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

Rystiggo 140 mg/ml solution for injection

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each ml of solution for injection contains 140 mg of rozanolixizumab.

One vial of 2 ml contains 280 mg of rozanolixizumab.

One vial of 3 ml contains 420 mg of rozanolixizumab.

One vial of 4 ml contains 560 mg of rozanolixizumab.

One vial of 6 ml contains 840 mg of rozanolixizumab.

Rozanolixizumab is a recombinant, humanised anti-neonatal Fc receptor (FcRn) immunoglobulin G 4P (IgG4P) monoclonal antibody produced in Chinese Hamster Ovary (CHO) by recombinant DNA technology.

Excipient(s) with known effect

Each ml of solution for injection contains 29 mg proline, see section 4.4.
Each ml of solution for injection contains 0.3 mg polysorbate 80, see section 4.4.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Solution for injection (injection)

Colourless to pale brownish-yellow, clear to slightly opalescent solution, pH 5.6.

Rystiggo has an osmolality of 309-371 mOsmol/kg.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Rystiggo is indicated as an add-on to standard therapy for the treatment of generalised myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.

4.2 Posology and method of administration

Treatment should be initiated and supervised by specialist healthcare professionals experienced in the management of patients with neuromuscular or neuro-inflammatory disorders.
Posology
A treatment cycle consists of 1 dose per week for 6 weeks.
The following table indicates the recommended total weekly dose of rozanolixizumab according to the patient's body weight. One or more vials might be needed to meet the appropriate volume to be administered, depending on vial size availability.

Body weight	**≥ 35 to < 50 kg**	**≥ 50 to < 70 kg**	**≥ 70 to < 100 kg**	**≥ 100 kg**
Weekly dose (mg)	280 mg	420 mg	560 mg	840 mg
Weekly dose (ml)	2 ml*	3 ml*	4 ml*	6 ml*

* One ml of solution for injection contains 140 mg of rozanolixizumab. Each vial contains excess volume for priming of the infusion line, see "Instructions For Use in the Package leaflet ".

Subsequent treatment cycles should be administered according to clinical evaluation. The frequency of treatment cycles may vary by patient. In the clinical development program, most patients had treatment-free intervals of 4-13 weeks between cycles.

From cycle to cycle approximately 10 % of patients had a treatment-free interval of less than 4 weeks.

If a scheduled infusion is missed, rozanolixizumab may be administered up to 4 days after the scheduled time point. Thereafter, the original dosing schedule should be resumed until the treatment cycle is completed.

Special populations

Elderly

No dose adjustment is required (see section 5.2).

Renal impairment

Limited safety and efficacy data is available in patients with mild to moderate renal impairment (eGFR > 45 ml/min/1.73 m_2). No data is available in patients with severe renal impairment. No dose adjustment is considered necessary as the pharmacokinetics of rozanolixizumab are unlikely to be affected by renal impairment (see section 5.2).

Hepatic impairment

No data is available in patients with hepatic impairment. No dose adjustment is considered necessary as the pharmacokinetics of rozanolixizumab are unlikely to be affected by hepatic impairment (see section 5.2).

Paediatric population

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

Method of administration

For subcutaneous use.

It is recommended that rozanolixizumab is administered subcutaneously preferably into the lower right or lower left part of the abdomen, below the belly button. Infusions should not be given into areas where the skin is tender, erythematous, or indurated.

During administration of the first treatment cycle and administration of the first dose of the second treatment cycle of rozanolixizumab, appropriate treatment for injection and hypersensitivity-related reactions should be readily available (see section 4.4).

For instructions on material specificities for administration, see below and section 6.6.

Before administering rozanolixizumab, the instructions for use must be read carefully, see section 6.6.

Rystiggo can be administered using:

- An infusion pump (also known as syringe pump), or
- By manual push with a syringe

Rystiggo can be self-administered or administered by a caregiver, following the Instructions for Use after proper training by a healthcare professional on how to administer subcutaneous infusions.

Infusion with a pump

Infusion pumps, syringes and infusion sets appropriate for subcutaneous administration of medicinal products should be used (see section 6.6). If not using a programmable pump, the volume in the syringe should be adjusted to the prescribed dose prior to administration. Rozanolixizumab administration using an infusion pump should be performed at a constant flow rate up to 20 ml/hr.

