

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

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 for how to report adverse reactions.

## 1. NAME OF THE MEDICINAL PRODUCT

Kymriah  $1.2 \times 10^6 - 6 \times 10^8$  cells dispersion for infusion

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

### 2.1 General description

Kymriah is an immunocellular therapy containing tisagenlecleucel, autologous T cells genetically modified *ex vivo* using a lentiviral vector encoding an anti-CD19 chimeric antigen receptor (CAR).

### 2.2 Qualitative and quantitative composition

Each ethylene vinyl acetate (EVA) infusion bag of Kymriah contains tisagenlecleucel cell dispersion at a batch-dependent concentration of autologous T cells genetically modified to express an anti-CD19 chimeric antigen receptor (CAR-positive viable T cells) (see section 4.2).

The concentration of CAR-positive viable T cells is dependent on indication and patient body weight (for B-cell acute lymphoblastic leukaemia [ALL]). The cellular composition and the final cell number varies between individual patient batches. In addition to T cells, NK cells may be present. The quantitative information regarding CAR-positive viable T cells/mL and total cells in the product is presented in the batch-specific documentation accompanying Kymriah.

1 or more infusion bags containing a total of  $1.2 \times 10^6$  to  $6 \times 10^8$  CAR-positive viable T cells.

#### Excipient with known effect

This medicinal product contains 2.43 mg sodium per mL and 24.3 to 121.5 mg sodium per dose.

For the full list of excipients, see section 6.1.

## 3. PHARMACEUTICAL FORM

Dispersion for infusion.

A colourless to slightly yellow dispersion.

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Kymriah is indicated for the treatment of:

- Paediatric and young adult patients up to and including 25 years of age with B-cell acute lymphoblastic leukaemia (ALL) that is refractory, in relapse post-transplant or in second or later relapse.
- Adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) after two or more lines of systemic therapy.

## 4.2 Posology and method of administration

Kymriah must be administered in a qualified treatment centre. Therapy should be initiated under the direction of and supervised by a healthcare professional experienced in the treatment of haematological malignancies and trained for administration and management of patients treated with Kymriah. Tocilizumab for use in the event of cytokine release syndrome and emergency equipment must be available per patient prior to infusion. The treatment centre must have access to additional doses of tocilizumab within 8 hours.

Kymriah is intended for autologous use only (see section 4.4). Manufacture and release of Kymriah usually takes about 3-4 weeks.

### Posology

#### Dosage in paediatric and young adult B-cell ALL patients

- For patients 50 kg and below:  $0.2$  to  $5 \times 10^6$  CAR-positive viable T cells/kg body weight.
- For patients above 50 kg:  $0.1$  to  $2.5 \times 10^8$  CAR-positive viable T cells (non-weight based).

#### Dosage in adult DLBCL patients

- $0.6$  to  $6 \times 10^8$  CAR-positive viable T cells (non-weight based).

### Pre-treatment conditioning (lymphodepleting chemotherapy)

Lymphodepleting chemotherapy is recommended to be administered before Kymriah infusion unless the white blood cell (WBC) count within one week prior to infusion is  $\leq 1,000$  cells/ $\mu$ L.

Kymriah is recommended to be infused 2 to 14 days after completion of the lymphodepleting chemotherapy. The availability of Kymriah must be confirmed prior to starting the lymphodepleting regimen. If there is a delay of more than 4 weeks between completing lymphodepleting chemotherapy and the infusion and the WBC count is  $>1,000$  cells/ $\mu$ L, then the patient should be re-treated with lymphodepleting chemotherapy prior to receiving Kymriah.

#### B-cell ALL

The recommended lymphodepleting chemotherapy regimen is:

- Fludarabine ( $30$  mg/ $m^2$  intravenous daily for 4 days) and cyclophosphamide ( $500$  mg/ $m^2$  intravenous daily for 2 days starting with the first dose of fludarabine).

If the patient experienced a previous Grade 4 haemorrhagic cystitis with cyclophosphamide, or demonstrated a chemorefractory state to a cyclophosphamide-containing regimen administered shortly before lymphodepleting chemotherapy, then the following should be used:

- Cytarabine ( $500$  mg/ $m^2$  intravenous daily for 2 days) and etoposide ( $150$  mg/ $m^2$  intravenous daily for 3 days starting with the first dose of cytarabine).

#### DLBCL

The recommended lymphodepleting chemotherapy regimen is:

- Fludarabine ( $25$  mg/ $m^2$  intravenous daily for 3 days) and cyclophosphamide ( $250$  mg/ $m^2$  intravenous daily for 3 days starting with the first dose of fludarabine).

If the patient experienced a previous Grade 4 haemorrhagic cystitis with cyclophosphamide, or demonstrated a chemorefractory state to a cyclophosphamide-containing regimen administered shortly before lymphodepleting chemotherapy, then the following should be used:

- Bendamustine ( $90$  mg/ $m^2$  intravenous daily for 2 days).

Lymphodepleting chemotherapy may be omitted if a patient's white blood cell (WBC) count is  $\leq 1,000$  cells/ $\mu$ L within 1 week prior to Kymriah infusion.

### Pre-medication

To minimise potential acute infusion reactions, it is recommended that patients be pre-medicated with paracetamol and diphenhydramine or another H1 antihistamine within approximately 30 to 60 minutes prior to Kymriah infusion. Corticosteroids should not be used at any time except in the case of a life-threatening emergency (see section 4.4).

### Clinical assessment prior to infusion

Kymriah treatment should be delayed in some patient groups at risk (see section 4.4).

### Monitoring after infusion

- Patients should be monitored daily for the first 10 days following infusion for signs and symptoms of potential cytokine release syndrome, neurological events and other toxicities. Physicians should consider hospitalisation for the first 10 days post infusion or at the first signs/symptoms of cytokine release syndrome and/or neurological events.
- After the first 10 days following the infusion, the patient should be monitored at the physician's discretion.
- Patients should be instructed to remain within proximity (within 2 hours of travel) of a qualified clinical facility for at least 4 weeks following infusion.

### Special populations

#### Paediatric population

*B-cell ALL*: No formal studies have been performed in paediatric patients below 3 years of age.

*DLBCL*: The safety and efficacy of Kymriah in children and adolescents below 18 years of age have not yet been established. No data are available.

#### Elderly

*B-cell ALL*: The safety and efficacy of Kymriah in this population have not been established.

*DLBCL*: No dose adjustment is required in patients over 65 years of age.

#### Patients seropositive for hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (HIV)

There is no experience with manufacturing Kymriah for patients with a positive test for HIV, active HBV, or active HCV infection. Leukapheresis material from these patients will not be accepted for Kymriah manufacturing. Screening for HBV, HCV, and HIV must be performed in accordance with clinical guidelines before collection of cells for manufacturing.

### Method of administration

Kymriah is for intravenous use only.

#### Precautions to be taken before handling or administering the medicinal product

This medicinal product contains genetically modified human blood cells. Healthcare professionals handling Kymriah should take appropriate precautions (wearing gloves and glasses) to avoid potential transmission of infectious diseases as for any human-derived material.

#### Preparation for infusion

Prior to Kymriah infusion, it must be confirmed that the patient's identity matches the essential unique patient information on the infusion bag(s).

The timing of thaw of Kymriah and infusion should be coordinated. Please refer to section 6.6 for details on inspection and thawing of the infusion bag. The infusion start time should be confirmed in advance and adjusted for thaw so that Kymriah is available for infusion when the recipient is ready. Once Kymriah has been thawed and is at room temperature (20°C -25°C), it should be infused within 30 minutes to maintain maximum product viability, including any interruption during the infusion.

### Administration

Kymriah should be administered as an intravenous infusion through latex-free intravenous tubing without a leukocyte depleting filter, at approximately 10 to 20 mL per minute by gravity flow. All contents of the infusion bag(s) should be infused. Sodium chloride 9 mg/mL (0.9%) solution for injection should be used to prime the tubing prior to infusion and to rinse it after infusion. When the full volume of Kymriah has been infused, the infusion bag should be rinsed with 10 to 30 mL sodium chloride 9 mg/mL (0.9%) solution for injection by back priming to ensure as many cells as possible are infused into the patient.

If the volume of Kymriah to be administered is  $\leq 20$  mL, intravenous push may be used as an alternative method of administration.

For special precautions for disposal see section 6.6.

### **4.3 Contraindications**

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

Contraindications of the lymphodepleting chemotherapy must be considered.

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

#### Traceability

To ensure traceability the name of the product, the batch number and the name of the treated patient should be kept for a period of 30 years.

#### Reasons to delay treatment

Due to the risks associated with Kymriah treatment, infusion should be delayed if a patient has any of the following conditions:

- Unresolved serious adverse reactions (especially pulmonary reactions, cardiac reactions or hypotension) from preceding chemotherapies.
- Active uncontrolled infection.
- Active graft-versus-host disease (GVHD).
- Significant clinical worsening of leukaemia burden or rapid progression of lymphoma following lymphodepleting chemotherapy.

#### Blood, organ, tissue and cell donation

Patients treated with Kymriah should not donate blood, organs, tissues or cells.

#### Active central nervous system (CNS) leukaemia or lymphoma

There is limited experience of use of Kymriah in patients with active CNS leukaemia and active CNS lymphoma. Therefore, the risk/benefit of Kymriah has not been established in these populations.

## Cytokine release syndrome

Cytokine release syndrome, including fatal or life-threatening events, has been frequently observed after Kymriah infusion (see section 4.8). In almost all cases, development of cytokine release syndrome occurred between 1 to 10 days (median onset 3 days) after Kymriah infusion. The median time to resolution of cytokine release syndrome was 8 days.

Symptoms of cytokine release syndrome may include high fever, rigors, myalgia, arthralgia, nausea, vomiting, diarrhoea, diaphoresis, rash, anorexia, fatigue, headache, hypotension, dyspnoea, tachypnoea, and hypoxia. Organ dysfunction, including cardiac insufficiency and arrhythmia, renal insufficiency and liver injury with accompanying elevated aspartate aminotransferase (AST), elevated alanine aminotransferase (ALT) or elevated total bilirubin may also be observed. In some cases, disseminated intravascular coagulation (DIC) with low fibrinogen levels, capillary leak syndrome (CLS), macrophage activation syndrome (MAS) and haemophagocytic lymphohistiocytosis (HLH) may occur in the setting of cytokine release syndrome. Patients should be closely monitored for signs or symptoms of these events, including fever.

Risk factors for severe cytokine release syndrome in paediatric and young adult B-cell ALL patients are: high pre-infusion tumour burden, uncontrolled or accelerating tumour burden following lymphodepleting chemotherapy, active infection and early onset of fever or cytokine release syndrome following Kymriah infusion. High tumour burden prior to Kymriah infusion was identified as a risk factor for developing severe cytokine release syndrome in adult DLBCL patients.

In all indications, appropriate prophylactic and therapeutic treatment for infections should be provided, and complete resolution of any existing infections should be ensured. Infections may also occur during cytokine release syndrome and may increase the risk of a fatal event.

