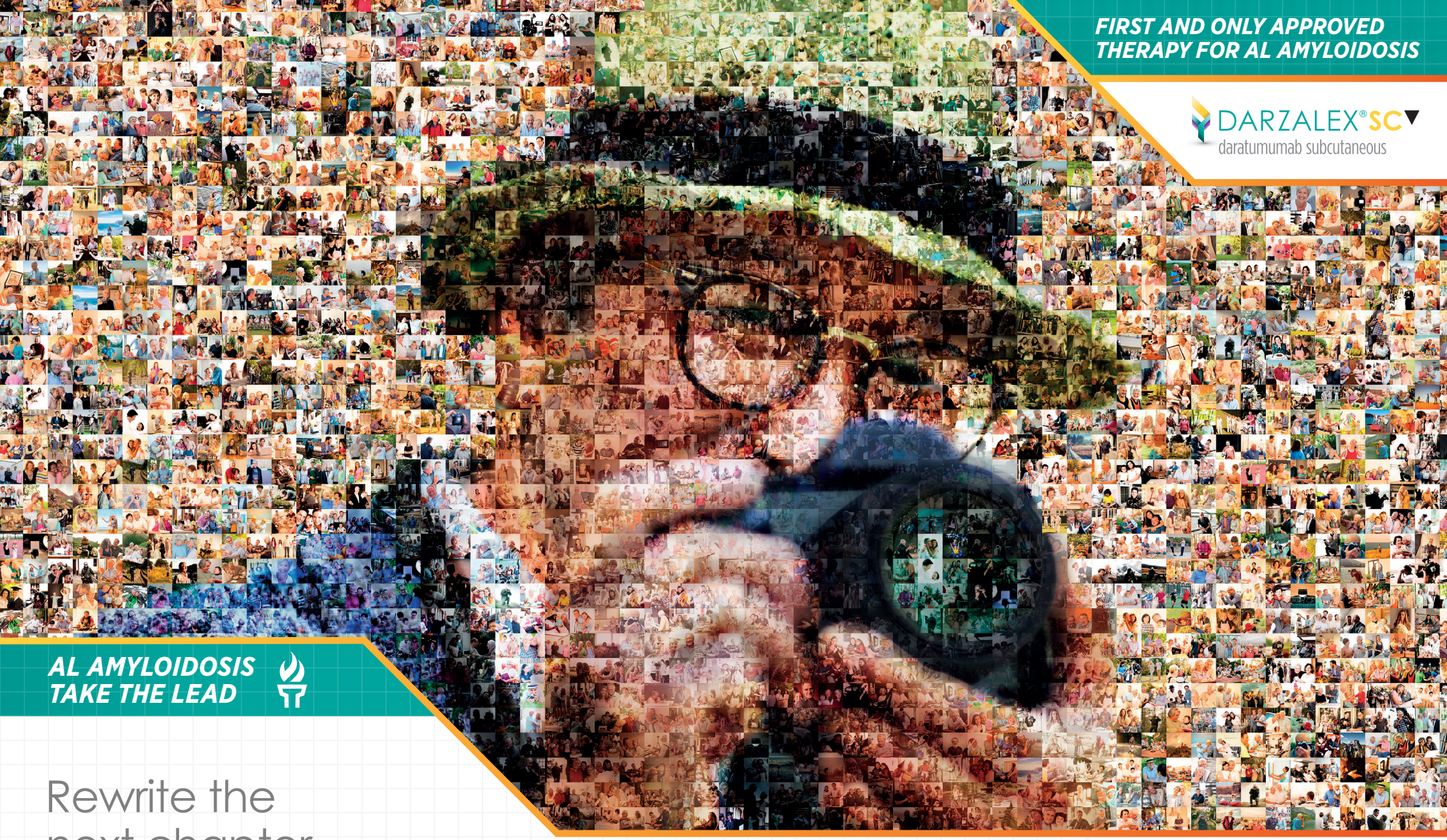


FIRST AND ONLY APPROVED THERAPY FOR AL AMYLOIDOSIS

DARZALEX® SC▼
daratumumab subcutaneous

AL AMYLOIDOSIS TAKE THE LEAD

Rewrite the next chapter

DARZALEX® SC + VCd is the first and only targeted therapy to significantly transform clinical outcomes of AL amyloidosis, allowing patients to finally move forward with their lives.[1,2]

Janssen Oncology
PHARMACEUTICAL COMPANIES OF Johnson & Johnson

▼ This medicinal product is subject to additional monitoring and it is therefore important to report any suspected adverse reactions related to this medicinal product. Date of preparation: March 2021 iMR code: CP-372836

References: 1. Kastritis E, Palladini G, Minnema MC, et al. Daratumumab-Based Treatment for Immunoglobulin Light-Chain Amyloidosis. N Engl J Med. 2021;385(1):46-58.
2. Darzalex Summary of product characteristics. Available at https://www.ema.europa.eu/en/documents/product-information/darzalex-epar-product-information_en.pdf Last Accessed February 2023.

