

SUMMARY OF PRODUCT CHARACTERISTICS

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 for how to report adverse reactions.

1 NAME OF THE MEDICINAL PRODUCT

Abecma 260 500 x 10⁶ cells dispersion for infusion

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

2.1 General description

Abecma (idecabtagene vicleucel) is a genetically modified autologous immunotherapy consisting of human T cells transduced with lentiviral vector (LVV) encoding a chimeric antigen receptor (CAR) that recognises B-cell maturation antigen.

2.2 Qualitative and quantitative composition

Each patient-specific infusion bag of Abecma contains idecabtagene vicleucel cell dispersion at a batch-dependent concentration of autologous T cells genetically modified to express an anti-BCMA chimeric antigen receptor (CAR-positive viable T cells). The finished product is packaged in one or more infusion bags containing a cell dispersion of 260 to 500 x 10⁶ CAR-positive viable T cells.

Each infusion bag contains 10-30 mL, 30-70 mL or 55-100 mL of dispersion for infusion.

The cellular composition and the final cell number varies between individual patient batches. In addition to T cells, natural killer (NK) cells may be present. The quantitative information regarding the number of CAR-positive viable T cells/bag are presented in the release for infusion certificate (RfIC) documentation located inside the lid of the dry vapour shipper used for transport.

Excipient(s) with known effect

This medicinal product contains 5% dimethyl sulfoxide (DMSO), up to 752 mg sodium and up to 274 mg potassium per dose.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Dispersion for infusion.

A colourless dispersion.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Abecma is indicated for the treatment of adult patients with relapsed and refractory multiple myeloma who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor and an anti CD38 antibody and have demonstrated disease progression on the last therapy.

4.2 Posology and method of administration

Abecma must be administered in a qualified treatment centre.

Abecma therapy should be initiated under the direction of and supervised by a healthcare professional experienced in the treatment of haematological malignancies and trained for the administration and management of patients treated with Abecma.

A minimum of one dose of tocilizumab for use in the event of cytokine release syndrome (CRS) and emergency equipment must be available prior to infusion of Abecma. The treatment centre must have access to an additional dose of tocilizumab within 8 hours of each previous dose. In the exceptional case where tocilizumab is not available due to a shortage that is listed in the MHRA Central Alerting System, suitable alternative measures to treat CRS instead of tocilizumab must be available prior to infusion.

Posology

Abecma is intended for autologous use only (see section 4.4). Manufacture and release of Abecma usually takes about 4-5 weeks.

Treatment consists of a single dose for infusion containing a dispersion of CAR-positive viable T cells in one or more infusion bags. The target dose is 420×10^6 CAR-positive viable T cells within a range of 260 to 500×10^6 CAR-positive viable T cells. See the accompanying release for infusion certificate (RfIC) for additional information pertaining to dose.

Pre-treatment (lymphodepleting chemotherapy)

Lymphodepleting chemotherapy consisting of cyclophosphamide 300 mg/m^2 intravenously (IV) and fludarabine 30 mg/m^2 IV should be administered for 3 days. See the prescribing information for cyclophosphamide and fludarabine for information on dose adjustment in renal impairment.

Abecma is to be administered 2 days after completion of lymphodepleting chemotherapy, up to a maximum of 9 days. The availability of Abecma must be confirmed prior to starting the lymphodepleting chemotherapy. If there is a delay of more than 4 weeks between completing lymphodepleting chemotherapy and the infusion, then the patient should be re-treated with lymphodepleting chemotherapy prior to receiving Abecma.

Pre-medication

To minimise the risk of infusion reactions, the patient should be pre-medicated with paracetamol (500 to 1,000 mg orally) and diphenhydramine (12.5 mg IV or 25 to 50 mg orally) or another H₁-antihistamine, approximately 30 to 60 minutes before infusion of Abecma.

Prophylactic use of systemic corticosteroids should be avoided as the use may interfere with the activity of Abecma. Therapeutic doses of corticosteroids should be avoided 72 hours prior to the start of lymphodepleting chemotherapy and following Abecma infusion except for the management of CRS, neurologic toxicities and other life-threatening emergencies (see section 4.4).

Clinical assessment prior to infusion

Abecma treatment should be delayed in some patient groups at risk (see section 4.4).

Monitoring after infusion

- Patients should be monitored for the first 10 days following infusion at the qualified treatment centre for signs and symptoms of CRS, neurologic events and other toxicities.
- After the first 10 days following infusion, the patient should be monitored at the physician's discretion.
- Patients should be instructed to remain within proximity (within 2 hours of travel) of the qualified treatment centre for at least 4 weeks following infusion.

Special populations

Patients with human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV) infection

There is no clinical experience in patients with active HIV, HBV or HCV infection. Screening for HBV, active HIV and active HCV must be performed before collection of cells for manufacturing. Leukapheresis material from patients with active HIV or active HCV infection will not be accepted for Abecma manufacturing (see section 4.4).

Elderly

No dose adjustment is required in patients over 65 years of age (see section 5.1).

Paediatric population

The safety and efficacy of Abecma in children and adolescents below 18 years of age have not been established. No data are available.

Method of administration

Abecma is for intravenous use only.

Administration

- Do NOT use a leukodepleting filter.

- Ensure that tocilizumab or suitable alternatives, in the exceptional case where tocilizumab is not available due to a shortage that is listed in the MHRA Central Alerting System, and emergency equipment are available prior to infusion and during the recovery period.
- Central venous access may be utilised for the infusion of Abecma and is encouraged in patients with poor peripheral access.
- Confirm the patient's identity matches the patient identifiers on the Abecma infusion bag.

For instructions on preparation, administration, accidental exposure and disposal of the medicinal product see section 6.6.

4.3 Contraindications

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

Contraindications of the lymphodepleting chemotherapy must be considered.

4.4 Special warnings and precautions for use

Traceability

The traceability requirements of cell-based advanced therapy medicinal products must apply. To ensure traceability the name of the product, the batch number and the name of the treated patient should be kept for a period of 30 years after expiry date of the product.

Reasons to delay treatment

Due to the risks associated with Abecma treatment, infusion should be delayed up to 7 days if a patient has any of the following conditions:

- Unresolved serious adverse events (especially pulmonary events, cardiac events or hypotension) including those after preceding chemotherapies.
- Active infections or inflammatory disorders (including pneumonitis, myocarditis or hepatitis).
- Active graft-versus-host disease (GVHD).

Autologous use

Abecma is intended solely for autologous use and should under no circumstances be administered to other patients. Before infusion, the patient's identity must match the patient identifiers on the Abecma infusion bag, cassette and the release for infusion certificate (RfIC). Abecma must not be administered if the information on the patient-specific label does not match the intended patient.

Concomitant disease

Patients with active central nervous system (CNS) disorder or inadequate renal, hepatic, pulmonary or cardiac function are likely to be more vulnerable to the consequences of the adverse reactions described below and require special attention.

