

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

WEZENLA 130 mg concentrate for solution for infusion

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each vial contains 130 mg ustekinumab in 26 mL (5 mg/mL).

Ustekinumab is a fully human IgG1κ monoclonal antibody to interleukin (IL)-12/23 produced in a Chinese hamster ovary cell line using recombinant DNA technology.

Excipient with known effect

This medicinal product contains 10.4 mg of polysorbate 80 (E 433) in each dosage unit.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Concentrate for solution for infusion.

The solution is clear to opalescent, colourless to light yellow. The solution has a pH of approximately 6.0 and an osmolality of approximately 280 mOsm/kg.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Adult Crohn's disease

WEZENLA is indicated for the treatment of adult patients with moderately to severely active Crohn's disease who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a TNF α antagonist.

Paediatric Crohn's disease

WEZENLA is indicated for the treatment of moderately to severely active Crohn's disease in paediatric patients weighing at least 40 kg, who have had an inadequate response to, or were intolerant to either conventional or biologic therapy.

4.2 Posology and method of administration

WEZENLA concentrate for solution for infusion is intended for use under the guidance and supervision of physicians experienced in the diagnosis and treatment of Crohn's disease. WEZENLA concentrate for solution for infusion should only be used for the intravenous induction dose.

Posology

Adults

Crohn's disease

WEZENLA treatment is to be initiated with a single intravenous dose based on body weight. The infusion solution is to be composed of the number of vials of WEZENLA 130 mg as specified in table 1 (see section 6.6 for preparation).

Table 1. Initial intravenous dosing of WEZENLA

| Body weight of patient at the time of dosing | Recommended dose^a | Number of 130 mg WEZENLA vials |
|---|-------------------------------------|---------------------------------------|
| ≤ 55 kg | 260 mg | 2 |
| > 55 kg to ≤ 85 kg | 390 mg | 3 |
| > 85 kg | 520 mg | 4 |

^a Approximately 6 mg/kg

The first subcutaneous dose should be given at week 8 following the intravenous dose. For the posology of the subsequent subcutaneous dosing regimen, see section 4.2 of the WEZENLA solution for injection (vial) and solution for injection in pre-filled syringe SmPC or pre-filled pen SmPC.

Elderly (≥ 65 years)

No dose adjustment is needed for elderly patients (see section 4.4).

Renal and hepatic impairment

Ustekinumab has not been studied in these patient populations. No dose recommendations can be made.

Paediatric population

Paediatric Crohn's disease (patients weighing at least 40 kg)

WEZENLA treatment is to be initiated with a single intravenous dose based on body weight. The infusion solution is to be composed of the number of vials of WEZENLA 130 mg as specified in table 2 (see section 6.6 for preparation).

Table 2. Initial intravenous dosing of WEZENLA

| Body weight of patient at the time of dosing | Recommended dose^a | Number of 130 mg WEZENLA vials |
|---|-------------------------------------|---------------------------------------|
| ≥ 40 kg to ≤ 55 kg | 260 mg | 2 |
| > 55 kg to ≤ 85 kg | 390 mg | 3 |
| > 85 kg | 520 mg | 4 |

^a Approximately 6 mg/kg

The first subcutaneous dose should be given at week 8 following the intravenous dose. For the posology of the subsequent subcutaneous dosing regimen, see section 4.2 of the WEZENLA solution for injection (vial) and solution for injection in pre-filled syringe SmPC.

The safety and efficacy of ustekinumab for the treatment of Crohn's disease in paediatric patients weighing less than 40 kg have not yet been established. No data are available.

Method of administration

WEZENLA 130 mg is for intravenous use only. It should be administered over at least one hour. For instructions on dilution of the medicinal product before administration, see section 6.6.

4.3 Contraindications

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

Clinically important, active infection (e.g. active tuberculosis; see section 4.4).

4.4 Special warnings and precautions for use

Traceability

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

Infections

Ustekinumab may have the potential to increase the risk of infections and reactivate latent infections. In clinical studies and a post-marketing observational study in patients with psoriasis, serious bacterial, fungal, and viral infections have been observed in patients receiving ustekinumab (see section 4.8).

Opportunistic infections including reactivation of tuberculosis, other opportunistic bacterial infections (including atypical mycobacterial infection, listeria meningitis, pneumonia legionella, and nocardiosis), opportunistic fungal infections, opportunistic viral infections (including encephalitis caused by herpes simplex 2), and parasitic infections (including ocular toxoplasmosis) have been reported in patients treated with ustekinumab.

Caution should be exercised when considering the use of WEZENLA in patients with a chronic infection or a history of recurrent infection (see section 4.3).

Prior to initiating treatment with WEZENLA, patients should be evaluated for tuberculosis infection. WEZENLA must not be given to patients with active tuberculosis (see section 4.3). Treatment of latent tuberculosis infection should be initiated prior to administering WEZENLA. Anti-tuberculosis therapy should also be considered prior to initiation of WEZENLA in patients with a history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed. Patients receiving WEZENLA should be monitored closely for signs and symptoms of active tuberculosis during and after treatment.

Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and WEZENLA should not be administered until the infection resolves.

Malignancies

Immunosuppressants like ustekinumab have the potential to increase the risk of malignancy. Some patients who received ustekinumab in clinical studies and in a post-marketing observational study in patients with psoriasis developed cutaneous and non-cutaneous malignancies (see section 4.8). The risk of malignancy may be higher in psoriasis patients who have been treated with other biologics during the course of their disease.

No studies have been conducted that include patients with a history of malignancy or that continue treatment in patients who develop malignancy while receiving ustekinumab. Thus, caution should be exercised when considering the use of ustekinumab in these patients.

All patients, in particular those greater than 60 years of age, patients with a medical history of prolonged immunosuppressant therapy or those with a history of PUVA treatment, should be monitored for the appearance of skin cancer (see section 4.8).

Systemic and respiratory hypersensitivity reactions

Systemic

Serious hypersensitivity reactions have been reported in the post-marketing setting, in some cases several days after treatment. Anaphylaxis and angioedema have occurred. If an anaphylactic or other serious hypersensitivity reaction occurs, appropriate therapy should be instituted and administration of WEZENLA should be discontinued (see section 4.8).

Infusion-related reactions

Infusion-related reactions were observed in clinical trials (see section 4.8). Serious infusion-related reactions including anaphylactic reactions to the infusion have been reported in the post-marketing setting. If a serious or life-threatening reaction is observed, appropriate therapy should be instituted and ustekinumab should be discontinued.

Respiratory

Cases of allergic alveolitis, eosinophilic pneumonia, and non-infectious organising pneumonia have been reported during post-approval use of ustekinumab. Clinical presentations included cough, dyspnoea, and interstitial infiltrates following one to three doses. Serious outcomes have included respiratory failure and prolonged hospitalisation. Improvement has been reported after discontinuation of ustekinumab and also, in some cases, administration of corticosteroids. If infection has been excluded and diagnosis is confirmed, discontinue ustekinumab and institute appropriate treatment (see section 4.8).

Cardiovascular events

Cardiovascular events including myocardial infarction and cerebrovascular accident have been observed in patients with psoriasis exposed to ustekinumab in a post-marketing observational study. Risk factors for cardiovascular disease should be regularly assessed during treatment with WEZENLA.

Vaccinations

It is recommended that live viral or live bacterial vaccines (such as Bacillus of Calmette and Guérin (BCG)) should not be given concurrently with WEZENLA. Specific studies have not been conducted in patients who had recently received live viral or live bacterial vaccines. No data are available on the secondary transmission of infection by live vaccines in patients receiving ustekinumab. Before live viral or live bacterial vaccination, treatment with WEZENLA should be withheld for at least 15 weeks after the last dose and can be resumed at least 2 weeks after vaccination. Prescribers should consult the Summary of Product Characteristics for the specific vaccine for additional information and guidance on concomitant use of immunosuppressive agents post-vaccination.

Administration of live vaccines (such as the BCG vaccine) to infants exposed *in utero* to ustekinumab is not recommended for twelve months following birth or until ustekinumab infant serum levels are undetectable (see sections 4.5 and 4.6). If there is a clear clinical benefit for the individual infant, administration of a live vaccine might be considered at an earlier timepoint, if infant ustekinumab serum levels are undetectable.

Patients receiving WEZENLA may receive concurrent inactivated or non-live vaccinations.

Long term treatment with WEZENLA does not suppress the humoral immune response to pneumococcal polysaccharide or tetanus vaccines (see section 5.1).

Concomitant immunosuppressive therapy

In psoriasis studies, the safety and efficacy of ustekinumab in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. In psoriatic arthritis studies, concomitant MTX use did not appear to influence the safety or efficacy of ustekinumab. In Crohn's disease and ulcerative colitis studies, concomitant use of immunosuppressants or corticosteroids did not appear to influence the safety or efficacy of ustekinumab. Caution should be exercised when considering concomitant use of other immunosuppressants and WEZENLA or when transitioning from other immunosuppressive biologics (see section 4.5).

Immunotherapy

Ustekinumab has not been evaluated in patients who have undergone allergy immunotherapy. It is not known whether WEZENLA may affect allergy immunotherapy.

Serious skin conditions

In patients with psoriasis, exfoliative dermatitis has been reported following ustekinumab treatment (see section 4.8). Patients with plaque psoriasis may develop erythrodermic psoriasis, with symptoms that may be clinically indistinguishable from exfoliative dermatitis, as part of the natural course of their disease. As part of the monitoring of the patient's psoriasis, physicians should be alert for symptoms of erythrodermic psoriasis or exfoliative dermatitis. If these symptoms occur, appropriate therapy should be instituted. WEZENLA should be discontinued if a drug reaction is suspected.

Lupus-related conditions

Cases of lupus-related conditions have been reported in patients treated with ustekinumab, including cutaneous lupus erythematosus and lupus-like syndrome. If lesions occur, especially in sun exposed areas of the skin or if accompanied by arthralgia, the patient should seek medical attention promptly. If the diagnosis of a lupus-related condition is confirmed, ustekinumab should be discontinued and appropriate treatment initiated.

Special populations

Elderly (≥ 65 years)

No overall differences in efficacy or safety in patients aged 65 and older who received ustekinumab were observed compared to younger patients in clinical studies in approved indications, however the number of patients aged 65 and older is not sufficient to determine whether they respond differently from younger patients. Because there is a higher incidence of infections in the elderly population in general, caution should be used in treating the elderly.

Sodium content

WEZENLA contains less than 1 mmol sodium (23 mg) per dose, i.e. essentially 'sodium-free'. WEZENLA is however, diluted in sodium chloride 9 mg/mL (0.9%) solution for infusion. This should be taken into consideration for patients on a controlled sodium diet (see section 6.6).

Polysorbate 80

WEZENLA contains 10.4 mg of polysorbate 80 (E 433) in each dosage unit which is equivalent to 0.40 mg/mL. Polysorbates may cause allergic reactions.

4.5 Interaction with other medicinal products and other forms of interaction

Live vaccines should not be given concurrently with WEZENLA.

Administration of live vaccines (such as the BCG vaccine) to infants exposed *in utero* to ustekinumab is not recommended for twelve months following birth or until ustekinumab infant serum levels are undetectable (see sections 4.4 and 4.6). If there is a clear clinical benefit for the individual infant, administration of a live vaccine might be considered at an earlier timepoint, if infant ustekinumab serum levels are undetectable.

In the population pharmacokinetic analyses of the phase 3 studies, the effect of the most frequently used concomitant medicinal products in patients with psoriasis (including paracetamol, ibuprofen, acetylsalicylic acid, metformin, atorvastatin, levothyroxine) on pharmacokinetics of ustekinumab was explored. There were no indications of an interaction with these concomitantly administered medicinal products. The basis for this analysis was that at least 100 patients (> 5% of the studied population) were treated concomitantly with these medicinal products for at least 90% of the study period. The pharmacokinetics of ustekinumab was not impacted by concomitant use of MTX, NSAIDs, 6-mercaptopurine, azathioprine and oral corticosteroids in patients with psoriatic arthritis, Crohn's disease or ulcerative colitis, or prior exposure to anti-TNF α agents, in patients with psoriatic arthritis or Crohn's disease or by prior exposure to biologics (i.e. anti-TNF α agents and/or vedolizumab) in patients with ulcerative colitis.

The results of an *in vitro* study and a phase 1 study in subjects with active Crohn's disease do not suggest the need for dose adjustments in patients who are receiving concomitant CYP450 substrates (see section 5.2).

In psoriasis studies, the safety and efficacy of ustekinumab in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. In psoriatic arthritis studies, concomitant MTX use did not appear to influence the safety or efficacy of ustekinumab. In Crohn's disease and ulcerative colitis studies, concomitant use of immunosuppressants or corticosteroids did not appear to influence the safety or efficacy of ustekinumab (see section 4.4).

4.6 Fertility, pregnancy and lactation

Women of childbearing potential

Women of childbearing potential should use effective methods of contraception during treatment and for at least 15 weeks after treatment.

Pregnancy

Data from a moderate number of prospectively collected pregnancies following exposure to ustekinumab with known outcomes, including more than 450 pregnancies exposed during the first trimester, do not indicate an increased risk of major congenital malformations in the newborn.

Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonic/foetal development, parturition or postnatal development (see section 5.3).

However, the available clinical experience is limited. As a precautionary measure, it is preferable to avoid the use of WEZENLA in pregnancy.

Ustekinumab crosses the placenta and has been detected in the serum of infants born to female patients treated with ustekinumab during pregnancy. The clinical impact of this is unknown, however, the risk of infection in infants exposed *in utero* to ustekinumab may be increased after birth. Administration of live vaccines (such as the BCG vaccine) to infants exposed *in utero* to ustekinumab is not recommended for twelve months following birth or until ustekinumab infant serum levels are undetectable (see sections 4.4 and 4.5). If there is a clear clinical benefit for the individual infant,

administration of a live vaccine might be considered at an earlier timepoint, if infant ustekinumab serum levels are undetectable.

Breast-feeding

Limited data from published literature suggests that ustekinumab is excreted in human breast milk in very small amounts. It is not known if ustekinumab is absorbed systemically after ingestion. Because of the potential for adverse reactions in nursing infants from ustekinumab, a decision on whether to discontinue breast-feeding during treatment and up to 15 weeks after treatment or to discontinue therapy with WEZENLA must be made taking into account the benefit of breast-feeding to the child and the benefit of WEZENLA therapy to the woman.

Fertility

The effect of ustekinumab on human fertility has not been evaluated (see section 5.3).

4.7 Effects on ability to drive and use machines

WEZENLA 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 adverse reactions (> 5%) in controlled periods of the adult psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies with ustekinumab were nasopharyngitis and headache. Most were considered to be mild and did not necessitate discontinuation of study treatment. The most serious adverse reaction that has been reported for ustekinumab is serious hypersensitivity reactions including anaphylaxis (see section 4.4). The overall safety profile was similar for patients with psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis.

Tabulated list of adverse reactions

The safety data described below reflect exposure in adults to ustekinumab in 14 phase 2 and phase 3 studies in 6 710 patients (4 135 with psoriasis and/or psoriatic arthritis, 1 749 with Crohn's disease and 826 patients with ulcerative colitis). This includes exposure to ustekinumab in the controlled and non-controlled periods of the clinical studies in patients with psoriasis, psoriatic arthritis, Crohn's disease or ulcerative colitis for at least 6 months (4 577 patients) or at least 1 year (3 648 patients). 2 194 patients with psoriasis, Crohn's disease or ulcerative colitis were exposed for at least 4 years while 1 148 patients with psoriasis or Crohn's disease were exposed for at least 5 years.

Table 3 provides a list of adverse reactions from adult psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies as well as adverse reactions reported from post-marketing experience. The adverse reactions are classified by system organ class and frequency, 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 reactions are presented in order of decreasing seriousness.

Table 3. List of adverse reactions

| System organ class | Frequency: adverse reaction |
|--|---|
| Infections and infestations | Common: Upper respiratory tract infection, nasopharyngitis, sinusitis Uncommon: Cellulitis, dental infections, herpes zoster, lower respiratory tract infection, viral upper respiratory tract infection, vulvovaginal mycotic infection |
| Immune system disorders | Uncommon: Hypersensitivity reactions (including rash, urticaria) Rare: Serious hypersensitivity reactions (including anaphylaxis, angioedema) |
| Psychiatric disorders | Uncommon: Depression |
| Nervous system disorders | Common: Dizziness, headache Uncommon: Facial palsy |
| Respiratory, thoracic and mediastinal disorders | Common: Oropharyngeal pain Uncommon: Nasal congestion Rare: Allergic alveolitis, eosinophilic pneumonia Very rare: Organising pneumonia* |
| Gastrointestinal disorders | Common: Diarrhoea, nausea, vomiting |
| Skin and subcutaneous tissue disorders | Common: Pruritus Uncommon: Pustular psoriasis, skin exfoliation, acne Rare: Exfoliative dermatitis, hypersensitivity vasculitis Very rare: Bullous pemphigoid, cutaneous lupus erythematosus |
| Musculoskeletal and connective tissue disorders | Common: Back pain, myalgia, arthralgia Very rare: Lupus-like syndrome |
| General disorders and administration site conditions | Common: Fatigue, injection site erythema, injection site pain Uncommon: Injection site reactions (including haemorrhage, haematoma, induration, swelling and pruritus), asthenia |

* See section 4.4, Systemic and respiratory hypersensitivity reactions.

Description of selected adverse reactions

Infections

In the placebo-controlled studies of patients with psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis, the rates of infection or serious infection were similar between ustekinumab-treated patients and those treated with placebo. In the placebo-controlled period of these clinical studies, the rate of infection was 1.36 per patient-year of follow-up in ustekinumab-treated patients, and 1.34 in placebo-treated patients. Serious infections occurred at the rate of 0.03 per patient-year of follow-up in ustekinumab-treated patients (30 serious infections in 930 patient-years of follow-up) and 0.03 in placebo-treated patients (15 serious infections in 434 patient-years of follow-up) (see section 4.4).

In the controlled and non-controlled periods of psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, representing 15 227 patient-years of ustekinumab exposure in 6 710 patients, the median follow-up was 1.2 years; 1.7 years for psoriatic disease studies, 0.6 year for Crohn's disease studies, and 2.3 years for ulcerative colitis studies. The rate of infection was 0.85 per patient-year of follow-up in ustekinumab-treated patients, and the rate of serious infections was 0.02 per patient-year of follow-up in ustekinumab-treated patients (289 serious infections in

15 227 patient-years of follow-up) and serious infections reported included pneumonia, anal abscess, cellulitis, diverticulitis, gastroenteritis and viral infections.

In clinical studies, patients with latent tuberculosis who were concurrently treated with isoniazid did not develop tuberculosis.

Malignancies

In the placebo-controlled period of the psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, the incidence of malignancies excluding non-melanoma skin cancer was 0.11 per 100 patient-years of follow-up for ustekinumab-treated patients (1 patient in 929 patient-years of follow-up) compared with 0.23 for placebo-treated patients (1 patient in 434 patient-years of follow-up). The incidence of non-melanoma skin cancer was 0.43 per 100 patient-years of follow-up for ustekinumab-treated patients (4 patients in 929 patient-years of follow-up) compared to 0.46 for placebo-treated patients (2 patients in 433 patient-years of follow-up).

In the controlled and non-controlled periods of psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, representing 15 205 patient-years of ustekinumab exposure in 6 710 patients, the median follow-up was 1.2 years; 1.7 years for psoriatic disease studies, 0.6 year for Crohn's disease studies and 2.3 years for ulcerative colitis studies. Malignancies excluding non-melanoma skin cancers were reported in 76 patients in 15 205 patient-years of follow-up (incidence of 0.50 per 100 patient-years of follow-up for ustekinumab-treated patients). The incidence of malignancies reported in ustekinumab-treated patients was comparable to the incidence expected in the general population (standardised incidence ratio = 0.94 [95% confidence interval: 0.73, 1.18], adjusted for age, gender and race). The most frequently observed malignancies, other than non-melanoma skin cancer, were prostate, melanoma, colorectal, and breast cancers. The incidence of non-melanoma skin cancer was 0.46 per 100 patient-years of follow-up for ustekinumab-treated patients (69 patients in 15 165 patient-years of follow-up). The ratio of patients with basal versus squamous cell skin cancers (3:1) is comparable with the ratio expected in the general population (see section 4.4).

Hypersensitivity and infusion reactions

In Crohn's disease and ulcerative colitis intravenous induction studies, no events of anaphylaxis or other serious infusion reactions were reported following the single intravenous dose. In these studies, 2.2% of 785 placebo-treated patients and 1.9% of 790 patients treated with the recommended dose of ustekinumab reported adverse events occurring during or within an hour of the infusion. Serious infusion-related reactions including anaphylactic reactions to the infusion have been reported in the post-marketing setting (see section 4.4).

Paediatric population

Paediatric patients 6 years and older with plaque psoriasis

The safety of ustekinumab has been studied in two phase 3 studies of paediatric patients with moderate to severe plaque psoriasis. The first study was in 110 patients from 12 to 17 years of age treated for up to 60 weeks and the second study was in 44 patients from 6 to 11 years of age treated for up to 56 weeks. In general, the adverse events reported in these two studies with safety data up to 1 year were similar to those seen in previous studies in adults with plaque psoriasis.

Paediatric patients weighing at least 40 kg with Crohn's disease

The safety of ustekinumab has been studied in one phase 1 and one phase 3 study of paediatric patients with moderately to severely active Crohn's disease up to week 240 and week 52, respectively. In general, the safety profile in this cohort (n = 71) was similar to that seen in previous studies in adults with Crohn's disease.

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

Single doses up to 6 mg/kg have been administered intravenously in clinical studies without dose-limiting toxicity. In case of overdose, it is recommended that the patient be monitored for any signs or symptoms of adverse reactions and appropriate symptomatic treatment be instituted immediately.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Immunosuppressants, interleukin inhibitors, ATC code: L04AC05.

WEZENLA 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

Ustekinumab is a fully human IgG1κ monoclonal antibody that binds with specificity to the shared p40 protein subunit of human cytokines interleukin (IL)-12 and IL-23. Ustekinumab inhibits the bioactivity of human IL-12 and IL-23 by preventing p40 from binding to the IL-12R β 1 receptor protein expressed on the surface of immune cells. Ustekinumab cannot bind to IL-12 or IL-23 that is already bound to IL-12R β 1 cell surface receptors. Thus, ustekinumab is not likely to contribute to complement- or antibody-mediated cytotoxicity of cells with IL-12 and/or IL-23 receptors. IL-12 and IL-23 are heterodimeric cytokines secreted by activated antigen presenting cells, such as macrophages and dendritic cells, and both cytokines participate in immune functions; IL-12 stimulates natural killer (NK) cells and drives the differentiation of CD4+ T cells toward the T helper 1 (Th1) phenotype, IL-23 induces the T helper 17 (Th17) pathway. However, abnormal regulation of IL 12 and IL 23 has been associated with immune mediated diseases, such as psoriasis, psoriatic arthritis and Crohn's disease.

By binding the shared p40 subunit of IL-12 and IL-23, ustekinumab may exert its clinical effects in psoriasis, psoriatic arthritis and Crohn's disease through interruption of the Th1 and Th17 cytokine pathways, which are central to the pathology of these diseases.

In patients with Crohn's disease, treatment with ustekinumab resulted in a decrease in inflammatory markers including C-reactive protein (CRP) and faecal calprotectin during the induction phase, which were then maintained throughout the maintenance phase. CRP was assessed during the study extension and the reductions observed during maintenance were generally sustained through week 252.

Immunisation

During the long term extension of Psoriasis Study 2 (PHOENIX 2), adult patients treated with ustekinumab for at least 3.5 years mounted similar antibody responses to both pneumococcal polysaccharide and tetanus vaccines as a non-systemically treated psoriasis control group. Similar proportions of adult patients developed protective levels of anti-pneumococcal and anti-tetanus antibodies and antibody titres were similar among ustekinumab-treated and control patients.

Clinical efficacy and safety

Crohn's disease

The safety and efficacy of ustekinumab was assessed in three randomised, double-blind, placebo-controlled, multicentre studies in adult patients with moderately to severely active Crohn's disease (Crohn's Disease Activity Index [CDAI] score of ≥ 220 and ≤ 450). The clinical development program consisted of two 8-week intravenous induction studies (UNITI-1 and UNITI-2) followed by a 44-week subcutaneous randomised withdrawal maintenance study (IM-UNITI) representing 52 weeks of therapy.

The induction studies included 1 409 (UNITI-1, n = 769; UNITI-2 n = 640) patients. The primary endpoint for both induction studies was the proportion of subjects in clinical response (defined as a reduction in CDAI score of ≥ 100 points) at week 6. Efficacy data were collected and analysed through week 8 for both studies. Concomitant doses of oral corticosteroids, immunomodulators, aminosalicylates and antibiotics were permitted and 75% of patients continued to receive at least one of these medications. In both studies, patients were randomised to receive a single intravenous administration of either the recommended tiered dose of approximately 6 mg/kg (see table 1, section 4.2), a fixed dose of 130 mg ustekinumab, or placebo at week 0.

Patients in UNITI-1 had failed or were intolerant to prior anti-TNF α therapy. Approximately 48% of the patients had failed 1 prior anti-TNF α therapy and 52% had failed 2 or 3 prior anti-TNF α therapies. In this study, 29.1% of the patients had an inadequate initial response (primary non-responders), 69.4% responded but lost response (secondary non-responders), and 36.4% were intolerant to anti-TNF α therapies.

Patients in UNITI-2 had failed at least one conventional therapy, including corticosteroids or immunomodulators, and were either anti-TNF- α naïve (68.6%) or had previously received but not failed anti-TNF α therapy (31.4%).

In both UNITI-1 and UNITI-2, a significantly greater proportion of patients were in clinical response and remission in the ustekinumab-treated group compared to placebo (see table 4). Clinical response and remission were significant as early as week 3 in ustekinumab-treated patients and continued to improve through week 8. In these induction studies, efficacy was higher and better sustained in the tiered dose group compared to the 130 mg dose group, and tiered dosing is therefore the recommended intravenous induction dose.

Table 4. Induction of clinical response and remission in UNITI-1 and UNITI-2

| | UNITI-1* | | UNITI-2** | |
|---------------------------------------|--------------------|--|--------------------|--|
| | Placebo N = 247 | Recommended dose of ustekinumab N = 249 | Placebo N = 209 | Recommended dose of ustekinumab N = 209 |
| Clinical remission, week 8 | 18 (7.3%) | 52 (20.9%) ^a | 41 (19.6%) | 84 (40.2%) ^a |
| Clinical response (100 point), week 6 | 53 (21.5%) | 84 (33.7%) ^b | 60 (28.7%) | 116 (55.5%) ^a |
| Clinical response (100 point), week 8 | 50 (20.2%) | 94 (37.8%) ^a | 67 (32.1%) | 121 (57.9%) ^a |
| 70 point response, week 3 | 67 (27.1%) | 101 (40.6%) ^b | 66 (31.6%) | 106 (50.7%) ^a |
| 70 point response, week 6 | 75 (30.4%) | 109 (43.8%) ^b | 81 (38.8%) | 135 (64.6%) ^a |

Clinical remission is defined as CDAI score < 150 ; Clinical response is defined as reduction in CDAI score by at least 100 points or being in clinical remission

70 point response is defined as reduction in CDAI score by at least 70 points

* Anti-TNF α failures

** Conventional therapy failures

^a p < 0.001

^b p < 0.01

The maintenance study (IM-UNITI), evaluated 388 patients who achieved 100 point clinical response at week 8 of induction with ustekinumab in studies UNITI-1 and UNITI-2. Patients were randomised to receive a subcutaneous maintenance regimen of either 90 mg ustekinumab every 8 weeks, 90 mg ustekinumab every 12 weeks or placebo for 44 weeks (for recommended maintenance posology, see section 4.2 of the WEZENLA solution for injection (vial) and solution for injection in pre-filled syringe SmPC or pre-filled pen SmPC).

Significantly higher proportions of patients maintained clinical remission and response in the ustekinumab-treated groups compared to the placebo group at week 44 (see table 5).

Table 5. Maintenance of clinical response and remission in IM-UNITI (week 44; 52 weeks from initiation of the induction dose)

| | Placebo* N = 131[†] | 90 mg ustekinumab every 8 weeks N = 128[†] | 90 mg ustekinumab every 12 weeks N = 129[†] |
|--|---|--|---|
| Clinical remission | 36% | 53% ^a | 49% ^b |
| Clinical response | 44% | 59% ^b | 58% ^b |
| Corticosteroid-free clinical remission | 30% | 47% ^a | 43% ^c |
| Clinical remission in patients: | | | |
| in remission at the start of maintenance therapy | 46% (36/79) | 67% (52/78) ^a | 56% (44/78) |
| who entered from study CRD3002 [‡] | 44% (31/70) | 63% (45/72) ^c | 57% (41/72) |
| who are Anti-TNF α naïve | 49% (25/51) | 65% (34/52) ^c | 57% (30/53) |
| who entered from study CRD3001 [§] | 26% (16/61) | 41% (23/56) | 39% (22/57) |

Clinical remission is defined as CDAI score < 150; Clinical response is defined as reduction in CDAI of at least 100 points or being in clinical remission

* The placebo group consisted of patients who were in response to ustekinumab and were randomised to receive placebo at the start of maintenance therapy

[†] Patients who were in 100 point clinical response to ustekinumab at start of maintenance therapy

[‡] Patients who failed conventional therapy but not anti-TNF α therapy

[§] Patients who are anti-TNF α refractory/intolerant

^a p < 0.01

^b p < 0.05

^c nominally significant (p < 0.05)

In IM-UNITI, 29 of 129 patients did not maintain response to ustekinumab when treated every 12 weeks and were allowed to dose adjust to receive ustekinumab every 8 weeks. Loss of response was defined as a CDAI score \geq 220 points and a \geq 100 point increase from the CDAI score at baseline. In these patients, clinical remission was achieved in 41.4% of patients 16 weeks after dose adjustment.

Patients who were not in clinical response to ustekinumab induction at week 8 of the UNITI-1 and UNITI-2 induction studies (476 patients) entered into the non-randomised portion of the maintenance study (IM-UNITI) and received a 90 mg subcutaneous injection of ustekinumab at that time. Eight weeks later, 50.5% of the patients achieved clinical response and continued to receive maintenance dosing every 8 weeks; among these patients with continued maintenance dosing, a majority maintained response (68.1%) and achieved remission (50.2%) at week 44, at proportions that were similar to the patients who initially responded to ustekinumab induction.

Of 131 patients who responded to ustekinumab induction, and were randomised to the placebo group at the start of the maintenance study, 51 subsequently lost response and received 90 mg ustekinumab subcutaneously every 8 weeks. The majority of patients who lost response and resumed ustekinumab did so within 24 weeks of the induction infusion. Of these 51 patients, 70.6% achieved clinical

response and 39.2% percent achieved clinical remission 16 weeks after receiving the first subcutaneous dose of ustekinumab.

In IM-UNITI, patients who completed the study through week 44 were eligible to continue treatment in a study extension. Among the 567 patients who entered on and were treated with ustekinumab in the study extension, clinical remission and response were generally maintained through week 252 for both patients who failed TNF-therapies and those who failed conventional therapies.

No new safety concerns were identified in this study extension with up to 5 years of treatment in patients with Crohn's disease.

Endoscopy

Endoscopic appearance of the mucosa was evaluated in 252 patients with eligible baseline endoscopic disease activity in a substudy. The primary endpoint was change from baseline in Simplified Endoscopic Disease Severity Score for Crohn's Disease (SES-CD), a composite score across 5 ileo-colonic segments of presence/size of ulcers, proportion of mucosal surface covered by ulcers, proportion of mucosal surface affected by any other lesions and presence/type of narrowing/strictures. At week 8, after a single intravenous induction dose, the change in SES-CD score was greater in the ustekinumab group (n = 155, mean change = -2.8) than in the placebo group (n = 97, mean change = -0.7, p = 0.012).

Fistula response

In a subgroup of patients with draining fistulas at baseline (8.8%; n = 26), 12/15 (80%) of ustekinumab-treated patients achieved a fistula response over 44 weeks (defined as $\geq 50\%$ reduction from baseline of the induction study in the number of draining fistulas) compared to 5/11 (45.5%) exposed to placebo.

Health-related quality of life

Health-related quality of life was assessed by Inflammatory Bowel Disease Questionnaire (IBDQ) and SF-36 questionnaires. At week 8, patients receiving ustekinumab showed statistically significantly greater and clinically meaningful improvements on IBDQ total score and SF-36 Mental Component Summary Score in both UNITI-1 and UNITI-2, and SF-36 Physical Component Summary Score in UNITI-2, when compared to placebo. These improvements were generally better maintained in ustekinumab-treated patients in the IM-UNITI study through week 44 when compared to placebo. Improvement in health-related quality of life was generally maintained during the extension through week 252.

Immunogenicity

Antibodies to ustekinumab may develop during ustekinumab treatment and most are neutralising. The formation of anti-ustekinumab antibodies is associated with increased clearance of ustekinumab in patients with Crohn's disease. No reduced efficacy was observed. There is no apparent correlation between the presence of anti-ustekinumab antibodies and the occurrence of injection site reactions.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with ustekinumab in one or more subsets of the paediatric population in Crohn's disease (see section 4.2 for information on paediatric use).

Paediatric Crohn's disease

The safety and efficacy of ustekinumab was evaluated in 48 paediatric patients weighing at least 40 kg, in an interim analysis of a multicentre phase 3 study (UNITI-Jr) for paediatric patients with

moderately to severely active Crohn's disease (defined by a Paediatric Crohn's Disease Activity Index [PCDAI] score > 30) through 52 weeks of treatment (8 weeks of induction and 44 weeks of maintenance treatment). Patients included in the study either had not adequately responded to or had not tolerated prior biologic therapy or conventional therapy for Crohn's disease. The study included an open-label induction treatment with a single ustekinumab intravenous dose, of approximately 6 mg/kg (see section 4.2), followed by a randomised double-blind subcutaneous maintenance regimen of 90 mg ustekinumab administered either every 8 weeks or every 12 weeks.

Efficacy results

The primary endpoint of the study was clinical remission at induction week 8 (defined as PCDAI score ≤ 10). The proportion of patients who achieved clinical remission was 52.1% (25/48) and is comparable to that observed in the adult ustekinumab phase 3 studies.

Clinical response was observed as early as week 3. The proportion of patients in clinical response at week 8 (defined as a reduction from baseline in the PCDAI score of > 12.5 points with a total PCDAI score not more than 30) was 93.8% (45/48).

Table 6 presents the analyses for the secondary endpoints through maintenance week 44.

Table 6. Summary of Secondary endpoints through Maintenance week 44

| | 90 mg ustekinumab every 8 weeks N = 23 | 90 mg ustekinumab every 12 weeks N = 25 | Total number of patients N = 48 |
|---|---|--|--|
| Clinical remission* | 43.5% (10/23) | 60.0% (15/25) | 52.1% (25/48) |
| Corticosteroid-free clinical remission [§] | 43.5% (10/23) | 60.0% (15/25) | 52.1% (25/48) |
| Clinical remission for patients who were in clinical remission at induction week 8* | 64.3% (9/14) | 54.5% (6/11) | 60.0% (15/25) |
| Clinical response [†] | 52.2% (12/23) | 60.0% (15/25) | 56.3% (27/48) |
| Endoscopic response [‡] | 22.7% (5/22) | 28.0% (7/25) | 25.5% (12/47) |

* Clinical remission is defined as PCDAI score ≤ 10 points

§ Corticosteroid-free remission is defined as PCDAI score of ≤ 10 points and not receiving corticosteroids for at least 90 days prior to Week M-44

† Clinical response is defined as a reduction from baseline in the PCDAI score of ≥ 12.5 points with a total PCDAI score not more than 30

‡ Endoscopic response is defined as a reduction in the SES-CD score of $\geq 50\%$ or SES-CD score ≤ 2 , in patients with a baseline SES-CD score of ≥ 3

Dosing frequency adjustment

Patients who entered the maintenance regimen and experienced loss of response (LOR) based on PCDAI score were eligible for dose adjustment. Patients were either switched from treatment every 12 weeks to every 8 weeks or stayed on treatment every 8 weeks (sham adjustment). Two patients were dose adjusted to the shorter dosing interval. In these patients, clinical remission was achieved in 100% (2/2) of patients 8 weeks after dose adjustment.

