

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

Stoboclo 60 mg solution for injection in pre-filled syringe

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each pre-filled syringe contains 60 mg of denosumab in 1 mL of solution (60 mg/mL).

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

Excipients with known effect

This medicine contains 47 mg sorbitol (E420) and 0.1 mg polysorbate 20 (E432) in each mL of solution.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Solution for injection (injection).

Clear, colourless to pale yellow solution with pH of 5.2.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Treatment of osteoporosis in postmenopausal women and in men at increased risk of fractures. In postmenopausal women denosumab significantly reduces the risk of vertebral, non-vertebral and hip fractures.

Treatment of bone loss associated with hormone ablation in men with prostate cancer at increased risk of fractures (see section 5.1). In men with prostate cancer receiving hormone ablation, denosumab significantly reduces the risk of vertebral fractures.

Treatment of bone loss associated with long-term systemic glucocorticoid therapy in adult patients at increased risk of fracture (see section 5.1).

4.2 Posology and method of administration

Posology

The recommended dose is 60 mg denosumab administered as a single subcutaneous injection once every 6 months into the thigh, abdomen or upper arm.

Patients must be adequately supplemented with calcium and vitamin D (see section 4.4).

Patients treated with denosumab should be given the package leaflet and the patient reminder card.

The optimal total duration of antiresorptive treatment for osteoporosis (including both denosumab and bisphosphonates) has not been established. The need for continued treatment should be re-evaluated periodically based on the benefits and potential risks of denosumab on an individual patient basis, particularly after 5 or more years of use (see section 4.4).

Elderly (age ≥ 65)

No dose adjustment is required in elderly patients.

Renal impairment

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

No data is available in patients with long-term systemic glucocorticoid therapy and severe renal impairment Glomerular filtration rate (GFR < 30 mL/min).

Hepatic impairment

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

Paediatric population

Stoboclo should not be used in children aged < 18 years because of safety concerns of serious hypercalcaemia, and potential inhibition of bone growth and lack of tooth eruption (see sections 4.4 and 5.3). Currently available data for children aged 2 to 17 years are described in sections 5.1 and 5.2.

Method of administration

For subcutaneous use.

Administration should be performed by an individual who has been adequately trained in injection techniques.

The instructions for use, handling and disposal are given in section 6.6.

4.3 Contraindications

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

Hypocalcaemia (see section 4.4).

4.4 Special warnings and precautions for use

Traceability

In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded.

Calcium and vitamin D supplementation

Adequate intake of calcium and vitamin D is important in all patients.

Precautions for use

Hypocalcaemia

It is important to identify patients at risk for hypocalcaemia. Hypocalcaemia must be corrected by adequate intake of calcium and vitamin D before initiating therapy. Clinical monitoring of calcium levels is recommended before each dose and, in patients predisposed to hypocalcaemia within

two weeks, after the initial dose. If any patient presents with suspected symptoms of hypocalcaemia during treatment (see section 4.8 for symptoms) calcium levels should be measured. Patients should be encouraged to report symptoms indicative of hypocalcaemia.

In the post-marketing setting, severe symptomatic hypocalcaemia (resulting in hospitalisation, life-threatening events, and fatal cases) have been reported. While most cases occurred in the first few weeks of initiating therapy, it has also occurred later.

Concomitant glucocorticoid treatment is an additional risk factor for hypocalcaemia.

Renal impairment

Patients with severe renal impairment (creatinine clearance < 30 mL/min) or receiving dialysis are at greater risk of developing hypocalcaemia. The risks of developing hypocalcaemia and accompanying parathyroid hormone elevations increase with increasing degree of renal impairment. Severe and fatal cases have been reported. Adequate intake of calcium, vitamin D and regular monitoring of calcium is especially important in these patients, see above.

Skin infections

Patients receiving denosumab may develop skin infections (predominantly cellulitis) leading to hospitalisation (see section 4.8). Patients should be advised to seek prompt medical attention if they develop signs or symptoms of cellulitis.

Osteonecrosis of the jaw (ONJ)

ONJ has been reported rarely in patients receiving denosumab for osteoporosis (see section 4.8).

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

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

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

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

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

Osteonecrosis of the external auditory canal

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

Atypical fractures of the femur

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

Long-term antiresorptive treatment

Long-term antiresorptive treatment (including both denosumab and bisphosphonates) may contribute to an increased risk for adverse outcomes such as osteonecrosis of the jaw and atypical femur fractures due to significant suppression of bone remodelling (see section 4.2).

Concomitant treatment with other denosumab-containing medicinal products

Patients being treated with denosumab should not be treated concomitantly with other denosumab-containing medicinal products (for prevention of skeletal related events in adults with bone metastases from solid tumours).

Hypercalcaemia in paediatric patients

Denosumab should not be used in paediatric patients (age < 18). Serious hypercalcaemia has been reported. Some clinical trial cases were complicated by acute renal injury.

Warnings for excipients

This medicine contains 47 mg sorbitol in each mL of solution. The additive effect of concomitantly administered products containing sorbitol (or fructose) and dietary intake of sorbitol (or fructose) should be taken into account.

This medicinal product contains less than 1 mmol sodium (23 mg) per 60 mg that is to say essentially 'sodium-free'.

This medicine contains 0.1 mg of polysorbate 20 in each syringe which is equivalent to 0.1 mg/mL. Polysorbates may cause allergic reactions. Tell your doctor if you have any known allergies.

4.5 Interaction with other medicinal products and other forms of interaction

In an interaction study, denosumab did not affect the pharmacokinetics of midazolam, which is metabolised by cytochrome P450 3A4 (CYP3A4). This indicates that denosumab should not alter the pharmacokinetics of medicinal products metabolised by CYP3A4.

There are no clinical data on the co-administration of denosumab and hormone replacement therapy (oestrogen), however the potential for a pharmacodynamic interaction is considered to be low.

In postmenopausal women with osteoporosis the pharmacokinetics and pharmacodynamics of denosumab were not altered by previous alendronate therapy, based on data from a transition study (alendronate to denosumab).

4.6 Fertility, pregnancy and lactation

Pregnancy

There are no or limited amount of data from the use of denosumab in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3).

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

Breast-feeding

It is unknown whether denosumab is excreted in human milk. In genetically engineered mice in which RANKL has been turned off by gene removal (a “knockout mouse”), studies suggest absence of RANKL (the target of denosumab see section 5.1) during pregnancy may interfere with maturation of the mammary gland leading to impaired lactation post-partum (see section 5.3). A decision on whether to abstain from breast-feeding or to abstain from therapy with denosumab should be made, taking into account the benefit of breast-feeding to the newborn/infant and the benefit of denosumab therapy to the woman.

Fertility

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

4.7 Effects on ability to drive and use machines

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

4.8 Undesirable effects

Summary of the safety profile

The most common side effects with denosumab (seen in more than one patient in ten) are musculoskeletal pain and pain in the extremity. Uncommon cases of cellulitis, rare cases of hypocalcaemia, hypersensitivity, osteonecrosis of the jaw and atypical femoral fractures (see sections 4.4 and 4.8 - description of selected adverse reactions) have been observed in patients taking denosumab.

Tabulated list of adverse reactions

The data in table 1 below describe adverse reactions reported from phase II and III clinical trials in patients with osteoporosis and breast or prostate cancer patients receiving hormone ablation; and/or spontaneous reporting.

The following convention has been used for the classification of the adverse reactions (see table 1): very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1\ 000$ to $< 1/100$), rare ($\geq 1/10\ 000$ to $< 1/1\ 000$), very rare ($< 1/10\ 000$) and not known (cannot be estimated from the available data). Within each frequency grouping and system organ class, adverse reactions are presented in order of decreasing seriousness.