Central nervous system pathology

There is no experience of use of Abecma in patients with CNS involvement of myeloma or other pre-existing, clinically relevant CNS pathologies.

Prior allogeneic stem cell transplantation

It is not recommended that patients receive Abecma within 4 months after an allogeneic stem cell transplant (SCT) because of the potential risk of Abecma worsening GVHD. Leukapheresis for Abecma manufacturing should be performed at least 12 weeks after allogeneic SCT.

Prior treatment with an anti-BCMA therapy

There is limited experience with Abecma in patients exposed to prior BCMA-directed therapy.

There is limited experience of retreatment patients with a second dose of Abecma. Responses after Abecma retreatment were infrequent and less durable when compared to initial treatment. Additionally, fatal outcomes were observed in retreated patients.

Cytokine release syndrome

CRS, including fatal or life-threatening reactions occurred following Abecma infusion. Nearly all patients experienced some degree of CRS. The median time to onset of CRS was 1 day (range: 1 to 12) (see section 4.8).

Monitoring and management of CRS

CRS should be identified based on clinical presentation. Patients should be evaluated and treated for other causes of fever, hypoxia and hypotension. CRS has been reported to be associated with findings of haemophagocytic lymphohistiocytosis/macrophage activation syndrome (HLH/MAS) and the physiology of the syndromes may overlap. MAS is a potentially life-threatening condition, and patients should be closely monitored for evidence of MAS. Treatment of MAS should be administered per institutional guidelines.

One dose of tocilizumab per patient must be on-site and available for administration prior to Abecma infusion. The treatment centre must have access to an additional dose of tocilizumab within 8 hours of each previous dose. In the exceptional case where tocilizumab is not available due to a shortage that is listed in the MHRA Central Alerting System, the treatment centre must have access to suitable alternative measures instead of tocilizumab to treat CRS. Patients should be monitored for the first 10 days following Abecma infusion at the qualified treatment centre for signs and symptoms of CRS. After the first 10 days following infusion, the patient should be monitored at the physician's discretion. Patients should be counselled to remain within proximity (within 2 hours of travel) of the qualified treatment centre for at least 4 weeks following infusion and to seek immediate medical attention should signs or symptoms of CRS occur at any time.

At the first sign of CRS, treatment with supportive care, tocilizumab or tocilizumab and corticosteroids should be instituted, as indicated in Table 1. Abecma can continue to expand and persist following administration of tocilizumab and corticosteroids (see section 4.5).

Patients who experience CRS should be closely monitored for cardiac and organ functioning until resolution of symptoms. For severe or life-threatening CRS, intensive care unit level monitoring and supportive therapy should be considered.

If concurrent neurologic toxicity is suspected during CRS, manage the neurologic toxicity according to the recommendations in Table 2 and use the more aggressive intervention of the two reactions specified in Tables 1 and 2.

Earlier escalation (i.e. higher corticosteroid dose, alternative anticytokine agents, anti-T cell therapies) is recommended in patients with refractory CRS within 72 hours post Abecma infusion characterised by persistent fever, end-organ toxicity (e.g. hypoxia, hypotension) and/or HLH/MAS not improving in grade within 12 hours of first line interventions.

Table 1. CRS grading and management guidance

CRS grade^a	Tocilizumab	Corticosteroids
<p>Grade 1 Symptoms require symptomatic treatment only (e.g. fever, nausea, fatigue, headache, myalgia, malaise).</p>	<p>If onset 72 hours or more after infusion, treat symptomatically. If onset less than 72 hours after infusion and symptoms not controlled by supportive care alone, consider tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg).</p>	—
<p>Grade 2 Symptoms require and respond to moderate intervention. Oxygen requirement less than 40% FiO₂ or hypotension responsive to fluids or low dose of one vasopressor or Grade 2 organ toxicity.</p>	<p>Administer tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg).</p>	<p>Consider dexamethasone 10 mg IV every 12 to 24 hours.</p>
<p>Grade 3 Symptoms require and respond to aggressive intervention. Fever, oxygen requirement greater than or equal to 40% FiO₂ or hypotension requiring high-dose or multiple vasopressors or Grade 3 organ toxicity or Grade 4 transaminitis.</p>	<p>Administer tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg).</p>	<p>Administer dexamethasone (e.g. 10 mg IV every 12 hours).</p>

CRS grade ^a	Tocilizumab	Corticosteroids
<p>For Grade 2 and 3: If no improvement within 24 hours or rapid progression, repeat tocilizumab and escalate dose and frequency of dexamethasone (20 mg IV every 6 to 12 hours). If no improvement within 24 hours or continued rapid progression, switch to methylprednisolone 2 mg/kg followed by 2 mg/kg divided 4 times per day. If steroids are initiated, continue steroids for at least 3 doses, and taper over a maximum of 7 days. After 2 doses of tocilizumab, consider alternative anticytokine agents. Do not exceed 3 doses tocilizumab in 24 hours or 4 doses in total.</p>		
<p>Grade 4 Life-threatening symptoms. Requirements for ventilator support, continuous veno-venous hemodialysis (CVVHD) or Grade 4 organ toxicity (excluding transaminitis).</p>	<p>Administer tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg).</p>	<p>Administer dexamethasone 20 mg IV every 6 hours.</p>
<p>For Grade 4: After 2 doses of tocilizumab, consider alternative anticytokine agents. Do not exceed 3 doses of tocilizumab in 24 hours or 4 doses in total. If no improvement within 24 hours, consider methylprednisolone (1 to 2 g, repeat every 24 hours if needed; taper as clinically indicated) or anti-T cell therapies such as cyclophosphamide 1.5 g/m² or others.</p>		

^a Lee et al, 2014.

Neurologic adverse reactions

Neurologic toxicities, such as aphasia and encephalopathy, which may be severe or life-threatening, occurred following treatment with Abecma. The median time to onset of the first event of neurotoxicity was 2 days (range: 1 to 10 days). Grade 3 parkinsonism has also been reported, with delayed onset. Neurologic toxicity may occur concurrently with CRS, after CRS resolution or in the absence of CRS (see section 4.8).

Monitoring and management of neurologic toxicities

Patients should be monitored for the first 10 days following Abecma infusion at the qualified treatment centre for signs and symptoms of neurologic toxicities. After the first 10 days following infusion, the patient should be monitored at the physician's discretion. Patients should be counselled to remain within proximity (within 2 hours of travel) of the qualified treatment centre for at least 4 weeks following infusion and to seek immediate medical attention should signs and symptoms of neurologic toxicities occur at any time.

If neurologic toxicity is suspected, manage according to the recommendations in Table 2. Other causes of neurologic symptoms should be ruled out. Intensive care supportive therapy should be provided for severe or life-threatening neurologic toxicities.

