</sup> The median is based on the Kaplan-Meier estimate

<sup>□</sup>PFS2 (an exploratory endpoint) was defined for all patients (ITT) as time from randomisation to start of 3rd line antimyeloma therapy (AMT) or death for all randomised patients

#### *Supportive newly diagnosed multiple myeloma studies*

An open-label, randomised, multicentre, phase 3 study (ECOG E4A03) was conducted in 445 patients with newly diagnosed multiple myeloma; 222 patients were randomised to the lenalidomide/low dose dexamethasone arm, and 223 were randomised to the lenalidomide/standard dose dexamethasone arm. Patients randomised to the lenalidomide/standard dose dexamethasone arm received lenalidomide 25 mg/day, days 1 to 21 every 28 days plus dexamethasone 40 mg/day on days 1 to 4, 9 to 12, and 17 to 20 every 28 days for the first four cycles. Patients randomised to the lenalidomide/low dose dexamethasone arm received lenalidomide 25 mg/day, days 1 to 21 every 28 days plus low dose dexamethasone – 40 mg/day on days 1, 8, 15, and 22 every 28 days. In the lenalidomide/low dose dexamethasone group, 20 patients (9.1%) underwent at least one dose interruption compared to 65 patients (29.3%) in the lenalidomide/standard dose dexamethasone arm.

In a post-hoc analysis, lower mortality was observed in the lenalidomide/low dose dexamethasone arm 6.8% (15/220) compared to the lenalidomide/standard dose dexamethasone arm 19.3% (43/223), in the newly diagnosed multiple myeloma patient population, with a median follow up of 72.3 weeks.

However with a longer follow-up, the difference in overall survival in favour of lenalidomide/ low dose dexamethasone tends to decrease.

#### *Multiple myeloma with at least one prior therapy*

The efficacy and safety of lenalidomide were evaluated in two phase 3 multicentre, randomised, double-blind, placebo-controlled, parallel-group controlled studies (MM-009 and MM-010) of lenalidomide plus dexamethasone therapy versus dexamethasone alone in previously treated patients with multiple myeloma. Out of 353 patients in the MM-009 and MM-010 studies who received lenalidomide/dexamethasone, 45.6% were aged 65 or over. Of the 704 patients evaluated in the MM-009 and MM-010 studies, 44.6% were aged 65 or over.

In both studies, patients in the lenalidomide/dexamethasone (len/dex) group took 25 mg of lenalidomide orally once daily on days 1 to 21 and a matching placebo capsule once daily on days 22 to 28 of each 28-day cycle. Patients in the placebo/dexamethasone (placebo/dex) group took 1 placebo capsule on days 1 to 28 of each 28-day cycle. Patients in both treatment groups took 40 mg of dexamethasone orally once daily on days 1 to 4, 9 to 12, and 17 to 20 of each 28-day cycle for the first 4 cycles of therapy. The dose of dexamethasone was reduced to 40 mg orally once daily on days 1 to 4 of each 28-day cycle after the first 4 cycles of therapy. In both studies, treatment was to continue until disease progression. In both studies, dose adjustments were allowed based on clinical and laboratory finding.

The primary efficacy endpoint in both studies was time to progression (TTP). In total, 353 patients were evaluated in the MM-009 study; 177 in the len/dex group and 176 in the placebo/dex group and, in total, 351 patients were evaluated in the MM-010 study; 176 in the len/dex group and 175 in the placebo/dex group.

In both studies, the baseline demographic and disease-related characteristics were comparable between the len/dex and placebo/dex groups. Both patient populations presented a median age of 63 years, with a comparable male to female ratio. The ECOG performance status was comparable between both groups, as was the number and type of prior therapies.

Pre-planned interim analyses of both studies showed that len/dex was statistically significantly superior ( $p < 0.00001$ ) to dexamethasone alone for the primary efficacy endpoint, TTP (median follow-up duration of 98.0 weeks). Complete response and overall response rates in the len/dex arm were also significantly higher than the placebo/dex arm in both studies. Results of these analyses subsequently led to an unblinding in both studies, in order to allow patients in the placebo/dex group to receive treatment with the len/dex combination.

An extended follow-up efficacy analysis was conducted with a median follow-up of 130.7 weeks. Table 9 summarises the results of the follow-up efficacy analyses – pooled studies MM-009 and MM-010.

In this pooled extended follow-up analysis, the median TTP was 60.1 weeks (95% CI: 44.3, 73.1) in patients treated with len/dex (N = 353) versus 20.1 weeks (95% CI: 17.7, 20.3) in patients treated with placebo/dex (N = 351). The median progression free survival was 48.1 weeks (95% CI: 36.4, 62.1) in patients treated with len/dex versus 20.0 weeks (95% CI: 16.1, 20.1) in patients treated with placebo/dex. The median duration of treatment was 44.0 weeks (min: 0.1, max: 254.9) for len/dex and 23.1 weeks (min: 0.3, max: 238.1) for placebo/dex. Complete response (CR), partial response (PR) and overall response (CR+PR) rates in the len/dex arm remain significantly higher than in the placebo/dex arm in both studies. The median overall survival in the extended follow-up analysis of the pooled studies is 164.3 weeks (95% CI: 145.1, 192.6) in patients treated with len/dex versus 136.4 weeks (95% CI: 113.1, 161.7) in patients treated with placebo/dex. Despite the fact that 170 out of the 351 patients randomised to placebo/dex received lenalidomide after disease progression or after the studies were unblinded, the pooled analysis of overall survival demonstrated a statistically significant survival advantage for len/dex relative to placebo/dex (HR = 0.833, 95% CI = [0.687, 1.009],  $p=0.045$ ).

**Table 9. Summary of results of efficacy analyses as of cut-off date for extended follow-up — pooled studies MM-009 and MM-010 (cut-offs 23 July 2008 and 2 March 2008, respectively)**

Endpoint	len/dex (N=353)	placebo/dex (N=351)	
<b>Time to event</b>			<b>HR [95% CI], p-value<sup>a</sup></b>
Time to progression Median [95% CI], weeks	60.1 [44.3, 73.1]	20.1 [17.7, 20.3]	0.350 [0.287, 0.426], $p < 0.001$
Progression free survival Median [95% CI], weeks	48.1 [36.4, 62.1]	20.0 [16.1, 20.1]	0.393 [0.326, 0.473], $p < 0.001$
Overall survival Median [95% CI], weeks 1-year Overall survival rate	164.3 [145.1,192.6] 82%	136.4 [113.1, 161.7] 75%	0.833 [0.687, 1.009], $p = 0.045$
<b>Response rate</b>			<b>Odds ratio [95% CI], p-value<sup>b</sup></b>
Overall response [n, %]	212 (60.1)	75 (21.4)	5.53 [3.97, 7.71], $p < 0.001$
Complete response [n, %]	58 (16.4)	11 (3.1)	6.08 [3.13, 11.80], $p < 0.001$

<sup>a</sup>: Two-tailed log rank test comparing survival curves between treatment groups.

<sup>b</sup>: Two-tailed continuity-corrected chi-square test.

### Follicular lymphoma

### AUGMENT - CC-5013-NHL-007

The efficacy and safety of lenalidomide in combination with rituximab versus rituximab plus placebo was evaluated in patients with relapsed/refractory iNHL including FL in a phase 3, multicentre, randomised, double-blind controlled study (CC-5013-NHL-007 [AUGMENT]).

A total of 358 patients who were at least 18 years of age with histologically confirmed MZL or Grade 1, 2 or 3a FL (CD20+ by flow cytometry or histochemistry) as assessed by the investigator or local pathologist were randomised in a 1:1 ratio. Subjects had been previously treated with at least one prior systemic chemotherapy, immunotherapy or chemoimmunotherapy.

Lenalidomide was administered orally 20 mg once daily for the first 21 days of repeating 28-day cycles for 12 cycles or until unacceptable toxicity. The dose of rituximab was 375 mg/m<sup>2</sup> every week in Cycle 1 (days 1, 8, 15, and 22) and on day 1 of every 28-day cycle from cycles 2 through 5. All dosage calculations for rituximab were based on the patient's body surface area (BSA), using actual patient weight.

The demographic and disease-related baseline characteristics were similar across the 2 treatment groups.

The primary objective of the study was to compare the efficacy of lenalidomide in combination with rituximab to rituximab plus placebo in subjects with relapsed/refractory FL Grade 1, 2 or 3a or MZL. Efficacy determination was based upon PFS as the primary endpoint, as assessed by the IRC using the 2007 International Working Group (IWG) criteria but without positron emission tomography (PET).

The secondary objectives of the study were to compare the safety of lenalidomide in combination with rituximab versus rituximab plus placebo. Further secondary objectives were to compare the efficacy of rituximab plus lenalidomide versus rituximab plus placebo using the following other parameters of efficacy: Overall response rate (ORR), CR rate, and duration of response (DoR) by IWG 2007 without PET and OS.

Results from the overall population including FL and MZL showed that at a median follow up of 28.3 months, the study met its primary endpoint of PFS with a hazard ratio (HR) (95% confidence interval [CI]) of 0.45 (0.33,0.61) p-value < 0.0001. The efficacy results from the follicular lymphoma population are presented in Table 10.

**Table 10: Summary of follicular lymphoma efficacy data - Study CC-5013-NHL-007**

	FL (N = 295)	
	Lenalidomide and Rituximab (N = 147)	Placebo and Rituximab (N = 148)
<b>Progression-free survival (PFS) (EMA Censoring Rules)</b>		
Median PFS <sup>a</sup> (95% CI) (months)	39.4 (25.1, NE)	13.8 (11.2, 16.0)
HR [95% CI]	0.40 (0.29, 0.55) <sup>b</sup>	
p-value	< 0.0001 <sup>c</sup>	
<b>Objective response<sup>d</sup> (CR +PR), n (%)</b> (IRC, 2007 IWGRC) 95 % CI <sup>f</sup>	118 (80.3) (72.9, 86.4)	82 (55.4) (47.0, 63.6)

<b>Complete response<sup>d</sup>, n (%)</b> <i>(IRC, 2007 IWGRC)</i> 95% CI <sup>f</sup>	51 (34.7) (27.0, 43.0)	29 (19.6) (13.5, 26.9)
<b>Duration of response<sup>d</sup> (median) (months)</b> 95% CI <sup>a</sup>	36.6 (24.9, NE)	15.5 (11.2, 25.0)
<b>Overall Survival<sup>d,e</sup> (OS)</b>		
OS rate at 2 years %	139 (94.8) (89.5, 97.5)	127 (85.8) (78.5, 90.7)
HR [95% CI]	0.45 (0.22, 0.92) <sup>b</sup>	
<b>Follow-up</b>		
Median duration of follow-up (min, max) (months)	29.2 (0.5, 50.9)	27.9 (0.6, 50.9)

<sup>a</sup> Median estimate from Kaplan-Meier analysis

<sup>b</sup> Hazard ratio and its confidence interval were estimated from unstratified Cox proportional hazard model.

