

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

BLINCYTO 38.5 micrograms powder for concentrate and solution for solution for infusion.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

One vial of powder contains 38.5 micrograms blinatumomab.

Reconstitution with water for injections results in a final blinatumomab concentration of 12.5 micrograms/mL.

Blinatumomab is produced in Chinese hamster ovary cells by recombinant DNA technology.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Powder for concentrate and solution for solution for infusion.

BLINCYTO powder (powder for concentrate): White to off-white powder.

Solution (stabiliser): Colourless-to-slightly yellow, clear solution with a pH of 7.0.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

BLINCYTO is indicated as monotherapy for the treatment of adults with CD19 positive relapsed or refractory B-cell precursor acute lymphoblastic leukaemia (ALL). Patients with Philadelphia chromosome-positive B-cell precursor ALL should have failed treatment with at least 2 tyrosine kinase inhibitors (TKIs) and have no alternative treatment options.

BLINCYTO is indicated as monotherapy for the treatment of adults with Philadelphia chromosome-negative CD19 positive B-cell precursor ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1%.

BLINCYTO is indicated as monotherapy for the treatment of paediatric patients aged 1 month or older with Philadelphia chromosome-negative CD19 positive B-cell precursor ALL which is refractory or in relapse after receiving at least two prior therapies or in relapse after receiving prior allogeneic haematopoietic stem cell transplantation.

BLINCYTO is indicated as monotherapy for the treatment of paediatric patients aged 1 month or older with high-risk first relapsed Philadelphia chromosome-negative CD19 positive B-cell precursor ALL as part of the consolidation therapy (see section 4.2).

BLINCYTO is indicated as monotherapy as part of consolidation therapy for the treatment of adult patients with newly diagnosed Philadelphia chromosome negative CD19 positive B-cell precursor ALL.

4.2 Posology and method of administration

Treatment should be initiated under the direction of and supervised by physicians experienced in the treatment of haematological malignancies. Patients treated with BLINCYTO should be given the Educational Brochure for Patients and Caregivers and the Patient Card.

For the treatment of relapsed or refractory B-cell precursor ALL, hospitalisation is recommended for initiation at a minimum for the first 9 days of the first cycle and the first 2 days of the second cycle.

For the treatment of Philadelphia chromosome-negative MRD positive B-cell precursor ALL, hospitalisation is recommended at a minimum for the first 3 days of the first cycle and the first 2 days of subsequent cycles.

For the treatment of B-cell precursor ALL in the consolidation phase, hospitalisation is recommended for the first 3 days of the first cycle and the first 2 days of the second cycle.

In patients with a history or presence of clinically relevant central nervous system (CNS) pathology (see section 4.4), hospitalisation is recommended at a minimum for the first 14 days of the first cycle. In the second cycle, hospitalisation is recommended at a minimum for 2 days, and clinical judgement should be based on tolerance to BLINCYTO in the first cycle. Caution should be exercised as cases of late occurrence of first neurological events have been observed.

For all subsequent cycle starts and reinitiation (e.g. if treatment is interrupted for 4 or more hours), supervision by a healthcare professional or hospitalisation is recommended.

Posology

Relapsed or refractory B-cell precursor ALL

Patients with relapsed or refractory B-cell precursor ALL, may receive 2 cycles of treatment. A single cycle of treatment is 28 days (4 weeks) of continuous infusion. Each cycle of treatment is separated by a 14-day (2 weeks) treatment-free interval.

Patients who have achieved complete remission (CR/CRh*) after 2 treatment cycles may receive up to 3 additional cycles of BLINCYTO consolidation treatment, based on an individual benefits-risks assessment.

Recommended daily dose is by body weight (see table 1). Patients greater than or equal to 45 kg receive a fixed-dose and for patients less than 45 kg, the dose is calculated using the patient's body surface area (BSA).

Table 1. BLINCYTO recommended dosage for relapsed or refractory B-cell precursor ALL

Body weight	Cycle 1			Subsequent cycles	
	Days 1-7	Days 8-28	Days 29-42	Days 1-28	Days 29-42
Greater than or equal to 45 kg (fixed-dose)	9 mcg/day via continuous infusion	28 mcg/day via continuous infusion	14-day treatment-free interval	28 mcg/day via continuous infusion	14-day treatment-free interval
Less than 45 kg (BSA-based dose)	5 mcg/m ² /day via continuous infusion (not to exceed 9 mcg/day)	15 mcg/m ² /day via continuous infusion (not to exceed 28 mcg/day)		15 mcg/m ² /day via continuous infusion (not to exceed 28 mcg/day)	

Premedication and additional medication recommendations

In adult patients, dexamethasone 20 mg intravenous should be administered 1 hour prior to initiation of each cycle of BLINCYTO therapy.

In paediatric patients, dexamethasone 10 mg/m² (not to exceed 20 mg) should be administered orally or intravenously 6 to 12 hours prior to the start of BLINCYTO (cycle 1, day 1). This should be followed by dexamethasone 5 mg/m² orally or intravenously within 30 minutes prior to the start of BLINCYTO (cycle 1, day 1).

Anti-pyretic use (e.g. paracetamol) is recommended to reduce pyrexia during the first 48 hours of each treatment cycle.

Intrathecal chemotherapy prophylaxis is recommended before and during BLINCYTO therapy to prevent central nervous system ALL relapse.

Pre-phase treatment for patients with high tumour burden

For patients with $\geq 50\%$ leukaemic blasts in bone marrow or $> 15\,000/\text{microlitre}$ peripheral blood leukaemic blast counts treat with dexamethasone (not to exceed 24 mg/day).

MRD positive B-cell precursor ALL

When considering the use of BLINCYTO as a treatment for Philadelphia chromosome-negative MRD positive B-cell precursor ALL, quantifiable MRD should be confirmed in a validated assay with minimum sensitivity of 10^{-4} (see section 5.1). Clinical testing of MRD, regardless of the choice of technique, should be performed by a qualified laboratory familiar with the technique, following well established technical guidelines.

Patients may receive 1 cycle of induction treatment followed by up to 3 additional cycles of BLINCYTO consolidation treatment. A single cycle of treatment of BLINCYTO induction or consolidation is 28 days (4 weeks) of continuous intravenous infusion followed by a 14-day (2 weeks) treatment-free interval (total 42 days). The majority of patients who respond to blinatumomab achieve a response after 1 cycle (see section 5.1). Therefore, the potential benefit and risks associated with continued therapy in patients who do not show haematological and/or clinical improvement after 1 treatment cycle should be assessed by the treating physician. See table 2 for the recommended daily dose.

Table 2. BLINCYTO recommended dosage for adult patients with MRD-positive B-cell precursor ALL

Body weight	Treatment cycle(s)	
	Days 1-28	Days 29-42
Greater than or equal to 45 kg (fixed-dose)	28 mcg/day	14-day treatment free interval
Less than 45 kg (BSA-based dose)	15 mcg/m ² /day (not to exceed 28 mcg/day)	14-day treatment-free interval

Premedication and additional medication recommendations

Prednisone 100 mg intravenously or equivalent (e.g. dexamethasone 16 mg) should be administered 1 hour prior to initiation of each cycle of BLINCYTO therapy.

Anti-pyretic use (e.g. paracetamol) is recommended to reduce pyrexia during the first 48 hours of each treatment cycle.

Intrathecal chemotherapy prophylaxis is recommended before and during BLINCYTO therapy to prevent central nervous system ALL relapse.

B-cell precursor ALL in the consolidation phase

BLINCYTO is administered as a continuous intravenous infusion delivered at a constant flow rate using an infusion pump. A single cycle of treatment is 28 days (4 weeks) of continuous infusion followed by a 14-day (2-week) treatment-free interval. Patients may receive up to 4 cycles of BLINCYTO consolidation treatment.

See table 3 for the recommended daily dose by body weight for adults. Patients weighing greater than or equal to 45 kg receive a fixed-dose, and for patients weighing less than 45 kg, the dose is calculated using the patient's body surface area (BSA).

Table 3. BLINCYTO recommended dosage for B-cell precursor ALL for Adults in the consolidation phase

Body weight	Consolidation cycles (Cycles 1-4)	
	Days 1-28	Days 29-42
Greater than or equal to 45 kg (fixed-dose)	28 mcg/day	14 day treatment-free interval
Less than 45 kg (BSA-based dose)	15 mcg/m ² /day (not to exceed 28 mcg/day)	14 day treatment-free interval

High-risk first relapsed B-cell precursor ALL

Paediatric patients with high-risk first relapsed B-cell precursor ALL may receive 1 cycle of BLINCYTO treatment after induction and 2 blocks of consolidation chemotherapy. A single cycle of treatment is 28 days (4 weeks) of continuous infusion. See table 4 for the recommended daily dose by body weight for paediatric patients.

Table 4. BLINCYTO recommended dosage for paediatric patients with high-risk first relapsed B-cell precursor ALL post-induction chemotherapy

One consolidation cycle	Body weight greater than or equal to 45 kg (fixed-dose)	Body weight less than 45 kg (BSA-based dose)
Days 1-28	28 mcg/day	15 mcg/m ² /day (not to exceed 28 mcg/day)

Premedication and additional medication recommendations

In adult patients, dexamethasone 20 mg intravenous should be administered within 1 hour prior to initiation of each cycle of BLINCYTO therapy.

In paediatric patients, dexamethasone 5 mg/m² (not to exceed 20 mg) should be administered prior to the first dose of BLINCYTO in the first cycle and when restarting an infusion after an interruption of 4 or more hours in the first cycle.

Intrathecal chemotherapy prophylaxis is recommended before and during BLINCYTO therapy to prevent central nervous system ALL relapse.

Dose adjustments

Consideration to discontinue BLINCYTO temporarily or permanently as appropriate should be made in the case of the following severe (grade 3) or life-threatening (grade 4) toxicities (see section 4.4): cytokine release syndrome, tumour lysis syndrome, neurological toxicity, elevated liver enzymes and any other clinically relevant toxicities.

If the interruption of treatment after an adverse reaction is no longer than 7 days, continue the same cycle to a total of 28 days of infusion inclusive of days before and after the interruption in that cycle. If an interruption due to an adverse reaction is longer than 7 days, start a new cycle. If the toxicity takes more than 14 days to resolve, discontinue BLINCYTO permanently, except if described differently in the table 5 below.

Table 5. Recommendations for toxicity management (excluding ICANS)

Toxicity	Grade*	Action for patients weighing greater than or equal to 45 kg	Action for patients weighing less than 45 kg
Cytokine release syndrome, tumour lysis syndrome	Grade 3	Interrupt BLINCYTO until resolved, then restart BLINCYTO at 9 mcg/day. Escalate to 28 mcg/day after 7 days if the toxicity does not recur.	Interrupt BLINCYTO until resolved, then restart BLINCYTO at 5 mcg/m ² /day. Escalate to 15 mcg/m ² /day after 7 days if the toxicity does not recur.
	Grade 4	Discontinue BLINCYTO permanently.	Discontinue BLINCYTO permanently.
Neurological toxicity (excluding ICANS)	Grade 3	Interrupt BLINCYTO until no more than grade 1 (mild) and for at least 3 days, then restart BLINCYTO at 9 mcg/day. Escalate to 28 mcg/day after 7 days if the toxicity does not recur. For reinitiation, premedicate with a 24 mg dose of dexamethasone. Then reduce dexamethasone step-wise over 4 days. If the toxicity occurred at 9 mcg/day, or if the toxicity takes more than 7 days to resolve, discontinue BLINCYTO permanently.	Interrupt BLINCYTO until no more than grade 1 (mild) and for at least 3 days, then restart BLINCYTO at 5 mcg/m ² /day. Escalate to 15 mcg/m ² /day after 7 days if the toxicity does not recur. If the toxicity occurred at 5 mcg/m ² /day, or if the toxicity takes more than 7 days to resolve, discontinue BLINCYTO permanently.
	Grade 4	Discontinue BLINCYTO permanently.	Discontinue BLINCYTO permanently.
Elevated liver enzymes	Grade 3	If clinically relevant, interrupt BLINCYTO until no more than grade 1 (mild), then restart BLINCYTO at 9 mcg/day. Escalate to 28 mcg/day after 7 days if the toxicity does not recur.	If clinically relevant, interrupt BLINCYTO until no more than grade 1 (mild), then restart BLINCYTO at 5 mcg/m ² /day. Escalate to 15 mcg/m ² /day after 7 days if the toxicity does not recur.
	Grade 4	Consider discontinuing BLINCYTO permanently.	Consider discontinuing BLINCYTO permanently.

Toxicity	Grade*	Action for patients weighing greater than or equal to 45 kg	Action for patients weighing less than 45 kg
Other clinically relevant (as determined by treating physician) adverse reactions	Grade 3	Interrupt BLINCYTO until no more than grade 1 (mild), then restart BLINCYTO at 9 mcg/day. Escalate to 28 mcg/day after 7 days if the toxicity does not recur.	Interrupt BLINCYTO until no more than grade 1 (mild), then restart BLINCYTO at 5 mcg/m ² /day. Escalate to 15 mcg/m ² /day after 7 days if the toxicity does not recur.
	Grade 4	Consider discontinuing BLINCYTO permanently.	Consider discontinuing BLINCYTO permanently.

* Based on the NCI Common Terminology Criteria for Adverse Events (CTCAE) version 4.0. Grade 3 is severe, and grade 4 is life-threatening.

Table 6. Recommendations for management of immune effector cell-associated neurotoxicity syndrome (ICANS)

Grade ^a	Presenting symptoms ^b	Actions
Grade 1	ICE score 7-9 ^c <i>CAPD score 1-8*</i> or depressed level of consciousness ^d : awakens spontaneously.	<p>Interrupt BLINCYTO until ICANS resolves. For reinitiation, premedicate with up to 20 mg dexamethasone 1-3 hours before blinatumomab restart.</p> <p>Monitor neurologic symptoms and consider consultation with a neurologist for further evaluation and management.</p> <p>Consider non-sedating, antiseizure medicinal products (e.g., levetiracetam) for seizure prophylaxis.</p> <p><i>Action for patients ≥ 45 kg:</i> Consider treatment with dexamethasone up to 8 mg/dose up to 3 doses administered over 24 hours.</p> <p><i>Action for patients < 45 kg:</i> Consider treatment with dexamethasone at a total daily dose up to 0.2-0.4 mg/kg/day (up to a maximum 24 mg/day).</p>

Grade ^a	Presenting symptoms ^b	Actions
Grade 2	ICE score 3-6 ^c <i>CAPD score 1-8*</i> or depressed level of consciousness ^d : awakens to voice.	<p>Interrupt BLINCYTO. Administer dexamethasone:</p> <p><i>For patients ≥ 45 kg:</i> Administer dexamethasone 8 mg/dose up to 3 doses/day (24 mg/day maximum) for up to 2 days or until event resolution, whichever is sooner.</p> <p><i>For patients < 45 kg:</i> Administer dexamethasone at a total daily dose of at least 0.2-0.4 mg/kg/day (maximum 24 mg per day) administered over 3 doses for up to 2 days or until event resolution, whichever is sooner.</p> <p>Monitor neurologic symptoms and consider consultation with a neurologist and other specialists for further evaluation and management.</p> <p>Consider non-sedating, antiseizure medicinal products (e.g., levetiracetam) for seizure prophylaxis.</p> <p><i>Action for patients ≥ 45 kg:</i> Interrupt BLINCYTO until ICANS resolves, then restart BLINCYTO at 9 mcg/day. Escalate to 28 mcg/day after 7 days if the toxicity does not recur. For reinitiation, premedicate with up to 20 mg dexamethasone 1-3 hours before blinatumomab restart.</p> <p><i>Action for patients < 45 kg:</i> Interrupt BLINCYTO until ICANS resolve, then restart BLINCYTO at 5 mcg/m²/day. Escalate to 15 mcg/m²/day after 7 days if the toxicity does not recur. For reinitiation, premedicate with 5 mg/m² dexamethasone (maximum 20 mg dose) 1-3 hours before blinatumomab restart.</p>

Grade ^a	Presenting symptoms ^b	Actions
Grade 3	<p>ICE score 0-2^c CAPD ≥ 9 or depressed level of consciousness^d:</p> <ul style="list-style-type: none"> awakens only to tactile stimulus, <p>or seizures^d, either:</p> <ul style="list-style-type: none"> any clinical seizure, focal or generalised, that resolves rapidly, or non-convulsive seizures on electroencephalogram (EEG) that resolve with intervention, <p>or raised intracranial pressure:</p> <ul style="list-style-type: none"> focal/local oedema on neuroimaging^d 	<p>Interrupt BLINCYTO. Administer dexamethasone:</p> <p><i>For patients ≥ 45 kg:</i> Administer dexamethasone 8 mg/dose 3 doses/day (24 mg/day maximum) until event resolution to grade 1 or less and then taper as clinically indicated.</p> <p><i>For patients < 45 kg:</i> Administer dexamethasone at a total daily dose of at least 0.2-0.4 mg/kg/day (maximum 24 mg per day) until event resolution to grade 1 or less and then taper as clinically indicated.</p> <p>Monitor neurologic symptoms and consider consultation with a neurologist and other specialists for further evaluation and management.</p> <p>Consider non-sedating, antiseizure medicinal products (e.g., levetiracetam) for seizure prophylaxis.</p> <p>Provide supportive therapy, which may include intensive care.</p> <p><i>Action for patients ≥ 45 kg:</i> Interrupt BLINCYTO until ICANS resolves, then restart BLINCYTO at 9 mcg/day. Escalate to 28 mcg/day after 7 days if the toxicity does not recur. For reinitiation, premedicate with up to 20 mg dexamethasone 1-3 hours before blinatumomab restart. If the toxicity occurred at 9 mcg/day, or if the toxicity takes more than 7 days to resolve, discontinue BLINCYTO permanently.</p> <p><i>Action for patients < 45 kg:</i> Interrupt BLINCYTO until ICANS resolves, then restart BLINCYTO at 5 mcg/m²/day. Escalate to 15 mcg/m²/day after 7 days if the toxicity does not recur. For reinitiation, premedicate with 5 mg/m² dexamethasone (maximum 20 mg/day) 1-3 hours before blinatumomab restart. If the toxicity occurred at 5 mcg/m²/day, or if the toxicity takes more than 7 days to resolve, discontinue BLINCYTO permanently.</p> <p><i>Action for all patients</i> Permanently discontinue BLINCYTO if more than one seizure occurs.</p>

Grade ^a	Presenting symptoms ^b	Actions
Grade 4	<p>ICE score 0^c <i>Unable to perform CAPD*</i> or, depressed level of consciousness^d either:</p> <ul style="list-style-type: none"> patient is unarousable or requires vigorous or repetitive tactile stimuli to arouse, or stupor or coma, <p>or seizures^d, either:</p> <ul style="list-style-type: none"> life-threatening prolonged seizure (> 5 minutes), or repetitive clinical or electrical seizures without return to baseline in between, <p>or motor findings^d:</p> <ul style="list-style-type: none"> deep focal motor weakness such as hemiparesis or paraparesis, <p>or raised intracranial pressure/cerebral oedema^d, with signs/symptoms such as:</p> <ul style="list-style-type: none"> diffuse cerebral oedema on neuroimaging, or decerebrate or decorticate posturing, or cranial nerve VI palsy, or papilledema, or Cushing's triad 	<p>Permanently discontinue BLINCYTO. Administer dexamethasone:</p> <p><i>For patients ≥ 45 kg:</i> Administer dexamethasone 8 mg/dose 3 doses/day until event resolution to grade 1 or less and then taper as clinically indicated. Alternatively, consider administration of methylprednisolone 1000 mg per day intravenously for 3 days; taper as clinically indicated.</p> <p><i>For patients < 45 kg:</i> Administer dexamethasone at a total daily dose of at least 0.2-0.4 mg/kg/day until event resolution to grade 1 or less and then taper as clinically indicated. Alternatively, consider administration of methylprednisolone 30 mg/kg/day (maximum 1000 mg/day) in divided doses intravenously for 3 days; taper as clinically indicated.</p> <p>Monitor neurologic symptoms and consider consultation with a neurologist and other specialists for further evaluation and management.</p> <p>Consider non-sedating, antiseizure medicinal products (e.g., levetiracetam) for seizure prophylaxis.</p> <p>Provide supportive therapy, which may include intensive care.</p>

Utilise ICE-Immune effector cell-associated encephalopathy score for patients aged ≥ 12 years of age
Utilise the CAPD- Cornell Assessment of Paediatric Delirium tool for patients aged < 12 years of age. For details on CAPD assessment please refer to Lee, et al, 2019.

^a Based on American Society for Transplantation and Cellular Therapy (ASTCT) 2019 grading for ICANS.

^b Management is determined by the most severe event, not attributable to any other cause.

^c If patient is arousable and able to perform ICE assessment, assess:

Orientation (oriented to year, month, city, hospital = 4 points); Naming (name 3 objects, e.g., point to clock, pen, button = 3 points); Following commands (e.g., “show me 2 fingers” or “close your eyes and stick out your tongue” = 1 point); Writing (ability to write a standard sentence = 1 point); and Attention (count backwards from 100 by ten = 1 point). If patient is unarousable and unable to perform ICE assessment (Grade 4 ICANS) = 0 points.

^d Not attributable to any other cause.

^e All references to dexamethasone administration are dexamethasone or equivalent medicinal products.