Infusion by manual push with a syringe

Syringes and infusion sets appropriate for subcutaneous administration of medicinal products should be used.

The volume in the syringe should be adjusted to the prescribed dose prior to administration.

Rozanolixizumab administration using a syringe should be performed at a flow rate that is comfortable for the patient. In clinical trials, infusion times by manual push ranged from 1 to 30 minutes with a median infusion time of 5 minutes per patient. This range of infusion times may serve as a guide when training the patient or caregiver.

4.3 Contraindications

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

4.4 Special warnings and precautions for use

Traceability

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

Myasthenic crisis

Treatment with rozanolixizumab in patients with impending or manifest myasthenic crisis has not been studied. The sequence of therapy initiation between established therapies for MG crisis and rozanolixizumab, and their potential interactions, should be considered (see section 4.5).

Aseptic meningitis

Aseptic meningitis (drug induced aseptic meningitis) has been reported following rozanolixizumab treatment. If symptoms consistent with aseptic meningitis (headache, pyrexia, neck stiffness, nausea, vomiting) occur, diagnostic workup and treatment should be initiated as per standard of care.

Infections

As rozanolixizumab causes transient reduction in IgG levels the risk of infections may increase (see section 5.1). Overall, in phase 3 studies in gMG, infections were reported in 45.2 % of all rozanolixizumab treated patients. No increase in the incidence of infections was observed from cycle to cycle. Serious infections were reported in 4.3 % of patients.

Treatment with rozanolixizumab should not be initiated in patients with a clinically important active infection until the infection resolves or is adequately treated. During treatment with rozanolixizumab, clinical signs and symptoms of infections should be monitored. If a clinically important active infection occurs, withholding rozanolixizumab until the infection has resolved should be considered.

Hypersensitivity

Infusion reactions such as rash or angioedema may occur (see section 4.8). In the clinical trial, these were mild to moderate. Patients should be monitored during treatment with rozanolixizumab and for 15 minutes after the administration is complete for clinical signs and symptoms of hypersensitivity reactions. If a hypersensitivity reaction occurs during administration (see section 4.8), rozanolixizumab infusion should be discontinued and appropriate measures should be initiated if needed. Once resolved, administration may be resumed.

Vaccination

Immunisation with vaccines during rozanolixizumab therapy has not been studied. The safety of immunisation with live or live-attenuated vaccines and the response to immunisation with vaccines are unknown. All vaccines should be administered according to immunisation guidelines and at least 4 weeks before initiation of treatment. For patients that are on treatment, vaccination with live or live-attenuated vaccines is not recommended. For all other vaccines, they should take place at least 2 weeks after the last infusion of a treatment cycle and 4 weeks before initiating the next cycle.

Immunogenicity

In the pooled cyclic treatment data from the phase 3 program, after 1 treatment cycle of 6 rozanolixizumab weekly doses, 27.1 % (42/155) of patients developed antidrug antibodies and 10.3 % (16/155) had antibodies that were classified as neutralising.

Upon reinitiating therapy, the proportion of patients who developed antidrug

antibodies and neutralising antibodies increased to 65 % (13/20) and 50 % (10/20) respectively, after 5 treatment cycles. Development of neutralising antibodies was associated with a 24 % decrease in overall plasma exposure of rozanolixizumab.

There was no apparent impact of immunogenicity on efficacy and safety (see sections 5.1 and 5.2).

Excipients

This medicinal product contains 29 mg of proline in each ml.

The use in patients suffering from hyperprolinaemia should be restricted to cases where no alternative treatment is available.

This medicinal product contains 0.3 mg of polysorbate 80 in each ml.

Polysorbates may cause allergic reactions.

4.5 Interaction with other medicinal products and other forms of interaction

No interaction studies have been performed.

As rozanolixizumab interferes with the FcRn recycling mechanism of immunoglobulin G (IgG), the serum concentrations of IgG-based medicinal products (e.g. monoclonal antibodies and intravenous immunoglobulin [IVIg]) and Fc–peptide fusion proteins are expected to be decreased if administered concomitantly or within 2 weeks after administration of rozanolixizumab. It is recommended to initiate these treatments 2 weeks after administration of rozanolixizumab and to monitor for attenuated efficacy of these medicinal products when administered concomitantly.