<sup>c</sup> P-value from log-rank test

<sup>d</sup> Secondary and exploratory endpoints are not  $\alpha$ -controlled

<sup>e</sup> With a median follow up of 28.6 months, there were 11 deaths in the R2 arm and 24 deaths in the Control Arm.

<sup>f</sup> Exact confidence interval for binomial distribution.

### Follicular lymphoma for patients refractory to Rituximab

#### MAGNIFY - CC-5013-NHL-008

A total of 232 subjects who were at least 18 years of age with histologically confirmed FL (Grade 1, 2, 3a or MZL), as assessed by the investigator or local pathologist, were enrolled into the initial treatment period with 12 cycles of lenalidomide plus rituximab. Subjects who achieved CR/CRu, PR, or SD by the end of the induction treatment period were randomised to enter the maintenance treatment period. All enrolled subjects must have previously been treated with at least one prior systemic antilymphoma therapy. In contrast to study NHL-007, the NHL-008 study included patients who were refractory to rituximab (no response or relapsed within 6 months of rituximab treatment or who were double-refractory to rituximab and chemotherapy).

During the induction treatment period, lenalidomide 20 mg was given on Days 1-21 of repeated 28-day cycles for up to 12 cycles or until unacceptable toxicity, or withdrawal of consent or disease progression. The dose of rituximab was 375 mg/m<sup>2</sup> every week in Cycle 1 (Days 1, 8, 15, and 22) and on Day 1 of every other 28-day cycle (cycles 3, 5, 7, 9, and 11) up to 12 cycles therapy. All dosage calculations for rituximab were based on the patient body surface area (BSA) and actual weight.

The data presented are based on an interim analysis focusing on the single-arm induction treatment period. Efficacy determinations are based on ORR by best response as the primary endpoint, using a modification of the 1999 International Working Group Response Criteria (IWGRC). The secondary objective was to evaluate other parameters of efficacy, such as DoR.

**Table 11: Summary of overall efficacy data (Induction Treatment Period) - Study CC-5013-NHL-008**

	All Subjects			FL Subjects		
	Total N=187 <sup>a</sup>	Rituximab Refractory: Yes N=77	Rituximab Refractory: No N=110	Total N=148	Rituximab Refractory: Yes N=60	Rituximab Refractory: No N=88
ORR, n (%) (CR+CRu+PR)	127 (67.9)	45 (58.4)	82 (75.2)	104 (70.3)	35 (58.3)	69 (79.3)

CRR, n (%) (CR+Cru)	79 (42.2)	27 (35.1)	52 (47.7)	62 (41.9)	20 (33.3)	42 (48.3)
<b>Number of Responders</b>	<b>N=127</b>	<b>N=45</b>	<b>N=82</b>	<b>N=104</b>	<b>N=35</b>	<b>N=69</b>
<b>% of Subjects with DoR<sup>b</sup> ≥ 6 months (95% CI)<sup>c</sup></b>	<b>93.0</b> (85.1, 96.8)	<b>90.4</b> (73.0, 96.8)	<b>94.5</b> (83.9, 98.2)	<b>94.3</b> (85.5, 97.9)	<b>96.0</b> (74.8, 99.4)	<b>93.5</b> (81.0, 97.9)
<b>% of Subjects with DoR<sup>b</sup> ≥ 12 months (95% CI)<sup>c</sup></b>	<b>79.1</b> (67.4, 87.0)	<b>73.3</b> (51.2, 86.6)	<b>82.4</b> (67.5, 90.9)	<b>79.5</b> (65.5, 88.3)	<b>73.9</b> (43.0, 89.8)	<b>81.7</b> (64.8, 91.0)

CI = confidence interval; DOR = duration of response; FL = follicular lymphoma

<sup>a</sup> Primary Analysis Population for this study is induction efficacy evaluable (IEE) population.

<sup>b</sup> Duration of response is defined as the time (months) from the initial response (at least PR) to documented disease progression or death, whichever occurs first.

<sup>c</sup> Statistics obtained from Kaplan-Meier method. 95% CI is based on Greenwood formula.

Notes: The analysis is only performed for subjects who have achieved PR or better after the first dose date of induction therapy and prior to any

Maintenance Period treatment and any subsequent anti-lymphoma therapy in Induction Period. Percentage is based on the total number of responders.

### Paediatric population

The European Medicines Agency (EMA) has granted a product-specific waiver for the reference medicinal product containing lenalidomide that applies to all subsets of the paediatric population for mature B-cell neoplasm conditions (see section 4.2 for information on paediatric use).

## 5.2 Pharmacokinetic properties

Lenalidomide has an asymmetric carbon atom and can therefore exist as the optically active forms S(-) and R(+). Lenalidomide is produced as a racemic mixture. Lenalidomide is generally more soluble in organic solvents but exhibits the greatest solubility in 0.1N HCl buffer.

### Absorption

Lenalidomide is rapidly absorbed following oral administration in healthy volunteers, under fasting conditions, with maximum plasma concentrations occurring between 0.5 and 2 hours post-dose. In patients, as well as in healthy volunteers, the maximum concentration ( $C_{max}$ ) and area-under-the-concentration time curve (AUC) increase proportionally with increases in dose. Multiple dosing does not cause marked medicinal product accumulation. In plasma, the relative exposures of the S- and R-enantiomers of lenalidomide are approximately 56% and 44%, respectively.

Co-administration with a high-fat and high-calorie meal in healthy volunteers reduces the extent of absorption, resulting in an approximately 20% decrease in area under the concentration versus time curve (AUC) and 50% decrease in  $C_{max}$  in plasma. However, in the main multiple myeloma registration trials where the efficacy and safety were established for lenalidomide, the medicinal product was administered without regard to food intake. Thus, lenalidomide can be administered with or without food.

### Distribution

*In vitro* (<sup>14</sup>C)-lenalidomide binding to plasma proteins was low with mean plasma protein binding at 23% and 29% in multiple myeloma patients and healthy volunteers, respectively.

Lenalidomide is present in human semen (< 0.01% of the dose) after administration of 25 mg/day and the medicinal product is undetectable in semen of a healthy subject 3 days after stopping the substance (see section 4.4).

### Biotransformation and elimination

Results from human *in vitro* metabolism studies indicate that lenalidomide is not metabolised by cytochrome P450 enzymes suggesting that administration of lenalidomide with medicinal products that inhibit cytochrome P450 enzymes is not likely to result in metabolic medicinal product interactions in humans. *In vitro* studies indicate that lenalidomide has no inhibitory effect on CYP1A2, CYP2C9, CYP2C19, CYP2D6, CYP2E1, CYP3A, or UGT1A1. Therefore, lenalidomide is unlikely to cause any clinically relevant medicinal product interactions when co-administered with substrates of these enzymes.

*In vitro* studies indicate that lenalidomide is not a substrate of human breast cancer resistance protein (BCRP), multidrug resistance protein (MRP) transporters MRP1, MRP2, or MRP3, organic anion transporters (OAT) OAT1 and OAT3, organic anion transporting polypeptide 1B1 (OATP1B1), organic cation transporters (OCT) OCT1 and OCT2, multidrug and toxin extrusion protein (MATE) MATE1, and organic cation transporters novel (OCTN) OCTN1 and OCTN2.

*In vitro* studies indicate that lenalidomide has no inhibitory effect on human bile salt export pump (BSEP), BCRP, MRP2, OAT1, OAT3, OATP1B1, OATP1B3, and OCT2.

A majority of lenalidomide is eliminated through urinary excretion. The contribution of renal excretion to total clearance in subjects with normal renal function was 90%, with 4% of lenalidomide eliminated in faeces.

Lenalidomide is poorly metabolized as 82% of the dose is excreted unchanged in urine. Hydroxy-lenalidomide and N-acetyl-lenalidomide represent 4.59% and 1.83% of the excreted dose, respectively. The renal clearance of lenalidomide exceeds the glomerular filtration rate and therefore is at least actively secreted to some extent.

At doses of 5 to 25 mg/day, half-life in plasma is approximately 3 hours in healthy volunteers and ranges from 3 to 5 hours in patients with multiple myeloma.

### Elderly

No dedicated clinical studies have been conducted to evaluate pharmacokinetics of lenalidomide in the elderly. Population pharmacokinetic analyses included patients with ages ranging from 39 to 85 years old and indicate that age does not influence lenalidomide clearance (exposure in plasma). Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection and it would be prudent to monitor renal function.

### Renal impairment

The pharmacokinetics of lenalidomide was studied in subjects with renal impairment due to nonmalignant conditions. In this study, two methods were used to classify renal function: the urinary creatinine clearance measured over 24 hours and the creatinine clearance estimated by Cockcroft-Gault formula. The results indicate that as renal function decreases (< 50 mL/min), the total lenalidomide clearance decreases proportionally resulting in an increase in AUC. The AUC was increased by approximately 2.5, 4 and 5-fold in subjects with moderate renal impairment, severe renal impairment, and end-stage renal disease, respectively, compared to the group combining subjects with normal renal function and subjects with mild renal impairment. The half-life of lenalidomide increased from approximately 3.5 hours in subjects with creatinine clearance > 50 mL/min to more than 9 hours in subjects with reduced renal function < 50 mL/min. However, renal impairment did not alter the oral absorption of lenalidomide. The  $C_{max}$  was similar between healthy subjects and patients with renal impairment. Approximately 30% of the medicinal product in the body was removed during a single 4-hour dialysis session. Recommended dose adjustments in patients with impaired renal function are described in section 4.2.

### Hepatic impairment

Population pharmacokinetic analyses included patients with mild hepatic impairment (N=16, total bilirubin >1 to ≤1.5 x ULN or AST > ULN) and indicate that mild hepatic impairment does not influence lenalidomide clearance (exposure in plasma). There are no data available for patients with moderate to severe hepatic impairment.

