

PRODUCT MONOGRAPH
INCLUDING PATIENT MEDICATION INFORMATION

Pr **SARCLISA**®

Isatuximab for injection

Concentrate for solution for infusion (20 mg/mL)

Professed

Antineoplastic, monoclonal antibody

ATC code: L01XC38

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PART I: HEALTH PROFESSIONAL INFORMATION

1 INDICATIONS

Sarclisa (isatuximab for injection) is indicated:

- in combination with pomalidomide and dexamethasone, for the treatment of patients with relapsed and refractory multiple myeloma who have received at least two prior therapies including lenalidomide and a proteasome inhibitor.
- in combination with carfilzomib and dexamethasone, for the treatment of adult patients with relapsed or refractory multiple myeloma who have received 1 to 3 prior lines of therapy.

1.1 Pediatrics

Pediatrics (< 18 years of age): No data are available to Health Canada; therefore, Health Canada has not authorized an indication for pediatric use.

1.2 Geriatrics

Geriatrics (≥ 65 years of age): No overall differences in safety and efficacy were observed between older and younger patients (see 7 WARNINGS AND PRECAUTIONS, 7.1.4 Geriatrics and 10 CLINICAL PHARMACOLOGY, 10.3 Pharmacokinetics, *Geriatrics*).

2 CONTRAINDICATIONS

Isatuximab for injection is contraindicated in patients who are hypersensitive to this drug or to any ingredient in the formulation, including any non-medicinal ingredient, or component of the container. For a complete listing, see 6 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING.

4 DOSAGE AND ADMINISTRATION

4.1 Dosing Considerations

- Sarclisa should be administered by a healthcare professional experienced in the treatment of cancer and with immediate access to emergency equipment and appropriate medical support to manage infusion-related reactions.
- Administer only as an intravenous infusion after dilution (see 4.3 Reconstitution).

Premedication

Premedication should be used prior to Sarclisa infusion with the following medications to reduce the risk and severity of infusion-related reactions (IRRs):

- Dexamethasone:

| Treatment regimen | Dexamethasone dose | Additional information |
|---|---|--|
| Sarclisa in combination with pomalidomide and dexamethasone (Isa-Pd) | - Patients < 75 years: 40 mg PO or IV - Patients ≥ 75 years: 20 mg PO or IV | - The recommended dose of dexamethasone (PO or IV) corresponds to the total dose to be administered before infusion, as part of the premedication and of the backbone treatment; do not administer another dose. Administer dexamethasone before Sarclisa and pomalidomide and before Sarclisa and carfilzomib administration. |
| Sarclisa in combination with carfilzomib and dexamethasone (Isa-Kd) | - 20 mg: IV on the days of Sarclisa and/or carfilzomib infusions, and PO on Day 22 in cycle 2 and beyond, and PO on Day 23 in all cycles. | |

PO: oral; IV: intravenous

- Acetaminophen 650 mg to 1000 mg orally (or equivalent).
- H2 antagonists
- Diphenhydramine 25 mg to 50 mg IV or PO (or equivalent [e.g., cetirizine, promethazine, dexchlorpheniramine]). The intravenous route is preferred for at least the first 4 infusions.

The recommended premedication agents should be administered 15 to 60 minutes prior to starting a Sarclisa infusion.

4.2 Recommended Dose and Dosage Adjustment

The recommended dose of Sarclisa is 10 mg/kg body weight administered as an intravenous (IV) infusion in combination with pomalidomide and dexamethasone (Isa-Pd) or in combination with carfilzomib and dexamethasone (Isa-Kd), according to the schedule in Table 1 (see 14 CLINICAL TRIALS).

Table 1: Sarclisa dosing schedule in combination with pomalidomide and dexamethasone or in combination with carfilzomib and dexamethasone

| Cycles | Dosing Schedule |
|--------------------|-------------------------------|
| Cycle 1 | Days 1, 8, 15 and 22 (weekly) |
| Cycle 2 and beyond | Days 1, 15 (every 2 weeks) |

Each treatment cycle consists of a 28-day period. Treatment is repeated until disease progression or unacceptable toxicity.

Sarclisa is used in combination with pomalidomide and dexamethasone or in combination with carfilzomib and dexamethasone. For dosing instructions of other medicinal products that are administered with Sarclisa, see 14 CLINICAL TRIALS and the respective current Product Monographs (see 17 SUPPORTING PRODUCT MONOGRAPHS).

Dosage Adjustment

Health Canada has not authorized an indication for pediatric use (see 1 INDICATIONS).

No dose adjustment is recommended in geriatric patients (≥ 65 years of age) (see 10 CLINICAL PHARMACOLOGY, 10.3 Pharmacokinetics, *Geriatrics*).

No dose adjustment is recommended in patients with mild hepatic impairment. Limited data are available in patients with moderate hepatic impairment, and no data are available in patients with severe hepatic impairment (see 10 CLINICAL PHARMACOLOGY, 10.3 Pharmacokinetics, *Hepatic Insufficiency*).

No dose adjustment is recommended in patients with renal impairment (see 10 CLINICAL PHARMACOLOGY, 10.3 Pharmacokinetics, *Renal Insufficiency*).

Temporary interruption or definitive discontinuation of Sarclisa treatment may be required for infusion-related reactions (IRRs) or neutropenia; no dose reduction of Sarclisa is recommended (Table 2).

Table 2 : Adjustments for Sarclisa treatment administration following IRRs or neutropenia

| Adverse Reaction | NCI-CTCAE version 4.03 criteria definition | Administration adjustment |
|-----------------------------------|--|---|
| Infusion-related reactions (IRRs) | Mild (Grade 1): Infusion interruption or intervention not indicated | <ul style="list-style-type: none">• Continue Sarclisa infusion per the judgment of the physician with close direct monitoring of the patient's clinical status.• Sarclisa infusion may be stopped at any time if deemed necessary. |
| | Moderate (Grade 2): Infusion interruption indicated but responsive promptly to symptomatic treatment (e.g., antihistamines, NSAIDs, narcotics, IV fluids); prophylactic medications indicated for ≤ 24 hours | <ul style="list-style-type: none">• Stop Sarclisa infusion.• Give additional medication with diphenhydramine 25 mg IV (or equivalent) and/or IV methylprednisolone 100 mg (or equivalent) as needed.• If symptoms improve to Grade ≤ 1, restart Sarclisa infusion at half of the initial infusion rate, with supportive care as needed, and closely monitor patients. If symptoms do not recur after 30 minutes, the infusion rate may be increased to the initial rate, and then increased incrementally, as shown in Table 3.• If symptoms do not resolve rapidly or do not improve to Grade ≤ 1 after interruption of Sarclisa infusion, persist or worsen despite appropriate medications, or require hospitalization or are life-threatening, treatment with Sarclisa should be permanently discontinued and additional supportive therapy should be administered, as needed. |
| | Severe (Grade 3) or life- | <ul style="list-style-type: none">• Stop Sarclisa infusion. |

Table 2 : Adjustments for Sarclisa treatment administration following IRRs or neutropenia

| Adverse Reaction | NCI-CTCAE version 4.03 criteria definition | Administration adjustment |
|------------------|---|---|
| | threatening (Grade 4) Grade 3: prolonged symptoms (e.g., not rapidly responsive to symptomatic medication and/or brief interruption of infusion); recurrence of symptoms following initial improvement; hospitalization indicated for clinical sequelae Grade 4: life-threatening consequences; urgent intervention indicated | <ul style="list-style-type: none"> • Give additional medication with diphenhydramine 25 mg IV (or equivalent) and/ or IV methylprednisolone 100 mg (or equivalent) and/or epinephrine as needed. • Discontinue Sarclisa treatment. |
| Neutropenia | Grade 3/4 | <ul style="list-style-type: none"> • Sarclisa administration should be delayed until neutrophil count improves to at least $1.0 \times 10^9/L$. • The use of colony-stimulating factors (e.g. G-CSF) should be considered, according to local guidelines (see 7 WARNINGS AND PRECAUTIONS). |

NSAIDs: nonsteroidal anti-inflammatory drugs

For dosage adjustment information concerning medicinal products given in combination with Sarclisa, consult the corresponding Product Monographs (see 17 SUPPORTING PRODUCT MONOGRAPHS).

4.3 Reconstitution

The preparation of the infusion solution must be done under aseptic conditions.

- The dose (mg) of required Sarclisa concentrate should be calculated based on patient weight (measured prior to each cycle to have the administered dose adjusted accordingly, see 4 DOSAGE AND ADMINISTRATION, 4.2 Recommended Dose and Dosage Adjustment). More than one Sarclisa concentrate vial may be necessary to obtain the required dose for the patient.
- Vials of Sarclisa concentrate should be visually inspected before dilution to ensure they do not contain any particles and are not discoloured.
- The appropriate volume of Sarclisa concentrate should be withdrawn from Sarclisa vial and diluted in an infusion bag with 250 mL of 0.9% sodium chloride or dextrose 5% solution.
- The infusion bag must be made of polyolefins (PO), polyethylene (PE), polypropylene (PP), polyvinyl chloride (PVC) with di (2-ethylhexyl) phthalate (DEHP) or ethyl vinyl acetate (EVA).
- Gently mix the diluted solution by inverting the bag. Do not shake.

4.4 Administration

- The infusion solution must be administered by intravenous infusion using an IV tubing infusion set (in polyethylene [PE], polyvinyl chloride [PVC] with or without di (2-ethylhexyl) phthalate [DEHP], polybutadiene [PBD] or polyurethane [PU]) with an in-line filter (polyethersulfone [PES], polysulfone or nylon).
 - The infusion solution should be administered for a period of time that will depend on the infusion rate (see Infusion Rates).
 - Prepared Sarclisa infusion solution should be used within 48 hours when stored at 2°C - 8°C, followed by 8 hours (including the infusion time) at room temperature.
 - No protection from light is required for the prepared infusion bag in a standard artificial light environment.
 - Do not infuse Sarclisa solution concomitantly in the same intravenous line with other agents.
- On the days where both Sarclisa and carfilzomib are administered, administer dexamethasone first, followed by Sarclisa infusion, then followed by carfilzomib infusion.

Infusion Rates

Following dilution, the Sarclisa infusion should be administered intravenously at the infusion rates presented in Table 3 below. Incremental escalation of the infusion rate should be considered only in the absence of infusion related reactions (IRRs) (see Dosage Adjustment, 7 WARNINGS AND PRECAUTIONS, and 8 ADVERSE REACTIONS).

Table 3: Infusion Rates of Sarclisa Administration

| | Dilution Volume | Initial Rate | Absence of Infusion Reaction | Rate Increment | Maximum Rate |
|-----------------------------|------------------------|---------------------|-------------------------------------|---|---------------------|
| First Infusion | 250 mL | 25 mL/hour | For 60 minutes | 25 mL/hour every 30 minutes | 150 mL/hour |
| Second Infusion | 250 mL | 50 mL/hour | For 30 minutes | 50 mL/hour for 30 minutes, then increase by 100 mL/hour | 200 mL/hour |
| Subsequent Infusions | 250 mL | 200 mL/hour | -- | -- | 200 mL/hour |

4.5 Missed Dose

The administration schedule must be carefully followed. If a planned dose of Sarclisa is missed, administer the dose as soon as possible and adjust the treatment schedule, accordingly, maintaining the treatment interval.

5 OVERDOSAGE

There has been no experience of overdose of isatuximab in clinical studies. Doses of intravenous Sarclisa up to 20 mg/kg have been administered in clinical studies. In the event of overdose, closely monitor patients for signs and symptoms of adverse reactions and initiate appropriate symptomatic and supportive treatment (see 7 WARNINGS AND PRECAUTIONS, 8 ADVERSE REACTIONS).

For management of a suspected drug overdose, contact your regional poison control centre.

6 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING

To help ensure the traceability of biologic products, including biosimilars, health professionals should recognise the importance of recording both the brand name and the non-proprietary (active ingredient) name as well as other product-specific identifiers such as the Drug Identification Number (DIN) and the batch/lot number of the product supplied.