Treatment with IV or SC immunoglobulins, PLEX/plasmapheresis and immunoadsorption may reduce circulating levels of rozanolixizumab.

Vaccination during treatment with rozanolixizumab has not been studied and the response to any vaccine is unknown. Because rozanolixizumab causes a reduction in IgG levels, vaccination with live-attenuated or live vaccines is not recommended during treatment with rozanolixizumab (see sections 4.4 and 5.3).

4.6 Fertility, pregnancy and lactation

Pregnancy

There are limited amount of data from the use of rozanolixizumab in pregnant women. In animal studies, offspring from treated dams had very low levels of IgG at birth, as expected by the pharmacological mode of action of rozanolixizumab (see section 5.3). However, animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonic/foetal development, parturition or postnatal development. Treatment of pregnant women with rozanolixizumab should only be considered if the clinical benefit outweighs the risks.

As rozanolixizumab is expected to reduce maternal antibody levels, and is also expected to inhibit the transfer of maternal antibodies to the foetus, reduction in passive protection to the newborn is anticipated. Therefore, risks and benefits of administering live / live attenuated vaccines to infants exposed to rozanolixizumab *in utero* should be considered (see section 4.4, subsection “Vaccination”).

Breast-feeding

It is unknown whether rozanolixizumab is excreted in human milk. Maternal IgG is known to be excreted in breast milk during the first days after birth, which is decreasing to low concentrations soon afterwards; consequently, a risk to breast-fed infants cannot be excluded during this short period. Afterwards, use of rozanolixizumab could be considered during breast-feeding only if the clinical benefit outweighs the risks.

Fertility

The effect of rozanolixizumab on human fertility is not known. Animal studies do not indicate harmful effects with respect to fertility (see section 5.3).

4.7 Effects on ability to drive and use machines

Rozanolixizumab has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

Summary of the safety profile

The most commonly reported adverse reactions were headache (48.4 %), diarrhoea (25.0 %) and pyrexia (12.5 %).

Tabulated list of adverse reactions

Adverse reactions from clinical studies and post-marketing experience in gMG are listed in Table 1 below, classified by MedDRA System Organ Class (SOC). Within each SOC, the adverse reactions are ranked by frequency, with the most frequent reactions first.

Frequency categories are defined as follows: 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), not known (cannot be estimated from the available data).

Table 1: List of adverse reactions

MedDRA system organ class	**Adverse reactions**	**Frequency category**
Infections and infestations	Upper respiratory tract infections[1]	Common
	Herpes viral infection*[6]	Not known
Nervous system disorders	Headache[2]	Very common
	Aseptic meningitis*	Not known
Gastrointestinal disorders	Diarrhoea	Very common
	Nausea*	Common
	Vomiting*	Common
Skin and subcutaneous tissue disorders	Rash[3]	Common
	Angioedema[4]	Common
Musculoskeletal and connective tissue disorders	Arthralgia	Common
General disorders and administration site	Pyrexia	Very common
	Injection site	Common

conditions	reactions[5]	

[1] Includes cases of nasopharyngitis
[2] Includes headache and migraine
[3] Includes rash, rash papular and rash erythematous
[4] Includes swollen tongue
[5] Includes injection site rash, reaction, erythema, inflammation, discomfort, and infusion site erythema, pain
[6] Includes cases of Herpes Zoster, simplex and oral
*From spontaneous post-marketing reporting

Description of selected adverse reactions

Headache

In MG0003, headache was the most common reaction reported in 31 (48.4 %) and 13 (19.4 %) of the patients treated with rozanolixizumab and placebo, respectively.

Headache occurred most frequently after the first infusion of rozanolixizumab and within 1 to 4 days after infusion. Except for 1 (1.6 %) severe headache, all headaches were either mild (28.1 % [n=18]) or moderate (18.8 % [n=12]) and there was no increase in incidences of headache with repeated cyclic treatment.

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:

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 no data on symptoms associated with an overdose. Single subcutaneous dose of up to 20 mg/kg (2 162 mg) and weekly subcutaneous doses of ≈10 mg/kg (1 120 mg) for up to 52 weeks have been administered per protocol in clinical studies without dose limiting toxicity.