The safety profile of the induction dose regimen and both maintenance dose regimens in the paediatric population weighing at least 40 kg is comparable with that established in the adult Crohn's disease population (see section 4.8).

Serum and faecal inflammatory biomarkers

The mean change from baseline at maintenance week 44 in C-reactive protein (CRP) and faecal calprotectin concentrations were -11.17 mg/L (24.159) and -538.2 mg/kg (1271.33), respectively.

Health-related quality of life

The total IMPACT-III scores and all subdomains (bowel symptoms, fatigue-related systemic symptoms, and well-being) demonstrated clinically meaningful improvements after 52 weeks.

5.2 Pharmacokinetic properties

Following the recommended intravenous induction dose, median peak serum ustekinumab concentration, observed 1 hour after the infusion, was 126.1 mcg/mL in patients with Crohn's disease.

Distribution

Median volume of distribution during the terminal phase (V_z) following a single intravenous administration to patients with psoriasis ranged from 57 to 83 mL/kg.

Biotransformation

The exact metabolic pathway for ustekinumab is unknown.

Elimination

Median systemic clearance (CL) following a single intravenous administration to patients with psoriasis ranged from 1.99 to 2.34 mL/day/kg. Median half-life ($t_{1/2}$) of ustekinumab was approximately 3 weeks in patients with Crohn's disease, psoriasis and/or psoriatic arthritis, ranging from 15 to 32 days across all psoriasis and psoriatic arthritis studies.

Dose linearity

The systemic exposure of ustekinumab (C_{max} and AUC) increased in an approximately dose-proportional manner after a single intravenous administration at doses ranging from 0.09 mg/kg to 4.5 mg/kg.

Special populations

No pharmacokinetic data are available in patients with impaired renal or hepatic function.

No specific studies have been conducted with intravenous ustekinumab in elderly or paediatric patients weighing less than 40 kg.

In patients with Crohn's disease, variability in ustekinumab clearance was affected by body weight, serum albumin level, sex, and antibody to ustekinumab status while body weight was the main covariate affecting the volume of distribution. Additionally in Crohn's disease, clearance was affected by C-reactive protein, TNF antagonist failure status and race (Asian versus non-Asian). The impact of these covariates was within $\pm 20\%$ of the typical or reference value of the respective PK parameter, thus dose adjustment is not warranted for these covariates. Concomitant use of immunomodulators did not have a significant impact on ustekinumab disposition.

Regulation of CYP450 enzymes

The effects of IL-12 or IL-23 on the regulation of CYP450 enzymes were evaluated in an *in vitro* study using human hepatocytes, which showed that IL-12 and/or IL-23 at levels of 10 ng/mL did not alter human CYP450 enzyme activities (CYP1A2, 2B6, 2C9, 2C19, 2D6, or 3A4; see section 4.5).

A phase 1, open-label, drug interaction study, Study CNT01275CRD1003, was conducted to evaluate the effect of ustekinumab on cytochrome P450 enzyme activities following induction and maintenance dosing in patients with active Crohn's disease (n = 18). No clinically significant changes in exposure of caffeine (CYP1A2 substrate), warfarin (CYP2C9 substrate), omeprazole (CYP2C19 substrate), dextromethorphan (CYP2D6 substrate), or midazolam (CYP3A substrate) were observed when used concomitantly with ustekinumab at the approved recommended dosing in patients with Crohn's disease (see section 4.5).

Paediatric population

Serum ustekinumab concentrations in paediatric Crohn's disease patients weighing at least 40 kg, treated with the recommended weight-based dose were generally comparable to those in the adult Crohn's disease population treated with the adult weight-based dose.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard (e.g. organ toxicity) for humans based on studies of repeated-dose toxicity and developmental and reproductive toxicity, including safety pharmacology evaluations. In developmental and reproductive toxicity studies in cynomolgus monkeys, neither adverse effects on male fertility indices nor birth defects or developmental toxicity were observed. No adverse effects on female fertility indices were observed using an analogous antibody to IL-12/23 in mice.

Dose levels in animal studies were up to approximately 45-fold higher than the highest equivalent dose intended to be administered to psoriasis patients and resulted in peak serum concentrations in monkeys that were more than 100-fold higher than observed in humans.

Carcinogenicity studies were not performed with ustekinumab due to the lack of appropriate models for an antibody with no cross-reactivity to rodent IL-12/23 p40.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

EDTA disodium salt dihydrate

L-histidine

L-histidine hydrochloride monohydrate

L-methionine

Polysorbate 80 (E 433)

Sucrose

Sodium hydroxide (for pH adjustment)

Water for injections

6.2 Incompatibilities

In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products. WEZENLA should only be diluted with sodium chloride 9 mg/mL (0.9%) solution.

WEZENLA should not be administered concomitantly in the same intravenous line with other medicinal products.

6.3 Shelf life

3 years

After dilution chemical and physical in-use stability has been demonstrated between 0.86 mg/mL and 2.60 mg/mL for 24 hours at 15°C-25°C. Do not return to the refrigerator.

From a microbiological point of view, unless the method of dilution precludes the risk of microbial contamination, the product should be used immediately. If not used immediately, in-use storage times and conditions are the responsibility of user.

6.4 Special precautions for storage

Store in a refrigerator (2°C – 8°C).

Do not freeze.

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

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

6.5 Nature and contents of container

26 mL solution in a type I glass 30 mL vial closed with an elastomeric stopper.

WEZENLA is available in a 1 vial pack.

6.6 Special precautions for disposal and other handling

The solution in the WEZENLA vial should not be shaken. The solution should be visually inspected for particulate matter or discolouration prior to administration. The solution is clear to opalescent, colourless to light yellow. The medicinal product should not be used if the solution is discoloured or cloudy, or if foreign particulate matter is present.

Dilution

WEZENLA concentrate for solution for infusion must be diluted and prepared by a healthcare professional using aseptic technique.

1. Calculate the dose and the number of WEZENLA vials needed based on patient weight (see section 4.2, table 1). Each 26 mL vial of WEZENLA contains 130 mg of ustekinumab. Only use complete vials of WEZENLA.
2. Withdraw and discard a volume of the sodium chloride 9 mg/mL (0.9%) solution from the 250 mL infusion bag equal to the volume of WEZENLA to be added. (discard 26 mL sodium chloride for each vial of WEZENLA needed, for 2 vials- discard 52 mL, for 3 vials- discard 78 mL, for 4 vials- discard 104 mL).
3. Withdraw 26 mL of WEZENLA from each vial needed and add it to the 250 mL infusion bag. The final volume in the infusion bag should be 250 mL. Gently mix.
4. Visually inspect the diluted solution before administration. Do not use if visibly opaque particles, discolouration or foreign particles are observed.
5. Administer the diluted solution over a period of at least one hour.
6. Use only an infusion set with an in-line, sterile, non-pyrogenic, low protein-binding filter (pore size 0.2 micrometre).
7. Each vial is for single use only and any unused medicinal product should be disposed of in accordance with local requirements.

7. MARKETING AUTHORISATION HOLDER

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/24/1823/004

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 20 June 2024

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>.

▼ 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

WEZENLA 45 mg solution for injection
WEZENLA 45 mg solution for injection in pre-filled syringe
WEZENLA 90 mg solution for injection in pre-filled syringe

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

WEZENLA 45 mg solution for injection

Each vial contains 45 mg ustekinumab in 0.5 mL.

WEZENLA 45 mg solution for injection in pre-filled syringe

Each pre-filled syringe contains 45 mg ustekinumab in 0.5 mL.

WEZENLA 90 mg solution for injection in pre-filled syringe

Each pre-filled syringe contains 90 mg ustekinumab in 1 mL.

Ustekinumab is a fully human IgG1κ monoclonal antibody to interleukin (IL)-12/23 produced in a Chinese hamster ovary cell line using recombinant DNA technology.

Excipient with known effect

This medicinal product contains 0.02 mg (45 mg/0.5 mL) or 0.04 mg (90 mg/1.0 mL) of polysorbate 80 (E 433) in each dosage unit.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

WEZENLA 45 mg solution for injection

Solution for injection.

WEZENLA 45 mg solution for injection in pre-filled syringe

Solution for injection.

WEZENLA 90 mg solution for injection in pre-filled syringe

Solution for injection.

The solution is clear to opalescent, colourless to light yellow. The solution has a pH of approximately 6.0 and an osmolality of approximately 280 mOsm/kg.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Plaque psoriasis

WEZENLA is indicated for the treatment of moderate to severe plaque psoriasis in adults who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapies including ciclosporin, methotrexate (MTX) or PUVA (psoralen and ultraviolet A) (see section 5.1).

Paediatric plaque psoriasis

WEZENLA is indicated for the treatment of moderate to severe plaque psoriasis in children and adolescent patients from the age of 6 years and older, who are inadequately controlled by, or are intolerant to, other systemic therapies or phototherapies (see section 5.1).

Psoriatic arthritis (PsA)

WEZENLA, alone or in combination with MTX, is indicated for the treatment of active psoriatic arthritis in adult patients when the response to previous non-biological disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate (see section 5.1).

Adult Crohn's disease

WEZENLA is indicated for the treatment of adult patients with moderately to severely active Crohn's disease who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a TNF α antagonist.

Paediatric Crohn's disease

WEZENLA is indicated for the treatment of moderately to severely active Crohn's disease in paediatric patients weighing at least 40 kg, who have had an inadequate response to, or were intolerant to either conventional or biologic therapy.

4.2 Posology and method of administration

WEZENLA is intended for use under the guidance and supervision of physicians experienced in the diagnosis and treatment of conditions for which WEZENLA is indicated.

Posology

Plaque psoriasis

The recommended posology of WEZENLA is an initial dose of 45 mg administered subcutaneously, followed by a 45 mg dose 4 weeks later, and then every 12 weeks thereafter.

Consideration should be given to discontinuing treatment in patients who have shown no response up to 28 weeks of treatment.

Patients with body weight > 100 kg

For patients with a body weight > 100 kg the initial dose is 90 mg administered subcutaneously, followed by a 90 mg dose 4 weeks later, and then every 12 weeks thereafter. In these patients, 45 mg was also shown to be efficacious. However, 90 mg resulted in greater efficacy (see section 5.1, table 4).

Psoriatic arthritis (PsA)

The recommended posology of WEZENLA is an initial dose of 45 mg administered subcutaneously, followed by a 45 mg dose 4 weeks later, and then every 12 weeks thereafter. Alternatively, 90 mg may be used in patients with a body weight > 100 kg.

Consideration should be given to discontinuing treatment in patients who have shown no response up to 28 weeks of treatment.

Elderly (≥ 65 years)

No dose adjustment is needed for elderly patients (see section 4.4).

Renal and hepatic impairment

Ustekinumab has not been studied in these patient populations. No dose recommendations can be made.

Paediatric population

The safety and efficacy of ustekinumab in children with psoriasis less than 6 years of age or in children with psoriatic arthritis less than 18 years of age have not yet been established.

Paediatric plaque psoriasis (6 years and older)

The recommended dose of WEZENLA based on body weight is shown below (see tables 1 and 2). WEZENLA should be administered subcutaneously at weeks 0 and 4, then every 12 weeks thereafter.

Table 1. Recommended dose of WEZENLA for paediatric psoriasis

| Body weight at the time of dosing | Recommended dose |
|--|-------------------------|
| < 60 kg | 0.75 mg/kg |
| ≥ 60-≤ 100 kg | 45 mg |
| > 100 kg | 90 mg |

To calculate the volume of injection (mL) for patients < 60 kg, use the following formula: body weight (kg) × 0.0083 (mL/kg) or see table 2. The calculated volume should be rounded to the nearest 0.01 mL and administered using a 1 mL graduated syringe. A 45 mg vial is available for paediatric patients who need to receive less than the full 45 mg dose.

Table 2. Injection volumes of WEZENLA for paediatric psoriasis patients < 60 kg

| Body weight at time of dosing (kg) | Dose (mg) | Volume of injection (mL) |
|---|------------------|---------------------------------|
| 15 | 11.3 | 0.12 |
| 16 | 12.0 | 0.13 |
| 17 | 12.8 | 0.14 |
| 18 | 13.5 | 0.15 |
| 19 | 14.3 | 0.16 |
| 20 | 15.0 | 0.17 |
| 21 | 15.8 | 0.17 |
| 22 | 16.5 | 0.18 |
| 23 | 17.3 | 0.19 |
| 24 | 18.0 | 0.20 |
| 25 | 18.8 | 0.21 |

| Body weight at time of dosing (kg) | Dose (mg) | Volume of injection (mL) |
|---|------------------|---------------------------------|
| 26 | 19.5 | 0.22 |
| 27 | 20.3 | 0.22 |
| 28 | 21.0 | 0.23 |
| 29 | 21.8 | 0.24 |
| 30 | 22.5 | 0.25 |
| 31 | 23.3 | 0.26 |
| 32 | 24.0 | 0.27 |
| 33 | 24.8 | 0.27 |
| 34 | 25.5 | 0.28 |
| 35 | 26.3 | 0.29 |
| 36 | 27.0 | 0.30 |
| 37 | 27.8 | 0.31 |
| 38 | 28.5 | 0.32 |
| 39 | 29.3 | 0.32 |
| 40 | 30.0 | 0.33 |
| 41 | 30.8 | 0.34 |
| 42 | 31.5 | 0.35 |
| 43 | 32.3 | 0.36 |
| 44 | 33.0 | 0.37 |
| 45 | 33.8 | 0.37 |
| 46 | 34.5 | 0.38 |
| 47 | 35.3 | 0.39 |
| 48 | 36.0 | 0.40 |
| 49 | 36.8 | 0.41 |
| 50 | 37.5 | 0.42 |
| 51 | 38.3 | 0.42 |
| 52 | 39.0 | 0.43 |
| 53 | 39.8 | 0.44 |
| 54 | 40.5 | 0.45 |
| 55 | 41.3 | 0.46 |
| 56 | 42.0 | 0.46 |
| 57 | 42.8 | 0.47 |
| 58 | 43.5 | 0.48 |
| 59 | 44.3 | 0.49 |

Consideration should be given to discontinuing treatment in patients who have shown no response up to 28 weeks of treatment.

Adults

Crohn's disease

In the treatment regimen, the first dose of WEZENLA is administered intravenously. For the posology of the intravenous dosing regimen, see section 4.2 of the WEZENLA 130 mg concentrate for solution for infusion SmPC.

The first subcutaneous administration of 90 mg WEZENLA should take place at week 8 after the intravenous dose. After this, dosing every 12 weeks is recommended.

Patients who have not shown adequate response at 8 weeks after the first subcutaneous dose, may receive a second subcutaneous dose at this time (see section 5.1).

Patients who lose response on dosing every 12 weeks may benefit from an increase in dosing frequency to every 8 weeks (see sections 5.1 and 5.2).

Patients may subsequently be dosed every 8 weeks or every 12 weeks according to clinical judgement (see section 5.1).

Consideration should be given to discontinuing treatment in patients who show no evidence of therapeutic benefit 16 weeks after the IV induction dose or 16 weeks after switching to the 8-weekly maintenance dose.

Immunomodulators and/or corticosteroids may be continued during treatment with ustekinumab. In patients who have responded to treatment with ustekinumab, corticosteroids may be reduced or discontinued in accordance with standard of care.

In Crohn's disease, if therapy is interrupted, resumption of treatment with subcutaneous dosing every 8 weeks is safe and effective.

Elderly (≥ 65 years)

No dose adjustment is needed for elderly patients (see section 4.4).

Renal and hepatic impairment

Ustekinumab has not been studied in these patient populations. No dose recommendations can be made.

Paediatric population

Paediatric Crohn's disease (patients weighing at least 40 kg)

In the treatment regimen, the first dose of WEZENLA is administered intravenously. For the posology of the intravenous dosing regimen, see section 4.2 of the WEZENLA 130 mg concentrate for solution for infusion SmPC.

The first subcutaneous administration of 90 mg WEZENLA should take place at week 8 after the intravenous dose. After this, dosing every 12 weeks is recommended.

Patients who lose response on dosing every 12 weeks may benefit from an increase in dosing frequency to every 8 weeks (see sections 5.1 and 5.2).

Patients may subsequently be dosed every 8 weeks or every 12 weeks according to clinical judgment (see section 5.1).

Consideration should be given to discontinuing treatment in patients who show no evidence of therapeutic benefit 16 weeks after the IV induction dose or 16 weeks after dose adjustment.

Immunomodulators, 5-aminosalicylate (5-ASA) compounds, antibiotics, and/or corticosteroids may be continued during treatment with WEZENLA. In patients who have responded to treatment with WEZENLA, these medications may be reduced or discontinued in accordance with standard of care.

The safety and efficacy of ustekinumab in treatment of Crohn's disease in paediatric patients weighing less than 40 kg have not yet been established. No data are available.

Method of administration

WEZENLA 45 mg vials or 45 mg and 90 mg pre-filled syringes are for subcutaneous injection only. If possible, areas of the skin that show psoriasis should be avoided as injection sites.

After proper training in subcutaneous injection technique, patients or their caregivers may inject WEZENLA if a physician determines that it is appropriate. However, the physician should ensure appropriate follow-up of patients. Patients or their caregivers should be instructed to inject the prescribed amount of WEZENLA according to the directions provided in the package leaflet. Comprehensive instructions for use are given in the package leaflet.

For further instructions on preparation and special precautions for handling, see section 6.6.

4.3 Contraindications

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

Clinically important, active infection (e.g. active tuberculosis; see section 4.4).

4.4 Special warnings and precautions for use

Traceability

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

Infections

Ustekinumab may have the potential to increase the risk of infections and reactivate latent infections. In clinical studies and a post-marketing observational study in patients with psoriasis, serious bacterial, fungal, and viral infections have been observed in patients receiving ustekinumab (see section 4.8).

Opportunistic infections including reactivation of tuberculosis, other opportunistic bacterial infections (including atypical mycobacterial infection, listeria meningitis, pneumonia legionella, and nocardiosis), opportunistic fungal infections, opportunistic viral infections (including encephalitis caused by herpes simplex 2), and parasitic infections (including ocular toxoplasmosis) have been reported in patients treated with ustekinumab.

Caution should be exercised when considering the use of WEZENLA in patients with a chronic infection or a history of recurrent infection (see section 4.3).

Prior to initiating treatment with WEZENLA, patients should be evaluated for tuberculosis infection. WEZENLA must not be given to patients with active tuberculosis (see section 4.3). Treatment of latent tuberculosis infection should be initiated prior to administering WEZENLA. Anti-tuberculosis therapy should also be considered prior to initiation of WEZENLA in patients with a history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed. Patients receiving WEZENLA should be monitored closely for signs and symptoms of active tuberculosis during and after treatment.

Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and WEZENLA should not be administered until the infection resolves.

Malignancies

Immunosuppressants like ustekinumab have the potential to increase the risk of malignancy. Some patients who received ustekinumab in clinical studies and in a post-marketing observational study in patients with psoriasis developed cutaneous and non-cutaneous malignancies (see section 4.8). The risk of malignancy may be higher in psoriasis patients who have been treated with other biologics during the course of their disease.

No studies have been conducted that include patients with a history of malignancy or that continue treatment in patients who develop malignancy while receiving ustekinumab. Thus, caution should be exercised when considering the use of ustekinumab in these patients.

All patients, in particular those greater than 60 years of age, patients with a medical history of prolonged immunosuppressant therapy or those with a history of PUVA treatment, should be monitored for the appearance of skin cancer (see section 4.8).

Systemic and respiratory hypersensitivity reactions

Systemic

Serious hypersensitivity reactions have been reported in the post-marketing setting, in some cases several days after treatment. Anaphylaxis and angioedema have occurred. If an anaphylactic or other serious hypersensitivity reaction occurs, appropriate therapy should be instituted and administration of WEZENLA should be discontinued (see section 4.8).

Respiratory

Cases of allergic alveolitis, eosinophilic pneumonia, and non-infectious organising pneumonia have been reported during post-approval use of ustekinumab. Clinical presentations included cough, dyspnoea, and interstitial infiltrates following one to three doses. Serious outcomes have included respiratory failure and prolonged hospitalisation. Improvement has been reported after discontinuation of ustekinumab and also, in some cases, administration of corticosteroids. If infection has been excluded and diagnosis is confirmed, discontinue ustekinumab and institute appropriate treatment (see section 4.8).

Cardiovascular events

Cardiovascular events including myocardial infarction and cerebrovascular accident have been observed in patients with psoriasis exposed to ustekinumab in a post-marketing observational study. Risk factors for cardiovascular disease should be regularly assessed during treatment with WEZENLA.

Vaccinations

It is recommended that live viral or live bacterial vaccines (such as Bacillus of Calmette and Guérin (BCG)) should not be given concurrently with WEZENLA. Specific studies have not been conducted in patients who had recently received live viral or live bacterial vaccines. No data are available on the secondary transmission of infection by live vaccines in patients receiving ustekinumab. Before live viral or live bacterial vaccination, treatment with WEZENLA should be withheld for at least 15 weeks after the last dose and can be resumed at least 2 weeks after vaccination. Prescribers should consult the Summary of Product Characteristics for the specific vaccine for additional information and guidance on concomitant use of immunosuppressive agents post-vaccination.

Administration of live vaccines (such as the BCG vaccine) to infants exposed *in utero* to ustekinumab is not recommended for twelve months following birth or until ustekinumab infant serum levels are undetectable (see sections 4.5 and 4.6). If there is a clear clinical benefit for the individual infant, administration of a live vaccine might be considered at an earlier timepoint, if infant ustekinumab serum levels are undetectable.

Patients receiving WEZENLA may receive concurrent inactivated or non-live vaccinations.

Long term treatment with WEZENLA does not suppress the humoral immune response to pneumococcal polysaccharide or tetanus vaccines (see section 5.1).

Concomitant immunosuppressive therapy

In psoriasis studies, the safety and efficacy of ustekinumab in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. In psoriatic arthritis studies, concomitant MTX use did not appear to influence the safety or efficacy of ustekinumab. In Crohn's disease and ulcerative colitis studies, concomitant use of immunosuppressants or corticosteroids did not appear to influence the safety or efficacy of ustekinumab. Caution should be exercised when considering concomitant use of other immunosuppressants and WEZENLA or when transitioning from other immunosuppressive biologics (see section 4.5).

Immunotherapy

Ustekinumab has not been evaluated in patients who have undergone allergy immunotherapy. It is not known whether WEZENLA may affect allergy immunotherapy.

Serious skin conditions

In patients with psoriasis, exfoliative dermatitis has been reported following ustekinumab treatment (see section 4.8). Patients with plaque psoriasis may develop erythrodermic psoriasis, with symptoms that may be clinically indistinguishable from exfoliative dermatitis, as part of the natural course of their disease. As part of the monitoring of the patient's psoriasis, physicians should be alert for symptoms of erythrodermic psoriasis or exfoliative dermatitis. If these symptoms occur, appropriate therapy should be instituted. WEZENLA should be discontinued if a drug reaction is suspected.

Lupus-related conditions

Cases of lupus-related conditions have been reported in patients treated with ustekinumab, including cutaneous lupus erythematosus and lupus-like syndrome. If lesions occur, especially in sun exposed areas of the skin or if accompanied by arthralgia, the patient should seek medical attention promptly. If the diagnosis of a lupus-related condition is confirmed, ustekinumab should be discontinued and appropriate treatment initiated.

Special populations

Elderly (≥ 65 years)

No overall differences in efficacy or safety in patients aged 65 and older who received ustekinumab were observed compared to younger patients in clinical studies in approved indications, however the number of patients aged 65 and older is not sufficient to determine whether they respond differently from younger patients. Because there is a higher incidence of infections in the elderly population in general, caution should be used in treating the elderly.

Polysorbate 80

WEZENLA contains 0.02 mg (45 mg/0.5 mL) or 0.04 mg (90 mg/1.0 mL) of polysorbate 80 (E 433) in each dosage unit which is equivalent to 0.04 mg/mL. Polysorbates may cause allergic reactions.

4.5 Interaction with other medicinal products and other forms of interaction

Live vaccines should not be given concurrently with WEZENLA.

Administration of live vaccines (such as the BCG vaccine) to infants exposed *in utero* to ustekinumab is not recommended for twelve months following birth or until ustekinumab infant serum levels are undetectable (see sections 4.4 and 4.6). If there is a clear clinical benefit for the individual infant, administration of a live vaccine might be considered at an earlier timepoint, if infant ustekinumab serum levels are undetectable.

In the population pharmacokinetic analyses of the phase 3 studies, the effect of the most frequently used concomitant medicinal products in patients with psoriasis (including paracetamol, ibuprofen, acetylsalicylic acid, metformin, atorvastatin, levothyroxine) on pharmacokinetics of ustekinumab was explored. There were no indications of an interaction with these concomitantly administered medicinal products. The basis for this analysis was that at least 100 patients (> 5% of the studied population) were treated concomitantly with these medicinal products for at least 90% of the study period. The pharmacokinetics of ustekinumab was not impacted by concomitant use of MTX, NSAIDs, 6-mercaptopurine, azathioprine and oral corticosteroids in patients with psoriatic arthritis, Crohn's disease or ulcerative colitis, or prior exposure to anti-TNF α agents, in patients with psoriatic arthritis or Crohn's disease or by prior exposure to biologics (i.e. anti-TNF α agents and/or vedolizumab) in patients with ulcerative colitis.

The results of an *in vitro* study and a phase 1 study in subjects with active Crohn's disease do not suggest the need for dose adjustments in patients who are receiving concomitant CYP450 substrates (see section 5.2).

In psoriasis studies, the safety and efficacy of ustekinumab in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. In psoriatic arthritis studies, concomitant MTX use did not appear to influence the safety or efficacy of ustekinumab. In Crohn's disease and ulcerative colitis studies, concomitant use of immunosuppressants or corticosteroids did not appear to influence the safety or efficacy of ustekinumab (see section 4.4).

4.6 Fertility, pregnancy and lactation

Women of childbearing potential

Women of childbearing potential should use effective methods of contraception during treatment and for at least 15 weeks after treatment.

Pregnancy

Data from a moderate number of prospectively collected pregnancies following exposure to ustekinumab with known outcomes, including more than 450 pregnancies exposed during the first trimester, do not indicate an increased risk of major congenital malformations in the newborn.

Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonic/foetal development, parturition or postnatal development (see section 5.3).

However, the available clinical experience is limited. As a precautionary measure, it is preferable to avoid the use of WEZENLA in pregnancy.

Ustekinumab crosses the placenta and has been detected in the serum of infants born to female patients treated with ustekinumab during pregnancy. The clinical impact of this is unknown, however, the risk of infection in infants exposed *in utero* to ustekinumab may be increased after birth. Administration of live vaccines (such as the BCG vaccine) to infants exposed *in utero* to ustekinumab is not recommended for twelve months following birth or until ustekinumab infant serum levels are undetectable (see sections 4.4 and 4.5). If there is a clear clinical benefit for the individual infant, administration of a live vaccine might be considered at an earlier timepoint, if infant ustekinumab serum levels are undetectable.

Breast-feeding

Limited data from published literature suggests that ustekinumab is excreted in human breast milk in very small amounts. It is not known if ustekinumab is absorbed systemically after ingestion. Because of the potential for adverse reactions in nursing infants from ustekinumab, a decision on whether to discontinue breast-feeding during treatment and up to 15 weeks after treatment or to discontinue

therapy with WEZENLA must be made taking into account the benefit of breast-feeding to the child and the benefit of WEZENLA therapy to the woman.

Fertility

The effect of ustekinumab on human fertility has not been evaluated (see section 5.3).

4.7 Effects on ability to drive and use machines

WEZENLA 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 adverse reactions (> 5%) in controlled periods of the adult psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies with ustekinumab were nasopharyngitis and headache. Most were considered to be mild and did not necessitate discontinuation of study treatment. The most serious adverse reaction that has been reported for ustekinumab is serious hypersensitivity reactions including anaphylaxis (see section 4.4). The overall safety profile was similar for patients with psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis.

Tabulated list of adverse reactions

The safety data described below reflect exposure in adults to ustekinumab in 14 phase 2 and phase 3 studies in 6 710 patients (4 135 with psoriasis and/or psoriatic arthritis, 1 749 with Crohn's disease and 826 patients with ulcerative colitis). This includes exposure to ustekinumab in the controlled and non-controlled periods of the clinical studies in patients with psoriasis, psoriatic arthritis, Crohn's disease or ulcerative colitis for at least 6 months (4 577 patients) or at least 1 year (3 648 patients). 2 194 patients with psoriasis, Crohn's disease or ulcerative colitis were exposed for at least 4 years while 1 148 patients with psoriasis or Crohn's disease were exposed for at least 5 years.

Table 3 provides a list of adverse reactions from adult psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies as well as adverse reactions reported from post-marketing experience. The adverse reactions are classified by system organ class and frequency, 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 reactions are presented in order of decreasing seriousness.

Table 3. List of adverse reactions

| System organ class | Frequency: adverse reaction |
|-----------------------------|---|
| Infections and infestations | Common: Upper respiratory tract infection, nasopharyngitis, sinusitis Uncommon: Cellulitis, dental infections, herpes zoster, lower respiratory tract infection, viral upper respiratory tract infection, vulvovaginal mycotic infection |
| Immune system disorders | Uncommon: Hypersensitivity reactions (including rash, urticaria) Rare: Serious hypersensitivity reactions (including anaphylaxis, angioedema) |
| Psychiatric disorders | Uncommon: Depression |
| Nervous system disorders | Common: Dizziness, headache Uncommon: Facial palsy |

| System organ class | Frequency: adverse reaction |
|--|---|
| Respiratory, thoracic and mediastinal disorders | Common: Oropharyngeal pain Uncommon: Nasal congestion Rare: Allergic alveolitis, eosinophilic pneumonia Very rare: Organising pneumonia* |
| Gastrointestinal disorders | Common: Diarrhoea, nausea, vomiting |
| Skin and subcutaneous tissue disorders | Common: Pruritus Uncommon: Pustular psoriasis, skin exfoliation, acne Rare: Exfoliative dermatitis, hypersensitivity vasculitis Very rare: Bullous pemphigoid, cutaneous lupus erythematosus |
| Musculoskeletal and connective tissue disorders | Common: Back pain, myalgia, arthralgia Very rare: Lupus-like syndrome |
| General disorders and administration site conditions | Common: Fatigue, injection site erythema, injection site pain Uncommon: Injection site reactions (including haemorrhage, haematoma, induration, swelling and pruritus), asthenia |

* See section 4.4, Systemic and respiratory hypersensitivity reactions.

Description of selected adverse reactions

Infections

In the placebo-controlled studies of patients with psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis, the rates of infection or serious infection were similar between ustekinumab-treated patients and those treated with placebo. In the placebo-controlled period of these clinical studies, the rate of infection was 1.36 per patient-year of follow-up in ustekinumab-treated patients, and 1.34 in placebo-treated patients. Serious infections occurred at the rate of 0.03 per patient-year of follow-up in ustekinumab-treated patients (30 serious infections in 930 patient-years of follow-up) and 0.03 in placebo-treated patients (15 serious infections in 434 patient-years of follow-up) (see section 4.4).

In the controlled and non-controlled periods of psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, representing 15 227 patient-years of ustekinumab exposure in 6 710 patients, the median follow-up was 1.2 years; 1.7 years for psoriatic disease studies, 0.6 year for Crohn's disease studies, and 2.3 years for ulcerative colitis studies. The rate of infection was 0.85 per patient-year of follow-up in ustekinumab-treated patients, and the rate of serious infections was 0.02 per patient-year of follow-up in ustekinumab-treated patients (289 serious infections in 15 227 patient-years of follow-up) and serious infections reported included pneumonia, anal abscess, cellulitis, diverticulitis, gastroenteritis and viral infections.

In clinical studies, patients with latent tuberculosis who were concurrently treated with isoniazid did not develop tuberculosis.

Malignancies

In the placebo-controlled period of the psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, the incidence of malignancies excluding non-melanoma skin cancer was 0.11 per 100 patient-years of follow-up for ustekinumab-treated patients (1 patient in 929 patient-years of follow-up) compared with 0.23 for placebo-treated patients (1 patient in 434 patient-years of follow-up). The incidence of non-melanoma skin cancer was 0.43 per 100 patient-years of follow-up for ustekinumab-treated patients (4 patients in 929 patient-years of follow-up) compared to 0.46 for placebo-treated patients (2 patients in 433 patient-years of follow-up).

In the controlled and non-controlled periods of psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, representing 15 205 patient-years of ustekinumab exposure in 6 710 patients, the median follow-up was 1.2 years; 1.7 years for psoriatic disease studies, 0.6 year for

Crohn's disease studies and 2.3 years for ulcerative colitis studies. Malignancies excluding non-melanoma skin cancers were reported in 76 patients in 15 205 patient-years of follow-up (incidence of 0.50 per 100 patient-years of follow-up for ustekinumab-treated patients). The incidence of malignancies reported in ustekinumab-treated patients was comparable to the incidence expected in the general population (standardised incidence ratio = 0.94 [95% confidence interval: 0.73, 1.18], adjusted for age, gender and race). The most frequently observed malignancies, other than non-melanoma skin cancer, were prostate, melanoma, colorectal, and breast cancers. The incidence of non-melanoma skin cancer was 0.46 per 100 patient-years of follow-up for ustekinumab-treated patients (69 patients in 15 165 patient-years of follow-up). The ratio of patients with basal versus squamous cell skin cancers (3:1) is comparable with the ratio expected in the general population (see section 4.4).

Hypersensitivity reactions

During the controlled periods of the psoriasis and psoriatic arthritis clinical studies of ustekinumab, rash and urticaria have each been observed in < 1% of patients (see section 4.4).

Paediatric population

Paediatric patients 6 years and older with plaque psoriasis

The safety of ustekinumab has been studied in two phase 3 studies of paediatric patients with moderate to severe plaque psoriasis. The first study was in 110 patients from 12 to 17 years of age treated for up to 60 weeks and the second study was in 44 patients from 6 to 11 years of age treated for up to 56 weeks. In general, the adverse events reported in these two studies with safety data up to 1 year were similar to those seen in previous studies in adults with plaque psoriasis.

Paediatric patients weighing at least 40 kg with Crohn's disease

The safety of ustekinumab has been studied in one phase 1 and one phase 3 study of paediatric patients with moderately to severely active Crohn's disease up to week 240 and week 52, respectively. In general, the safety profile in this cohort (n = 71) was similar to that seen in previous studies in adults with Crohn's disease.

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

Single doses up to 6 mg/kg have been administered intravenously in clinical studies without dose-limiting toxicity. In case of overdose, it is recommended that the patient be monitored for any signs or symptoms of adverse reactions and appropriate symptomatic treatment be instituted immediately.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Immunosuppressants, interleukin inhibitors, ATC code: L04AC05.

WEZENLA 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

Ustekinumab is a fully human IgG1κ monoclonal antibody that binds with specificity to the shared p40 protein subunit of human cytokines interleukin IL-12 and IL-23. Ustekinumab inhibits the bioactivity of human IL-12 and IL-23 by preventing p40 from binding to the IL-12R β 1 receptor protein expressed on the surface of immune cells. Ustekinumab cannot bind to IL-12 or IL-23 that is already bound to IL-12R β 1 cell surface receptors. Thus, ustekinumab is not likely to contribute to complement- or antibody-mediated cytotoxicity of cells with IL-12 and/or IL-23 receptors. IL-12 and IL-23 are heterodimeric cytokines secreted by activated antigen presenting cells, such as macrophages and dendritic cells, and both cytokines participate in immune functions; IL-12 stimulates natural killer (NK) cells and drives the differentiation of CD4+ T cells toward the T helper 1 (Th1) phenotype, IL-23 induces the T helper 17 (Th17) pathway. However, abnormal regulation of IL-12 and IL-23 has been associated with immune mediated diseases, such as psoriasis, psoriatic arthritis and Crohn's disease.

By binding the shared p40 subunit of IL-12 and IL-23, ustekinumab may exert its clinical effects in psoriasis, psoriatic arthritis and Crohn's disease through interruption of the Th1 and Th17 cytokine pathways, which are central to the pathology of these diseases.

In patients with Crohn's disease, treatment with ustekinumab resulted in a decrease in inflammatory markers including C-reactive protein (CRP) and faecal calprotectin during the induction phase, which were then maintained throughout the maintenance phase. CRP was assessed during the study extension and the reductions observed during maintenance were generally sustained through week 252.