Table 1. Adverse reactions reported in patients with osteoporosis and breast or prostate cancer patients receiving hormone ablation

MedDRA system organ class	Frequency category	Adverse reactions
Infections and infestations	Common Common Uncommon Uncommon Uncommon	Urinary tract infection Upper respiratory tract infection Diverticulitis ¹ Cellulitis ¹ Ear infection
Immune system disorders	Rare Rare	Drug hypersensitivity ¹ Anaphylactic reaction ¹
Metabolism and nutrition disorders	Rare	Hypocalcaemia ¹
Nervous system disorders	Common	Sciatica
Gastrointestinal disorders	Common Common	Constipation Abdominal discomfort
Skin and subcutaneous tissue disorders	Common Common Common Uncommon Very rare	Rash Eczema Alopecia Lichenoid drug eruptions ¹ Hypersensitivity vasculitis
Musculoskeletal and connective tissue disorders	Very common Very common Rare Rare Not Known	Pain in extremity Musculoskeletal pain ¹ Osteonecrosis of the jaw ¹ Atypical femoral fractures ¹ Osteonecrosis of the external auditory canal ²

¹ See section Description of selected adverse reactions.

² See section 4.4.

In a pooled analysis of data from all phase II and phase III placebo-controlled studies, influenza-like illness was reported with a crude incidence rate of 1.2% for denosumab and 0.7% for placebo. Although this imbalance was identified via a pooled analysis, it was not identified via a stratified analysis.

Description of selected adverse reactions

Hypocalcaemia

In two phase III placebo-controlled clinical trials in postmenopausal women with osteoporosis, approximately 0.05% (2 out of 4,050) of patients had declines of serum calcium levels (less than 1.88 mmol/L) following denosumab administration. Declines of serum calcium levels (less than 1.88 mmol/L) were not reported in either the two phase III placebo-controlled clinical trials in patients receiving hormone ablation or the phase III placebo-controlled clinical trial in men with osteoporosis.

In the post-marketing setting, rare cases of severe symptomatic hypocalcaemia resulting in hospitalisation, life-threatening events, and fatal cases have been reported, predominantly in patients at increased risk of hypocalcaemia receiving denosumab, with most cases occurring in the first weeks of initiating therapy. Examples of the clinical manifestations of severe symptomatic hypocalcaemia have included QT interval prolongation, tetany, seizures and altered mental status (see section 4.4). Symptoms of hypocalcaemia in denosumab clinical studies included paraesthesias or muscle stiffness, twitching, spasms and muscle cramps.

Skin infections

In phase III placebo-controlled clinical trials, the overall incidence of skin infections was similar in the placebo and the denosumab groups: in postmenopausal women with osteoporosis (placebo [1.2%, 50 out of 4,041] versus denosumab [1.5%, 59 out of 4,050]); in men with osteoporosis (placebo [0.8%, 1 out of 120] versus denosumab [0%, 0 out of 120]); in breast or prostate cancer patients receiving hormone ablation (placebo [1.7%, 14 out of 845] versus denosumab [1.4%, 12 out of 860]). Skin

infections leading to hospitalisation were reported in 0.1% (3 out of 4,041) of postmenopausal women with osteoporosis receiving placebo versus 0.4% (16 out of 4,050) of women receiving denosumab. These cases were predominantly cellulitis. Skin infections reported as serious adverse reactions were similar in the placebo (0.6%, 5 out of 845) and the denosumab (0.6%, 5 out of 860) groups in the breast and prostate cancer studies.

Osteonecrosis of the jaw

ONJ has been reported rarely, in 16 patients, in clinical trials in osteoporosis and in breast or prostate cancer patients receiving hormone ablation including a total of 23,148 patients (see section 4.4). Thirteen of these ONJ cases occurred in postmenopausal women with osteoporosis during the phase III clinical trial extension following treatment with denosumab for up to 10 years. Incidence of ONJ was 0.04% at 3 years, 0.06% at 5 years and 0.44% at 10 years of denosumab treatment. The risk of ONJ increased with duration of exposure to denosumab.

The risk of ONJ has also been assessed in a retrospective cohort study among 76,192 postmenopausal women newly initiating treatment with denosumab. The incidence of ONJ was 0.32% (95% confidence interval [CI]: 0.26, 0.39) among patients using denosumab up to 3 years and 0.51% (95% CI: 0.39, 0.65) among patients using denosumab up to 5 years of follow-up.

Atypical fractures of the femur

In the osteoporosis clinical trial programme, atypical femoral fractures were reported rarely in patients treated with denosumab (see section 4.4).

Diverticulitis

In a single phase III placebo-controlled clinical trial in patients with prostate cancer receiving androgen deprivation therapy (ADT), an imbalance in diverticulitis adverse events was observed (1.2% denosumab, 0% placebo). The incidence of diverticulitis was comparable between treatment groups in postmenopausal women or men with osteoporosis and in women undergoing aromatase inhibitor therapy for non-metastatic breast cancer.

Drug-related hypersensitivity reactions

In the post-marketing setting, rare events of drug-related hypersensitivity, including rash, urticaria, facial swelling, erythema, and anaphylactic reactions have been reported in patients receiving denosumab.

Musculoskeletal pain

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

Lichenoid drug eruptions

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

Other special populations

Paediatric population

Denosumab should not be used in paediatric patients (age < 18). Serious hypercalcaemia has been reported (see section 5.1). Some clinical trial cases were complicated by acute renal injury.

Renal impairment

In clinical studies, patients with severe renal impairment (creatinine clearance < 30 mL/min) or receiving dialysis were at greater risk of developing hypocalcaemia in the absence of calcium supplementation. Adequate intake of calcium and vitamin D is important in patients with severe renal impairment or receiving dialysis (see section 4.4).

Reporting of suspected adverse reactions

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

4.9 Overdose

There is no experience with overdose in clinical studies. Denosumab has been administered in clinical studies using doses up to 180 mg every 4 weeks (cumulative doses up to 1,080 mg over 6 months), and no additional adverse reactions were observed.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

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

Stoboclo is a biosimilar medicinal product. Detailed information is available on the website of the European Medicines Agency <https://www.ema.europa.eu>.

Mechanism of action

Denosumab is a human monoclonal antibody (IgG2) that targets and binds with high affinity and specificity to RANKL, preventing activation of its receptor, RANK, on the surface of osteoclast precursors and osteoclasts. Prevention of the RANKL/RANK interaction inhibits osteoclast formation, function and survival, thereby decreasing bone resorption in cortical and trabecular bone.

Pharmacodynamic effects

Denosumab treatment rapidly reduced the rate of bone turnover, reaching a nadir for the bone resorption marker serum type 1 C-telopeptides (CTX) (85% reduction) by 3 days, with reductions maintained over the dosing interval. At the end of each dosing interval, CTX reductions were partially attenuated from maximal reduction of $\geq 87\%$ to approximately $\geq 45\%$ (range 45-80%), reflecting the reversibility of denosumab's effects on bone remodelling once serum levels diminish. These effects were sustained with continued treatment. Bone turnover markers generally reached pre-treatment levels within 9 months after the last dose. Upon re-initiation, reductions in CTX by denosumab were similar to those observed in patients initiating primary denosumab treatment.

Immunogenicity

Anti-denosumab antibodies may develop during denosumab treatment. No apparent correlation of antibody development with pharmacokinetics, clinical response or adverse events has been observed.

Clinical efficacy and safety in postmenopausal women with osteoporosis

Efficacy and safety of denosumab administered once every 6 months for 3 years were investigated in postmenopausal women (7,808 women aged 60-91 years, of which 23.6% had prevalent vertebral fractures) with baseline bone mineral density (BMD) T-scores at the lumbar spine or total hip between -2.5 and -4.0 and a mean absolute 10-year fracture probability of 18.60% (deciles: 7.9-32.4%) for major osteoporotic fracture and 7.22% (deciles: 1.4-14.9%) for hip fracture. Women with other diseases or on therapies that may affect bone were excluded from this study. Women received calcium (at least 1,000 mg) and vitamin D (at least 400 IU) supplementation daily.

Effect on vertebral fractures

Denosumab significantly reduced the risk of new vertebral fractures at 1, 2 and 3 years ($p < 0.0001$) (see table 2).

