SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Fabrazyme 35 mg powder for concentrate for solution for infusion

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each vial of Fabrazyme contains a nominal value of 35 mg of agalsidase beta. After reconstitution with 7.2 ml water for injections, each vial of Fabrazyme contains 5 mg/ml (35 mg/7 ml) of agalsidase beta. The reconstituted solution must be diluted further (see section 6.6).

Agalsidase beta is a recombinant form of human α-galactosidase A and is produced by recombinant DNA technology using a mammalian Chinese Hamster Ovary (CHO) cell culture. The amino acid sequence of the recombinant form, as well as the nucleotide sequence which encoded it, are identical to the natural form of α-galactosidase A.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Powder for concentrate for solution for infusion.
White to off-white lyophilisate or powder.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Fabrazyme is indicated for long-term enzyme replacement therapy in patients with a confirmed diagnosis of Fabry disease (α-galactosidase A deficiency).

Fabrazyme is indicated in adults, children and adolescents aged 8 years and older.

4.2 Posology and method of administration

Fabrazyme treatment should be supervised by a physician experienced in the management of patients with Fabry disease or other inherited metabolic diseases.

Posology

The recommended dose of Fabrazyme is 1 mg/kg body weight administered once every 2 weeks as an intravenous infusion.

Infusion of Fabrazyme at home may be considered for patients who are tolerating their infusions well. The decision to have a patient move to home infusion should be made after evaluation and recommendation by the treating physician. Patients experiencing adverse events during the home infusion need to immediately **stop the infusion process** and seek the attention of a healthcare professional. Subsequent infusions may need to occur in a clinical setting. Dose and infusion rate should remain constant while at home, and not be changed without supervision of a healthcare professional.

Special populations

Renal impairment
No dose adjustment is necessary for patients with renal insufficiency.

Hepatic impairment
Studies in patients with hepatic insufficiency have not been performed.

Elderly
The safety and efficacy of Fabrazyme in patients older than 65 years have not been established and no dosage regimen can presently be recommended in these patients.

Paediatric population
The safety and efficacy of Fabrazyme in children aged 0 to7 years have not yet been established. Currently available data are described in sections 5.1 and 5.2 but no recommendation on posology can be made in children aged 5 to 7 years. No data are available in children 0 to 4 years
No dose adjustment is necessary for children 8-16 years

For patients weighing < 30 kg, the maximum infusion rate should remain at 0.25 mg/min (15 mg/hr).

Method of administration

Fabrazyme should be administered as an intravenous (IV) infusion.

The initial IV infusion rate should be no more than 0.25 mg/min (15 mg/hour). The infusion rate may be slowed in the event of infusion-associated reactions.

After patient tolerance is well established, the infusion rate may be increased in increments of 0.05 to 0.083 mg/min (increments of 3 to 5 mg/hr) with each subsequent infusion. In clinical trials with classic patients, the infusion rate was

increased incrementally to reach a minimum duration of 2 hours. This was achieved after 8 initial infusions at 0.25 mg/min (15 mg/hr), without any IARs, change in infusion rate, or infusion interruption. A further decrease of infusion time to 1.5 hours was allowed for patients without new IARs during the last 10 infusions or reported serious adverse events within the last 5 infusions. Each rate increment of 0.083 mg/min (~5 mg/hr) was maintained for 3 consecutive infusions, without any new IARs, change in infusion rate, or infusion interruption, before subsequent rate increases.

For instructions on reconstitution and dilution of the medicinal product before administration, see section 6.6.

4.3 Contraindications

Life threatening hypersensitivity (anaphylactic reaction) to the active substance or any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

Immunogenicity

Since agalsidase beta (r-hαGAL) is a recombinant protein, the development of IgG antibodies is expected in patients with little or no residual enzyme activity. The majority of patients developed IgG antibodies to r-hαGAL, typically within 3 months of the first infusion with Fabrazyme. Over time, the majority of seropositive patients in clinical trials demonstrated either a downward trend in titres (based on a $\geq$ 4-fold reduction in titre from the peak measurement to the last measurement) (40% of the patients), tolerised (no detectable antibodies confirmed by 2 consecutive radioimmunoprecipitation (RIP) assays) (14% of the patients) or demonstrated a plateau (35% of the patients).