### Management of cytokine release syndrome associated with Kymriah

Cytokine release syndrome should be managed solely based on the patient's clinical presentation and according to the cytokine release syndrome management algorithm provided in Table 1. Anti-IL-6 based therapy such as tocilizumab has been administered for moderate or severe cytokine release syndrome associated with Kymriah. One dose of tocilizumab per patient must be on site and available for administration prior to Kymriah infusion. The treatment centre should have access to additional doses of tocilizumab within 8 hours. Corticosteroids may be administered in cases of life-threatening emergencies. Tisagenlecleucel continues to expand and persist following administration of tocilizumab and corticosteroids. Patients with medically significant cardiac dysfunction should be managed by standards of critical care and measures such as echocardiography should be considered. Tumour necrosis factor (TNF) antagonists are not recommended for management of Kymriah-associated cytokine release syndrome.

**Table 1 Cytokine release syndrome management algorithm**

<b>Cytokine release syndrome severity</b>	<b>Management</b>
<p><b><i>Prodromal syndrome:</i></b> Low-grade fever, fatigue, anorexia</p>	Observe in person; exclude infection; administer antibiotics per local guidelines if neutropenic; provide symptomatic support.
<p><b><i>Cytokine release syndrome requiring mild intervention - one or more of the following:</i></b></p> <ul style="list-style-type: none"> <li>– High fever</li> <li>– Hypoxia</li> <li>– Mild hypotension</li> </ul>	Administer antipyretics, oxygen, intravenous fluids and/or low-dose vasopressors as needed.
<p><b><i>Cytokine release syndrome requiring moderate to aggressive intervention - one or more of the following:</i></b></p> <ul style="list-style-type: none"> <li>– Haemodynamic instability despite intravenous fluids and vasopressor support</li> <li>– Worsening respiratory distress, including pulmonary infiltrates, increasing oxygen requirement including high-flow oxygen and/or need for mechanical ventilation</li> <li>– Rapid clinical deterioration</li> </ul>	<ul style="list-style-type: none"> <li>• Administer high-dose or multiple vasopressors, oxygen, mechanical ventilation and/or other supportive care as needed.</li> <li>• Administer tocilizumab. <ul style="list-style-type: none"> <li>- Patient weight less than 30 kg: 12 mg/kg intravenously over 1 hour</li> <li>- Patient weight <math>\geq</math>30 kg: 8 mg/kg intravenously over 1 hour (maximum dose 800 mg)</li> </ul> </li> </ul> <p>Repeat tocilizumab as needed at a minimum interval of 8 hours if there is no clinical improvement.</p> <p>If no response to second dose of tocilizumab, consider a third dose of tocilizumab or pursue alternative measures for treatment of cytokine release syndrome.</p> <p>Limit to a maximum total of 4 tocilizumab doses.</p> <ul style="list-style-type: none"> <li>• If no clinical improvement within 12 to 18 hours of the first tocilizumab dose, or worsening at any time, administer methylprednisolone 2 mg/kg as an initial dose, then 2 mg/kg per day until vasopressors and high-flow oxygen are no longer needed, then taper.</li> </ul>

Neurological adverse reactions

Neurological events, in particular encephalopathy, confusional state or delirium, occur frequently with Kymriah and can be severe or life-threatening (see section 4.8). Other manifestations included depressed level of consciousness, seizures, aphasia and speech disorder. The majority of neurological events occurred within 8 weeks following Kymriah infusion and were transient. The median time to onset of the first neurological events was 8 days in B-cell ALL and 6 days in DLBCL. The median time to resolution was 7 days for B-cell ALL and 13 days for DLBCL. Neurological events can be concurrent with cytokine release syndrome, following resolution of cytokine release syndrome or in the absence of cytokine release syndrome.

Patients should be monitored for neurological events. In case of neurological events, patients should be diagnostically worked up and managed depending on the underlying pathophysiology and in accordance with local standard of care.

### Infections and febrile neutropenia

Patients with active, uncontrolled infection should not start Kymriah treatment until the infection is resolved. Prior to Kymriah infusion, infection prophylaxis should follow standard guidelines based on the degree of preceding immunosuppression.

Serious infections, including life-threatening or fatal infections, occurred frequently in patients after Kymriah infusion (see section 4.8). Patients should be monitored for signs and symptoms of infection and treated appropriately. As appropriate, prophylactic antibiotics should be administered and surveillance testing should be employed prior to and during treatment with Kymriah. Infections are known to complicate the course and management of concurrent cytokine release syndrome.

Febrile neutropenia was frequently observed in patients after Kymriah infusion (see section 4.8) and may be concurrent with cytokine release syndrome. In the event of febrile neutropenia, infection should be evaluated and managed appropriately with broad-spectrum antibiotics, fluids and other supportive care, as medically indicated.

In patients achieving complete remission following Kymriah, resulting low immunoglobulin levels can increase the risk for infections. Attention to signs and symptoms of infection should be implemented according to age and standard specific guidelines.

### Prolonged cytopenias

Patients may continue to exhibit cytopenias for several weeks following lymphodepleting chemotherapy and Kymriah infusion and should be managed according to standard guidelines. The majority of patients who had cytopenias at day 28 following Kymriah treatment resolved to Grade 2 or below within three months after treatment. Prolonged neutropenia has been associated with increased risk of infection. Myeloid growth factors, particularly granulocyte macrophage-colony stimulating factor (GM-CSF), have the potential to worsen cytokine release syndrome symptoms and are not recommended during the first 3 weeks after Kymriah infusion or until cytokine release syndrome has resolved.

### Secondary malignancies

Patients treated with Kymriah may develop secondary malignancies or recurrence of their cancer. They should be monitored life-long for secondary malignancies. In the event that a secondary malignancy occurs, the company should be contacted to obtain instructions on patient samples to collect for testing.

### Hypogammaglobulinaemia

Hypogammaglobulinaemia and agammaglobulinaemia can occur in patients after Kymriah infusion. Immunoglobulin levels should be monitored after treatment with Kymriah. In patients with low immunoglobulin levels pre-emptive measures such as infection precautions, antibiotic prophylaxis and immunoglobulin replacement should be taken according to age and standard guidelines.

### Tumour lysis syndrome (TLS)

TLS, which may be severe, has occasionally been observed. To minimise risk of TLS, patients with elevated uric acid or high tumour burden should receive allopurinol, or an alternative prophylaxis, prior to Kymriah infusion. Signs and symptoms of TLS should be monitored and events managed according to standard guidelines.



### Concomitant disease

Patients with a history of active CNS disorder or inadequate renal, hepatic, pulmonary or cardiac function were excluded from the studies. These patient are likely to be more vulnerable to the consequences of the adverse reactions described below and require special attention.

### Prior stem cell transplantation

It is not recommended that patients receive Kymriah within 4 months of undergoing an allogeneic stem cell transplant (SCT) because of the potential risk of Kymriah worsening GVHD. Leukapheresis for Kymriah manufacturing should be performed at least 12 weeks after allogeneic SCT.

### Serological testing

There is currently no experience with manufacturing Kymriah for patients testing positive for HBV, HCV and HIV.

Screening for HBV, HCV and HIV must be performed in accordance with clinical guidelines before collection of cells for manufacturing. Hepatitis B virus (HBV) reactivation, can occur in patients treated with medicinal products directed against B cells and could result in fulminant hepatitis, hepatic failure and death.

### Prior treatment with anti-CD19 therapy

There is limited experience with Kymriah in patients exposed to prior CD19-directed therapy. Kymriah is not recommended if the patient has relapsed with CD19-negative leukaemia after prior anti-CD19 therapy.

### Interference with serological testing

Due to limited and short spans of identical genetic information between the lentiviral vector used to create Kymriah and HIV, some commercial HIV nucleic acid tests (NAT) may give a false positive result.

### Sodium and potassium content

This medicinal product contains 24.3 to 121.5 mg sodium per dose, equivalent to 1 to 6% of the WHO recommended maximum daily intake of 2 g sodium for an adult.

This medicinal product contains potassium, less than 1 mmol (39 mg) per dose, i.e. essentially “potassium-free”.

### Content of dextran 40 and dimethyl sulfoxide (DMSO)

This medicinal product contains 11 mg dextran 40 and 82.5 mg dimethyl sulfoxide (DMSO) per mL. Each of these excipients are known to possibly cause anaphylactic reaction following parenteral administration. Patients not previously exposed to dextran and DMSO should be observed closely during the first minutes of the infusion period.

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

No pharmacokinetic or pharmacodynamic drug interaction studies with tisagenlecleucel have been performed. The co-administration of agents known to inhibit T-cell function has not been formally studied. Administration of low-dose steroids as per the cytokine release syndrome treatment algorithm does not impact the expansion and persistence of CAR-T cells. The co-administration of agents known to stimulate T-cell function has not been investigated and the effects are unknown.

## Live vaccines

The safety of immunisation with live vaccines during or following Kymriah treatment has not been studied. Vaccination with live vaccines is not recommended for at least 6 weeks prior to the start of lymphodepleting chemotherapy, during Kymriah treatment, and until immune recovery following treatment with Kymriah.

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

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

Pregnancy status for females of child-bearing age should be verified prior to starting treatment with Kymriah.

See the prescribing information for lymphodepleting chemotherapy for information on the need for effective contraception in patients who receive the lymphodepleting chemotherapy.

There are insufficient exposure data to provide a recommendation concerning duration of contraception following treatment with Kymriah.

### Pregnancy

There are no data from the use of Kymriah in pregnant women. No animal studies have been conducted with Kymriah to assess whether it can cause foetal harm when administered to a pregnant woman (see section 5.3). It is not known whether Kymriah has the potential to be transferred to the foetus via the placenta and could cause foetal toxicity, including B-cell lymphocytopenia. Kymriah is not recommended during pregnancy and in women of childbearing potential not using contraception.

Pregnant women should be advised on the potential risks to the foetus. Pregnancy after Kymriah therapy should be discussed with the treating physician. Pregnant women who have received Kymriah may have hypogammaglobulinaemia. Assessment of immunoglobulin levels is indicated in newborns of mothers treated with Kymriah.

### Breast-feeding

It is unknown whether Kymriah cells are excreted in human milk. A risk to the breast-fed infant cannot be excluded. Women who are breast-feeding should be advised of the potential risk to the breast-fed infant.

Following administration of Kymriah, breast-feeding should be discussed with the treating physician.

### Fertility

There are no data on the effect of Kymriah on fertility. Effects of Kymriah on male and female fertility have not been evaluated in animal studies.

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

Kymriah has major influence on the ability to drive and use machines.

Due to the potential for neurological events, including altered mental status or seizures, patients receiving Kymriah are at risk for altered or decreased consciousness or coordination in the 8 weeks following infusion.

## 4.8 Undesirable effects

### Summary of the safety profile

Safety assessment was based on a total of 194 patients (with paediatric and young adult B-cell ALL and DLBCL) who received Kymriah in two multi-centre pivotal clinical studies.

#### B-cell ALL

The adverse reactions described in this section were characterised in 79 patients infused with Kymriah in the multi-centre, pivotal clinical study CCTL019B2202.

