ANNEX I

SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Truxima 100 mg concentrate for solution for infusion
Truxima 500 mg concentrate for solution for infusion

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Truxima 100mg concentrate for solution for infusion
Each mL contains 10 mg of rituximab.
Each 10 mL vial contains 100 mg of rituximab.

Truxima 500 mg concentrate for solution for infusion
Each mL contains 10 mg of rituximab.
Each 50 mL vial contains 500 mg of rituximab.

Rituximab is a genetically engineered chimeric mouse/human monoclonal antibody representing a glycosylated immunoglobulin with human IgG1 constant regions and murine light-chain and heavy-chain variable region sequences. The antibody is produced by mammalian (Chinese hamster ovary) cell suspension culture and purified by affinity chromatography and ion exchange, including specific viral inactivation and removal procedures.

Excipients with known effects

Polysorbates
Each 10 mL vial contains 7 mg of polysorbate 80.
Each 50 mL vial contains 35 mg of polysorbate 80.

Sodium
Each 10 mL vial contains 2.3 mmol (52. 6 mg) sodium.
Each 50 mL vial contains 11.5 mmol (263.2 mg) sodium.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Concentrate for solution for infusion.
Clear, colourless liquid with pH of 6.3 – 6.8 and osmolality of 329 - 387 mOsmol/kg.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Non-Hodgkin's lymphoma (NHL)

Truxima is indicated for the treatment of previously untreated adult patients with stage III-IV follicular lymphoma in combination with chemotherapy.

Truxima maintenance therapy is indicated for the treatment of adult follicular lymphoma patients responding to induction therapy.

Truxima monotherapy is indicated for treatment of adult patients with stage III-IV follicular lymphoma who are chemo resistant or are in their second or subsequent relapse after chemotherapy.

Truxima is indicated for the treatment of adult patients with CD20 positive diffuse large B-cell

non-Hodgkin's lymphoma in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisolone) chemotherapy.

Truxima in combination with chemotherapy is indicated for the treatment of paediatric patients (aged 6 months to less than 18 years old) with previously untreated advanced stage CD20 positive diffuse large B-cell lymphoma (DLBCL), Burkitt lymphoma (BL)/Burkitt leukaemia (mature B-cell acute leukaemia) (BAL) or Burkitt-like lymphoma (BLL).

Chronic lymphocytic leukaemia (CLL)

Truxima in combination with chemotherapy is indicated for the treatment of adult patients with previously untreated and relapsed/refractory CLL. Only limited data are available on efficacy and safety for patients previously treated with monoclonal antibodies including Truxima or patients refractory to previous Truxima plus chemotherapy.

See section 5.1 for further information.

Rheumatoid arthritis

Truxima in combination with methotrexate is indicated for the treatment of adult patients with severe active rheumatoid arthritis who have had an inadequate response or intolerance to other disease-modifying anti-rheumatic medicinal product (DMARD) including one or more tumour necrosis factor (TNF) inhibitor therapies.

Truxima has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function, when given in combination with methotrexate.

Granulomatosis with polyangiitis and microscopic polyangiitis

Truxima, in combination with glucocorticoids, is indicated for the treatment of adult patients with severe, active granulomatosis with polyangiitis (Wegener's) (GPA) and microscopic polyangiitis (MPA).

Truxima, in combination with glucocorticoids, is indicated for the induction of remission in paediatric patients (aged 2 to less than 18 years old) with severe, active GPA (Wegener's) and MPA.

Pemphigus vulgaris

Truxima is indicated for the treatment of adult patients with moderate to severe pemphigus vulgaris (PV).

4.2 Posology and method of administration

Rituximab should be administered under the close supervision of an experienced healthcare professional, and in an environment where full resuscitation facilities are immediately available (see section 4.4).

Premedication and prophylactic medications

All indications
Premedication consisting of an anti-pyretic and an antihistaminic, e.g. paracetamol and diphenhydramine, should always be given before each administration of rituximab.

Non-Hodgkin's lymphoma and chronic lymphocytic leukaemia
In adult patients with non-Hodgkin's lymphoma and CLL, premedication with glucocorticoids should be considered if rituximab is not given in combination with glucocorticoid-containing chemotherapy.

For adult NHL and CLL patients administered rituximab according to the 90-minute infusion rate, premedication with glucocorticoids should be considered if rituximab is not given in combination with glucocorticoid-containing chemotherapy.

In paediatric patients with non-Hodgkin's lymphoma, premedication with paracetamol and H1 antihistamine (= diphenhydramine or equivalent) should be administered 30 to 60 minutes before the start of the infusion of rituximab. In addition, prednisone should be given as indicated in Table 1.

Prophylaxis with adequate hydration and administration of uricostatics starting 48 hours prior to start of therapy is recommended for CLL patients to reduce the risk of tumour lysis syndrome. For CLL patients whose lymphocyte counts are > 25 x 10^9/L it is recommended to administer prednisone/prednisolone 100 mg intravenous shortly before infusion with rituximab to decrease the rate and severity of acute infusion reactions and/or cytokine release syndrome.

Rheumatoid arthritis, granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA), and pemphigus vulgaris
In patients with rheumatoid arthritis, GPA or MPA or pemphigus vulgaris, premedication with 100 mg intravenous methylprednisolone should be completed 30 minutes prior to each infusion of rituximab to decrease the incidence and severity of infusion-related reactions (IRRs).

In adult patients with GPA or MPA, methylprednisolone given intravenously for 1 to 3 days at a dose of 1000 mg per day is recommended prior to the first infusion of rituximab (the last dose of methylprednisolone may be given on the same day as the first infusion of rituximab). This should be followed by oral prednisone 1 mg/kg/day (not to exceed 80 mg/day, and tapered as rapidly as possible based on clinical need) during and after the 4-week induction course of rituximab treatment.

Pneumocystis jirovecii pneumonia (PJP) prophylaxis is recommended for adult and paediatric patients with GPA/MPA and adult patients with PV during and following rituximab treatment, as appropriate according to local clinical practice guidelines.

In paediatric patients with GPA or MPA, prior to the first rituximab intravenous infusion, methylprednisolone should be given intravenous for three daily doses of 30 mg/kg/day (not to exceed 1 g/day) to treat severe vasculitis symptoms. Up to three additional daily doses of 30 mg/kg intravenous methylprednisolone can be given prior to the first rituximab infusion.

Following completion of intravenous methylprednisolone administration, paediatric patients should receive oral prednisone 1 mg/kg/day (not to exceed 60 mg/day) and tapered as rapidly as possible per clinical need (see section 5.1).

Posology

It is important to check the medicinal product labels to ensure that the appropriate formulation (intravenous or subcutaneous formulation) is being given to the patient, as prescribed.

Dose adjustments during treatment

No dose reductions of rituximab are recommended. When rituximab is given in combination with chemotherapy, standard dose reductions for the chemotherapeutic medicinal products should be applied.

Non-Hodgkin's lymphoma

Follicular non-Hodgkin's lymphoma

Combination therapy
The recommended dose of rituximab in combination with chemotherapy for induction treatment of previously untreated or relapsed/refractory patients with follicular lymphoma is: 375 mg/m^2 body surface area per cycle, for up to 8 cycles.

Rituximab should be administered on Day 1 of each chemotherapy cycle, after intravenous administration of the glucocorticoid component of the chemotherapy if applicable.

Maintenance therapy

- Previously untreated follicular lymphoma

The recommended dose of rituximab used as a maintenance treatment for patients with previously untreated follicular lymphoma who have responded to induction treatment is: 375 mg/m^2 body surface area once every 2 months (starting 2 months after the last dose of induction therapy) until disease progression or for a maximum period of two years (12 infusions in total).

- Relapsed/refractory follicular lymphoma

The recommended dose of rituximab used as a maintenance treatment for patients with relapsed/refractory follicular lymphoma who have responded to induction treatment is: 375 mg/m^2 body surface area once every 3 months (starting 3 months after the last dose of induction therapy) until disease progression or for a maximum period of two years (8 infusions in total).

Monotherapy

- Relapsed/refractory follicular lymphoma

The recommended dose of rituximab monotherapy used as induction treatment for adult patients with stage III-IV follicular lymphoma who are chemoresistant or are in their second or subsequent relapse after chemotherapy is: 375 mg/m^2 body surface area, administered as an intravenous infusion once weekly for four weeks.

For retreatment with rituximab monotherapy for patients who have responded to previous treatment with rituximab monotherapy for relapsed/refractory follicular lymphoma, the recommended dose is: 375 mg/m^2 body surface area, administered as an intravenous infusion once weekly for four weeks (see section 5.1).

Adult diffuse large B-cell non-Hodgkin's lymphoma

Rituximab should be used in combination with CHOP chemotherapy. The recommended dosage is 375 mg/m^2 body surface area, administered on Day 1 of each chemotherapy cycle for 8 cycles after intravenous infusion of the glucocorticoid component of CHOP. Safety and efficacy of rituximab have not been established in combination with other chemotherapies in diffuse large B-cell non-Hodgkin’s lymphoma.

Chronic lymphocytic leukaemia

The recommended dosage of rituximab in combination with chemotherapy for previously untreated and relapsed/refractory patients is 375 mg/m^2 body surface area administered on Day 0 of the first treatment cycle followed by 500 mg/m^2 body surface area administered on Day 1 of each subsequent cycle for 6 cycles in total. The chemotherapy should be given after rituximab infusion.

Rheumatoid arthritis

Patients treated with rituximab must be given the patient alert card with each infusion.

A course of rituximab consists of two 1000 mg intravenous infusions. The recommended dosage of rituximab is 1000 mg by intravenous infusion followed by a second 1000 mg intravenous infusion two weeks later.

The need for further courses should be evaluated 24 weeks following the previous course. Retreatment should be given at that time if residual disease activity remains, otherwise retreatment should be delayed until disease activity returns.

Available data suggest that clinical response is usually achieved within 16 – 24 weeks of an initial treatment course. Continued therapy should be carefully reconsidered in patients who show no evidence of therapeutic benefit within this time period.

Granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA)

Patients treated with rituximab must be given the patient alert card with each infusion.

Adult induction of remission
The recommended dosage of rituximab for induction of remission therapy in adult patients with GPA and MPA is 375 mg/m^2 body surface area, administered as an intravenous infusion once weekly for 4 weeks (four infusions in total).

Adult maintenance treatment
Following induction of remission with rituximab, maintenance treatment in adult patients with GPA and MPA should be initiated no sooner than 16 weeks after the last rituximab infusion.

Following induction of remission with other standard of care immunosuppressants, rituximab maintenance treatment should be initiated during the 4-week period that follows disease remission.

Rituximab should be administered as two 500 mg intravenous infusions separated by two weeks, followed by a 500 mg intravenous infusion every 6 months thereafter. Patients should receive rituximab for at least 24 months after achievement of remission (absence of clinical signs and symptoms). For patients who may be at higher risk for relapse, physicians should consider a longer duration of rituximab maintenance therapy, up to 5 years.

Pemphigus vulgaris

Patients treated with rituximab must be given the patient alert card with each infusion.

The recommended dosage of rituximab for the treatment of pemphigus vulgaris is 1000 mg administered as an intravenous infusion followed two weeks later by a second 1000 mg IV infusion in combination with a tapering course of glucocorticoids.

Maintenance treatment
A maintenance infusion of 500 mg intravenous should be administered at months 12 and 18, and then every 6 months thereafter if needed, based on clinical evaluation.

Treatment of relapse
In the event of relapse, patients may receive 1000 mg intravenous. The healthcare provider should also consider resuming or increasing the patient's glucocorticoid dose based on clinical evaluation.

Subsequent infusions may be administered no sooner than 16 weeks following the previous infusion.

Special populations

Paediatric population

Non-Hodgkin's lymphoma
In paediatric patients from 6 months to less than 18 years of age with previously untreated, advanced stage CD20 positive DLBCL/BL/BAL/BLL, rituximab should be used in combination with systemic Lymphome Malin B (LMB) chemotherapy (see Tables 1 and 2). The recommended dosage of rituximab is 375 mg/m^2 BSA, administered as an intravenous infusion. No rituximab dose adjustments, other than by BSA, are required.

The safety and efficacy of rituximab in paediatric patients aged 6 months to less than 18 years of age has not been established in indications other than previously untreated advanced stage CD20 positive DLBCL/BL/BAL/BLL. Only limited data are available for patients under 3 years of age. See section 5.1 for further information.

Rituximab should not be used in paediatric patients from birth to 6 months of age with CD20 positive diffuse large B-cell lymphoma (see section 5.1)

Table 1 Posology of rituximab administration for non-Hodgkin's lymphoma paediatric patients

Cycle	Day of treatment	Administration details
Prephase (COP)	No rituximab given	-
Induction course 1 (COPDAM1)	Day -2 (corresponding to day 6 of the prephase) 1st rituximab infusion	During the 1st induction course, prednisone is given as part of the chemotherapy course, and should be administered prior to rituximab.
	Day 1 2nd rituximab infusion	Rituximab will be given 48 hours after the first infusion of rituximab.
Induction course 2 (COPDAM2)	Day -2 3rd rituximab infusion	In the 2nd induction course, prednisone is not given at the time of rituximab administration.
	Day 1 4th rituximab infusion	Rituximab will be given 48 hours after the third infusion of rituximab.
Consolidation course 1 (CYM/CYVE)	Day 1 5th rituximab infusion	Prednisone is not given at the time of rituximab administration.
Consolidation course 2 (CYM/CYVE)	Day 1 6th rituximab infusion	Prednisone is not given at the time of rituximab administration.
Maintenance course 1 (M1)	Day 25 to 28 of consolidation course 2 (CYVE) No rituximab given	Starts when peripheral counts have recovered from consolidation course 2 (CYVE) with ANC> 1.0 x 10^9/l and platelets > 100 x 10^9/l
Maintenance course 2 (M2)	Day 28 of maintenance course 1 (M1) No rituximab given	-

ANC = Absolute Neutrophil Count; COP = Cyclophosphamide, Vincristine, Prednisone; COPDAM = Cyclophosphamide, Vincristine, Prednisolone, Doxorubicin, Methotrexate; CYM = CYtarabine (Aracytine, Ara-C), Methotrexate; CYVE = CYtarabine (Aracytine, Ara-C), VEposide (VP16)

Table 2 Treatment Plan for non-Hodgkin's lymphoma paediatric patients: Concomitant Chemotherapy with rituximab

Treatment Plan	Patient Staging	Administration details
Group B	Stage III with high LDH level (> N x 2), Stage IV CNS negative	Prephase followed by 4 courses: 2 induction courses (COPADM) with HDMTX 3g/m^2 and 2 consolidation courses (CYM)
Group C	Group C1: BAL CNS negative, Stage IV & BAL CNS positive and CSF negative	Prephase followed by 6 courses: 2 induction courses (COPADM) with HDMTX 8g/m², 2 consolidation courses (CYVE) and 2 maintenance courses (M1 and M2)
	Group C3: BAL CSF positive, Stage IV CSF positive	
Consecutive courses should be given as soon as blood count recovery and patient's condition allows except for the maintenance courses which are given at 28 day intervals		

BAL = Burkitt leukaemia (mature B-cell acute leukaemia); CSF = Cerebrospinal Fluid; CNS = Central Nervous System; HDMTX = High-dose Methotrexate; LDH = Lactic Acid Dehydrogenase

Granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA)

Induction of remission

The recommended dosage of rituximab for induction of remission therapy in paediatric patients with severe, active GPA or MPA is 375 mg/m^2 BSA, administered as an intravenous infusion once weekly for 4 weeks.

The safety and efficacy of rituximab in paediatric patients aged 2 to less than 18 years of age has not been established in indications other than severe, active GPA or MPA.

Rituximab should not be used in paediatric patients less than 2 years of age with severe, active GPA or MPA as there is a possibility of an inadequate immune response towards childhood vaccinations against common, vaccine preventable childhood diseases (e.g. measles, mumps, rubella, and poliomyelitis) (see section 5.1).

Elderly
No dose adjustment is required in patients aged 65 years and above.

Method of administration

All indications

The prepared rituximab solution should be administered as an intravenous infusion through a dedicated line. It should not be administered as an intravenous push or bolus.

Patients should be closely monitored for the onset of cytokine release syndrome (see section 4.4). Patients who develop evidence of severe reactions, especially severe dyspnoea, bronchospasm or hypoxia should have the infusion interrupted immediately. Patients with non-Hodgkin's lymphoma should then be evaluated for evidence of tumour lysis syndrome including appropriate laboratory tests and, for pulmonary infiltration, with a chest X-ray. In all patients, the infusion should not be restarted until complete resolution of all symptoms, and normalisation of laboratory values and chest X-ray findings. At this time, the infusion can be initially resumed at not more than one-half the previous rate. If the same severe adverse reactions occur for a second time, the decision to stop the treatment should be seriously considered on a case by case basis.

Mild or moderate infusion-related reactions (IRRs) (section 4.8) usually respond to a reduction in the rate of infusion. The infusion rate may be increased upon improvement of symptoms.

Adult non-Hodgkin's lymphoma, chronic lymphocytic leukaemia, rheumatoid arthritis, pemphigus vulgaris, adult and paediatric granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA)

First infusion

The recommended initial rate for infusion is 50 mg/h; after the first 30 minutes, it can be escalated in 50 mg/h increments every 30 minutes, to a maximum of 400 mg/h.

Subsequent infusions

Subsequent doses of rituximab can be infused at an initial rate of 100 mg/h, and increased by 100 mg/h increments at 30-minute intervals, to a maximum of 400 mg/h.

Non-Hodgkin's lymphoma – paediatric patients

First infusion

The recommended initial rate for infusion is 0.5 mg/kg/h (maximum 50 mg/h); it can be escalated by 0.5 mg/kg/h every 30 minutes if there is no hypersensitivity or infusion-related reactions, to a maximum of 400 mg/h.

Subsequent infusions

Subsequent doses of rituximab can be infused at an initial rate of 1 mg/kg/h (maximum 50 mg/h); it can be increased by 1 mg/kg/h every 30 minutes to a maximum of 400 mg/h.

Adult patients - Non-Hodgkin's lymphoma (NHL) and Chronic lymphocytic leukaemia (CLL) only:

If patients did not experience a Grade 3 or 4 infusion-related adverse event during Cycle 1, a 90-minute infusion can be administered in Cycle 2 with a glucocorticoid-containing chemotherapy regimen. Initiate at a rate of 20% of the total dose given in the first 30 minutes and the remaining 80% of the total dose given over the next 60 minutes. If the 90-minute infusion is tolerated in Cycle 2, the same rate can be used when administering the remainder of the treatment regimen (through Cycle 6 or 8).
Patients who have clinically significant cardiovascular disease, including arrhythmias, or previous serious infusion reactions to any prior biologic therapy or to rituximab, should not be administered the more rapid infusion.

Rheumatoid arthritis

Alternative subsequent, faster, infusion schedule

If patients did not experience a serious infusion-related reaction with their first or subsequent infusions of a dose of 1000 mg rituximab administered over the standard infusion schedule, a more rapid infusion can be administered for second and subsequent infusions using the same concentration as in previous infusions (4 mg/mL in a 250 mL volume). Initiate at a rate of 250 mg/hour for the first 30 minutes and then 600 mg/hour for the next 90 minutes. If the more rapid infusion is tolerated, this infusion schedule can be used when administering subsequent infusions.

Patients who have clinically significant cardiovascular disease, including arrhythmias, or previous serious infusion reactions to any prior biologic therapy or to rituximab, should not be administered the more rapid infusion.

4.3 Contraindications

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

Active, severe infections (see section 4.4).

Patients in a severely immunocompromised state.

Severe heart failure (New York Heart Association Class IV) or severe, uncontrolled cardiac disease for use in rheumatoid arthritis, granulomatosis with polyangiitis, microscopic polyangiitis and pemphigus vulgaris only (see section 4.4 regarding other cardiovascular diseases).

4.4 Special warnings and precautions for use

Traceability

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

Progressive multifocal leukoencephalopathy

All patients treated with rituximab for rheumatoid arthritis, GPA, MPA or pemphigus vulgaris must be given the patient alert card with each infusion. The alert card contains important safety information for patients regarding potential increased risk of infections, including progressive multifocal leukoencephalopathy (PML).

Very rare cases of fatal PML have been reported following use of rituximab for the treatment of rheumatoid arthritis and autoimmune diseases [including Systemic Lupus Erythematosus (SLE) and vasculitis] and during post-marketing use of rituximab in NHL and CLL (where the majority of patients had received rituximab in combination with chemotherapy or as part of haematopoietic stem cell transplant). Patients must be monitored at regular intervals for any new or worsening neurological symptoms or signs that may be suggestive of PML. If PML is suspected, further dosing must be suspended until PML has been excluded. The clinician should evaluate the patient to determine if the symptoms are indicative of neurological dysfunction, and if so, whether these symptoms are possibly suggestive of PML. Consultation with a Neurologist should be considered as clinically indicated.

If any doubt exists, further evaluation, including MRI scan preferably with contrast, cerebrospinal fluid (CSF) testing for JC Viral DNA and repeat neurological assessments, should be considered.

The physician should be particularly alert to symptoms suggestive of PML that the patient may not notice (e.g. cognitive, neurological or psychiatric symptoms). Patients should also be advised to inform their partner or caregivers about their treatment, since they may notice symptoms that the patient is not aware of.

If a patient develops PML, the dosing of rituximab must be permanently discontinued. Following reconstitution of the immune system in immunocompromised patients with PML, stabilisation or improved outcome has been seen. It remains unknown if early detection of PML and suspension of rituximab therapy may lead to similar stabilisation or improved outcome.

Cardiac disorders
Angina pectoris, cardiac arrhythmias such as atrial flutter and fibrillation, heart failure and/or myocardial infarction have occurred in patients treated with rituximab. Therefore, patients with a history of cardiac disease and/or cardiotoxic chemotherapy should be monitored closely (see infusion-related reactions, below).

Infections
Based on the mechanism of action of rituximab and the knowledge that B-cells play an important role in maintaining normal immune response, patients have an increased risk of infection following rituximab therapy (see section 5.1). Serious infections, including fatalities, can occur during therapy with rituximab (see section 4.8). Rituximab should not be administered to patients with an active, severe infection (e.g. tuberculosis, sepsis and opportunistic infections, see section 4.3) or severely immunocompromised patients (e.g. where levels of CD4 or CD8 are very low). Physicians should exercise caution when considering the use of rituximab in patients with a history of recurring or chronic infections or with underlying conditions which may further predispose patients to serious infection, e.g. hypogammaglobulinaemia (see section 4.8). It is recommended that immunoglobulin levels are determined prior to initiating treatment with rituximab.

Patients reporting signs and symptoms of infection following rituximab therapy should be promptly evaluated and treated appropriately. Before giving a subsequent course of rituximab treatment, patients should be re-evaluated for any potential risk for infections.

For information on progressive multifocal leukoencephalopathy (PML) please see PML section above.

Cases of enteroviral meningoencephalitis including fatalities have been reported following use of rituximab.

Hepatitis B Infections
Cases of hepatitis B reactivation, including those with a fatal outcome, have been reported in patients receiving rituximab. The majority of these patients were also exposed to cytotoxic chemotherapy.

Limited information from one study in relapsed/refractory CLL patients suggests that rituximab treatment may also worsen the outcome of primary hepatitis B infections.