Infusion associated reactions

Patients with antibodies to r-hαGAL have a greater potential to experience infusion-associated reactions (IARs), which are defined as any related adverse event occurring on the infusion day. These patients should be treated with caution when re-administering agalsidase beta (see section 4.8). Antibody status should be regularly monitored.

In clinical trials, sixty seven percent (67 %) of the patients experienced at least one infusion-associated reaction (see section 4.8). The frequency of IARs decreased over time. Patients experiencing mild or moderate infusion-associated reactions when treated with agalsidase beta during clinical trials have continued therapy after a reduction in the infusion rate (~0.15 mg/min; 10 mg/hr) and/or pre-treatment with antihistamines, paracetamol, ibuprofen and/or corticosteroids.

Hypersensitivity

As with any intravenous protein medicinal product, allergic-type hypersensitivity reactions are possible.

A small number of patients have experienced reactions suggestive of immediate (Type I) hypersensitivity. If severe allergic or anaphylactic-type reactions occur, immediate discontinuation of the administration of Fabrazyme should be considered and appropriate treatment initiated. The current medical standards for emergency treatment are to be observed. With careful rechallenge Fabrazyme has been re-administered to all 6 patients who tested positive for IgE antibodies or had a positive skin test to Fabrazyme in a clinical trial. In this trial, the initial rechallenge administration was at a low dose and a lower infusion rate ($^1/_2$ the therapeutic dose at $^1/_{25}$ the initial standard recommended rate). Once a patient tolerates the infusion, the dose may be increased to reach the therapeutic dose of 1 mg/kg and the infusion rate may be increased by slowly titrating upwards, as tolerated.

Patients with advanced renal disease

The effect of Fabrazyme treatment on the kidneys may be limited in patients with advanced renal disease.

Sodium

This medicinal product contains less than 1 mmol sodium (23 mg) per vial, that is to say essentially 'sodium-free'.

Traceability

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

4.5 Interaction with other medicinal products and other forms of interaction

No interaction studies and no *in vitro* metabolism studies have been performed. Based on its metabolism, agalsidase beta is an unlikely candidate for cytochrome P450 mediated drug-drug interactions.

Fabrazyme should not be administered with chloroquine, amiodarone, benoquin or gentamycin due to a theoretical risk of inhibition of intra-cellular α-galactosidase A activity.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are limited data from the use of agalsidase beta in pregnant women.

Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity. As a precautionary measure, it is preferable to avoid the use of Fabrazyme during pregnancy.

Breast-feeding

Agalsidase beta is excreted in human milk. The effect of agalsidase beta on newborns/infants is unknown. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from Fabrazyme therapy taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman.

Fertility

Studies have not been conducted to assess the potential effects of Fabrazyme on impairment of fertility.

4.7 Effects on ability to drive and use machines

Fabrazyme may have a minor influence on the ability to drive or use machines on the day of Fabrazyme administration because dizziness, somnolence, vertigo and syncope may occur (see section 4.8).

4.8 Undesirable effects

Summary of the safety profile

Since agalsidase beta (r-hαGAL) is a recombinant protein, the development of IgG antibodies is expected in patients with little or no residual enzyme activity. Patients with antibodies to r-hαGAL have a greater potential to experience infusion-associated reactions (IARs). Reactions suggestive of immediate (Type I) hypersensitivity have been reported in a small number of patients (see section 4.4).

Very common adverse reactions included chills, pyrexia, feeling cold, nausea, vomiting, headache and paraesthesia. Sixty seven percent (67%) of the patients experienced at least one infusion-associated reaction. Anaphylactoid reactions have been reported in the postmarketing setting.