Table 4: Dosage Forms, Strengths, Composition and Packaging

| Route of Administration | Dosage Form / Strength/Composition | Non-medicinal Ingredients |
|---------------------------|--|--|
| Intravenous (IV) Infusion | Concentrate for solution for infusion <ul style="list-style-type: none"> • 100 mg/5 mL (6 mL single use vial); Pack size of one or three single-use vials • 500 mg/25 mL (30 mL single use vial); Pack size of one single-use vial Each mL of Sarclisa concentrate contains 20 mg of isatuximab. | Histidine, Histidine hydrochloride monohydrate, Polysorbate 80, Sucrose, Water for injection |

7 WARNINGS AND PRECAUTIONS

General

Sarclisa is administered in combination with other medications; therefore, the contraindications, warnings and precautions and distribution restriction applicable for use with those medications also apply to Sarclisa combination therapy. The Product Monographs of all medications used in combination with Sarclisa should be consulted before starting the therapy (see 17 SUPPORTING PRODUCT MONOGRAPHS).

Interference with Response Assessment

Sarclisa is an IgG kappa monoclonal antibody that can be incidentally detected on both serum protein electrophoresis (SPE) and immunofixation electrophoresis (IFE) assays used for the clinical monitoring of endogenous myeloma (M)-protein (see 9 DRUG INTERACTIONS, 9.7 Drug-Laboratory Test Interactions). This interference can impact the accuracy of the determination of complete response in some patients with IgG kappa-expressing myeloma protein. In patients with persistent very good partial response (VGPR), consider other methods to evaluate the depth of response (see 9 DRUG INTERACTIONS).

Interference with Serological Testing (*indirect antiglobulin test*)

Sarclisa binds to CD38 on red blood cells (RBCs) and may result in a false positive indirect antiglobulin test (indirect Coombs test). ABO/RhD typing was not affected by Sarclisa treatment. To avoid potential problems with RBC transfusion, patients being treated with Sarclisa should have blood type and screen tests performed prior to the first Sarclisa infusion. Phenotyping may be considered prior to starting Sarclisa treatment as per local practice. If treatment with Sarclisa has already started, the blood bank should be informed that the patient is receiving Sarclisa and Sarclisa interference with blood compatibility testing can be resolved using dithiothreitol (DTT)-treated RBCs. If an emergency transfusion is required, non-cross-matched ABO/RhD-compatible RBCs can be given as per local blood bank practices (see 9 DRUG INTERACTIONS, 9.7 Drug-Laboratory Test Interactions).

Driving and Operating Machinery

Fatigue and dizziness have been reported in patients taking Sarclisa. Patients should exercise caution when driving or using machines.

Hematologic

Neutropenia

In the pivotal study ICARIA-MM, Grade 3 and 4 neutropenia as laboratory abnormalities were reported in 24.3% and 60.5% of patients treated with Sarclisa in combination with pomalidomide and dexamethasone (Isa-Pd). Neutropenic complications included febrile neutropenia (11.8% of patients) and neutropenic infections (25% of patients) (see 8 ADVERSE REACTIONS). Sarclisa infusion was omitted due to neutropenia in 9.2% of patients. Pomalidomide and dexamethasone dose reduction or omission due to neutropenia occurred in 29.6% and 9.2% of patients, respectively. Use of granulocyte-colony stimulating factor (G-CSF) was required in 69.1% of the patients, either for prophylaxis or as treatment for neutropenia.

In the pivotal study IKEMA, in patients treated with Sarclisa in combination with carfilzomib and dexamethasone (Isa-Kd), neutropenia occurred as a laboratory abnormality in 54.8% of patients, with Grade 3-4 neutropenia reported as a laboratory abnormality in 19.2% of patients (with 17.5% Grade 3 and 1.7% Grade 4). Neutropenic complications occurred in 2.8% of patients, including febrile neutropenia (1.1%) and neutropenic infections (1.7%).

Monitor complete blood cell counts at baseline and periodically during treatment. Antibiotics, and antiviral prophylaxis can be considered during treatment. Monitor patients with neutropenia for signs of infection. No dose reductions of Sarclisa are recommended. Sarclisa dose delays, modification of pomalidomide and dexamethasone treatment and the use of G-CSF may be required to allow improvement of neutrophil count (see 4 DOSAGE AND ADMINISTRATION, 4.2 Recommended Dose and Dosage Adjustment).

Immune

Infusion-Related Reactions (IRRs)

In ICARIA-MM, IRRs, mostly Grade 1 or 2, were observed in 38.2% of patients treated with Sarclisa in combination with pomalidomide and dexamethasone (Isa-Pd) (see 8 ADVERSE REACTIONS). Sarclisa was discontinued due to a Grade 3 or 4 IRR in 4 (2.6%) patients. All IRRs started during the first Sarclisa infusion and resolved on the same day in most patients. The most common symptoms of an IRR included dyspnea, cough, nasal congestion, chills and nausea. The most common severe signs and symptoms included hypertension, dyspnea and bronchospasm (see 8 ADVERSE REACTIONS).

In IKEMA, IRRs, were reported in 81 patients (45.8%) treated with Sarclisa in combination with carfilzomib and dexamethasone (Isa-Kd). Grade 1 IRRs were reported in 13.6%, Grade 2 in 31.6%, and Grade 3 in 0.6% of the patients treated with Isa-Kd. The IRRs occurred on the infusion day in 99.2% of episodes. In patients treated with Isa-Kd, 94.4% of those experiencing an IRR experienced it during the first cycle of treatment. All IRRs resolved, with 73.8% of IRRs resolving on the same day they were experienced, 23.8% resolving the day after, and 2.5% resolving after more than 2 days. The most common symptoms of an IRR included cough, dyspnea, nasal congestion, vomiting and nausea. The most common severe signs and symptoms included hypertension and dyspnea. Sarclisa was discontinued in 0.6% of patients due to IRRs (see 8 ADVERSE REACTIONS).

Sarclisa may cause serious infusion reactions including anaphylactic reactions. Signs and symptoms of anaphylactic reactions included bronchospasm, dyspnea, angioedema, and swelling (see 8 ADVERSE REACTIONS).

To decrease the risk and severity of IRRs, patients should be pre-medicated prior to Sarclisa infusion with acetaminophen, H2 antagonists, diphenhydramine or equivalent; dexamethasone is to be used as both premedication and anti-myeloma treatment on the day of Sarclisa infusion (see 4 DOSAGE AND ADMINISTRATION, 4.1 Dosing Considerations, Premedication). Vital signs should be frequently monitored during the entire Sarclisa infusion. In the event of an IRR in which infusion interruption or intervention (Grade 2) is indicated, interrupt Sarclisa infusion and provide appropriate medical and supportive measures (see 4 DOSAGE AND ADMINISTRATION, 4.2 Recommended Dose and Dosage Adjustment). If symptoms improve to Grade ≤ 1 , restart Sarclisa infusion at half of the initial infusion rate, with supportive care as needed, and closely monitor patients. If symptoms do not recur after 30 minutes, the infusion rate may be increased to the initial rate, and then increased incrementally, as shown in Table 3. In case symptoms do not improve to Grade ≤ 1 after interruption of Sarclisa infusion, persist or worsen despite appropriate medications, require hospitalization or are life-threatening (Grade 3 or 4), permanently discontinue Sarclisa and institute appropriate management (see 4 DOSAGE AND ADMINISTRATION, 4.2 Recommended Dose and Dosage Adjustment).

Second primary malignancies

The incidence of second primary malignancies is increased in patients treated with Sarclisa-containing regimens. The overall incidence of second primary malignancies (SPMs) in all the Sarclisa exposed patients was 3.6%.

In ICARIA-MM, 6 (3.9%) patients were diagnosed with SPMs in the Isa-Kd group compared with 1 (0.7%) in the Pd group. The SPMs in the Isa-Pd group were 4 cases of squamous cell carcinoma of skin, 1 post-radiation breast angiosarcoma and 1 myelodysplastic syndrome (MDS). None of the patients discontinued treatment because of the SPMs, with the exception of the patient who developed MDS.

In IKEMA, SPMs were reported in 13 (7.3%) patients treated with Isa-Kd and in 6 (4.9%) patients treated with Kd. SPMs were skin cancers in 9 (5.1%) patients in the Isa-Kd group and in 3 (2.5%) patients in the Kd group, and were solid tumors other than skin cancer in 5 (2.8%) patients in the Isa-Kd group and in 4 (3.3%) patients in the Kd group. One (0.6%) patient in the Isa-Kd group and one (0.8%) patient in the Kd group had both skin cancer and solid tumors other than skin cancer. Patients with skin cancer continued treatment after resection of the skin cancer.

Physicians should carefully monitor patients before and during treatment as per International Myeloma Working Group (IMWG) guidelines for occurrence of SPM and initiate treatment as indicated (see 8 ADVERSE REACTIONS).

Reproductive Health: Female and Male Potential

- **Fertility**

No human and animal data are available to determine potential effects of Sarclisa on fertility in males and females (see 16 NON-CLINICAL TOXICOLOGY).

7.1 Special Populations

7.1.1 Pregnant Women

There are no available data on Sarclisa use in pregnant women. Animal reproduction toxicity studies have not been conducted with Sarclisa. Sarclisa is an immunoglobulin G1 (IgG1) monoclonal antibody which is known to cross the placenta. Based on its mechanism of action and findings in CD38-knockout mice, exposure to isatuximab may cause fetal harm, e.g., immune cell depletion, neurological deficits, decreased bone density and metabolic disorders. The use of Sarclisa in pregnant women is not recommended. Women of childbearing potential treated with Sarclisa should use effective contraception during treatment and for at least 5 months after cessation of Sarclisa treatment.

Sarclisa in combination with pomalidomide is contraindicated in pregnant women and women at risk of becoming pregnant, as pomalidomide is contraindicated in these populations. Refer to pomalidomide and dexamethasone Product Monographs for requirements regarding contraception and for additional details (see 17 SUPPORTING PRODUCT MONOGRAPHS).

7.1.2 Breast-feeding

There are no available data on the presence of Sarclisa in human milk, milk production, or the effects on the breastfed infant. Human IgG antibody is known to be present in human milk. However, the effect of exposure to isatuximab via gastrointestinal tract is unclear in breastfed infants. As there is a potential for serious adverse reactions in breastfed infants, the use of Sarclisa in breastfeeding women is not recommended.

Sarclisa in combination with pomalidomide is contraindicated in breast-feeding women, as pomalidomide is contraindicated in this population. Refer to pomalidomide and dexamethasone Product Monographs for additional details (see 17 SUPPORTING PRODUCT MONOGRAPHS).

7.1.3 Pediatrics (< 18 years of age):

No data are available to Health Canada; therefore, Health Canada has not authorized an indication for pediatric use.

7.1.4 Geriatrics (≥ 65 years of age):

In ICARIA-MM Isa-Pd group, 43.5% of patients were 65 to 74 years of age, and 21.1% were 75 to 84 years of age. No overall differences in safety and efficacy were observed between younger (< 65 years of age) and older patients (see 10 CLINICAL PHARMACOLOGY, 10.3 Pharmacokinetics, *Geriatrics*).

8 ADVERSE REACTIONS

8.1 Adverse Reaction Overview

Combination therapy with Sarclisa, pomalidomide and low-dose dexamethasone in multiple myeloma (ICARIA-MM study)

The safety data described in this section are based on ICARIA-MM, a randomized, open-label clinical

trial in patients with multiple myeloma. In ICARIA-MM, patients received Sarclisa 10 mg/kg in combination with pomalidomide and dexamethasone (Isa-Pd) or pomalidomide and dexamethasone (Pd) (see 14 CLINICAL TRIALS).

The most frequent treatment-emergent adverse events (TEAEs, in >20% of Isa-Pd patients) were neutropenia, infusion reactions, pneumonia, upper respiratory tract infection, diarrhea and bronchitis.