Table 2. The effect of denosumab on the risk of new vertebral fractures

	Proportion of women with fracture (%)		Absolute risk reduction (%) (95% CI)	Relative risk reduction (%) (95% CI)
	Placebo n = 3,906	Denosumab n = 3,902		
0-1 year	2.2	0.9	1.4 (0.8, 1.9)	61 (42, 74)**
0-2 years	5.0	1.4	3.5 (2.7, 4.3)	71 (61, 79)**
0-3 years	7.2	2.3	4.8 (3.9, 5.8)	68 (59, 74)*

* $p < 0.0001$, ** $p < 0.0001$ – exploratory analysis

Effect on hip fractures

Denosumab demonstrated a 40% relative reduction (0.5% absolute risk reduction) in the risk of hip fracture over 3 years ($p < 0.05$). The incidence of hip fracture was 1.2% in the placebo group compared to 0.7% in the denosumab group at 3 years.

In a post-hoc analysis in women > 75 years, a 62% relative risk reduction was observed with denosumab (1.4% absolute risk reduction, $p < 0.01$).

Effect on all clinical fractures

Denosumab significantly reduced fractures across all fracture types/groups (see table 3).

Table 3. The effect of denosumab on the risk of clinical fractures over 3 years

	Proportion of women with fracture (%) ⁺		Absolute risk reduction (%) (95% CI)	Relative risk reduction (%) (95% CI)
	Placebo n = 3,906	Denosumab n = 3,902		
Any clinical fracture ¹	10.2	7.2	2.9 (1.6, 4.2)	30 (19, 41)***
Clinical vertebral fracture	2.6	0.8	1.8 (1.2, 2.4)	69 (53, 80)***
Non-vertebral fracture ²	8.0	6.5	1.5 (0.3, 2.7)	20 (5, 33)**
Major non-vertebral fracture ³	6.4	5.2	1.2 (0.1, 2.2)	20 (3, 34)*
Major osteoporotic fracture ⁴	8.0	5.3	2.7 (1.6, 3.9)	35 (22, 45)***

* $p \leq 0.05$, ** $p = 0.0106$ (secondary endpoint included in multiplicity adjustment), *** $p \leq 0.0001$

⁺ Event rates based on Kaplan-Meier estimates at 3 years.

¹ Includes clinical vertebral fractures and non-vertebral fractures.

² Excludes those of the vertebrae, skull, facial, mandible, metacarpus, and finger and toe phalanges.

³ Includes pelvis, distal femur, proximal tibia, ribs, proximal humerus, forearm, and hip.

⁴ Includes clinical vertebral, hip, forearm, and humerus fractures, as defined by the WHO.

In women with baseline femoral neck BMD ≤ -2.5 , denosumab reduced the risk of non-vertebral fracture (35% relative risk reduction, 4.1% absolute risk reduction, $p < 0.001$, exploratory analysis).

The reduction in the incidence of new vertebral fractures, hip fractures and non-vertebral fractures by denosumab over 3 years were consistent regardless of the 10-year baseline fracture risk.

Effect on bone mineral density

Denosumab significantly increased BMD at all clinical sites measured, versus placebo at 1, 2 and 3 years. Denosumab increased BMD by 9.2% at the lumbar spine, 6.0% at the total hip, 4.8% at the femoral neck, 7.9% at the hip trochanter, 3.5% at the distal 1/3 radius and 4.1% at the total body over 3 years (all $p < 0.0001$).

In clinical studies examining the effects of discontinuation of denosumab, BMD returned to approximately pre-treatment levels and remained above placebo within 18 months of the last dose. These data indicate that continued treatment with denosumab is required to maintain the effect of the

medicinal product. Re-initiation of denosumab resulted in gains in BMD similar to those when denosumab was first administered.

Open-label extension study in the treatment of postmenopausal osteoporosis

A total of 4,550 women (2,343 denosumab & 2,207 placebo) who missed no more than one dose of investigational product in the pivotal study described above and completed the month 36 study visit agreed to enrol in a 7-year, multinational, multicentre, open-label, single-arm extension study to evaluate the long-term safety and efficacy of denosumab. All women in the extension study were to receive denosumab 60 mg every 6 months, as well as daily calcium (at least 1 g) and vitamin D (at least 400 IU). A total of 2,626 subjects (58% of the women included in the extension study i.e. 34% of the women included in the pivotal study) completed the extension study.

In patients treated with denosumab for up to 10 years, BMD increased from the pivotal study baseline by 21.7% at the lumbar spine, 9.2% at the total hip, 9.0% at the femoral neck, 13.0% at the trochanter and 2.8% at the distal 1/3 radius. The mean lumbar spine BMD T-score at the end of the study was -1.3 in patients treated for 10 years.

Fracture incidence was evaluated as a safety endpoint but efficacy in fracture prevention cannot be estimated due to high number of discontinuations and open-label design. The cumulative incidence of new vertebral and non-vertebral fractures were approximately 6.8% and 13.1% respectively, in patients who remained on denosumab treatment for 10 years (n = 1,278). Patients who did not complete the study for any reason had higher on-treatment fracture rates.

Thirteen adjudicated cases of osteonecrosis of the jaw (ONJ) and two adjudicated cases of atypical fractures of the femur occurred during the extension study.

Clinical efficacy and safety in men with osteoporosis

Efficacy and safety of denosumab once every 6 months for 1 year were investigated in 242 men aged 31-84 years. Subjects with an eGFR < 30 mL/min/1.73 m² were excluded from the study. All men received calcium (at least 1,000 mg) and vitamin D (at least 800 IU) supplementation daily.

The primary efficacy variable was percent change in lumbar spine BMD, fracture efficacy was not evaluated. Denosumab significantly increased BMD at all clinical sites measured, relative to placebo at 12 months: 4.8% at lumbar spine, 2.0% at total hip, 2.2% at femoral neck, 2.3% at hip trochanter, and 0.9% at distal 1/3 radius (all p < 0.05). Denosumab increased lumbar spine BMD from baseline in 94.7% of men at 1 year. Significant increases in BMD at lumbar spine, total hip, femoral neck and hip trochanter were observed by 6 months (p < 0.0001).

Bone histology in postmenopausal women and men with osteoporosis

Bone histology was evaluated in 62 postmenopausal women with osteoporosis or with low bone mass who were either naïve to osteoporosis therapies or had transitioned from previous alendronate therapy following 1-3 years treatment with denosumab. Fifty-nine women participated in the bone biopsy sub-study at month 24 (n = 41) and/or month 84 (n = 22) of the extension study in postmenopausal women with osteoporosis. Bone histology was also evaluated in 17 men with osteoporosis following 1 year treatment with denosumab. Bone biopsy results showed bone of normal architecture and quality with no evidence of mineralisation defects, woven bone or marrow fibrosis. Histomorphometry findings in the extension study in postmenopausal women with osteoporosis showed that the antiresorptive effects of denosumab, as measured by activation frequency and bone formation rates, were maintained over time.

Clinical efficacy and safety in patients with bone loss associated with androgen deprivation

Efficacy and safety of denosumab once every 6 months for 3 years were investigated in men with histologically confirmed non-metastatic prostate cancer receiving ADT (1,468 men aged 48-97 years) who were at increased risk of fracture (defined as > 70 years, or < 70 years with a BMD T-score at the

lumbar spine, total hip, or femoral neck < -1.0 or a history of an osteoporotic fracture). All men received calcium (at least 1,000 mg) and vitamin D (at least 400 IU) supplementation daily.

Denosumab significantly increased BMD at all clinical sites measured, relative to treatment with placebo at 3 years: 7.9% at the lumbar spine, 5.7% at the total hip, 4.9% at the femoral neck, 6.9% at the hip trochanter, 6.9% at the distal 1/3 radius and 4.7% at the total body (all $p < 0.0001$). In a prospectively planned exploratory analysis, significant increases in BMD were observed at the lumbar spine, total hip, femoral neck and the hip trochanter 1 month after the initial dose.

Denosumab demonstrated a significant relative risk reduction of new vertebral fractures: 85% (1.6% absolute risk reduction) at 1 year, 69% (2.2% absolute risk reduction) at 2 years and 62% (2.4% absolute risk reduction) at 3 years (all $p < 0.01$).

Clinical efficacy and safety in patients with bone loss associated with adjuvant aromatase inhibitor therapy

Efficacy and safety of denosumab once every 6 months for 2 years were investigated in women with non-metastatic breast cancer (252 women aged 35-84 years) and baseline BMD T-scores between -1.0 to -2.5 at the lumbar spine, total hip or femoral neck. All women received calcium (at least 1,000 mg) and vitamin D (at least 400 IU) supplementation daily.