Tabulated list of adverse reactions

Adverse reactions reported from clinical trials with a total of 168 patients (154 males and 14 females) treated with Fabrazyme administered at a dose of 1 mg/kg every 2 weeks for a minimum of one infusion up to a maximum of 5 years are listed by System Organ Class and frequency (very common ≥ 1/10; common ≥ 1/100 to < 1/10 and uncommon ≥ 1/1,000 to < 1/100) in the table below. The occurrence of an adverse reaction in a single patient is defined as uncommon in light of the relatively small

number of patients treated. Adverse reactions only reported during the Post Marketing period are also included in the table below at a frequency category of “not known” (cannot be estimated from the available data). Adverse reactions were mostly mild to moderate in severity:

Incidence of adverse reactions with Fabrazyme treatment

System organ class	Very common	Common	Uncommon	Not known
Infections and infestations	---	nasopharyngitis	rhinitis	
Immune system disorders	---	---	---	anaphylactoid reaction
Nervous system disorders	headache, paraesthesia	dizziness, somnolence, hypoaesthesia, burning sensation, lethargy, syncope	hyperaesthesia, tremor	---
Eye disorders	---	lacrimation increased	eye pruritus, ocular hyperaemia	---
Ear and labyrinth disorders	---	tinnitus, vertigo	auricular swelling, ear pain	---
Cardiac Disorders	---	tachycardia, palpitations, bradycardia	sinus bradycardia	---
Vascular disorders	---	flushing, hypertension, pallor, hypotension, hot flush	peripheral coldness	---
Respiratory, thoracic and mediastinal disorders	---	dyspnoea, nasal congestion, throat tightness, wheezing, cough, dyspnoea exacerbated	bronchospasm, pharyngolaryngeal pain, rhinnorhoea, tachypnoea, upper respiratory tract congestion	hypoxia
Gastrointestinal Disorders	nausea, vomiting	abdominal pain, abdominal pain upper, abdominal discomfort, stomach discomfort, hypoaesthesia oral, diarrhoea	dyspepsia, dysphagia	---
Skin and subcutaneous tissue disorders	---	pruritus, urticaria, rash, erythema, pruritus generalised, angioneurotic oedema, swelling face, rash maculo-papular	livedo reticularis, rash erythematous, rash pruritic, skin discolouration, skin discomfort	leukocytoclastic vasculitis
Musculoskeletal and connective tissue disorders	---	pain in extremity, myalgia, back pain, muscle spasms, arthralgia, muscle tightness, musculoskeletal stiffness	musculoskeletal pain	---
General	chills, pyrexia,	fatigue, chest	feeling hot and	---

disorders and administration site conditions	feeling cold	discomfort, feeling hot, oedema peripheral, pain, asthenia, chest pain, face oedema, hyperthermia	cold, influenza-like illness, infusion site pain, infusion site reaction, injection site thrombosis, malaise, oedema	
Investigations				oxygen saturation decreased
For the purpose of this table, ≥1% is defined as reactions occurring in 2 or more patients. Adverse reaction terminology is based upon the Medical Dictionary for Regulatory Activities (MedDRA)				

Description of selected adverse reactions

Infusion associated reactions
Infusion associated reactions consisted most often of fever and chills. Additional symptoms included mild or moderate dyspnoea, hypoxia (oxygen saturation decreased), throat tightness, chest discomfort, flushing, pruritus, urticaria, face oedema, angioneurotic oedema, rhinitis, bronchospasm, tachypnoea, wheezing, hypertension, hypotension, tachycardia, palpitations, abdominal pain, nausea, vomiting, infusion-related pain including pain at the extremities, myalgia, and headache.

The infusion-associated reactions were managed by a reduction in the infusion rate together with the administration of non-steroidal anti-inflammatory medicinal products, antihistamines and/or corticosteroids. Sixty seven percent (67%) of the patients experienced at least one infusion-associated reaction. The frequency of these reactions decreased over time. The majority of these reactions can be attributed to the formation of IgG antibodies and/or complement activation. In a limited number of patients IgE antibodies were demonstrated (see section 4.4).