The overall incidence of serious TEAEs was 61.8% in the Isa-Pd group and 53.7% in the Pd group. Serious TEAEs ($\geq 2\%$) with at least a 2% higher incidence in the Isa-Pd group versus the Pd group included infections (39.5% vs. 30.9%), febrile neutropenia (6.6% vs. 2.0%), neutropenia (3.3% vs. 1.3%) and infusion-related reactions (3.9% vs. 0%). Fatal adverse events (AEs) were reported in 11.2% of patients in the Isa-Pd group and 11.4% in the Pd group. Fatal AEs reported in > 1% of patients in the Isa-Pd group were pneumonia and other infections (3.3%) (see 8.2 Clinical Trial Adverse Reactions).

Permanent discontinuation of treatment because of TEAEs was reported in 11 patients (7.2%) treated with Isa-Pd and in 19 patients (12.8%) treated with Pd. The most common TEAEs leading to treatment discontinuation in the Isa-Pd group were infections (2.6%).

Sarclisa dose reduction was not permitted in ICARIA-MM. In the Isa-Pd group, Sarclisa dose delay because of TEAEs was reported in 58.6% of patients, most frequently ($\geq 3\%$ of patients) due to neutropenia (27.0%), pneumonia (6.6%), bronchitis (4.6%), upper respiratory infection (3.9%) and diarrhea (3.9%).

Combination therapy with Sarclisa, carfilzomib and dexamethasone in multiple myeloma (IKEMA study)

The safety data described in this section are based on IKEMA, a randomized, open-label clinical trial in adult patients with previously treated multiple myeloma. In IKEMA, patients received Sarclisa 10 mg/kg in combination with carfilzomib and dexamethasone (Isa-Kd) (N=177) or carfilzomib and dexamethasone (Kd) (N=122) (see 14 CLINICAL TRIALS). Among patients who received Isa-Kd, the median duration of Sarclisa exposure was 79.9 weeks (range: 1 to 111 weeks).

The most frequent adverse reactions (in $\geq 20\%$ of patients who received Isa-Kd) were upper respiratory tract infection (66.7%), infusion reactions (45.8%), fatigue (41.8%), hypertension (37.3%), pneumonia (36.2%), diarrhea (36.2%), dyspnea (28.8%), insomnia (23.7%), bronchitis (23.7%), and back pain (22.0%).

Serious adverse reactions occurred in 59.3% of patients receiving Isa-Kd and in 57.4% of patients receiving Kd. The most frequent serious adverse reactions (in >5% of patients) were pneumonia (24.9% with Isa-Kd vs 18.0% with Kd) and upper respiratory tract infections (9.0% with Isa-Kd vs 8.2% with Kd). Adverse reactions with a fatal outcome during treatment were reported in 3.4% of patients in the Isa-Kd group and in 3.3% of patients in the Kd group (those occurring in more than 1% of patients were pneumonia and cardiac failure both occurring in 1.1% of patients in the Isa-Kd group and in 0.8% of patients in the Kd group).

Permanent discontinuation of treatment because of adverse reactions was reported in 8.5% of patients treated with Isa-Kd and in 13.9% of patients treated with Kd. The most frequent adverse reactions requiring permanent discontinuation in patients who received Isa-Kd were infections (2.8%). Sarclisa alone was discontinued in 0.6% of patients due to infusion-related reactions.

Sarclisa dose interruptions due to an adverse reaction occurred in 32.8% of patients. The most frequent adverse reaction requiring Sarclisa dose interruption was infusion-related reaction (29.9%).

8.2 Clinical Trial Adverse Reactions

Clinical trials are conducted under very specific conditions. The adverse reaction rates observed in the clinical trials; therefore, may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse reaction information from clinical trials may be useful in identifying and approximating rates of adverse drug reactions in real-world use.

Combination therapy with Sarclisa with pomalidomide and low-dose dexamethasone in multiple myeloma

Adverse reactions presented in Table 5 were observed during the treatment period in 301 patients in ICARIA-MM (see 14 CLINICAL TRIALS). At the time of analysis, the median duration of exposure was 41 weeks (range 1.3 to 76.7) in the Isa-Pd arm and 24 weeks (range 1.0 to 73.7) in the Pd arm.

Table 5: Summary of treatment-emergent adverse events with an all grades incidence $\geq 5\%$ in the Isa-Pd group and with an all grades incidence difference $\geq 2\%$ between Isa-Pd group and Pd group in ICARIA-MM (EFC14335) study - Safety Population

| Primary System Organ Class [#] Preferred Term [#] | Pd (N=149) | | | Isa-Pd 10 mg/kg (N=152) | | |
|--|---------------------|-----------------|-----------------|----------------------------|-----------------|-----------------|
| | All Grades* (n%) | Grade 3 (n%) | Grade 4 (n%) | All grades* (n%) | Grade 3 (n%) | Grade 4 (n%) |
| Blood and lymphatic system disorders | | | | | | |
| Neutropenia ^a | 50 (33.6) | 25 (16.8) | 23 (15.4) | 71 (46.7) | 24 (15.8) | 45 (29.6) |
| Febrile neutropenia | 3 (2.0) | 2 (1.3) | 1 (0.7) | 18 (11.8) | 16 (10.5) | 2 (1.3) |
| Gastrointestinal disorders | | | | | | |
| Diarrhea | 29 (19.5) | 1 (0.7) | 0 | 39 (25.7) | 3 (2.0) | 0 |
| Nausea | 14 (9.4) | 0 | 0 | 23 (15.1) | 0 | 0 |
| Vomiting | 5 (3.4) | 0 | 0 | 18 (11.8) | 2 (1.3) | 0 |
| Stomatitis | 4 (2.7) | 0 | 0 | 10 (6.6) | 1 (0.7) | 0 |
| General disorders | | | | | | |
| Edema peripheral | 16 (10.7) | 0 | 0 | 20 (13.2) | 1 (0.7) | 0 |
| Immune system disorders | | | | | | |
| Infusion related reaction ^b | 0 | 0 | 0 | 58 (38.2) | 2 (1.3) | 2 (1.3) |
| Infections and infestations | | | | | | |
| Upper respiratory tract infection | 26 (17.4) | 1 (0.7) | 0 | 43 (28.3) | 5 (3.3) | 0 |
| Pneumonia ^c | 34 (22.8) | 24 (16.1) | 4 (2.7) | 47 (30.9) | 33 (21.7) | 5 (3.3) |
| Bronchitis | 13 (8.7) | 1 (0.7) | 0 | 36 (23.7) | 5 (3.3) | 0 |
| Herpes viral infection ^d | 4 (2.7) | 0 | 0 | 15 (9.9) | 1 (0.7) | 0 |
| Nasopharyngitis | 7 (4.7) | 0 | 0 | 14 (9.2) | 0 | 0 |
| Investigations | | | | | | |
| Weight decreased | 2 (1.3) | 0 | 0 | 10 (6.6) | 0 | 0 |

Table 5: Summary of treatment-emergent adverse events with an all grades incidence $\geq 5\%$ in the Isa-Pd group and with an all grades incidence difference $\geq 2\%$ between Isa-Pd group and Pd group in ICARIA-MM (EFC14335) study - Safety Population

| Primary System Organ Class [#] Preferred Term [#] | Pd (N=149) | | | Isa-Pd 10 mg/kg (N=152) | | |
|--|---------------------|-----------------|-----------------|----------------------------|-----------------|-----------------|
| | All Grades* (n%) | Grade 3 (n%) | Grade 4 (n%) | All grades* (n%) | Grade 3 (n%) | Grade 4 (n%) |
| Metabolism and nutrition disorders | | | | | | |
| Decreased appetite | 7 (4.7) | 1 (0.7) | 0 | 15 (9.9) | 2 (1.3) | 0 |
| Musculoskeletal and connective tissue disorders | | | | | | |
| Musculoskeletal chest pain | 7 (4.7) | 0 | 0 | 13 (8.6) | 0 | 0 |
| Bone pain | 8 (5.4) | 2 (1.3) | 0 | 12 (7.9) | 1 (0.7) | 0 |
| Muscular weakness | 7 (4.7) | 0 | 0 | 11 (7.2) | 1 (0.7) | 0 |
| Myalgia | 5 (3.4) | 0 | 0 | 10 (6.6) | 0 | 0 |
| Nervous system disorders | | | | | | |
| Headache | 8 (5.4) | 0 | 0 | 15 (9.9) | 0 | 0 |
| Tremor | 6 (4.0) | 0 | 0 | 12 (7.9) | 3 (2.0) | 0 |
| Dizziness | 4 (2.7) | 0 | 0 | 8 (5.3) | 0 | 0 |
| Respiratory, thoracic and mediastinal disorders | | | | | | |
| Dyspnea | 15 (10.1) | 2 (1.3) | 0 | 23 (15.1) | 6 (3.9) | 0 |

Pd: pomalidomide and dexamethasone; Isa-Pd: isatuximab in combination with pomalidomide and dexamethasone

^a Grade 5 neutropenia was reported in 1 patient (0.7%) in the Isa-Pd arm; considered as non-related to study treatment

^b Infusion related reaction was a TEAE considered to be related to infusion by site investigators and with onset typically within 24 hours from the start of infusion

^c Pneumonia includes TEAEs in the narrow Standard MedDRA Query (SMQ) Infective pneumonia. Grade 5 pneumonia was reported in 1 patient (0.7%) in the Pd arm and in 2 patients (1.3%) in the Isa-Pd arm.

^d Herpes viral infection includes the following list of terms: Herpes simplex, Herpes zoster, Herpes zoster disseminated, Oral herpes and Varicella

Note: Percentages are calculated using the number of treated patients as denominator.

[#]MedDRA 21.0

*CTCAE 4.03

Table 6: Treatment Emergent Hematology Laboratory Abnormalities in Patients Receiving Isa-Pd Treatment Versus Pd Treatment - ICARIA-MM (EFC14335)

| Laboratory parameter | Pomalidomide + low-dose Dexamethasone (N=149) | | | Sarclisa + Pomalidomide + low-dose Dexamethasone (N=152) | | |
|-------------------------|---|----------------------------|----------------------------|--|----------------------------|----------------------------|
| | All grades* n (%) ^a | Grade 3 n (%) ^a | Grade 4 n (%) ^a | All grades* n (%) ^a | Grade 3 n (%) ^a | Grade 4 n (%) ^a |
| Anemia | 145 (98.6) | 41 (27.9) | 0 | 151 (99.3) | 48 (31.6) | 0 |
| Neutropenia | 137 (93.2) | 57 (38.8) | 46 (31.3) | 146 (96.1) | 37 (24.3) | 92 (60.5) |
| Lymphopenia | 137 (93.2) | 52 (35.4) | 12 (8.2) | 140 (92.1) | 64 (42.1) | 19 (12.5) |
| Thrombocytopenia | 118 (80.3) | 14 (9.5) | 22 (15.0) | 127 (83.6) | 22 (14.5) | 25 (16.4) |

^a The denominator used for the percentage calculation is the number of patients with at least 1 evaluation of the laboratory test during the considered observation period.

* CTCAE version: 4.03

Combination therapy with Sarclisa, carfilzomib and dexamethasone in multiple myeloma (IKEMA study)

Table 7 and Table 8 presents the adverse reactions observed during the treatment period of IKEMA in 299 patients with multiple myeloma, treated with Sarclisa 10 mg/kg in combination with carfilzomib and dexamethasone (Isa-Kd) or carfilzomib and dexamethasone (Kd) (see 14 CLINICAL TRIALS).