* Scores between 1-8 may represent no impairment, grade 1 or grade 2 ICANS and must be combined with clinical assessment.

Special populations

Elderly

No dose adjustment is necessary in elderly patients (≥ 65 years of age), see section 5.1. There is limited experience with BLINCYTO in patients ≥ 75 years of age.

Renal impairment

Based on pharmacokinetic analyses, dose adjustment is not necessary in patients with mild to moderate renal dysfunction (see section 5.2). The safety and efficacy of BLINCYTO have not been studied in patients with severe renal impairment.

Hepatic impairment

Based on pharmacokinetic analyses, no effect of baseline liver function on blinatumomab exposure is expected and adjustment of the initial dose is not necessary (see section 5.2). The safety and efficacy of BLINCYTO have not been studied in patients with severe hepatic impairment.

Paediatric population

There is limited experience with BLINCYTO in children < 1 year of age. Currently available data in children are described in sections 4.8 and 5.1.

Method of administration

BLINCYTO is for intravenous use.

For instructions on the handling and preparation of the medicinal product before administration, see section 6.6.

Administer BLINCYTO as a continuous intravenous infusion delivered at a constant flow rate using an infusion pump over a period of up to 96 hours. The pump should be programmable, lockable, non-elastomeric, and have an alarm.

The starting volume (270 mL) is more than the volume administered to the patient (240 mL) to account for the priming of the intravenous tubing and to ensure that the patient will receive the full dose of BLINCYTO.

Infuse prepared BLINCYTO final infusion solution according to the instructions on the pharmacy label on the prepared bag at one of the following constant infusion rates:

- Infusion rate of 10 mL/h for a duration of 24 hours
- Infusion rate of 5 mL/h for a duration of 48 hours
- Infusion rate of 3.3 mL/h for a duration of 72 hours
- Infusion rate of 2.5 mL/h for a duration of 96 hours

Administer prepared BLINCYTO final infusion solution using intravenous tubing that contains a sterile, non-pyrogenic, low protein-binding 0.2 micrometre in-line filter.

Important note: Do not flush the BLINCYTO infusion line, especially when changing infusion bags. Flushing when changing bags or at completion of infusion can result in excess dosage and complications thereof. When administering via a multi-lumen venous catheter, BLINCYTO should be infused through a dedicated lumen.

The choice of the infusion duration should be made by the treating physician considering the frequency of the infusion bag changes and the weight of the patient. The target therapeutic dose of BLINCYTO delivered does not change.

Change of infusion bag

The infusion bag must be changed at least every 96 hours by a healthcare professional for sterility reasons.

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Breast-feeding (see section 4.6).

4.4 Special warnings and precautions for use

Traceability

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

Neurologic events including ICANS

Neurologic events including events with a fatal outcome have been observed. Grade 3 (CTCAE version 4.0) or higher (severe or life-threatening) neurologic events including ICANS following initiation of blinatumomab administration included encephalopathy, seizures, speech disorders, disturbances in consciousness, confusion and disorientation, and coordination and balance disorders. Among patients that experienced a neurologic event, the median time to the first event was within the first 2 weeks of treatment and the majority of events resolved after treatment interruption and infrequently led to BLINCYTO treatment discontinuation.

Elderly patients may be more susceptible to serious neurologic events such as cognitive disorder, encephalopathy, and confusion.

Patients with a medical history of neurologic signs and symptoms (such as dizziness, hypoaesthesia, hyporeflexia, tremor, dysaesthesia, paraesthesia and memory impairment) demonstrated a higher rate of neurologic events (such as tremor, dizziness, confusional state, encephalopathy and ataxia). Among these patients, the median time to the first neurologic event was within the first cycle of treatment.

There is limited experience in patients with a history or presence of clinically relevant CNS pathology (e.g. epilepsy, seizure, paresis, aphasia, stroke, severe brain injuries, dementia, Parkinson's disease, cerebellar disease, organic brain syndrome and psychosis) as they were excluded from clinical studies. There is a possibility of a higher risk of neurologic events in this population. The potential benefits of treatment should be carefully weighed against the risk of neurologic events and heightened caution should be exercised when administering BLINCYTO to these patients.

There is limited experience with blinatumomab in patients with documented active ALL in the CNS or cerebrospinal fluid (CSF). However, patients have been treated with blinatumomab in clinical studies after clearance of CSF blasts with CNS directed therapy (such as intrathecal chemotherapy). Therefore, once the CSF is cleared, treatment with BLINCYTO may be initiated.

It is recommended that a neurological examination be performed in patients prior to starting BLINCYTO therapy and that patients be clinically monitored for signs and symptoms of neurologic events including ICANS (e.g. writing test which could be part of a comprehensive neurological assessment). Management of these signs and symptoms to resolution may require either temporary interruption or permanent discontinuation of BLINCYTO and/or treatment with corticosteroids (see section 4.2). In the event of a seizure, secondary prophylaxis with appropriate anticonvulsant medicinal products (e.g. levetiracetam) is recommended.

Infections

In patients receiving blinatumomab, serious infections, including sepsis, pneumonia, bacteraemia, opportunistic infections and catheter site infections have been observed, some of which were life-threatening or fatal. Adult patients with Eastern Cooperative Oncology Group (ECOG) performance status at baseline of 2 experienced a higher incidence of serious infections compared to

patients with ECOG performance status of < 2 . There is limited experience with BLINCYTO in patients with an active uncontrolled infection.

Patients receiving BLINCYTO should be clinically monitored for signs and symptoms of infection and treated appropriately. Management of infections may require either temporary interruption or discontinuation of BLINCYTO (see section 4.2).

Cytokine release syndrome and infusion reactions

Cytokine release syndrome (CRS) which may be life-threatening or fatal (grade ≥ 4) has been reported in patients receiving BLINCYTO (see section 4.8).

Serious adverse reactions that may be signs and symptoms of CRS included pyrexia, asthenia, headache, hypotension, total bilirubin increased, and nausea; uncommonly, these events led to BLINCYTO discontinuation. The median time to onset of a CRS event was 2 days. Patients should be closely monitored for signs or symptoms of these events.

Disseminated intravascular coagulation (DIC) and capillary leak syndrome (CLS, e.g. hypotension, hypoalbuminaemia, oedema and haemoconcentration) have been commonly associated with CRS (see section 4.8). Patients experiencing capillary leak syndrome should be managed promptly.

Haemophagocytic histiocytosis/macrophage activation syndrome (MAS) has been uncommonly reported in the setting of CRS.

Infusion reactions may be clinically indistinguishable from manifestations of CRS (see section 4.8). The infusion reactions were generally rapid, occurring within 48 hours after initiating infusion. However, some patients reported delayed onset of infusion reactions or in later cycles. Patients should be observed closely for infusion reactions, especially during the initiation of the first and second treatment cycles and treated appropriately. Anti-pyretic use (e.g. paracetamol) is recommended to help reduce pyrexia during the first 48 hours of each cycle. To mitigate the risk of CRS, it is important to initiate BLINCYTO (cycle 1, days 1-7) at the recommended starting dose in section 4.2.

Management of these events may require either temporary interruption or discontinuation of BLINCYTO (see section 4.2).

Tumour lysis syndrome

Tumour lysis syndrome (TLS), which may be life-threatening or fatal (grade ≥ 4) has been observed in patients receiving BLINCYTO.

Appropriate prophylactic measures including aggressive hydration and anti-hyperuricaemic therapy (such as allopurinol or rasburicase) should be used for the prevention and treatment of TLS during BLINCYTO treatment, especially in patients with higher leukocytosis or a high tumour burden. Patients should be closely monitored for signs or symptoms of TLS, including renal function and fluid balance in the first 48 hours after the first infusion. In clinical studies, patients with moderate renal impairment showed an increased incidence of TLS compared with patients with mild renal impairment or normal renal function. Management of these events may require either temporary interruption or discontinuation of BLINCYTO (see section 4.2).

Neutropenia and febrile neutropenia

Neutropenia and febrile neutropenia, including life-threatening cases, have been observed in patients receiving BLINCYTO. Laboratory parameters (including, but not limited to white blood cell count and absolute neutrophil count) should be monitored routinely during BLINCYTO infusion, especially during the first 9 days of the first cycle, and treated appropriately.

Elevated liver enzymes

Treatment with BLINCYTO was associated with transient elevations in liver enzymes. The majority of the events were observed within the first week of treatment initiation and did not require interruption or discontinuation of BLINCYTO (see section 4.8).

Monitoring of alanine aminotransferase (ALT), aspartate aminotransferase (AST), gamma-glutamyl transferase (GGT), and total blood bilirubin prior to the start of and during BLINCYTO treatment especially during the first 48 hours of the first 2 cycles should be performed. Management of these events may require either temporary interruption or discontinuation of BLINCYTO (see section 4.2).

Pancreatitis

Pancreatitis, life-threatening or fatal, has been reported in patients receiving BLINCYTO in clinical studies and the post-marketing setting. High-dose steroid therapy may have contributed, in some cases, to the pancreatitis.

Patients should be closely monitored for signs and symptoms of pancreatitis. Patient evaluation may include physical examination, laboratory evaluation for serum amylase and serum lipase, and abdominal imaging, such as ultrasound and other appropriate diagnostic measures. Management of pancreatitis may require either temporary interruption or discontinuation of BLINCYTO (see section 4.2).

Leukoencephalopathy including progressive multifocal leukoencephalopathy

Cranial magnetic resonance imaging (MRI) changes showing leukoencephalopathy have been observed in patients receiving BLINCYTO, especially in patients with prior treatment with cranial irradiation and anti-leukaemic chemotherapy (including systemic high-dose methotrexate or intrathecal cytarabine). The clinical significance of these imaging changes is unknown.

Due to the potential for progressive multifocal leukoencephalopathy (PML), patients should be monitored for signs and symptoms. In case of suspicious events consider consultation with a neurologist, brain MRI and examination of cerebral spinal fluid (CSF), see section 4.8.

CD19-negative relapse

CD19-negative B-cell precursor ALL has been reported in relapsed patients receiving BLINCYTO. Particular attention should be given to assessment of CD19 expression at the time of bone marrow testing.

Lineage switch from ALL to acute myeloid leukaemia (AML)

Lineage switch from ALL to AML has been rarely reported in relapsed patients receiving BLINCYTO, including those with no immunophenotypic and/or cytogenetic abnormalities at initial diagnosis. All relapsed patients should be monitored for presence of AML.

Immunisations

The safety of immunisation with live viral vaccines during or following BLINCYTO therapy has not been studied. Vaccination with live virus vaccines is not recommended for at least 2 weeks prior to the start of BLINCYTO treatment, during treatment, and until recovery of B-lymphocytes to normal ranges following last treatment cycle.

Due to the potential depletion of B-cells in newborns following exposure to blinatumomab during pregnancy, newborns should be monitored for B-cell depletion and vaccinations with live virus vaccines should be postponed until the infant's B-cell count has recovered (see section 4.6).

Contraception

Women of childbearing potential have to use effective contraception during and for at least 48 hours, after treatment with BLINCYTO (see section 4.6).

Medication errors

Medication errors have been observed with BLINCYTO treatment. It is very important that the instructions for preparation (including reconstitution and dilution) and administration are strictly followed to minimise medication errors (including underdose and overdose) (see section 4.2).

Excipients with known effect

This medicinal product contains less than 1 mmol (23 mg) sodium over a 24 hour infusion, that is to say essentially 'sodium-free'.

4.5 Interaction with other medicinal products and other forms of interaction

No formal drug interaction studies have been performed. Results from an *in vitro* test in human hepatocytes suggest that blinatumomab did not affect CYP450 enzyme activities.

Initiation of BLINCYTO treatment causes transient release of cytokines during the first days of treatment that may suppress CYP450 enzymes. Patients who are receiving medicinal products that are CYP450 and transporter substrates with a narrow therapeutic index should be monitored for adverse effects (e.g. warfarin) or drug concentrations (e.g. cyclosporine) during this time. The dose of the concomitant medicinal product should be adjusted as needed.

4.6 Fertility, pregnancy and lactation

Women of childbearing potential/Contraception

Women of childbearing potential have to use effective contraception during and for at least 48 hours after treatment with blinatumomab (see section 4.4).

Pregnancy

Reproductive toxicity studies have not been conducted with blinatumomab. In an embryo-foetal developmental toxicity study conducted in mice, the murine surrogate molecule crossed the placenta and did not induce embryotoxicity, or teratogenicity (see section 5.3). The expected depletions of B- and T-cells were observed in the pregnant mice but haematological effects were not assessed in foetuses.

There are no data from the use of blinatumomab in pregnant women.

Blinatumomab should not be used during pregnancy unless the potential benefit outweighs the potential risk to the foetus.

In case of exposure during pregnancy, depletion of B-cells may be expected in newborns due to the pharmacological properties of the product. Consequently, newborns should be monitored for B-cell depletion and vaccinations with live virus vaccines should be postponed until the infant's B-cell count has recovered (see section 4.4).

Breast-feeding

It is unknown whether blinatumomab or metabolites are excreted in human milk. Based on its pharmacological properties, a risk to the suckling child cannot be excluded. Consequently, as a

precautionary measure, breast-feeding is contraindicated during and for at least 48 hours after treatment with blinatumomab.

Fertility

No studies have been conducted to evaluate the effects of blinatumomab on fertility. No adverse effects on male or female mouse reproductive organs in 13-week toxicity studies with the murine surrogate molecule (see section 5.3).

4.7 Effects on ability to drive and use machines

Blinatumomab has major influence on the ability to drive and use machines. Confusion and disorientation, coordination and balance disorders, risk of seizures and disturbances in consciousness can occur (see section 4.4). Due to the potential for neurologic events, patients receiving blinatumomab should refrain from driving, engaging in hazardous occupations or activities such as driving or operating heavy or potentially dangerous machinery while blinatumomab is being administered. Patients must be advised that they may experience neurologic events.

4.8 Undesirable effects

Summary of the safety profile

The adverse reactions described in this section were identified in clinical studies of patients with B-cell precursor ALL (N = 1 045).

The most serious adverse reactions that may occur during blinatumomab treatment include: infections (22.6%), neurologic events (12.2%), neutropenia/febrile neutropenia (9.1%), cytokine release syndrome (2.7%), and tumour lysis syndrome (0.8%).

The most common adverse reactions were: pyrexia (70.8%), infections – pathogen unspecified (41.4%), infusion-related reactions (33.4%), headache (32.7%), nausea (23.9%), anaemia (23.3%), thrombocytopenia (21.6%), oedema (21.4%), neutropenia (20.8%), febrile neutropenia (20.4%), diarrhoea (19.7%), vomiting (19.0%), rash (18.0%), hepatic enzyme increased (17.2%), cough (15.0%), bacterial infectious disorders (14.1%), tremor (14.1%), cytokine release syndrome (13.8%), leukopenia (13.8%), constipation (13.5%), decreased immunoglobulins (13.4%), viral infectious disorders (13.3%), hypotension (13.0%), back pain (12.5%), chills (11.7%), abdominal pain (10.6%), tachycardia (10.6%), insomnia (10.4%), pain in extremity (10.1%), and fungal infectious disorders (9.6%).

Tabulated list of adverse reactions

Adverse reactions are presented below by system organ class and frequency category. Frequency categories were determined from the crude incidence rate reported for each adverse reaction in clinical studies of patients with B-cell precursor ALL (N = 1 045). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

MedDRA system organ class	Very common (≥ 1/10)	Common (≥ 1/100 to < 1/10)	Uncommon (≥ 1/1 000 to < 1/100)
Infections and infestations	Bacterial infections ^{a, b} Viral infections ^{a, b} Infections - pathogen unspecified ^{a, b}	Sepsis Pneumonia Fungal infections ^{a, b}	
Blood and lymphatic system disorders	Febrile neutropenia Anaemia ¹ Neutropenia ² Thrombocytopenia ³ Leukopenia ⁴	Leukocytosis ⁵ Lymphopenia ⁶	Lymphadenopathy Histiocytosis haematophagic

MedDRA system organ class	Very common (≥ 1/10)	Common (≥ 1/100 to < 1/10)	Uncommon (≥ 1/1 000 to < 1/100)
Immune system disorders	Cytokine release syndrome ^a	Hypersensitivity	Cytokine storm
Metabolism and nutrition disorders		Tumour lysis syndrome	
Psychiatric disorders ^a	Insomnia ¹⁸	Confusional state ¹⁸ Disorientation ¹⁸	
Nervous system disorders ^a	Headache ¹⁸ Tremor ¹⁸	Encephalopathy ¹⁸ Aphasia ¹⁸ Paraesthesia ¹⁸ Seizure ¹⁸ Cognitive disorder ¹⁸ Memory impairment Dizziness ¹⁸ Somnolence ¹⁸ Hypoaesthesia ¹⁸ Cranial nerve disorder ^b Ataxia ¹⁸ Immune effector cell-associated neurotoxicity syndrome (ICANS)	Speech disorder ¹⁸
Cardiac disorders	Tachycardia ⁷		
Vascular disorders	Hypotension ⁸ Hypertension ⁹	Flushing	Capillary leak syndrome
Respiratory, thoracic and mediastinal disorders	Cough	Dyspnoea Productive cough Respiratory failure Wheezing	Dyspnoea exertional Acute respiratory failure
Gastrointestinal disorders	Nausea Diarrhoea Vomiting Constipation Abdominal pain		Pancreatitis ^a
Hepatobiliary disorders		Hyperbilirubinaemia ^{a, 10}	
Skin and subcutaneous tissue disorders	Rash ¹¹		
Musculoskeletal and connective tissue disorders	Back pain Pain in extremity	Bone pain	
General disorders and administration site conditions	Pyrexia ¹² Chills Oedema ¹³	Chest pain ¹⁴ Pain	
Investigations	Hepatic enzyme increased ^{a, 15} Decreased immunoglobulins ¹⁶	Weight increased Blood alkaline phosphatase increased	
Injury, poisoning and procedural complications	Infusion-related reactions ¹⁷		

^a Additional information is provided in “Description of selected adverse reactions”.

^b MedDRA high level group terms (MedDRA version 23.0).

Event terms that represent the same medical concept or condition were grouped together and reported as a single adverse reaction in the table above. The terms contributing to the relevant adverse reaction are indicated below:

¹ Anaemia includes anaemia and haemoglobin decreased.

- ² Neutropenia includes neutropenia and neutrophil count decreased.
- ³ Thrombocytopenia includes platelet count decreased and thrombocytopenia.
- ⁴ Leukopenia includes leukopenia and white blood cell count decreased.
- ⁵ Leukocytosis includes leukocytosis and white blood cell count increased.
- ⁶ Lymphopenia includes lymphocyte count decreased and lymphopenia.
- ⁷ Tachycardia includes sinus tachycardia, supraventricular tachycardia, tachycardia, atrial tachycardia and ventricular tachycardia.
- ⁸ Hypotension includes blood pressure decreased and hypotension.
- ⁹ Hypertension includes blood pressure increased and hypertension.
- ¹⁰ Hyperbilirubinaemia includes blood bilirubin increased and hyperbilirubinaemia.
- ¹¹ Rash includes erythema, rash, rash erythematous, rash generalised, rash macular, rash maculo-papular, rash pruritic, catheter site rash, rash pustular, genital rash, rash papular and rash vesicular.
- ¹² Pyrexia includes body temperature increased and pyrexia.
- ¹³ Oedema includes bone marrow oedema, periorbital oedema, eyelid oedema, eye oedema, lip oedema, face oedema, localised oedema, generalised oedema, oedema, oedema peripheral, infusion site oedema, oedematous kidney, scrotal oedema, oedema genital, pulmonary oedema, laryngeal oedema, angioedema, circumoral oedema and lymphoedema.
- ¹⁴ Chest pain includes chest discomfort, chest pain, musculoskeletal chest pain and non-cardiac chest pain.
- ¹⁵ Hepatic enzyme increased includes alanine aminotransferase increased, aspartate aminotransferase increased, gamma-glutamyl transferase increased, hepatic enzyme increased, liver function test increased and transaminases increased.
- ¹⁶ Decreased immunoglobulins includes blood immunoglobulin G decreased, blood immunoglobulin A decreased, blood immunoglobulin M decreased, globulins decreased, hypogammaglobulinaemia, hypoglobulinaemia and immunoglobulins decreased.
- ¹⁷ Infusion-related reactions is a composite term that includes the term infusion-related reaction and the following events occurring with the first 48 hours of infusion and event lasted ≤ 2 days: pyrexia, cytokine release syndrome, hypotension, myalgia, acute kidney injury, hypertension, rash, tachypnoea, swelling face, face oedema and rash erythematous.
- ¹⁸ Events may represent ICANS.

Description of selected adverse reactions

Neurologic events including ICANS

In the randomised phase III clinical study (N = 267) and the single-arm phase II clinical study (N = 189) in patients with Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL treated with BLINCYTO, 66.0% of patients experienced one or more neurologic adverse reactions (including psychiatric disorders), primarily involving the CNS. Serious and grade ≥ 3 neurologic adverse reactions were observed in 11.6% and 12.1% of patients respectively, of which the most common serious adverse reactions were encephalopathy, tremor, aphasia, and confusional state. The majority of neurologic events (80.5%) were clinically reversible and resolved following interruption of BLINCYTO. The median time to the first event was within the first 2 weeks of treatment. One case of fatal encephalopathy has been reported in an earlier phase II clinical single-arm study.