AL amyloidosis is a life-threatening disease[1–4]

PROPER DIAGNOSIS COMMONLY TAKES

≥1 YEAR AFTER INITIAL PRESENTATION[3]

BEFORE DIAGNOSIS, NEARLY ONE-THIRD OF PATIENTS MAY VISIT

≥5 PHYSICIANS[3]

- AL amyloidosis impacts the lives of tens of thousands of patients each year[3]
- **~50%** of patients die within 1 year of diagnosis[4]
- A delayed diagnosis is directly linked to **poorer outcomes**[1–4]

to find out more about AL amyloidosis

AL, amyloidosis light chain.

AL amyloidosis is a life-threatening disease[1–4]

AL amyloidosis impacts multiple organs[2]

HEART

74%

LIVER

20%

KIDNEYS

65%

NERVES

15%

- Improved disease awareness is one of the critical components of achieving **earlier diagnosis** and **improved prognosis**[1,3]
- No therapies were approved for the treatment of AL amyloidosis until now[5]

IT'S TIME TO REWRITE THE STORY FOR PATIENTS WITH AL AMYLOIDOSIS

AL amyloidosis is also clinically evident in soft tissues and the GI tract in **17%** and **8%** of cases, respectively.[2]

AL, amyloidosis light chain; GI, gastrointestinal.

References

1. Desport E, *et al. Orphanet J Rare Dis*. 2012;7:54.
2. Dispenzieri A and Merlini G. *Cancer Treat Res*. 2016;169:273–318.
3. Lousada I, *et al. Adv Ther*. 2015;32(10):920–928.
4. Weiss BM, *et al. J Clin Oncol*. 2014;32(25):2699–2704.
5. DARZALEX® Summary of product characteristics. Available at https://www.ema.europa.eu/en/documents/product-information/darzalex-epar-product-information_en.pdf Last Accessed February 2023.

The first and only targeted treatment approved in AL amyloidosis

ANDROMEDA - randomised, open-label, active-controlled, phase 3 study (N=388)[1]

Key eligibility criteria:

- AL amyloidosis with ≥1 organ impacted
- No prior therapy for AL amyloidosis or MM
- Cardiac stage I–IIIA (Mayo 2004)
- eGFR ≥20 mL/min

Stratification:

- Cardiac stage (I vs. II vs. IIIA)
- Transplant typically offered in local country (yes vs. no)
- CrCl (≥60 mL/min vs. <60 mL/min)

1:1 Randomisation

DVCd (n=195)

D: 1,800 mg SC QW cycles 1–2, Q2W cycles 3–6

VCd*: weekly 6 cycles

VCd (n=193)

VCd*: weekly 6 cycles

Beyond cycle 6

D: 1,800 mg SC Q4W until MOD-PFS or maximum of 24 total cycles

Primary end point

- Overall haematologic CR rate

Secondary endpoints

- MOD-PFS
- Organ response rate
- Time to haematologic response
- Overall survival
- Safety

The median duration of follow-up was 11.4 months†

*Dexamethasone 40 mg IV or PO, followed by cyclophosphamide 300 mg/m2 IV or PO, followed by bortezomib 1.3 mg/m2 SC on Days 1, 8, 15, and 22 in every 28-day cycle for a maximum of 6 cycles. Patients will receive dexamethasone 20 mg on the day of DARZALEX® SC dosing and 20 mg on the day after DARZALEX® SC dosing.[1] †The study design of ANDROMEDA allowed continuation of single-agent DARZALEX® SC in the investigational group beyond the fixed 6 cycles (6 months) of VCd; therefore, the median treatment duration (median follow-up 11.4 months) was longer in those who received DARZALEX® SC + VCd (9.6 months) vs. VCd alone (5.3 months).[1]

AL, amyloidosis light chain; CR, complete response; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate; MM, multiple myeloma; MOD-PFS, major organ deterioration progression-free survival; PO, orally; QW, weekly; SC, subcutaneous; VCd, bortezomib + cyclophosphamide + dexamethasone.

