Submitted by:
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Date of request: April 10, 2012
NCCN Guidelines Panel: Multiple Myeloma

On behalf of Millennium Pharmaceuticals, Inc., I respectfully request the NCCN Multiple Myeloma Guidelines Panel to review the enclosed data on the use of VELCADE® (bortezomib) as maintenance therapy in patients with multiple myeloma.

Specific Changes:
Inclusion of new data from studies employing bortezomib-based maintenance in the Myeloma Therapy section (MYEL-D) of the NCCN Clinical Practice Guidelines (NCCN Guidelines™) in Multiple Myeloma. Specifically:

- Inclusion of bortezomib + thalidomide as a category 1 recommendation for maintenance therapy, based on recently presented data from a Spanish phase III trial in transplant-eligible patients, and supported by recently presented data from a Spanish phase III trial in transplant-ineligible patients
- Inclusion of bortezomib + prednisone as a category 2A recommendation for maintenance therapy, based on recently presented data from a Spanish phase III trial in transplant-ineligible patients

In addition, inclusion of these new data is warranted within the narrative section of the Guidelines, specifically on pages M20–M21 of version V1.2012, where the current data on bortezomib as maintenance therapy are included.

FDA Clearance: The FDA has approved VELCADE for the treatment of multiple myeloma. The US Prescribing Information describes a standard schedule and a maintenance schedule, albeit a different schedule than the studies described in this document. Data from the studies referenced below are not included in the US Prescribing Information for VELCADE.

Rationale: New data were presented at the 2011 Annual Meeting of the American Society of Hematology (ASH) from the Spanish GEM05MENOS65 phase III randomized trial. Findings were reported from the second randomization of the study, following autologous stem cell transplantion, at which patients were assigned to maintenance therapy with either bortezomib-thalidomide (VT), thalidomide alone, or alfa-2b-interferon. Results showed that:

- Maintenance with VT, thalidomide, or alfa-2b-interferon increased the complete response (CR) rate by 23%, 11%, and 19%, respectively, from post-transplant CR rates of 52%, 49%, and 50%, respectively
- After a median follow-up of 24 months, progression-free survival from the onset of maintenance was significantly longer with VT versus thalidomide and alfa-2b-interferon, with 2-year rates of 78%, 63%, and 49%, respectively (p=0.01)
- Overall survival was not significantly different between the three arms, after median follow-up of 24 months
- Grade 3/4 hematologic toxicity rates were similar (22.2% vs. 16% vs. 21.8%) between maintenance regimens
- Rates of grade 3 peripheral neuropathy were 12%, 10%, and 0, respectively, and rates of discontinuation due to toxicity were 15%, 30%, and 18%, respectively, with VT, thalidomide, and alfa-2b-interferon

New data were also presented at ASH 2011 from the Spanish GEM2005MAS65 phase III randomized trial in transplant-ineligible patients. Findings were reported from the second randomization of the study, following initial bortezomib-based induction therapy, at which patients were assigned to maintenance therapy with either VT or bortezomib-prednisone (VP). Results showed that:

- After a median of 20 months of maintenance therapy with VT or VP, the overall CR rate increased from 24% to 42% (VT: 46%, VP: 39%; difference between the two maintenance regimens was not significant)
- After a median follow-up of 46 months from the initial randomization to induction therapy, the overall median progression-free survival among patients receiving maintenance was 35 months regardless of the maintenance regimen (VT: 39 months, VP: 32 months; p=0.1)
- The median overall survival for all patients receiving maintenance had not been reached, and the 5-year survival rate was 51% (VT: median not reached, VP: median overall survival 60 months; p=0.1)
- Rates of discontinuation due to toxicity were 13% with VT and 9% with VP, and respective rates of grade 1-2 peripheral neuropathy were 37% and 17%, and of grade 3-4 peripheral neuropathy were 9% and 3%

The following enclosures are submitted in support of the above proposed changes.

- Rosiñol L et al. A Phase III PETHEMA/GEM Randomized Trial of Postransplant (ASCT) Maintenance in Multiple Myeloma: Superiority of Bortezomib/Thalidomide Compared with Thalidomide and Alfa-2b Interferon. *Blood*. 2011;118(22):abstract #3962; poster presentation at the 2011 Annual Meeting of the American Society of Hematology
- Mateos M-V et al. Maintenance Therapy with Bortezomib Plus Thalidomide (VT) or Bortezomib Plus Prednisone (VP) In Elderly Myeloma Patients Included In the GEM2005MAS65 Spanish Randomized Trial. *Blood*. 2011;118(22):abstract #477; oral presentation at the 2011 Annual Meeting of the American Society of Hematology
- VELCADE (bortezomib) for Injection. United States prescribing information, Rev 13, issued January 2012.

Yours sincerely

Oliver Rosen, MD
Vice President, Global Medical Affairs

Blood 2011;118(21): abstract #3962

A Phase III PETHEMA/GEM Randomized Trial of Postransplant (ASCT) Maintenance in Multiple Myeloma: Superiority of Bortezomib/Thalidomide Compared with Thalidomide and Alfa-2b Interferon

Laura Rosiñol, MD[1*], María Teresa Cibeira[1*], Maria Victoria Mateos[2*], Joaquin Martinez, MD[3*], Albert Oriol[4*], Ana Isabel Teruel[5*], Dolores Hernández[6*], Javier López, MD[7*], Javier de la Rubia[8*], Miquel Granell, MD[9*], Juan Besalduch, MD, PhD[10], Luis Palomera[11*], Yolanda González, MD[12*], Maria Asunción Etxebeste, MD[13*], Joaquín Díaz-Mediavilla[14*], Miguel T Hernández, MD[15*], Felipe de Arriba[16*], Adrian Alegre[17], Juan José Lahuerta[18*], Jesus F San Miguel, MD PhD[19] and Joan Blade[20]

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Introduction: In April 2006, the Spanish Myeloma Group (PETHEMA/GEM) activated a randomized phase III trial comparing induction with TD vs. VTD vs. VBMCP/VBAD/Bortezomib (VBMCP/VBAD/B) in patients 65 years-old or younger with newly diagnosed symptomatic MM and ASCT with MEL-200 followed by maintenance with thalidomide/bortezomib (TV) vs. thalidomide (T) vs. alfa-2b-interferon (alfa2-IFN). Primary end points: response rate after induction and after ASCT and time to progression.
Patients and Methods: The maintenance program consisted of TV (thalidomide 100 mg daily plus one cycle of bortezomib-1.3 mg/m2 on days 1, 4, 8 and 11 every 3 months) versus T (single agent thalidomide at a dose of 100 mg daily) versus alfa2-IFN (subcutaneous alfa2b-IFN at a dose of 3 MU three times per week). The planned maintenance duration was three years or until disease progression or toxicity. From February 1, 2007 to January 27, 2011 266 patients were randomized to

maintenance therapy (TV:90; T: 89, alfa2-IFN: 87). Response and survival were evaluated on an intention-to-treat basis. Responses and progressions reported by the investigators were centrally reassessed.

Results: the patient's characteristics at diagnosis such as age, ISS stage, cytogenetics and presence of extramedullary plasmacytomas as well as induction regimen (VTD, TD and VBMCP/VBAD/Bortezomib) and diagnosis-randomization interval were similarly distributed among the 3 arms. The response status at the time of randomization after ASCT was CR: 51%, VGPR: 23%, PR: 24% and SD: 2% and was well balanced in the three groups. The CR rate with maintenance was improved by 23% with TV, 11% with T and 19% with alfa2-IFN (p=NS). After a median follow-up of 24 months, the PFS was significantly longer with TV compared with T and alfa2-IFN (PFS at 2 yrs: 78% vs. 63% vs. 49%, p=0.01). However, OS was not significantly different among the 3 arms. Grade 3 and 4 hematological toxicity was similar (22.2% vs. 16% vs. 21.8%). No peripheral neuropathy (PN) was observed with alfa2-IFN being its frequency similar with TV (12.2%) and T (10.1%). No grade IV PN was observed. Dose reductions for TV, T and alfa2-IFN were required in 33.3%, 33.7% and 19.5% of the patients, respectively. The discontinuation rate due to toxicity was significantly higher with thalidomide compared with TV (30.3% vs. 15.6%, p= 0.08) and with alfa2-IFN (30.3% vs. 18.3%, p= 0.17).

Conclusion: the addition of bortezomib to thalidomide maintenance resulted in a significantly longer PFS when compared with thalidomide alone or with IFN with no increased toxicity.

A Phase III PETHEMA/GEM Randomized Trial of Postransplant (ASCT) Maintenance in Multiple Myeloma: Superiority of Bortezomib /Thalidomide Compared with Thalidomide and alfa-2b Interferon.

Laura Rosiñol, Mª Teresa Cibeira, Mª Victoria Mateos, Joaquín Martínez, Albert Oriol, Ana Isabel Teruel, Dolores Hernández, Javier López Jiménez, Javier de la Rubia, Miquel Granell, Joan Besalduch, Luis Palomera, Yolanda González, Mª Asunción Etxebeste, Joaquín Díaz-Mediavilla, Miguel T. Hernández, Felipe de Arriba, Adrián Alegre, Juan José Lahuerta, Jesús San Miguel and Joan Bladé

On behalf of PETHEMA group

CLÍNIC
BARCELONA
Hospital Universitari

Background

- Autologous stem cell transplantation (ASCT) has become the standard of care in the up-front therapy of younger patients with multiple myeloma.

- The achievement of a complete remission (CR) post-ASCT is the crucial step for long-lasting response and prolonged survival.

- The role of postransplant maintenance therapy is not well stablished.

Aim

- To investigate the efficacy and safety of three maintenance regimens after ASCT:
  - Alfa2-IFN
  - Thalidomide
  - Thalidomide/bortezomib

Aim

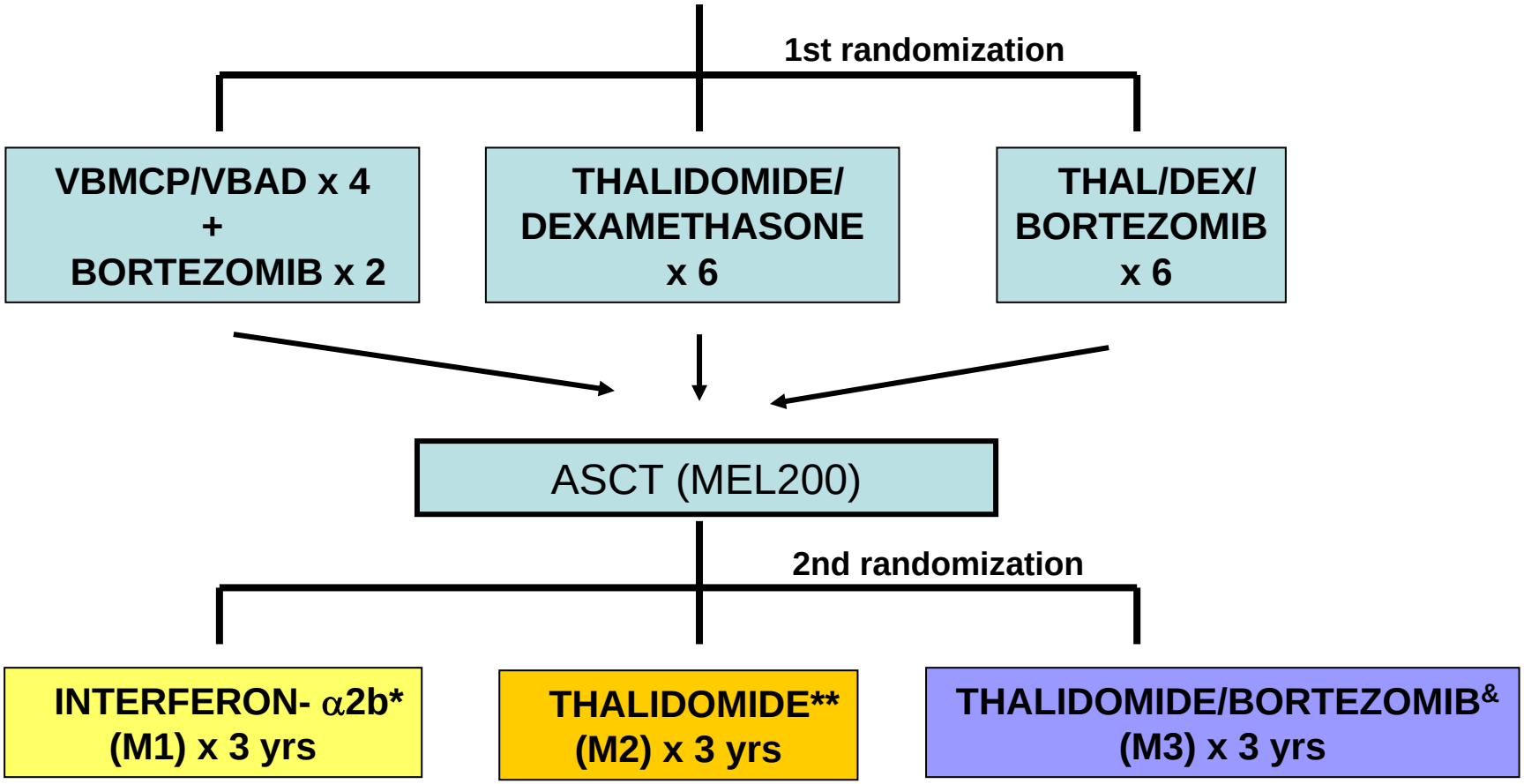
- Efficacy and safety of three maintenance regiments after ASCT:
  - Alfa2-IFN
  - Thalidomide
  - Thalidomide / bortezomib

End-points

- Primary
  - Progression free survival
- Secondary
  - Response rate
  - Overall survival
  - Safety

GEM05MENOS65

De “novo” symptomatic MM <65 yrs



*3 MU/sc 3 times a week

**100 mg/day

& Thal 100mg/day. Bortezomib 1.3 mg/m2 days 1,4,8,11 every 3 months

End-points

- Primary
  - Progresion free survival
- Secondary
  - Response rate
  - Overall survival
  - Safety

Patients and Methods

- **Patients < 65 yrs-old with symptomatic MM**
- **Response criteria: EBMT (plus VGPR)**
- **Sample size: 266 patients included in maintenance therapy**
- **Median follow-up (from maintenance): 24 months**
- **Response rate, survival and toxicity evaluated on an intention to treat basis.**
- **Statistical methods: chi-square, Kaplan and Meier method, log-rank test.**

Patient characteristics (I)

	M1 (n=87)	M2 (n=89)	M3 (n=90)
Age (median)	55	59	56
Gender (M/F)	65/35	52/48	45/55
M-protein type (%)			
IgG	61	55	65
IgA	21	25	19
Light chain	15	17	12
IgD	2	3	3
IgM	1	-	1

Patient characteristics (II)

	M1 (n=87)	M2 (n=89)	M3 (n=90)
Durie-Salmon (%)			
I	8	7	10
II	44	53	53
III	48	40	37
ISS (%)			
I	42	45	41
II	40	42	41
III	18	13	18
EMP* at diagnosis (%)	17	15	13
Poor cytogenetics (%): t(4;14); t(14;16); del (17p)	14	13	12

*EMP: extramedullary plasmacytomas

Patient characteristics (III)

Induction treatment received prior maintenance therapy

	M1 (n=87)	M2 (n=89)	M3 (n=90)
QT+V (%)	37	37	34
TD (%)	30	28	25
VTD (%)	33	35	40

Patient characteristics (IV)

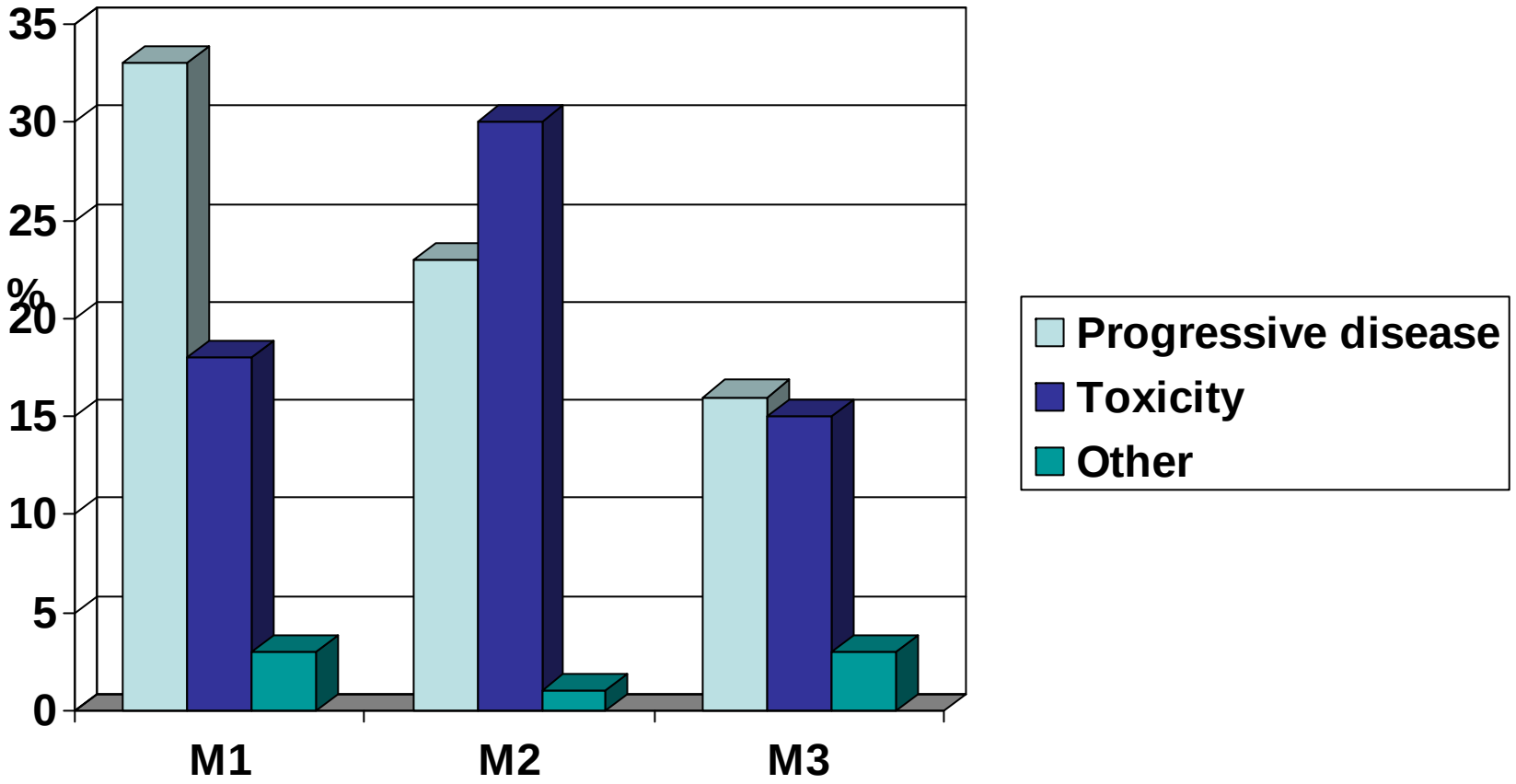
Reponse status before maintenance therapy

	M1 (n=87)	M2 (n=89)	M3 (n=90)
CR (%)	50	49	52
VGPR (%)	22	23	23
PR (%)	26	23	22
MR (%)	1	2	2
Stable disease (%)	-	1	-