Immunisation

During the long term extension of Psoriasis Study 2 (PHOENIX 2), adult patients treated with ustekinumab for at least 3.5 years mounted similar antibody responses to both pneumococcal polysaccharide and tetanus vaccines as a non-systemically treated psoriasis control group. Similar proportions of adult patients developed protective levels of anti-pneumococcal and anti-tetanus antibodies and antibody titers were similar among ustekinumab-treated and control patients.

Clinical efficacy and safety

Plaque psoriasis (adults)

The safety and efficacy of ustekinumab was assessed in 1 996 patients in two randomised, double-blind, placebo-controlled studies in patients with moderate to severe plaque psoriasis and who were candidates for phototherapy or systemic therapy. In addition, a randomised, blinded assessor, active-controlled study compared ustekinumab and etanercept in patients with moderate to severe plaque psoriasis who had had an inadequate response to, intolerance to, or contraindication to ciclosporin, MTX, or PUVA.

Psoriasis Study 1 (PHOENIX 1) evaluated 766 patients. 53% of these patients were either non-responsive, intolerant, or had a contraindication to other systemic therapy. Patients randomised to ustekinumab received 45 mg or 90 mg doses at weeks 0 and 4 and followed by the same dose every 12 weeks. Patients randomised to receive placebo at weeks 0 and 4 crossed over to receive ustekinumab (either 45 mg or 90 mg) at weeks 12 and 16 followed by dosing every 12 weeks. Patients originally randomised to ustekinumab who achieved Psoriasis Area and Severity Index 75 response (PASI improvement of at least 75% relative to baseline) at both weeks 28 and 40 were re-randomised to receive ustekinumab every 12 weeks or to placebo (i.e. withdrawal of therapy). Patients who were re-randomised to placebo at week 40 reinitiated ustekinumab at their original dosing regimen when they experienced at least a 50% loss of their PASI improvement obtained at week 40. All patients were followed for up to 76 weeks following first administration of study treatment.

Psoriasis Study 2 (PHOENIX 2) evaluated 1 230 patients. 61% of these patients were either non-responsive, intolerant, or had a contraindication to other systemic therapy. Patients randomised to ustekinumab received 45 mg or 90 mg doses at weeks 0 and 4 followed by an additional dose at 16 weeks. Patients randomised to receive placebo at weeks 0 and 4 crossed over to receive ustekinumab (either 45 mg or 90 mg) at weeks 12 and 16. All patients were followed for up to 52 weeks following first administration of study treatment.

Psoriasis Study 3 (ACCEPT) evaluated 903 patients with moderate to severe psoriasis who inadequately responded to, were intolerant to, or had a contraindication to other systemic therapy and compared the efficacy of ustekinumab to etanercept and evaluated the safety of ustekinumab and etanercept. During the 12-week active-controlled portion of the study, patients were randomised to receive etanercept (50 mg twice a week), ustekinumab 45 mg at weeks 0 and 4, or ustekinumab 90 mg at weeks 0 and 4.

Baseline disease characteristics were generally consistent across all treatment groups in Psoriasis Studies 1 and 2 with a median baseline PASI score from 17 to 18, median baseline Body Surface Area (BSA) \geq 20, and median Dermatology Life Quality Index (DLQI) range from 10 to 12. Approximately one third (Psoriasis Study 1) and one quarter (Psoriasis Study 2) of subjects had Psoriatic Arthritis (PsA). Similar disease severity was also seen in Psoriasis Study 3.

The primary endpoint in these studies was the proportion of patients who achieved PASI 75 response from baseline at week 12 (see tables 4 and 5).

Table 4. Summary of clinical response in Psoriasis Study 1 (PHOENIX 1) and Psoriasis Study 2 (PHOENIX 2)

| | Week 12 2 doses (week 0 and week 4) | | | Week 28 3 doses (week 0, week 4 and week 16) | |
|--|--|------------------------|------------------------|---|-----------|
| | PBO | 45 mg | 90 mg | 45 mg | 90 mg |
| Psoriasis Study 1 | | | | | |
| Number of patients randomised | 255 | 255 | 256 | 250 | 243 |
| PASI 50 response N (%) | 26 (10%) | 213 (84%) ^a | 220 (86%) ^a | 228 (91%) | 234 (96%) |
| PASI 75 response N (%) | 8 (3%) | 171 (67%) ^a | 170 (66%) ^a | 178 (71%) | 191 (79%) |
| PASI 90 response N (%) | 5 (2%) | 106 (42%) ^a | 94 (37%) ^a | 123 (49%) | 135 (56%) |
| PGA ^b of cleared or minimal N (%) | 10 (4%) | 151 (59%) ^a | 156 (61%) ^a | 146 (58%) | 160 (66%) |
| Number of patients \leq 100 kg | 166 | 168 | 164 | 164 | 153 |
| PASI 75 response N (%) | 6 (4%) | 124 (74%) | 107 (65%) | 130 (79%) | 124 (81%) |
| Number of patients $>$ 100 kg | 89 | 87 | 92 | 86 | 90 |
| PASI 75 response N (%) | 2 (2%) | 47 (54%) | 63 (68%) | 48 (56%) | 67 (74%) |
| Psoriasis Study 2 | | | | | |
| Number of patients randomised | 410 | 409 | 411 | 397 | 400 |
| PASI 50 response N (%) | 41 (10%) | 342 (84%) ^a | 367 (89%) ^a | 369 (93%) | 380 (95%) |
| PASI 75 response N (%) | 15 (4%) | 273 (67%) ^a | 311 (76%) ^a | 276 (70%) | 314 (79%) |
| PASI 90 response N (%) | 3 (1%) | 173 (42%) ^a | 209 (51%) ^a | 178 (45%) | 217 (54%) |
| PGA ^b of cleared or minimal N (%) | 18 (4%) | 277 (68%) ^a | 300 (73%) ^a | 241 (61%) | 279 (70%) |
| Number of patients \leq 100 kg | 290 | 297 | 289 | 287 | 280 |
| PASI 75 response N (%) | 12 (4%) | 218 (73%) | 225 (78%) | 217 (76%) | 226 (81%) |
| Number of patients $>$ 100 kg | 120 | 112 | 121 | 110 | 119 |
| PASI 75 response N (%) | 3 (3%) | 55 (49%) | 86 (71%) | 59 (54%) | 88 (74%) |

^a p < 0.001 for ustekinumab 45 mg or 90 mg in comparison with placebo (PBO).

^b PGA = Physician Global Assessment.

Table 5. Summary of clinical response at week 12 in Psoriasis Study 3 (ACCEPT)

| | Psoriasis Study 3 | | |
|----------------------------------|---|--|------------------------|
| | Etanercept 24 doses (50 mg twice a week) | Ustekinumab 2 doses (week 0 and week 4) | |
| | | 45 mg | 90 mg |
| Number of patients randomised | 347 | 209 | 347 |
| PASI 50 response N (%) | 286 (82%) | 181 (87%) | 320 (92%) ^a |
| PASI 75 response N (%) | 197 (57%) | 141 (67%) ^b | 256 (74%) ^a |
| PASI 90 response N (%) | 80 (23%) | 76 (36%) ^a | 155 (45%) ^a |
| PGA of cleared or minimal N (%) | 170 (49%) | 136 (65%) ^a | 245 (71%) ^a |
| Number of patients \leq 100 kg | 251 | 151 | 244 |
| PASI 75 response N (%) | 154 (61%) | 109 (72%) | 189 (77%) |
| Number of patients $>$ 100 kg | 96 | 58 | 103 |
| PASI 75 response N (%) | 43 (45%) | 32 (55%) | 67 (65%) |

^a p < 0.001 for ustekinumab 45 mg or 90 mg in comparison with etanercept.

^b p = 0.012 for ustekinumab 45 mg in comparison with etanercept.

In Psoriasis Study 1 maintenance of PASI 75 was significantly superior with continuous treatment compared with treatment withdrawal (p < 0.001). Similar results were seen with each dose of ustekinumab. At 1 year (week 52), 89% of patients re-randomised to maintenance treatment were PASI 75 responders compared with 63% of patients re-randomised to placebo (treatment withdrawal) (p < 0.001). At 18 months (week 76), 84% of patients re-randomised to maintenance treatment were PASI 75 responders compared with 19% of patients re-randomised to placebo (treatment withdrawal). At 3 years (week 148), 82% of patients re-randomised to maintenance treatment were PASI 75 responders. At 5 years (week 244), 80% of patients re-randomised to maintenance treatment were PASI 75 responders.

In patients re-randomised to placebo, and who reinitiated their original ustekinumab treatment regimen after loss of \geq 50% of PASI improvement 85% regained PASI 75 response within 12 weeks after re-initiating therapy.

In Psoriasis Study 1, at week 2 and week 12, significantly greater improvements from baseline were demonstrated in the DLQI in each ustekinumab treatment group compared with placebo. The improvement was sustained through week 28. Similarly, significant improvements were seen in Psoriasis Study 2 at week 4 and 12, which were sustained through week 24. In Psoriasis Study 1, improvements in nail psoriasis (Nail Psoriasis Severity Index), in the physical and mental component summary scores of the SF-36 and in the Itch Visual Analogue Scale (VAS) were also significant in each ustekinumab treatment group compared with placebo. In Psoriasis Study 2, the Hospital Anxiety and Depression Scale (HADS) and Work Limitations Questionnaire (WLQ) were also significantly improved in each ustekinumab treatment group compared with placebo.

Psoriatic arthritis (PsA) (adults)

Ustekinumab has been shown to improve signs and symptoms, physical function and health-related quality of life, and reduce the rate of progression of peripheral joint damage in adult patients with active PsA.

The safety and efficacy of ustekinumab was assessed in 927 patients in two randomised, double-blind, placebo-controlled studies in patients with active PsA (\geq 5 swollen joints and \geq 5 tender joints) despite non-steroidal anti-inflammatory (NSAID) or disease modifying anti-rheumatic (DMARD) therapy. Patients in these studies had a diagnosis of PsA for at least 6 months. Patients with each subtype of PsA were enrolled, including polyarticular arthritis with no evidence of rheumatoid nodules (39%),

spondylitis with peripheral arthritis (28%), asymmetric peripheral arthritis (21%), distal interphalangeal involvement (12%) and arthritis mutilans (0.5%). Over 70% and 40% of the patients in both studies had enthesitis and dactylitis at baseline, respectively. Patients were randomised to receive treatment with ustekinumab 45 mg, 90 mg, or placebo subcutaneously at weeks 0 and 4 followed by every 12 weeks (q12w) dosing. Approximately 50% of patients continued on stable doses of MTX (≤ 25 mg/week).

In PsA Study 1 (PSUMMIT I) and PsA Study 2 (PSUMMIT II), 80% and 86% of the patients, respectively, had been previously treated with DMARDs. In Study 1 previous treatment with anti-tumour necrosis factor (TNF) α agent was not allowed. In Study 2, the majority of patients (58%, n = 180) had been previously treated with one or more anti-TNF α agent(s), of whom over 70% had discontinued their anti-TNF α treatment for lack of efficacy or intolerance at any time.

Signs and symptoms

Treatment with ustekinumab resulted in significant improvements in the measures of disease activity compared to placebo at week 24. The primary endpoint was the percentage of patients who achieved American College of Rheumatology (ACR) 20 response at week 24. The key efficacy results are shown in table 6 below.

Table 6. Number of patients who achieved clinical response in Psoriatic arthritis Study 1 (PSUMMIT I) and Study 2 (PSUMMIT II) at week 24

| | Psoriatic arthritis Study 1 | | | Psoriatic arthritis Study 2 | | |
|--|-----------------------------|-----------------------|------------------------|-----------------------------|-----------------------|-----------------------|
| | PBO | 45 mg | 90 mg | PBO | 45 mg | 90 mg |
| Number of patients randomised | 206 | 205 | 204 | 104 | 103 | 105 |
| ACR 20 response, N (%) | 47 (23%) | 87 (42%) ^a | 101 (50%) ^a | 21 (20%) | 45 (44%) ^a | 46 (44%) ^a |
| ACR 50 response, N (%) | 18 (9%) | 51 (25%) ^a | 57 (28%) ^a | 7 (7%) | 18 (17%) ^b | 24 (23%) ^a |
| ACR 70 response, N (%) | 5 (2%) | 25 (12%) ^a | 29 (14%) ^a | 3 (3%) | 7 (7%) ^c | 9 (9%) ^c |
| <i>Number of patients with $\geq 3\%$ BSA^d</i> | 146 | 145 | 149 | 80 | 80 | 81 |
| PASI 75 response, N (%) | 16 (11%) | 83 (57%) ^a | 93 (62%) ^a | 4 (5%) | 41 (51%) ^a | 45 (56%) ^a |
| PASI 90 response, N (%) | 4 (3%) | 60 (41%) ^a | 65 (44%) ^a | 3 (4%) | 24 (30%) ^a | 36 (44%) ^a |
| Combined PASI 75 and ACR 20 response, N (%) | 8 (5%) | 40 (28%) ^a | 62 (42%) ^a | 2 (3%) | 24 (30%) ^a | 31 (38%) ^a |
| Number of patients ≤ 100 kg | 154 | 153 | 154 | 74 | 74 | 73 |
| ACR 20 response, N (%) | 39 (25%) | 67 (44%) | 78 (51%) | 17 (23%) | 32 (43%) | 34 (47%) |
| <i>Number of patients with $\geq 3\%$ BSA^d</i> | 105 | 105 | 111 | 54 | 58 | 57 |
| PASI 75 response, N (%) | 14 (13%) | 64 (61%) | 73 (66%) | 4 (7%) | 31 (53%) | 32 (56%) |

| | Psoriatic arthritis Study 1 | | | Psoriatic arthritis Study 2 | | |
|---|-----------------------------|----------|----------|-----------------------------|----------|----------|
| | PBO | 45 mg | 90 mg | PBO | 45 mg | 90 mg |
| Number of patients > 100 kg | 52 | 52 | 50 | 30 | 29 | 31 |
| ACR 20 response, N (%) | 8 (15%) | 20 (38%) | 23 (46%) | 4 (13%) | 13 (45%) | 12 (39%) |
| Number of patients with $\geq 3\%$ BSA ^d | 41 | 40 | 38 | 26 | 22 | 24 |
| PASI 75 response, N (%) | 2 (5%) | 19 (48%) | 20 (53%) | 0 | 10 (45%) | 13 (54%) |

^ap < 0.001

^bp < 0.05

^cp = NS

^dNumber of patients with $\geq 3\%$ BSA psoriasis skin involvement at baseline

ACR 20, 50 and 70 responses continued to improve or were maintained through week 52 (PsA Study 1 and 2) and week 100 (PsA Study 1). In PsA Study 1, ACR 20 responses at week 100 were achieved by 57% and 64%, for 45 mg and 90 mg, respectively. In PsA Study 2, ACR 20 responses at week 52 were achieved by 47% and 48%, for 45 mg and 90 mg, respectively.

The proportion of patients achieving a modified PsA response criteria (PsARC) response was also significantly greater in the ustekinumab groups compared to placebo at week 24. PsARC responses were maintained through weeks 52 and 100. A higher proportion of patients treated with ustekinumab who had spondylitis with peripheral arthritis as their primary presentation, demonstrated 50 and 70 percent improvement in Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) scores compared with placebo at week 24.

Responses observed in the ustekinumab-treated groups were similar in patients receiving and not receiving concomitant MTX, and were maintained through weeks 52 and 100. Patients previously treated with anti-TNF α agents who received ustekinumab achieved a greater response at week 24 than patients receiving placebo (ACR 20 response at week 24 for 45 mg and 90 mg was 37% and 34%, respectively, compared with placebo 15%; p < 0.05), and responses were maintained through week 52.

For patients with enthesitis and/or dactylitis at baseline, in PsA Study 1 significant improvement in enthesitis and dactylitis score was observed in the ustekinumab groups compared with placebo at week 24. In PsA Study 2 significant improvement in enthesitis score and numerical improvement (not statistically significant) in dactylitis score was observed in the ustekinumab 90 mg group compared with placebo at week 24. Improvements in enthesitis score and dactylitis score were maintained through weeks 52 and 100.

Radiographic response

Structural damage in both hands and feet was expressed as change in total van der Heijde-Sharp score (vdH-S score), modified for PsA by addition of hand distal interphalangeal joints, compared to baseline. A pre-specified integrated analysis combining data from 927 subjects in both PsA Study 1 and 2 was performed. Ustekinumab demonstrated a statistically significant decrease in the rate of progression of structural damage compared to placebo, as measured by change from baseline to week 24 in the total modified vdH-S score (mean \pm SD score was 0.97 ± 3.85 in the placebo group compared with 0.40 ± 2.11 and 0.39 ± 2.40 in the ustekinumab 45 mg (p < 0.05) and 90 mg (p < 0.001) groups, respectively). This effect was driven by PsA Study 1. The effect is considered demonstrated irrespective of concomitant MTX use, and was maintained through weeks 52 (integrated analysis) and 100 (PsA Study 1).

Physical function and health-related quality of life

Ustekinumab-treated patients showed significant improvement in physical function as assessed by the Disability Index of the Health Assessment Questionnaire (HAQ-DI) at week 24. The proportion of patients achieving a clinically meaningful ≥ 0.3 improvement in HAQ-DI score from baseline was also significantly greater in the ustekinumab groups when compared with placebo. Improvement in HAQ-DI score from baseline was maintained through weeks 52 and 100.

There was significant improvement in DLQI scores in the ustekinumab groups as compared with placebo at week 24, which was maintained through weeks 52 and 100. In PsA Study 2 there was a significant improvement in Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F) scores in the ustekinumab groups when compared with placebo at week 24. The proportion of patients achieving a clinically significant improvement in fatigue (4 points in FACIT-F) was also significantly greater in the ustekinumab groups compared with placebo. Improvements in FACIT scores were maintained through week 52.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with ustekinumab in one or more subsets of the paediatric population with juvenile idiopathic arthritis (see section 4.2 for information on paediatric use).

Paediatric plaque psoriasis

Ustekinumab has been shown to improve signs and symptoms, and health-related quality of life in paediatric patients 6 years and older with plaque psoriasis.

Adolescent patients (12-17 years)

The efficacy of ustekinumab was studied in 110 paediatric patients aged 12 to 17 years with moderate to severe plaque psoriasis in a multicentre, phase 3, randomised, double-blind, placebo-controlled study (CADMUS). Patients were randomised to receive either placebo (n = 37), or the recommended dose of ustekinumab (see section 4.2; n = 36) or half of the recommended dose of ustekinumab (n = 37) by subcutaneous injection at weeks 0 and 4 followed by every 12 week (q12w) dosing. At week 12, placebo-treated patients crossed over to receive ustekinumab.

Patients with PASI ≥ 12 , PGA ≥ 3 and BSA involvement of at least 10%, who were candidates for systemic therapy or phototherapy, were eligible for the study. Approximately 60% of the patients had prior exposure to conventional systemic therapy or phototherapy. Approximately 11% of the patients had prior exposure to biologics.

The primary endpoint was the proportion of patients who achieved a PGA score of cleared (0) or minimal (1) at week 12. Secondary endpoints included PASI 75, PASI 90, change from baseline in Children's Dermatology Life Quality Index (CDLQI), change from baseline in the total scale score of PedsQL (Paediatric Quality of Life Inventory) at week 12. At week 12, subjects treated with ustekinumab showed significantly greater improvement in their psoriasis and health-related quality of life compared with placebo (see table 7).

All patients were followed for efficacy for up to 52 weeks following first administration of study agent. The proportion of patients with a PGA score of cleared (0) or minimal (1) and the proportion achieving PASI 75 showed separation between the ustekinumab-treated group and placebo at the first post-baseline visit at week 4, reaching a maximum by week 12. Improvements in PGA, PASI, CDLQI and PedsQL were maintained through week 52 (see table 7).

Table 7. Summary of primary and secondary endpoints at week 12 and week 52

| Paediatric Psoriasis Study (CADMUS) (age 12-17) | | | |
|---|--------------|---------------------------------|---------------------------------|
| | Week 12 | | Week 52 |
| | Placebo | Recommended dose of ustekinumab | Recommended dose of ustekinumab |
| | N (%) | N (%) | N (%) |
| Patients randomised | 37 | 36 | 35 |
| PGA | | | |
| PGA of cleared (0) or minimal (1) | 2 (5.4%) | 25 (69.4%) ^a | 20 (57.1%) |
| PGA of Cleared (0) | 1 (2.7%) | 17 (47.2%) ^a | 13 (37.1%) |
| PASI | | | |
| PASI 75 responders | 4 (10.8%) | 29 (80.6%) ^a | 28 (80.0%) |
| PASI 90 responders | 2 (5.4%) | 22 (61.1%) ^a | 23 (65.7%) |
| PASI 100 responders | 1 (2.7%) | 14 (38.9%) ^a | 13 (37.1%) |
| CDLQI | | | |
| CDLQI of 0 or 1 ^b | 6 (16.2%) | 18 (50.0%) ^c | 20 (57.1%) |
| PedsQL | | | |
| Change from baseline Mean (SD) ^d | 3.35 (10.04) | 8.03 (10.44) ^c | 7.26 (10.92) |

^ap < 0.001^bCDLQI: The CDLQI is a dermatology instrument to assess the effect of a skin problem on the health-related quality of life in the paediatric population. CDLQI of 0 or 1 indicates no effect on child's quality of life.^cp = 0.002^dPedsQL: The PedsQL Total Scale Score is a general health-related quality of life measure developed for use in children and adolescent populations. For the placebo group at week 12, N = 36^ep = 0.028

During the placebo-controlled period through week 12, the efficacy of both the recommended and half of the recommended dose groups were generally comparable at the primary endpoint (69.4% and 67.6%, respectively) although there was evidence of a dose response for higher level efficacy criteria (e.g. PGA of cleared (0), PASI 90). Beyond week 12, efficacy was generally higher and better sustained in the recommended dose group compared with half of the recommended dosage group in which a modest loss of efficacy was more frequently observed toward the end of each 12-week dosing interval. The safety profiles of the recommended dose and half of the recommended dose were comparable.

Children (6-11 years)

The efficacy of ustekinumab was studied in 44 paediatric patients aged 6 to 11 years with moderate to severe plaque psoriasis in an open-label, single-arm, multicentre, phase 3, study (CADMUS Jr.). Patients were treated with the recommended dose of ustekinumab (see section 4.2; n = 44) by subcutaneous injection at weeks 0 and 4 followed by every 12-week (q12w) dosing.

Patients with PASI \geq 12, PGA \geq 3 and BSA involvement of at least 10%, who were candidates for systemic therapy or phototherapy, were eligible for the study. Approximately 43% of the patients had prior exposure to conventional systemic therapy or phototherapy. Approximately 5% of the patients had prior exposure to biologics.

The primary endpoint was the proportion of patients who achieved a PGA score of cleared (0) or minimal (1) at week 12. Secondary endpoints included PASI 75, PASI 90, and change from baseline in Children's Dermatology Life Quality Index (CDLQI) at week 12. At week 12, subjects treated with ustekinumab showed clinically meaningful improvements in their psoriasis and health-related quality of life (see table 8).

All patients were followed for efficacy for up to 52 weeks following first administration of study agent. The proportion of patients with a PGA score of cleared (0) or minimal (1) at week 12 was 77.3%. Efficacy (defined as PGA 0 or 1) was observed as early as the first post-baseline visit at week 4 and the proportion of subjects who achieved a PGA score of 0 or 1 increased through week 16 and then remained relatively stable through week 52. Improvements in PGA, PASI, and CDLQI were maintained through week 52 (see table 8).

Table 8. Summary of primary and secondary endpoints at week 12 and week 52

| Paediatric Psoriasis Study (CADMUS Jr.) (age 6-11) | | |
|--|---------------------------------|---------------------------------|
| | Week 12 | Week 52 |
| | Recommended dose of ustekinumab | Recommended dose of ustekinumab |
| | N (%) | N (%) |
| Patients enrolled | 44 | 41 |
| PGA | | |
| PGA of cleared (0) or minimal (1) | 34 (77.3%) | 31 (75.6%) |
| PGA of cleared (0) | 17 (38.6%) | 23 (56.1%) |
| PASI | | |
| PASI 75 responders | 37 (84.1%) | 36 (87.8%) |
| PASI 90 responders | 28 (63.6%) | 29 (70.7%) |
| PASI 100 responders | 15 (34.1%) | 22 (53.7%) |
| CDLQI^a | | |
| Patients with a CDLQI > 1 at baseline | (N = 39) | (N = 36) |
| CDLQI of 0 or 1 | 24 (61.5%) | 21 (58.3%) |

^aCDLQI: The CDLQI is a dermatology instrument to assess the effect of a skin problem on the health-related quality of life in the paediatric population. CDLQI of 0 or 1 indicates no effect on child's quality of life.

Crohn's disease

The safety and efficacy of ustekinumab was assessed in three randomised, double-blind, placebo-controlled, multicentre studies in adult patients with moderately to severely active Crohn's disease (Crohn's Disease Activity Index [CDAI] score of ≥ 220 and ≤ 450). The clinical development program consisted of two 8 week intravenous induction studies (UNITI-1 and UNITI-2) followed by a 44-week subcutaneous randomised withdrawal maintenance study (IM-UNITI) representing 52 weeks of therapy.

The induction studies included 1 409 (UNITI-1, n = 769; UNITI-2 n = 640) patients. The primary endpoint for both induction studies was the proportion of subjects in clinical response (defined as a reduction in CDAI score of ≥ 100 points) at week 6. Efficacy data were collected and analysed through week 8 for both studies. Concomitant doses of oral corticosteroids, immunomodulators, aminosalicylates and antibiotics were permitted and 75% of patients continued to receive at least one of these medications. In both studies, patients were randomised to receive a single intravenous administration of either the recommended tiered dose of approximately 6 mg/kg (see section 4.2 of the WEZENLA 130 mg concentrate for solution for infusion SmPC), a fixed dose of 130 mg ustekinumab, or placebo at week 0.

Patients in UNITI-1 had failed or were intolerant to prior anti-TNF α therapy. Approximately 48% of the patients had failed 1 prior anti-TNF α therapy and 52% had failed 2 or 3 prior anti-TNF α therapies. In this study, 29.1% of the patients had an inadequate initial response (primary non-responders), 69.4% responded but lost response (secondary non-responders), and 36.4% were intolerant to anti-TNF α therapies.

Patients in UNITI-2 had failed at least one conventional therapy, including corticosteroids or immunomodulators, and were either anti-TNF- α naïve (68.6%) or had previously received but not failed anti-TNF α therapy (31.4%).

In both UNITI-1 and UNITI-2, a significantly greater proportion of patients were in clinical response and remission in the ustekinumab-treated group compared to placebo (see table 9). Clinical response and remission were significant as early as week 3 in ustekinumab-treated patients and continued to improve through week 8. In these induction studies, efficacy was higher and better sustained in the tiered dose group compared to the 130 mg dose group, and tiered dosing is therefore the recommended intravenous induction dose.

Table 9. Induction of clinical response and remission in UNITI-1 and UNITI-2

| | UNITI-1* | | UNITI-2** | |
|---------------------------------------|--------------------|--|--------------------|--|
| | Placebo N = 247 | Recommended dose of ustekinumab N = 249 | Placebo N = 209 | Recommended dose of ustekinumab N = 209 |
| Clinical remission, week 8 | 18 (7.3%) | 52 (20.9%) ^a | 41 (19.6%) | 84 (40.2%) ^a |
| Clinical response (100 point), week 6 | 53 (21.5%) | 84 (33.7%) ^b | 60 (28.7%) | 116 (55.5%) ^a |
| Clinical response (100 point), week 8 | 50 (20.2%) | 94 (37.8%) ^a | 67 (32.1%) | 121 (57.9%) ^a |
| 70 point response, week 3 | 67 (27.1%) | 101 (40.6%) ^b | 66 (31.6%) | 106 (50.7%) ^a |
| 70 point response, week 6 | 75 (30.4%) | 109 (43.8%) ^b | 81 (38.8%) | 135 (64.6%) ^a |

Clinical remission is defined as CDAI score < 150; Clinical response is defined as reduction in CDAI score by at least 100 points or being in clinical remission

70 point response is defined as reduction in CDAI score by at least 70 points

* Anti-TNF α failures

** Conventional therapy failures

^a p < 0.001

^b p < 0.01

The maintenance study (IM-UNITI), evaluated 388 patients who achieved 100 point clinical response at week 8 of induction with ustekinumab in studies UNITI-1 and UNITI-2. Patients were randomised to receive a subcutaneous maintenance regimen of either 90 mg ustekinumab every 8 weeks, 90 mg ustekinumab every 12 weeks or placebo for 44 weeks (for recommended maintenance posology, see section 4.2).

Significantly higher proportions of patients maintained clinical remission and response in the ustekinumab-treated groups compared to the placebo group at week 44 (see table 10).

Table 10. Maintenance of clinical response and remission in IM-UNITI (week 44; 52 weeks from initiation of the induction dose)

| | Placebo* | 90 mg ustekinumab every 8 weeks | 90 mg ustekinumab every 12 weeks |
|--|----------------------|---------------------------------------|--|
| | N = 131 [†] | N = 128 [†] | N = 129 [†] |
| Clinical remission | 36% | 53% ^a | 49% ^b |
| Clinical response | 44% | 59% ^b | 58% ^b |
| Corticosteroid-free clinical remission | 30% | 47% ^a | 43% ^c |

| | Placebo* | 90 mg ustekinumab every 8 weeks | 90 mg ustekinumab every 12 weeks |
|--|----------------------|---------------------------------------|--|
| | N = 131 [†] | N = 128 [†] | N = 129 [†] |
| Clinical remission in patients: | | | |
| in remission at the start of maintenance therapy | 46% (36/79) | 67% (52/78) ^a | 56% (44/78) |
| who entered from study CRD3002 [‡] | 44% (31/70) | 63% (45/72) ^c | 57% (41/72) |
| who are Anti-TNF α naïve | 49% (25/51) | 65% (34/52) ^c | 57% (30/53) |
| who entered from study CRD3001 [§] | 26% (16/61) | 41% (23/56) | 39% (22/57) |

Clinical remission is defined as CDAI score < 150; Clinical response is defined as reduction in CDAI of at least 100 points or being in clinical remission

* The placebo group consisted of patients who were in response to ustekinumab and were randomised to receive placebo at the start of maintenance therapy

[†] Patients who were in 100 point clinical response to ustekinumab at start of maintenance therapy

[‡] Patients who failed conventional therapy but not anti-TNF α therapy

[§] Patients who are anti-TNF α refractory/intolerant

^a p < 0.01

^b p < 0.05

^c nominally significant (p < 0.05)

In IM-UNITI, 29 of 129 patients did not maintain response to ustekinumab when treated every 12 weeks and were allowed to dose adjust to receive ustekinumab every 8 weeks. Loss of response was defined as a CDAI score \geq 220 points and a \geq 100 point increase from the CDAI score at baseline. In these patients, clinical remission was achieved in 41.4% of patients 16 weeks after dose adjustment.

Patients who were not in clinical response to ustekinumab induction at week 8 of the UNITI-1 and UNITI-2 induction studies (476 patients) entered into the non-randomised portion of the maintenance study (IM-UNITI) and received a 90 mg subcutaneous injection of ustekinumab at that time. Eight weeks later, 50.5% of the patients achieved clinical response and continued to receive maintenance dosing every 8 weeks; among these patients with continued maintenance dosing, a majority maintained response (68.1%) and achieved remission (50.2%) at week 44, at proportions that were similar to the patients who initially responded to ustekinumab induction.

Of 131 patients who responded to ustekinumab induction, and were randomised to the placebo group at the start of the maintenance study, 51 subsequently lost response and received 90 mg ustekinumab subcutaneously every 8 weeks. The majority of patients who lost response and resumed ustekinumab did so within 24 weeks of the induction infusion. Of these 51 patients, 70.6% achieved clinical response and 39.2% percent achieved clinical remission 16 weeks after receiving the first subcutaneous dose of ustekinumab.

In IM-UNITI, patients who completed the study through week 44 were eligible to continue treatment in a study extension. Among the 567 patients who entered on and were treated with ustekinumab in the study extension, clinical remission and response were generally maintained through week 252 for both patients who failed TNF-therapies and those who failed conventional therapies.

No new safety concerns were identified in this study extension with up to 5 years of treatment in patients with Crohn's disease.

Endoscopy

Endoscopic appearance of the mucosa was evaluated in 252 patients with eligible baseline endoscopic disease activity in a substudy. The primary endpoint was change from baseline in Simplified Endoscopic Disease Severity Score for Crohn's Disease (SES-CD), a composite score across 5 ileo-colonic segments of presence/size of ulcers, proportion of mucosal surface covered by ulcers, proportion of mucosal surface affected by any other lesions and presence/type of narrowing/strictures. At week 8, after a single intravenous induction dose, the change in SES-CD score was greater in the

ustekinumab group (n = 155, mean change = -2.8) than in the placebo group (n = 97, mean change = -0.7, p = 0.012).

Fistula response

In a subgroup of patients with draining fistulas at baseline (8.8%; n = 26), 12/15 (80%) of ustekinumab-treated patients achieved a fistula response over 44 weeks (defined as $\geq 50\%$ reduction from baseline of the induction study in the number of draining fistulas) compared to 5/11 (45.5%) exposed to placebo.

Health-related quality of life

Health-related quality of life was assessed by Inflammatory Bowel Disease Questionnaire (IBDQ) and SF-36 questionnaires. At week 8, patients receiving ustekinumab showed statistically significantly greater and clinically meaningful improvements on IBDQ total score and SF-36 Mental Component Summary Score in both UNITI-1 and UNITI-2, and SF-36 Physical Component Summary Score in UNITI-2, when compared to placebo. These improvements were generally better maintained in ustekinumab-treated patients in the IM-UNITI study through week 44 when compared to placebo. Improvement in health-related quality of life was generally maintained during the extension through week 252.

Immunogenicity

Antibodies to ustekinumab may develop during ustekinumab treatment and most are neutralising. The formation of anti-ustekinumab antibodies is associated with both increased clearance and reduced efficacy of ustekinumab, except in patients with Crohn's disease where no reduced efficacy was observed. There is no apparent correlation between the presence of anti-ustekinumab antibodies and the occurrence of injection site reactions.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with ustekinumab in one or more subsets of the paediatric population in Crohn's disease (see section 4.2 for information on paediatric use).

Paediatric Crohn's disease

The safety and efficacy of ustekinumab was evaluated in 48 paediatric patients weighing at least 40 kg, in an interim analysis of a multicentre phase 3 study (UNITI-Jr) for paediatric patients with moderately to severely active Crohn's disease (defined by a Paediatric Crohn's Disease Activity Index [PCDAI] score > 30) through 52 weeks of treatment (8 weeks of induction and 44 weeks of maintenance treatment). Patients included in the study either had not adequately responded to or had not tolerated prior biologic therapy or conventional therapy for Crohn's disease. The study included an open-label induction treatment with a single ustekinumab intravenous dose, of approximately 6 mg/kg (see section 4.2), followed by a randomised double-blind subcutaneous maintenance regimen of 90 mg ustekinumab administered either every 8 weeks or every 12 weeks.

Efficacy results

The primary endpoint of the study was clinical remission at induction week 8 (defined as PCDAI score ≤ 10). The proportion of patients who achieved clinical remission was 52.1% (25/48) and is comparable to that observed in the adult ustekinumab phase 3 studies.

Clinical response was observed as early as week 3. The proportion of patients in clinical response at week 8 (defined as a reduction from baseline in the PCDAI score of >12.5 points with a total PCDAI score not more than 30) was 93.8% (45/48).

Table 11 presents the analyses for the secondary endpoints through maintenance week 44.