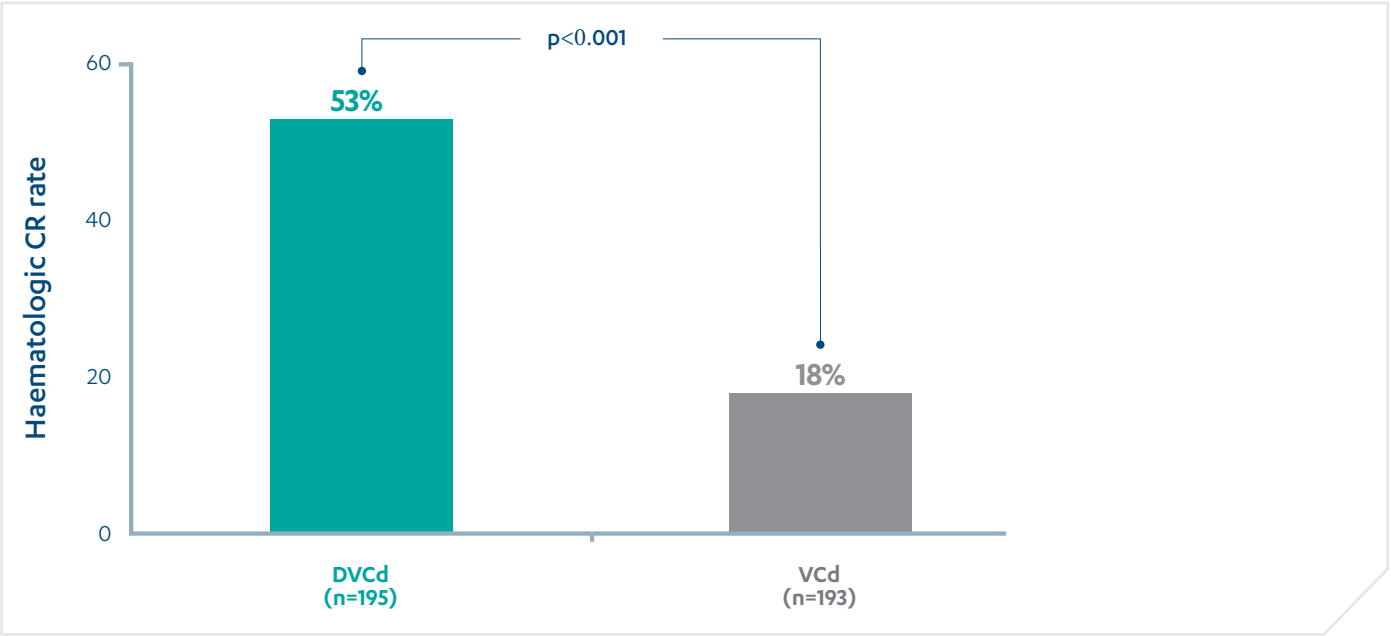
Reference

1. Kastritis E, Palladini G, Minnema MC, et al. Daratumumab-Based Treatment for Immunoglobulin Light-Chain Amyloidosis. N Engl J Med. 2021;385(1):46-58.

Reinvent their story with breakthrough efficacy

DARZALEX® SC + VCd delivers superior efficacy vs. VCd alone, providing deeper and more rapid responses[1]

Haematologic CR (primary endpoint)[1]



Data from Kastritis E, *et al.* 2020

SUPERIOR
haematologic CR rate
53%
vs. 18% with VCd alone
(OR 5.1; p<0.001)[1]

60 days
median time to CR
vs. 85 days
with VCd alone*[1]

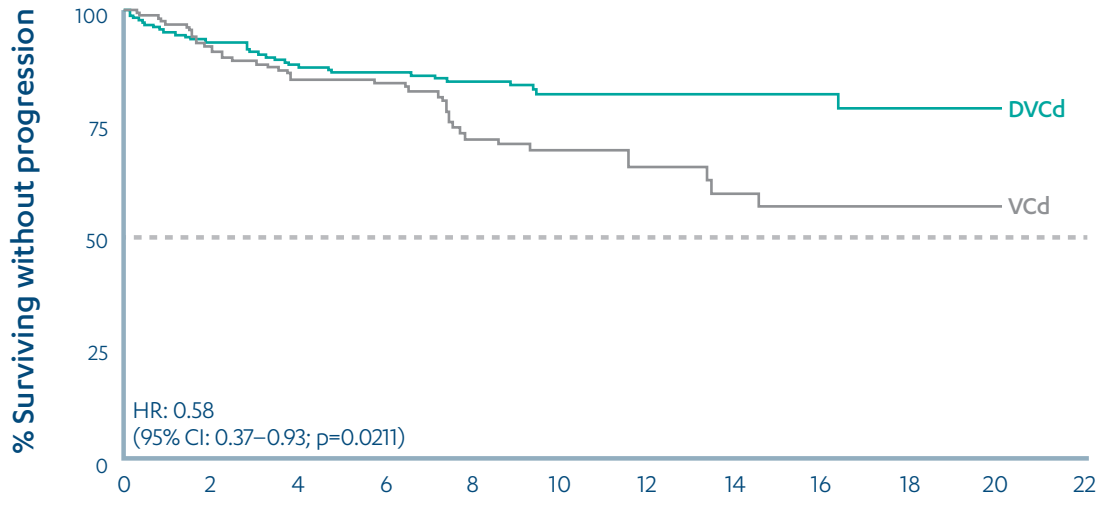
- Haematologic CR rate was **nearly three times higher** with DARZALEX® SC + VCd vs. VCd alone (53% vs. 18%; OR 5.1; p<0.001)[1]

Data from Kastritis E, *et al.* 2020 *Among CR responders (DVCd: n=104; VCd: n=35)[1]
CR, complete response; MOD-PFS, major organ deterioration progression-free survival; OR, odds ratio; ORR, organ response rate; SC, subcutaneous; VCd, bortezomib + cyclophosphamide + dexamethasone.