Hepatitis B virus (HBV) screening should be performed in all patients before initiation of treatment with rituximab. At minimum this should include HBsAg-status and HBcAb-status. These can be complemented with other appropriate markers as per local guidelines. Patients with active hepatitis B disease should not be treated with rituximab. Patients with positive hepatitis B serology (either HBsAg or HBcAb) should consult liver disease experts before start of treatment and should be monitored and managed following local medical standards to prevent hepatitis B reactivation.

False negative serologic testing of infections
Due to the risk of false negative serologic testing of infections, alternative diagnostic tools should be considered in case of patients presenting with symptoms indicative of rare infectious disease e.g. West Nile virus and neuroborreliosis.

Skin reactions
Severe skin reactions such as Toxic Epidermal Necrolysis (Lyell's syndrome) and Stevens-Johnson syndrome, some with fatal outcome, have been reported (see section 4.8). In case of such an event with a suspected relationship to rituximab, treatment should be permanently discontinued.

Non-Hodgkin's lymphoma and chronic lymphocytic leukaemia
Infusion-related reactions
Rituximab is associated with infusion-related reactions, which may be related to release of cytokines and/or other chemical mediators. Cytokine release syndrome may be clinically indistinguishable from acute hypersensitivity reactions.

This set of reactions which includes syndrome of cytokine release, tumour lysis syndrome and anaphylactic and hypersensitivity reactions are described below.

Severe infusion-related reactions with fatal outcome have been reported during post-marketing use of the rituximab intravenous formulation, with an onset ranging within 30 minutes to 2 hours after starting the first rituximab intravenous infusion. They were characterised by pulmonary events and in some cases included rapid tumour lysis and features of tumour lysis syndrome in addition to fever, chills, rigors, hypotension, urticaria, angioedema and other symptoms (see section 4.8).

Severe cytokine release syndrome is characterised by severe dyspnoea, often accompanied by bronchospasm and hypoxia, in addition to fever, chills, rigors, urticaria, and angioedema. This syndrome may be associated with some features of tumour lysis syndrome such as hyperuricaemia, hyperkalaemia, hypocalcaemia, hyperphosphataemia, acute renal failure, elevated lactate dehydrogenase (LDH) and may be associated with acute respiratory failure and death. The acute respiratory failure may be accompanied by events such as pulmonary interstitial infiltration or oedema, visible on a chest X-ray. The syndrome frequently manifests itself within one or two hours of initiating the first infusion. Patients with a history of pulmonary insufficiency or those with pulmonary tumour infiltration may be at greater risk of poor outcome and should be treated with increased caution.

Patients who develop severe cytokine release syndrome should have their infusion interrupted immediately (see section 4.2) and should receive aggressive symptomatic treatment. Since initial improvement of clinical symptoms may be followed by deterioration, these patients should be closely monitored until tumour lysis syndrome and pulmonary infiltration have been resolved or ruled out. Further treatment of patients after complete resolution of signs and symptoms has rarely resulted in repeated severe cytokine release syndrome.

Patients with a high tumour burden or with a high number ($\geq 25 \times 10^9$/L) of circulating malignant cells such as patients with CLL, who may be at higher risk of especially severe cytokine release syndrome, should be treated with extreme caution. These patients should be very closely monitored throughout the first infusion. Consideration should be given to the use of a reduced infusion rate for the first infusion in these patients or a split dosing over two days during the first cycle and any subsequent cycles if the

lymphocyte count is still > 25 x 10^9/L.

Infusion-related adverse reactions of all kinds have been observed in 77% of patients treated with rituximab (including cytokine release syndrome accompanied by hypotension and bronchospasm in 10% of patients) see section 4.8. These symptoms are usually reversible with interruption of rituximab infusion and administration of an anti-pyretic, an antihistaminic and occasionally oxygen, intravenous sodium chloride solution or bronchodilators, and glucocorticoids if required. Please see cytokine release syndrome above for severe reactions.

Anaphylactic and other hypersensitivity reactions have been reported following the intravenous administration of proteins to patients. In contrast to cytokine release syndrome, true hypersensitivity reactions typically occur within minutes after starting infusion. Medicinal products for the treatment of hypersensitivity reactions, e.g. epinephrine (adrenaline), antihistamines and glucocorticoids, should be available for immediate use in the event of an allergic reaction during administration of rituximab. Clinical manifestations of anaphylaxis may appear similar to clinical manifestations of the cytokine release syndrome (described above). Reactions attributed to hypersensitivity have been reported less frequently than those attributed to cytokine release.

Additional reactions reported in some cases were myocardial infarction, atrial fibrillation, pulmonary oedema and acute reversible thrombocytopenia.

Since hypotension may occur during rituximab administration, consideration should be given to withholding anti-hypertensive medicinal product 12 hours prior to the rituximab infusion.

Haematological toxicities
Although rituximab is not myelosuppressive in monotherapy, caution should be exercised when considering treatment of patients with neutrophils < 1.5 x 10^9/L and/or platelet counts < 75 x 10^9/L as clinical experience in this population is limited. Rituximab has been used in 21 patients who underwent autologous bone marrow transplantation and other risk groups with a presumable reduced bone marrow function without inducing myelotoxicity.

Regular full blood counts, including neutrophil and platelet counts, should be performed during rituximab therapy.

Immunisations
The safety of immunisation with live viral vaccines, following rituximab therapy has not been studied for NHL and CLL patients and vaccination with live virus vaccines is not recommended. Patients treated with rituximab may receive non-live vaccinations; however, with non-live vaccines response rates may be reduced. In a non-randomised study, adult patients with relapsed low-grade NHL who received rituximab monotherapy when compared to healthy untreated controls had a lower rate of response to vaccination with tetanus recall antigen (16% vs. 81%) and Keyhole Limpet Haemocyanin (KLH) neoantigen (4% vs. 76% when assessed for >2-fold increase in antibody titer). For CLL patients, similar results are assumable considering similarities between both diseases but that has not been investigated in clinical trials.

Mean pre-therapeutic antibody titres against a panel of antigens (Streptococcus pneumoniae, influenza A, mumps, rubella, varicella) were maintained for at least 6 months after treatment with rituximab.

<u>Paediatric population</u>
Only limited data are available for patients under 3 years of age. See section 5.1 for further information.

<u>Rheumatoid arthritis, granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA), and pemphigus vulgaris</u>

Methotrexate (MTX) naïve populations with rheumatoid arthritis
The use of rituximab is not recommended in MTX-naïve patients since a favourable benefit risk relationship has not been established.

Infusion-related reactions
Rituximab is associated with infusion related reactions (IRRs), which may be related to release of cytokines and/or other chemical mediators.

Severe IRRs with fatal outcome have been reported in rheumatoid arthritis patients in the post-marketing setting. In rheumatoid arthritis most infusion-related events reported in clinical trials were mild to moderate in severity. The most common symptoms were allergic reactions like headache, pruritus, throat irritation, flushing, rash, urticaria, hypertension and pyrexia. In general, the proportion of patients experiencing any infusion reaction was higher following the first infusion than following the second infusion of any treatment course. The incidence of IRR decreased with subsequent courses (see section 4.8). The reactions reported were usually reversible with a reduction in rate, or interruption, of rituximab infusion and administration of an anti-pyretic, an antihistamine, and, occasionally, oxygen, intravenous sodium chloride solution or bronchodilators, and glucocorticoids if required. Closely monitor patients with pre-existing cardiac conditions and those who experienced prior cardiopulmonary adverse reactions. Depending on the severity of the IRR and the required interventions, temporarily or permanently discontinue rituximab. In most cases, the infusion can be resumed at a 50% reduction in rate (e.g. from 100 mg/h to 50 mg/h) when symptoms have completely resolved.

Medicinal products for the treatment of hypersensitivity reactions, e.g. epinephrine (adrenaline), antihistamines and glucocorticoids, should be available for immediate use in the event of an allergic reaction during administration of rituximab.

There are no data on the safety of rituximab in patients with moderate heart failure (NYHA class III) or severe, uncontrolled cardiovascular disease. In patients treated with rituximab, the occurrence of pre-existing ischemic cardiac conditions becoming symptomatic, such as angina pectoris, has been observed, as well as atrial fibrillation and flutter. Therefore, in patients with a known cardiac history, and those who experienced prior cardiopulmonary adverse reactions, the risk of cardiovascular complications resulting from infusion reactions should be considered before treatment with rituximab and patients closely monitored during administration. Since hypotension may occur during rituximab infusion, consideration should be given to withholding anti-hypertensive medicinal product 12 hours prior to the rituximab infusion.

IRRs in patients with GPA, MPA and pemphigus vulgaris were consistent with those seen for rheumatoid arthritis patients in clinical trials and in the post-marketing setting (see section 4.8).

Late neutropenia
Measure blood neutrophils prior to each course of rituximab, and regularly up to 6-months after cessation of treatment, and upon signs or symptoms of infection (see section 4.8).

Immunisation
Physicians should review the patient's vaccination status and patients should, if possible, be brought up-to-date with all immunisations in agreement with current immunisation guidelines prior to initiating rituximab therapy. Vaccination should be completed at least 4 weeks prior to first administration of rituximab.

The safety of immunisation with live viral vaccines following rituximab therapy has not been studied. Therefore, vaccination with live virus vaccines is not recommended whilst on rituximab or whilst peripherally B-cell depleted.

Patients treated with rituximab may receive non-live vaccinations; however, response rates to non-live vaccines may be reduced. In a randomised trial, patients with rheumatoid arthritis treated with rituximab and methotrexate had comparable response rates to tetanus recall antigen (39% vs. 42%), reduced rates to pneumococcal polysaccharide vaccine (43% vs. 82% to at least 2 pneumococcal antibody serotypes), and KLH neoantigen (47% vs. 93%), when given 6 months after rituximab as compared to patients only receiving methotrexate. Should non-live vaccinations be required whilst receiving rituximab therapy, these should be completed at least 4 weeks prior to commencing the next course of rituximab.

In the overall experience of rituximab repeat treatment over one year in rheumatoid arthritis, the proportions of patients with positive antibody titres against S. pneumoniae, influenza, mumps, rubella, varicella and tetanus toxoid were generally similar to the proportions at baseline.

Concomitant/sequential use of other DMARDs in rheumatoid arthritis
The concomitant use of rituximab and anti-rheumatic therapies other than those specified under the rheumatoid arthritis indication and posology is not recommended.

There are limited data from clinical trials to fully assess the safety of the sequential use of other DMARDs (including TNF inhibitors and other biologics) following rituximab (see section 4.5). The available data indicate that the rate of clinically relevant infection is unchanged when such therapies are used in patients previously treated with rituximab, however patients should be closely observed for signs of infection if biologic agents and/or DMARDs are used following rituximab therapy.

Malignancy
Immunomodulatory medicinal products may increase the risk of malignancy. However, available data do not suggest an increased risk of malignancy for rituximab used in autoimmune indications beyond the malignancy risk already associated with the underlying autoimmune condition.

Excipients

Polysorbates
This medicine contains 7 mg of polysorbate 80 (E433) in 10 mL vial and 35 mg of polysorbate 80 (E433) in 50 mL vial, which equivalent to 0.7 mg/mL (for 10 mL vial) and 3.5 mg/mL (for 50 mL/vial). Polysorbates may cause allergic reactions.

Sodium
This medicinal product contains 2.3 mmol (or 52.6 mg) sodium per 10 mL vial and 11.5 mmol (or 263.2 mg) sodium per 50 mL vial, equivalent to 2.6% (for 10 mL vial) and 13.2% (for 50 mL vial) of the WHO recommended maximum daily intake of 2 g sodium for an adult.

4.5 Interaction with other medicinal products and other forms of interaction

Currently, there are limited data on possible drug interactions with rituximab.

In CLL patients, co-administration with rituximab did not appear to have an effect on the pharmacokinetics of fludarabine or cyclophosphamide. In addition, there was no apparent effect of fludarabine and cyclophosphamide on the pharmacokinetics of rituximab.

Co-administration with methotrexate had no effect on the pharmacokinetics of rituximab in rheumatoid arthritis patients.

Patients with human anti-mouse antibody (HAMA) or anti-drug antibody (ADA) titres may have allergic or hypersensitivity reactions when treated with other diagnostic or therapeutic monoclonal antibodies.

In patients with rheumatoid arthritis, 283 patients received subsequent therapy with a biologic DMARD following rituximab. In these patients the rate of clinically relevant infection while on rituximab was 6.01 per 100 patient years compared to 4.97 per 100 patient years following treatment with the biologic DMARD.

4.6 Fertility, pregnancy and lactation

Contraception in males and females

Due to the long retention time of rituximab in B-cell depleted patients, women of childbearing potential should use effective contraceptive methods during and for 12 months following treatment

with rituximab.

Pregnancy

IgG immunoglobulins are known to cross the placental barrier.

B-cell levels in human neonates following maternal exposure to rituximab have not been studied in clinical trials. There are no adequate and well-controlled data from studies in pregnant women, however transient B-cell depletion and lymphocytopenia have been reported in some infants born to mothers exposed to rituximab during pregnancy. Similar effects have been observed in animal studies (see section 5.3). For these reasons rituximab should not be administered to pregnant women unless the possible benefit outweighs the potential risk.

Breast-feeding

Limited data on rituximab excretion into breast milk suggest very low rituximab concentrations in milk (relative infant dose less than 0.4%). Few cases of follow-up of breastfed infants describe normal growth and development up to 2 years. However, as these data are limited and the long-term outcomes of breastfed infants remain unknown, breast-feeding is not recommended while being treated with rituximab and optimally for 6 months following rituximab treatment.

Fertility

Animal studies did not reveal deleterious effects of rituximab on reproductive organs.

4.7 Effects on ability to drive and use machines

No studies on the effects of rituximab on the ability to drive and use machines have been performed, although the pharmacological activity and adverse reactions reported to date suggest that rituximab would have no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

Experience from non-Hodgkin's lymphoma and chronic lymphocytic leukaemia in adults

Summary of the safety profile

The overall safety profile of rituximab in non-Hodgkin's lymphoma and CLL is based on data from patients from clinical trials and from post-marketing surveillance. These patients were treated either with rituximab monotherapy (as induction treatment or maintenance treatment following induction treatment) or in combination with chemotherapy.

The most frequently observed adverse reactions in patients receiving rituximab were IRRs which occurred in the majority of patients during the first infusion. The incidence of infusion-related symptoms decreases substantially with subsequent infusions and is less than 1% after eight doses of rituximab.

Infectious events (predominantly bacterial and viral) occurred in approximately 30-55% of patients during clinical trials in patients with NHL and in 30-50% of patients during clinical trials in patients with CLL.

The most frequently reported or observed serious adverse reactions were:
- IRRs (including cytokine-release syndrome, tumour-lysis syndrome), see section 4.4.
- Infections, see section 4.4.
- Cardiovascular events, see section 4.4.

Other serious adverse reactions reported include hepatitis B reactivation and PML (see section 4.4.).

Tabulated list of adverse reactions

The frequencies of adverse reactions reported with rituximab alone or in combination with chemotherapy are summarised in Table 3. Frequencies are defined as very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1000 to < 1/100), rare (≥ 1/10000 to < 1/1000), very rare (< 1/10000) and not known (cannot be estimated from the available data). Within each frequency grouping, undesirable effects are presented in the order of decreasing seriousness.

The adverse reactions identified only during post-marketing surveillance, and for which a frequency could not be estimated, are listed under "not known", see footnotes.

Table 3 Adverse reactions reported in clinical trials or during post-marketing surveillance in patients with NHL and CLL disease treated with rituximab monotherapy/maintenance or in combination with chemotherapy

MedDRA System Organ Class	Very Common	Common	Uncommon	Rare	Very Rare	Not known
Infections and infestations	bacterial infections, viral infections, +bronchitis	sepsis, +pneumonia, +febrile infection, +herpes zoster, +respiratory tract infection, fungal infections, infections of unknown aetiology, +acute bronchitis, +sinusitis, hepatitis B[1]		serious viral infection[2], pneumocystis jirovecii	PML	enteroviral meningoencephalitis[2, 3]
Blood and lymphatic system disorders	neutropenia, leucopenia, +febrile neutropenia, +thrombocytopenia	anaemia, +pancytopenia, +granulocytopenia	coagulation disorders, aplastic anaemia, haemolytic anaemia, lymphadenopathy		transient increase in serum IgM levels[4]	late neutropenia[4]
Immune system disorders	infusion-related reactions[5], angioedema	hypersensitivity		anaphylaxis	tumour lysis syndrome, cytokine release syndrome[5], serum sickness	infusion-related acute reversible thrombocytopenia[5]
Metabolism and nutrition disorders		hyperglycaemia, weight decrease, peripheral oedema, face oedema, increased LDH, hypocalcaemia				
Psychiatric disorders			depression, nervousness			
Nervous system disorders		paraesthesia, hypoaesthesia, agitation, insomnia, vasodilatation, dizziness, anxiety	dysgeusia		peripheral neuropathy, facial nerve palsy[6]	cranial neuropathy, loss of other senses[6]
Eye disorders		lacrimation disorder, conjunctivitis			severe vision loss[6]	
Ear and labyrinth		tinnitus, ear pain				hearing loss[6]

disorders						
Cardiac disorders		+myocardial infarction[5,7], arrhythmia, +atrial fibrillation, tachycardia, +cardiac disorder	+left ventricular failure, +supraventri-cular tachycardia, +ventricular tachycardia, +angina, +myocardial ischaemia, bradycardia	severe cardiac disorders[5, 7]	heart failure[5, 7]	
Vascular disorders		hypertension, orthostatic hypotension, hypotension			vasculitis (predominately cutaneous), leukocytoclasti c vasculitis	
Respiratory, thoracic and mediastinal disorders		bronchospasm[5], respiratory disease, chest pain, dyspnoea, increased cough, rhinitis	asthma, bronchiolitis obliterans, lung disorder, hypoxia	interstitial lung disease[8]	respiratory failure[5]	lung infiltration
Gastrointestin al disorders	nausea	vomiting, diarrhoea, abdominal pain, dysphagia, stomatitis, constipation, dyspepsia, anorexia, throat irritation	abdominal enlargement		gastro-intestina l perforation[8]	
Skin and subcutaneous tissue disorders	pruritus, rash, +alopecia	urticaria, sweating, night sweats, +skin disorder			severe bullous skin reactions, Stevens-Johnson syndrome, toxic epidermal necrolysis (Lyell's syndrome)[8]	
Musculoskelet al, connective tissue disorders		hypertonia, myalgia, arthralgia, back pain, neck pain, pain				
Renal and urinary disorders					renal failure[5]	
General disorders and administratio n site conditions	fever, chills, asthenia, headache	tumour pain, flushing, malaise, cold syndrome, +fatigue, +shivering, +multi-organ failure[5]	infusion site pain			
Investigations	decreased IgG levels					

For each term, the frequency count was based on reactions of all grades (from mild to severe), except for terms marked with "+" where the frequency count was based only on severe (≥ grade 3 NCI common toxicity criteria) reactions. Only the highest frequency observed in the trials is reported

[1] includes reactivation and primary infections; frequency based on R-FC regimen in relapsed/refractory CLL

[2] see also section infection below

[3] observed during post-marketing surveillance

[4] see also section haematologic adverse reactions below

[5] see also section infusion-related reactions below. Rarely fatal cases reported
[6] signs and symptoms of cranial neuropathy. Occurred at various times up to several months after completion of rituximab therapy
[7] observed mainly in patients with prior cardiac condition and/or cardiotoxic chemotherapy and were mostly associated with infusion-related reactions
[8] includes fatal cases

The following terms have been reported as adverse reactions during clinical trials, however, were reported at a similar or lower incidence in the rituximab-arms compared to control arms: haematotoxicity, neutropenic infection, urinary tract infection, sensory disturbance, pyrexia.

Signs and symptoms suggestive of an infusion-related reaction were reported in more than 50% of patients in clinical trials, and were predominantly seen during the first infusion, usually in the first one to two hours. These symptoms mainly comprised fever, chills and rigors. Other symptoms included flushing, angioedema, bronchospasm, vomiting, nausea, urticaria/rash, fatigue, headache, throat irritation, rhinitis, pruritus, pain, tachycardia, hypertension, hypotension, dyspnoea, dyspepsia, asthenia and features of tumour lysis syndrome. Severe infusion-related reactions (such as bronchospasm, hypotension) occurred in up to 12% of the cases. Additional reactions reported in some cases were myocardial infarction, atrial fibrillation, pulmonary oedema and acute reversible thrombocytopenia. Exacerbations of pre-existing cardiac conditions such as angina pectoris or congestive heart failure or severe cardiac disorders (heart failure, myocardial infarction, atrial fibrillation), pulmonary oedema, multi-organ failure, tumour lysis syndrome, cytokine release syndrome, renal failure, and respiratory failure were reported at lower or unknown frequencies. The incidence of infusion-related symptoms decreased substantially with subsequent infusions and is < 1% of patients by the eighth cycle of rituximab-containing treatment.

Description of selected adverse reactions

Infections
Rituximab induces B-cell depletion in about 70-80% of patients, but was associated with decreased serum immunoglobulins only in a minority of patients.

Localised candida infections as well as Herpes zoster were reported at a higher incidence in the rituximab-containing arm of randomised studies. Severe infections were reported in about 4% of patients treated with rituximab monotherapy. Higher frequencies of infections overall, including grade 3 or 4 infections, were observed during rituximab maintenance treatment up to 2 years when compared to observation. There was no cumulative toxicity in terms of infections reported over a 2-year treatment period. In addition, other serious viral infections either new, reactivated or exacerbated, some of which were fatal, have been reported with rituximab treatment. The majority of patients had received rituximab in combination with chemotherapy or as part of a haematopoetic stem cell transplant. Examples of these serious viral infections are infections caused by the herpes viruses (Cytomegalovirus, Varicella Zoster Virus and Herpes Simplex Virus), JC virus (progressive multifocal leukoencephalopathy (PML)), enterovirus (meningoencephalitis) and hepatitis C virus (see section 4.4.). Cases of fatal PML that occurred after disease progression and retreatment have also been reported in clinical trials. Cases of hepatitis B reactivation, have been reported, the majority of which were in patients receiving rituximab in combination with cytotoxic chemotherapy. In patients with relapsed/refractory CLL, the incidence of grade 3/4 hepatitis B infection (reactivation and primary infection) was 2% in R-FC vs. 0% FC. Progression of Kaposi's sarcoma has been observed in rituximab-exposed patients with pre-existing Kaposi's sarcoma. These cases occurred in non-approved indications and the majority of patients were HIV positive.