Table 11. Summary of Secondary endpoints through Maintenance week 44

| | 90 mg ustekinumab every 8 weeks N = 23 | 90 mg ustekinumab every 12 weeks N = 25 | Total number of patients N = 48 |
|---|---|--|--|
| Clinical remission* | 43.5% (10/23) | 60.0% (15/25) | 52.1% (25/48) |
| Corticosteroid-free clinical remission [§] | 43.5% (10/23) | 60.0% (15/25) | 52.1% (25/48) |
| Clinical remission for patients who were in clinical remission at induction week 8* | 64.3% (9/14) | 54.5% (6/11) | 60.0% (15/25) |
| Clinical response [†] | 52.2% (12/23) | 60.0% (15/25) | 56.3% (27/48) |
| Endoscopic response [‡] | 22.7% (5/22) | 28.0% (7/25) | 25.5% (12/47) |

* Clinical remission is defined as PCDAI score \leq 10 points

[§] Corticosteroid-free remission is defined as PCDAI score of \leq 10 points and not receiving corticosteroids for at least 90 days prior to Week M-44

[†] Clinical response is defined as a reduction from baseline in the PCDAI score of \geq 12.5 points with a total PCDAI score not more than 30

[‡] Endoscopic response is defined as a reduction in the SES-CD score of \geq 50% or SES-CD score \leq 2, in patients with a baseline SES-CD score of \geq 3

Dosing frequency adjustment

Patients who entered the maintenance regimen and experienced loss of response (LOR) based on PCDAI score were eligible for dose adjustment. Patients were either switched from treatment every 12 weeks to every 8 weeks or stayed on treatment every 8 weeks (sham adjustment). Two patients were dose adjusted to the shorter dosing interval. In these patients, clinical remission was achieved in 100% (2/2) of patients 8 weeks after dose adjustment.

The safety profile of the induction dose regimen and both maintenance dose regimens in the paediatric population weighing at least 40 kg is comparable with that established in the adult Crohn's disease population (see section 4.8).

Serum and faecal inflammatory biomarkers

The mean change from baseline at maintenance week 44 in C-reactive protein (CRP) and faecal calprotectin concentrations were -11.17 mg/L (24.159) and -538.2 mg/kg (1271.33), respectively.

Health-related quality of life

The total IMPACT-III scores and all subdomains (bowel symptoms, fatigue-related systemic symptoms, and well-being) demonstrated clinically meaningful improvements after 52 weeks.

5.2 Pharmacokinetic properties

Absorption

The median time to reach the maximum serum concentration (t_{max}) was 8.5 days after a single 90 mg subcutaneous administration in healthy subjects. The median t_{max} values of ustekinumab following a single subcutaneous administration of either 45 mg or 90 mg in patients with psoriasis were comparable to those observed in healthy subjects.

The absolute bioavailability of ustekinumab following a single subcutaneous administration was estimated to be 57.2% in patients with psoriasis.

Distribution

Median volume of distribution during the terminal phase (V_z) following a single intravenous administration to patients with psoriasis ranged from 57 to 83 mL/kg.

Biotransformation

The exact metabolic pathway for ustekinumab is unknown.

Elimination

Median systemic clearance (CL) following a single intravenous administration to patients with psoriasis ranged from 1.99 to 2.34 mL/day/kg. Median half-life ($t_{1/2}$) of ustekinumab was approximately 3 weeks in patients with psoriasis, psoriatic arthritis or Crohn's disease, ranging from 15 to 32 days across all psoriasis and psoriatic arthritis studies. In a population pharmacokinetic analysis, the apparent clearance (CL/F) and apparent volume of distribution (V/F) were 0.465 L/day and 15.7 L, respectively, in patients with psoriasis. The CL/F of ustekinumab was not impacted by gender. Population pharmacokinetic analysis showed that there was a trend towards a higher clearance of ustekinumab in patients who tested positive for antibodies to ustekinumab.

Dose linearity

The systemic exposure of ustekinumab (C_{max} and AUC) increased in an approximately dose-proportional manner after a single intravenous administration at doses ranging from 0.09 mg/kg to 4.5 mg/kg or following a single subcutaneous administration at doses ranging from approximately 24 mg to 240 mg in patients with psoriasis.

Single dose versus multiple doses

Serum concentration-time profiles of ustekinumab were generally predictable after single or multiple subcutaneous dose administrations. In patients with psoriasis, steady-state serum concentrations of ustekinumab were achieved by week 28 after initial subcutaneous doses at weeks 0 and 4 followed by doses every 12 weeks. The median steady-state trough concentration ranged from 0.21 mcg/mL to 0.26 mcg/mL (45 mg) and from 0.47 mcg/mL to 0.49 mcg/mL (90 mg). There was no apparent accumulation in serum ustekinumab concentration over time when given subcutaneously every 12 weeks.

In patients with Crohn's disease, following an intravenous dose of ~6 mg/kg, starting at week 8, subcutaneous maintenance dosing of 90 mg ustekinumab was administered every 8 or 12 weeks. Steady state ustekinumab concentration was achieved by the start of the second maintenance dose. In patients with Crohn's disease, median steady-state trough concentrations ranged from 1.97 mcg/mL to 2.24 mcg/mL and from 0.61 mcg/mL to 0.76 mcg/mL for 90 mg ustekinumab every 8 weeks or every 12 weeks respectively. The steady-state trough ustekinumab levels resulting from 90 mg ustekinumab every 8 weeks were associated with higher clinical remission rates as compared to the steady-state trough levels following 90 mg every 12 weeks.

Impact of weight on pharmacokinetics

In a population pharmacokinetic analysis using data from patients with psoriasis, body weight was found to be the most significant covariate affecting the clearance of ustekinumab. The median CL/F in patients with weight > 100 kg was approximately 55% higher compared to patients with weight ≤ 100 kg. The median V/F in patients with weight > 100 kg was approximately 37% higher as compared to patients with weight ≤ 100 kg. The median trough serum concentrations of ustekinumab in patients with higher weight (> 100 kg) in the 90 mg group were comparable to those in patients with lower weight (≤ 100 kg) in the 45 mg group. Similar results were obtained from a confirmatory population pharmacokinetic analysis using data from patients with psoriatic arthritis.

Dosing frequency adjustment

In patients with Crohn's disease, based on observed data and population PK analyses, randomised subjects who lost response to treatment had lower serum ustekinumab concentrations over time compared with subjects who did not lose response. In Crohn's disease, dose adjustment from 90 mg every 12 weeks to 90 mg every 8 weeks was associated with an increase in trough serum ustekinumab concentrations and an accompanying increase in efficacy.

Special populations

No pharmacokinetic data are available in patients with impaired renal or hepatic function. No specific studies have been conducted in elderly patients.

The pharmacokinetics of ustekinumab were generally comparable between Asian and non-Asian patients with psoriasis.

In patients with Crohn's disease, variability in ustekinumab clearance was affected by body weight, serum albumin level, sex, and antibody to ustekinumab status while body weight was the main covariate affecting the volume of distribution. Additionally in Crohn's disease, clearance was affected by C-reactive protein, TNF antagonist failure status and race (Asian versus non-Asian). The impact of these covariates was within $\pm 20\%$ of the typical or reference value of the respective PK parameter, thus dose adjustment is not warranted for these covariates. Concomitant use of immunomodulators did not have a significant impact on ustekinumab disposition.

In the population pharmacokinetic analysis, there were no indications of an effect of tobacco or alcohol on the pharmacokinetics of ustekinumab.

The bioavailability of ustekinumab following administration by syringe or pre-filled pen was comparable.

Serum ustekinumab concentrations in paediatric psoriasis patients 6 to 17 years of age, treated with the recommended weight-based dose were generally comparable to those in the adult psoriasis population treated with the adult dose. Serum ustekinumab concentrations in paediatric psoriasis patients 12-17 years of age (CADMUS) treated with half of the recommended weight-based dose were generally lower than those in adults.

The steady-state serum concentrations in paediatric patients with Crohn's disease weighing at least 40 kg were comparable to those in the adult Crohn's disease population.

Regulation of CYP450 enzymes

The effects of IL-12 or IL-23 on the regulation of CYP450 enzymes were evaluated in an *in vitro* study using human hepatocytes, which showed that IL-12 and/or IL-23 at levels of 10 ng/mL did not alter human CYP450 enzyme activities (CYP1A2, 2B6, 2C9, 2C19, 2D6, or 3A4; see section 4.5).

A phase 1, open-label, drug interaction study, Study CNTO1275CRD1003, was conducted to evaluate the effect of ustekinumab on cytochrome P450 enzyme activities following induction and maintenance dosing in patients with active Crohn's disease (n = 18). No clinically significant changes in exposure of caffeine (CYP1A2 substrate), warfarin (CYP2C9 substrate), omeprazole (CYP2C19 substrate), dextromethorphan (CYP2D6 substrate), or midazolam (CYP3A substrate) were observed when used concomitantly with ustekinumab at the approved recommended dosing in patients with Crohn's disease (see section 4.5).

5.3 Preclinical safety data

Non-clinical data reveal no special hazard (e.g. organ toxicity) for humans based on studies of repeated-dose toxicity and developmental and reproductive toxicity, including safety pharmacology evaluations. In developmental and reproductive toxicity studies in cynomolgus monkeys, neither adverse effects on male fertility indices nor birth defects or developmental toxicity were observed. No adverse effects on female fertility indices were observed using an analogous antibody to IL-12/23 in mice.

Dose levels in animal studies were up to approximately 45-fold higher than the highest equivalent dose intended to be administered to psoriasis patients and resulted in peak serum concentrations in monkeys that were more than 100-fold higher than observed in humans.

Carcinogenicity studies were not performed with ustekinumab due to the lack of appropriate models for an antibody with no cross-reactivity to rodent IL-12/23 p40.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

L-histidine
L-histidine hydrochloride monohydrate
Polysorbate 80 (E 433)
Sucrose
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

WEZENLA 45 mg solution for injection

3 years

WEZENLA 45 mg solution for injection in pre-filled syringe

3 years

WEZENLA 90 mg solution for injection in pre-filled syringe

3 years

Individual pre-filled syringes or vials may be stored at room temperature up to 30°C for a maximum single period of up to 30 days in the original carton in order to protect from light. Record the date when the pre-filled syringe or vial is first removed from the refrigerator and the discard date. The discard date must not exceed the original expiry date printed on the carton. Once a syringe or vial has been stored at room temperature (up to 30°C), it should not be returned to the refrigerator. Discard the syringe or vial if not used within 30 days at room temperature storage or by the original expiry date, whichever is earlier.

After withdrawing in disposable syringe the chemical and physical in-use stability has been demonstrated for 24 hours at 15°C-25°C. Do not return to the refrigerator.

From a microbiological point of view, the product should be used immediately. If not used immediately, in-use storage times and conditions are the responsibility of user.

6.4 Special precautions for storage

Store in a refrigerator (2°C – 8°C).

Do not freeze.

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

If needed, individual pre-filled syringes or vials may be stored at room temperature up to 30°C (see section 6.3).

6.5 Nature and contents of container

WEZENLA 45 mg solution for injection

0.5 mL solution in a type I glass 2 mL vial closed with an elastomeric stopper.

WEZENLA 45 mg solution for injection in pre-filled syringe

0.5 mL solution in a type I glass 1 mL pre-filled syringe with a fixed stainless steel needle and a needle cap. The syringe is fitted with an automatic needle guard.

WEZENLA 90 mg solution for injection in pre-filled syringe

1 mL solution in a type I glass 1 mL pre-filled syringe with a fixed stainless steel needle and a needle cap. The syringe is fitted with an automatic needle guard.

WEZENLA is available in 1 vial pack or a pack of 1 pre-filled syringe.

6.6 Special precautions for disposal and other handling

The solution in the WEZENLA vial or pre-filled syringe should not be shaken. The solution should be visually inspected for particulate matter or discolouration prior to subcutaneous administration. The solution is clear to opalescent, colourless to light yellow. The medicinal product should not be used if the solution is discoloured or cloudy, or if foreign particulate matter is present. Before administration, WEZENLA should be allowed to reach room temperature (approximately half an hour). Detailed instructions for use are provided in the package leaflet.

WEZENLA does not contain preservatives; therefore any unused medicinal product remaining in the vial and the syringe should not be used. WEZENLA is supplied as a sterile, single-use vial or single-use pre-filled syringe. The syringe, needle and vial must never be re-used. Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

When using the single-dose vial, a 1 mL syringe with a 27 gauge, ½ inch (13 mm) needle is recommended.

7. MARKETING AUTHORISATION HOLDER

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

8. MARKETING AUTHORISATION NUMBER(S)

WEZENLA 45 mg solution for injection

EU/1/24/1823/001

WEZENLA 45 mg solution for injection in pre-filled syringe

EU/1/24/1823/002

WEZENLA 90 mg solution for injection in pre-filled syringe

EU/1/24/1823/003

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 20 June 2024

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>.

▼ 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

WEZENLA 45 mg solution for injection in pre-filled pen
WEZENLA 90 mg solution for injection in pre-filled pen

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

WEZENLA 45 mg solution for injection in pre-filled pen

Each pre-filled pen contains 45 mg ustekinumab in 0.5 mL.

WEZENLA 90 mg solution for injection in pre-filled pen

Each pre-filled pen contains 90 mg ustekinumab in 1 mL.

Ustekinumab is a fully human IgG1κ monoclonal antibody to interleukin (IL)-12/23 produced in a Chinese hamster ovary cell line using recombinant DNA technology.

Excipient with known effect

This medicinal product contains 0.02 mg (45 mg/0.5 mL) or 0.04 mg (90 mg/1.0 mL) of polysorbate 80 (E 433) in each dosage unit.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

WEZENLA 45 mg solution for injection in pre-filled pen

Solution for injection (ConfiPen).

WEZENLA 90 mg solution for injection in pre-filled pen

Solution for injection (ConfiPen).

The solution is clear to opalescent, colourless to light yellow. The solution has a pH of approximately 6.0 and an osmolality of approximately 280 mOsm/kg.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Plaque psoriasis

WEZENLA is indicated for the treatment of moderate to severe plaque psoriasis in adults who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapies including ciclosporin, methotrexate (MTX) or PUVA (psoralen and ultraviolet A) (see section 5.1).

Psoriatic arthritis (PsA)

WEZENLA, alone or in combination with MTX, is indicated for the treatment of active psoriatic arthritis in adult patients when the response to previous non-biological disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate (see section 5.1).

Crohn's disease

WEZENLA is indicated for the treatment of adult patients with moderately to severely active Crohn's disease who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a TNF α antagonist.

4.2 Posology and method of administration

WEZENLA is intended for use under the guidance and supervision of physicians experienced in the diagnosis and treatment of conditions for which WEZENLA is indicated.

Posology

Plaque psoriasis

The recommended posology of WEZENLA is an initial dose of 45 mg administered subcutaneously, followed by a 45 mg dose 4 weeks later, and then every 12 weeks thereafter.

Consideration should be given to discontinuing treatment in patients who have shown no response up to 28 weeks of treatment.

Patients with body weight > 100 kg

For patients with a body weight > 100 kg the initial dose is 90 mg administered subcutaneously, followed by a 90 mg dose 4 weeks later, and then every 12 weeks thereafter. In these patients, 45 mg was also shown to be efficacious. However, 90 mg resulted in greater efficacy (see section 5.1, table 2).

Psoriatic arthritis (PsA)

The recommended posology of WEZENLA is an initial dose of 45 mg administered subcutaneously, followed by a 45 mg dose 4 weeks later, and then every 12 weeks thereafter. Alternatively, 90 mg may be used in patients with a body weight > 100 kg.

Consideration should be given to discontinuing treatment in patients who have shown no response up to 28 weeks of treatment.

Elderly (≥ 65 years)

No dose adjustment is needed for elderly patients (see section 4.4).

Renal and hepatic impairment

Ustekinumab has not been studied in these patient populations. No dose recommendations can be made.

Paediatric population

The safety and efficacy of WEZENLA in children with psoriasis less than 6 years of age or in children with psoriatic arthritis less than 18 years of age have not yet been established. The pre-filled pen has not been studied in the paediatric population and is not recommended for use in paediatric patients.

See section 4.2 of the pre-filled syringe SmPC for posology and method of administration in paediatric patients 6 years and older with psoriasis.

Crohn's disease

In the treatment regimen, the first dose of WEZENLA is administered intravenously. For the posology of the intravenous dosing regimen, see section 4.2 of the WEZENLA 130 mg concentrate for solution for infusion SmPC.

The first subcutaneous administration of 90 mg WEZENLA should take place at week 8 after the intravenous dose. After this, dosing every 12 weeks is recommended.

Patients who have not shown adequate response at 8 weeks after the first subcutaneous dose, may receive a second subcutaneous dose at this time (see section 5.1).

Patients who lose response on dosing every 12 weeks may benefit from an increase in dosing frequency to every 8 weeks (see sections 5.1 and 5.2).

Patients may subsequently be dosed every 8 weeks or every 12 weeks according to clinical judgement (see section 5.1).

Consideration should be given to discontinuing treatment in patients who show no evidence of therapeutic benefit 16 weeks after the IV induction dose or 16 weeks after switching to the 8-weekly maintenance dose.

Immunomodulators and/or corticosteroids may be continued during treatment with ustekinumab. In patients who have responded to treatment with ustekinumab, corticosteroids may be reduced or discontinued in accordance with standard of care.

In Crohn's disease, if therapy is interrupted, resumption of treatment with subcutaneous dosing every 8 weeks is safe and effective.

Elderly (≥ 65 years)

No dose adjustment is needed for elderly patients (see section 4.4).

Renal and hepatic impairment

Ustekinumab has not been studied in these patient populations. No dose recommendations can be made.

Paediatric population

The safety and efficacy of ustekinumab for the treatment of Crohn's disease in paediatric patients weighing less than 40 kg have not yet been established. No data are available. The pre-filled pen has not been studied in the paediatric population and is not recommended for use in paediatric patients. See section 4.2 of the concentrate for solution for infusion and pre-filled syringe SmPC for posology and method of administration in paediatric patients weighing at least 40 kg with Crohn's disease.

Method of administration

WEZENLA 45 mg and 90 mg pre-filled pens are for subcutaneous injection only. If possible, areas of the skin that show psoriasis should be avoided as injection sites.

After proper training in subcutaneous injection technique, patients or their caregivers may inject WEZENLA if a physician determines that it is appropriate. However, the physician should ensure appropriate follow-up of patients. Patients or their caregivers should be instructed to inject the

prescribed amount of WEZENLA according to the directions provided in the package leaflet. Comprehensive instructions for use are given in the package leaflet.

For further instructions on preparation and special precautions for handling, see section 6.6.

4.3 Contraindications

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

Clinically important, active infection (e.g. active tuberculosis; see section 4.4).

4.4 Special warnings and precautions for use

Traceability

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

Infections

Ustekinumab may have the potential to increase the risk of infections and reactivate latent infections. In clinical studies and a post-marketing observational study in patients with psoriasis, serious bacterial, fungal, and viral infections have been observed in patients receiving ustekinumab (see section 4.8).

Opportunistic infections including reactivation of tuberculosis, other opportunistic bacterial infections (including atypical mycobacterial infection, listeria meningitis, pneumonia legionella, and nocardiosis), opportunistic fungal infections, opportunistic viral infections (including encephalitis caused by herpes simplex 2), and parasitic infections (including ocular toxoplasmosis) have been reported in patients treated with ustekinumab.

Caution should be exercised when considering the use of WEZENLA in patients with a chronic infection or a history of recurrent infection (see section 4.3).

Prior to initiating treatment with WEZENLA, patients should be evaluated for tuberculosis infection. WEZENLA must not be given to patients with active tuberculosis (see section 4.3). Treatment of latent tuberculosis infection should be initiated prior to administering WEZENLA. Anti-tuberculosis therapy should also be considered prior to initiation of WEZENLA in patients with a history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed. Patients receiving WEZENLA should be monitored closely for signs and symptoms of active tuberculosis during and after treatment.

Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and WEZENLA should not be administered until the infection resolves.

Malignancies

Immunosuppressants like ustekinumab have the potential to increase the risk of malignancy. Some patients who received ustekinumab in clinical studies and in a post-marketing observational study in patients with psoriasis developed cutaneous and non-cutaneous malignancies (see section 4.8). The risk of malignancy may be higher in psoriasis patients who have been treated with other biologics during the course of their disease.

No studies have been conducted that include patients with a history of malignancy or that continue treatment in patients who develop malignancy while receiving ustekinumab. Thus, caution should be exercised when considering the use of ustekinumab in these patients.

All patients, in particular those greater than 60 years of age, patients with a medical history of prolonged immunosuppressant therapy or those with a history of PUVA treatment, should be monitored for the appearance of skin cancer (see section 4.8).

Systemic and respiratory hypersensitivity reactions

Systemic

Serious hypersensitivity reactions have been reported in the post-marketing setting, in some cases several days after treatment. Anaphylaxis and angioedema have occurred. If an anaphylactic or other serious hypersensitivity reaction occurs, appropriate therapy should be instituted and administration of WEZENLA should be discontinued (see section 4.8).

Respiratory

Cases of allergic alveolitis, eosinophilic pneumonia, and non-infectious organising pneumonia have been reported during post-approval use of ustekinumab. Clinical presentations included cough, dyspnoea, and interstitial infiltrates following one to three doses. Serious outcomes have included respiratory failure and prolonged hospitalisation. Improvement has been reported after discontinuation of ustekinumab and also, in some cases, administration of corticosteroids. If infection has been excluded and diagnosis is confirmed, discontinue ustekinumab and institute appropriate treatment (see section 4.8).

Cardiovascular events

Cardiovascular events including myocardial infarction and cerebrovascular accident have been observed in patients with psoriasis exposed to ustekinumab in a post-marketing observational study. Risk factors for cardiovascular disease should be regularly assessed during treatment with WEZENLA.

Vaccinations

It is recommended that live viral or live bacterial vaccines (such as Bacillus of Calmette and Guérin (BCG)) should not be given concurrently with WEZENLA. Specific studies have not been conducted in patients who had recently received live viral or live bacterial vaccines. No data are available on the secondary transmission of infection by live vaccines in patients receiving ustekinumab. Before live viral or live bacterial vaccination, treatment with WEZENLA should be withheld for at least 15 weeks after the last dose and can be resumed at least 2 weeks after vaccination. Prescribers should consult the Summary of Product Characteristics for the specific vaccine for additional information and guidance on concomitant use of immunosuppressive agents post-vaccination.

Administration of live vaccines (such as the BCG vaccine) to infants exposed in utero to ustekinumab is not recommended for twelve months following birth or until ustekinumab infant serum levels are undetectable (see sections 4.5 and 4.6). If there is a clear clinical benefit for the individual infant, administration of a live vaccine might be considered at an earlier timepoint, if infant ustekinumab serum levels are undetectable.

Patients receiving WEZENLA may receive concurrent inactivated or non-live vaccinations.

Long term treatment with WEZENLA does not suppress the humoral immune response to pneumococcal polysaccharide or tetanus vaccines (see section 5.1).

Concomitant immunosuppressive therapy

In psoriasis studies, the safety and efficacy of ustekinumab in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. In psoriatic arthritis studies, concomitant MTX use did not appear to influence the safety or efficacy of ustekinumab. In Crohn's

disease and ulcerative colitis studies, concomitant use of immunosuppressants or corticosteroids did not appear to influence the safety or efficacy of ustekinumab. Caution should be exercised when considering concomitant use of other immunosuppressants and WEZENLA or when transitioning from other immunosuppressive biologics (see section 4.5).

Immunotherapy

Ustekinumab has not been evaluated in patients who have undergone allergy immunotherapy. It is not known whether WEZENLA may affect allergy immunotherapy.

Serious skin conditions

In patients with psoriasis, exfoliative dermatitis has been reported following ustekinumab treatment (see section 4.8). Patients with plaque psoriasis may develop erythrodermic psoriasis, with symptoms that may be clinically indistinguishable from exfoliative dermatitis, as part of the natural course of their disease. As part of the monitoring of the patient's psoriasis, physicians should be alert for symptoms of erythrodermic psoriasis or exfoliative dermatitis. If these symptoms occur, appropriate therapy should be instituted. WEZENLA should be discontinued if a drug reaction is suspected.

Lupus-related conditions

Cases of lupus-related conditions have been reported in patients treated with ustekinumab, including cutaneous lupus erythematosus and lupus-like syndrome. If lesions occur, especially in sun exposed areas of the skin or if accompanied by arthralgia, the patient should seek medical attention promptly. If the diagnosis of a lupus-related condition is confirmed, ustekinumab should be discontinued and appropriate treatment initiated.

Special populations

Elderly (≥ 65 years)

No overall differences in efficacy or safety in patients aged 65 and older who received ustekinumab were observed compared to younger patients in clinical studies in approved indications, however the number of patients aged 65 and older is not sufficient to determine whether they respond differently from younger patients. Because there is a higher incidence of infections in the elderly population in general, caution should be used in treating the elderly.

Polysorbate 80

WEZENLA contains 0.02 mg (45 mg/0.5 mL) or 0.04 mg (90 mg/1.0 mL) of polysorbate 80 (E 433) in each dosage unit which is equivalent to 0.04 mg/mL. Polysorbates may cause allergic reactions.

4.5 Interaction with other medicinal products and other forms of interaction

Live vaccines should not be given concurrently with WEZENLA.

Administration of live vaccines (such as the BCG vaccine) to infants exposed *in utero* to ustekinumab is not recommended for twelve months following birth or until ustekinumab infant serum levels are undetectable (see sections 4.4 and 4.6). If there is a clear clinical benefit for the individual infant, administration of a live vaccine might be considered at an earlier timepoint, if infant ustekinumab serum levels are undetectable.

In the population pharmacokinetic analyses of the phase 3 studies, the effect of the most frequently used concomitant medicinal products in patients with psoriasis (including paracetamol, ibuprofen, acetylsalicylic acid, metformin, atorvastatin, levothyroxine) on pharmacokinetics of ustekinumab was explored. There were no indications of an interaction with these concomitantly administered medicinal products. The basis for this analysis was that at least 100 patients (> 5% of the studied population)

were treated concomitantly with these medicinal products for at least 90% of the study period. The pharmacokinetics of ustekinumab was not impacted by concomitant use of MTX, NSAIDs, 6-mercaptopurine, azathioprine and oral corticosteroids in patients with psoriatic arthritis, Crohn's disease or ulcerative colitis, or prior exposure to anti-TNF α agents, in patients with psoriatic arthritis or Crohn's disease or by prior exposure to biologics (i.e. anti-TNF α agents and/or vedolizumab) in patients with ulcerative colitis.

The results of an *in vitro* study and a phase 1 study in subjects with active Crohn's disease do not suggest the need for dose adjustments in patients who are receiving concomitant CYP450 substrates (see section 5.2).

In psoriasis studies, the safety and efficacy of ustekinumab in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. In psoriatic arthritis studies, concomitant MTX use did not appear to influence the safety or efficacy of ustekinumab. In Crohn's disease and ulcerative colitis studies, concomitant use of immunosuppressants or corticosteroids did not appear to influence the safety or efficacy of ustekinumab (see section 4.4).

4.6 Fertility, pregnancy and lactation

Women of childbearing potential

Women of childbearing potential should use effective methods of contraception during treatment and for at least 15 weeks after treatment.

Pregnancy

Data from a moderate number of prospectively collected pregnancies following exposure to ustekinumab with known outcomes, including more than 450 pregnancies exposed during the first trimester, do not indicate an increased risk of major congenital malformations in the newborn.

Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonic/foetal development, parturition or postnatal development (see section 5.3).

However, the available clinical experience is limited. As a precautionary measure, it is preferable to avoid the use of WEZENLA in pregnancy.

Ustekinumab crosses the placenta and has been detected in the serum of infants born to female patients treated with ustekinumab during pregnancy. The clinical impact of this is unknown, however, the risk of infection in infants exposed *in utero* to ustekinumab may be increased after birth. Administration of live vaccines (such as the BCG vaccine) to infants exposed *in utero* to ustekinumab is not recommended for twelve months following birth or until ustekinumab infant serum levels are undetectable (see sections 4.4 and 4.5). If there is a clear clinical benefit for the individual infant, administration of a live vaccine might be considered at an earlier timepoint, if infant ustekinumab serum levels are undetectable.

Breast-feeding

Limited data from published literature suggests that ustekinumab is excreted in human breast milk in very small amounts. It is not known if ustekinumab is absorbed systemically after ingestion. Because of the potential for adverse reactions in nursing infants from ustekinumab, a decision on whether to discontinue breast-feeding during treatment and up to 15 weeks after treatment or to discontinue therapy with WEZENLA must be made taking into account the benefit of breast-feeding to the child and the benefit of WEZENLA therapy to the woman.

Fertility

The effect of ustekinumab on human fertility has not been evaluated (see section 5.3).

4.7 Effects on ability to drive and use machines

WEZENLA 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 adverse reactions (> 5%) in controlled periods of the adult psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies with ustekinumab were nasopharyngitis and headache. Most were considered to be mild and did not necessitate discontinuation of study treatment. The most serious adverse reaction that has been reported for ustekinumab is serious hypersensitivity reactions including anaphylaxis (see section 4.4). The overall safety profile was similar for patients with psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis.

Tabulated list of adverse reactions

The safety data described below reflect exposure in adults to ustekinumab in 14 phase 2 and phase 3 studies in 6 710 patients (4 135 with psoriasis and/or psoriatic arthritis, 1 749 with Crohn's disease and 826 patients with ulcerative colitis). This includes exposure to ustekinumab in the controlled and non-controlled periods of the clinical studies in patients with psoriasis, psoriatic arthritis, Crohn's disease or ulcerative colitis for at least 6 months (4 577 patients) or at least 1 year (3 648 patients). 2 194 patients with psoriasis, Crohn's disease or ulcerative colitis were exposed for at least 4 years while 1 148 patients with psoriasis or Crohn's disease were exposed for at least 5 years.

Table 1 provides a list of adverse reactions from adult psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies as well as adverse reactions reported from post-marketing experience. The adverse reactions are classified by system organ class and frequency, 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 reactions are presented in order of decreasing seriousness.

Table 1. List of adverse reactions

| System organ class | Frequency: adverse reaction |
|---|---|
| Infections and infestations | Common: Upper respiratory tract infection, nasopharyngitis, sinusitis Uncommon: Cellulitis, dental infections, herpes zoster, lower respiratory tract infection, viral upper respiratory tract infection, vulvovaginal mycotic infection |
| Immune system disorders | Uncommon: Hypersensitivity reactions (including rash, urticaria) Rare: Serious hypersensitivity reactions (including anaphylaxis, angioedema) |
| Psychiatric disorders | Uncommon: Depression |
| Nervous system disorders | Common: Dizziness, headache Uncommon: Facial palsy |
| Respiratory, thoracic and mediastinal disorders | Common: Oropharyngeal pain Uncommon: Nasal congestion Rare: Allergic alveolitis, eosinophilic pneumonia Very rare: Organising pneumonia* |

| System organ class | Frequency: adverse reaction |
|--|---|
| Gastrointestinal disorders | Common: Diarrhoea, nausea, vomiting |
| Skin and subcutaneous tissue disorders | Common: Pruritus Uncommon: Pustular psoriasis, skin exfoliation, acne Rare: Exfoliative dermatitis, hypersensitivity vasculitis Very rare: Bullous pemphigoid, cutaneous lupus erythematosus |
| Musculoskeletal and connective tissue disorders | Common: Back pain, myalgia, arthralgia Very rare: Lupus-like syndrome |
| General disorders and administration site conditions | Common: Fatigue, injection site erythema, injection site pain Uncommon: Injection site reactions (including haemorrhage, haematoma, induration, swelling and pruritus), asthenia |

* See section 4.4, Systemic and respiratory hypersensitivity reactions.

Description of selected adverse reactions

Infections

In the placebo-controlled studies of patients with psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis, the rates of infection or serious infection were similar between ustekinumab-treated patients and those treated with placebo. In the placebo-controlled period of these clinical studies, the rate of infection was 1.36 per patient-year of follow-up in ustekinumab-treated patients, and 1.34 in placebo-treated patients. Serious infections occurred at the rate of 0.03 per patient-year of follow-up in ustekinumab-treated patients (30 serious infections in 930 patient-years of follow-up) and 0.03 in placebo-treated patients (15 serious infections in 434 patient-years of follow-up) (see section 4.4).

In the controlled and non-controlled periods of psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, representing 15 227 patient-years of ustekinumab exposure in 6 710 patients, the median follow-up was 1.2 years; 1.7 years for psoriatic disease studies, 0.6 year for Crohn's disease studies, and 2.3 years for ulcerative colitis studies. The rate of infection was 0.85 per patient-year of follow-up in ustekinumab-treated patients, and the rate of serious infections was 0.02 per patient-year of follow-up in ustekinumab-treated patients (289 serious infections in 15 227 patient-years of follow-up) and serious infections reported included pneumonia, anal abscess, cellulitis, diverticulitis, gastroenteritis and viral infections.

In clinical studies, patients with latent tuberculosis who were concurrently treated with isoniazid did not develop tuberculosis.

Malignancies

In the placebo-controlled period of the psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, the incidence of malignancies excluding non-melanoma skin cancer was 0.11 per 100 patient-years of follow-up for ustekinumab-treated patients (1 patient in 929 patient-years of follow-up) compared with 0.23 for placebo-treated patients (1 patient in 434 patient-years of follow-up). The incidence of non-melanoma skin cancer was 0.43 per 100 patient-years of follow-up for ustekinumab-treated patients (4 patients in 929 patient-years of follow-up) compared to 0.46 for placebo-treated patients (2 patients in 433 patient-years of follow-up).

In the controlled and non-controlled periods of psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis clinical studies, representing 15 205 patient-years of ustekinumab exposure in 6 710 patients, the median follow-up was 1.2 years; 1.7 years for psoriatic disease studies, 0.6 year for Crohn's disease studies and 2.3 years for ulcerative colitis studies. Malignancies excluding non-melanoma skin cancers were reported in 76 patients in 15 205 patient-years of follow-up (incidence of 0.50 per 100 patient-years of follow-up for ustekinumab-treated patients). The incidence of malignancies reported in ustekinumab-treated patients was comparable to the incidence expected in the

general population (standardised incidence ratio = 0.94 [95% confidence interval: 0.73, 1.18], adjusted for age, gender and race). The most frequently observed malignancies, other than non-melanoma skin cancer, were prostate, melanoma, colorectal, and breast cancers. The incidence of non-melanoma skin cancer was 0.46 per 100 patient-years of follow-up for ustekinumab-treated patients (69 patients in 15 165 patient-years of follow-up). The ratio of patients with basal versus squamous cell skin cancers (3:1) is comparable with the ratio expected in the general population (see section 4.4).

Hypersensitivity reactions

During the controlled periods of the psoriasis and psoriatic arthritis clinical studies of ustekinumab, rash and urticaria have each been observed in < 1% of patients (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

Single doses up to 6 mg/kg have been administered intravenously in clinical studies without dose-limiting toxicity. In case of overdose, it is recommended that the patient be monitored for any signs or symptoms of adverse reactions and appropriate symptomatic treatment be instituted immediately.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Immunosuppressants, interleukin inhibitors, ATC code: L04AC05.

WEZENLA 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

Ustekinumab is a fully human IgG1κ monoclonal antibody that binds with specificity to the shared p40 protein subunit of human cytokines interleukin IL-12 and IL-23. Ustekinumab inhibits the bioactivity of human IL-12 and IL-23 by preventing p40 from binding to the IL-12R β 1 receptor protein expressed on the surface of immune cells. Ustekinumab cannot bind to IL-12 or IL-23 that is already bound to IL-12R β 1 cell surface receptors. Thus, ustekinumab is not likely to contribute to complement- or antibody-mediated cytotoxicity of cells with IL-12 and/or IL-23 receptors. IL-12 and IL-23 are heterodimeric cytokines secreted by activated antigen presenting cells, such as macrophages and dendritic cells, and both cytokines participate in immune functions; IL-12 stimulates natural killer (NK) cells and drives the differentiation of CD4+ T cells toward the T helper 1 (Th1) phenotype, IL-23 induces the T helper 17 (Th17) pathway. However, abnormal regulation of IL-12 and IL-23 has been associated with immune mediated diseases, such as psoriasis, psoriatic arthritis and Crohn's disease.

By binding the shared p40 subunit of IL-12 and IL-23, ustekinumab may exert its clinical effects in psoriasis, psoriatic arthritis and Crohn's disease through interruption of the Th1 and Th17 cytokine pathways, which are central to the pathology of these diseases.

In patients with Crohn's disease, treatment with ustekinumab resulted in a decrease in inflammatory markers including C-reactive protein (CRP) and faecal calprotectin during the induction phase, which

were then maintained throughout the maintenance phase. CRP was assessed during the study extension and the reductions observed during maintenance were generally sustained through week 252.