Neurologic events were reported for 62.2% of adult patients with Philadelphia chromosome-positive relapsed or refractory B-cell precursor ALL (N = 45). Serious and grade ≥ 3 neurologic events were reported at 13.3% each in adult patients with Philadelphia chromosome-positive relapsed or refractory B-cell precursor ALL.

Neurologic events were reported for 71.5% of adult patients with MRD positive B-cell precursor ALL (N = 137), 22.6% of patients experienced serious events. Grade ≥ 3 and grade ≥ 4 events, respectively, were reported for 16.1% and 2.2% of adult patients with MRD positive B-cell precursor ALL.

Neurologic events were reported in 61.2% of adult patients in CD19-positive B-cell precursor ALL in the consolidation phase where BLINCYTO was administered alternating with chemotherapy (N = 147). Grade ≥ 3 and grade ≥ 4 events, respectively, were reported for 28.6% and 2.0% of adult patients with CD19-positive B-cell precursor ALL in the consolidation phase.

ICANS, including Grade 3 and higher ICANS, were reported in clinical trials and with post-marketing experience. The most frequent clinical manifestations of ICANS were confusional state, aphasia, disorientation, altered state of consciousness, dysarthria, encephalopathy, seizure, mental status changes, somnolence and dysgraphia.

The observed time to onset of ICANS ranged from 0 to 299 days with the majority of ICANS occurring within the first three weeks.

For clinical management of neurologic events and ICANS, see section 4.2.

Infections

Life-threatening or fatal (grade ≥ 4) viral, bacterial and fungal infections have been reported in patients treated with BLINCYTO. In addition, reactivations of virus infection (e.g. Polyoma (BK)) have been observed in the phase II clinical study in adults with Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL. Patients with Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL with ECOG performance status at baseline of 2 experienced a higher incidence of serious infections compared to patients with ECOG performance status of < 2 .

Infections were reported in 34.7% of adult patients with CD19-positive B-cell precursor ALL in the consolidation phase where BLINCYTO was administered alternating with chemotherapy (N = 147). Grade ≥ 3 and grade ≥ 4 events, respectively, were reported for 28.6% and 10.2% of adult patients with CD19-positive B-cell precursor ALL in the consolidation phase.

For clinical management of infections, see section 4.4.

Cytokine release syndrome (CRS)

In the randomised phase III clinical study (N = 267) and the single-arm phase II clinical study (N = 189) in patients with Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL treated with BLINCYTO, 14.7% of patients experienced CRS. Serious CRS reactions were reported in 2.4% of patients with a median time to onset of 2 days.

Cytokine release syndrome was reported in 8.9% of adult patients with Philadelphia chromosome-positive relapsed or refractory B-cell precursor ALL (N = 45), 2.2% of patients experienced serious events. No grade ≥ 3 or ≥ 4 events were reported.

Cytokine release syndrome was reported in 2.9% of adult patients with MRD positive B-cell precursor ALL (N = 137). Grade 3 and serious events were reported for 1.5% each of adult patients with MRD positive B-cell precursor ALL; no grade ≥ 4 events were reported.

Cytokine release syndrome was reported in 15.6% of adult patients with CD19-positive B-cell precursor ALL in the consolidation phase where BLINCYTO was administered alternating with chemotherapy (N = 147). Grade ≥ 3 and grade ≥ 4 events, respectively, were reported for 4.1% and 0.7% of adult patients with CD19-positive B-cell precursor ALL in the consolidation phase.

Capillary leak syndrome was observed in 1 patient in the phase II clinical study in adult patients with Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL and in 1 patient in the phase II clinical study in adult patients with MRD positive B-cell precursor ALL. Capillary leak syndrome was not observed in adult patients in the phase II clinical study in patients with Philadelphia chromosome-positive relapsed or refractory B-cell precursor ALL. Capillary leak syndrome was reported in 1 patient (0.7%) with CD19-positive B-cell precursor ALL in the consolidation phase where BLINCYTO was administered alternating with chemotherapy (N = 147); the event was grade 3.

For clinical management of CRS, see section 4.4.

Elevated liver enzymes

In the randomised phase III clinical study (N = 267) and the single-arm phase II clinical study (N = 189) in patients with Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL treated with BLINCYTO, 22.4% of patients reported elevated liver enzymes and associated signs/symptoms. Serious and grade ≥ 3 adverse reactions (such as ALT increased, AST increased, and blood bilirubin increased) were observed in 1.5% and 13.6% of patients respectively. The median time to onset to the first event was 4 days from the start of BLINCYTO treatment initiation.

Elevated liver enzyme events were reported for 17.8% of adult patients with Philadelphia chromosome-positive relapsed or refractory B-cell precursor ALL (N = 45), 2.2% of patients experienced serious events. Grade ≥ 3 and grade ≥ 4 events, respectively, were reported for 13.3% and 6.7% of adult patients with Philadelphia chromosome-positive relapsed or refractory B-cell precursor ALL.

Elevated liver enzyme events were reported for 12.4% of adult patients with MRD positive B-cell precursor ALL (N = 137). Grade ≥ 3 and grade ≥ 4 events, respectively, were reported for 8.0% and 4.4% of adult patients with MRD positive B-cell precursor ALL.

Elevated liver enzyme events were reported in 15.6% of adult patients with CD19-positive B-cell precursor ALL in the consolidation phase where BLINCYTO was administered alternating with chemotherapy (N = 147). Grade ≥ 3 and Grade ≥ 4 events, respectively, were reported for 8.8% and 2.7% of adult patients with CD-19 positive B-cell precursor ALL in the consolidation phase.

The duration of hepatic adverse reactions has generally been brief and with rapid resolution, often when continuing uninterrupted treatment with BLINCYTO.

For clinical management of elevated liver enzymes, see section 4.4.

Pancreatitis

Pancreatitis, life-threatening or fatal, has been reported in patients receiving BLINCYTO in the clinical studies and the post-marketing settings. The median time to onset was 7.5 days. For clinical management of pancreatitis, see section 4.4.

Leukoencephalopathy including progressive multifocal leukoencephalopathy

Leukoencephalopathy has been reported. Patients with brain MRI/CT findings consistent with leukoencephalopathy experienced concurrent serious adverse reactions including confusional state, tremor, cognitive disorder, encephalopathy, and convulsion. Although there is a potential for the development of progressive multifocal leukoencephalopathy (PML), no confirmed case of PML has been reported in the clinical studies.

Paediatric population

The safety and effectiveness of BLINCYTO have been evaluated in paediatric patients with Philadelphia chromosome negative relapsed or refractory B-cell precursor ALL in two open label studies: a single-arm Phase I/II study (MT103-205) and a randomised, controlled Phase III study (20120215).

Study MT103-205 was a dose escalation/evaluation study in paediatric patients with relapsed or refractory B-cell precursor ALL in a phase I/II, single-arm dose escalation/evaluation study (MT103-205), in which 70 patients, aged 7 months to 17 years, were treated with the recommended dosage regimen.

The most frequently reported serious adverse reactions were pyrexia (11.4%), febrile neutropenia (11.4%), cytokine release syndrome (5.7%), sepsis (4.3%), device-related infection (4.3%), overdose

(4.3%), convulsion (2.9%), respiratory failure (2.9%), hypoxia (2.9%), pneumonia (2.9%), and multi-organ failure (2.9%).

The adverse reactions in BLINCYTO-treated paediatric patients were similar in type to those seen in adult patients. Adverse reactions that were observed more frequently ($\geq 10\%$ difference) in the paediatric population compared to the adult population were anaemia, thrombocytopenia, leukopenia, pyrexia, infusion-related reactions, weight increase, and hypertension.

The type and frequency of adverse reactions were similar across different paediatric subgroups (gender, age and geographic region).

At a dose higher than the recommended dose in study MT103-205, a case of fatal cardiac failure occurred in the setting of life-threatening cytokine release syndrome (CRS) and tumour lysis syndrome (TLS), see section 4.4.

BLINCYTO has also been evaluated in paediatric patients with high-risk first relapsed B-cell precursor ALL in a randomised, controlled, open-label phase III study (20120215), in which 54 patients, aged 1 to 18 years, were treated with the recommended dosage regimen for high-risk first relapsed B-cell precursor ALL. The safety profile of BLINCYTO in study 20120215 is consistent with that of the studied paediatric relapsed or refractory B-cell precursor ALL population.

Other special populations

There is limited experience with BLINCYTO in patients ≥ 75 years of age. Generally, safety was similar between elderly patients (≥ 65 years of age) and patients less than 65 years of age treated with BLINCYTO. However, elderly patients may be more susceptible to serious neurologic events such as cognitive disorder, encephalopathy and confusion.

Elderly patients with MRD positive ALL treated with BLINCYTO may have an increased risk of hypogammaglobulinaemia compared to younger patients. It is recommended that immunoglobulin levels are monitored in elderly patients during treatment with BLINCYTO.

The safety of BLINCYTO has not been studied in patients with severe renal impairment.

Immunogenicity

In clinical studies of adult ALL patients treated with BLINCYTO, less than 2% tested positive for anti-blinatumomab antibodies. Of patients who developed anti-blinatumomab antibodies, the majority had *in vitro* neutralising activity. No anti-blinatumomab antibodies were detected in clinical studies of paediatric patients with relapsed or refractory ALL treated with blinatumomab.

Anti-blinatumomab antibody formation may affect the pharmacokinetics of BLINCYTO.

Overall, the totality of clinical evidence supports the finding that anti-blinatumomab antibodies are not suggestive of any clinical impact on the safety or effectiveness of BLINCYTO.

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

Overdoses have been observed including one patient who received 133-fold the recommended therapeutic dose of BLINCYTO delivered over a short duration. Overdoses resulted in adverse

reactions which were consistent with the reactions observed at the recommended therapeutic dose and included fever, tremors, and headache. In the event of overdose, the infusion should be temporarily interrupted and patients should be monitored. Reinitiation of BLINCYTO at the correct therapeutic dose should be considered when all toxicities have resolved and no earlier than 12 hours after interruption of the infusion (see section 4.2).

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antineoplastic agents, other monoclonal antibodies and antibody drug conjugates, ATC code: L01FX07.

Mechanism of action

Blinatumomab is a bispecific T-cell engager molecule that binds specifically to CD19 expressed on the surface of cells of B-lineage origin and CD3 expressed on the surface of T-cells. It activates endogenous T-cells by connecting CD3 in the T-cell receptor (TCR) complex with CD19 on benign and malignant B-cells. The anti-tumour activity of blinatumomab immunotherapy is not dependent on T-cells bearing a specific TCR or on peptide antigens presented by cancer cells, but is polyclonal in nature and independent of human leukocyte antigen (HLA) molecules on target cells. Blinatumomab mediates the formation of a cytolytic synapse between the T-cell and the tumour cell, releasing proteolytic enzymes to kill both proliferating and resting target cells. Blinatumomab is associated with transient upregulation of cell adhesion molecules, production of cytolytic proteins, release of inflammatory cytokines, and proliferation of T-cells, and results in elimination of CD19+ cells.

Pharmacodynamic effects

Consistent immune-pharmacodynamic responses were observed in patients studied. During the continuous intravenous infusion over 4 weeks, the pharmacodynamic response was characterised by T-cell activation and initial redistribution, rapid peripheral B-cell depletion, and transient cytokine elevation.

Peripheral T-cell redistribution (i.e. T-cell adhesion to blood vessel endothelium and/or transmigration into tissue) occurred after start of blinatumomab infusion or dose escalation. T-cell counts initially declined within 1 to 2 days and then returned to baseline levels within 7 to 14 days in the majority of patients. Increase of T-cell counts above baseline (T-cell expansion) was observed in few patients.

Peripheral B-cell counts decreased rapidly to an undetectable level during treatment at doses ≥ 5 mcg/m²/day or ≥ 9 mcg/day in the majority of patients. No recovery of peripheral B-cell counts was observed during the 2-week treatment-free period between treatment cycles. Incomplete depletion of B-cells occurred at doses of 0.5 mcg/m²/day and 1.5 mcg/m²/day and in a few non-responders at higher doses.

Peripheral lymphocytes were not measured in paediatric subjects.

Cytokines including IL-2, IL-4, IL-6, IL-8, IL-10, IL-12, TNF- α and IFN- γ were measured and, IL-6, IL-10 and IFN- γ were most elevated. Transient elevation of cytokines was observed in the first 2 days following start of blinatumomab infusion. The elevated cytokine levels returned to baseline within 24 to 48 hours during the infusion. In subsequent treatment cycles, cytokine elevation occurred in fewer patients with lesser intensity compared to the initial 48 hours of the first treatment cycle.

Clinical efficacy and safety

Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL

A total of 456 patients aged ≥ 18 years of age with relapsed or refractory B-cell precursor ALL were exposed to BLINCYTO during the phase II and phase III clinical studies described below.

The safety and efficacy of BLINCYTO compared to standard of care (SOC) chemotherapy were evaluated in a randomised, open-label, multicentre, phase III study (TOWER). Eligible patients were ≥ 18 years of age and ECOG status ≤ 2 with relapsed or refractory B-cell precursor ALL (had $> 5\%$ blasts in the bone marrow and either relapse at any time after allogeneic HSCT, untreated first relapse with first remission duration < 12 months, or refractory to last therapy).

Patients were randomised 2:1 to receive BLINCYTO or 1 of 4 prespecified, investigator-selected, SOC backbone chemotherapy regimens. Randomisation was stratified by age (< 35 years versus ≥ 35 years of age), prior salvage therapy (yes versus no), and prior allogeneic HSCT (yes versus no) as assessed at the time of consent. The demographics and baseline characteristics were well-balanced between the two arms (see table 7).

Table 7. Demographics and baseline characteristics in phase III study (TOWER)

Characteristic	BLINCYTO (N = 271)	SOC chemotherapy (N = 134)
Age		
Median, years (min, max)	37 (18, 80)	37 (18, 78)
Mean, years (SD)	40.8 (17.1)	41.1 (17.3)
≥ 65 years, n (%)	33 (12.2)	15 (11.2)
Prior salvage therapy	164 (60.5)	80 (59.7)
0	114 (42.1)	65 (48.5)
1	91 (33.6)	43 (32.1)
≥ 2	66 (24.3)	26 (19.4)
Prior alloHSCT	94 (34.7)	46 (34.3)
ECOG status - n (%)		
0	96 (35.4)	52 (38.8)
1	134 (49.4)	61 (45.5)
2	41 (15.1)	20 (14.9)
Refractory status - n (%)		
Primary refractory	46 (17.0)	27 (20.1)
Refractory to salvage therapy	87 (32.1)	34 (25.4)
Maximum of central/local bone marrow blasts - n (%)		
$\geq 50\%$	201 (74.2)	104 (77.6)

alloHSCT = allogeneic haematopoietic stem cell transplantation

SOC = standard of care

BLINCYTO was administered as a continuous intravenous infusion. In the first cycle, the initial dose was 9 mcg/day for week 1, then 28 mcg/day for the remaining 3 weeks. The target dose of 28 mcg/day was administered in cycle 2 and subsequent cycles starting on day 1 of each cycle. Dose adjustment was possible in case of adverse reactions. Of the 267 patients who received BLINCYTO, the mean number of completed treatment cycles was 2.0; of the 109 patients who received SOC chemotherapy, the mean number of treatment cycles was 1.3.

The primary endpoint was overall survival (OS). The median OS was 4.0 months (95% CI: 2.9, 5.3) in the SOC chemotherapy arm compared with 7.7 months (95% CI: 5.6, 9.6) in the BLINCYTO arm. The hazard ratio (95% CI) was 0.71 (0.55, 0.93) between treatment arms favouring BLINCYTO, indicated a 29% reduction in hazard rate in the BLINCYTO arm (p-value = 0.012 (stratified log-rank test)), see figure 1. Consistency in OS results was shown in subgroups by stratification factors.

Consistent results were observed after censoring at the time of HSCT; median OS, censored at the time of HSCT, was 6.9 months (95% CI: 5.3, 8.8) in the BLINCYTO group and 3.9 months (95% CI: 2.8, 4.9) in the SOC group (HR, 0.66; 95% CI: 0.50, 0.88; p-value = 0.004). The mortality rate following alloHSCT among all responders who did not receive anti-leukaemic therapy was 10/38 (26.3%; 95% CI: 13.4, 43.1) in the BLINCYTO group and 3/12 (25%; 95% CI: 5.5, 57.2) in the SOC group; such mortality rate at 100 days post alloHSCT was 4/38 (12.4%; 95% CI: 4.8%, 29.9%) in the BLINCYTO group and 0/12 (0%; 95% CI: not estimable) in the SOC group. Efficacy results from other key endpoints in the study are summarised in table 8.

Figure 1. Kaplan-Meier curve of overall survival

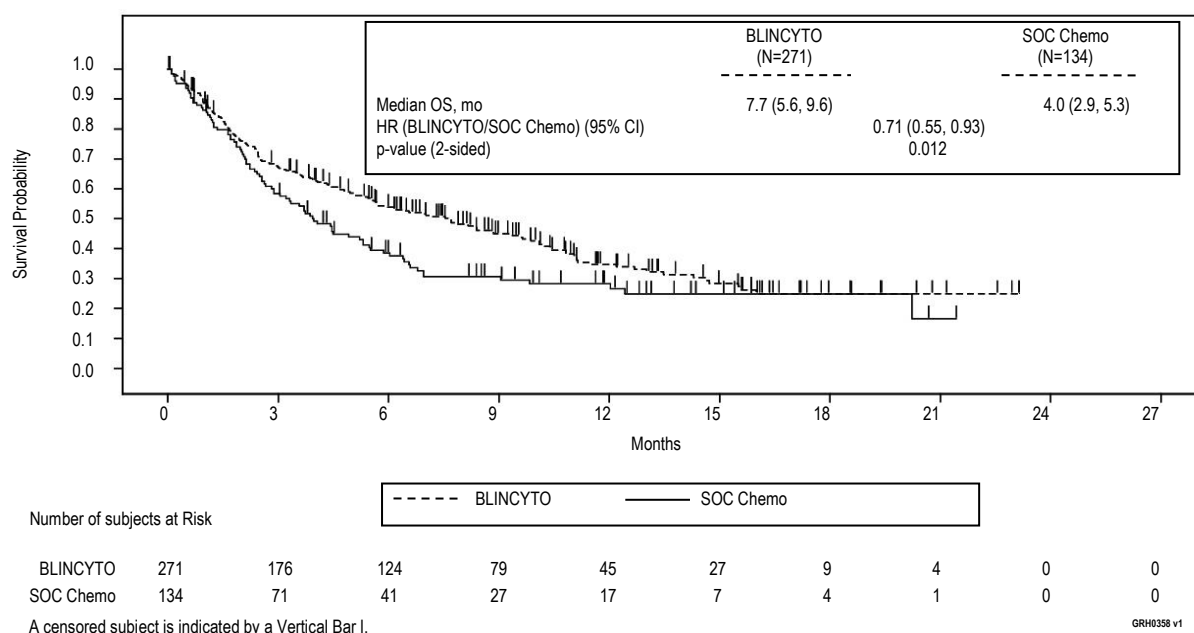


Table 8. Efficacy results in patients ≥ 18 years of age with Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL (TOWER)

	BLINCYTO (N = 271)	SOC chemotherapy (N = 134)
Complete remission (CR)		
CR ^a /CRh ^{*b} /CRi ^c , n (%) [95% CI]	119 (43.9) (37.9, 50.0)	33 (24.6) (17.6, 32.8)
Treatment difference [95% CI]	19.3 (9.9, 28.7)	
p-value	< 0.001	
CR, n (%) [95% CI]	91 (33.6) (28.0, 39.5)	21 (15.7) (10.0, 23.0)
Treatment difference [95% CI]	17.9 (9.6, 26.2)	
p-value	< 0.001	
Event-free survival ^d		
6-month estimate % [95% CI]	30.7 (25.0, 36.5)	12.5 (7.2, 19.2)
18-months estimate % [95% CI]	9.5 (5.1, 15.6)	7.9 (3.7, 14.2)
HR [95% CI]	0.55 (0.43, 0.71)	
Duration of haematological response-		
Median time to event [95% CI]		
CR	8.3 (5.7, 10.7)	7.8 (2.2, 19.0)
CR/CRh [*] /CRi	7.3 (5.8, 9.9)	4.6 (1.8, 19.0)
MRD ^e response for CR/CRh [*] /CRi		
MRD evaluable patients (%) [95% CI] ^f	74/97 (76.3) (66.6, 84.3)	16/33 (48.5) (30.8, 66.5)
Duration of MRD response-		
Median time to event [95% CI]	4.5 months (3.6, 9.0)	3.8 months (1.9, 19.0)

	BLINCYTO (N = 271)	SOC chemotherapy (N = 134)
Postbaseline alloHSCT - n (%)		
Overall subjects	65 (24)	32 (23.9)
Haematological responders (CR/CRh*/CRi)	50 (42.0)	18 (54.5)
Time to alloHSCT among all transplanted patients Median time to event (Interquartile range)	3.7 months (3.0, 5.3) (N = 65)	3.1 months (2.6, 4.3) (N = 32)
Time to alloHSCT among CR/CRh*/CRi responders Median time to event [95% CI] (KM estimate)	11.3 months (5.2, NE) (N = 119)	3.6 months (2.3, 7.2) (N = 33)
100 day mortality after alloHSCT		
n/N (%), [95% CI]	4/38, 12.4% (4.8, 29.9)	0/12, 0.0% (0.0, NE)

^a CR was defined as $\leq 5\%$ blasts in the bone marrow, no evidence of disease, and full recovery of peripheral blood counts (platelets $> 100\,000/\text{microlitre}$ and absolute neutrophil counts [ANC] $> 1\,000/\text{microlitre}$).