Reinvent their story with breakthrough efficacy

DARZALEX® SC + VCd delivers superior efficacy vs. VCd alone, providing deeper and more rapid responses[1]

Major organ deterioration (MOD) PFS[1]



PROLONGED MOD-PFS

42%

reduction in the risk of MOD-PFS vs. VCd alone (HR 0.58; p=0.0211)[1]

- DVCd substantially delayed MOD-PFS at a median follow up of 11.4 months[1]

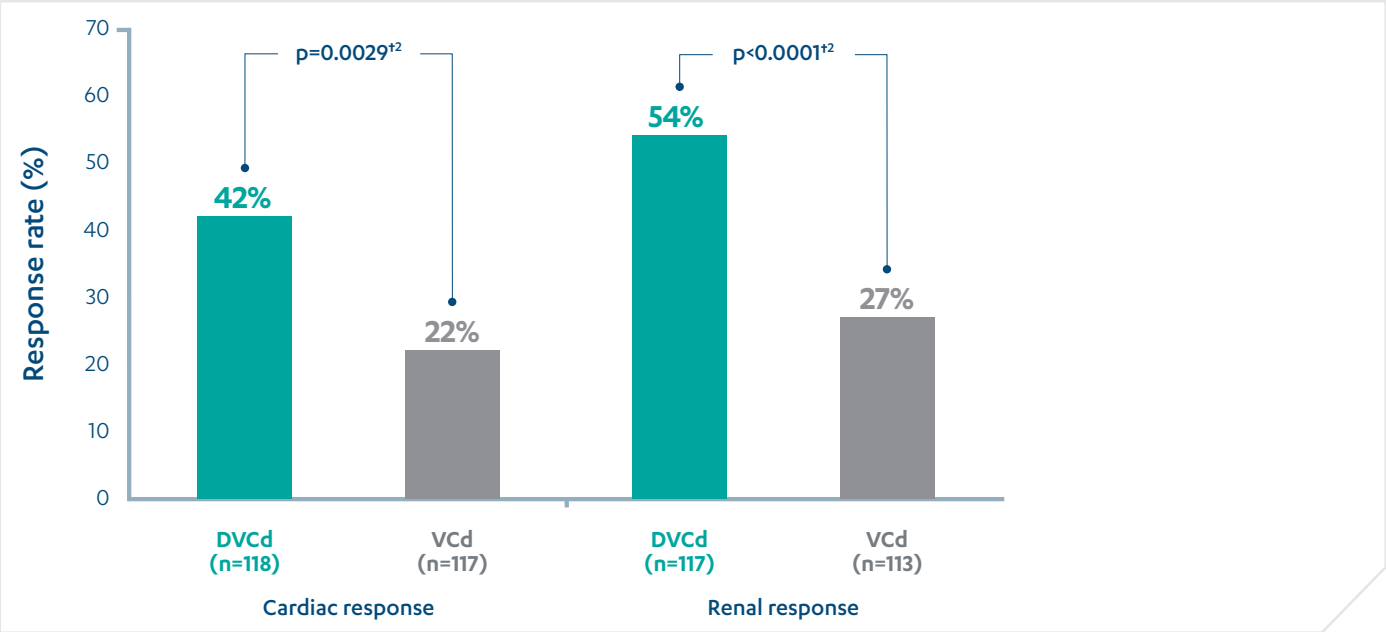
Data from Kastritis E, *et al.* 2020

*MOD-PFS defined as haematologic progression (IRC assessed), end-stage cardiac or renal disease, or death.
CI, confidence interval; CR, complete response; DVCd, DARZALEX® SC + bortezomib + cyclophosphamide + dexamethasone; HR, hazard ratio; IRC, independent review committee; MOD-PFS, major organ deterioration progression-free survival; ORR, organ response rate; SC, subcutaneous; VCd, bortezomib + cyclophosphamide + dexamethasone.

Reinvent their story with breakthrough efficacy

DARZALEX® SC + VCd delivers superior efficacy vs. VCd alone, providing deeper and more rapid responses[1]

Organ response at 6 months*[1]



SIGNIFICANTLY IMPROVED

organ response rates at 6 months vs. VCd alone[1]

cardiac = 42% vs. 22%;
renal = 54% vs. 27%

Data from Kastritis E, *et al.* 2020

*Organ response evaluable set (patients with organ involvement); organ responses were assessed by blinded IRC.[2] †Nominal p value.[2]
CR, complete response; DVCd, DARZALEX® SC + bortezomib + cyclophosphamide + dexamethasone; MOD-PFS, major organ deterioration progression-free survival; ORR, organ response rate; SC, subcutaneous; VCd, bortezomib + cyclophosphamide + dexamethasone.

References

1. Kastritis E, Palladini G, Minnema MC, et al. Daratumumab-Based Treatment for Immunoglobulin Light-Chain Amyloidosis. N Engl J Med. 2021;385(1):46-58.
2. Kastritis E, *et al.* Subcutaneous Daratumumab + Cyclophosphamide, Bortezomib, and Dexamethasone (CyBorD) in Patients With Newly Diagnosed Light Chain (AL) Amyloidosis: Primary Results From the Phase 3 ANDROMEDA Study. Oral presentation at the 25th Annual Congress of European Hematology Association, Virtual meeting. June 11–21, 2020.