Paediatric population

Limited information from clinical trials suggests that the safety profile of Fabrazyme treatment in paediatric patients ages 5-7, treated with either 0.5 mg/kg every 2 weeks or 1.0 mg/kg every 4 weeks is similar to that of patients (above the age of 7) treated at 1.0 mg/kg every 2 weeks.

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

4.9 Overdose

In clinical trials doses up to 3 mg/kg body weight were used.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other alimentary tract and metabolism products, enzymes. ATC code: A16AB04.

Fabry disease

Fabry disease is an inherited heterogeneous and multisystemic progressive disease, that affects both males and females. It is characterised by the deficiency of α-galactosidase. Reduced or absent α-galactosidase activity results in the presence of elevated concentrations of GL-3 and its associated soluble form lyso-GL-3 in plasma and in accumulation of GL-3 in the lysosomes of many cell types including the endothelial and parenchymal cells, ultimately leading to life-threatening clinical deteriorations as a result of renal, cardiac and cerebrovascular complications.

Mechanism of action

The rationale for enzyme replacement therapy is to restore a level of enzymatic activity sufficient to clear the accumulating substrate in the organ tissues; thereby, preventing, stabilizing or reversing the progressive decline in function of these organs before irreversible damage has occurred.

After intravenous infusion, agalsidase beta is rapidly removed from the circulation and taken up by vascular endothelial and parenchymal cells into lysosomes, likely through the mannose-6 phosphate, mannose and asialoglycoprotein receptors.

Clinical efficacy and safety

Efficacy and safety of Fabrazyme was evaluated in two studies with children, one dose-finding study, two double-blind placebo-controlled studies, one open-label extension study in both male and female patients and published scientific literature.

In the dose finding study, the effects of 0.3, 1.0 and 3.0 mg/kg once every 2 weeks and 1.0 and 3.0 mg/kg once every 2 days were evaluated. A reduction in GL-3 was observed in kidney, heart, skin and plasma at all doses. Plasma GL-3 was cleared in a dose dependent manner but was less consistent at the dose of 0.3 mg/kg. In addition, infusion-associated reactions were dose dependent.

In the first placebo-controlled clinical trial of 58 Fabry patients with classic phenotype (56 males and 2 females), Fabrazyme was effective in clearing GL-3 from the

vascular endothelium of the kidney after 20 weeks of treatment. This clearance was achieved in 69% (20/29) of the Fabrazyme treated patients, but in none of the placebo patients ($p<0.001$). This finding was further supported by a statistically significant decrease in GL-3 inclusions in kidney, heart and skin combined and in the individual organs in patients treated with agalsidase beta compared to placebo patients ($p<0.001$). Sustained clearance of GL-3 from kidney vascular endothelium upon agalsidase beta treatment was demonstrated further in the open label extension of this trial. This was achieved in 47 of the 49 patients (96%) with available information at month 6, and in 8 of the 8 patients (100%) with available information at the end of the study (up to a total of 5 years of treatment). Clearance of GL-3 was also achieved in several other cell types from the kidney. Plasma GL-3 levels rapidly normalised with treatment and remained normal through 5 years.

Renal function, as measured by glomerular filtration rate and serum creatinine, as well as proteinuria, remained stable in the majority of the patients. However, the effect of Fabrazyme treatment on the kidney function was limited in some patients with advanced renal disease.

Although no specific study has been conducted to assess the effect on the neurological signs and symptoms, the results also indicate that patients may achieve reduced pain and enhanced quality of life upon enzyme replacement therapy.