Table 7: Adverse Reactions (≥10%) in Patients Receiving Sarclisa, Carfilzomib, and Dexamethasone with a Difference Between Arms of ≥5% Compared to Control Arm in IKEMA

| Adverse Reactions | Sarclisa + Carfilzomib + Dexamethasone (Isa-Kd) (N=177) | | | Carfilzomib + Dexamethasone (Kd) (N=122) | | |
|--|---|---------|---------|--|---------|---------|
| | All Grades | Grade 3 | Grade 4 | All Grades | Grade 3 | Grade 4 |
| Infusion-related reaction ^a | 45.8% | 0.6% | 0% | 3.3% | 0% | 0% |
| Infections | | | | | | |
| Upper respiratory tract infection ^b | 66.7% | 9.0% | 0% | 57.4% | 7.4% | 0% |
| Pneumonia ^c | 36.2% | 19.2% | 3.4% | 30.3% | 14.8% | 2.5% |
| Bronchitis ^d | 23.7% | 2.3% | 0% | 13.1% | 0.8% | 0% |
| Vascular disorders | | | | | | |
| Hypertension ^e | 37.3% | 20.3% | 0.6% | 32.0% | 18.0% | 1.6% |
| Respiratory, thoracic and mediastinal disorders | | | | | | |
| Dyspnea ^f | 28.8% | 5.1% | 0 | 23.8% | 0.8% | 0% |

| Adverse Reactions | Sarclisa + Carfilzomib + Dexamethasone (Isa-Kd) (N=177) | | | Carfilzomib + Dexamethasone (Kd) (N=122) | | |
|---|--|---------|---------|---|---------|---------|
| | All Grades | Grade 3 | Grade 4 | All Grades | Grade 3 | Grade 4 |
| Cough ^g | 22.6% | 0% | 0% | 14.8% | 0% | 0% |
| Gastrointestinal disorders | | | | | | |
| Diarrhea | 36.2% | 2.8% | 0% | 28.7% | 2.5% | 0% |
| Vomiting | 15.3% | 1.1% | 0% | 9.0% | 0.8% | 0% |
| General disorders and administration site conditions | | | | | | |
| Fatigue ^h | 41.8% | 5.1% | 0% | 32.0% | 3.3% | 0% |

^a Infusion-related reaction includes infusion-related reaction, cytokine release syndrome, and hypersensitivity.

^b Upper respiratory tract infection includes acute sinusitis, chronic sinusitis, H1N1 influenza, H3N2 influenza, influenza, laryngitis, laryngitis viral, nasal herpes, nasopharyngitis, pharyngitis, pharyngotonsillitis, respiratory syncytial virus infection, rhinitis, sinusitis, sinusitis bacterial, tonsillitis, tracheitis, upper respiratory tract infection, viral rhinitis, respiratory tract infection, respiratory tract infection viral, influenza like illness, parainfluenzae virus infection, respiratory tract infection bacterial, and viral upper respiratory tract infection.

^c Pneumonia includes atypical pneumonia, lower respiratory tract infection, lower respiratory tract infection viral, pneumocystis jirovecii pneumonia, pneumonia, pneumonia influenzal, pneumonia legionella, pneumonia pneumococcal, pneumonia respiratory syncytial viral, pneumonia streptococcal, pneumonia viral, pulmonary sepsis, and pulmonary tuberculosis.

^d Bronchitis includes bronchitis, bronchitis viral, respiratory syncytial virus bronchitis, bronchitis chronic, and tracheobronchitis.

^e Hypertension includes hypertension, blood pressure increased, and hypertensive crisis.

^f Dyspnea includes dyspnea and dyspnea exertional.

^g Cough includes cough, productive cough, and allergic cough.

^h Fatigue includes fatigue and asthenia.

Table 8: Treatment emergent laboratory abnormalities in patients receiving Isa-Kd treatment versus Kd treatment – IKEMA study

| Laboratory parameter | Sarclisa + Carfilzomib + Dexamethasone (N=177) | | | Carfilzomib + Dexamethasone (N=122) | | |
|-------------------------|---|---------|---------|--|---------|---------|
| | All Grades | Grade 3 | Grade 4 | All Grades | Grade 3 | Grade 4 |
| Anemia | 99.4% | 22.0% | 0% | 99.2% | 19.7% | 0% |
| Lymphopenia | 94.4% | 52.0% | 16.9% | 95.1% | 43.4% | 13.9% |
| Thrombocytopenia | 94.4% | 18.6% | 11.3% | 87.7% | 15.6% | 8.2% |
| Neutropenia | 54.8% | 17.5% | 1.7% | 43.4% | 6.6% | 0.8% |

The denominator used for the percentage calculation is the number of patients with at least 1 evaluation of the laboratory test during the considered observation period.

CTCAE version: 4.03

Description of selected adverse reactions

Cardiac Arrhythmias

In ICARIA-MM, a higher incidence of all Grades cardiac arrhythmias TEAEs occurred in the Isa-Pd group (11.2%) compared with Pd group (2.0%). Grade ≥ 3 arrhythmias were reported in 3.3% patients in the Isa-Pd group compared with 0.7% in the Pd group. Most patients had pre-existing cardiovascular disorders. The most common TEAE in this category in the Isa-Pd group was atrial fibrillation (4.6%; Grade ≥ 3 2.0%).

Cardiac failure

In IKEMA, cardiac failure (including cardiac failure, cardiac failure congestive, cardiac failure acute, cardiac failure chronic, left ventricular failure and pulmonary edema) was reported in 7.3% of patients in the Isa-Kd group (4.0% of Grade ≥ 3) and in 6.6% of patients in the Kd group (4.1% of Grade ≥ 3). Serious cardiac failure was observed in 4.0% of patients in the Isa-Kd group and in 3.3% of patients in the Kd group. Fatal events of cardiac disorders occurred in 1.1% of patients in the Isa-Kd group (cardiac failure) and in 0.8% of patients in the Kd group (acute myocardial infarction). See the current Product Monograph for carfilzomib for additional information.

Infusion related reactions (IRRs)

In ICARIA-MM, IRRs, defined as adverse reactions associated with the Sarclisa infusions, with an onset typically within 24 hours from the start of the infusion, were reported in 58 patients (38.2%) treated with Sarclisa. All patients who experienced IRRs, had the events during the 1st infusion of Sarclisa, with 3 patients (2.0%) also having IRRs at their 2nd infusion, and 2 patients (1.3%) at their 4th infusion. Grade 1 IRRs were reported in 3.9%, Grade 2 in 31.6%, Grade 3 in 1.3%, and Grade 4 in 1.3% of the patients. The incidence of infusion interruptions because of IRRs was 28.9%. The incidence of infusion interruptions because of infusion-related reactions was 28.9%. The median time to infusion interruption was 55 minutes. The median duration of Sarclisa infusion was 3.3 hours during the first infusion and 2.8 hours for the subsequent infusions.

In multiple myeloma clinical trials, anaphylactic reactions have been reported in association with infusion reactions in 5 patients (0.3%). Signs and symptoms of anaphylactic reactions included bronchospasm, dyspnea, angioedema, and swelling. No anaphylactic reactions were reported in the ICARIA-MM clinical trial (see 7 WARNINGS AND PRECAUTIONS).

In a separate study (TCD14079 Part B) with Sarclisa 10 mg/kg administered from a 250 mL fixed infusion volume in combination with Pd, IRRs (all Grade 2) were reported in 19 patients (40.4%), at the first administration. The median duration of infusion was 3.9 hours for the first infusion, 1.9 hours for the second infusion and 1.3 hours from third infusion onwards.

In all patients treated with Sarclisa in the clinical studies, 267 patients (46.4%) had at least one IRR symptom and 28 (4.9%) experienced Grade 3 or 4 symptoms. Sarclisa was discontinued due to a Grade 3 or 4 IRR in 4 (2.6%) patients. The most common symptoms of an IRR were dyspnea, cough, nasal congestion, chills and nausea. Other reported symptoms included hypertension, hypoxia, pulmonary edema, hypotension, tachycardia, syncope, bronchospasm, cytokine release syndrome, anaphylactic reaction, face edema, and hyperglycemia.

In IKEMA, IRRs were reported in 81 patients (45.8%) treated with Isa-Kd. Grade 1 IRRs were reported in 13.6%, Grade 2 in 31.6%, and Grade 3 in 0.6% of the patients treated with Isa-Kd. Signs and symptoms

of Grade 3 IRRs included dyspnea and hypertension. The incidence of Sarclisa infusion interruptions due to IRRs was 29.9%. Sarclisa was discontinued in 0.6% of patients due to infusion-related reactions.

Infections

In ICARIA-MM, the incidence of Grade 3 or higher infections was 42.8%. Pneumonia was the most commonly reported severe infection with Grade 3 reported in 21.7% of patients in the Isa-Pd group compared to 16.1% in the Pd group, and Grade 4 in 3.3% of patients in the Isa-Pd group compared to 2.7% in the Pd group. Discontinuations from treatment due to infection were reported in 2.6% of patients in the Isa-Pd group compared to 5.4% in the Pd group. Fatal infections were reported in 3.3% of patients in the Isa-Pd group and 4.0% in the Pd group.

In IKEMA, the incidence of Grade 3 or higher infections was 38.4% in the Isa-Kd group. Pneumonia was the most commonly reported severe infection with Grade 3 reported in 19.2% of patients in the Isa-Kd group compared to 14.8% in the Kd group, and Grade 4 in 3.4% of patients in the Isa-Kd group compared to 2.5% in the Kd group. Treatment was discontinued due to infection in 2.8% of patients in the Isa-Kd group compared to 4.9% in the Kd group. Fatal infections were reported in 2.3% of patients in the Isa-Kd group and 0.8% in the Kd group.

Immunogenicity

As with all therapeutic proteins, there is a potential for immunogenicity to Sarclisa. In ICARIA-MM and IKEMA, no patients tested positive for anti-drug antibodies (ADA). Therefore, the neutralizing ADA status was not determined. Overall, across 9 clinical studies in multiple myeloma (MM) with Sarclisa single agent and combination therapies including ICARIA-MM and IKEMA (N= 1018), the incidence of treatment emergent ADAs was 1.9%. No effect of ADAs was observed on pharmacokinetics, safety or efficacy of Sarclisa.

8.3 Less Common Clinical Trial Adverse Reactions

Other TEAEs of clinical relevance in the Isa-Pd arm in ICARIA-MM include:

Blood and lymphatic system disorders: anemia.

Eye disorders: cataract; vision blurred.

Gastrointestinal disorders: abdominal distension; abdominal pain upper; gastroesophageal reflux disease.

General disorders and administration site conditions: pyrexia.

Immune system disorders: cytokine release syndrome.

Infections and infestations: influenza; Pneumocystis jirovecii pneumonia; sepsis.

Investigations: gamma-glutamyltransferase increased.

Metabolism and nutrition disorders: diabetes mellitus; hyperglycemia.

Musculoskeletal and connective tissue disorders: joint swelling; arthralgia.

Neoplasms benign, malignant and unspecified (incl cysts and polyps): squamous cell carcinoma of skin.

Nervous system disorders: dizziness; lethargy.

Psychiatric disorders: anxiety; confusional state; agitation; restlessness.

Renal and urinary disorders: urinary incontinence.

Respiratory, thoracic and mediastinal disorders; hiccups, pulmonary embolism.

Vascular disorders: hypertension; hot flush.

Other TEAEs of clinical relevance in the Isa-Kd arm in IKEMA include:

Eye disorders: cataract.

Ear and labyrinth disorders: vertigo.

Cardiac disorders: angina pectoris

Gastrointestinal disorders: dyspepsia, gastroesophageal reflux disease, stomatitis.

Investigations: weight decreased.

Metabolism and nutrition disorders: decreased appetite, hyperglycemia, fluid retention.

Neoplasm benign, malignant and unspecified (incl cysts and polyps): skin cancer, solid tumor other than skin cancer.

Nervous system disorder: paresthesia.

Psychiatric disorders: anxiety.

Respiratory, thoracic and mediastinal disorders: pulmonary hypertension.

Skin and subcutaneous tissue disorders: erythema, purpura.

9 DRUG INTERACTIONS

9.4 Drug-Drug Interactions

The pharmacokinetics of isatuximab and pomalidomide were not influenced by their co-administration. Analysis suggests administration of carfilzomib with isatuximab did not alter isatuximab pharmacokinetics or vice versa.

9.5 Drug-Food Interactions

Interactions with food have not been established.

9.6 Drug-Herb Interactions

Interactions with herb have not been established.