^b CRh* (complete remission with partial haematologic recovery) was defined as $\leq 5\%$ blasts in the bone marrow, no evidence of disease, and partial recovery of peripheral blood counts (platelets $> 50\,000/\text{microlitre}$ and ANC $> 500/\text{microlitre}$).

^c CRi (complete remission with incomplete haematologic recovery) was defined as $\leq 5\%$ blasts in the bone marrow, no evidence of disease, and incomplete recovery of peripheral blood counts (platelets $> 100\,000/\text{microlitre}$ or ANC $> 1\,000/\text{microlitre}$).

^d EFS time was calculated from the time of randomisation until the date of disease assessment indicating a relapse after achieving a CR/CRh*/CRi or death, whichever is earlier. Subjects who fail to achieve a CR/CRh*/CRi within 12 weeks of treatment initiation are considered treatment failures and assigned an EFS duration of 1 day.

^e MRD (minimum residual disease) response was defined as MRD by PCR or flow cytometry $< 1 \times 10^{-4}$.

^f Patients who achieved CR/CRh*/CRi and had an evaluable post baseline MRD assessment.

Health-related quality of life

In this open-label study, Health related quality of life (HRQoL) reported by patients were measured using the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire - Core 30 (EORTC QLQ-C30). In a post-hoc sensitivity analysis, compared to SOC, BLINCYTO consistently delayed the time to clinically meaningful deterioration of HRQoL (≥ 10 -points worsening from baseline) for global health status [median BLINCYTO versus SOC: 8.1 months versus 1.0 month; HR = 0.60 (95% CI = 0.42, 0.85)], functional scales, symptom scales and individual items. Because the health-related quality of life results are based on a post-hoc sensitivity analysis, the results should be interpreted with caution.

BLINCYTO was also evaluated in an open-label, multicentre, single-arm phase II study of 189 patients (MT103-211). Eligible patients were ≥ 18 years of age with Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL (relapsed with first remission duration of ≤ 12 months in first salvage, or relapsed or refractory after first salvage therapy, or relapsed within 12 months of allogeneic HSCT, and had $\geq 10\%$ blasts in bone marrow).

Premedication, BLINCYTO dose per treatment cycle and route of administration were identical to those in the phase III study. Patients were premedicated with a mandatory cerebrospinal fluid prophylaxis consisting of an intrathecal regimen according to institutional or national guidelines within 1 week prior to start of BLINCYTO treatment. BLINCYTO was administered as a continuous intravenous infusion. In the first cycle, the initial dose was 9 mcg/day for week 1, then 28 mcg/day for the remaining 3 weeks. The target dose of 28 mcg/day was administered in cycle 2 and subsequent cycles starting on day 1 of each cycle. Dose adjustment was possible in the case of adverse reactions. The treated population included 189 patients who received at least 1 infusion of BLINCYTO; the mean number of cycles per patient was 1.6. Patients who responded to BLINCYTO but later relapsed had the option to be retreated with BLINCYTO. Among treated patients, the median age was 39 years

(range: 18 to 79 years, including 25 patients ≥ 65 years of age), 64 of 189 (33.9%) had undergone HSCT prior to receiving BLINCYTO and 32 of 189 (16.9%) had received more than 2 prior salvage therapies.

The primary endpoint was the complete remission/complete remission with partial haematological recovery (CR/CRh*) rate within 2 cycles of treatment with BLINCYTO. Eighty-one of 189 (42.9%) patients achieved CR/CRh* within the first 2 treatment cycles with the majority of responses (64 of 81) occurring within 1 cycle of treatment. In the elderly population (≥ 65 years of age) 11 of 25 patients (44.0%) achieved CR/CRh* within the first 2 treatment cycles (see section 4.8 for safety in elderly). Four patients achieved CR during consolidation cycles, resulting in a cumulative CR rate of 35.4% (67/189; 95% CI: 28.6% - 42.7%). Thirty-two of 189 (17%) patients underwent allogeneic HSCT in CR/CRh* induced with BLINCYTO (see table 9).

Table 9. Efficacy results in patients ≥ 18 years of age with Philadelphia chromosome-negative relapsed or refractory B-cell precursor ALL (MT103-211)

	n (%) n = 189	95% CI
Complete remission (CR) ¹ /Complete remission with partial haematological recovery (CRh*) ²	81 (42.9%)	[35.7% - 50.2%]
CR	63 (33.3%)	[26.7% - 40.5%]
CRh*	18 (9.5%)	[5.7% - 14.6%]
Blast free hypoplastic or aplastic bone marrow ³	17 (9.0%)	[5.3% - 14.0%]
Partial remission ⁴	5 (2.6%)	[0.9% - 6.1%]
Relapse ⁵ -free survival (RFS) for CR/CRh*	5.9 months	[4.8 to 8.3 months]
Overall survival	6.1 months	[4.2 to 7.5 months]

¹ CR was defined as $\leq 5\%$ of blasts in the bone marrow, no evidence of disease, and full recovery of peripheral blood counts (platelets $> 100\ 000/\text{microlitre}$ and absolute neutrophil counts [ANC] $> 1\ 000/\text{microlitre}$).

² CRh* was defined as $\leq 5\%$ of blasts in the bone marrow, no evidence of disease, and partial recovery of peripheral blood counts (platelets $> 50\ 000/\text{microlitre}$ and ANC $> 500/\text{microlitre}$).

³ Blast free hypoplastic or aplastic bone marrow was defined as bone marrow blasts $\leq 5\%$, no evidence of disease, insufficient recovery of peripheral blood counts: platelets $\leq 50\ 000/\text{microlitre}$ and/or ANC $\leq 500/\text{microlitre}$.

⁴ Partial remission was defined as bone marrow blasts 6% to 25% with at least a 50% reduction from baseline.

⁵ Relapse was defined as haematological relapse (blasts in bone marrow greater than 5% following CR) or an extramedullary relapse.

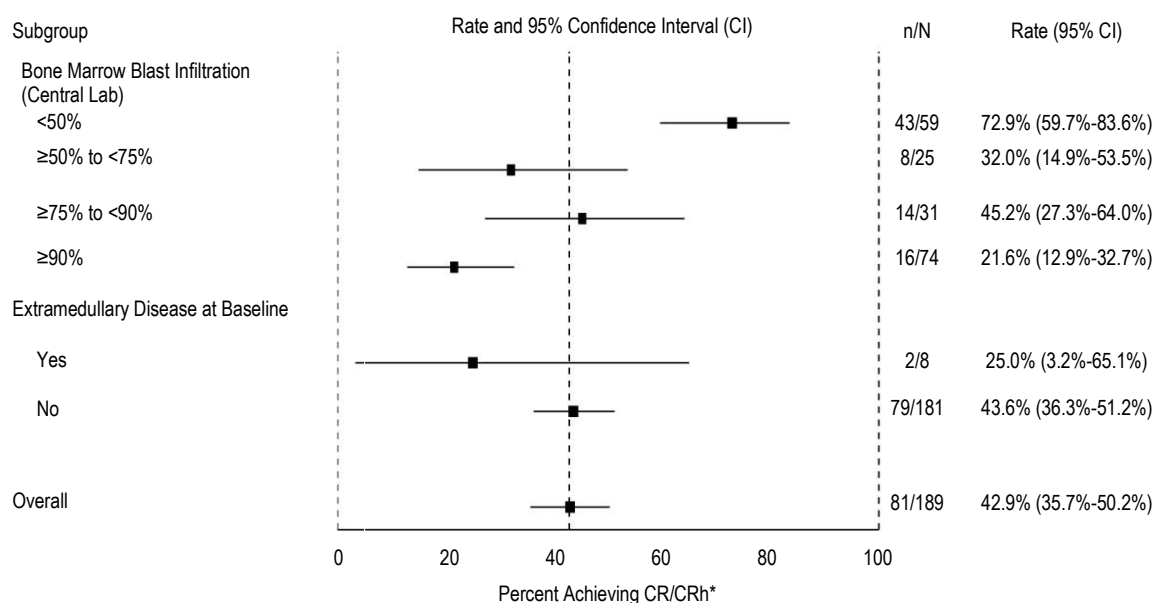
In a prespecified exploratory analysis, 60 of 73 MRD evaluable patients with CR/CRh* (82.2%) also had a MRD response (defined as MRD by PCR $< 1 \times 10^{-4}$).

Patients with prior allogeneic HSCT had similar response rates to those without prior HSCT, older patients had similar response rates to younger patients, and no substantial difference was observed in remission rates based on the number of lines of prior salvage treatment.

In patients with non-CNS/non-testes extramedullary disease (defined as at least 1 lesion ≥ 1.5 cm) at screening (N = 8/189) clinical response rates (25% [95% CI: 3.2-65.1]) were lower compared with patients with no evidence of extramedullary disease (N = 181, 43.6% [95% CI: 36.3 - 51.2]) (see figure 2).

Patients with the highest tumour burden as measured by the percentage of bone marrow blast cells at baseline ($\geq 90\%$) still had a clinically meaningful response with a CR/CRh* rate of 21.6% (95% CI: 12.9 - 32.7) (see figure 2). Patients with low tumour burden ($< 50\%$) responded best to BLINCYTO treatment with CR/CRh* rate of 72.9% (95% CI: 59.7 - 83.6).

Figure 2. Forest plot of CR/CRh* rate during the first 2 cycles for study MT103-211 (primary analysis set)



n = number of patients who achieved CR or CRh* in the first 2 cycles of treatment in the specified subgroup.
N = total number of patients in the specified subgroup.

There is limited data in patients with late first relapse of B-cell precursor ALL defined as a relapse occurring more than 12 months after first remission or more than 12 months after HSCT in the first remission. In clinical phase II studies, 88.9% (8/9) of patients with late first relapse as defined in the individual studies achieved CR/CRh* within the first 2 treatment cycles with 62.5% (6/9) achieving MRD response and 37.5% (3/9) undergoing allogeneic HSCT after treatment with BLINCYTO. The median overall survival (OS) was 17.7 months (95% CI: 3.1 - not estimable).

In the randomised, open-label, multicentre, phase III study (TOWER), 70% (7/10) of post-transplant patients in late first relapse treated with BLINCYTO compared to 20% (1/5) treated with SOC chemotherapy achieved CR/CRh* within the first 2 treatment cycles. Fifty percent (5/10) compared to 0% (0/5) achieved MRD response and 20% (2/10) compared to 40% (2/5) underwent allogeneic HSCT after treatment. The median OS was 15.6 months (95% CI: 5.5 – not estimable) for the BLINCYTO group and 5.3 months (95% CI: 1.1 – not estimable) for the SOC chemotherapy group.

Philadelphia chromosome-positive relapsed or refractory B-cell precursor ALL in adult patients

The safety and efficacy of BLINCYTO were evaluated in an open-label, multicentre, single-arm phase II study (ALCANTARA). Eligible patients were ≥ 18 years of age with Philadelphia chromosome-positive B-cell precursor ALL: relapsed or refractory to at least 1 second generation or later tyrosine kinase inhibitor (TKI); OR intolerant to second generation TKI, and intolerant or refractory to imatinib mesylate.

BLINCYTO was administered as a continuous intravenous infusion. In the first cycle, the initial dose was 9 mcg/day for week 1, then 28 mcg/day for the remaining 3 weeks. The dose of 28 mcg/day was administered in cycle 2 and subsequent cycles starting on day 1 of each cycle. Dose adjustment was possible in case of adverse reactions. The treated population included 45 patients who received at least one infusion of BLINCYTO; the mean number of treatment cycles was 2.2 (see table 10 for patient demographics and baseline characteristics).

Table 10. Demographics and baseline characteristics in phase II study (ALCANTARA)

Characteristic	BLINCYTO (N = 45)
Age	
Median, years (min, max)	55 (23, 78)
Mean, years (SD)	52.8 (15)
≥ 65 years and < 75 years, n (%)	10 (22.2)
≥ 75 years, n (%)	2 (4.4)
Males, n (%)	24 (53.3)
Race, n (%)	
Asian	1 (2.2)
Black (or African American)	3 (6.7)
Other	2 (4.4)
White	39 (86.7)
Disease History, n (%)	
Prior TKI treatment ^a	
1	7 (15.6)
2	21 (46.7)
≥ 3	17 (37.8)
Prior salvage therapy	31 (61.9)
Prior alloHSCT ^b	20 (44.4)
Bone marrow blasts ^c , n (%)	
≥ 50% to < 75%	6 (13.3)
≥ 75%	28 (62.2)

^a Number of patients that failed ponatinib = 23 (51.1%)

^b alloHSCT = allogeneic haematopoietic stem cell transplantation

^c centrally assessed

The primary endpoint was the CR/CRh* rate within 2 cycles of treatment with BLINCYTO. Sixteen out of 45 (35.6%) patients achieved CR/CRh* within the first 2 treatment cycles. Of the 16 patients with CR/CRh* in the first 2 cycles, 12 of 14 (85.7%) patients with a CR and 2 of 2 (100%) patients with a CRh* also achieved an MRD complete response (see table 11).

Two patients achieved CR during subsequent cycles, resulting in a cumulative CR rate of 35.6% (16 out of 45; 95% CI: 21.9 – 51.2). Five out of 16 (31.3%) patients underwent allogeneic HSCT in CR/CRh* induced with BLINCYTO.

Table 11. Efficacy results in patients ≥ 18 years of age with Philadelphia chromosome-positive relapsed or refractory B-cell precursor acute lymphoblastic leukaemia (ALL) (ALCANTARA)

	N = 45
Complete remission (CR) ^a /Complete remission with partial haematological recovery (CRh*) ^b , n (%) [95% CI]	16 (35.6) [21.9, 51.2]
CR	14 (31.1) [18.2, 46.6]
CRh*	2 (4.4) [0.5, 15.1]
CRi ^c (without CRh*), n (%) [95% CI]	2 (4.4) [0.5, 15.1]
Blast free hypoplastic or aplastic bone marrow (without CRi) ^d , n (%) [95% CI]	3 (6.7) [1.4, 18.3]
Partial remission ^e , n (%) [95% CI]	2 (4.4) [0.5, 15.1]
Complete MRD response ^f , n (%) [95% CI]	18 (40.0) [25.7, 55.7]
Median Relapse ^g -free survival (RFS) for CR/CRh* [95% CI]	6.7 months [4.4 to NE ^h]
Median Overall survival [95% CI]	7.1 months [5.6 to NE ^h]

^a CR was defined as ≤ 5% of blasts in the bone marrow, no evidence of disease, and full recovery of peripheral blood counts (platelets > 100 000/microlitre and absolute neutrophil counts [ANC] > 1 000/microlitre).

^b CRh* was defined as $\leq 5\%$ of blasts in the bone marrow, no evidence of disease, and partial recovery of peripheral blood counts (platelets $> 50\,000/\text{microlitre}$ and ANC $> 500/\text{microlitre}$).

^c CRi (complete remission with incomplete haematologic recovery) was defined as $\leq 5\%$ blasts in the bone marrow, no evidence of disease, and incomplete recovery of peripheral blood counts (platelets $> 100\,000/\text{microlitre}$ or ANC $> 1\,000/\text{microlitre}$).

^d Blast free hypoplastic or aplastic bone marrow was defined as bone marrow blasts $\leq 5\%$, no evidence of disease, insufficient recovery of peripheral counts: platelets $\leq 50\,000/\text{microlitre}$ and/or ANC $\leq 500/\text{microlitre}$.

^e Partial remission was defined as bone marrow blasts 6% to 25% with at least a 50% reduction from baseline.

^f Complete MRD response was defined as the absence of detectable MRD confirmed in an assay with minimum sensitivity of 10^{-4} .

^g Relapse was defined as haematological relapse (blasts in bone marrow greater than 5% following CR) or an extramedullary relapse.

^h NE = not estimable.

Patients with the higher tumour burden as measured by the percentage of bone marrow blast cells at baseline ($\geq 50\%$) still had a clinically meaningful response with a CR/CRh* rate of 26.5% (95% CI: 12.9 – 44.4). Patients with low tumour burden ($< 50\%$) responded best to BLINCYTO treatment with CR/CRh* rate of 63.6% (95% CI: 30.8 – 89.1). For patients with high peripheral white blood cell counts ($\geq 3.0 \times 10^9/\text{L}$), response rate was 27.3% (95% CI: 10.7 – 50.2) while percentage of response for those with a lower white blood cell count ($< 3.0 \times 10^9/\text{L}$) was 43.5% (95% CI: 23.2 – 65.5).

Treatment effects in evaluable subgroups (e.g. mutation status, number of prior TKIs, prior HSCT status, and relapse without prior HSCT) were in general consistent with the results in the overall population. Patients with T315I mutation, other mutations, or additional cytogenetic abnormalities responded with a similar rate as compared to those that did not have these mutations or abnormalities.

MRD positive B-cell precursor ALL

The safety and efficacy of BLINCYTO in adult patients with MRD positive B-cell precursor ALL were evaluated in an open-label, multicentre, single-arm phase II study (BLAST). Eligible patients were ≥ 18 years of age with no prior HSCT, had received at least 3 blocks of standard ALL induction therapy, were in complete haematologic remission (defined as $< 5\%$ blasts in bone marrow, absolute neutrophil count $\geq 1\,000/\text{microlitres}$, platelets $\geq 50\,000/\text{microlitres}$, and haemoglobin level $\geq 9\text{ g/dL}$) and had molecular failure or molecular relapse (defined as MRD $\geq 10^{-3}$), see table 12. MRD status at screening was determined from bone marrow aspirations using flow cytometry or polymerase chain reaction (PCR) at a minimum sensitivity of 10^{-4} based on local site evaluations. A central laboratory subsequently confirmed MRD levels by PCR. Final interpretation of MRD results followed EuroMRD Consortium guidelines.

Table 12. Demographics and baseline characteristics in MRD study (BLAST)

Characteristic	BLINCYTO (N = 116)
Age	
Median, years (min, max)	45 (18, 76)
Mean, years (SD)	44.6 (16.4)
≥ 65 years, n (%)	15 (12.9)
Males, n (%)	68 (58.6)
Race, n (%)	
Asian	1 (0.9)
Other (mixed)	1 (0.9)
White	102 (87.9)
Unknown	12 (10.3)

Characteristic	BLINCYTO (N = 116)
Relapse history, n (%)	
Patients in 1 st CR	75 (64.7)
Patients in 2 nd CR	39 (33.6)
Patients in 3 rd CR	2 (1.7)
MRD level at baseline*, n (%)	
$\geq 10^{-1}$ and < 1	9 (7.8)
$\geq 10^{-2}$ and $< 10^{-1}$	45 (38.8)
$\geq 10^{-3}$ and $< 10^{-2}$	52 (44.8)
$< 10^{-3}$	3 (2.6)
Below lower limit of quantification	5 (4.3)
Unknown	2 (1.7)

* Centrally assessed in an assay with minimum sensitivity of 10^{-4}

BLINCYTO was administered as a continuous intravenous infusion. Patients received BLINCYTO at a constant dose of 15 mcg/m²/day (equivalent to the recommended dosage of 28 mcg/day) for all treatment cycles. Patients received up to 4 cycles of treatment. Dose adjustment was possible in case of adverse reactions. The treated population included 116 patients who received at least one infusion of BLINCYTO; the mean number of completed treatment cycles was 1.8 (range: 1 to 4).

The primary endpoint was the proportion of patients who achieved a complete MRD response within one cycle of BLINCYTO treatment. Eighty-eight out of 113 (77.9%) evaluable patients achieved a complete MRD response after one cycle of treatment; see table 13. Two subjects achieved a complete MRD response with 1 additional cycle of BLINCYTO. MRD response rates by age and MRD level at baseline subgroups were consistent with the results in the overall population. RFS in patients with Philadelphia chromosome-negative B-cell precursor ALL at 18 months censored at HSCT or post-BLINCYTO chemotherapy was 54% (33%, 70%). RFS at 18 months not censored at HSCT or post-BLINCYTO chemotherapy was 53% (44%, 62%).

Table 13. Efficacy results in patients ≥ 18 years of age with MRD positive B-cell precursor ALL (BLAST)

Complete MRD response ^a , n/N (%), [95% CI]	88/113 ^b (77.9) [69.1-85.1]
≥ 65 years old	12/15 (80.0) [51.9-95.7]
Patients in 1 st CR	60/73 (82.2) [71.5-90.2]
Patients in 2 nd CR	27/38 (71.1) [54.1-84.6]
Patients in 3 rd CR	1/2 (50.0) [1.3-98.7]
Duration of complete MRD response [95% CI]	17.3 months [12.6-23.3]

^a Complete MRD response was defined as the absence of detectable MRD confirmed in an assay with minimum sensitivity of 10^{-4} .

^b One hundred thirteen patients (97.4%; 113/116) were included in the primary endpoint full analysis set.

B-cell precursor ALL in the consolidation phase

The efficacy of BLINCYTO in consolidation phase treatment of B-cell precursor ALL in adult and paediatric patients was evaluated in study E1910 and study 20120215. The efficacy results from Study E1910 are described below and the paediatric and young adult studies are described in section paediatric population.

