

ANNEX I
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

Otezla 10 mg film-coated tablets
Otezla 20 mg film-coated tablets
Otezla 30 mg film-coated tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 10 mg of apremilast.
Each film-coated tablet contains 20 mg of apremilast.
Each film-coated tablet contains 30 mg of apremilast.

Excipient(s) with known effect:

Each film-coated tablet contains 57 mg of lactose (as lactose monohydrate).
Each film-coated tablet contains 114 mg of lactose (as lactose monohydrate).
Each film-coated tablet contains 171 mg of lactose (as lactose monohydrate).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet (tablet).

Pink, diamond shaped 10 mg film-coated tablet of 8 mm length with “APR” engraved on one side and “10” on the opposite side.

Brown, diamond shaped 20 mg film-coated tablet of 10 mm length with “APR” engraved on one side and “20” on the opposite side.

Beige, diamond shaped 30 mg film-coated tablet of 12 mm length with “APR” engraved on one side and “30” on the opposite side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Psoriatic arthritis

Otezla, alone or in combination with Disease Modifying Antirheumatic Drugs (DMARDs), is indicated for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior DMARD therapy (see section 5.1).

Psoriasis

Otezla is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or psoralen and ultraviolet-A light (PUVA).

4.2 Posology and method of administration

Treatment with Otezla should be initiated by specialists experienced in the diagnosis and treatment of psoriasis or psoriatic arthritis.

Posology

The recommended dose of Otezla is 30 mg twice daily taken orally, morning and evening, approximately 12 hours apart, with no food restrictions. An initial titration schedule is required as shown below in Table 1. No re-titration is required after initial titration.

Table 1: Dose titration schedule

Day 1	Day2		Day 3		Day 4		Day 5		Day 6 & thereafter	
AM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
10 mg	10 mg	10 mg	10 mg	20 mg	20 mg	20 mg	20 mg	30 mg	30 mg	30 mg

If patients miss a dose, the next dose should be taken as soon as possible. If it is close to the time for their next dose, the missed dose should not be taken and the next dose should be taken at the regular time.

During pivotal trials the greatest improvement was observed within the first 24 weeks of treatment. If a patient shows no evidence of therapeutic benefit after 24 weeks, treatment should be reconsidered. The patient's response to treatment should be evaluated on a regular basis. Clinical experience beyond 52 weeks is not available (see section 5.1).

Special populations

Elderly patients

No dose adjustment is required for this patient population (see sections 4.8 and 5.2).

Patients with renal impairment

No dose adjustment is needed in patients with mild and moderate renal impairment. The dose of apremilast should be reduced to 30 mg once daily in patients with severe renal impairment (creatinine clearance of less than 30 mL per minute estimated by the Cockcroft-Gault equation). For initial dose titration in this group, it is recommended that Otezla be titrated using only the AM schedule listed in Table 1 and the PM doses be skipped (see section 5.2).

Patients with hepatic impairment

No dose adjustment is necessary for patients with hepatic impairment (see section 5.2).

Paediatric population

The safety and efficacy of apremilast in children aged 0 to 17 years have not been established. No data are available.

Method of administration

Otezla is for oral use. The film-coated tablets should be swallowed whole, and can be taken either with or without food.

4.3 Contraindications

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

Pregnancy (see section 4.6).

4.4 Special warnings and precautions for use

Patients with rare hereditary problems of galactose intolerance, lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

Otezla should be dose reduced to 30 mg once daily in patients with severe renal impairment (see sections 4.2 and 5.2).

Patients who are underweight at the start of treatment should have their body weight monitored regularly. In the event of unexplained and clinically significant weight loss, these patients should be evaluated by a medical practitioner and discontinuation of treatment should be considered.

4.5 Interaction with other medicinal products and other forms of interaction

Co-administration of strong cytochrome P450 3A4 (CYP3A4) enzyme inducer, rifampicin, resulted in a reduction of systemic exposure of apremilast, which may result in a loss of efficacy of apremilast. Therefore, the use of strong CYP3A4 enzyme inducers (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin and St. John's Wort) with apremilast is not recommended. Co-administration of apremilast with multiple doses of rifampicin resulted in a decrease in apremilast area-under-the-concentration time curve (AUC) and maximum serum concentration (C_{max}) by approximately 72% and 43%, respectively. Apremilast exposure is decreased when administered concomitantly with strong inducers of CYP3A4 (e.g. rifampicin) and may result in reduced clinical response.

In clinical studies, apremilast has been administered concomitantly with topical therapy (including corticosteroids, coal tar shampoo and saliicylic acid scalp preparations) and UVB phototherapy.

There was no clinically meaningful drug-drug interaction between ketoconazole and apremilast. Apremilast can be co-administered with a potent CYP3A4 inhibitor such as ketoconazole.

There was no pharmacokinetic drug-drug interaction between apremilast and methotrexate in psoriatic arthritis patients. Apremilast can be co-administered with methotrexate.

There was no pharmacokinetic drug-drug interaction between apremilast and oral contraceptives containing ethinyl estradiol and norgestimate. Apremilast can be co-administered with oral contraceptives.

4.6 Fertility, pregnancy and lactation

Women of childbearing potential

Pregnancy should be excluded before treatment can be initiated. Women of childbearing potential should use an effective method of contraception to prevent pregnancy during treatment.

Pregnancy

There are limited data about the use of apremilast in pregnant women.

Apremilast is contraindicated during pregnancy. Effects of apremilast on pregnancy included embryofetal loss in mice and monkeys, and reduced fetal weights and delayed ossification in mice at doses higher than the currently recommended highest human dose. No such effects were observed when exposure in animals was at 1.3-fold the clinical exposure (see section 5.3).

Breast-feeding

Apremilast was detected in milk of lactating mice (see section 5.3). It is not known whether apremilast, or its metabolites, are excreted in human milk. A risk to the breastfed infant cannot be excluded, therefore apremilast should not be used during breast-feeding.

Fertility

No fertility data is available in humans. In animal studies in mice, no adverse effects on fertility were observed in males at exposure levels 3-fold clinical exposure and in females at exposure levels 1-fold clinical exposure. For pre-clinical fertility data see section 5.3.

4.7 Effects on ability to drive and use machines

Apremilast has no influence on the ability to drive and use machines.

4.8 Undesirable effects

Summary of the safety profile

The most commonly reported adverse reactions in Phase III clinical studies have been gastrointestinal (GI) disorders including diarrhoea (15.7%) and nausea (13.9%). These GI adverse reactions were mostly mild to moderate in severity, with 0.3% of diarrhoea and 0.3% of nausea reported as being severe. These adverse reactions generally occurred within the first 2 weeks of treatment and usually resolved within 4 weeks. The other most commonly reported adverse reactions included upper respiratory tract infections (8.4%), headache (7.9%), and tension headache (7.2%). Overall, most adverse reactions were considered to be mild or moderate in severity.

The most common adverse reactions leading to discontinuation during the first 16 weeks of treatment were diarrhoea (1.7%), and nausea (1.5%). The overall incidence of serious adverse reactions was low and did not indicate any specific system organ involvement.

Hypersensitivity reactions were uncommonly observed in apremilast clinical studies (see section 4.3).

Tabulated list of adverse reactions

The adverse reactions observed in patients treated with apremilast are listed below by system organ class (SOC) and frequency for all adverse reactions. Within each SOC and frequency grouping, adverse reactions are presented in order of decreasing seriousness.

The adverse drug reactions were determined based on data from the apremilast clinical development programme. The frequencies of adverse drug reactions are those reported in the apremilast arms of the four Phase III studies in PsA (n = 1945) or the two Phase III studies in PSOR (n=1184) (highest frequency from either data pool is represented in Table 2).

Frequencies are defined as: very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$).

Table 2. Summary of adverse reactions in phase III psoriatic arthritis (PsA) and/or psoriasis (PSOR) clinical studies

System Organ Class	Frequency	Adverse reaction
Infections and infestations	Common	Bronchitis
		Upper respiratory tract infection
		Nasopharyngitis*
Immune system disorders	Uncommon	Hypersensitivity
Metabolism and nutrition disorders	Common	Decreased appetite*
Psychiatric disorders	Common	Insomnia

System Organ Class	Frequency	Adverse reaction
Nervous system disorders	Common	Migraine*
		Tension headache*
		Headache*
Respiratory, thoracic, and mediastinal disorders	Common	Cough
Gastrointestinal disorders	Very Common	Diarrhoea*
		Nausea*
	Common	Vomiting*
		Dyspepsia
		Frequent bowel movements
		Upper abdominal pain *
		Gastroesophageal reflux disease
Skin and subcutaneous tissue disorders	Uncommon	Rash
Musculoskeletal and connective tissue disorders	Common	Back pain*
General disorders and administrative site conditions	Common	Fatigue
Investigations	Uncommon	Weight decrease

*At least one of these adverse reactions was reported as serious

Description of selected adverse reactions

Body weight loss

Patient weight was measured routinely in clinical studies. The mean observed weight loss in patients treated for up to 52 weeks with apremilast was 1.99 kg. A total of 14.3% of patients receiving apremilast had observed weight loss between 5-10% while 5.7% of the patients receiving apremilast had observed weight loss greater than 10%. None of these patients had overt clinical consequences resulting from weight loss. A total of 0.1% of patients treated with apremilast discontinued due to adverse reaction of weight decreased.

Please see additional warning in section 4.4 for patients who are underweight at beginning of treatment.

Depression

During the placebo-controlled period of the phase III clinical trials PSOR, 1.2% (14/1184) of patients treated with apremilast reported depression compared to 0.5% (2/418) treated with placebo. None of these reports of depression was serious or led to study discontinuation.

Special populations

Elderly patients

No overall differences were observed in the safety profile of elderly patients ≥ 65 years of age and younger adult patients < 65 years of age in the clinical studies.

Patients with hepatic impairment

The safety of apremilast was not evaluated in PsA or PSOR patients with hepatic impairment.

Patients with renal impairment

In the PsA or PSOR clinical studies, the safety profile observed in patients with mild renal impairment was comparable to patients with normal renal function. The safety of apremilast was not evaluated in PsA or PSOR patients with moderate or severe renal impairment in the clinical studies.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system listed in Appendix V.

4.9 Overdose

Apremilast was studied in healthy subjects at a maximum total daily dose of 100 mg (given as 50 mg BID) for 4.5 days without evidence of dose limiting toxicities. In case of an overdose, it is recommended that the patient is monitored for any signs or symptoms of adverse effects and appropriate symptomatic treatment is instituted. In the event of overdose, symptomatic and supportive care is advised.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Immunosuppressants, selective immunosuppressants, ATC code: L04AA32

Mechanism of action

Apremilast, an oral small-molecule inhibitor of phosphodiesterase 4 (PDE4), works intracellularly to modulate a network of pro-inflammatory and anti-inflammatory mediators. PDE4 is a cyclic adenosine monophosphate (cAMP)-specific PDE and the dominant PDE in inflammatory cells. PDE4 inhibition elevates intracellular cAMP levels, which in turn down-regulates the inflammatory response by modulating the expression of TNF- α , IL-23, IL-17 and other inflammatory cytokines. Cyclic AMP also modulates levels of anti-inflammatory cytokines such as IL-10. These pro- and anti-inflammatory mediators have been implicated in psoriatic arthritis and psoriasis.

Pharmacodynamics effects

In clinical studies in patients with psoriatic arthritis, apremilast significantly modulated, but did not fully inhibit, plasma protein levels of IL-1 α , IL-6, IL-8, MCP-1, MIP-1 β , MMP-3, and TNF- α . After 40 weeks of treatment with apremilast, there was a decrease in plasma protein levels of IL-17 and IL-23, and an increase in IL-10. In clinical trials in patients with psoriasis, apremilast decreased lesional skin epidermal thickness, inflammatory cell infiltration, and expression of pro-inflammatory genes, including those for inducible nitric oxide synthase (iNOS), IL-12/IL-23p40, IL-17A, IL-22 and IL-8.