Results (I)
Increase in response rate with maintenance therapy

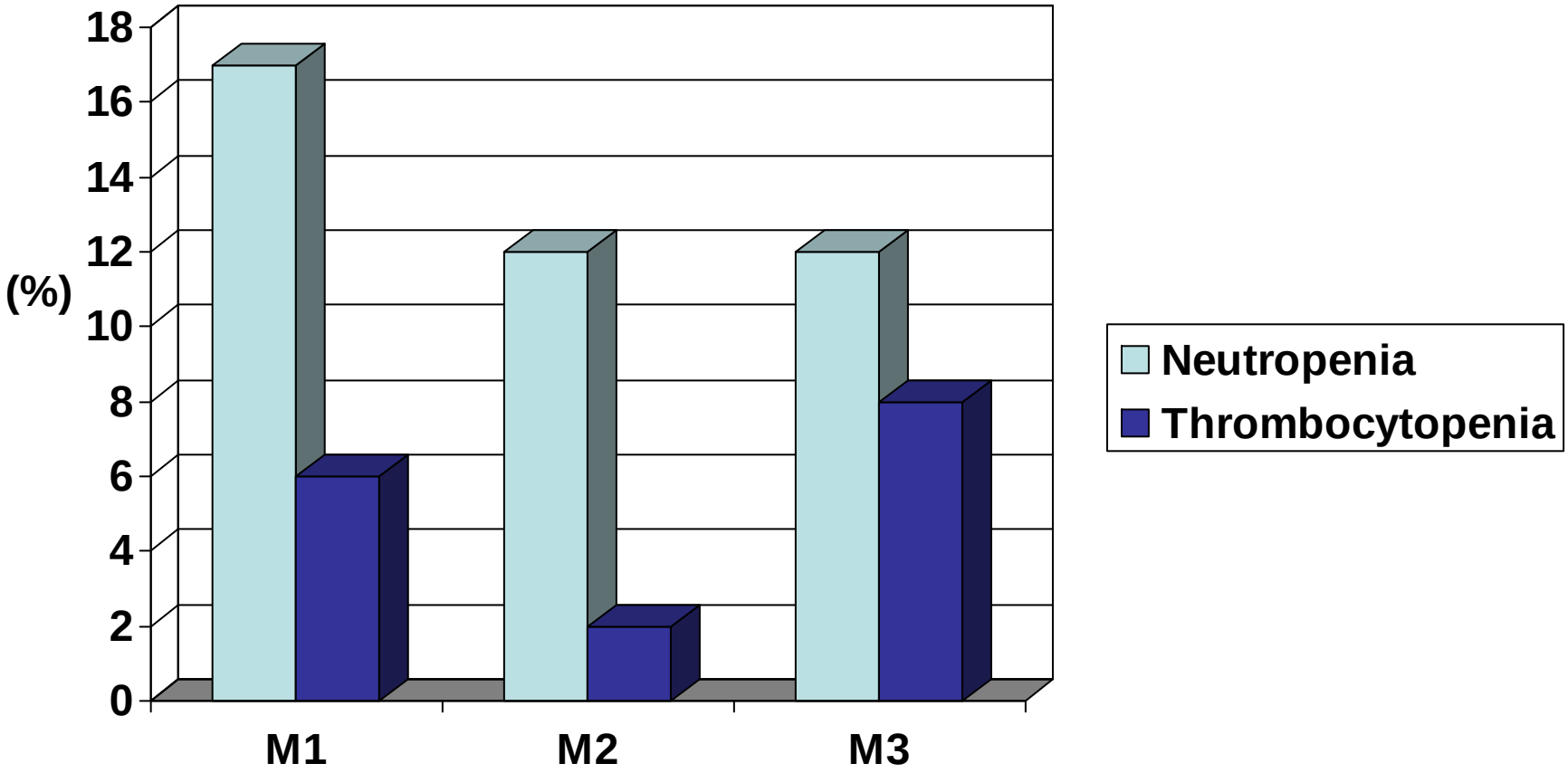
	M1 (n=87)	M2 (n=89)	M3 (n=90)
No (%)	72	79	72
Yes (%)	22	16	24
– CR (%)	19	11	23
– VGPR (%)	3	5	1

Results (II)
Discontinuation of maintenance therapy



M2 vs. M1: 30% vs. 18%, p= 0.17
M2 vs. M3: 30% vs. 15%, p= 0.08

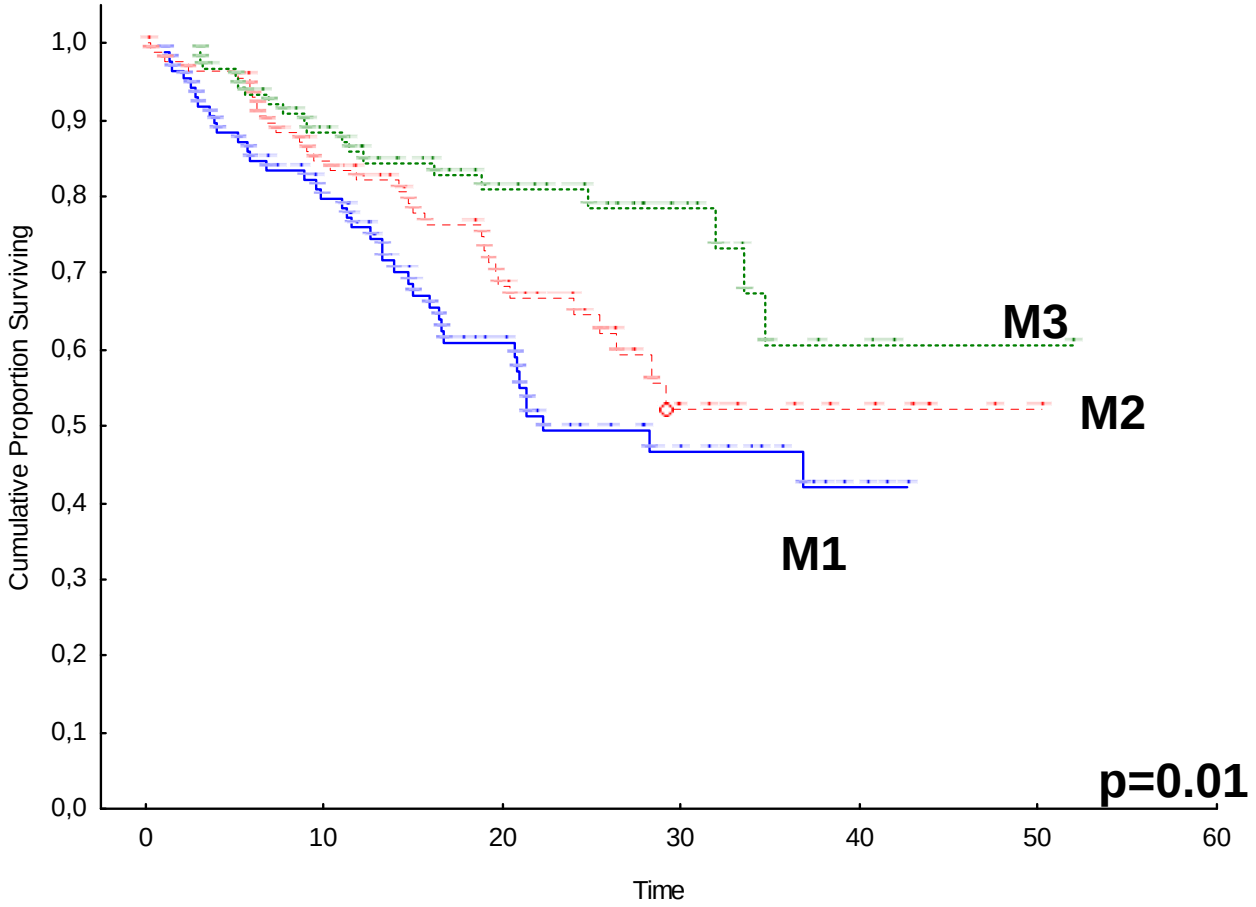
Hematological toxicity (grade 3-4)



Extrahematological toxicity

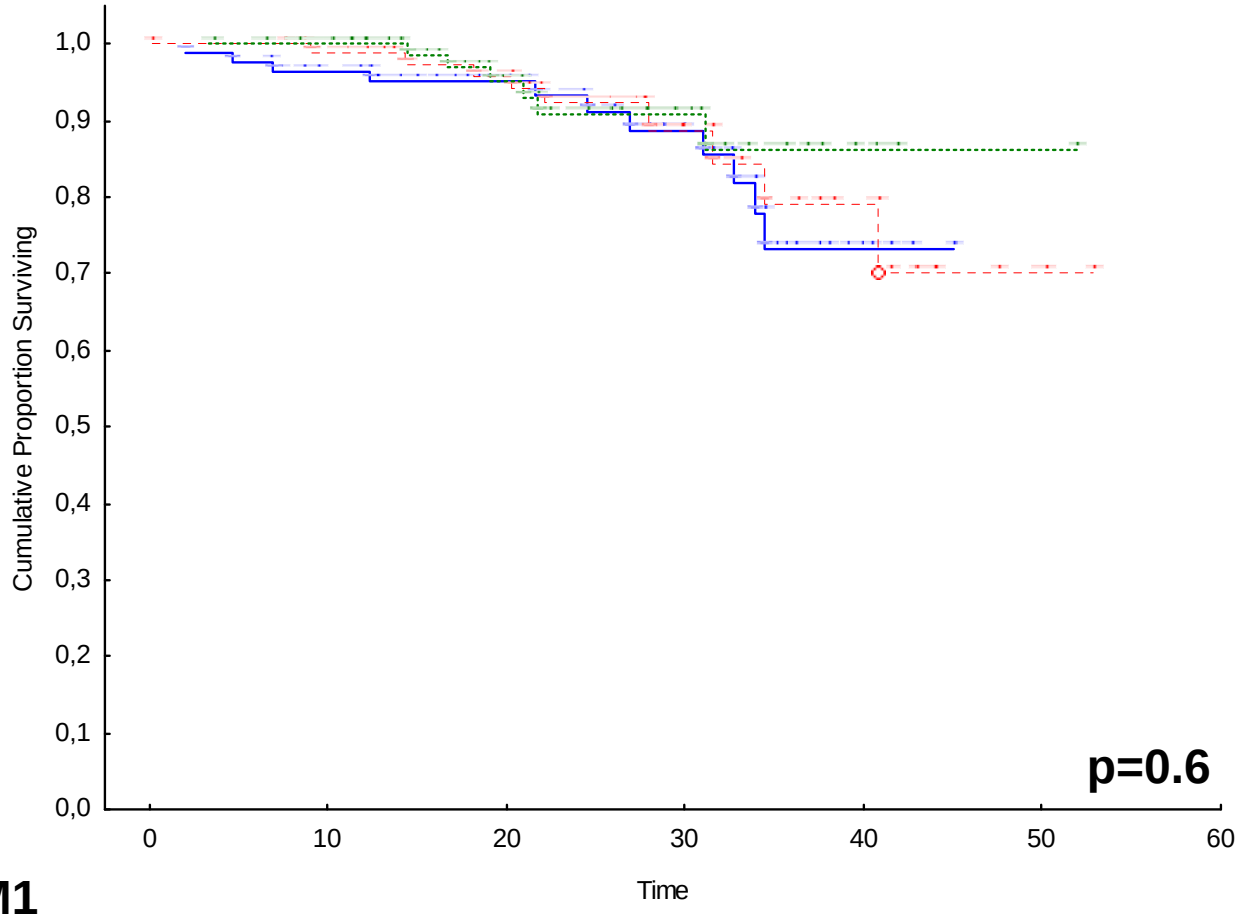
	M1 (n=87)	M2 (n=89)	M3 (n=90)
Overall (%)	21	44	45
Peripheral neuropathy (%)			
– Grade 2	1	17	24
– Grade 3	-	10	12
Asthenia (grade 2-4)	6	2	3
Dose reduction (%)	19	33	33

PFS from onset of maintenance



Median follow-up: 24 months

OS from onset of maintenance therapy



M1

M2

M3

Median follow-up: 24 months

Conclusions

- Maintenance therapy with interferon, thalidomide and thalidomide and bortezomib increases the CR rate in 19%, 11% and 23% of the patients, respectively.

- Discontinuations of maintenance therapy in thalidomide arm are mainly due to toxicity while progressive disease is the main reason to discontinuation with interpheron.

- The addition of bortezomib to thalidomide maintenance resulted in a significantly longer PFS when compared with thalidomide alone or with IFN.

Disclosures

Honoraria:	
–Janssen,Celgene	L. Rosiñol, M.T. Cibeira, M.V. Mateos, J. Martinez, J. de la Rubia, J. Díaz-Mediavilla, A. Alegre, J. J. Lahuerta, J. Bladé
Advisory committees:	
–Janssen, Celgene, Novartis	J. San Miguel

Blood 2011;118(21): abstract #477

Maintenance Therapy with Bortezomib Plus Thalidomide (VT) or Bortezomib Plus Prednisone (VP) In Elderly Myeloma Patients Included In the GEM2005MAS65 Spanish Randomized Trial

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In 2005, Spanish Myeloma Group (GEM/Pethema) activated a two-stage, randomized trial including 260 elderly untreated myeloma patients. In the first stage, patients received induction therapy based mainly on a once per week dosing of bortezomib in combination with prednisone plus either melphalan (VMP) or thalidomide (VTP). The results of this first stage were already published (Mateos et al. Lancet Oncology 2010) and among all the 260 patients included in the trial, VMP and VTP as induction regimens yielded similar overall responses rate (80% and 81%, respectively). Patients completing the six induction cycles, in absence of disease progression or toxicity, moved to the second stage, in which each of the arms were equally randomly assigned to maintenance therapy with bortezomib plus prednisone (VP) or bortezomib plus thalidomide (VT). Maintenance consisted of one conventional cycle of bortezomib (1.3 mg/m^2 on days 1, 4, 8 and 11) every 3 months, plus either oral prednisone 50 mg every other day or oral thalidomide 50 mg daily, for up to 3 years. We report the results of this second stage of the trial comparing VT with VP for up to three years as maintenance following induction with VMP or VTP.

178 out of 260 patients were randomized to receive VT or VP. Concerning baseline characteristics, both groups were well balanced, including the response status at the moment of randomization to maintenance (23% of patients were in CR in VT arm and 20% in VP arm). Median follow-up after randomization to maintenance therapy was 34 months (8-54). Overall, maintenance therapy resulted in an improvement of the depth of response and the IF-CR rate was increased from 24% after induction up to 42%. Although no significant differences were observed between VT and VP, the IF-CR rate was slightly higher for VT versus VP (46% versus 39%). For all patients receiving

maintenance therapy, the median progression free survival (PFS) from initiation of treatment was 35 months (95% CI 29-39) and the median overall survival (OS) 60 months (95%C CI 51-69). From the randomization to maintenance therapy, the median PFS was 30 months (95% CI 21–39) for patients receiving VT and 24 months (95% CI 15–33) for those receiving VP (p=0·1). The slight benefit of VT versus VP as maintenance was independent of the type of induction therapy (VMP or VTP) (p=0·9). No differences in overall survival from this timepoint for VT and VP arms were observed (HR 1·4, 95% CI 0·8–2·4). Concerning safety profile, grade 3 or higher hematological toxicity was recorded only as neutropenia in one patient (1%) in each arm and grade 1-2 occurred in less than 5% of patients (3% and 2% of patients in VT arm developped neutropenia and thrombocytopenia, respectively; and 1% of anemia in VP arm). Concerning non-hematological toxicity, although more of the side effects were of grade 1-2 in both arms, their incidence was superior for VT as compared with VP arm (p=0·0001). Of note, seven patients (7%) in VT arm developped cardiac events, consisting on bradycardia (2 pts), tachycardia (2 pts), heart attack (2 pts) and cardiac failure (1 pt), while only one patient in VP arm. Gastrointestinal toxicity, as constipation or paralitic ileus, was reported in 11 patients (11%) in VT and 3 patients (3%) in VP arm. Grade 3-4 peripheral neuropathy was observed in 9 patients (9%) in VT and 3 (3%) in VP arm.

In summary, VT or VP as maintenance therapy resulted in a substantial increase in complete response rate, from 24% after induction to 42%, which can not be attributed to thalidomide or prednisone single agents but to their combination with bortezomib. In terms of CR, PFS and OS, although no significant differences between VT and VP were observed, a trend to better outcome for VT patients was observed, with a PFS that is one of the longest so far reported for elderly MM patients (39 months from diagnosis). However, VT arm was also associated with a higher incidence of non-hematological toxicity. These regimens, including bortezomib-based induction schemes that use weekly dosing of bortezomib, followed by bortezomib-maintenance schemes represent a platform for further optimisation of the treatment for elderly patients with multiple myeloma through use of lenalidomide instead of thalidomide by reducing adverse events and potentially improving the efficacy.

Maintenance therapy with Bortezomib plus Thalidomide (VT) or Bortezomib plus Prednisone (VP) in elderly Myeloma patients included in the *GEM2005MAS65* spanish randomized trial

MV Mateos, A Oriol, J Martínez, AI Teruel, E Bengoechea, M Pérez, J López, J Díaz-Mediavilla, JM Hernández, Y González, Joan Blade, Juan-Jose Lahuerta, and Jesús F. San Miguel

On behalf of **Spanish Myeloma Group (PETHEMA/GEM)**

PETHEMA
GEM
GRUPO ESPAÑOL DE MIELOMA

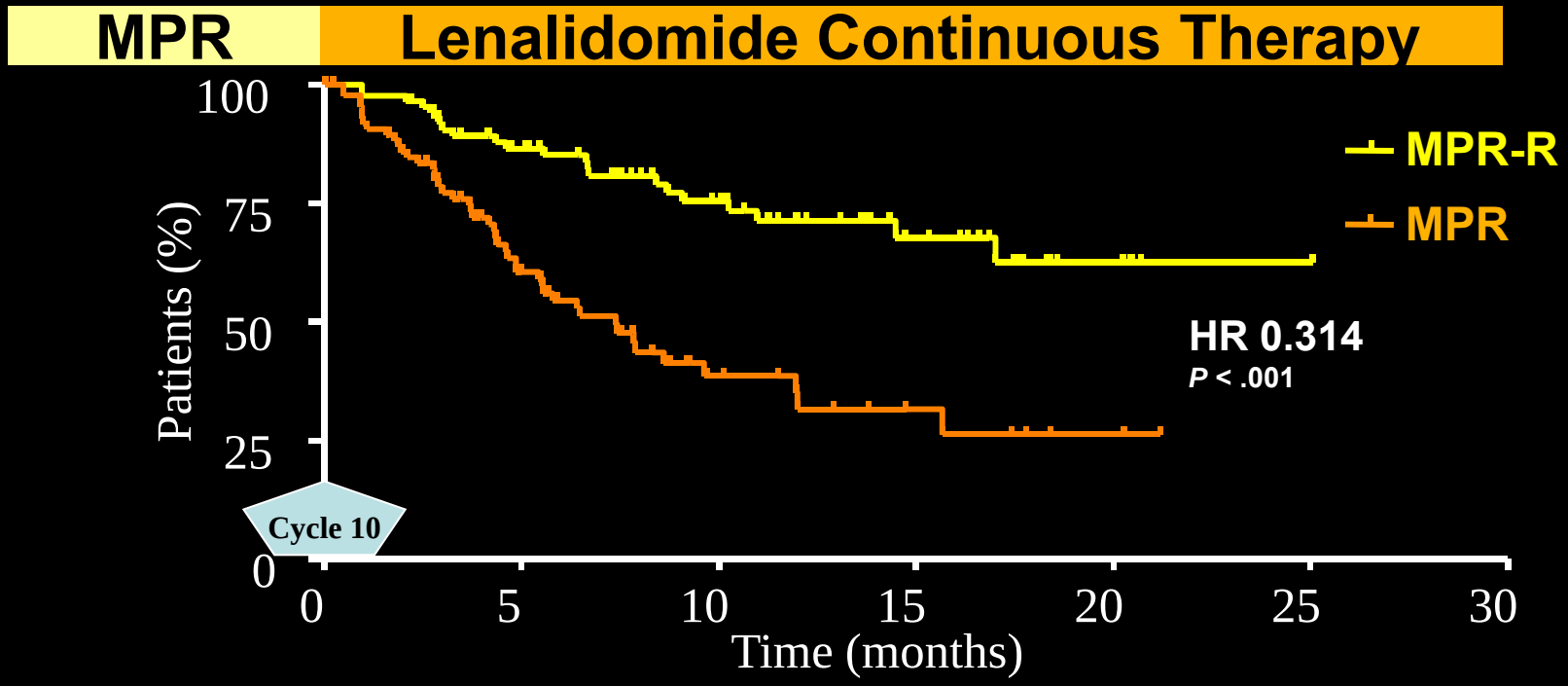
Maintenance treatment in non-transplant setting: Thalidomide

	Median follow-up (months)	Median PFS (months)	Median OS (months)	Reference
MPT + T vs MP	38	21.8 14.5	45.1 47.6	*Palumbo A. Blood 2008*
MPT + T vs MP	39	13 9	40* *p=0.05 31	*Wijermans A. JCO 2010*
MPT + T vs MP	-	20 18	29 33	*Waage A. Blood 2010*
CTDa/MP + T CTD/MP	38	Thal maintenance improves PFS with no OS advantage		*Morgan G. Blood 2011*
Thal-IFN vs IFN*	35	27.7 13.2	52.6 51.4	*Ludwig H. Haematol 2010*