### Other intrinsic factors

Population pharmacokinetic analyses indicate that body weight (33- 135 kg), gender, race and type of haematological malignancy do not have a clinically relevant effect on lenalidomide clearance in adult patients.

## **5.3 Preclinical safety data**

An embryofetal development study has been conducted in monkeys administered lenalidomide at doses from 0.5 and up to 4 mg/kg/day. Findings from this study indicate that lenalidomide produced external malformations including non-patent anus and malformations of upper and lower extremities (bent, shortened, malformed, malrotated and/or absent part of the extremities, oligo and/or polydactyly) in the offspring of female monkeys who received the active substance during pregnancy.

Various visceral effects (discoloration, red foci at different organs, small colourless mass above atrio-ventricular valve, small gall bladder, malformed diaphragm) were also observed in single foetuses.

Lenalidomide has a potential for acute toxicity; minimum lethal doses after oral administration were > 2000 mg/kg/day in rodents. Repeated oral administration of 75, 150 and 300 mg/kg/day to rats for up to 26 weeks produced a reversible treatment-related increase in kidney pelvis mineralisation in all 3 doses, most notably in females. The no observed adverse effect level (NOAEL) was considered to be less than 75 mg/kg/day, and is approximately 25-fold greater than the human daily exposure based on AUC exposure. Repeated oral administration of 4 and 6 mg/kg/day to monkeys for up to 20 weeks produced mortality and significant toxicity (marked weight loss, reduced red and white blood cell and platelet counts, multiple organ haemorrhage, gastrointestinal tract inflammation, lymphoid, and bone marrow atrophy). Repeated oral administration of 1 and 2 mg/kg/day to monkeys for up to 1 year produced reversible changes in bone marrow cellularity, a slight decrease in myeloid/erythroid cell ratio and thymic atrophy. Mild suppression of white blood cell count was observed at 1 mg/kg/day corresponding to approximately the same human dose based on AUC comparisons.

*In vitro* (bacterial mutation, human lymphocytes, mouse lymphoma, Syrian Hamster Embryo cell transformation) and *in vivo* (rat micronucleus) mutagenicity studies revealed no drug related effects at either the gene or chromosomal level. Carcinogenicity studies with lenalidomide have not been conducted.

Developmental toxicity studies were previously conducted in rabbits. In these studies, rabbits were administered 3, 10 and 20 mg/kg/day orally. An absence of the intermediate lobe of the lung was observed at 10 and 20 mg/kg/day with dose dependence and displaced kidneys were observed at 20 mg/kg/day. Although it was observed at maternotoxic levels they may be attributable to a direct effect. Soft tissue and skeletal variations in the foetuses were also observed at 10 and 20 mg/kg/day.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

#### Capsule contents

Mannitol (E421)

Microcrystalline cellulose (E460)

Pregelatinised maize starch  
Tartaric acid (E334)  
Glycerol dibehenate

Capsule shell

*Lenalidomide Krka d.d. Novo mesto 2.5 mg hard capsules*

Hypromellose  
Carrageenan (E407)  
Potassium chloride (E508)  
Titanium dioxide (E171)  
Yellow iron oxide (E172)  
Indigo carmine (E132)  
Imprinting ink:  
- shellac (E904)  
- black iron oxide (E172)

*Lenalidomide Krka d.d. Novo mesto 5 mg hard capsules*

Hypromellose  
Carrageenan (E407)  
Potassium chloride (E508)  
Titanium dioxide (E171)  
Indigo carmine (E132)  
Imprinting ink:  
- shellac (E904)  
- black iron oxide (E172)

*Lenalidomide Krka d.d. Novo mesto 7.5 mg hard capsules*

Hypromellose  
Carrageenan (E407)  
Potassium chloride (E508)  
Titanium dioxide (E171)  
Yellow iron oxide (E172)  
Red iron oxide (E172)  
Black iron oxide (E172)  
Imprinting ink:  
- shellac (E904)  
- povidone  
- titanium dioxide (E171)

*Lenalidomide Krka d.d. Novo mesto 10 mg hard capsules*

Hypromellose  
Carrageenan (E407)  
Potassium chloride (E508)  
Titanium dioxide (E171)  
Yellow iron oxide (E172)  
Red iron oxide (E172)  
Black iron oxide (E172)  
Indigo carmine (E132)  
Imprinting ink:  
- shellac (E904)  
- povidone  
- titanium dioxide (E171)

*Lenalidomide Krka d.d. Novo mesto 15 mg hard capsules*

Hypromellose  
Carrageenan (E407)

Potassium chloride (E508)  
Titanium dioxide (E171)  
Yellow iron oxide (E172)  
Red iron oxide (E172)  
Black iron oxide (E172)  
Indigo carmine (E132)  
Imprinting ink:  
- shellac (E904)  
- black iron oxide (E172)

*Lenalidomide Krka d.d. Novo mesto 20 mg hard capsules*

Hypromellose  
Carrageenan (E407)  
Potassium chloride (E508)  
Titanium dioxide (E171)  
Yellow iron oxide (E172)  
Indigo carmine (E132)  
Imprinting ink: shellac (E904)  
- black iron oxide (E172)

*Lenalidomide Krka d.d. Novo mesto 25 mg hard capsules*

Hypromellose  
Carrageenan (E407)  
Potassium chloride (E508)  
Titanium dioxide (E171)  
Yellow iron oxide (E172)  
Red iron oxide (E172)  
Black iron oxide (E172)  
Imprinting ink:  
- shellac (E904)  
- povidone  
- titanium dioxide (E171)

## **6.2 Incompatibilities**

Not applicable.

## **6.3 Shelf life**

3 years

## **6.4 Special precautions for storage**

This medicinal product does not require any special storage conditions.

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

Peel open, unit dose blister (OPA/Al/PVC//PET/Al), calendar pack: 7 x 1 or 21 x 1 hard capsule, in a box.

Not all pack sizes may be marketed.

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

Capsules should not be opened or crushed. If powder from lenalidomide makes contact with the skin, the skin should be washed immediately and thoroughly with soap and water. If lenalidomide makes contact with the mucous membranes, they should be thoroughly flushed with water.

Healthcare professionals and caregivers should wear disposable gloves when handling the blister or capsule. Gloves should then be removed carefully to prevent skin exposure, placed in a sealable plastic polyethylene bag and disposed of in accordance with local requirements. Hands should then be washed thoroughly with soap and water. Women who are pregnant or suspect they may be pregnant should not handle the blister or capsule (see section 4.4).

Any unused product or waste material should be returned to the pharmacist for safe disposal in accordance with local requirements.

## **7. MARKETING AUTHORISATION HOLDER**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

## **8. MARKETING AUTHORISATION NUMBER(S)**

*Lenalidomide Krka d.d. Novo mesto 2.5 mg hard capsules*

7 x 1 hard capsule: EU/1/20/1520/001

21 x 1 hard capsule: EU/1/20/1520/002

*Lenalidomide Krka d.d. Novo mesto 5 mg hard capsules*

7 x 1 hard capsule: EU/1/20/1520/003

21 x 1 hard capsule: EU/1/20/1520/004

*Lenalidomide Krka d.d. Novo mesto 7.5 mg hard capsules*

7 x 1 hard capsule: EU/1/20/1520/005

21 x 1 hard capsule: EU/1/20/1520/006

*Lenalidomide Krka d.d. Novo mesto 10 mg hard capsules*

7 x 1 hard capsule: EU/1/20/1520/007

21 x 1 hard capsule: EU/1/20/1520/008

*Lenalidomide Krka d.d. Novo mesto 15 mg hard capsules*

7 x 1 hard capsule: EU/1/20/1520/009

21 x 1 hard capsule: EU/1/20/1520/010

*Lenalidomide Krka d.d. Novo mesto 20 mg hard capsules*

7 x 1 hard capsule: EU/1/20/1520/011

21 x 1 hard capsule: EU/1/20/1520/012

*Lenalidomide Krka d.d. Novo mesto 25 mg hard capsules*

7 x 1 hard capsule: EU/1/20/1520/013

21 x 1 hard capsule: EU/1/20/1520/014

## **9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

Date of first authorisation: 11 February 2021

## **10. DATE OF REVISION OF THE TEXT**

Detailed information on this medicinal product is available on the website of the European Medicines

Agency <http://www.ema.europa.eu>.

**ANNEX II**

- A. MANUFACTURER(S) RESPONSIBLE FOR BATCH RELEASE**
- B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE**
- C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION**
- D. CONDITIONS OR RESTRICTIONS WITH REGARD TO THE SAFE AND EFFECTIVE USE OF THE MEDICINAL PRODUCT**

## **A. MANUFACTURER(S) RESPONSIBLE FOR BATCH RELEASE**

Name and address of the manufacturer(s) responsible for batch release

KRKA, d.d., Novo mesto  
Šmarješka cesta 6  
8501 Novo mesto  
Slovenia

KRKA – FARMA d.o.o.  
V. Holjevca 20/E  
10450 Jastrebarsko  
Croatia

TAD Pharma GmbH  
Heinz-Lohmann-Straße 5  
27472 Cuxhaven  
Germany

The printed package leaflet of the medicinal product must state the name and address of the manufacturer responsible for the release of the concerned batch.

## **B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE**

Medicinal product subject to restricted medical prescription (see Annex I: Summary of Product Characteristics, section 4.2).

## **C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION**

- **Periodic safety update reports (PSURs)**

The requirements for submission of PSURs for this medicinal product are set out in the list of Union reference dates (EURD list) provided for under Article 107c(7) of Directive 2001/83/EC and any subsequent updates published on the European medicines web-portal.

## **D. CONDITIONS OR RESTRICTIONS WITH REGARD TO THE SAFE AND EFFECTIVE USE OF THE MEDICINAL PRODUCT**

- **Risk management plan (RMP)**

The marketing authorisation holder (MAH) shall perform the required pharmacovigilance activities and interventions detailed in the agreed RMP presented in Module 1.8.2 of the marketing authorisation and any agreed subsequent updates of the RMP.

An updated RMP should be submitted:

- At the request of the European Medicines Agency;
- Whenever the risk management system is modified, especially as the result of new information being received that may lead to a significant change to the benefit/risk profile or as the result of an important (pharmacovigilance or risk minimisation) milestone being reached.