Haematologic adverse reactions
In clinical trials with rituximab monotherapy given for 4 weeks, haematological abnormalities occurred in a minority of patients and were usually mild and reversible. Severe (grade 3/4) neutropenia was reported in 4.2%, anaemia in 1.1% and thrombocytopenia in 1.7% of the patients. During rituximab maintenance treatment for up to 2 years, leucopenia (5% vs. 2%, grade 3/4) and neutropenia (10% vs. 4%, grade 3/4) were reported at a higher incidence when compared to observation. The incidence of thrombocytopenia was low (<1%, grade 3/4) and was not different between treatment arms. During the

treatment course in studies with rituximab in combination with chemotherapy, grade 3/4 leucopenia (R-CHOP 88% vs. CHOP 79%, R-FC 23% vs. FC 12%), neutropenia (R-CVP 24% vs. CVP 14%; R-CHOP 97% vs. CHOP 88%, R-FC 30% vs. FC 19% in previously untreated CLL), pancytopenia (R-FC 3% vs. FC 1% in previously untreated CLL) were usually reported with higher frequencies when compared to chemotherapy alone. However, the higher incidence of neutropenia in patients treated with rituximab and chemotherapy was not associated with a higher incidence of infections and infestations compared to patients treated with chemotherapy alone. Studies in previously untreated and relapsed/refractory CLL have established that in up to 25% of patients treated with R-FC neutropenia was prolonged (defined as neutrophil count remaining below $1x10^9$/L between day 24 and 42 after the last dose) or occurred with a late onset (defined as neutrophil count below $1x10^9$/L later than 42 Days after last dose in patients with no previous prolonged neutropenia or who recovered prior to day 42) following treatment with rituximab plus FC. There were no differences reported for the incidence of anaemia. Some cases of late neutropenia occurring more than four weeks after the last infusion of rituximab were reported. In the CLL first-line study, Binet stage C patients experienced more adverse events in the R-FC arm compared to the FC arm (R-FC 83% vs. FC 71%). In the relapsed/refractory CLL study grade 3/4 thrombocytopenia was reported in 11% of patients in the R-FC group compared to 9% of patients in the FC group.

In studies of rituximab in patients with Waldenstrom's macroglobulinaemia, transient increases in serum IgM levels have been observed following treatment initiation, which may be associated with hyperviscosity and related symptoms. The transient IgM increase usually returned to at least baseline level within 4 months.

Cardiovascular adverse reactions
Cardiovascular reactions during clinical trials with rituximab monotherapy were reported in 18.8% of patients with the most frequently reported events being hypotension and hypertension. Cases of grade 3 or 4 arrhythmia (including ventricular and supraventricular tachycardia) and angina pectoris during infusion were reported. During maintenance treatment, the incidence of grade 3/4 cardiac disorders was comparable between patients treated with rituximab and observation. Cardiac events were reported as serious adverse events (including atrial fibrillation, myocardial infarction, left ventricular failure, myocardial ischaemia) in 3% of patients treated with rituximab compared to < 1% on observation. In studies evaluating rituximab in combination with chemotherapy, the incidence of grade 3 and 4 cardiac arrhythmias, predominantly supraventricular arrhythmias such as tachycardia and atrial flutter/fibrillation, was higher in the R-CHOP group (14 patients, 6.9%) as compared to the CHOP group (3 patients, 1.5%). All of these arrhythmias either occurred in the context of a rituximab infusion or were associated with predisposing conditions such as fever, infection, acute myocardial infarction or pre-existing respiratory and cardiovascular disease. No difference between the R-CHOP and CHOP group was observed in the incidence of other grade 3 and 4 cardiac events including heart failure, myocardial disease and manifestations of coronary artery disease. In CLL, the overall incidence of grade 3 or 4 cardiac disorders was low both in the first-line study (4% R-FC, 3% FC) and in the relapsed/refractory study (4% R-FC, 4% FC).

Respiratory system
Cases of interstitial lung disease, some with fatal outcome have been reported.

Neurologic disorders
During the treatment period (induction treatment phase comprising of R-CHOP for at most eight cycles), four patients (2%) treated with R-CHOP, all with cardiovascular risk factors, experienced thromboembolic cerebrovascular accidents during the first treatment cycle. There was no difference between the treatment groups in the incidence of other thromboembolic events. In contrast, three patients (1.5%) had cerebrovascular events in the CHOP group, all of which occurred during the follow-up period. In CLL, the overall incidence of grade 3 or 4 nervous system disorders was low both in the first-line study (4% R-FC, 4% FC) and in the relapsed/refractory study (3% R-FC, 3% FC).

Cases of posterior reversible encephalopathy syndrome (PRES) / reversible posterior leukoencephalopathy syndrome (RPLS) have been reported. Signs and symptoms included visual disturbance, headache, seizures and altered mental status, with or without associated hypertension. A diagnosis of PRES/RPLS requires confirmation by brain imaging. The reported cases had recognised risk factors for PRES/RPLS, including the patients' underlying disease, hypertension, immunosuppressive

therapy and/or chemotherapy.

Gastrointestinal disorders
Gastrointestinal perforation in some cases leading to death has been observed in patients receiving rituximab for treatment of non-Hodgkin's lymphoma. In the majority of these cases, rituximab was administered with chemotherapy.

IgG levels
In the clinical trial evaluating rituximab maintenance treatment in relapsed/refractory follicular lymphoma, median IgG levels were below the lower limit of normal (LLN) (< 7 g/L) after induction treatment in both the observation and the rituximab groups. In the observation group, the median IgG level subsequently increased to above the LLN, but remained constant in the rituximab group. The proportion of patients with IgG levels below the LLN was about 60% in the rituximab group throughout the 2-year treatment period, while it decreased in the observation group (36% after 2 years).

A small number of spontaneous and literature cases of hypogammaglobulinaemia have been observed in paediatric patients treated with rituximab, in some cases severe and requiring long-term immunoglobulin substitution therapy. The consequences of long term B-cell depletion in paediatric patients are unknown.

Skin and subcutaneous tissue disorders
Toxic Epidermal Necrolysis (Lyell's syndrome) and Stevens-Johnson syndrome, some with fatal outcome, have been reported very rarely.

Patient subpopulations - rituximab monotherapy
Elderly (65 years and above):
The incidence of adverse reactions of all grades and grade 3/4 adverse reactions was similar in elderly patients compared to younger patients (below 65 years).

Bulky disease
There was a higher incidence of grade 3/4 adverse reactions in patients with bulky disease than in patients without bulky disease (25.6% vs. 15.4%). The incidence of adverse reactions of any grade was similar in these two groups.

Re-treatment
The percentage of patients reporting adverse reactions upon re-treatment with further courses of rituximab was similar to the percentage of patients reporting adverse reactions upon initial exposure (any grade and grade 3/4 adverse reactions).

Patient subpopulations - rituximab combination therapy
Elderly (65 years and above)
The incidence of grade 3/4 blood and lymphatic adverse events was higher in elderly patients compared to younger patients (below 65 years), with previously untreated or relapsed/refractory CLL.

Experience from paediatric DLBCL/BL/BAL/BLL

Summary of the safety profile

A multicentre, open-label randomised study of Lymphome Malin B chemotherapy (LMB) with or without rituximab was conducted in paediatric patients (aged 6 months to less than 18 years old) with previously untreated advanced stage CD20 positive DLBCL/BL/BAL/BLL.

A total of 309 paediatric patients received rituximab and were included in the safety analysis population. Paediatric patients randomised to the LMB chemotherapy arm with rituximab, or enrolled in the single arm part of the study, were administered rituximab at a dose of 375 mg/m^2 BSA and received a total of six intravenous infusions of rituximab (two during each of the two induction courses and one during each of the two consolidation courses of the LMB scheme).

The safety profile of rituximab in paediatric patients (aged 6 months to less than 18 years old) with previously untreated advanced stage CD20 positive DLBCL/BL/BAL/BLL was generally consistent in type, nature and severity with the known safety profile in adult NHL and CLL patients. Addition of rituximab to chemotherapy did result in an increased risk of some events including infections (including sepsis) compared to chemotherapy only.

Experience from rheumatoid arthritis

Summary of the safety profile

The overall safety profile of rituximab in rheumatoid arthritis is based on data from patients from clinical trials and from post-marketing surveillance.

The safety profile of rituximab in patients with moderate to severe rheumatoid arthritis (RA) is summarised in the sections below. In clinical trials more than 3,100 patients received at least one treatment course and were followed for periods ranging from 6 months to over 5 years; approximately 2,400 patients received two or more courses of treatment with over 1,000 having received 5 or more courses. The safety information collected during post-marketing experience reflects the expected adverse reaction profile as seen in clinical trials for rituximab (see section 4.4).

Patients received 2 x 1,000 mg of rituximab separated by an interval of two weeks; in addition to methotrexate (10-25 mg/week). Rituximab infusions were administered after an intravenous infusion of 100 mg methylprednisolone; patients also received treatment with oral prednisone for 15 days.

Tabulated list of adverse reactions

Adverse reactions are listed in Table 4. Frequencies are defined as very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100), rare (≥ 1/10,000 to < 1/1,000), very rare (< 1/10,000) and not known (cannot be estimated from the available data). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

The adverse reactions identified only during post marketing surveillance, and for which a frequency could not be estimated, are listed under “not known”, see footnotes.

The most frequent adverse reactions considered due to receipt of rituximab were IRRs. The overall incidence of IRRs in clinical trials was 23% with the first infusion and decreased with subsequent infusions. Serious IRRs were uncommon (0.5% of patients) and were predominantly seen during the initial course. In addition to adverse reactions seen in RA clinical trials for rituximab, progressive multifocal leukoencephalopathy (PML) (see section 4.4) and serum sickness-like reaction have been reported during post marketing experience.

Table 4 Summary of adverse reactions reported in clinical trials or during post-marketing surveillance occurring in patients with rheumatoid arthritis receiving rituximab

MedDRA System Organ Class	Very Common	Common	Uncommon	Rare	Very rare	Not known
Infections and infestations	upper respiratory tract infection, urinary tract infections	bronchitis, sinusitis, gastroenteritis, tinea pedís			PML, reactivation of hepatitis B	serious viral infection [1, 2], enteroviral meningoencephalitis[2]
Blood and lymphatic system disorders		neutropenia[3]		late neutropenia[4]	serum sickness-like reaction	
Immune system disorders	[5]infusion-related reactions (hypertension, nausea, rash,		[5]infusion-related reactions (generalised oedema,			
General disorders and						

MedDRA System Organ Class	Very Common	Common	Uncommon	Rare	Very rare	Not known
administration site conditions	pyrexia, pruritus, urticaria, throat irritation, hot flush, hypotension, rhinitis, rigors, tachycardia, fatigue, oropharyngeal pain, peripheral oedema, erythema)		bronchospasm, wheezing, laryngeal oedema, angioneurotic oedema, generalised pruritus, anaphylaxis, anaphylactoid reaction)			
Metabolism and nutritional disorders		hypercholesterolemia				
Psychiatric disorders		depression, anxiety				
Nervous system disorders	headache	paraesthesia, migraine, dizziness, sciatica				
Cardiac disorders				angina pectoris, atrial fibrillation, heart failure, myocardial infarction	atrial flutter	
Gastrointestinal disorders		dyspepsia, diarrhoea, gastro-oesophageal reflux, mouth ulceration, upper abdominal pain				
Skin and subcutaneous tissue disorders		alopecia			toxic epidermal necrolysis (Lyell's syndrome), Stevens-Johnson syndrome[7]	
Musculo-skeletal disorders		arthralgia / musculoskeletal pain, osteoarthritis, bursitis				
Investigations	decreased IgM levels[6]	decreased IgG levels[6]				

[1] See also section infections below
[2] Observed during post-marketing surveillance
[3] Frequency category derived from laboratory values collected as part of routine laboratory monitoring in clinical trials
[4] Frequency category derived from post-marketing data.
[5] Reactions occurring during or within 24 hours of infusion. See also infusion-related reactions below. IRRs may occur as a result of hypersensitivity and/or to the mechanism of action.
[6] Includes observations collected as part of routine laboratory monitoring.
[7] Includes fatal cases

Multiple courses

Multiple courses of treatment are associated with a similar adverse reaction profile to that observed following first exposure. The rate of all adverse reactions following first rituximab exposure was highest during the first 6 months and declined thereafter. This is mostly accounted for by IRRs (most frequent during the first treatment course), RA exacerbation and infections, all of which were more frequent in the first 6 months of treatment.

Description of selected adverse reactions

Infusion-related reactions
The most frequent adverse reactions following receipt of rituximab in clinical trials were IRRs (refer to Table 4). Among the 3189 patients treated with rituximab, 1135 (36%) experienced at least one IRR with 733/3189 (23%) of patients experiencing an IRR following first infusion of the first exposure to rituximab. The incidence of IRRs declined with subsequent infusions. In clinical trials fewer than 1% (17/3189) of patients experienced a serious IRR. There were no CTC Grade 4 IRRs and no deaths due to IRRs in the clinical trials. The proportion of CTC Grade 3 events, and of IRRs leading to withdrawal decreased by course and were rare from course 3 onwards. Premedication with intravenous glucocorticoid significantly reduced the incidence and severity of IRRs (see sections 4.2 and 4.4). Severe IRRs with fatal outcome have been reported in the post-marketing setting.

In a trial designed to evaluate the safety of a more rapid rituximab infusion in patients with rheumatoid arthritis, patients with moderate-to-severe active RA who did not experience a serious IRR during or within 24 hours of their first studied infusion were allowed to receive a 2-hour intravenous infusion of rituximab. Patients with a history of a serious infusion reaction to a biologic therapy for RA were excluded from entry. The incidence, types and severity of IRRs were consistent with that observed historically. No serious IRRs were observed.

Infections
The overall rate of infection reported from clinical trials was approximately 94 per 100 patient years in rituximab treated patients. The infections were predominately mild to moderate and consisted mostly of upper respiratory tract infections and urinary tract infections. The incidence of infections that were serious or required intravenous antibiotics, was approximately 4 per 100 patient years. The rate of serious infections did not show any significant increase following multiple courses of rituximab. Lower respiratory tract infections (including pneumonia) have been reported during clinical trials, at a similar incidence in the rituximab-arms compared to control arms.

In the post marketing setting, serious viral infections have been reported in RA patients treated with rituximab.

Cases of progressive multifocal leukoencephalopathy with fatal outcome have been reported following use of rituximab for the treatment of autoimmune diseases. This includes rheumatoid arthritis and off-label autoimmune diseases, including Systemic Lupus Erythematosus (SLE) and vasculitis.

In patients with non-Hodgkin's lymphoma receiving rituximab in combination with cytotoxic chemotherapy, cases of hepatitis B reactivation have been reported (see non-Hodgkin's lymphoma). Reactivation of hepatitis B infection has also been very rarely reported in rheumatoid arthritis patients receiving rituximab (see section 4.4).

Cardiovascular adverse reactions
Serious cardiac reactions were reported at a rate of 1.3 per 100 patient years in the rituximab treated patients compared to 1.3 per 100 patient years in placebo treated patients. The proportions of patients experiencing cardiac reactions (all or serious) did not increase over multiple courses.

Neurologic events
Cases of posterior reversible encephalopathy syndrome (PRES)/reversible posterior leukoencephalopathy syndrome (RPLS) have been reported. Signs and symptoms included visual disturbance, headache, seizures and altered mental status, with or without associated hypertension. A diagnosis of PRES/RPLS requires confirmation by brain imaging. The reported cases had recognised risk factors for PRES/RPLS, including the patients' underlying disease, hypertension, immunosuppressive therapy and/or chemotherapy.

Neutropenia
Events of neutropenia were observed with rituximab treatment, the majority of which were transient and mild or moderate in severity. Neutropenia can occur several months after the administration of rituximab

(see section 4.4).

In placebo-controlled periods of clinical trials, 0.94% (13/1382) of rituximab treated patients and 0.27% (2/731) of placebo patients developed severe neutropenia.

Neutropenic events, including severe late onset and persistent neutropenia, have been rarely reported in the post-marketing setting, some of which were associated with fatal infections.

Skin and subcutaneous tissue disorders
Toxic Epidermal Necrolysis (Lyell's syndrome) and Stevens-Johnson syndrome, some with fatal outcome, have been reported very rarely.

Laboratory abnormalities
Hypogammaglobulinaemia (IgG or IgM below the lower limit of normal) has been observed in RA patients treated with rituximab. There was no increased rate in overall infections or serious infections after the development of low IgG or IgM (see section 4.4).

A small number of spontaneous and literature cases of hypogammaglobulinaemia have been observed in paediatric patients treated with rituximab, in some cases severe and requiring long-term immunoglobulin substitution therapy. The consequences of long-term B-cell depletion in paediatric patients are unknown.

Experience from granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA)

The overall safety profile of rituximab in adult and paediatric GPA/MPA patients is based on data from patients from 3 clinical trials and from post-marketing surveillance.

Adult induction of remission (GPA/MPA Study 1)
In GPA/MPA Study 1, 99 adult patients were treated for induction of remission of GPA and MPA with rituximab (375 mg/m^2, once weekly for 4 weeks) and glucocorticoids (see section 5.1).

The adverse reactions from GPA/MPA Study 1 listed in Table 5 with a frequency categorisation of "common" or "very common" were all adverse events which occurred at an incidence of ≥ 5% in the rituximab group and at a higher frequency than the comparator group.

The adverse reactions identified only during post-marketing surveillance, and for which a frequency could not be estimated, are listed under "not known", see footnotes.

Table 5 Adverse reactions occurring at 6-months in ≥ 5% of adult patients receiving rituximab in GPA/MPA Study 1 (Rituximab n=99), at a higher frequency than the comparator group or during post-marketing surveillance.

MedDRA System Organ Class	Very Common	Common	Not Known
Infections and infestations		urinary tract infection, bronchitis, herpes zoster, nasopharyngitis	serious viral infection [1, 2] enteroviral meningoencephalitis [1]
Blood and lymphatic system disorders		thrombocytopenia	
Immune system disorders		cytokine release syndrome	
Metabolism and nutrition disorders		hyperkalaemia	
Psychiatric disorders	insomnia		

MedDRA System Organ Class	Very Common	Common	Not Known
Nervous system disorders	dizziness, tremor		
Vascular disorders	hypertension	flushing	
Respiratory, thoracic and mediastinal disorders	cough, dyspnoea, epistaxis	nasal congestion	
Gastrointestinal disorders	diarrhoea	dyspepsia, constipation	
Skin and subcutaneous tissue disorders		acne	
Musculoskeletal and connective tissue disorders	muscle spasms, arthralgia, back pain	muscle weakness, musculoskeletal pain, pain in extremities	
General disorders and administration site conditions	oedema peripheral		
Investigations		decreased haemoglobin	

[1] Observed during post-marketing surveillance.
[2] See also section infections below.

Adult maintenance treatment (GPA/MPA Study 2)
In GPA/MPA Study 2, a total of 57 adult patients with severe, active GPA and MPA were treated with rituximab for the maintenance of remission (see section 5.1).

Table 6 Adverse reactions occurring in ≥ 5% of adult patients receiving rituximab in GPA/MPA Study 2 (Rituximab n=57), at a higher frequency than the comparator group, or during post-marketing surveillance.

MedDRA System Organ Class	Very Common	Common	Not Known
Infections and infestations	bronchitis	rhinitis	serious viral infection [1, 2] enteroviral meningoencephalitis [1]
General disorders and administration site conditions		pyrexia, influenza-like illness, oedema peripheral	
Gastrointestinal disorders		diarrhoea	
Respiratory, thoracic and mediastinal disorders		dyspnoea	

MedDRA System Organ Class	Very Common	Common	Not Known
Injury, poisoning and procedural complications	infusion-related reactions[3]		

[1] Observed during post-marketing surveillance.

[2] See also section infections below.

[3] Details on infusion-related reactions are provided in the description of selected adverse drug reactions section.

The overall safety profile was consistent with the well-established safety profile for rituximab in approved autoimmune indications, including GPA/MPA. Overall, 4% of patients in the rituximab arm experienced adverse events leading to discontinuation. Most adverse events in the rituximab arm were mild or moderate in intensity. No patients in the rituximab arm had fatal adverse events.

The most commonly reported events considered as adverse reactions were infusion-related reactions and infections.

Long-term follow-up (GPA/MPA Study 3)
In a long-term observational safety study, 97 GPA/MPA patients received treatment with rituximab (mean of 8 infusions [range 1-28]) for up to 4 years, according to their physician's standard practice and discretion. The overall safety profile was consistent with the well-established safety profile of rituximab in RA and GPA/MPA and no new adverse drug reactions were reported.

Paediatric population
An open-label, single arm study was conducted in 25 paediatric patients with severe, active GPA or MPA. The overall study period consisted of a 6-month remission induction phase with a minimum 18-month follow-up, up to 4.5 years overall. During the follow-up phase, rituximab was given at the discretion of the investigator (17 out of 25 patients received additional rituximab treatment). Concomitant treatment with other immunosuppressive therapy was permitted (see section 5.1).

Adverse reactions were considered as adverse events that occurred at an incidence of $\geq$ 10%. These included: infections (17 patients [68%] in the remission induction phase; 23 patients [92%] in the overall study period), IRRs (15 patients [60%] in the remission induction phase; 17 patients [68%] in the overall study period), and nausea (4 patients [16%] in the remission induction phase; 5 patients [20%] in the overall study period).

During the overall study period, the safety profile of rituximab was consistent with that reported during the remission induction phase.

The safety profile of rituximab in paediatric GPA or MPA patients was consistent in type, nature and severity with the known safety profile in adult patients in the approved autoimmune indications, including adult GPA or MPA.

Description of selected adverse reactions

Infusion-related reactions
In GPA/MPA Study 1 (adult induction of remission study), IRRs were defined as any adverse event occurring within 24 hours of an infusion and considered to be infusion-related by investigators in the safety population. Of the 99 patients treated with rituximab, 12 (12%) experienced at least one IRR. All IRRs were CTC Grade 1 or 2. The most common IRRs included cytokine release syndrome, flushing, throat irritation, and tremor. Rituximab was given in combination with intravenous glucocorticoids which may reduce the incidence and severity of these events.

In GPA/MPA Study 2 (adult maintenance study), 7/57 (12%) patients in the rituximab arm experienced at least one infusion-related reaction. The incidence of IRR symptoms was highest during or after the first infusion (9%) and decreased with subsequent infusions (< 4%). All IRR symptoms were mild or

moderate and most of them were reported from the SOCs Respiratory, Thoracic and Mediastinal Disorders and Skin and Subcutaneous Tissue disorders.

In the clinical trial in paediatric patients with GPA or MPA, the reported IRRs were predominantly seen with the first infusion (8 patients [32%]), and then decreased over time with the number of rituximab infusions (20% with the second infusion, 12% with the third infusion and 8% with the fourth infusion). The most common IRR symptoms reported during the remission induction phase were: headache, rash, rhinorrhea and pyrexia (8%, for each symptom). The observed symptoms of IRRs were similar to those known in adult GPA or MPA patients treated with rituximab. The majority of IRRs were Grade 1 and Grade 2, there were two non-serious Grade 3 IRRs, and no Grade 4 or 5 IRRs reported. One serious Grade 2 IRR (generalised oedema which resolved with treatment) was reported in one patient (see section 4.4).

Infections
In GPA/MPA Study 1, the overall rate of infection was approximately 237 per 100 patient years (95% CI 197-285) at the 6-month primary endpoint. Infections were predominately mild to moderate and consisted mostly of upper respiratory tract infections, herpes zoster and urinary tract infections. The rate of serious infections was approximately 25 per 100 patient years. The most frequently reported serious infection in the rituximab group was pneumonia at a frequency of 4%.

In GPA/MPA Study 2, 30/57 (53%) patients in the rituximab arm experienced infections. The incidence of all grade infections was similar between the arms. Infections were predominately mild to moderate. The most common infections in the rituximab arm included upper respiratory tract infections, gastroenteritis, urinary tract infections and herpes zoster. The incidence of serious infections was similar in both arms (approximately 12%). The most commonly reported serious infection in the rituximab group was mild or moderate bronchitis.