In case of overdose, it is recommended that patients are monitored closely for any adverse reactions, and appropriate supportive measures should be instituted immediately.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Immunosuppressants, neonatal fragment crystallizable receptor (FcRn) inhibitors, ATC code: L04AL02

Mechanism of action

Rozanolixizumab is a humanised IgG4 monoclonal antibody that decreases serum IgG concentration by inhibiting the binding of IgG to FcRn, a receptor that under physiological conditions protects IgG from intracellular degradation and recycles IgG back to the cell surface.

By the same mechanism, rozanolixizumab decreases the concentration of pathogenic IgG autoantibodies associated with gMG. Clinical data with rozanolixizumab have not identified any clinically relevant impact on levels of albumin, which binds at a different site on FcRn.

Pharmacodynamic effects

In a double-blind placebo-controlled study in gMG patients, weekly subcutaneous administration of rozanolixizumab at the recommended dose (see section 4.2) resulted in a rapid and sustained reduction in total IgG serum concentrations, with significant lowering of IgG of 45 % compared to baseline within 1 week, and a maximum decrease of 73 % at about 3 weeks. After stopping administration, IgG concentrations recovered towards baseline levels within approximately 8 weeks. Similar changes were observed during the subsequent cycles of the study.

The reduction in total IgG by rozanolixizumab in neutralising antibody-positive patients was not different from patients who were antidrug antibody-negative (see section 4.4).

Clinical efficacy and safety

The safety and efficacy of rozanolixizumab was evaluated in patients with gMG in the pivotal phase 3 study MG0003. Long-term safety, tolerability and efficacy of rozanolixizumab were evaluated in 2 phase 3 open-label extension (OLE) studies, with 1 OLE (MG0007) administering rozanolixizumab as 6-week treatment cycles based on clinical needs.

Study MG0003

The study MG0003 evaluated 200 patients for up to 18 weeks where patients were randomised to receive weight-tiered doses of rozanolixizumab equivalent to approximately (≈) 7 mg/kg (corresponding to the recommended dose; see section 4.2) or a higher dose, or placebo. Treatment consisted of 1 dose per week for a period of 6 weeks followed by an 8-week observation period.

In this study, patients had to meet the following main criteria at screening:

- at least 18 years of age, had a bodyweight of at least 35 kg
- diagnosis of gMG and had autoantibodies against AChR or MuSK
- a Myasthenia Gravis Foundation of America (MGFA) Class II to IVa,
- an MG-Activities of Daily Living (MG-ADL, a patient reported outcome [PRO] measure) score of at least 3 (with ≥ 3 points from non-ocular symptoms)
- a Quantitative Myasthenia Gravis (QMG) score of at least 11

- if on gMG therapy, to be kept stable prior to baseline and for the duration of the study (except for cholinesterase inhibitors)
- considered for additional treatment such as IVIg and/or PLEX

Patients were not permitted in the study if they had:

- a serum total IgG level ≤ 5.5 g/l or an absolute neutrophil count < 1 500 cells/mm3
- clinically relevant active infection or serious infections, mycobacterial infections, hepatitis B, hepatitis C, HIV infections
- been treated with PLEX, IVIg 1 month and monoclonal antibodies 3 to 6 months prior to starting treatment

The primary endpoint was the change from baseline to day 43 in the MG-ADL score. Secondary efficacy endpoints included a change from baseline to day 43 in MG-C (Myasthenia Gravis Composite) score and QMG score. Response in this study was defined as an at least 2.0-points improvement in MG-ADL at day 43 compared to the treatment cycle baseline.

In general, patient demographics and baseline disease characteristics were balanced across treatment groups. The majority of patients were female (60.5 %), below 65 years of age (75.5 %), were of predominantly White (68.0 %) or Asian (10.5 %) race, and presented with MGFA class II or III gMG (96.0 %). The median age at MG diagnosis was 44.0 years, and the median time since diagnosis was 5.8 years. There was a lower proportion of male patients in the placebo group (29.9 %) than in the rozanolixizumab ≈ 7 mg/kg dose group (40.9 %). The autoantibody distribution among MG0003 patients were 10.5 % anti-MuSK positive, 89.5 % anti-AChR positive. Overall, 95.5 % of patients received at least one MG baseline medication that continued during the study, including 85.5 % receiving acetylcholinesterase inhibitors, as well as 64.0 % receiving corticosteroids, 50.0 % receiving immunosuppressants, and 35.5 % receiving corticosteroids and immunosuppressants at stable doses.