The primary efficacy variable was percent change in lumbar spine BMD, fracture efficacy was not evaluated. Denosumab significantly increased BMD at all clinical sites measured, relative to treatment with placebo at 2 years: 7.6% at lumbar spine, 4.7% at total hip, 3.6% at femoral neck, 5.9% at hip trochanter, 6.1% at distal 1/3 radius and 4.2% at total body (all $p < 0.0001$).

Treatment of bone loss associated with systemic glucocorticoid therapy

Efficacy and safety of denosumab were investigated in 795 patients (70% women and 30% men) aged 20 to 94 years treated with ≥ 7.5 mg daily oral prednisone (or equivalent).

Two subpopulations were studied: glucocorticoid-continuing (≥ 7.5 mg daily prednisone or its equivalent for ≥ 3 months prior to study enrolment; $n = 505$) and glucocorticoid-initiating (≥ 7.5 mg daily prednisone or its equivalent for < 3 months prior to study enrolment; $n = 290$). Patients were randomised (1:1) to receive either denosumab 60 mg subcutaneously once every 6 months or oral risedronate 5 mg once daily (active control) for 2 years. Patients received calcium (at least 1,000 mg) and vitamin D (at least 800 IU) supplementation daily.

Effect on Bone Mineral Density (BMD)

In the glucocorticoid-continuing subpopulation, denosumab demonstrated a greater increase in lumbar spine BMD compared to risedronate at 1 year (denosumab 3.6%, risedronate 2.0%; $p < 0.001$) and 2 years (denosumab 4.5%, risedronate 2.2%; $p < 0.001$). In the glucocorticoid-initiating subpopulation, denosumab demonstrated a greater increase in lumbar spine BMD compared to risedronate at 1 year (denosumab 3.1%, risedronate 0.8%; $p < 0.001$) and 2 years (denosumab 4.6%, risedronate 1.5%; $p < 0.001$).

In addition, denosumab demonstrated a significantly greater mean percent increase in BMD from baseline compared to risedronate at the total hip, femoral neck, and hip trochanter.

The study was not powered to show a difference in fractures. At 1 year, the subject incidence of new radiological vertebral fracture was 2.7% (denosumab) versus 3.2% (risedronate). The subject incidence of non-vertebral fracture was 4.3% (denosumab) versus 2.5% (risedronate). At 2 years, the corresponding numbers were 4.1% versus 5.8% for new radiological vertebral fractures and 5.3% versus 3.8% for non-vertebral fractures. Most of the fractures occurred in the GC-C subpopulation.

Paediatric population

A single-arm phase 3 study evaluated the efficacy, safety, and pharmacokinetics was conducted in children with osteogenesis imperfecta, aged 2 to 17 years, 52.3% male, 88.2% Caucasian. A total of 153 subjects initially received subcutaneous (SC) denosumab 1 mg/kg, up to a maximum of 60 mg, every 6 months for 36 months. Sixty subjects transitioned to every 3 months dosing.

At month 12 of every 3 months dosing, the least squares (LS) mean (standard error, SE) change from baseline in lumbar spine BMD Z-score was 1.01 (0.12).

The most common adverse events reported during every 6 months dosing were arthralgia (45.8%), pain in extremity (37.9%), back pain (32.7%), and hypercalciuria (32.0%). Hypercalcaemia was reported during every 6 months (19%) and every 3 months (36.7%) dosing. Serious adverse events of hypercalcaemia (13.3%) were reported during every 3 months dosing.

In an extension study (N = 75), serious adverse events of hypercalcaemia (18.5%) were observed during every 3 months dosing.

The studies were terminated early due to the occurrence of life-threatening events and hospitalisations due to hypercalcaemia (see section 4.2).

The European Medicines Agency has waived the obligation to submit the results of studies with denosumab in all subsets of the paediatric population in the treatment of bone loss associated with sex hormone ablative therapy, and in subsets of the paediatric population below the age of 2 in the treatment of osteoporosis. See section 4.2 for information on paediatric use.

5.2 Pharmacokinetic properties

Absorption

Following subcutaneous administration of a 1.0 mg/kg dose, which approximates the approved 60 mg dose, exposure based on AUC was 78% as compared to intravenous administration at the same dose level. For a 60 mg subcutaneous dose, maximum serum denosumab concentrations (C_{max}) of 6 mcg/mL (range 1-17 mcg/mL) occurred in 10 days (range 2-28 days).

Biotransformation

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

Elimination

After C_{max} , serum levels declined with a half-life of 26 days (range 6-52 days) over a period of 3 months (range 1.5-4.5 months). Fifty-three percent (53%) of patients had no measurable amounts of denosumab detected at 6 months post-dose.

No accumulation or change in denosumab pharmacokinetics with time was observed upon subcutaneous multiple-dosing of 60 mg once every 6 months. Denosumab pharmacokinetics were not affected by the formation of binding antibodies to denosumab and were similar in men and women. Age (28-87 years), race and disease state (low bone mass or osteoporosis; prostate or breast cancer) do not appear to significantly affect the pharmacokinetics of denosumab.

A trend was observed between higher body weight and lower exposure based on AUC and C_{max} . However, the trend is not considered clinically important, since pharmacodynamic effects based on bone turnover markers and BMD increases were consistent across a wide range of body weight.

Linearity/non-linearity

In dose ranging studies, denosumab exhibited non-linear, dose-dependent pharmacokinetics, with lower clearance at higher doses or concentrations, but approximately dose-proportional increases in exposures for doses of 60 mg and greater.

Renal impairment

In a study of 55 patients with varying degrees of renal function, including patients on dialysis, the degree of renal impairment had no effect on the pharmacokinetics of denosumab.

Hepatic impairment

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

Paediatric population

Denosumab should not be used in paediatric populations (see sections 4.2 and 5.1).

In a phase 3 study of paediatric patients with osteogenesis imperfecta (N = 153), maximum serum denosumab concentrations were observed on day 10 across all age groups. For every 3 months and every 6 months dosing, mean serum denosumab trough concentrations were observed to be higher for children 11 to 17 years of age, while children 2 to 6 years of age had the lowest mean trough concentrations.

5.3 Preclinical safety data

In single and repeated dose toxicity studies in cynomolgus monkeys, denosumab doses resulting in 100 to 150 times greater systemic exposure than the recommended human dose had no impact on cardiovascular physiology, male or female fertility, or produced specific target organ toxicity.

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

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

In preclinical studies conducted in knockout mice lacking RANK or RANKL, impairment of lymph node formation was observed in the foetus. An absence of lactation due to inhibition of mammary gland maturation (lobulo-alveolar gland development during pregnancy) was also observed in knockout mice lacking RANK or RANKL.

In a study of cynomolgus monkeys dosed with denosumab during the period equivalent to the first trimester at AUC exposures up to 99-fold higher than the human dose (60 mg every 6 months), there was no evidence of maternal or foetal harm. In this study, foetal lymph nodes were not examined.

In another study of cynomolgus monkeys dosed with denosumab throughout pregnancy at AUC exposures 119-fold higher than the human dose (60 mg every 6 months), there were increased stillbirths and postnatal mortality; abnormal bone growth resulting in reduced bone strength, reduced haematopoiesis, and tooth malalignment; absence of peripheral lymph nodes; and decreased neonatal growth. A no observed adverse effect level for reproductive effects was not established. Following a 6 month period after birth, bone related changes showed recovery and there was no effect on tooth eruption. However, the effects on lymph nodes and tooth malalignment persisted, and minimal to moderate mineralisation in multiple tissues was seen in one animal (relation to treatment uncertain).

There was no evidence of maternal harm prior to labour; adverse maternal effects occurred infrequently during labour. Maternal mammary gland development was normal.

In preclinical bone quality studies in monkeys on long-term denosumab treatment, decreases in bone turnover were associated with improvement in bone strength and normal bone histology. Calcium levels were transiently decreased and parathyroid hormone levels transiently increased in ovariectomised monkeys treated with denosumab.