Apremilast administered at doses of up to 50 mg BID did not prolong the QT interval in healthy subjects.

Clinical trials experience

Psoriatic Arthritis

The safety and efficacy of apremilast were evaluated in 3 multi-center, randomized, double-blind, placebo-controlled studies (Studies PALACE 1, PALACE 2, and PALACE 3) of similar design in adult patients with active PsA (≥ 3 swollen joints and ≥ 3 tender joints) despite prior treatment with small molecule or biologic DMARDs. A total of 1493 patients were randomised and treated with either placebo, apremilast 20 mg or apremilast 30 mg given orally twice daily.

Patients in these studies had a diagnosis of PsA for at least 6 months. One qualifying psoriatic skin lesion (at least 2 cm in diameter) was also required in PALACE 3. Apremilast was used as a monotherapy (34.8%) or

in combination with stable doses of small molecule DMARDs (65.2%). Patients received apremilast in combination with one or more of the following: methotrexate (MTX, ≤ 25 mg/week, 54.5%), sulfasalazine (SSZ, ≤ 2 g/day, 9.0%), and leflunomide (LEF; ≤ 20 mg/day, 7.4%). Concomitant treatment with biologic DMARDs, including TNF blockers, was not allowed. Patients with each subtype of PsA were enrolled in the 3 studies, including symmetric polyarthritis (62.0%), asymmetric oligoarthritis (26.9%), distal interphalangeal (DIP) joint arthritis (6.2%), arthritis mutilans (2.7%), and predominant spondylitis (2.1%). Patients with pre-existing enthesopathy (63%) or pre-existing dactylitis (42%) were enrolled. A total of 76.4% of patients were previously treated with only small-molecule DMARDs and 22.4% of patients were previously treated with biologic DMARDs, which includes 7.8% who had a therapeutic failure with a prior biologic DMARD. The median duration of PsA disease was 5 years.

Based on the study design, patients whose tender and swollen joint counts had not improved by at least 20% were considered non-responders at Week 16. Placebo patients who were considered non-responders were re-randomized 1:1 in a blinded fashion to either apremilast 20 mg twice daily or 30 mg twice daily. At Week 24, all remaining placebo-treated patients were switched to either apremilast 20 or 30 mg BID. The primary endpoint was the percentage of patients achieving American College of Rheumatology (ACR) 20 response at Week 16.

Treatment with apremilast resulted in significant improvements in the signs and symptoms of PsA, as assessed by the ACR 20 response criteria compared to placebo at Weeks 16. The proportion of patients with ACR 20/50/70 (responses in Studies PALACE 1, PALACE 2 and PALACE 3, and the pooled data for studies PALACE 1, PALACE 2 and PALACE 3, for apremilast 30 mg twice daily at Week 16, are shown in Table 3. ACR 20/50/70 responses were maintained at Week 24.

Among patients who were initially randomized to apremilast 30 mg twice daily treatment, ACR 20/50/70 response rates were maintained through Week 52 in the pooled Studies PALACE 1, PALACE 2 and PALACE 3 (Figure 1).

Table 3. Proportion of patients with ACR responses in studies PALACE 1, PALACE 2 and PALACE 3 and pooled studies at Week 16

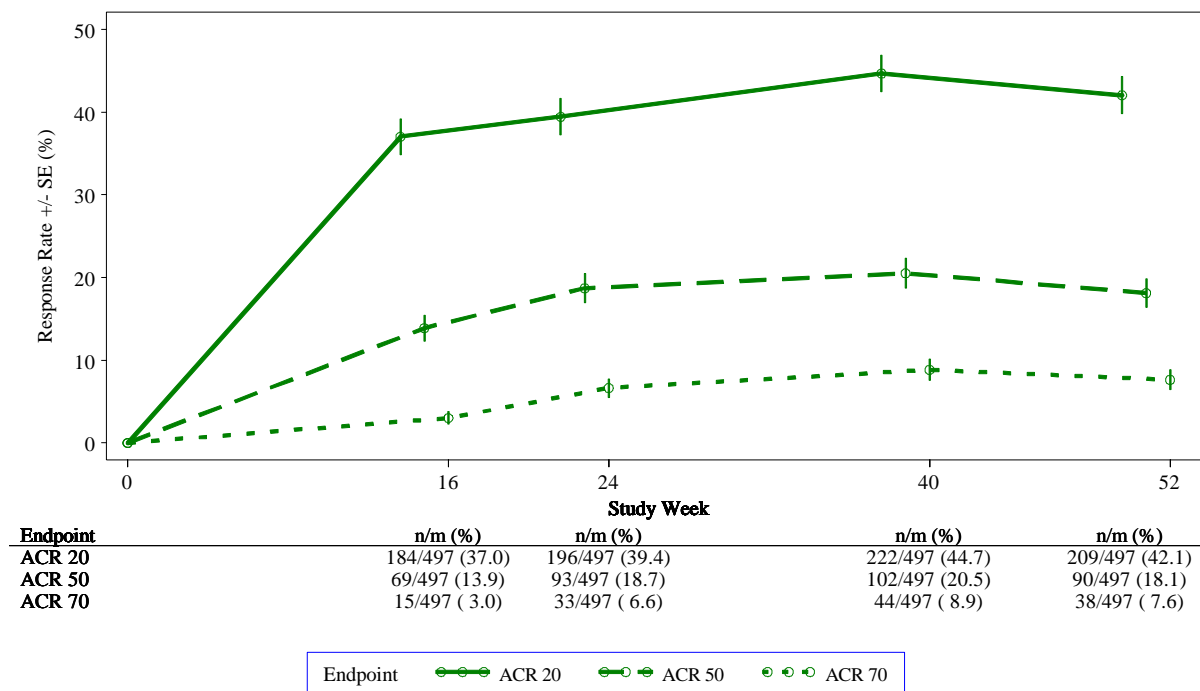
	<u>PALACE 1</u>		<u>PALACE 2</u>		<u>PALACE 3</u>		<u>POOLED</u>	
	<u>Placebo</u> <u>+/-</u> <u>DMARDs</u> <u>N=168</u>	<u>Apremilast</u> <u>30 mg BID</u> <u>+/-</u> <u>DMARDs</u> <u>N=168</u>	<u>Placebo</u> <u>+/-</u> <u>DMARDs</u> <u>N=159</u>	<u>Apremilast</u> <u>30 mg BID</u> <u>+/-</u> <u>DMARDs</u> <u>N=162</u>	<u>Placebo</u> <u>+/-</u> <u>DMARDs</u> <u>N=169</u>	<u>Apremilast</u> <u>30 mg BID</u> <u>+/-</u> <u>DMARDs</u> <u>N=167</u>	<u>Placebo</u> <u>+/-</u> <u>DMARDs</u> <u>N=496</u>	<u>Apremilast</u> <u>30 mg BID</u> <u>+/-</u> <u>DMARDs</u> <u>N=497</u>
ACR 20^a								
Week 16	19.0%	38.1% **	18.9%	32.1% *	18.3%	40.7% **	18.8%	37.0% **
ACR 50								
Week 16	6.0%	16.1% *	5.0%	10.5%	8.3%	15.0%	6.5%	13.9% **
ACR 70								
Week 16	1.2%	4.2%	0.6%	1.2%	2.4%	3.6%	1.4%	3.0%

*p ≤ 0.01 for apremilast vs. placebo.

**p ≤ 0.001 for apremilast vs. placebo

^aN is the number of patients as randomized and treated.

Figure 1 Proportion of ACR 20/50/70 responders through Week 52 in the pooled analysis of studies PALACE 1, PALACE 2 and PALACE 3 (NRI*)



*NRI: None responder imputation. Subjects who discontinued early prior to the time point and subjects who did not have sufficient data for a definitive determination of response status at the time point are counted as non-responders.

Among 497 patients initially randomized to apremilast 30 mg twice daily, 375 (75%) patients were still on this treatment on Week 52. In these patients, ACR 20/50/70 responses at Week 52 were of 57%, 25%, and 11% respectively.

Responses observed in the apremilast treated group were similar in patients receiving and not receiving concomitant DMARDs, including MTX. Patients previously treated with DMARDs or biologics who received apremilast achieved a greater ACR 20 response at Week 16 than patients receiving placebo.

Similar ACR responses were observed in patients with different PsA subtypes, including DIP. The number of patients with arthritis mutilans and predominant spondylitis subtypes was too small to allow meaningful assessment.

In PALACE 1, PALACE 2 and PALACE 3, improvements in Disease Activity Scale (DAS) 28 C-reactive protein (CRP) and in the proportion of patients achieving a modified PsA response criteria (PsARC) were greater in the apremilast group, compared to placebo at Week 16 (nominal p-value $p \leq 0.0004$, p-value ≤ 0.0017 , respectively). These improvements were maintained at Week 24. Among patients who remained on the apremilast treatment to which they were randomized at study start, DAS28(CRP) score and PsARC response were maintained through Week 52.

At Weeks 16 and 24 improvements in parameters of peripheral activity characteristic of psoriatic arthritis (e.g. number of swollen joints, number of painful/tender joints, dactylitis and enthesitis) and in the skin manifestations of psoriasis were seen in the apremilast-treated patients. Among patients who remained on the apremilast treatment to which they were randomized at study start, these improvements were maintained through Week 52.

Physical function and health-related quality of life

Apremilast-treated patients demonstrated statistically significant improvement in physical function, as assessed by the disability index of the health assessment questionnaire (HAQ-DI) change from baseline,

compared to placebo at Weeks 16 in PALACE 1, PALACE 2 and PALACE 3 and in the pooled studies (Table 4). Improvement in HAQ-DI scores was maintained at Week 24.

Among patients who were initially randomized to apremilast 30 mg twice daily treatment, the change from baseline in the HAQ-DI score at week 52 was -0.333 in the apremilast 30 mg twice daily group in a pooled analysis of the open label phase of studies PALACE 1, PALACE 2 and PALACE 3.

In studies PALACE 1, PALACE 2 and PALACE 3, significant improvements were demonstrated in health-related quality of life, as measured by the changes from baseline in the physical functioning (PF) domain of the Short Form Health Survey version 2 (SF-36v2), and in the Functional Assessment of Chronic Illness Therapy – Fatigue (FACIT-fatigue) scores in patients treated with apremilast compared to placebo at Weeks 16 and 24. Among patients who remained on the apremilast treatment, to which they were initially randomized at study start, improvement in physical function and FACIT- fatigue was maintained through Week 52.

Psoriasis

The safety and efficacy of apremilast were evaluated in two multicenter, randomized, double-blind, placebo-controlled studies (Studies ESTEEM 1 and ESTEEM 2) which enrolled a total of 1257 patients with moderate to severe plaque psoriasis who had a body surface area (BSA) involvement of $\geq 10\%$, Psoriasis Area and Severity Index (PASI) score ≥ 12 , static Physician Global Assessment (sPGA) of ≥ 3 (moderate or severe), and who were candidates for phototherapy or systemic therapy.

These studies had a similar design through Week 32. In both studies, patients were randomized 2:1 to apremilast 30 mg BID or placebo for 16 weeks (placebo-controlled phase) and from Weeks 16-32, all patients received apremilast 30 mg BID (maintenance phase). During the Randomized Treatment Withdrawal Phase (Weeks 32-52), patients originally randomized to apremilast who achieved at least a 75% reduction in their PASI score (PASI-75) (ESTEEM 1) or a 50% reduction in their PASI score (PASI-50) (ESTEEM 2) were re-randomized at Week 32 to either placebo or apremilast 30 mg BID. Patients who were re-randomized to placebo and who lost PASI-75 response (ESTEEM 1) or lost 50% of the PASI improvement at Week 32 compared to baseline (ESTEEM 2) were retreated with apremilast 30 mg BID. Patients who did not achieve the designated PASI response by Week 32, or who were initially randomized to placebo, remained on apremilast until Week 52. The use of low potency topical corticosteroids on the face, axillae, and groin, coal tar shampoo and/or salicylic acid scalp preparations was permitted throughout the studies. In addition, at Week 32, subjects who did not achieve a PASI-75 response in ESTEEM 1, or a PASI-50 response in ESTEEM 2, were permitted to use topical psoriasis therapies and/or phototherapy in addition to apremilast 30 mg BID treatment.