The most common non-haematological adverse reactions were cytokine release syndrome (77%), infections (73%), hypogammaglobulinaemia (53%), pyrexia (42%) and decreased appetite (38%).

The most common haematological adverse reactions were decreased white blood cells (100%), decreased haemoglobin (100%), decreased neutrophils (100%), decreased lymphocytes (100%) and decreased platelets (97%).

Grade 3 and 4 adverse reactions were reported in 89% of patients. The most common Grade 3 and 4 non-haematological adverse reaction was cytokine release syndrome (48%).

The most common Grade 3 and 4 haematological laboratory abnormalities were white blood cells decreased (97%), lymphocytes decreased (96%), neutrophils decreased (95%), platelets decreased (77%) and haemoglobin decreased (48%).

Grade 3 and 4 adverse reactions were more often observed within the initial 8 weeks post-infusion (82% of patients) compared to after 8 weeks post-infusion (51% of patients).

#### DLBCL

The adverse reactions described in this section were characterised in 115 patients infused with Kymriah in one global multicentre international study, i.e. the ongoing pivotal clinical study CCTL019C2201.

The most common non-haematological adverse reactions were cytokine release syndrome (57%), infections (58%), pyrexia (35%), diarrhoea (31%), nausea (29%), fatigue (27%) and hypotension (25%).

The most common haematological adverse reactions were decreased lymphocytes (100%), decreased white blood cells (99%), decreased haemoglobin (99%), decreased neutrophils (97%), and decreased platelets (95%).

Grade 3 and 4 adverse reactions were reported in 88% of patients. The most common Grade 3 and 4 non-haematological adverse reactions were infections (34%) and cytokine release syndrome (23%).

The most common (>25%) Grade 3 and 4 haematological laboratory abnormalities were lymphocyte count decreased (95%), neutrophil count decreased (82%), white blood cell count decreased (78%), haemoglobin decreased (59%) and platelet count decreased (56%).

Grade 3 and 4 adverse reactions were more often observed within the initial 8 weeks post-infusion (82%) compared to after 8 weeks post-infusion (48%).

Tabulated list of adverse drug reactions

The adverse reactions described in this section were identified in 79 and 115 patients in the ongoing multicentre pivotal clinical studies (CCTL019B2202 and CCTL019C2201). Adverse drug reactions from these clinical studies (Table 2) are listed by MedDRA system organ class. Within each system organ class, the adverse drug reactions are ranked by frequency, with the most frequent reactions first, using the following convention: 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). Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness.

**Table 2 Adverse drug reactions observed in clinical studies**

Adverse drug reaction (MedDRA system organ class)	Studies B2202 (N=79) + C2201 (N=115)		
	Very common ( $\geq 1/10$ )	Common ( $\geq 1/100$ to $< 1/10$ )	Uncommon ( $\geq 1/1000$ to $< 1/100$ )
Infections and infestations <sup>1)</sup>	Infections - pathogen unspecified Viral infections Bacterial infections Fungal infections		
Blood and lymphatic system disorders	Anaemia Haemorrhage <sup>2)</sup> Febrile neutropenia Neutropenia Thrombocytopenia	Haemophagocytic lymphohistiocytosis Leukopenia Pancytopenia Coagulopathy Lymphopenia	B-cell aplasia
Immune system disorders	Cytokine release syndrome Hypogammaglobulinaemia <sup>3)</sup>	Infusion-related reaction Graft-versus-host disease	
Metabolism and nutrition disorders	Decreased appetite Hypokalaemia Hypophosphataemia Hypomagnesaemia Hypocalcaemia	Hypoalbuminaemia Hyperglycaemia Hyponatraemia Hyperuricaemia Fluid overload Hypercalcaemia Tumour lysis syndrome Hyperkalaemia Hyperphosphataemia Hypernatraemia Hypermagnesaemia	
Psychiatric disorders	Anxiety Delirium <sup>4)</sup> Sleep disorder <sup>5)</sup>		
Nervous system disorders	Headache <sup>6)</sup> Encephalopathy <sup>7)</sup>	Dizziness <sup>8)</sup> Peripheral neuropathy <sup>9)</sup> Tremor <sup>10)</sup> Motor dysfunction <sup>11)</sup> Seizure <sup>12)</sup> Speech disorders <sup>13)</sup> Neuralgia <sup>14)</sup> Ataxia <sup>15)</sup>	Ischaemic cerebral infarction
Eye disorders		Visual impairment <sup>16)</sup>	
Cardiac disorders	Arrhythmia <sup>17)</sup>	Cardiac failure <sup>18)</sup> Cardiac arrest	
Vascular disorders	Hypotension <sup>19)</sup> Hypertension	Thrombosis <sup>20)</sup> Capillary leak syndrome	Flushing

Respiratory, thoracic and mediastinal disorders	Cough <sup>21)</sup> Dyspnoea <sup>22)</sup> Hypoxia	Oropharyngeal pain <sup>23)</sup> Pulmonary oedema <sup>24)</sup> Nasal congestion Pleural effusion Tachypnoea Acute respiratory distress syndrome	Lung infiltration
Gastrointestinal disorders	Diarrhoea Nausea Vomiting Constipation Abdominal pain <sup>25)</sup>	Stomatitis Abdominal distension Dry mouth Ascites	
Hepatobiliary disorders		Hyperbilirubinaemia	
Skin and subcutaneous tissue disorders	Rash <sup>26)</sup>	Pruritus Erythema Hyperhidrosis Night sweats	
Musculoskeletal and connective tissue disorders	Arthralgia	Back pain Myalgia Musculoskeletal pain	
Renal and urinary disorders	Acute kidney injury <sup>27)</sup>		
General disorders and administration site conditions	Pyrexia Fatigue <sup>28)</sup> Oedema <sup>29)</sup> Pain <sup>30)</sup> Chills	Influenza-like illness Asthenia Multiple organ dysfunction syndrome	
Investigations	Lymphocyte count decreased* White blood cell count decreased* Haemoglobin decreased* Neutrophil count decreased* Platelet count decreased* Aspartate aminotransferase increased	Alanine aminotransferase increased Blood bilirubin increased Weight decreased Serum ferritin increased Blood fibrinogen decreased International normalised ratio increased Fibrin D dimer increased Activated partial thromboplastin time prolonged Blood alkaline phosphatase increased Prothrombin time prolonged	

1) Infections and infestations presented reflect high-level group terms.

2) Haemorrhage includes anal haemorrhage, blood urine present, catheter site haemorrhage, cerebral haemorrhage, conjunctival haemorrhage, contusion, cystitis haemorrhagic, duodenal ulcer haemorrhage, disseminated intravascular coagulation, epistaxis, eye contusion, gastrointestinal haemorrhage, gingival bleeding, haematochezia, haemarthrosis, haematemesis, haematuria, haemoptysis, large intestinal haemorrhage, melaena, menorrhagia, mouth haemorrhage, peritoneal haematoma, petechiae, pharyngeal haemorrhage, post-procedural haemorrhage, pulmonary haemorrhage, purpura, retinal haemorrhage, traumatic haematoma, tumour haemorrhage, upper gastrointestinal haemorrhage and vaginal haemorrhage.

3) Hypogammaglobulinaemia includes immunoglobulins decreased, blood immunoglobulin A decreased, blood immunoglobulin G decreased, blood immunoglobulin M decreased, immunodeficiency, immunodeficiency common variable and hypogammaglobulinaemia.

4) Delirium includes agitation, delirium, hallucination, hallucination visual, irritability and restlessness.

5) Sleep disorder includes sleep disorder, insomnia and nightmare.

6) Headache includes headache and migraine.

7) Encephalopathy includes depressed level of consciousness, mental status changes, automatism, cognitive disorder, confusional state, disturbance in attention, encephalopathy, somnolence, lethargy, memory impairment, metabolic encephalopathy and thinking abnormal.

8) Dizziness includes dizziness, presyncope and syncope.

- 9) Peripheral neuropathy includes paraesthesia, peripheral sensory neuropathy, neuropathy peripheral, hyperaesthesia and hypoaesthesia.
- 10) Tremor includes dyskinesia and tremor.
- 11) Motor dysfunction includes muscle spasms, muscle twitching, myoclonus and myopathy.
- 12) Seizure includes seizure, generalised tonic-clonic seizures and status epilepticus.
- 13) Speech disorders includes speech disorders, dysarthria and aphasia.
- 14) Neuralgia includes neuralgia and sciatica.
- 15) Ataxia includes ataxia and dysmetria.
- 16) Visual impairment includes vision blurred and visual impairment.
- 17) Arrhythmia includes atrial fibrillation, supraventricular tachycardia, tachycardia and ventricular extrasystoles.
- 18) Cardiac failure includes cardiac failure, left ventricular dysfunction, cardiac failure congestive and right ventricular dysfunction.
- 19) Hypotension includes hypotension and orthostatic hypotension.
- 20) Thrombosis includes deep vein thrombosis, embolism, pulmonary embolism, thrombosis, vena cava thrombosis and venous thrombosis.
- 21) Cough includes cough, productive cough and upper-airway cough syndrome.
- 22) Dyspnoea includes dyspnoea, dyspnoea exertional, respiratory distress and respiratory failure.
- 23) Oropharyngeal pain includes oral pain and oropharyngeal pain.
- 24) Pulmonary oedema includes acute pulmonary oedema and pulmonary oedema
- 25) Abdominal pain includes abdominal pain, abdominal pain upper and abdominal discomfort.
- 26) Rash includes dermatitis, dermatitis acneiform, dermatitis contact, rash, rash maculo-papular, rash papular and rash pruritic.
- 27) Acute kidney injury includes acute kidney injury, anuria, azotaemia, blood creatinine abnormal, blood creatinine increased, renal failure, renal tubular dysfunction and renal tubular necrosis.
- 28) Fatigue includes fatigue and malaise.
- 29) Oedema includes oedema peripheral, generalised oedema, localised oedema, face oedema and peripheral swelling.
- 30) Pain includes pain and pain in extremity.
- \* Frequency is based on laboratory values. Patients are counted only for the worst grade observed post baseline.

## Description of selected adverse drug reactions

### Cytokine release syndrome

In the ongoing clinical study in paediatric and young adult B-cell ALL (N=79), cytokine release syndrome was reported in 77% of patients (48% with Grade 3 or 4). Two deaths occurred within 30 days of tisagenlecleucel infusion, including one patient, who died from progressive leukaemia in the setting of possible cytokine release syndrome and one patient who experienced fatal intracranial haemorrhage that developed during the course of resolved cytokine release syndrome, abdominal compartment syndrome, coagulopathy and renal failure.

In the ongoing clinical study in DLBCL (N=115), cytokine release syndrome was reported in 57% of patients (23% with Grade 3 or 4).

Cytokine release syndrome was graded with the Penn scale as follows: Grade 1: mild reactions, reactions requiring supportive care; Grade 2: moderate reactions, reactions requiring intravenous therapies; Grade 3: severe reactions, reactions requiring low-dose vasopressors or supplemental oxygen; Grade 4: life-threatening reactions, those requiring high-dose vasopressors or intubation; Grade 5: death.