In the clinical trial in paediatric patients with severe, active GPA and MPA, 91% of reported infections were non-serious and 90% were mild to moderate.

The most common infections in the overall phase were: upper respiratory tract infections (URTIs) (48%), influenza (24%), conjunctivitis (20%), nasopharyngitis (20%), lower respiratory tract infections (16%), sinusitis (16%), viral URTIs (16%), ear infection (12%), gastroenteritis (12%), pharyngitis (12%), urinary tract infection (12%). Serious infections were reported in 7 patients (28%), and included: influenza (2 patients [8%]) and lower respiratory tract infection (2 patients [8%]) as the most frequently reported events.

In the post marketing setting, serious viral infections have been reported in GPA/MPA patients treated with rituximab.

Malignancies
In GPA/MPA Study 1, the incidence of malignancy in rituximab treated patients in the GPA and MPA clinical study was 2.00 per 100 patient years at the study common closing date (when the final patient had completed the follow-up period). On the basis of standardised incidence ratios, the incidence of malignancies appears to be similar to that previously reported in patients with ANCA-associated vasculitis.

In the paediatric clinical trial, no malignancies were reported with a follow-up period of up to 54 months.

Cardiovascular adverse reactions
In GPA/MPA Study 1, cardiac events occurred at a rate of approximately 273 per 100 patient years (95% CI 149-470) at the 6-month primary endpoint. The rate of serious cardiac events was 2.1 per 100 patient years (95% CI 3-15). The most frequently reported events were tachycardia (4%) and atrial fibrillation (3%) (see section 4.4).

Neurologic events
Cases of posterior reversible encephalopathy syndrome (PRES)/reversible posterior leukoencephalopathy syndrome (RPLS) have been reported in autoimmune conditions. Signs and symptoms included visual disturbance, headache, seizures and altered mental status, with or without associated hypertension. A

diagnosis of PRES/RPLS requires confirmation by brain imaging. The reported cases had recognised risk factors for PRES/RPLS, including the patients' underlying disease, hypertension, immunosuppressive therapy and/or chemotherapy.

Hepatitis B reactivation
A small number of cases of hepatitis B reactivation, some with fatal outcome, have been reported in granulomatosis with polyangiitis and microscopic polyangiitis patients receiving rituximab in the post-marketing setting.

Hypogammaglobulinaemia
Hypogammaglobulinaemia (IgA, IgG or IgM below the lower limit of normal) has been observed in adult and paediatric GPA and MPA patients treated with rituximab.

In GPA/MPA Study 1, at 6 months, in the rituximab group, 27%, 58% and 51% of patients with normal immunoglobulin levels at baseline had low IgA, IgG and IgM levels, respectively, compared to 25%, 50% and 46% in the cyclophosphamide group. The rate of overall infections and serious infections was not increased after the development of low IgA, IgG or IgM.

In GPA/MPA Study 2, no clinically meaningful differences between the two treatment arms or decreases in total immunoglobulin, IgG, IgM or IgA levels were observed throughout the trial.

In the paediatric clinical trial, during the overall study period, 3/25 (12%) patients reported an event of hypogammaglobulinaemia, 18 patients (72%) had prolonged (defined as Ig levels below lower limit of normal for at least 4 months) low IgG levels (of whom 15 patients also had prolonged low IgM). Three patients received treatment with intravenous immunoglobulin (IV-IG). Based on limited data, no firm conclusions can be drawn regarding whether prolonged low IgG and IgM led to an increased risk of serious infection in these patients. The consequences of long term B-cell depletion in paediatric patients are unknown.

Neutropenia
In GPA/MPA Study 1, 24% of patients in the rituximab group (single course) and 23% of patients in the cyclophosphamide group developed CTC grade 3 or greater neutropenia. Neutropenia was not associated with an observed increase in serious infection in rituximab-treated patients.

In GPA/MPA Study 2, the incidence of all-grade neutropenia was 0% for rituximab-treated patients vs. 5% for azathioprine treated patients.

Skin and subcutaneous tissue disorders
Toxic Epidermal Necrolysis (Lyell's syndrome) and Stevens-Johnson syndrome, some with fatal outcome, have been reported very rarely.

Experience from pemphigus vulgaris

The overall safety profile of rituximab in pemphigus vulgaris is based on data from patients from 2 clinical trials and from post-marketing surveillance.

Summary of the safety profile in PV Study 1 (Study ML22196) and PV Study 2 (Study WA29330)

The safety profile of rituximab in combination with short-term, low-dose glucocorticoids in the treatment of patients with pemphigus vulgaris was studied in a Phase 3, randomised, controlled, multicentre, open-label study in pemphigus patients that included 38 pemphigus vulgaris (PV) patients randomised to the rituximab group (PV Study 1). Patients randomised to the rituximab group received an initial 1000 mg intravenous on Study Day 1 and a second 1000 mg intravenous on Study Day 15. Maintenance doses of 500 mg intravenous were administered at months 12 and 18. Patients could receive 1000 mg intravenous at the time of relapse (see section 5.1).

In PV Study 2, a randomised, double-blind, double-dummy, active-comparator, multicentre study evaluating the efficacy and safety of rituximab compared with mycophenolate mofetil (MMF) in patients

with moderate-to-severe PV requiring oral corticosteroids, 67 PV patients received treatment with rituximab (initial 1000 mg intravenous on Study Day 1 and a second 1000 mg intravenous on Study Day 15 repeated at Weeks 24 and 26) for up to 52 weeks (see section 5.1).

The safety profile of rituximab in PV was consistent with the established safety profile in other approved autoimmune indications.

Tabulated list of adverse reactions for PV Studies 1 and 2, or during post-marketing surveillance

The adverse reactions from PV Studies 1 and 2 with a frequency categorisation of "common" or "very common" are presented in Table 7. In PV Study 1, adverse reactions were defined as adverse events which occurred at a rate of ≥ 5% among rituximab-treated PV patients, with a ≥ 2% absolute difference in incidence between the rituximab-treated group and the standard-dose prednisone group up to Month 24. No patients were withdrawn due to adverse reactions in Study 1. In PV Study 2, adverse reactions were defined as adverse events occurring in ≥5% of patients in the rituximab arm and assessed as related.

The adverse reactions identified only during post-marketing surveillance, and for which a frequency could not be estimated, are listed under "not known", see footnotes.

Table 7 Adverse reactions in rituximab-treated pemphigus vulgaris patients in PV Study 1 (up to Month 24) and PV Study 2 (up to Week 52), or during post-marketing surveillance

MedDRA System Organ Class	Very Common	Common	Not Known
Infections and infestations	upper respiratory tract infection	herpes virus infection herpes zoster oral herpes conjunctivitis nasopharyngitis oral candidiasis urinary tract infection	serious viral infection [1, 2] enteroviral meningoencephalitis [1]
Neoplasms benign, malignant and unspecified (incl cysts and polyps)		skin papilloma	
Psychiatric disorders	persistent depressive disorder	major depression irritability	
Nervous system disorders	headache	dizziness	
Cardiac disorders		tachycardia	
Gastrointestinal disorders		abdominal pain upper	
Skin and subcutaneous tissue disorders	alopecia	pruritus urticaria skin disorder	
Musculoskeletal , connective tissue and bone disorders		musculoskeletal pain arthralgia back pain	
General disorders and administration site conditions		fatigue asthenia pyrexia	
Injury, poisoning and procedural complications	infusion-related reactions[3]		

MedDRA System Organ Class	Very Common	Common	Not Known
[1] Observed during post-marketing surveillance. [2] See also section infections below. [3] Infusion-related reactions for PV Study 1 included symptoms collected on the next scheduled visit after each infusion, and adverse reactions occurring on the day of or one day after the infusion. The most common infusion-related reaction symptoms/Preferred Terms for PV Study 1 included headaches, chills, high blood pressure, nausea, asthenia and pain. The most common infusion-related reaction symptoms/Preferred Terms for PV Study 2 were dyspnoea, erythema, hyperhidrosis, flushing/hot flush, hypotension/low blood pressure and rash/rash pruritic.			

Description of selected adverse reactions

Infusion-related reactions
In PV Study 1, infusion-related reactions were common (58%). Nearly all infusion-related reactions were mild to moderate. The proportion of patients experiencing an infusion-related reaction was 29% (11 patients), 40% (15 patients), 13% (5 patients), and 10% (4 patients) following the first, second, third, and fourth infusions, respectively. No patients were withdrawn from treatment due to infusion-related reactions. Symptoms of infusion-related reactions were similar in type and severity to those seen in RA and GPA/MPA patients.

In PV Study 2, IRRs occurred primarily at the first infusion and the frequency of IRRs decreased with subsequent infusions: 17.9%, 4.5%, 3% and 3% of patients experienced IRRs at the first, second, third, and fourth infusions, respectively. In 11/15 patients who experienced at least one IRR, the IRRs were Grade 1 or 2. In 4/15 patients, Grade $\geq$3 IRRs were reported and led to discontinuation of rituximab treatment; three of the four patients experienced serious (life-threatening) IRRs. Serious IRRs occurred at the first (2 patients) or second (1 patient) infusion and resolved with symptomatic treatment.

Infections
In PV Study 1, 14 patients (37%) in the rituximab group experienced treatment-related infections compared to 15 patients (42%) in the standard-dose prednisone group. The most common infections in the rituximab group were herpes simplex and zoster infections, bronchitis, urinary tract infection, fungal infection and conjunctivitis. Three patients (8%) in the rituximab group experienced a total of 5 serious infections (*Pneumocystis jirovecii* pneumonia, infective thrombosis, intervertebral discitis, lung infection, Staphylococcal sepsis) and one patient (3%) in the standard-dose prednisone group experienced a serious infection (*Pneumocystis jirovecii* pneumonia).

In PV Study 2, 42 patients (62.7%) in the rituximab arm experienced infections. The most common infections in the rituximab group were upper respiratory tract infection, nasopharyngitis, oral candidiasis and urinary tract infection. Six patients (9%) in the rituximab arm experienced serious infections.

In the post marketing setting, serious viral infections have been reported in PV patients treated with rituximab.

Laboratory abnormalities
PV Study 2, in the rituximab arm, transient decreases in lymphocyte count, driven by decreases in the peripheral T-cell populations, as well as a transient decrease in phosphorus level were very commonly observed post-infusion. These were considered to be induced by intravenous methylprednisolone premedication infusion.

In PV Study 2, low IgG levels were commonly observed and low IgM levels were very commonly observed; however, there was no evidence of an increased risk of serious infections after the development of low IgG or IgM.

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

Limited experience with doses higher than the approved dose of intravenous rituximab formulation is available from clinical trials in humans. The highest intravenous dose of rituximab tested in humans to date is 5000 mg (2250 mg/m^2), tested in a dose escalation study in patients with CLL. No additional safety signals were identified.

Patients who experience overdose should have immediate interruption of their infusion and be closely monitored.

In the post-marketing setting five cases of rituximab overdose have been reported. Three cases had no reported adverse event. The two adverse events that were reported were flu-like symptoms, with a dose of 1.8 g of rituximab and fatal respiratory failure, with a dose of 2 g of rituximab.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: antineoplastic agents, monoclonal antibodies and antibody drug conjugates, ATC code: L01FA01.

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

Mechanisms of action

Rituximab binds specifically to the transmembrane antigen, CD20, a non-glycosylated phosphoprotein, located on pre-B and mature B lymphocytes. The antigen is expressed on > 95% of all B-cell non-Hodgkin's lymphomas.

CD20 is found on both normal and malignant B-cells, but not on haematopoietic stem cells, pro-B-cells, normal plasma cells or other normal tissue. This antigen does not internalise upon antibody binding and is not shed from the cell surface. CD20 does not circulate in the plasma as a free antigen and, thus, does not compete for antibody binding.

The Fab domain of rituximab binds to the CD20 antigen on B lymphocytes and the Fc domain can recruit immune effector functions to mediate B-cell lysis. Possible mechanisms of effector-mediated cell lysis include complement-dependent cytotoxicity (CDC) resulting from C1q binding, and antibody-dependent cellular cytotoxicity (ADCC) mediated by one or more of the Fcγ receptors on the surface of granulocytes, macrophages and NK cells. Rituximab binding to CD20 antigen on B lymphocytes has also been demonstrated to induce cell death via apoptosis.

Pharmacodynamic effects

Peripheral B-cell counts declined below normal following completion of the first dose of rituximab. In patients treated for haematological malignancies, B-cell recovery began within 6 months of treatment and generally returned to normal levels within 12 months after completion of therapy, although in some patients this may take longer (up to a median recovery time of 23 months post-induction therapy). In rheumatoid arthritis patients, immediate depletion of B-cells in the peripheral blood was observed following two infusions of 1000 mg rituximab separated by a 14-day interval. Peripheral blood B-cell counts begin to increase from Week 24 and evidence for repopulation is observed in the majority of patients by Week 40, whether rituximab was administered as monotherapy or in combination with

methotrexate. A small proportion of patients had prolonged peripheral B-cell depletion lasting 2 years or more after their last dose of rituximab. In patients with GPA or MPA, the number of peripheral blood B-cells decreased to < 10 cells/μL after two weekly infusions of rituximab 375 mg/m^2, and remained at that level in most patients up to the 6 month timepoint. The majority of patients (81%) showed signs of B-cell return, with counts > 10 cells/μL by Month 12, increasing to 87% of patients by Month 18.

Clinical efficacy and safety

Clinical efficacy and safety in non-Hodgkin's lymphoma and in chronic lymphocytic leukaemia

Follicular lymphoma

Monotherapy
Initial treatment, weekly for 4 doses
In the pivotal trial, 166 patients with relapsed or chemoresistant low-grade or follicular B-cell NHL received 375 mg/m^2 of rituximab as an intravenous infusion once weekly for four weeks. The overall response rate (ORR) in the intent-to-treat (ITT) population was 48% (CI_{95}% 41% - 56%) with a 6% complete response (CR) and a 42% partial response (PR) rate. The projected median time to progression (TTP) for responding patients was 13.0 months. In a subgroup analysis, the ORR was higher in patients with IWF B, C, and D histological subtypes as compared to IWF A subtype (58% vs. 12%), higher in patients whose largest lesion was < 5 cm vs. > 7 cm in greatest diameter (53% vs. 38%), and higher in patients with chemosensitive relapse as compared to chemoresistant (defined as duration of response < 3 months) relapse (50% vs. 22%). ORR in patients previously treated with autologous bone marrow transplant (ABMT) was 78% versus 43% in patients with no ABMT. Neither age, sex, lymphoma grade, initial diagnosis, presence or absence of bulky disease, normal or high LDH nor presence of extranodal disease had a statistically significant effect (Fisher's exact test) on response to rituximab. A statistically significant correlation was noted between response rates and bone marrow involvement. 40% of patients with bone marrow involvement responded compared to 59% of patients with no bone marrow involvement (p=0.0186). This finding was not supported by a stepwise logistic regression analysis in which the following factors were identified as prognostic factors: histological type, bcl-2 positivity at baseline, resistance to last chemotherapy and bulky disease.

Initial treatment, weekly for 8 doses
In a multi-centre, single-arm trial, 37 patients with relapsed or chemoresistant, low grade or follicular B-cell NHL received 375 mg/m^2 of rituximab as intravenous infusion weekly for eight doses. The ORR was 57% (95% Confidence interval (CI); 41% – 73%; CR 14%, PR 43%) with a projected median TTP for responding patients of 19.4 months (range 5.3 to 38.9 months).

Initial treatment, bulky disease, weekly for 4 doses
In pooled data from three trials, 39 patients with relapsed or chemoresistant, bulky disease (single lesion $\geq$ 10 cm in diameter), low grade or follicular B-cell NHL received 375 mg/m^2 of rituximab as intravenous infusion weekly for four doses. The ORR was 36% (CI_{95}% 21% – 51%; CR 3%, PR 33%) with a median TTP for responding patients of 9.6 months (range 4.5 to 26.8 months).

Re-treatment, weekly for 4 doses
In a multicentre, single-arm trial, 58 patients with relapsed or chemoresistant low grade or follicular B-cell NHL, who had achieved an objective clinical response to a prior course of rituximab, were re-treated with 375 mg/m^2 of rituximab as intravenous infusion weekly for four doses. Three of the patients had received two courses of rituximab before enrolment and thus were given a third course in the study. Two patients were re-treated twice in the study. For the 60 re-treatments on study, the ORR was 38% (CI_{95}% 26% – 51%; 10% CR, 28% PR) with a projected median TTP for responding patients of 17.8 months (range 5.4 – 26.6). This compares favourably with the TTP achieved after the prior course of rituximab (12.4 months).

Initial treatment, in combination with chemotherapy
In an open-label randomised trial, a total of 322 previously untreated patients with follicular lymphoma were randomised to receive either CVP chemotherapy (cyclophosphamide 750 mg/m^2,

vincristine 1.4 mg/m^2 up to a maximum of 2 mg on Day 1, and prednisolone 40 mg/m^2/day on days 1-5) every 3 weeks for 8 cycles or rituximab 375 mg/m^2 in combination with CVP (R-CVP). Rituximab was administered on the first day of each treatment cycle. A total of 321 patients (162 R-CVP, 159 CVP) received therapy and were analysed for efficacy. The median follow-up of patients was 53 months. R-CVP led to a significant benefit over CVP for the primary endpoint, time to treatment failure (27 months vs. 6.6 months, $p < 0.0001$, log-rank test). The proportion of patients with a tumour response (CR, CRu, PR) was significantly higher ($p< 0.0001$ Chi-Square test) in the R-CVP group (80.9%) than the CVP group (57.2%). Treatment with R-CVP significantly prolonged the time to disease progression or death compared to CVP, 33.6 months and 14.7 months, respectively ($p < 0.0001$, log-rank test). The median duration of response was 37.7 months in the R-CVP group and was 13.5 months in the CVP group ($p < 0.0001$, log-rank test).

The difference between the treatment groups with respect to overall survival showed a significant clinical difference (p=0.029, log-rank test stratified by centre): survival rates at 53 months were 80.9% for patients in the R-CVP group compared to 71.1% for patients in the CVP group.

Results from three other randomised trials using rituximab in combination with chemotherapy regimen other than CVP (CHOP, MCP, CHVP/Interferon-α) have also demonstrated significant improvements in response rates, time-dependent parameters as well as in overall survival. Key results from all four studies are summarised in Table 8.

Table 8 Summary of key results from four phase III randomised studies evaluating the benefit of rituximab with different chemotherapy regimens in follicular lymphoma

Study	Treatment, N	Median FU, months	ORR, %	CR,%	Median TTF/PFS/ EFS, months	OS rates, %
M39021	CVP, 159 R-CVP, 162	53	57 81	10 41	Median TTP: 14.7 33.6 P<0.0001	53-months 71.1 80.9 p=0.029
GLSG'00	CHOP, 205 R-CHOP, 223	18	90 96	17 20	Median TTF: 2.6 years Not reached p < 0.001	18-months 90 95 p = 0.016
OSHO-39	MCP, 96 R-MCP, 105	47	75 92	25 50	Median PFS: 28.8 Not reached p < 0.0001	48-months 74 87 p = 0.0096
FL2000	CHVP-IFN, 183 R-CHVP-IFN, 175	42	85 94	49 76	Median EFS: 36 Not reached p < 0.0001	42-months 84 91 p = 0.029

EFS – Event Free Survival
TTP – Time to progression or death
PFS – Progression-Free Survival
TTF – Time to Treatment Failure
OS rates – survival rates at the time of the analyses

Maintenance therapy
Previously untreated follicular lymphoma
In a prospective, open label, international, multi-centre, phase III trial 1193 patients with previously untreated advanced follicular lymphoma received induction therapy with R-CHOP (n=881), R-CVP (n=268) or R-FCM (n=44), according to the investigators' choice. A total of 1078 patients responded to induction therapy, of which 1018 were randomised to rituximab maintenance therapy (n=505) or observation (n=513). The two treatment groups were well balanced with regards to baseline characteristics and disease status. Rituximab maintenance treatment consisted of a single infusion of rituximab at 375 mg/m^2 body surface area given every 2 months until disease progression or for a

maximum period of two years.

The pre-specified primary analysis was conducted at a median observation time of 25 months from randomisation, maintenance therapy with rituximab resulted in a clinically relevant and statistically significant improvement in the primary endpoint of investigator assessed progression-free survival (PFS) as compared to observation in patients with previously untreated follicular lymphoma (Table 9).

Significant benefit from maintenance treatment with rituximab was also seen for the secondary endpoints event-free survival (EFS), time to next anti-lymphoma treatment (TNLT) time to next chemotherapy (TNCT) and overall response rate (ORR) in the primary analysis (Table 9).

Data from extended follow-up of patients in the study (median follow-up 9 years) confirmed the long-term benefit of rituximab maintenance therapy in terms of PFS, EFS, TNLT and TNCT (Table 9).

Table 9 Overview of efficacy results for rituximab maintenance vs. observation at the protocol-defined primary analysis and after 9 years median follow-up (final analysis)

	Primary analysis (median FU: 25 months)		**Final analysis (median FU: 9.0 years)**	
	Observation N=513	**Rituximab N=505**	**Observation N=513**	**Rituximab N=505**
Primary efficacy				
Progression-free survival (median)	NR	NR	4.06 years	10.49 years
log-rank p value	<0.0001		<0.0001	
hazard ratio (95% CI)	0.50 (0.39, 0.64)		0.61 (0.52, 0.73)	
risk reduction	50%		39%	
Secondary efficacy				
Overall survival (median)	NR	NR	NR	NR
log-rank p value	0.7246		0.7948	
hazard ratio (95% CI)	0.89 (0.45, 1.74)		1.04 (0.77, 1.40)	
risk reduction	11%		-6%	
Event-free survival (median)	38 months	NR	4.04 years	9.25 years
log-rank p value	<0.0001		<0.0001	
hazard ratio (95% CI)	0.54 (0.43, 0.69)		0.64 (0.54, 0.76)	
risk reduction	46%		36%	
TNLT (median)	NR	NR	6.11 years	NR
log-rank p value	0.0003		<0.0001	
hazard ratio (95% CI)	0.61 (0.46, 0.80)		0.66 (0.55, 0.78)	
risk reduction	39%		34%	
TNCT (median)	NR	NR	9.32 years	NR
log-rank p value	0.0011		0.0004	
hazard ratio (95% CI)	0.60 (0.44, 0.82)		0.71 (0.59, 0.86)	
risk reduction	40%		39%	
Overall response rate*	55%	74%	61%	79%
chi-squared test p value	<0.0001		<0.0001	
odds ratio (95% CI)	2.33 (1.73, 3.15)		2.43 (1.84, 3.22)	
Complete response (CR/CRu) rate*	48%	67%	53%	72%
chi-squared test p value	<0.0001		<0.0001	
odds ratio (95% CI)	2.21 (1.65, 2.94)		2.34 (1.80, 3.03)	

* at end of maintenance/observation; final analysis results based on median follow-up of 73 months.
FU: follow-up; NR: not reached at time of clinical cut-off, TNCT: time to next chemotherapy treatment; TNLT: time to next anti lymphoma treatment.

Rituximab maintenance treatment provided consistent benefit in all predefined subgroups tested: gender (male, female), age (< 60 years, ≥ 60 years), FLIPI score (≤1, 2 or ≥ 3), induction therapy (R-CHOP, R-CVP or R-FCM) and regardless of the quality of response to induction treatment (CR, CRu or PR). Exploratory analyses of the benefit of maintenance treatment showed a less pronounced effect in elderly

patients (> 70 years of age), however sample sizes were small.