In study E1910 (20129152), the safety and efficacy of BLINCYTO were evaluated in a Phase III, randomised, controlled study in adult patients with newly diagnosed Philadelphia chromosome negative B-cell precursor ALL. Eligible patients received induction chemotherapy. After induction, patients in haematologic complete remission (CR) or CR with incomplete peripheral blood count recovery (CRi) continued on study and received intensification chemotherapy. After intensification therapy, 286 patients were randomised or assigned to receive BLINCYTO alternating with

consolidation chemotherapy (n = 152) or standard of care (SOC) consolidation chemotherapy alone (n = 134). The chemotherapy regimens used in Study E1910 were based on the UKALL12/ECOG2993 protocol. Each arm received maintenance therapy at a total treatment duration of 2.5 years after the start of intensification. Randomisation was stratified by MRD status (MRD negativity defined as $< 1 \times 10^{-4}$), age (< 55 years versus ≥ 55 years), CD20 status, rituximab use, and intent to receive allogeneic stem cell transplant (SCT).

Study treatment in the BLINCYTO arm consisted of 4 cycles of blinatumomab and 4 cycles of chemotherapy in the following sequence. It included 2 cycles of BLINCYTO (each cycle consisted of 28 mcg/day BLINCYTO administered as continuous intravenous infusion for 28 days, with a 14-day treatment-free interval between cycles), followed by 3 cycles of consolidation chemotherapy, a third cycle of BLINCYTO followed by an additional cycle of consolidation chemotherapy, and then a fourth cycle of BLINCYTO. In a posthoc analysis in subjects who did not receive HSCT, numerically greater OS was observed in patients who received 4 cycles vs 1-2 cycles of BLINCYTO in frontline consolidation. Patients received an average of 3.04 cycles of BLINCYTO. If a patient proceeded to allogeneic SCT, it was strongly encouraged that patients randomized to blinatumomab receive both cycles of blinatumomab therapy before proceeding to allogeneic SCT. The SOC arm of the study consisted of 4 cycles of consolidation chemotherapy. Patients in each arm received the same number of cycles and doses of consolidation chemotherapy. Patients who were randomised to the SOC arm could proceed directly to allogeneic SCT or to consolidation chemotherapy.

Baseline demographics and characteristics were similar between the treatment arms. Demographics and characteristics information is provided in table 14.

Table 14. Demographics and characteristics (E1910)

Characteristic	BLINCYTO arm (N = 152)		SOC arm ^a (N = 134)	
	MRD Positive (N = 40)	MRD Negative (N = 112)	MRD Positive (N = 22)	MRD Negative (N = 112)
Age				
Mean, years (min, max)	49.6 (30, 69)		50.2 (30, 70)	
Males, n (%)	69 (45.4)		70 (52.2)	
Race, n (%)				
American Indian or Alaska Native	2 (1.3)		1 (0.7)	
Asian	4 (2.6)		2 (1.5)	
Black (or African American)	12 (7.9)		5 (3.7)	
Hispanic (or Latino)	21 (13.8)		15 (11.2)	
Native Hawaiian or Other Pacific Islander	1 (0.7)		0 (0.0)	
White	117 (77.0)		110 (82.1)	
Received allogeneic SCT ^b , n (%)	37 (24.3)		28 (20.9)	
Mean number of BLINCYTO cycles in patients who received allogeneic SCT ^b , n (cycles)	15 (1.93)	22 (1.95)		
Mean number of BLINCYTO cycles in patients who did not receive allogeneic SCT ^b , n (cycles)	21 (2.90)	89 (3.30)		

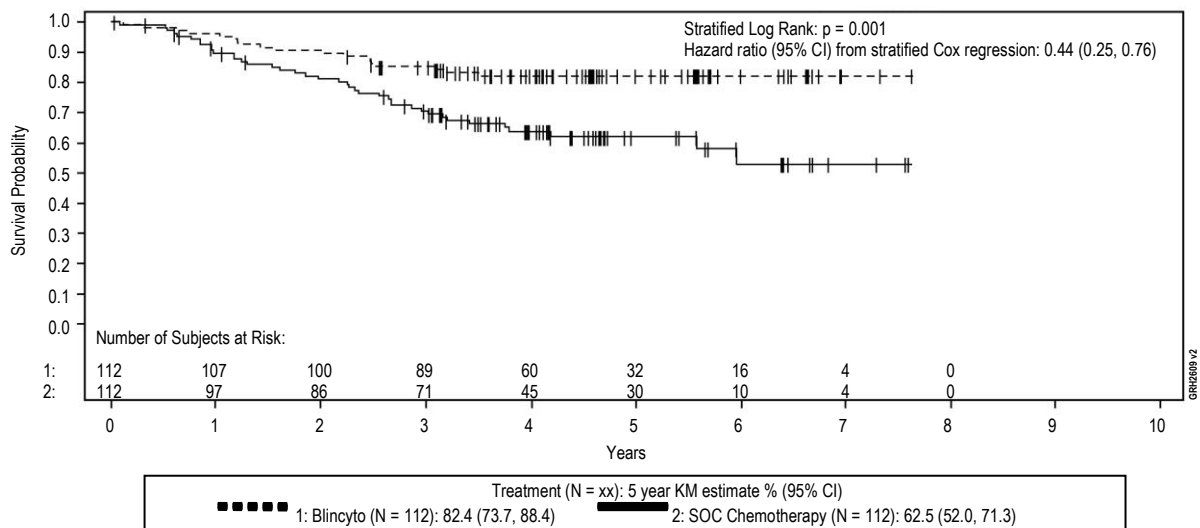
^a SOC = Standard of care.

^b allogeneic SCT = allogeneic stem cell transplantation.

The primary endpoint was overall survival (OS) in patients who were MRD-negative. Secondary endpoints included relapse-free survival (RFS) in patients who were MRD-negative, OS and RFS in patients who were MRD-positive.

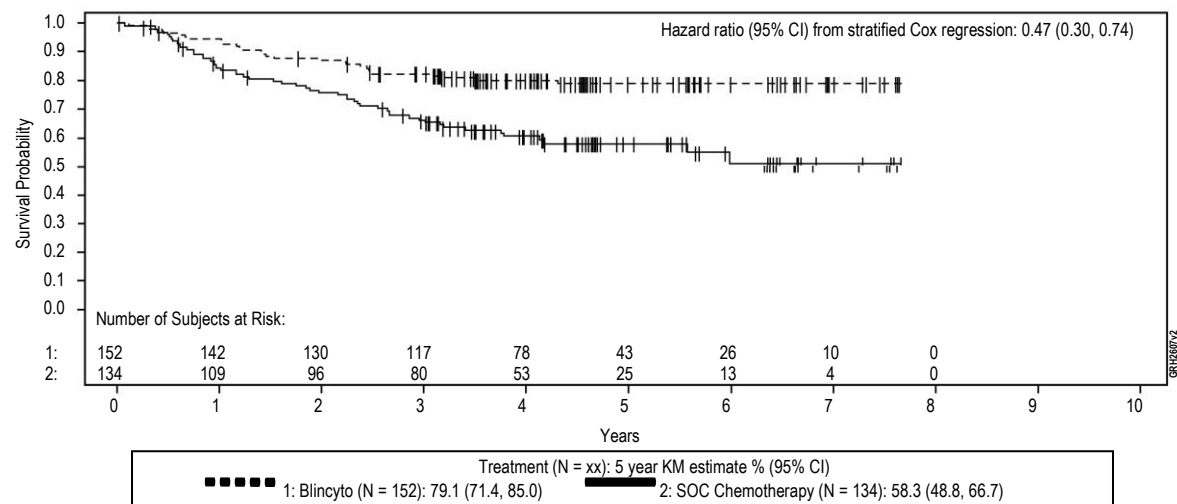
The study demonstrated improvement in OS and RFS. The stratified hazard ratios and Kaplan-Meier estimates for OS and RFS in patients who were MRD-negative, MRD-positive, and all patients combined regardless of MRD status are provided in table 15. The Kaplan Meier plot for OS in patients who were MRD negative is provided in figure 3. The Kaplan Meier plot for OS in all patients combined regardless of MRD status is provided in figure 4.

Figure 3. Kaplan-Meier for overall survival in patients who were MRD negative at randomisation (prior to start of consolidation) (E1910)



SOC = Standard of Care, KM = Kaplan-Meier, CI = Confidence Interval, N = Number of patients in the analysis set, Censor indicated by vertical bar.

Figure 4. Kaplan-Meier for overall survival combining patients who were MRD-positive and MRD-negative at randomisation (prior to start of consolidation) (E1910)



SOC = Standard of Care, KM = Kaplan-Meier, CI = Confidence Interval, N = Number of patients in the analysis set, Censor indicated by vertical bar.

Table 15. Overall survival and relapse-free survival in MRD-negative and MRD-positive patients (E1910)

	BLINCYTO Arm	SOC Arm
MRD-Negative		
Number of patients	112	112
Median follow-up time (years) ^{a, b}	4.5	4.5
Overall Survival		
5-year Kaplan-Meier estimate (%) [95% CI]	82.4 [73.7, 88.4]	62.5 [52.0, 71.3]
Hazard ratio [95% CI] ^c	0.44 [0.25, 0.76]	
p-value	0.003	
Relapse-free Survival		
5-year Kaplan-Meier estimate (%) [95% CI]	77.0 [67.8, 83.8]	60.5 [50.1, 69.4]
Hazard ratio [95% CI] ^d	0.53 [0.32, 0.88]	
MRD-Positive		
Number of patients	40	22
Median follow-up time (years) ^{e, b}	4.6	5.0
Overall Survival		
5-year Kaplan-Meier estimate (%) [95% CI]	70.1 [52.0, 82.5]	37.8 [17.8, 57.7]
Hazard ratio [95% CI] ^f	0.40 [0.14, 1.12]	
Relapse-free Survival		
5-year Kaplan-Meier estimate (%) [95% CI]	71.8 [54.8, 83.3]	39.4 [19.3, 59.0]
Hazard ratio (95% CI) ^g	0.37 [0.13, 1.03]	
Combined MRD-Negative and MRD-Positive		
Number of patients	152	134
Median follow-up time (years) ^{a, b, c}	4.5	4.5
Overall Survival		
5-year Kaplan-Meier estimate (%) [95% CI]	79.1 [71.4, 85.0]	58.3 [48.8, 66.7]
Hazard ratio [95% CI] ^f	0.47 [0.30, 0.74]	
Relapse-free Survival		
5-year Kaplan-Meier estimate (%) [95% CI]	75.6 [67.8, 81.8]	57.2 [47.9, 65.4]
Hazard ratio (95% CI) ^g	0.53 [0.35, 0.81]	

Full analysis set includes all randomised or assigned patients who are assessed as MRD-negative or MRD-positive centrally after induction and intensification chemotherapy. CI = Confidence interval. Relapse-free survival (RFS) is calculated from time of randomisation or registration until relapse or death due to any cause. Overall survival (OS) is calculated from time of randomisation or registration until death due to any cause. MRD-positive defined as MRD value $\geq 1 \times 10^{-4}$ and MRD-negative defined as MRD value $< 1 \times 10^{-4}$.

^a Years are calculated as days from randomisation date to event/censor date, divided by 365.25.

^b Time to censoring measures follow-up time calculated by reversing the status indicator for censored and events.

^c The hazard ratio estimates are obtained from a stratified Cox regression model. A hazard ratio < 1.0 indicates a lower average death rate and a longer survival for patients in the BLINCYTO arm relative to patients in the SOC arm.

^d The hazard ratio estimates are obtained from a stratified Cox regression model. A hazard ratio < 1.0 indicates a lower average event rate and a longer relapse-free survival for patients in the BLINCYTO arm relative to patients in the SOC arm.

^e Years are calculated as days from randomisation or registration date to event/censor date, divided by 365.25.

^f The hazard ratio estimates are obtained from a stratified Cox proportional hazards model. A hazard ratio < 1.0 indicates a lower average death rate and a longer survival for patients in the BLINCYTO arm relative to patients in the SOC arm.

^g The hazard ratio estimates are obtained from a stratified Cox proportional hazards model. A hazard ratio < 1.0 indicates a lower average event rate and a longer relapse-free survival for patients in the BLINCYTO arm relative to patients in the SOC arm.

Paediatric population

The safety and effectiveness of BLINCYTO have been established in paediatric patients with Philadelphia chromosome negative relapsed or refractory B-cell precursor ALL in two open label studies: a single-arm Phase I/II study (MT103-205) and a randomised, controlled Phase III study (20120215).

The safety and efficacy of BLINCYTO compared to standard of care (SOC) consolidation chemotherapy were evaluated in a randomised, controlled, open-label, multicentre study (20120215). Eligible patients were between 28 days and 18 years of age with high-risk first relapsed Philadelphia chromosome-negative B-cell precursor ALL and had < 25% blasts in the bone marrow. High-risk patients were defined as per IntReALL criteria. Patients with clinically relevant CNS pathology requiring treatment (e.g. unstable epilepsy) or evidence of current CNS involvement by ALL were excluded from the study. Patients were enrolled and randomised after induction and 2 blocks of consolidation chemotherapy.

Patients were randomised 1:1 to receive BLINCYTO or a third block of SOC consolidation chemotherapy (High-risk consolidation 3, HC3). Patients in the BLINCYTO arm received one cycle of BLINCYTO as a continuous intravenous infusion at 15 mcg/m²/day over 4 weeks (maximum daily dose was not to exceed 28 mcg/day). Dose adjustment was possible in case of adverse reactions. Randomisation was stratified by age (< 1 year, 1 to 9 years, and > 9 years), bone marrow status determined at the end of the second block of consolidation chemotherapy and MRD status determined at the end of induction (blasts < 5% with MRD level < 10⁻³, blasts < 5% with MRD level ≥ 10⁻³, and blasts ≥ 5% and < 25%). The demographics and baseline characteristics were well-balanced between the two arms (see table 16). No subject had prior HSCT.

Table 16. Demographics and baseline characteristics in study 20120215

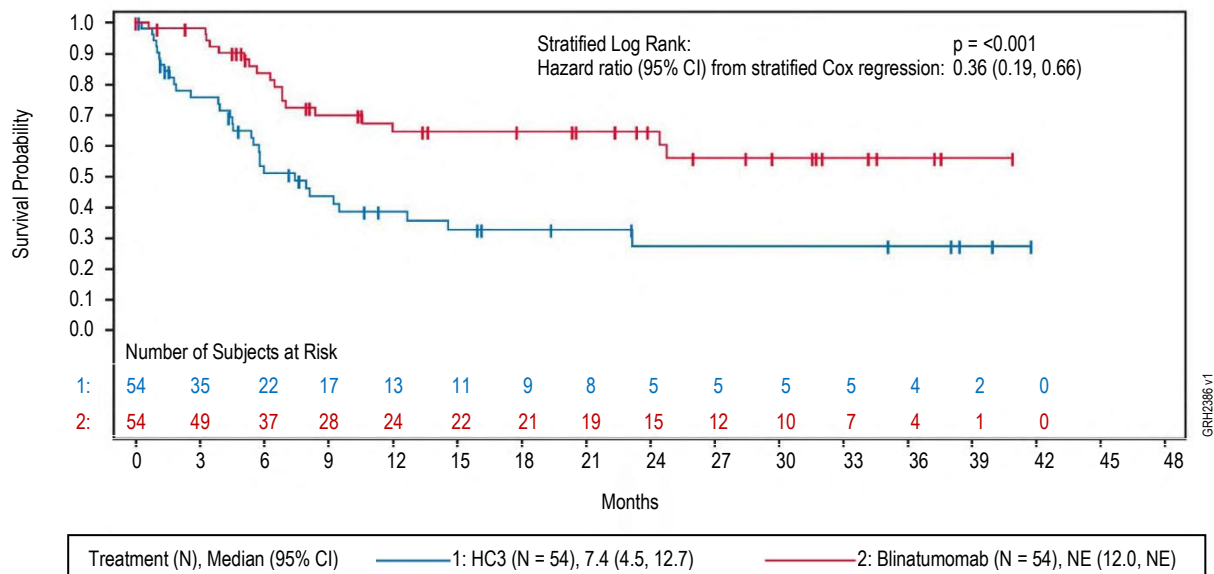
Characteristics	BLINCYTO (N = 54)	SOC Chemotherapy (N = 54)
Age, n (%)		
< 1 year	0 (0.0)	0 (0.0)
1 to 9 years	39 (72.2)	38 (70.4)
≥ 10 to 18 years	15 (27.8)	16 (29.6)
Males, n (%)	30 (55.6)	22 (40.7)
Race, n (%)		
American Indian or Alaska Native	0 (0.0)	0 (0.0)
Asian	1 (1.9)	3 (5.6)
Black (or African American)	0 (0.0)	3 (5.6)
Native Hawaiian or Other Pacific Islander	0 (0.0)	0 (0.0)
Other	3 (5.6)	5 (9.3)
White	50 (92.6)	43 (79.6)
Occurrence and type of any genetic abnormality, n (%)		
No	34 (63.0)	29 (53.7)
Yes	20 (37.0)	25 (46.3)
Hyperdiploidy	6 (11.1)	6 (11.1)
Hypodiploidy	1 (1.9)	0 (0.0)
t(v;11q23)/MLL rearranged	0 (0.0)	4 (7.4)
t(12;21)(p13;q22)/TEL-AML1	2 (3.7)	3 (5.6)
t(1;19)(q23;p13.3)/E2A-PBX1	2 (3.7)	2 (3.7)
t(5;14)(q31;32)/IL3-IGH	0 (0.0)	0 (0.0)
Other	9 (16.7)	10 (18.5)

Characteristics	BLINCYTO (N = 54)	SOC Chemotherapy (N = 54)
Extramedullary disease at relapse, n (%)		
No	44 (81.5)	40 (74.1)
Yes	10 (18.5)	14 (25.9)
Cytomorphology, n (%)		
Blasts < 5%	54 (100.0)	51 (94.4)
Blasts ≥ 5% and < 25%	0 (0.0)	2 (3.7)
Blasts ≥ 25%	0 (0.0)	0 (0.0)
Not evaluable	0 (0.0)	1 (1.9)
MRD PCR value, n (%)		
≥ 10 ⁻⁴	10 (18.5)	13 (24.1)
< 10 ⁻⁴	20 (37.0)	22 (40.7)
Time from first diagnosis to relapse (month), n (%)		
< 18 months	19 (35.2)	22 (40.7)
≥ 18 months and ≤ 30 months	32 (59.3)	28 (51.9)
> 30 months	3 (5.6)	4 (7.4)

N = number of patients in the analysis set; n = number of patients with observed data; MRD = minimal residual disease; PCR = polymerase chain reaction.

The primary endpoint was event-free survival (EFS). The study demonstrated statistically significant improvement in EFS for patients treated with BLINCYTO as compared to SOC consolidation chemotherapy. Treatment effects in subgroups (e.g. age, tumour burden/MRD status, time from first diagnosis to relapse) were in general consistent with the results in the overall population. See figure 5 and table 17 for primary analysis efficacy results from study 20120215.

Figure 5. Kaplan-Meier curve of event-free survival



CI = confidence interval, HC3 = High-risk consolidation 3, N = number of patients in the analysis set, NE = not evaluable.

Table 17. Efficacy results in paediatric patients with high-risk first relapsed B-cell precursor ALL (20120215)

	BLINCYTO (N = 54)	SOC Chemotherapy (N = 54)
Event-free survival ^a		
Events (%)	18 (33.3)	31 (57.4)
Median, months [95% CI]	NE ^b [12.0, NE ^b]	7.4 [4.5, 12.7]
Hazard ratio [95% CI] ^c	0.36 [0.19, 0.66]	
p-value ^d	< 0.001	
Overall survival		
Number of deaths (%)	8 (14.8)	16 (29.6)
36-month estimate (%) [95% CI]	81.1 [65.5, 90.2]	55.8 [36.9, 71.0]
Hazard ratio [95% CI] ^{c,d}	0.43 [0.18, 1.01]	
p-value ^{e,f}	0.047	
MRD response ^g		
Number of MRD response, n1/n2 ^h (%)	44/49 (89.8)	26/48 (54.2)
[95% CI]	[77.8, 96.6]	[39.2, 68.6]
p-value ^{f,i}	< 0.001	

Note: Efficacy results from primary analysis (data cut-off of 17 July 2019).

^a EFS time was calculated from the time of randomisation until the date of relapse or tumour burden of $\geq 5\%$ and $< 25\%$ blasts after having achieved a complete remission (CR), failure to achieve a CR at the end of treatment, secondary malignancy, or death due to any cause, whichever occurs first.

^b NE = not estimable.

^c Based on stratified Cox's model.

^d The updated hazard ratio for OS (data cut-off of 14 September 2020) was 0.33 (95% CI: 0.15 to 0.72).

^e The p-value was derived using a stratified log-rank test.

^f Endpoint not formally tested. The p-value was not adjusted for multiplicity.

^g MRD (minimum residual disease) response was defined as MRD by PCR $< 1 \times 10^{-4}$.

^h n1: number of patients who achieved a MRD response after having a baseline MRD $\geq 10^{-4}$ or $< 10^{-4}$;

n2: number of patients assessed.

ⁱ The p-value was derived using Cochran Mantel Haenszel test.

The overall median follow-up time for EFS was 51.9 months (95% CI: 47.2, 62.1). In patients who received the SOC consolidation chemotherapy (HC3), the 5-year Kaplan-Meier estimate of EFS, was 27.6% (95% CI: 16.2, 40.3) compared to 57.8% (95% CI: 42.5, 70.4) in patients who received BLINCYTO and the hazard ratio (95% CI) was 0.35 (0.20, 0.61).