Rewrite their next chapter with confidence

DARZALEX® SC provides the reassurance of a consistent and well-characterised safety profile[1,2]

Adverse events[1]*

	DARZALEX® SC + VCd[1] (n=193)		VCd[1] (n=188)	
	Any Grade	Grade 3/4	Any Grade	Grade 3/4
Diarrhoea	69	11	57	7
Peripheral oedema	69	6	68	11
Constipation	66	3	54	0
Peripheral sensory neuropathy	60	5	37	4
Fatigue	52	8	53	6
Nausea	52	3	52	0
Upper respiratory tract infection	50	1	21	1
Lymphopaenia	36	25	28	19
Hypokalemia	24	3	28	10
Neutropaenia	21	10	12	5
Pneumonia	21	15	12	8
Syncope	14	10	12	12
Cardiac failure**	18	12	14	9

Data from Kastritis E, *et al.* 2020

- The rate of grade 3 or 4 infection for DARZALEX® SC +VCd was 12% vs. 10% for VCd alone[1]
- Rates of serious TEAEs were 43% with DARZALEX® SC + VCd vs. 36% with VCd alone[1]
- Discontinuation rates due to TEAEs were the same in both arms (4%)[1]
- Rates of ARRs and ISRs were low with DARZALEX® SC + VCd (systemic ARRs occurred in 7% of patients; ISRs occurred in 28% of DARZALEX® SC + VCd patients and 24% of VCd patients)[1]
- The median duration of treatment was 9.6 months for DARZALEX® SC + VCd and 5.3 months for VCd[1]

*The safety population included patients who received one or more administration of study treatment. Adverse events of any grade are listed that included those occurring in more than 25% of the patients in either group, or grade 3 or 4 events occurring in at least 5% of patients in either group. **Includes overall and congestive cardiac failure.[1]
ARR, administration-related reaction; ISR, injection-site reaction; SC, subcutaneous; bortezomib + cyclophosphamide + dexamethasone.

References

1. Kastritis E, Palladini G, Minnema MC, et al. Daratumumab-Based Treatment for Immunoglobulin Light-Chain Amyloidosis. N Engl J Med. 2021;385(1):46-58.
2. DARZALEX® Summary of product characteristics. Available at https://www.ema.europa.eu/en/documents/product-information/darzalex-epar-product-information_en.pdf Last Accessed February 2023.

Rewrite the next chapter without adding to their burden

DARZALEX® SC offers patients with AL amyloidosis the treatment flexibility they deserve and reduces provider burden[1]

Fixed
dosing schedule

DARZALEX® fits seamlessly into a VCd 4-week cycle dosing schedule[1]

Finite
treatment duration

DARZALEX® treatment recommended for a maximum of 24 cycles (~2 years)[1]

Subcutaneous
injection

DARZALEX® SC administered as a convenient 3-to-5-minute injection[1]

AL, amyloidosis light chain; SC, subcutaneous.

Reference

1. DARZALEX® Summary of product characteristics. Available at https://www.ema.europa.eu/en/documents/product-information/darzalex-epar-product-information_en.pdf Last Accessed February 2023.

A new chapter in AL amyloidosis, backed by real-world experience in MM

DARZALEX® is redefining treatment paradigms across indications[1–8]

DARZALEX® is the breakthrough therapy revolutionising treatment outcomes in haematology, addressing urgent unmet needs in critical situations[1–8]

- The **only** anti-CD38 monoclonal antibody with superior PFS outcomes in MM vs. SOC across all lines[1–6]
- **Deep responses** in MM with significantly more FL and RR patients reaching MRD-negativity vs. SOC[1–6]
- **Flexibility** to treat a variety of patients with minimal additional toxicity[1–7,11]

AL, amyloidosis light chain; FL, frontline; MM, multiple myeloma; MRD, minimal residual disease; PFS, progression-free survival; RR, relapsed and/or refractory; SOC, standard of care.

Strong track record of deep responses

Rates of MRD-negativity*

Newly-diagnosed

DVTd[2]

1.45x

64% vs. 44%
for VTd

(p<0.0001)
after two
post-transplant cycles†

DRd[3]

3x

31% vs. 10%
for Rd

(p<0.0001)‡

DVMP[4]

4x

28% vs. 7%
for VMP

(p<0.0001)§

Relapsed and/or refractory

DRd[5]

6x

30% vs. 5%
for Rd

(p<0.001)¶

DVd[6]

7x

15% vs. 2%
for Vd

(p<0.001)**

Deep responses help eliminate residual disease

- DARZALEX® has helped patients across the treatment pathway achieve responses deep enough to eliminate detectable disease[2–6]

Deep responses lead to superior outcomes[12–14]

ASCT, autologous stem cell transplant; DRd, DARZALEX® + lenalidomide + dexamethasone; DVTd, DARZALEX® + Velcade® + thalidomide + dexamethasone; DVd, DARZALEX® + Velcade® + dexamethasone; DVMP, DARZALEX® + Velcade® + melphalan + prednisone; MM, multiple myeloma; MRD, minimal residual disease; PFS, progression-free survival; Rd, lenalidomide + dexamethasone; Vd, Velcade® + dexamethasone; VTd, Velcade® + thalidomide + dexamethasone; VMP, Velcade® + melphalan + prednisone.