Relapsed/Refractory follicular lymphoma

In a prospective, open label, international, multi-centre, phase III trial, 465 patients with relapsed/refractory follicular lymphoma were randomised in a first step to induction therapy with either CHOP (cyclophosphamide, doxorubicin, vincristine, prednisolone; n=231) or rituximab plus CHOP (R-CHOP, n=234). The two treatment groups were well balanced with regard to baseline characteristics and disease status. A total of 334 patients achieving a complete or partial remission following induction therapy were randomised in a second step to rituximab maintenance therapy (n=167) or observation (n=167). Rituximab maintenance treatment consisted of a single infusion of rituximab at 375 mg/m^2 body surface area given every 3 months until disease progression or for a maximum period of two years.

The final efficacy analysis included all patients randomised to both parts of the study. After a median observation time of 31 months for patients randomised to the induction phase, R-CHOP significantly improved the outcome of patients with relapsed/refractory follicular lymphoma when compared to CHOP (see Table 10).

Table 10 Induction phase: overview of efficacy results for CHOP vs. R-CHOP (31 months median observation time)

	CHOP	**R-CHOP**	**p-value**	**Risk Reduction[1)]**
Primary efficacy				
ORR[2)]	74%	87%	0.0003	NA
CR[2)]	16%	29%	0.0005	NA
PR[2)]	58%	58%	0.9449	NA

[1)] Estimates were calculated by hazard ratios
[2)] Last tumour response as assessed by the investigator. The "primary" statistical test for "response" was the trend test of CR versus PR versus non-response ($p < 0.0001$)
Abbreviations: NA, not available; ORR: overall response rate; CR: complete response; PR: partial response

For patients randomised to the maintenance phase of the trial, the median observation time was 28 months from maintenance randomisation. Maintenance treatment with rituximab led to a clinically relevant and statistically significant improvement in the primary endpoint, PFS, (time from maintenance randomisation to relapse, disease progression or death) when compared to observation alone ($p< 0.0001$ log-rank test). The median PFS was 42.2 months in the rituximab maintenance arm compared to 14.3 months in the observation arm. Using a cox regression analysis, the risk of experiencing progressive disease or death was reduced by 61% with rituximab maintenance treatment when compared to observation (95% CI; 45%-72%). Kaplan-Meier estimated progression-free rates at 12 months were 78% in the rituximab maintenance group vs. 57% in the observation group. An analysis of overall survival confirmed the significant benefit of rituximab maintenance over observation (p=0.0039 log-rank test). Rituximab maintenance treatment reduced the risk of death by 56% (95% CI; 22%-75%).

Table 11 Maintenance phase: overview of efficacy results rituximab vs. observation (28 months median observation time)

Efficacy parameter	**Kaplan-Meier Estimate of Median Time to Event (Months)**			**Risk Reduction**
	Observation (N = 167)	**Rituximab (N=167)**	**Log-Rank p value**	
Progression-free survival (PFS)	14.3	42.2	< 0.0001	61%
Overall survival	NR	NR	0.0039	56%
Time to new lymphoma treatment	20.1	38.8	< 0.0001	50%

Efficacy parameter	Kaplan-Meier Estimate of Median Time to Event (Months)			Risk Reduction
	Observation (N = 167)	Rituximab (N=167)	Log-Rank p value	
Disease-free survival[a]	16.5	53.7	0.0003	67%
Subgroup analysis				
PFS				
CHOP	11.6	37.5	< 0.0001	71%
R-CHOP	22.1	51.9	0.0071	46%
CR	14.3	52.8	0.0008	64%
PR	14.3	37.8	< 0.0001	54%
OS				
CHOP	NR	NR	0.0348	55%
R-CHOP	NR	NR	0.0482	56%

NR: not reached; [a]: only applicable to patients achieving a CR

The benefit of rituximab maintenance treatment was confirmed in all subgroups analysed, regardless of induction regimen (CHOP or R-CHOP) or quality of response to induction treatment (CR or PR) (Table 11). Rituximab maintenance treatment significantly prolonged median PFS in patients responding to CHOP induction therapy (median PFS 37.5 months vs. 11.6 months, p< 0.0001) as well as in those responding to R-CHOP induction (median PFS 51.9 months vs. 22.1 months, p=0.0071). Although subgroups were small, rituximab maintenance treatment provided a significant benefit in terms of overall survival for both patients responding to CHOP and patients responding to R-CHOP, although longer follow-up is required to confirm this observation.

Adult diffuse large B-cell non-Hodgkin's lymphoma

In a randomised, open-label trial, a total of 399 previously untreated elderly patients (age 60 to 80 years) with diffuse large B-cell lymphoma received standard CHOP chemotherapy (cyclophosphamide 750 mg/m^2, doxorubicin 50 mg/m^2, vincristine 1.4 mg/m^2 up to a maximum of 2 mg on Day 1, and prednisolone 40 mg/m^2/day on days 1-5) every 3 weeks for eight cycles, or rituximab 375 mg/m^2 plus CHOP (R-CHOP). Rituximab was administered on the first day of the treatment cycle.

The final efficacy analysis included all randomised patients (197 CHOP, 202 R-CHOP), and had a median follow-up duration of approximately 31 months. The two treatment groups were well balanced in baseline disease characteristics and disease status. The final analysis confirmed that R-CHOP treatment was associated with a clinically relevant and statistically significant improvement in the duration of event-free survival (the primary efficacy parameter; where events were death, relapse or progression of lymphoma, or institution of a new anti-lymphoma treatment) (p=0.0001). Kaplan Meier estimates of the median duration of event-free survival were 35 months in the R-CHOP arm compared to 13 months in the CHOP arm, representing a risk reduction of 41%. At 24 months, estimates for overall survival were 68.2% in the R-CHOP arm compared to 57.4% in the CHOP arm. A subsequent analysis of the duration of overall survival, carried out with a median follow-up duration of 60 months, confirmed the benefit of R-CHOP over CHOP treatment (p=0.0071), representing a risk reduction of 32%.

The analysis of all secondary parameters (response rates, progression-free survival, disease-free survival, duration of response) verified the treatment effect of R-CHOP compared to CHOP. The complete response rate after cycle 8 was 76.2% in the R-CHOP group and 62.4% in the CHOP group (p=0.0028). The risk of disease progression was reduced by 46% and the risk of relapse by 51%. In all patient subgroups (gender, age, age adjusted IPI, Ann Arbor stage, ECOG, β2 microglobulin, LDH, albumin, B symptoms, bulky disease, extranodal sites, bone marrow involvement), the risk ratios for event-free survival and overall survival (R-CHOP compared with CHOP) were less than 0.83 and 0.95 respectively. R-CHOP was associated with improvements in outcome for both high- and low-risk patients according to age adjusted IPI.

Clinical laboratory findings
Of 67 patients evaluated for human anti-mouse antibody (HAMA), no responses were noted. Of 356

patients evaluated for anti-drug antibody (ADA), 1.1% (4 patients) were positive.

Chronic lymphocytic leukaemia

In two open-label randomised trials, a total of 817 previously untreated patients and 552 patients with relapsed/refractory CLL were randomised to receive either FC chemotherapy (fludarabine 25 mg/m^2, cyclophosphamide 250 mg/m^2, days 1-3) every 4 weeks for 6 cycles or rituximab in combination with FC (R-FC). Rituximab was administered at a dosage of 375 mg/m^2 during the first cycle one day prior to chemotherapy and at a dosage of 500 mg/m^2 on Day 1 of each subsequent treatment cycle. Patients were excluded from the study in relapsed/refractory CLL if they had previously been treated with monoclonal antibodies or if they were refractory (defined as failure to achieve a partial remission for at least 6 months) to fludarabine or any nucleoside analogue. A total of 810 patients (403 R-FC, 407 FC) for the first-line study (Table 12a and Table 12b) and 552 patients (276 R-FC, 276 FC) for the relapsed/refractory study (Table 13) were analysed for efficacy.

In the first-line study, after a median observation time of 48.1 months, the median PFS was 55 months in the R-FC group and 33 months in the FC group ($p < 0.0001$, log-rank test). The analysis of overall survival showed a significant benefit of R-FC treatment over FC chemotherapy alone (p=0.0319, log-rank test) (Table 12a). The benefit in terms of PFS was consistently observed in most patient subgroups analysed according to disease risk at baseline (i.e. Binet stages A-C) (Table 12b).

Table 12a First-line treatment of chronic lymphocytic leukaemia Overview of efficacy results for rituximab plus FC vs. FC alone - 48.1 months median observation time

Efficacy Parameter	Kaplan-Meier Estimate of Median Time to Event (Months)			Risk Reduction
	FC (N = 409)	R-FC (N=408)	Log-rank p value	
Progression-free survival (PFS)	32.8	55.3	<0.0001	45%
Overall survival	NR	NR	0.0319	27%
Event free survival	31.3	51.8	<0.0001	44%
Response rate (CR, nPR, or PR) CR rates	72.6% 16.9%	85.8% 36.0%	<0.0001 <0.0001	N/A N/A
Duration of response*	36.2	57.3	<0.0001	44%
Disease free survival (DFS)**	48.9	60.3	0.0520	31%
Time to new treatment	47.2	69.7	<0.0001	42%

Response rate and CR rates analysed using Chi-squared Test. NR: not reached; N/A: not applicable
*: only applicable to patients achieving a CR, nPR, PR
**: only applicable to patients achieving a CR

Table 12b First-line treatment of chronic lymphocytic leukaemia Hazard ratios of progression-free survival according to Binet stage (ITT) - 48.1 months median observation time

Progression-free survival (PFS)	Number of patients		Hazard Ratio (95% CI)	p-value (Wald test, not adjusted)
	FC	R-FC		
Binet stage A	22	18	0.39 (0.15; 0.98)	0.0442
Binet stage B	259	263	0.52 (0.41; 0.66)	<0.0001
Binet stage C	126	126	0.68 (0.49; 0.95)	0.0224

CI: Confidence Interval

In the relapsed/refractory study, the median progression-free survival (primary endpoint) was 30.6 months in the R-FC group and 20.6 months in the FC group (p=0.0002, log-rank test). The benefit in terms of PFS was observed in almost all patient subgroups analysed according to disease risk at baseline. A slight but

not significant improvement in overall survival was reported in the R-FC compared to the FC arm.

Table 13 Treatment of relapsed/refractory chronic lymphocytic leukaemia - overview of efficacy results for rituximab plus FC vs. FC alone (25.3 months median observation time)

Efficacy Parameter	Kaplan-Meier Estimate of Median Time to Event (Months)			Risk Reduction
	FC (N = 276)	R-FC (N=276)	Log-rank p value	
Progression-free survival (PFS)	20.6	30.6	0.0002	35%
Overall survival	51.9	NR	0.2874	17%
Event free survival	19.3	28.7	0.0002	36%
Response rate (CR, nPR, or PR)	58.0%	69.9%	0.0034	N/A
CR rates	13.0%	24.3%	0.0007	N/A
Duration of response *	27.6	39.6	0.0252	31%
Disease free survival (DFS)**	42.2	39.6	0.8842	-6%
Time to new CLL treatment	34.2	NR	0.0024	35%

Response rate and CR rates analysed using Chi-squared Test. NR: not reached; N/A: not applicable
*: only applicable to patients achieving a CR, nPR, PR;
**: only applicable to patients achieving a CR;

Results from other supportive studies using rituximab in combination with other chemotherapy regimens (including CHOP, FCM, PC, PCM, bendamustine and cladribine) for the treatment of previously untreated and/or relapsed/refractory CLL patients have also demonstrated high overall response rates with benefit in terms of PFS rates, albeit with modestly higher toxicity (especially myelotoxicity). These studies support the use of rituximab with any chemotherapy.

Data in approximately 180 patients pre-treated with rituximab have demonstrated clinical benefit (including CR) and are supportive for rituximab re-treatment.

Paediatric population

A multi-centre, open-label, randomised study of Lymphome Malin B (LMB) chemotherapy (corticosteroids, vincristine, cyclophosphamide, high-dose methotrexate, cytarabine, doxorubicin, etoposide and triple drug [methotrexate/cytarabine/ corticosteroid] intrathecal therapy) alone or in combination with rituximab was conducted in paediatric patients with previously untreated advanced stage CD20 positive DLBCL/BL/BAL/BLL. Advanced stage is defined as Stage III with elevated LDH level ("B-high"), [LDH > twice the institutional upper limit of the adult normal values (> Nx2)] or any stage IV or BAL. Patients were randomised to receive either LMB chemotherapy or six intravenous infusions of rituximab at a dose of 375 mg/m^2 BSA in combination with LMB chemotherapy (two during each of the two induction courses and one during each of the two consolidation courses) as per the LMB scheme. A total of 328 randomised patients were included in the efficacy analyses, of which one patient under 3 years of age received rituximab in combination with LMB chemotherapy.

The two treatment arms, LMB (LMB chemotherapy) and R-LMB (LMB chemotherapy with rituximab), were well balanced with regards to baseline characteristics. Patients had a median age of 7 and 8 years in the LMB arm and R-LMB arm, respectively. Approximately half of patients were in Group B (50.6% in the LMB arm and 49.4% in the R-LMB arm), 39.6% in Group C1 in both arms, and 9.8% and 11.0% were in Group C3 in the LMB and R-LMB arms, respectively. Based on Murphy staging, most patients were either BL stage III (45.7% in the LMB arm and 43.3% in the R-LMB arm) or BAL, CNS negative (21.3% in the

LMB arm and 24.4% in the R-LMB arm). Less than half of the patients (45.1% in both arms) had bone marrow involvement, and most patients (72.6% in the LMB arm and 73.2% in the R-LMB arm) had no CNS involvement. The primary efficacy endpoint was EFS, where an event was defined as occurrence of progressive disease, relapse, second malignancy, death from any cause, or non-response as evidenced by detection of viable cells in residue after the second CYVE course, whichever occurs first. The secondary efficacy endpoints were OS and CR (complete remission).

At the pre-specified interim analysis with approximately 1 year of median follow-up, clinically relevant improvement in the primary endpoint of EFS was observed, with 1-year rate estimates of 94.2% (95% CI, 88.5% - 97.2%) in the R-LMB arm vs. 81.5% (95% CI, 73.0% - 87.8%) in the LMB arm, and adjusted Cox HR 0.33 (95% CI, 0.14 – 0.79). Upon IDMC (independent data monitoring committee) recommendation based on this result, the randomisation was halted and patients in the LMB arm were allowed to cross over to receive rituximab.

Primary efficacy analyses were performed in 328 randomised patients with a median follow-up of 3.1 years. The results are described in Table 14.

Table 14: Overview of Primary Efficacy Results (ITT population)

Analysis	**LMB (N = 164)**	**R-LMB (N=164)**
EFS	28 events	10 events
	One-sided log-rank test p-value 0.0006	
	Adjusted Cox HR 0.32 (90% CI: 0.17, 0.58)	
3-year EFS rates	82.3% (95% CI: 75.7%, 87.5%)	93.9% (95% CI: 89.1%, 96.7%)
OS	20 deaths	8 deaths
	One-sided log-rank test p-value 0.0061	
	Adjusted Cox model HR 0.36 (95% CI: 0.16; 0.81)	
3-year OS rates	87.3% (95% CI: 81.2%, 91.6%)	95.1% (95% CI: 90.5%, 97.5%)
CR rate	93.6% (95% CI: 88.2%; 97.0%)	94.0% (95% CI: 88.8%, 97.2%)

The primary efficacy analysis showed an EFS benefit of rituximab addition to LMB chemotherapy over LMB chemotherapy alone, with an EFS HR 0.32 (90% CI 0.17 - 0.58) from a Cox regression analysis adjusting for national group, histology, and therapeutic group. While no major differences in numbers of patients achieving CR was observed between the two treatment groups, the benefit of rituximab addition to LMB chemotherapy was also shown in the secondary endpoint of OS, with the OS HR of 0.36 (95% CI, 0.16 – 0.81).

The European Medicines Agency has waived the obligation to submit the results of studies with rituximab in all subsets of the paediatric population with follicular lymphoma and chronic lymphocytic leukaemia, and in the paediatric population from birth to < 6 months of age in CD20 positive diffuse large B-cell lymphoma. See Section 4.2 for information on paediatric use.

Clinical efficacy and safety in rheumatoid arthritis

The efficacy and safety of rituximab in alleviating the symptoms and signs of rheumatoid arthritis in patients with an inadequate response to TNF-inhibitors was demonstrated in a pivotal randomised, controlled, double-blind, multicentre trial (Trial 1).

Trial 1 evaluated 517 patients that had experienced an inadequate response or intolerance to one or more TNF inhibitor therapies. Eligible patients had active rheumatoid arthritis, diagnosed according to the criteria of the American College of Rheumatology (ACR). Rituximab was administered as two intravenous infusions separated by an interval of 15 days. Patients received 2 x 1000 mg intravenous infusions of rituximab or placebo in combination with MTX. All patients received concomitant 60 mg oral prednisone on days 2-7 and 30 mg on days 8-14 following the first infusion. The primary endpoint was the proportion of patients who achieved an ACR20 response at Week 24. Patients were followed beyond Week 24 for long-term endpoints, including radiographic assessment at 56 weeks and at 104 weeks.

During this time, 81% of patients, from the original placebo group received rituximab between weeks 24 and 56, under an open label extension study protocol.

Trials of rituximab in patients with early arthritis (patients without prior methotrexate treatment and patients with an inadequate response to methotrexate, but not yet treated with TNF-alpha inhibitors) have met their primary endpoints. Rituximab is not indicated for these patients, since the safety data about long-term rituximab treatment are insufficient, in particular concerning the risk of development of malignancies and PML.

Disease activity outcomes
Rituximab in combination with methotrexate significantly increased the proportion of patients achieving at least a 20% improvement in ACR score compared with patients treated with methotrexate alone (Table 15). Across all development studies the treatment benefit was similar in patients independent of age, gender, body surface area, race, number of prior treatments or disease status.

Clinically and statistically significant improvement was also noted on all individual components of the ACR response (tender and swollen joint counts, patient and physician global assessment, disability index scores (HAQ), pain assessment and C-Reactive Proteins (mg/dL).

Table 15 Clinical response outcomes at primary endpoint in Trial 1 (ITT population)

	Outcome†	**Placebo+MTX**	**Rituximab+MTX (2 x 1000 mg)**
Trial 1		N= 201	N= 298
	ACR20	36 (18%)	153 (51%)***
	ACR50	11 (5%)	80 (27%)***
	ACR70	3 (1%)	37 (12%)***
	EULAR Response (Good/Moderate)	44 (22%)	193 (65%)***
	Mean change in DAS	-0.34	-1.83***

† Outcome at 24 weeks
Significant difference from placebo + MTX at the primary time point: ***p $\leq$ 0.0001

Patients treated with rituximab in combination with methotrexate had a significantly greater reduction in disease activity score (DAS28) than patients treated with methotrexate alone (Table 15). Similarly, a good to moderate European League Against Rheumatism (EULAR) response was achieved by significantly more rituximab treated patients treated with rituximab and methotrexate compared to patients treated with methotrexate alone (Table 15).

Radiographic response
Structural joint damage was assessed radiographically and expressed as change in modified Total Sharp Score (mTSS) and its components, the erosion score and joint space narrowing score.

In Trial 1, conducted in patients with inadequate response or intolerance to one or more TNF inhibitor therapies, receiving rituximab in combination with methotrexate demonstrated significantly less

radiographic progression than patients originally receiving methotrexate alone at 56 weeks. Of the patients originally receiving methotrexate alone, 81% received rituximab either as rescue between weeks 16-24 or in the extension trial, before Week 56. A higher proportion of patients receiving the original rituximab/MTX treatment also had no erosive progression over 56 weeks (Table 16).

Table 16 Radiographic outcomes at 1 year (mITT population)

	Placebo+MTX	**Rituximab +MTX 2 × 1000 mg**
Trial 1	(n=184)	(n=273)
Mean change from baseline		
Modified total sharp score	2.30	1.01*
Erosion score	1.32	0.60*
Joint space narrowing score	0.98	0.41**
Proportion of patients with no radiographic change	46%	53%, NS
Proportion of patients with no erosive change	52%	60%, NS

150 patients originally randomised to placebo + MTX in Trial 1 received at least one course of RTX + MTX by one year

* p <0.05, ** p < 0.001. Abbreviation: NS: non significant

Inhibition of the rate of progressive joint damage was also observed long term. Radiographic analysis at 2 years in Trial 1 demonstrated significantly reduced progression of structural joint damage in patients receiving rituximab in combination with methotrexate compared to methotrexate alone as well as a significantly higher proportion of patients with no progression of joint damage over the 2-year period.

Physical function and quality of life outcomes

Significant reductions in disability index (HAQ-DI) and fatigue (FACIT-Fatigue) scores were observed in patients treated with rituximab compared to patients treated with methotrexate alone. The proportions of rituximab treated patients showing a minimal clinically important difference (MCID) in HAQ-DI (defined as an individual total score decrease of >0.22) was also higher than among patients receiving methotrexate alone (Table 17).

Significant improvement in health-related quality of life was also demonstrated with significant improvement in both the physical health score (PHS) and mental health score (MHS) of the SF-36. Further, a significantly higher proportion of patients achieved MCIDs for these scores (Table 17).

Table 17 Physical function and quality of life outcomes at Week 24 in Trial 1

Outcome†	Placebo+MTX	Rituximab+MTX *(2 x 1000 mg)*
Mean change in HAQ-DI	n=201 0.1	n=298 -0.4***
% HAQ-DI MCID	20%	51%
Mean change in FACIT-T	-0.5	-9.1***
Mean change in SF-36 PHS	n=197 0.9	n=294 5.8***
% SF-36 PHS MCID	13%	48%***

Mean change in SF-36 MHS	1.3	4.7**
% SF-36 MHS MCID	20%	38%*

† Outcome at 24 weeks
Significant difference from placebo at the primary time point: * p < 0.05, **p < 0.001 ***p ≤ 0.0001
MCID HAQ-DI ≥0.22, MCID SF-36 PHS >5.42, MCID SF-36 MHS >6.33

Efficacy in autoantibody (RF and or anti-CCP) seropositive patients
Patients seropositive to Rheumatoid Factor (RF) and/or anti-Cyclic Citrullinated Peptide (anti-CCP) who were treated with rituximab in combination with methotrexate showed an enhanced response compared to patients negative to both.