If concurrent CRS is suspected during the neurologic toxicity reaction, it should be managed according to the recommendations in Table 1 and the more aggressive intervention used for the two reactions specified in Tables 1 and 2.

Table 2. Neurologic toxicity grading and management guidance

Neurologic toxicity grade^a	Corticosteroids and antiseizure medications
Grade 1 Mild or asymptomatic.	Start non-sedating, antiseizure medicines (e.g. levetiracetam) for seizure prophylaxis. If 72 hours or more after infusion, observe patient. If less than 72 hours after infusion, and symptoms not controlled by supportive care alone, consider dexamethasone 10 mg IV every 12 to 24 hours for 2 to 3 days.
Grade 2 Moderate.	Start non-sedating, antiseizure medicines (e.g. levetiracetam) for seizure prophylaxis. Start dexamethasone 10 mg IV every 12 hours for 2 to 3 days or longer for persistent symptoms. Consider taper for a total steroid exposure of greater than 3 days. Steroids are not recommended for isolated Grade 2 headaches. If no improvement after 24 hours or worsening of neurologic toxicity, increase the dose and/or frequency of dexamethasone up to a maximum of 20 mg IV every 6 hours.
Grade 3 Severe or medically significant but not immediately life-threatening; hospitalization or prolongation; disabling.	Start non-sedating, antiseizure medicines (e.g. levetiracetam) for seizure prophylaxis. Start dexamethasone 10 to 20 mg IV every 8 to 12 hours. Steroids are not recommended for isolated Grade 3 headaches. If no improvement after 24 hours or worsening of neurologic toxicity, escalate to methylprednisolone (2 mg/kg loading dose, followed by 2 mg/kg divided into 4 times a day; taper within 7 days). If cerebral oedema is suspected, consider hyperventilation and hyperosmolar therapy. Give high-dose methylprednisolone (1 to 2 g, repeat every 24 hours if needed; taper as clinically indicated) and cyclophosphamide 1.5 g/m ² .
Grade 4 Life-threatening.	Start non-sedating, antiseizure medicines (e.g. levetiracetam) for seizure prophylaxis. Start dexamethasone 20 mg IV every 6 hours. If no improvement after 24 hours or worsening of neurologic toxicity, escalate to high-dose methylprednisolone (1 to 2 g, repeated every 24 hours if needed; taper as clinically indicated). Consider cyclophosphamide 1.5 g/m ² .

Neurologic toxicity grade^a	Corticosteroids and antiseizure medications
	If cerebral oedema is suspected, consider hyperventilation and hyperosmolar therapy. Give high-dose methylprednisolone (1 to 2 g, repeat every 24 hours if needed; taper as clinically indicated) and cyclophosphamide 1.5 g/m ² .

^a NCI CTCAE v.4 criteria for grading neurologic toxicities.

Prolonged cytopenias

Patients may exhibit prolonged cytopenias for several weeks following lymphodepleting chemotherapy and Abecma infusion (see section 4.8). Blood counts should be monitored prior to and after Abecma infusion. Cytopenias should be managed with myeloid growth factor and blood transfusion support according to institutional guidelines.

Infections and febrile neutropenia

Abecma should not be administered to patients with active infections or inflammatory disorders. Severe infections, including life-threatening or fatal infections, have occurred in patients after receiving Abecma (see section 4.8). Patients should be monitored for signs and symptoms of infection before and after Abecma infusion and treated appropriately. Prophylactic, pre-emptive and/or therapeutic antimicrobials should be administered according to institutional guidelines.

Febrile neutropenia was observed in patients after Abecma infusion (see section 4.8) and may be concurrent with CRS. In the event of febrile neutropenia, infection should be evaluated and managed with broad-spectrum antibiotics, fluids and other supportive care as medically indicated.

Viral reactivation

Cytomegalovirus (CMV) infection resulting in pneumonia and death have occurred following Abecma administration (see section 4.8). Patients should be monitored and treated for CMV infection according to clinical guidelines.

HBV reactivation, in some cases resulting in fulminant hepatitis, hepatic failure and death, can occur in patients treated with medicinal products directed against plasma cells (see section 4.8).

Screening for CMV, HBV, active HIV and active HCV must be performed before collection of cells for manufacturing (see section 4.2).

Hypogammaglobulinaemia

Plasma cell aplasia and hypogammaglobulinaemia can occur in patients receiving treatment with Abecma (see section 4.8). Immunoglobulin levels should be monitored after treatment with Abecma and managed per institutional guidelines including infection precautions, antibiotic or antiviral prophylaxis and immunoglobulin replacement.

Secondary malignancies

Patients treated with Abecma may develop secondary malignancies. Patients should be monitored life-long for secondary malignancies. In the event that a secondary malignancy of T cell origin occurs, the company should be contacted to obtain instructions on the collection of patient samples for testing.

Hypersensitivity reactions

Allergic reactions may occur with the infusion of Abecma. Serious hypersensitivity reactions, including anaphylaxis, may be due to dimethyl sulfoxide (DMSO), an excipient in Abecma. Patients not previously exposed to DMSO should be observed closely. Vital signs (blood pressure, heart rate, and oxygen saturation) and the occurrence of any symptom should be monitored prior to the start of the infusion, approximately every ten minutes during the infusion and every hour, for 3 hours, after the infusion.

Interference with serological testing

HIV and the lentivirus used to make Abecma have limited, short spans of identical genetic material (RNA). Therefore, some commercial HIV nucleic acid tests may yield false-positive results in patients who have received Abecma.

Blood, organ, tissue and cell donation

Patients treated with Abecma should not donate blood, organs, tissues and cells for transplantation.

Long-term follow-up

Patients are expected to be enrolled in a registry and will be followed in the registry in order to better understand the long-term safety and efficacy of Abecma.

Excipients

This medicinal product contains up to 33 mmol (752 mg) sodium per dose, equivalent to 37.6% of the WHO recommended maximum daily intake of 2 g sodium for an adult.

This medicinal product contains up to 7 mmol (274 mg) potassium per dose. To be taken into consideration by patients with reduced kidney function or patients on a controlled potassium diet.

4.5 Interaction with other medicinal products and other forms of interaction

No interaction studies have been performed.

The co-administration of agents known to inhibit T cell function has not been formally studied. The co-administration of agents known to stimulate T cell function has not been investigated and the effects are unknown.

Tocilizumab and corticosteroid use

Some patients required tocilizumab and/or corticosteroid for the management of CRS (see section 4.8). The use of tocilizumab and/or steroids for CRS management was more common in patients with higher cellular expansion.