- **Additional risk minimisation measures**

1. The MAH shall agree the details of a controlled distribution system with the National

Competent Authorities and must implement such programme nationally to ensure that:

- Prior to prescribing (in agreement with the national competent authority, prior to dispensing) all healthcare professionals who intend to prescribe (and dispense) Lenalidomide Krka d.d. Novo mesto are provided with a physician information pack containing the following:
  - Educational health care professional's kit
  - Educational brochures for patients
  - Patient cards
  - Summary of Product Characteristics (SmPC) and Package Leaflet and Labelling.
- 2. The MAH shall implement a pregnancy prevention programme (PPP) in each Member State. Details of the PPP should be agreed with the National Competent Authorities in each Member State and put in place prior to the launch of the product.
- 3. The MAH should agree the final text of the physician information pack contents with the National Competent Authority in each Member State and ensure that the materials contain the key elements as described below.
- 4. The MAH should agree on the implementation of the patient card system in each Member State.

### **Key elements to be included**

#### ***The Educational Healthcare Professional's Kit***

The Educational Health Care Professional's Kit shall contain the following elements:

- Brief background on lenalidomide and its licensed indication
- Posology
- Maximum duration of prescription
  - 4 weeks for women with childbearing potential
  - 12 weeks for men and women without childbearing potential
- The need to avoid foetal exposure due to teratogenicity of lenalidomide in animals and the expected teratogenic effect of lenalidomide in humans
- Guidance on handling the blister or capsule of Lenalidomide Krka d.d. Novo mesto for healthcare professionals and caregivers
- Obligations of the health care professional in relation to the prescribing of Lenalidomide Krka d.d. Novo mesto
  - Need to provide comprehensive advice and counselling to patients
  - That patients should be capable of complying with the requirements for the safe use of Lenalidomide Krka d.d. Novo mesto
  - Need to provide patients with appropriate patient educational brochure and patient card
- Safety advice relevant to all patients
  - Disposal of unwanted medicine
  - Local country specific arrangements for a prescription for Lenalidomide Krka d.d. Novo mesto to be dispensed if needed
  - Description of risk of tumour flare reaction
  - Description of risk of SPM
- Description of the PPP and categorisation of patients based on sex and childbearing potential
  - Algorithm for implementation of PPP
  - Definition of women of childbearing potential (WCBP) and actions the physician should take if unsure
- Safety advice for women of childbearing potential
  - The need to avoid foetal exposure
  - Description of the PPP
  - Need for adequate contraception (even if woman has amenorrhoea) and definition of adequate contraception
  - Pregnancy test regime
    - Advice on suitable tests
    - Before commencing treatment
    - During treatment based on method of contraception

- After finishing treatment
  - Need to stop Lenalidomide Krka d.d. Novo mesto immediately upon suspicion of pregnancy
  - Need to tell treating doctor immediately upon suspicion of pregnancy
- Safety advice for men
  - The need to avoid foetal exposure
  - The need to use condoms if sexual partner is pregnant or a WCBP not using effective contraceptions (even if man has had a vasectomy)
    - During Lenalidomide Krka d.d. Novo mesto treatment
    - For at least 7 days following final dose.
  - That if his partner becomes pregnant whilst he is taking Lenalidomide Krka d.d. Novo mesto or shortly after he has stopped taking Lenalidomide Krka d.d. Novo mesto he should inform his treating doctor immediately
- Requirements in the event of pregnancy
  - Instructions to stop Lenalidomide Krka d.d. Novo mesto immediately upon suspicion of pregnancy, if female patient
  - Need to refer to physician specialised or experienced in dealing with teratology and its diagnosis for evaluation and advice
  - Local contact details for reporting of any suspected pregnancy
  - Pregnancy reporting form
- Check list for physicians ensuring that patients receive the appropriate counselling concerning the treatment, contraceptive methods and pregnancy prevention appropriate for their sex and childbearing status at treatment initiation
- Adverse event reporting form.

### **Educational Brochures for patients**

The Educational brochures for patients should contain:

- Brochure for women patients of childbearing potential
- Brochure for women patients who are not of childbearing potential
- Brochure for male patients

All patient brochures should contain the following elements:

- That lenalidomide is teratogenic in animals and is expected to be teratogenic in humans
- Description of the patient card and its necessity
- Disposal of unwanted medicine
- Guidance on handling lenalidomide for patients, caregivers and family members
- National or other applicable specific arrangements for a prescription for Lenalidomide Krka d.d. Novo mesto to be dispensed
- That the patient should not give Lenalidomide Krka d.d. Novo mesto to any other person
- That the patient should not donate blood during therapy (including during dose interruptions) and for at least 7 days after discontinuation of Lenalidomide Krka d.d. Novo mesto treatment
- That the patient should tell their doctor about any adverse events

The following information should also be provided in the appropriate brochure:

### **Brochure for women patients with childbearing potential**

- The need to avoid foetal exposure
- Description of the PPP
- Need for adequate contraception and definition of adequate contraception
- Pregnancy test regime
  - Before commencing treatment
  - During treatment, at least every 4 weeks except in case of confirmed tubal sterilisation
  - After finishing treatment
- The need to stop Lenalidomide Krka d.d. Novo mesto immediately upon suspicion of pregnancy
- The need to contact their doctor immediately upon suspicion of pregnancy

#### Brochure for male patients

- The need to avoid foetal exposure
- The need to use condoms if sexual partner is pregnant or a WCBP not using effective contraceptions (even if man has had vasectomy)
  - During Lenalidomide Krka d.d. Novo mesto treatment
  - For at least 7 days following final dose
- That if his partner becomes pregnant he should inform his treating doctor immediately
- That he should not donate semen or sperm during therapy (including during dose interruptions) and at least for 7 days after discontinuation of Lenalidomide Krka d.d. Novo mesto treatment

#### Patient Card

The patient card shall contain the following elements:

- Verification that appropriate counselling has taken place
- Documentation of childbearing status potential
- Pregnancy test dates and results

**ANNEX III**  
**LABELLING AND PACKAGE LEAFLET**

## **A. LABELLING**

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING**

**BOX**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 2.5 mg hard capsules

lenalidomide

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each hard capsule contains lenalidomide hydrochloride monohydrate equivalent to 2.5 mg lenalidomide.

**3. LIST OF EXCIPIENTS**

**4. PHARMACEUTICAL FORM AND CONTENTS**

hard capsule

7 x 1 hard capsule

21 x 1 hard capsule

**5. METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.

Oral use

**6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

**7. OTHER SPECIAL WARNING(S), IF NECESSARY**

WARNING: Risk of severe birth defects. Do not use while pregnant or breast-feeding. You must follow the Lenalidomide Pregnancy Prevention Programme.

**8. EXPIRY DATE**

EXP

**9. SPECIAL STORAGE CONDITIONS**

**10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE**

**11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

**12. MARKETING AUTHORISATION NUMBER(S)**

7 x 1 hard capsule: EU/1/20/1520/001

21 x 1 hard capsule: EU/1/20/1520/002

**13. BATCH NUMBER**

Lot

**14. GENERAL CLASSIFICATION FOR SUPPLY**

**15. INSTRUCTIONS ON USE**

**16. INFORMATION IN BRAILLE**

Lenalidomide Krka d.d. Novo mesto 2.5 mg

**17. UNIQUE IDENTIFIER – 2D BARCODE**

2D barcode carrying the unique identifier included.

**18. UNIQUE IDENTIFIER - HUMAN READABLE DATA**

PC  
SN  
NN

**MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS**

**BLISTER**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 2.5 mg capsules

lenalidomide

**2. NAME OF THE MARKETING AUTHORISATION HOLDER**

KRKA

**3. EXPIRY DATE**

EXP

**4. BATCH NUMBER**

Lot

**5. OTHER**

1. Bend and tear
2. Peel

Mon.  
Tue.  
Wed.  
Thu.  
Fri.  
Sat.  
Sun.

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING**

**BOX**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 5 mg hard capsules

lenalidomide

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each hard capsule contains lenalidomide hydrochloride monohydrate equivalent to 5 mg lenalidomide.

**3. LIST OF EXCIPIENTS**

**4. PHARMACEUTICAL FORM AND CONTENTS**

hard capsule

7 x 1 hard capsule

21 x 1 hard capsule

**5. METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.

Oral use

**6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

**7. OTHER SPECIAL WARNING(S), IF NECESSARY**

WARNING: Risk of severe birth defects. Do not use while pregnant or breast-feeding. You must follow the Lenalidomide Pregnancy Prevention Programme.

**8. EXPIRY DATE**

EXP

**9. SPECIAL STORAGE CONDITIONS**

**10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE**

**11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

**12. MARKETING AUTHORISATION NUMBER(S)**

7 x 1 hard capsule: EU/1/20/1520/003  
21 x 1 hard capsule: EU/1/20/1520/004

**13. BATCH NUMBER**

Lot

**14. GENERAL CLASSIFICATION FOR SUPPLY**

**15. INSTRUCTIONS ON USE**

**16. INFORMATION IN BRAILLE**

Lenalidomide Krka d.d. Novo mesto 5 mg

**17. UNIQUE IDENTIFIER – 2D BARCODE**

2D barcode carrying the unique identifier included.

**18. UNIQUE IDENTIFIER - HUMAN READABLE DATA**

PC  
SN  
NN

**MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS**

**BLISTER**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 5 mg capsules

lenalidomide

**2. NAME OF THE MARKETING AUTHORISATION HOLDER**

KRKA

**3. EXPIRY DATE**

EXP

**4. BATCH NUMBER**

Lot

**5. OTHER**

1. Bend and tear
2. Peel

Mon.  
Tue.  
Wed.  
Thu.  
Fri.  
Sat.  
Sun.

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING**

**BOX**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 7.5 mg hard capsules

lenalidomide

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each hard capsule contains lenalidomide hydrochloride monohydrate equivalent to 7.5 mg lenalidomide.

**3. LIST OF EXCIPIENTS**

**4. PHARMACEUTICAL FORM AND CONTENTS**

hard capsule

7 x 1 hard capsule

21 x 1 hard capsule

**5. METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.

Oral use

**6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

**7. OTHER SPECIAL WARNING(S), IF NECESSARY**

WARNING: Risk of severe birth defects. Do not use while pregnant or breast-feeding. You must follow the Lenalidomide Pregnancy Prevention Programme.