*Thal/Dex vs MP as induction

Maintenance treatment in non-transplant setting: Lenalidomide

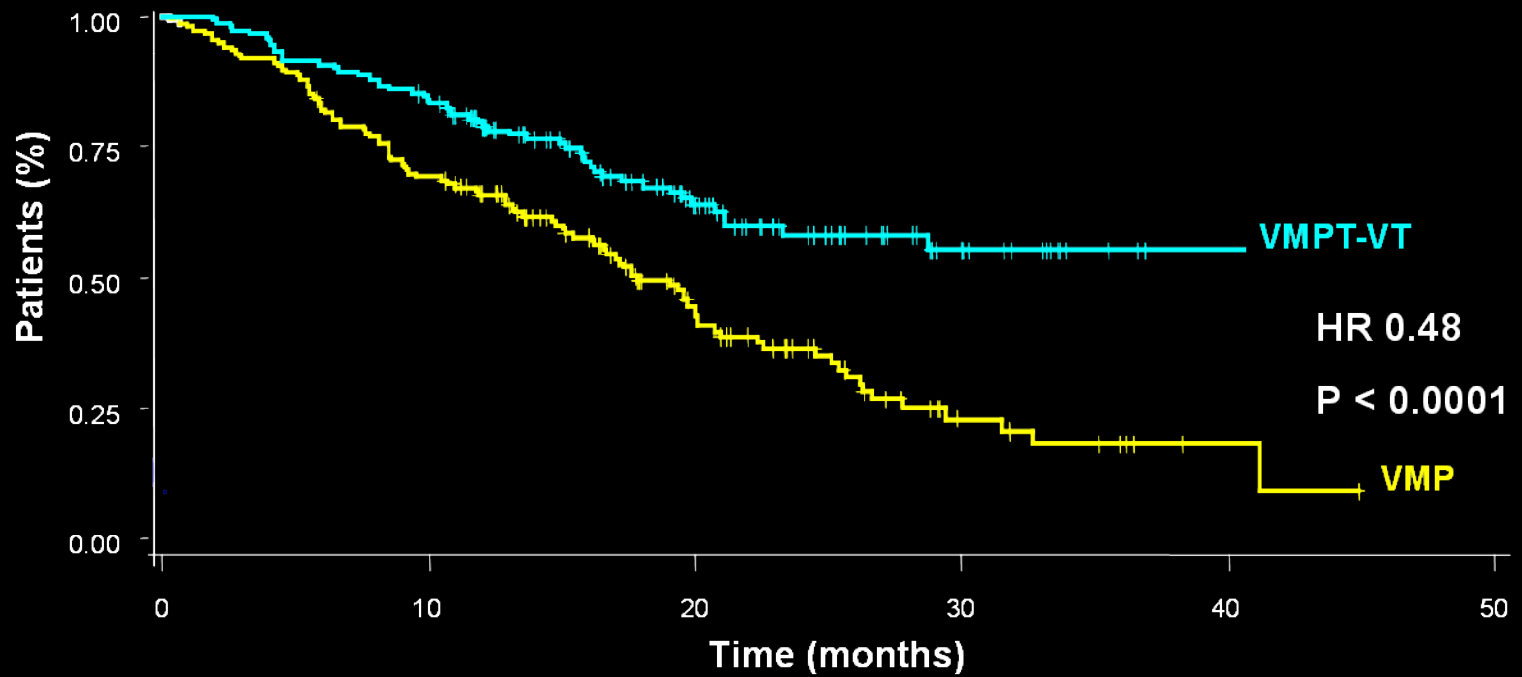
	Median follow-up (months)	Median PFS (months)	Median OS (months)	Reference
MPR + R vs MPR vs MP	21	31 14 13 *p<0.0001	NR	*Palumbo A. ASH 2010*



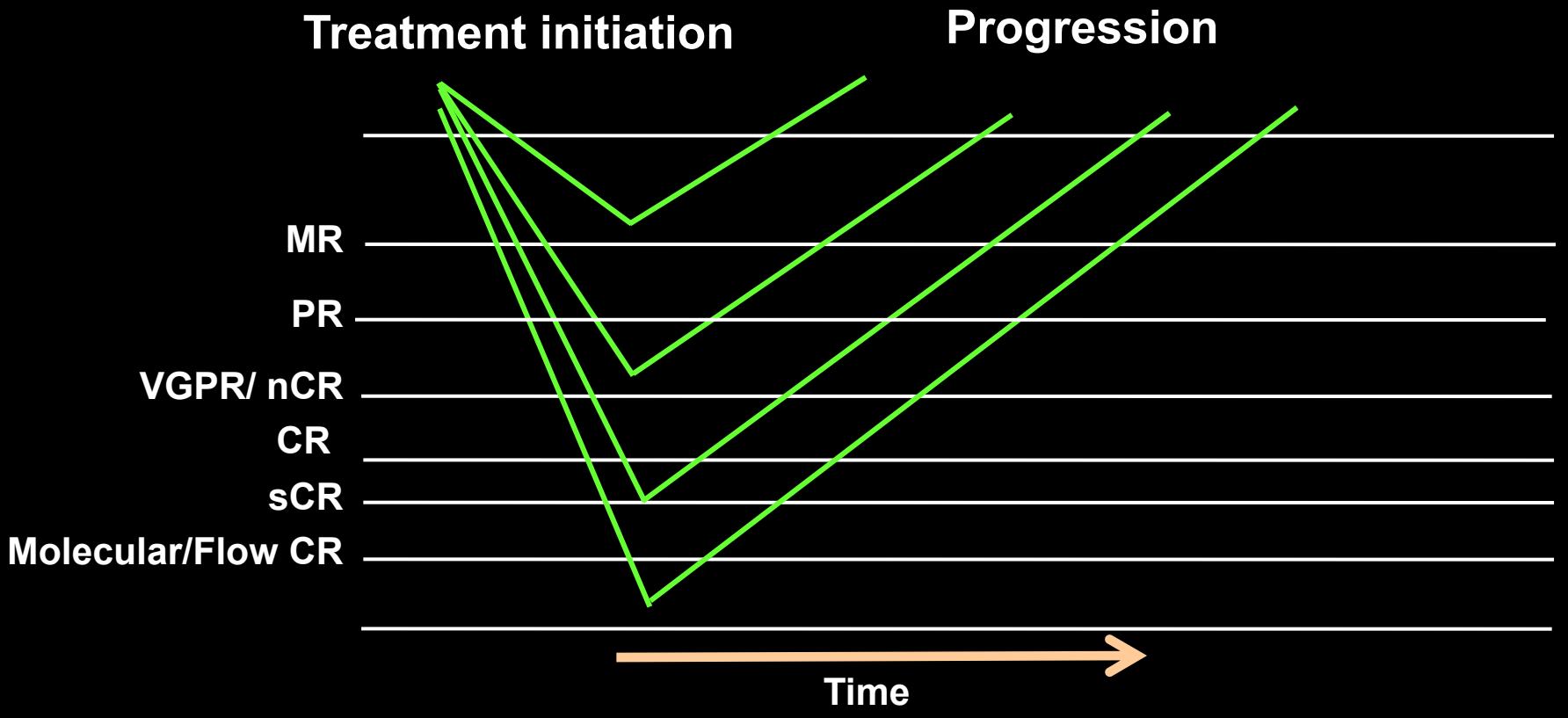
Maintenance treatment in non-transplant setting: Bortezomib

	Median follow-up (months)	Median PFS (months)	Median OS (months)	Reference
VMPT-VT vs VMP	32	**37** *p<0.0001 **27**	NR	*Palumbo A. ASH 2010*

VMPT | **VT Continuous Therapy**



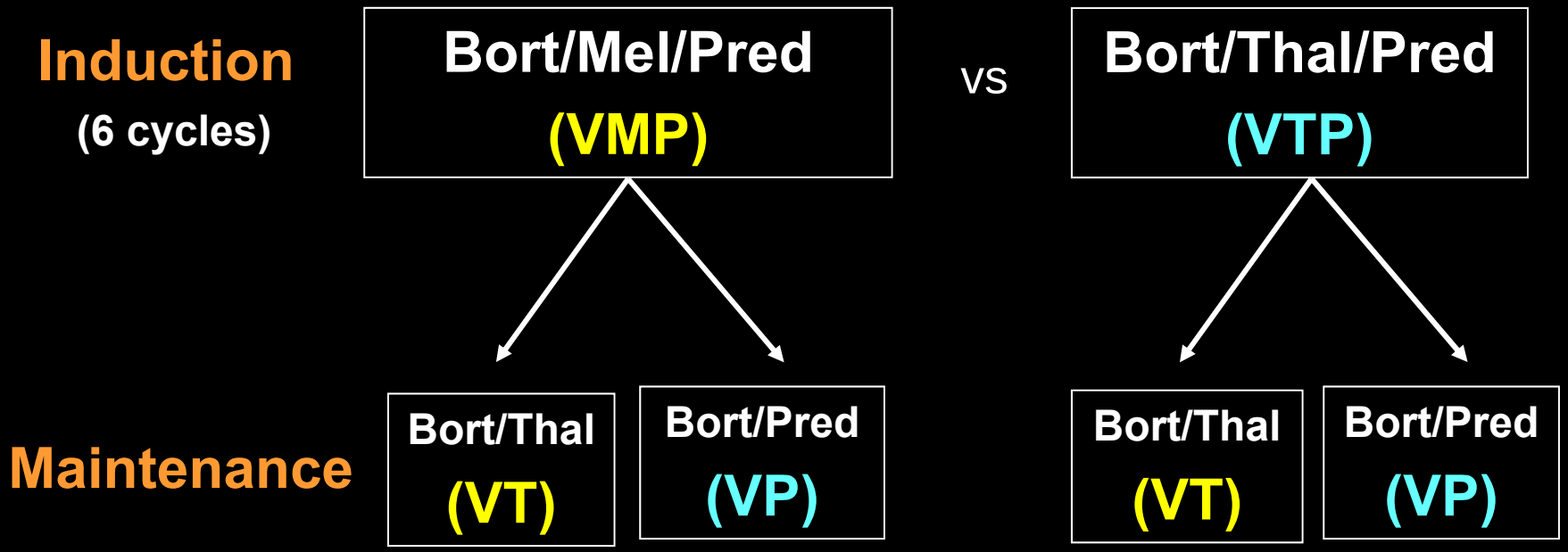
Rationale for the use of maintenance



The objective of maintenance treatment would be to *maintain the response* or to *improve its quality*, in order to prolong the *PFS* and finally, the *OS*.

Study design and aim

Series of 260 elderly untreated MM patients included in the GEM2005 spanish trial



No significant differences in ORR between VMP and VTP

(80% and 81%), and CR rate (20% and 27%)

Mateos *et al*. Lancet Oncology 2010; 10(11): 934-41

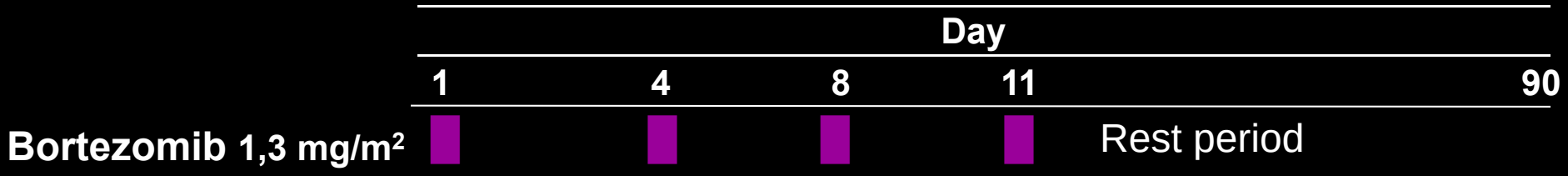
Study design and aim

- Can maintenance therapy upgrade the response rate with a favourable toxicity profile?

- What is the benefit in terms of PFS/OS?

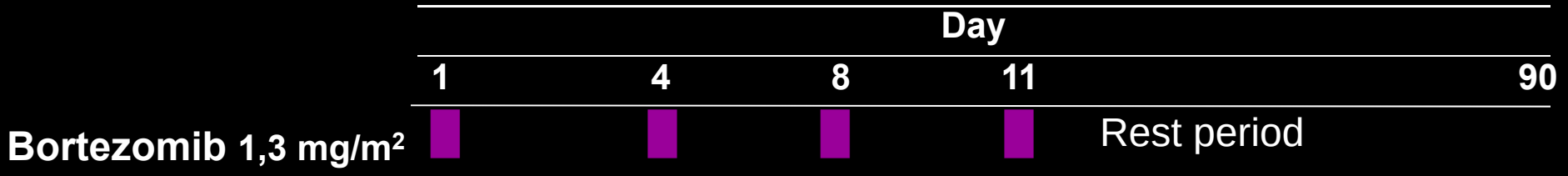
Maintenance therapy (n:178)

VT (n=91)



- **Thalidomide, 50 mg daily up to 3 years**

VP (n=87)



- **Prednisone, 50 mg every 48 h up to 3 years**

Bortezomib was administered every 3 months up to 3 years

Baseline patients' characteristics (n:178)

	VT (n:91)	VP (n:87)
Male, %	53	47
Mean (Median) Age, yr	71 (66-82)	72 (65-84)
Age ≥ 75 yr (%)	32	36
IgG / IgA / light chain, %	62 / 28 / 9	55 / 32 / 12
ISS stage I / II / III, %	30 / 41 / 29	28 / 41 / 30
Beta2microglobulin mean,	3.7 mg/dL	3.8mg/dL
Induction group		
VMP, %	52%	51%
VTP, %	48%	49%
High-risk [t(4;14), t(14;16), del 17p] cytogenetic by FISH, (%)	17%	15%

No significant differences

Efficacy: Response rate to maintenance therapy (n=178)

After a median of 20 months of maintenance therapy (1-36)

CR (IF-) increased from 24% (after induction) up to 42% (maintenance)

	Pre-maintenance	VT (n: 91)	VP (n:87)
IF-CR	24 %	46 %	39 %
IF+CR, %	10 %	10 %	11 %
PR, %	47 %	39 %	47 %
MR, %	8 %	3 %	1 %
SD, %	10 %	1 %	1 %

Not significant differences between VT/VP

Efficacy: Response rate to maintenance therapy (n=178)

After a median of 20 months of maintenance therapy (1-36)

CR (IF-) increased from 24% (after induction) up to 42% (maintenance)

	Pre-maintenance	VT (n: 91)	VP (n:87)
IF-CR	24 %	46 %	39 %
IF+CR, %	10 %	10 %	11 %
PR, %	47 %	39 %	47 %
MR, %	8 %	3 %	1 %
SD, %	10 %	1 %	1 %

Not significant differences between VT/VP

Efficacy: Response rate to maintenance therapy by induction arm (n=178)

	VT (n: 91)		VP (n:87)	
	VMP (n:47)	VTP (n:44)	VMP (n:44)	VTP (n:43)
IF-CR	38%	53%	41%	37%
	53%	58%	50%	49%
IF+CR	15%	5%	11%	11%
PR	40%	37%	45%	49%
MR	4%	2%	2%	-
SD	-	2%	-	2%

Median time to improvement of response: 2 months (1-31)

Not significant differences

VP vs VT: Toxicity profile (AEs) (n:178)

	VT (n:91)		VP (n:87)	
Hematologic toxicity, n(%)	Grade 1-2	Grade 3-4	Grade 1-2	Grade 3-4
Anemia	-	-	1(1%)	-
Thrombocytopenia	2 (2%)	-	-	-
Neutropenia	3 (3%)	1 (1%)	-	-

VP vs VT: Toxicity profile (AEs) (n:178)

	VT (n:91)	VP (n:87)
Non-Hematologic toxicity, n(%)	Grade 3-4	Grade 3-4
Astenia	2 (2%)	-
Skin Rash	-	-
G-I symptoms	4 (4%)	1 (1%)
Infections	-	-
Thrombotic events	-	-
PN *-Emergent PN* *-Worsened PN*	9 (9%)** *1pt* *8pts*	3 (3%)** - *3pts*
Cardiac events*	2 (2%)	1 (1%)

**Cardiac events: Tachycardia (1), Hearth atack (2)*

VP vs VT: Toxicity profile (n:178)

	VT (n:91)	VP (n:87)
Discontinuations,n (%)	**52 (57%)**	**51 (59%)**
Disease Progression	32 (35%)	40(46%)
Toxicity	*12* (13%)*	*8* (9%)*
Others - SPM*	6 (7%) 3pts	2 (3%) 1pt

Discontinuations due to toxicity: Peripheral neuropathy and cardiac toxicity

SPM: Second primary malignancies

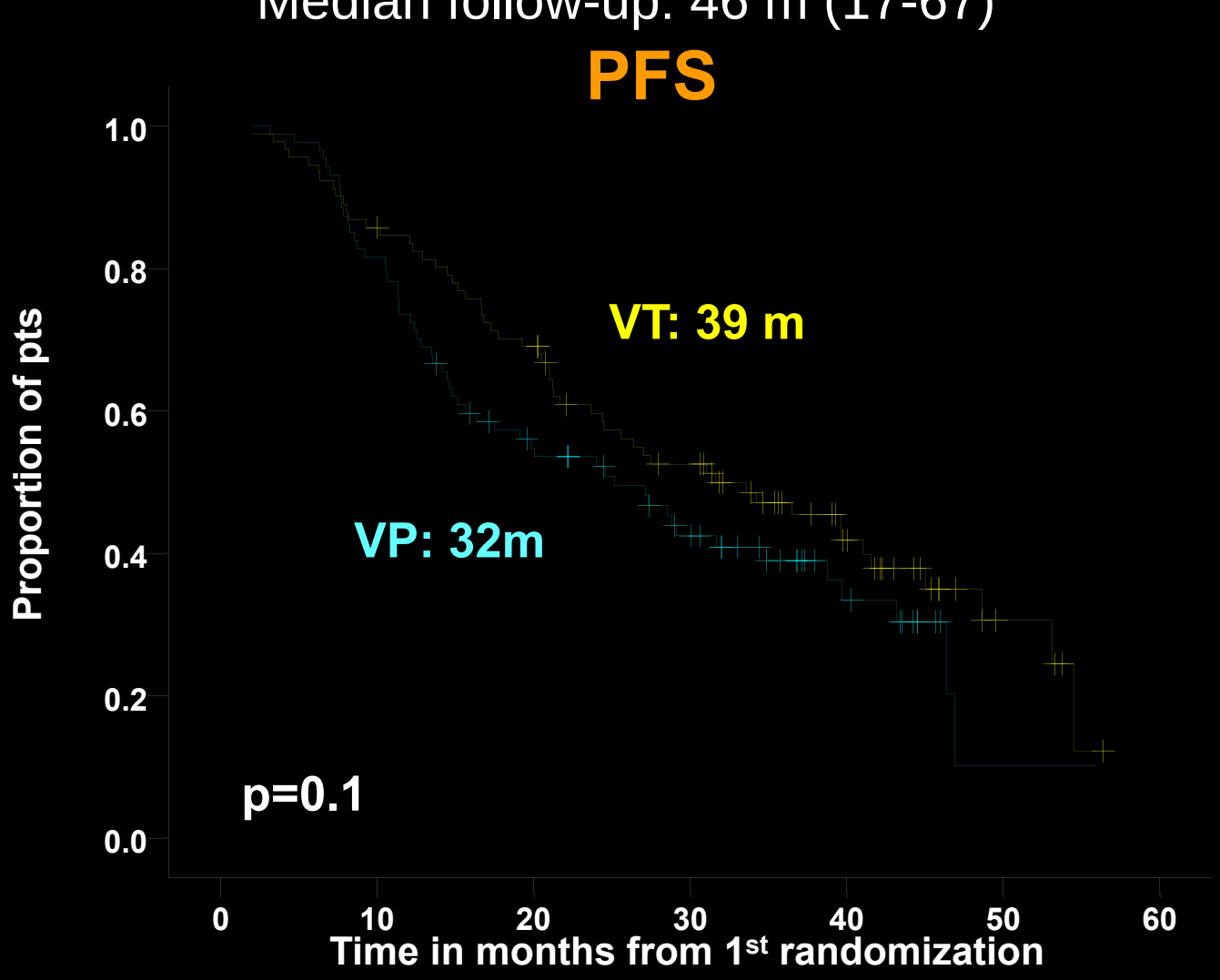
VP vs VT: Toxicity profile (n:178)

	VT (n:91)	VP (n:87)
Discontinuations, n(%)	**52 (57%)**	**51 (59%)**
Disease Progression	32 (35%)	40(46%)
Toxicity	*12* (13%)*	*8* (9%)*
Others - SMP	6 (7%) 3pts	2 (3%) 1pt
Deaths, n(%)	**24 (26%)**	**30 (35%)**
Disease Progression	19 (20%)	26(30%)
Toxicity	5 (6%)	4 (5%)

Discontinuations due to toxicity: Peripheral neuropathy and cardiac toxicity

PFS according to maintenance arm (n: 178 pts)

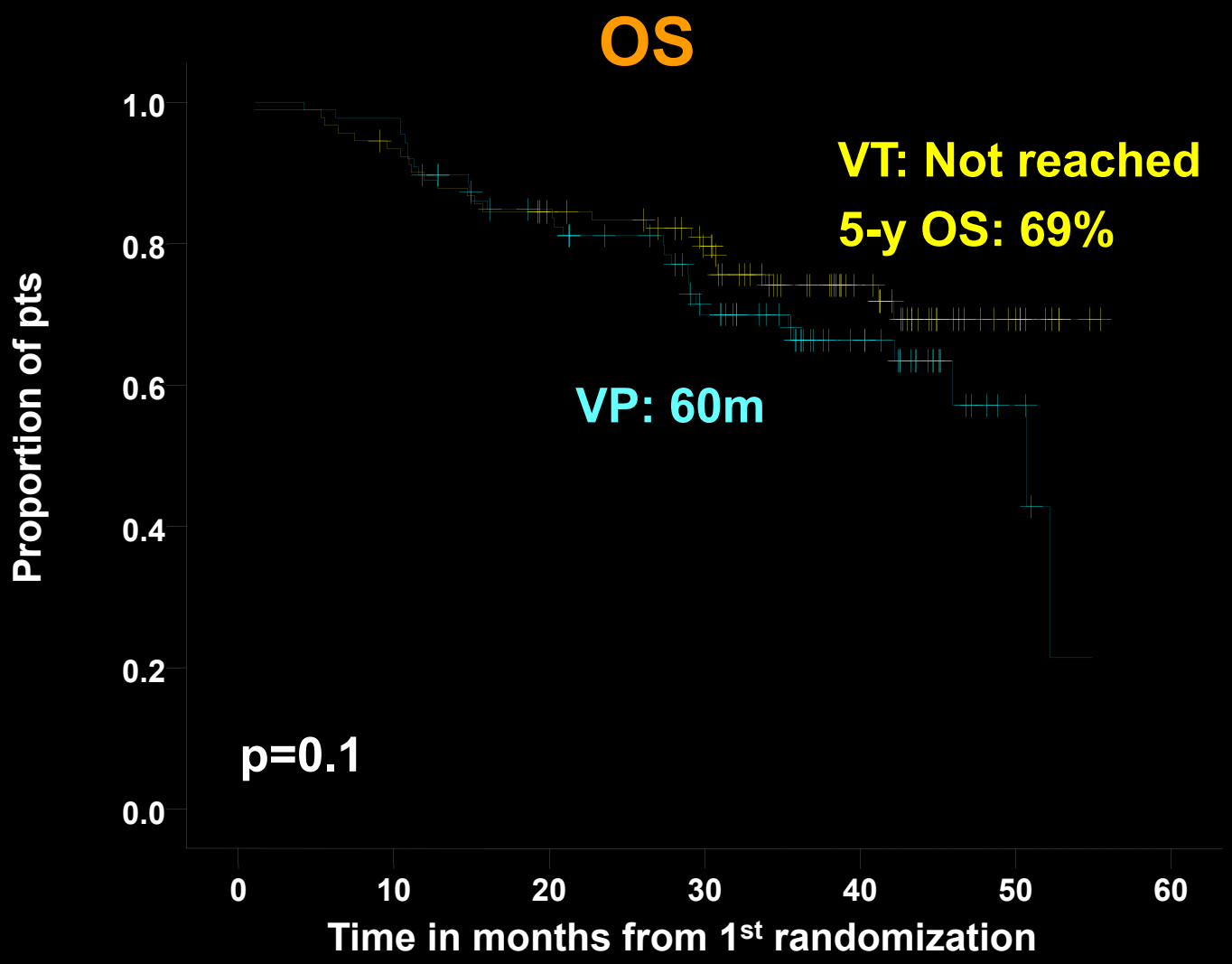
Median follow-up: 46 m (17-67)