The median follow-up time for OS was 55.2 months for the overall population and was similar between treatment arms. The 5-year Kaplan-Meier estimate of OS was 41.4% (95% CI: 26.3 to 55.9) in the chemotherapy (HC3) arm and 78.4% (95% CI: 64.2 to 87.4) in the BLINCYTO arm and the hazard ratio (95% CI) was 0.33 (0.16, 0.66). The median time to transplant was 1.7 months (range: 1 to 4 months) in the HC3 arm and 1.9 months (range: 1 to 3 months) in the BLINCYTO arm.

A numerically higher incidence of postbaseline alloHSCT was reported in the BLINCYTO arm compared with the HC3 arm; 82.5% of subjects (47 of 57) in the HC3 arm and 94.4% of subjects (51 of 54) in the BLINCYTO arm. In the HC3 arm, 39 of 57 subjects (68.4%) received a transplant while in complete remission, whereas 51 of 54 subjects (94.4%) in the BLINCYTO arm received a transplant while in complete remission.

At time of 100 days post-transplant, the mortality rates reached 3.9% (95% CI: 1.0 to 14.8) in the BLINCYTO arm and 5.1% (95% CI: 1.3 to 19.0) in the chemotherapy (HC3) arm. The Kaplan-Meier median time to death was 1558.0 days in the HC3 arm (95% CI: 431.0 days to NE) and not reached in the blinatumomab arm (95% CI: NE, NE).

The safety and efficacy of BLINCYTO were also evaluated in an open-label, multicentre, single-arm study in 93 paediatric patients with relapsed or refractory B-cell precursor ALL (second or later bone

marrow relapse, in any marrow relapse after allogeneic HSCT, or refractory to other treatments, and also with > 25% blasts in bone marrow) (MT103-205). This was a two-part study, a dose-finding part to determine the appropriate dosing regimen, followed by a single-arm efficacy part using this regimen.

BLINCYTO was administered as a continuous intravenous infusion. In the dose-finding part of the study, doses of up to 30 mcg/m²/day were evaluated. The recommended dose for the pharmacokinetics (PK) expansion and efficacy parts of the study was determined to be 5 mcg/m²/day on days 1-7 and 15 mcg/m²/day on days 8-28 for cycle 1, and 15 mcg/m²/day on days 1-28 for subsequent cycles. Dose adjustment was possible in case of adverse reactions. Patients who responded to BLINCYTO but later relapsed had the option to be retreated with BLINCYTO.

The treated population (in the dose-finding, PK expansion, and efficacy parts) included 70 patients who received at least 1 infusion of BLINCYTO at the recommended dose; the mean number of treatment cycles was 1.5. Among treated patients, the median age was 8 years (range: 7 months to 17 years), 40 out of 70 (57.1%) had undergone allogeneic HSCT prior to receiving BLINCYTO, and 39 out of 70 (55.7%) had refractory disease. Most patients had a high tumour burden (\geq 50% leukaemic blasts in bone marrow) at baseline with a median of 75.5% bone marrow blasts.

Twenty out of 70 (28.6%) patients achieved CR/CRh* within the first 2 treatment cycles with 17 out of 20 (85%) occurring within cycle 1 of treatment. Four patients achieved M1 bone marrow but did not meet the peripheral blood count recovery criteria for CR or CRh*. Eleven of the 20 patients (55%) who achieved CR/CRh* received an allogeneic HSCT. The CR/CRh* for patients less than 2 years of age was 40.0% (4/10), for patients 2 to 6 years was 30.0% (6/20); and for patients aged 7 to 17 years was 25.0% (10/40). Three patients < 1 year of age refractory to prior treatment and without prior alloHSCT received one cycle of BLINCYTO at a dose of 5-15 mcg/m²/day. None of the 3 subjects < 1 year old achieved a CR/CRh*, 1 patient had progressive disease (OS 2.3 months) and 2 were non-responders (OS 1.1 months and 8.7 months, respectively). The type of adverse reactions observed in infants were similar to those observed in the overall paediatric population. See table 18 for the efficacy results.

Table 18. Efficacy results in patients < 18 years of age with relapsed or refractory B-cell precursor ALL (MT103-205)

	N = 70
CR ^a /CRh ^{*b} , n (%) [95% CI]	20 (28.6%) [18.4% – 40.6%]
CR, n (%) [95% CI]	11 (15.7%) [8.1% – 26.4%]
CRh [*] , n (%) [95% CI]	9 (12.9%) [6.1% – 23.0%]
Complete MRD response for CR/CRh ^{*c} , n1/n2 ^d (%) [95% CI]	11/20 (55.0%) [31.5 – 76.9]
CR, n1/n2 ^d (%) [95% CI]	6/11 (54.5%) [23.4 – 83.3]
CRh [*] , n1/n2 ^d (%) [95% CI]	5/9 (55.6%) [21.2 – 86.3]
Median relapse ^e -free survival (RFS) ^e for CR/CRh [*] [95% CI]	6.8 months [2.2 to 12.0 months]
Median overall survival [95% CI]	7.5 months [4.0 to 11.8 months]
100-day mortality after alloHSCT ^f	
n/N (%), [95% CI]	1/6 (16.7%) [2.5% – 72.7%]

^a CR was defined as M1 marrow (\leq 5% of blasts in the bone marrow), no evidence of circulating blasts or extramedullary disease, and full recovery of peripheral blood counts (platelets > 100 000/microlitre and absolute neutrophil counts [ANC] > 1 000/microlitre) and no relapse within 28 days.

^b CRh* was defined as M1 marrow (\leq 5% of blasts in the bone marrow), no evidence of circulating blasts or extramedullary disease, and partial recovery of peripheral blood counts (platelets > 50 000/microlitre and ANC > 500/microlitre) and no relapse within 28 days.

^c Complete MRD response. No detectable signal for leukaemic cells either by PCR or flow cytometry.

^d n1: number of patients who achieved MRD response and the respective remission status; n2: number of patients who achieved the respective remission status. One CR /CRh* responder with missing MRD data was considered as a MRD-nonresponder.

^e Relapse was defined as haematological relapse (blasts in bone marrow greater than 25% following CR) or an extramedullary relapse.

^f Only patients with HSCT in CR/CRh* remission (with no anti-leukaemia agents used prior to HSCT) are included.

5.2 Pharmacokinetic properties

The pharmacokinetics of blinatumomab appear linear over a dose range from 5 to 90 mcg/m²/day (approximately equivalent to 9-162 mcg/day) in adult patients. Following continuous intravenous infusion, the steady state serum concentration (C_{ss}) was achieved within a day and remained stable over time. The increase in mean C_{ss} values was approximately proportional to the dose in the range tested. At the clinical doses of 9 mcg/day and 28 mcg/day for the treatment of relapsed or refractory ALL, the mean (SD) C_{ss} was 228 (356) pg/mL and 616 (537) pg/mL, respectively. The pharmacokinetics of blinatumomab in patients with MRD positive B-cell precursor ALL were similar to patients with relapsed or refractory ALL. The pharmacokinetics of blinatumomab in the consolidation phase in adults with B-cell precursor ALL, including patients with newly diagnosed ALL and first relapsed ALL, were similar to adult patients with relapsed or refractory ALL.

Distribution

The estimated mean (SD) volume of distribution based on terminal phase (V_z) was 5.27 (4.37) L with the continuous intravenous infusion of blinatumomab.

Biotransformation

The metabolic pathway of blinatumomab has not been characterised. Like other protein therapeutics, blinatumomab is expected to be degraded into small peptides and amino acids via catabolic pathways.

Elimination

The estimated mean (SD) systemic clearance with continuous intravenous infusion in patients receiving blinatumomab in clinical studies was 3.10 (2.94) L/hour. The mean (SD) half-life was 2.20 (1.34) hours. Negligible amounts of blinatumomab were excreted in the urine at the tested clinical doses.

Specific Populations

No clinically meaningful differences in the pharmacokinetics of blinatumomab were observed based on age, sex, race, ethnicity, Philadelphia chromosome status, or mild (total bilirubin \leq upper limit of normal [ULN] and AST $>$ ULN or total bilirubin $>$ 1 to $1.5 \times$ ULN and any AST) or moderate hepatic impairment (total bilirubin $>$ 1.5 to $3 \times$ ULN and any AST). Body surface area (0.4 to 2.9 m²) influences the pharmacokinetics of blinatumomab, supporting BSA-based dosing in patients $<$ 45 kg.

Renal impairment

No formal pharmacokinetic studies of blinatumomab have been conducted in patients with renal impairment.

Pharmacokinetic analyses showed an approximately 2-fold difference in mean blinatumomab clearance values between patients with moderate renal dysfunction and normal renal function. However since high inter-patient variability was discerned (CV% up to 98.4%), and clearance values in renal impaired patients were essentially within the range observed in patients with normal renal function, no clinically meaningful impact of renal function on clinical outcomes is expected. The effect of severe renal impairment on the pharmacokinetics of blinatumomab has not been studied.

Hepatic impairment

No formal pharmacokinetic studies using blinatumomab have been conducted in patients with hepatic impairment. The effect of hepatic impairment on the clearance of blinatumomab was evaluated by

population pharmacokinetic analysis in patients with mild and moderate hepatic dysfunction compared to normal hepatic function using the criteria defined by the National Cancer Institute Organ Dysfunction Working Group. No clinically meaningful differences in the clearance of blinatumomab were observed between patients with mild and moderate hepatic dysfunction and patients with normal function. The effect of severe hepatic impairment on the pharmacokinetics of blinatumomab has not been studied.

Paediatric population

The pharmacokinetics of blinatumomab appear linear over a dose range from 5 to 30 mcg/m²/day in paediatric patients. At the recommended doses of 5 and 15 mcg/m²/day for the treatment of relapsed or refractory B-cell precursor ALL, the mean (SD) steady state concentration (C_{ss}) values were 162 (179) and 533 (392) pg/mL, respectively. The estimated mean (SD) volume of distribution (V_z), clearance (CL) and terminal half-life (t_{1/2,z}) were 4.14 (3.32) L/m², 1.65 (1.62) L/hr/m² and 2.14 (1.44) hours, respectively.

The pharmacokinetics of blinatumomab in the consolidation phase in paediatric patients with B-cell precursor ALL, including patients with first relapsed B-cell precursor ALL, were similar to paediatric patients with relapsed or refractory B-cell precursor ALL.

5.3 Preclinical safety data

Repeat-dose toxicity studies conducted with blinatumomab and the murine surrogate revealed the expected pharmacologic effects (including release of cytokines, decreases in leukocyte counts, depletion of B-cells, decreases in T-cells, decreased cellularity in lymphoid tissues). These changes reversed after cessation of treatment.

Reproductive toxicity studies have not been conducted with blinatumomab. In an embryo-foetal developmental toxicity study performed in mice, the murine surrogate crossed the placenta to a limited extent (foetal-to-maternal serum concentration ratio < 1%) and did not induce embryo-foetal toxicity or teratogenicity. The expected depletions of B- and T-cells were observed in the pregnant mice but haematological effects were not assessed in foetuses. No studies have been conducted to evaluate treatment-related effects on fertility. There were no effects on male or female reproductive organs in toxicity studies with the murine surrogate.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Powder

Citric acid monohydrate (E330)
Trehalose dihydrate
Lysine hydrochloride
Polysorbate 80 (E433)
Sodium hydroxide (for pH-adjustment)

Solution (stabiliser)

Citric acid monohydrate (E330)
Lysine hydrochloride
Polysorbate 80 (E433)
Sodium hydroxide (for pH-adjustment)
Water for injections

6.2 Incompatibilities

This medicinal product must not be mixed with other medicinal products except those mentioned in section 6.6.

6.3 Shelf life

Unopened vials

5 years

Reconstituted solution

Chemical and physical in-use stability has been demonstrated for 24 hours at 2°C - 8°C or 4 hours at or below 27°C.

From a microbiological point of view, unless the method of reconstituting precludes the risks of microbial contamination, the reconstituted solution should be diluted immediately. If not diluted immediately, in-use storage times and conditions are the responsibility of the user.

Diluted solution (prepared infusion bag)

Chemical and physical in-use stability has been demonstrated for 10 days at 2°C - 8°C or 96 hours at or below 27°C.

From a microbiological point of view, the prepared infusion bags should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2°C - 8°C, unless dilution has taken place in controlled and validated aseptic conditions.

6.4 Special precautions for storage

Store and transport refrigerated (2°C - 8°C).

Do not freeze.

Store the vials in the original package in order to protect from light.

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

6.5 Nature and contents of container

Each BLINCYTO pack contains 1 vial of powder for concentrate for solution for infusion and 1 vial of solution (stabiliser):

- 38.5 micrograms blinatumomab powder in a vial (type I glass) with a stopper (elastomeric rubber), seal (aluminium) and a flip off cap, and
- 10 mL solution in a vial (type I glass) with a stopper (elastomeric rubber), seal (aluminium) and a flip off cap.

6.6 Special precautions for disposal and other handling

Aseptic preparation

Aseptic handling must be ensured when preparing the infusion. Preparation of BLINCYTO should be:

- performed under aseptic conditions by trained personnel in accordance with good practice rules especially with respect to the aseptic preparation of parenteral products.
- prepared in a laminar flow hood or biological safety cabinet using standard precautions for the safe handling of intravenous agents.

It is very important that the instructions for preparation and administration provided in this section are strictly followed to minimise medication errors (including underdose and overdose).

Other instructions

- BLINCYTO is compatible with polyolefin, PVC non-di-ethylhexylphthalate (non-DEHP), or ethyl vinyl acetate (EVA) infusion bags/pump cassettes.
- At the end of infusion, any unused medicinal product or waste material should be disposed of in accordance with local requirements.

Preparation of the solution for infusion

These supplies are also required, but **not** included in the package:

- Sterile single-use disposable syringes
- 21-23 gauge needle(s) (recommended)
- Water for injections
- Infusion bag with 250 mL sodium chloride 9 mg/mL (0.9%) solution for injection;
 - To minimise the number of aseptic transfers, use a 250 mL pre-filled infusion bag.
BLINCYTO dose calculations are based on a usual overfill volume of 265 to 275 mL sodium chloride 9 mg/mL (0.9%) solution for injection.
 - Use only polyolefin, PVC non-di-ethylhexylphthalate (non-DEHP), or ethyl vinyl acetate (EVA) infusion bags/pump cassettes.
- Polyolefin, PVC non-DEHP, or EVA intravenous tubing with a sterile, non-pyrogenic, low protein-binding 0.2 micrometre in-line filter.
 - Ensure that the tubing is compatible with the infusion pump.

Reconstitute BLINCYTO with water for injections. Do not reconstitute BLINCYTO vials with the solution (stabiliser).

To prime the intravenous tubing, use only the solution in the bag containing the FINAL prepared BLINCYTO solution for infusion. Do not prime with sodium chloride 9 mg/mL (0.9%) solution for injection.

Reconstitution of BLINCYTO

1. Determine the number of BLINCYTO vials needed for a dose and infusion duration.
2. Using a syringe, reconstitute each vial of BLINCYTO powder for concentrate using 3 mL of water for injections. Direct the water along the walls of the BLINCYTO vial and not directly on the lyophilised powder.
 - **Do not reconstitute BLINCYTO powder for concentrate with the solution (stabiliser).**
 - The addition of water for injections to the powder for concentrate results in a total volume of 3.08 mL for a final BLINCYTO concentration of 12.5 mcg/mL.
3. Gently swirl contents to avoid excess foaming.
 - **Do not shake.**
4. Visually inspect the reconstituted solution for particulate matter and discolouration during reconstitution and prior to infusion. The resulting solution should be clear to slightly opalescent, colourless-to-slightly yellow.
 - **Do not use if the solution is cloudy or has precipitated.**

Preparation of BLINCYTO infusion bag

Verify the prescribed dose and infusion duration for each BLINCYTO infusion bag. To minimise errors, **use the specific volumes described in tables 19 and 20 to prepare the BLINCYTO infusion bag.**

- Table 19 for patients weighing greater than or equal to 45 kg
 - Table 20 for patients weighing less than 45 kg
1. Use an infusion bag pre-filled with 250 mL sodium chloride 9 mg/mL (0.9%) solution for injection that usually contains a total volume of 265 to 275 mL.
 2. To coat the infusion bag, using a syringe, aseptically transfer 5.5 mL of the solution (stabiliser) to the infusion bag. Gently mix the contents of the bag to avoid foaming. Discard the remaining solution (stabiliser).
 3. Using a syringe, aseptically transfer the required volume of reconstituted BLINCYTO solution into the infusion bag containing sodium chloride 9 mg/mL (0.9%) solution for injection and the solution (stabiliser). Gently mix the contents of the bag to avoid foaming.
 - Refer to table 19 for patients weighing greater than or equal to 45 kg for the specific volume of reconstituted BLINCYTO.
 - Refer to table 20 for patients weighing less than 45 kg (dose based on BSA) for the specific volume of reconstituted BLINCYTO.
 - Discard the vial containing any unused BLINCYTO reconstituted solution.
 4. Under aseptic conditions, attach the intravenous tubing to the infusion bag with the sterile 0.2 micron in-line filter. Ensure that the intravenous tubing is compatible with the infusion pump.
 5. Remove air from the infusion bag. This is particularly important for use with an ambulatory infusion pump.
 6. **Prime the intravenous infusion line only with the solution in the bag containing the FINAL prepared BLINCYTO solution for infusion.**
 7. Store refrigerated at 2°C - 8°C if not used immediately.

Table 19. For patients weighing greater than or equal to 45 kg: volumes of sodium chloride 9 mg/mL (0.9%) solution for injection, solution (stabiliser), and reconstituted BLINCYTO to add to infusion bag

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)			250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)			5.5 mL	
Infusion duration	Dose	Infusion rate	Reconstituted BLINCYTO	
			Volume	Vials
24 hours	9 mcg/day	10 mL/hour	0.83 mL	1
	28 mcg/day	10 mL/hour	2.6 mL	1
48 hours	9 mcg/day	5 mL/hour	1.7 mL	1
	28 mcg/day	5 mL/hour	5.2 mL	2
72 hours	9 mcg/day	3.3 mL/hour	2.5 mL	1
	28 mcg/day	3.3 mL/hour	8 mL	3
96 hours	9 mcg/day	2.5 mL/hour	3.3 mL	2
	28 mcg/day	2.5 mL/hour	10.7 mL	4

Table 20. For patients weighing less than 45 kg: volumes of sodium chloride 9 mg/mL (0.9%) solution for injection, solution (stabiliser), and reconstituted BLINCYTO to add to infusion bag

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)				250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)				5.5 mL	
Infusion duration	Dose	Infusion rate	BSA (m ²)*	Reconstituted BLINCYTO	
				Volume	Vials
24 hours	5 mcg/m ² /day	10 mL/hour	1.5 – 1.59	0.7 mL	1
			1.4 – 1.49	0.66 mL	1
			1.3 – 1.39	0.61 mL	1
			1.2 – 1.29	0.56 mL	1
			1.1 – 1.19	0.52 mL	1
			1 – 1.09	0.47 mL	1
			0.9 – 0.99	0.43 mL	1
			0.8 – 0.89	0.38 mL	1
			0.7 – 0.79	0.33 mL	1
			0.6 – 0.69	0.29 mL	1
			0.5 – 0.59	0.24 mL	1
			0.4 – 0.49	0.2 mL	1
24 hours	15 mcg/m ² /day	10 mL/hour	1.5 – 1.59	2.1 mL	1
			1.4 – 1.49	2 mL	1
			1.3 – 1.39	1.8 mL	1
			1.2 – 1.29	1.7 mL	1
			1.1 – 1.19	1.6 mL	1
			1 – 1.09	1.4 mL	1
			0.9 – 0.99	1.3 mL	1
			0.8 – 0.89	1.1 mL	1
			0.7 – 0.79	1 mL	1
			0.6 – 0.69	0.86 mL	1
			0.5 – 0.59	0.72 mL	1
			0.4 – 0.49	0.59 mL	1

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)				250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)				5.5 mL	
Infusion duration	Dose	Infusion rate	BSA (m ²)*	Reconstituted BLINCYTO	
				Volume	Vials
48 hours	5 mcg/m ² /day	5 mL/hour	1.5 – 1.59	1.4 mL	1
			1.4 – 1.49	1.3 mL	1
			1.3 – 1.39	1.2 mL	1
			1.2 – 1.29	1.1 mL	1
			1.1 – 1.19	1 mL	1
			1 – 1.09	0.94 mL	1
			0.9 – 0.99	0.85 mL	1
			0.8 – 0.89	0.76 mL	1
			0.7 – 0.79	0.67 mL	1
			0.6 – 0.69	0.57 mL	1
			0.5 – 0.59	0.48 mL	1
			0.4 – 0.49	0.39 mL	1
48 hours	15 mcg/m ² /day	5 mL/hour	1.5 – 1.59	4.2 mL	2
			1.4 – 1.49	3.9 mL	2
			1.3 – 1.39	3.7 mL	2
			1.2 – 1.29	3.4 mL	2
			1.1 – 1.19	3.1 mL	2
			1 – 1.09	2.8 mL	1
			0.9 – 0.99	2.6 mL	1
			0.8 – 0.89	2.3 mL	1
			0.7 – 0.79	2 mL	1
			0.6 – 0.69	1.7 mL	1
			0.5 – 0.59	1.4 mL	1
			0.4 – 0.49	1.2 mL	1

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)				250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)				5.5 mL	
Infusion duration	Dose	Infusion rate	BSA (m ²)*	Reconstituted BLINCYTO	
				Volume	Vials
72 hours	5 mcg/m ² /day	3.3 mL/hour	1.5 – 1.59	2.1 mL	1
			1.4 – 1.49	2 mL	1
			1.3 – 1.39	1.8 mL	1
			1.2 – 1.29	1.7 mL	1
			1.1 – 1.19	1.6 mL	1
			1 – 1.09	1.4 mL	1
			0.9 – 0.99	1.3 mL	1
			0.8 – 0.89	1.1 mL	1
			0.7 – 0.79	1 mL	1
			0.6 – 0.69	0.86 mL	1
			0.5 – 0.59	0.72 mL	1
			0.4 – 0.49	0.59 mL	1
72 hours	15 mcg/m ² /day	3.3 mL/hour	1.5 – 1.59	6.3 mL	3
			1.4 – 1.49	5.9 mL	3
			1.3 – 1.39	5.5 mL	2
			1.2 – 1.29	5.1 mL	2
			1.1 – 1.19	4.7 mL	2
			1 – 1.09	4.2 mL	2
			0.9 – 0.99	3.8 mL	2
			0.8 – 0.89	3.4 mL	2
			0.7 – 0.79	3 mL	2
			0.6 – 0.69	2.6 mL	1
			0.5 – 0.59	2.2 mL	1
			0.4 – 0.49	1.8 mL	1

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)				250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)				5.5 mL	
Infusion duration	Dose	Infusion rate	BSA (m ²)*	Reconstituted BLINCYTO	
				Volume	Vials
96 hours	5 mcg/m ² /day	2.5 mL/hour	1.5 – 1.59	2.8 mL	1
			1.4 – 1.49	2.6 mL	1
			1.3 – 1.39	2.4 mL	1
			1.2 – 1.29	2.3 mL	1
			1.1 – 1.19	2.1 mL	1
			1 – 1.09	1.9 mL	1
			0.9 – 0.99	1.7 mL	1
			0.8 – 0.89	1.5 mL	1
			0.7 – 0.79	1.3 mL	1
			0.6 – 0.69	1.2 mL	1
			0.5 – 0.59	0.97 mL	1
			0.4 – 0.49	0.78 mL	1
96 hours	15 mcg/m ² /day	2.5 mL/hour	1.5 – 1.59	8.4 mL	3
			1.4 – 1.49	7.9 mL	3
			1.3 – 1.39	7.3 mL	3
			1.2 – 1.29	6.8 mL	3
			1.1 – 1.19	6.2 mL	3
			1 – 1.09	5.7 mL	3
			0.9 – 0.99	5.1 mL	2
			0.8 – 0.89	4.6 mL	2
			0.7 – 0.79	4 mL	2
			0.6 – 0.69	3.4 mL	2
			0.5 – 0.59	2.9 mL	2
			0.4 – 0.49	2.3 mL	1

BSA = body surface area

*The safety of the administration of BLINCYTO for BSA of less than 0.4 m² has not been established.