In the rozanolixizumab and placebo groups, the median MG-ADL total score was 8.0, and the median QMG total score was 15.0.

Results for the primary and secondary efficacy endpoints are provided in Table 2 below. In total, 71.9 % and 31.3 % of patients in the rozanolixizumab and placebo groups, respectively, met MG-ADL responder criteria.

Table 2: Efficacy outcomes change from baseline to day 43

	Placebo (N=67)	**Rozanolixizumab ≈7 mg/kg (N=66)**
MG-ADL		
Baseline mean	8.4	8.4
Change from baseline LS mean (SE)	-0.784 (0.488)	-3.370 (0.486)
Difference vs placebo	-2.586	

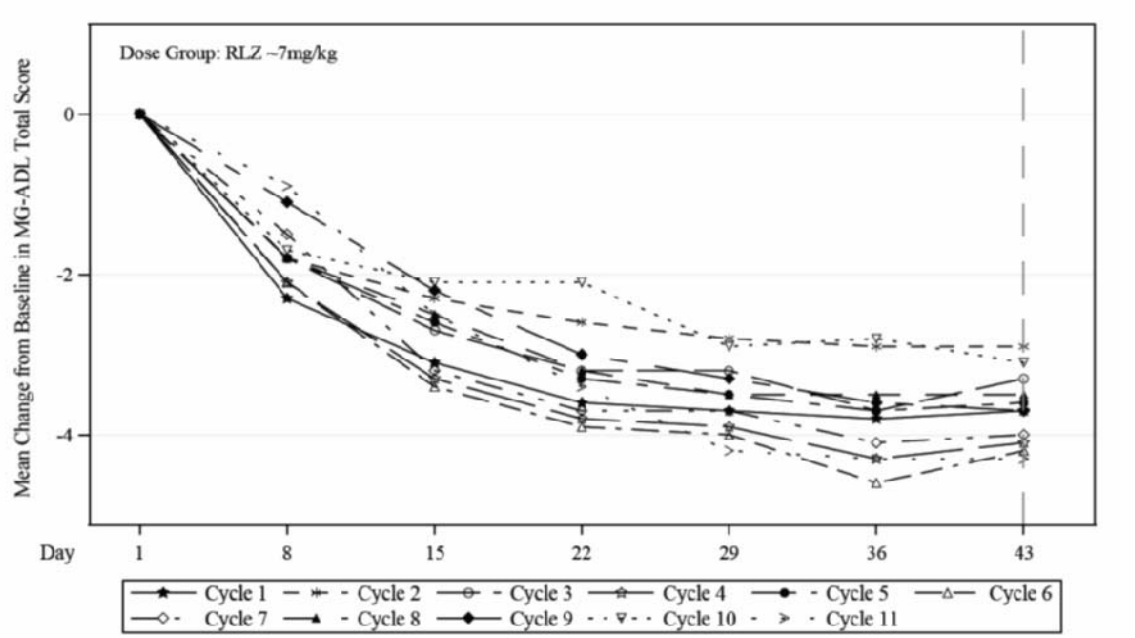
95 % CI for difference	-4.091, -1.249	
P-value for difference	< 0.001	
MG-C		
Baseline mean	15.6	15.9
Change from baseline LS mean (SE)	-2.029 (0.917)	-5.930 (0.916)
Difference vs placebo	-3.901	
95 % CI for difference	-6.634, -1.245	
P-value for difference	< 0.001	
QMG		
Baseline mean	15.8	15.4
Change from baseline LS mean (SE)	-1.915 (0.682)	-5.398 (0.679)
Difference vs placebo	-3.483	
95 % CI for difference	-5.614, -1.584	
P-value for difference	< 0.001	

≈=approximate dose; CI= confidence interval; N=total number of patients in treatment group; LS=least square; SE=standard error; MG-ADL=MG-Activities of Daily Living; MG-C=Myasthenia Gravis Composite score; QMG= Quantitative Myasthenia Gravis; MG=myasthenia gravis.