*Assessed using next-generation sequencing at 10^{-5} sensitivity threshold. †Post-transplant: 100 days after ASCT. ‡Median follow-up was 47.9 months. §Median follow-up was 40.1 months. ¶Median follow-up was 44.3 months. **Median follow-up was 50.2 months.

Proven PFS benefit across the board

Progression-free survival

Newly-diagnosed

DVTd

18-month PFS

93%

vs. 85% for VTd*[2]

DRd

48-month PFS

60%

vs. 38% for Rd†[3]

DVMP

median PFS

36.4 months

vs. 19.3 months for VMP‡[4]

Relapsed and/or refractory

DRd

Median PFS

44.5 months

vs. 17.5 months for Rd§[5]

DVd

16.7 months

vs. 7.1 months for Vd¶[6]

DRd, DARZALEX® + lenalidomide + dexamethasone; DVd, DARZALEX® + Velcade® + dexamethasone; DVMP, DARZALEX® + Velcade® + melphalan + prednisone; DVTd, DARZALEX® + Velcade® + thalidomide + dexamethasone; PFS, progression-free survival; Rd, lenalidomide + dexamethasone; Vd, Velcade® + dexamethasone; VMP, Velcade® + melphalan + prednisone; VTd, Velcade® + thalidomide + dexamethasone.

*CASSIOPEIA trial median follow-up of 18.8 months. †MAIA trial median follow-up of 48 months. ‡ALCYONE trial median follow-up of 40.1 months. §POLLUX trial median follow-up of 54.8 months.¶ CASTOR trial median follow-up of 50.2 months.

A tolerability profile that allows flexibility to treat a variety of patients

Patients aged <65 years with no co-morbidities[2,3,5,6,15]

Elderly patients, including those aged >75 years[2,3,6,15,16]

Transplant-eligible, -ineligible and/or frail patients[2,3,5,6,15]

Patients with high- or standard-risk cytogenics[2,3,5,6,15,17]

- Safety profiles of DARZALEX® combinations remain **consistent** with the known tolerability of regimen components[1–6]
- In phase 3 trials, discontinuation rates were **similar or lower** compared with the standard of care alone[2–6]
- Inclusive phase 3 study designs demonstrate that DARZALEX® is well tolerated and effective **across a range of patient and disease types**[2–6,16,17]—meaning more patients can benefit from the efficacy it can bring

References

1. DARZALEX® Summary of product characteristics. Available at https://www.ema.europa.eu/en/documents/product-information/darzalex-epar-product-information_en.pdf Last Accessed February 2023.
2. Moreau P, *et al. Lancet*. 2019;394(10192):29–38.
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4. Mateos MV, *et al. Lancet*. 2020;395:132–141.
5. Bahlis NJ, *et al. Leukemia*. 2020;34(7):1875–1884.
6. Weisel K, *et al*. Poster presented at the 61st annual meeting of the American Society of Hematology (ASH). Orlando, FL. December 7–10, 2019. #3192.
7. Usmani SZ, *et al. Lancet Hematol*. 2020;7:e447–e455.
8. Kastritis E, Palladini G, Minnema MC, et al. Daratumumab-Based Treatment for Immunoglobulin Light-Chain Amyloidosis. N Engl J Med. 2021;385(1):46-58.
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12. Landgren O, Iskander K. *J Intern Med*. 2017;281:365–382.
13. Pavia B, *et al. Blood*. 2015;125:3059–3068.
14. Lahuerta JJ, *et al. J Clin Oncol.* 2017:35:2900–2910.
15. Dimopoulos MA, *et al*. Oral presentation at the 60th annual meeting of the American Society of Hematology (ASH). San Diego, CA. December 1–4, 2018. #156.
16. Kaufman JL, *et al*. Poster presented at the 61st annual meeting of the American Society of Hematology (ASH). Orlando, FL. December 7–10, 2019. #1866.
17. Kaufman JL, *et al. Blood Cancer Journal*. 2020;10:111.

Prescribing Information

DARZALEX® 1800 mg SOLUTION FOR INJECTION ABBREVIATED PRESCRIBING INFORMATION BASED ON THE EU SUMMARY OF PRODUCT CHARACTERISTICS
ACTIVE INGREDIENT: Daratumumab
Please refer to Summary of Product Characteristics (SmPC) before prescribing.
INDICATION(S): DARZALEX is indicated:

- in combination with lenalidomide and dexamethasone or with bortezomib, melphalan and prednisone for the treatment of adult patients with newly diagnosed multiple myeloma who are ineligible for autologous stem cell transplant.
- in combination with bortezomib, thalidomide and dexamethasone for the treatment of adult patients with newly diagnosed multiple myeloma who are eligible for autologous stem cell transplant.
- in combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy.
- as monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on the last therapy.