PFS was not influenced by the previous induction regimen: VMP/VTP

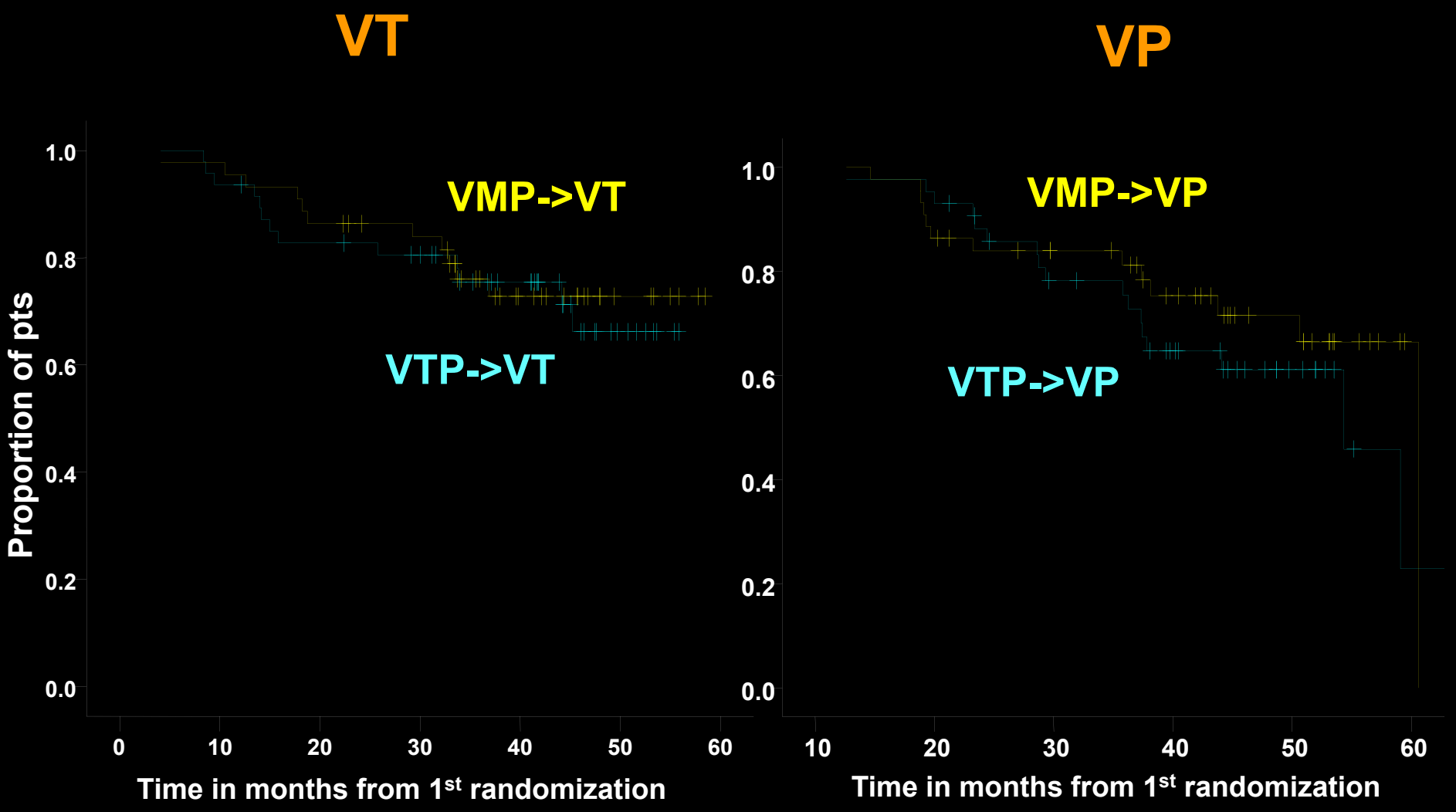
OS according to maintenance arm (n: 178 pts)

Median follow-up: 46 m (17-67)



OS according to maintenance therapy by induction arm (n: 178 pts)

Median follow-up: 46 m (17-67)



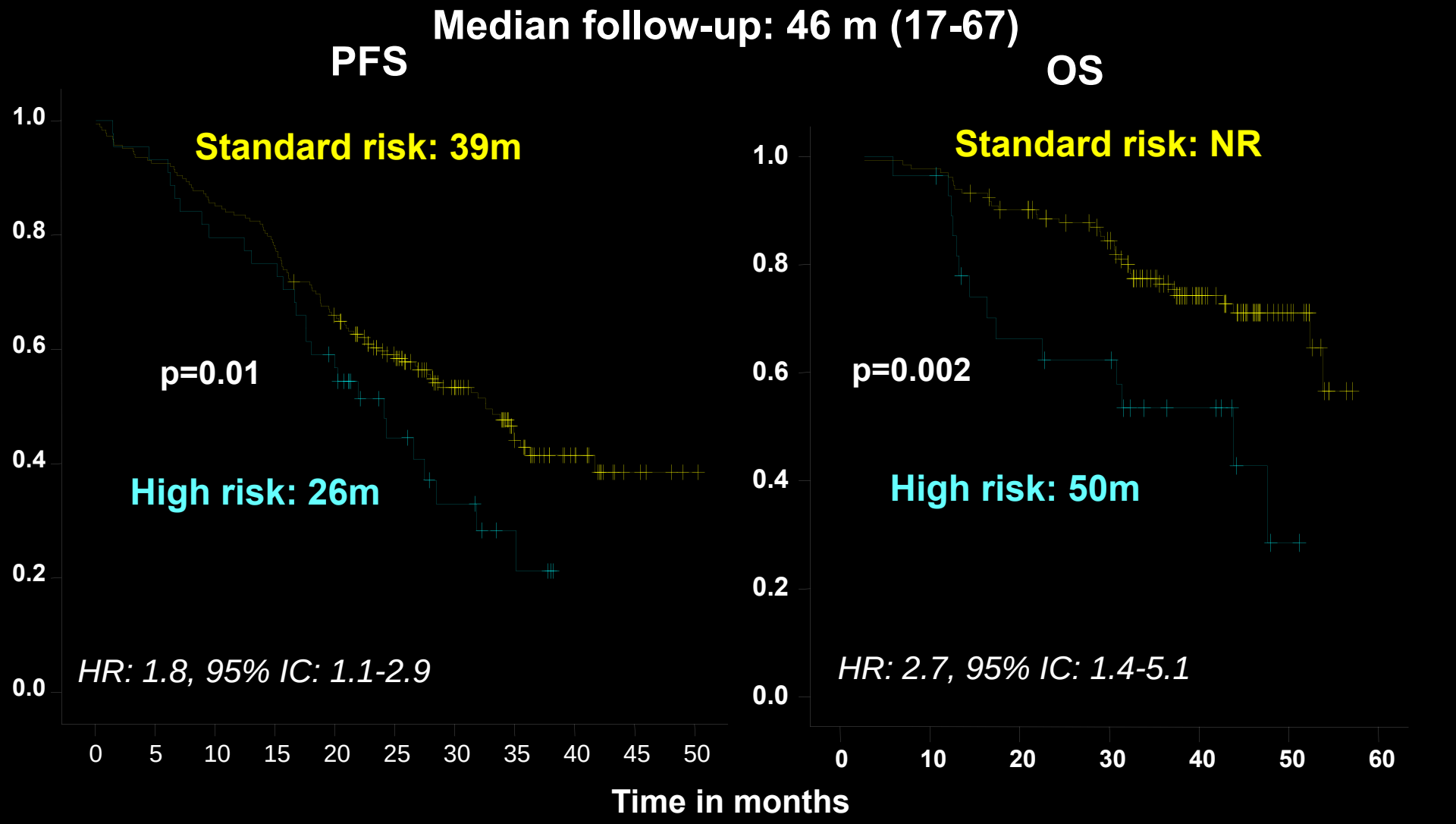
Efficacy according to cytogenetic abnormalities by FISH after maintenance (n:139)

	Standard-risk (n:111)	High-risk (n:28, 20%) t (4;14) ± t (14;16) ± del(17p)
IF-CR	45%	40%
IF+CR	13%	11%
PR	38%	50%

Not significant differences between VT/VP as maintenance regimen

Outcome according to cytogenetic abnormalities: influence of maintenance

Median follow-up: 46 m (17-67)



Not significant differences between VT/VP as maintenance regimen

Conclusions

- Maintenance therapy with VT or VP improved the ORR and CR rate after soft induction therapy
- No significant differences were observed between both maintenance arms, with a trend to better outcome for VT
- Toxicity profile was acceptable, slightly higher for VT arm
- Both maintenance regimens don't overcome the poor prognosis of high-risk CA
- These bortezomib-based maintenance regimens represent an attractive platform for further optimization

Acknowledgments

Investigators including cases in trials of the Spanish Myeloma Group, and most of all, the patients!

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use VELCADE safely and effectively. See full prescribing information for VELCADE.

VELCADE® (bortezomib) for Injection
Initial U.S. Approval: 2003

----------RECENT MAJOR CHANGES----------

Dosage and Administration	
Management of Peripheral Neuropathy (2.5)	1/2012
Administration Precautions (2.7)	1/2012
Reconstitution/Preparation for Intravenous and Subcutaneous Administration (2.8)	1/2012
Warnings and Precautions, Peripheral Neuropathy (5.1)	1/2012

----------INDICATIONS AND USAGE----------

VELCADE is a proteasome inhibitor indicated for:

- treatment of patients with multiple myeloma (1.1)
- treatment of patients with mantle cell lymphoma who have received at least 1 prior therapy (1.2)

----------DOSAGE AND ADMINISTRATION----------

The recommended dose of VELCADE is 1.3 mg/m^2 administered either as a 3 to 5 second bolus intravenous injection or subcutaneous injection. (2.1, 2.3)

----------DOSAGE FORMS AND STRENGTHS----------

- 1 single-use vial contains 3.5 mg of bortezomib. Dose must be individualized to prevent overdose. (3)

----------CONTRAINDICATIONS----------

- VELCADE is contraindicated in patients with hypersensitivity to bortezomib, boron, or mannitol. (4)
- VELCADE is contraindicated for intrathecal administration. (4)

----------WARNINGS AND PRECAUTIONS----------

- Peripheral neuropathy, including severe cases, may occur - manage with dose modification or discontinuation. (2.5) Patients with preexisting severe neuropathy should be treated with VELCADE only after careful risk-benefit assessment. (2.5, 5.1)
- Hypotension can occur. Use caution when treating patients receiving antihypertensives, those with a history of syncope, and those who are dehydrated. (5.2)
- Closely monitor patients with existing heart disease or risk factors for heart disease. (5.3)
- Acute diffuse infiltrative pulmonary disease has been reported. (5.4)
- Nausea, diarrhea, constipation, and vomiting have occurred and may require use of antiemetic and antidiarrheal medications or fluid replacement. (5.6)
- Thrombocytopenia or neutropenia can occur; complete blood counts should be regularly monitored throughout treatment. (5.7)
- Tumor Lysis Syndrome (5.8), Reversible Posterior Leukoencephalopathy Syndrome (5.5), and acute hepatic failure (5.9) have been reported.
- Women should avoid becoming pregnant while being treated with VELCADE. Pregnant women should be apprised of the potential harm to the fetus. (5.11, 8.1)

----------ADVERSE REACTIONS----------

Most commonly reported adverse reactions (incidence ≥ 30%) in clinical studies include asthenic conditions, diarrhea, nausea, constipation, peripheral neuropathy, vomiting, pyrexia, thrombocytopenia, psychiatric disorders, anorexia and decreased appetite, neutropenia, neuralgia, leukopenia and anemia. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Millennium Pharmaceuticals at 1-866 VELCADE or FDA at 1-800-FDA-1088 or *www.fda.gov/medwatch*.

----------DRUG INTERACTIONS----------

- Closely monitor patients receiving VELCADE in combination with strong CYP3A4 inhibitors. (7.1)
- Concomitant use of strong CYP3A4 inducers is not recommended. (7.3)

----------USE IN SPECIFIC POPULATIONS----------

- Patients with diabetes may require close monitoring of blood glucose and adjustment of anti-diabetic medication. (8.8)
- Hepatic Impairment: Use a lower starting dose for patients with moderate or severe hepatic impairment. (2.6, 5.10, 8.7, 12.3)

See 17 for PATIENT COUNSELING INFORMATION.

Revised: [1/2012]

FULL PRESCRIBING INFORMATION: CONTENTS*

*Sections or subsections omitted from the full prescribing information are not listed

FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

1.1 Multiple Myeloma

VELCADE® (bortezomib) for Injection is indicated for the treatment of patients with multiple myeloma.

1.2 Mantle Cell Lymphoma

VELCADE (bortezomib) for Injection is indicated for the treatment of patients with mantle cell lymphoma who have received at least 1 prior therapy.

2 DOSAGE AND ADMINISTRATION

The recommended starting dose of VELCADE is 1.3 mg/m^2. VELCADE may be administered intravenously at a concentration of 1 mg/mL, or subcutaneously at a concentration of 2.5 mg/mL [*see Reconstitution/Preparation for Intravenous and Subcutaneous Administration (2.8)*]. When administered intravenously, VELCADE is administered as a 3 to 5 second bolus intravenous injection. VELCADE is for intravenous or subcutaneous use only. VELCADE should not be administered by any other route.

Because each route of administration has a different reconstituted concentration, caution should be used when calculating the volume to be administered.

2.1 Dosage in Previously Untreated Multiple Myeloma

VELCADE (bortezomib) for Injection is administered in combination with oral melphalan and oral prednisone for nine 6-week treatment cycles as shown in Table 1. In Cycles 1-4, VELCADE is administered twice weekly (days 1, 4, 8, 11, 22, 25, 29 and 32). In Cycles 5-9, VELCADE is administered once weekly (days 1, 8, 22 and 29). At least 72 hours should elapse between consecutive doses of VELCADE.

Table 1: Dosage Regimen for Patients with Previously Untreated Multiple Myeloma

Twice Weekly VELCADE (Cycles 1-4)

Week	**1**				**2**		**3**	**4**		**5**		**6**
VELCADE (1.3 mg/m^2)	Day 1	--	--	Day 4	Day 8	Day 11	rest period	Day 22	Day 25	Day 29	Day 32	rest period
Melphalan(9 mg/m^2) Prednisone(60 mg/m^2)	Day 1	Day 2	Day 3	Day 4	--	--	rest period	--	--	--	--	rest period

Once Weekly VELCADE (Cycles 5-9 when used in combination with Melphalan and Prednisone)

Week	**1**				**2**		**3**	**4**		**5**		**6**
VELCADE (1.3 mg/m^2)	Day 1	--	--		Day 8		rest period	Day 22		Day 29		rest period
Melphalan(9 mg/m^2) Prednisone(60 mg/m^2)	Day 1	Day 2	Day 3	Day 4	--	--	rest period	--	--	--	--	rest period

2.2 Dose Modification Guidelines for Combination Therapy with VELCADE, Melphalan and Prednisone

Prior to initiating any cycle of therapy with VELCADE in combination with melphalan and prednisone:

- Platelet count should be at least 70 x 10^9/L and the absolute neutrophil count (ANC) should be at least 1.0 x 10^9/L
- Non-hematological toxicities should have resolved to Grade 1 or baseline

Table 2: Dose Modifications during Cycles of Combination VELCADE, Melphalan and Prednisone Therapy

Toxicity	Dose modification or delay
Hematological toxicity during a cycle: If prolonged Grade 4 neutropenia or thrombocytopenia, or thrombocytopenia with bleeding is observed in the previous cycle	Consider reduction of the melphalan dose by 25% in the next cycle
If platelet count is not above 30×10^9/L or ANC is not above 0.75×10^9/L on a VELCADE dosing day (other than day 1)	VELCADE dose should be withheld
If several VELCADE doses in consecutive cycles are withheld due to toxicity	VELCADE dose should be reduced by 1 dose level (from 1.3 mg/m^2 to 1 mg/m^2, or from 1 mg/m^2 to 0.7 mg/m^2)
Grade 3 or higher non-hematological toxicities	VELCADE therapy should be withheld until symptoms of the toxicity have resolved to Grade 1 or baseline. Then, VELCADE may be reinitiated with one dose level reduction (from 1.3 mg/m^2 to 1 mg/m^2, or from 1 mg/m^2 to 0.7 mg/m^2). For VELCADE-related neuropathic pain and/or peripheral neuropathy, hold or modify VELCADE as outlined in Table 3.

For information concerning melphalan and prednisone, see manufacturer's prescribing information.

For dose modifications guidelines for peripheral neuropathy see Management of Peripheral Neuropathy section (2.5).

2.3 Dosage in Relapsed Multiple Myeloma and Mantle Cell Lymphoma

VELCADE (1.3 mg/m^2/dose) is administered twice weekly for 2 weeks (Days 1, 4, 8, and 11) followed by a 10-day rest period (Days 12-21). For extended therapy of more than 8 cycles, VELCADE may be administered on the standard schedule or on a maintenance schedule of once weekly for 4 weeks (Days 1, 8, 15, and 22) followed by a 13-day rest period (Days 23 to 35) [*see Clinical Studies section (14) for a description of dose administration during the trials*]. At least 72 hours should elapse between consecutive doses of VELCADE.

2.4 Dose Modification Guidelines for Relapsed Multiple Myeloma and Mantle Cell Lymphoma

VELCADE therapy should be withheld at the onset of any Grade 3 non-hematological or Grade 4 hematological toxicities excluding neuropathy as discussed below [*see Warnings and Precautions (5)*]. Once the symptoms of the toxicity have resolved, VELCADE therapy may be reinitiated at a 25% reduced dose (1.3 mg/m^2/dose reduced to 1 mg/m^2/dose; 1 mg/m^2/dose reduced to 0.7 mg/m^2/dose).

For dose modifications guidelines for peripheral neuropathy see Management of Peripheral Neuropathy section (2.5).

2.5 Management of Peripheral Neuropathy

Starting VELCADE subcutaneously may be considered for patients with pre-existing or at high risk of peripheral neuropathy. Patients with pre-existing severe neuropathy should be treated with VELCADE only after careful risk-benefit assessment.

Patients experiencing new or worsening peripheral neuropathy during VELCADE therapy may require a decrease in the dose and/or a less dose-intense schedule.

For dose or schedule modification guidelines for patients who experience VELCADE-related neuropathic pain and/or peripheral neuropathy see Table 3.