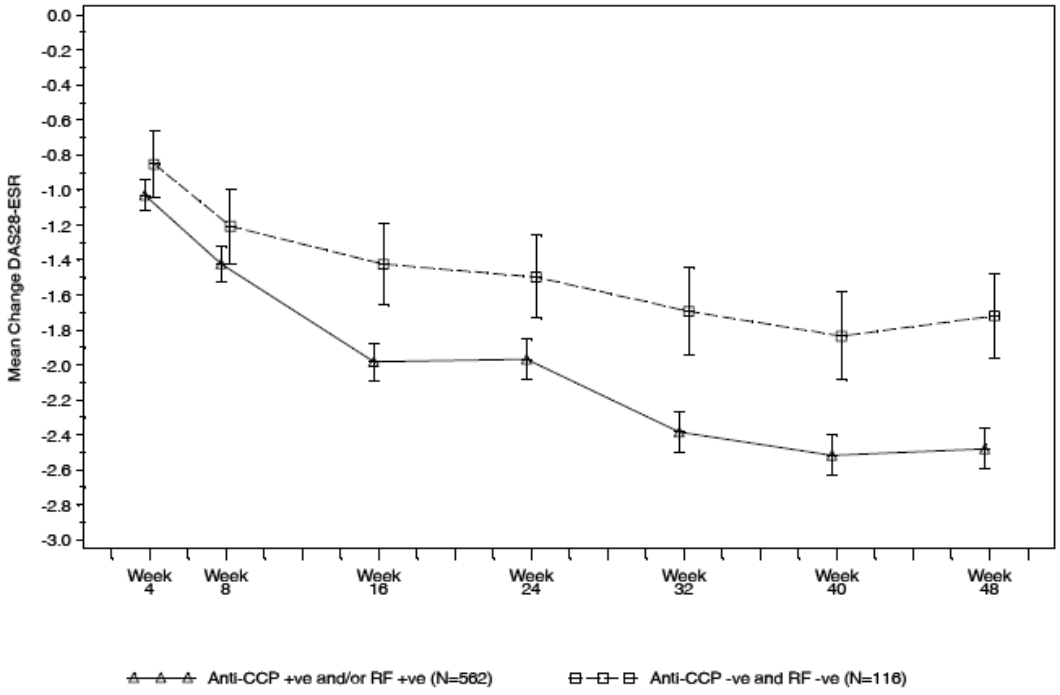
Efficacy outcomes in rituximab treated patients were analysed based on autoantibody status prior to commencing treatment. At Week 24, patients who were seropositive to RF and/or anti-CCP at baseline had a significantly increased probability of achieving ACR20 and 50 responses compared to seronegative patients (p=0.0312 and p=0.0096) (Table 18). These findings were replicated at Week 48, where autoantibody seropositivity also significantly increased the probability of achieving ACR70. At week 48 seropositive patients were 2-3 times more likely to achieve ACR responses compared to seronegative patients. Seropositive patients also had a significantly greater decrease in DAS28-ESR compared to seronegative patients (Figure 1).

Table 18 Summary of efficacy by baseline autoantibody status

	Week 24		Week 48	
	Seropositive (n=514)	**Seronegative (n=106)**	**Seropositive (n=506)**	**Seronegative (n=101)**
ACR20 (%)	62.3*	50.9	71. 1*	51.5
ACR50 (%)	32.7*	19.8	44.9**	22.8
ACR70 (%)	12.1	5.7	20.9*	6.9
EULAR Response (%)	74.8*	62.9	84.3*	72.3
Mean change DAS28-ESR	-1.97**	-1.50	-2.48***	-1.72

Significance levels were defined as ** p<0.05, **p<0.001, ***p<0.0001.*

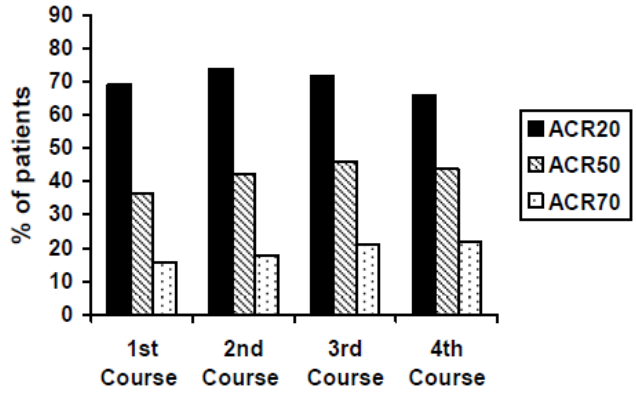
Figure 1: Change from baseline of DAS28-ESR by baseline autoantibody status



Long-term efficacy with multiple course therapy

Treatment with rituximab in combination with methotrexate over multiple courses resulted in sustained improvements in the clinical signs and symptoms of RA, as indicated by ACR, DAS28-ESR and EULAR responses which was evident in all patient populations studied (Figure 2). Sustained improvement in physical function as indicated by the HAQ-DI score and the proportion of patients achieving MCID for HAQ-DI were observed.

Figure 2: ACR responses for 4 treatment courses (24 weeks after each course (within patient, within visit) in patients with an inadequate response to TNF-inhibitors (n=146)



Clinical laboratory findings

A total of 392/3095 (12.7%) patients with rheumatoid arthritis tested positive for ADA in clinical trials following therapy with rituximab. The emergence of ADA was not associated with clinical deterioration or with an increased risk of reactions to subsequent infusions in the majority of patients. The presence of ADA may be associated with worsening of infusion or allergic reactions after the second infusion of subsequent courses.

Paediatric population

The European Medicines Agency has waived the obligation to submit the results of studies with rituximab in all subsets of the paediatric population with autoimmune arthritis. See section 4.2 for information on paediatric use.

Clinical efficacy and safety in granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA)

Adult induction of remission treatment

In GPA/MPA Study 1, a total of 197 patients aged 15 years or older with severe active GPA (75%) and MPA (24%) were enrolled and treated in an active-comparator, randomised, double-blind, multicentre, non-inferiority trial.

Patients were randomised in a 1:1 ratio to receive either oral cyclophosphamide daily (2 mg/kg/day) for 3-6 months or rituximab (375 mg/m^2) once weekly for 4 weeks. All patients in the cyclophosphamide arm received azathioprine maintenance therapy during follow-up. Patients in both arms received 1000 mg of pulse intravenous (IV) methylprednisolone (or another equivalent-dose glucocorticoid) per day for 1 to 3 days, followed by oral prednisone (1 mg/kg/day, not exceeding 80 mg/day). Prednisone tapering was to be completed by 6 months from the start of study treatment.

The primary outcome measure was achievement of complete remission at 6 months defined as a Birmingham Vasculitis Activity Score for Wegener's granulomatosis (BVAS/WG) of 0, and off glucocorticoid therapy. The pre-specified non-inferiority margin for the treatment difference was 20%. The trial demonstrated non-inferiority of rituximab to cyclophosphamide for complete remission (CR) at 6

months (Table 19).

Efficacy was observed both for patients with newly diagnosed disease and for patients with relapsing disease (Table 20).

Table 19 Percentage of adult patients who achieved complete remission at 6 months (Intent-to-treat population*)

	Rituximab (n = 99)	**Cyclophosphamide (n = 98)**	**Treatment difference (Rituximab - Cyclophosphamide)**
Rate	63.6%	53.1%	10.6% 95.1%[b] CI (−3.2%, 24.3%) [a]

– CI = confidence interval.
– * Worst case imputation
[a] Non-inferiority was demonstrated since the lower bound (−3.2%) was higher than the pre-determined non-inferiority margin (− 20%).
[b] The 95.1% confidence level reflects an additional 0.001 alpha to account for an interim efficacy analysis.

Table 20 Complete remission at 6-months by disease status

	Rituximab	**Cyclophosphamide**	**Difference (CI 95%)**
All patients Newly Diagnosed Relapsing	n=99 n=48 n=51	n=98 n=48 n=50	
Complete remission			
All Patients	63.6%	53.1%	10.6% (− 3.2, 24.3)
Newly diagnosed	60.4%	64.6%	− 4.2% (− 23.6, 15.3)
Relapsing	66.7%	42.0%	24.7% (5.8, 43.6)

Worst case imputation is applied for patients with missing data

Complete remission at 12 and 18 months
In the rituximab group, 48% of patients achieved CR at 12 months, and 39% of patients achieved CR at 18 months. In patients treated with cyclophosphamide (followed by azathioprine for maintenance of complete remission), 39% of patients achieved CR at 12 months, and 33% of patients achieved CR at 18 months. From month 12 to month 18, 8 relapses were observed in the rituximab group compared with four in the cyclophosphamide group.

Laboratory evaluations
A total of 23/99 (23%) rituximab-treated patients from the induction of remission trial tested positive for ADA by 18 months. None of the 99 rituximab-treated patients were ADA positive at screening. There was no apparent trend or negative impact of the presence of ADA on safety or efficacy in the induction of remission trial.

Adult maintenance of remission treatment

A total of 117 patients (88 with GPA, 24 with MPA, and 5 with renal-limited ANCA-associated vasculitis) in disease remission were randomised to receive azathioprine (59 patients) or rituximab (58 patients) in a prospective, multi-centre, controlled, open-label study. Included patients were 21 to 75 years of age and had newly diagnosed or relapsing disease in complete remission after combined treatment with glucocorticoids and pulse cyclophosphamide. The majority of patients were ANCA-positive at diagnosis or during the course of their disease; had histologically confirmed necrotizing small-vessel vasculitis with a clinical phenotype of GPA or MPA, or renal limited ANCA-associated vasculitis; or both.

Remission-induction therapy included intravenous prednisone, administered as per the investigator's discretion, preceded in some patients by methylprednisolone pulses, and pulse cyclophosphamide until remission was attained after 4 to 6 months. At that time, and within a maximum of 1 month after the last cyclophosphamide pulse, patients were randomly assigned to receive either rituximab (two 500 mg intravenous infusions separated by two weeks (on Day 1 and Day 15) followed by 500 mg intravenous every 6 months for 18 months) or azathioprine (administered orally at a dose of 2 mg/kg/day for 12 months, then 1.5 mg/kg/day for 6 months, and finally 1 mg/kg/day for 4 months (treatment discontinuation after these 22 months)). Prednisone treatment was tapered and then kept at a low dose (approximately 5 mg per day) for at least 18 months after randomisation. Prednisone dose tapering and the decision to stop prednisone treatment after month 18 were left at the investigator's discretion.

All patients were followed until month 28 (10 or 6 months, respectively, after the last rituximab infusion or azathioprine dose). *Pneumocystis jirovecii* pneumonia prophylaxis was required for all patients with CD4+ T-lymphocyte counts less than 250 per cubic millimeter.

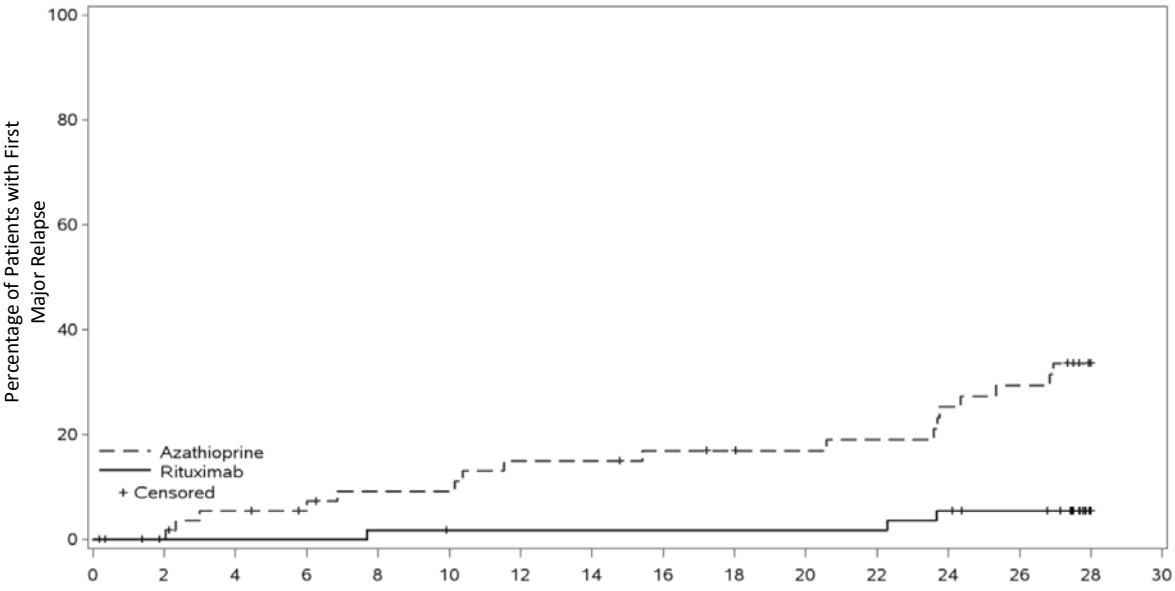
The primary outcome measure was the rate of major relapse at Month 28.

Results

At Month 28, major relapse (defined by the reappearance of clinical and/or laboratory signs of vasculitis activity ([BVAS] > 0) that could lead to organ failure or damage or could be life threatening) occurred in 3 patients (5%) in the rituximab group and 17 patients (29%) in the azathioprine group (p=0.0007). Minor relapses (not life threatening and not involving major organ damage) occurred in seven patients in the rituximab group (12%) and eight patients in the azathioprine group (14%).

The cumulative incidence rate curves showed that time to first major relapse was longer in patients with rituximab starting from Month 2 and was maintained up to Month 28 (Figure 3).

Figure 3: Cumulative incidence over time of first major relapse



Number of Subjects with Major Relapse															
Azathioprine	0	0	3	3	5	5	8	8	9	9	9	10	13	15	17
Rituximab	0	0	0	0	1	1	1	1	1	1	1	1	3	3	3
Number of subjects at risk															
Azathioprine	59	56	52	50	47	47	44	44	42	41	40	39	36	34	0
Rituximab	58	56	56	56	55	54	54	54	54	54	54	54	52	50	0

Note: Patients were censored at Month 28 if they had no event.

Laboratory evaluations
A total of 6/34 (18%) of rituximab treated patients from the maintenance therapy clinical trial developed ADA. There was no apparent trend or negative impact of the presence of ADA on safety or efficacy in the maintenance therapy clinical trial.

Paediatric population

Study WA25615 (PePRS) was a multicentre, open-label, single-arm, uncontrolled study in 25 paediatric patients (≥ 2 to < 18 years old) with severe, active GPA or MPA. The median age of patients in the study was: 14 years (range: 6-17 years) and the majority of patients (20/25 [80%]) were female. A total of 19 patients (76%) had GPA and 6 patients (24%) had MPA at baseline. Eighteen patients (72%) had newly diagnosed disease upon study entry (13 patients with GPA and 5 patients with MPA) and 7 patients had relapsing disease (6 patients with GPA and 1 patient with MPA).

The study design consisted of an initial 6-month remission induction phase, with a minimum 18-month follow-up, up to a maximum of 54 months (4.5 years) overall. Patients were to receive a minimum of 3 doses of intravenous methylprednisolone (30 mg/kg/day, not exceeding 1 g/day) prior to the first rituximab intravenous infusion. If clinically indicated, additional daily doses (up to three), of intravenous methylprednisolone could be given. The remission induction regimen consisted of four once weekly intravenous infusions of rituximab at a dose of 375 mg/m^2 BSA, on study days 1, 8, 15 and 22 in combination with oral prednisolone or prednisone at 1 mg/kg/day (max 60 mg/day) tapered to 0.2 mg/kg/day minimum (max 10 mg/day) by Month 6. After the remission induction phase, patients could, at the discretion of the investigator, receive subsequent rituximab infusions on or after Month 6 to maintain PVAS remission and control disease activity (including progressive disease or flare) or to achieve first remission.

All 25 patients completed all four once weekly intravenous infusions for the 6-month remission induction phase. A total of 24 out of 25 patients completed at least 18 months of follow-up.

The objectives of this study were to evaluate safety, PK parameters, and efficacy of rituximab in paediatric GPA and MPA patients (≥ 2 to < 18 years old). The efficacy objectives of the study were exploratory and principally assessed using the Pediatric Vasculitis Activity Score (PVAS) (Table 21).

Cumulative Glucocorticoid dose (intravenous and oral) by Month 6:
Twenty-four out of 25 patients (96%) in Study WA25615 achieved oral glucocorticoid taper to 0.2 mg/kg/day (or less than or equal to 10 mg/day, whichever was lower) at or by Month 6 during the protocol-defined oral steroid taper.

A decrease in median overall oral glucocorticoid use was observed from Week 1 (median = 45 mg prednisone equivalent dose [IQR: 35 – 60]) to Month 6 (median = 7.5 mg [IQR: 4-10]), which was subsequently maintained at Month 12 (median = 5 mg [IQR: 2-10]) and Month 18 (median =5 mg [IQR: 1-5]).

Follow-Up Treatment
During the Overall Study Period, patients received between 4 and 28 infusions of rituximab (up to 4.5 yrs [53.8 months]). Patients received up to 375 mg/m^2 x 4 of rituximab, approximately every 6 months at the discretion of the investigator. In total, 17 out of 25 patients (68%) received additional rituximab treatment at or post Month 6 until the Common Close Out, 14 out of these 17 patients received additional rituximab treatment between Month 6 and Month 18.

Table 21: Study WA25615 (PePRS) - PVAS Remission at Month 1, 2, 4, 6, 12 and 18

Study visit	Number of Responders in PVAS Remission* (response rate [%]) n=25	95% CI[α]
Month 1	0	0.0%, 13.7%
Month 2	1 (4.0%)	0.1%, 20.4%
Month 4	5 (20.0%)	6.8%, 40.7%
Month 6	13 (52.0%)	31.3%, 72.2%
Month 12	18 (72.0%)	50.6%, 87.9%
Month 18	18 (72.0%)	50.6%, 87.9%

* PVAS of 0 and achieved glucocorticoid taper to 0.2 mg/kg/day (or 10 mg/day, whichever is lower) at the assessment time-point.
α the efficacy results are exploratory and no formal statistical testing was performed for these endpoints rituximab, treatment (375 mg/m^2 x 4 infusions) up to Month 6 was identical for all patients. Follow-up treatment post Month 6 was at the discretion of the investigator.

Laboratory evaluations
A total of 4/25 patients (16%) developed ADA during the overall study period. Limited data shows there was no trend observed in the adverse reactions reported in ADA positive patients.

There was no apparent trend or negative impact of the presence of ADA on safety or efficacy in the paediatric GPA and MPA clinical trials.

The European Medicines Agency has waived the obligation to submit the results of studies with rituximab in paediatric population < 2 years of age in severe, active GPA or MPA. See section 4.2 for information on paediatric use.

Clinical efficacy and safety in pemphigus vulgaris

PV Study 1 (Study ML22196)
The efficacy and safety of rituximab in combination with short-term, low-dose glucocorticoid (prednisone) therapy were evaluated in newly diagnosed patients with moderate to severe pemphigus (74 pemphigus vulgaris [PV] and 16 pemphigus foliaceus [PF]) in this randomised, open-label, controlled, multicentre study. Patients were between 19 and 79 years of age and had not received prior therapies for pemphigus. In the PV population, 5 (13%) patients in the rituximab group and 3 (8%) patients in the standard prednisone group had moderate disease and 33 (87%) patients in the rituximab group and 33 (92%) patients in the standard-dose prednisone group had severe disease according to disease severity defined by Harman's criteria.

Patients were stratified by baseline disease severity (moderate or severe) and randomised 1:1 to receive either rituximab and low-dose prednisone or standard-dose prednisone. Patients randomised to the rituximab group received an initial intravenous infusion of 1000 mg rituximab on Study Day 1 in combination with 0.5 mg/kg/day oral prednisone tapered off over 3 months if they had moderate disease or 1 mg/kg/day oral prednisone tapered off over 6 months if they had severe disease, and a second intravenous infusion of 1000 mg on Study Day 15. Maintenance infusions of rituximab 500 mg were administered at months 12 and 18. Patients randomised to the standard-dose prednisone group received an initial 1 mg/kg/day oral prednisone tapered off over 12 months if they had moderate disease or 1.5 mg/kg/day oral prednisone tapered off over 18 months if they had severe disease. Patients in the rituximab group who relapsed could receive an additional infusion of rituximab 1000 mg in combination with reintroduced or escalated prednisone dose. Maintenance and relapse infusions were administered no sooner than 16 weeks following the previous infusion.

The primary objective for the study was complete remission (complete epithelialisation and absence of new and/or established lesions) at Month 24 without the use of prednisone therapy for two months or more (CR_{off} for ≥ 2 months).

PV Study 1 Results
The study showed statistically significant results of rituximab and low-dose prednisone over standard-dose prednisone in achieving CR_{off} ≥ 2 months at Month 24 in PV patients (see Table 22).

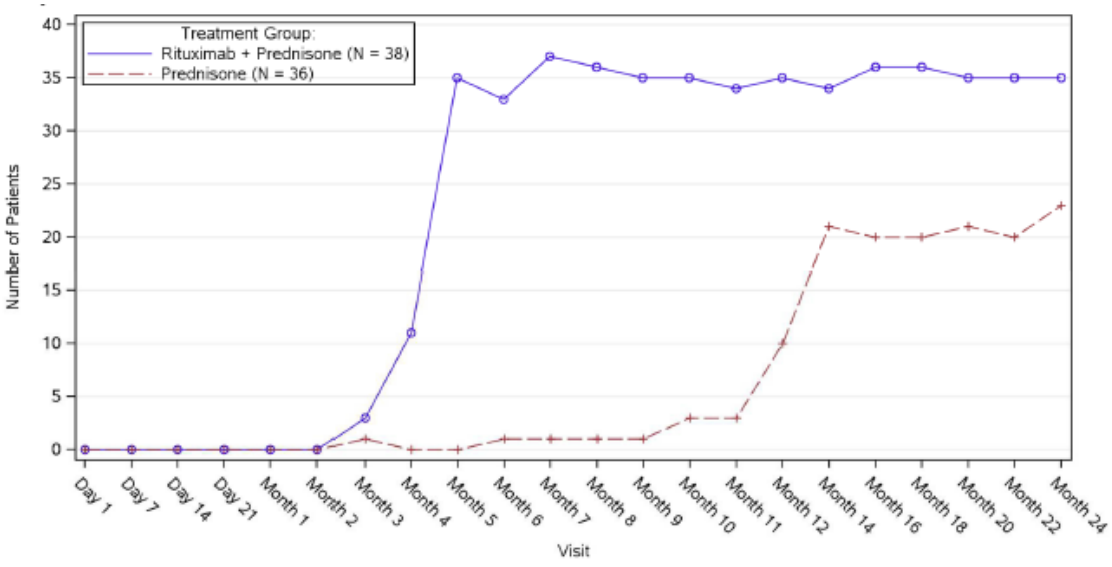
Table 22 Percentage of PV patients who achieved complete remission off corticosteroid therapy for two months or more at Month 24 (Intent-to-Treat Population - PV)

	Rituximab + Prednisone N=38	Prednisone N=36	p-value [a]	95% CI [b]
Number of responders (response rate [%])	34 (89.5%)	10 (27.8%)	<0.0001	61.7% (38.4, 76.5)

[a] p-value is from Fisher's exact test with mid-p correction
[b] 95% confidence interval is corrected Newcombe interval

The number of rituximab plus low-dose prednisone patients off prednisone therapy or on minimal therapy (prednisone dose of 10 mg or less per day) compared to standard-dose prednisone patients over the 24-month treatment period shows a steroid-sparing effect of rituximab (Figure 4).

Figure 4: Number of patients who were off or on minimal corticosteroid (≤10 mg/day) therapy over time



Post-hoc retrospective laboratory evaluation
A total of 19/34 (56%) patients with PV, who were treated with rituximab, tested positive for ADA antibodies by 18 months. The clinical relevance of ADA formation in rituximab-treated PV patients is unclear.