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

Knockout mice (see section 4.6) lacking RANK or RANKL exhibited decreased body weight, reduced bone growth and lack of tooth eruption. In neonatal rats, inhibition of RANKL (target of denosumab therapy) with high doses of a construct of osteoprotegerin bound to Fc (OPG-Fc) was associated with inhibition of bone growth and tooth eruption. These changes were partially reversible in this model when dosing with RANKL inhibitors was discontinued. Adolescent primates dosed with denosumab at 27 and 150 times (10 and 50 mg/kg dose) the clinical exposure had abnormal growth plates. Therefore, treatment with denosumab may impair bone growth in children with open growth plates and may inhibit eruption of dentition.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Acetic acid*

Sodium acetate trihydrate (for pH adjustment)*

Sorbitol (E420)

Polysorbate 20 (E432)

Water for injections

* Acetate buffer is formed by mixing acetic acid with sodium acetate trihydrate

6.2 Incompatibilities

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

6.3 Shelf life

4 years.

Once removed from the refrigerator, Stoboclo may be stored at room temperature (up to 25°C) for up to 30 days in the original carton. It must be used within this 1-month period.

6.4 Special precautions for storage

Store in a refrigerator (2°C – 8°C).

Do not freeze.

Keep the pre-filled syringe in the outer carton in order to protect from light.

6.5 Nature and contents of container

One mL solution in a single use pre-filled syringe made of type I borosilicate glass, (bromobutyl) rubber stopper and stainless steel 27 gauge needle with safety guard.

Pack size of one pre-filled syringe with safety guard.

6.6 Special precautions for disposal and other handling

- Before administration, the solution should be inspected. Do not inject the solution if it contains visible particles or is cloudy or discoloured.
- Do not shake.
- To avoid discomfort at the site of injection, allow the pre-filled syringe to reach room temperature (up to 25°C) before injecting and inject slowly.
- Inject the entire contents of the pre-filled syringe.
- Comprehensive instructions for the preparation and administration of Stoboclo are included in the pack.

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

7. MARKETING AUTHORISATION HOLDER

Celltrion Healthcare Hungary Kft.
1062 Budapest
Váci út 1-3. WestEnd Office Building B torony
Hungary

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/24/1905/001

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 14 February 2025

10. DATE OF REVISION OF THE TEXT

Detailed information on this medicinal product is available on the website of the European Medicines Agency <https://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 manufacturer of the biological active substance

CELLTRION, Inc.
20, Academy-ro 51 beon-gil,
Yeonsu-gu, Incheon, 22014
Republic of Korea

Name and address of the manufacturers responsible for batch release

Nuvisan France S.A.R.L
2400 Route des Colles,
Biot, 06410
France

Midas Pharma GmbH
Rheinstrasse 49, West,
Ingelheim Am Rhein,
Rhineland-Palatinate, 55218
Germany

Kymos S.L.
Ronda de Can Fatjó, 7B
Parc Tecnològic del Vallès,
Cerdanyola del Vallès,
Barcelona, 08290
Spain

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 medical prescription.

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

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

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

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

- **Risk management plan (RMP)**

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

An updated RMP should be submitted:

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

The MAH shall ensure that a patient reminder card regarding osteonecrosis of the jaw is implemented.

ANNEX III

LABELLING AND PACKAGE LEAFLET

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

OUTER CARTON FOR PRE-FILLED SYRINGE WITH SAFETY GUARD

1. NAME OF THE MEDICINAL PRODUCT

Stoboclo 60 mg solution for injection in pre-filled syringe
denosumab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

1 mL pre-filled syringe containing 60 mg of denosumab (60 mg/mL).

3. LIST OF EXCIPIENTS

Excipients: Acetic acid, sodium acetate trihydrate, sorbitol (E420), polysorbate 20 (E432), water for injections.

See package leaflet for further information.

4. PHARMACEUTICAL FORM AND CONTENTS

Solution for injection

1 pre-filled syringe with safety guard.

60 mg/1 mL

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Subcutaneous use.

Important: read the package leaflet before handling pre-filled syringe.

Do not shake.

Read the package leaflet before use.

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

Keep out of the sight and reach of children.

7. OTHER SPECIAL WARNING(S), IF NECESSARY

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

Store in a refrigerator.

Do not freeze.

Keep the pre-filled syringe in the outer carton in order to protect from light.

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

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

Celltrion Healthcare Hungary Kft.
1062 Budapest
Váci út 1-3. WestEnd Office Building B torony
Hungary

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/24/1905/001 1 pre-filled syringe

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Stoboclo 60 mg

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

PC
SN
NN

MINIMUM PARTICULARS TO APPEAR ON SMALL IMMEDIATE PACKAGING UNITS LABEL FOR PRE-FILLED SYRINGE WITH SAFETY GUARD
--

1. NAME OF THE MEDICINAL PRODUCT AND ROUTE(S) OF ADMINISTRATION
--

Stoboclo 60 mg injection
denosumab
SC

2. METHOD OF ADMINISTRATION

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT
--

60 mg/1 mL

6. OTHER

REMINDER CARD TEXT (included in pack)
--

Stoboclo 60 mg injection
denosumab

SC

Next injection in 6 months:

Use Stoboclo for as long as your doctor prescribes it for you.

Celltrion Healthcare Hungary Kft.

B. PACKAGE LEAFLET

Package leaflet: Information for the user

Stoboclo 60 mg solution for injection in pre-filled syringe denosumab

▼ 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 start using this medicine because it contains important information for you.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.
- Your doctor will give you a patient reminder card, which contains important safety information you need to be aware of before and during your treatment with Stoboclo.

What is in this leaflet

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

1. What Stoboclo is and what it is used for

What Stoboclo is and how it works

Stoboclo contains denosumab, a protein (monoclonal antibody) that interferes with the action of another protein, in order to treat bone loss and osteoporosis. Treatment with Stoboclo makes bone stronger and less likely to break.

Bone is a living tissue and is renewed all the time. Oestrogen helps keep bones healthy. After the menopause, oestrogen level drops which may cause bones to become thin and fragile. This can eventually lead to a condition called osteoporosis. Osteoporosis can also occur in men due to a number of causes including ageing and/or a low level of the male hormone, testosterone. It can also occur in patients receiving glucocorticoids. Many patients with osteoporosis have no symptoms, but they are still at risk of breaking bones, especially in the spine, hips and wrists.

Surgery or medicines that stop the production of oestrogen or testosterone used to treat patients with breast or prostate cancer can also lead to bone loss. The bones become weaker and break more easily.

What Stoboclo is used for

Stoboclo is used to treat:

- osteoporosis in women after the menopause (postmenopausal) and men who have an increased risk of fracture (broken bones), reducing the risk of spinal, non-spinal and hip fractures.
- bone loss that results from a reduction in hormone (testosterone) level caused by surgery or treatment with medicines in patients with prostate cancer.
- bone loss that results from long-term treatment with glucocorticoids in patients who have an increased risk of fracture.

2. What you need to know before you use Stoboclo

Do not use Stoboclo

- if you have low calcium levels in the blood (hypocalcaemia).
- if you are allergic to denosumab or any of the other ingredients of this medicine (listed in section 6).

Warnings and precautions

Talk to your doctor or pharmacist before using Stoboclo.

Whilst being treated with Stoboclo you may develop a skin infection with symptoms such as a swollen, red area of skin, most commonly in the lower leg, that feels hot and tender (cellulitis), and possibly with symptoms of fever. Please tell your doctor immediately if you develop any of these symptoms.

You should also take calcium and vitamin D supplements while being on treatment with Stoboclo. Your doctor will discuss this with you.

You may have low levels of calcium in your blood while receiving Stoboclo. Please tell your doctor immediately if you notice any of the following symptoms: spasms, twitches, or cramps in your muscle, and/or numbness or tingling in your fingers, toes or around your mouth, and/or seizures, confusion, or loss of consciousness.

Severe low blood calcium levels leading to hospitalisation and even life-threatening reactions have been reported in rare cases. Before each dose and in patients predisposed to hypocalcaemia within two weeks after initial dose, the calcium levels in your blood will therefore be checked (via blood test).

Tell your doctor if you have or have ever had severe kidney problems, kidney failure or have needed dialysis or are taking medicines called glucocorticoids (such as prednisolone or dexamethasone), which may increase your risk of getting low blood calcium if you do not take calcium supplements.