**8. EXPIRY DATE**

EXP

**9. SPECIAL STORAGE CONDITIONS**

**10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE**

**11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

**12. MARKETING AUTHORISATION NUMBER(S)**

7 x 1 hard capsule: EU/1/20/1520/005

21 x 1 hard capsule: EU/1/20/1520/006

**13. BATCH NUMBER**

Lot

**14. GENERAL CLASSIFICATION FOR SUPPLY**

**15. INSTRUCTIONS ON USE**

**16. INFORMATION IN BRAILLE**

Lenalidomide Krka d.d. Novo mesto 7.5 mg

**17. UNIQUE IDENTIFIER – 2D BARCODE**

2D barcode carrying the unique identifier included.

**18. UNIQUE IDENTIFIER - HUMAN READABLE DATA**

PC  
SN  
NN

**MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS**

**BLISTER**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 7.5 mg capsules

lenalidomide

**2. NAME OF THE MARKETING AUTHORISATION HOLDER**

KRKA

**3. EXPIRY DATE**

EXP

**4. BATCH NUMBER**

Lot

**5. OTHER**

1. Bend and tear
2. Peel

Mon.  
Tue.  
Wed.  
Thu.  
Fri.  
Sat.  
Sun.

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING**

**BOX**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 10 mg hard capsules

lenalidomide

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each hard capsule contains lenalidomide hydrochloride monohydrate equivalent to 10 mg lenalidomide.

**3. LIST OF EXCIPIENTS**

**4. PHARMACEUTICAL FORM AND CONTENTS**

hard capsule

7 x 1 hard capsule

21 x 1 hard capsule

**5. METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.

Oral use

**6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

**7. OTHER SPECIAL WARNING(S), IF NECESSARY**

WARNING: Risk of severe birth defects. Do not use while pregnant or breast-feeding. You must follow the Lenalidomide Pregnancy Prevention Programme.

**8. EXPIRY DATE**

EXP

**9. SPECIAL STORAGE CONDITIONS**

**10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE**

**11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

**12. MARKETING AUTHORISATION NUMBER(S)**

7 x 1 hard capsule: EU/1/20/1520/007  
21 x 1 hard capsule: EU/1/20/1520/008

**13. BATCH NUMBER**

Lot

**14. GENERAL CLASSIFICATION FOR SUPPLY**

**15. INSTRUCTIONS ON USE**

**16. INFORMATION IN BRAILLE**

Lenalidomide Krka d.d. Novo mesto 10 mg

**17. UNIQUE IDENTIFIER – 2D BARCODE**

2D barcode carrying the unique identifier included.

**18. UNIQUE IDENTIFIER - HUMAN READABLE DATA**

PC  
SN  
NN

**MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS**

**BLISTER**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 10 mg capsules

lenalidomide

**2. NAME OF THE MARKETING AUTHORISATION HOLDER**

KRKA

**3. EXPIRY DATE**

EXP

**4. BATCH NUMBER**

Lot

**5. OTHER**

1. Bend and tear
2. Peel

Mon.  
Tue.  
Wed.  
Thu.  
Fri.  
Sat.  
Sun.

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING**

**BOX**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 15 mg hard capsules

lenalidomide

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each hard capsule contains lenalidomide hydrochloride monohydrate equivalent to 15 mg lenalidomide.

**3. LIST OF EXCIPIENTS**

**4. PHARMACEUTICAL FORM AND CONTENTS**

hard capsule

7 x 1 hard capsule

21 x 1 hard capsule

**5. METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.

Oral use

**6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

**7. OTHER SPECIAL WARNING(S), IF NECESSARY**

WARNING: Risk of severe birth defects. Do not use while pregnant or breast-feeding. You must follow the Lenalidomide Pregnancy Prevention Programme.

**8. EXPIRY DATE**

EXP

**9. SPECIAL STORAGE CONDITIONS**

**10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE**

**11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

**12. MARKETING AUTHORISATION NUMBER(S)**

7 x 1 hard capsule: EU/1/20/1520/009  
21 x 1 hard capsule: EU/1/20/1520/010

**13. BATCH NUMBER**

Lot

**14. GENERAL CLASSIFICATION FOR SUPPLY**

**15. INSTRUCTIONS ON USE**

**16. INFORMATION IN BRAILLE**

Lenalidomide Krka d.d. Novo mesto 15 mg

**17. UNIQUE IDENTIFIER – 2D BARCODE**

2D barcode carrying the unique identifier included.

**18. UNIQUE IDENTIFIER - HUMAN READABLE DATA**

PC  
SN  
NN

**MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS**

**BLISTER**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 15 mg capsules

lenalidomide

**2. NAME OF THE MARKETING AUTHORISATION HOLDER**

KRKA

**3. EXPIRY DATE**

EXP

**4. BATCH NUMBER**

Lot

**5. OTHER**

1. Bend and tear
2. Peel

Mon.  
Tue.  
Wed.  
Thu.  
Fri.  
Sat.  
Sun.

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING**

**BOX**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 20 mg hard capsules

lenalidomide

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each hard capsule contains lenalidomide hydrochloride monohydrate equivalent to 20 mg lenalidomide.

**3. LIST OF EXCIPIENTS**

**4. PHARMACEUTICAL FORM AND CONTENTS**

hard capsule

7 x 1 hard capsule

21 x 1 hard capsule

**5. METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.

Oral use

**6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

**7. OTHER SPECIAL WARNING(S), IF NECESSARY**

WARNING: Risk of severe birth defects. Do not use while pregnant or breast-feeding. You must follow the Lenalidomide Pregnancy Prevention Programme.

**8. EXPIRY DATE**

EXP

**9. SPECIAL STORAGE CONDITIONS**

**10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE**

**11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

**12. MARKETING AUTHORISATION NUMBER(S)**

7 x 1 hard capsule: EU/1/20/1520/011

21 x 1 hard capsule: EU/1/20/1520/012

**13. BATCH NUMBER**

Lot

**14. GENERAL CLASSIFICATION FOR SUPPLY**

**15. INSTRUCTIONS ON USE**

**16. INFORMATION IN BRAILLE**

Lenalidomide Krka d.d. Novo mesto 20 mg

**17. UNIQUE IDENTIFIER – 2D BARCODE**

2D barcode carrying the unique identifier included.

**18. UNIQUE IDENTIFIER - HUMAN READABLE DATA**

PC  
SN  
NN

**MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS**

**BLISTER**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 20 mg capsules

lenalidomide

**2. NAME OF THE MARKETING AUTHORISATION HOLDER**

KRKA

**3. EXPIRY DATE**

EXP

**4. BATCH NUMBER**

Lot

**5. OTHER**

1. Bend and tear
2. Peel

Mon.  
Tue.  
Wed.  
Thu.  
Fri.  
Sat.  
Sun.

**PARTICULARS TO APPEAR ON THE OUTER PACKAGING**

**BOX**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 25 mg hard capsules

lenalidomide

**2. STATEMENT OF ACTIVE SUBSTANCE(S)**

Each hard capsule contains lenalidomide hydrochloride monohydrate equivalent to 25 mg lenalidomide.

**3. LIST OF EXCIPIENTS**

**4. PHARMACEUTICAL FORM AND CONTENTS**

hard capsule

7 x 1 hard capsule

21 x 1 hard capsule

**5. METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.

Oral use

**6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

**7. OTHER SPECIAL WARNING(S), IF NECESSARY**

WARNING: Risk of severe birth defects. Do not use while pregnant or breast-feeding. You must follow the Lenalidomide Pregnancy Prevention Programme.

**8. EXPIRY DATE**

EXP

**9. SPECIAL STORAGE CONDITIONS**

**10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE**

**11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

**12. MARKETING AUTHORISATION NUMBER(S)**

7 x 1 hard capsule: EU/1/20/1520/013  
21 x 1 hard capsule: EU/1/20/1520/014

**13. BATCH NUMBER**

Lot

**14. GENERAL CLASSIFICATION FOR SUPPLY**

**15. INSTRUCTIONS ON USE**

**16. INFORMATION IN BRAILLE**

Lenalidomide Krka d.d. Novo mesto 25 mg

**17. UNIQUE IDENTIFIER – 2D BARCODE**

2D barcode carrying the unique identifier included.

**18. UNIQUE IDENTIFIER - HUMAN READABLE DATA**

PC  
SN  
NN

**MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS**

**BLISTER**

**1. NAME OF THE MEDICINAL PRODUCT**

Lenalidomide Krka d.d. Novo mesto 25 mg capsules

lenalidomide

**2. NAME OF THE MARKETING AUTHORISATION HOLDER**

KRKA

**3. EXPIRY DATE**

EXP

**4. BATCH NUMBER**

Lot

**5. OTHER**

1. Bend and tear
2. Peel

Mon.  
Tue.  
Wed.  
Thu.  
Fri.  
Sat.  
Sun.

**B. PACKAGE LEAFLET**

## Package leaflet: Information for the patient

**Lenalidomide Krka d.d. Novo mesto 2.5 mg hard capsules**  
**Lenalidomide Krka d.d. Novo mesto 5 mg hard capsules**  
**Lenalidomide Krka d.d. Novo mesto 7.5 mg hard capsules**  
**Lenalidomide Krka d.d. Novo mesto 10 mg hard capsules**  
**Lenalidomide Krka d.d. Novo mesto 15 mg hard capsules**  
**Lenalidomide Krka d.d. Novo mesto 20 mg hard capsules**  
**Lenalidomide Krka d.d. Novo mesto 25 mg hard capsules**  
lenalidomide

**Read all of this leaflet carefully before you start taking this medicine because it contains important information for you.**

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.

### What is in this leaflet

1. What Lenalidomide Krka d.d. Novo mesto is and what it is used for
2. What you need to know before you take Lenalidomide Krka d.d. Novo mesto
3. How to take Lenalidomide Krka d.d. Novo mesto
4. Possible side effects
5. How to store Lenalidomide Krka d.d. Novo mesto
6. Contents of the pack and other information

### 1. What Lenalidomide Krka d.d. Novo mesto is and what it is used for

#### What Lenalidomide Krka d.d. Novo mesto is

Lenalidomide Krka d.d. Novo mesto contains the active substance 'lenalidomide'. This medicine belongs to a group of medicines which affect how your immune system works.

#### What Lenalidomide Krka d.d. Novo mesto is used for

Lenalidomide Krka d.d. Novo mesto is used in adults for:

- Multiple myeloma
- Follicular lymphoma

#### Multiple myeloma

Multiple myeloma is a type of cancer which affects a certain kind of white blood cell, called the plasma cell. These cells collect in the bone marrow and divide, becoming out of control. This can damage the bones and kidneys.