In both studies, the primary endpoint was the proportion of patients who achieved PASI-75 at Week 16. The major secondary endpoint was the proportion of patients who achieved a sPGA score of clear (0) or almost clear (1) at Week 16.

The mean baseline PASI score was 19.07 (median 16.80), and the proportion of patients with sPGA score of 3 (moderate) and 4 (severe) at baseline was 70.0% and 29.8%, respectively with a mean baseline BSA involvement of 25.19% (median 21.0%). Approximately 30% of all patients had received prior phototherapy and 54% had received prior conventional systemic and/or biologic therapy for the treatment of psoriasis (including treatment failures), with 37% receiving prior conventional systemic therapy and 30% receiving prior biologic therapy. Approximately one-third of patients had not received prior phototherapy, conventional systemic or biologic therapy. A total of 18% of patients had a history of psoriatic arthritis.

The proportion of patients achieving PASI-50, -75 and -90 responses, and sPGA score of clear (0) or almost clear (1), are presented in Table 4 below. Treatment with apremilast resulted in significant improvement in moderate to severe plaque psoriasis as demonstrated by the proportion of patients with PASI-75 response at Week 16, compared to placebo. Clinical improvement measured by sPGA, PASI-50 and PASI-90 responses were also demonstrated at Week 16. In addition, apremilast demonstrated a treatment benefit across multiple manifestations of psoriasis including pruritus, nail disease, scalp involvement and quality of life measures.

Table 4. Clinical response at week 16 in studies ESTEEM 1 and ESTEEM 2 (FAS^a, LOCF^b)

	ESTEEM 1		ESTEEM 2	
	Placebo	30 mg BID APR*	Placebo	30 mg BID APR*
N	282	562	137	274
PASI^c 75, n (%)	15 (5.3)	186 (33.1)	8 (5.8)	79 (28.8)
sPGA^d of Clear or Almost Clear, n (%)	11 (3.9)	122 (21.7)	6 (4.4)	56 (20.4)
PASI 50, n (%)	48 (17.0)	330 (58.7)	27 (19.7)	152 (55.5)
PASI 90, n (%)	1 (0.4)	55 (9.8)	2 (1.5)	24 (8.8)
Percent Change BSA^e (%) mean± SD	- 6.9 ± 38.95	- 47.8 ± 38.48	- 6.1 ± 47.57	-48.4 ± 40.78
Change in Pruritus VAS^f (mm), mean± SD	- 7.3 ± 27.08	- 31.5 ± 32.43	- 12.2 ± 30.94	- 33.5 ±35.46
Change in DLQI^g, mean± SD	- 2.1 ± 5.69	- 6.6 ± 6.66	-2.8 ± 7.22	-6.7 ± 6.95
Change in SF-36 MCS^h, mean± SD	- 1.02 ± 9.161	2.39 ± 9.504	0.00 ±10.498	2.58 ± 10.129

* p< 0.0001 for apremilast vs placebo, except for ESTEEM 2 PASI 90 and Change in SF-36 MCS where p=0.0042 and p=0.0078, respectively.

^a FAS = Full Analysis Set

^b LOCF= Last Observation Carried forward

^c PASI = Psoriasis Area and Severity Index

^d sPGA = Static Physician Global Assessment

^e BSA = Body Surface Area

^f VAS = Visual Analog Scale; 0 = best, 100 = worst

^g DLQI = Dermatology Life Quality Index; 0 = best, 30 = worst

^h SF-36 MCS = Medical Outcome Study Short Form 36-Item Health Survey, Mental Component Summary

The clinical benefit of apremilast was demonstrated across multiple subgroups defined by baseline demographics and baseline clinical disease characteristics (including psoriasis disease duration and patients with a history of psoriatic arthritis). The clinical benefit of apremilast was also demonstrated regardless of prior psoriasis medication usage and response to prior psoriasis treatments. Similar response rates were observed across all weight ranges.

Response to apremilast was rapid, with significantly greater improvements in the signs and symptoms of psoriasis, including PASI, skin discomfort/pain and pruritus, compared to placebo by Week 2. In general, PASI responses were achieved by Week 16 and were maintained through Week 32.

In both studies, the mean percent improvement in PASI from baseline remained stable during the Randomized Treatment Withdrawal Phase for patients re-randomized to apremilast at Week 32 (Table 5).

Table 5. Persistence of effect among subjects randomized to APR 30 BID at Week 0 and re-randomized to APR 30 BID at Week 32 to Week 52

	Time Point	ESTEEM 1	ESTEEM 2
		Patients who achieved PASI-75 at Week 32	Patients who achieved PASI-50 at Week 32
Percent Change in PASI from baseline, mean (%) ± SD^a	Week 16	-77.7 ± 20.30	-69.7 ± 24.23
	Week 32	-88 ± 8.30	-76.7 ± 13.42

	<u>Time Point</u>	<u>ESTEEM 1</u>	<u>ESTEEM 2</u>
		<u>Patients who achieved PASI-75 at Week 32</u>	<u>Patients who achieved PASI-50 at Week 32</u>
	Week 52	-80.5 ± 12.60	-74.4 ± 18.91
Change in DLQI from baseline, mean ± SD^a	Week 16	-8.3 ± 6.26	-7.8 ± 6.41
	Week 32	-8.9 ± 6.68	-7.7 ± 5.92
	Week 52	-7.8 ± 5.75	-7.5 ± 6.27
Proportion of subjects with Scalp Psoriasis PGA (ScPGA) 0 or 1, n/N (%)^b	Week 16	40/48 (83.3)	21/37 (56.8)
	Week 32	39/48 (81.3)	27/37 (73.0)
	Week 52	35/48 (72.9)	20/37 (54.1)

^a Includes subjects re-randomized to APR 30 BID at Week 32 with a baseline value and a post-baseline value at the evaluated study week.

^b N is based on subjects with moderate or greater scalp psoriasis at baseline who were re-randomized to APR 30 BID at Week 32. Subjects with missing data were counted as nonresponders.

In Study ESTEEM 1, approximately 61% of patients re-randomized to apremilast at Week 32 had a PASI-75 response at Week 52. Of the patients with at least a PASI-75 response who were re-randomized to placebo at Week 32 during a Randomized Treatment Withdrawal Phase, 11.7% were PASI-75 responders at Week 52. The median time to loss of PASI-75 response among the patients re-randomized to placebo was 5.1 weeks.

In Study ESTEEM 2, approximately 80.3% of patients re-randomized to apremilast at Week 32 had a PASI-50 response at Week 52. Of the patients with at least a PASI-50 response who were re-randomized to placebo at Week 32, 24.2% were PASI-50 responders at Week 52. The median time to loss of 50% of their Week 32 PASI improvement was 12.4 weeks.

After randomized withdrawal from therapy at Week 32, approximately 70% of patients in Study ESTEEM 1, and 65.6% of patients in Study ESTEEM 2, regained PASI-75 (ESTEEM 1) or PASI-50 (ESTEEM 2) responses after re-initiation of apremilast treatment. Due to the study design the duration of re-treatment was variable, and ranged from 2.6 to 22.1 weeks.

In Study ESTEEM 1, patients randomized to apremilast at the start of the study who did not achieve a PASI-75 response at Week 32 were permitted to use concomitant topical therapies and/or UVB phototherapy between Weeks 32 to 52. Of these patients, 12% achieved a PASI-75 response at Week 52 with apremilast plus topical and/or phototherapy treatment.

In Studies ESTEEM 1 and ESTEEM 2, significant improvements (reductions) in nail psoriasis, as measured by the mean percent change in Nail Psoriasis Severity Index (NAPSI) from baseline, were observed in patients receiving apremilast compared to placebo-treated patients at Week 16 ($p < 0.0001$ and $p = 0.0052$, respectively). Further improvements in nail psoriasis were observed at Week 32 in patients continuously treated with apremilast.

In Studies ESTEEM 1 and ESTEEM 2, significant improvements in scalp psoriasis of at least moderate severity (≥ 3), measured by the proportion of patients achieving Scalp Psoriasis Physician's Global Assessment (ScPGA) of clear (0) or minimal (1) at Week 16, were observed in patients receiving apremilast compared to placebo-treated patients ($p < 0.0001$ for both studies). The improvements were generally maintained in subjects who were re-randomized to Otezla at Week 32 through Week 52 (Table 5).

In Studies ESTEEM 1 and ESTEEM 2, significant improvements in quality of life as measured by the Dermatology Life Quality Index (DLQI) and the SF-36v2MCS were demonstrated in patients receiving apremilast compared with placebo-treated patients (Table 4). Improvements in DLQI were maintained through Week 52 in subjects who were re-randomized to apremilast at Week 32 (Table 5). In addition, in Study ESTEEM 1, significant improvement in the Work Limitations Questionnaire (WLQ-25) Index was achieved in patients receiving apremilast compared to placebo.

5.2 Pharmacokinetic properties

Absorption

Apremilast is well absorbed with an absolute oral bioavailability of approximately 73%, with peak plasma concentrations (C_{max}) occurring at a median time (t_{max}) of approximately 2.5 hours. Apremilast pharmacokinetics are linear, with a dose-proportional increase in systemic exposure in the dose range of 10 to 100 mg daily. Accumulation is minimal when apremilast is administered once daily and approximately 53% in healthy subjects and 68% in patients with psoriasis when administered twice daily. Co-administration with food does not alter the bioavailability therefore, apremilast can be administered with or without food.

Distribution

Human plasma protein binding of apremilast is approximately 68%. The mean apparent volume of distribution (V_d) is 87 L, indicative of extravascular distribution.

Biotransformation

Apremilast is extensively metabolised by both CYP and non-CYP mediated pathways including oxidation, hydrolysis, and conjugation, suggesting inhibition of a single clearance pathway is not likely to cause a marked drug-drug interaction. Oxidative metabolism of apremilast is primarily mediated by CYP3A4, with minor contributions from CYP1A2 and CYP2A6. Apremilast is the major circulating component following oral administration. Apremilast undergoes extensive metabolism with only 3% and 7% of the administered parent compound recovered in urine and faeces, respectively. The major circulating inactive metabolite is the glucuronide conjugate of *O*-demethylated apremilast (M12). Consistent with apremilast being a substrate of CYP3A4, apremilast exposure is decreased when administered concomitantly with rifampicin, a strong inducer of CYP3A4.

In vitro, apremilast is not an inhibitor or inducer of cytochrome P450 enzymes. Hence, apremilast co-administered with substrates of CYP enzymes is unlikely to affect the clearance and exposure of active substances that are metabolised by CYP enzymes.

In vitro, apremilast is a substrate, and a weak inhibitor of P-glycoprotein ($IC_{50} > 50 \mu M$), however clinically relevant drug interactions mediated via P-gp are not expected to occur.

In vitro, apremilast has little to no inhibitory effect ($IC_{50} > 10 \mu M$) on Organic Anion Transporter (OAT)1 and OAT3, Organic Cation Transporter (OCT)2, Organic Anion Transporting Polypeptide (OATP)1B1 and OATP1B3, or breast cancer resistance protein (BCRP) and is not a substrate for these transporters. Hence, clinically relevant drug-drug interactions are unlikely when apremilast is co-administered with drugs that are substrates or inhibitors of these transporters.

Elimination

The plasma clearance of apremilast is on average about 10 L/hr in healthy subjects, with a terminal elimination half-life of approximately 9 hours. Following oral administration of radiolabelled apremilast, about 58% and 39% of the radioactivity is recovered in urine and faeces, respectively, with about 3% and 7% of the radioactive dose recovered as apremilast in urine and faeces, respectively.