Patients with CRS treated with tocilizumab had higher Abecma cellular expansion levels, as measured by 1.4-fold and 1.6-fold higher median C_{\max} (N = 66) and $AUC_{0-28\text{days}}$ (N = 65), respectively, compared to patients who did not receive tocilizumab (N = 61 for C_{\max} and N = 60 for $AUC_{0-28\text{days}}$). Similarly, patients with CRS treated with corticosteroids had higher Abecma cellular expansion levels, as measured by 1.7-fold and 2.2-fold higher median C_{\max} (N = 18) and $AUC_{0-28\text{days}}$ (N = 18), respectively, compared to patients who did not receive corticosteroids (N = 109 for C_{\max} and N = 107 for $AUC_{0-28\text{days}}$).

Live vaccines

The safety of immunisation with live viral vaccines during or following Abecma treatment has not been studied. Vaccination with live virus vaccines is not recommended for at least 6 weeks prior to the start of lymphodepleting chemotherapy, during Abecma treatment and until immune recovery following treatment with Abecma.

4.6 Fertility, Pregnancy and lactation

Women of childbearing potential/Contraception in males and females

Pregnancy status for women of childbearing potential should be verified using a pregnancy test prior to starting treatment with Abecma.

See the prescribing information for fludarabine and cyclophosphamide for information on the need for effective contraception in patients who receive the lymphodepleting chemotherapy.

There are insufficient exposure data to provide a recommendation concerning duration of contraception following treatment with Abecma.

Pregnancy

There are no data from the use of idecabtagene vicleucel in pregnant women. No animal reproductive and developmental toxicity studies have been conducted with idecabtagene vicleucel to assess whether it can cause foetal harm when administered to a pregnant woman (see section 5.3).

It is not known if idecabtagene vicleucel has the potential to be transferred to the foetus. Based on the mechanism of action, if the transduced cells cross the placenta, they may cause foetal toxicity, including plasma cell aplasia or hypogammaglobulinaemia. Therefore, Abecma is not recommended for women who are pregnant or for women of childbearing potential not using contraception. Pregnant women should be advised on the potential risks to the foetus. Pregnancy after Abecma therapy should be discussed with the treating physician.

Assessment of immunoglobulin levels in newborn infants of mothers treated with Abecma should be considered.

Breast-feeding

It is unknown whether idecabtagene vicleucel cells are excreted in human milk or transferred to the breast-feeding child. A risk to the breast-fed infant cannot be excluded. Women who are breast-feeding should be advised of the potential risk to the breast-fed child.

Fertility

There are no data on the effect of idecabtagene vicleucel on fertility. Effects of idecabtagene vicleucel on male and female fertility have not been evaluated in animal studies.

4.7 Effects on ability to drive and use machines

Abecma may have major influence on the ability to drive and use machines.

Due to the potential for neurologic adverse reactions, including altered mental status or seizures with Abecma, patients receiving Abecma should refrain from driving or operating heavy or potentially dangerous machines for at least 8 weeks after Abecma infusion or until resolution of neurologic adverse reactions.

4.8 Undesirable effects

Summary of the safety profile

The safety data described in this section reflect the exposure to Abecma in the KarMMa and CRB-401 studies in which 184 patients with relapsed and refractory multiple myeloma received Abecma. The median duration of follow-up was 15.5 months. The most common adverse reactions included neutropenia (91.3%), CRS (81.0%), anaemia (70.7%), thrombocytopenia (66.8%), infections - pathogen unspecified (53.8%), leucopenia (48.4%), fatigue (39.1%), diarrhoea (36.4%), hypokalaemia (34.2%), hypophosphataemia (32.6%), nausea (32.6%), lymphopenia (31.5%), pyrexia (28.8%), cough (27.2%), hypocalcaemia (26.6%), infections - viral (26.1%), headache (23.9%), hypomagnesaemia (22.3%), upper respiratory tract infection (21.7%), arthralgia (20.7%), oedema peripheral (20.1%), decreased appetite (19.6%), hypogammaglobulinaemia (19.6%) and febrile neutropenia (16.3%); other common adverse events occurring at lower frequency and considered clinically important included pneumonia (10.3%), tremor (8.2%), somnolence (5.4%), aphasia (4.3%), encephalopathy (4.3%) and syncope (4.3%).

Serious adverse reactions occurred in 70.1% of patients. The most common serious adverse reactions included CRS (17.4%), pneumonia (7.1%), febrile neutropenia (6.0%) and pyrexia (6.0%); other serious

adverse events occurring at lower frequency and considered clinically important include neutropenia (4.3%), sepsis (3.8%), thrombocytopenia (3.8%), confusional state (2.2%), dyspnoea (2.2%), hypoxia (1.6%), mental status changes (1.6%) and encephalopathy (1.6%).

The most common Grade 3 or 4 adverse reactions were neutropenia (88.6%), anaemia (58.2%), thrombocytopenia (53.5%), leucopenia (45.1%), lymphopenia (30.4%), infections - pathogen unspecified (17.9%), hypophosphataemia (17.4%), febrile neutropenia (14.7%), hypocalcaemia (7.1%), infections - viral (7.1%), pneumonia (6.0%), CRS (5.4%), hypertension (5.4%) and hyponatraemia (5.4%).

Grade 3 or 4 adverse reactions were more often observed within the initial 8 weeks post-infusion (97.8%) compared to after 8 weeks post-infusion (60.8%). The most frequently reported Grade 3 or 4 adverse reactions reported within the first 8 weeks after infusion were neutropenia (87.0%), anaemia (56.0%), thrombocytopenia (48.4%), leucopenia (44.0%) lymphopenia (27.7%) and hypophosphataemia (16.3%).

Tabulated list of adverse reactions

Table 3 summarises the adverse reactions observed in 128 and 56 patients treated with Abecma across the target dose levels of 150 to 450 x 10⁶ CAR-positive T cells (see Table 4 in section 5.1 for the corresponding dose range of CAR-positive viable T cells) in the KarMMa and CRB-401 studies, respectively. Adverse reactions are presented by MedDRA system organ class and by frequency. 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 available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

Table 3. Adverse reactions observed in patients treated with Abecma

System organ class	Adverse reaction	All grades frequency
Infections and infestations ^a	Infections – bacterial Infections – viral Infections – pathogen unspecified Infections – fungal	Very common Very common Very common Common
Blood and lymphatic system disorders	Neutropenia Leucopenia Thrombocytopenia a Febrile neutropenia Lymphopenia Anaemia Disseminated intravascular coagulation	Very common Very common Very common Very common Very common Very common Very common Common
Immune system disorders	Cytokine release syndrome Hypogammaglobulinaemia Haemophagocytic lymphohistiocytosis*	Very common Very common Common

		Common
Metabolism and nutrition disorders	Hypophosphataemia Hypokalaemia Hyponatraemia Hypocalcaemia Hypoalbuminaemia Decreased appetite Hypomagnesaemia	Very common Very common Very common Very common Very common Very common Very common Very common
Psychiatric disorders	Delirium ^b Insomnia	Common Common