Immunisation

During the long term extension of Psoriasis Study 2 (PHOENIX 2), adult patients treated with ustekinumab for at least 3.5 years mounted similar antibody responses to both pneumococcal polysaccharide and tetanus vaccines as a non-systemically treated psoriasis control group. Similar proportions of adult patients developed protective levels of anti-pneumococcal and anti-tetanus antibodies and antibody titres were similar among ustekinumab-treated and control patients.

Clinical efficacy and safety

Plaque psoriasis (adults)

The safety and efficacy of ustekinumab was assessed in 1 996 patients in two randomised, double-blind, placebo-controlled studies in patients with moderate to severe plaque psoriasis and who were candidates for phototherapy or systemic therapy. In addition, a randomised, blinded assessor, active-controlled study compared ustekinumab and etanercept in patients with moderate to severe plaque psoriasis who had had an inadequate response to, intolerance to, or contraindication to ciclosporin, MTX, or PUVA.

Psoriasis Study 1 (PHOENIX 1) evaluated 766 patients. 53% of these patients were either non-responsive, intolerant, or had a contraindication to other systemic therapy. Patients randomised to ustekinumab received 45 mg or 90 mg doses at weeks 0 and 4 and followed by the same dose every 12 weeks. Patients randomised to receive placebo at weeks 0 and 4 crossed over to receive ustekinumab (either 45 mg or 90 mg) at weeks 12 and 16 followed by dosing every 12 weeks. Patients originally randomised to ustekinumab who achieved Psoriasis Area and Severity Index 75 response (PASI improvement of at least 75% relative to baseline) at both weeks 28 and 40 were re-randomised to receive ustekinumab every 12 weeks or to placebo (i.e. withdrawal of therapy). Patients who were re-randomised to placebo at week 40 reinitiated ustekinumab at their original dosing regimen when they experienced at least a 50% loss of their PASI improvement obtained at week 40. All patients were followed for up to 76 weeks following first administration of study treatment.

Psoriasis Study 2 (PHOENIX 2) evaluated 1 230 patients. 61% of these patients were either non-responsive, intolerant, or had a contraindication to other systemic therapy. Patients randomised to ustekinumab received 45 mg or 90 mg doses at weeks 0 and 4 followed by an additional dose at 16 weeks. Patients randomised to receive placebo at weeks 0 and 4 crossed over to receive ustekinumab (either 45 mg or 90 mg) at weeks 12 and 16. All patients were followed for up to 52 weeks following first administration of study treatment.

Psoriasis Study 3 (ACCEPT) evaluated 903 patients with moderate to severe psoriasis who inadequately responded to, were intolerant to, or had a contraindication to other systemic therapy and compared the efficacy of ustekinumab to etanercept and evaluated the safety of ustekinumab and etanercept. During the 12-week active-controlled portion of the study, patients were randomised to receive etanercept (50 mg twice a week), ustekinumab 45 mg at weeks 0 and 4, or ustekinumab 90 mg at weeks 0 and 4.

Baseline disease characteristics were generally consistent across all treatment groups in Psoriasis Studies 1 and 2 with a median baseline PASI score from 17 to 18, median baseline Body Surface Area (BSA) ≥ 20 , and median Dermatology Life Quality Index (DLQI) range from 10 to 12. Approximately one third (Psoriasis Study 1) and one quarter (Psoriasis Study 2) of subjects had Psoriatic Arthritis (PsA). Similar disease severity was also seen in Psoriasis Study 3.

The primary endpoint in these studies was the proportion of patients who achieved PASI 75 response from baseline at week 12 (see tables 2 and 3).

Table 2. Summary of clinical response in Psoriasis Study 1 (PHOENIX 1) and Psoriasis Study 2 (PHOENIX 2)

| | Week 12 2 doses (week 0 and week 4) | | | Week 28 3 doses (week 0, week 4 and week 16) | |
|--|--|------------------------|------------------------|---|-----------|
| | PBO | 45 mg | 90 mg | 45 mg | 90 mg |
| Psoriasis Study 1 | | | | | |
| Number of patients randomised | 255 | 255 | 256 | 250 | 243 |
| PASI 50 response N (%) | 26 (10%) | 213 (84%) ^a | 220 (86%) ^a | 228 (91%) | 234 (96%) |
| PASI 75 response N (%) | 8 (3%) | 171 (67%) ^a | 170 (66%) ^a | 178 (71%) | 191 (79%) |
| PASI 90 response N (%) | 5 (2%) | 106 (42%) ^a | 94 (37%) ^a | 123 (49%) | 135 (56%) |
| PGA ^b of cleared or minimal N (%) | 10 (4%) | 151 (59%) ^a | 156 (61%) ^a | 146 (58%) | 160 (66%) |
| Number of patients ≤ 100 kg | 166 | 168 | 164 | 164 | 153 |
| PASI 75 response N (%) | 6 (4%) | 124 (74%) | 107 (65%) | 130 (79%) | 124 (81%) |
| Number of patients > 100 kg | 89 | 87 | 92 | 86 | 90 |
| PASI 75 response N (%) | 2 (2%) | 47 (54%) | 63 (68%) | 48 (56%) | 67 (74%) |
| Psoriasis Study 2 | | | | | |
| Number of patients randomised | 410 | 409 | 411 | 397 | 400 |
| PASI 50 response N (%) | 41 (10%) | 342 (84%) ^a | 367 (89%) ^a | 369 (93%) | 380 (95%) |
| PASI 75 response N (%) | 15 (4%) | 273 (67%) ^a | 311 (76%) ^a | 276 (70%) | 314 (79%) |
| PASI 90 response N (%) | 3 (1%) | 173 (42%) ^a | 209 (51%) ^a | 178 (45%) | 217 (54%) |
| PGA ^b of cleared or minimal N (%) | 18 (4%) | 277 (68%) ^a | 300 (73%) ^a | 241 (61%) | 279 (70%) |
| Number of patients ≤ 100 kg | 290 | 297 | 289 | 287 | 280 |
| PASI 75 response N (%) | 12 (4%) | 218 (73%) | 225 (78%) | 217 (76%) | 226 (81%) |
| Number of patients > 100 kg | 120 | 112 | 121 | 110 | 119 |
| PASI 75 response N (%) | 3 (3%) | 55 (49%) | 86 (71%) | 59 (54%) | 88 (74%) |

^a p < 0.001 for ustekinumab 45 mg or 90 mg in comparison with placebo (PBO).

^b PGA = Physician Global Assessment.

Table 3. Summary of clinical response at week 12 in Psoriasis Study 3 (ACCEPT)

| | Psoriasis Study 3 | | |
|---------------------------------|---|--|------------------------|
| | Etanercept 24 doses (50 mg twice a week) | Ustekinumab 2 doses (week 0 and week 4) | |
| | | 45 mg | 90 mg |
| Number of patients randomised | 347 | 209 | 347 |
| PASI 50 response N (%) | 286 (82%) | 181 (87%) | 320 (92%) ^a |
| PASI 75 response N (%) | 197 (57%) | 141 (67%) ^b | 256 (74%) ^a |
| PASI 90 response N (%) | 80 (23%) | 76 (36%) ^a | 155 (45%) ^a |
| PGA of cleared or minimal N (%) | 170 (49%) | 136 (65%) ^a | 245 (71%) ^a |
| Number of patients ≤ 100 kg | 251 | 151 | 244 |
| PASI 75 response N (%) | 154 (61%) | 109 (72%) | 189 (77%) |
| Number of patients > 100 kg | 96 | 58 | 103 |
| PASI 75 response N (%) | 43 (45%) | 32 (55%) | 67 (65%) |

^a p < 0.001 for ustekinumab 45 mg or 90 mg in comparison with etanercept.

^b p = 0.012 for ustekinumab 45 mg in comparison with etanercept.

In Psoriasis Study 1 maintenance of PASI 75 was significantly superior with continuous treatment compared with treatment withdrawal ($p < 0.001$). Similar results were seen with each dose of ustekinumab. At 1 year (week 52), 89% of patients re-randomised to maintenance treatment were PASI 75 responders compared with 63% of patients re-randomised to placebo (treatment withdrawal) ($p < 0.001$). At 18 months (week 76), 84% of patients re-randomised to maintenance treatment were PASI 75 responders compared with 19% of patients re-randomised to placebo (treatment withdrawal). At 3 years (week 148), 82% of patients re-randomised to maintenance treatment were PASI 75 responders. At 5 years (week 244), 80% of patients re-randomised to maintenance treatment were PASI 75 responders.

In patients re-randomised to placebo, and who reinitiated their original ustekinumab treatment regimen after loss of $\geq 50\%$ of PASI improvement 85% regained PASI 75 response within 12 weeks after re-initiating therapy.

In Psoriasis Study 1, at week 2 and week 12, significantly greater improvements from baseline were demonstrated in the DLQI in each ustekinumab treatment group compared with placebo. The improvement was sustained through week 28. Similarly, significant improvements were seen in Psoriasis Study 2 at week 4 and 12, which were sustained through week 24. In Psoriasis Study 1, improvements in nail psoriasis (Nail Psoriasis Severity Index), in the physical and mental component summary scores of the SF-36 and in the Itch Visual Analogue Scale (VAS) were also significant in each ustekinumab treatment group compared with placebo. In Psoriasis Study 2, the Hospital Anxiety and Depression Scale (HADS) and Work Limitations Questionnaire (WLQ) were also significantly improved in each ustekinumab treatment group compared with placebo.

Psoriatic arthritis (PsA) (adults)

Ustekinumab has been shown to improve signs and symptoms, physical function and health-related quality of life, and reduce the rate of progression of peripheral joint damage in adult patients with active PsA.

The safety and efficacy of ustekinumab was assessed in 927 patients in two randomised, double-blind, placebo-controlled studies in patients with active PsA (≥ 5 swollen joints and ≥ 5 tender joints) despite non-steroidal anti-inflammatory (NSAID) or disease modifying anti-rheumatic (DMARD) therapy. Patients in these studies had a diagnosis of PsA for at least 6 months. Patients with each subtype of PsA were enrolled, including polyarticular arthritis with no evidence of rheumatoid nodules (39%), spondylitis with peripheral arthritis (28%), asymmetric peripheral arthritis (21%), distal interphalangeal involvement (12%) and arthritis mutilans (0.5%). Over 70% and 40% of the patients in both studies had enthesitis and dactylitis at baseline, respectively. Patients were randomised to receive treatment with ustekinumab 45 mg, 90 mg, or placebo subcutaneously at weeks 0 and 4 followed by every 12 weeks (q12w) dosing. Approximately 50% of patients continued on stable doses of MTX (≤ 25 mg/week).

In PsA Study 1 (PSUMMIT I) and PsA Study 2 (PSUMMIT II), 80% and 86% of the patients, respectively, had been previously treated with DMARDs. In Study 1 previous treatment with anti-tumour necrosis factor (TNF) α agent was not allowed. In Study 2, the majority of patients (58%, $n = 180$) had been previously treated with one or more anti-TNF α agent(s), of whom over 70% had discontinued their anti-TNF α treatment for lack of efficacy or intolerance at any time.

Signs and symptoms

Treatment with ustekinumab resulted in significant improvements in the measures of disease activity compared to placebo at week 24. The primary endpoint was the percentage of patients who achieved American College of Rheumatology (ACR) 20 response at week 24. The key efficacy results are shown in table 4 below.

Table 4. Number of patients who achieved clinical response in Psoriatic arthritis Study 1 (PSUMMIT I) and Study 2 (PSUMMIT II) at week 24

| | Psoriatic arthritis Study 1 | | | Psoriatic arthritis Study 2 | | |
|--|-----------------------------|-----------------------|------------------------|-----------------------------|-----------------------|-----------------------|
| | PBO | 45 mg | 90 mg | PBO | 45 mg | 90 mg |
| Number of patients randomised | 206 | 205 | 204 | 104 | 103 | 105 |
| ACR 20 response, N (%) | 47 (23%) | 87 (42%) ^a | 101 (50%) ^a | 21 (20%) | 45 (44%) ^a | 46 (44%) ^a |
| ACR 50 response, N (%) | 18 (9%) | 51 (25%) ^a | 57 (28%) ^a | 7 (7%) | 18 (17%) ^b | 24 (23%) ^a |
| ACR 70 response, N (%) | 5 (2%) | 25 (12%) ^a | 29 (14%) ^a | 3 (3%) | 7 (7%) ^c | 9 (9%) ^c |
| <i>Number of patients with $\geq 3\%$ BSA^d</i> | 146 | 145 | 149 | 80 | 80 | 81 |
| PASI 75 response, N (%) | 16 (11%) | 83 (57%) ^a | 93 (62%) ^a | 4 (5%) | 41 (51%) ^a | 45 (56%) ^a |
| PASI 90 response, N (%) | 4 (3%) | 60 (41%) ^a | 65 (44%) ^a | 3 (4%) | 24 (30%) ^a | 36 (44%) ^a |
| Combined PASI 75 and ACR 20 response, N (%) | 8 (5%) | 40 (28%) ^a | 62 (42%) ^a | 2 (3%) | 24 (30%) ^a | 31 (38%) ^a |
| Number of patients ≤ 100 kg | 154 | 153 | 154 | 74 | 74 | 73 |
| ACR 20 response, N (%) | 39 (25%) | 67 (44%) | 78 (51%) | 17 (23%) | 32 (43%) | 34 (47%) |
| <i>Number of patients with $\geq 3\%$ BSA^d</i> | 105 | 105 | 111 | 54 | 58 | 57 |
| PASI 75 response, N (%) | 14 (13%) | 64 (61%) | 73 (66%) | 4 (7%) | 31 (53%) | 32 (56%) |
| Number of patients > 100 kg | 52 | 52 | 50 | 30 | 29 | 31 |
| ACR 20 response, N (%) | 8 (15%) | 20 (38%) | 23 (46%) | 4 (13%) | 13 (45%) | 12 (39%) |
| <i>Number of patients with $\geq 3\%$ BSA^d</i> | 41 | 40 | 38 | 26 | 22 | 24 |
| PASI 75 response, N (%) | 2 (5%) | 19 (48%) | 20 (53%) | 0 | 10 (45%) | 13 (54%) |

^ap < 0.001

^bp < 0.05

^cp = NS

^dNumber of patients with $\geq 3\%$ BSA psoriasis skin involvement at baseline

ACR 20, 50 and 70 responses continued to improve or were maintained through week 52 (PsA Study 1 and 2) and week 100 (PsA Study 1). In PsA Study 1, ACR 20 responses at week 100 were achieved by 57% and 64%, for 45 mg and 90 mg, respectively. In PsA Study 2, ACR 20 responses at week 52 were achieved by 47% and 48%, for 45 mg and 90 mg, respectively.

The proportion of patients achieving a modified PsA response criteria (PsARC) response was also significantly greater in the ustekinumab groups compared to placebo at week 24. PsARC responses were maintained through weeks 52 and 100. A higher proportion of patients treated with ustekinumab

who had spondylitis with peripheral arthritis as their primary presentation, demonstrated 50 and 70 percent improvement in Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) scores compared with placebo at week 24.

Responses observed in the ustekinumab-treated groups were similar in patients receiving and not receiving concomitant MTX, and were maintained through weeks 52 and 100. Patients previously treated with anti-TNF α agents who received ustekinumab achieved a greater response at week 24 than patients receiving placebo (ACR 20 response at week 24 for 45 mg and 90 mg was 37% and 34%, respectively, compared with placebo 15%; $p < 0.05$), and responses were maintained through week 52.

For patients with enthesitis and/or dactylitis at baseline, in PsA Study 1 significant improvement in enthesitis and dactylitis score was observed in the ustekinumab groups compared with placebo at week 24. In PsA Study 2 significant improvement in enthesitis score and numerical improvement (not statistically significant) in dactylitis score was observed in the ustekinumab 90 mg group compared with placebo at week 24. Improvements in enthesitis score and dactylitis score were maintained through weeks 52 and 100.

Radiographic response

Structural damage in both hands and feet was expressed as change in total van der Heijde-Sharp score (vdH-S score), modified for PsA by addition of hand distal interphalangeal joints, compared to baseline. A pre-specified integrated analysis combining data from 927 subjects in both PsA Study 1 and 2 was performed. Ustekinumab demonstrated a statistically significant decrease in the rate of progression of structural damage compared to placebo, as measured by change from baseline to week 24 in the total modified vdH-S score (mean \pm SD score was 0.97 ± 3.85 in the placebo group compared with 0.40 ± 2.11 and 0.39 ± 2.40 in the ustekinumab 45 mg ($p < 0.05$) and 90 mg ($p < 0.001$) groups, respectively). This effect was driven by PsA Study 1. The effect is considered demonstrated irrespective of concomitant MTX use, and was maintained through weeks 52 (integrated analysis) and 100 (PsA Study 1).

Physical function and health-related quality of life

Ustekinumab-treated patients showed significant improvement in physical function as assessed by the Disability Index of the Health Assessment Questionnaire (HAQ-DI) at week 24. The proportion of patients achieving a clinically meaningful ≥ 0.3 improvement in HAQ-DI score from baseline was also significantly greater in the ustekinumab groups when compared with placebo. Improvement in HAQ-DI score from baseline was maintained through weeks 52 and 100.

There was significant improvement in DLQI scores in the ustekinumab groups as compared with placebo at week 24, which was maintained through weeks 52 and 100. In PsA Study 2 there was a significant improvement in Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F) scores in the ustekinumab groups when compared with placebo at week 24. The proportion of patients achieving a clinically significant improvement in fatigue (4 points in FACIT-F) was also significantly greater in the ustekinumab groups compared with placebo. Improvements in FACIT scores were maintained through week 52.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with ustekinumab in one or more subsets of the paediatric population with juvenile idiopathic arthritis. The pre-filled pen has not been studied in the paediatric psoriasis population and is not recommended for use by paediatric patients.

Crohn's disease

The safety and efficacy of ustekinumab was assessed in three randomised, double-blind, placebo-controlled, multicentre studies in adult patients with moderately to severely active Crohn's

disease (Crohn's Disease Activity Index [CDAI] score of ≥ 220 and ≤ 450). The clinical development program consisted of two 8 week intravenous induction studies (UNITI-1 and UNITI-2) followed by a 44-week subcutaneous randomised withdrawal maintenance study (IM-UNITI) representing 52 weeks of therapy.

The induction studies included 1 409 (UNITI-1, n = 769; UNITI-2 n = 640) patients. The primary endpoint for both induction studies was the proportion of subjects in clinical response (defined as a reduction in CDAI score of ≥ 100 points) at week 6. Efficacy data were collected and analysed through week 8 for both studies. Concomitant doses of oral corticosteroids, immunomodulators, aminosalicylates and antibiotics were permitted and 75% of patients continued to receive at least one of these medications. In both studies, patients were randomised to receive a single intravenous administration of either the recommended tiered dose of approximately 6 mg/kg (see section 4.2 of the WEZENLA 130 mg concentrate for solution for infusion SmPC), a fixed dose of 130 mg ustekinumab, or placebo at week 0.

Patients in UNITI-1 had failed or were intolerant to prior anti-TNF α therapy. Approximately 48% of the patients had failed 1 prior anti-TNF α therapy and 52% had failed 2 or 3 prior anti-TNF α therapies. In this study, 29.1% of the patients had an inadequate initial response (primary non-responders), 69.4% responded but lost response (secondary non-responders), and 36.4% were intolerant to anti-TNF α therapies.

Patients in UNITI-2 had failed at least one conventional therapy, including corticosteroids or immunomodulators, and were either anti-TNF- α naïve (68.6%) or had previously received but not failed anti-TNF α therapy (31.4%).

In both UNITI-1 and UNITI-2, a significantly greater proportion of patients were in clinical response and remission in the ustekinumab-treated group compared to placebo (see table 5). Clinical response and remission were significant as early as week 3 in ustekinumab-treated patients and continued to improve through week 8. In these induction studies, efficacy was higher and better sustained in the tiered dose group compared to the 130 mg dose group, and tiered dosing is therefore the recommended intravenous induction dose.

Table 5. Induction of clinical response and remission in UNITI-1 and UNITI-2

| | UNITI-1* | | UNITI-2** | |
|---------------------------------------|--------------------|--|--------------------|--|
| | Placebo N = 247 | Recommended dose of ustekinumab N = 249 | Placebo N = 209 | Recommended dose of ustekinumab N = 209 |
| Clinical remission, week 8 | 18 (7.3%) | 52 (20.9%) ^a | 41 (19.6%) | 84 (40.2%) ^a |
| Clinical response (100 point), week 6 | 53 (21.5%) | 84 (33.7%) ^b | 60 (28.7%) | 116 (55.5%) ^a |
| Clinical response (100 point), week 8 | 50 (20.2%) | 94 (37.8%) ^a | 67 (32.1%) | 121 (57.9%) ^a |
| 70 point response, week 3 | 67 (27.1%) | 101 (40.6%) ^b | 66 (31.6%) | 106 (50.7%) ^a |
| 70 point response, week 6 | 75 (30.4%) | 109 (43.8%) ^b | 81 (38.8%) | 135 (64.6%) ^a |

Clinical remission is defined as CDAI score < 150 ; Clinical response is defined as reduction in CDAI score by at least 100 points or being in clinical remission

70 point response is defined as reduction in CDAI score by at least 70 points

* Anti-TNF α failures

** Conventional therapy failures

^a p < 0.001

^b p < 0.01

The maintenance study (IM-UNITI), evaluated 388 patients who achieved 100 point clinical response at week 8 of induction with ustekinumab in studies UNITI-1 and UNITI-2. Patients were randomised to receive a subcutaneous maintenance regimen of either 90 mg ustekinumab every 8 weeks, 90 mg

ustekinumab every 12 weeks or placebo for 44 weeks (for recommended maintenance posology, see section 4.2).

Significantly higher proportions of patients maintained clinical remission and response in the ustekinumab-treated groups compared to the placebo group at week 44 (see table 6).

Table 6. Maintenance of clinical response and remission in IM-UNITI (week 44; 52 weeks from initiation of the induction dose)

| | Placebo* | 90 mg ustekinumab every 8 weeks | 90 mg ustekinumab every 12 weeks |
|--|----------------------|---------------------------------------|--|
| | N = 131 [†] | N = 128 [†] | N = 129 [†] |
| Clinical remission | 36% | 53% ^a | 49% ^b |
| Clinical response | 44% | 59% ^b | 58% ^b |
| Corticosteroid-free clinical remission | 30% | 47% ^a | 43% ^c |
| Clinical remission in patients: | | | |
| in remission at the start of maintenance therapy | 46% (36/79) | 67% (52/78) ^a | 56% (44/78) |
| who entered from study CRD3002 [‡] | 44% (31/70) | 63% (45/72) ^c | 57% (41/72) |
| who are Anti-TNF α naïve | 49% (25/51) | 65% (34/52) ^c | 57% (30/53) |
| who entered from study CRD3001 [§] | 26% (16/61) | 41% (23/56) | 39% (22/57) |

Clinical remission is defined as CDAI score < 150; Clinical response is defined as reduction in CDAI of at least 100 points or being in clinical remission

* The placebo group consisted of patients who were in response to ustekinumab and were randomised to receive placebo at the start of maintenance therapy

[†] Patients who were in 100 point clinical response to ustekinumab at start of maintenance therapy

[‡] Patients who failed conventional therapy but not anti-TNF α therapy

[§] Patients who are anti-TNF α refractory/intolerant

^a p < 0.01

^b p < 0.05

^c nominally significant (p < 0.05)

In IM-UNITI, 29 of 129 patients did not maintain response to ustekinumab when treated every 12 weeks and were allowed to dose adjust to receive ustekinumab every 8 weeks. Loss of response was defined as a CDAI score \geq 220 points and a \geq 100 point increase from the CDAI score at baseline. In these patients, clinical remission was achieved in 41.4% of patients 16 weeks after dose adjustment.

Patients who were not in clinical response to ustekinumab induction at week 8 of the UNITI-1 and UNITI-2 induction studies (476 patients) entered into the non-randomised portion of the maintenance study (IM-UNITI) and received a 90 mg subcutaneous injection of ustekinumab at that time. Eight weeks later, 50.5% of the patients achieved clinical response and continued to receive maintenance dosing every 8 weeks; among these patients with continued maintenance dosing, a majority maintained response (68.1%) and achieved remission (50.2%) at week 44, at proportions that were similar to the patients who initially responded to ustekinumab induction.

Of 131 patients who responded to ustekinumab induction, and were randomised to the placebo group at the start of the maintenance study, 51 subsequently lost response and received 90 mg ustekinumab subcutaneously every 8 weeks. The majority of patients who lost response and resumed ustekinumab did so within 24 weeks of the induction infusion. Of these 51 patients, 70.6% achieved clinical response and 39.2% percent achieved clinical remission 16 weeks after receiving the first subcutaneous dose of ustekinumab.

In IM-UNITI, patients who completed the study through week 44 were eligible to continue treatment in a study extension. Among the 567 patients who entered on and were treated with ustekinumab in the study extension, clinical remission and response were generally maintained through week 252 for both patients who failed TNF-therapies and those who failed conventional therapies.

No new safety concerns were identified in this study extension with up to 5 years of treatment in patients with Crohn's disease.

Endoscopy

Endoscopic appearance of the mucosa was evaluated in 252 patients with eligible baseline endoscopic disease activity in a substudy. The primary endpoint was change from baseline in Simplified Endoscopic Disease Severity Score for Crohn's Disease (SES-CD), a composite score across 5 ileo-colonic segments of presence/size of ulcers, proportion of mucosal surface covered by ulcers, proportion of mucosal surface affected by any other lesions and presence/type of narrowing/strictures. At week 8, after a single intravenous induction dose, the change in SES-CD score was greater in the ustekinumab group (n = 155, mean change = -2.8) than in the placebo group (n = 97, mean change = -0.7, p = 0.012).

Fistula response

In a subgroup of patients with draining fistulas at baseline (8.8%; n = 26), 12/15 (80%) of ustekinumab-treated patients achieved a fistula response over 44 weeks (defined as $\geq 50\%$ reduction from baseline of the induction study in the number of draining fistulas) compared to 5/11 (45.5%) exposed to placebo.

Health-related quality of life

Health-related quality of life was assessed by Inflammatory Bowel Disease Questionnaire (IBDQ) and SF-36 questionnaires. At week 8, patients receiving ustekinumab showed statistically significantly greater and clinically meaningful improvements on IBDQ total score and SF-36 Mental Component Summary Score in both UNITI-1 and UNITI-2, and SF-36 Physical Component Summary Score in UNITI-2, when compared to placebo. These improvements were generally better maintained in ustekinumab-treated patients in the IM-UNITI study through week 44 when compared to placebo. Improvement in health-related quality of life was generally maintained during the extension through week 252.

Immunogenicity

Antibodies to ustekinumab may develop during ustekinumab treatment and most are neutralising. The formation of anti-ustekinumab antibodies is associated with both increased clearance and reduced efficacy of ustekinumab, except in patients with Crohn's disease where no reduced efficacy was observed. There is no apparent correlation between the presence of anti-ustekinumab antibodies and the occurrence of injection site reactions.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with ustekinumab in one or more subsets of the paediatric population in Crohn's disease. The pre-filled pen has not been studied in the paediatric population and is not recommended for use by paediatric patients.

5.2 Pharmacokinetic properties

Absorption

The median time to reach the maximum serum concentration (t_{max}) was 8.5 days after a single 90 mg subcutaneous administration in healthy subjects. The median t_{max} values of ustekinumab following a single subcutaneous administration of either 45 mg or 90 mg in patients with psoriasis were comparable to those observed in healthy subjects.

The absolute bioavailability of ustekinumab following a single subcutaneous administration was estimated to be 57.2% in patients with psoriasis.

Distribution

Median volume of distribution during the terminal phase (V_z) following a single intravenous administration to patients with psoriasis ranged from 57 to 83 mL/kg.

Biotransformation

The exact metabolic pathway for ustekinumab is unknown.

Elimination

Median systemic clearance (CL) following a single intravenous administration to patients with psoriasis ranged from 1.99 to 2.34 mL/day/kg. Median half-life ($t_{1/2}$) of ustekinumab was approximately 3 weeks in patients with psoriasis, psoriatic arthritis or Crohn's disease, ranging from 15 to 32 days across all psoriasis and psoriatic arthritis studies. In a population pharmacokinetic analysis, the apparent clearance (CL/F) and apparent volume of distribution (V/F) were 0.465 L/day and 15.7 L, respectively, in patients with psoriasis. The CL/F of ustekinumab was not impacted by gender. Population pharmacokinetic analysis showed that there was a trend towards a higher clearance of ustekinumab in patients who tested positive for antibodies to ustekinumab.

Dose linearity

The systemic exposure of ustekinumab (C_{max} and AUC) increased in an approximately dose-proportional manner after a single intravenous administration at doses ranging from 0.09 mg/kg to 4.5 mg/kg or following a single subcutaneous administration at doses ranging from approximately 24 mg to 240 mg in patients with psoriasis.

Single dose versus multiple doses

Serum concentration-time profiles of ustekinumab were generally predictable after single or multiple subcutaneous dose administrations. In patients with psoriasis, steady-state serum concentrations of ustekinumab were achieved by week 28 after initial subcutaneous doses at weeks 0 and 4 followed by doses every 12 weeks. The median steady-state trough concentration ranged from 0.21 mcg/mL to 0.26 mcg/mL (45 mg) and from 0.47 mcg/mL to 0.49 mcg/mL (90 mg). There was no apparent accumulation in serum ustekinumab concentration over time when given subcutaneously every 12 weeks.

In patients with Crohn's disease, following an intravenous dose of ~6 mg/kg, starting at week 8, subcutaneous maintenance dosing of 90 mg ustekinumab was administered every 8 or 12 weeks. Steady state ustekinumab concentration was achieved by the start of the second maintenance dose. In patients with Crohn's disease, median steady-state trough concentrations ranged from 1.97 mcg/mL to 2.24 mcg/mL and from 0.61 mcg/mL to 0.76 mcg/mL for 90 mg ustekinumab every 8 weeks or every 12 weeks respectively. The steady-state trough ustekinumab levels resulting from 90 mg ustekinumab every 8 weeks were associated with higher clinical remission rates as compared to the steady-state trough levels following 90 mg every 12 weeks.

Impact of weight on pharmacokinetics

In a population pharmacokinetic analysis using data from patients with psoriasis, body weight was found to be the most significant covariate affecting the clearance of ustekinumab. The median CL/F in patients with weight > 100 kg was approximately 55% higher compared to patients with weight ≤ 100 kg. The median V/F in patients with weight > 100 kg was approximately 37% higher as compared to patients with weight ≤ 100 kg. The median trough serum concentrations of ustekinumab in patients with higher weight (> 100 kg) in the 90 mg group were comparable to those in patients with

lower weight (≤ 100 kg) in the 45 mg group. Similar results were obtained from a confirmatory population pharmacokinetic analysis using data from patients with psoriatic arthritis.

Dosing frequency adjustment

In patients with Crohn's disease, based on observed data and population PK analyses, randomised subjects who lost response to treatment had lower serum ustekinumab concentrations over time compared with subjects who did not lose response. In Crohn's disease, dose adjustment from 90 mg every 12 weeks to 90 mg every 8 weeks was associated with an increase in trough serum ustekinumab concentrations and an accompanying increase in efficacy.

Special populations

No pharmacokinetic data are available in patients with impaired renal or hepatic function. No specific studies have been conducted in elderly patients.

The pharmacokinetics of ustekinumab were generally comparable between Asian and non-Asian patients with psoriasis.

In patients with Crohn's disease, variability in ustekinumab clearance was affected by body weight, serum albumin level, sex, and antibody to ustekinumab status while body weight was the main covariate affecting the volume of distribution. Additionally in Crohn's disease, clearance was affected by C-reactive protein, TNF antagonist failure status and race (Asian versus non-Asian). The impact of these covariates was within $\pm 20\%$ of the typical or reference value of the respective PK parameter, thus dose adjustment is not warranted for these covariates. Concomitant use of immunomodulators did not have a significant impact on ustekinumab disposition.

In the population pharmacokinetic analysis, there were no indications of an effect of tobacco or alcohol on the pharmacokinetics of ustekinumab.

The bioavailability of ustekinumab following administration by syringe or pre-filled pen was comparable.

The pre-filled pen has not been studied in the paediatric population and is not recommended for use by paediatric patients.

Regulation of CYP450 enzymes

The effects of IL-12 or IL-23 on the regulation of CYP450 enzymes were evaluated in an *in vitro* study using human hepatocytes, which showed that IL-12 and/or IL-23 at levels of 10 ng/mL did not alter human CYP450 enzyme activities (CYP1A2, 2B6, 2C9, 2C19, 2D6, or 3A4; see section 4.5).

A phase 1, open-label, drug interaction study, Study CNT01275CRD1003, was conducted to evaluate the effect of ustekinumab on cytochrome P450 enzyme activities following induction and maintenance dosing in patients with active Crohn's disease (n = 18). No clinically significant changes in exposure of caffeine (CYP1A2 substrate), warfarin (CYP2C9 substrate), omeprazole (CYP2C19 substrate), dextromethorphan (CYP2D6 substrate), or midazolam (CYP3A substrate) were observed when used concomitantly with ustekinumab at the approved recommended dosing in patients with Crohn's disease (see section 4.5).

5.3 Preclinical safety data

Non-clinical data reveal no special hazard (e.g. organ toxicity) for humans based on studies of repeated-dose toxicity and developmental and reproductive toxicity, including safety pharmacology evaluations. In developmental and reproductive toxicity studies in cynomolgus monkeys, neither adverse effects on male fertility indices nor birth defects or developmental toxicity were observed. No

adverse effects on female fertility indices were observed using an analogous antibody to IL-12/23 in mice.

Dose levels in animal studies were up to approximately 45-fold higher than the highest equivalent dose intended to be administered to psoriasis patients and resulted in peak serum concentrations in monkeys that were more than 100-fold higher than observed in humans.

Carcinogenicity studies were not performed with ustekinumab due to the lack of appropriate models for an antibody with no cross-reactivity to rodent IL-12/23 p40.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

L-histidine
L-histidine hydrochloride monohydrate
Polysorbate 80 (E 433)
Sucrose
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

WEZENLA 45 mg solution for injection in pre-filled pen

3 years

WEZENLA 90 mg solution for injection in pre-filled pen

3 years

Individual pre-filled pens may be stored at room temperature up to 30°C for a maximum single period of up to 30 days in the original carton in order to protect from light. Record the date when the pre-filled pen is first removed from the refrigerator and the discard date. The discard date must not exceed the original expiry date printed on the carton. Once a pre-filled pen has been stored at room temperature (up to 30°C), it should not be returned to the refrigerator. Discard the pre-filled pen if not used within 30 days at room temperature storage or by the original expiry date, whichever is earlier.

6.4 Special precautions for storage

Store in a refrigerator (2°C – 8°C).

Do not freeze.

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

If needed, individual pre-filled pens may be stored at room temperature up to 30°C (see section 6.3).

6.5 Nature and contents of container

WEZENLA 45 mg solution for injection in pre-filled pen

0.5 mL solution in a type I glass 1 mL pre-filled syringe with a fixed stainless steel needle, assembled in a pen.

WEZENLA 90 mg solution for injection in pre-filled pen

1 mL solution in a type I glass 1 mL pre-filled syringe with a fixed stainless steel needle, assembled in a pen.

WEZENLA is available in a pack of 1 pre-filled pen.

6.6 Special precautions for disposal and other handling

The solution in the WEZENLA pre-filled pen should not be shaken. The solution should be visually inspected for particulate matter or discolouration prior to subcutaneous administration. The solution is clear to opalescent, colourless to light yellow. The medicinal product should not be used if the solution is discoloured or cloudy, or if foreign particulate matter is present. Before administration, WEZENLA should be allowed to reach room temperature (approximately half an hour). Detailed instructions for use are provided in the package leaflet.