Elderly patients

Apremilast was studied in young and elderly healthy subjects. The exposure in elderly subjects (65 to 85 years of age) is about 13% higher in AUC and about 6% higher in C_{max} for apremilast than that in young subjects (18 to 55 years of age). There is limited pharmacokinetic data in subjects over 75 years of age in clinical trials. No dosage adjustment is necessary for elderly patients.

Renal impairment

There is no meaningful difference in the PK of apremilast between mild or moderate renal impaired subjects and matched healthy subjects (N=8 each). The results support that no dose adjustment is needed in patients with mild and moderate renal impairment. Reduce apremilast dose to 30 mg once daily in patients with severe renal impairment (eGFR less than 30 mL/min/1.73 m² or CLcr < 30 mL/min). In 8 subjects with severe renal impairment to whom a single dose of 30 mg apremilast was administered, the AUC and C_{max} of apremilast increased by approximately 89% and 42%, respectively.

Hepatic impairment

The pharmacokinetics of apremilast and its major metabolite M12 are not affected by moderate or severe hepatic impairment. No dose adjustment is necessary for patients with hepatic impairment.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology and repeated dose toxicity. There is no evidence for immunotoxic, dermal irritation, or phototoxic potential.

Fertility and early embryonic development

In a male mouse fertility study, apremilast at oral dosages of 1, 10, 25, and 50 mg/kg/day produced no effects on male fertility; the no observed adverse effect level (NOAEL) for male fertility was greater than 50 mg/kg/day 3-fold clinical exposure).

In a combined female mouse fertility and embryo-fetal developmental toxicity study with oral dosages of 10, 20, 40, and 80 mg/kg/day, a prolongation of oestrous cycles and increased time to mating were observed at 20 mg/kg/day and above; despite this, all mice mated and pregnancy rates were unaffected. The no observed effect level (NOEL) for female fertility was 10 mg/kg/day (1.0-fold clinical exposure).

Embryo-fetal development

In a combined female mouse fertility and embryo-fetal developmental toxicity study with oral dosages of 10, 20, 40, and 80 mg/kg/day, absolute and/or relative heart weights of maternal animals were increased at 20, 40, and 80 mg/kg/day. Increased numbers of early resorptions and reduced numbers of ossified tarsals were observed at 20, 40, and 80 mg/kg/day. Reduced fetal weights and retarded ossification of the supraoccipital bone of the skull were observed at 40 and 80 mg/kg/day. The maternal and developmental NOEL in the mouse was 10 mg/kg/day (1.3-fold clinical exposure).

In a monkey embryo-fetal developmental toxicity study, oral dosages of 20, 50, 200, and 1000 mg/kg/day resulted in a dose-related increase in prenatal loss (abortions) at dosages of 50 mg/kg/day and above; no test article-related effect in prenatal loss was observed at 20 mg/kg/day (1.4-fold clinical exposure).

Pre- and post-natal development

In a pre- and postnatal study, apremilast was administered orally to pregnant female mice at dosages of 10, 80 and 300 mg/kg/day from gestation day (GD) 6 to Day 20 of lactation. Reductions in maternal body weight and weight gain, and one death associated with difficulty in delivering pups were observed at 300 mg/kg/day. Physical signs of maternal toxicity associated with delivering pups were also observed in one mouse at each of 80 and 300 mg/kg/day. Increased peri- and postnatal pup deaths and reduced pup body weights during the first week of lactation were observed at ≥ 80 mg/kg/day (≥ 4.0-fold clinical exposure). There were no apremilast-related effects on duration of pregnancy, number of pregnant mice at the end of the gestation period, number of mice that delivered a litter, or any developmental effects in the pups beyond postnatal day 7. It is likely that pup developmental effects observed during the first week of the postnatal period were related to the apremilast-related pup toxicity (decreased pup weight and viability) and/or lack of maternal care (higher incidence of no milk in the stomach of pups). All developmental effects were observed during the first week of the postnatal period; no apremilast-related effects were seen during the remaining pre- and post-weaning periods, including sexual maturation, behavioural, mating, fertility and uterine parameters. The NOEL in the mouse for maternal toxicity and F1 generation was 10 mg/kg/day (1.3-fold clinical AUC).

Carcinogenicity studies

Carcinogenicity studies in mice and rats showed no evidence of carcinogenicity related to treatment with apremilast.

Genotoxicity studies

Apremilast is not genotoxic. Apremilast did not induce mutations in an Ames assay or chromosome aberrations in cultured human peripheral blood lymphocytes in the presence or absence of metabolic activation. Apremilast was not clastogenic in an in vivo mouse micronucleus assay at doses up to 2000 mg/kg/day.

Other studies

There is no evidence for immunotoxic, dermal irritation, or phototoxic potential.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Microcrystalline cellulose
Lactose monohydrate
Croscarmellose sodium
Magnesium stearate.

Film-coating

Polyvinyl alcohol
Titanium dioxide (E171)
Macrogol 3350
Talc
Iron oxide red (E172).

The 20 mg tablets also contain iron oxide yellow (E172).

The 30 mg tablets also contain iron oxide yellow (E172) and iron oxide black(E172).

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

21 months.

6.4 Special precautions for storage

Do not store above 30°C.

6.5 Nature and contents of container

The treatment initiation pack contains 27 film- coated tablets (4 x10 mg, 4x 20 mg, 19 x 30 mg).

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

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

7. MARKETING AUTHORISATION HOLDER

Celgene Europe Ltd.
1 Longwalk Road
Stockley Park
Uxbridge
UB11 1DB
United Kingdom

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/981/001

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

10. DATE OF REVISION OF THE TEXT

Detailed information on this medicinal product is available on the website of the European Medicines Agency <http://www.ema.europa.eu>.

▼ 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

Otezla 30 mg film-coated tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 30 mg of apremilast.

Excipient(s) with known effect:

Each film-coated tablet contains 171 mg of lactose (as lactose monohydrate).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet (tablet).

Beige, diamond shaped 30 mg film-coated tablet of 12 mm length with “APR” engraved on one side and “30” on the opposite side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Psoriatic arthritis

Otezla, alone or in combination with Disease Modifying Antirheumatic Drugs (DMARDs), is indicated for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior DMARD therapy (see section 5.1).

Psoriasis

Otezla is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or psoralen and ultraviolet-A light (PUVA).

4.2 Posology and method of administration

Treatment with Otezla should be initiated by specialists experienced in the diagnosis and treatment of psoriasis or psoriatic arthritis.

Posology

The recommended dose of Otezla is 30 mg twice daily taken orally, morning and evening, approximately 12 hours apart, with no food restrictions. An initial titration schedule is required as shown below in Table 1. No re-titration is required after initial titration.

Table 1: Dose titration schedule

Day 1	Day2		Day 3		Day 4		Day 5		Day 6 & thereafter	
AM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
10 mg	10 mg	10 mg	10 mg	20 mg	20 mg	20 mg	20 mg	30 mg	30 mg	30 mg

If patients miss a dose, the next dose should be taken as soon as possible. If it is close to the time for their next dose, the missed dose should not be taken and the next dose should be taken at the regular time.

During pivotal trials the greatest improvement was observed within the first 24 weeks of treatment. If a patient shows no evidence of therapeutic benefit after 24 weeks, treatment should be reconsidered. The patient's response to treatment should be evaluated on a regular basis. Clinical experience beyond 52 weeks is not available (see section 5.1).

Special populations

Elderly patients

No dose adjustment is required for this patient population (see sections 4.8 and 5.2).

Patients with renal impairment

No dose adjustment is needed in patients with mild and moderate renal impairment. The dose of apremilast should be reduced to 30 mg once daily in patients with severe renal impairment (creatinine clearance of less than 30 mL per minute estimated by the Cockcroft-Gault equation). For initial dose titration in this group, it is recommended that Otezla be titrated using only the AM schedule listed in Table 1 and the PM doses be skipped (see section 5.2).

Patients with hepatic impairment

No dose adjustment is necessary for patients with hepatic impairment (see section 5.2).

Paediatric population

The safety and efficacy of apremilast in children aged 0 to 17 years have not been established. No data are available.

Method of administration

Otezla is for oral use. The film-coated tablets should be swallowed whole, and can be taken either with or without food.

4.3 Contraindications

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

Pregnancy (see section 4.6).

4.4 Special warnings and precautions for use

Patients with rare hereditary problems of galactose intolerance, lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

Otezla should be dose reduced to 30 mg once daily in patients with severe renal impairment (see sections 4.2 and 5.2).

Patients who are underweight at the start of treatment should have their body weight monitored regularly. In the event of unexplained and clinically significant weight loss, these patients should be evaluated by a medical practitioner and discontinuation of treatment should be considered.

4.5 Interaction with other medicinal products and other forms of interaction

Co-administration of strong cytochrome P450 3A4 (CYP3A4) enzyme inducer, rifampicin, resulted in a reduction of systemic exposure of apremilast, which may result in a loss of efficacy of apremilast. Therefore, the use of strong CYP3A4 enzyme inducers (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin and St. John's Wort) with apremilast is not recommended. Co-administration of apremilast with multiple doses of rifampicin resulted in a decrease in apremilast area-under-the-concentration time curve (AUC) and maximum serum concentration (C_{max}) by approximately 72% and 43%, respectively. Apremilast exposure is decreased when administered concomitantly with strong inducers of CYP3A4 (e.g. rifampicin) and may result in reduced clinical response.

In clinical studies, apremilast has been administered concomitantly with topical therapy (including corticosteroids, coal tar shampoo and salicylic acid scalp preparations) and UVB phototherapy.

There was no clinically meaningful drug-drug interaction between ketoconazole and apremilast. Apremilast can be co-administered with a potent CYP3A4 inhibitor such as ketoconazole.

There was no pharmacokinetic drug-drug interaction between apremilast and methotrexate in psoriatic arthritis patients. Apremilast can be co-administered with methotrexate.

There was no pharmacokinetic drug-drug interaction between apremilast and oral contraceptives containing ethinyl estradiol and norgestimate. Apremilast can be co-administered with oral contraceptives.

4.6 Fertility, pregnancy and lactation

Women of childbearing potential

Pregnancy should be excluded before treatment can be initiated. Women of childbearing potential should use an effective method of contraception to prevent pregnancy during treatment.

Pregnancy

There are limited data about the use of apremilast in pregnant women.

Apremilast is contraindicated during pregnancy. Effects of apremilast on pregnancy included embryofetal loss in mice and monkeys, and reduced fetal weights and delayed ossification in mice at doses higher than the currently recommended highest human dose. No such effects were observed when exposure in animals was at 1.3-fold the clinical exposure (see section 5.3).

Breast-feeding

Apremilast was detected in milk of lactating mice (see section 5.3). It is not known whether apremilast, or its metabolites, are excreted in human milk. A risk to the breastfed infant cannot be excluded, therefore apremilast should not be used during breast-feeding.

Fertility

No fertility data is available in humans. In animal studies in mice, no adverse effects on fertility were observed in males at exposure levels 3-fold clinical exposure and in females at exposure levels 1-fold clinical exposure. For pre-clinical fertility data see section 5.3.

4.7 Effects on ability to drive and use machines

Apremilast has no influence on the ability to drive and use machines.

4.8 Undesirable effects

Summary of the safety profile

The most commonly reported adverse reactions in Phase III clinical studies have been gastrointestinal (GI) disorders including diarrhoea (15.7%) and nausea (13.9%). These GI adverse reactions were mostly mild to

moderate in severity, with 0.3% of diarrhoea and 0.3% of nausea reported as being severe. These adverse reactions generally occurred within the first 2 weeks of treatment and usually resolved within 4 weeks. The other most commonly reported adverse reactions included upper respiratory tract infections (8.4%), headache (7.9%), and tension headache (7.2%). Overall, most adverse reactions were considered to be mild or moderate in severity.