Multiple myeloma generally cannot be cured. However, the signs and symptoms can be greatly reduced or disappear for a period of time. This is called a 'response'.

#### Newly diagnosed multiple myeloma – in patients who have had a bone marrow transplant

Lenalidomide Krka d.d. Novo mesto is used on its own as a maintenance therapy after patients have recovered enough following a bone marrow transplant.

#### Newly diagnosed multiple myeloma – in patients who cannot have a bone marrow transplant

Lenalidomide Krka d.d. Novo mesto is taken with other medicines. These may include:

- a chemotherapy medicine called 'bortezomib'
- an anti-inflammatory medicine called 'dexamethasone'
- a chemotherapy medicine called 'melphalan' and

- an immunosuppressant medicine called 'prednisone'.

You will take these other medicines at the start of treatment and then continue to take Lenalidomide Krka d.d. Novo mesto on its own.

If you are aged 75 years or older or have moderate to severe kidney problems - your doctor will check you carefully before starting treatment.

#### Multiple myeloma – in patients who have had treatment before

Lenalidomide Krka d.d. Novo mesto is taken together with an anti-inflammatory medicine called 'dexamethasone'.

Lenalidomide Krka d.d. Novo mesto can stop the signs and symptoms of multiple myeloma getting worse. It has also been shown to delay multiple myeloma from coming back following treatment.

#### **Follicular lymphoma (FL)**

FL is a slow growing cancer that affects the B-lymphocytes. These are a type of white blood cells that help your body fight infection. When you have FL, too many of these B-lymphocytes may collect in your blood, bone marrow, lymph nodes and spleen.

Lenalidomide Krka d.d. Novo mesto is taken together with another medicine called 'rituximab' for the treatment of adult patients with previously treated follicular lymphoma.

#### **How Lenalidomide Krka d.d. Novo mesto works**

Lenalidomide Krka d.d. Novo mesto works by affecting the body's immune system and directly attacking the cancer. It works in a number of different ways:

- by stopping the cancer cells developing
- by stopping blood vessels growing in the cancer
- by stimulating part of the immune system to attack the cancer cells.

## **2. What you need to know before you take Lenalidomide Krka d.d. Novo mesto**

**You must read the package leaflet of all medicinal products to be taken in combination with Lenalidomide Krka d.d. Novo mesto before starting treatment with Lenalidomide Krka d.d. Novo mesto.**

#### **Do not take Lenalidomide Krka d.d. Novo mesto**

- if you are pregnant, think you may be pregnant or are planning to become pregnant, **as Lenalidomide Krka d.d. Novo mesto is expected to be harmful to an unborn child** (see section 2, 'Pregnancy, breast-feeding and contraception – information for women and men').
- if you are able to become pregnant, unless you follow all the necessary measures to prevent you from becoming pregnant (see section 2, 'Pregnancy, breast-feeding and contraception – information for women and men'). If you are able to become pregnant, your doctor will record with each prescription that the necessary measures have been taken and provide you with this confirmation.
- if you are allergic to lenalidomide or any of the other ingredients of this medicine listed in section 6. If you think you may be allergic, ask your doctor for advice.

If any of these apply to you, do not take Lenalidomide Krka d.d. Novo mesto. Talk to your doctor if you are not sure.

#### **Warnings and precautions**

**Talk to your doctor, pharmacist or nurse before taking Lenalidomide Krka d.d. Novo mesto if:**

- you have had blood clots in the past - you have an increased risk of developing blood clots in the veins and arteries during treatment
- you have any signs of an infection, such as a cough or fever
- you have or have ever had previous viral infection, particularly: hepatitis B infection, varicella

zoster, HIV. If you are in doubt, talk to your doctor. Treatment with Lenalidomide Krka d.d. Novo mesto may cause the virus to become active again, in patients who carry the virus. This results in a recurrence of the infection. Your doctor should check whether you have ever had hepatitis B infection

- you have kidney problems - your doctor may adjust your dose of Lenalidomide Krka d.d. Novo mesto
- you have had a heart attack, have ever had a blood clot, or if you smoke, have high blood pressure or high cholesterol levels
- you have had an allergic reaction whilst taking thalidomide (another medicine used to treat multiple myeloma) such as rash, itching, swelling, dizziness or trouble breathing
- you have experienced in the past a combination of any of the following symptoms: widespread rash, red skin, high body temperature, flu-like symptoms, liver enzyme elevations, blood abnormalities (eosinophilia), enlarged lymph nodes – these are signs of a severe skin reaction called Drug Reaction with Eosinophilia and Systemic Symptoms which is also known as DRESS or drug hypersensitivity syndrome. (see also section 4 “Possible side effects”).

If any of the above apply to you, tell your doctor, pharmacist or nurse before starting treatment.

At any time during or after your treatment, tell your doctor or nurse immediately if you:

- experience blurred, loss of or double vision, difficulty speaking, weakness in an arm or a leg, a change in the way you walk or problems with your balance, persistent numbness, decreased sensation or loss of sensation, memory loss or confusion. These may all be symptoms of a serious and potentially fatal brain condition known as progressive multifocal leukoencephalopathy (PML). If you had these symptoms prior to treatment with Lenalidomide Krka d.d. Novo mesto, tell your doctor about any change in these symptoms.
- experience shortness of breath, tiredness, dizziness, pain in the chest, a faster heartbeat, or swelling in the legs or ankles. These may be symptoms of a serious condition known as pulmonary hypertension (see section 4).

### **Tests and checks**

Before and during the treatment with Lenalidomide Krka d.d. Novo mesto you will have regular blood tests. This is because Lenalidomide Krka d.d. Novo mesto may cause a fall in the blood cells that help fight infection (white blood cells) and help the blood to clot (platelets).

Your doctor will ask you to have a blood test:

- before treatment
- every week for the first 8 weeks of treatment
- then at least every month after that.

You may be evaluated for signs of cardiopulmonary problems before and during the treatment with lenalidomide.

### **For patients with FL taking Lenalidomide Krka d.d. Novo mesto**

Your doctor will ask you to have a blood test:

- before treatment
- every week for the first 3 weeks (1 cycle) of treatment
- then every 2 weeks in cycles 2 to 4 (see Section 3 ‘Treatment cycle’ for more information)
- After this it will happen at the start of each cycle and at least every month.

Your doctor may check if you have a high total amount of tumour throughout the body, including your bone marrow. This could lead to a condition where the tumours break down and cause unusual levels of chemicals in the blood which can lead to kidney failure (this condition is called ‘Tumour Lysis Syndrome’).

Your doctor may check you for changes to your skin such as red spots or rashes.

Your doctor may adjust your dose of Lenalidomide Krka d.d. Novo mesto or stop your treatment based on the results of your blood tests and on your general condition. If you are newly diagnosed,

your doctor may also assess your treatment based on your age and other conditions you already have.

### **Blood donation**

You should not donate blood during treatment and for at least 7 days after the end of treatment.

### **Children and adolescents**

Lenalidomide Krka d.d. Novo mesto is not recommended for use in children and adolescents under 18 years.

### **Elderly and people with kidney problems**

If you are aged 75 years or older or have moderate to severe kidney problems - your doctor will check you carefully before starting treatment.

### **Other medicines and Lenalidomide Krka d.d. Novo mesto**

Tell your doctor or nurse if you are taking, have recently taken or might take any other medicines. This is because Lenalidomide Krka d.d. Novo mesto can affect the way some other medicines work. Also, some other medicines can affect the way Lenalidomide Krka d.d. Novo mesto works.

In particular, tell your doctor or nurse if you are taking any of the following medicines:

- some medicines used to prevent pregnancy such as oral contraceptives, as they may stop working
- some medicines used for heart problems – such as digoxin
- some medicines used to thin the blood – such as warfarin.

### **Pregnancy, breast-feeding and contraception - information for women and men**

#### **Pregnancy**

##### For women taking Lenalidomide Krka d.d. Novo mesto

- You must not take Lenalidomide Krka d.d. Novo mesto if you are pregnant, as it is expected to be harmful to an unborn baby.
- You must not become pregnant while taking Lenalidomide Krka d.d. Novo mesto. Therefore you must use effective methods of contraception if you are a woman of childbearing potential (see 'Contraception').
- If you do become pregnant during your treatment with Lenalidomide Krka d.d. Novo mesto, you must stop the treatment and inform your doctor immediately.

##### For men taking Lenalidomide Krka d.d. Novo mesto

- If your partner becomes pregnant whilst you are taking Lenalidomide Krka d.d. Novo mesto, you should inform your doctor immediately. It is recommended that your partner seeks medical advice.
- You must also use effective methods of contraception (see 'Contraception').

#### **Breast-feeding**

You must not breast-feed when taking Lenalidomide Krka d.d. Novo mesto, as it is not known if Lenalidomide Krka d.d. Novo mesto passes into breast milk.

#### **Contraception**

##### For women taking Lenalidomide Krka d.d. Novo mesto

Before starting the treatment, ask your doctor if you are able to become pregnant, even if you think this is unlikely.

If you are able to become pregnant

- you will have pregnancy tests under the supervision of your doctor (before every treatment, at least every 4 weeks during treatment, and at least 4 weeks after the treatment has finished) except where it has been confirmed that the fallopian tubes have been severed and sealed, to stop eggs from reaching the uterus (tubal sterilisation)

AND

- you must use effective methods of contraception for at least 4 weeks before starting treatment, during treatment, and until at least 4 weeks after stopping treatment. Your doctor will advise you on appropriate methods of contraception.

#### For men taking Lenalidomide Krka d.d. Novo mesto

Lenalidomide Krka d.d. Novo mesto passes into human semen. If your female partner is pregnant or able to become pregnant, and she does not use effective methods of contraception, you must use condoms during treatment and for at least 7 days after the end of treatment, even if you have had a vasectomy.

#### **Driving and using machines**

Do not drive or operate machines if you feel dizzy, tired, sleepy, have vertigo or blurred vision after taking Lenalidomide Krka d.d. Novo mesto.

### **3. How to take Lenalidomide Krka d.d. Novo mesto**

Lenalidomide Krka d.d. Novo mesto must be given to you by healthcare professionals with experience in treating multiple myeloma or FL.