WEZENLA does not contain preservatives; therefore any unused medicinal product remaining in the pre-filled pen should not be used. WEZENLA is supplied as a sterile, single-use pre-filled pen. The pre-filled pen must never be re-used. Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MARKETING AUTHORISATION HOLDER

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

8. MARKETING AUTHORISATION NUMBER(S)

WEZENLA 45 mg solution for injection in pre-filled pen

EU/1/24/1823/005

WEZENLA 90 mg solution for injection in pre-filled pen

EU/1/24/1823/006

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 20 June 2024

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

Name and address of the manufacturer of the biological active substance

Immunex Rhode Island Corporation
40 Technology Way
West Greenwich
Rhode Island, 02817
United States

Name and address of the manufacturers responsible for batch release

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

Amgen NV
Telecomlaan 5-7
1831 Diegem
Belgium

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

B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE

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

C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION

• Periodic safety update reports (PSURs)

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

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

• Risk management plan (RMP)

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

An updated RMP should be submitted:

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

ANNEX III
LABELLING AND PACKAGE LEAFLET

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

OUTER CARTON VIAL

1. NAME OF THE MEDICINAL PRODUCT

WEZENLA 130 mg concentrate for solution for infusion
ustekinumab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each vial contains 130 mg of ustekinumab in 26 mL.

3. LIST OF EXCIPIENTS

EDTA disodium salt dihydrate, L-histidine, L-histidine hydrochloride monohydrate, L-methionine, polysorbate 80 (E 433), sucrose, sodium hydroxide (for pH adjustment), water for injections.

4. PHARMACEUTICAL FORM AND CONTENTS

Concentrate for solution for infusion
1 vial

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Do not shake.
Read the package leaflet before use.
For single use only.
For intravenous use after dilution.

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 vial 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

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/24/1823/004

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Justification for not including in Braille accepted.

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

VIAL LABEL

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

WEZENLA 130 mg concentrate for solution for infusion
ustekinumab

2. METHOD OF ADMINISTRATION

For IV use after dilution.
Do not shake.

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT

130 mg/26 mL

6. OTHER

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

OUTER CARTON VIAL

1. NAME OF THE MEDICINAL PRODUCT

WEZENLA 45 mg solution for injection
ustekinumab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each vial contains 45 mg of ustekinumab in 0.5 mL.

3. LIST OF EXCIPIENTS

Sucrose, L-histidine, L-histidine hydrochloride monohydrate, polysorbate 80 (E 433), water for injections.

4. PHARMACEUTICAL FORM AND CONTENTS

Solution for injection

1 vial

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Do not shake.

For subcutaneous use.

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 vial 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

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/24/1823/001

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

WEZENLA 45 mg vial

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

VIAL LABEL

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

WEZENLA 45 mg solution for injection
ustekinumab
SC

2. METHOD OF ADMINISTRATION

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT

45 mg/0.5 mL

6. OTHER

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

OUTER CARTON PRE-FILLED SYRINGE

1. NAME OF THE MEDICINAL PRODUCT

WEZENLA 45 mg solution for injection in pre-filled syringe
ustekinumab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each pre-filled syringe contains 45 mg of ustekinumab in 0.5 mL.

3. LIST OF EXCIPIENTS

Sucrose, L-histidine, L-histidine hydrochloride monohydrate, polysorbate 80 (E 433), water for injections.

4. PHARMACEUTICAL FORM AND CONTENTS

Solution for injection in pre-filled syringe
1 pre-filled syringe

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Do not shake.
For subcutaneous use.
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

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/24/1823/002

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

WEZENLA 45 mg syringe

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER – HUMAN READABLE DATA

PC
SN
NN

MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS

BLISTERED PRE-FILLED SYRINGE

1. NAME OF THE MEDICINAL PRODUCT

WEZENLA 45 mg injection
ustekinumab

2. NAME OF THE MARKETING AUTHORISATION HOLDER

Amgen

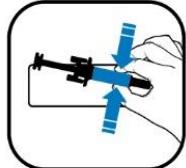
3. EXPIRY DATE

EXP

4. BATCH NUMBER<, DONATION AND PRODUCT CODES>

Lot

5. OTHER



MINIMUM PARTICULARS TO APPEAR ON SMALL IMMEDIATE PACKAGING UNITS
PRE-FILLED SYRINGE LABEL

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

WEZENLA 45 mg injection
ustekinumab
SC

2. METHOD OF ADMINISTRATION

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT

45 mg/0.5 mL

6. OTHER

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

CARTON PRE-FILLED SYRINGE

1. NAME OF THE MEDICINAL PRODUCT

WEZENLA 90 mg solution for injection in pre-filled syringe
ustekinumab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each pre-filled syringe contains 90 mg of ustekinumab in 1 mL.

3. LIST OF EXCIPIENTS

Sucrose, L-histidine, L-histidine hydrochloride monohydrate, polysorbate 80 (E 433), water for injections.

4. PHARMACEUTICAL FORM AND CONTENTS

Solution for injection in pre-filled syringe
1 pre-filled syringe

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Do not shake.
For subcutaneous use.
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

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/24/1823/003

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

WEZENLA 90 mg syringe

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER – HUMAN READABLE DATA

PC
SN
NN

MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS

BLISTERED PRE-FILLED SYRINGE

1. NAME OF THE MEDICINAL PRODUCT

WEZENLA 90 mg injection
ustekinumab

2. NAME OF THE MARKETING AUTHORISATION HOLDER

Amgen

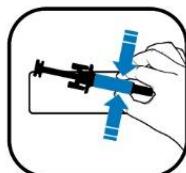
3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. OTHER



MINIMUM PARTICULARS TO APPEAR ON SMALL IMMEDIATE PACKAGING UNITS
LABEL PRE-FILLED SYRINGE

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

WEZENLA 90 mg injection
ustekinumab
SC

2. METHOD OF ADMINISTRATION

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT

90 mg/1 mL

6. OTHER

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

OUTER CARTON PRE-FILLED PEN

1. NAME OF THE MEDICINAL PRODUCT

WEZENLA 45 mg solution for injection in pre-filled pen
ustekinumab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each pre-filled pen contains 45 mg of ustekinumab in 0.5 mL.

3. LIST OF EXCIPIENTS

Sucrose, L-histidine, L-histidine hydrochloride monohydrate, polysorbate 80 (E 433), water for injections.

4. PHARMACEUTICAL FORM AND CONTENTS

Solution for injection in pre-filled pen
1 pre-filled pen (ConfiPen)

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Do not shake.

For subcutaneous use.

Read the package leaflet before use.

Push to open

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 pen 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**

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/24/1823/005

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY**15. INSTRUCTIONS ON USE****16. INFORMATION IN BRAILLE**

WEZENLA 45 mg pen

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
PRE-FILLED PEN LABEL

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

WEZENLA 45 mg injection
ustekinumab
SC

2. METHOD OF ADMINISTRATION

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT

45 mg/0.5 mL

6. OTHER

PARTICULARS TO APPEAR ON THE OUTER PACKAGING**CARTON PRE-FILLED PEN****1. NAME OF THE MEDICINAL PRODUCT**

WEZENLA 90 mg solution for injection in pre-filled pen
ustekinumab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each pre-filled pen contains 90 mg of ustekinumab in 1 mL.

3. LIST OF EXCIPIENTS

Sucrose, L-histidine, L-histidine hydrochloride monohydrate, polysorbate 80 (E 433), water for injections.

4. PHARMACEUTICAL FORM AND CONTENTS

Solution for injection in pre-filled pen
1 pre-filled pen (ConfiPen)

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Do not shake.
For subcutaneous use.
Read the package leaflet before use.
Push to open

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 pen 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

Amgen Technology (Ireland) UC,
Pottery Road,
Dun Laoghaire,
Co Dublin,
Ireland

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/24/1823/006

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

WEZENLA 90 mg pen

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 PRE-FILLED PEN

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

WEZENLA 90 mg injection
ustekinumab
SC

2. METHOD OF ADMINISTRATION

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT

90 mg/1 mL

6. OTHER

B. PACKAGE LEAFLET

Package leaflet: Information for the user

WEZENLA 130 mg concentrate for solution for infusion ustekinumab

▼ 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.

This leaflet has been written for the person taking the medicine.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet

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

1. What WEZENLA is and what it is used for

What WEZENLA is

WEZENLA contains the active substance 'ustekinumab', a monoclonal antibody. Monoclonal antibodies are proteins that recognise and bind specifically to certain proteins in the body.

WEZENLA belongs to a group of medicines called 'immunosuppressants'. These medicines work by weakening part of the immune system.

What WEZENLA is used for

WEZENLA is used to treat moderate to severe Crohn's disease in adults and children who weigh at least 40 kg.

Crohn's disease is an inflammatory disease of the bowel. If you have Crohn's disease you will first be given other medicines. If you do not respond well enough or are intolerant to these medicines, you may be given WEZENLA to reduce the signs and symptoms of your disease.

2. What you need to know before you use WEZENLA

Do not use WEZENLA

- **If you are allergic to ustekinumab** or any of the other ingredients of this medicine (listed in section 6).
- **If you have an active infection** which your doctor thinks is important.

If you are not sure if any of the above applies to you, talk to your doctor or pharmacist before using WEZENLA.

Warnings and precautions

Talk to your doctor or pharmacist before using WEZENLA. Your doctor will check how well you are before treatment. Make sure you tell your doctor about any illness you have before treatment. Also tell your doctor if you have recently been near anyone who might have tuberculosis. Your doctor will examine you and do a test for tuberculosis, before you have WEZENLA. If your doctor thinks you are at risk of tuberculosis, you may be given medicines to treat it.

Look out for serious side effects

WEZENLA can cause serious side effects, including allergic reactions and infections. You must look out for certain signs of illness while you are taking WEZENLA. See 'Serious side effects' in section 4 for a full list of these side effects.

Before you use WEZENLA tell your doctor:

- **If you ever had an allergic reaction to WEZENLA.** Ask your doctor if you are not sure.
- **If you have ever had any type of cancer** – this is because immunosuppressants like WEZENLA weaken part of the immune system. This may increase the risk of cancer.
- **If you have been treated for psoriasis with other biologic medicines (a medicine produced from a biological source and usually given by injection)** – the risk of cancer may be higher.
- **If you have or have had a recent infection or if you have any abnormal skin openings (fistulae).**
- **If you have any new or changing lesions** within psoriasis areas or on normal skin.
- **If you are having any other treatment for psoriasis and/or psoriatic arthritis** – such as another immunosuppressant or phototherapy (when your body is treated with a type of ultraviolet (UV) light). These treatments may also weaken part of the immune system. Using these therapies together with WEZENLA has not been studied. However it is possible it may increase the chance of diseases related to a weaker immune system.
- **If you are having or have ever had injections to treat allergies** – it is not known if WEZENLA may affect these.
- **If you are 65 years of age or over** – you may be more likely to get infections.

If you are not sure if any of the above applies to you, talk to your doctor or pharmacist before using WEZENLA.

Some patients have experienced lupus-like reactions including skin lupus or lupus-like syndrome during treatment with ustekinumab. Talk to your doctor right away if you experience a red, raised, scaly rash sometimes with a darker border, in areas of the skin that are exposed to the sun or with joint pains.

Heart attack and strokes

Heart attack and strokes have been observed in a study in patients with psoriasis treated with ustekinumab. Your doctor will regularly check your risk factors for heart disease and stroke in order to ensure that they are appropriately treated. Seek medical attention right away if you develop chest pain, weakness or abnormal sensation on one side of your body, facial droop, or speech or visual abnormalities.

Children and adolescents

WEZENLA is not recommended for use in children who weigh less than 40 kg with Crohn's disease because it has not been studied in this group.

Other medicines, vaccines and WEZENLA

Tell your doctor or pharmacist:

- If you are taking, have recently taken or might take any other medicines.
- If you have recently had or are going to have a vaccination. Some types of vaccines (live vaccines) should not be given while using WEZENLA.

- If you received WEZENLA while pregnant, tell your baby's doctor about your WEZENLA treatment before the baby receives any vaccine, including live vaccines, such as the BCG vaccine (used to prevent tuberculosis). Live vaccines are not recommended for your baby in the first twelve months after birth if you received WEZENLA during the pregnancy unless your baby's doctor recommends otherwise.

Pregnancy and breast-feeding

- If you are pregnant, think you may be pregnant or are planning to have a baby, ask your doctor for advice before taking this medicine.
- A higher risk of birth defects has not been seen in babies exposed to WEZENLA in the womb. However, there is limited experience with WEZENLA in pregnant women. It is therefore preferable to avoid the use of WEZENLA in pregnancy.
- If you are a woman of childbearing potential, you are advised to avoid becoming pregnant and must use adequate contraception while using WEZENLA and for at least 15 weeks after the last WEZENLA treatment.
- WEZENLA can pass across the placenta to the unborn baby. If you received WEZENLA during your pregnancy, your baby may have a higher risk for getting an infection.
- It is important that you tell your baby's doctors and other health care professionals if you received WEZENLA during your pregnancy before the baby receives any vaccine. Live vaccines such as the BCG vaccine (used to prevent tuberculosis) are not recommended for your baby in the first twelve months after birth if you received WEZENLA during the pregnancy unless your baby's doctor recommends otherwise.
- Ustekinumab may pass into breast milk in very small amounts. Talk to your doctor if you are breast-feeding or are planning to breast-feed. You and your doctor should decide if you should breast-feed or use WEZENLA - do not do both.

Driving and using machines

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

WEZENLA contains sodium

WEZENLA contains less than 1 mmol sodium (23 mg) per dose, that is to say essentially 'sodium-free'. However, before WEZENLA is given to you, it is mixed with a solution that contains sodium. Talk to your doctor if you are on a low salt diet.

WEZENLA contains polysorbate 80

WEZENLA contains 10.4 mg of polysorbate 80 (E 433) in each dosage unit which is equivalent to 0.40 mg/mL. Polysorbates may cause allergic reactions. Tell your doctor if you have any known allergies.

3. How WEZENLA will be given

WEZENLA is intended for use under the guidance and supervision of a doctor experienced in the diagnosis and treatment of Crohn's disease.

WEZENLA 130 mg concentrate for solution for infusion will be given to you by your doctor, through a drip in the vein of your arm (intravenous infusion) over at least one hour. Talk to your doctor about when you will have your injections and follow-up appointments.

How much WEZENLA is given

Your doctor will decide how much WEZENLA you need to receive and for how long.

Adults aged 18 years or older

- The doctor will work out the recommended intravenous infusion dose for you based on your body weight.

| Your body weight | Dose |
|--------------------|--------|
| ≤ 55 kg | 260 mg |
| > 55 kg to ≤ 85 kg | 390 mg |
| > 85 kg | 520 mg |

- After the starting intravenous dose, you will have the next dose of 90 mg WEZENLA by an injection under your skin (subcutaneous injection) 8 weeks later, and then every 12 weeks thereafter.

Children with Crohn's disease who weigh at least 40 kg

- The doctor will work out the recommended intravenous infusion dose for you based on your body weight.

| Your body weight | Dose |
|--------------------|--------|
| ≥ 40 kg to ≤ 55 kg | 260 mg |
| > 55 kg to ≤ 85 kg | 390 mg |
| > 85 kg | 520 mg |

- After the starting intravenous dose, you will have the next dose of 90 mg WEZENLA by an injection under your skin (subcutaneous injection) 8 weeks later, and then every 12 weeks thereafter.

How WEZENLA is given

- The first dose of WEZENLA for treatment of Crohn's disease is given by a doctor as a drip in the vein of an arm (intravenous infusion).

Talk to your doctor if you have any questions about receiving WEZENLA.

If you forget to use WEZENLA

If you forget or miss the appointment for receiving the dose, contact your doctor to reschedule your appointment.

If you stop using WEZENLA

It is not dangerous to stop using WEZENLA. However, if you stop, your symptoms may come back.

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

4. Possible side effects

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

Serious side effects

Some patients may have serious side effects that may need urgent treatment.

Allergic reactions – these may need urgent treatment. Tell your doctor or get emergency medical help straight away if you notice any of the following signs.

- Serious allergic reactions ('anaphylaxis') are rare in people taking ustekinumab (may affect up to 1 in 1 000 people). Signs include:
 - difficulty breathing or swallowing
 - low blood pressure, which can cause dizziness or light-headedness
 - swelling of the face, lips, mouth or throat.

- Common signs of an allergic reaction include skin rash and hives (these may affect up to 1 in 100 people).

Infusion-related reactions – If you are being treated for Crohn's disease, the first dose of WEZENLA is given through a drip into a vein (intravenous infusion). Some patients have experienced serious allergic reactions during the infusion.

In rare cases, allergic lung reactions and lung inflammation have been reported in patients who receive ustekinumab. Tell your doctor right away if you develop symptoms such as cough, shortness of breath, and fever.

If you have a serious allergic reaction, your doctor may decide that you should not use WEZENLA again.

Infections – these may need urgent treatment. Tell your doctor straight away if you notice any of the following signs.

- Infections of the nose or throat and common cold are common (may affect up to 1 in 10 people)
- Infections of the chest are uncommon (may affect up to 1 in 100 people)
- Inflammation of tissue under the skin ('cellulitis') is uncommon (may affect up to 1 in 100 people)
- Shingles (a type of painful rash with blisters) are uncommon (may affect up to 1 in 100 people)

WEZENLA may make you less able to fight infections. Some infections could become serious and may include infections caused by viruses, fungi, bacteria (including tuberculosis), or parasites, including infections that mainly occur in people with a weakened immune system (opportunistic infections). Opportunistic infections of the brain (encephalitis, meningitis), lungs, and eye have been reported in patients receiving treatment with ustekinumab.

You must look out for signs of infection while you are using WEZENLA. These include:

- fever, flu-like symptoms, night sweats, weight loss
- feeling tired or short of breath; cough which will not go away
- warm, red and painful skin, or a painful skin rash with blisters
- burning when passing water
- diarrhoea
- visual disturbance or vision loss
- headache, neck stiffness, light sensitivity, nausea or confusion.

Tell your doctor straight away if you notice any of these signs of infection. These may be signs of infections such as chest infections, skin infections, shingles or opportunistic infections that could have serious complications. Tell your doctor if you have any kind of infection that will not go away or keeps coming back. Your doctor may decide that you should not use WEZENLA until the infection goes away. Also tell your doctor if you have any open cuts or sores as they might get infected.

Shedding of skin – increase in redness and shedding of skin over a larger area of the body may be symptoms of erythrodermic psoriasis or exfoliative dermatitis, which are serious skin conditions. You should tell your doctor straight away if you notice any of these signs.

Other side effects

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

- Diarrhoea
- Nausea
- Vomiting
- Feeling tired
- Feeling dizzy
- Headache

- Itching ('pruritus')
- Back, muscle or joint pain
- Sore throat
- Redness and pain where the injection is given
- Sinus infection

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

- Tooth infections
- Vaginal yeast infection
- Depression
- Blocked or stuffy nose
- Bleeding, bruising, hardness, swelling and itching where the injection is given
- Feeling weak
- Drooping eyelid and sagging muscles on one side of the face ('facial palsy' or 'Bell's palsy'), which is usually temporary
- A change in psoriasis with redness and new tiny, yellow or white skin blisters, sometimes accompanied by fever (pustular psoriasis)
- Peeling of the skin (skin exfoliation)
- Acne

Rare side effects (may affect up to 1 in 1 000 people):

- Redness and shedding of skin over a larger area of the body, which may be itchy or painful (exfoliative dermatitis). Similar symptoms sometimes develop as a natural change in the type of psoriasis symptoms (erythrodermic psoriasis)
- Inflammation of small blood vessels, which can lead to a skin rash with small red or purple bumps, fever or joint pain (vasculitis)

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

- Blistering of the skin that may be red, itchy, and painful (Bullous pemphigoid)
- Skin lupus or lupus-like syndrome (red, raised scaly rash on areas of the skin exposed to the sun possibly with joint pains).

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 WEZENLA

- WEZENLA 130 mg concentrate for solution for infusion is given in a hospital or clinic and patients should not need to store or handle it.
- Keep this medicine out of the sight and reach of children.
- Store in a refrigerator (2°C – 8°C). Do not freeze.
- Keep the vial in the outer carton in order to protect from light.
- Do not shake the WEZENLA vials. Prolonged vigorous shaking may damage the medicine.

Do not use this medicine:

- After the expiry date which is stated on the label and the carton after 'EXP'. The expiry date refers to the last day of that month.
- If the liquid is discoloured, cloudy or you can see foreign particles floating in it (see section 6 'What WEZENLA looks like and contents of the pack').
- If you know, or think that it may have been exposed to extreme temperatures (such as accidentally frozen or heated).

- If the product has been shaken vigorously.
- If the seal is broken.

WEZENLA is for single use only. Any diluted infusion solution or unused product remaining in the vial should be thrown away in accordance with local requirements.

6. Contents of the pack and other information

What WEZENLA contains

- The active substance is ustekinumab. Each vial contains 130 mg ustekinumab in 26 mL.
- The other ingredients are EDTA disodium salt dihydrate, L-histidine, L-histidine hydrochloride monohydrate, L-methionine, polysorbate 80 (E 433), sucrose, sodium hydroxide (for pH adjustment) and water for injections.

What WEZENLA looks like and contents of the pack

WEZENLA is a clear to opalescent, colourless to light yellow concentrate for solution for infusion. It is supplied as a carton pack containing 1 single-dose, glass 30 mL vial. Each vial contains 130 mg ustekinumab in 26 mL of concentrate for solution for infusion.

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Ireland

Marketing Authorisation Holder

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

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This leaflet was last revised in**Other sources of information**

Detailed information on this medicine is available on the European Medicines Agency web site:
<https://www.ema.europa.eu>

The following information is intended for healthcare professionals only:

Traceability:

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

Instructions for dilution:

WEZENLA concentrate for solution for infusion must be diluted, prepared and infused by a healthcare professional using aseptic technique.

1. Calculate the dose and the number of WEZENLA vials needed based on patient weight (see section 3, table 1, table 2). Each 26 mL vial of WEZENLA contains 130 mg of ustekinumab.
2. Withdraw and then discard a volume of the sodium chloride 9 mg/mL (0.9%) solution from the 250 mL infusion bag equal to the volume of WEZENLA to be added (discard 26 mL sodium chloride for each vial of WEZENLA needed, for 2 vials- discard 52 mL, for 3 vials- discard 78 mL, for 4 vials- discard 104 mL).
3. Withdraw 26 mL of WEZENLA from each vial needed and add it to the 250 mL infusion bag. The final volume in the infusion bag should be 250 mL. Gently mix.
4. Visually inspect the diluted solution before infusion. Do not use if visibly opaque particles, discolouration or foreign particles are observed.
5. Infuse the diluted solution over a period of at least one hour.
6. Use only an infusion set with an in-line, sterile, non-pyrogenic, low protein-binding filter (pore size 0.2 micrometre).
7. Each vial is for single use only and any unused medicinal product should be disposed of in accordance with local requirements.

Storage

If necessary, the diluted infusion solution may be stored at room temperature.

After dilution chemical and physical in-use stability has been demonstrated between 0.86 mg/mL and 2.60 mg/mL for 24 hours at 15°C-25°C. Do not return to the refrigerator. Do not freeze.

Package leaflet: Information for the user

WEZENLA 45 mg solution for injection ustekinumab

▼ 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.

This leaflet has been written for the person taking the medicine. If you are the parent or caregiver who will give WEZENLA to a child, please read this information carefully.

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

What is in this leaflet

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

1. What WEZENLA is and what it is used for

What WEZENLA is

WEZENLA contains the active substance 'ustekinumab', a monoclonal antibody. Monoclonal antibodies are proteins that recognise and bind specifically to certain proteins in the body.

WEZENLA belongs to a group of medicines called 'immunosuppressants'. These medicines work by weakening part of the immune system.

What WEZENLA is used for

WEZENLA is used to treat the following inflammatory diseases:

- Plaque psoriasis - in adults and children aged 6 years and older
- Psoriatic arthritis - in adults
- Moderate to severe Crohn's disease - in adults and children who weigh at least 40 kg

Plaque psoriasis

Plaque psoriasis is a skin condition that causes inflammation affecting the skin and nails. WEZENLA will reduce the inflammation and other signs of the disease.

WEZENLA is used in adults with moderate to severe plaque psoriasis, who cannot use ciclosporin, methotrexate or phototherapy, or where these treatments did not work.

WEZENLA is used in children and adolescents aged 6 years and older with moderate to severe plaque psoriasis who are unable to tolerate phototherapy or other systemic therapies or where these treatments did not work.

Psoriatic arthritis

Psoriatic arthritis is an inflammatory disease of the joints, usually accompanied by psoriasis. If you have active psoriatic arthritis you will first be given other medicines. If you do not respond well enough to these medicines, you may be given WEZENLA to:

- Reduce the signs and symptoms of your disease.
- Improve your physical function.
- Slow down the damage to your joints.

Crohn's disease

Crohn's disease is an inflammatory disease of the bowel. If you have Crohn's disease you will first be given other medicines. If you do not respond well enough or are intolerant to these medicines, you may be given WEZENLA to reduce the signs and symptoms of your disease.

2. What you need to know before you use WEZENLA

Do not use WEZENLA

- **If you are allergic to ustekinumab** or any of the other ingredients of this medicine (listed in section 6).
- **If you have an active infection** which your doctor thinks is important.

If you are not sure if any of the above applies to you, talk to your doctor or pharmacist before using WEZENLA.

Warnings and precautions

Talk to your doctor or pharmacist before using WEZENLA. Your doctor will check how well you are before each treatment. Make sure you tell your doctor about any illness you have before each treatment. Also tell your doctor if you have recently been near anyone who might have tuberculosis. Your doctor will examine you and do a test for tuberculosis, before you have WEZENLA. If your doctor thinks you are at risk of tuberculosis, you may be given medicines to treat it.

Look out for serious side effects

WEZENLA can cause serious side effects, including allergic reactions and infections. You must look out for certain signs of illness while you are taking WEZENLA. See 'Serious side effects' in section 4 for a full list of these side effects.

Before you use WEZENLA tell your doctor:

- **If you ever had an allergic reaction to WEZENLA.** Ask your doctor if you are not sure.
- **If you have ever had any type of cancer** – this is because immunosuppressants like WEZENLA weaken part of the immune system. This may increase the risk of cancer.
- **If you have been treated for psoriasis with other biologic medicines (a medicine produced from a biological source and usually given by injection)** – the risk of cancer may be higher.
- **If you have or have had a recent infection.**
- **If you have any new or changing lesions** within psoriasis areas or on normal skin.
- **If you are having any other treatment for psoriasis and/or psoriatic arthritis** – such as another immunosuppressant or phototherapy (when your body is treated with a type of ultraviolet (UV) light). These treatments may also weaken part of the immune system. Using these therapies together with WEZENLA has not been studied. However it is possible it may increase the chance of diseases related to a weaker immune system.
- **If you are having or have ever had injections to treat allergies** – it is not known if WEZENLA may affect these.
- **If you are 65 years of age or over** – you may be more likely to get infections.

If you are not sure if any of the above applies to you, talk to your doctor or pharmacist before using WEZENLA.

Some patients have experienced lupus-like reactions including skin lupus or lupus-like syndrome during treatment with ustekinumab. Talk to your doctor right away if you experience a red, raised, scaly rash sometimes with a darker border, in areas of the skin that are exposed to the sun or with joint pains.

Heart attack and strokes

Heart attack and strokes have been observed in a study in patients with psoriasis treated with ustekinumab. Your doctor will regularly check your risk factors for heart disease and stroke in order to ensure that they are appropriately treated. Seek medical attention right away if you develop chest pain, weakness or abnormal sensation on one side of your body, facial droop, or speech or visual abnormalities.

Children and adolescents

WEZENLA is not recommended for use in children with psoriasis under 6 years of age, children with Crohn's disease who weigh less than 40 kg or for use in children under 18 years of age with psoriatic arthritis, because it has not been studied in this age group.

Other medicines, vaccines and WEZENLA

Tell your doctor or pharmacist:

- If you are taking, have recently taken or might take any other medicines.
- If you have recently had or are going to have a vaccination. Some types of vaccines (live vaccines) should not be given while using WEZENLA.
- If you received WEZENLA while pregnant, tell your baby's doctor about your WEZENLA treatment before the baby receives any vaccine, including live vaccines, such as the BCG vaccine (used to prevent tuberculosis). Live vaccines are not recommended for your baby in the first twelve months after birth if you received WEZENLA during the pregnancy unless your baby's doctor recommends otherwise.

Pregnancy and breast-feeding

- If you are pregnant, think you may be pregnant or are planning to have a baby, ask your doctor for advice before taking this medicine.
- A higher risk of birth defects has not been seen in babies exposed to WEZENLA in the womb. However, there is limited experience with WEZENLA in pregnant women. It is therefore preferable to avoid the use of WEZENLA in pregnancy.
- If you are a woman of childbearing potential, you are advised to avoid becoming pregnant and must use adequate contraception while using WEZENLA and for at least 15 weeks after the last WEZENLA treatment.
- WEZENLA can pass across the placenta to the unborn baby. If you received WEZENLA during your pregnancy, your baby may have a higher risk for getting an infection.
- It is important that you tell your baby's doctors and other health care professionals if you received WEZENLA during your pregnancy before the baby receives any vaccine. Live vaccines such as the BCG vaccine (used to prevent tuberculosis) are not recommended for your baby in the first twelve months after birth if you received WEZENLA during the pregnancy unless your baby's doctor recommends otherwise.
- Ustekinumab may pass into breast milk in very small amounts. Talk to your doctor if you are breast-feeding or are planning to breast-feed. You and your doctor should decide if you should breast-feed or use WEZENLA - do not do both.

Driving and using machines

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

WEZENLA contains polysorbate 80

WEZENLA contains 0.02 mg of polysorbate 80 (E 433) in each dosage unit which is equivalent to 0.04 mg/mL. Polysorbates may cause allergic reactions. Tell your doctor if you have any known allergies.

3. How to use WEZENLA

WEZENLA is intended for use under the guidance and supervision of a doctor experienced in treating conditions for which WEZENLA is intended.

Always use this medicine exactly as your doctor has told you. Check with your doctor if you are not sure. Talk to your doctor about when you will have your injections and follow-up appointments.

How much WEZENLA is given

Your doctor will decide how much WEZENLA you need to use and for how long.

Adults aged 18 years or older

Psoriasis or Psoriatic Arthritis

- The recommended starting dose is 45 mg WEZENLA. Patients who weigh more than 100 kilograms (kg) may start on a dose of 90 mg instead of 45 mg.
- After the starting dose, you will have the next dose 4 weeks later, and then every 12 weeks. The following doses are usually the same as the starting dose.

Crohn's disease

- During treatment, the first dose of approximately 6 mg/kg WEZENLA will be given by your doctor through a drip in a vein in your arm (intravenous infusion). After the starting dose, you will receive the next dose of 90 mg WEZENLA after 8 weeks, then every 12 weeks thereafter by an injection under the skin ('subcutaneously').
- In some patients, after the first injection under the skin, 90 mg WEZENLA may be given every 8 weeks. Your doctor will decide when you should receive your next dose.

Children and adolescents aged 6 years or older

Psoriasis

- The doctor will work out the right dose for you, including the amount (volume) of WEZENLA to be injected to give the right dose. The right dose for you will depend on your body weight at the time each dose is given.
- If you weigh less than 60 kg, the recommended dose is 0.75 mg of WEZENLA per kg body weight.
- If you weigh 60 kg to 100 kg, the recommended dose is 45 mg WEZENLA.
- If you weigh more than 100 kg, the recommended dose is 90 mg WEZENLA.
- After the starting dose, you will have the next dose 4 weeks later, and then every 12 weeks.

Children who weigh at least 40 kg

Crohn's disease

- During treatment, the first dose of approximately 6 mg/kg WEZENLA will be given by your doctor through a drip in a vein in your arm (intravenous infusion). After the starting dose, you will receive the next dose of 90 mg WEZENLA after 8 weeks, then every 12 weeks thereafter by an injection under the skin ('subcutaneously').
- In some patients, after the first injection under the skin, 90 mg WEZENLA may be given every 8 weeks. Your doctor will decide when you should receive your next dose.

How WEZENLA is given

- WEZENLA is given as an injection under the skin ('subcutaneously'). At the start of your treatment, medical or nursing staff may inject WEZENLA.
- However, you and your doctor may decide that you may inject WEZENLA yourself. In this case you will get training on how to inject WEZENLA yourself.
- For instructions on how to inject WEZENLA, see 'Instructions for use' at the end of this leaflet. Talk to your doctor if you have any questions about giving yourself an injection.

If you use more WEZENLA than you should

If you have used or been given too much WEZENLA, talk to a doctor or pharmacist straight away. Always have the outer carton of the medicine with you, even if it is empty.

If you forget to use WEZENLA

If you forget a dose, contact your doctor or pharmacist. Do not take a double dose to make up for a forgotten dose.

If you stop using WEZENLA

It is not dangerous to stop using WEZENLA. However, if you stop, your symptoms may come back.

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

4. Possible side effects

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

Serious side effects

Some patients may have serious side effects that may need urgent treatment.

Allergic reactions – these may need urgent treatment. Tell your doctor or get emergency medical help straight away if you notice any of the following signs.

- Serious allergic reactions ('anaphylaxis') are rare in people taking ustekinumab (may affect up to 1 in 1 000 people). Signs include:
 - difficulty breathing or swallowing
 - low blood pressure, which can cause dizziness or light-headedness
 - swelling of the face, lips, mouth or throat.
- Common signs of an allergic reaction include skin rash and hives (these may affect up to 1 in 100 people).

In rare cases, allergic lung reactions and lung inflammation have been reported in patients who receive ustekinumab. Tell your doctor right away if you develop symptoms such as cough, shortness of breath, and fever.

If you have a serious allergic reaction, your doctor may decide that you should not use WEZENLA again.

Infections – these may need urgent treatment. Tell your doctor straight away if you notice any of the following signs.

- Infections of the nose or throat and common cold are common (may affect up to 1 in 10 people)
- Infections of the chest are uncommon (may affect up to 1 in 100 people)
- Inflammation of tissue under the skin ('cellulitis') is uncommon (may affect up to 1 in 100 people)
- Shingles (a type of painful rash with blisters) are uncommon (may affect up to 1 in 100 people)

WEZENLA may make you less able to fight infections. Some infections could become serious and may include infections caused by viruses, fungi, bacteria (including tuberculosis), or parasites, including infections that mainly occur in people with a weakened immune system (opportunistic infections). Opportunistic infections of the brain (encephalitis, meningitis), lungs, and eye have been reported in patients receiving treatment with ustekinumab.

You must look out for signs of infection while you are using WEZENLA. These include:

- fever, flu-like symptoms, night sweats, weight loss
- feeling tired or short of breath; cough which will not go away
- warm, red and painful skin, or a painful skin rash with blisters

- burning when passing water
- diarrhoea
- visual disturbance or vision loss
- headache, neck stiffness, light sensitivity, nausea or confusion.

Tell your doctor straight away if you notice any of these signs of infection. These may be signs of infections such as chest infections, skin infections, shingles or opportunistic infections that could have serious complications. Tell your doctor if you have any kind of infection that will not go away or keeps coming back. Your doctor may decide that you should not use WEZENLA until the infection goes away. Also tell your doctor if you have any open cuts or sores as they might get infected.

Shedding of skin – increase in redness and shedding of skin over a larger area of the body may be symptoms of erythrodermic psoriasis or exfoliative dermatitis, which are serious skin conditions. You should tell your doctor straight away if you notice any of these signs.

Other side effects

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

- Diarrhoea
- Nausea
- Vomiting
- Feeling tired
- Feeling dizzy
- Headache
- Itching ('pruritus')
- Back, muscle or joint pain
- Sore throat
- Redness and pain where the injection is given
- Sinus infection

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

- Tooth infections
- Vaginal yeast infection
- Depression
- Blocked or stuffy nose
- Bleeding, bruising, hardness, swelling and itching where the injection is given
- Feeling weak
- Drooping eyelid and sagging muscles on one side of the face ('facial palsy' or 'Bell's palsy'), which is usually temporary
- A change in psoriasis with redness and new tiny, yellow or white skin blisters, sometimes accompanied by fever (pustular psoriasis)
- Peeling of the skin (skin exfoliation)
- Acne

Rare side effects (may affect up to 1 in 1 000 people):

- Redness and shedding of skin over a larger area of the body, which may be itchy or painful (exfoliative dermatitis). Similar symptoms sometimes develop as a natural change in the type of psoriasis symptoms (erythrodermic psoriasis)
- Inflammation of small blood vessels, which can lead to a skin rash with small red or purple bumps, fever or joint pain (vasculitis)

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

- Blistering of the skin that may be red, itchy, and painful (Bullous pemphigoid)
- Skin lupus or lupus-like syndrome (red, raised scaly rash on areas of the skin exposed to the sun possibly with joint pains).