Another double-blind, placebo-controlled study of 82 Fabry patients with classic phenotype (72 males and 10 females) was performed to determine whether Fabrazyme would reduce the rate of occurrence of renal, cardiac, or cerebrovascular disease or death. The rate of clinical events was substantially lower among Fabrazyme-treated patients compared to placebo-treated patients (risk reduction = 53% intent-to-treat population ($p=0.0577$); risk reduction = 61 % per-protocol population ($p=0.0341$)). This result was consistent across renal, cardiac and cerebrovascular events.

Two large observational studies followed a group of patients (n=89 to 105) who were maintained on standard-dose Fabrazyme (1.0 mg/kg every 2 weeks) or assigned to a reduced dose of Fabrazyme (0.3-0.5 mg/kg every 2 weeks) followed by a switch to agalsidase alfa (0.2 mg/kg every 2 weeks) or directly switched to agalsidase alfa (0.2 mg/kg every 2 weeks). Due to the observational, multi-centre design of these studies based in a real-world clinical setting, there are confounding factors affecting the interpretation of the results, including the selection of patients and assignment of treatment groups and available parameters between centres over time. Due to the rarity of Fabry disease, the study populations of the observational studies overlapped and the treatment groups in respective studies were small. Moreover, most patients with more severe disease, especially men, remained on standard dose Fabrazyme, whereas a treatment switch occurred more frequently in patients with less severe disease and women. Comparisons between the groups should therefore be cautiously interpreted.

The Fabrazyme standard-dose group demonstrated no significant changes in cardiac, renal, or neurologic organ function or in symptoms related to Fabry disease. Similarly, no significant changes in cardiac or neurologic function were observed in patients in the Fabrazyme dose-reduction group. However, deterioration in renal parameters, as measured by estimated glomerular filtration rate (eGFR), was observed in patients

treated with a lower dose ($p<0.05$). The annual decreases in eGFR were attenuated in patients who re-switched back to standard dose Fabrazyme. These results are consistent with 10-year follow-up evidence from the Canadian Fabry Disease Initiative Registry.

In the observational studies an increase in symptoms related to Fabry disease (e.g., gastrointestinal pain, diarrhoea) was observed in patients who had received a dose reduction of agalsidase beta.

Also, in the postmarketing setting, experience was gained in patients who initiated Fabrazyme treatment at a dose of 1 mg/kg every 2 weeks and subsequently received a reduced dose for an extended period. In some of these patients, an increase of some of the following symptoms was spontaneously reported: pain, paraesthesia and diarrhoea, as well as cardiac, central nervous system and renal manifestations. These reported symptoms resemble the natural course of Fabry disease.

In an analysis conducted in the Fabry Registry, the incidence rates (95% confidence interval) of the first severe clinical event in Classic male Fabrazyme-treated patients with sustained anti-agalsidase beta IgG antibodies were 43.98 (18.99, 86.66), 48.60 (32.03, 70.70), and 56.07 (30.65, 94.07) per 1000 person-years in the low, medium, and high peak titer groups, respectively. These observed differences were not statistically significant.

Paediatric population

In one open-label paediatric study, sixteen patients with Fabry disease (8-16 years old; 14 males, 2 females) had been treated for one year at 1.0 mg/kg every 2 weeks. Clearance of GL-3 in the superficial skin vascular endothelium was achieved in all patients who had accumulated GL-3 at baseline. The 2 female patients had little or no GL-3 accumulation in the superficial skin vascular endothelium at baseline, making this conclusion applicable in male patients only.

In an additional 5-year open-label paediatric study, 31 male patients aged 5 to 18 years were randomised prior to the onset of clinical symptoms involving major organs and treated with two lower dose regimens of agalsidase beta, 0.5 mg/kg every 2 weeks or 1.0 mg/kg every 4 weeks. Results were similar between the two treatment groups. Superficial skin capillary endothelium GL-3 scores were reduced to zero or maintained at zero at all time points post-baseline upon treatment in 19/27 patients completing the study without a dose increase. Both baseline and 5-year kidney biopsies were obtained in a subset of 6 patients: in all, kidney capillary endothelium GL-3 scores were reduced to zero, but highly variable effects were observed in podocyte GL-3, with a reduction in 3 patients. Ten (10) patients met per protocol dose increase criteria, two (2) had a dose increase to the recommended dose of 1.0 mg/kg every 2 weeks.