- When Lenalidomide Krka d.d. Novo mesto is used to treat multiple myeloma in patients who cannot have a bone marrow transplant or have had other treatments before, it is taken with other medicines (see section 1 'What Lenalidomide Krka d.d. Novo mesto is used for').
- When Lenalidomide Krka d.d. Novo mesto is used to treat multiple myeloma in patients who have had a bone marrow transplant, it is taken alone.
- When Lenalidomide Krka d.d. Novo mesto is used to treat follicular lymphoma, it is taken with another medicine called 'rituximab'.

Always take Lenalidomide Krka d.d. Novo mesto exactly as your doctor has told you. Check with your doctor or pharmacist if you are not sure.

If you are taking Lenalidomide Krka d.d. Novo mesto in combination with other medicines, you should refer to the package leaflets for these medicines for further information on their use and effects.

#### **Treatment cycle**

Lenalidomide Krka d.d. Novo mesto is taken on certain days over 3 weeks (21 days).

- Every 21 days is called a 'treatment cycle'.
- Depending on the day of the cycle, you will take one or more of the medicines. However, on some days you do not take any of the medicines.
- After completing every 21-day cycle, you should start a new 'cycle' over the next 21 days.

OR

Lenalidomide Krka d.d. Novo mesto is taken on certain days over 4 weeks (28 days).

- Every 28 days is called a 'treatment cycle'.
- Depending on the day of the cycle, you will take one or more of the medicines. However, on some days you do not take any of the medicines.
- After completing every 28-day cycle, you should start a new 'cycle' over the next 28 days.

#### **How much Lenalidomide Krka d.d. Novo mesto to take**

Before you start treatment, your doctor will tell you:

- how much Lenalidomide Krka d.d. Novo mesto you should take
- how much of the other medicines you should take in combination with Lenalidomide Krka d.d. Novo mesto, if any
- on what days of your treatment cycle to take each medicine.

#### **How and when to take Lenalidomide Krka d.d. Novo mesto**

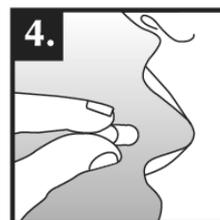
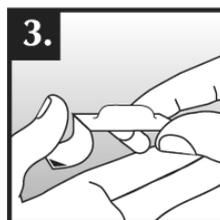
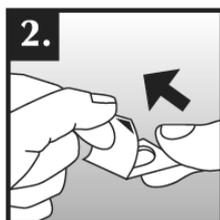
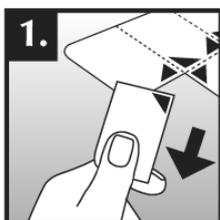
- swallow the capsules whole, preferably with water.
- do not break, open or chew the capsules. If powder from a broken Lenalidomide Krka d.d. Novo mesto capsule makes contact with the skin, wash the skin immediately and thoroughly with soap

- and water.
- healthcare professionals, caregivers and family members should wear disposable gloves when handling the blister or capsule. Gloves should then be removed carefully to prevent skin exposure, placed in a sealable plastic polyethylene bag and disposed of in accordance with local requirements. Hands should then be washed thoroughly with soap and water. Women who are pregnant or suspect they may be pregnant should not handle the blister or capsule.
- the capsules can be taken either with or without food.
- you should take Lenalidomide Krka d.d. Novo mesto at about the same time on the scheduled days.

### **Taking this medicine**

To remove the capsule from the blister:

1. Hold the blister at the edges and separate one blister cell from the rest of the blister by gently tearing along the perforations around it.
2. Pull up the edge of the foil and peel the foil off completely.
3. Tip the capsule out onto your hand.
4. Swallow the capsule whole, preferably with water.



### **Duration of the treatment with Lenalidomide Krka d.d. Novo mesto**

Lenalidomide Krka d.d. Novo mesto is taken in treatment cycles, each cycle lasting 21 or 28 days (see above 'Treatment cycle'). You should continue the cycles of treatment until your doctor tells you to stop.

### **If you take more Lenalidomide Krka d.d. Novo mesto than you should**

If you take more Lenalidomide Krka d.d. Novo mesto than was prescribed, tell your doctor immediately.

### **If you forget to take Lenalidomide Krka d.d. Novo mesto**

If you forget to take Lenalidomide Krka d.d. Novo mesto at your regular time and:

- less than 12 hours have passed - take your capsule immediately.
- more than 12 hours have passed - do not take your capsule. Take your next capsule at the usual time the next day.

If you have any further questions on the use of this medicine, ask your doctor or pharmacist.

## **4. Possible side effects**

Like all medicines, this medicine can cause side effects, although not everybody gets them.

### **Stop taking Lenalidomide Krka d.d. Novo mesto and see a doctor straight away if you notice any of the following serious side effects – you may need urgent medical treatment:**

- Hives, rashes, swelling of eyes, mouth or face, difficulty breathing, or itching, which may be symptoms of serious types of allergic reactions called angioedema and anaphylactic reaction.
- A serious allergic reaction that may begin as a rash in one area but spread with extensive loss of skin over the whole body (Stevens-Johnson syndrome and/or toxic epidermal necrolysis).
- Widespread rash, high body temperature, liver enzyme elevations, blood abnormalities (eosinophilia), enlarged lymph nodes and other body organs involvement (Drug Reaction

with Eosinophilia and Systemic Symptoms which is also known as DRESS or drug hypersensitivity syndrome). See also section 2.

**Tell your doctor straight away if you notice any of the following serious side effects:**

- Fever, chills, sore throat, cough, mouth ulcers or any other symptoms of infection including within the bloodstream (sepsis)
- Bleeding or bruising in the absence of injury
- Chest pain or leg pain
- Shortness of breath
- Bone pain, muscle weakness, confusion or tiredness that might be due to high level of calcium in the blood.

Lenalidomide Krka d.d. Novo mesto may reduce the number of white blood cells that fight infection and also the blood cells which help the blood to clot (platelets) which may lead to bleeding disorders such as nosebleeds and bruising.

Lenalidomide Krka d.d. Novo mesto may also cause blood clots in the veins (thrombosis).

**Other side effects**

It is important to note that a small number of patients may develop additional types of cancer, and it is possible that this risk may be increased with Lenalidomide Krka d.d. Novo mesto treatment. Therefore your doctor should carefully evaluate the benefit and risk when you are prescribed Lenalidomide Krka d.d. Novo mesto.

**Very common** (may affect more than 1 in 10 people)

- A fall in the number of red blood cells which may cause anaemia leading to tiredness and weakness
- Rashes, itching
- Muscle cramps, muscle weakness, muscle pain, muscle aches, bone pain, joint pain, back pain, pain in the extremities
- Generalised swelling including swelling of your arms and legs
- Weakness, tiredness
- Fever and flu like symptoms including fever, muscle ache, headache, earache, cough and chills
- Numbness, tingling or burning sensation to the skin, pains in hands or feet, dizziness, tremor
- Decreased appetite, change in the way things taste
- Increase in pain, tumour size or redness around the tumour
- Weight loss
- Constipation, diarrhoea, nausea, vomiting, stomach pain, heartburn
- Low levels of potassium or calcium and/or sodium in the blood
- Thyroid functioning less than it should be
- Leg pain (which could be a symptom of thrombosis), chest pain or shortness of breath (which may be a symptom of blood clots in the lungs, called pulmonary embolism)
- Infections of all types, including infection of the sinuses that surround the nose, infection of the lung and the upper respiratory tract
- Shortness of breath
- Blurred vision
- Clouding of your eye (cataract)
- Kidney problems which include kidneys not working properly or not being able to maintain normal function
- Abnormal liver test results
- Increase in liver test results
- Changes to a protein in the blood that can cause swelling of the arteries (vasculitis)
- Increases in your blood sugar levels (diabetes)
- Decreases in your blood sugar levels
- Headache
- Nosebleed
- Dry skin
- Depression, mood change, difficulty sleeping

- Cough
- A fall in blood pressure
- A vague feeling of bodily discomfort, feeling bad
- Sore inflamed mouth, dry mouth
- Dehydration

**Common** (may affect up to 1 in 10 people)

- Destruction of red blood cells (haemolytic anaemia)
- Certain types of skin tumour
- Bleeding of the gums, stomach, or bowels
- Increased blood pressure, slow, fast or irregular heart beat
- Increase in the amount of a substance which results from normal and abnormal breakdown of red blood cells
- Increase in a type of protein that indicates inflammation in body
- Darkening of your skin, discoloration of your skin resulting from bleeding underneath, typically caused by bruising, swelling of skin filled with blood, bruise
- Increase in uric acid in the blood
- Skin eruptions, redness of skin, cracking, flaking or peeling skin, hives
- Increased sweating, night sweats
- Difficulty swallowing, sore throat, difficulty with voice quality or voice changes
- Runny nose
- Production of much more or much less urine than usual or the inability to control when to urinate
- Passing blood in the urine
- Shortness of breath especially when lying down (which may be a symptom of heart failure)
- Difficulty getting an erection
- Stroke, fainting, vertigo (problem with inner ear which leads to feeling that everything is spinning), temporary loss of consciousness
- Chest pain spreading to the arms, neck, jaw, back or stomach, feeling sweaty and breathless, feeling sick or vomiting, which may be symptoms of a heart attack (myocardial infarction)
- Muscle weakness, lack of energy
- Neck pain, chest pain
- Chills
- Joint swelling
- Bile flow from liver slowed or blocked
- Low levels of phosphate or magnesium in the blood
- Difficulty speaking
- Liver injury
- Impaired balance, difficulty moving
- Deafness, ringing in the ears (tinnitus)
- Nerve pain, unpleasant abnormal sensation especially to touch
- An excess of iron in the body
- Thirst
- Confusion
- Toothache
- Fall which may result in injury

**Uncommon** (may affect up to 1 in 100 people)

- Bleeding within the skull
- Circulatory problems
- Loss of vision
- Loss of sex drive (libido)
- Passing large amounts of urine with bone pain and weakness, which may be symptoms of a kidney disorder (Fanconi syndrome)
- Yellow pigmentation to the skin, mucus membrane or eyes (jaundice), pale coloured stools, dark coloured urine, skin itch, rash, pain or swelling of the stomach – these may be symptoms of injury to the liver (hepatic failure)

- Stomach pain, bloating, or diarrhoea, which may be symptoms of inflammation in the large intestine (called colitis or caecitis)
- Damage to the cells of the kidney (called renal tubular necrosis)
- Changes to the colour of your skin, sensitivity to sunlight
- Tumour lysis syndrome - metabolic complications that can occur during treatment of cancer and sometimes even without treatment. These complications are caused by the break-down products of dying cancer cells and may include the following: changes to blood chemistry; high potassium, phosphorus, uric acid, and low calcium consequently leading to changes in kidney function, heart beat, seizures, and sometimes death
- Increase in blood pressure within blood vessels that supply the lungs (pulmonary hypertension).