For clinical management of cytokine release syndrome, see section 4.4 and Table 1.

### Infections and febrile neutropenia

In B-cell ALL patients severe infections (Grade 3 and higher), which can be life-threatening or fatal, occurred in 48% of patients after Kymriah infusion. The overall incidence (all grades) was 73% (unspecified 57%, viral 38%, bacterial 27% and fungal 15%) (see section 4.4). 43% of the patients experienced an infection of any type within 8 weeks after Kymriah infusion.

In DLBCL patients severe infections (Grade 3 and higher), which can be life-threatening or fatal, occurred in 34% of patients. The overall incidence (all grades) was 58% (unspecified 48%, bacterial 15%, fungal 11% and viral 11%) (see section 4.4). 37% of the patients experienced an infection of any type within 8 weeks.

Severe febrile neutropenia (Grade 3 or 4) was observed in 34% of paediatric and young adult B-cell ALL patients and 17% of DLBCL patients. See section 4.4 for the management of febrile neutropenia before and after Kymriah infusion.

#### Prolonged cytopenias

Cytopenias are very common based on prior chemotherapies and Kymriah therapy.

All paediatric and young adult B-cell ALL patients had a Grade 3 or 4 cytopenia at some time after Kymriah infusion. Grade 3 and 4 cytopenias not resolved by day 28 after Kymriah infusion based on laboratory findings included decreased count of white blood cells (57%), neutrophils (54%), lymphocytes (44%), and thrombocytes (42%) and decreased haemoglobin (13%).

All adult DLBCL patients had Grade 3 and 4 cytopenias at some time after Kymriah infusion. Grade 3 and 4 cytopenias not resolved by day 28 based on laboratory findings included decreased count of thrombocytes (39%), lymphocytes (29%), neutrophils (25%), and white blood cells (21%) and decreased haemoglobin (14%).

#### Neurological adverse reactions

The majority of neurotoxic events occurred within 8 weeks following infusion and were transient.

In paediatric and young adult B-cell ALL patients, manifestations of encephalopathy and/or delirium occurred in 39% of patients (10% were Grade 3 or 4) within 8 weeks after Kymriah infusion. In DLBCL patients, manifestations of encephalopathy and/or delirium occurred in 20% of patients (11% were Grade 3 or 4) within 8 weeks after Kymriah infusion.

#### Hypogammaglobulinaemia

Hypogammaglobulinaemia was reported in 53% of patients treated with Kymriah for r/r ALL and 17% of patients with r/r DLBCL.

Pregnant women who have received Kymriah may have hypogammaglobulinaemia. Immunoglobulin levels should be assessed in newborns of mothers treated with Kymriah.

#### Immunogenicity

In clinical studies, humoral immunogenicity of tisagenlecleucel was measured by determination of anti-murine CAR19 antibodies (anti-mCAR19) in serum pre- and post-administration. The majority of patients tested positive for pre-dose anti-mCAR19 antibodies in paediatric and young adult ALL (B2202, 91.1%) and adult DLBCL (C2201, 93.9%) patients.

Treatment-induced anti-mCAR19 antibodies were found in 40.5% of paediatric and young adult ALL and 8.7% of adult DLBCL patients. Pre-existing and treatment-induced antibodies were not associated with an impact on clinical response nor did they have an impact on the expansion and persistence of tisagenlecleucel. There is no evidence that the presence of pre-existing and treatment-induced anti-mCAR19 antibodies impacts the safety or effectiveness of Kymriah.

T-cell immunogenicity responses were not observed in paediatric and young adult B-cell ALL and adult r/r DLBCL patients.

## 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**

Not applicable.

## **5. PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: other antineoplastic agents, ATC code: L01XX71.

#### Mechanism of action

Tisagenlecleucel is an autologous, immunocellular cancer therapy which involves reprogramming a patient's own T cells with a transgene encoding a chimeric antigen receptor (CAR) to identify and eliminate CD19 expressing cells. The CAR is comprised of a murine single chain antibody fragment which recognises CD19 and is fused to intracellular signalling domains from 4-1BB (CD137) and CD3 zeta. The CD3 zeta component is critical for initiating T-cell activation and anti-tumour activity, while 4-1BB enhances the expansion and persistence of tisagenlecleucel. Upon binding to CD19-expressing cells, the CAR transmits a signal promoting T-cell expansion and persistence of tisagenlecleucel.

#### Clinical efficacy and safety

##### Acute lymphoblastic leukaemia (ALL)

The safety and efficacy of Kymriah treatment in paediatric and young adult patients up to and including 25 years of age, with relapsed or refractory (r/r) B-cell ALL were evaluated in a total of 203 patients in one pivotal (B2202, N=79) and two supportive (B2205J, N=64, and B2101J, N=60) open-label, single-arm phase I/II studies. All patients had leukapheresis products collected and cryopreserved prior to or during study entry.

The pivotal study B2202 (ELIANA) is a multicentre, single-arm phase II study in paediatric and young adult patients with r/r B-cell ALL. Of 97 patients enrolled, 79 received infusion with Kymriah; for 8 patients (8%) Kymriah could not be manufactured; reasons for discontinuation prior to Kymriah infusion included death (n=7; 7%) or adverse events (n=3; 3%) while awaiting Kymriah manufacturing in the clinical study. The median duration of study follow-up defined as the time from Kymriah infusion to the date of completion or discontinuation from follow-up prior to the data cut-off date was 16.0 months (range: 0.4-34.4). The median time from Kymriah infusion to the data cut-off date was 24.2 months (range: 4.5-35.1). The study is still ongoing.

Key baseline information for enrolled and infused patients is presented in Table 3. The majority of patients (69/79, 87%) received bridging therapy while waiting for Kymriah. A total of 76 out of 79 patients (96%) who received Kymriah infusion also received lymphodepleting chemotherapy after enrolment and prior to infusion of a single dose of Kymriah (see section 4.2 for condition of lymphodepleting chemotherapy).



**Table 3 Study B2202: Baseline information across the enrolled and the infused patient population**

	<b>Enrolled N=97 n (%)</b>	<b>Infused N=79 n (%)</b>
<b>Age (years)</b>		
Mean (standard deviation)	12 (5.48)	12 (5.38)
Median (minimum – maximum)	11 (3 – 27)	11 (3 – 24)
<b>Age category (years) - n (%)</b>		
<10 years	40 (41.2)	32 (40.5)
≥10 years and <18 years	40 (41.2)	33 (41.8)
≥18 years	17 (17.5)	14 (17.7)
<b>Sex - n (%)</b>		
Male	54 (55.7)	45 (57.0)
Female	43 (44.3)	34 (43)
<b>Disease status (%)</b>		
Primary refractory <sup>1</sup>	8 (8.2)	6 (7.6)
Relapsed disease <sup>2</sup>	89 (91.8)	73 (92.4)
<b>Prior stem-cell transplantation - n (%)</b>		
0	39 (40.2)	31 (39.2)
1	50 (51.5)	42 (53.2)
2	8 (8.2)	6 (7.6)
<sup>1</sup> Primary refractory: Never had a morphologic complete remission (CR) prior to the study;		
<sup>2</sup> Relapsed disease: Had at least one relapse prior to the study		

Efficacy was established through the primary endpoint of overall remission rate (ORR), which includes best overall response as complete remission (CR) or complete remission with incomplete blood count recovery (CRi) within 3 months post infusion, as determined by Independent Review Committee (IRC) assessment, as well as secondary endpoints including duration of remission (DOR) and the proportion of patients who achieved CR or CRi with minimal residual disease (MRD) <0.01% by flow cytometry (MRD-negative). See Table 4 for efficacy results from this study. ORR was consistent across all subgroups. Eight patients (10.1%) who achieved CR/CRi after Kymriah infusion went to haematopoietic stem cell transplant while in remission of which 6 of the patients (7.6%) proceeded to transplant within the first 6 months post-infusion while in remission. Kymriah was administered in a qualified Kymriah treatment centre in an inpatient and outpatient setting.

**Table 4 Study B2202: Efficacy results in paediatric and young adult patients with relapsed/refractory B-cell acute lymphoblastic leukaemia (ALL)**

<b>Primary endpoint</b>	<b>Enrolled patients N=97</b>	<b>Infused patients N=79</b>
<b>Overall remission rate (ORR)<sup>1,2</sup>, n (%)</b> 95% CI	<b>65 (67.0)</b> (56.7, 76.2) p<0.0001	<b>65 (82.3)</b> (72.1, 90.0) p<0.0001
CR <sup>3</sup> , n (%)	49 (50.5)	49 (62.0)
CRi <sup>4</sup> , n (%)	16 (16.5)	16 (20.3)
<b>Key secondary endpoint</b>	<b>N=97</b>	<b>N=79</b>
CR or CRi with MRD negative bone marrow <sup>5,6</sup> , n (%) 95% CI	64 (66.0) (55.7, 75.3) p<0.0001	64 (81.0) (70.6, 89.0) p<0.0001
<b>Duration of remission (DOR)<sup>7</sup></b>	<b>N=65</b>	<b>N=65</b>
% event free probability at 12 months	66.3	66.3
% event free probability at 18 months	66.3	66.3
Median (months) (95% CI)	Not reached (20.0, NE <sup>9</sup> )	Not reached (20.0, NE)
<b>Other secondary endpoint</b>	<b>N=97</b>	<b>N=79</b>
<b>Overall survival (OS)<sup>8</sup></b>		
% survival probability at 12 months	69.8	76.4
% survival probability at 24 months	56.9	66.3
Median (months) (95% CI)	Not reached (19.4, NE)	Not reached (28.2, NE)
<sup>1</sup>	Requires remission status to be maintained for at least 28 days without clinical evidence of relapse.	
<sup>2</sup>	Nominal one-sided exact p-value based on H0: ORR ≤20% vs. Ha: ORR >20%	
<sup>3</sup>	CR (complete remission) was defined as <5% of blasts in the bone marrow, circulating blasts in blood should be <1%, no evidence of extramedullary disease, and full recovery of peripheral blood counts (platelets >100,000/μL and absolute neutrophil counts [ANC] >1,000/μL) without blood transfusion.	
<sup>4</sup>	CRi (complete remission with incomplete blood count recovery) was defined as <5% of blasts in the bone marrow, circulating blasts in blood should be <1%, no evidence of extramedullary disease, and without full recovery of peripheral blood counts with or without blood transfusion.	
<sup>5</sup>	MRD (minimal residual disease) negative was defined as MRD by flow cytometry <0.01%.	
<sup>6</sup>	Nominal one-sided exact p-value based on H0: Rate of MRD negative remission ≤15% vs. Ha: >15%.	
<sup>7</sup>	DOR was defined as time since onset of CR or CRi to relapse or death due to underlying indication, whichever is earlier (N=65).	
<sup>8</sup>	OS was defined as time from date of Kymriah infusion to the date of death due to any cause for infused patients and from time of date of enrolment to the date of death due to any cause for enrolled patients.	
<sup>9</sup>	Not estimable	

Health-related quality of life (HRQoL) was evaluated by PedsQL and EQ-5D questionnaires completed by patients aged 8 years and above (n=61). Among patients responding (n=51), the mean (SD) change from baseline in the PedsQL total score was 13.1 (13.45) at month 3, 15.4 (16.81) at month 6 and 25.0 (19.09) at month 12, and the mean (SD) change from baseline in the EQ-5D VAS score was 16.0 (16.45) at month 3, 15.3 (18.33) at month 6 and 21.7 (17.14) at month 12, indicating overall clinically meaningful improvement in HRQoL following Kymriah infusion.