System organ class	Adverse reaction	All grades frequency
Nervous system disorders	Encephalopathy ^c Headache* Dizziness ^d Seizure Hemiparesis Aphasia ^e Ataxia ^f Motor dysfunction ^g Tremor	Very common Very common Very common Very common Common Common Common Common Common Common
Cardiac disorders	Tachycardia* Atrial fibrillation*	Very common Common
Vascular disorders	Hypertension Hypotension* ^h	Very common Very common
Respiratory, thoracic, and mediastinal disorders	Dyspnoea Cough Pulmonary oedema Hypoxia*	Very common Very common Very common Common Common
Gastrointestinal disorders	Vomiting Diarrhoea Nausea Constipation Gastrointestinal haemorrhage ⁱ	Very common Very common Very common Very common Very common Common
Musculoskeletal and connective tissue disorders	Arthralgia Myalgia	Very common Common
General disorders and administration site conditions	Pyrexia* Fatigue* ^j Asthenia ^a Oedema ^k Chills*	Very common Very common Very common Very common Very common Very common

Investigations	Alanine aminotransferase increased Aspartate aminotransferase increased Blood alkaline phosphatase increased C-reactive protein increased*	Very common Very common Very common Common
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* Event that has been reported as a manifestation of CRS.

^a Infections and infestations system organ class adverse events are grouped by pathogen type.

^b Delirium includes delirium, disorientation, hallucination.

^c Encephalopathy includes amnesia, bradyphrenia, cognitive disorder, confusional state, disturbance in attention, dyscalculia, dysgraphia, encephalopathy, lethargy, memory impairment, mental status changes, metabolic encephalopathy, somnolence, toxic encephalopathy.

^d Dizziness includes dizziness, presyncope, syncope, vertigo.

^e Aphasia includes aphasia, dysarthria.

^f Ataxia includes ataxia, gait disturbance.

^g Motor dysfunction includes motor dysfunction, muscular spasms, muscular weakness, parkinsonism.

^h Hypotension includes hypotension, orthostatic hypotension.

ⁱ Gastrointestinal haemorrhage includes gastrointestinal haemorrhage, haemorrhoidal haemorrhage, melaena, mouth haemorrhage.

^j Fatigue includes fatigue, malaise.

^k Oedema includes oedema, face oedema, generalised oedema, peripheral oedema, peripheral swelling.

Description of selected adverse reactions

Cytokine release syndrome

In the pooled studies (KarMMa and CRB-401), CRS occurred in 81.0% of patients receiving Abecma. Grade 3 or higher CRS (Lee et al, 2014) occurred in 5.4% of patients, with fatal (Grade 5) CRS reported in 0.5% of patients. The median time-to-onset, any grade, was 1 day (range: 1 to 17) and the median duration of CRS was 5 days (range: 1 to 63).

The most common manifestations of CRS included pyrexia (78.3%), hypotension (32.1%), tachycardia (25.5%), chills (23.4%), hypoxia (16.3%), C-reactive protein increased (16.3%), headache (14.7%) and fatigue (10.9%). Grade 3 or higher events that may be observed in association with CRS included atrial fibrillation, capillary leak syndrome, hypotension, hypoxia and HLH/MAS.

Of the 184 patients, 45.1% of patients received tocilizumab; 32.6% received a single dose while 12.5% received more than 1 dose of tocilizumab for treatment of CRS. Overall, across the target dose levels, 15.8% of patients received at least 1 dose of corticosteroids for treatment of CRS. Of the 92 patients, at the target dose of 450×10^6 CAR-positive T cells, 54.3% of patients received tocilizumab and 22.8% received at least 1 dose of corticosteroids for treatment of CRS. See section 4.4 for monitoring and management guidance.

Neurologic adverse reactions

In the pooled studies, of the 184 patients, independent of investigator attribution of neurotoxicity, the most frequent neurologic or psychiatric adverse reactions included headache (28.8%), dizziness (15.2%), confusional state (13.0%), insomnia (9.8%), anxiety (8.2%), tremor (8.2%), and somnolence (6.5%). Other neurological adverse reactions occurring at a lower frequency and considered clinically important included aphasia (4.3%) and encephalopathy (4.3%).

Neurotoxicity identified by the investigators, which was the primary method of assessing CAR T cell-associated neurotoxicity in the KarMMa study only, occurred in 18.0% of the 128 patients receiving

Abecma, including Grade 3 in 3.1% of patients (with no Grade 4 or 5 events). The median time to onset of the first event was 2 days (range: 1 to 10). The median duration was 3 days (range: 1 to 26). Overall, 7.8% of patients received at least 1 dose of corticosteroid for treatment of CAR T cell-associated neurotoxicity, while at the target dose of 450×10^6 CAR-positive T cells, 14.8% of patients received at least 1 dose of corticosteroids. The most common manifestations of investigator identified neurotoxicity included confusional state (9.4%), encephalopathy (5.5%), aphasia (4.7%), hallucination (3.1%), and mental status changes (3.1%). See section 4.4 for monitoring and management guidance.

Febrile neutropenia and infections

In the pooled studies, infections occurred in 71.2% of patients. Grade 3 or 4 infections occurred in 23.4% of patients. Grade 3 or 4 infections with an unspecified pathogen occurred in 17.9%, viral infections in 7.1%, bacterial infections in 3.8% and fungal infections in 0.5% of patients. Fatal infections of unspecified pathogen were reported in 1.6 % of patients and 0.5% of patients had fatal fungal or viral infection. See section 4.4 for monitoring and management guidance.

Febrile neutropenia (Grade 3 or 4) was observed in 14.7% of patients after Abecma infusion. Febrile neutropenia may be concurrent with CRS. See section 4.4 for monitoring and management guidance.

Prolonged cytopenia

Patients may exhibit prolonged cytopenias following lymphodepleting chemotherapy and Abecma infusion. In the pooled studies, 34.8% of the 178 patients who had Grade 3 or 4 neutropenia and 72.7% of the 110 patients who had Grade 3 or 4 thrombocytopenia during the first month following Abecma infusion had not resolved by last assessment during the first month. Among the 62 patients with neutropenia not resolved by month 1, 82.3% recovered from Grade 3 or 4 neutropenia with a median time to recovery from Abecma infusion of 1.9 months. Of the 80 patients with thrombocytopenia not resolved by month 1, 71.3% recovered from Grade 3 or 4 thrombocytopenia with the median time to recovery of 2.2 months. See section 4.4 for monitoring and management guidance.

Hypogammaglobulinaemia

Hypogammaglobulinaemia was reported in 19.6% of patients treated with Abecma in the pooled studies with a median time to onset of 100 days (range 15 to 326). See section 4.4 for monitoring and management guidance.