5.2 Pharmacokinetic properties

Following an intravenous administration of agalsidase beta to adults at doses of 0.3 mg, 1 mg and 3 mg/kg body weight, the AUC values increased more than dose

proportional, due to a decrease in clearance, indicating a saturated clearance. The elimination half-life was dose independent and ranged from 45 to 100 minutes.

After intravenous administration of agalsidase beta to adults with an infusion time of approximately 300 minutes and at a dose of 1 mg/kg body weight, biweekly, mean C_{max} plasma concentrations ranged from 2000-3500 ng/ml, while the AUC_{inf} ranged from 370-780 µg min/ml. Vss ranged from 8.3-40.8 l, plasma clearance from 119-345 ml/min and the mean elimination half-life from 80-120 minutes.

Agalsidase beta is a protein and is expected to be metabolically degraded through peptide hydrolysis. Consequently, impaired liver function is not expected to affect the pharmacokinetics of agalsidase beta in a clinically significant way. Renal elimination of agalsidase beta is considered to be a minor pathway for clearance.

Paediatric population

Fabrazyme pharmacokinetics was also evaluated in two paediatric studies. In one of these studies, 15 paediatric patients with available pharmacokinetics data, aged 8.5 to 16 years weighing 27.1 to 64.9 kg were treated with 1.0 mg/kg every 2 weeks. Agalsidase beta clearance was not influenced by weight in this population. Baseline CL was 77 ml/min with a Vss of 2.6 l; half-life was 55 min. After IgG seroconversion, CL decreased to 35 ml/min, Vss increased to 5.4 l, and half-life increased to 240 min. The net effect of these changes after seroconversion was an increase in exposure of 2- to 3-fold based on AUC and C_{max}. No unexpected safety issues were encountered in patients with an increase in exposure after seroconversion.
In another study with 30 paediatric patients with available pharmacokinetics data, aged 5 to 18 years, treated with two lower dose regimens of 0.5 mg/kg every 2 weeks and 1.0 mg/kg every 4 weeks, mean CL was 4.6 and 2.3 ml/min/kg, respectively, mean Vss was 0.27 and 0.22 l/kg, respectively, and mean elimination half-life was 88 and 107 minutes, respectively. After IgG seroconversion, there was no apparent change in CL (+24% and +6%, resp.), while Vss was 1.8 and 2.2-fold higher, with the net effect being a small decrease in C_{max} (up to -34% and -11%, resp.) and no change in AUC (-19% and -6%, resp.).

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on studies of safety pharmacology, single dose toxicity, repeated dose toxicity and embryonal/foetal toxicity. Studies with regard to other stages of the development have not been carried out. Genotoxic and carcinogenic potential are not expected.

6.1 List of excipients

Mannitol (E421)
Sodium dihydrogen phosphate monohydrate (E339)
Disodium phosphate heptahydrate (E339)

6.2 Incompatibilities

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

6.3 Shelf life

3 years.

Reconstituted and diluted solutions
From a microbiological point of view, the medicinal product should be used immediately. If not used immediately, in-use storage and conditions of the medicinal product prior to use are the responsibility of the user. The reconstituted solution cannot be stored and should be promptly diluted; only the diluted solution can be held for up to 24 hours at 2°C-8°C.

6.4 Special precautions for storage

Store in a refrigerator (2°C – 8°C).

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

6.5 Nature and contents of container

Fabrazyme 35 mg is supplied in clear Type I glass 20 ml vials. The closure consists of a siliconised butyl stopper and an aluminium seal with a plastic flip-off cap.

Package sizes: 1, 5 and 10 vials per carton.
Not all pack sizes may be marketed.