Problems with your mouth, teeth or jaw

A side effect called osteonecrosis of the jaw (ONJ) (bone damage in the jaw) has been reported rarely (may affect up to 1 in 1,000 people) in patients receiving denosumab for osteoporosis. The risk of ONJ increases in patients treated for a long time (may affect up to 1 in 200 people if treated for 10 years). ONJ can also occur after stopping treatment. It is important to try to prevent ONJ developing as it may be a painful condition that can be difficult to treat. In order to reduce the risk of developing ONJ, take the following precautions:

Before receiving treatment, tell your doctor or nurse (health care professional) if you:

- have any problems with your mouth or teeth such as poor dental health, gum disease, or a planned tooth extraction.
- don't receive routine dental care or have not had a dental check-up for a long time.
- are a smoker (as this may increase the risk of dental problems).
- have previously been treated with a bisphosphonate (used to treat or prevent bone disorders).
- are taking medicines called corticosteroids (such as prednisolone or dexamethasone).
- have cancer.

Your doctor may ask you to undergo a dental examination before you start treatment with Stoboclo.

While being treated, you should maintain good oral hygiene and receive routine dental check-ups. If you wear dentures you should make sure these fit properly. If you are under dental treatment or will undergo dental surgery (e.g. tooth extractions), inform your doctor about your dental treatment and tell your dentist that you are being treated with Stoboclo.

Contact your doctor and dentist immediately if you experience any problems with your mouth or teeth such as loose teeth, pain or swelling, or non-healing of sores or discharge, as these could be signs of ONJ.

Unusual thigh bone fractures

Some people have developed unusual fractures in their thigh bone while being treated with denosumab. Contact your doctor if you experience new or unusual pain in your hip, groin, or thigh.

Children and adolescents

Stoboclo should not be used in children and adolescents under 18 years of age.

Other medicines and Stoboclo

Tell your doctor or pharmacist if you are taking, have recently taken or might take any other medicines. It is especially important that you tell your doctor if you are being treated with another medicine containing denosumab.

You should not take Stoboclo together with another medicine containing denosumab.

Pregnancy and breast-feeding

Stoboclo has not been tested in pregnant women. It is important to tell your doctor if you are pregnant; think you may be pregnant; or plan to get pregnant. Stoboclo is not recommended for use if you are pregnant. Women of child-bearing potential should use effective methods of contraception while being treated with Stoboclo and for at least 5 months after stopping treatment with Stoboclo.

If you become pregnant during treatment with Stoboclo or less than 5 months after stopping treatment with Stoboclo, please inform your doctor.

It is not known whether denosumab is excreted in breast milk. It is important to tell your doctor if you are breast-feeding or plan to do so. Your doctor will then help you decide whether to stop breast-feeding, or whether to stop taking Stoboclo, considering the benefit of breast-feeding to the baby and the benefit of Stoboclo to the mother.

If you are breast-feeding during Stoboclo treatment, please inform your doctor.

Ask your doctor or pharmacist for advice before taking any medicine.

Driving and using machines

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

Stoboclo contains sorbitol (E420)

This medicine contains 47 mg sorbitol in each mL of solution.

Stoboclo contains sodium

This medicine contains less than 1 mmol sodium (23 mg) per 60 mg, that is to say essentially 'sodium-free'.

Stoboclo contains polysorbate 20 (E432)

This medicine contains 0.1 mg of polysorbate 20 in each syringe which is equivalent to 0.1 mg/mL. Polysorbates may cause allergic reactions. Tell your doctor if you have any known allergies.

3. How to use Stoboclo

The recommended dose is one pre-filled syringe of 60 mg administered once every 6 months, as a single injection under the skin (subcutaneous). The best places to inject are the top of your thighs and the abdomen. Your carer can also use the outer area of your upper arm. Please consult your doctor on the date for a potential next injection. Each pack of Stoboclo contains a reminder card included in the carton and used to keep a record of the next injection date.

You should also take calcium and vitamin D supplements while being on treatment with Stoboclo. Your doctor will discuss this with you.

Your doctor may decide that it is best for you or a carer to inject Stoboclo. Your doctor or healthcare provider will show you or your carer how to use Stoboclo. For instructions on how to inject Stoboclo, please read the section at the end of this leaflet.

Do not shake.

If you forget to use Stoboclo

If a dose of Stoboclo is missed, the injection should be administered as soon as possible. Thereafter, injections should be scheduled every 6 months from the date of the last injection.

If you stop using Stoboclo

To get the most benefit from your treatment in reducing the risk of fractures, it is important to use Stoboclo for as long as your doctor prescribes it for you. Do not stop your treatment without contacting your doctor.

4. Possible side effects

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

Uncommonly, patients receiving Stoboclo may develop skin infections (predominantly cellulitis).

Please tell your doctor immediately if you develop any of these symptoms while being on treatment with Stoboclo: swollen, red area of skin, most commonly in the lower leg, that feels hot and tender, and possibly with symptoms of fever.

Rarely, patients receiving Stoboclo may develop pain in the mouth and/or jaw, swelling or non-healing of sores in the mouth or jaw, discharge, numbness or a feeling of heaviness in the jaw, or loosening of a tooth. These could be signs of bone damage in the jaw (osteonecrosis). **Tell your doctor and dentist immediately** if you experience such symptoms while being treated with Stoboclo or after stopping treatment.

Rarely, patients receiving Stoboclo may have low calcium levels in the blood (hypocalcaemia); severely low blood calcium levels may lead to hospitalisation and may even be life-threatening. Symptoms include spasms, twitches, or cramps in your muscles, and/or numbness or tingling in your fingers, toes or around your mouth and/or seizures, confusion, or loss of consciousness. If any of these apply to you, **tell your doctor immediately**. Low calcium in the blood may also lead to a change in heart rhythm called QT prolongation which is seen by electrocardiogram (ECG).

Rarely unusual fractures of the thigh bone may occur in patients receiving Stoboclo. **Contact your doctor** if you experience new or unusual pain in your hip, groin or thigh as this may be an early indication of a possible fracture of the thigh bone.

Rarely, allergic reactions may occur in patients receiving Stoboclo. Symptoms include swelling of the face, lips, tongue, throat or other parts of the body; rash, itching or hives on the skin, wheezing or

difficulty breathing. **Please tell your doctor** if you develop any of these symptoms while being treated with Stoboclo.

Very common side effects (may affect more than 1 in 10 people):

- bone, joint, and/or muscle pain which is sometimes severe,
- arm or leg pain (pain in extremity).

Common side effects (may affect up to 1 in 10 people):

- painful urination, frequent urination, blood in the urine, inability to hold your urine,
- upper respiratory tract infection,
- pain, tingling or numbness that moves down your leg (sciatica),
- constipation,
- abdominal discomfort,
- rash,
- skin condition with itching, redness and/or dryness (eczema),
- hair loss (alopecia).

Uncommon side effects (may affect up to 1 in 100 people):

- fever, vomiting and abdominal pain or discomfort (diverticulitis),
- ear infection,
- rash that may occur on the skin or sores in the mouth (lichenoid drug eruptions).

Very rare side effects (may affect up to 1 in 10 000 people):

- allergic reaction that can damage blood vessels mainly in the skin (e.g. purple or brownish-red spots, hives or skin sores) (hypersensitivity vasculitis).

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

- talk to your doctor if you have ear pain, discharge from the ear and/or an ear infection. These could be signs of bone damage in the ear.

Reporting of side effects

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

5. How to store Stoboclo

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 label and carton after EXP. The expiry date refers to the last day of that month.

Store in a refrigerator (2°C – 8°C).

Do not freeze.

Keep the pre-filled syringe in the outer carton in order to protect from light.

Your pre-filled syringe may be left outside the refrigerator to reach room temperature (up to 25°C) before injection. This will make the injection more comfortable. Once your syringe has been left to reach room temperature (up to 25°C), it must be used within 1-month period.

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

6. Contents of the pack and other information

What Stoboclo contains

- The active substance is denosumab. Each 1 mL pre-filled syringe contains 60 mg of denosumab (60 mg/mL).
- The other ingredients are acetic acid, sodium acetate trihydrate, sorbitol (E420), polysorbate 20 (E432) and water for injections.