For the MuSK+ patients who received rozanolixizumab ≈ 7 mg/kg and had data available at day 43 (n=5), the results were consistent with the overall group.

No rozanolixizumab-treated patients and 3 placebo-treated patients received rescue therapy during the treatment period. During the course of the observation period, amongst the patients treated with ≈ 7 mg/kg, one patient received rescue therapy and 19 patients rolled over early to an open label extension study to receive treatment with rozanolixizumab.

In the OLE study MG0007, consistent clinical improvement has been observed following administration of subsequent cycles of rozanolixizumab.



Paediatric population

The licensing authority has deferred the obligation to submit the results of studies with Rystiggo in one or more subsets of the paediatric population in the treatment of myasthenia gravis (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Absorption

Following subcutaneous administration of rozanolixizumab, peak plasma levels are achieved after approximately 2 days. The absolute bioavailability of rozanolixizumab after subcutaneous administration was about 70 % as estimated by population pharmacokinetic analysis.

Distribution

The apparent volume of distribution of rozanolixizumab is approximately 7 l estimated by population pharmacokinetic analysis.

Biotransformation

Rozanolixizumab is expected to be degraded into small peptides and amino acids via catabolic pathways in a manner similar to endogenous IgG.

Elimination

The apparent linear clearance for the free active substance is approximately 0.9 l/day. The half-life of rozanolixizumab is concentration-dependent and cannot be calculated. Rozanolixizumab plasma concentrations are undetectable within one week after dosing.

Linearity/non-linearity

Rozanolixizumab exhibited nonlinear pharmacokinetics typical for a monoclonal antibody that undergoes target-mediated drug disposition. At steady-state, maximum plasma concentrations and area under the concentration time curve (AUC) were predicted to be 3-fold and 4-fold higher at weight-tiered doses of ≈10 mg/kg as compared to ≈7 mg/kg, respectively.

Special populations

Age, sex, or race

A population pharmacokinetic analysis did not reveal a clinically significant impact of age, sex or race on the pharmacokinetics of rozanolixizumab.

Renal or hepatic impairment

No dedicated studies have been conducted in patients with renal or hepatic impairment. However, renal or hepatic impairment is not expected to affect the pharmacokinetics of rozanolixizumab. Based on a population pharmacokinetic analysis, renal function (estimated glomerular filtration rate [eGFR] 38-161 ml/min/1.73 m2) or hepatic biochemical and function tests (alanine transaminase [ALT], aspartate transaminase [AST], alkaline phosphatase and bilirubin) had no clinically significant effect on rozanolixizumab apparent linear clearance.

Immunogenicity

Development of neutralising antibodies was associated with a 24 % decrease in overall plasma exposure of rozanolixizumab. There was no apparent impact of immunogenicity on efficacy and safety (see section 4.4).

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of repeated dose toxicity (including safety pharmacology and fertility endpoints) and toxicity to reproduction and development. Administration to cynomolgus and rhesus monkeys resulted in the expected reduction in IgG. Vaccination during the treatment phase elicited normal IgM levels and a low IgG response due to accelerated IgG degradation. However, boost vaccination after rozanolixizumab clearance resulted in normal IgM and IgG response.

The mutagenic potential of rozanolixizumab has not been evaluated; however, monoclonal antibodies are not expected to alter DNA or chromosomes.

Carcinogenicity studies have not been conducted with rozanolixizumab.

No treatment-related changes were noted in the male and female reproductive organs or male and female fertility parameters of sexually mature animals in 26-week repeated dose toxicity study.

Rozanolixizumab had no effects on embryo-foetal and postnatal development. Offspring from treated dams had very low levels of IgG at birth, as expected from the pharmacology. IgG level recovered to control values or greater within 60 days. There was no impact on immune cell number, lymphoid organ architecture and immune function of the pups of treated mothers as assessed by a T-cell Dependent Antibody Response (TDAR) assay.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Histidine

Histidine hydrochloride monohydrate

Proline

Polysorbate 80

Water for injections

6.2 Incompatibilities

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

6.3 Shelf life

3 years

The chemical and physical in-use stability has been demonstrated for 19 hours at 25 °C. From a microbiological point of view, unless the method of preparation precludes the risks of microbial contamination, the product should be used immediately. If not used immediately, in-use storage times and conditions are the responsibility of the user.