9.7 Drug-Laboratory Test Interactions

Interference with Serological Testing

Because CD38 protein is expressed on the surface of red blood cells, Sarclisa, an anti-CD38 antibody, may interfere with blood bank serologic tests with potential false positive reactions in indirect antiglobulin tests (indirect Coombs tests), antibody detection (screening) tests, antibody identification panels, and antihuman globulin (AHG) crossmatches in patients treated with Sarclisa (see 7 WARNINGS AND PRECAUTIONS). The indirect antiglobulin test was positive during Isa-Pd treatment in 67.7% of the tested patients in ICARIA-MM, and during Isa-Kd treatment in 63.3% of the tested patients in IKEMA. In patients with a positive indirect antiglobulin test, blood transfusions were administered without evidence of hemolysis. ABO/RhD typing was not affected by Sarclisa treatment.

Interference with Serum Protein Electrophoresis and Immunofixation Electrophoresis Tests

Sarclisa may be incidentally detected by serum protein electrophoresis (SPE) and immunofixation electrophoresis (IFE) assays used for the monitoring of M-protein and could interfere with accurate response classification based on International Myeloma Working Group (IMWG) criteria (see 7 WARNINGS AND PRECAUTIONS). Twenty-two patients in the Isa-Pd arm who met very good partial response (VGPR) criteria with only residual immunofixation-positivity were tested for interference. Serum samples from these patients were tested by mass spectrometry to separate Sarclisa signal from the myeloma M protein signal. In 11 out of the 22 patients, there was no residual myeloma M protein detectable at the sensitivity level of the immunofixation test (25 mg/dL); 10 of the 11 patients had IgG subtype myeloma at baseline, indicating Sarclisa interference with the immunofixation assay. In patients with persistent very good partial response, consider other methods to evaluate the depth of response.

In the Isa-Kd arm, out of the 27 patients identified with potential interference and tested by mass spectrometry at the sensitivity level of the immunofixation test (25 mg/dL), 15 non-Complete Response (non-CR) patients as per Independent Response Committee (IRC) showed no detectable residual myeloma M-protein. Among these 15 patients, 11 patients had plasma cell <5% in bone marrow.

10 CLINICAL PHARMACOLOGY

10.1 Mechanism of Action

Isatuximab is an IgG1-derived monoclonal antibody that binds to a specific extracellular epitope of CD38 and triggers several mechanisms leading to the death of CD38 expressing tumour cells. CD38 is a transmembrane glycoprotein with ectoenzymatic activity, expressed in hematological malignancies, including multiple myeloma cells, as well as other cell types and tissues at various levels.

Isatuximab acts through IgG Fc-dependent mechanisms including: antibody dependent cell mediated cytotoxicity (ADCC), antibody dependent cellular phagocytosis (ADCP), and complement dependent cytotoxicity (CDC). Isatuximab can also trigger tumour cell death by induction of apoptosis via an Fc-independent mechanism.

Isatuximab inhibits the enzymatic activity of CD38 which catalyzes the synthesis and hydrolysis of cyclic ADP-ribose (cADPR), which may contribute to immunoregulatory functions. Isatuximab inhibits the cADPR production from extracellular nicotinamide adenine dinucleotide (NAD) in multiple myeloma cells.

The combination of isatuximab and pomalidomide in vitro enhances cell lysis of CD38-expressing multiple myeloma cells by effector cells (ADCC), and by direct tumor cell killing compared to that of isatuximab alone. In vivo experiments using a human multiple myeloma xenograft model demonstrated that the combination of isatuximab and pomalidomide results in enhanced antitumor activity compared to the activity of isatuximab or pomalidomide alone.

10.2 Pharmacodynamics

NK Cell, CD19+ B-cell, CD4+ T-cell and TREG Cell Count

The pharmacodynamic activity of isatuximab was characterized in monotherapy. A decrease in absolute counts of total NK cells (including inflammatory CD16⁺ low CD56⁺ bright and cytotoxic CD16⁺ bright CD56⁺ dim NK cells), CD19⁺ B-cells, CD4⁺ T-cells and T_{REG} (CD3⁺, CD4⁺, CD25⁺, CD127⁻) was observed in peripheral blood.

In human peripheral blood mononuclear cells (PBMCs), natural killer (NK) cells express the highest CD38 levels. In vitro, isatuximab can activate NK cells in the absence of CD38 positive target tumor cells through a mechanism which is dependent of the Fc portion of isatuximab.

Also, isatuximab inhibits Tregs which express higher levels of CD38 in MM patients compared to healthy individuals. The decrease of the T_{REG} was higher in the responder patients compared to non-responder patients.

T-cell receptor (TCR) DNA sequencing was used to quantify expansion of individual T-cell clones, each of them having a unique TCR conferring antigen specificity. In multiple myeloma patients, Sarclisa monotherapy induced clonal expansion of the T-cell receptor repertoire.

In multiple myeloma patients treated with Sarclisa combined with pomalidomide and dexamethasone, a decrease in absolute counts of total NK cells (including inflammatory CD16⁺ low CD56⁺ bright and cytotoxic CD16⁺ bright CD56⁺ dim NK cells) and CD19⁺ B-cells was observed in peripheral blood. An increase of CD4⁺ T-cells and T_{REG} (CD3⁺, CD4⁺, CD25⁺, CD127⁻) was observed.

Cardiac Electrophysiology

The relationship between isatuximab plasma concentration and QT interval and other electrocardiogram parameters was analyzed by PK/PD modeling. Patients included in the modeling

received single agent Sarclisa up to 20 mg/kg QW which resulted in an isatuximab plasma concentration consistent with the predicted steady state C_{max} of isatuximab administered at the recommended dose.

Isatuximab had no apparent effect on Frederica-corrected QT interval (QTcF) change from baseline and on PR or QRS interval.

A concentration-related effect on heart rate (HR) was demonstrated by the PK/PD modeling. The predicted geometric mean HR change from baseline for Sarclisa administered at the recommended dose is 13 beats per minute (bpm) (95% CI: 9.3, 16.6).

10.3 Pharmacokinetics

The pharmacokinetics of isatuximab were characterized primarily by population pharmacokinetics in 476 patients with multiple myeloma treated with Sarclisa intravenous infusion as a single agent or in combination with pomalidomide/dexamethasone, at doses ranging from 1 to 20 mg/kg, administered either once weekly; every 2 weeks; or every 2 weeks for 8 weeks followed by every 4 weeks; or every week for 4 weeks followed by every 2 weeks.

Isatuximab displays nonlinear pharmacokinetics with target-mediated drug disposition due to its binding to CD38 receptor.

Isatuximab exposure (area under the plasma concentration-time curve over the dosing interval AUC) increased in a greater than dose proportional manner from 1 to 20 mg/kg following every 2 weeks schedule, while no deviation to the dose proportionality was observed between 5 and 20 mg/kg following every week for 4 weeks followed by every 2 weeks schedule.

After Sarclisa administration at the recommended dose (10 mg/kg administration every week for 4 weeks followed by every 2 weeks), the median time to reach steady state was 8 weeks with a 3.1-fold accumulation. In ICARIA-MM (Sarclisa in combination with pomalidomide and dexamethasone), the mean (CV%) predicted maximum plasma concentration C_{max} and AUC at steady state were 351 $\mu\text{g/mL}$ (36.0%) and 72,600 $\mu\text{g}\cdot\text{h/mL}$ (51.7%), respectively.

In IKEMA (Sarclisa in combination with carfilzomib and dexamethasone), the mean (CV%) predicted maximum plasma concentration C_{max} and AUC at steady state were 655 $\mu\text{g/mL}$ (30.8%) and 159,000 $\mu\text{g}\cdot\text{h/mL}$ (37.1%), respectively.

Distribution:

The mean (CV%) predicted total volume of distribution of isatuximab is 8.13 L (26.2%).

Metabolism:

As a large protein, isatuximab is expected to be metabolized by non-saturable proteolytic catabolism processes.

Elimination

Isatuximab is eliminated by two parallel pathways, a nonlinear target-mediated pathway predominating at low concentrations, and a nonspecific linear pathway predominating at higher concentrations. In the therapeutic plasma concentrations range, the linear pathway is predominant. The mean (CV%) clearance of isatuximab decreases over time by 50% to a steady state value of 0.00840 L/h [0.202 L/day] (58.8%). This is associated with a mean (CV%) terminal half-life of 37 days (50%).

Special Populations and Conditions

- **Pediatrics:** Isatuximab was not studied in patients under 18 years of age.
- **Geriatrics:** The population pharmacokinetic analyses of 476 patients aged 36 to 85 years showed no clinically meaningful difference in exposure to isatuximab in patients < 75 years old versus > 75 years old (n=70).
- **Sex:** Based on population pharmacokinetic analyses, gender had no clinically meaningful effect on the pharmacokinetics of isatuximab.
- **Ethnic Origin:** Based on population pharmacokinetic analyses, race (Caucasian, Black, Asian and other races) had no clinical meaningful effect on isatuximab pharmacokinetics.
- **Hepatic Insufficiency:** No formal studies of isatuximab in patients with hepatic impairment have been conducted. Out of the 476 patients of the population pharmacokinetic analyses, 65 patients presented with mild hepatic impairment (total bilirubin 1 to 1.5 times upper limit of normal [ULN] or aspartate amino transferase [AST] > ULN and 1 patient had moderate hepatic impairment (total bilirubin > 1.5 to 3 times ULN and any AST). Mild hepatic impairment had no clinically meaningful effect on the pharmacokinetics of isatuximab. The effect of moderate (total bilirubin >1.5 times to 3 times ULN and any AST) and severe hepatic impairment (total bilirubin >3 times ULN and any AST) on isatuximab pharmacokinetics is unknown.
- **Renal Insufficiency:** No formal studies of isatuximab in patients with renal impairment have been conducted. The population pharmacokinetic analyses on 476 patients included 192 patients with mild renal impairment ($60 \text{ mL/min/1.73 m}^2 \leq \text{estimated glomerular filtration rate [e-GFR]} < 90 \text{ mL/min/1.73 m}^2$), 163 patients with moderate renal impairment ($30 \text{ mL/min/1.73 m}^2 \leq \text{e-GFR} < 60 \text{ mL/min/1.73 m}^2$) and 12 patients with severe renal impairment ($\text{e-GFR} < 30 \text{ mL/min/1.73 m}^2$). Analyses suggested no clinically meaningful effect of mild to severe renal impairment on isatuximab pharmacokinetics compared to normal renal function.

11 STORAGE, STABILITY AND DISPOSAL

Vials of Sarclisa concentrate for solution for infusion should be stored between 2°C and 8°C (36°F to 46°F) and protected from light. Do not freeze. Do not shake.

After Dilution

Sarclisa infusion solution should be prepared in sodium chloride 0.9% or dextrose 5%. Microbiological, chemical and physical in-use stability of Sarclisa infusion solution has been demonstrated for 48 hours at 2°C - 8°C, followed by 8 hours (including the infusion time) at room temperature. No protection from light is required for storage in the infusion bag.

Disposal

Unused portions of solution must be discarded. All materials that have been utilized for dilution and administration should be disposed of according to standard procedures.

12 SPECIAL HANDLING INSTRUCTIONS

Sarclisa must not be mixed with other medicinal products except those mentioned in the 4 DOSAGE AND ADMINISTRATION section.

The preparation of the infusion solution must be done under aseptic conditions (refer to 4 DOSAGE

AND ADMINISTRATION).