The most common adverse reactions leading to discontinuation during the first 16 weeks of treatment were diarrhoea (1.7%), and nausea (1.5%). The overall incidence of serious adverse reactions was low and did not indicate any specific system organ involvement.

Hypersensitivity reactions were uncommonly observed in apremilast clinical studies (see section 4.3).

Tabulated list of adverse reactions

The adverse reactions observed in patients treated with apremilast are listed below by system organ class (SOC) and frequency for all adverse reactions. Within each SOC and frequency grouping, adverse reactions are presented in order of decreasing seriousness.

The adverse drug reactions were determined based on data from the apremilast clinical development programme. The frequencies of adverse drug reactions are those reported in the apremilast arms of the four Phase III studies in PsA (n = 1945) or the two Phase III studies in PSOR (n=1184) (highest frequency from either data pool is represented in Table 2).

Frequencies are defined as: very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$).

Table 2. Summary of adverse reactions in phase III psoriatic arthritis (PsA) and/or psoriasis (PSOR) clinical studies

System Organ Class	Frequency	Adverse reaction
Infections and infestations	Common	Bronchitis
		Upper respiratory tract infection
		Nasopharyngitis*
Immune system disorders	Uncommon	Hypersensitivity
Metabolism and nutrition disorders	Common	Decreased appetite*
Psychiatric disorders	Common	Insomnia
Nervous system disorders	Common	Migraine*
		Tension headache*
		Headache*
Respiratory, thoracic, and mediastinal disorders	Common	Cough
Gastrointestinal disorders	Very Common	Diarrhoea*
		Nausea*
	Common	Vomiting*
		Dyspepsia
		Frequent bowel movements
		Upper abdominal pain *
		Gastroesophageal reflux disease

System Organ Class	Frequency	Adverse reaction
Skin and subcutaneous tissue disorders	Uncommon	Rash
Musculoskeletal and connective tissue disorders	Common	Back pain*
General disorders and administrative site conditions	Common	Fatigue
Investigations	Uncommon	Weight decrease

*At least one of these adverse reactions was reported as serious

Description of selected adverse reactions

Body weight loss

Patient weight was measured routinely in clinical studies. The mean observed weight loss in patients treated for up to 52 weeks with apremilast was 1.99 kg. A total of 14.3% of patients receiving apremilast had observed weight loss between 5-10% while 5.7% of the patients receiving apremilast had observed weight loss greater than 10%. None of these patients had overt clinical consequences resulting from weight loss. A total of 0.1% of patients treated with apremilast discontinued due to adverse reaction of weight decreased.

Please see additional warning in section 4.4 for patients who are underweight at beginning of treatment.

Depression

During the placebo-controlled period of the phase III clinical trials PSOR, 1.2% (14/1184) of patients treated with apremilast reported depression compared to 0.5% (2/418) treated with placebo. None of these reports of depression was serious or led to study discontinuation.

Special populations

Elderly patients

No overall differences were observed in the safety profile of elderly patients ≥ 65 years of age and younger adult patients < 65 years of age in the clinical studies.

Patients with hepatic impairment

The safety of apremilast was not evaluated in PsA or PSOR patients with hepatic impairment.

Patients with renal impairment

In the PsA or PSOR clinical studies, the safety profile observed in patients with mild renal impairment was comparable to patients with normal renal function. The safety of apremilast was not evaluated in PsA or PSOR patients with moderate or severe renal impairment in the clinical studies.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system listed in Appendix V.

4.9 Overdose

Apremilast was studied in healthy subjects at a maximum total daily dose of 100 mg (given as 50 mg BID) for 4.5 days without evidence of dose limiting toxicities. In case of an overdose, it is recommended that the patient is monitored for any signs or symptoms of adverse effects and appropriate symptomatic treatment is instituted. In the event of overdose, symptomatic and supportive care is advised.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Immunosuppressants, selective immunosuppressants, ATC code: L04AA32

Mechanism of action

Apremilast, an oral small-molecule inhibitor of phosphodiesterase 4 (PDE4), works intracellularly to modulate a network of pro-inflammatory and anti-inflammatory mediators. PDE4 is a cyclic adenosine monophosphate (cAMP)-specific PDE and the dominant PDE in inflammatory cells. PDE4 inhibition elevates intracellular cAMP levels, which in turn down-regulates the inflammatory response by modulating the expression of TNF- α , IL-23, IL-17 and other inflammatory cytokines. Cyclic AMP also modulates levels of anti-inflammatory cytokines such as IL-10. These pro- and anti-inflammatory mediators have been implicated in psoriatic arthritis and psoriasis.

Pharmacodynamics effects

In clinical studies in patients with psoriatic arthritis, apremilast significantly modulated, but did not fully inhibit, plasma protein levels of IL-1 α , IL-6, IL-8, MCP-1, MIP-1 β , MMP-3, and TNF- α . After 40 weeks of treatment with apremilast, there was a decrease in plasma protein levels of IL-17 and IL-23, and an increase in IL-10. In clinical trials in patients with psoriasis, apremilast decreased lesional skin epidermal thickness, inflammatory cell infiltration, and expression of pro-inflammatory genes, including those for inducible nitric oxide synthase (iNOS), IL-12/IL-23p40, IL-17A, IL-22 and IL-8.

Apremilast administered at doses of up to 50 mg BID did not prolong the QT interval in healthy subjects.

Clinical trials experience

Psoriatic Arthritis

The safety and efficacy of apremilast were evaluated in 3 multi-center, randomized, double-blind, placebo-controlled studies (Studies PALACE 1, PALACE 2, and PALACE 3) of similar design in adult patients with active PsA (≥ 3 swollen joints and ≥ 3 tender joints) despite prior treatment with small molecule or biologic DMARDs. A total of 1493 patients were randomised and treated with either placebo, apremilast 20 mg or apremilast 30 mg given orally twice daily.

Patients in these studies had a diagnosis of PsA for at least 6 months. One qualifying psoriatic skin lesion (at least 2 cm in diameter) was also required in PALACE 3. Apremilast was used as a monotherapy (34.8%) or in combination with stable doses of small molecule DMARDs (65.2%). Patients received apremilast in combination with one or more of the following: methotrexate (MTX, ≤ 25 mg/week, 54.5%), sulfasalazine (SSZ, ≤ 2 g/day, 9.0%), and leflunomide (LEF; ≤ 20 mg/day, 7.4%). Concomitant treatment with biologic DMARDs, including TNF blockers, was not allowed. Patients with each subtype of PsA were enrolled in the 3 studies, including symmetric polyarthritis (62.0%), asymmetric oligoarthritis (26.9%), distal interphalangeal (DIP) joint arthritis (6.2%), arthritis mutilans (2.7%), and predominant spondylitis (2.1%). Patients with pre-existing enthesopathy (63%) or pre-existing dactylitis (42%) were enrolled. A total of 76.4% of patients were previously treated with only small-molecule DMARDs and 22.4% of patients were previously treated with biologic DMARDs, which includes 7.8% who had a therapeutic failure with a prior biologic DMARD. The median duration of PsA disease was 5 years.

Based on the study design, patients whose tender and swollen joint counts had not improved by at least 20% were considered non-responders at Week 16. Placebo patients who were considered non-responders were re-randomized 1:1 in a blinded fashion to either apremilast 20 mg twice daily or 30 mg twice daily. At Week 24, all remaining placebo-treated patients were switched to either apremilast 20 or 30 mg BID. The primary endpoint was the percentage of patients achieving American College of Rheumatology (ACR) 20 response at Week 16.

Treatment with apremilast resulted in significant improvements in the signs and symptoms of PsA, as assessed by the ACR 20 response criteria compared to placebo at Weeks 16. The proportion of patients with ACR 20/50/70 (responses in Studies PALACE 1, PALACE 2 and PALACE 3, and the pooled data for studies PALACE 1, PALACE 2 and PALACE 3, for apremilast 30 mg twice daily at Week 16, are shown in Table 3. ACR 20/50/70 responses were maintained at Week 24.

Among patients who were initially randomized to apremilast 30 mg twice daily treatment, ACR 20/50/70 response rates were maintained through Week 52 in the pooled Studies PALACE 1, PALACE 2 and PALACE 3 (Figure 1).

Table 3. Proportion of patients with ACR responses in studies PALACE 1, PALACE 2 and PALACE 3 and pooled studies at Week 16

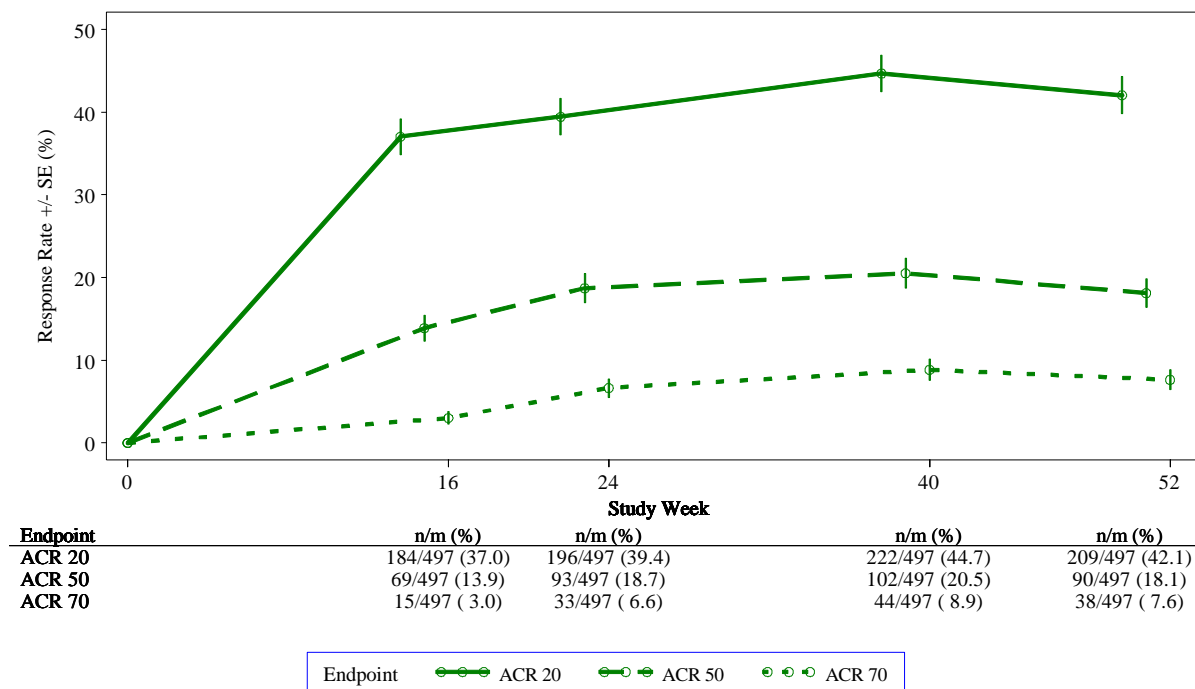
	<u>PALACE 1</u>		<u>PALACE 2</u>		<u>PALACE 3</u>		<u>POOLED</u>	
	<u>Placebo</u>	<u>Apremilast 30 mg BID</u>	<u>Placebo</u>	<u>Apremilast 30 mg BID</u>	<u>Placebo</u>	<u>Apremilast 30 mg BID</u>	<u>Placebo</u>	<u>Apremilast 30 mg BID</u>
	<u>+/- DMARDs N=168</u>	<u>+/- DMARDs N=168</u>	<u>+/- DMARDs N=159</u>	<u>+/- DMARDs N=162</u>	<u>+/- DMARDs N=169</u>	<u>+/- DMARDs N=167</u>	<u>+/- DMARDs N=496</u>	<u>+/- DMARDs N=497</u>
ACR 20^a								
Week 16	19.0%	38.1% **	18.9%	32.1% *	18.3%	40.7% **	18.8%	37.0% **
ACR 50								
Week 16	6.0%	16.1% *	5.0%	10.5%	8.3%	15.0%	6.5%	13.9% **
ACR 70								
Week 16	1.2%	4.2%	0.6%	1.2%	2.4%	3.6%	1.4%	3.0%

*p ≤ 0.01 for apremilast vs. placebo.