- Light chain (AL) amyloidosis

  DARZALEX is indicated in combination with cyclophosphamide, bortezomib and dexamethasone for the treatment of adult patients with newly diagnosed systemic AL amyloidosis.

DOSAGE & ADMINISTRATION: DARZALEX subcutaneous formulation is not intended for intravenous administration and should be given by subcutaneous injection only. DARZALEX should be administered by a healthcare professional, and the first dose should be administered in an environment where resuscitation facilities are available. For patients currently receiving daratumumab intravenous formulation, DARZALEX solution for subcutaneous injection may be used as an alternative to the intravenous daratumumab formulation starting at the next scheduled dose. Administer pre and postinjection medicinal products to reduce the risk of IRRs and delayed IRRs (please refer to the full SmPC). Adults: Recommended dose: Inject 1,800 mg of DARZALEX solution for subcutaneous injection administered into the subcutaneous tissue of the abdomen approximately 7.5 cm to the right or left of the navel over approximately 35 minutes. Dosing schedule in combination with lenalidomide (4week cycle regimen) and for monotherapy, is weekly from week 1 to 8, every two weeks from week 9 to 24, followed by every four weeks from week 25 until disease progression. Dosing schedule in combination with bortezomib, melphalan and prednisone (6-week cycle regimen), is weekly from week 1 to 6, every three weeks from week 7 to 54, followed by every four weeks from week 55 until disease progression. Bortezomib is given twice weekly at Weeks 1, 2, 4 and 5 for the first 6-week cycle, followed by once weekly at Weeks 1, 2, 4 and 5 for eight more 6-week cycles. Dosing schedule in combination with bortezomib, thalidomide and dexamethasone (4-week cycle regimens) for treatment of newly diagnosed patients eligible for autologous stem cell transplant (ASCT): Induction phase: is weekly from week 1 to 8, every two weeks from week 9 to 16. The dosing schedule is stopped for high dose chemotherapy and ASCT. Consolidation phase: The dosing schedule is every two weeks from week 1 to 8 upon re-initiation of treatment following ASCT. Dosing schedule in combination with bortezomib (3week cycle regimen) is weekly from week 1 to 9, every three weeks from week 10 to 24, followed by every four weeks from week 25 until disease progression. Prevention of herpes zoster virus reactivation: Consider antiviral prophylaxis. Children (≤ 18 years): Safety/efficacy not established. No data available. Elderly patients: No dose adjustment. Renal impairment: No dose adjustment. Hepatic impairment: No dose adjustment. Body weight (>120 kg): Limited number of patients with body weight >120 kg have been studied using flat-dose (1,800 mg) DARZALEX solution for subcutaneous injection and efficacy in these patients has not been established. No dose adjustment based on body weight can currently be recommended. CONTRAINDICATIONS: Hypersensitivity to the active substance(s) or any of the excipients. SPECIAL WARNINGS & PRECAUTIONS: Traceability: In order to improve the traceability of biological medicinal products, the tradename and the batch number of the administered product should be clearly recorded. Infusionrelated reactions (IRRs): DARZALEX solution for subcutaneous injection can cause severe and/or serious IRRs, including