Immunogenicity

Abecma has the potential to induce anti-CAR antibodies. In clinical studies, humoral immunogenicity of Abecma was measured by determination of anti-CAR antibody in serum pre- and post-administration. In the pooled studies, 4.3% of patients tested positive for pre-infusion anti-CAR antibodies and post-infusion anti-CAR antibodies were detected in 50.5% of the patients. There is no evidence that the presence of pre-existing or post-infusion anti-CAR antibodies impact the cellular expansion, safety or effectiveness of Abecma.

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 Yellow Card Scheme

Website: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

There are limited data regarding overdose with Abecma.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: not yet assigned, ATC code: L01XL07

Mechanism of action

Abecma is a chimeric antigen receptor (CAR)-positive T cell therapy targeting B-cell maturation antigen (BCMA), which is expressed on the surface of normal and malignant plasma cells. The CAR construct includes an anti-BCMA scFv-targeting domain for antigen specificity, a transmembrane domain, a CD3-zeta T cell activation domain, and a 4-1BB costimulatory domain. Antigen-specific activation of Abecma results in CAR-positive T cell proliferation, cytokine secretion and subsequent cytolytic killing of BCMA-expressing cells.

Clinical efficacy and safety

KarMMA was an open-label, single-arm, multicentre study that evaluated the efficacy and safety of Abecma in adult patients with relapsed and refractory multiple myeloma who had received at least 3 prior antimyeloma therapies including an immunomodulatory agent, a proteasome inhibitor and an anti-CD38 antibody and who were refractory to the last treatment regimen. Patients with CNS involvement of myeloma, a history of other BCMA targeting therapies, allogeneic SCT or prior gene therapy based or other genetically modified T cell therapy were excluded. Patients with a history of CNS disorders (such as seizures), inadequate hepatic, renal, bone marrow function, cardiac, pulmonary function or ongoing treatment with immunosuppressants were excluded.

The study consisted of pre-treatment (screening, leukapheresis and bridging therapy [if needed]); treatment (lymphodepleting chemotherapy and Abecma infusion); and posttreatment (ongoing) for a minimum of 24 months following Abecma infusion or until documented disease progression, whichever was longer. The lymphodepleting chemotherapy period was one 3-day cycle of cyclophosphamide (300 mg/m² IV infusion daily for 3 days) and fludarabine (30 mg/m² IV infusion daily for 3 days) starting 5 days prior to the target infusion date of Abecma. Patients were hospitalised for 14 days after infusion of Abecma to monitor and manage potential CRS and neurotoxicity.

Of the 140 patients who were enrolled (i.e. underwent leukapheresis), 128 patients received the Abecma infusion. Out of the 140 patients, only one did not receive the product due to manufacturing failure. Eleven

other patients were not treated with Abecma, due to physician decision (n = 3), patient withdrawal (n = 4), adverse events (n = 1), progressive disease (n = 1) or death (n = 2) prior to receiving Abecma.

Anticancer therapy for disease control (bridging) was permitted between apheresis and lymphodepletion with the last dose being administered at least 14 days prior to initiation of lymphodepleting chemotherapy. Of the 128 patients treated with Abecma, most patients (87.5%) received anticancer therapy for disease control at the discretion of the investigator.

The doses targeted in the clinical study were 150, 300 or 450 x 10⁶ CAR-positive T cells per infusion. The allowed dose range was 150 to 540 x 10⁶ CAR-positive T cells. Table 4 below shows the target dose levels used in the clinical study based on total CAR-positive T cells and the corresponding range of actual dose administered defined as CAR-positive viable T cells.

Table 4. Total CAR-positive T cells dose with the corresponding dose range of CAR-positive viable T cells (x10⁶)

Target dose based on total CAR-positive T cells, including both viable and non-viable cells (x10 ⁶)	CAR-positive viable T cells (x10 ⁶) (min, max)
150	133 to 181
300	254 to 299
450	307 to 485

Table 5 summarises the baseline patient and disease characteristics for the enrolled and treated population in study.

Table 5. Baseline demographic/disease characteristics for study population

Characteristic	Total enrolled (N = 140)	Total treated (N = 128)
Age (years)		
Median (min, max)	60.5 (33, 78)	60.5 (33, 78)
≥ 65 years, n (%)	48 (34.3)	45 (35.2)
≥ 75 years, n (%)	5 (3.6)	4 (3.1)
Gender, male, n (%)	82 (58.6)	76 (59.4)
Race, n (%)		
Asian	3 (2.1)	3 (2.3)
Black	8 (5.7)	6 (4.7)
White	113 (80.7)	103 (80.5)
ECOG performance status, n (%)		
0	60 (42.9)	57 (44.5)
1	77 (55.0)	68 (53.1)
2 ^a	3 (2.1)	3 (2.3)
Patients with extramedullary plasmacytoma, n (%)	52 (37.1)	50 (39.1)
Time since initial diagnosis (years), median (min, max)	6 (1.0, 17.9)	6 (1.0, 17.9)
Prior stem cell transplant, n (%)	131 (93.6)	120 (93.8)

Baseline cytogenetic high risk^{b,c}	46 (32.9)	45 (35.2)
Revised ISS stage at baseline (derived)^d, n (%)		
Stage I	14 (10.0)	14 (10.9)
Stage II	97 (69.3)	90 (70.3)
Stage III	26 (18.6)	21 (16.4)
Unknown	3 (2.1)	3 (2.3)
Number of prior anti-myeloma therapies^e, median (min, max)	6 (3, 17)	6 (3, 16)
Triple refractory^f, n (%)	117 (83.6)	108 (84.4)
Creatinine clearance (mL/min), n (%)		
< 30	3 (2.1)	1 (0.8)
30 to < 45	9 (6.4)	8 (6.3)
45 to < 60	13 (9.3)	10 (7.8)
60 to < 80	38 (27.1)	36 (28.1)
≥ 80	77 (55.0)	73 (57.0)

max = maximum; min = minimum

^a These patients had ECOG scores of < 2 at screening for eligibility but subsequently deteriorated to ECOG scores of ≥ 2 at baseline prior to start of LD chemotherapy.

^b Baseline cytogenetic abnormality was based on baseline cytogenetics from central laboratory if available. If central laboratory was not available or was unknown, cytogenetics prior to screening was used.

^c High-risk defined as deletion in chromosome 17p (del[17p]), translocation involving chromosomes 4 and 14 (t[4;14]) or translocation involving chromosomes 14 and 16 (t[14;16]).

^d Revised ISS was derived using baseline ISS stage, cytogenetic abnormality and serum lactate dehydrogenase.

^e Induction with or without haematopoietic stem cell transplant and with or without maintenance therapy was considered a single therapy.

^f Triple refractory is defined as refractory to an immunomodulatory agent, a proteasome inhibitor and an anti-CD38 antibody.

The median time from leukapheresis to product availability was 32 days (range: 24 to 55 days) and the median time from leukapheresis to infusion was 40 days (range: 33 to 79 days). The median actual dose received across all doses targeted in the clinical study was 315.3 x 10⁶ CAR-positive T cells (range 150.5 to 518.4).