What Stoboclo looks like and contents of the pack

Stoboclo is a clear, colourless to pale yellow solution for injection provided in a ready to use pre-filled syringe.

Each pack contains one pre-filled syringe with safety guard.

Marketing Authorisation Holder

Celltrion Healthcare Hungary Kft.
1062 Budapest
Váci út 1-3. WestEnd Office Building B torony
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Nuvisan France S.A.R.L
2400 Route des Colles,
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Manufacturer

Midas Pharma GmbH
Rheinstrasse 49, West,
Ingelheim Am Rhein,
Rhineland-Palatinate, 55218
Germany

Manufacturer

Kymos S.L.
Ronda de Can Fatjó, 7B
Parc Tecnològic del Vallès,
Cerdanyola del Vallès,
Barcelona, 08290
Spain

For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:

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Other sources of information

Detailed information on this medicine is available on the European Medicines Agency web site:

<https://www.ema.europa.eu>.

Instructions for use:

Read and follow the Instructions for use that come with your Stoboclo pre-filled syringe before you start using it and each time you get a refill. There may be new information. Stoboclo may be administered by healthcare professionals (HCPs), caregivers or may be self-administered by the patients if they have received training. Talk to your doctor if you have any questions about giving yourself an injection.

Important Information

- Stoboclo is given as an injection into the tissue just under the skin (subcutaneous injection).
- **Do not** open the sealed carton until you are ready to use the pre-filled syringe.
- **Do not** remove the needle cap from the pre-filled syringe until just before you give the injection.
- **Do not** attempt to activate the pre-filled syringe prior to injection.
- **Do not** attempt to remove the clear safety guard from the pre-filled syringe.
- **Do not** use the pre-filled syringe if it has been dropped on a hard surface. Use a new pre-filled syringe.
- **Do not** shake the pre-filled syringe. Strong shaking may damage the medicine.
- The pre-filled syringe cannot be re-used. Dispose of the used pre-filled syringe immediately after use in a sharps disposal container (see **Step 15. Dispose of Stoboclo**).

Storing Stoboclo

- **Keep the pre-filled syringe out of the sight and reach of children. Contains small parts.**
- Store the pre-filled syringe in a refrigerator between 2 °C and 8 °C. **Do not** freeze.
- Once removed from the refrigerator, Stoboclo must not be exposed to temperatures above 25 °C. Stoboclo must be stored in its original carton and used within 30 days. If not used within the 1-month period, Stoboclo should be discarded.
- Store the pre-filled syringe sealed inside its carton to protect it from light.

Parts of the pre-filled syringe (see Figure A)

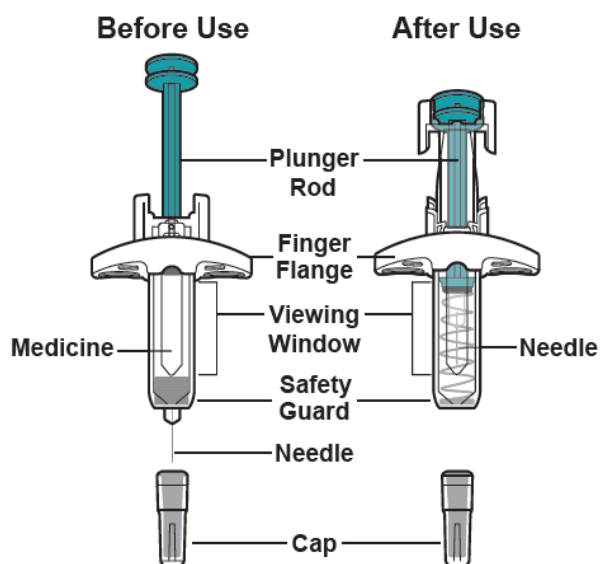


Figure A

Preparing for the Injection

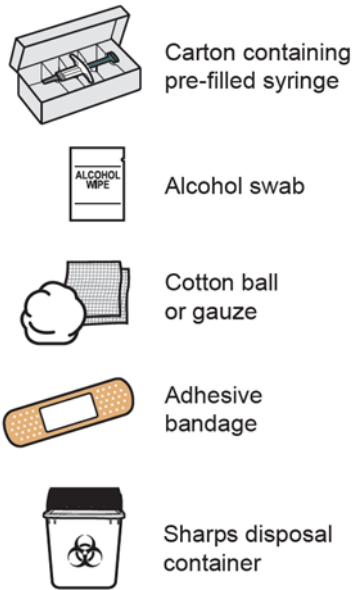


Figure B

1. Gather the supplies for the injection.

1a. Prepare a clean, flat surface, such as a table or counter top, in a well-lit area.

1b. Take the carton containing the pre-filled syringe out of the refrigerator.

1c. Make sure you have the following supplies (see **Figure B**):

- Carton containing pre-filled syringe

Not included in the carton:

- Alcohol swab
- Cotton ball or gauze
- Adhesive bandage
- Sharps disposal container

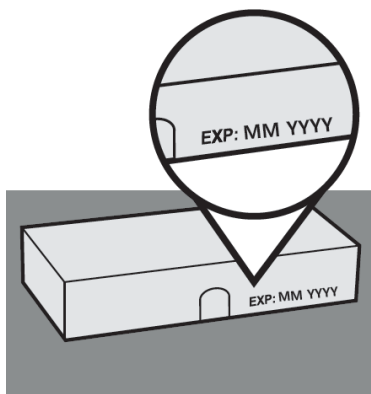


Figure C

2. Check the expiration date on the carton (see Figure C).

- **Do not** use it if the expiration date has passed. If the expiration date has passed, return the entire carton to the pharmacy.
- The printed expiration date refers to the last day of the month.

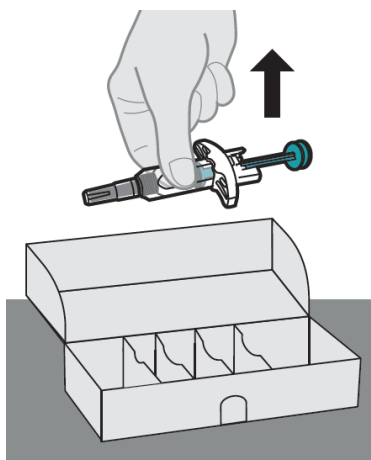


Figure D

3. Remove the pre-filled syringe from the carton.

3a. Open the carton. Gripping the syringe body, lift the pre-filled syringe from the carton (see **Figure D**).

- **Do not** hold by the head of the plunger rod, plunger rod, safety guard, wings, or needle cap.
- **Do not** pull back on the plunger rod at any time.

Preparing for the Injection

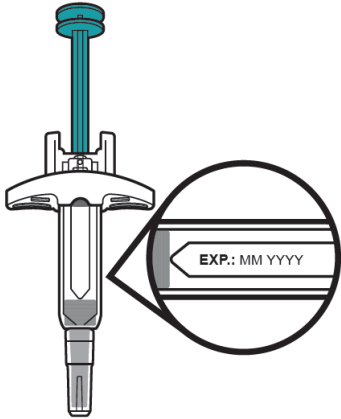


Figure E

4. Inspect the pre-filled syringe.

4a. Look at the pre-filled syringe and make sure you have the correct medicine (Stoboclo).

4b. Look at the pre-filled syringe and make sure it is not cracked or damaged.

4c. Check the expiration date on the label of the pre-filled syringe (see **Figure E**).

- **Do not** use if the needle cap is missing or not securely attached.
- **Do not** use if the expiration date has passed.
- **Do not** shake the pre-filled syringe.

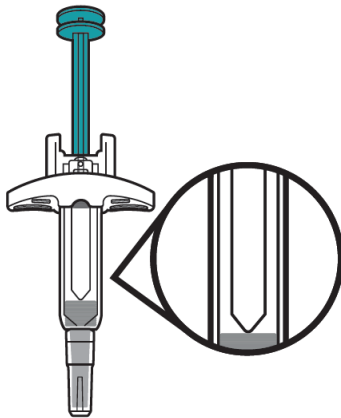


Figure F

5. Inspect the medicine.

5a. Look at the medicine and confirm that the liquid is clear, colourless to pale yellow, and does not contain any visible particles or flakes in it (see **Figure F**).