Prescribing Information

anaphylactic reactions. In clinical studies, approximately 11% of patients experienced an IRR. Most IRRs occurred following the first injection and were Grade 12. The median time to onset of IRRs following DARZALEX injection was 3.7 hours. Delayed IRRs have occurred in less than 1% of patients. Signs and symptoms of IRRs may include respiratory symptoms, such as nasal congestion, cough, throat irritation, allergic rhinitis, wheezing as well as pyrexia, chest pain, pruritis, chills, vomiting, nausea, and hypotension. Severe reactions have occurred, including bronchospasm, hypoxia, dyspnoea, hypertension and tachycardia. Patients should be premedicated with antihistamines, antipyretics, and corticosteroids as well as monitored and counselled regarding IRRs, especially during and following the first and second injections. If an anaphylactic reaction or lifethreatening (Grade 4) reactions occur, appropriate emergency care should be initiated immediately. DARZALEX therapy should be discontinued immediately and permanently. To reduce the risk of delayed IRRs, oral corticosteroids should be administered to all patients following DARZALEX injection. Patients with a history of chronic obstructive pulmonary disease may require additional postinjection medicinal products to manage respiratory complications. The use of postinjection medicinal products (e.g. short and longacting bronchodilators and inhaled corticosteroids) should be considered for patients with chronic obstructive pulmonary disease. Neutropenia/Thrombocytopenia: DARZALEX may increase neutropenia and thrombocytopenia induced by background therapy. Complete blood cell counts should be monitored periodically during treatment according to manufacturer's prescribing information for background therapies. Patients with neutropenia should be monitored for signs of infection. DARZALEX delay may be required to allow recovery of blood cell counts. In lower body weight patients receiving DARZALEX subcutaneous formulation, higher rates of neutropenia were observed; however, this was not associated with higher rates of serious infections. No dose reduction of DARZALEX is recommended. Consider supportive care with transfusions or growth factors. Interference with indirect antiglobulin test (indirect Coombs test): Daratumumab binds to CD38 found at low levels on red blood cells (RBCs) and may result in a positive indirect Coombs test. Daratumumabmediated positive indirect Coombs test may persist for up to 6 months after the last DARZALEX administration. Type and screen patient prior to treatment with DARZALEX. Consider phenotyping prior to starting DARZALEX treatment per local practice. Red blood cell genotyping is not impacted by DARZALEX and may be performed at any time. Notify centres of this interference with indirect antiglobulin tests in the event of a planned blood transfusion. Give noncrossmatched ABO/RhDcompatible RBCs per local blood bank practices if an emergency transfusion is required. Interference with determination of complete response: Daratumumab can be detected on both the serum protein electrophoresis (SPE) and immunofixation (IFE) assays used for the clinical monitoring of endogenous Mprotein. This interference can impact the determination of complete response and of disease progression in some patients with IgG kappa myeloma protein. Hepatitis B virus (HBV) reactivation: HBV reactivation, in some cases fatal, has been reported in patients treated with DARZALEX. Before initiating treatment with DARZALEX, HBV screening should be performed in all patients. Patients with evidence of positive HBV serology should be monitored for clinical and laboratory signs of HBV reactivation during, and for at least six months post treatment with DARZALEX. Current clinical guidelines are to be followed for managing patients. Consider consulting a hepatitis disease expert as clinically indicated. Suspend treatment with DARZALEX and institute appropriate treatment, in patients who develop reactivation of HBV while on DARZALEX. Resumption of DARZALEX treatment in patients whose HBV reactivation is adequately controlled should be discussed with physicians with expertise in managing HBV. Body weight (>120 kg): There is a potential for reduced efficacy with DARZALEX solution for subcutaneous injection in patients with body weight >120 kg. Excipients: Contains sorbitol (E420)- Patients with rare hereditary fructose intolerance (HFI) should not take this medicinal product. Contains less than 1 mmol (23 mg) sodium per dose, that is to say essentially 'sodiumfree'. SIDE EFFECTS: The most frequent adverse reactions of any grade (≥ 20% patients) with daratumumab (either intravenous or subcutaneous formulations) when administered either as monotherapy or in combination were IRRs, fatigue, nausea, diarrhoea, constipation, pyrexia, cough, neutropenia, thrombocytopenia, anaemia, oedema peripheral, peripheral sensory neuropathy and upper respiratory tract infection. Serious adverse reactions were sepsis, pneumonia, bronchitis, upper respiratory tract infection, pulmonary oedema, influenza, pyrexia, dehydration, diarrhoea and atrial fibrillation. Rare occasions of anaphylactic reactions were reported from post marketing data of the IV formulation. The incidence of serious adverse reactions was higher in older than in younger patients, most commonly pneumonia and sepsis. Please refer to the SmPC for further details and information on other side effects. PREGNANCY: Women of childbearing potential should use effective contraception during, and for 3 months after cessation of DARZALEX treatment. Daratumumab should not be used during pregnancy unless the benefit of treatment to the woman is considered to outweigh the potential risks

Prescribing Information

to the fetus. LACTATION: The effect of DARZALEX on new-borns/infants is unknown. A decision should be made whether to discontinue breast-feeding or to discontinue DARZALEX therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. INTERACTIONS: Interference with indirect antiglobulin test (indirect Coombs test): Daratumumab binds to CD38 on RBCs and interferes with compatibility testing, including antibody screening and cross matching. Interference mitigation methods include treating reagent RBCs with dithiothreitol (DTT) to disrupt DARZALEX binding or other locally validated methods. Kellnegative units should be supplied after ruling out or identifying alloantibodies using DTTtreated RBCs. Interference with serum protein electrophoresis and immunofixation tests: In patients with persistent very good partial response, where daratumumab interference is suspected, consider using a validated daratumumab-specific IFE assay to distinguish daratumumab from any remaining endogenous M protein in the patient's serum, to facilitate determination of a complete response. See SPECIAL WARNINGS & PRECAUTIONS. Clinical pharmacokinetic assessments with daratumumab and lenalidomide, pomalidomide, thalidomide, bortezomib, melphalan, prednisone, carfilzomib and dexamethasone indicated no clinically-relevant drug-drug interaction between daratumumab and these small molecule medicinal products.
LEGAL CLASSIFICATION: Prescription Only Medicine
MARKETING AUTHORISATION NUMBER(S): EU/1/16/1101/004 (15 mL vial).
MARKETING AUTHORISATION HOLDER: Janssen-Cilag International NV, Turnhoutseweg 30, B-2340 Beerse, Belgium.
Prescribing Information may vary per country. Health Care Providers must refer to their country prescribing information.
Prescribing information based on Jan 2022 EU Summary of Product Characteristics available at: www.ema.europa.eu/en/documents/product-information/darzalex-epar-product-information_en.pdf