**Not known** (frequency cannot be estimated from the available data)

- Sudden, or mild but worsening pain in the upper stomach and/or back, which remains for a few days, possibly accompanied by nausea, vomiting, fever and a rapid pulse – these symptoms may be due to inflammation of the pancreas.
- Wheezing, shortness of breath or a dry cough, which may be symptoms caused by inflammation of the tissue in the lungs.
- Rare cases of muscle breakdown (muscle pain, weakness or swelling) which can lead to kidney problems (rhabdomyolysis) have been observed, some of them when Lenalidomide Krka d.d. Novo mesto is administered with a statin (a type of cholesterol lowering medicines).
- A condition affecting the skin caused by inflammation of small blood vessels, along with pain in the joints and fever (leukocytoclastic vasculitis).
- Breakdown of the wall of the stomach or gut. This may lead to very serious infection. Tell your doctor if you have severe stomach pain, fever, nausea, vomiting, blood in your stool, or changes in bowel habits.
- Viral infections, including herpes zoster (also known as ‘shingles’, a viral disease that causes a painful skin rash with blisters) and recurrence of hepatitis B infection (which can cause yellowing of the skin and eyes, dark brown-colored urine, right-sided stomach pain, fever and feeling nauseous or being sick).
- Rejection of solid organ transplant (such as kidney, heart).

### **Reporting of side effects**

If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via [the national reporting system](#) listed in [Appendix V](#). By reporting side effects you can help provide more information on the safety of this medicine.

## **5. How to store Lenalidomide Krka d.d. Novo mesto**

Keep this medicine out of the sight and reach of children.

Do not use this medicine after the expiry date which is stated on the packaging after EXP. The expiry date refers to the last day of that month.

This medicine does not require any special storage conditions.

Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

## **6. Contents of the pack and other information**

### **What Lenalidomide Krka d.d. Novo mesto contains**

- The active substance is lenalidomide. Each hard capsule contains lenalidomide hydrochloride monohydrate equivalent to 2.5 mg, 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg or 25 mg lenalidomide.

- The other ingredients in the capsule contents are mannitol (E421), microcrystalline cellulose (E460), pregelatinised maize starch, tartaric acid (E334) and glycerol dibehenate.
- The other ingredients in capsule shell are:  
Lenalidomide Krka d.d. Novo mesto 2.5 mg hard capsules:  
hypromellose, carrageenan (E407), potassium chloride (E508), titanium dioxide (E171), yellow iron oxide (E172), indigo carmine (E132), imprinting ink (shellac (E904), black iron oxide (E172)).

Lenalidomide Krka d.d. Novo mesto 5 mg hard capsules:  
hypromellose, carrageenan (E407), potassium chloride (E508), titanium dioxide (E171), indigo carmine (E132), imprinting ink (shellac (E904), black iron oxide (E172)).

Lenalidomide Krka d.d. Novo mesto 7.5 mg hard capsules:  
hypromellose, carrageenan (E407), potassium chloride (E508), titanium dioxide (E171), yellow iron oxide (E172), red iron oxide (E172), black iron oxide (E172), imprinting ink (shellac (E904), povidone, titanium dioxide (E171)).

Lenalidomide Krka d.d. Novo mesto 10 mg hard capsules:  
hypromellose, carrageenan (E407), potassium chloride (E508), titanium dioxide (E171), yellow iron oxide (E172), red iron oxide (E172), black iron oxide (E172), indigo carmine (E132), imprinting ink (shellac (E904), povidone, titanium dioxide (E171)).

Lenalidomide Krka d.d. Novo mesto 15 mg hard capsules:  
hypromellose, carrageenan (E407), potassium chloride (E508), titanium dioxide (E171), yellow iron oxide (E172), red iron oxide (E172), black iron oxide (E172), indigo carmine (E132), imprinting ink (shellac (E904), black iron oxide (E172)).

Lenalidomide Krka d.d. Novo mesto 20 mg hard capsules:  
hypromellose, carrageenan (E407), potassium chloride (E508), titanium dioxide (E171), yellow iron oxide (E172), indigo carmine (E132), imprinting ink (shellac (E904), black iron oxide (E172)).

Lenalidomide Krka d.d. Novo mesto 25 mg hard capsules:  
hypromellose, carrageenan (E407), potassium chloride (E508), titanium dioxide (E171), yellow iron oxide (E172), red iron oxide (E172), black iron oxide (E172), imprinting ink (shellac (E904), povidone, titanium dioxide (E171)).

### **What Lenalidomide Krka d.d. Novo mesto looks like and contents of the pack**

#### Lenalidomide Krka d.d. Novo mesto 2.5 mg hard capsules (capsules):

Capsule cap is green, capsule body is green with imprinted black mark 2.5. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 4, length  $14 \pm 1$  mm.

#### Lenalidomide Krka d.d. Novo mesto 5 mg hard capsules (capsules):

Capsule cap is blue, capsule body is blue with imprinted black mark 5. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 2, length  $18 \pm 1$  mm.

#### Lenalidomide Krka d.d. Novo mesto 7.5 mg hard capsules (capsules):

Capsule cap is brown, capsule body is brown with imprinted white mark 7.5. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 1, length  $19 \pm 1$  mm.

#### Lenalidomide Krka d.d. Novo mesto 10 mg hard capsules (capsules):

Capsule cap is green, capsule body is brown with imprinted white mark 10. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 0, length  $21 \pm 1$  mm.

#### Lenalidomide Krka d.d. Novo mesto 15 mg hard capsules (capsules):

Capsule cap is brown, capsule body is blue with imprinted black mark 15. Capsule content is white to

yellow white or to brown white powder. Hard capsule size: 2, length  $18 \pm 1$  mm.

Lenalidomide Krka d.d. Novo mesto 20 mg hard capsules (capsules):

Capsule cap is green, capsule body is blue with imprinted black mark 20. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 1, length  $19 \pm 1$  mm.

Lenalidomide Krka d.d. Novo mesto 25 mg hard capsules (capsules):

Capsule cap is brown, capsule body is brown with imprinted white mark 25. Capsule content is white to yellow white or to brown white powder. Hard capsule size: 0, length  $21 \pm 1$  mm.

Lenalidomide Krka d.d. Novo mesto is available in boxes containing 7 x 1 or 21 x 1 hard capsule in peel open, unit dose blisters.

Not all pack sizes may be marketed.

**Marketing Authorisation Holder**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

**Manufacturer**

KRKA, d.d., Novo mesto, Šmarješka cesta 6, 8501 Novo mesto, Slovenia

KRKA – FARMA d.o.o., V. Holjevca 20/E, 10450 Jastrebarsko, Croatia

TAD Pharma GmbH, Heinz-Lohmann-Straße 5, 27472 Cuxhaven, Germany

For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:

**België/Belgique/Belgien**

KRKA Belgium, SA.

Tél/Tel: + 32 (0) 487 50 73 62

**Lietuva**

UAB KRKA Lietuva

Tel: + 370 5 236 27 40

**България**

КРКА България ЕООД

Тел.: + 359 (02) 962 34 50

**Luxembourg/Luxemburg**

KRKA Belgium, SA.

Tél/Tel: + 32 (0) 487 50 73 62 (BE)

**Česká republika**

KRKA ČR, s.r.o.

Tel: + 420 (0) 221 115 150

**Magyarország**

KRKA Magyarország Kereskedelmi Kft.

Tel.: + 36 (1) 355 8490

**Danmark**

KRKA Sverige AB

Tlf: + 46 (0)8 643 67 66 (SE)

**Malta**

E. J. Busuttil Ltd.

Tel: + 356 21 445 885

**Deutschland**

TAD Pharma GmbH

Tel: + 49 (0) 4721 606-0

**Nederland**

KRKA Belgium, SA.

Tel: + 32 (0) 487 50 73 62 (BE)

**Eesti**

KRKA, d.d., Novo mesto Eesti filiaal

Tel: + 372 (0) 6 671 658

**Norge**

KRKA Sverige AB

Tlf: + 46 (0)8 643 67 66 (SE)

**Ελλάδα**

KRKA ΕΛΛΑΣ ΕΠΕ

Τηλ: + 30 2100101613

**Österreich**

KRKA Pharma GmbH, Wien

Tel: + 43 (0)1 66 24 300

**España**

KRKA Farmacéutica, S.L.

Tel: + 34 911 61 03 80

**Polska**

KRKA-POLSKA Sp. z o.o.

Tel.: + 48 (0)22 573 7500

**France**

KRKA France Eurl  
Tél: + 33 (0)1 57 40 82 25

**Hrvatska**

KRKA - FARMA d.o.o.  
Tel: + 385 1 6312 100

**Ireland**

KRKA Pharma Dublin, Ltd.  
Tel: + 353 1 413 3710

**Ísland**

LYFIS ehf.  
Sími: + 354 534 3500

**Italia**

KRKA Farmaceutici Milano S.r.l.  
Tel: + 39 02 3300 8841

**Κύπρος**

KI.PA. (PHARMACAL) LIMITED  
Τηλ: + 357 24 651 882

**Latvija**

KRKA Latvija SIA  
Tel: + 371 6 733 86 10

**Portugal**

KRKA Farmacêutica, Sociedade Unipessoal Lda.  
Tel: + 351 (0)21 46 43 650

**România**

KRKA Romania S.R.L., Bucharest  
Tel: + 4 021 310 66 05

**Slovenija**

KRKA, d.d., Novo mesto  
Tel: + 386 (0) 1 47 51 100

**Slovenská republika**

KRKA Slovensko, s.r.o.  
Tel: + 421 (0) 2 571 04 501

**Suomi/Finland**

KRKA Finland Oy  
Puh/Tel: + 358 20 754 5330

**Sverige**

KRKA Sverige AB  
Tel: + 46 (0)8 643 67 66 (SE)

**United Kingdom (Northern Ireland)**

KRKA Pharma Dublin, Ltd.  
Tel: + 353 1 413 3710

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**Other sources of information**

Detailed information on this medicine is available on the European Medicines Agency web site:  
<http://www.ema.europa.eu>.