- **Do not** use the pre-filled syringe if the liquid is discoloured, cloudy, or has any visible particles or flakes in it.
- You may see air bubbles in the liquid. This is normal.

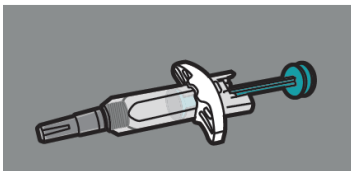


Figure G

6. Wait 30 minutes.

6a. Let the pre-filled syringe stand outside the box for 30 minutes at room temperature (20 °C to 25 °C) to allow it to warm up (see **Figure G**).

- **Do not** warm the pre-filled syringe using heat sources such as hot water or a microwave.
- If the syringe does not reach room temperature, this could cause the injection to feel uncomfortable.

Preparing for the Injection

■ = Caregiver and HCP ONLY

□ = Self-injection and Caregiver

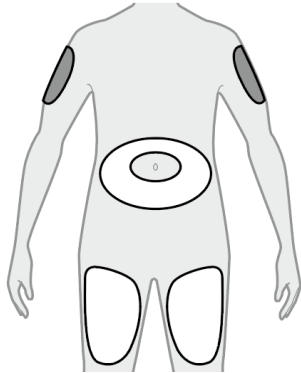


Figure H

7. Choose an appropriate injection site (see Figure H).

7a. You may inject into:

- the upper thighs.
- the abdomen, except for the 5 cm around the belly button (navel).
- the outer area of the upper arms (only if you are a caregiver or HCP).

- **Do not** inject into moles, scars, bruises, or areas where the skin is tender, red, hard, or if there are cracks in the skin.

- **Do not** inject through clothing.

7b. Choose a different injection site for each new injection at least 2.5 cm away from the area used for the last injection.

8. Wash your hands.

8a. Wash your hands with soap and water and dry them thoroughly (see Figure I).

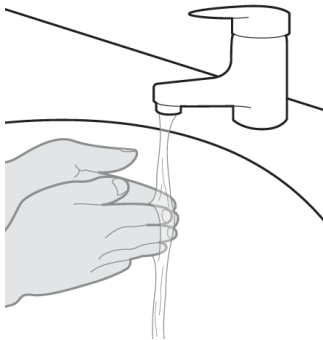


Figure I

9. Clean the injection site.

9a. Clean the injection site with an alcohol swab using a circular motion (see Figure J).

9b. Let the skin dry before injecting.

- **Do not** blow on or touch the injection site again before giving the injection.



Figure J

Administering the Injection

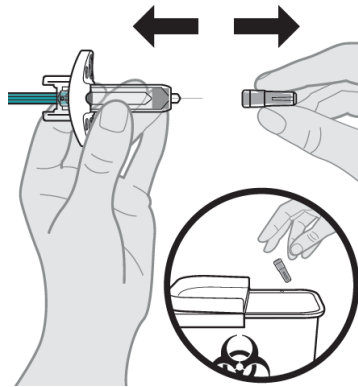


Figure K

10. Remove the cap.

10a. Hold the body of the pre-filled syringe in one hand between the thumb and index finger. With the other hand, carefully pull the needle cap straight off (see **Figure K**).

- **Do not** hold the plunger rod while removing the cap.
- You may notice a drop of liquid at the tip of needle. This is normal.

10b. Dispose of the cap right away in a sharps disposal container (see **Step 15** and **Figure K**).

- **Do not** use the pre-filled syringe if it is dropped without the needle cap in place. If this happens, use a new pre-filled syringe.
- Remove the needle cap only when you are ready to inject.
- **Do not** re-cap the pre-filled syringe.
- **Do not** touch the needle. Doing so may result in a needle stick injury.

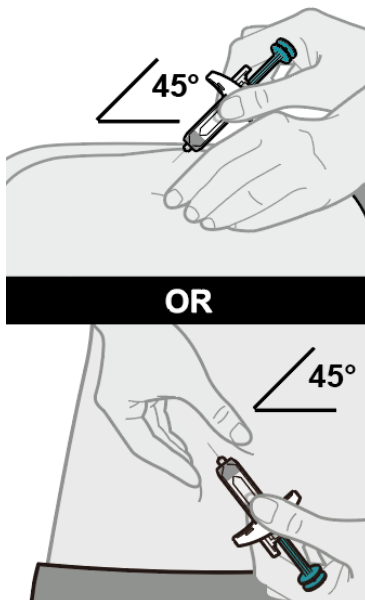


Figure L

11. Insert the pre-filled syringe into the injection site.

11a. Hold the body of the pre-filled syringe in one hand between the thumb and index finger.

11b. Use the other hand to gently pinch the cleaned skin between your thumb and index finger. **Do not** squeeze it tightly.

Note: It is important to keep the skin pinched when inserting the needle to make sure that you inject under the skin (into the fatty area) but not any deeper (into muscle).

11c. With a quick and “dart-like” motion, insert the needle completely into the fold of skin at a 45-degree angle (see **Figure L**).

- **Do not** pull back on the plunger rod at any time.

12. Give the injection.

12a. After the needle is inserted, release the pinched skin.

12b. Slowly push the plunger rod **all the way down** until the full dose of medicine gets injected, and the syringe is empty (see **Figure M**).

- **Do not** change the position of the pre-filled syringe after the injection has started.
- If the plunger rod is not fully pressed, the safety guard will not extend to cover the needle when it is removed.

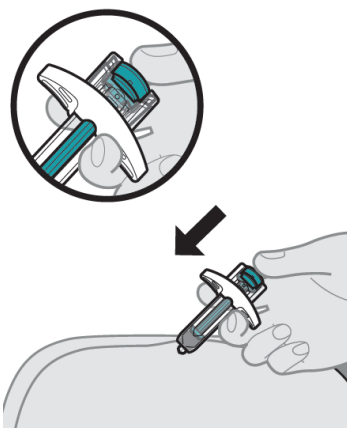


Figure M

Administering the Injection

13. Remove the pre-filled syringe from the injection site.

13a. After the pre-filled syringe is empty, as the needle is being taken out, slowly remove the needle by lifting your thumb from the plunger rod until the needle is completely covered by the safety guard (see **Figure N**).

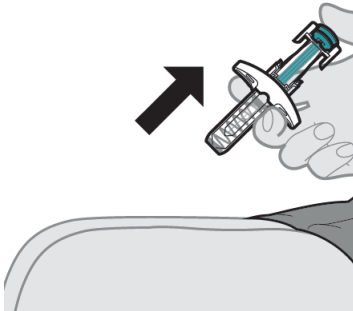


Figure N

- If the needle is not covered, proceed to carefully dispose of the syringe (see **Step 15. Dispose of Stoboclo**).
- **Do not** put the needle cap back on used pre-filled syringes.
- **Do not** reuse the pre-filled syringe.
- **Do not** rub the injection site.

After the Injection

14. Care for the injection site.

14a. If some bleeding occurs, treat the injection site by gently pressing, not rubbing, a cotton ball or gauze to the site and apply an adhesive bandage if needed.

15. Dispose of the pre-filled syringe.

15a. Put the used pre-filled syringe in a sharps disposal container right away after use (see **Figure O**).

15b. **Do not** throw away (dispose of) the pre-filled syringe in your household trash.

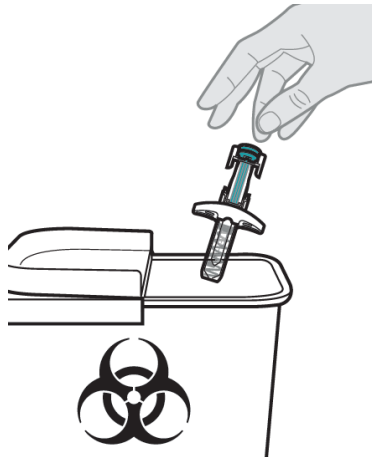


Figure O

- Keep the syringe and sharps disposal container out of the sight and reach of children.
- If you do not have a sharps disposal container, you may use a household container that is closable and puncture resistant.
- For the safety and health of you and others, needles and used syringes must never be re-used. Any unused medicinal product or waste material should be disposed of in accordance with local requirements.
- **Do not** throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.