7.4 Special precautions for storage

Store in a refrigerator (2 °C – 8 °C).

Do not freeze.

Keep the vial in the outer carton in order to protect from light.

The Rystiggo vial may be stored at room temperature (up to 25 °C) for a single period of maximum 20 days with protection from light. Once removed from the refrigerator and stored under these conditions, discard after 20 days or by the expiry date, whichever occurs first.

6.5 Nature and contents of container

Vial (Type I glass) with a stopper (rubber) sealed with a crimp seal and flip off cap. Pack size of 1 vial.

Each single use vial contains 2 ml, 3 ml, 4 ml or 6 ml of solution for injection.
Not all vials may be marketed.

9.6 Special precautions for disposal

Material specificities

The rozanolixizumab solution for injection can be administered using polypropylene syringes as well as infusion sets containing polyethylene (PE), polypropylene (PP), low density polyethylene (LDPE), polyester, polyvinyl chloride (PVC without DEHP), polycarbonate (PC), fluorinated ethylene polypropylene (FEP), urethane/acrylate, polyurethane, meta-acrylonitrile butadiene styrene (MABS), silicone or cyclohexanone. Do not use administration devices labelled as containing di(2- ethylhexyl)phthalate (DEHP).

Each vial is for single use only. Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

Instructions for use

Before administering Rystiggo, the instructions for use must be read carefully (for further details please refer to the instructions for use included in the patient information leaflet):

Common instructions for infusion with a pump and manual push

Allow vials to reach room temperature. This may take a minimum of 30 minutes up to 120 minutes. Do not use heating devices. If the vials are stored at room temperature, they can be used immediately.

- Check each vial before using:
  - Expiration date: do not use beyond expiration date.
  - Colour: the solution should be colourless to pale brownish-yellow, clear to slightly opalescent. Do not use the vial if the liquid looks cloudy, contains foreign particles, or has changed colour.
  - Cap: do not use if protective cap of the vial is missing or defective.
- Collect all items for the infusion. In addition to the vial unit(s), collect the following, which are not supplied: syringe (5-10 ml, depending on the prescribed dose), syringe needle (s), transfer needle or vented vial adaptor, alcohol wipe, infusion set, bowl or paper towel, tape or transparent dressing, infusion pump (if applicable) and sharps container.
- In order to avoid potential interruptions in delivery of Rystiggo, the following criteria should be respected:
  - Administration tubing length of 61 cm or shorter is recommended. An infusion set with a needle of 26 gauge or with a larger diameter should be used.
- Use aseptic technique when preparing and administering this product.
- Use transfer needles with a needle of 18 gauge or with a larger diameter to fill the syringe.
- Extract the entire content of the vial into the syringe. A small amount will remain in the vial and should be discarded.
- For multiple vials, use a fresh needle and repeat previous steps.
- Remove the needle from the syringe and attach the infusion set to the syringe.
- Each vial contains excess volume (to allow priming of the infusion line); therefore, pre-set the pump to deliver the prescribed volume or adjust the volume to be administered by expelling any excess volume.
- Administer immediately after priming the infusion set. Choose an infusion area: lower right or lower left part of the abdomen, below the belly button. Never infuse into areas where the skin is tender, bruised, red or hard. Avoid infusing into scars or stretch marks.
- Clean the infusion site using alcohol wipe. Allow to dry.
- Insert the infusion set needle into the subcutaneous tissue.
- If necessary, use tape or transparent dressing to hold the needle in place.

- When the infusion is complete, do not flush the infusion line as the volume of infusion has been adjusted taking into account the losses in the line.

When Rystiggo is administered through an infusion pump

- Syringe pump occlusion alarm limits must be set to the maximum setting, if applicable.
- Follow the instructions provided with the infusion pump to prepare the pump and prime the infusion line.

7 MARKETING AUTHORISATION HOLDER

UCB Pharma Ltd

208 Bath Road

Slough

Berkshire

SL1 3WE

United Kingdom

8 MARKETING AUTHORISATION NUMBER(S)

PLGB 00039/0808

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

07/03/2024

10 DATE OF REVISION OF THE TEXT

14/04/2026