**p ≤ 0.001 for apremilast vs. placebo

^a N is the number of patients as randomized and treated.

Figure 1 Proportion of ACR 20/50/70 responders through Week 52 in the pooled analysis of studies PALACE 1, PALACE 2 and PALACE 3 (NRI*)



*NRI: None responder imputation. Subjects who discontinued early prior to the time point and subjects who did not have sufficient data for a definitive determination of response status at the time point are counted as non-responders.

Among 497 patients initially randomized to apremilast 30 mg twice daily, 375 (75%) patients were still on this treatment on Week 52. In these patients, ACR 20/50/70 responses at Week 52 were of 57%, 25%, and 11% respectively.

Responses observed in the apremilast treated group were similar in patients receiving and not receiving concomitant DMARDs, including MTX. Patients previously treated with DMARDs or biologics who received apremilast achieved a greater ACR 20 response at Week 16 than patients receiving placebo.

Similar ACR responses were observed in patients with different PsA subtypes, including DIP. The number of patients with arthritis mutilans and predominant spondylitis subtypes was too small to allow meaningful assessment.

In PALACE 1, PALACE 2 and PALACE 3, improvements in Disease Activity Scale (DAS) 28 C-reactive protein (CRP) and in the proportion of patients achieving a modified PsA response criteria (PsARC) were greater in the apremilast group, compared to placebo at Week 16 (nominal p-value $p \leq 0.0004$, p-value ≤ 0.0017 , respectively). These improvements were maintained at Week 24. Among patients who remained on the apremilast treatment to which they were randomized at study start, DAS28(CRP) score and PsARC response were maintained through Week 52.

At Weeks 16 and 24 improvements in parameters of peripheral activity characteristic of psoriatic arthritis (e.g. number of swollen joints, number of painful/tender joints, dactylitis and enthesitis) and in the skin manifestations of psoriasis were seen in the apremilast-treated patients. Among patients who remained on the apremilast treatment to which they were randomized at study start, these improvements were maintained through Week 52.

Physical function and health-related quality of life

Apremilast-treated patients demonstrated statistically significant improvement in physical function, as assessed by the disability index of the health assessment questionnaire (HAQ-DI) change from baseline,

compared to placebo at Weeks 16 in PALACE 1, PALACE 2 and PALACE 3 and in the pooled studies (Table 4). Improvement in HAQ-DI scores was maintained at Week 24.

Among patients who were initially randomized to apremilast 30 mg twice daily treatment, the change from baseline in the HAQ-DI score at week 52 was -0.333 in the apremilast 30 mg twice daily group in a pooled analysis of the open label phase of studies PALACE 1, PALACE 2 and PALACE 3.

In studies PALACE 1, PALACE 2 and PALACE 3, significant improvements were demonstrated in health-related quality of life, as measured by the changes from baseline in the physical functioning (PF) domain of the Short Form Health Survey version 2 (SF-36v2), and in the Functional Assessment of Chronic Illness Therapy – Fatigue (FACIT-fatigue) scores in patients treated with apremilast compared to placebo at Weeks 16 and 24. Among patients who remained on the apremilast treatment, to which they were initially randomized at study start, improvement in physical function and FACIT- fatigue was maintained through Week 52.

Psoriasis

The safety and efficacy of apremilast were evaluated in two multicenter, randomized, double-blind, placebo-controlled studies (Studies ESTEEM 1 and ESTEEM 2) which enrolled a total of 1257 patients with moderate to severe plaque psoriasis who had a body surface area (BSA) involvement of $\geq 10\%$, Psoriasis Area and Severity Index (PASI) score ≥ 12 , static Physician Global Assessment (sPGA) of ≥ 3 (moderate or severe), and who were candidates for phototherapy or systemic therapy.

These studies had a similar design through Week 32. In both studies, patients were randomized 2:1 to apremilast 30 mg BID or placebo for 16 weeks (placebo-controlled phase) and from Weeks 16-32, all patients received apremilast 30 mg BID (maintenance phase). During the Randomized Treatment Withdrawal Phase (Weeks 32-52), patients originally randomized to apremilast who achieved at least a 75% reduction in their PASI score (PASI-75) (ESTEEM 1) or a 50% reduction in their PASI score (PASI-50) (ESTEEM 2) were re-randomized at Week 32 to either placebo or apremilast 30 mg BID. Patients who were re-randomized to placebo and who lost PASI-75 response (ESTEEM 1) or lost 50% of the PASI improvement at Week 32 compared to baseline (ESTEEM 2) were retreated with apremilast 30 mg BID. Patients who did not achieve the designated PASI response by Week 32, or who were initially randomized to placebo, remained on apremilast until Week 52. The use of low potency topical corticosteroids on the face, axillae, and groin, coal tar shampoo and/or salicylic acid scalp preparations was permitted throughout the studies. In addition, at Week 32, subjects who did not achieve a PASI-75 response in ESTEEM 1, or a PASI-50 response in ESTEEM 2, were permitted to use topical psoriasis therapies and/or phototherapy in addition to apremilast 30 mg BID treatment.

In both studies, the primary endpoint was the proportion of patients who achieved PASI-75 at Week 16. The major secondary endpoint was the proportion of patients who achieved a sPGA score of clear (0) or almost clear (1) at Week 16.

The mean baseline PASI score was 19.07 (median 16.80), and the proportion of patients with sPGA score of 3 (moderate) and 4 (severe) at baseline was 70.0% and 29.8%, respectively with a mean baseline BSA involvement of 25.19% (median 21.0%). Approximately 30% of all patients had received prior phototherapy and 54% had received prior conventional systemic and/or biologic therapy for the treatment of psoriasis (including treatment failures), with 37% receiving prior conventional systemic therapy and 30% receiving prior biologic therapy. Approximately one-third of patients had not received prior phototherapy, conventional systemic or biologic therapy. A total of 18% of patients had a history of psoriatic arthritis.

The proportion of patients achieving PASI-50, -75 and -90 responses, and sPGA score of clear (0) or almost clear (1), are presented in Table 4 below. Treatment with apremilast resulted in significant improvement in moderate to severe plaque psoriasis as demonstrated by the proportion of patients with PASI-75 response at Week 16, compared to placebo. Clinical improvement measured by sPGA, PASI-50 and PASI-90 responses were also demonstrated at Week 16. In addition, apremilast demonstrated a treatment benefit across multiple manifestations of psoriasis including pruritus, nail disease, scalp involvement and quality of life measures.

Table 4. Clinical response at week 16 in studies ESTEEM 1 and ESTEEM 2 (FAS^a, LOCF^b)

	<u>ESTEEM 1</u>		<u>ESTEEM 2</u>	
	<u>Placebo</u>	<u>30 mg BID APR*</u>	<u>Placebo</u>	<u>30 mg BID APR*</u>
N	282	562	137	274
PASI^c 75, n (%)	15 (5.3)	186 (33.1)	8 (5.8)	79 (28.8)
sPGA^d of Clear or Almost Clear, n (%)	11 (3.9)	122 (21.7)	6 (4.4)	56 (20.4)
PASI 50, n (%)	48 (17.0)	330 (58.7)	27 (19.7)	152 (55.5)
PASI 90, n (%)	1 (0.4)	55 (9.8)	2 (1.5)	24 (8.8)
Percent Change BSA^e (%) mean± SD	- 6.9 ± 38.95	- 47.8 ± 38.48	- 6.1 ± 47.57	-48.4 ± 40.78
Change in Pruritus VAS^f (mm), mean± SD	- 7.3 ± 27.08	- 31.5 ± 32.43	- 12.2 ± 30.94	- 33.5 ±35.46
Change in DLQI^g, mean± SD	- 2.1 ± 5.69	- 6.6 ± 6.66	-2.8 ± 7.22	-6.7 ± 6.95
Change in SF-36 MCS^h, mean± SD	- 1.02 ± 9.161	2.39 ± 9.504	0.00 ±10.498	2.58 ± 10.129

* p< 0.0001 for apremilast vs placebo, except for ESTEEM 2 PASI 90 and Change in SF-36 MCS where p=0.0042 and p=0.0078, respectively.

^a FAS = Full Analysis Set

^b LOCF= Last Observation Carried forward

^c PASI = Psoriasis Area and Severity Index

^d sPGA = Static Physician Global Assessment

^e BSA = Body Surface Area

^f VAS = Visual Analog Scale; 0 = best, 100 = worst

^g DLQI = Dermatology Life Quality Index; 0 = best, 30 = worst

^h SF-36 MCS = Medical Outcome Study Short Form 36-Item Health Survey, Mental Component Summary

The clinical benefit of apremilast was demonstrated across multiple subgroups defined by baseline demographics and baseline clinical disease characteristics (including psoriasis disease duration and patients with a history of psoriatic arthritis). The clinical benefit of apremilast was also demonstrated regardless of prior psoriasis medication usage and response to prior psoriasis treatments. Similar response rates were observed across all weight ranges.

Response to apremilast was rapid, with significantly greater improvements in the signs and symptoms of psoriasis, including PASI, skin discomfort/pain and pruritus, compared to placebo by Week 2. In general, PASI responses were achieved by Week 16 and were maintained through Week 32.

In both studies, the mean percent improvement in PASI from baseline remained stable during the Randomized Treatment Withdrawal Phase for patients re-randomized to apremilast at Week 32 (Table 5).

Table 5. Persistence of effect among subjects randomized to APR 30 BID at Week 0 and re-randomized to APR 30 BID at Week 32 to Week 52

	<u>Time Point</u>	<u>ESTEEM 1</u>	<u>ESTEEM 2</u>
		<u>Patients who achieved PASI-75 at Week 32</u>	<u>Patients who achieved PASI-50 at Week 32</u>
Percent Change in PASI from baseline, mean (%) ± SD^a	Week 16	-77.7 ± 20.30	-69.7 ± 24.23
	Week 32	-88 ± 8.30	-76.7 ± 13.42

	<u>Time Point</u>	<u>ESTEEM 1</u>	<u>ESTEEM 2</u>
		<u>Patients who achieved PASI-75 at Week 32</u>	<u>Patients who achieved PASI-50 at Week 32</u>
	Week 52	-80.5 ± 12.60	-74.4 ± 18.91
Change in DLQI from baseline, mean ± SD^a	Week 16	-8.3 ± 6.26	-7.8 ± 6.41
	Week 32	-8.9 ± 6.68	-7.7 ± 5.92
	Week 52	-7.8 ± 5.75	-7.5 ± 6.27
Proportion of subjects with Scalp Psoriasis PGA (ScPGA) 0 or 1, n/N (%)^b	Week 16	40/48 (83.3)	21/37 (56.8)
	Week 32	39/48 (81.3)	27/37 (73.0)
	Week 52	35/48 (72.9)	20/37 (54.1)

^a Includes subjects re-randomized to APR 30 BID at Week 32 with a baseline value and a post-baseline value at the evaluated study week.

^b N is based on subjects with moderate or greater scalp psoriasis at baseline who were re-randomized to APR 30 BID at Week 32. Subjects with missing data were counted as nonresponders.

In Study ESTEEM 1, approximately 61% of patients re-randomized to apremilast at Week 32 had a PASI-75 response at Week 52. Of the patients with at least a PASI-75 response who were re-randomized to placebo at Week 32 during a Randomized Treatment Withdrawal Phase, 11.7% were PASI-75 responders at Week 52. The median time to loss of PASI-75 response among the patients re-randomized to placebo was 5.1 weeks.

In Study ESTEEM 2, approximately 80.3% of patients re-randomized to apremilast at Week 32 had a PASI-50 response at Week 52. Of the patients with at least a PASI-50 response who were re-randomized to placebo at Week 32, 24.2% were PASI-50 responders at Week 52. The median time to loss of 50% of their Week 32 PASI improvement was 12.4 weeks.