7. MARKETING AUTHORISATION HOLDER

Amgen Europe B.V.
Minervum 7061
4817 ZK Breda
The Netherlands

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/15/1047/001

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 23 November 2015
Date of last renewal: 9 March 2023

10. DATE OF REVISION OF THE TEXT

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

ANNEX II

- A. MANUFACTURERS OF THE BIOLOGICAL ACTIVE
SUBSTANCE AND MANUFACTURERS RESPONSIBLE FOR
BATCH RELEASE**
- B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY
AND USE**
- C. OTHER CONDITIONS AND REQUIREMENTS OF THE
MARKETING AUTHORISATION**
- D. CONDITIONS OR RESTRICTIONS WITH REGARD TO
THE SAFE AND EFFECTIVE USE OF THE MEDICINAL
PRODUCT**

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

Name and address of the manufacturers of the biological active substance

Lonza Biologics plc
228 Bath Road
Slough
Berkshire, SL1 4DX
UK

Amgen Inc
One Amgen Center Drive
Thousand Oaks, CA 91320
USA

Name and address of the manufacturers responsible for batch release

Amgen Europe B.V.
Minervum 7061
4817 ZK Breda
The Netherlands

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.

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

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

• Risk management plan (RMP)

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

An updated RMP should be submitted:

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

• Additional risk minimisation measures

Prior to launch of BLINCYTO in each Member State, the Marketing Authorisation Holder (MAH) must agree about the content and format of the educational programme, including communication media, distribution modalities, and any other aspects of the programme, with the National Competent Authority.

The educational programme is aimed to inform about important risks associated with BLINCYTO, namely Immune effector cell associated neurotoxicity syndrome (ICANS).

The MAH shall ensure that, following discussions and agreement with the National Competent Authorities in each Member State where BLINCYTO is marketed:

- all nurses who are expected to take care of the patients treated with BLINCYTO will receive Nurse educational brochure described below.
- all patients/caregivers are provided with the:
- Patient/caregivers educational material
- Patient card

Key elements to be included

The nurse's educational material should be in a form of a brochure or as a web-based online interactive tool depending on discussions and agreement with the NCA and containing the following key elements:

- Description of ICE scoring system for grading ICANS, actions to be taken when ICANS symptoms occur,
- Description of CAPD scoring system for grading ICANS in paediatric population and actions to be taken when ICANS symptoms occur,
- Information on the importance of educating patients not to drive and to contact the treating physician/nurse in case of neurological symptoms

The patient (including caregivers) educational material should contain the following key elements:

- Description of the administration procedures of BLINCYTO
- Description of the main signs and/or symptoms of ICANS and the importance of notifying the treating physician or nurse immediately if symptoms occur
- Recommendation for patients not to drive while receiving BLINCYTO

The **patient card** should contain the following key elements:

- A warning message for HCPs treating the patient at any time, including emergency conditions, that the patient is using BLINCYTO
- A description of the key signs and symptoms of CRS and ICANS
- A description of when to seek urgent attention from the healthcare provider or to seek emergency help, should signs and symptoms of CRS or ICANS present themselves

- The prescribing physician's contact details
- **Obligation to conduct post-authorisation measures**

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

Description	Due date
Non-interventional post-authorisation safety study (PASS): Study 20150136: an observational study of blinatumomab safety and effectiveness, utilisation, and treatment practices*.	Q12025

* The study protocol needs to be developed and presented for PRAC review within 2 months after the EU Commission Decision.

Description	Due date
Non-interventional post-authorisation safety study (PASS): Study 20180130: an observational study to further characterise the long-term safety of BLINCYTO including developmental aspects, HSCT and secondary malignancy in paediatric patients with B-cell precursor ALL who have been treated with either blinatumomab or chemotherapy followed by transplantation*.	Q42038

* The study protocol needs to be developed and presented for PRAC review within 3 months after the EU Commission Decision.

ANNEX III
LABELLING AND PACKAGE LEAFLET

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING**CARTON****1. NAME OF THE MEDICINAL PRODUCT**

BLINCYTO 38.5 micrograms powder for concentrate and solution for solution for infusion
blinatumomab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

One vial of powder contains 38.5 micrograms of blinatumomab.
After reconstitution with water for injections each vial contains 12.5 micrograms/mL of
blinatumomab.

3. LIST OF EXCIPIENTS

Powder: citric acid monohydrate (E330), trehalose dihydrate, lysine hydrochloride, polysorbate 80 (E433) and sodium hydroxide.
Solution (stabiliser): citric acid monohydrate (E330), lysine hydrochloride, polysorbate 80 (E433), sodium hydroxide and water for injections.
See leaflet for further information.

4. PHARMACEUTICAL FORM AND CONTENTS

Powder for concentrate and solution for solution for infusion.
1 vial of powder.
1 vial of solution (stabiliser). Add to the sodium chloride bag only.

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Read the package leaflet before use.
Intravenous use after reconstitution and 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

Do not shake the reconstituted solution.

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

Store and transport refrigerated.
Do not freeze.
Store in the original 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 Europe B.V.
Minervum 7061
4817 ZK Breda
The Netherlands

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/15/1047/001

13. BATCH NUMBER

Lot

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

Justification for not including 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 POWDER VIAL

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

BLINCYTO 38.5 mcg powder for concentrate
blinatumomab
IV after reconstitution and dilution

2. METHOD OF ADMINISTRATION

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

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

6. OTHER

MINIMUM PARTICULARS TO APPEAR ON SMALL IMMEDIATE PACKAGING UNITS SOLUTION (STABILISER) VIAL
--

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

Solution (stabiliser).
BLINCYTO

2. METHOD OF ADMINISTRATION

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

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

10 mL

6. OTHER

Add to the sodium chloride bag only.

B. PACKAGE LEAFLET

Package leaflet: Information for the patient

BLINCYTO 38.5 micrograms powder for concentrate and solution for solution for infusion blinatumomab

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

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

- Keep this leaflet. You may need to read it again.
- Your doctor will also give you the following educational materials:
 - Educational Brochure for Patients and Caregivers, which contains important safety information that you need to be aware of before you are given BLINCYTO and during treatment with BLINCYTO.
 - Patient Card with contact details of your medical team and information when to call your doctor or nurse. Keep this Patient Card with you, at all times.
- If you have any further questions, ask your doctor, pharmacist or nurse.
- If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet

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

1. What BLINCYTO is and what it is used for

The active ingredient in BLINCYTO is blinatumomab. This belongs to a group of medicines called antineoplastic agents which target cancer cells.

BLINCYTO is used to treat adults, children and young adults with acute lymphoblastic leukaemia. Acute lymphoblastic leukaemia is a cancer of the blood in which a particular kind of white blood cell called “B-lymphocyte” is growing out of control. This medicine works by enabling your immune system to attack and destroy these abnormal white blood cancer cells. BLINCYTO is used when acute lymphoblastic leukaemia has come back or has not responded to previous treatment (referred to as relapsed/refractory acute lymphoblastic leukaemia).

It is also used in adult patients with acute lymphoblastic leukaemia who still have a small number of cancer cells remaining after previous treatment (referred to as minimal residual disease).

BLINCYTO is also used during consolidation therapy. Consolidation therapy for acute lymphoblastic leukaemia is a phase of treatment that comes after the initial phase of therapy. Its purpose is to further eliminate any remaining leukaemia cells that may still present after the first phase of treatment.

2. What you need to know before you use BLINCYTO

Do not use BLINCYTO

- if you are allergic to blinatumomab or any of the other ingredients of this medicine (listed in section 6).
- if you are breast-feeding.

Warnings and precautions

Talk to your doctor, pharmacist or nurse before using BLINCYTO if any of these apply to you. BLINCYTO may not be suitable for you:

- if you have ever had neurological problems, for example, shaking (or tremor), abnormal sensations, seizures, memory loss, confusion, disorientation, loss of balance, or difficulty speaking. If you are still suffering from active neurological problems or conditions, tell your doctor. If your leukaemia has spread to your brain and/or spinal cord, your doctor may have to treat this first before you can start treatment with BLINCYTO. Your doctor will assess your nervous system and conduct tests before deciding if you should receive BLINCYTO. Your doctor may need to take special care of you during your treatment with BLINCYTO.
- if you have an active infection.
- if you have ever had an infusion reaction after previously using BLINCYTO. Symptoms may include wheezing, flushing, face swelling, difficulty breathing, low or high blood pressure.
- if you think you may need any vaccinations in the near future, including those needed to travel to other countries. Some vaccines must not be given within two weeks before, at the same time as or in the months after you receive treatment with BLINCYTO. Your doctor will check if you should have the vaccination.

Tell your doctor, pharmacist or nurse immediately if you experience any new symptoms, including but not limited to the following symptoms whilst receiving BLINCYTO as these may need to be treated and your dose adjusted:

- Effects on your nervous system. Symptoms include feeling confused, feeling less alert, or having difficulty speaking and/or writing. Some of these may be signs of a serious immune reaction called ‘immune effector cell-associated neurotoxicity syndrome’ (ICANS).
- if you develop chills or shivering, or you feel warm; you should take your temperature as you may have a fever - these may be symptoms of an infection.
- if you develop a reaction at any time during your infusion, which may include dizziness, feeling faint, nauseated, face swelling, difficulty breathing, wheezing, or rash.
- if you have severe and persistent stomach pain, with or without nausea and vomiting, as these may be symptoms of a serious and potentially fatal condition known as pancreatitis (inflammation of the pancreas).

Your doctor or nurse will monitor you for signs and symptoms of these reactions.

Tell your doctor, pharmacist or nurse immediately if you became pregnant whilst receiving BLINCYTO. Your doctor will talk to you about precautions in using vaccinations for your baby.

Before each infusion cycle of BLINCYTO, you will be given medicines which help reduce a potentially life-threatening complication known as tumour lysis syndrome, which is caused by chemical disturbances in the blood due to the breakdown of dying cancer cells. You may also be given medicines to reduce fever.

During treatment, especially in the first few days after treatment start, you may experience a severe low white blood cell count (neutropenia), severe low white blood cell count with a fever (febrile neutropenia), elevated liver enzymes, or elevated uric acid. Your doctor will take regular blood tests to monitor your blood counts during treatment with BLINCYTO.

Children and adolescents

There is limited experience with BLINCYTO in the treatment of children below 1 year of age.

Other medicines and BLINCYTO

Tell your doctor, pharmacist or nurse if you are taking, have recently taken or might take any other medicines.

Pregnancy and breast-feeding

If you are pregnant or breast-feeding, think you may be pregnant or are planning to have a baby, ask your doctor or nurse for advice before taking this medicine.

Contraception

Women who are able to become pregnant have to use effective contraception during treatment and for at least 48 hours after your last treatment. Talk to your doctor or nurse about suitable methods of contraception.

Pregnancy

The effects of BLINCYTO in pregnant women are not known but based on its mechanism of action, BLINCYTO may harm your unborn baby. You should not use BLINCYTO during pregnancy, unless your doctor thinks that it is the best medicine for you.

If you become pregnant during BLINCYTO treatment, please inform your doctor or nurse. Your doctor will talk to you about precautions in using vaccinations for your baby.

Breast-feeding

You must not breast-feed during and for at least 48 hours after your last treatment. It is not known whether BLINCYTO is excreted in breast milk but a risk for suckling baby cannot be excluded.

Driving and using machines

Do not drive, use heavy machines, or engage in hazardous activities while you are being given BLINCYTO. BLINCYTO can cause neurological problems such as dizziness, seizures, confusion, coordination and balance disorders.

BLINCYTO contains sodium

This medicine contains less than 1 mmol sodium (23 mg) over a 24-hour infusion, that is to say essentially 'sodium-free'.

3. How BLINCYTO is given

Always use this medicine exactly as your doctor, pharmacist or nurse have told you. Check with your doctor, pharmacist or nurse if you are not sure.

BLINCYTO will be given to you through a vein (intravenous) continuously for 4 weeks using an infusion pump (this is 1 treatment cycle). You will then have a 2-week break where you will not be given the infusion. Your infusion catheter will be attached to you at all times during each cycle of your treatment. Your doctor will determine when your BLINCYTO infusion bag will be changed, which may range from every day to every 4 days. The infusion rate may be faster or slower depending on how often the bag is changed.

How long will you receive BLINCYTO treatment

BLINCYTO is usually given for 2 treatment cycles if you have relapsed/refractory acute lymphoblastic leukaemia, or for 1 treatment cycle if you have minimal residual acute lymphoblastic leukaemia. If you respond to this treatment, your doctor may decide to give you up to 3 additional cycles of treatment.

If you have acute lymphoblastic leukaemia and receive BLINCYTO as part of consolidation therapy, your doctor will determine the number of cycles of BLINCYTO that should be given.

The number of treatment cycles and the dose which you will be given will depend on how you tolerate and respond to BLINCYTO. Your doctor will discuss with you how long your treatment will last. Your treatment may also be interrupted depending on how you tolerate BLINCYTO.

How long will you have to stay in hospital

If you have relapsed/refractory acute lymphoblastic leukaemia it is recommended that the first 9 days of treatment and the first 2 days of the second cycle will be given to you in a hospital or clinic under the supervision of a doctor or nurse experienced in the use of anti-cancer medicines.

If you have minimal residual acute lymphoblastic leukaemia, it is recommended that the first 3 days of treatment and the first 2 days of subsequent cycles will be given to you in a hospital or clinic under the supervision of a doctor or nurse experienced in the use of anti-cancer medicines.

If you have acute lymphoblastic leukaemia and receive BLINCYTO as part of consolidation therapy, it is recommended that the first 3 days of your first treatment cycle and the first 2 days of your second cycle be given to you in a hospital or clinic under the supervision of a doctor or nurse experienced in the use of anti-cancer medicines.

If you have or had neurological problems, it is recommended that the first 14 days of treatment will be given to you in a hospital or clinic. Your doctor will discuss with you if you can continue treatment at home after your initial hospital stay. Treatment may include a bag change by a nurse.

How much BLINCYTO will be given

If you have relapsed/refractory acute lymphoblastic leukaemia and your body weight is greater than or equal to 45 kilograms, the recommended initial dose in your first cycle is 9 micrograms per day for 1 week. Your doctor may decide to then increase your dose to 28 micrograms per day for weeks 2, 3, and 4 of your treatment. If your doctor determines that you should be given more cycles of BLINCYTO, your pump will be set to infuse a dose of 28 micrograms per day for all following treatment cycles.

If your body weight is less than 45 kilograms, the recommended initial dose in your first cycle will be based on your weight and height. For the first week of BLINCYTO treatment, your pump will be set to infuse a dose of 5 micrograms/m²/day. Your dose should be increased to infuse 15 micrograms/m²/day for weeks 2, 3, and 4 depending on how you respond to treatment with BLINCYTO. If your doctor determines that you should be given more cycles of BLINCYTO, your pump will be set to infuse a dose of 15 micrograms/m²/day for all following treatment cycles. You may not be able to tell the difference between the dose infused during the first week of your first cycle and the increased dose infused for the remainder of the first cycle and for the subsequent cycles.

If you have minimal residual acute lymphoblastic leukaemia and your body weight is greater than or equal to 45 kilograms, your dose of BLINCYTO will be 28 micrograms per day for all treatment cycles. If your body weight is less than 45 kilograms, the dose that the pump will be set to infuse is 15 micrograms/m²/day based on your weight and height for all treatment cycles.

If you have acute lymphoblastic leukaemia and receive BLINCYTO as part of consolidation therapy, and your body weight is greater than or equal to 45 kilograms, your dose of BLINCYTO will be 28 micrograms per day for all treatment cycles. If your body weight is less than 45 kilograms, the dose that the pump will be set to infuse is 15 micrograms/m²/day based on your weight and height for all treatment cycles.

Medicines given before each cycle of BLINCYTO

Before your treatment with BLINCYTO, you will be given other medicines (premedication) to help reduce infusion reactions and other possible side effects. These may include corticosteroids (e.g. dexamethasone).

Before and during BLINCYTO treatment, you may be given chemotherapy through intrathecal injection (injection into the space that surrounds the spinal cord and the brain) to help prevent central nervous system relapse of the acute lymphoblastic leukaemia. If you have questions regarding your treatment, discuss with your doctor.

Infusion catheter

If you have a catheter for infusion, it is very important to keep the area around the catheter clean; otherwise you could get an infection. Your doctor or nurse will show you how to care for your catheter site.

Infusion pump and intravenous tubing

Do not adjust the settings on the pump, even if there is a problem or the pump alarm sounds. Any changes to the pump settings may result in a dose that is too high or too low.

Contact your doctor or nurse immediately if:

- there is a problem with the pump or the pump alarm sounds
- the infusion bag empties before the scheduled bag change
- if the infusion pump stops unexpectedly. Do not try to restart your pump.

Your doctor or nurse will advise you on how to manage your daily activities around your infusion pump. Contact your doctor or nurse if you have questions.

4. Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them. Some of these side effects may be serious.

Tell your doctor immediately if you get any of the following or combination of the following side effects:

- chills, shivering, fever, rapid heart rate, decreased blood pressure, aching muscles, feeling tired, coughing, difficulty breathing, confusion, redness, swelling or discharge in the affected area or at the site of the infusion line - these may be signs of an infection.
- neurologic events: shaking (or tremor), confusion, disturbances of brain function (encephalopathy), difficulty in communicating (aphasia), seizure (convulsion).
- fever, swelling, chills, decreased or increased blood pressure and fluid in the lungs, which may become severe - these may be signs of a so-called cytokine release syndrome.
- if you have severe and persistent stomach pain, with or without nausea and vomiting, as these may be symptoms of a serious and potentially fatal condition known as pancreatitis (inflammation of the pancreas).

Treatment with BLINCYTO can cause a decrease in the levels of certain white blood cells with or without fever (febrile neutropenia or neutropenia) or can lead to increased blood levels of potassium,

uric acid, and phosphate and decreased blood levels of calcium (tumour lysis syndrome). Your doctor will take regular blood tests during treatment with BLINCYTO.