The supportive study B2205J (ENSIGN) was a multicentre single-arm phase II study in paediatric and young adult patients with r/r B-cell ALL. The study had similar study design and enrolled comparable patient populations as the pivotal study B2202. The main difference between the two studies was the definition of the primary efficacy endpoint ORR, which was measured within 6 months after Kymriah infusion in study B2205J compared to 3 months in the pivotal study. Of 75 patients enrolled, 64 received infusion of Kymriah; for 5 patients (6.7%), Kymriah could not be manufactured and 6 patients (8.0%) died while awaiting Kymriah manufacturing in the clinical study. The median duration of study follow-up defined as the time from Kymriah infusion to the date of completion or discontinuation from follow-up prior to the data cut-off date in the final analyses was 12.2 months (range: 0.4-49.3). The median time from Kymriah infusion to the data cut-off date was 31.7 months (range: 17.6-56.0).

Among the patients infused, the median age was 12.5 years (range: 3 to 25), 34 (53.1%) were female and 30 (46.9%) were male, 10.9% had primary refractory disease, 89.1% had relapsed disease, and 43.8% of patients had at least one prior haematopoietic stem cell transplant. Baseline disease characteristics were similar in the enrolled patients with regard to age (median age 13.0 years, range: 3 to 25), gender (46.7% female and 53.3% male), primary refractoriness (10.7%), and prior transplant history (42.7%). The majority of infused patients (57/64, 89.1%) received bridging chemotherapy while waiting for Kymriah. A total of 60 out of 64 patients (93.8%) who received Kymriah infusion also received lymphodepleting chemotherapy after enrolment and prior to infusion of a single dose of Kymriah.

Efficacy was established through the primary endpoint of ORR, which included best overall response as CR or CRi that were maintained for at least 28 days within 6 months post-infusion, as determined by IRC assessment, as well as secondary endpoints including DOR, proportion of patients who achieved CR or CRi with MRD-negative disease status, and OS. Among the patients infused, ORR was demonstrated in 45 patients (70.3%; 59.4% CR and 10.9% CRi). CR/CRi with MRD-negative bone marrow was reported in 43 patients (67.2%). The median DOR was not reached and the event-free probability at 12 months was 70.5%. The survival probability at 24 months was 54.7%, and the median OS was estimated as 29.9 months (95% CI: 15.1, 42.4). The OS results were confirmed in an updated OS analyses (i.e. median OS 29.9 months [95% CI: 15.2, NE] with 57.6% survival probability at 24 months; with a median follow-up for OS of 25.9 months), which included patients transitioned to a separate long-term follow-up study. Seven patients (10.9%) who achieved CR/CRi after Kymriah infusion proceeded to haematopoietic stem cell transplant while in remission during the study, of which 5 of the patients (7.8%) proceeded to transplant within the first 6 months post-infusion. Efficacy results reported for the enrolled patients (n=75) demonstrate an ORR of 60.0% (50.7% CR and 9.3% CRi; 57.3% with MRD-negative bone marrow). The reported overall survival in the enrolled population is in accordance with the infused population.

#### *Special populations*

No differences in efficacy or safety were observed between different age subgroups.

#### *Patients with active CNS leukaemia*

Of four patients with active CNS leukaemia (i.e. CNS-3) included in study B2101J, three experienced cytokine release syndrome (Grade 2-4) and transient neurological abnormalities (Grade 1-3) that resolved within 1-3 months of infusion. One patient died due to disease progression and the remaining three patients achieved a CR or CRi and remain alive 1.5-2 years after infusion.

#### *Diffuse large B-cell lymphoma (DLBCL)*

The safety and efficacy of Kymriah treatment in adult patients with relapsed or refractory (r/r) diffuse large B-cell lymphoma (DLBCL) who received  $\geq 2$  lines of chemotherapy, including rituximab and anthracycline, or relapsed following autologous haematopoietic stem cell transplantation (HSCT), was evaluated in an open-label, pivotal, single-arm study. Patients with T-cell rich/histiocyte-rich large B-cell lymphoma (THRBCL), primary cutaneous large B-cell lymphoma, primary mediastinal B-cell lymphoma (PMBCL), EBV-positive DLBCL of the elderly, Richter's transformation, and Burkitt lymphoma were not enrolled in study C2201.

The pivotal study C2201 (JULIET) is a multicentre, single-arm phase II study in adult patients with relapsed or refractory DLBCL. Of 167 patients enrolled, 115 patients received infusion with Kymriah. Approximately 31% of patients discontinued the study prior to Kymriah infusion. For 13 patients (8%) Kymriah could not be manufactured. Other reasons for discontinuation prior to Kymriah infusion included death (n=16; 10%), physician decision/primary disease progression (n=16; 10%), patient decision (n=2; 1%), protocol deviation (n=1; 1%) or adverse events (n=4; 2%) while awaiting Kymriah manufacturing in the clinical study. The median duration of study follow-up defined as the time from Kymriah infusion to date of completion or discontinuation from follow-up prior to the data cut-off date was 7.7 months (range: 0.4-35.6). The median time from Kymriah infusion to the data cut-off date was 26.0 months (range: 9.7-38.2). The study is still ongoing.

Key baseline information for enrolled and infused patients is presented in Table 5. All patients had leukapheresis starting material collected and cryopreserved prior to or during study entry. The majority of patients (103/115, 90%) received bridging therapy for disease stabilisation. The type and duration of bridging therapy was left to the discretion of the physician. 107/115 patients (93%) received lymphodepleting chemotherapy prior to Kymriah infusion. Kymriah was given as a single-dose ( $0.6-6.0 \times 10^8$  CAR-positive viable T cells) intravenous infusion in a qualified Kymriah treatment centre in an inpatient and outpatient setting.

**Table 5 Study C2201: Baseline information across the enrolled and the infused patient populations**

	<b>Enrolled N=167 n (%)</b>	<b>Infused N=115 n (%)</b>
<b>Age (years)</b>		
Mean (standard deviation)	56 (12.9)	54 (13.1)
Median (minimum – maximum)	58 (22 - 76)	56 (22 - 76)
<b>Age category (years) - n (%)</b>		
<65 years	120 (71.9)	89 (77.4)
≥65 years	47 (28.1)	26 (22.6)
<b>Sex - n (%)</b>		
Male	105 (62.9)	71 (61.7)
Female	62 (37.1)	44 (38.3)
<b>Prior haematopoietic stem cell transplant (SCT) - n (%)</b>		
No	93 (55.7)	59 (51.3)
Yes	74 (44.3)	56 (48.7)
<b>Stage III/IV disease at study entry - n (%)</b>		
No	36 (21.6)	27 (23.5)
Yes	131 (78.4)	88 (76.5)
<b>Number of prior lines of antineoplastic therapy - n (%)</b>		
1	6 (3.6)	5 (4.3)
2	73 (43.7)	51 (44.3)
3	52 (31.1)	36 (31.3)
≥4	36 (21.6)	23 (20.0)
<b>Disease status (%)</b>		
Refractory to last line of therapy	98 (58.7)	63 (54.8)
Relapse to last line of therapy	69 (41.3)	52 (45.2)

The efficacy of Kymriah was evaluated through the primary endpoint of best overall response rate (ORR), which includes complete response (CR) and partial response (PR) as determined by Independent Review Committee (IRC) assessment as well as secondary endpoints including duration of response (Table 6).

**Table 6 Study C2201: Efficacy results in adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) after two or more lines of systemic therapy**

	<b>Enrolled patients N=167</b>	<b>Infused patients N=115</b>
<b>Primary endpoint<sup>1</sup></b>	<b>N=147</b>	<b>N=99</b>
<b>Overall response rate (ORR) (CR+PR)<sup>2</sup>, n (%)</b>	<b>54 (36.7)</b>	<b>54 (54.5)</b>
95% CI	(28.9, 45.1)	(44.2, 64.6)
CR, n (%)	41 (27.9)	41 (41.4)
PR, n (%)	13 (8.8)	13 (13.1)
Response at month 3	N=147	N=99
ORR (%)	40 (27.2)	40 (40.4)
CR (%)	34 (23.1)	34 (34.3)
Response at month 6	N=147	N=99
ORR (%)	34 (23.1)	34 (34.3)
CR (%)	31 (21.1)	31 (31.3)
<b>Duration of response (DOR)<sup>3</sup></b>	<b>N=54</b>	<b>N=54</b>
Median (months) (95% CI)	Not reached (10.0, NE <sup>5</sup> )	Not reached (10.0, NE <sup>5</sup> )
% relapse free probability at 12 months	63.4	63.4
% relapse free probability at 18 months	63.4	63.4
% relapse free probability at 24 months	60.8	60.8
% relapse free probability at 30 months	60.8	60.8
<b>Other secondary endpoints</b>	<b>N=167</b>	<b>N=115</b>
Overall survival (OS) <sup>4</sup>		
% survival probability at 12 months	41.0	48.2
% survival probability at 24 months	33.3	40.4
% survival probability at 36 months	29.0	36.2
Median (months) (95% CI)	8.2 (5.8, 11.7)	11.1 (6.6, 23.9)
<sup>1</sup> The primary endpoint was analysed on all patients whose Kymriah was manufactured at the Novartis US facility. <sup>2</sup> ORR is the proportion of patients with best overall response (BOR) of CR or PR based on the Lugano response criteria (Cheson 2014); non-infused patients were assigned BOR=Unknown (i.e. non-responders). <sup>3</sup> DOR was defined as time from achievement of CR or PR to relapse or death due to DLBCL, whichever occurs first. <sup>4</sup> OS was defined as time from date of Kymriah infusion to the date of death due to any cause (N=115) and time from date of enrolment to the date of death due to any cause for enrolled patients (N=167). <sup>5</sup> Not estimable.		

Among 41 patients who achieved CR, 16 patients initially had an overall disease response of PR which improved to CR over time; most patients (13/16) achieved PR to CR conversion within 6 months post-tisagenlecleucel infusion. ORR was consistent across subgroups.

#### Special populations

There are not enough data to determine whether there are any differences in efficacy or safety between different age subgroups, although the clinical benefit and safety experience in elderly patients with DLBCL above the age of 65 years (23% of the study population) were comparable to the overall population.

#### Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with Kymriah in one or more subsets of the paediatric population in the following conditions: a) treatment of B-cell lymphoblastic lymphoma, and b) treatment of mature B-cell neoplasms (see section 4.2 for information on paediatric use).

## 5.2 Pharmacokinetic properties

Following infusion of Kymriah into paediatric and young adult r/r B-cell ALL and r/r DLBCL patients, tisagenlecleucel typically exhibited an initial rapid expansion followed by a slower bi-exponential decline.