PV Study 2 (Study WA29330)
In a randomised, double-blind, double-dummy, active-comparator, multicentre study, the efficacy and safety of rituximab compared with mycophenolate mofetil (MMF) were evaluated in patients with moderate-to-severe PV receiving 60-120 mg/day oral prednisone or equivalent (1.0-1.5 mg/kg/day) at study entry and tapered to reach a dose of 60 or 80 mg/day by Day 1. Patients had a confirmed diagnosis of PV within the previous 24 months and evidence of moderate-to-severe disease (defined as a total Pemphigus Disease Area Index, PDAI, activity score of ≥ 15).

One hundred and thirty-five patients were randomised to treatment with rituximab 1000 mg administered on Day 1, Day 15, Week 24 and Week 26 or oral MMF 2 g/day for 52 weeks in combination with 60 or 80 mg oral prednisone with the aim of tapering to 0 mg/day prednisone by Week 24.

The primary efficacy objective for this study was to evaluate at Week 52, the efficacy of rituximab compared with MMF in achieving sustained complete remission defined as achieving healing of lesions with no new active lesions (i.e., PDAI activity score of 0) while on 0 mg/day prednisone or equivalent, and maintaining this response for at least 16 consecutive weeks, during the 52-week treatment period.

PV Study 2 Results
The study demonstrated the superiority of rituximab over MMF in combination with a tapering course of oral corticosteroids in achieving CR off corticosteroid ≥ 16 weeks at Week 52 in PV patients (Table 23). The majority of patients in the mITT population were newly diagnosed (74%) and 26% of patients had established disease (duration of illness ≥ 6 months and received prior treatment for PV).

Table 23 Percentage of PV Patients Who Achieved Sustained Complete Remission Off Corticosteroid Therapy for 16 Weeks or More at Week 52 (Modified Intent-to-Treat Population)

	Rituximab (N=62)	MMF (N=63)	Difference (95% CI)	p-value
Number of responders (response rate [%])	25 (40.3%)	6 (9.5%)	30.80% (14.70%, 45.15%)	<0.0001
Newly diagnosed patients	19 (39.6%)	4 (9.1%)		
Patients with established disease	6 (42.9%)	2 (10.5%)		
MMF = Mycophenolate mofetil. CI = Confidence Interval. Newly diagnosed patients = duration of illness < 6 months or no prior treatment for PV. Patients with established disease = duration of illness ≥ 6 months and received prior treatment for PV. Cochran-Mantel-Haenszel test is used for p-value.				

The analysis of all secondary parameters (including cumulative oral corticosteroid dose, the total number of disease flares, and change in health-related quality of life, as measured by the Dermatology Life Quality Index) verified the statistically significant results of rituximab compared to MMF. Testing of secondary endpoints were controlled for multiplicity.

Glucocorticoid exposure
The cumulative oral corticosteroid dose was significantly lower in patients treated with rituximab. The median (min, max) cumulative prednisone dose at Week 52 was 2775 mg (450, 22180) in the rituximab group compared to 4005 mg (900, 19920) in the MMF group (p=0.0005).

Disease flare
The total number of disease flares was significantly lower in patients treated with rituximab compared to MMF (6 vs. 44, p<0.0001) and there were fewer patients who had at least one disease flare (8.1% vs. 41.3%).

Laboratory evaluations
By Week 52, a total of 20/63 (31.7%) (19 treatment-induced and 1 treatment-enhanced) rituximab-treated PV patients tested positive for ADA. There was no apparent negative impact of the presence of ADA on safety or efficacy in PV Study 2.

5.2 Pharmacokinetic properties

Adult non-Hodgkin's lymphoma

Based on a population pharmacokinetic analysis in 298 NHL patients who received single or multiple infusions of rituximab as a single agent or in combination with CHOP therapy (applied rituximab doses

ranged from 100 to 500 mg/m^2), the typical population estimates of nonspecific clearance (CL_1), specific clearance (CL_2) likely contributed by B-cells or tumour burden, and central compartment volume of distribution (V_1) were 0.14 L/day, 0.59 L/day, and 2.7 L, respectively. The estimated median terminal elimination half-life of rituximab was 22 days (range, 6.1 to 52 days). Baseline CD19-positive cell counts and size of measurable tumour lesions contributed to some of the variability in CL_2 of rituximab in data from 161 patients given 375 mg/m^2 as an intravenous infusion for 4 weekly doses. Patients with higher CD19-positive cell counts or tumour lesions had a higher CL_2. However, a large component of inter-individual variability remained for CL_2 after correction for CD19-positive cell counts and tumour lesion size. V_1 varied by body surface area (BSA) and CHOP therapy. This variability in V_1 (27.1% and 19.0%) contributed by the range in BSA (1.53 to 2.32 m^2) and concurrent CHOP therapy, respectively, were relatively small. Age, gender and WHO performance status had no effect on the pharmacokinetics of rituximab. This analysis suggests that dose adjustment of rituximab with any of the tested covariates is not expected to result in a meaningful reduction in its pharmacokinetic variability.

Rituximab, administered as an intravenous infusion at a dose of 375 mg/m^2 at weekly intervals for 4 doses to 203 patients with NHL naive to rituximab, yielded a mean C_{max} following the fourth infusion of 486 µg/mL (range, 77.5 to 996.6 µg/mL). Rituximab was detectable in the serum of patients 3 – 6 months after completion of last treatment.

Upon administration of rituximab at a dose of 375 mg/m^2 as an intravenous infusion at weekly intervals for 8 doses to 37 patients with NHL, the mean C_{max} increased with each successive infusion, spanning from a mean of 243 µg/mL (range, 16 – 582 µg/mL) after the first infusion to 550 µg/mL (range, 171 – 1177 µg/mL) after the eighth infusion.

The pharmacokinetic profile of rituximab when administered as 6 infusions of 375 mg/m^2 in combination with 6 cycles of CHOP chemotherapy was similar to that seen with rituximab alone.

Paediatric DLBCL/BL/BAL/BLL

In the clinical trial studying paediatric DLBCL/BL/BAL/BLL, the PK was studied in a subset of 35 patients aged 3 years and older. The PK was comparable between the two age groups (≥3 to <12 years vs. ≥12 to <18 years). After two rituximab intravenous infusions of 375 mg/m^2 in each of the two induction cycles (cycle 1 and 2) followed by one rituximab intravenous infusion of 375 mg/m^2 in each of the consolidation cycles (cycle 3 and 4) the maximum concentration was highest after the fourth infusion (cycle 2) with a geometric mean of 347 µg/mL followed by lower geometric mean maximum concentrations thereafter (Cycle 4: 247 µg/mL). With this dose regimen, trough levels were sustained (geometric means: 41.8 µg/mL (pre-dose Cycle 2; after 1 cycle), 67.7 µg/mL (pre-dose Cycle 3, after 2 cycles) and 58.5 µg/mL (pre-dose Cycle 4, after 3 cycles)). The median elimination half-life in paediatric patients aged 3 years and older was 26 days.

The PK characteristics of rituximab in paediatric patients with DLBCL/BL/BAL/BLL were similar to what has been observed in adult NHL patients.

No PK data are available in the ≥ 6 months to < 3 years age group, however, population PK prediction supports comparable systemic exposure (AUC, C_{trough}) in this age group compared to ≥ 3 years (Table 24). Smaller baseline tumour size is related to higher exposure due to lower time dependent clearance, however, systemic exposures impacted by different tumour sizes remain in the range of exposure that was efficacious and had an acceptable safety profile.

Table 24: Predicted PK Parameters following the Rituximab Dosing Regimen in Paediatric DLBCL/BL/BAL/BLL

Age group	**≥ 6 mo to < 3 years**	**≥ 3 to < 12 years**	**≥ 12 to < 18 years**
C_{trough} (µg/mL)	47.5 (0.01-179)	51.4 (0.00-182)	44.1 (0.00-149)
$AUC_{1\text{-}4\ cycles}$ (µg*day/mL)	13501 (278-31070)	11609 (135-31157)	11467 (110-27066)

Results are presented as median (min – max); C_{trough} is pre-dose Cycle 4.

Chronic lymphocytic leukaemia

Rituximab was administered as an intravenous infusion at a first-cycle dose of 375 mg/m^2 increased to 500 mg/m^2 each cycle for 5 doses in combination with fludarabine and cyclophosphamide in CLL patients. The mean C_{max} (N=15) was 408 µg/mL (range, 97 – 764 µg/mL) after the fifth 500 mg/m^2 infusion and the mean terminal half-life was 32 days (range, 14 – 62 days).

Rheumatoid arthritis

Following two intravenous infusions of rituximab at a dose of 1000 mg, two weeks apart, the mean terminal half-life was 20.8 days (range, 8.58 to 35.9 days), mean systemic clearance was 0.23 L/day (range, 0.091 to 0.67 L/day), and mean steady-state distribution volume was 4.6 L (range, 1.7 to 7.51 L). Population pharmacokinetic analysis of the same data gave similar mean values for systemic clearance and half-life, 0.26 L/day and 20.4 days, respectively. Population pharmacokinetic analysis revealed that BSA and gender were the most significant covariates to explain inter-individual variability in pharmacokinetic parameters. After adjusting for BSA, male subjects had a larger volume of distribution and a faster clearance than female subjects. The gender-related pharmacokinetic differences are not considered to be clinically relevant and dose adjustment is not required. No pharmacokinetic data are available in patients with hepatic or renal impairment.

The pharmacokinetics of rituximab were assessed following two intravenous (IV) doses of 500 mg and 1000 mg on Days 1 and 15 in four studies. In all these studies, rituximab pharmacokinetics were dose proportional over the limited dose range studied. Mean C_{max} for serum rituximab following first infusion ranged from 157 to 171 µg/mL for 2 × 500 mg dose and ranged from 298 to 341 µg/mL for 2 × 1000 mg dose. Following second infusion, mean C_{max} ranged from 183 to 198 µg/mL for the 2 × 500 mg dose and ranged from 355 to 404 µg/mL for the 2 × 1000 mg dose. Mean terminal elimination half-life ranged from 15 to 16 days for the 2 × 500 mg dose group and 17 to 21 days for the 2 × 1000 mg dose group. Mean C_{max} was 16 to 19% higher following second infusion compared to the first infusion for both doses.

The pharmacokinetics of rituximab were assessed following two intravenous doses of 500 mg and 1000 mg upon re-treatment in the second course. Mean C_{max} for serum rituximab following first infusion was 170 to 175 µg/mL for 2 × 500 mg dose and 317 to 370 µg/mL for 2 × 1000 mg dose. C_{max} following second infusion, was 207 µg/mL for the 2 × 500 mg dose and ranged from 377 to 386 µg/mL for the 2 × 1000 mg dose. Mean terminal elimination half-life after the second infusion, following the second course, was 19 days for 2 × 500 mg dose and ranged from 21 to 22 days for the 2 × 1000 mg dose. PK parameters for rituximab were comparable over the two treatment courses.

The pharmacokinetic (PK) parameters in the anti-TNF inadequate responder population, following the same dosage regimen (2 × 1000 mg, intravenous, 2 weeks apart), were similar with a mean maximum serum concentration of 369 µg/mL and a mean terminal half-life of 19.2 days.

Granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA)

Adult Population

Based on the population pharmacokinetic analysis of data in 97 patients with granulomatosis with

polyangiitis and microscopic polyangiitis who received 375 mg/m^2 rituximab once weekly for four doses, the estimated median terminal elimination half-life was 23 days (range, 9 to 49 days). Rituximab mean clearance and volume of distribution were 0.313 L/day (range, 0.116 to 0.726 L/day) and 4.50 L (range 2.25 to 7.39 L) respectively. Maximum concentration during the first 180 days (C_{max}), minimum concentration at Day 180 (C180) and Cumulative area under the curve over 180 days (AUC_{180}) were (median [range]) 372.6 (252.3-533.5) µg/mL, 2.1 (0-29.3) µg/mL and 10302 (3653-21874) µg/mL*days, respectively. The PK parameters of rituximab in adult GPA and MPA patients appear similar to what has been observed in rheumatoid arthritis patients.

Paediatric Population

Based on the population pharmacokinetic analysis of 25 children (6-17 years old) with GPA and MPA who received 375 mg/m^2 rituximab once weekly for four doses, the estimated median terminal elimination half-life was 22 days (range, 11 to 42 days). Rituximab mean clearance and volume of distribution were 0.221 L/day (range, 0. 0996 to 0.381 L/day) and 2.27 L (range 1.43 to 3.17 L) respectively. Maximum concentration during the first 180 days (C_{max}), minimum concentration at Day 180 (C180) and Cumulative area under the curve over 180 days (AUC_{180}) were (median [range]) 382.8 (270.6-513.6) µg/mL, 0.9 (0-17.7) µg/mL and 9787 (4838-20446) µg/mL*day, respectively. The PK parameters of rituximab in paediatric patients with GPA or MPA were similar to those in adults with GPA or MPA, once taking into account the BSA effect on clearance and volume of distribution parameters.

Pemphigus vulgaris

The PK parameters in adult PV patients receiving rituximab 1000 mg at Days 1, 15, 168, and 182 are summarised in Table 25.

Table 25 Population PK in adult PV patients from PV Study 2

Parameter	**Infusion Cycle**	
	1st cycle of 1000 mg Day 1 and Day 15 N=67	2nd cycle of 1000 mg Day 168 and Day 182 N=67
Terminal Half-life (days) Median (Range)	21.0 (9.3-36.2)	26.5 (16.4-42.8)
Clearance (L/day) Mean (Range)	391 (159-1510)	247 (128-454)
Central Volume of Distribution (L) Mean (Range)	3.52 (2.48-5.22)	3.52 (2.48-5.22)

Following the first two rituximab administrations (at Day 1 and 15, corresponding to cycle 1), the PK parameters of rituximab in patients with PV were similar to those in patients with GPA/MPA and patients with RA. Following the last two administrations (at Day 168 and 182, corresponding to cycle 2), rituximab clearance decreased while the central volume of distribution remained unchanged.

5.3 Preclinical safety data

Rituximab has shown to be highly specific to the CD20 antigen on B-cells. Toxicity studies in cynomolgus monkeys have shown no other effect than the expected pharmacological depletion of B-cells in peripheral blood and in lymphoid tissue.

Developmental toxicity studies have been performed in cynomolgus monkeys at doses up to 100 mg/kg (treatment on gestation days 20-50) and have revealed no evidence of toxicity to the foetus due to rituximab. However, dose-dependent pharmacologic depletion of B-cells in the lymphoid organs

of the foetuses was observed, which persisted post natally and was accompanied by a decrease in IgG level in the newborn animals affected. B-cell counts returned to normal in these animals within 6 months of birth and did not compromise the reaction to immunisation.

Standard tests to investigate mutagenicity have not been carried out, since such tests are not relevant for this molecule. No long-term animal studies have been performed to establish the carcinogenic potential of rituximab.

Specific studies to determine the effects of rituximab on fertility have not been performed. In general toxicity studies in cynomolgus monkeys no deleterious effects on reproductive organs in males or females were observed.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Sodium chloride
Tri-sodium citrate dihydrate (E331)
Polysorbate 80 (E433)
Water for injections

6.2 Incompatibilities

No incompatibilities between rituximab and polyvinyl chloride or polyethylene bags or infusion sets have been observed.

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

6.3 Shelf life

Unopened vial
4 years

Truxima may be stored at temperatures up to a maximum of 30 °C for a single period of up to 10 days, but not exceeding the original expiry date. The new expiry date must be written on the carton. Upon removal from refrigerated storage, Truxima must not be returned to refrigerated storage.

Diluted product
The prepared infusion solution of rituximab in 0.9% sodium chloride solution is physically and chemically stable for 60 days at 2 °C - 8 °C and subsequently 24 hours at room temperature (≤ 30 °C), or for 10 days at ≤ 30 °C.

The prepared infusion solution of rituximab in 5% D-glucose solution is physically and chemically stable for 24 hours at 2 °C - 8 °C and subsequently 12 hours at room temperature (not more than 30 °C).

From a microbiological point of view, the prepared infusion solution 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 in a refrigerator (2 °C – 8 °C).
Keep the vial in the outer carton in order to protect from light.

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

6.5 Nature and contents of container

Truxima 100 mg concentrate for solution for infusion
Clear Type I glass vial with butyl rubber stopper containing 100 mg of rituximab in 10 mL. Pack of 2 vials.

Truxima 500 mg concentrate for solution for infusion
Clear Type I glass vial with butyl rubber stopper containing 500 mg of rituximab in 50 mL. Pack of 1 vial or 2 (2 x 1) vials (multipack).

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Truxima is provided in sterile, preservative-free, non-pyrogenic, single use vials.

Use sterile needle and syringe to prepare Truxima. Aseptically withdraw the necessary amount of Truxima, and dilute to a calculated concentration of 1 to 4 mg/mL rituximab into an infusion bag containing sterile, pyrogen-free sodium chloride 9 mg/mL (0.9%) solution for injection or 5% D-glucose in water. For mixing the solution, gently invert the bag in order to avoid foaming. Care must be taken to ensure the sterility of prepared solutions. Since the medicinal product does not contain any anti-microbial preservative or bacteriostatic agents, aseptic technique must be observed. Parenteral medicinal products should be inspected visually for particulate matter and discolouration prior to administration.

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

7. MARKETING AUTHORISATION HOLDER

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

8. MARKETING AUTHORISATION NUMBER(S)

Truxima 100 mg concentrate for solution for infusion
EU/1/16/1167/002

Truxima 500 mg concentrate for solution for infusion
EU/1/16/1167/001
EU/1/16/1167/003

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 17 February 2017
Date of latest renewal: 15 November 2021

10. DATE OF REVISION OF THE TEXT

Detailed information on this medicinal product is available on the website of the European Medicines

Agency http://www.ema.europa.eu/.

ANNEX II

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

B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE

C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION

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

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

Name and address of the manufacturer of the biological active substance

CELLTRION Inc. (Plant I, CLT1),
23 Academy–ro
Yeonsu-gu, Incheon, 22014, Republic of Korea

CELLTRION Inc. (Plant II, CLT2),
20, Academy-ro, 51 beon-gil,
Yeonsu-gu, Incheon, 22014, Republic of Korea

Name and address of the manufacturers responsible for batch release

Nuvisan GmbH
Wegenerstrasse 13, Ludwigsfeld
89231 Neu-Ulm, Bavaria
Germany

Nuvisan France SARL
2400, Route des Colles,
06410, Biot,
France

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

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

B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE

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

C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION

- **Periodic Safety Update Reports (PSURs)**

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

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

- **Risk Management Plan (RMP)**

The marketing authorisation holder (MAH) shall perform the pharmacovigilance activities and

interventions detailed in the agreed RMP presented in Module 1.8.2 of the Marketing Authorisation and any agreed and 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.

If the dates for submission of a PSUR and the update of a RMP coincide, they can be submitted at the same time.

- **Additional risk minimisation measures**

Non-oncology indications

The MAH must ensure that all physicians who are expected to prescribe Truxima are provided with the following:

Product information
Patient Alert card

The Patient Alert Card for Truxima in non-oncology indications should contain the following key elements:

- The need to carry the card at all times and to show the card to all treating healthcare professionals
- Warning on the risk of infections and PML, including the symptoms
- The need for patients to contact their healthcare professional if symptoms occur

Product information
Physician information
TheThe MAH must ensure that all physicians who are expected to prescribe Truxima are provided with the following:Patient Alert Card must be agreed with the National Competent Authorities prior to distribution.

ANNEX III

LABELLING AND PACKAGE LEAFLET

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

OUTER CARTON

1. NAME OF THE MEDICINAL PRODUCT

Truxima 100 mg concentrate for solution for infusion
rituximab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

1 vial contains 100 mg of rituximab.
1 mL contains 10 mg of rituximab.

3. LIST OF EXCIPIENTS

Excipients: sodium chloride, tri-sodium citrate dihydrate, polysorbate 80, water for injections.
This medicinal product contains sodium. Read the leaflet for further information.

4. PHARMACEUTICAL FORM AND CONTENTS

Concentrate for solution for infusion
100 mg / 10 mL
2 vials

5. METHOD AND ROUTE(S) OF ADMINISTRATION

For intravenous use after dilution.
Read the package leaflet before use.

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

Keep out of the sight and reach of children.

7. OTHER SPECIAL WARNING(S), IF NECESSARY

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

Store in a refrigerator. Keep the vial in the outer carton, in order to protect from light.
Can be stored at temperatures up to 30 °C for a single period up to 10 days, but not exceeding the original expiry date.

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

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

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

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/16/1167/002

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

truxima 100 mg

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

PC
SN
NN

MINIMUM PARTICULARS TO APPEAR ON SMALL IMMEDIATE PACKAGING UNITS

VIAL LABEL

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

Truxima 100 mg concentrate for solution for infusion
rituximab
Intravenous use

2. METHOD OF ADMINISTRATION

For intravenous use after dilution

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT

(10 mg/mL)
100 mg / 10 mL

6. OTHER

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

OUTER CARTON

1. NAME OF THE MEDICINAL PRODUCT

Truxima 500 mg concentrate for solution for infusion
rituximab

2. STATEMENT OF ACTIVE SUBSTANCE(S)

1 vial contains 500 mg of rituximab.
1 mL contains 10 mg of rituximab.

3. LIST OF EXCIPIENTS

Excipients: sodium chloride, tri-sodium citrate dihydrate, polysorbate 80, water for injections.
This medicinal product contains sodium. Read the leaflet for further information.

4. PHARMACEUTICAL FORM AND CONTENTS

Concentrate for solution for infusion
500 mg / 50 mL
1 vial
2 (2 x 1) vials (multipack)

5. METHOD AND ROUTE(S) OF ADMINISTRATION

For intravenous use after dilution.
Read the package leaflet before use.

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

Keep out of the sight and reach of children.

7. OTHER SPECIAL WARNING(S), IF NECESSARY

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

Store in a refrigerator. Keep the vial in the outer carton, in order to protect from light.
Can be stored at temperatures up to 30 °C for a single period up to 10 days, but not exceeding the original expiry date.

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

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

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

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/16/1167/001
EU/1/16/1167/003

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

truxima 500 mg

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

PC
SN
NN

MINIMUM PARTICULARS TO APPEAR ON SMALL IMMEDIATE PACKAGING UNITS

VIAL LABEL

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

Truxima 500 mg concentrate for solution for infusion
rituximab
Intravenous use

2. METHOD OF ADMINISTRATION

For intravenous use after dilution

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. CONTENTS BY WEIGHT, BY VOLUME OR BY UNIT

(10 mg/mL)
500 mg / 50 mL

6. OTHER

PATIENT ALERT CARD TEXT FOR NON-ONCOLOGY INDICATIONS

Truxima (rituximab) Alert Card for patients with non-oncology diseases

Why have I been given this card?

This medicine may make you more likely to get infections. This card tells you:

- What you need to know before having Truxima
- What the signs of an infection are
- What to do if you think you might be getting an infection.

It also includes your name and doctor's name and phone number on the back.

What should I do with this card?

- Keep this card with you all the time - such as in your wallet or purse.
- Show this card to any doctor, nurse or dentist you see - not just the specialist who prescribes your Truxima.

Keep this card with you for 2 years after your last dose of Truxima.
This is because side effects can develop several months after you have had treatment.

When should I not have Truxima?

Do not have Truxima if you have an active infection or a serious problem with your immune system.

Tell your doctor or nurse if you are taking or have previously taken medicines which may affect your immune system this includes chemo-therapy.