6.6 Special precautions for disposal

The powder for concentrate for solution for infusion has to be reconstituted with water for injections, diluted with 0.9% sodium chloride solution for injection and then administered by intravenous infusion. Aseptic technique should be used

The number of vials should be determined to be reconstituted based on the individual patient's weight and the required vials should be removed from the refrigerator in order to allow them to reach room temperature (in approximately 30 minutes). Each vial of Fabrazyme is intended for single use only.

Reconstitution

Each vial of Fabrazyme 35 mg has to be reconstituted with 7.2 ml water for injections. Forceful impact of the water for injections on the powder and foaming should be avoided. This is done by slow drop-wise addition of the water for injection down the inside of the vial and not directly onto the lyophilisate. Each vial should be rolled and tilted gently. The vial should not be inverted, swirled or shaken.

The reconstituted solution contains 5 mg agalsidase beta per ml and appears as a clear colourless solution. The pH of the reconstituted solution is approximately 7.0. Before further dilution, the reconstituted solution in each vial should be visually inspected for particulate matter and discolouration. The solution should not be used if foreign particles are observed or if the solution is discoloured.

After reconstitution it is recommended to promptly dilute the vials, to minimise protein particle formation over time.

Dilution

Prior to adding the reconstituted volume of Fabrazyme required for the patient dose, it is recommended to remove an equal volume of 0.9% sodium chloride solution for injection, from the infusion bag.

The airspace within the infusion bag should be removed to minimise the air/liquid interface.

7.0 ml (equal to 35 mg) of the reconstituted solution from each vial up to the total volume required should be slowly withdrawn for the patient dose. Filter needles should not be used and foaming should be avoided.

The reconstituted solution should slowly be injected directly into the 0.9% sodium chloride solution for injection (not in any remaining airspace) to a final concentration between 0.05 mg/ml and 0.7 mg/ml. The total volume of sodium chloride 0.9% solution for infusion (between 50 and 500 ml) should be determined based on the individual dose. For doses lower than 35 mg a minimum of 50 ml should be used, for doses 35 to 70 mg a minimum of 100 ml should be used, for doses 70 to 100 mg a minimum of 250 ml should be used and for doses greater than 100 mg only 500 ml should be used. The infusion bag should be gently inverted or lightly massaged to mix the diluted solution. The infusion bag should not be shaken or excessively agitated.

Administration

It is recommended to administer the diluted solution through an in-line low protein-binding 0.2 µm filter to remove any protein particles which will not lead to any loss of agalsidase beta activity. The initial (IV) infusion rate should be no more than

0.25 mg/min (15 mg/hour) The infusion rate may be slowed in the event of infusion-associated reactions.

After patient tolerance is well established, the infusion rate may be increased in increments of 0.05 to 0.083 mg/min (increments of 3 to 5 mg/hr) with each subsequent infusion. In clinical trials with classic patients, the infusion rate was increased incrementally to reach a minimum duration of 2 hours. This was achieved after 8 initial infusions at 0.25 mg/min (15 mg/hr), without any IARs, change in infusion rate, or infusion interruption. A further decrease of infusion time to 1.5 hours was allowed for patients without new IARs during the last 10 infusions or reported serious adverse events within the last 5 infusions. Each rate increment of 0.083 mg/min (~5 mg/hr) was maintained for 3 consecutive infusions, without any new IARs, change in infusion rate, or infusion interruption, before subsequent rate increases.

For patients weighing < 30 kg, the maximum infusion rate should remain at 0.25 mg/min (15 mg/hr).

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

7. MARKETING AUTHORISATION HOLDER

Aventis Pharma Ltd
410 Thames Valley Park Drive
Reading
Berkshire
RG6 1PT
UK

Trading as:

Sanofi
410 Thames Valley Park Drive
Reading
Berkshire
RG6 1PT
UK

8 MARKETING AUTHORISATION NUMBER(S)

PLGB 04425/0767

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

01/01/2021

10 DATE OF REVISION OF THE TEXT

16/04/2024