PART II: SCIENTIFIC INFORMATION

13 PHARMACEUTICAL INFORMATION

Drug Substance

| | |
|---------------------------------------|---|
| Proper name: | Isatuximab |
| Chemical name: | Immunoglobulin G1, anti – (human CD38 antigen) (human-Mus musculus monoclonal hu38SB19 heavy chain), disulfide with human-Mus musculus monoclonal hu38SB19 light chain, dimer |
| Molecular formula and molecular mass: | <p>Isatuximab is composed of light and heavy chains. Each light chain consists of 214 amino acid residues and each heavy chain consists of 450 amino acid residues. The heavy chain N-terminal glutamine residue is fully converted to pyroglutamate.</p> <p>The majority of the heavy chain C-terminal K450 is clipped (between 9 and 11 % of C-terminal K450 using reduced peptide mapping).</p> <p>Isatuximab contains 32 cysteines leading to 16 disulfide bonds and two glycosylation sites located on Asparagine N300 of heavy chain.</p> <p>147 825 Da (G₀F-G₀F glycosylated form)</p> |
| Structural formula: | <p>Isatuximab is an IgG₁ derived-monoclonal antibody binding selectively the human CD38 membrane protein.</p> <p>The protein structure is composed of 2 kappa light chains each with molecular weight of approximately 23 kDa and 2 IgG1 heavy chains each with a molecular weight of approximately 49 kDa (deglycosylated form) linked through disulfide bridges.</p> |
| Physicochemical properties: | The concentrate for solution for infusion is a colorless to slightly yellow solution, essentially free of visible particulates. |
| Pharmaceutical standard: | Professed |
| Product Characteristics: | Isatuximab is produced by recombinant deoxyribonucleic acid (DNA) technology from a mammalian cell line (Chinese Hamster Ovary, CHO). The manufacture of isatuximab is based on a CHO master and working cell bank system, where the master and working cell banks have been thoroughly |

characterized and tested for adventitious contaminants and endogenous viruses. Results from genetic characterization studies also demonstrated stability of these cell banks. The manufacturing process of isatuximab consists of a series of steps which include cell culture, harvest, purification (including viral inactivation/removal steps), and formulation buffer exchange. The purification process includes a combination of chromatographic steps.

Isatuximab is produced by recombinant deoxyribonucleic acid (DNA) technology from a mammalian cell line (Chinese Hamster Ovary, CHO). The manufacture of isatuximab is based on a CHO master and working cell bank system, where the master and working cell banks have been thoroughly characterized and tested for adventitious contaminants and endogenous viruses. Results from genetic characterization studies also demonstrated stability of these cell banks. The manufacturing process of isatuximab consists of a series of steps which include cell culture, harvest, purification (including viral inactivation/removal steps), and formulation buffer exchange. The purification process includes a combination of chromatographic steps.

The manufacturing of Sarclisa (the drug product) consists of steps which include drug substance thawing, pooling and homogenization, prefiltration, sterilizing filtration of the pre-filtered solution at the point of fill, aseptic filling into glass vials, and stoppering and crimping of the vials. The drug product manufacturing process uses appropriate aseptic process techniques, equipment, and facilities.

14 CLINICAL TRIALS

14.1 Trial Design and Study Demographics

Table 9 Summary of patient demographics for clinical trials in Multiple Myeloma

| Study # | Trial design | Dosage, route of administration and duration | Study subjects (n) | Mean age, years (Range) | Sex |
|----------------------|--|--|--------------------------------------|-------------------------|--|
| ICARIA-MM (EFC14335) | Phase 3 Multicenter, multinational, randomized, open-label, 2-arm clinical study in patients with relapsed and refractory multiple myeloma (MM) | Isa-Pd: Sarclisa (10mg/kg; IV) ^a + pomalidomide (4mg; PO) ^b + low-dose dexamethasone (40mg PO/IV; 20mg for patients ≥ 75) ^c Pd: Pomalidomide (4mg; PO) ^b + low-dose dexamethasone (40mg PO/IV; 20mg for patients ≥ 75) ^c 28-day cycle | Total: 307 Isa-Pd: 154 Pd: 153 | 67 (range 36-86) | Male: 148 (48.2%) Female: 159 (51.8%) |
| IKEMA (EFC15246) | Phase 3 Multicenter, multinational, randomized, open-label, 2-arm study in patients with relapsed and/or refractory multiple myeloma who had received one to three prior therapies. | Isa-Kd: Sarclisa (10 mg/Kg IV) ^a + carfilzomib IV ^d + dexamethasone (20 mg IV/PO) ^e Kd: Carfilzomib IV ^d + dexamethasone (20 mg IV/PO) ^e 28-day cycle | Total:302 Isa-Kd: 179 Kd: 123 | 63.1 (range: 33-90) | Male: 169 (56%) Female: 133 (44%) |

^a administered as an IV weekly in the first cycle and every two weeks thereafter

^b 4mg taken orally once daily from day 1 to day 21 of each 28-day cycle

^c Given on days 1, 8, 15 and 22 for each 28-day cycle

^d 20 mg/m² on days 1 and 2; 56 mg/m² on days 8, 9, 15 and 16 of cycle 1; and at the dose of 56 mg/m² on days 1, 2, 8, 9, 15 and 16 for subsequent cycles of each 28-day cycle

^e IV on the days of isatuximab and/or carfilzomib infusions, and PO the other days; given on days 1, 2, 8, 9, 15, 16, 22 and 23 for each 28-day cycle

IV = Intravenous; PO = Taken orally

Study ICARIA-MM (EFC14335)

The efficacy and safety of Sarclisa in combination with pomalidomide and low-dose dexamethasone were evaluated in ICARIA-MM (EFC14335), a multicenter, multinational, randomized, open-label, 2-arm, phase III study in patients with relapsed and refractory multiple myeloma. Patients had received

at least two prior therapies including lenalidomide and a proteasome inhibitor. All patients had refractory disease to the last prior therapy.

Key eligibility criteria included patients aged ≥ 18 years with a known diagnosis of multiple myeloma with evidence of measurable disease who had received prior treatment with at least 2 prior lines of therapy for multiple myeloma including lenalidomide and a proteasome inhibitor (PI) alone or in combination, and demonstrated disease progression on or within 60 days of completion of the last therapy. Eligible patients should have Eastern Cooperative Oncology Group (ECOG) status of 0-2, platelets $\geq 75,000$ cells/mm³, absolute neutrophil count $\geq 1 \times 10^9$ /L, creatinine clearance ≥ 30 mL/min (MDRD formula), and aspartate aminotransferase (AST) and/or alanine aminotransferase (ALT) $\leq 3 \times$ upper limit of normal (ULN). Patients who had primary refractory disease or who received prior anti-CD38 therapy were not eligible.

A total of 307 patients were randomized in a 1:1 ratio to receive either Sarclisa in combination with pomalidomide and low-dose dexamethasone (Isa-Pd, 154 patients) or pomalidomide and low-dose dexamethasone (Pd, 153 patients). Randomization was stratified by age (< 75 years versus ≥ 75 years) and number of previous lines of therapy (2 or 3 versus more than 3).

Treatment was administered in both groups in 28-day cycles until disease progression or unacceptable toxicity. Sarclisa 10 mg/kg was administered as an IV infusion weekly in the first cycle and every two weeks thereafter. Pomalidomide 4 mg was taken orally once daily from day 1 to day 21 of each 28-day cycle. Low-dose dexamethasone (PO/IV) 40 mg (20 mg for patients ≥ 75 years of age) was given on days 1, 8, 15 and 22 for each 28-day cycle.

Overall, demographic and disease characteristics at baseline were similar between the two treatment groups. The median patient age was 67 years (range 36-86), 19.9% of patients were ≥ 75 years, 10.4% of patients entered the study with a history of chronic obstructive pulmonary disease (COPD) or asthma. The proportion of patients with renal impairment (creatinine clearance < 60 mL/min/1.73 m²) was 38.7% in Isa-Pd group versus 33.8% in Pd group. The International Staging System (ISS) Stage at initial diagnosis was I in 25.1%, II in 31.6% and III in 28.0% of patients. Overall, 19.5% of patients had high-risk chromosomal abnormalities at study entry; del(17p), t(4;14) and t(14;16) were present in 12.1%, 8.5% and 1.6% of patients, respectively.

The median number of prior lines of therapy was 3 (range 2-11). All patients received a prior proteasome inhibitor, all patients received prior lenalidomide, 56.4% of patients received prior stem cell transplantation, and 93.5% of patients received prior alkylating agents. The majority of patients were refractory to lenalidomide (92.5%), to a proteasome inhibitor (75.9%), and to both an immunomodulator and a proteasome inhibitor (72.6%); 59% of patients were refractory to lenalidomide at last prior line of therapy.

The median duration of treatment was 10.3 months for the Isa-Pd group compared to 6 months for the Pd group.

Progression free survival (PFS) was the primary efficacy endpoint of ICARIA-MM. PFS results were assessed by an Independent Response Committee (IRC) based on central laboratory data for M-protein and central radiologic imaging review using the 2016 International Myeloma Working Group (IMWG) criteria. Key secondary efficacy endpoints included overall response rate (ORR) as per IMWG criteria and overall survival (OS).

Study IKEMA (EFC15246)

The efficacy and safety of Sarclisa in combination with carfilzomib and dexamethasone were evaluated in IKEMA (EFC15246), a multicenter, multinational, randomized, open-label, 2-arm, phase III study in adult patients with relapsed and/or refractory multiple myeloma. Patients had received one to three prior lines of therapy. Eligible patients had an ECOG status of 0-2, platelets $\geq 50,000$ cells/ μL if $< 50\%$ of bone marrow nucleated cells were plasma cells and $\geq 30,000$ cells/ μL if $\geq 50\%$ of bone marrow nucleated cells were plasma cells, absolute neutrophil count $\geq 1 \times 10^9/\text{L}$, creatinine clearance ≥ 15 mL/min/1.73 m² (MDRD formula), aspartate aminotransferase (AST) and alanine aminotransferase (ALT) ≤ 3 x upper limit of normal (ULN). Patients with primary refractory disease or who were refractory to previous anti-CD38 monoclonal antibody treatment were excluded.

A total of 302 patients were randomized in a 3:2 ratio to receive either Sarclisa in combination with carfilzomib and dexamethasone (Isa-Kd, 179 patients) or carfilzomib and dexamethasone (Kd, 123 patients). Treatment was administered in both groups in 28-day cycles until disease progression or unacceptable toxicity. Sarclisa 10 mg/kg was administered as an intravenous (IV) infusion weekly in the first cycle and every two weeks thereafter. Carfilzomib was administered as an IV infusion at the dose of 20 mg/m² on days 1 and 2; 56 mg/m² on days 8, 9, 15 and 16 of cycle 1; and at the dose of 56 mg/m² on days 1, 2, 8, 9, 15 and 16 for subsequent cycles of each 28-day cycle. Dexamethasone (IV on the days of isatuximab and/or carfilzomib infusions, and orally on the other days) 20 mg was given on days 1, 2, 8, 9, 15, 16, 22 and 23 for each 28-day cycle. On the days where both Sarclisa and carfilzomib were administered, dexamethasone was administered first, followed by Sarclisa infusion, then followed by carfilzomib infusion.

Overall, demographic and disease characteristics at baseline were similar between the two treatment groups. The median patient age was 64 years (range 33-90), 8.9% of patients were ≥ 75 years. The proportion of patients with renal impairment (eGFR < 60 mL/min/1.73 m²) was 24.0% in the Isa-Kd group versus 14.6% in the Kd group. The International Staging System (ISS) stage at study entry was I in 53.0%, II in 31.1%, and III in 15.2% of patients. Overall, 24.2% of patients had high-risk chromosomal abnormalities at study entry; del(17p), t(4;14), t(14;16) were present in 11.3%, 13.9% and 2.0% of patients, respectively. In addition, gain(1q21) was present in 42.1% of patients.

The median number of prior lines of therapy was 2 (range 1-4) with 44.4% of patients who received 1 prior line of therapy. Overall, 89.7% of patients received prior proteasome inhibitors, 78.1% received prior immunomodulators (including 43.4% who received prior lenalidomide), and 61.3% received prior stem cell transplantation. Overall, 33.1% of patients were refractory to prior proteasome inhibitors, 45.0% were refractory to prior immunomodulators (including 32.8% refractory to lenalidomide), and 20.5% were refractory to both a proteasome inhibitor and an immunomodulator.

The median duration of treatment was 80.0 weeks for the Isa-Kd group compared to 61.4 weeks for the Kd group.