What are the signs of getting an infection?

What else do I need to know?

Rarely Truxima can cause a serious brain infection, called "Progressive Multifocal Leukoencephalopathy" or PML. This can be fatal.

- Signs of PML include:
  – Confusion, memory loss or problems thinking
  – Loss of balance or a change in the way you walk or talk
  – Decreased strength or weakness on one side of your body
  – Blurred vision or loss of vision.

If you get any of these, tell a doctor or nurse straight away. You should also tell them about your Truxima treatment.

Where can I get more information?

See the Truxima package leaflet for more information.

Treatment start date and contact details

Date of most recent infusion:
_____
Date of first infusion:
_____
Patient's
Name:_____
Doctor's
Name:_____
Doctor's contact details:_____

Make sure you have a list of all your medicines when you see a health care professional.

Please talk to your doctor or nurse if you have any questions about the information in this card.

Look out for the following possible signs of infection: • Fever or cough all the time • Weight loss • Pain without injuring yourself • Feeling generally unwell or listless. **If you get any of these, tell a doctor or nurse straight away.** **You should also tell them about your Truxima treatment.**	

B. PACKAGE LEAFLET

Package leaflet: Information for the patient

Truxima 100 mg concentrate for solution for infusion
Truxima 500 mg concentrate for solution for infusion

rituximab

Read all of this leaflet carefully before you start taking this medicine because it contains important information for you.
- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor, 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 Truxima is and what it is used for
2. What you need to know before you are given Truxima
3. How Truxima is given
4. Possible side effects
5. How to store Truxima
6. Contents of the pack and other information

1. What Truxima is and what it is used for

What Truxima is
Truxima contains the active substance “rituximab”. This is a type of protein called a “monoclonal antibody”. It sticks to the surface of a type of white blood cell called “B-Lymphocyte”. When rituximab sticks to the surface of this cell, the cell dies.

What Truxima is used for
Truxima may be used for the treatment of several different conditions in adults and children. Your doctor may prescribe Truxima for the treatment of:

a) Non-Hodgkin’s Lymphoma
This is a disease of the lymph tissue (part of the immune system) that affects a type of white blood cell called B-Lymphocytes.
In adults, Truxima can be given alone or with other medicines called “chemotherapy”.
In adult patients where the treatment is working, Truxima may be used as a maintenance treatment for 2 years after completing the initial treatment.
In children and adolescents, Truxima is given in combination with “chemotherapy”.

b) Chronic lymphocytic leukaemia
Chronic lymphocytic leukaemia (CLL) is the most common form of adult leukaemia. CLL affects a particular lymphocyte, the B-cell, which originates from the bone marrow and develops in the lymph nodes. Patients with CLL have too many abnormal lymphocytes, which accumulate mainly in the bone marrow and blood. The proliferation of these abnormal B-lymphocytes is the cause of symptoms you may have. Truxima in combination with chemotherapy destroys these cells which are gradually removed from the body by biological processes.

c) Rheumatoid arthritis
Truxima is used for the treatment of rheumatoid arthritis. Rheumatoid arthritis is a disease of the joints. B-lymphocytes are involved in the cause of some of the symptoms you have. Truxima is used to treat rheumatoid arthritis in people who have already tried some other medicines which have either stopped working, have not worked well enough or have caused side effects. Truxima is usually taken together with another medicine called methotrexate.

Truxima slows down the damage to your joints caused by rheumatoid arthritis and improves your ability to do normal daily activities.

The best responses to Truxima are seen in those who have a positive blood test to rheumatoid factor (RF) and/or anti-Cyclic Citrullinated Peptide (anti-CCP). Both tests are commonly positive in rheumatoid arthritis and aid in confirming the diagnosis.

d) Granulomatosis with polyangiitis or microscopic polyangiitis
Truxima is used for the treatment of adults and children 2 years of age and older with granulomatosis with polyangiitis (formerly called Wegener's granulomatosis) or microscopic polyangiitis, taken in combination with corticosteroids. Granulomatosis with polyangiitis and microscopic polyangiitis are two forms of inflammation of the blood vessels which mainly affects the lungs and kidneys, but may affect other organs as well. B-lymphocytes are involved in the cause of these conditions.

e) Pemphigus vulgaris
Truxima is used for the treatment of patients with moderate to severe pemphigus vulgaris. Pemphigus vulgaris is an autoimmune condition that causes painful blisters on the skin and lining of the mouth, nose, throat and genitals.

2. What you need to know before you are given Truxima

Do not take Truxima if:
- you are allergic to rituximab, other proteins which are like rituximab, or any of the other ingredients of this medicine (listed in section 6)
- you have a severe active infection at the moment
- you have a weak immune system
- you have severe heart failure or severe uncontrolled heart disease and have rheumatoid arthritis, granulomatosis with polyangiitis, microscopic polyangiitis or pemphigus vulgaris.

Do not have Truxima if any of the above apply to you. If you are not sure, talk to your doctor, pharmacist or nurse before you are given Truxima.

Warnings and precautions
Talk to your doctor, pharmacist or nurse before you are given Truxima if:

- you have ever had or might now have a hepatitis infection. This is because in a few cases, Truxima could cause hepatitis B to become active again, which can be fatal in very rare cases. Patients who have ever had hepatitis B infection will be carefully checked by their doctor for signs of this infection.
- you have ever had heart problems (such as angina, palpitations or heart failure) or breathing problems.

If any of the above apply to you (or you are not sure), talk to your doctor, pharmacist or nurse before you are given Truxima. Your doctor may need to take special care of you during your treatment with Truxima.

Also talk to your doctor if you think you may need any vaccinations in the near future, including vaccinations needed to travel to other countries. Some vaccines should not be given at the same time as Truxima or in the months after you receive Truxima. Your doctor will check if you should have any vaccines before you receive Truxima.

If you have rheumatoid arthritis, granulomatosis with polyangiitis, microscopic polyangiitis or pemphigus vulgaris also tell your doctor
- if you think you may have an infection, even a mild one like a cold. The cells that are affected by Truxima help to fight infection and you should wait until the infection has passed before you are given Truxima. Also please tell your doctor if you had a lot of infections in the past or suffer

from severe infections.

Children and adolescents
Non-Hodgkin's lymphoma
Truxima can be used for the treatment of children and adolescents, 6 months of age and older, with non-Hodgkin's lymphoma, specifically CD20 positive diffuse large B-cell lymphoma (DLBCL), Burkitt lymphoma (BL)/Burkitt leukaemia (mature B-cell acute leukaemia) (BAL) or Burkitt-like lymphoma (BLL).
Talk to your doctor, pharmacist or nurse before you are given this medicine if you, or your child, are under 18 years of age.

Granulomatosis with polyangiitis or microscopic polyangiitis
Truxima can be used for treatment of children and adolescents, 2 years of age and older, with granulomatosis with polyangiitis (formerly called Wegener's granulomatosis) or microscopic polyangiitis. There is not much information about the use of Truxima in children and adolescents with other diseases.
Talk to your doctor, pharmacist or nurse before you are given this medicine if you, or your child, are under 18 years of age.

Other medicines and Truxima
Tell your doctor, pharmacist or nurse if you are taking, have recently taken or might take any other medicines. This includes medicines obtained without a prescription and herbal medicines. This is because Truxima can affect the way some other medicines work. Also some other medicines can affect the way Truxima works.

In particular, tell your doctor:
- if you are taking medicines for high blood pressure. You may be asked not to take these other medicines 12 hours before you are given Truxima. This is because some people have a fall in their blood pressure while they are being given Truxima.
- if you have ever taken medicines which affect your immune system – such as chemotherapy or immune-suppressive medicines.

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

Pregnancy and breast-feeding
You must tell your doctor or nurse if you are pregnant, think that you might be pregnant or are planning to become pregnant. This is because Truxima can cross the placenta and may affect your baby.

If you can get pregnant, you and your partner must use an effective method of contraception while using Truxima. You must also do this for 12 months after your last treatment with Truxima.

Truxima passes into breast milk in very small amounts. As the long-term effects on breastfed infants are not known, for precautionary reasons, breast-feeding is not recommended during treatment with Truxima and for 6 months after the treatment.

Driving and using machines
It is not known whether Truxima has an effect on you being able to drive or use any tools or machines

Truxima contains polysorbate 80
This medicine contains 7 mg of polysorbate 80 (E433) in 10 mL vial and 35 mg of polysorbate 80 (E433) in 50 mL vial, which is equivalent to 0.7 mg/mL (for 10 mL vial) or 3.5 mg/mL (for 50 mL vial). Polysorbates may cause allergic reactions. Tell your doctor if you have any known allergies.

Truxima contains sodium
This medicine contains 52.6 mg sodium (main component of cooking/table salt) in each 10 mL vial and 263.2 mg sodium (main component of cooking/table salt) in each 50 mL vial.
This is equivalent to 2.6% (for 10 mL vial) and 13.2% (for 50 mL vial) of the recommended maximum daily dietary intake of sodium for an adult.

3. How Truxima is given

How it is given
Truxima will be given to you by a doctor or nurse who is experienced in the use of this treatment. They will watch you closely while you are being given this medicine. This is in case you get any side effects.
You will always be given Truxima as a drip (intravenous infusion).

Medicines given before each Truxima administration
Before you are given Truxima, you will be given other medicines (pre-medication) to prevent or reduce possible side effects.

How much and how often you will receive your treatment

a) If you are being treated for non-Hodgkin's lymphoma
- *If you are having Truxima alone*
  Truxima will be given to you once a week for 4 weeks. Repeated treatment courses with Truxima are possible.
- *If you are having Truxima with chemotherapy*
  Truxima will be given to you on the same day as your chemotherapy. This is usually given every 3 weeks up to 8 times.
- If you respond well to treatment, you may be given Truxima as a maintenance treatment every 2 or 3 months for two years. Your doctor may change this, depending on how you respond to the medicine.
- If you are less than 18 years of age, you will be given Truxima with chemotherapy. You will receive Truxima up to 6 times over a 3.5 – 5.5 month period.

b) If you are being treated for chronic lymphocytic leukaemia
When you are treated with Truxima in combination with chemotherapy, you will receive Truxima infusions on Day 0 cycle 1 then Day 1 of each cycle for 6 cycles in total. Each cycle has a duration of 28 days. The chemotherapy should be given after the Truxima infusion. Your doctor will decide if you should receive concomitant supportive therapy.

c) If you are being treated for rheumatoid arthritis
Each course of treatment is made up of two separate infusions which are given 2 weeks apart. Repeated courses of treatment with Truxima are possible. Depending on the signs and symptoms of your disease, your doctor will decide when you should receive more Truxima. This may be months from now.

d) If you are being treated for granulomatosis with polyangiitis or microscopic polyangiitis
Treatment with Truxima uses four separate infusions given at weekly intervals. Corticosteroids will usually be given by injection before the start of Truxima treatment. Corticosteroids given by mouth may be started at any time by your doctor to treat your condition. If you are 18 years of age and older and respond well to treatment, you may be given Truxima as a maintenance treatment. This will be administered as 2 separate infusions which are given 2 weeks apart, followed by 1 infusion every 6 months for at least 2 years. Your doctor may decide to treat you longer with Truxima (up to 5 years), depending on how you respond to the medicine.

e) If you are being treated for pemphigus vulgaris
Each course of treatment is made up of two separate infusions which are given 2 weeks apart. If you

respond well to treatment, you may be given Truxima as a maintenance treatment. This will be administered 1 year and 18 months after the initial treatment and then every 6 months as needed or your doctor may change this, depending on how you respond to the medicine.

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

4. Possible side effects

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

Most side effects are mild to moderate but some may be serious and require treatment. Rarely, some of these reactions have been fatal.

Infusion reactions
During or within the first 24 hours of the infusion you may develop fever, chills and shivering. Less frequently, some patients may experience pain at the infusion site, blisters, itching, sickness (nausea), tiredness, headache, breathing difficulties, blood pressure raised, wheezing, throat discomfort, tongue or throat swelling, itchy or runny nose, vomiting, flushing or palpitations, heart attack or low number of platelets. If you have heart disease or angina, these reactions might get worse. **Tell the person giving you the infusion immediately** if you or your child develops any of these symptoms, as the infusion may need to be slowed down or stopped. You may require additional treatment such as an antihistamine or paracetamol. When these symptoms go away, or improve, the infusion can be continued. These reactions are less likely to happen after the second infusion. Your doctor may decide to stop your Truxima treatment if these reactions are serious.

Infections
Tell your doctor immediately if you or your child gets signs of an infection including:

- fever, cough, sore throat, burning pain when passing urine or feeling weak or generally unwell
- memory loss, trouble thinking, difficulty walking or sight loss – these may be due to a very rare, serious brain infection, which has been fatal (Progressive Multifocal Leukoencephalopathy or PML).
- fever, headache and stiff neck, incoordination (ataxia), personality change, hallucinations, altered consciousness, seizures or coma – these may be due to a serious brain infection (enteroviral meningoencephalitis), which can be fatal.

You might get infections more easily during your treatment with Truxima.
These are often colds, but there have been cases of pneumonia, urinary infections and serious viral infections. These are listed below under “Other side effects”.

If you are being treated for rheumatoid arthritis, granulomatosis with polyangiitis, microscopic polyangiitis or pemphigus vulgaris, you will also find this information in the Patient Alert Card you have been given by your doctor. It is important that you keep this Alert Card and show it to your partner or caregiver.

Skin Reactions
Very rarely, severe blistering skin conditions that can be life-threatening may occur. Redness, often associated with blisters, may appear on the skin or on mucous membranes, such as inside the mouth, the genital areas or the eyelids, and fever may be present. **Tell your doctor immediately if you experience any of these symptoms.**

Other side effects include:

a) If you or your child are being treated for non-Hodgkin’s lymphoma or chronic lymphocytic leukaemia

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

- bacterial or viral infections, bronchitis
- low number of white blood cells, with or without fever or blood cells called “platelets”
- feeling sick (nausea)
- bald spots on the scalp, chills, headache
- lower immunity – because of lower levels of anti-bodies called “immunoglobulins” (IgG) in the blood which help protect against infection

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

- infections of the blood (sepsis), pneumonia, shingles, cold, bronchial tube infections, fungal infections, infections of unknown origin, sinus inflammation, hepatitis B,
- low number of red blood cells (anaemia), low number of all blood cells,
- allergic reactions (hypersensitivity),
- high blood sugar level, weight loss, swelling in the face and body, high levels of the enzyme “lactate dehydrogenase (LDH)” in the blood, low calcium levels in the blood,
- unusual feelings of the skin – such as numbness, tingling, pricking, burning, a creeping skin feeling, reduced sense of touch,
- feeling restless, problems falling asleep,
- becoming very red in the face and other areas of the skin as a consequence of dilation of the blood vessels,
- feeling dizzy or anxious,
- producing more tears, tear duct problems, inflamed eye (conjunctivitis),
- ringing sound in the ears, ear pain,
- heart problems – such as heart attack, uneven or fast heart rate,
- high or low blood pressure (low blood pressure especially when standing upright),
- tightening of the muscles in the airways which causes wheezing (bronchospasm), inflammation, irritation in the lungs, throat or sinuses, being short of breath, runny nose,
- being sick (vomiting), diarrhoea, pain in the stomach, irritation or ulcers in the throat and mouth, problems swallowing, constipation, indigestion,
- eating disorders, not eating enough, leading to weight loss,
- hives, increased sweating, night sweats,
- muscle problems – such as tight muscles, joint or muscle pain, back and neck pain,
- tumour pain,
- general discomfort or feeling uneasy or tired, shaking, signs of flu,
- multiple-organ failure.

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

- blood clotting problems, decrease of red blood cell production and increase of red blood cell destruction (aplastic haemolytic anaemia), swollen or enlarged lymph nodes,
- low mood and loss of interest or enjoyment in doing things, feeling nervous,
- taste problems – such as changes in the way things taste,
- heart problems – such as reduced heart rate or chest pain (angina),
- asthma, too little oxygen reaching the body organs,
- swelling of the stomach.

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

- short term increase in the amount of some types of anti-bodies in the blood (called immunoglobulins – IgM), chemical disturbances in the blood caused by break-down of dying cancer cells,
- nerve damage in arms and legs, paralysed face,
- heart failure,
- inflammation of blood vessels including those leading to skin symptoms,
- respiratory failure,
- damage to the intestinal wall (perforation),
- severe skin problems causing blisters that can be life-threatening. Redness, often associated with blisters, may appear on the skin or on mucous membranes, such as inside

the mouth, the genital areas or the eyelids, and fever may be present,
- kidney failure,
- severe vision loss

Not known (it is not known how often these side effects happen):
- a reduction in white blood cells which does not happen straight away,
- reduced platelets number just after the infusion – this can be reversed, but can be fatal in rare cases,
- hearing loss, loss of other senses,
- brain and meningeal infection/inflammation (enteroviral meningoencephalitis)

Children and adolescents with non-Hodgkin's lymphoma:
In general, side effects in children and adolescents with non-Hodgkin's lymphoma were similar to those in adults with non-Hodgkin's lymphoma or chronic lymphocytic leukaemia. The most common side effects seen were fever associated with low levels of a type of white blood cell (neutrophil), inflammation or sores in the lining of the mouth, and allergic reactions (hypersensitivity).

b) If you are being treated for rheumatoid arthritis

Very common side effects (may affect more than 1 in 10 people):
- infections such as pneumonia (bacterial),
- pain on passing water (urinary tract infection),
- allergic reactions that are most likely to occur during an infusion, but can occur up to 24-hours after infusion,
- changes in blood pressure, nausea, rash, fever, feeling itchy, runny or blocked nose and sneezing, shaking, rapid heart beat, and tiredness,
- headache,
- changes in laboratory tests carried out by your doctor. These include a decrease in the amount of some specific proteins in the blood (immunoglobulins) which help protect against infection.

Common side effects (may affect up to 1 in 10 people):
- infections such as bronchial tube inflammation (bronchitis),
- a feeling of fullness or a throbbing pain behind the nose, cheeks and eyes (sinusitis), pain in the abdomen, vomiting and diarrhoea, breathing problems,
- fungal foot infection (athlete's foot),
- high cholesterol levels in the blood,
- abnormal sensations of the skin, such as numbness, tingling, pricking or burning, sciatica, migraine, dizziness,
- loss of hair,
- anxiety, depression,
- indigestion, diarrhoea, acid reflux, irritation and /or ulceration of the throat and the mouth,
- pain in the tummy, back, muscles and/or joints.

Uncommon side effects (may affect up to 1 in 100 people):
- excess fluid retention in the face and body,
- inflammation, irritation and / or tightness of the lungs and throat, coughing,
- skin reactions including hives, itching and rash,
- allergic reactions including wheezing or shortness of breath, swelling of the face and tongue, collapse.

Very rare side effects (may affect up to 1 in 10,000 people):
- a complex of symptoms occurring within a few weeks of an infusion of Truxima including allergic like reactions such as rash, itching, joint pain, swollen lymph glands and fever,
- severe blistering skin conditions that can be life-threatening. Redness, often associated with blisters, may appear on the skin or on mucous membranes, such as inside the mouth, the genital areas or the eyelids, and fever may be present.

Not known (frequency cannot be estimated from the available data):
- serious viral infection,
- brain and meningeal infection/inflammation (enteroviral meningoencephalitis)

Other rarely reported side effects due to Truxima include a decreased number of white cells in the blood (neutrophils) that help to fight against infection. Some infections may be severe (please see information on ***Infections*** within this section).

c) If you or your child are being treated for granulomatosis with polyangiitis or microscopic polyangiitis

Very common side effects (may affect more than 1 in 10 people):
- infections, such as chest infections, urinary tract infections (pain on passing water), colds and herpes infections,
- allergic reactions that are most likely to occur during an infusion, but can occur up to 24-hours after infusion,
- diarrhoea,
- coughing or shortness of breath,
- nose bleeds,
- raised blood pressure,
- painful joints or back,
- muscle twitches or shakiness,
- feeling dizzy,
- tremors (shakiness, often in the hands),
- difficulty sleeping (insomnia),
- swelling of the hands or ankles.

Common side effects (may affect up to 1 in 10 people):
- indigestion,
- constipation,
- skin rashes, including acne or spots,
- flushing or redness of the skin,
- fever,
- blocked or runny nose,
- tight or painful muscles,
- pain in the muscles or in the hands or feet,
- low number of red blood cells (anaemia),
- low numbers of platelets in the blood,
- an increase in the amount of potassium in the blood,
- changes in the rhythm of the heart, or the heart beating faster than normal.

Very rare side effects (may affect up to 1 in 10,000 people):
- severe blistering skin conditions that can be life-threatening. Redness, often associated with blisters, may appear on the skin or on mucous membranes, such as inside the mouth, the genital areas or the eyelids, and fever may be present,
- recurrence of a previous Hepatitis B infection.

Not known (frequency cannot be estimated from the available data):
- serious viral infection,
- brain and meningeal infection/inflammation (enteroviral meningoencephalitis).

Children and adolescents with granulomatosis with polyangiitis or microscopic polyangiitis
In general, side effects in children and adolescents with granulomatosis with polyangiitis or microscopic polyangiitis were of a similar type to those in adults with granulomatosis with polyangiitis or microscopic polyangiitis. Most common side effects seen were infections, allergic reactions and feeling sick (nausea).

d) If you are being treated for pemphigus vulgaris

Very common side effects (may affect more than 1 in 10 people):
- allergic reactions that are most likely to occur during an infusion, but can occur up to 24 hours after infusion,
- headache,
- infections such as chest infections,
- long lasting depression,
- loss of hair

Common side effects (may affect up to 1 in 10 people):
- infections such as common cold, herpes infections, eye infection, oral thrush and urinary tract infections (pain on passing urine),
- mood disorders such as irritability and depression,
- skin disorders such as itching, hives, and benign lumps,
- feeling tired or dizzy,
- fever,
- painful joints or back,
- pain in the tummy,
- pain in the muscles,
- heart beating faster than normal.

Not known (frequency cannot be estimated from the available data):
- serious viral infection,
- brain and meningeal infection/inflammation (enteroviral meningoencephalitis).

Truxima may also cause changes in laboratory tests carried out by your doctor.
If you are having Truxima with other medicines, some of the side effects you may get may be due to the other medicines.

Reporting of side effects

If you get any side effects talk to your doctor, pharmacist or nurse. This includes any 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 Truxima

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

Store in a refrigerator (2 °C – 8 °C). Keep the vial in the outer carton in order to protect from light.

The medicine can also be stored in the original carton outside of refrigerated storage up to a maximum of 30 °C for a single period up to 10 days, but not beyond the original expiry date. In this situation, do not return to the refrigerated storage again.

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

6. Contents of the pack and other information

What Truxima contains

- The active ingredient in Truxima is called rituximab.
  The 10 mL vial contains 100 mg of rituximab (10 mg/mL).
  The 50 mL vial contains 500 mg of rituximab (10 mg/mL).

- The other ingredients are sodium chloride, tri-sodium citrate dihydrate, polysorbate 80 (E 433) and water for injections (see section 2 “Truxima contains sodium”).

What Truxima looks like and contents of the pack

Truxima is a clear, colourless solution, supplied as a concentrate for solution for infusion.
10 mL vial – Pack of 2 vials
50 mL vial – Pack of 1 vial or 2 (2 x 1) vials (multipack)

Not all pack sizes may be marketed.

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Other sources of information

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