Table 3: Recommended Dose Modification for VELCADE related Neuropathic Pain and/or Peripheral Sensory or Motor Neuropathy

Severity of Peripheral Neuropathy Signs and Symptoms*	Modification of Dose and Regimen
Grade 1 (asymptomatic; loss of deep tendon reflexes or paresthesia) without pain or loss of function	No action
Grade 1 with pain or Grade 2 (moderate symptoms; limiting instrumental Activities of Daily Living (ADL)**)	Reduce VELCADE to 1 mg/m^2
Grade 2 with pain or Grade 3 (severe symptoms; limiting self care ADL ***)	Withhold VELCADE therapy until toxicity resolves. When toxicity resolves reinitiate with a reduced dose of VELCADE at 0.7 mg/m^2 once per week.
Grade 4 (life-threatening consequences; urgent intervention indicated)	Discontinue VELCADE

*Grading based on NCI Common Terminology Criteria CTCAE v4.0

**Instrumental ADL: refers to preparing meals, shopping for groceries or clothes, using telephone, managing money etc;

***Self care ADL: refers to bathing, dressing and undressing, feeding self, using the toilet, taking medications, and not bedridden

2.6 Dosage in Patients with Hepatic Impairment

Patients with mild hepatic impairment do not require a starting dose adjustment and should be treated per the recommended VELCADE dose. Patients with moderate or severe hepatic impairment should be started on VELCADE at a reduced dose of 0.7 mg/m^2 per injection during the first cycle, and a subsequent dose escalation to 1.0 mg/m^2 or further dose reduction to 0.5 mg/m^2 may be considered based on patient tolerance (see Table 4). [*see Warnings and Precautions (5.10), Use in Specific Populations (8.7) and Clinical Pharmacology (12.3)*]

Table 4: Recommended Starting Dose Modification for VELCADE in Patients with Hepatic Impairment

	Bilirubin Level	SGOT (AST) Levels	Modification of Starting Dose
Mild	Less than or equal to 1.0x ULN	More than ULN	None
	More than 1.0x–1.5x ULN	Any	None
Moderate	More than 1.5x–3x ULN	Any	Reduce VELCADE to 0.7 mg/m^2 in the first cycle. Consider dose escalation to 1.0 mg/m^2 or further dose reduction to 0.5 mg/m^2 in subsequent cycles based on patient tolerability.
Severe	More than 3x ULN	Any	

Abbreviations: SGOT = serum glutamic oxaloacetic transaminase;
AST = aspartate aminotransferase; ULN = upper limit of the normal range.

2.7 Administration Precautions

The drug quantity contained in one vial (3.5 mg) may exceed the usual dose required. Caution should be used in calculating the dose to prevent overdose. [*see Reconstitution/Preparation for Intravenous and Subcutaneous Administration (2.8)*]

When administered subcutaneously, sites for each injection (thigh or abdomen) should be rotated. New injections should be given at least one inch from an old site and never into areas where the site is tender, bruised, erythematous, or indurated.

If local injection site reactions occur following VELCADE administration subcutaneously, a less concentrated VELCADE solution (1 mg/mL instead of 2.5 mg/mL) may be administered subcutaneously [*see Reconstitution/Preparation for Intravenous and Subcutaneous Administration (2.8)* and follow reconstitution instructions for 1 mg/mL]. Alternatively, the intravenous route of administration should be considered [*see Reconstitution/Preparation for Intravenous and Subcutaneous Administration (2.8)*]

VELCADE is an antineoplastic. Procedures for proper handling and disposal should be considered. [*see How Supplied/Storage and Handling (16)*]

In clinical trials of VELCADE intravenous, local skin irritation was reported in 5% of patients, but extravasation of VELCADE was not associated with tissue damage. In a clinical trial of subcutaneous VELCADE, a local reaction was reported in 6% of patients as an adverse event, mostly redness.

2.8 Reconstitution/Preparation for Intravenous and Subcutaneous Administration

Proper aseptic technique should be used. Reconstitute **only with 0.9% sodium chloride**. The reconstituted product should be a clear and colorless solution.

Different volumes of 0.9% sodium chloride are used to reconstitute the product for the different routes of administration. The reconstituted concentration of bortezomib for subcutaneous administration (2.5 mg/mL) is greater than the reconstituted concentration of bortezomib for intravenous administration (1 mg/mL). **Because each route of administration has a different reconstituted concentration, caution should be used when calculating the volume to be administered** [*see Administration Precautions (2.7)*]

For each 3.5 mg single-use vial of bortezomib reconstitute with the following volume of 0.9% sodium chloride based on route of administration (Table 5):

Table 5: Reconstitution Volumes and Final Concentration for Intravenous and Subcutaneous Administration

Route of administration	Bortezomib (mg/vial)	Diluent (0.9% Sodium Chloride)	Final Bortezomib concentration (mg/mL)
Intravenous	3.5 mg	3.5 mL	1 mg/mL
Subcutaneous	3.5 mg	1.4 mL	2.5 mg/mL

After determining patient body surface area (BSA) in square meters, use the following equations to calculate the total volume (mL) of reconstituted VELCADE to be administered:

- **Intravenous Administration [1 mg/mL concentration**]

$$\frac{\text{VELCADE dose (mg/m}^2\text{) x patient BSA (m}^2\text{)}}{\text{1 mg/mL}} = \text{Total VELCADE volume (mL) to be administered}$$

- **Subcutaneous Administration [2.5 mg/mL concentration]**

$$\frac{\text{VELCADE dose (mg/m}^2\text{) x patient BSA (m}^2\text{)}}{\text{2.5 mg/mL}} = \text{Total VELCADE volume (mL) to be administered}$$

Stickers that indicate the route of administration are provided with each VELCADE vial. These stickers should be placed directly on the syringe of VELCADE once VELCADE is prepared to help alert practitioners of the correct route of administration for VELCADE.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit. If any discoloration or particulate matter is observed, the reconstituted product should not be used.

Stability: Unopened vials of VELCADE are stable until the date indicated on the package when stored in the original package protected from light.

VELCADE contains no antimicrobial preservative. Reconstituted VELCADE should be administered within 8 hours of preparation. When reconstituted as directed, VELCADE may be stored at 25ºC (77ºF). The reconstituted material may be stored in the original vial and/or the syringe prior to administration. The product may be stored for up to 8 hours in a syringe; however, total storage time for the reconstituted material must not exceed 8 hours when exposed to normal indoor lighting.

3 DOSAGE FORMS AND STRENGTHS

Each single-use vial of VELCADE contains 3.5 mg of bortezomib as a sterile lyophilized powder.

4 CONTRAINDICATIONS

VELCADE is contraindicated in patients with hypersensitivity to bortezomib, boron, or mannitol.

VELCADE is contraindicated for intrathecal administration. Fatal events have occurred with intrathecal administration of VELCADE.

5 WARNINGS AND PRECAUTIONS

VELCADE should be administered under the supervision of a physician experienced in the use of antineoplastic therapy. Complete blood counts (CBC) should be monitored frequently during treatment with VELCADE.

5.1 Peripheral Neuropathy

VELCADE treatment causes a peripheral neuropathy that is predominantly sensory. However, cases of severe sensory and motor peripheral neuropathy have been reported. Patients with pre-existing symptoms (numbness, pain or a burning feeling in the feet or hands) and/or signs of peripheral neuropathy may experience worsening peripheral neuropathy (including ≥ Grade 3) during treatment with VELCADE. Patients should be monitored for symptoms of neuropathy, such as a burning sensation, hyperesthesia, hypoesthesia, paresthesia, discomfort, neuropathic pain or weakness. In the Phase 3 relapsed multiple myeloma trial comparing VELCADE subcutaneous vs. intravenous the incidence of Grade ≥ 2 peripheral neuropathy events was 24% for subcutaneous and 41% for intravenous. Grade ≥ 3 peripheral neuropathy occurred in 6% of patients in the subcutaneous treatment group, compared with 16% in the intravenous treatment group. Starting VELCADE subcutaneously may be considered for patients with pre-existing or at high risk of peripheral neuropathy.

Patients experiencing new or worsening peripheral neuropathy during VELCADE therapy may benefit from a decrease in the dose and/or a less dose-intense schedule [*see Dosage and Administration (2.5)*]. In the single agent phase 3 relapsed multiple myeloma study of VELCADE vs. Dexamethasone following dose adjustments, improvement in or resolution of peripheral neuropathy was reported in 51% of patients with ≥ Grade 2 peripheral neuropathy in the relapsed multiple myeloma study. Improvement in or resolution of peripheral neuropathy was reported in 73% of patients who discontinued due to Grade 2 neuropathy or who had ≥ Grade 3 peripheral neuropathy in the phase 2 multiple myeloma studies [*see Adverse Reactions (6)*]. The long-term outcome of peripheral neuropathy has not been studied in mantle cell lymphoma.

5.2 **Hypotension**

The incidence of hypotension (postural, orthostatic, and hypotension NOS) was 13%. These events are observed throughout therapy. Caution should be used when treating patients with a history of syncope, patients receiving medications known to be associated with hypotension, and patients who are dehydrated. Management of orthostatic/postural hypotension may include adjustment of antihypertensive medications, hydration, and administration of mineralocorticoids and/or sympathomimetics [*see Adverse Reactions (6)*].

5.3 **Cardiac Disorders**

Acute development or exacerbation of congestive heart failure and new onset of decreased left ventricular ejection fraction have been reported, including reports in patients with no risk factors for decreased left ventricular ejection fraction. Patients with risk factors for, or existing heart disease should be closely monitored. In the relapsed multiple myeloma study of VELCADE vs. dexamethasone, the incidence of any treatment-emergent cardiac disorder was 15% and 13% in the VELCADE and dexamethasone groups, respectively. The incidence of heart failure events (acute pulmonary edema, cardiac failure, congestive cardiac failure, cardiogenic shock, pulmonary edema) was similar in the VELCADE and dexamethasone groups, 5% and 4%, respectively. There have been isolated cases of QT-interval prolongation in clinical studies; causality has not been established.

5.4 **Pulmonary Disorders**

There have been reports of acute diffuse infiltrative pulmonary disease of unknown etiology such as pneumonitis, interstitial pneumonia, lung infiltration and Acute Respiratory Distress Syndrome (ARDS) in patients receiving VELCADE. Some of these events have been fatal.

In a clinical trial, the first two patients given high-dose cytarabine ($2g/m^2$ per day) by continuous infusion with daunorubicin and VELCADE for relapsed acute myelogenous leukemia died of ARDS early in the course of therapy.

There have been reports of pulmonary hypertension associated with VELCADE administration in the absence of left heart failure or significant pulmonary disease.

In the event of new or worsening cardiopulmonary symptoms, a prompt comprehensive diagnostic evaluation should be conducted.

5.5 **Reversible Posterior Leukoencephalopathy Syndrome (RPLS)**

There have been reports of RPLS in patients receiving VELCADE. RPLS is a rare, reversible, neurological disorder which can present with seizure, hypertension, headache, lethargy, confusion, blindness, and other visual and neurological disturbances. Brain imaging, preferably MRI (Magnetic Resonance Imaging), is used to confirm the diagnosis. In patients developing RPLS, discontinue VELCADE. The safety of reinitiating VELCADE therapy in patients previously experiencing RPLS is not known.

5.6 **Gastrointestinal Adverse Events**

VELCADE treatment can cause nausea, diarrhea, constipation, and vomiting [*see Adverse Reactions (6)*] sometimes requiring use of antiemetic and antidiarrheal medications. Ileus can occur. Fluid and electrolyte replacement should be administered to prevent dehydration.

5.7 **Thrombocytopenia/Neutropenia**

VELCADE is associated with thrombocytopenia and neutropenia that follow a cyclical pattern with nadirs occurring following the last dose of each cycle and typically recovering prior to initiation of the subsequent cycle. The cyclical pattern of platelet and neutrophil decreases and recovery remained consistent over the 8 cycles of twice weekly dosing, and there was no evidence of cumulative thrombocytopenia or neutropenia. The mean platelet count nadir measured was approximately 40% of baseline. The severity of thrombocytopenia related to pretreatment platelet count is shown in Table 6. In the relapsed multiple myeloma study of VELCADE vs. dexamethasone, the incidence of significant bleeding events ($\geq$ Grade 3) was similar on both the

VELCADE (4%) and dexamethasone (5%) arms. Platelet count should be monitored prior to each dose of VELCADE. Patients experiencing thrombocytopenia may require change in the dose and schedule of VELCADE [*see Table 2 and Dosage and Administration (2.4)*]. There have been reports of gastrointestinal and intracerebral hemorrhage in association with VELCADE. Transfusions may be considered. The incidence of febrile neutropenia was < 1%.

Table 6: Severity of Thrombocytopenia Related to Pretreatment Platelet Count in the Relapsed Multiple Myeloma Study of VELCADE vs. Dexamethasone

Pretreatment Platelet Count*	Number of Patients (N=331)**	Number (%) of Patients with Platelet Count < 10,000/µL	Number (%) of Patients with Platelet Count 10,000-25,000/µL
≥ 75,000/µL	309	8 (3%)	36 (12%)
≥ 50,000/µL- < 75,000/µL	14	2 (14%)	11 (79%)
≥ 10,000/µL- < 50,000/µL	7	1 (14%)	5 (71%)

* A baseline platelet count of 50,000/µL was required for study eligibility
** Data were missing at baseline for 1 patient

5.8 Tumor Lysis Syndrome

Because VELCADE is a cytotoxic agent and can rapidly kill malignant cells, the complications of tumor lysis syndrome may occur. Patients at risk of tumor lysis syndrome are those with high tumor burden prior to treatment. These patients should be monitored closely and appropriate precautions taken.

5.9 Hepatic Events

Cases of acute liver failure have been reported in patients receiving multiple concomitant medications and with serious underlying medical conditions. Other reported hepatic events include increases in liver enzymes, hyperbilirubinemia, and hepatitis. Such changes may be reversible upon discontinuation of VELCADE. There is limited re-challenge information in these patients.

5.10 Hepatic Impairment

Bortezomib is metabolized by liver enzymes. Bortezomib exposure is increased in patients with moderate or severe hepatic impairment; these patients should be treated with VELCADE at reduced starting doses and closely monitored for toxicities. [*see Dosage and Administration (2.6), Use In Specific Populations (8.7) and Clinical Pharmacology (12.3)*]

5.11 Use in Pregnancy

Women of childbearing potential should avoid becoming pregnant while being treated with VELCADE. Bortezomib administered to rabbits during organogenesis at a dose approximately 0.5 times the clinical dose of 1.3 mg/m^2 based on body surface area caused post-implantation loss and a decreased number of live fetuses. [*see Use in Specific Populations (8.1)*]

6 ADVERSE REACTIONS

The following adverse reactions are also discussed in other sections of the labeling:

- Peripheral Neuropathy [*see Warnings and Precautions (5.1); Dosage and Administration (2.5)(Table 3)*]
- Hypotension [*see Warnings and Precautions (5.2)*]
- Cardiac Disorders [*see Warnings and Precautions (5.3)*]
- Pulmonary Disorders [*see Warnings and Precautions (5.4)*]
- Reversible Posterior Leukoencephalopathy Syndrome (RPLS) [*see Warnings and Precautions (5.5)*]

- Gastrointestinal Adverse Events [*see Warnings and Precautions (5.6)*]
- Thrombocytopenia/Neutropenia [*see Warnings and Precautions (5.7)*]
- Tumor Lysis Syndrome [*see Warnings and Precautions (5.8)*]
- Hepatic Events [*see Warnings and Precautions (5.9)*]

6.1 **Clinical Trials Safety Experience**

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

***Summary of Clinical Trial in Patients with Previously Untreated Multiple Myeloma*:**

Table 7 describes safety data from 340 patients with previously untreated multiple myeloma who received VELCADE (1.3 mg/m^2) administered intravenously in combination with melphalan (9 mg/m^2) and prednisone (60 mg/m^2) in a prospective randomized study.

The safety profile of VELCADE in combination with melphalan/prednisone is consistent with the known safety profiles of both VELCADE and melphalan/prednisone.

Table 7: Most Commonly Reported Adverse Events (≥ 10% in VELCADE, Melphalan and Prednisone arm) with Grades 3 and ≥ 4 Intensity in the Previously Untreated Multiple Myeloma Study

	VELCADE, Melphalan and Prednisone (N=340)			**Melphalan and Prednisone** (N=337)		
MedDRA System Organ Class	Total	Toxicity Grade, n (%)		Total	Toxicity Grade, n (%)	
Preferred Term	n (%)	3	≥ 4	n (%)	3	≥ 4
Blood and Lymphatic System Disorders						
Thrombocytopenia	178 (52)	68 (20)	59 (17)	159 (47)	55 (16)	47 (14)
Neutropenia	165 (49)	102 (30)	35 (10)	155 (46)	79 (23)	49 (15)
Anemia	147 (43)	53 (16)	9 (3)	187 (55)	66 (20)	26 (8)
Leukopenia	113 (33)	67 (20)	10 (3)	100 (30)	55 (16)	13 (4)
Lymphopenia	83 (24)	49 (14)	18 (5)	58 (17)	30 (9)	7 (2)
Gastrointestinal Disorders						
Nausea	164 (48)	14 (4)	0	94 (28)	1 (<1)	0
Diarrhea	157 (46)	23 (7)	2 (1)	58 (17)	2 (1)	0
Constipation	125 (37)	2 (1)	0	54 (16)	0	0
Vomiting	112 (33)	14 (4)	0	55 (16)	2 (1)	0
Abdominal Pain	49 (14)	7 (2)	0	22 (7)	1 (<1)	0
Abdominal Pain Upper	40 (12)	1 (<1)	0	29 (9)	0	0
Dyspepsia	39 (11)	0	0	23 (7)	0	0
Nervous System Disorders						
Peripheral Neuropathy	159 (47)	43 (13)	2 (1)	18 (5)	0	0
Neuralgia	121 (36)	28 (8)	2 (1)	5 (1)	1 (<1)	0
Dizziness	56 (16)	7 (2)	0	37 (11)	1 (<1)	0
Headache	49 (14)	2 (1)	0	35 (10)	4 (1)	0
Paresthesia	45 (13)	6 (2)	0	15 (4)	0	0

General Disorders and Administration Site Conditions						
Pyrexia	99 (29)	8 (2)	2 (1)	64 (19)	6 (2)	2 (1)
Fatigue	98 (29)	23 (7)	2 (1)	86 (26)	7 (2)	0
Asthenia	73 (21)	20 (6)	1 (<1)	60 (18)	9 (3)	0
Edema Peripheral	68 (20)	2 (1)	0	34 (10)	0	0
Infections and Infestations						
Pneumonia	56 (16)	16 (5)	13 (4)	36 (11)	13 (4)	9 (3)
Herpes Zoster	45 (13)	11 (3)	0	14 (4)	6 (2)	0
Bronchitis	44 (13)	4 (1)	0	27 (8)	4 (1)	0
Nasopharyngitis	39 (11)	1 (<1)	0	27 (8)	0	0
Musculoskeletal and Connective Tissue Disorders						
Back Pain	58 (17)	9 (3)	1 (<1)	62 (18)	11 (3)	1 (<1)
Pain In Extremity	47 (14)	8 (2)	0	32 (9)	3 (1)	1 (<1)
Bone Pain	37 (11)	7 (2)	1 (<1)	35 (10)	7 (2)	0
Arthralgia	36 (11)	4 (1)	0	50 (15)	2 (1)	1 (<1)
Metabolism and Nutrition Disorders						
Anorexia	77 (23)	9 (3)	1 (<1)	34 (10)	4 (1)	0
Hypokalemia	44 (13)	19 (6)	3 (1)	25 (7)	8 (2)	2 (1)
Skin and Subcutaneous Tissue Disorders						
Rash	66 (19)	2 (1)	0	24 (7)	1 (<1)	0
Pruritus	35 (10)	3 (1)	0	18 (5)	0	0
Respiratory, Thoracic and Mediastinal Disorders						
Cough	71 (21)	0	0	45 (13)	2 (1)	0
Dyspnea	50 (15)	11 (3)	2 (1)	44 (13)	5 (1)	4 (1)
Psychiatric Disorders						
Insomnia	69 (20)	1 (<1)	0	43 (13)	0	0
Vascular Disorders						
Hypertension	45 (13)	8 (2)	1 (<1)	25 (7)	2 (1)	0
Hypotension	41 (12)	4 (1)	3 (1)	10 (3)	2 (1)	2 (1)

Relapsed Multiple Myeloma Randomized Study of VELCADE vs. Dexamethasone

The safety data described below and in Table 8 reflect exposure to either VELCADE (n=331) or dexamethasone (n=332) in a study of patients with relapsed multiple myeloma. VELCADE was administered intravenously at doses of 1.3 mg/m^2 twice weekly for 2 out of 3 weeks (21 day cycle). After eight 21-day cycles patients continued therapy for three 35-day cycles on a weekly schedule. Duration of treatment was up to 11 cycles (9 months) with a median duration of 6 cycles (4.1 months). For inclusion in the trial, patients must have had measurable disease and 1 to 3 prior therapies. There was no upper age limit for entry. Creatinine clearance could be as low as 20 mL/min and bilirubin levels as high as 1.5 times the upper limit of normal. The overall frequency of adverse events was similar in men and women, and in patients < 65 and ≥ 65 years of age. Most patients were Caucasian. [*see Clinical Studies (14.1)*]

Among the 331 VELCADE-treated patients, the most commonly reported events overall were asthenic conditions (61%), diarrhea and nausea (each 57%), constipation (42%), peripheral neuropathy NEC (36%), vomiting, pyrexia, thrombocytopenia, and psychiatric disorders (each 35%), anorexia and appetite decreased (34%), paresthesia and dysesthesia (27%), anemia and headache (each 26%), and cough (21%). The most commonly reported adverse events reported among the 332 patients in the dexamethasone group were psychiatric disorders (49%), asthenic conditions (45%), insomnia (27%), anemia (22%), and diarrhea and lower respiratory/lung infections (each 21%). Fourteen percent (14%) of patients in the VELCADE treated arm experienced a Grade 4 adverse event; the most common toxicities were thrombocytopenia (4%), neutropenia (2%) and hypercalcemia (2%). Sixteen percent (16%) of dexamethasone treated patients experienced a Grade 4 adverse event; the most common toxicity was hyperglycemia (2%).