Efficacy was assessed on the basis of overall response rate (ORR), complete response (CR) rate and duration of response (DOR), as determined by an independent review committee. Other efficacy endpoints included minimal residual disease (MRD) using next-generation sequencing (NGS).

Efficacy results across doses targeted in the clinical study (150 to 450 x 10⁶ CAR-positive T cells) are shown in the Table 6. Median follow-up was 19.9 months for all Abecma treated patients.

Table 6. Summary of efficacy based on the KarMMa study

	Enrolled ^a (N = 140)	Treated population Target dose of Abecma (CAR-positive T cells)			
		150 x 10 ^{6b} (N = 4)	300 x 10 ⁶ (N = 70)	450 x 10 ⁶ (N = 54)	Total 150 to 450 x 10 ⁶ (N = 128)
Overall response rate (sCR+CR+VGPR+PR), n (%)	94 (67.1)	2 (50.0)	48 (68.6)	44 (81.5)	94 (73.4)

	Enrolled ^a (N = 140)	Treated population Target dose of Abecma (CAR-positive T cells)			
		150 x 10 ^{6b} (N = 4)	300 x 10 ⁶ (N = 70)	450 x 10 ⁶ (N = 54)	Total 150 to 450 x 10 ⁶ (N = 128)
95% CI ^c	59.4, 74.9	6.8, 93.2	56.4, 79.1	68.6, 90.7	65.8, 81.1
CR or better, n (%)	42 (30.0)	1 (25.0)	20 (28.6)	21 (38.9)	42 (32.8)
95% CI ^c	22.4, 37.6	0.6, 80.6	18.4, 40.6	25.9, 53.1	24.7, 40.9
VGPR or better, n (%)	68 (48.6)	2 (50.0)	31 (44.3)	35 (64.8)	68 (53.1)
95% CI ^c	40.3, 56.9	6.8, 93.2	32.4, 56.7	50.6, 77.3	44.5, 61.8
MRD-negative status^d and ≥ CR					
Based on treated patients	–	4	70	54	128
n (%)	–	1 (25.0)	17 (24.3)	14 (25.9)	32 (25.0)
95% CI	–	0.6, 80.6	14.8, 36.0	15.0, 39.7	17.8, 33.4
Time to response, n	94	2	48	44	94
Median (months)	1.0	1.0	1.0	1.0	1.0
Min, max	0.5, 8.8	1.0, 1.0	0.5, 8.8	0.9, 2.0	0.5, 8.8
Duration of response (PR or better)^e, n	94	2	48	44	94
Median (months)	10.6	15.8	8.5	11.3	10.6
95% CI	8.0, 11.4	2.8, 28.8	5.4, 11.0	10.3, 17.0	8.0, 11.4

CAR = chimeric antigen receptor; CI = confidence interval; CR = complete response; MRD = minimal residual disease; NE = not estimable; PR = partial response; sCR = stringent complete response; VGPR = very good partial response.

^a All patients who underwent leukapheresis.

^b The 150 x 10⁶ CAR-positive T cell dose is not part of the approved dose range.

^c For “Total (Treated population” and “Enrolled population”): Wald CI; for individual target dose levels: Clopper-Pearson exact CI.

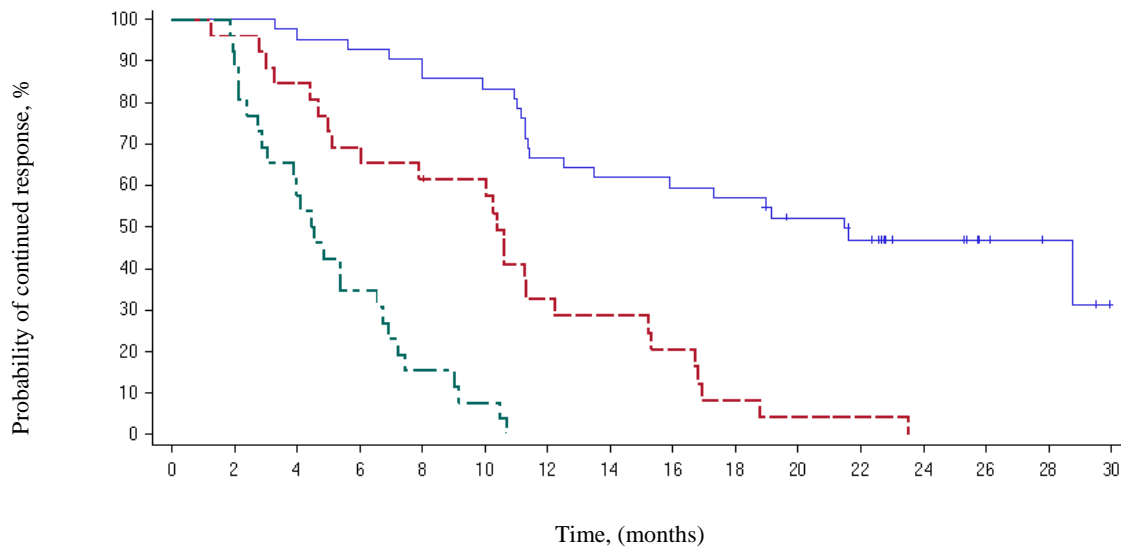
^d Based on a threshold of 10⁻⁵ using a next-generation sequencing assay. 95% CI for percentage of MRD negativity use Clopper-Pearson exact CI for individual target dose levels as well as for Treated population.

^e Median and 95% CI are based on the Kaplan-Meier approach.

Note: The target dose is 450 x 10⁶ CAR-positive T cells within a range of 150 to 540 × 10⁶ CAR-positive T cells. The 150 x 10⁶ CAR-positive T cell dose is not part of the approved dose range.

The Kaplan-Meier curve of duration of response by best overall response is shown in Figure 1.

Figure 1. Kaplan-Meier curve of duration of response based on independent response committee review according to IMWG criteria – by best overall response (Abecma-treated population)



CR or better	42	42	40	39	36	35	28	26	25	24	20	17	10	6	3	0
VGPR	26	25	22	18	16	15	8	7	5	2	1	1	0	0	0	0
PR	26	23	15	9	4	2	0	0	0	0	0	0	0	0	0	0

— CR or better: Subjects: 42; Events: 23; Median: 21.45 (95% CI: 12.52, NE)
- - - VGPR: Subjects: 26; Events: 25; Median: 10.38 (95% CI: 5.09, 12.22)
- - - PR: Subjects: 26; Events: 26; Median: 4.50 (95% CI: 2.86, 6.54)

CI= confidence interval; IMWG = International Myeloma Working Group; NE = not estimable. Two patients with 150×10^6 CAR-positive T cell dose, which is not part of the approved dose range, are included in Figure 1.