14.2 Study Results

Study ICARIA-MM (EFC14335)

PFS was significantly prolonged in the Isa-Pd group compared to the Pd group. The median PFS was 11.6 months (95% confidence interval [CI]: 8.9-13.9) in the Isa-Pd group versus 6.5 months (95% CI: 4.5-

8.3) in the Pd group (hazard ratio [HR] = 0.596; 95% CI: 0.436-0.814, p=0.0010), representing a 40.4% reduction in the risk of disease progression or death in patients treated with Isa-Pd (Table 10, Figure 1).

Key efficacy results are presented in the following table.

Table 10 Efficacy of Sarclisa in combination with pomalidomide and low-dose dexamethasone versus pomalidomide and low-dose dexamethasone in the treatment of multiple myeloma (intent-to-treat analysis)

| Endpoint | Sarclisa + pomalidomide + low-dose dexamethasone (N = 154) | Pomalidomide + low-dose dexamethasone (N = 153) |
|---|--|---|
| Progression-Free Survival | | |
| Median (months) [95%CI] | 11.5 [8.9-13.9] | 6.5 [4.5-8.3] |
| Hazard Ratio ^a [95%CI] | 0.596 [0.44-0.81] | |
| p-value ^a (stratified-log-rank test) | 0.0010 | |
| Overall Response Rate^b | | |
| Responders (sCR+CR+VGPR+PR) n(%) [95% CI] ^c | 93 (60.4) [0.522-0.682] | 54 (35.3) [0.278-0.434] |
| p-value (stratified Cochran-Mantel-Haenszel) ^a | < 0.0001 | |
| Stringent Complete Response (sCR) + Complete Response (CR) n(%) | 7 (4.5) | 3 (2.0) |
| Very Good Partial Response (VGPR) n(%) | 42 (27.3) | 10 (6.5) |
| Partial Response (PR) n(%) | 44 (28.6) | 41 (26.8) |

- Stratified on age (<75y vs ≥75 y) and number of previous lines of therapy (2 or 3 vs >3) according to IRT. The p-value for PFS was derived based on stratified log-rank test. A pre-defined hierarchical procedure allows for testing of an endpoint only when the previous one is statistically significant, in the following order: PFS, ORR and OS.
- sCR, CR, VGPR and PR were evaluated by the IRC using the IMWG response criteria (2016)
- Estimated using Clopper-Pearson method.

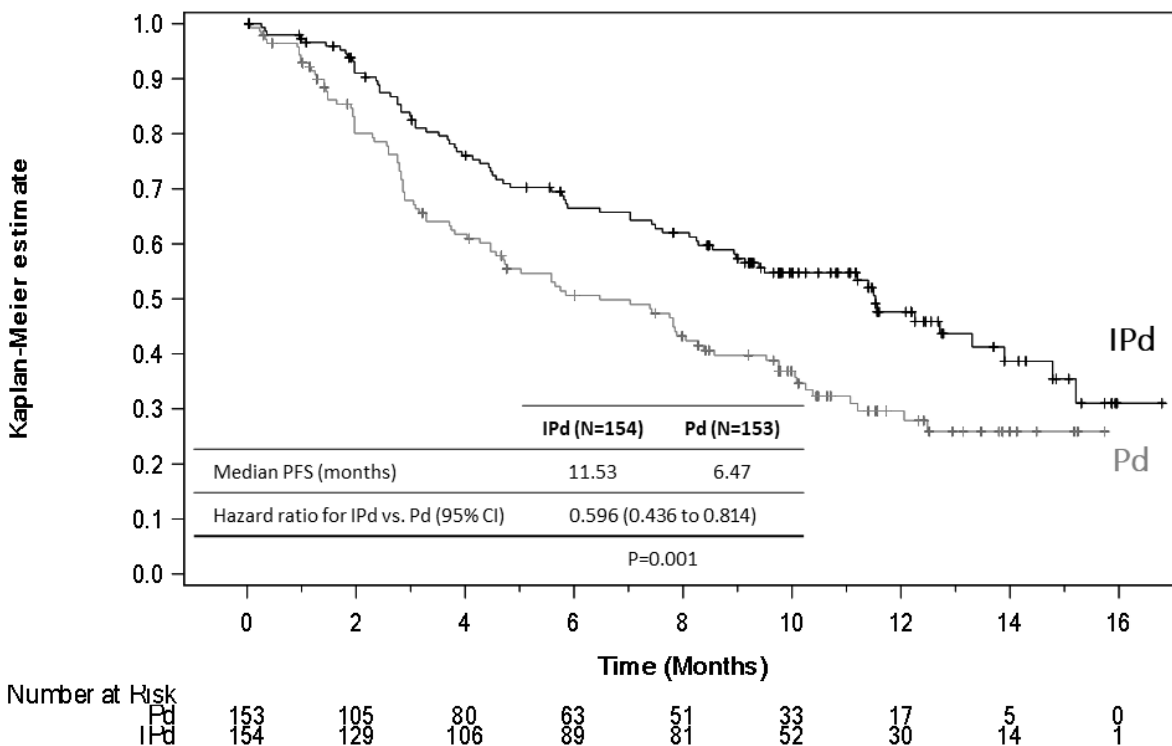
CI= Confidence Interval. CI for Kaplan-Meier estimates are calculated with log-log transformation of survival function and methods of Brookmeyer and Crowle.

The median duration of response was 13.3 months (95% CI: 10.6-NR) in the Isa-Pd group versus 11.1 months (95% CI: 8.5-NR) in the Pd group.

Subgroup analyses based on PFS hazard ratio were generally consistent with that of the primary PFS analysis across the pre-defined subgroups, including patients with high-risk cytogenetics, > 75 years, with ISS stage III at study entry, with baseline creatinine clearance < 60 ml/min/1.73 m², with > 3 prior lines of therapy, refractory to lenalidomide or proteasome inhibitor, and refractory to lenalidomide at the last line before the study entry.

The median time to first response was 35 days in the Isa-Pd group versus 58 days in the Pd group. The median duration of response was 13.3 months (95% CI: 10.6-not reached [NR]) in the Isa-Pd group versus 11.0 months (95% CI: 8.5-NR) in the Pd group.

Figure 1: Kaplan-Meier Curves of PFS – ITT population – ICARIA-MM (assessment by the IRC)



OS results were from a preplanned interim analysis when the primary analyses for PFS and ORR were conducted. The OS was not mature at the time of analysis. At a median follow-up time of 11.6 months, 43 (27.9%) patients on Isa-Pd and 56 (36.6%) patients on Pd had died. The hazard ratio for OS was 0.687 (95% CI: 0.461-1.023); the OS results did not reach statistical significance. Median overall survival (OS) was not reached for either treatment group.

Study IKEMA (EFC15246)

Progression-free survival (PFS) was the primary efficacy endpoint of IKEMA. PFS results were assessed by an Independent Response Committee based on central laboratory data for M-protein and central radiologic imaging review using the IMWG criteria. The improvement in PFS represented a 46.9% reduction in the risk of disease progression or death in patients treated with Isa-Kd compared to patients treated with Kd.

Efficacy results are presented in Table 11 and Kaplan-Meier curves for PFS are provided in Figure 2:

Table 11: Efficacy of Sarclisa in combination with carfilzomib and dexamethasone versus carfilzomib and dexamethasone in the treatment of multiple myeloma in IKEMA (intent-to-treat analysis)*

| Endpoint | Sarclisa + carfilzomib + dexamethasone N = 179 | Carfilzomib + dexamethasone N = 123 |
|--|---|--|
| Progression-Free Survival^a | | |
| Median (months) [95%CI] | NR [NR -NR] | 19.15 [15.77-NR] |
| Hazard Ratio ^b [95%CI] | 0.531 [0.318-0.889] | |
| p-value (stratified-log-rank test) ^b | 0.0013 | |
| Overall Response Rate^c | | |
| Responders (sCR+CR+VGPR+PR) n (%) [95% CI] ^d | 155 (86.6) [0.8071-0.9122] | 102 (82.9) [0.7509-0.8911] |
| p-value (stratified Cochran-Mantel-Haenszel) ^b | 0.3859 | |
| Complete Response (CR) n (%) | 71 (39.7) | 34 (27.6) |
| Very Good Partial Response (VGPR) n (%) | 59 (33.0) | 35 (28.5) |
| Partial Response (PR) n (%) | 25 (14.0) | 33 (26.8) |

- PFS results were assessed by an Independent Response Committee based on central laboratory data for M-protein and central radiologic imaging review using the International Myeloma Working Group (IMWG) criteria.
- Stratified on number of previous lines of therapy (1 versus >1) and R-ISS (I or II versus III versus not classified) according to IRT.
- sCR, CR, VGPR and PR were evaluated by the IRC using the IMWG response criteria (2016)
- Estimated using Clopper Pearson method.

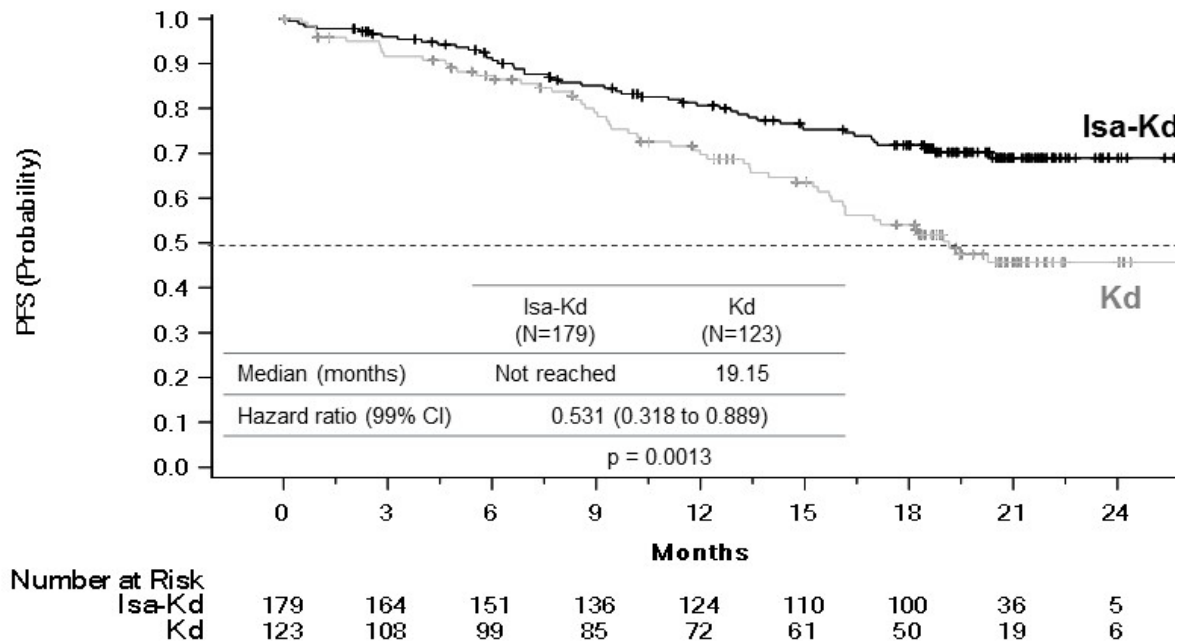
*Results are based on a prespecified interim analysis. Cut-off date of 7 February 2020. Median follow-up time 20.7 months

NR: not reached.

The percentage of patients achieving a best overall response of VGPR or better, defined as patients with sCR, CR, or VGPR by the IRC using the IMWG response criteria, was 72.6% in the Isa-Kd group and 56.1% in the Kd group.

Subgroup analyses based on PFS hazard ratio were consistent across the pre-specified subgroups including patients with high-risk cytogenetics, ≥ 65 years of age, with baseline eGFR (MDRD) < 60 mL/min/1.73 m², with >1 prior line of therapy, or with ISS stage III at study entry.

Figure 2: Kaplan-Meier Curves of PFS – ITT population – IKEMA (assessment by the IRC)



Cut-off date: 07-Feb-2020

15 MICROBIOLOGY

No microbiological information is required for this drug product.

16 NON-CLINICAL TOXICOLOGY

Carcinogenicity: Carcinogenicity studies have not been conducted with Sarclisa.

Genotoxicity: Genotoxicity studies have not been conducted with Sarclisa.