After randomized withdrawal from therapy at Week 32, approximately 70% of patients in Study ESTEEM 1, and 65.6% of patients in Study ESTEEM 2, regained PASI-75 (ESTEEM 1) or PASI-50 (ESTEEM 2) responses after re-initiation of apremilast treatment. Due to the study design the duration of re-treatment was variable, and ranged from 2.6 to 22.1 weeks.

In Study ESTEEM 1, patients randomized to apremilast at the start of the study who did not achieve a PASI-75 response at Week 32 were permitted to use concomitant topical therapies and/or UVB phototherapy between Weeks 32 to 52. Of these patients, 12% achieved a PASI-75 response at Week 52 with apremilast plus topical and/or phototherapy treatment.

In Studies ESTEEM 1 and ESTEEM 2, significant improvements (reductions) in nail psoriasis, as measured by the mean percent change in Nail Psoriasis Severity Index (NAPSI) from baseline, were observed in patients receiving apremilast compared to placebo-treated patients at Week 16 ($p < 0.0001$ and $p = 0.0052$, respectively). Further improvements in nail psoriasis were observed at Week 32 in patients continuously treated with apremilast.

In Studies ESTEEM 1 and ESTEEM 2, significant improvements in scalp psoriasis of at least moderate severity (≥ 3), measured by the proportion of patients achieving Scalp Psoriasis Physician's Global Assessment (ScPGA) of clear (0) or minimal (1) at Week 16, were observed in patients receiving apremilast compared to placebo-treated patients ($p < 0.0001$ for both studies). The improvements were generally maintained in subjects who were re-randomized to Otezla at Week 32 through Week 52 (Table 5).

In Studies ESTEEM 1 and ESTEEM 2, significant improvements in quality of life as measured by the Dermatology Life Quality Index (DLQI) and the SF-36v2MCS were demonstrated in patients receiving apremilast compared with placebo-treated patients (Table 4). Improvements in DLQI were maintained through Week 52 in subjects who were re-randomized to apremilast at Week 32 (Table 5). In addition, in Study ESTEEM 1, significant improvement in the Work Limitations Questionnaire (WLQ-25) Index was achieved in patients receiving apremilast compared to placebo.

5.2 Pharmacokinetic properties

Absorption

Apremilast is well absorbed with an absolute oral bioavailability of approximately 73%, with peak plasma concentrations (C_{max}) occurring at a median time (t_{max}) of approximately 2.5 hours. Apremilast pharmacokinetics are linear, with a dose-proportional increase in systemic exposure in the dose range of 10 to 100 mg daily. Accumulation is minimal when apremilast is administered once daily and approximately 53% in healthy subjects and 68% in patients with psoriasis when administered twice daily. Co-administration with food does not alter the bioavailability therefore, apremilast can be administered with or without food.

Distribution

Human plasma protein binding of apremilast is approximately 68%. The mean apparent volume of distribution (V_d) is 87 L, indicative of extravascular distribution.

Biotransformation

Apremilast is extensively metabolised by both CYP and non-CYP mediated pathways including oxidation, hydrolysis, and conjugation, suggesting inhibition of a single clearance pathway is not likely to cause a marked drug-drug interaction. Oxidative metabolism of apremilast is primarily mediated by CYP3A4, with minor contributions from CYP1A2 and CYP2A6. Apremilast is the major circulating component following oral administration. Apremilast undergoes extensive metabolism with only 3% and 7% of the administered parent compound recovered in urine and faeces, respectively. The major circulating inactive metabolite is the glucuronide conjugate of *O*-demethylated apremilast (M12). Consistent with apremilast being a substrate of CYP3A4, apremilast exposure is decreased when administered concomitantly with rifampicin, a strong inducer of CYP3A4.

In vitro, apremilast is not an inhibitor or inducer of cytochrome P450 enzymes. Hence, apremilast co-administered with substrates of CYP enzymes is unlikely to affect the clearance and exposure of active substances that are metabolised by CYP enzymes.

In vitro, apremilast is a substrate, and a weak inhibitor of P-glycoprotein ($IC_{50} > 50 \mu M$), however clinically relevant drug interactions mediated via P-gp are not expected to occur.

In vitro, apremilast has little to no inhibitory effect ($IC_{50} > 10 \mu M$) on Organic Anion Transporter (OAT)1 and OAT3, Organic Cation Transporter (OCT)2, Organic Anion Transporting Polypeptide (OATP)1B1 and OATP1B3, or breast cancer resistance protein (BCRP) and is not a substrate for these transporters. Hence, clinically relevant drug-drug interactions are unlikely when apremilast is co-administered with drugs that are substrates or inhibitors of these transporters.

Elimination

The plasma clearance of apremilast is on average about 10 L/hr in healthy subjects, with a terminal elimination half-life of approximately 9 hours. Following oral administration of radiolabelled apremilast, about 58% and 39% of the radioactivity is recovered in urine and faeces, respectively, with about 3% and 7% of the radioactive dose recovered as apremilast in urine and faeces, respectively.

Elderly patients

Apremilast was studied in young and elderly healthy subjects. The exposure in elderly subjects (65 to 85 years of age) is about 13% higher in AUC and about 6% higher in C_{max} for apremilast than that in young subjects (18 to 55 years of age). There is limited pharmacokinetic data in subjects over 75 years of age in clinical trials. No dosage adjustment is necessary for elderly patients.

Renal impairment

There is no meaningful difference in the PK of apremilast between mild or moderate renal impaired subjects and matched healthy subjects (N=8 each). The results support that no dose adjustment is needed in patients with mild and moderate renal impairment. Reduce apremilast dose to 30 mg once daily in patients with severe renal impairment (eGFR less than 30 mL/min/1.73 m² or CLcr < 30 mL/min). In 8 subjects with severe renal impairment to whom a single dose of 30 mg apremilast was administered, the AUC and C_{max} of apremilast increased by approximately 89% and 42%, respectively.

Hepatic impairment

The pharmacokinetics of apremilast and its major metabolite M12 are not affected by moderate or severe hepatic impairment. No dose adjustment is necessary for patients with hepatic impairment.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology and repeated dose toxicity. There is no evidence for immunotoxic, dermal irritation, or phototoxic potential.

Fertility and early embryonic development

In a male mouse fertility study, apremilast at oral dosages of 1, 10, 25, and 50 mg/kg/day produced no effects on male fertility; the no observed adverse effect level (NOAEL) for male fertility was greater than 50 mg/kg/day 3-fold clinical exposure).

In a combined female mouse fertility and embryo-fetal developmental toxicity study with oral dosages of 10, 20, 40, and 80 mg/kg/day, a prolongation of oestrous cycles and increased time to mating were observed at 20 mg/kg/day and above; despite this, all mice mated and pregnancy rates were unaffected. The no observed effect level (NOEL) for female fertility was 10 mg/kg/day (1.0-fold clinical exposure).

Embryo-fetal development

In a combined female mouse fertility and embryo-fetal developmental toxicity study with oral dosages of 10, 20, 40, and 80 mg/kg/day, absolute and/or relative heart weights of maternal animals were increased at 20, 40, and 80 mg/kg/day. Increased numbers of early resorptions and reduced numbers of ossified tarsals were observed at 20, 40, and 80 mg/kg/day. Reduced fetal weights and retarded ossification of the supraoccipital bone of the skull were observed at 40 and 80 mg/kg/day. The maternal and developmental NOEL in the mouse was 10 mg/kg/day (1.3-fold clinical exposure).

In a monkey embryo-fetal developmental toxicity study, oral dosages of 20, 50, 200, and 1000 mg/kg/day resulted in a dose-related increase in prenatal loss (abortions) at dosages of 50 mg/kg/day and above; no test article-related effect in prenatal loss was observed at 20 mg/kg/day (1.4-fold clinical exposure).

Pre- and post-natal development

In a pre- and postnatal study, apremilast was administered orally to pregnant female mice at dosages of 10, 80 and 300 mg/kg/day from gestation day (GD) 6 to Day 20 of lactation. Reductions in maternal body weight and weight gain, and one death associated with difficulty in delivering pups were observed at 300 mg/kg/day. Physical signs of maternal toxicity associated with delivering pups were also observed in one mouse at each of 80 and 300 mg/kg/day. Increased peri- and postnatal pup deaths and reduced pup body weights during the first week of lactation were observed at ≥ 80 mg/kg/day (≥ 4.0 -fold clinical exposure). There were no apremilast-related effects on duration of pregnancy, number of pregnant mice at the end of the gestation period, number of mice that delivered a litter, or any developmental effects in the pups beyond postnatal day 7. It is likely that pup developmental effects observed during the first week of the postnatal period were related to the apremilast-related pup toxicity (decreased pup weight and viability) and/or lack of maternal care (higher incidence of no milk in the stomach of pups). All developmental effects were observed during the first week of the postnatal period; no apremilast-related effects were seen during the remaining pre- and post-weaning periods, including sexual maturation, behavioural, mating, fertility and uterine parameters. The NOEL in the mouse for maternal toxicity and F1 generation was 10 mg/kg/day (1.3-fold clinical AUC).

Carcinogenicity studies

Carcinogenicity studies in mice and rats showed no evidence of carcinogenicity related to treatment with apremilast.

Genotoxicity studies

Apremilast is not genotoxic. Apremilast did not induce mutations in an Ames assay or chromosome aberrations in cultured human peripheral blood lymphocytes in the presence or absence of metabolic activation. Apremilast was not clastogenic in an in vivo mouse micronucleus assay at doses up to 2000 mg/kg/day.

Other studies

There is no evidence for immunotoxic, dermal irritation, or phototoxic potential.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Microcrystalline cellulose
Lactose monohydrate
Croscarmellose sodium
Magnesium stearate.

Film-coating

Polyvinyl alcohol
Titanium dioxide (E171)
Macrogol 3350
Talc
Iron oxide red (E172).

The 30 mg tablets also contain iron oxide yellow (E172) and iron oxide black(E172).

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

21 months.

6.4 Special precautions for storage

Do not store above 30°C.

6.5 Nature and contents of container

PVC/ aluminium foil blisters containing 14 film- coated tablets, in pack sizes of 56 tablets (30 mg) and 168 tablets (30 mg).

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

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

7. MARKETING AUTHORISATION HOLDER

Celgene Europe Ltd.
1 Longwalk Road
Stockley Park
Uxbridge
UB11 1DB
United Kingdom

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/981/002
EU/1/14/981/003

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

10. DATE OF REVISION OF THE TEXT

Detailed information on this medicinal product is available on the website of the European Medicines Agency <http://www.ema.europa.eu>.

ANNEX II

- A. MANUFACTURER RESPONSIBLE FOR BATCH RELEASE**
- B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE**
- C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION**
- D. CONDITIONS OR RESTRICTIONS WITH REGARD TO THE SAFE AND EFFECTIVE USE OF THE MEDICINAL PRODUCT**

A. MANUFACTURER RESPONSIBLE FOR BATCH RELEASE

Name and address of the manufacturer responsible for batch release

Celgene Europe Limited
1 Longwalk Road
Stockley Park
Uxbridge
Middlesex
UB11 1DB
United Kingdom

B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE

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

C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION

• Periodic safety update reports

The marketing authorisation holder shall submit the first periodic safety update report for this product within 6 months following authorisation. Subsequently, the marketing authorisation holder shall submit periodic safety update reports for this product in accordance with the requirements set out in the list of Union reference dates (EURD list) provided for under Article 107c(7) of Directive 2001/83/EC and published on the European medicines web-portal.

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

• Risk Management Plan (RMP)

The MAH shall perform the required pharmacovigilance activities and interventions detailed in the agreed RMP presented in Module 1.8.2 of the Marketing Authorisation and any agreed subsequent updates of the RMP.