Serious Adverse Events (SAEs) and Events Leading to Treatment Discontinuation in the Relapsed Multiple Myeloma Study of VELCADE vs. Dexamethasone

Serious adverse events are defined as any event, regardless of causality, that results in death, is life-threatening, requires hospitalization or prolongs a current hospitalization, results in a significant disability, or is deemed to be an important medical event. A total of 144 (44%) patients from the VELCADE treatment arm experienced an SAE during the study, as did 144 (43%) dexamethasone-treated patients. The most commonly reported SAEs in the VELCADE treatment arm were pyrexia (6%), diarrhea (5%), dyspnea and pneumonia (4%), and vomiting (3%). In the dexamethasone treatment group, the most commonly reported SAEs were pneumonia (7%), pyrexia (4%), and hyperglycemia (3%).

A total of 145 patients, including 84 (25%) of 331 patients in the VELCADE treatment group and 61 (18%) of 332 patients in the dexamethasone treatment group were discontinued from treatment due to adverse events assessed as drug-related by the investigators. Among the 331 VELCADE treated patients, the most commonly reported drug-related event leading to discontinuation was peripheral neuropathy (8%). Among the 332 patients in the dexamethasone group, the most commonly reported drug-related events leading to treatment discontinuation were psychotic disorder and hyperglycemia (2% each).

Four deaths were considered to be VELCADE related in this relapsed multiple myeloma study: 1 case each of cardiogenic shock, respiratory insufficiency, congestive heart failure and cardiac arrest. Four deaths were considered dexamethasone-related: 2 cases of sepsis, 1 case of bacterial meningitis, and 1 case of sudden death at home.

Most Commonly Reported Adverse Events in the Relapsed Multiple Myeloma Study of VELCADE vs. Dexamethasone

The most common adverse events from the relapsed multiple myeloma study are shown in Table 8. All adverse events with incidence ≥ 10% in the VELCADE arm are included.

Table 8: Most Commonly Reported Adverse Events (≥ 10% in VELCADE arm), with Grades 3 and 4 Intensity in the Relapsed Multiple Myeloma Study of VELCADE vs. Dexamethasone (N=663)

	Treatment Group					
	VELCADE (n=331) [n (%)]			Dexamethasone (n=332) [n (%)]		
	All Events	Grade 3 Events	Grade 4 Events	All Events	Grade 3 Events	Grade 4 Events
Adverse Event	331 (100)	203 (61)	45 (14)	327 (98)	146 (44)	52 (16)
Asthenic conditions	201 (61)	39 (12)	1 (<1)	148 (45)	20 (6)	0
Diarrhea	190 (57)	24 (7)	0	69 (21)	6 (2)	0
Nausea	190 (57)	8 (2)	0	46 (14)	0	0
Constipation	140 (42)	7 (2)	0	49 (15)	4 (1)	0
Peripheral neuropathy	120 (36)	24 (7)	2 (<1)	29 (9)	1 (<1)	1 (<1)
Vomiting	117 (35)	11 (3)	0	20 (6)	4 (1)	0
Pyrexia	116 (35)	6 (2)	0	54 (16)	4 (1)	1 (<1)
Thrombocytopenia	115 (35)	85 (26)	12 (4)	36 (11)	18 (5)	4 (1)
Psychiatric disorders	117 (35)	9 (3)	2 (<1)	163 (49)	26 (8)	3 (<1)
Anorexia and appetite decreased	112 (34)	9 (3)	0	31 (9)	1 (<1)	0
Paresthesia and dysesthesia	91 (27)	6 (2)	0	38 (11)	1 (<1)	0
Anemia	87 (26)	31 (9)	2 (<1)	74 (22)	32 (10)	3 (<1)
Headache	85 (26)	3 (<1)	0	43 (13)	2 (<1)	0
Cough	70 (21)	2 (<1)	0	35 (11)	1 (<1)	0
Dyspnea	65 (20)	16 (5)	1 (<1)	58 (17)	9 (3)	2 (<1)
Neutropenia	62 (19)	40 (12)	8 (2)	5 (2)	4 (1)	0
Rash	61 (18)	4 (1)	0	20 (6)	0	0
Insomnia	60 (18)	1 (<1)	0	90 (27)	5 (2)	0
Abdominal pain	53 (16)	6 (2)	0	12 (4)	1 (<1)	0
Bone pain	52 (16)	12 (4)	0	50 (15)	9 (3)	0
Lower respiratory/ lung infections	48 (15)	12 (4)	2 (<1)	69 (21)	24 (7)	1 (<1)
Pain in limb	50 (15)	5 (2)	0	24 (7)	2 (<1)	0
Back pain	46 (14)	10 (3)	0	33 (10)	4 (1)	0
Arthralgia	45 (14)	3 (<1)	0	35 (11)	5 (2)	0
Dizziness (excl. vertigo)	45 (14)	3 (<1)	0	34 (10)	0	0
Nasopharyngitis	45 (14)	1 (<1)	0	22 (7)	0	0
Herpes zoster	42 (13)	6 (2)	0	15 (5)	4 (1)	1 (<1)
Muscle cramps	41 (12)	0	0	50 (15)	3 (<1)	0
Myalgia	39 (12)	1 (<1)	0	18 (5)	1 (<1)	0
Rigors	37 (11)	0	0	8 (2)	0	0
Edema lower limb	35 (11)	0	0	43 (13)	1 (<1)	0

Safety Experience from the Phase 2 Open-Label Extension Study in Relapsed Multiple Myeloma

In the phase 2 extension study of 63 patients, no new cumulative or new long-term toxicities were observed with prolonged VELCADE treatment. These patients were treated for a total of 5.3 to 23 months, including time on VELCADE in the prior VELCADE study. [*see Clinical Studies (14)*]

Safety Experience from the Phase 3 Open-Label Study of VELCADE Subcutaneous vs. Intravenous in Relapsed Multiple Myeloma

The safety and efficacy of VELCADE administered subcutaneously were evaluated in one Phase 3 study at the recommended dose of 1.3 mg/m^2. This was a randomized, comparative study of VELCADE subcutaneous vs. intravenous in 222 patients with relapsed multiple myeloma. The safety data described below and in Table 9 reflect exposure to either VELCADE subcutaneous (n=147) or VELCADE intravenous (n=74) [*see Clinical Studies (14.1)*]

Table 9: Most Commonly Reported Adverse Events (≥ 10%), with Grade 3 and ≥ 4 Intensity in the Relapsed Multiple Myeloma Study (N=221) of VELCADE Subcutaneous vs. Intravenous

	Subcutaneous (N=147)[a]			Intravenous (N=74)[a]		
MedDRA System Organ Class	Total	Toxicity Grade, n (%)		Total	Toxicity Grade, n (%)	
MedDRA Preferred Term	n (%)	3	≥ 4	n (%)	3	≥ 4
Blood and lymphatic system disorders						
Anaemia	53 (36)	14 (10)	4 (3)	26 (35)	6 (8)	0
Leukopenia	29 (20)	9 (6)	0	16 (22)	4 (5)	1 (1)
Neutropenia	42 (29)	22 (15)	4 (3)	20 (27)	10 (14)	3 (4)
Thrombocytopenia	52 (35)	12 (8)	7 (5)	27 (36)	8 (11)	6 (8)
Gastrointestinal disorders						
Abdominal pain	5 (3)	1 (1)	0	8 (11)	0	0
Abdominal pain upper	3 (2)	0	0	8 (11)	0	0
Constipation	21 (14)	1 (1)	0	11 (15)	1 (1)	0
Diarrhea	35 (24)	2 (1)	1 (1)	27 (36)	3 (4)	1 (1)
Nausea	27 (18)	0	0	14 (19)	0	0
Vomiting	17 (12)	3 (2)	0	12 (16)	0	1 (1)
General disorders and administration site conditions						
Asthenia	23 (16)	3 (2)	0	14 (19)	4 (5)	0
Fatigue	17 (12)	3 (2)	0	15 (20)	3 (4)	0
Pyrexia	28 (19)	0	0	12 (16)	0	0
Infections and infestations						
Herpes zoster	16 (11)	2 (1)	0	7 (9)	1 (1)	0
Investigations						
Weight decreased	22 (15)	0	0	2 (3)	1 (1)	0
Metabolism and nutrition disorders						
Decreased appetite	14 (10)	0	0	7 (9)	0	0
Musculoskeletal and connective tissue disorders						
Back pain	21 (14)	1 (1)	0	8 (11)	1 (1)	1 (1)
Pain in extremity	8 (5)	1 (1)	0	8 (11)	2 (3)	0
Nervous system disorders						
Headache	5 (3)	0	0	8 (11)	0	0
Neuralgia	35 (24)	5 (3)	0	17 (23)	7 (9)	0
Peripheral neuropathies NEC[b]	56 (38)	8 (5)	1 (1)	39 (53)	11 (15)	1 (1)
Psychiatric disorders						
Insomnia	18 (12)	0	0	8 (11)	0	0
Respiratory, thoracic and mediastinal disorders						
Dyspnoea	11 (7)	2 (1)	0	9 (12)	2 (3)	0
Vascular disorders						
Hypertension	14 (10)	3 (2)	0	3 (4)	0	0

[a] Safety population: 147 patients in the subcutaneous treatment and 74 patients in the intravenous treatment who received at least 1 dose of study medication

[b] Represents MedDRA high level term

In general, safety data were similar for the subcutaneous and intravenous treatment groups. Differences were observed in the rates of some Grade ≥ 3 adverse events. Differences of ≥ 5% were reported in neuralgia (3%

subcutaneous vs. 9% intravenous), peripheral neuropathy (6% subcutaneous vs. 16% intravenous), and thrombocytopenia (13% subcutaneous vs. 19% intravenous).

A local reaction was reported in 6% of patients in the subcutaneous group as an adverse event, mostly redness. Only 2 (1%) patients were reported as having severe reactions, 1 case of pruritus and 1 case of redness. Local reactions led to reduction in injection concentration in one patient and drug discontinuation in one patient. Local reaction events resolved in a median of 6 days.

Dose reductions occurred due to drug related adverse events in 31% of patients in the subcutaneous treatment group compared with 43% of the intravenously treated patients. The most common adverse events leading to a dose reduction included peripheral sensory neuropathy (17% in the subcutaneous treatment group compared with 31% in the intravenous treatment group); and neuralgia (11% in the subcutaneous treatment group compared with 19% in the intravenous treatment group).

Serious Adverse Events (SAEs) and Events Leading to Treatment Discontinuation in the Relapsed Multiple Myeloma Study of VELCADE Subcutaneous vs. Intravenous

The incidence of serious adverse events was similar for the subcutaneous treatment group (36%) and the intravenous treatment group (35%). The most commonly reported SAEs in the subcutaneous treatment arm were pneumonia (6%) and pyrexia (3%). In the intravenous treatment group, the most commonly reported SAEs were pneumonia (7%), diarrhea (4%), peripheral sensory neuropathy (3%) and renal failure (3%).

In the subcutaneous treatment group, 27 patients (18%) discontinued study treatment due to a drug related adverse event compared with 17 patients (23%) in the intravenous treatment group. Among the 147 subcutaneously treated patients, the most commonly reported drug-related event leading to discontinuation was peripheral sensory neuropathy (5%) and neuralgia (5%). Among the 74 patients in the intravenous treatment group, the most commonly reported drug-related events leading to treatment discontinuation were peripheral sensory neuropathy (9%) and neuralgia (9%).

Two patients (1%) in the subcutaneous treatment group and 1 (1%) patient in the intravenous treatment group died due to a drug-related adverse event during treatment. In the subcutaneous group the causes of death were one case of pneumonia and one of sudden death. In the intravenous group the cause of death was coronary artery insufficiency.

Integrated Summary of Safety (Relapsed Multiple Myeloma and Mantle Cell Lymphoma)

Safety data from phase 2 and 3 studies of single agent VELCADE 1.3 mg/m^2/dose twice weekly for 2 weeks followed by a 10-day rest period in 1163 patients with previously treated multiple myeloma (N=1008) and previously treated mantle cell lymphoma (N=155) were integrated and tabulated. This analysis does not include data from the Phase 3 Open-Label Study of VELCADE subcutaneous vs. intravenous in relapsed multiple myeloma. In the integrated studies, the safety profile of VELCADE was similar in patients with multiple myeloma and mantle cell lymphoma. [*see Clinical Studies (14)*]

In the integrated analysis, the most commonly reported adverse events were asthenic conditions (including fatigue, malaise, and weakness) (64%), nausea (55%), diarrhea (52%), constipation (41%), peripheral neuropathy NEC (including peripheral sensory neuropathy and peripheral neuropathy aggravated) (39%), thrombocytopenia and appetite decreased (including anorexia) (each 36%), pyrexia (34%), vomiting (33%), and anemia (29%). Twenty percent (20%) of patients experienced at least 1 episode of ≥ Grade 4 toxicity, most commonly thrombocytopenia (5%) and neutropenia (3%).

Serious Adverse Events (SAEs) and Events Leading to Treatment Discontinuation in the Integrated Summary of Safety

A total of 50% of patients experienced SAEs during the studies. The most commonly reported SAEs included pneumonia (7%), pyrexia (6%), diarrhea (5%), vomiting (4%), and nausea, dehydration, dyspnea and thrombocytopenia (each 3%).

Adverse events thought by the investigator to be drug-related and leading to discontinuation occurred in 22% of patients. The reasons for discontinuation included peripheral neuropathy (8%), asthenic conditions (3%) and thrombocytopenia and diarrhea (each 2%).

In total, 2% of the patients died and the cause of death was considered by the investigator to be possibly related to study drug: including reports of cardiac arrest, congestive heart failure, respiratory failure, renal failure, pneumonia and sepsis.

Most Commonly Reported Adverse Events in the Integrated Summary of Safety

The most common adverse events are shown in Table 10. All adverse events occurring at ≥ 10% are included. In the absence of a randomized comparator arm, it is often not possible to distinguish between adverse events that are drug-caused and those that reflect the patient's underlying disease. Please see the discussion of specific adverse reactions that follows.

Table 10: Most Commonly Reported (≥ 10% Overall) Adverse Events in Integrated Analyses of Relapsed Multiple Myeloma and Mantle Cell Lymphoma Studies using the 1.3 mg/m^2 Dose (N=1163)

	All Patients (N=1163)		Multiple Myeloma (N=1008)		Mantle Cell Lymphoma (N=155)	
Adverse Events	**All Events**	**≥ Grade 3**	**All Events**	**≥ Grade 3**	**All Events**	**≥ Grade 3**
Asthenic conditions	740 (64)	189 (16)	628 (62)	160 (16)	112 (72)	29 (19)
Nausea	640 (55)	43 (4)	572 (57)	39 (4)	68 (44)	4 (3)
Diarrhea	604 (52)	96 (8)	531 (53)	85 (8)	73 (47)	11 (7)
Constipation	481 (41)	26 (2)	404 (40)	22 (2)	77 (50)	4 (3)
Peripheral neuropathy	457 (39)	134 (12)	372 (37)	114 (11)	85 (55)	20 (13)
Thrombocytopenia	421 (36)	337 (29)	388 (38)	320 (32)	33 (21)	17 (11)
Appetite decreased	417 (36)	30 (3)	357 (35)	25 (2)	60 (39)	5 (3)
Pyrexia	401 (34)	36 (3)	371 (37)	34 (3)	30 (19)	2 (1)
Vomiting	385 (33)	57 (5)	343 (34)	53 (5)	42 (27)	4 (3)
Anemia	333 (29)	124 (11)	306 (30)	120 (12)	27 (17)	4 (3)
Edema	262 (23)	10 (<1)	218 (22)	6 (<1)	44 (28)	4 (3)
Paresthesia and dysesthesia	254 (22)	16 (1)	240 (24)	14 (1)	14 (9)	2 (1)
Headache	253 (22)	17 (1)	227 (23)	17 (2)	26 (17)	0
Dyspnea	244 (21)	59 (5)	209 (21)	52 (5)	35 (23)	7 (5)
Cough	232 (20)	5 (<1)	202 (20)	5 (<1)	30 (19)	0
Insomnia	232 (20)	7 (<1)	199 (20)	6 (<1)	33 (21)	1 (<1)
Rash	213 (18)	10 (<1)	170 (17)	6 (<1)	43 (28)	4 (3)
Arthralgia	199 (17)	27 (2)	179 (18)	25 (2)	20 (13)	2 (1)
Neutropenia	195 (17)	143 (12)	185 (18)	137 (14)	10 (6)	6 (4)
Dizziness (excluding vertigo)	195 (17)	18 (2)	159 (16)	13 (1)	36 (23)	5 (3)
Pain in limb	179 (15)	36 (3)	172 (17)	36 (4)	7 (5)	0
Abdominal pain	170 (15)	30 (3)	146 (14)	22 (2)	24 (15)	8 (5)
Bone pain	166 (14)	37 (3)	163 (16)	37 (4)	3 (2)	0
Back pain	151 (13)	39 (3)	150 (15)	39 (4)	1 (<1)	0
Hypotension	147 (13)	37 (3)	124 (12)	32 (3)	23 (15)	5 (3)
Herpes zoster	145 (12)	22 (2)	131 (13)	21 (2)	14 (9)	1 (<1)
Nasopharyngitis	139 (12)	2 (<1)	126 (13)	2 (<1)	13 (8)	0
Upper respiratory tract infection	138 (12)	2 (<1)	114 (11)	1 (<1)	24 (15)	1 (<1)
Myalgia	136 (12)	9 (<1)	121 (12)	9 (<1)	15 (10)	0
Pneumonia	134 (12)	72 (6)	120 (12)	65 (6)	14 (9)	7 (5)
Muscle cramps	125 (11)	1 (<1)	118 (12)	1 (<1)	7 (5)	0
Dehydration	120 (10)	40 (3)	109 (11)	33 (3)	11 (7)	7 (5)
Anxiety	118 (10)	6 (<1)	111 (11)	6 (<1)	7 (5)	0

Description of Selected Adverse Events from the Integrated Phase 2 and 3 Relapsed Multiple Myeloma and Phase 2 Mantle Cell Lymphoma Studies

Gastrointestinal Events

A total of 87% of patients experienced at least one GI disorder. The most common GI disorders included nausea, diarrhea, constipation, vomiting, and appetite decreased. Other GI disorders included dyspepsia and dysgeusia. Grade 3 GI events occurred in 18% of patients; Grade 4 events were 1%. GI events were considered serious in 11% of patients. Five percent (5%) of patients discontinued due to a GI event. Nausea was reported more often in patients with multiple myeloma (57%) compared to patients with mantle cell lymphoma (44%). [*see Warnings and Precautions (5.6)*]

Thrombocytopenia

Across the studies, VELCADE associated thrombocytopenia was characterized by a decrease in platelet count during the dosing period (days 1 to 11) and a return toward baseline during the 10-day rest period during each treatment cycle. Overall, thrombocytopenia was reported in 36% of patients. Thrombocytopenia was Grade 3 in 24%, ≥ Grade 4 in 5%, and serious in 3% of patients, and the event resulted in VELCADE discontinuation in 2% of patients [*see Warnings and Precautions (5.7)*]. Thrombocytopenia was reported more often in patients with multiple myeloma (38%) compared to patients with mantle cell lymphoma (21%). The incidence of ≥ Grade 3 thrombocytopenia also was higher in patients with multiple myeloma (32%) compared to patients with mantle cell lymphoma (11%). [*see Warnings and Precautions (5.7)*]

Peripheral Neuropathy

Overall, peripheral neuropathy NEC occurred in 39% of patients. Peripheral neuropathy was Grade 3 for 11% of patients and Grade 4 for < 1% of patients. Eight percent (8%) of patients discontinued VELCADE due to peripheral neuropathy. The incidence of peripheral neuropathy was higher among patients with mantle cell lymphoma (55%) compared to patients with multiple myeloma (37%).

In the relapsed multiple myeloma study, among the 87 patients who experienced ≥ Grade 2 peripheral neuropathy, 51% had improved or resolved with a median of 3.5 months from first onset.

Among the patients with peripheral neuropathy in the phase 2 multiple myeloma studies that was Grade 2 and led to discontinuation or was ≥ Grade 3, 73% (24 of 33) reported improvement or resolution following VELCADE dose adjustment, with a median time to improvement of one Grade or more from the last dose of VELCADE of 33 days**.** [*see Warnings and Precautions (5.1)*]

Hypotension

The incidence of hypotension (postural hypotension, orthostatic hypotension and hypotension NOS) was 13% in patients treated with VELCADE. Hypotension was Grade 1 or 2 in the majority of patients and Grade 3 in 3% and ≥ Grade 4 in < 1%. Three percent (3%) of patients had hypotension reported as an SAE, and 1% discontinued due to hypotension. The incidence of hypotension was similar in patients with multiple myeloma (12%) and those with mantle cell lymphoma (15%). In addition, 2% of patients experienced hypotension and had a syncopal event. Doses of antihypertensive medications may need to be adjusted in patients receiving VELCADE. [*see Warnings and Precautions (5.2)*]

Neutropenia

Neutrophil counts decreased during the VELCADE dosing period (days 1 to 11) and returned toward baseline during the 10-day rest period during each treatment cycle. Overall, neutropenia occurred in 17% of patients and was Grade 3 in 9% of patients and ≥ Grade 4 in 3%. Neutropenia was reported as a serious event in < 1% of patients and < 1% of patients discontinued due to neutropenia. The incidence of neutropenia was higher in patients with multiple myeloma (18%) compared to patients with mantle cell lymphoma (6%). The incidence of ≥ Grade 3 neutropenia also was higher in patients with multiple myeloma (14%) compared to patients with mantle cell lymphoma (4%). [*see Warnings and Precautions (5.7)*]

Asthenic conditions (Fatigue, Malaise, Weakness)
Asthenic conditions were reported in 64% of patients. Asthenia was Grade 3 for 16% and ≥ Grade 4 in < 1% of patients. Four percent (4%) of patients discontinued treatment due to asthenia. Asthenic conditions were reported in 62% of patients with multiple myeloma and 72% of patients with mantle cell lymphoma.