Reproductive and Developmental Toxicology: Reproductive, developmental toxicity and embryofetal toxicity studies have not been conducted with Sarclisa.

17 SUPPORTING PRODUCT MONOGRAPHS

1. Pomalyst® (pomalidomide)¹ (capsule, 1 mg, 2 mg, 3 mg and 4 mg), Submission Control Number 243491, Product Monograph. Date of revision: February 2, 2021
2. Dexamethasone Product Monograph

¹ Pomalyst® is a registered trademark of Celgene Corporation

3. Kyprolis® (carfilzomib for injection)² Product Monograph. Date of initial approval: Jan. 15, 2016.

² Kyprolis is a registered trademark of Onyx Pharmaceuticals, Inc.

PATIENT MEDICATION INFORMATION

READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE

Pr SARCLISA[®]

Isatuximab for injection

concentrate for solution for infusion

Read this carefully before you start taking **Sarclisa (sar-KLEE-sah)** and each time you get a refill. This leaflet is a summary and will not tell you everything about this drug. Talk to your healthcare professional about your medical condition and treatment and ask if there is any new information about **Sarclisa**.

What is Sarclisa used for?

Sarclisa is used in adults 18 years or older to treat a type of cancer called multiple myeloma. This is a cancer of your plasma cells which are found in your bone marrow.

Sarclisa is used to treat multiple myeloma in patients who have received treatments for multiple myeloma before.

Sarclisa is used together with two other combinations of medicines

- pomalidomide and dexamethasone or;
- carfilzomib and dexamethasone

How does Sarclisa work?

Sarclisa is a cancer medicine that contains the active substance isatuximab (ee-sah-TUKS-i-mab). It belongs to a group of medicines called “monoclonal antibodies”.

Monoclonal antibodies, such as Sarclisa, are proteins that have been designed to recognise and attach themselves to a target substance. In the case of Sarclisa, the target is a substance called CD38 that is found on cells of multiple myeloma, a cancer of the bone marrow. By attaching to multiple myeloma cells, the medicine helps the natural defences of your body (immune system) identify and destroy them.

What are the ingredients in Sarclisa?

Medicinal ingredients: Isatuximab

Non-medicinal ingredients: Histidine, Histidine hydrochloride monohydrate, Polysorbate 80, Sucrose, Water for injection

Sarclisa comes in the following dosage forms:

Sarclisa is provided as a concentrate that must be diluted and is then administered by intravenous infusion. It comes in vials. Each vial of 5 mL concentrate contains 100 mg of isatuximab (concentration of 20 mg/mL). Each vial of 25 mL concentrate contains 500 mg of isatuximab (concentration of 20 mg/mL).

Do not use Sarclisa if:

- You are allergic to isatuximab or any other ingredients in Sarclisa.

If you are not sure, talk to your doctor or nurse before you receive Sarclisa.

To help avoid side effects and ensure proper use, talk to your healthcare professional before you take Sarclisa. Talk about any health conditions or problems you may have, including if you:

- Are pregnant, think you might be pregnant, or are planning to have a baby. If you become pregnant while being treated with Sarclisa, tell your doctor or nurse immediately. You and your doctor will decide if the benefit of receiving Sarclisa is greater than the risk to your baby. Women who are being treated with Sarclisa must use effective contraception during treatment and for at least 5 months after treatment.
- Are producing breast milk. You and your doctor will decide if the benefit of breast feeding is greater than the risk to your baby. This is because the medicine may pass into the mother's milk and it is not known if it will affect the baby.

Other warnings you should know about:**Infusion-Related Reactions**

Infusion-related reactions can happen during Sarclisa infusion or after the infusion and may be serious. Tell your doctor or nurse immediately if you feel unwell during or after infusion of Sarclisa. These symptoms may include:

- Feeling short of breath
- Cough
- Stuffy or runny nose
- Chills
- Nausea
- Vomiting

Severe symptoms of infusion reaction are less common, including:

- High blood pressure (hypertension)
- Low oxygen level in the blood (hypoxia)
- Low blood pressure (hypotension)
- Fast heartbeat (tachycardia)
- High level of blood sugar (hyperglycemia)
- Swollen face, lips, mouth, tongue or throat

If you have an infusion-related reaction, you may need other medicines to treat your symptoms, or the infusion may need to be slowed down or stopped. When these reactions go away or get better, the infusion can be started again.

Blood Transfusion

If you need a blood transfusion, you will have a blood test first to match your blood type. Sarclisa can affect the results of this blood test. Tell the person doing the test that you are using Sarclisa. Your doctor should do blood tests to match your blood type before you start treatment with Sarclisa.

Decreased Number of White Blood Cells

Sarclisa can decrease the number of your white blood cells, which are important in fighting infections. Your doctor will monitor for your white blood cells during Sarclisa treatment. You may receive other medications to treat low white blood cells.

Infections

Sarclisa when combined with other drugs including pomalidomide and dexamethasone or carfilzomib and dexamethasone may increase the risk of infections. These infections can be severe or life-threatening. Tell your doctor right away if you have a fever or chill, feel very tired, have a cough or have flu-like symptoms.

Children and Adolescents

Sarclisa is not approved for use in children and adolescents under the age of 18.

Driving and Using Machines

Sarclisa is not expected to affect your ability to drive or use machines. However, fatigue and dizziness have been reported by patients taking Sarclisa. If you experience side effects of this medicine, do not drive or use machines before discussing with your doctor, pharmacist or nurse.

Heart Problems

Sarclisa can cause heart problems and/or make your heart beat faster. Tell your doctor or nurse if you have any heart problems, or if you have ever taken a medicine for your heart. During Sarclisa treatment, if you feel heart racing, irregular heartbeat, dizziness, shortness of breath, chest pain, cough or leg swelling, contact your doctor or nurse immediately.

New Cancers

New cancers have happened in patients during treatment with Sarclisa. It is not clear if Sarclisa has caused the new cancers. Your doctor will monitor you for new cancers.

Tell your healthcare professional about all the medicines you take, including any drugs, vitamins, minerals, natural supplements or alternative medicines. Tell your doctor or nurse before Sarclisa treatment if you have ever taken a medicine for your heart.

How to take Sarclisa:

- Your doctor or nurse will give you Sarclisa in your vein (intravenously) as a drip infusion.

Usual dose:

Your doctor will determine your dose of Sarclisa. This will depend on your body weight. The recommended dose is 10 mg of Sarclisa per kilogram of your body weight.

Sarclisa is used in treatment cycles of 28 days (4 weeks) together with either pomalidomide and dexamethasone or carfilzomib and dexamethasone:

- In Cycle 1: Sarclisa is administered weekly on days 1, 8, 15 and 22
- In Cycle 2 and beyond: Sarclisa is administered every 2 weeks on day 1 and 15

Your doctor will continue to treat you with Sarclisa as long as you benefit from it and tolerate the potential side effects.

Medicines given before an infusion of Sarclisa

You must receive the following medicines before infusion of Sarclisa to help reduce possible infusion-related reactions:

- Medicine to reduce allergic reactions (anti-histamine)
- Medicine to reduce inflammation (corticosteroid)
- Medicine to reduce pain and fever

Overdose:

Sarclisa will be given to you by your doctor or nurse. In the unlikely event that you are given too much (an overdose), your doctor will monitor you for side effects.

If you think you, or a person you are caring for, have taken too much Sarclisa, contact a healthcare professional, hospital emergency department, or regional poison control centre immediately, even if there are no symptoms.

Missed Dose:

It is very important that you go to all your appointments to make sure your treatment works. If you miss any appointments, call your doctor or nurse as soon as possible to reschedule your appointment. Your doctor or nurse will decide how your treatment should be continued.

What are possible side effects from using Sarclisa?

These are not all the possible side effects you may have when taking Sarclisa. If you experience any side effects not listed here, tell your healthcare professional.

- Headache
- Dizziness
- Feeling tired
- Decreased appetite
- Hiccups
- Runny or stuffy nose, sneezing, coughing, sore or scratchy throat (infection of the upper airways, such as nose, sinuses or throat)
- Nausea, vomiting
- Diarrhea
- Abdominal pain or discomfort
- Heartburn
- Swelling of the hands or legs
- Muscle, bone or joint pain
- Decreased body weight
- Feeling anxious
- Blurred vision
- High blood sugar
- Loss of bladder control (urinary incontinence)
- High blood pressure (hypertension)
- Hot flushes

| Serious side effects and what to do about them | | | |
|--|--------------------------------------|--------------|---|
| Symptom / effect | Talk to your healthcare professional | | Stop taking drug and get immediate medical help |
| | Only if severe | In all cases | |
| VERY COMMON (1 in 10 people) | | | |
| Infusion-related reactions Symptoms can include one or more of the following: feeling short of breath, cough, stuffy or runny nose, chills, nausea, high blood pressure (hypertension), fast heartbeat, low blood pressure, swollen face, lips, mouth, tongue or throat. | | | ✓ |
| Low number of blood cells such as: <ul style="list-style-type: none"> • Platelets (thrombocytopenia) (symptoms like unusual bruising or bleeding) • White blood cells (neutropenia or lymphopenia) • Red blood cells (anemia) (symptoms like fatigue, loss of energy, weakness, shortness of breath) | | ✓ | |
| Lung infection such as pneumonia, bronchitis, lower respiratory tract infections Symptoms can include congestion, cough (may produce phlegm), body ache, tiredness, wheezing, shortness of breath, chest pain when breathing or cough, fever, sweating and chill, and confusion or change of mental awareness (mostly in older patients). | | ✓ | |
| Shortness of breath | | ✓ | |
| COMMON (less than 1 in 10, but more than 1 in 100) | | | |
| Herpes viral infection The infection can present as cold sore, shingles, or chickenpox. The symptoms can include sore on the lip or in the mouth, painful blisters on the skin, fever, feeling tired, body ache, rash, and red spots and blisters over the entire body. | ✓ | | |
| Irregular or rapid heartbeat Symptoms can include heart racing, irregular heartbeat, dizziness, shortness of breath and chest pain. | | ✓ | |
| Squamous cell carcinoma of the skin It may appear as a firm, red nodule, or a flat sore with a rough scaly patch on | | ✓ | |

| Serious side effects and what to do about them | | | |
|---|--------------------------------------|--------------|---|
| Symptom / effect | Talk to your healthcare professional | | Stop taking drug and get immediate medical help |
| | Only if severe | In all cases | |
| the skin, lips or inside the mouth. | | | |
| Pulmonary embolism. Symptoms can include sudden feeling short of breath, sharp chest pain, cough, heart racing, sweating, feeling anxious and fainting. | | | ✓ |
| Heart problems, which may present as difficulty breathing, cough, or leg swelling when Sarclisa is given with carfilzomib and dexamethasone | | ✓ | |
| RARE (may affect up to 1 in 100 people) | | | |
| Serious allergic reaction (anaphylactic reaction), which may include rash, itching, difficulty breathing, shortness of breath, swelling of the face, mouth, throat, or tongue, cold, clammy skin, palpitations, dizziness, weakness or fainting | | | ✓ |

If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, tell your healthcare professional.

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| <p>Reporting Side Effects</p> <p>You can report any suspected side effects associated with the use of health products to Health Canada by:</p> <ul style="list-style-type: none"> • Visiting the Web page on Adverse Reaction Reporting (https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada.html) for information on how to report online, by mail or by fax; or • Calling toll-free at 1-866-234-2345. <p><i>NOTE: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.</i></p> |
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Storage:

Sarclisa should not be used after the expiry date which is stated on the label and carton.

Sarclisa should be stored in a refrigerator (2°C to 8°C), in its original package to protect from light.

Do not freeze.

Keep out of reach and sight of children.

If you want more information about Sarclisa:

- Talk to your healthcare professional
 - Find the full product monograph that is prepared for healthcare professionals and includes this Patient Medication Information by visiting the Health Canada website: <https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-product-database.html>; Sanofi-aventis Canada website www.sanofi.ca, or by calling 1-800-265-7927.

This leaflet was prepared by Sanofi-aventis Canada Inc.

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