### Cellular kinetics in paediatric and young adult B-cell ALL patients

A summary of cellular kinetic parameters of tisagenlecleucel in paediatric and young adult B-cell ALL patients is provided in Table 7 below. The maximal expansion ( $C_{max}$ ) was approximately 1.6-fold higher in CR/CRi patients (n=103) compared with non-responding (NR) patients (n=10) as measured by qPCR. Delayed and lower expansion was observed in NR patients compared to CR/CRi patients.

**Table 7 Cellular kinetic parameters of tisagenlecleucel in paediatric and young adult r/r B-cell ALL (Studies B2202 and B2205J)**

Parameter	Summary statistics	Responding patients (CR/CRi) N=105	Non-responding patients (NR) N=12
$C_{max}$ (copies/ $\mu$ g)	Geometric mean (CV%), n	35,300 (154.0), 103	21,900 (80.7), 10
$T_{max}^{\ddagger}$ (day)	Median [min;max], n	9.83 [5.70; 27.8], 103	20.1 [12.6; 62.7], 10
$AUC_{0-28d}$ (copies/ $\mu$ g*day)	Geometric mean (CV%), n	309,000 (178.1), 103	232,000 (104.5), 8
$T_{1/2}$ (day)	Geometric mean (CV%), n	25.2 (307.8), 71	3.80 (182.4), 4
$T_{last}$	Median [min;max], n	166 [20.9; 916], 103	28.8 [26.7; 742], 9

### Cellular kinetics in adult DLBCL patients

A summary of cellular kinetic parameters of tisagenlecleucel in DLBCL patients is provided in Table 8 below.

**Table 8 Cellular kinetic parameters of tisagenlecleucel in r/r DLBCL patients**

Parameter	Summary statistics	Responding patients (CR and PR) N=43	Non-responding patients (SD/PD/Unknown) N=72
$C_{max}$ (copies/ $\mu$ g)	Geometric mean (CV%), n	5,840 (254.3), 43	5,460 (326.89), 65
$T_{max}$ (day)	Median [min;max], n	9.00 [5.78; 19.8], 35	8.84 [3.04; 27.7], 65
$AUC_{0-28d}$ (copies/ $\mu$ g*day)	Geometric mean (CV%), n	61,200 (177.7), 40	67,000 (275.2), 56
$T_{1/2}$ (day)	Geometric mean (CV%), n	129 (199.2), 33	14.7 (147.1), 44
$T_{last}$	Median [min;max], n	551 [17.1; 1030], 43	61.4 [19.8; 685], 56

## Distribution

In paediatric and young adult B-cell ALL patients, tisagenlecleucel has been shown to be present in the blood and bone marrow beyond 2 years. The blood to bone marrow partitioning of tisagenlecleucel in bone marrow was 47.2% of that present in blood at day 28 while at months 3 and 6 it distributes at 68.3% and 69%, respectively (Studies B2202 and B2205J). Tisagenlecleucel also traffics and persists in cerebrospinal fluid in paediatric and young adult B-cell ALL patients (Study B2101J) for up to 1 year.

In adult DLBCL patients (Study C2201), tisagenlecleucel has been detected for up to 3 years in peripheral blood and up to month 9 in bone marrow for complete responder patients. The blood to bone marrow partitioning in bone marrow was nearly 70% of that present in blood at day 28 and 50% at month 3 in both responder and non-responder patients.

## Elimination

The elimination profile of Kymriah includes a bi-exponential decline in peripheral blood and bone marrow.

## Linearity/non-linearity

There is no apparent relationship between dose and  $AUC_{0-28d}$  or  $C_{max}$ .

## Special populations

### Elderly

The scatter plots of cellular kinetic parameters versus age (22-76 years) revealed no relevant relationship between cellular kinetic parameters ( $AUC_{0-28d}$  and  $C_{max}$ ) with age.

### Gender

Gender is not a significant characteristic influencing tisagenlecleucel expansion in B-cell ALL and DLBCL patients. In Study B2202, there were 43% female and 57% male patients and in Study C2201 38% female and 62% male patients who received Kymriah.

### Race/ethnicity

There is limited evidence that race/ethnicity impact the expansion of Kymriah in paediatric and young adult ALL and DLBCL patients. In Study B2202 there were 73.4% Caucasian, 12.7% Asian and 13.9% other ethnic patients. In Study C2201 there were 85% Caucasian, 9% Asian, 4% Black or African American patients, and 3 patients (3%) of unknown race.

### Body weight

In ALL and DLBCL patients, across the weight ranges (ALL; 14.4 to 137 kg; DLBCL: 38.4 to 186.7 kg), the scatter plots of qPCR cellular kinetic parameters versus weight revealed no apparent relationship between cellular kinetic parameters with weight.

### Prior transplantation

Prior transplantation did not impact the expansion/persistence of Kymriah in paediatric and young adult B-Cell ALL patients or DLBCL patients.

### 5.3 Preclinical safety data

Non-clinical safety assessment of Kymriah addressed the safety concerns of potential uncontrolled cell growth of transduced T cells *in vitro* and *in vivo* as well as dose-related toxicity, biodistribution and persistence. No such risks were identified based on these studies.

#### Carcinogenicity and mutagenicity

Genotoxicity assays and carcinogenicity studies in rodents are not appropriate to assess the risk of insertional mutagenesis for genetically-modified cell therapy products. No alternative adequate animal models are available.

*In vitro* expansion studies with CAR-positive T cells (Kymriah) from healthy donors and patients showed no evidence for transformation and/or immortalisation of T cells. *In vivo* studies in immunocompromised mice did not show signs of abnormal cell growth or signs of clonal cell expansion for up to 7 months, which represents the longest meaningful observation period for immunocompromised mouse models. A genomic insertion site analysis of the lentiviral vector was performed on Kymriah products from 14 individual donors (12 patients and 2 healthy volunteers). There was no evidence for preferential integration near genes of concern or preferential outgrowth of cells harbouring integration sites of concern.

#### Reproductive toxicity

No non-clinical reproductive safety studies were conducted as no adequate animal model is available.

#### Juvenile animal studies

Juvenile toxicity studies were not conducted.

## 6. PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

Glucose  
Sodium chloride  
Human albumin solution  
Dextran 40 for injection  
Dimethylsulfoxide  
Sodium gluconate  
Sodium acetate  
Potassium chloride  
Magnesium chloride  
Sodium-N-acetyltryptophanate  
Sodium caprylate  
Aluminium  
Water for injections

### 6.2 Incompatibilities

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



### **6.3 Shelf life**

9 months.

The product should be administered immediately after thawing. After thawing, the product should be kept at room temperature (20°C-25°C) and infused within 30 minutes to maintain maximum product viability, including any interruption during the infusion.

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

Store and transport below -120°C, e.g. in a container for cryogenic storage (Dewar) in the vapour phase of liquid nitrogen.

Store in the original cassette protecting the infusion bag.

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

### **6.5 Nature and contents of container and special equipment for use, administration or implantation**

Ethylene vinyl acetate (EVA) infusion bag with polyvinyl chloride (PVC) tubing and a luer spike interconnector closed by a luer-lock cap containing either 10–30 mL (50 mL bags) or 30–50 mL (250 mL bags) cell dispersion.

Each infusion bag is placed into an aluminum cassette.

One individual treatment dose comprises 1 or more infusion bags.

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

#### Inspection and thawing of the infusion bag(s)

Do not thaw the product until it is ready to be used.

The infusion bag should be placed inside a second sterile bag during thawing to protect ports from contamination and avoid spills in the unlikely event of the bag leaking. Kymriah should be thawed at 37°C using either a water bath or dry thaw method until there is no visible ice in the infusion bag. The bag should be removed immediately from the thawing device and kept at room temperature (20°C-25°C) until infusion. If more than one infusion bag has been received for the treatment dose, the next bag should only be thawed after the contents of the preceding bag have been infused.

Kymriah should not be manipulated. For example, Kymriah should not be washed (spun down and resuspended in new media) prior to infusion.

The infusion bag(s) should be examined for any breaks or cracks prior to thawing. If the infusion bag appears to have been damaged or to be leaking, it should not be infused and should be disposed of according to local procedures on handling of biological waste (see section 4.2.).

#### Precautions to be taken for transport and disposal of the medicinal product

Kymriah should be transported within the facility in closed, break-proof, leak-proof containers.

Kymriah contains genetically-modified human blood cells. Local guidelines on handling of biological waste should be followed for unused medicinal product or waste material. All material that has been in contact with Kymriah (solid and liquid waste) should be handled and disposed in accordance with local guidelines on handling of biological waste.

**7. MARKETING AUTHORISATION HOLDER**

Novartis Europharm Limited  
Vista Building  
Elm Park, Merrion Road  
Dublin 4  
Ireland

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

EU/1/18/1297/001

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

23 August 2018

**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. MANUFACTURERS OF THE BIOLOGICAL ACTIVE SUBSTANCE AND MANUFACTURERS 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. MANUFACTURERS OF THE BIOLOGICAL ACTIVE SUBSTANCE AND  
MANUFACTURERS RESPONSIBLE FOR BATCH RELEASE**

Name and address of the manufacturers of the biological active substance

Fraunhofer Institut für Zelltherapie und Immunologie  
Perlickstrasse 1  
Hauptgebäude und Erweiterungsbau 1  
D-04103 Leipzig  
Germany

Novartis Pharmaceutical Corporation  
220 East Hanover Avenue  
Morris Plains  
New Jersey  
NJ07950  
United States

Novartis Pharma Stein AG  
Novartis Technical Operations Schweiz  
Stein Cell and Gene Therapy,  
Schaffhauserstrasse  
4332 Stein  
Switzerland

CELLFORCURE  
ZA de Courtabœuf  
11 avenue des Tropiques  
91940 Les Ulis  
France

Name and address of the manufacturers responsible for batch release

Novartis Pharma GmbH  
Roonstrasse 25  
D-90429 Nuremberg  
Germany

CELLFORCURE  
ZA de Courtabœuf  
11 avenue des Tropiques  
91940 Les Ulis  
France

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.

The marketing authorisation holder (MAH) shall submit the first PSUR for this product within 6 months following authorisation.

## **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**

### **Key elements:**

#### Availability of tocilizumab and site qualification

To minimise the risks associated with KYMRIA treatment, the MAH must ensure that hospitals and their associated centres that dispense KYMRIA are specially qualified in accordance with the agreed control distribution programme.

The MAH must ensure on-site, immediate access to tocilizumab for each patient as CRS management medication prior to treating patients. Hospitals should have access to additional doses of tocilizumab within 8 hours.

KYMRIA will only be supplied to hospitals and associated centres that are qualified and only if the healthcare professionals involved in the treatment of a patient have completed the educational programme.

## Educational programme

Prior to the launch of KYMRIAH in each Member State, the MAH must agree about the content and format of the educational materials with the National Competent Authority.