Pyrexia
Pyrexia (> 38ºC) was reported as an adverse event for 34% of patients. The event was Grade 3 in 3% and ≥ Grade 4 in < 1%. Pyrexia was reported as a serious adverse event in 6% of patients and led to VELCADE discontinuation in < 1% of patients. The incidence of pyrexia was higher among patients with multiple myeloma (37%) compared to patients with mantle cell lymphoma (19%). The incidence of ≥ Grade 3 pyrexia was 3% in patients with multiple myeloma and 1% in patients with mantle cell lymphoma.

Herpes Virus Infection
Physicians should consider using antiviral prophylaxis in subjects being treated with VELCADE. In the randomized studies in previously untreated and relapsed multiple myeloma, herpes zoster reactivation was more common in subjects treated with VELCADE (13%) than in the control groups (4-5%). Herpes simplex was seen in 2-8% in subjects treated with VELCADE and 1-5% in the control groups. In the previously untreated multiple myeloma study, herpes zoster virus reactivation in the VELCADE, melphalan and prednisone arm was less common in subjects receiving prophylactic antiviral therapy (3%) than in subjects who did not receive prophylactic antiviral therapy (17%). In the postmarketing experience, rare cases of herpes meningoencephalitis and ophthalmic herpes have been reported.

Additional Adverse Events from Clinical Studies

The following clinically important SAEs that are not described above have been reported in clinical trials in patients treated with VELCADE administered as monotherapy or in combination with other chemotherapeutics. These studies were conducted in patients with hematological malignancies and in solid tumors.

Blood and lymphatic system disorders: Disseminated intravascular coagulation, lymphopenia, leukopenia

Cardiac disorders: Angina pectoris, atrial fibrillation aggravated, atrial flutter, bradycardia, sinus arrest, cardiac amyloidosis, complete atrioventricular block, myocardial ischemia, myocardial infarction, pericarditis, pericardial effusion, *Torsades de pointes*, ventricular tachycardia

Ear and labyrinth disorders: Hearing impaired, vertigo

Eye disorders: Diplopia and blurred vision, conjunctival infection, irritation

Gastrointestinal disorders: Ascites, dysphagia, fecal impaction, gastroenteritis, gastritis hemorrhagic, hematemesis, hemorrhagic duodenitis, ileus paralytic, large intestinal obstruction, paralytic intestinal obstruction, peritonitis, small intestinal obstruction, large intestinal perforation, stomatitis, melena, pancreatitis acute, oral mucosal petechiae, gastroesophageal reflux

General disorders and administration site conditions: Injection site erythema, neuralgia, injection site pain, irritation, phlebitis

Hepatobiliary disorders: Cholestasis, hepatic hemorrhage, hyperbilirubinemia, portal vein thrombosis, hepatitis, liver failure

Immune system disorders: Anaphylactic reaction, drug hypersensitivity, immune complex mediated hypersensitivity, angioedema, laryngeal edema

Infections and infestations: Aspergillosis, bacteremia, urinary tract infection, herpes viral infection, listeriosis, septic shock, toxoplasmosis, oral candidiasis, sinusitis, catheter related infection

Injury, poisoning and procedural complications: Catheter related complication, skeletal fracture, subdural hematoma

Metabolism and nutrition disorders: Hypocalcemia, hyperuricemia, hypokalemia, hyperkalemia, hyponatremia, hypernatremia

Nervous system disorders*:* Ataxia, coma, dysarthria, dysautonomia, encephalopathy, cranial palsy, grand mal convulsion, hemorrhagic stroke, motor dysfunction, spinal cord compression, paralysis, postherpetic neuralgia, transient ischemic attack

Psychiatric disorders*:* Agitation, confusion, mental status change, psychotic disorder, suicidal ideation

Renal and urinary disorders: Calculus renal, bilateral hydronephrosis, bladder spasm, hematuria, hemorrhagic cystitis, urinary incontinence, urinary retention, renal failure (acute and chronic), glomerular nephritis proliferative

Respiratory, thoracic and mediastinal disorders: Acute respiratory distress syndrome, aspiration pneumonia, atelectasis, chronic obstructive airways disease exacerbated, dysphagia, dyspnea, dyspnea exertional, epistaxis, hemoptysis, hypoxia, lung infiltration, pleural effusion, pneumonitis, respiratory distress, pulmonary hypertension

Skin and subcutaneous tissue disorders*:* Urticaria, face edema, rash (which may be pruritic), leukocytoclastic vasculitis

Vascular disorders*:* Cerebrovascular accident, cerebral hemorrhage, deep venous thrombosis, peripheral embolism, pulmonary embolism, pulmonary hypertension

6.2 Postmarketing Experience

The following adverse drug reactions have been identified from the worldwide postmarketing experience with VELCADE. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure: atrioventricular block complete, cardiac tamponade, ischemic colitis, encephalopathy, dysautonomia, deafness bilateral, disseminated intravascular coagulation, hepatitis, acute pancreatitis, acute diffuse infiltrative pulmonary disease, reversible posterior leukoencephalopathy syndrome, toxic epidermal necrolysis, acute febrile neutrophilic dermatosis (Sweet's syndrome), herpes meningoencephalitis, optic neuropathy, blindness and ophthalmic herpes.

7 DRUG INTERACTIONS

Bortezomib is a substrate of cytochrome P450 enzyme 3A4, 2C19 and 1A2.

7.1 CYP3A4 inhibitors: Co-administration of ketoconazole, a strong CYP3A4 inhibitor, increased the exposure of bortezomib by 35% in 12 patients. Therefore, patients should be closely monitored when given bortezomib in combination with strong CYP3A4 inhibitors (e.g. ketoconazole, ritonavir).

7.2 CYP2C19 inhibitors: Co-administration of omeprazole, a strong inhibitor of CYP2C19, had no effect on the exposure of bortezomib in 17 patients.

7.3 CYP3A4 inducers: Co-administration of rifampin, a strong CYP3A4 inducer, is expected to decrease the exposure of bortezomib by at least 45%. Because the drug interaction study (n=6) was not designed to exert the maximum effect of rifampin on bortezomib PK, decreases greater than 45% may occur.

Efficacy may be reduced when VELCADE is used in combination with strong CYP3A4 inducers; therefore, concomitant use of strong CYP3A4 inducers is not recommended in patients receiving VELCADE.

St. John's Wort (*Hypericum perforatum*) may decrease bortezomib exposure unpredictably and should be avoided.

7.4 Dexamethasone: Co-administration of dexamethasone, a weak CYP3A4 inducer, had no effect on the exposure of bortezomib in 7 patients.

7.5 Melphalan-Prednisone: Co-administration of melphalan-prednisone increased the exposure of bortezomib by 17% in 21 patients. However, this increase is unlikely to be clinically relevant.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category D [*see Warnings and Precautions (5.11)*]

Bortezomib was not teratogenic in nonclinical developmental toxicity studies in rats and rabbits at the highest dose tested (0.075 mg/kg; 0.5 mg/m^2 in the rat and 0.05 mg/kg; 0.6 mg/m^2 in the rabbit) when administered during organogenesis. These dosages are approximately half the clinical dose of 1.3 mg/m^2 based on body surface area.

Pregnant rabbits given bortezomib during organogenesis at a dose of 0.05mg/kg (0.6 mg/m^2) experienced significant post-implantation loss and decreased number of live fetuses. Live fetuses from these litters also showed significant decreases in fetal weight. The dose is approximately 0.5 times the clinical dose of 1.3 mg/m^2 based on body surface area.

There are no adequate and well-controlled studies in pregnant women. If VELCADE is used during pregnancy, or if the patient becomes pregnant while receiving this drug, the patient should be apprised of the potential hazard to the fetus.

8.3 Nursing Mothers

It is not known whether bortezomib is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VELCADE, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

The safety and effectiveness of VELCADE in children have not been established.

8.5 Geriatric Use

Of the 669 patients enrolled in the relapsed multiple myeloma study, 245 (37%) were 65 years of age or older: 125 (38%) on the VELCADE arm and 120 (36%) on the dexamethasone arm. Median time to progression and median duration of response for patients ≥ 65 were longer on VELCADE compared to dexamethasone [5.5 mo versus 4.3 mo, and 8.0 mo versus 4.9 mo, respectively]. On the VELCADE arm, 40% (n=46) of evaluable patients aged ≥ 65 experienced response (CR+PR) versus 18% (n=21) on the dexamethasone arm. The incidence of Grade 3 and 4 events was 64%, 78% and 75% for VELCADE patients ≤ 50, 51-64 and ≥ 65 years old, respectively. [*see Adverse Reactions (6.1); Clinical Studies (14)*]

No overall differences in safety or effectiveness were observed between patients≥ age 65 and younger patients receiving VELCADE; but greater sensitivity of some older individuals cannot be ruled out.

8.6 Patients with Renal Impairment

The pharmacokinetics of VELCADE are not influenced by the degree of renal impairment. Therefore, dosing adjustments of VELCADE are not necessary for patients with renal insufficiency. Since dialysis may reduce VELCADE concentrations, VELCADE should be administered after the dialysis procedure. For information concerning dosing of melphalan in patients with renal impairment see manufacturer's prescribing information. [*see Clinical Pharmacology (12.3)*]

8.7 Patients with Hepatic Impairment

The exposure of bortezomib is increased in patients with moderate and severe hepatic impairment. Starting dose should be reduced in those patients. [*see Dosage and Administration (2.6), Warnings and Precautions (5.10), and Pharmacokinetics (12.3)*]

8.8 Patients with Diabetes

During clinical trials, hypoglycemia and hyperglycemia were reported in diabetic patients receiving oral hypoglycemics. Patients on oral antidiabetic agents receiving VELCADE treatment may require close monitoring of their blood glucose levels and adjustment of the dose of their antidiabetic medication.

10 OVERDOSAGE

There is no known specific antidote for VELCADE overdosage [*see Warnings and Precautions (5) and Dosage and Administration (2)*]. In humans, fatal outcomes following the administration of more than twice the recommended therapeutic dose have been reported, which were associated with the acute onset of symptomatic hypotension (5.2) and thrombocytopenia (5.7). In the event of an overdosage, the patient's vital signs should be monitored and appropriate supportive care given.

Studies in monkeys and dogs showed that intravenous bortezomib doses as low as 2 times the recommended clinical dose on a mg/m^2 basis were associated with increases in heart rate, decreases in contractility, hypotension, and death. In dog studies, a slight increase in the corrected QT interval was observed at doses resulting in death. In monkeys, doses of 3.0 mg/m^2 and greater (approximately twice the recommended clinical dose) resulted in hypotension starting at 1 hour post-administration, with progression to death in 12 to 14 hours following drug administration.

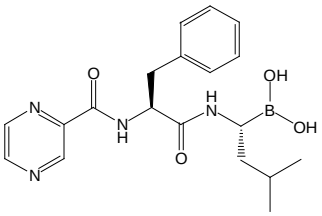
11 DESCRIPTION

VELCADE® (bortezomib) for Injection is an antineoplastic agent available for intravenous injection or subcutaneous use. Each single use vial contains 3.5 mg of bortezomib as a sterile lyophilized powder. Inactive ingredient: 35 mg mannitol, USP.

Bortezomib is a modified dipeptidyl boronic acid. The product is provided as a mannitol boronic ester which, in reconstituted form, consists of the mannitol ester in equilibrium with its hydrolysis product, the monomeric boronic acid. The drug substance exists in its cyclic anhydride form as a trimeric boroxine.

The chemical name for bortezomib, the monomeric boronic acid, is [(1R)-3-methyl-1-[[(2S)-1-oxo-3-phenyl-2-[(pyrazinylcarbonyl) amino]propyl]amino]butyl] boronic acid.

Bortezomib has the following chemical structure:



The molecular weight is 384.24. The molecular formula is $C_{19}H_{25}BN_4O_4$. The solubility of bortezomib, as the monomeric boronic acid, in water is 3.3 to 3.8 mg/mL in a pH range of 2 to 6.5.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Bortezomib is a reversible inhibitor of the chymotrypsin-like activity of the 26S proteasome in mammalian cells. The 26S proteasome is a large protein complex that degrades ubiquitinated proteins. The ubiquitin-proteasome pathway plays an essential role in regulating the intracellular concentration of specific proteins, thereby maintaining homeostasis within cells. Inhibition of the 26S proteasome prevents this targeted proteolysis, which can affect multiple signaling cascades within the cell. This disruption of normal homeostatic mechanisms can lead to cell death. Experiments have demonstrated that bortezomib is cytotoxic to a variety of cancer cell types *in vitro*. Bortezomib causes a delay in tumor growth *in vivo* in nonclinical tumor models, including multiple myeloma.

12.2 Pharmacodynamics

Following twice weekly administration of 1 mg/m^2 and 1.3 mg/m^2 bortezomib doses (n=12 per each dose level), the maximum inhibition of 20S proteasome activity (relative to baseline) in whole blood was observed 5 minutes after drug administration. Comparable maximum inhibition of 20S proteasome activity was observed between 1 and 1.3 mg/m^2 doses. Maximal inhibition ranged from 70% to 84% and from 73% to 83% for the 1 mg/m^2 and 1.3 mg/m^2 dose regimens, respectively.

12.3 Pharmacokinetics

Following intravenous administration of 1 mg/m^2 and 1.3 mg/m^2 doses to 24 patients with multiple myeloma (n=12, per each dose level), the mean maximum plasma concentrations of bortezomib (C_{max}) after the first dose (Day 1) were 57 and 112 ng/mL, respectively. In subsequent doses, when administered twice weekly, the mean maximum observed plasma concentrations ranged from 67 to 106 ng/mL for the 1 mg/m^2 dose and 89 to 120 ng/mL for the 1.3 mg/m^2 dose. The mean elimination half-life of bortezomib upon multiple dosing ranged from 40 to 193 hours after the 1 mg/m^2 dose and 76 to 108 hours after the 1.3mg/m^2 dose. The mean total body clearances was 102 and 112 L/h following the first dose for doses of 1 mg/m^2 and 1.3 mg/m^2, respectively, and ranged from 15 to 32 L/h following subsequent doses for doses of 1 and 1.3 mg/m^2, respectively.

Following an intravenous bolus or subcutaneous injection of a 1.3 mg/m^2 dose to patients (n = 14 for intravenous, n = 17 for subcutaneous) with multiple myeloma, the total systemic exposure after repeat dose administration (AUC_{last}) was equivalent for subcutaneous and intravenous administration. The C_{max} after subcutaneous administration (20.4 ng/mL) was lower than intravenous (223 ng/mL). The AUC_{last} geometric mean ratio was 0.99 and 90% confidence intervals were 80.18% - 122.80%.

Distribution: The mean distribution volume of bortezomib ranged from approximately 498 to 1884 L/m^2 following single- or repeat-dose administration of 1 mg/m^2 or 1.3mg/m^2 to patients with multiple myeloma. This suggests bortezomib distributes widely to peripheral tissues. The binding of bortezomib to human plasma proteins averaged 83% over the concentration range of 100 to 1000 ng/mL.

Metabolism: *In vitro* studies with human liver microsomes and human cDNA-expressed cytochrome P450 isozymes indicate that bortezomib is primarily oxidatively metabolized via cytochrome P450 enzymes 3A4, 2C19, and 1A2. Bortezomib metabolism by CYP 2D6 and 2C9 enzymes is minor. The major metabolic pathway is deboronation to form 2 deboronated metabolites that subsequently undergo hydroxylation to several metabolites. Deboronated bortezomib metabolites are inactive as 26S proteasome inhibitors. Pooled plasma data from 8 patients at 10 min and 30 min after dosing indicate that the plasma levels of metabolites are low compared to the parent drug.

Elimination: The pathways of elimination of bortezomib have not been characterized in humans.

Age: Analyses of data after the first dose of Cycle 1 (Day 1) in 39 multiple myeloma patients who had received intravenous doses of 1 mg/m^2 and 1.3 mg/m^2 showed that both dose-normalized AUC and C_{max} tend to be less in younger patients. Patients < 65 years of age (n=26) had about 25% lower mean dose-normalized AUC and C_{max} than those ≥ 65 years of age (n=13).

Gender: Mean dose-normalized AUC and C_{max} values were comparable between male (n=22) and female (n=17) patients after the first dose of Cycle 1 for the 1 and 1.3 mg/m^2 doses.

Race: The effect of race on exposure to bortezomib could not be assessed as most of the patients were Caucasian.

Hepatic Impairment: The effect of hepatic impairment (see Table 4 for definition of hepatic impairment) on the pharmacokinetics of bortezomib was assessed in 51 cancer patients at bortezomib doses ranging from 0.5 to 1.3 mg/m^2. When compared to patients with normal hepatic function, mild hepatic impairment did not alter dose-normalized bortezomib AUC. However, the dose-normalized mean AUC values were increased by

approximately 60% in patients with moderate or severe hepatic impairment. A lower starting dose is recommended in patients with moderate or severe hepatic impairment, and those patients should be monitored closely. [*see Dosage and Administration (2.6), Warnings and Precautions (5.10) and Use in Specific Populations (8.7)*]

Renal Impairment*:* A pharmacokinetic study was conducted in patients with various degrees of renal impairment who were classified according to their creatinine clearance values (CrCl) into the following groups: Normal (CrCl ≥60 mL/min/1.73 m^2, N=12), Mild (CrCl=40-59 mL/min/1.73 m^2, N=10), Moderate (CrCl=20-39 mL/min/1.73 m^2, N=9), and Severe (CrCl < 20 mL/min/1.73 m^2, N=3). A group of dialysis patients who were dosed after dialysis was also included in the study (N=8). Patients were administered intravenous doses of 0.7 to 1.3 mg/m^2 of bortezomib twice weekly. Exposure of bortezomib (dose-normalized AUC and C_{max}) was comparable among all the groups. [*see Use in Specific Populations (8.6)*]

Pediatric: There are no pharmacokinetic data in pediatric patients.

Cytochrome P450**:** Bortezomib is a poor inhibitor of human liver microsome cytochrome P450 1A2, 2C9, 2D6, and 3A4, with IC_{50} values of > 30μM (> 11.5μg/mL). Bortezomib may inhibit 2C19 activity (IC_{50} = 18 μM, 6.9 μg/mL) and increase exposure to drugs that are substrates for this enzyme. Bortezomib did not induce the activities of cytochrome P450 3A4 and 1A2 in primary cultured human hepatocytes.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenicity studies have not been conducted with bortezomib.

Bortezomib showed clastogenic activity (structural chromosomal aberrations) in the in vitro chromosomal aberration assay using Chinese hamster ovary cells. Bortezomib was not genotoxic when tested in the in vitro mutagenicity assay (Ames test) and in vivo micronucleus assay in mice.

Fertility studies with bortezomib were not performed but evaluation of reproductive tissues has been performed in the general toxicity studies. In the 6-month rat toxicity study, degenerative effects in the ovary were observed at doses ≥ 0.3 mg/m^2 (one-fourth of the recommended clinical dose), and degenerative changes in the testes occurred at 1.2 mg/m^2. VELCADE could have a potential effect on either male or female fertility.

13.2 Animal Toxicology and/or Pharmacology

Cardiovascular Toxicity: Studies in monkeys showed that administration of dosages approximately twice the recommended clinical dose resulted in heart rate elevations, followed by profound progressive hypotension, bradycardia, and death 12 to 14 hours post dose. Doses ≥ 1.2 mg/m^2 induced dose-proportional changes in cardiac parameters. Bortezomib has been shown to distribute to most tissues in the body, including the myocardium. In a repeated dosing toxicity study in the monkey, myocardial hemorrhage, inflammation, and necrosis were also observed.

Chronic Administration: In animal studies at a dose and schedule similar to that recommended for patients (twice weekly dosing for 2 weeks followed by 1-week rest), toxicities observed included severe anemia and thrombocytopenia, and gastrointestinal, neurological and lymphoid system toxicities. Neurotoxic effects of bortezomib in animal studies included axonal swelling and degeneration in peripheral nerves, dorsal spinal roots, and tracts of the spinal cord. Additionally, multifocal hemorrhage and necrosis in the brain, eye, and heart were observed.

14 CLINICAL STUDIES

14.1 Multiple Myeloma

Randomized, Open-Label Clinical Study in Patients with Previously Untreated Multiple Myeloma:
A prospective, international, randomized (1:1), open-label clinical study of 682 patients was conducted to determine whether VELCADE administered intravenously (1.3 mg/m^2) in combination with melphalan

(9 mg/m^2) and prednisone (60 mg/m^2) resulted in improvement in time to progression (TTP) when compared to melphalan (9 mg/m^2) and prednisone (60 mg/m^2) in patients with previously untreated multiple myeloma. Treatment was administered for a maximum of 9 cycles (approximately 54 weeks) and was discontinued early for disease progression or unacceptable toxicity. Antiviral prophylaxis was recommended for patients on the VELCADE study arm.