Other side effects include:

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

- infections in the blood including bacteria, viruses, or other types of infection
- decreased levels of certain white blood cells with or without fever ((febrile) neutropenia, leukopenia), decreased levels of red blood cells, decreased levels of platelets
- fever, swelling, chills, decreased or increased blood pressure and fluid in the lungs, which may become severe (cytokine release syndrome)
- not being able to sleep, headache, shaking (or tremor). These may be symptoms of neurological problems associated with a condition called immune effector cell-associated neurotoxicity syndrome (ICANS).
- rapid heart rate (tachycardia)
- low blood pressure
- high blood pressure (hypertension)
- cough
- nausea, diarrhoea, vomiting, constipation, abdominal pain
- rash
- back pain, pain in extremity
- fever (pyrexia), swelling of the face, lips, mouth, tongue or throat which may cause difficulty in swallowing or breathing (oedema), chills
- low levels of antibodies called “immunoglobulins” which help the immune system fight infection (decreased immunoglobulins)
- increased levels of liver enzymes (ALT, AST, GGT)
- reactions related to infusion may include, wheezing, flushing, face swelling, difficulty breathing, low blood pressure, high blood pressure

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

- serious infection which can result in organ failure, shock or can be fatal (sepsis)
- lung infection (pneumonia)
- fungal infection
- increased levels of white blood cell count (leukocytosis), decreased levels of certain white blood cells (lymphopenia)
- allergic reaction
- complications occurring after cancer treatment leading to increased blood levels of potassium, uric acid, and phosphate and decreased blood levels of calcium (tumour lysis syndrome)
- confusion, disorientation, disturbances of brain function (encephalopathy) such as difficulty in communicating (aphasia), tingling of skin (paraesthesia), seizure, difficulty thinking or processing thoughts, difficulty remembering, difficulty in controlling movement (ataxia), feeling sleepy (somnolence), numbness, dizziness. These may be symptoms of neurological problems associated with a condition called immune effector cell-associated neurotoxicity syndrome (ICANS).
- nerve problems affecting the head and neck such as visual disturbances, drooping eyelid and/or sagging muscles on one side of the face, difficulty hearing or trouble swallowing (cranial nerve disorders)
- wheezing or difficulty in breathing (dyspnoea), breathlessness (respiratory failure)
- flushing
- coughing with phlegm
- increased bilirubin in the blood
- bone pain
- chest pain or other pain
- high levels of some enzymes including blood enzymes
- increase in your weight

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

- excessive activation of white blood cells associated with inflammation (haemophagocytic histiocytosis)
- swollen lymph nodes (lymphadenopathy)
- fever, swelling, chills, decreased or increased blood pressure and fluid in the lungs, which may be severe and can be fatal (cytokine storm)
- a condition which causes fluid to leak from the small blood vessels into your body (capillary leak syndrome)
- difficulty speaking and/or writing. These may be symptoms of neurological problems associated with a condition called immune effector cell-associated neurotoxicity syndrome (ICANS).

Additionally, the side effects that happened more often in adolescents and children include:

- decreased levels of red blood cells (anaemia), decreased levels of platelets (thrombocytopenia), decreased levels of certain white blood cells (leukopenia)
- fever (pyrexia)
- reactions related to infusion may include face swelling, low blood pressure, high blood pressure (infusion-related reaction)
- increase in your weight
- high blood pressure (hypertension)

Reporting of side effects

If you get any side effects, talk to your doctor, pharmacist or nurse. 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 BLINCYTO

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

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

Unopened vials:

- Store and transport refrigerated (2°C - 8°C).
- Do not freeze.
- Store in the original carton in order to protect from light.

Reconstituted solution (BLINCYTO solution):

- When refrigerated, the reconstituted solution must be used within 24 hours. Alternatively, the vials can be stored at room temperature (up to 27°C) for up to 4 hours.

Diluted solution (prepared infusion bag):

If your infusion bag is changed at home:

- Infusion bags containing BLINCYTO solution for infusion will arrive in special packaging containing cooling packs.
 - Do not open the package.
 - Store the package at room temperature (up to 27°C).
 - Do not refrigerate or freeze the package.
- The package will be opened by your nurse and the infusion bags will be stored in a refrigerator until infusion.
- When refrigerated, the infusion bags must be used within 10 days of preparation.
- Once at room temperature (up to 27°C) the solution will be infused within 96 hours.

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 BLINCYTO contains

- The active substance is blinatumomab. Each vial of powder contains 38.5 micrograms of blinatumomab. Reconstitution with water for injections results in a final blinatumomab concentration of 12.5 micrograms/mL.
- The other ingredients in the powder are citric acid monohydrate (E330), trehalose dihydrate, lysine hydrochloride, polysorbate 80 (E433), and sodium hydroxide.
- The solution (stabiliser) contains citric acid monohydrate (E330), lysine hydrochloride, polysorbate 80 (E433), sodium hydroxide and water for injections.

What BLINCYTO looks like and contents of the pack

BLINCYTO is a powder for concentrate and solution for solution for infusion.

Each pack of BLINCYTO contains:

- 1 glass vial containing a white to off-white powder.
- 1 glass vial containing a colourless-to-slightly yellow, clear solution.

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The Netherlands

Marketing Authorisation Holder

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Manufacturer

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

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Other sources of information

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

The following information is intended for healthcare professionals only:

BLINCYTO solution for infusion is administered as a continuous intravenous infusion delivered at a constant flow rate using an infusion pump, over a period of up to 96 hours.

Relapsed or refractory B-cell precursor ALL

Recommended daily dose is by body weight. Patients greater than or equal to 45 kg receive a fixed-dose and for patients less than 45 kg, the dose is calculated using the patient's body surface area (BSA). See the table below for the recommended daily dose for relapsed or refractory B-cell precursor ALL.

Body weight	Cycle 1			Subsequent cycles	
	Days 1-7	Days 8-28	Days 29-42	Days 1-28	Days 29-42
Greater than or equal to 45 kg (fixed-dose)	9 mcg/day via continuous infusion	28 mcg/day via continuous infusion	14-day treatment-free interval	28 mcg/day via continuous infusion	14-day treatment-free interval
Less than 45 kg (BSA-based dose)	5 mcg/m ² /day via continuous infusion (not to exceed 9 mcg/day)	15 mcg/m ² /day via continuous infusion (not to exceed 28 mcg/day)		15 mcg/m ² /day via continuous infusion (not to exceed 28 mcg/day)	

Paediatric patients with high-risk first relapsed B-cell precursor ALL may receive 1 cycle of BLINCYTO treatment after induction and 2 blocks of consolidation chemotherapy. See the table below for the recommended daily dose by body weight for paediatric patients with high-risk first relapsed B-cell precursor ALL post-induction chemotherapy.

One consolidation cycle	Body weight greater than or equal to 45 kg (fixed-dose)	Body weight less than 45 kg (BSA-based dose)
Days 1-28	28 mcg/day	15 mcg/m ² /day (not to exceed 28 mcg/day)

MRD positive B-cell precursor ALL

Recommended daily dose is by body weight. The recommended dose of BLINCYTO for patients greater than or equal to 45 kg throughout each 4-week treatment cycle is 28 mcg/day. For patients less than 45 kg, the dose is calculated using the BSA. The recommended dose of BLINCYTO throughout each 4-week treatment cycle is 15 mcg/m²/day.

B-cell precursor ALL in adults in the consolidation phase

Recommended daily dose is by body weight. The recommended dose of BLINCYTO for patients greater than or equal to 45 kg throughout each 4-week treatment cycle is 28 mcg/day. For patients less

than 45 kg, the dose is calculated using the BSA. The recommended dose of BLINCYTO throughout each 4-week treatment cycle is 15 mcg/m²/day.

The starting volume (270 mL) is more than the volume administered to the patient (240 mL) to account for the priming of the intravenous tubing and to ensure that the patient will receive the full dose of BLINCYTO.

Infuse prepared BLINCYTO final infusion solution according to the instructions on the pharmacy label on the prepared bag at one of the following constant infusion rates:

- Infusion rate of 10 mL/h for a duration of 24 hours
- Infusion rate of 5 mL/h for a duration of 48 hours
- Infusion rate of 3.3 mL/h for a duration of 72 hours
- Infusion rate of 2.5 mL/h for a duration of 96 hours

The choice of the infusion duration should be made by the treating physician considering the frequency of the infusion bag changes and the weight of the patient. The target therapeutic dose of BLINCYTO delivered does not change.

Aseptic preparation

Aseptic handling must be ensured when preparing the infusion. Preparation of BLINCYTO should be:

- performed under aseptic conditions by trained personnel in accordance with good practice rules especially with respect to the aseptic preparation of parenteral products.
- prepared in a laminar flow hood or biological safety cabinet using standard precautions for the safe handling of intravenous agents.

It is very important that the instructions for preparation and administration provided in this section are strictly followed to minimise medication errors (including underdose and overdose).

Other instructions

- BLINCYTO is compatible with polyolefin, PVC non-di-ethylhexylphthalate (non-DEHP), or ethyl vinyl acetate (EVA) infusion bags/pump cassettes.
- At the end of infusion, any unused medicinal product or waste material should be disposed of in accordance with local requirements.

Preparation of the solution for infusion

These supplies are also required, but **not** included in the package:

- Sterile single-use disposable syringes
- 21-23 gauge needle(s) (recommended)
- Water for injections
- Infusion bag with 250 mL sodium chloride 9 mg/mL (0.9%) solution for injection;
 - To minimise the number of aseptic transfers, use a 250 mL pre-filled infusion bag.
BLINCYTO dose calculations are based on a usual overfill volume of 265 to 275 mL sodium chloride 9 mg/mL (0.9%) solution for injection.
 - Use only polyolefin, PVC non-di-ethylhexylphthalate (non-DEHP), or ethyl vinyl acetate (EVA) infusion bags/pump cassettes.
- Polyolefin, PVC non-DEHP, or EVA intravenous tubing with a sterile, non-pyrogenic, low protein-binding 0.2 micrometre in-line filter.
 - Ensure that the tubing is compatible with the infusion pump.

Reconstitute BLINCYTO with water for injections. Do not reconstitute BLINCYTO vials with the solution (stabiliser).

To prime the intravenous tubing, use only the solution in the bag containing the FINAL prepared BLINCYTO solution for infusion. Do not prime with sodium chloride 9 mg/mL (0.9%) solution for injection.

Reconstitution of BLINCYTO

1. Determine the number of BLINCYTO vials needed for a dose and infusion duration.
2. Using a syringe, reconstitute each vial of BLINCYTO powder for concentrate using 3 mL of water for injections. Direct the water along the walls of the BLINCYTO vial and not directly on the lyophilised powder.
 - **Do not reconstitute BLINCYTO powder for concentrate with the solution (stabiliser).**
 - The addition of water for injections to the powder for concentrate results in a total volume of 3.08 mL for a final BLINCYTO concentration of 12.5 mcg/mL.
3. Gently swirl contents to avoid excess foaming.
 - **Do not shake.**
4. Visually inspect the reconstituted solution for particulate matter and discolouration during reconstitution and prior to infusion. The resulting solution should be clear to slightly opalescent, colourless-to-slightly yellow.
 - **Do not use if the solution is cloudy or has precipitated.**

Preparation of BLINCYTO infusion bag

Verify the prescribed dose and infusion duration for each BLINCYTO infusion bag. To minimise errors, **use the specific volumes described in tables 1 and 2 to prepare the BLINCYTO infusion bag.**

- Table 1 for patients weighing greater than or equal to 45 kg
 - Table 2 for patients weighing less than 45 kg
1. Use an infusion bag pre-filled with 250 mL sodium chloride 9 mg/mL (0.9%) solution for injection that usually contains a total volume of 265 to 275 mL.
 2. To coat the infusion bag, using a syringe, aseptically transfer 5.5 mL of the solution (stabiliser) to the infusion bag. Gently mix the contents of the bag to avoid foaming. Discard the remaining solution (stabiliser).
 3. Using a syringe, aseptically transfer the required volume of reconstituted BLINCYTO solution into the infusion bag containing sodium chloride 9 mg/mL (0.9%) solution for injection and the solution (stabiliser). Gently mix the contents of the bag to avoid foaming.
 - Refer to table 1 for patients weighing greater than or equal to 45 kg for the specific volume of reconstituted BLINCYTO.
 - Refer to table 2 for patients weighing less than 45 kg (dose based on BSA) for the specific volume of reconstituted BLINCYTO.
 - Discard the vial containing any unused BLINCYTO reconstituted solution.
 4. Under aseptic conditions, attach the intravenous tubing to the infusion bag with the sterile 0.2 micron in-line filter. Ensure that the intravenous tubing is compatible with the infusion pump.
 5. Remove air from the infusion bag. This is particularly important for use with an ambulatory infusion pump.
 6. **Prime the intravenous infusion line only with the solution in the bag containing the FINAL prepared BLINCYTO solution for infusion.**
 7. Store refrigerated at 2°C - 8°C if not used immediately.

Table 1. For patients weighing greater than or equal to 45 kg: volumes of sodium chloride 9 mg/mL (0.9%) solution for injection, solution (stabiliser), and reconstituted BLINCYTO to add to infusion bag

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)			250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)			5.5 mL	
Infusion duration	Dose	Infusion rate	Reconstituted BLINCYTO	
			Volume	Vials
24 hours	9 mcg/day	10 mL/hour	0.83 mL	1
	28 mcg/day	10 mL/hour	2.6 mL	1
48 hours	9 mcg/day	5 mL/hour	1.7 mL	1
	28 mcg/day	5 mL/hour	5.2 mL	2
72 hours	9 mcg/day	3.3 mL/hour	2.5 mL	1
	28 mcg/day	3.3 mL/hour	8 mL	3
96 hours	9 mcg/day	2.5 mL/hour	3.3 mL	2
	28 mcg/day	2.5 mL/hour	10.7 mL	4

Table 2. For patients weighing less than 45 kg: volumes of sodium chloride 9 mg/mL (0.9%) solution for injection, solution (stabiliser), and reconstituted BLINCYTO to add to infusion bag

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)				250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)				5.5 mL	
Infusion duration	Dose	Infusion rate	BSA (m ²)*	Reconstituted BLINCYTO	
				Volume	Vials
24 hours	5 mcg/m ² /day	10 mL/hour	1.5 – 1.59	0.7 mL	1
			1.4 – 1.49	0.66 mL	1
			1.3 – 1.39	0.61 mL	1
			1.2 – 1.29	0.56 mL	1
			1.1 – 1.19	0.52 mL	1
			1 – 1.09	0.47 mL	1
			0.9 – 0.99	0.43 mL	1
			0.8 – 0.89	0.38 mL	1
			0.7 – 0.79	0.33 mL	1
			0.6 – 0.69	0.29 mL	1
			0.5 – 0.59	0.24 mL	1
			0.4 – 0.49	0.2 mL	1

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)				250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)				5.5 mL	
Infusion duration	Dose	Infusion rate	BSA (m ²)*	Reconstituted BLINCYTO	
				Volume	Vials
24 hours	15 mcg/m ² /day	10 mL/hour	1.5 – 1.59	2.1 mL	1
			1.4 – 1.49	2 mL	1
			1.3 – 1.39	1.8 mL	1
			1.2 – 1.29	1.7 mL	1
			1.1 – 1.19	1.6 mL	1
			1 – 1.09	1.4 mL	1
			0.9 – 0.99	1.3 mL	1
			0.8 – 0.89	1.1 mL	1
			0.7 – 0.79	1 mL	1
			0.6 – 0.69	0.86 mL	1
			0.5 – 0.59	0.72 mL	1
			0.4 – 0.49	0.59 mL	1
48 hours	5 mcg/m ² /day	5 mL/hour	1.5 – 1.59	1.4 mL	1
			1.4 – 1.49	1.3 mL	1
			1.3 – 1.39	1.2 mL	1
			1.2 – 1.29	1.1 mL	1
			1.1 – 1.19	1 mL	1
			1 – 1.09	0.94 mL	1
			0.9 – 0.99	0.85 mL	1
			0.8 – 0.89	0.76 mL	1
			0.7 – 0.79	0.67 mL	1
			0.6 – 0.69	0.57 mL	1
			0.5 – 0.59	0.48 mL	1
			0.4 – 0.49	0.39 mL	1

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)				250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)				5.5 mL	
Infusion duration	Dose	Infusion rate	BSA (m ²)*	Reconstituted BLINCYTO	
				Volume	Vials
48 hours	15 mcg/m ² /day	5 mL/hour	1.5 – 1.59	4.2 mL	2
			1.4 – 1.49	3.9 mL	2
			1.3 – 1.39	3.7 mL	2
			1.2 – 1.29	3.4 mL	2
			1.1 – 1.19	3.1 mL	2
			1 – 1.09	2.8 mL	1
			0.9 – 0.99	2.6 mL	1
			0.8 – 0.89	2.3 mL	1
			0.7 – 0.79	2 mL	1
			0.6 – 0.69	1.7 mL	1
			0.5 – 0.59	1.4 mL	1
			0.4 – 0.49	1.2 mL	1
72 hours	5 mcg/m ² /day	3.3 mL/hour	1.5 – 1.59	2.1 mL	1
			1.4 – 1.49	2 mL	1
			1.3 – 1.39	1.8 mL	1
			1.2 – 1.29	1.7 mL	1
			1.1 – 1.19	1.6 mL	1
			1 – 1.09	1.4 mL	1
			0.9 – 0.99	1.3 mL	1
			0.8 – 0.89	1.1 mL	1
			0.7 – 0.79	1 mL	1
			0.6 – 0.69	0.86 mL	1
			0.5 – 0.59	0.72 mL	1
			0.4 – 0.49	0.59 mL	1

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)				250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)				5.5 mL	
Infusion duration	Dose	Infusion rate	BSA (m ²)*	Reconstituted BLINCYTO	
				Volume	Vials
72 hours	15 mcg/m ² /day	3.3 mL/hour	1.5 – 1.59	6.3 mL	3
			1.4 – 1.49	5.9 mL	3
			1.3 – 1.39	5.5 mL	2
			1.2 – 1.29	5.1 mL	2
			1.1 – 1.19	4.7 mL	2
			1 – 1.09	4.2 mL	2
			0.9 – 0.99	3.8 mL	2
			0.8 – 0.89	3.4 mL	2
			0.7 – 0.79	3 mL	2
			0.6 – 0.69	2.6 mL	1
			0.5 – 0.59	2.2 mL	1
			0.4 – 0.49	1.8 mL	1
96 hours	5 mcg/m ² /day	2.5 mL/hour	1.5 – 1.59	2.8 mL	1
			1.4 – 1.49	2.6 mL	1
			1.3 – 1.39	2.4 mL	1
			1.2 – 1.29	2.3 mL	1
			1.1 – 1.19	2.1 mL	1
			1 – 1.09	1.9 mL	1
			0.9 – 0.99	1.7 mL	1
			0.8 – 0.89	1.5 mL	1
			0.7 – 0.79	1.3 mL	1
			0.6 – 0.69	1.2 mL	1
			0.5 – 0.59	0.97 mL	1
			0.4 – 0.49	0.78 mL	1

Sodium chloride 9 mg/mL (0.9%) solution for injection (starting volume)				250 mL (usual overfill volume of 265 to 275 mL)	
Solution (stabiliser) (fixed volume for 24, 48, 72, and 96-hour infusion durations)				5.5 mL	
Infusion duration	Dose	Infusion rate	BSA (m ²)*	Reconstituted BLINCYTO	
				Volume	Vials
96 hours	15 mcg/m ² /day	2.5 mL/hour	1.5 – 1.59	8.4 mL	3
			1.4 – 1.49	7.9 mL	3
			1.3 – 1.39	7.3 mL	3
			1.2 – 1.29	6.8 mL	3
			1.1 – 1.19	6.2 mL	3
			1 – 1.09	5.7 mL	3
			0.9 – 0.99	5.1 mL	2
			0.8 – 0.89	4.6 mL	2
			0.7 – 0.79	4 mL	2
			0.6 – 0.69	3.4 mL	2
			0.5 – 0.59	2.9 mL	2
			0.4 – 0.49	2.3 mL	1

BSA = body surface area

*The safety of the administration of BLINCYTO for BSA of less than 0.4 m² has not been established.

For instructions on administration, see Summary of Product Characteristics, section 4.2.

Method of administration

Important Note: Do not flush the BLINCYTO infusion line, especially when changing infusion bags. Flushing when changing bags or at completion of infusion can result in excess dosage and complications thereof. When administering via a multi-lumen venous catheter, BLINCYTO should be infused through a dedicated lumen.

BLINCYTO solution for infusion is administered as a continuous intravenous infusion delivered at a constant flow rate using an infusion pump over a period of up to 96 hours.

The BLINCYTO solution for infusion must be administered using intravenous tubing that contains a sterile, non-pyrogenic, low protein-binding 0.2 micrometre in-line filter.

The infusion bag must be changed at least every 96 hours by a healthcare professional for sterility reasons.

Storage conditions and shelf life

Unopened vials:

5 years (2°C - 8°C)

Reconstituted solution:

Chemical and physical in-use stability has been demonstrated for 24 hours at 2°C - 8°C or 4 hours at or below 27°C.

From a microbiological point of view, unless the method of reconstituting precludes the risks of microbial contamination, the reconstituted solution should be diluted immediately. If not diluted immediately, in-use storage times and conditions are the responsibility of the user.

Diluted solution (prepared infusion bag)

Chemical and physical in-use stability has been demonstrated for 10 days at 2°C - 8°C or 96 hours at or below 27°C.

From a microbiological point of view, the prepared infusion bags should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2°C - 8°C, unless dilution has taken place in controlled and validated aseptic conditions.