Special populations

Elderly

In the clinical trial of Abecma, 48 (34.3%) patients in the KarMMa study were 65 years of age or older and 5 (3.6%) were 75 years of age or older (see Table 5). No clinically important differences in the safety or effectiveness of Abecma were observed between these patients and patients younger than 65 years of age.

Paediatric population

The European Medicines Agency has waived the obligation to submit the results of studies with Abecma in all subsets of the paediatric population in the treatment of mature B-cell neoplasms (see section 4.2 for information on paediatric use).

This medicinal product has been authorised under a so-called ‘conditional approval scheme’. This means that further evidence on this medicinal product is awaited.

The European Medicines Agency will review new information on this medicinal product at least every year and this SmPC will be updated as necessary.

5.2 Pharmacokinetic properties

Following Abecma infusion, the CAR-positive T cells proliferate and undergo rapid multi-log expansion followed by a bi-exponential decline. The median time of maximal expansion in peripheral blood (T_{max}) occurred 11 days after infusion.

Abecma can persist in peripheral blood for up to 1 year post-infusion.

Abecma transgene levels were positively associated with objective tumour response (partial response or better). The median C_{max} levels in responders (N = 93) were approximately 4.5-fold higher compared to the corresponding levels in non-responders (N = 34). Median $AUC_{0-28days}$ in responding patients (N = 93) was approximately 5.5-fold higher than non-responders (N = 32).

Special populations

Renal and hepatic impairment

Hepatic and renal impairment studies of Abecma were not conducted.

Effects of age, weight, gender or race

Age (range: 33 to 78 years) had no impact on Abecma expansion parameters. The pharmacokinetics of Abecma in patients less than 18 years of age have not been evaluated.

Patients with lower body weight had higher cellular expansion. Due to high variability in pharmacokinetic cellular expansion, the overall effect of weight on the expansion parameters of Abecma is considered not to be clinically relevant.

Gender had no impact on Abecma expansion parameters.

Race and ethnicity had no significant impact on Abecma expansion parameters.

5.3 Preclinical safety data

Abecma comprises engineered human T cells, therefore there are no representative in vitro assays, *ex vivo* models, or *in vivo* models that can accurately address the toxicological characteristics of the human product. Hence, traditional toxicology studies used for drug development were not performed.

Genotoxicity assays and carcinogenicity studies were not conducted.

In vitro expansion studies from healthy donors and patients showed no evidence for transformation and/or immortalisation and no preferential integration near genes of concern in Abecma T cells.

Given the nature of the product, non-clinical studies on fertility, reproduction and development were not conducted.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

CryoStor CS10

Sodium chloride

Sodium gluconate

Sodium acetate trihydrate

Potassium chloride

Magnesium chloride

Water for injections

6.2 Incompatibilities

In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products.

6.3 Shelf life

Abecma is stable for 1 year when stored in the vapour phase of liquid nitrogen ($\leq -130^{\circ}\text{C}$).

Each bag must be infused within 1 hour from start of thaw. After thawing, the volume of the product intended for infusion should be kept at room temperature ($20^{\circ}\text{C} - 25^{\circ}\text{C}$).

6.4 Special precautions for storage

Store and transport frozen in the vapour phase of liquid nitrogen ($\leq -130^{\circ}\text{C}$) and must remain frozen until the patient is ready for treatment to ensure viable live autologous cells are available for patient administration. Product must NOT be refrozen following thaw.

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

6.5 Nature and contents of container

Ethylene vinyl acetate cryopreservation bag(s) with sealed addition tube containing 10-30 mL (50 mL bag), 30-70 mL (250 mL bag) or 55-100 mL (500 mL bag) of cell dispersion.

Each cryopreservation bag is individually packed in a metal cassette.

One individual treatment dose is comprised of one or more infusion bags of the same size and fill volume.

6.6 Special precautions for disposal

Precautions to be taken before handling or administering the medicinal product

Abecma should be transported within the treatment centre in closed, break-proof, leak-proof containers.

This medicinal product contains human blood cells. Healthcare professionals handling Abecma should take appropriate precautions (wearing gloves and glasses) to avoid potential transmission of infectious diseases.

Preparation prior to administration

Prior to Abecma infusion, it must be confirmed that the patient's identity matches the patient identifiers on the Abecma cassette(s), the infusion bag(s) and the release for infusion certificate (RFIC). The Abecma infusion bag must not be removed from the cassette if the information on the patient-specific label does not match the intended patient. The company must be contacted immediately if there are any discrepancies between the labels and the patient identifiers.

If more than one infusion bag has been received for treatment, thaw each infusion bag one at a time. The timing of thaw of Abecma and infusion should be coordinated. The infusion start time should be confirmed in advance and adjusted for thaw so that Abecma is available for infusion when the patient is ready.

Thawing

- Remove the Abecma infusion bag from the cassette and inspect the infusion bag for any breaches of container integrity such as breaks or cracks before thawing. If the infusion bag appears to have been damaged or to be leaking, it should not be infused and should be disposed of according to local guidelines on handling of waste of human-derived material.
- Place the infusion bag inside a second sterile bag.
- Thaw Abecma at approximately 37°C using an approved thaw device or water bath until there is no visible ice in the infusion bag. Gently mix the contents of the bag to disperse clumps of cellular material. If visible cell clumps remain, continue to gently mix the

contents of the bag. Small clumps of cellular material should disperse with gentle manual mixing. Do not wash, spin down and/or resuspend Abecma in new media prior to infusion.

Abecma administration

- Prime the tubing of the infusion set with sodium chloride 9 mg/mL (0.9%) solution for injection prior to infusion.
- Infuse Abecma within 1 hour from start of thaw as quickly as tolerated by gravity flow.
- After the entire content of the infusion bag is infused, rinse the tubing with sodium chloride 9 mg/mL (0.9%) solution for injection at the same infusion rate to ensure all product is delivered.
- Follow the same procedure for all subsequent infusion bags for the identified patient.

Precautions to be taken for disposal of the medicinal product

Unused medicinal product and all material that has been in contact with Abecma (solid and liquid waste) should be handled and disposed of as potentially infectious waste in accordance with local guidelines on handling of human-derived material.

Accidental exposure

In case of accidental exposure local guidelines on handling of human-derived material should be followed. Work surfaces and materials which have potentially been in contact with Abecma must be decontaminated with appropriate disinfectant.

7 MARKETING AUTHORISATION HOLDER

Bristol-Myers Squibb Pharma EEIG
Plaza 254
Blanchardstown Corporate Park 2
Dublin 15, D15 T867
Ireland

8 MARKETING AUTHORISATION NUMBER(S)

PLGB 15105/0191

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 24/06/2022.

Date of latest renewal: 25/07/2023

10 DATE OF REVISION OF THE TEXT

20/12/2023