### HCP educational programme

The MAH shall ensure that in each Member State where KYMRIAH is marketed, all HCPs who are expected to prescribe, dispense and administer KYMRIAH shall be provided with a guidance document to:

- facilitate identification of CRS and serious neurological adverse reactions
- facilitate management of the CRS and serious neurological adverse reactions
- ensure adequate monitoring of CRS and serious neurological adverse reactions
- facilitate provision of all relevant information to patients
- ensure that adverse reactions are adequately and appropriately reported
- ensure that detailed instructions about the thawing procedure are provided
- before treating a patient, ensure that tocilizumab for each patient are available on site

### Patient educational programme

To inform and explain to patients:

- the risks of CRS and serious neurological adverse reactions associated with KYMRIAH
- the need to report the symptoms to their treating doctor immediately
- the need to remain in the proximity of the location where KYMRIAH was received for at least 4 weeks following KYMRIAH infusion
- the need to carry the patient alert card at all times

- **Obligation to conduct post-authorisation measures**

The MAH shall complete, within the stated timeframe, the below measures:

<b>Description</b>	<b>Due date</b>
Non-interventional post-authorisation safety study (PASS): In order to further characterise the safety – including long-term safety – of Kymriah, the applicant should conduct and submit a study based on data from a disease registry in ALL and DLBCL patients.	Update reports: Annual safety reports and 5-yearly interim reports  Final report of study results: December 2038
Post-authorisation efficacy study (PAES): In order to further evaluate the efficacy and safety of Kymriah in ALL patients below the age of 3 years, the applicant should conduct and submit a study based on data from a disease registry in ALL patients.	Update reports: Included as part of the annual reports of the non-interventional PASS  Final report: December 2023
Post-authorisation efficacy study (PAES): In order to further evaluate the efficacy of Kymriah in patients with relapsed/refractory DLBCL, the applicant should conduct and submit a prospective, observational study in patients with r/r DLBCL based on data from registry with efficacy outcome measures in line with study C2201, including details of the manufacturing turnaround time (i.e. time from last relapse or confirmed refractory status, time from decision to treat, and time from leukapheresis to infusion).	June 2022
Post-authorisation efficacy study (PAES): In order to further characterise the long-term efficacy and safety of Kymriah in relapsed/refractory DLBCL, the applicant should submit the final CSR including 5 years of follow-up from study C2201.	Final CSR: August 2023
Post-authorisation efficacy study (PAES): In order to further characterise the long-term efficacy and safety of Kymriah in relapsed/refractory DLBCL, the applicant should submit the results of study CCTL019H2301 – open-label, Phase III study of Kymriah versus standard of care in adult patients with relapsed or refractory aggressive B-cell non-Hodgkin lymphoma.	June 2022

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



## **A. LABELLING**

**PARTICULARS TO APPEAR ON THE IMMEDIATE PACKAGING**

**INFUSION BAG LABEL**

**1. NAME OF THE MEDICINAL PRODUCT**

Kymriah  $1.2 \times 10^6 - 6 \times 10^8$  cells dispersion for infusion  
tisagenlecleucel (CAR+ viable T cells)

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

Autologous human T cells genetically modified *ex vivo* using a lentiviral vector encoding an anti-CD19 chimeric antigen receptor (CAR).  
Contains  $1.2 \times 10^6$  to  $6 \times 10^8$  CAR+ viable T cells.

**3. LIST OF EXCIPIENTS**

Also contains: glucose, sodium chloride, human albumin solution, dextran 40 for injection, dimethylsulfoxide, sodium gluconate, sodium acetate, potassium chloride, magnesium chloride, sodium-N-acetyltryptophanate, sodium caprylate, aluminium, water for injections. See leaflet for further information.

**4. PHARMACEUTICAL FORM AND CONTENTS**

Dispersion for infusion  
10 mL - 50 mL per bag.

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

Intravenous use  
Do not use leukocyte depleting filter.

**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**

For autologous use only.

**8. EXPIRY DATE**

EXP

**9. SPECIAL STORAGE CONDITIONS**

Store and transport below -120°C; do not thaw the product until use.

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

Contains genetically-modified cells.  
Dispose of as per local guideline on handling of biological waste.

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

Novartis Europharm Limited  
Vista Building  
Elm Park, Merrion Road  
Dublin 4  
Ireland

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

EU/1/18/1297/001

10 – 50 ml

**13. BATCH NUMBER, DONATION AND PRODUCT CODES**

Name:  
Date of birth: {DD MMM YYYY}  
Aph ID/DIN:  
Batch:  
Bag x

**14. GENERAL CLASSIFICATION FOR SUPPLY**

**15. INSTRUCTIONS ON USE**

**16. INFORMATION IN BRAILLE**

Justification for not including Braille accepted.

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

Not applicable

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

Not applicable

**B. PACKAGE LEAFLET**

## Package leaflet: Information for the patient or carer

### **Kymriah 1.2 x 10<sup>6</sup> – 6 x 10<sup>8</sup> cells dispersion for infusion** tisagenlecleucel (CAR+ viable T cells)

▼ This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get. See the end of section 4 for how to report side effects.

**Read all of this leaflet carefully before you (or your child) are given this medicine because it contains important information.**

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor.
- If you get any side effects, talk to your doctor. This includes any possible side effects not listed in this leaflet. See section 4.
- Your doctor will give you a Patient Alert Card. Read it carefully and follow the instructions on it.
- Always show the Patient Alert Card to the doctor or nurse when you see them or if you go to hospital.
- The information in this leaflet is for you or your child – but in the leaflet it will just say “you”.

#### **What is in this leaflet**

1. What Kymriah is and what it is used for
2. What you need to know before you are given Kymriah
3. How Kymriah is given
4. Possible side effects
5. How to store Kymriah
6. Contents of the pack and other information

#### **1. What Kymriah is and what it is used for**

##### **What Kymriah is**

Kymriah, also known as tisagenlecleucel, is made from some of your own white blood cells called T cells. T cells are important for your immune system (the body's defences) to work properly.

##### **How does Kymriah work?**

The T cells are taken from your blood and a new gene is put into the T cells so that they can target the cancer cells in your body. When Kymriah is infused into your blood, the modified T cells will find and kill the cancer cells.

##### **What Kymriah is used for**

Kymriah is used to treat:

- **B-cell acute lymphoblastic leukaemia (B-cell ALL)** - a form of cancer that affects some other types of white blood cells. The medicine can be used in children and young adults up to and including 25 years of age with this cancer.
- **Diffuse large B-cell lymphoma (DLBCL)** - another form of cancer that affects some types of white blood cells, mostly in the lymph nodes. The medicine can be used in adults (18 years of age or older) with this cancer.

If you have any questions about how Kymriah works or why this medicine has been prescribed for you, ask your doctor.

## **2. What you need to know before you are given Kymriah**

### **You should not be given Kymriah:**

- if you are allergic to any of the ingredients of this medicine (listed in section 6). If you think you may be allergic, ask your doctor for advice.

### **Warnings and precautions**

Kymriah is made from your own white blood cells and should only be given to you.

### **Before you are given Kymriah you should tell your doctor if:**

- You have had a stem cell transplant in the last 4 months. Your doctor will check if you have signs or symptoms of graft-versus-host disease. This happens when transplanted cells attack your body, causing symptoms such as rash, nausea, vomiting, diarrhoea and bloody stools.
- You have any lung, heart or blood pressure (low or raised) problems.
- You notice the symptoms of your cancer are getting worse. If you have leukaemia this might include fever, feeling weak, bleeding gums, bruising. If you have lymphoma, this might include unexplained fever, feeling weak, night sweats, sudden weight loss.
- You have an infection. The infection will be treated before the Kymriah infusion.
- You have had hepatitis B, hepatitis C or human immunodeficiency virus (HIV) infection.
- You are pregnant, think you may be pregnant, or plan to become pregnant (see sections “Pregnancy and breast-feeding” and “Contraception for women and men” below).
- You had a vaccination in the previous 6 weeks or are planning to have one in the next few months.

If any of the above apply to you (or you are not sure), talk to your doctor before being given Kymriah.

### **Test and checks**

#### **Before you are given Kymriah your doctor will:**

- Check your lungs, heart and blood pressure.
- Look for signs of infection; any infection will be treated before you are given Kymriah.
- Check if your lymphoma or leukaemia is getting worse.
- Look for signs of graft-versus-host disease that can happen after a transplant.
- Check your blood for uric acid and for how many cancer cells there are in your blood. This will show if you are likely to develop a condition called tumour lysis syndrome. You may be given medicines to help prevent the condition.
- Check for hepatitis B, hepatitis C or HIV infection.

#### **After you have been given Kymriah**

#### **Tell your doctor or nurse immediately if you have any of the following:**

- Fever, which may be a symptom of an infection. Your doctor will regularly check your blood counts as the number of blood cells and other blood components may decrease.
- Take your temperature twice a day for 3-4 weeks after treatment with Kymriah. If your temperature is high, see your doctor immediately.
- Extreme tiredness, weakness and shortness of breath, which may be symptoms of a lack of red blood cells.
- Bleeding or bruising more easily, which may be symptoms of low levels of cells in the blood known as platelets.

There may be an effect on the results of some types of HIV test – ask your doctor about this.

Your doctor will regularly monitor your blood counts after you receive Kymriah as you may experience a reduction in the number of blood cells and other blood components.

Do not donate blood, organs, tissues or cells.

### **Children and adolescents**

- No formal studies have been performed in paediatric patients below 3 years of age in B-cell ALL.
- Kymriah should not be used in children and adolescents below 18 years of age to treat DLBCL. This is because Kymriah has not been studied in this age group.

### **Other medicines and Kymriah**

Tell your doctor if you are taking, have recently taken or might take any other medicines, including medicines obtained without a prescription. This is because other medicines can affect the way Kymriah works.

In particular, you must not be given certain vaccines called live vaccines:

- in the 6 weeks before you are given the short course of chemotherapy (called lymphodepleting chemotherapy) to prepare your body for the Kymriah cells.
- during Kymriah treatment.
- after treatment while the immune system is recovering.

Talk to your doctor if you need to have any vaccinations.

Before you are given Kymriah tell your doctor or nurse if you are taking any medicines that weaken your immune system such as corticosteroids, since these medicines may interfere with the effect of Kymriah.

### **Pregnancy and breast-feeding**

If you are pregnant or breast-feeding, think you may be pregnant or are planning to have a baby, ask your doctor for advice before being given this medicine. This is because the effects of Kymriah in pregnant or breast-feeding women are not known, and it may harm your unborn baby or your newborn/infant.

- If you become pregnant or think you may be pregnant after treatment with Kymriah, talk your doctor immediately.
- You will be given a pregnancy test before treatment starts. Kymriah should only be given if the result shows you are not pregnant.

### **Contraception for women and men**

Discuss pregnancy with your doctor if you have received Kymriah.

### **Driving and using machines**

Do not drive, use machines, or take part in activities that need you to be alert for. Kymriah can cause problems such as altered or decreased consciousness, confusion and seizures (fits) in the 8 weeks following infusion.