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 WEZENLA

- Keep this medicine out of the sight and reach of children.
- Store in a refrigerator (2°C – 8°C). Do not freeze.
- Keep the vial in the outer carton in order to protect from light.
- If needed, individual WEZENLA vials may also be stored at room temperature up to 30°C for a maximum single period of up to 30 days in the original carton in order to protect from light. Record the date when the vial is first removed from the refrigerator and the discard date. The discard date must not exceed the original expiry date printed on the carton. Once a vial has been stored at room temperature (up to 30°C), it should not be returned to the refrigerator. Discard the vial if not used within 30 days at room temperature storage or by the original expiry date, whichever is earlier.
- After withdrawing in disposable syringe the chemical and physical in-use stability has been demonstrated for 24 hours at 15°C-25°C. Do not return to the refrigerator. From a microbiological point of view, the product should be used immediately. If not used immediately, in-use storage times and conditions are the responsibility of user.
- Do not shake the WEZENLA vials. Prolonged vigorous shaking may damage the medicine.

Do not use this medicine:

- After the expiry date which is stated on the label and the carton after 'EXP'. The expiry date refers to the last day of that month.
- If the liquid is discoloured, cloudy or you can see foreign particles floating in it (see section 6 'What WEZENLA looks like and contents of the pack').
- If you know, or think that it may have been exposed to extreme temperatures (such as accidentally frozen or heated).
- If the product has been shaken vigorously.
- If the seal is broken.

WEZENLA is for single use only. Any unused product remaining in the vial and the syringe should be thrown away. Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. Contents of the pack and other information

What WEZENLA contains

- The active substance is ustekinumab. Each vial contains 45 mg ustekinumab in 0.5 mL.
- The other ingredients are L-histidine, L-histidine hydrochloride monohydrate, polysorbate 80 (E 433), sucrose and water for injections.

What WEZENLA looks like and contents of the pack

WEZENLA is a clear to opalescent, colourless to light yellow solution for injection. It is supplied as a carton pack containing 1 single-dose, glass 2 mL vial. Each vial contains 45 mg ustekinumab in 0.5 mL of solution for injection.

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This leaflet was last revised in**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

At the start of treatment, your healthcare provider will assist you with your first injection. However, you and your doctor may decide that you may inject WEZENLA yourself. If this happens, you will get training on how to inject WEZENLA. Talk to your doctor if you have any questions about giving yourself an injection.

- Do not mix WEZENLA with other liquids for injection.
- Do not shake WEZENLA vials. This is because strong shaking may damage the medicine. Do not use the medicine if it has been shaken strongly.

1. Check the number of vials and prepare the materials:

Take the vial(s) out of the refrigerator. Let the vial stand for about half an hour. This will let the liquid come to a comfortable temperature for injection (room temperature).

Check the vial(s) to make sure:

- the number of vials and strength is correct
 - If your dose is 45 mg or less, you will get one 45 mg vial of WEZENLA.
 - If your dose is 90 mg you will get two 45 mg vials of WEZENLA and you will need to give yourself two injections. Choose two different sites for these injections (for example one injection in the right thigh and the other injection in the left thigh), and give the injections one right after the other. Use a new needle and syringe for each injection.
- it is the right medicine
- it has not passed its expiry date
- the vial is not damaged and the seal is not broken
- the solution in the vial is clear to opalescent and colourless to light yellow
- the solution is not discoloured or cloudy and does not contain any foreign particles
- the solution is not frozen.

Children with paediatric psoriasis weighing less than 60 kg need a dose lower than 45 mg. Make sure you know the proper amount (volume) to remove from the vial and type of syringe needed for dosing. If you don't know the amount or type of syringe needed, contact your healthcare provider for further instruction.

Get everything together that you need and lay out on a clean surface. This includes a syringe, needle, antiseptic wipes, a cotton ball or gauze, and a sharps container (see figure 1).

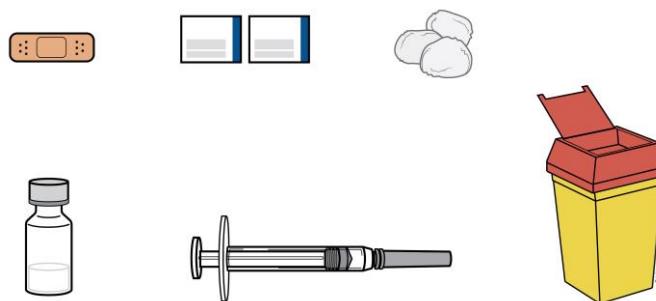


Figure 1

2. Choose and prepare the injection site:

Choose an injection site (see figure 2)

- WEZENLA is given by injection under the skin (subcutaneously).
- Good places for the injection are the upper thigh or around the belly (abdomen) at least 5 cm away from the navel (belly button).
- If possible, do not use areas of skin that show signs of psoriasis.
- If someone will assist in giving you the injection, then he or she may also choose the upper arms as an injection site.

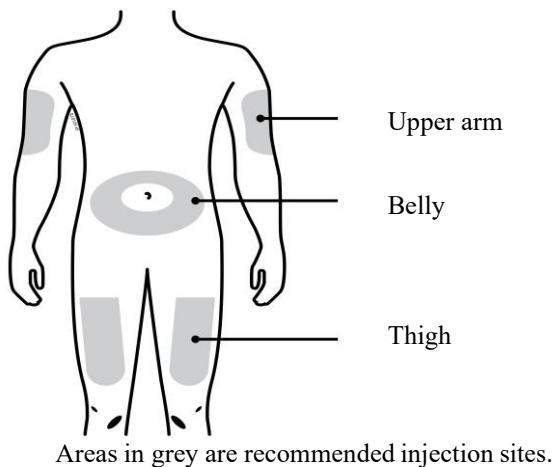


Figure 2

Prepare the injection site

- Wash your hands very well with soap and warm water.
- Wipe the injection site on the skin with an antiseptic wipe.
- Do not touch this area again before giving the injection.

3. Prepare the dose:

- Take the cap off the top of the vial (see figure 3).



Figure 3

- Do not remove the stopper.
- Clean the stopper with an antiseptic swab.
- Put the vial on a flat surface.
- Pick up the syringe and remove the needle cover.
- Do not touch the needle or let the needle touch anything.
- Push the needle through the rubber stopper.
- Turn the vial and the syringe upside down.
- Pull on the syringe plunger to fill the syringe with the amount of liquid prescribed by your doctor.
- It is important that the needle is always in the liquid. This stops air bubbles forming in the syringe (see figure 4).

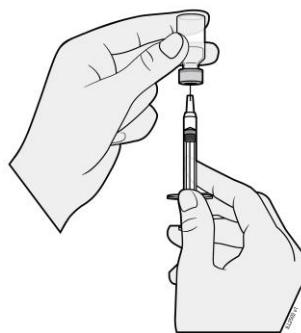


Figure 4

- Remove the needle from the vial.
- Hold the syringe with the needle pointing up to see if it has any air bubbles inside.
- If there are air bubbles, tap the side gently until the air bubbles go to the top of the syringe (see figure 5).

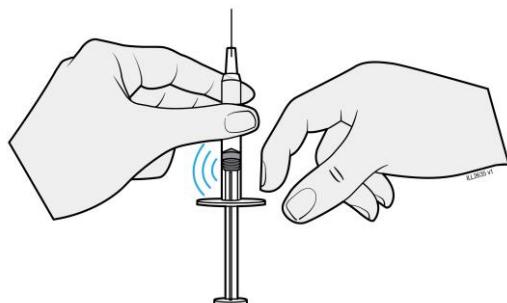


Figure 5

- Then press the plunger until all of the air (but none of the liquid) has been removed.
- Do not lay the syringe down or allow the needle to touch anything.

4. Inject the dose:

- Gently pinch the cleaned skin between your thumb and index finger. Do not squeeze it tightly.
- Push the needle into the pinched skin at a 45-degree angle.
- Push the plunger with your thumb as far as it will go to inject all of the liquid. Push it slowly and evenly, keeping the skin gently pinched.
- When the plunger is pushed as far as it will go, take out the needle and let go of the skin.

5. After the injection:

- Press an antiseptic wipe over the injection site for a few seconds after the injection.
- There may be a small amount of blood or liquid at the injection site. This is normal.
- You can press a cotton ball or gauze over the injection site and hold for 10 seconds.
- Do not rub the skin at the injection site. You may cover the injection site with a small adhesive bandage, if necessary.

6. Disposal:

- Used syringes and needles should be placed in a puncture-resistant container, like a sharps container. Never re-use needles and syringes, for your safety and health, and for the safety of others. Dispose of your sharps container according to your local regulations.
- Empty vials, antiseptic wipes, and other supplies can be disposed of in your garbage.

Package leaflet: Information for the user

WEZENLA 45 mg solution for injection in pre-filled syringe WEZENLA 90 mg solution for injection in pre-filled syringe ustekinumab

▼ 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.

This leaflet has been written for the person taking the medicine. If you are the parent or caregiver who will give WEZENLA to a child, please read this information carefully.

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

What is in this leaflet

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

1. What WEZENLA is and what it is used for

What WEZENLA is

WEZENLA contains the active substance 'ustekinumab', a monoclonal antibody. Monoclonal antibodies are proteins that recognise and bind specifically to certain proteins in the body.

WEZENLA belongs to a group of medicines called 'immunosuppressants'. These medicines work by weakening part of the immune system.

What WEZENLA is used for

WEZENLA is used to treat the following inflammatory diseases:

- Plaque psoriasis - in adults and children aged 6 years and older
- Psoriatic arthritis - in adults
- Moderate to severe Crohn's disease - in adults and children who weigh at least 40 kg

Plaque psoriasis

Plaque psoriasis is a skin condition that causes inflammation affecting the skin and nails. WEZENLA will reduce the inflammation and other signs of the disease.

WEZENLA is used in adults with moderate to severe plaque psoriasis, who cannot use ciclosporin, methotrexate or phototherapy, or where these treatments did not work.

WEZENLA is used in children and adolescents aged 6 years and older with moderate to severe plaque psoriasis who are unable to tolerate phototherapy or other systemic therapies or where these treatments did not work.

Psoriatic arthritis

Psoriatic arthritis is an inflammatory disease of the joints, usually accompanied by psoriasis. If you have active psoriatic arthritis you will first be given other medicines. If you do not respond well enough to these medicines, you may be given WEZENLA to:

- Reduce the signs and symptoms of your disease.
- Improve your physical function.
- Slow down the damage to your joints.

Crohn's disease

Crohn's disease is an inflammatory disease of the bowel. If you have Crohn's disease you will first be given other medicines. If you do not respond well enough or are intolerant to these medicines, you may be given WEZENLA to reduce the signs and symptoms of your disease.

2. What you need to know before you use WEZENLA

Do not use WEZENLA

- **If you are allergic to ustekinumab** or any of the other ingredients of this medicine (listed in section 6).
- **If you have an active infection** which your doctor thinks is important.

If you are not sure if any of the above applies to you, talk to your doctor or pharmacist before using WEZENLA.

Warnings and precautions

Talk to your doctor or pharmacist before using WEZENLA. Your doctor will check how well you are before each treatment. Make sure you tell your doctor about any illness you have before each treatment. Also tell your doctor if you have recently been near anyone who might have tuberculosis. Your doctor will examine you and do a test for tuberculosis, before you have WEZENLA. If your doctor thinks you are at risk of tuberculosis, you may be given medicines to treat it.

Look out for serious side effects

WEZENLA can cause serious side effects, including allergic reactions and infections. You must look out for certain signs of illness while you are taking WEZENLA. See 'Serious side effects' in section 4 for a full list of these side effects.

Before you use WEZENLA tell your doctor:

- **If you ever had an allergic reaction to WEZENLA.** Ask your doctor if you are not sure.
- **If you have ever had any type of cancer** – this is because immunosuppressants like WEZENLA weaken part of the immune system. This may increase the risk of cancer.
- **If you have been treated for psoriasis with other biologic medicines (a medicine produced from a biological source and usually given by injection)** – the risk of cancer may be higher.
- **If you have or have had a recent infection.**
- **If you have any new or changing lesions** within psoriasis areas or on normal skin.
- **If you are having any other treatment for psoriasis and/or psoriatic arthritis** – such as another immunosuppressant or phototherapy (when your body is treated with a type of ultraviolet (UV) light). These treatments may also weaken part of the immune system. Using these therapies together with WEZENLA has not been studied. However, it is possible it may increase the chance of diseases related to a weaker immune system.
- **If you are having or have ever had injections to treat allergies** – it is not known if WEZENLA may affect these.
- **If you are 65 years of age or over** – you may be more likely to get infections.

If you are not sure if any of the above applies to you, talk to your doctor or pharmacist before using WEZENLA.

Some patients have experienced lupus-like reactions including skin lupus or lupus-like syndrome during treatment with ustekinumab. Talk to your doctor right away if you experience a red, raised, scaly rash sometimes with a darker border, in areas of the skin that are exposed to the sun or with joint pains.

Heart attack and strokes

Heart attack and strokes have been observed in a study in patients with psoriasis treated with ustekinumab. Your doctor will regularly check your risk factors for heart disease and stroke in order to ensure that they are appropriately treated. Seek medical attention right away if you develop chest pain, weakness or abnormal sensation on one side of your body, facial droop, or speech or visual abnormalities.

Children and adolescents

WEZENLA is not recommended for use in children with psoriasis under 6 years of age, children with Crohn's disease who weigh less than 40 kg or for use in children under 18 years of age with psoriatic arthritis, because it has not been studied in this age group.

Other medicines, vaccines and WEZENLA

Tell your doctor or pharmacist:

- If you are taking, have recently taken or might take any other medicines.
- If you have recently had or are going to have a vaccination. Some types of vaccines (live vaccines) should not be given while using WEZENLA.
- If you received WEZENLA while pregnant, tell your baby's doctor about your WEZENLA treatment before the baby receives any vaccine, including live vaccines, such as the BCG vaccine (used to prevent tuberculosis). Live vaccines are not recommended for your baby in the first twelve months after birth if you received WEZENLA during the pregnancy unless your baby's doctor recommends otherwise.

Pregnancy and breast-feeding

- If you are pregnant, think you may be pregnant or are planning to have a baby, ask your doctor for advice before taking this medicine.
- A higher risk of birth defects has not been seen in babies exposed to WEZENLA in the womb. However, there is limited experience with WEZENLA in pregnant women. It is therefore preferable to avoid the use of WEZENLA in pregnancy.
- If you are a woman of childbearing potential, you are advised to avoid becoming pregnant and must use adequate contraception while using WEZENLA and for at least 15 weeks after the last WEZENLA treatment.
- WEZENLA can pass across the placenta to the unborn baby. If you received WEZENLA during your pregnancy, your baby may have a higher risk for getting an infection.
- It is important that you tell your baby's doctors and other health care professionals if you received WEZENLA during your pregnancy before the baby receives any vaccine. Live vaccines such as the BCG vaccine (used to prevent tuberculosis) are not recommended for your baby in the first twelve months after birth if you received WEZENLA during the pregnancy unless your baby's doctor recommends otherwise.
- Ustekinumab may pass into breast milk in very small amounts. Talk to your doctor if you are breast-feeding or are planning to breast-feed. You and your doctor should decide if you should breast-feed or use WEZENLA - do not do both.

Driving and using machines

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

WEZENLA contains polysorbate 80

WEZENLA contains 0.02 mg (45 mg/0.5 mL) or 0.04 mg (90 mg/1.0 mL) of polysorbate 80 (E 433) in each dosage unit which is equivalent to 0.04 mg/mL. Polysorbates may cause allergic reactions. Tell your doctor if you have any known allergies.

3. How to use WEZENLA

WEZENLA is intended for use under the guidance and supervision of a doctor experienced in treating conditions for which WEZENLA is intended.

Always use this medicine exactly as your doctor has told you. Check with your doctor if you are not sure. Talk to your doctor about when you will have your injections and follow-up appointments.

How much WEZENLA is given

Your doctor will decide how much WEZENLA you need to use and for how long.

Adults aged 18 years or older

Psoriasis or Psoriatic Arthritis

- The recommended starting dose is 45 mg WEZENLA. Patients who weigh more than 100 kilograms (kg) may start on a dose of 90 mg instead of 45 mg.
- After the starting dose, you will have the next dose 4 weeks later, and then every 12 weeks. The following doses are usually the same as the starting dose.

Crohn's disease

- During treatment, the first dose of approximately 6 mg/kg WEZENLA will be given by your doctor through a drip in a vein in your arm (intravenous infusion). After the starting dose, you will receive the next dose of 90 mg WEZENLA after 8 weeks, then every 12 weeks thereafter by an injection under the skin ('subcutaneously').
- In some patients, after the first injection under the skin, 90 mg WEZENLA may be given every 8 weeks. Your doctor will decide when you should receive your next dose.

Children and adolescents aged 6 years or older

Psoriasis

- The doctor will work out the right dose for you, including the amount (volume) of WEZENLA to be injected to give the right dose. The right dose for you will depend on your body weight at the time each dose is given.
- A 45 mg vial is available for children who need to receive less than the full 45 mg dose.
- If you weigh less than 60 kg, the recommended dose is 0.75 mg of WEZENLA per kg body weight.
- If you weigh 60 kg to 100 kg, the recommended dose is 45 mg WEZENLA.
- If you weigh more than 100 kg, the recommended dose is 90 mg WEZENLA.
- After the starting dose, you will have the next dose 4 weeks later, and then every 12 weeks.

Children who weigh at least 40 kg

Crohn's disease

- During treatment, the first dose of approximately 6 mg/kg WEZENLA will be given by your doctor through a drip in a vein in your arm (intravenous infusion). After the starting dose, you will receive the next dose of 90 mg WEZENLA after 8 weeks, then every 12 weeks thereafter by an injection under the skin ('subcutaneously').
- In some patients, after the first injection under the skin, 90 mg WEZENLA may be given every 8 weeks. Your doctor will decide when you should receive your next dose.

How WEZENLA is given

- WEZENLA is given as an injection under the skin ('subcutaneously'). At the start of your treatment, medical or nursing staff may inject WEZENLA.

- However, you and your doctor may decide that you may inject WEZENLA yourself. In this case you will get training on how to inject WEZENLA yourself.
- For instructions on how to inject WEZENLA, see 'Instructions for use' at the end of this leaflet. Talk to your doctor if you have any questions about giving yourself an injection.

If you use more WEZENLA than you should

If you have used or been given too much WEZENLA, talk to a doctor or pharmacist straight away. Always have the outer carton of the medicine with you, even if it is empty.

If you forget to use WEZENLA

If you forget a dose, contact your doctor or pharmacist. Do not take a double dose to make up for a forgotten dose.

If you stop using WEZENLA

It is not dangerous to stop using WEZENLA. However, if you stop, your symptoms may come back.

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

4. Possible side effects

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

Serious side effects

Some patients may have serious side effects that may need urgent treatment.

Allergic reactions – these may need urgent treatment. Tell your doctor or get emergency medical help straight away if you notice any of the following signs.

- Serious allergic reactions ('anaphylaxis') are rare in people taking ustekinumab (may affect up to 1 in 1 000 people). Signs include:
 - difficulty breathing or swallowing
 - low blood pressure, which can cause dizziness or light-headedness
 - swelling of the face, lips, mouth or throat.
- Common signs of an allergic reaction include skin rash and hives (these may affect up to 1 in 100 people).

In rare cases, allergic lung reactions and lung inflammation have been reported in patients who receive ustekinumab. Tell your doctor right away if you develop symptoms such as cough, shortness of breath, and fever.

If you have a serious allergic reaction, your doctor may decide that you should not use WEZENLA again.

Infections – these may need urgent treatment. Tell your doctor straight away if you notice any of the following signs.

- Infections of the nose or throat and common cold are common (may affect up to 1 in 10 people)
- Infections of the chest are uncommon (may affect up to 1 in 100 people)
- Inflammation of tissue under the skin ('cellulitis') is uncommon (may affect up to 1 in 100 people)
- Shingles (a type of painful rash with blisters) are uncommon (may affect up to 1 in 100 people)

WEZENLA may make you less able to fight infections. Some infections could become serious and may include infections caused by viruses, fungi, bacteria (including tuberculosis), or parasites, including infections that mainly occur in people with a weakened immune system (opportunistic infections). Opportunistic infections of the brain (encephalitis, meningitis), lungs, and eye have been reported in patients receiving treatment with ustekinumab.

You must look out for signs of infection while you are using WEZENLA. These include:

- fever, flu-like symptoms, night sweats, weight loss
- feeling tired or short of breath; cough which will not go away
- warm, red and painful skin, or a painful skin rash with blisters
- burning when passing water
- diarrhoea
- visual disturbance or vision loss
- headache, neck stiffness, light sensitivity, nausea or confusion.

Tell your doctor straight away if you notice any of these signs of infection. These may be signs of infections such as chest infections, skin infections, shingles or opportunistic infections that could have serious complications. Tell your doctor if you have any kind of infection that will not go away or keeps coming back. Your doctor may decide that you should not use WEZENLA until the infection goes away. Also tell your doctor if you have any open cuts or sores as they might get infected.

Shedding of skin – increase in redness and shedding of skin over a larger area of the body may be symptoms of erythrodermic psoriasis or exfoliative dermatitis, which are serious skin conditions. You should tell your doctor straight away if you notice any of these signs.

Other side effects

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

- Diarrhoea
- Nausea
- Vomiting
- Feeling tired
- Feeling dizzy
- Headache
- Itching ('pruritus')
- Back, muscle or joint pain
- Sore throat
- Redness and pain where the injection is given
- Sinus infection

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

- Tooth infections
- Vaginal yeast infection
- Depression
- Blocked or stuffy nose
- Bleeding, bruising, hardness, swelling and itching where the injection is given
- Feeling weak
- Drooping eyelid and sagging muscles on one side of the face ('facial palsy' or 'Bell's palsy'), which is usually temporary
- A change in psoriasis with redness and new tiny, yellow or white skin blisters, sometimes accompanied by fever (pustular psoriasis)
- Peeling of the skin (skin exfoliation)
- Acne

Rare side effects (may affect up to 1 in 1 000 people):

- Redness and shedding of skin over a larger area of the body, which may be itchy or painful (exfoliative dermatitis). Similar symptoms sometimes develop as a natural change in the type of psoriasis symptoms (erythrodermic psoriasis)
- Inflammation of small blood vessels, which can lead to a skin rash with small red or purple bumps, fever or joint pain (vasculitis)

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

- Blistering of the skin that may be red, itchy, and painful (Bullous pemphigoid)
- Skin lupus or lupus-like syndrome (red, raised scaly rash on areas of the skin exposed to the sun possibly with joint pains).

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 WEZENLA

- Keep this medicine out of the sight and reach of children.
- 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.
- If needed, individual WEZENLA pre-filled syringes may also be stored at room temperature up to 30°C for a maximum single period of up to 30 days in the original carton in order to protect from light. Record the date when the pre-filled syringe is first removed from the refrigerator and the discard date. The discard date must not exceed the original expiry date printed on the carton. Once a syringe has been stored at room temperature (up to 30°C), it should not be returned to the refrigerator. Discard the syringe if not used within 30 days at room temperature storage or by the original expiry date, whichever is earlier.
- Do not shake WEZENLA pre-filled syringes. Prolonged vigorous shaking may damage the medicine.

Do not use this medicine:

- After the expiry date which is stated on the label and the carton after 'EXP'. The expiry date refers to the last day of that month.
- If the liquid is discoloured, cloudy or you can see foreign particles floating in it (see section 6 'What WEZENLA looks like and contents of the pack').
- If you know, or think that it may have been exposed to extreme temperatures (such as accidentally frozen or heated).
- If the product has been shaken vigorously.

WEZENLA is for single use only. Any unused product remaining in the syringe should be thrown away. Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. Contents of the pack and other information

What WEZENLA contains

- The active substance is ustekinumab. Each pre-filled syringe contains 45 mg ustekinumab in 0.5 mL or 90 mg ustekinumab in 1 mL.
- The other ingredients are L-histidine, L-histidine hydrochloride monohydrate, polysorbate 80 (E 433), sucrose and water for injections.

What WEZENLA looks like and contents of the pack

WEZENLA is a clear to opalescent, colourless to light yellow solution for injection. It is supplied as a carton pack containing 1 single-dose, glass 1 mL pre-filled syringe. Each pre-filled syringe contains 45 mg ustekinumab in 0.5 mL or 90 mg ustekinumab in 1 mL of solution for injection.

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This leaflet was last revised in**Other sources of information**

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

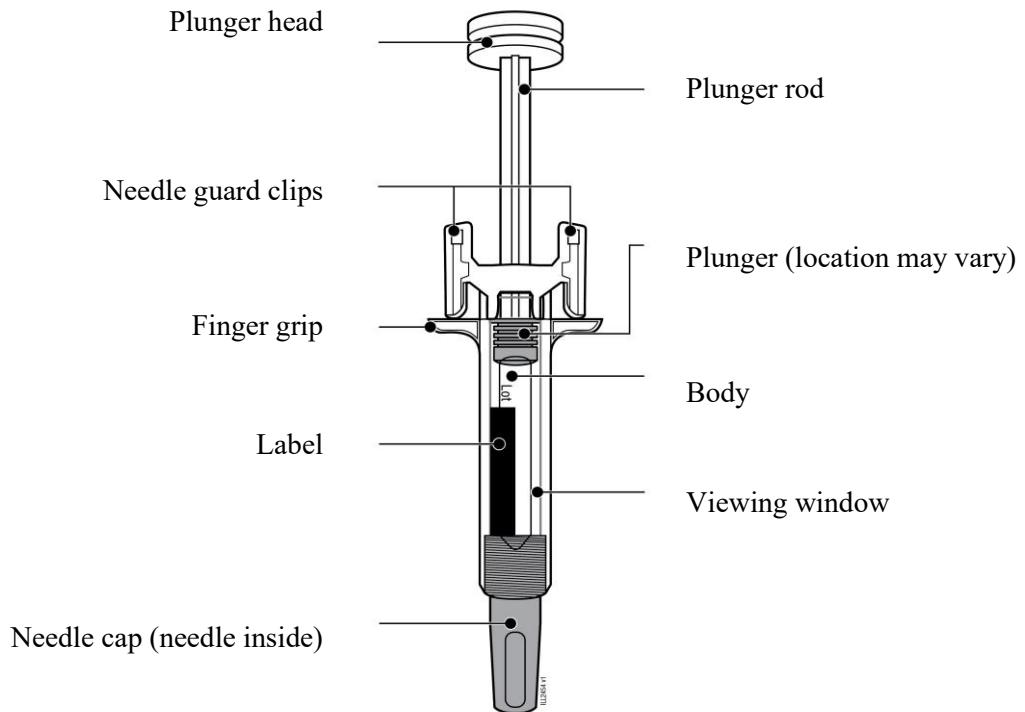
<https://www.ema.europa.eu>.

INSTRUCTIONS FOR USE

This Instructions for Use contains information on how to inject WEZENLA with a pre-filled syringe.

This pre-filled syringe delivers WEZENLA with an under-the-skin (subcutaneous) injection. See Package Leaflet for medicine information.

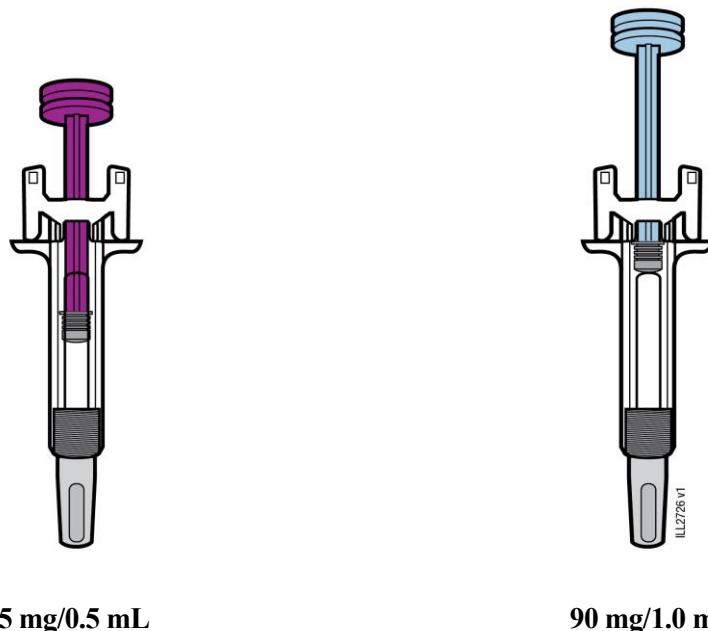
Getting to know your pre-filled syringe



1 Important information you need to know before injecting WEZENLA

Dosing:

- WEZENLA comes in two different doses: 45 mg/0.5 mL and 90 mg/1.0 mL. Check your prescription to make sure you have the correct dose.
- The look of the pre-filled syringe will be different for each dose. The amount of medicine in the pre-filled syringe will also be different for each dose.
- The 45 mg/0.5 mL dose has a smaller amount of medicine than the 90 mg/1.0 mL. Check the illustrations below to see what your dose looks like in the pre-filled syringe.



45 mg/0.5 mL

90 mg/1.0 mL

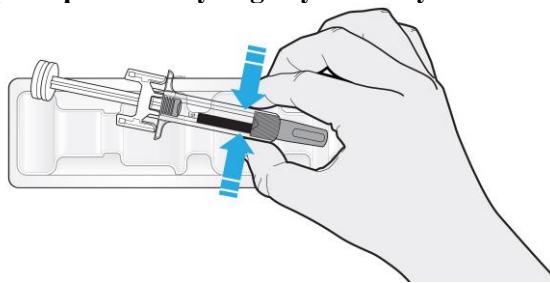
Using your WEZENLA pre-filled syringe:

- It is important that you do not try to give yourself the injection unless you have received training from your doctor or healthcare provider.
- In children 12 years of age and older with psoriasis who weigh 60 kg or more, it is recommended that WEZENLA is used by or under supervision of a parent or caregiver.
- Do not** use the pre-filled syringe if the carton is damaged or seal is broken.
- Do not** use the pre-filled syringe after the expiry date on the label.
- Do not** shake the pre-filled syringe.
- Do not** remove the needle cap from the pre-filled syringe until you are ready to inject.
- Do not** use the pre-filled syringe if it has been frozen.
- Do not** use the pre-filled syringe if it has been dropped on a hard surface. Part of the pre-filled syringe may be broken even if you cannot see the break. If available, use a new pre-filled syringe and call your doctor or healthcare provider.

Important: Keep the pre-filled syringe and sharps disposal container out of the sight and reach of children.

2 Preparing to inject WEZENLA

2a Grasp the pre-filled syringe by the body and remove from carton.



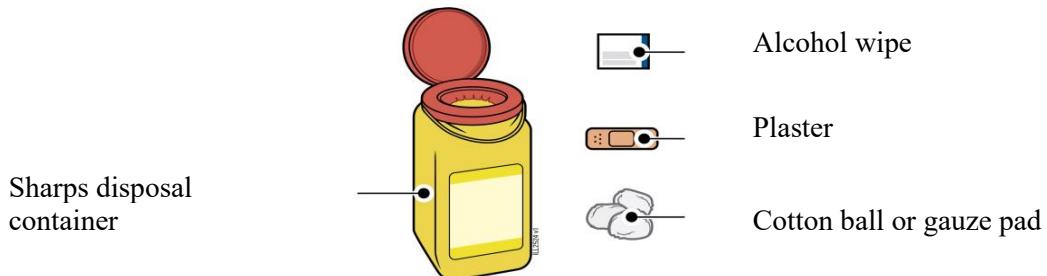
- **Do not** grab the plunger rod, finger grip or the needle cap.
- **Do not** grab the needle guard clips.
- Remove the number of pre-filled syringes you need for your injection.
- Put any unused pre-filled syringes back into the refrigerator.

2b Wait 30 minutes for the pre-filled syringe to reach room temperature.

WAIT
30
minutes

- Let the pre-filled syringe warm up naturally.
- **Do not** heat with hot water, a microwave or direct sunlight.
- **Do not** shake the pre-filled syringe at any time.
- Using the pre-filled syringe at room temperature allows for a more comfortable injection.

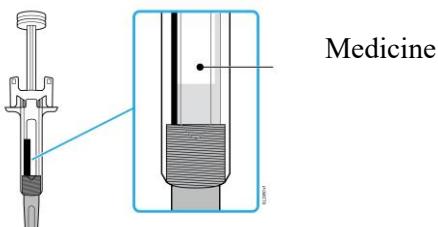
2c Gather and place the items for your injection on a clean, well-lit surface.



- WEZENLA pre-filled syringe (room temperature)
- Sharps disposal container
- Alcohol wipe
- Plaster
- Cotton ball or gauze pad

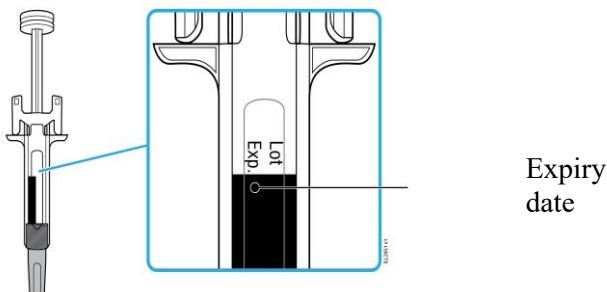
3 Getting ready for your injection

3a Inspect the medicine. It should be clear to opalescent, colourless to light yellow solution.



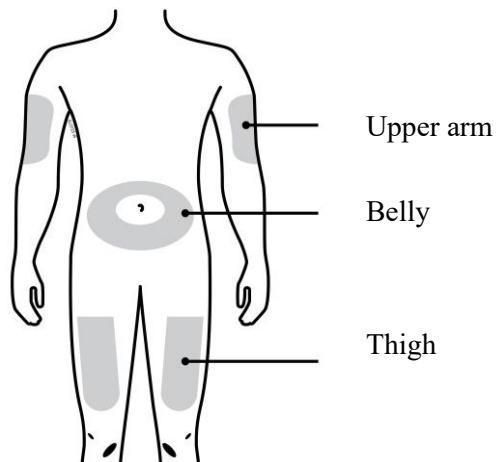
- It is ok to see air bubbles in the pre-filled syringe.
- **Do not** use if the medicine is frozen, cloudy, discoloured or has foreign particles floating in it.

3b Check the expiry date (EXP) and inspect the pre-filled syringe.



- **Do not** use if the expiry date has passed.
- **Do not** use the pre-filled syringe if:
 - The cap is missing or loose.
 - It has cracks or broken parts.
 - It has been dropped on a hard surface.
- Make sure you have the correct medicine and dose.

3c Inject in one of these locations.



- Inject in your thigh or belly (except 5 cm around your belly button).
- Choose a different site for each injection.
- Someone else can inject in your thigh, belly or back of the upper arm.

Important: Avoid areas with scars, stretch marks or where skin is tender, bruised, red, or hard. If possible, do not use areas of skin that show signs of psoriasis.

3d Wash hands thoroughly with soap and water.

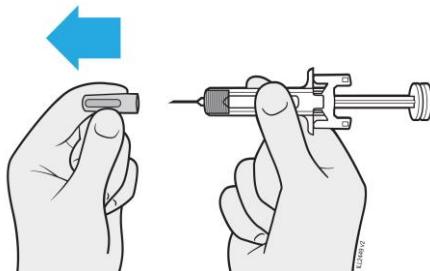
3e Clean injection site with alcohol wipe.

- Let your skin dry on its own.
- **Do not** touch this area before injecting.

4 Injecting WEZENLA

4a Pull the needle cap straight off while holding the syringe body.

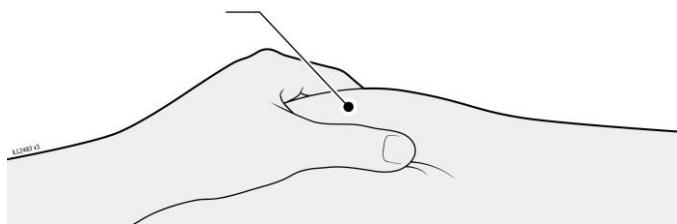
Important: Only remove the cap when you can inject right away (within 5 minutes) because the medicine can dry out.



- **Do not** twist or bend the needle cap.
- **Never** put the cap back on. It may damage the needle.
- **Do not** let anything touch the needle once the cap is removed.
- **Do not** place uncapped pre-filled syringe on any surface once the cap is removed.
- **Do not** try to push air bubbles out. It is ok to see air bubbles.
- A drop of medicine is normal.