An updated RMP should be submitted:

- At the request of the European Medicines Agency;
- Whenever the risk management system is modified, especially as the result of new information being received that may lead to a significant change to the benefit/risk profile or as the result of an important (pharmacovigilance or risk minimisation) milestone being reached.

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

ANNEX III
LABELLING AND PACKAGE LEAFLET

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING
Wallet card containing 2-week treatment initiation pack

1. NAME OF THE MEDICINAL PRODUCT

Otezla 10 mg film-coated tablets
Otezla 20 mg film-coated tablets
Otezla 30 mg film-coated tablets
apremilast

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each film-coated tablet contains 10 mg, 20 mg or 30 mg of apremilast.

3. LIST OF EXCIPIENTS

Contains lactose. See package leaflet for further information.

4. PHARMACEUTICAL FORM AND CONTENTS

Film-coated tablets
Treatment initiation pack
4 film-coated tablets of 10 mg
4 film-coated tablets of 20 mg
19 film-coated tablets of 30 mg

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Read the package leaflet before use.
For oral use.

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

Keep out of the sight and reach of children.

7. OTHER SPECIAL WARNING(S), IF NECESSARY

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

Do not store above 30°C.

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

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

Celgene Europe Ltd.
1 Longwalk Road
Stockley Park
Uxbridge
UB11 1DB
United Kingdom

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/981/001

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

Medicinal product subject to medical prescription.

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Otezla 10 mg
Otezla 20 mg
Otezla 30 mg

MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS

Blister (Particulars printed directly onto the wallet card with the blank blister sealed inside)

1. NAME OF THE MEDICINAL PRODUCT

Otezla 10 mg tablets
Otezla 20 mg tablets
Otezla 30 mg tablets

apremilast

2. NAME OF THE MARKETING AUTHORISATION HOLDER

Celgene

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. OTHER

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

Carton

1. NAME OF THE MEDICINAL PRODUCT

Otezla 30 mg film-coated tablets
apremilast

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each film-coated tablet contains 30 mg of apremilast.

3. LIST OF EXCIPIENTS

Contains lactose. See leaflet for further information.

4. PHARMACEUTICAL FORM AND CONTENTS

Film-coated tablets
56 film-coated tablets
168 film-coated tablets

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Read the package leaflet before use.
For oral use.

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

Keep out of the sight and reach of children.

7. OTHER SPECIAL WARNING(S), IF NECESSARY

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

Do not store above 30°C.

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

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

Celgene Europe Ltd.
1 Longwalk Road
Stockley Park
Uxbridge
UB11 1DB
United Kingdom

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/981/002
EU/1/14/981/003

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

Medicinal product subject to medical prescription.

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Otezla 30 mg

MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS

BLISTER

1. NAME OF THE MEDICINAL PRODUCT

Otezla 30 mg tablets
apremilast

2. NAME OF THE MARKETING AUTHORISATION HOLDER

Celgene

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. OTHER

B. PACKAGE LEAFLET

Package leaflet: Information for the patient

Otezla 10 mg film-coated tablets

Otezla 20 mg film-coated tablets

Otezla 30 mg film-coated tablets

Apremilast

▼ This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get. See the end of section 4 for how to report side effects.

Read all of this leaflet carefully before you start taking this medicine - because it contains important information for you.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor, pharmacist or nurse.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet

1. What Otezla is and what it is used for
2. What you need to know before you take Otezla
3. How to take Otezla
4. Possible side effects
5. How to store Otezla
6. Contents of the pack and other information

1. What Otezla is and what it is used for

What Otezla is

Otezla contains the active substance 'apremilast'. This belongs to a group of medicines called phosphodiesterase 4 inhibitors, which help to reduce inflammation.

What Otezla is used for

Otezla is used to treat adults with the following conditions:

- **Psoriatic arthritis** - if you cannot use another type of medicine called 'Disease-Modifying Antirheumatic Drugs' (DMARDs) or when you have tried one of these medicines and it did not work.
- **Moderate to severe plaque psoriasis** - if you cannot use one of the following treatments or when you have tried one of these treatments and it did not work:
 - phototherapy - a treatment where certain areas of skin are exposed to ultraviolet light
 - systemic therapy - a treatment that affects the entire body rather than just one local area, such as 'ciclosporin' or 'methotrexate'.

What psoriatic arthritis is

Psoriatic arthritis is an inflammatory disease of the joints, usually accompanied by psoriasis, an inflammatory disease of the skin.

What plaque psoriasis is

Psoriasis is an inflammatory disease of the skin, which can cause red, scaly, thick, itchy, painful patches on your skin and can also affect your scalp and nails.

How Otezla works

Psoriatic arthritis and psoriasis are usually lifelong conditions and there is currently no cure. Otezla works by reducing the activity of an enzyme in the body called ‘phosphodiesterase 4’, which is involved in the process of inflammation. By reducing the activity of this enzyme, Otezla can help to control the inflammation associated with psoriatic arthritis and psoriasis, and thereby reduce the signs and symptoms of these conditions.

In psoriatic arthritis, treatment with Otezla results in an improvement in swollen and painful joints, and can improve your general physical function.

In psoriasis, treatment with Otezla results in a reduction in psoriatic skin plaques and other signs and symptoms of the disease.

Otezla has also been shown to improve the quality of life in patients with psoriasis or psoriatic arthritis. This means that the impact of your condition on daily activities, relationships and other factors should be less than it was before.

2. What you need to know before you take Otezla

Do not take Otezla:

- if you are allergic to apremilast or any of the other ingredients of this medicine (listed in section 6).
- if you are pregnant or think you may be pregnant.

Warnings and precautions

Talk to your doctor or pharmacist before taking Otezla.

If your doctor considers you to be underweight, and you observe an unintentional loss of body weight while being treated with Otezla, you should talk to your doctor.

If you have severe kidney problems then the recommended dose of Otezla is 30 mg **once a day (morning dose)**. Your doctor will talk to you about how to increase your dose when you first start taking Otezla.

Children and adolescents

Otezla has not been studied in children and adolescents, therefore it is not recommended for use in children and adolescents aged 17 years and under.

Other medicines and Otezla

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

In particular, tell your doctor or pharmacist before taking Otezla if you are taking any of the following medicines:

- rifampicin – an antibiotic used for tuberculosis
- phenytoin, phenobarbital and carbamazepine - medicines used in the treatment of seizures or epilepsy
- St John’s Wort – a herbal medicine for mild anxiety and depression.

Pregnancy and breast-feeding

There is little information about the effects of Otezla in pregnancy. You should not become pregnant while taking this medicine and should use an effective method of contraception during treatment with Otezla. It is not known if this medicine passes into human milk. You should not use Otezla while breast-feeding.

Tell your doctor if you think you may be pregnant or are planning to have a baby, or if you are breast-feeding or intend to breast-feed.

Driving and using machines

Otezla has no effect on the ability to drive and use machines.

Otezla contains lactose

Otezla contains lactose (a type of sugar). If you have been told by your doctor that you cannot tolerate or digest some sugars, talk to your doctor before taking this medicine.

3. How to take Otezla

Always take this medicine exactly as your doctor has told you. Check with your doctor or pharmacist if you are not sure.

How much to take

- When you first start taking Otezla, you will receive a ‘treatment initiation pack’ which contains all the doses as listed in the table below.
- The ‘treatment initiation pack’ is clearly labelled to make sure you take the correct tablet at the correct time.
- Your treatment will start at a lower dose and will gradually be increased over the first 6 days of treatment.
- The ‘treatment initiation pack’ will also contain enough tablets for another 8 days at the recommended dose (Days 7 to 14).
- The recommended dose of Otezla is 30 mg twice a day after the titration phase is complete - one 30 mg dose in the morning and one 30 mg dose in the evening, approximately 12 hours apart, with or without food.
- This is a total daily dose of 60 mg. By the end of Day 6 you will have reached this recommended dose.
- Once the recommended dose has been reached, you will only get the 30 mg tablet strength in your prescribed packs. You will only ever need to go through this stage of gradually increasing your dose once even if you re-start treatment.

Day	Morning Dose	Evening Dose	Total Daily Dose
Day 1	10 mg (pink)	Do not take a dose	10 mg
Day 2	10 mg (pink)	10 mg (pink)	20 mg
Day 3	10 mg (pink)	20 mg (brown)	30 mg
Day 4	20 mg (brown)	20 mg (brown)	40 mg
Day 5	20 mg (brown)	30 mg (beige)	50 mg
Day 6 onwards	30 mg (beige)	30 mg (beige)	60 mg

People
kidney

with

problems

If you have severe kidney problems then the recommended dose of Otezla is 30 mg **once a day (morning dose)**. Your doctor will talk to you about how to increase your dose when you first start taking Otezla.

How and when to take Otezla

- Swallow the tablets whole, preferably with water.
- You can take the tablets either with or without food.
- Take Otezla at about the same time each day, one tablet in the morning and one tablet in the evening.

- If your condition has not improved after six months of treatment, you should talk to your doctor.

If you take more Otezla than you should

If you take more Otezla than you should, talk to a doctor or go to a hospital straight away. Take the medicine pack and this leaflet with you.

If you forget to take Otezla

- If you miss a dose of Otezla, take it as soon as you remember. If it is close to the time for your next dose, just skip the missed dose. Take the next dose at your regular time.
- Do not take two doses at the same time.

If you stop taking Otezla

- You should continue taking Otezla until your doctor tells you to stop.
- Do not stop taking Otezla without talking to your doctor first.

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

4. Possible side effects

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

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

- diarrhoea
- nausea

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

- cough
- back pain
- vomiting
- feeling tired
- stomach pain
- loss of appetite
- frequent bowel movements
- difficulty sleeping (insomnia)
- indigestion or heartburn
- headaches, migraines or tension headaches
- upper respiratory tract infections such as cold, runny nose, sinus infection.
- inflammation and swelling of the tubes in your lungs (bronchitis).
- common cold (nasopharyngitis)

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

- rash
- weight loss
- allergic reaction

If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet.

Reporting of side effects

If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly **via the national reporting system listed in Appendix V**. By reporting side effects you can help provide more information on the safety of this medicine.

5. How to store Otezla

- Keep this medicine out of the sight and reach of children.
- Do not use this medicine after the expiry date which is stated on the blister and carton after EXP. The expiry date refers to the last day of that month.
- Do not store above 30°C.
- Do not use Otezla if you notice any damage or signs of tampering to the medicine packaging.

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

6. Contents of the pack and other information

What Otezla contains

- The active substance is apremilast.
- Each film-coated tablet contains 10 mg of apremilast.
- Each film-coated tablet contains 20 mg of apremilast.
- Each film-coated tablet contains 30 mg of apremilast.

- The other ingredients in the tablet core are microcrystalline cellulose, lactose monohydrate, croscarmellose sodium and magnesium stearate.
- The film-coating contains polyvinyl alcohol, titanium dioxide (E171), - macrogol, talc, iron oxide red (E172).
- The 20 mg film-coated tablet also contains iron oxide yellow (E172).
- The 30 mg film-coated tablet also contains iron oxide yellow (E172) and iron oxide black (E172).

What Otezla looks like and contents of the pack

The Otezla 10 mg film-coated tablet is a pink, diamond shaped film-coated tablet with “APR” engraved on one side and “10” on the opposite side.

The Otezla 20 mg film-coated tablet is a brown, diamond shaped film-coated tablet with “APR” engraved on one side and “20” on the opposite side.

The Otezla 30 mg film-coated tablet is a beige, diamond shaped film-coated tablet with “APR” engraved on one side and “30” on the opposite side.

Pack sizes

- The treatment initiation pack is a folding wallet containing 27 tablets: 4 x 10 mg tablets, 4 x 20 mg tablets and 19 x 30 mg tablets.
- The one-month standard pack contains 56 x 30 mg tablets.
- The three-month standard pack contains 168 x 30 mg tablets.

Marketing Authorisation Holder and Manufacturer

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Other sources of information

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