### **Kymriah contains sodium, dimethylsulfoxide (DMSO) and dextran 40.**

This medicine contains 24.3 to 121.5 mg sodium per dose. This is equivalent to 1 to 6% of the recommended maximum daily dietary intake of 2 g sodium for an adult. If you have not been previously exposed to dextran or DMSO you should be observed closely during the first minutes of the infusion period.

### **3. How Kymriah is given**

Kymriah will always be given to you by a doctor in a qualified treatment centre.

Kymriah contains human blood cells. Your doctor handling Kymriah will therefore take appropriate precautions (wearing gloves and glasses) to avoid potential transmission of infectious diseases.

#### **Giving blood to make Kymriah**

Kymriah is made from your own white blood cells.

- Your doctor will take some of your blood using a catheter placed in your vein (a procedure called leukapheresis). Some of your white blood cells are separated from your blood and the rest of your blood is returned to your vein. This can take 3 to 6 hours and may need to be repeated.
- Your white blood cells are frozen and sent away to make Kymriah. It usually takes about 3 to 4 weeks to make Kymriah but the time may vary.
- Kymriah is a treatment that is manufactured specifically for you. There are situations where Kymriah cannot be successfully manufactured and be given to you. In some cases, a second manufacturing of Kymriah may be attempted.

Before you are given Kymriah, your doctor may give you a type of treatment called lymphodepleting chemotherapy for a few days to prepare your body.

#### **Cancer treatment while Kymriah is being made**

During the period while Kymriah is being made, your lymphoma or leukaemia may get worse and your doctor may decide to use an additional treatment (a type of chemotherapy known as “bridging therapy”) to stabilise your cancer by stopping new cancer cells from developing. This treatment may lead to side effects and these may be severe or life-threatening. Your doctor will inform you of the potential side effects of this treatment.

#### **Medicines given immediately before Kymriah treatment**

During the 30 to 60 minutes before you are given Kymriah you may be given other medicines. This is to help prevent infusion reactions and fever. These other medicines may include:

- Paracetamol
- An antihistamine such as diphenhydramine.

#### **How you are given Kymriah**

- Your doctor will check that the individual patient identifiers on the Kymriah infusion bag match up to you.
- Your doctor will give you Kymriah by infusion, which means it will be given as a drip through a tube in your vein. This usually takes less than 1 hour.
- Kymriah is a one-time treatment.

#### **After you are given Kymriah**

- Plan to stay within 2 hours’ travel from the hospital where you were treated for at least 4 weeks after you have been given Kymriah. Your doctor will recommend that you return to the hospital daily for at least 10 days and will consider whether you need to stay at the hospital as an in-patient for the first 10 days after infusion. This is so your doctor can check if your treatment is working and help you if you have any side effects.

If you miss an appointment, call your doctor or the hospital as soon as possible to reschedule.



#### 4. Possible side effects

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

**Tell your doctor immediately** if you get any of the following side effects after the Kymriah infusion. They usually happen in the first 8 weeks after the infusion, but can also develop later:

##### **Very common: may affect more than 1 in 10 people**

- high fever and chills. These may be symptoms of a serious condition called cytokine release syndrome which may be life-threatening or fatal. Other symptoms of cytokine release syndrome are difficulty breathing, nausea, vomiting, diarrhoea, loss of appetite, fatigue, muscle pain, joint pain, swelling, low blood pressure, headache, heart, lung and kidney failure and liver injury. These symptoms almost always occur within the first 10 days after infusion.
- problems such as altered thinking or decreased consciousness, loss of contact with reality, confusion, agitation, seizures, difficulty speaking and understanding speech, difficulty walking.
- feeling warm, fever, chills or shivering, sore throat or mouth ulcers may be signs of an infection. Some infections may be life-threatening or fatal.

##### **Common: may affect up to 1 in 10 people**

- Rapid breakdown of tumour cells causing release of their contents into the bloodstream. This can interfere with the workings of various body organs, especially the kidneys, heart and nervous system (tumour lysis syndrome).

##### **Other possible side effects**

Other side effects are listed below. If these side effects become severe or serious, tell your doctor immediately.

##### **Very common:** *may affect more than 1 in 10 people*

- Pale skin, weakness, breathlessness due to low number of red blood cells or low haemoglobin
- Excessive or prolonged bleeding or bruising due to low number of platelets
- Fever with dangerously low white blood cell count
- Increased risk of infection due to abnormally low number of white blood cells
- Frequent and persistent infections due to decreased antibodies in your blood
- Weakness, abnormal heart rhythms, muscle spasms/cramping due to abnormal low level of blood salts including phosphorus, calcium, potassium, magnesium
- High levels of liver enzymes or creatinine in the blood that show that your liver or kidneys are not working normally
- Anxiety, irritability
- Fast or irregular heart beat
- Raised blood pressure
- Shortness of breath, laboured breathing, rapid breathing, fluid in the lungs
- Cough
- Abdominal pain, constipation
- Skin rash
- Difficulty sleeping
- Swollen ankles, limbs and face

**Common:** *may affect up to 1 in 10 people*

- Fever, malaise, enlarged liver, yellow colour of your skin and eyes, low blood cell counts due to severe immune activation
- Dizziness or fainting, flushing, rash, itching, fever, shortness of breath or vomiting, abdominal pain, diarrhoea due to infusion related reaction
- Rash, nausea, vomiting, diarrhoea including bloody stools (possible symptoms of graft-versus-host disease which is when transplanted cells attack your cells)
- Pain in the joints due to high level of uric acid
- Abnormal blood test results (high level of: phosphorus, potassium, calcium, magnesium and sodium, an enzyme called alkaline phosphatase to help detect liver disease, fibrin d-dimer, serum ferritin; low level of: blood protein called albumin, sodium)
- Convulsion, fits (seizures)
- Involuntary or uncontrollable movements
- Tingling or numbness, difficulty moving because of nerve damage
- Decreased vision
- Thirst
- Weight loss
- Nerve pain
- Breathlessness, difficulty breathing when lying down, swelling of the feet or legs (possible symptoms of heart failure), stopped heart beat
- Swelling and pain due to blood clots
- Swelling due to fluids leaking from blood vessels into the surrounding tissue
- Bloating and discomfort (abdominal distension), due to an accumulation of fluid in the abdomen
- Dry mouth, sore mouth, bleeding in the mouth, inflammation in the gums
- Yellow skin and eyes due to abnormally high levels of bilirubin in the blood
- Itching
- Excessive sweating, night sweats
- Bone and back pain
- Flu-like illness
- Failure of multiple organs

**Uncommon:** *may affect up to 1 in 100 people*

- Weakness or paralysis of limbs or face, difficulty speaking (possible symptoms of stroke as a result of reduced blood supply)
- Warm or rapidly reddening skin
- Cough that produces phlegm or sometimes blood, fever, shortness of breath or difficulty breathing

**Reporting of side effects**

If you get any side effects, talk to your doctor. 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 Kymriah

**The following information is intended for doctors only.**

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 infusion bag label after EXP. The expiry date refers to the last day of that month.

Store and transport below -120°C. Do not thaw the product until it is ready to be used.

Do not use this medicine if the infusion bag is damaged or leaking.

This medicine contains genetically-modified blood cells. Local guidelines on handling of biological waste should be followed for unused medicine or waste material.

## 6. Contents of the pack and other information

### What Kymriah contains

- The active substance of Kymriah is called tisagenlecleucel. Each infusion bag of Kymriah contains tisagenlecleucel cell dispersion at a batch-dependent concentration of autologous T cells genetically modified to express an anti-CD19 chimeric antigen receptor (CAR-positive viable T cells). 1 or more bags contain a total of  $1.2 \times 10^6 - 6 \times 10^8$  CAR+ viable T cells.
- The other ingredients are glucose, sodium chloride, human albumin solution, dextran 40 for injection, dimethylsulfoxide, sodium gluconate, sodium acetate, potassium chloride, magnesium chloride, sodium-N-acetyltryptophanate, sodium caprylate, aluminium, and water for injections. See section 2, “Kymriah contains sodium, dimethylsulfoxide (DMSO) and dextran 40”.

### What Kymriah looks like and contents of the pack

Kymriah is a cell dispersion for infusion. It is supplied as an infusion bag containing a cloudy to clear, colourless to slightly yellow dispersion of cells. Each bag contains 10 mL to 50 mL of dispersion.

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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>

**The following information is intended for healthcare professionals only:**

Preparation of the infusion bag

The timing of thaw of Kymriah and of infusion should be coordinated. Confirm the infusion time in advance and adjust the start time for thaw so that Kymriah is available for infusion when the recipient is ready. Once Kymriah has been thawed and is at room temperature (20°C-25°C), it should be infused within 30 minutes to maintain maximum product viability, including any interruption during the infusion.

The infusion bag should be placed inside a second, sterile bag during thawing to protect ports from contamination and avoid spills in the unlikely event of the bag leaking. Kymriah should be thawed at 37°C using either a water bath or dry thaw method until there is no visible ice in the infusion bag. The bag should be removed immediately from the thawing device and kept at room temperature (20°C-25°C) until infusion. If more than one infusion bag has been received for the treatment dose (refer to the batch certificate for number of bags constituting one dose), the next bag should only be thawed after the contents of the preceding bag have been infused.

Kymriah should not be manipulated. For example, Kymriah should not be washed (spun down and resuspended in new media) prior to infusion.

The infusion bag(s) should be examined for any breaks or cracks prior to thawing. If the infusion bag appears to have been damaged or to be leaking, it should not be infused and should be disposed of according to local guidelines on handling of biological waste.

Administration

Kymriah intravenous infusion should be administered by a healthcare professional experienced with immunosuppressed patients and prepared to manage anaphylaxis. Ensure that one dose of tocilizumab per patient and emergency equipment are available prior to infusion and during the recovery period. Hospitals should have access to additional doses of tocilizumab within 8 hours.

The patient's identity should be matched with the patient identifiers on the infusion bag. Kymriah is for autologous use only. Kymriah should be administered as an intravenous infusion using latex-free intravenous tubing without a leukocyte depleting filter, at approximately 10 to 20 mL per minute by gravity flow. All contents of the infusion bags should be infused. Sterile sodium chloride 9 mg/mL (0.9%) solution for injection should be used to prime the tubing prior to infusion as well as rinse it afterwards. When the full volume of Kymriah has been infused, the infusion bag should be rinsed with 10 to 30 mL sodium chloride 9 mg/mL (0.9%) solution for injection by back priming to ensure as many cells as possible are infused into the patient.

Precautions to be taken before handling or administering Kymriah

Kymriah contains genetically-modified human blood cells. Local guidelines on handling of biological waste should be followed for disposal.

All material that has been in contact with Kymriah (solid and liquid waste) should be handled and disposed of as potentially infectious waste in accordance with local guidelines on handling of biological waste.

Kymriah should be transported within the facility in closed, break-proof, leak-proof containers.

Kymriah is prepared from autologous blood of the patient collected by leukapheresis. Patient leukapheresis material and Kymriah may carry a risk of transmitting infectious viruses to healthcare professionals handling the product. Accordingly, healthcare professionals should employ appropriate precautions (wearing gloves and glasses) when handling leukapheresis material or Kymriah to avoid potential transmission of infectious diseases.