4b Pinch the skin around the injection site before injection.

PINCH

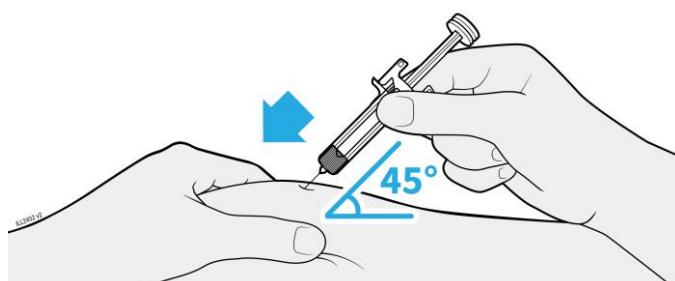


- Pinch the skin between thumb and index finger to create a bump for injection.
- If possible, the bump should be about 5 cm wide.

Important: Continue to pinch the skin until injection is complete.

4c Insert the needle into the pinched skin.

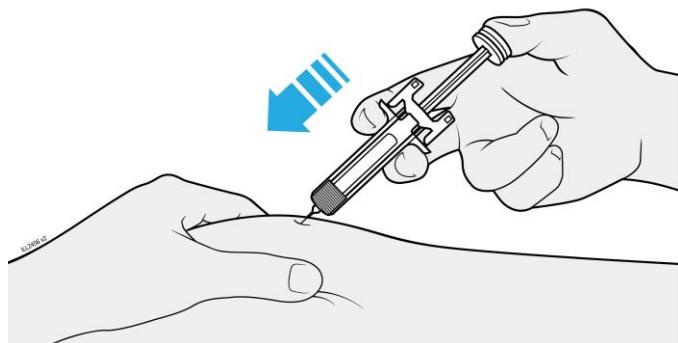
INSERT



- Insert the needle into the pinched skin at a 45-degree angle.
- **Do not** place your finger on the plunger rod while inserting the needle, as this may result in lost medicine.

4d Slowly press the plunger head down until it is completely between the needle guard clips.

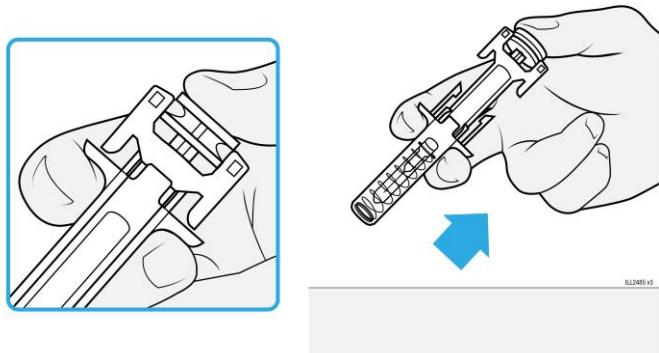
INJECT



- **Do not** pull back on the plunger at any time.
- **Do not** remove pre-filled syringe until all medicine is delivered.

4e Keep pressure on the plunger head and remove needle from skin.

LIFT



- Keep pressure on the plunger head and take the needle out of the skin.
- Let go of the skin after needle is removed.
- Slowly take your thumb off the plunger head. This will let the empty syringe move up until the entire needle is entirely covered by the needle guard.

If a second injection is required...

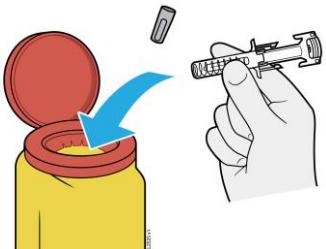
4f Repeat steps 2a-4e if a second injection is required.

- Check your prescription for your dose. If your dose is 90 mg, you will receive either one 90 mg pre-filled syringe or two 45 mg pre-filled syringes.
 - If you receive two 45 mg pre-filled syringes for a 90 mg dose, you will need to give yourself a second injection immediately after the first.
- Repeat Steps 2a–4e for the second injection using a new pre-filled syringe. Choose a different site for the second injection.

5 Disposing and finishing WEZENLA

Important: Never put the cap back on.

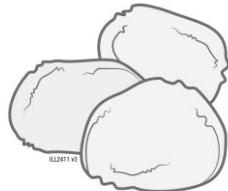
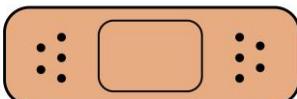
5a Place the used pre-filled syringe and needle cap in the sharps disposal container.



- **Do not** reuse the pre-filled syringe.

Do not throw away the pre-filled syringe into the household waste.

5b Check injection site.



- **Do not** rub the injection site.
- If there is blood, press a cotton ball or gauze pad on your injection site. Apply a plaster if necessary.

Any unused product remaining in the syringe should be thrown away. 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.

Package leaflet: Information for the user

WEZENLA 45 mg solution for injection in pre-filled pen WEZENLA 90 mg solution for injection in pre-filled pen ustekinumab

▼ 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.

This leaflet has been written for the person taking the medicine.

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

What is in this leaflet

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

1. What WEZENLA is and what it is used for

What WEZENLA is

WEZENLA contains the active substance 'ustekinumab', a monoclonal antibody. Monoclonal antibodies are proteins that recognise and bind specifically to certain proteins in the body.

WEZENLA belongs to a group of medicines called 'immunosuppressants'. These medicines work by weakening part of the immune system.

What WEZENLA is used for

WEZENLA is used to treat the following inflammatory diseases:

- Plaque psoriasis - in adults
- Psoriatic arthritis - in adults
- Moderate to severe Crohn's disease - in adults

Plaque psoriasis

Plaque psoriasis is a skin condition that causes inflammation affecting the skin and nails. WEZENLA will reduce the inflammation and other signs of the disease.

WEZENLA is used in adults with moderate to severe plaque psoriasis, who cannot use ciclosporin, methotrexate or phototherapy, or where these treatments did not work.

Psoriatic arthritis

Psoriatic arthritis is an inflammatory disease of the joints, usually accompanied by psoriasis. If you have active psoriatic arthritis you will first be given other medicines. If you do not respond well enough to these medicines, you may be given WEZENLA to:

- Reduce the signs and symptoms of your disease.
- Improve your physical function.
- Slow down the damage to your joints.

Crohn's disease

Crohn's disease is an inflammatory disease of the bowel. If you have Crohn's disease you will first be given other medicines. If you do not respond well enough or are intolerant to these medicines, you may be given WEZENLA to reduce the signs and symptoms of your disease.

2. What you need to know before you use WEZENLA

Do not use WEZENLA

- **If you are allergic to ustekinumab** or any of the other ingredients of this medicine (listed in section 6).
- **If you have an active infection** which your doctor thinks is important.

If you are not sure if any of the above applies to you, talk to your doctor or pharmacist before using WEZENLA.

Warnings and precautions

Talk to your doctor or pharmacist before using WEZENLA. Your doctor will check how well you are before each treatment. Make sure you tell your doctor about any illness you have before each treatment. Also tell your doctor if you have recently been near anyone who might have tuberculosis. Your doctor will examine you and do a test for tuberculosis, before you have WEZENLA. If your doctor thinks you are at risk of tuberculosis, you may be given medicines to treat it.

Look out for serious side effects

WEZENLA can cause serious side effects, including allergic reactions and infections. You must look out for certain signs of illness while you are taking WEZENLA. See 'Serious side effects' in section 4 for a full list of these side effects.

Before you use WEZENLA tell your doctor:

- **If you ever had an allergic reaction to WEZENLA.** Ask your doctor if you are not sure.
- **If you have ever had any type of cancer** – this is because immunosuppressants like WEZENLA weaken part of the immune system. This may increase the risk of cancer.
- **If you have been treated for psoriasis with other biologic medicines (a medicine produced from a biological source and usually given by injection)** – the risk of cancer may be higher.
- **If you have or have had a recent infection.**
- **If you have any new or changing lesions** within psoriasis areas or on normal skin.
- **If you are having any other treatment for psoriasis and/or psoriatic arthritis** – such as another immunosuppressant or phototherapy (when your body is treated with a type of ultraviolet (UV) light). These treatments may also weaken part of the immune system. Using these therapies together with WEZENLA has not been studied. However, it is possible it may increase the chance of diseases related to a weaker immune system.
- **If you are having or have ever had injections to treat allergies** – it is not known if WEZENLA may affect these.
- **If you are 65 years of age or over** – you may be more likely to get infections.

If you are not sure if any of the above applies to you, talk to your doctor or pharmacist before using WEZENLA.

Some patients have experienced lupus-like reactions including skin lupus or lupus-like syndrome during treatment with ustekinumab. Talk to your doctor right away if you experience a red, raised, scaly rash sometimes with a darker border, in areas of the skin that are exposed to the sun or with joint pains.

Heart attack and strokes

Heart attack and strokes have been observed in a study in patients with psoriasis treated with ustekinumab. Your doctor will regularly check your risk factors for heart disease and stroke in order to ensure that they are appropriately treated. Seek medical attention right away if you develop chest pain, weakness or abnormal sensation on one side of your body, facial droop, or speech or visual abnormalities.

Children and adolescents

The WEZENLA pre-filled pen is not recommended for use in children and adolescents under 18 years of age with psoriasis or Crohn's disease because it has not been studied in this age group. The pre-filled syringe or vial should be used instead for children 6 years of age and older and adolescents with psoriasis. The solution for infusion, pre-filled vial or syringe should be used instead for children weighing at least 40 kg with Crohn's disease.

WEZENLA is not recommended for use in children and adolescents under 18 years of age with psoriatic arthritis or children with Crohn's disease who weigh less than 40 kg because it has not been studied in this age group.

Other medicines, vaccines and WEZENLA

Tell your doctor or pharmacist:

- If you are taking, have recently taken or might take any other medicines.
- If you have recently had or are going to have a vaccination. Some types of vaccines (live vaccines) should not be given while using WEZENLA.
- If you received WEZENLA while pregnant, tell your baby's doctor about your WEZENLA treatment before the baby receives any vaccine, including live vaccines, such as the BCG vaccine (used to prevent tuberculosis). Live vaccines are not recommended for your baby in the first twelve months after birth if you received WEZENLA during the pregnancy unless your baby's doctor recommends otherwise.

Pregnancy and breast-feeding

- If you are pregnant, think you may be pregnant or are planning to have a baby, ask your doctor for advice before taking this medicine.
- A higher risk of birth defects has not been seen in babies exposed to WEZENLA in the womb. However, there is limited experience with WEZENLA in pregnant women. It is therefore preferable to avoid the use of WEZENLA in pregnancy.
- If you are a woman of childbearing potential, you are advised to avoid becoming pregnant and must use adequate contraception while using WEZENLA and for at least 15 weeks after the last WEZENLA treatment.
- WEZENLA can pass across the placenta to the unborn baby. If you received WEZENLA during your pregnancy, your baby may have a higher risk for getting an infection.
- It is important that you tell your baby's doctors and other health care professionals if you received WEZENLA during your pregnancy before the baby receives any vaccine. Live vaccines such as the BCG vaccine (used to prevent tuberculosis) are not recommended for your baby in the first twelve months after birth if you received WEZENLA during the pregnancy unless your baby's doctor recommends otherwise.
- Ustekinumab may pass into breast milk in very small amounts. Talk to your doctor if you are breast-feeding or are planning to breast-feed. You and your doctor should decide if you should breast-feed or use WEZENLA - do not do both.

Driving and using machines

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

WEZENLA contains polysorbate 80

WEZENLA contains 0.02 mg (45 mg/0.5 mL) or 0.04 mg (90 mg/1.0 mL) of polysorbate 80 (E 433) in each dosage unit which is equivalent to 0.04 mg/mL. Polysorbates may cause allergic reactions. Tell your doctor if you have any known allergies.

3. How to use WEZENLA

WEZENLA is intended for use under the guidance and supervision of a doctor experienced in treating conditions for which WEZENLA is intended.

Always use this medicine exactly as your doctor has told you. Check with your doctor if you are not sure. Talk to your doctor about when you will have your injections and follow-up appointments.

How much WEZENLA is given

Your doctor will decide how much WEZENLA you need to use and for how long.

Adults aged 18 years or older

Psoriasis or psoriatic arthritis

- The recommended starting dose is 45 mg WEZENLA. Patients who weigh more than 100 kilograms (kg) may start on a dose of 90 mg instead of 45 mg.
- After the starting dose, you will have the next dose 4 weeks later, and then every 12 weeks. The following doses are usually the same as the starting dose.

Crohn's disease

- During treatment, the first dose of approximately 6 mg/kg WEZENLA will be given by your doctor through a drip in a vein in your arm (intravenous infusion). After the starting dose, you will receive the next dose of 90 mg WEZENLA after 8 weeks, then every 12 weeks thereafter by an injection under the skin ('subcutaneously').
- In some patients, after the first injection under the skin, 90 mg WEZENLA may be given every 8 weeks. Your doctor will decide when you should receive your next dose.

How WEZENLA is given

- WEZENLA is given as an injection under the skin ('subcutaneously'). At the start of your treatment, medical or nursing staff may inject WEZENLA.
- However, you and your doctor may decide that you may inject WEZENLA yourself. In this case you will receive training on how to inject WEZENLA yourself.
- For instructions on how to inject WEZENLA, see 'Instructions for use' at the end of this leaflet. Talk to your doctor if you have any questions about giving yourself an injection.

If you use more WEZENLA than you should

If you have used or been given too much WEZENLA, talk to a doctor or pharmacist straight away. Always have the outer carton of the medicine with you, even if it is empty.

If you forget to use WEZENLA

If you forget a dose, contact your doctor or pharmacist. Do not take a double dose to make up for a forgotten dose.

If you stop using WEZENLA

It is not dangerous to stop using WEZENLA. However, if you stop, your symptoms may come back.

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

4. Possible side effects

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

Serious side effects

Some patients may have serious side effects that may need urgent treatment.

Allergic reactions – these may need urgent treatment. Tell your doctor or get emergency medical help straight away if you notice any of the following signs.

- Serious allergic reactions ('anaphylaxis') are rare in people taking ustekinumab (may affect up to 1 in 1 000 people). Signs include:
 - difficulty breathing or swallowing
 - low blood pressure, which can cause dizziness or light-headedness
 - swelling of the face, lips, mouth or throat.
- Common signs of an allergic reaction include skin rash and hives (these may affect up to 1 in 100 people).

In rare cases, allergic lung reactions and lung inflammation have been reported in patients who receive ustekinumab. Tell your doctor right away if you develop symptoms such as cough, shortness of breath, and fever.

If you have a serious allergic reaction, your doctor may decide that you should not use WEZENLA again.

Infections – these may need urgent treatment. Tell your doctor straight away if you notice any of the following signs.

- Infections of the nose or throat and common cold are common (may affect up to 1 in 10 people)
- Infections of the chest are uncommon (may affect up to 1 in 100 people)
- Inflammation of tissue under the skin ('cellulitis') is uncommon (may affect up to 1 in 100 people)
- Shingles (a type of painful rash with blisters) are uncommon (may affect up to 1 in 100 people)

WEZENLA may make you less able to fight infections. Some infections could become serious and may include infections caused by viruses, fungi, bacteria (including tuberculosis), or parasites, including infections that mainly occur in people with a weakened immune system (opportunistic infections). Opportunistic infections of the brain (encephalitis, meningitis), lungs, and eye have been reported in patients receiving treatment with ustekinumab.

You must look out for signs of infection while you are using WEZENLA. These include:

- fever, flu-like symptoms, night sweats, weight loss
- feeling tired or short of breath; cough which will not go away
- warm, red and painful skin, or a painful skin rash with blisters
- burning when passing water
- diarrhoea
- visual disturbance or vision loss
- headache, neck stiffness, light sensitivity, nausea or confusion.

Tell your doctor straight away if you notice any of these signs of infection. These may be signs of infections such as chest infections, skin infections, shingles or opportunistic infections that could have serious complications. Tell your doctor if you have any kind of infection that will not go away or keeps coming back. Your doctor may decide that you should not use WEZENLA until the infection goes away. Also tell your doctor if you have any open cuts or sores as they might get infected.

Shedding of skin – increase in redness and shedding of skin over a larger area of the body may be symptoms of erythrodermic psoriasis or exfoliative dermatitis, which are serious skin conditions. You should tell your doctor straight away if you notice any of these signs.

Other side effects

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

- Diarrhoea
- Nausea
- Vomiting

- Feeling tired
- Feeling dizzy
- Headache
- Itching ('pruritus')
- Back, muscle or joint pain
- Sore throat
- Redness and pain where the injection is given
- Sinus infection

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

- Tooth infections
- Vaginal yeast infection
- Depression
- Blocked or stuffy nose
- Bleeding, bruising, hardness, swelling and itching where the injection is given
- Feeling weak
- Drooping eyelid and sagging muscles on one side of the face ('facial palsy' or 'Bell's palsy'), which is usually temporary
- A change in psoriasis with redness and new tiny, yellow or white skin blisters, sometimes accompanied by fever (pustular psoriasis)
- Peeling of the skin (skin exfoliation)
- Acne

Rare side effects (may affect up to 1 in 1 000 people):

- Redness and shedding of skin over a larger area of the body, which may be itchy or painful (exfoliative dermatitis). Similar symptoms sometimes develop as a natural change in the type of psoriasis symptoms (erythrodermic psoriasis)
- Inflammation of small blood vessels, which can lead to a skin rash with small red or purple bumps, fever or joint pain (vasculitis)

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

- Blistering of the skin that may be red, itchy, and painful (Bullous pemphigoid)
- Skin lupus or lupus-like syndrome (red, raised scaly rash on areas of the skin exposed to the sun possibly with joint pains).

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 WEZENLA

- Keep this medicine out of the sight and reach of children.
- Store in a refrigerator (2°C–8°C). Do not freeze.
- Keep the pre-filled pen in the outer carton in order to protect from light.
- If needed, individual WEZENLA pre-filled pens may also be stored at room temperature up to 30°C for a maximum single period of up to 30 days in the original carton in order to protect from light. Record the date when the pre-filled pen is first removed from the refrigerator and the discard date. The discard date must not exceed the original expiry date printed on the carton. Once a pre-filled pen has been stored at room temperature (up to 30°C), it should not be returned to the refrigerator. Discard the pre-filled pen if not used within 30 days at room temperature storage or by the original expiry date, whichever is earlier.

- Do not shake the WEZENLA pre-filled pens. Prolonged vigorous shaking may damage the medicine.

Do not use this medicine:

- After the expiry date which is stated on the label and the carton after 'EXP'. The expiry date refers to the last day of that month.
- If the liquid is discoloured, cloudy or you can see foreign particles floating in it (see section 6 'What WEZENLA looks like and contents of the pack').
- If you know, or think that it may have been exposed to extreme temperatures (such as accidentally frozen or heated).
- If the product has been shaken vigorously.

WEZENLA is for single use only. Any unused product remaining in the pre-filled pen should be thrown away. Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. Contents of the pack and other information

What WEZENLA contains

- The active substance is ustekinumab. Each pre-filled pen contains 45 mg ustekinumab in 0.5 mL or 90 mg ustekinumab in 1 mL.
- The other ingredients are L-histidine, L-histidine hydrochloride monohydrate, polysorbate 80 (E 433), sucrose and water for injections.

What WEZENLA looks like and contents of the pack

WEZENLA is a clear to opalescent, colourless to light yellow solution for injection. It is supplied as a carton pack containing 1 single-dose, glass 1 mL pre-filled pen. Each pre-filled pen contains 45 mg ustekinumab in 0.5 mL or 90 mg ustekinumab in 1 mL of solution for injection.

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Other sources of information

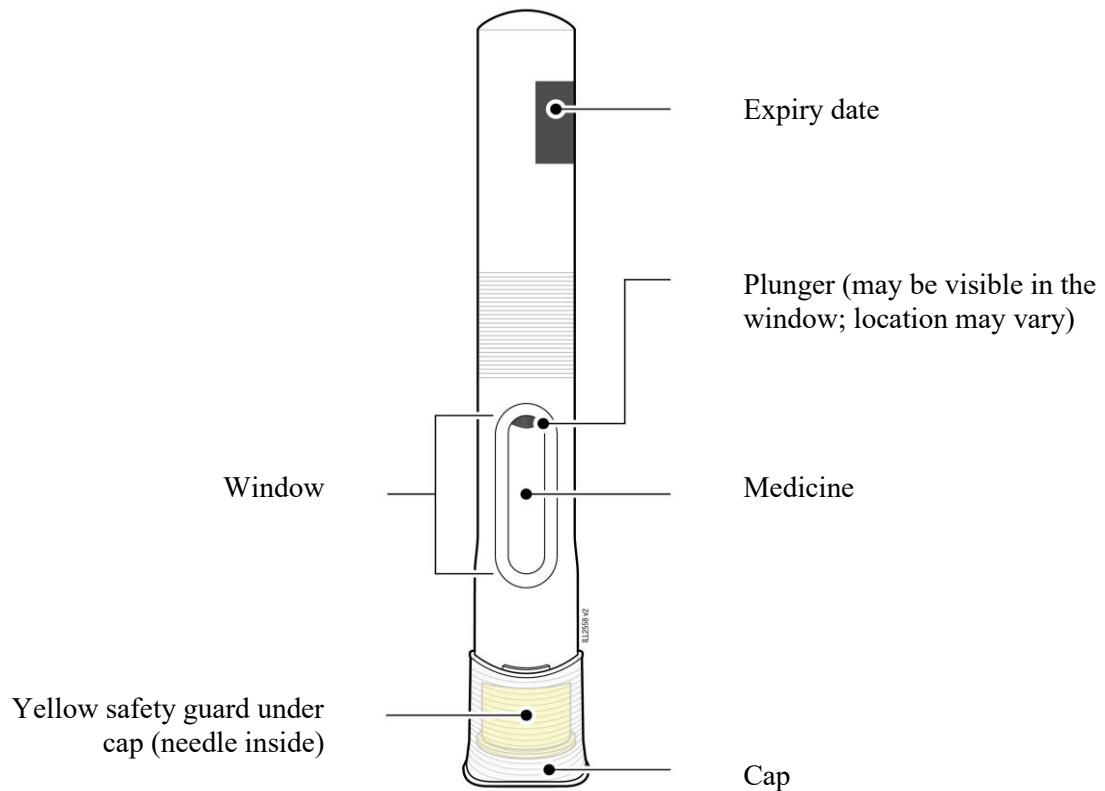
Detailed information on this medicine is available on the European Medicines Agency web site:
<https://www.ema.europa.eu>.

INSTRUCTIONS FOR USE

This Instructions for Use contains information on how to inject WEZENLA with a pre-filled pen (ConfiPen).

This pre-filled pen delivers WEZENLA with an under-the-skin (subcutaneous) injection. See Package Leaflet for medicine information.

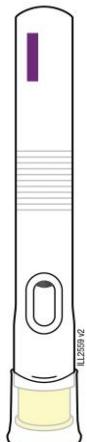
Getting to know the pre-filled pen



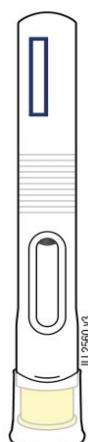
Important information you need to know before injecting WEZENLA

Dosing:

- WEZENLA comes in two different doses: 45 mg/0.5 mL and 90 mg/1.0 mL. Check the prescription to make sure you have the correct dose.
- The label colour and window size of the pre-filled pen will be different for each dose. The amount of medicine in the pre-filled pen will also be different for each dose.



45 mg/0.5 mL



90 mg/1.0 mL

Important:

- If the dose is 90 mg, you will receive either one 90 mg pre-filled pen or two 45 mg pre-filled pens.
 - If you receive two 45 mg pre-filled pens for a 90 mg dose, you will need to give a second injection straight after the first.
 - Repeat steps 1-14 for the second injection using a new pre-filled pen.
 - Choose a different site for the second injection.

Using your WEZENLA pre-filled pen:

- It is important that you or your caregiver do not try to perform the injection unless you have received training from your doctor or healthcare provider.
- Do not** use the pre-filled pen if the carton is damaged or the seal is broken.
- Do not** use the pre-filled pen after the expiry date on the label.
- Do not** shake the pre-filled pen.
- Do not** remove the cap from the pre-filled pen until you are ready to inject.
- Do not** use the pre-filled pen if it has been frozen.
- Do not** use the pre-filled pen if it has been dropped on a hard surface. Part of the pre-filled pen may be broken even if you cannot see the break. If available, use a new pre-filled pen and call your doctor or healthcare provider.

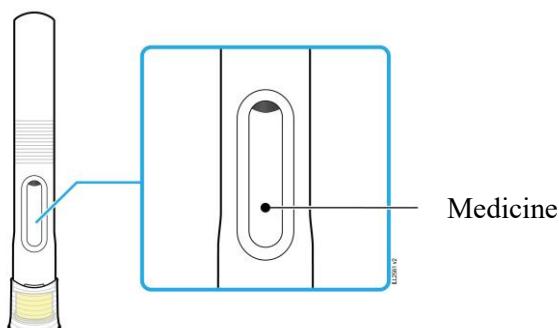
Important: Keep the pre-filled pen and sharps disposal container out of the sight and reach of children.

Preparing to inject WEZENLA

1 Wait 30 minutes for the pre-filled pen to reach room temperature.

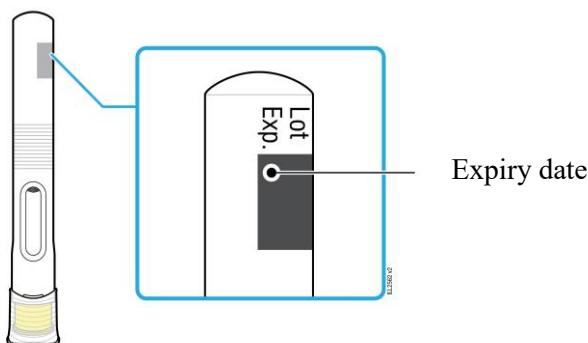
**WAIT
30
minutes**

- Remove the number of pre-filled pens you need for the injection from the refrigerator.
- Let the pre-filled pen warm up naturally.
- **Do not** heat the pre-filled pen with hot water, a microwave or direct sunlight.
- **Do not** put it back in the refrigerator once the pre-filled pen reaches room temperature.
- **Do not** shake the pre-filled pen at any time.
- Using the pre-filled pen at room temperature ensures the full dose is delivered and allows for a more comfortable injection.



2 Inspect the medicine. It should be clear to opalescent, colourless to light yellow.

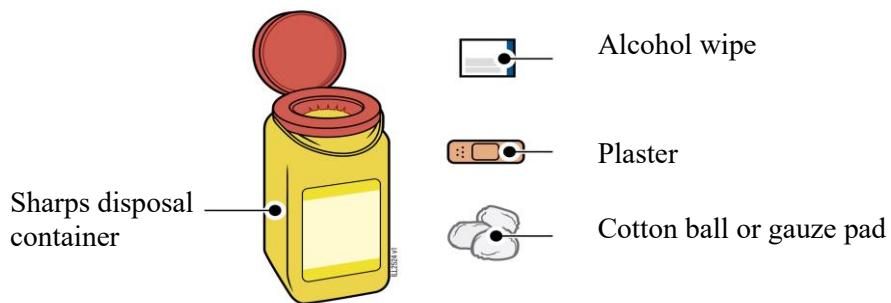
- It is ok to see air bubbles.
- **Do not** use WEZENLA if the medicine is frozen, cloudy, discoloured or has foreign particles floating in it.



3 Check the expiry date (EXP) and inspect the pre-filled pen for damage.

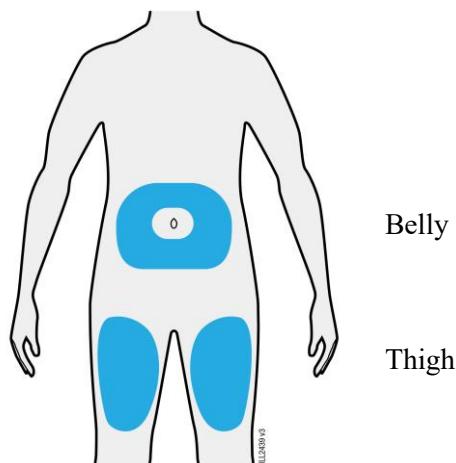
- **Do not** use the pre-filled pen if the expiry date has passed.
- **Do not** use the pre-filled pen if:
 - the cap is missing or loose,
 - it has cracks or broken parts, or
 - it has been dropped on a hard surface.
- Make sure you have the right medicine and dose.

Getting ready to inject WEZENLA



4 Gather and place the following items for the injection on a clean, flat and well-lit surface:

- WEZENLA pre-filled pen (room temperature),
- Sharps disposal container,
- Alcohol wipe,
- Plaster, and
- Cotton ball or gauze pad.



5 Select one of these injection locations.

- Select the front of your thigh or belly (except for 5 cm around your belly button).
- Someone else can inject in your thigh or belly.

Important: Avoid areas with scars, stretch marks or where the skin is tender, bruised, red or hard. If possible, do not use areas of skin that show sign of psoriasis.

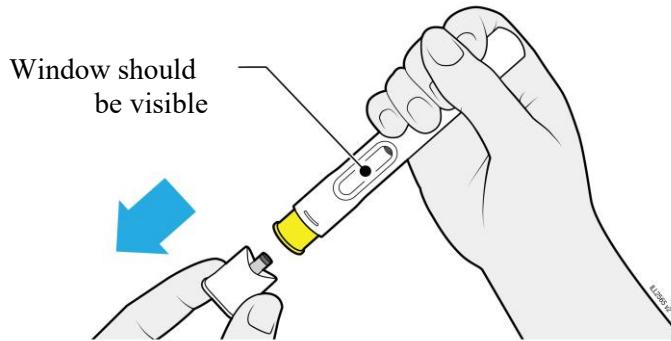
6 Wash your hands thoroughly with soap and water.

7 Clean the injection site with an alcohol wipe.

- Let the skin dry on its own.
- **Do not** touch this area again before injecting.

Injecting WEZENLA

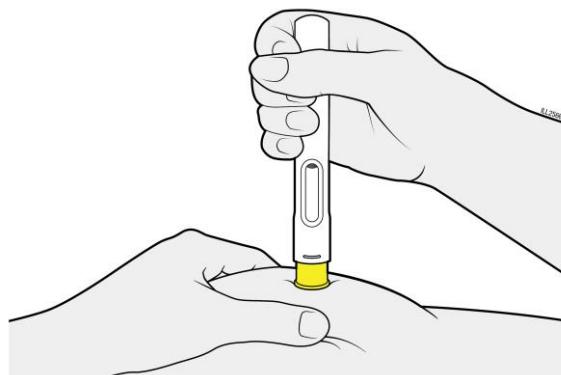
Important: Only remove the cap when you can inject straight away (within 5 minutes) because the medicine can dry out. **Do not recap.**



8 Grasp the pre-filled pen so you can see the window. Pull hard to remove the cap. You may twist the cap to help remove it.

- Never put the cap back on. It may damage the needle.
- It is normal to see a drop of medicine at the end of the needle or yellow safety guard.

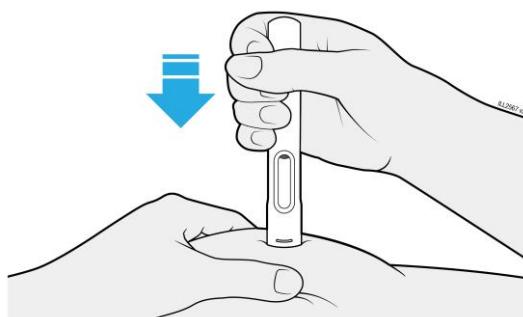
Important: Do not touch or push the yellow safety guard. Do not put your finger inside of the yellow safety guard.



**9 Pinch the skin to create a firm surface at the injection site.
Place the yellow safety guard straight against the pinched skin.**

- Keep the skin pinched until the injection is finished.
- Make sure you can see the window.
- Make sure the pre-filled pen is positioned straight on the injection site (at a 90 degree angle).

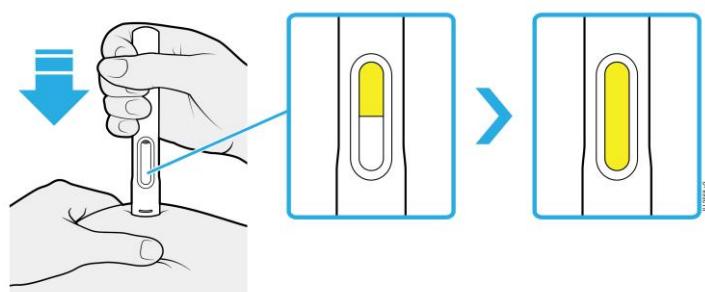
**PUSH & HOLD
down to start injection**



10 Firmly push the pre-filled pen down until the yellow safety guard stops moving. Hold the pre-filled pen down, do not lift.

- The needle will insert automatically and the injection will begin.
- You may hear or feel a click.
- Hold the pre-filled pen straight and steady on the skin.

**WATCH
the window will turn fully yellow**

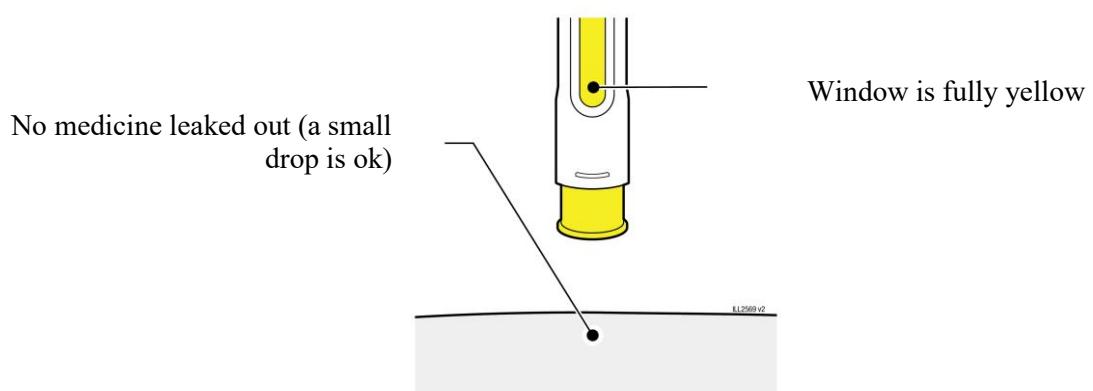


11 Keep pushing down the pre-filled pen. Wait for the window to turn fully yellow.

- The injection can take up to 15 seconds to complete. You may hear or feel a click.
- After the window turns fully yellow, lift the pre-filled pen away from the skin.

Checking the injection site and disposing of the pre-filled pen

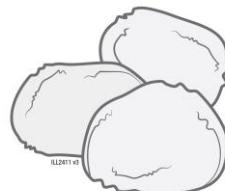
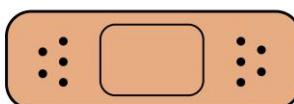
CONFIRM



12 Confirm a full dose of medicine was injected.

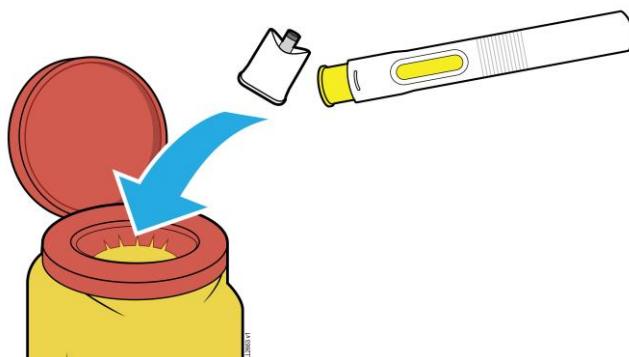
- **Do not** touch the yellow safety guard.
- A small amount of liquid on the injection site is ok.

Important: If the window has not turned fully yellow, if it looks like the medicine is still coming out, or if you see several drops of medicine, a full dose was not injected. Call your healthcare provider immediately.



13 Check the injection site.

- **Do not** rub the injection site.
- If there is blood, press a cotton ball or gauze pad on the injection site.
- Apply a plaster if necessary.



14 Place the used pre-filled pen and cap in the sharps disposal container.

Important: Do not throw away the pre-filled pen in your household waste.

- **Do not** reuse the pre-filled pen.
- **Do not** touch the yellow safety guard.

Any unused product remaining in the pre-filled pen should be thrown away. 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.