The median age of the patients in the study was 71 years (48;91), 50% were male, 88% were Caucasian and the median Karnofsky performance status score for the patients was 80 (60;100). Patients had IgG/IgA/Light chain myeloma in 63%/25%/8% instances, a median hemoglobin of 105 g/L (64;165), and a median platelet count of 221,500 /microliter (33,000;587,000).

Efficacy results for the trial are presented in Table 11. At a pre-specified interim analysis (with median follow-up of 16.3 months), the combination of VELCADE, melphalan and prednisone therapy resulted in significantly superior results for time to progression, progression-free survival, overall survival and response rate. Further enrollment was halted, and patients receiving melphalan and prednisone were offered VELCADE in addition. A later, pre-specified analysis of overall survival (with median follow-up of 36.7 months with a hazard ratio of 0.65, 95% CI: 0.51, 0.84) resulted in a statistically significant survival benefit for the VELCADE, melphalan and prednisone treatment arm despite subsequent therapies including VELCADE based regimens. In an updated analysis of overall survival based on 387 deaths (median follow-up 60.1 months), the median overall survival for the VELCADE, melphalan and prednisone treatment arm was 56.4 months and for the melphalan and prednisone treatment arm was 43.1 months, with a hazard ratio of 0.695 (95% CI: 0.57, 0.85).

Table 11: Summary of Efficacy Analyses in the Previously Untreated Multiple Myeloma Study

Efficacy Endpoint	VELCADE, Melphalan and Prednisone n=344	Melphalan and Prednisone n=338
Time to Progression		
Events n (%)	101 (29)	152 (45)
Median[a] (months)	20.7	15.0
(95% CI)	(17.6, 24.7)	(14.1, 17.9)
Hazard ratio[b]	0.54	
(95% CI)	(0.42, 0.70)	
p-value[c]	0.000002	
Progression-free Survival		
Events n (%)	135 (39)	190 (56)
Median[a] (months)	18.3	14.0
(95% CI)	(16.6, 21.7)	(11.1, 15.0)
Hazard ratio[b]	0.61	
(95% CI)	(0.49, 0.76)	
p-value[c]	0.00001	
Response Rate		
CR[d] n (%)	102 (30)	12 (4)
PR[d] n (%)	136 (40)	103 (30)
nCR n (%)	5 (1)	0
CR + PR[d] n (%)	238 (69)	115 (34)
p-value[e]	$<10^{-10}$	
Overall Survival at median follow up of 36.7 months		
Events (deaths) n (%)	109 (32)	148 (44)
Median[a] (months)	Not Reached	43.1
(95% CI)	(46.2, NR)	(34.8, NR)
Hazard ratio[b]	0.65	
(95% CI)	(0.51, 0.84)	
p-value[c]	0.00084	

Note: All results are based on the analysis performed at a median follow-up duration of 16.3 months except for the overall survival analysis.

[a] Kaplan-Meier estimate

[b] Hazard ratio estimate is based on a Cox proportional-hazard model adjusted for stratification factors: beta2-microglobulin, albumin, and region. A hazard ratio less than 1 indicates an advantage for VELCADE, melphalan and prednisone

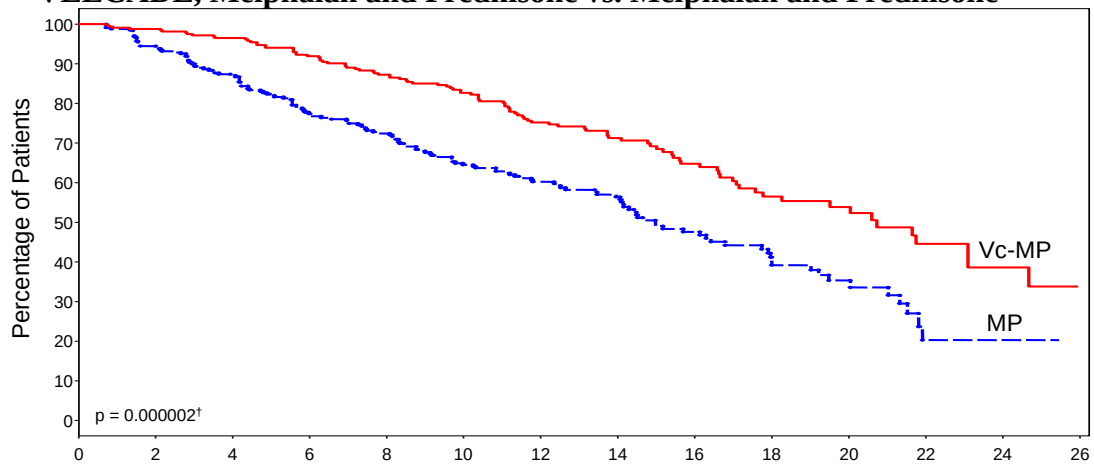
[c] p-value based on the stratified log-rank test adjusted for stratification factors: beta2-microglobulin, albumin, and region

[d] EBMT criteria

[e] p-value for Response Rate (CR + PR) from the Cochran-Mantel-Haenszel chi-square test adjusted for the stratification factors

TTP was statistically significantly longer on the VELCADE, melphalan and prednisone arm (see Figure 1). (median follow-up 16.3 months)

Figure 1: Time to Progression
VELCADE, Melphalan and Prednisone vs. Melphalan and Prednisone



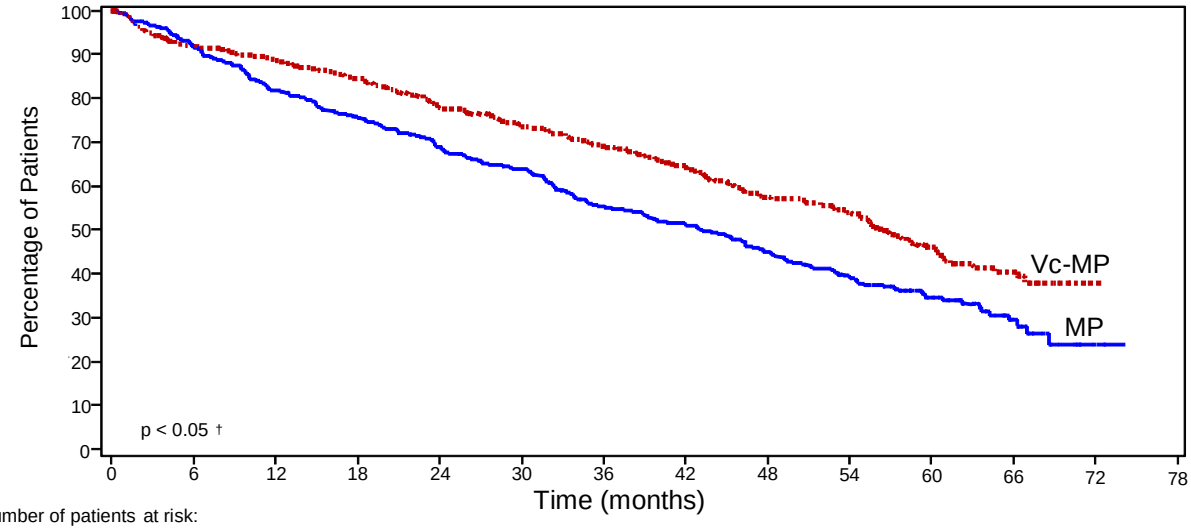
Number of patients at risk:

Vc-MP (n*)	344	309	280	258	240	200	159	114	81	53	35	20	13
MP (n*)	338	298	264	218	200	160	128	90	61	41	20	6	3

* Patients remaining after the indicated timepoint
† p-value from log-rank test

Overall survival was statistically significantly longer on the VELCADE, melphalan and prednisone arm (see Figure 2). (median follow-up 60.1 months)

Figure 2: Overall Survival
VELCADE, Melphalan and Prednisone vs. Melphalan and Prednisone



Number of patients at risk:

Vc-MP (n*):	344	300	288	270	246	232	216	199	176	158	78	34	1	0
MP (n*):	338	301	262	240	216	196	168	153	133	112	61	24	3	0

* Patients remaining after the indicated timepoint
† p-value from log-rank test

Randomized, Clinical Study in Relapsed Multiple Myeloma of VELCADE vs. Dexamethasone

A prospective phase 3, international, randomized (1:1), stratified, open-label clinical study enrolling 669 patients was designed to determine whether VELCADE resulted in improvement in time to progression (TTP) compared to high-dose dexamethasone in patients with progressive multiple myeloma following 1 to 3 prior therapies. Patients considered to be refractory to prior high-dose dexamethasone were excluded as were those with baseline Grade ≥ 2 peripheral neuropathy or platelet counts < 50,000/μL. A total of 627 patients were evaluable for response.

Stratification factors were based on the number of lines of prior therapy the patient had previously received (1 previous line versus more than 1 line of therapy), time of progression relative to prior treatment (progression during or within 6 months of stopping their most recent therapy versus relapse > 6 months after receiving their most recent therapy), and screening β_2-microglobulin levels (≤ 2.5 mg/L versus > 2.5 mg/L).

Baseline patient and disease characteristics are summarized in Table 12.

Table 12: Summary of Baseline Patient and Disease Characteristics in the Relapsed Multiple Myeloma Study

Patient Characteristics	**VELCADE N=333**	**Dexamethasone N=336**
Median age in years (range)	62.0 (33, 84)	61.0 (27, 86)
Gender: Male/female	56% / 44%	60% / 40%
Race: Caucasian/black/other	90% / 6% / 4%	88% / 7% / 5%
Karnofsky performance status score ≤70	13%	17%
Hemoglobin <100 g/L	32%	28%
Platelet count <75 x 10^9/L	6%	4%
Disease Characteristics		
Type of myeloma (%): IgG/IgA/Light chain	60% / 23% / 12%	59% / 24% / 13%
Median β_2-microglobulin (mg/L)	3.7	3.6
Median albumin (g/L)	39.0	39.0
Creatinine clearance ≤30 mL/min [n (%)]	17 (5%)	11 (3%)
Median Duration of Multiple Myeloma Since Diagnosis (Years)	3.5	3.1
Number of Prior Therapeutic Lines of Treatment		
Median	2	2
1 prior line	40%	35%
>1 prior line	60%	65%
Previous Therapy		
Any prior steroids, e.g., dexamethasone, VAD	98%	99%
Any prior anthracyclines, e.g., VAD, mitoxantrone	77%	76%
Any prior alkylating agents, e.g., MP, VBMCP	91%	92%
Any prior thalidomide therapy	48%	50%
Vinca alkaloids	74%	72%
Prior stem cell transplant/other high-dose therapy	67%	68%
Prior experimental or other types of therapy	3%	2%

Patients in the VELCADE treatment group were to receive eight 3-week treatment cycles followed by three 5-week treatment cycles of VELCADE. Patients achieving a CR were treated for 4 cycles beyond first evidence of CR. Within each 3-week treatment cycle, VELCADE 1.3 mg/m^2/dose alone was administered by intravenous bolus twice weekly for 2 weeks on Days 1, 4, 8, and 11 followed by a 10-day rest period (Days 12 to 21).

Within each 5-week treatment cycle, VELCADE 1.3 mg/m^2/dose alone was administered by intravenous bolus once weekly for 4 weeks on Days 1, 8, 15, and 22 followed by a 13-day rest period (Days 23 to 35). [*see Dosage and Administration (2.1)*]

Patients in the dexamethasone treatment group were to receive four 5-week treatment cycles followed by five 4-week treatment cycles. Within each 5-week treatment cycle, dexamethasone 40 mg/day PO was administered once daily on Days 1 to 4, 9 to 12, and 17 to 20 followed by a 15-day rest period (Days 21-35). Within each 4-week treatment cycle, dexamethasone 40 mg/day PO was administered once daily on Days 1 to 4 followed by a 24-day rest period (Days 5 to 28). Patients with documented progressive disease on dexamethasone were offered VELCADE at a standard dose and schedule on a companion study. Following a preplanned interim analysis of time to progression, the dexamethasone arm was halted and all patients randomized to dexamethasone were offered VELCADE, regardless of disease status.

In the VELCADE arm, 34% of patients received at least one VELCADE dose in all 8 of the 3-week cycles of therapy, and 13% received at least one dose in all 11 cycles. The average number of VELCADE doses during the study was 22, with a range of 1 to 44. In the dexamethasone arm, 40% of patients received at least one dose in all 4 of the 5-week treatment cycles of therapy, and 6% received at least one dose in all 9 cycles.

The time to event analyses and response rates from the relapsed multiple myeloma study are presented in Table 13. Response and progression were assessed using the European Group for Blood and Marrow Transplantation (EBMT) criteria. Complete response (CR) required < 5% plasma cells in the marrow, 100% reduction in M-protein, and a negative immunofixation test (IF^-). Partial response (PR) requires ≥ 50% reduction in serum myeloma protein and ≥ 90% reduction of urine myeloma protein on at least 2 occasions for a minimum of at least 6 weeks along with stable bone disease and normal calcium. Near complete response (nCR) was defined as meeting all the criteria for complete response including 100% reduction in M-protein by protein electrophoresis; however, M-protein was still detectable by immunofixation (IF^+).

Table 13: Summary of Efficacy Analyses in the Relapsed Multiple Myeloma Study

	All Patients		1 Prior Line of Therapy		> 1 Prior Line of Therapy	
	VELCADE	**Dex**	**VELCADE**	**Dex**	**VELCADE**	**Dex**
Efficacy Endpoint	**n=333**	**n=336**	**n=132**	**n=119**	**n=200**	**n=217**
Time to Progression						
Events n (%)	147 (44)	196 (58)	55 (42)	64 (54)	92 (46)	132 (61)
Median [a] (95% CI)	6.2 mo (4.9, 6.9)	3.5 mo (2.9, 4.2)	7.0 mo (6.2, 8.8)	5.6 mo (3.4, 6.3)	4.9 mo (4.2, 6.3)	2.9 mo (2.8, 3.5)
Hazard ratio [b] (95% CI)	0.55 (0.44, 0.69)		0.55 (0.38, 0.81)		0.54 (0.41, 0.72)	
p-value [c]	<0.0001		0.0019		<0.0001	
Overall Survival						
Events (deaths) n (%)	51 (15)	84 (25)	12 (9)	24 (20)	39 (20)	60 (28)
Hazard ratio [b] (95% CI)	0.57 (0.40, 0.81)		0.39 (0.19, 0.81)		0.65 (0.43, 0.97)	
p-value [c,d]	<0.05		<0.05		<0.05	
Response Rate						
Population [e] n = 627	n=315	n=312	n=128	n=110	n=187	n=202
CR [f] n (%)	20 (6)	2 (<1)	8 (6)	2 (2)	12 (6)	0 (0)
PR [f] n(%)	101 (32)	54 (17)	49 (38)	27 (25)	52 (28)	27 (13)
nCR [f,g] n(%)	21 (7)	3 (<1)	8 (6)	2 (2)	13 (7)	1 (<1)
CR + PR [f] n (%)	121 (38)	56 (18)	57 (45)	29 (26)	64 (34)	27 (13)
p-value [h]	<0.0001		0.0035		<0.0001	

[a] Kaplan-Meier estimate

[b] Hazard ratio is based on Cox proportional-hazard model with the treatment as single independent variable. A hazard ratio less than 1 indicates an advantage for VELCADE

[c] p-value based on the stratified log-rank test including randomization stratification factors

[d] Precise p-value cannot be rendered

[e] Response population includes patients who had measurable disease at baseline and received at least 1 dose of study drug

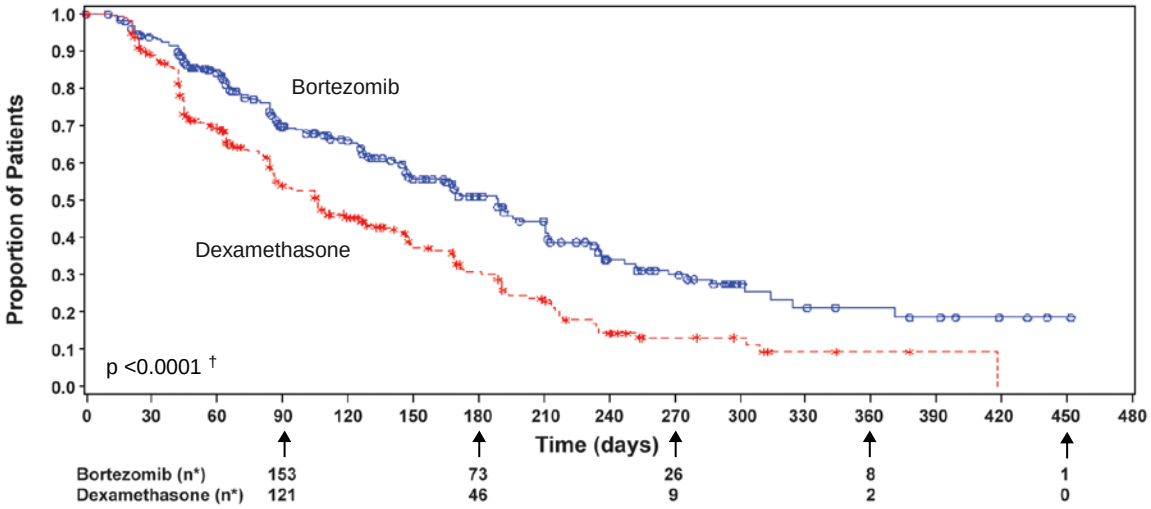
[f] EBMT criteria; nCR meets all EBMT criteria for CR but has positive IF. Under EBMT criteria nCR is in the PR category

[g] In 2 patients, the IF was unknown

[h] p-value for Response Rate (CR + PR) from the Cochran-Mantel-Haenszel chi-square test adjusted for the stratification factors

TTP was statistically significantly longer on the VELCADE arm (see Figure 3).

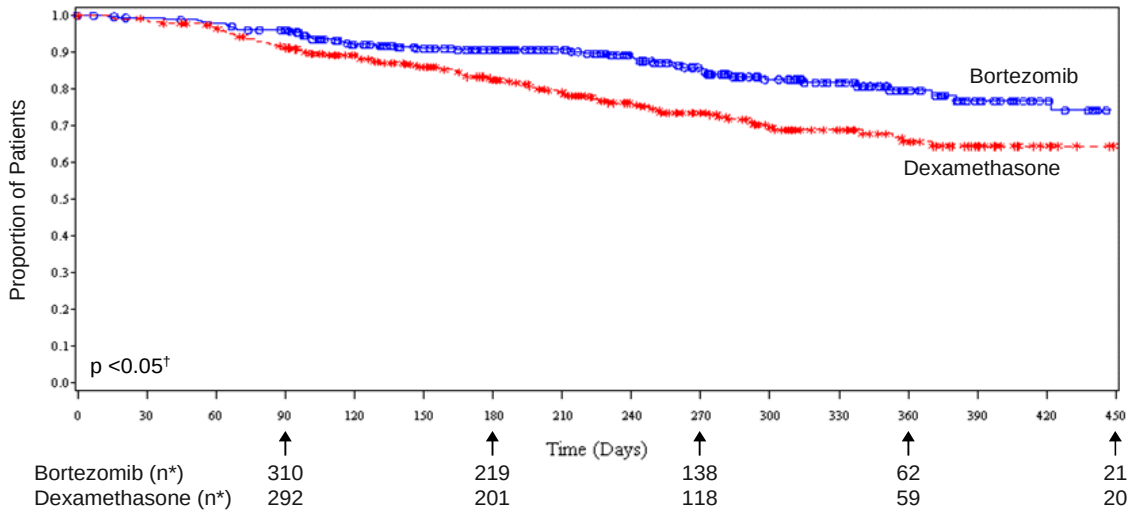
Figure 3: Time to Progression
Bortezomib vs. Dexamethasone (relapsed multiple myeloma study)



* Patients remaining after the indicated timepoint
† p-value from log-rank test

As shown in Figure 4 VELCADE had a significant survival advantage relative to dexamethasone ($p < 0.05$). The median follow-up was 8.3 months.

Figure 4: Overall Survival
Bortezomib vs. Dexamethasone (relapsed multiple myeloma study)



* Patients remaining after the indicated timepoint
† p-value from log-rank test

For the 121 patients achieving a response (CR or PR) on the VELCADE arm, the median duration was 8.0 months (95% CI: 6.9, 11.5 months) compared to 5.6 months (95% CI: 4.8, 9.2 months) for the 56 responders on the dexamethasone arm. The response rate was significantly higher on the VELCADE arm regardless of β_2-microglobulin levels at baseline.

Randomized, Open-Label Clinical Study of VELCADE Subcutaneous vs. Intravenous in Relapsed Multiple Myeloma

An open-label, randomized, phase 3 non-inferiority study compared the efficacy and safety of the subcutaneous administration of VELCADE versus the intravenous administration. This study included 222 bortezomib naïve patients with relapsed multiple myeloma, who were randomized in a 2:1 ratio to receive 1.3 mg/m^2 of VELCADE by either the subcutaneous (n=148) or intravenous (n=74) route for 8 cycles. Patients who did not obtain an optimal response (less than Complete Response (CR)) to therapy with VELCADE alone after 4 cycles were allowed to receive oral dexamethasone 20 mg daily on the day of and after VELCADE administration (82 patients in subcutaneous treatment group and 39 patients in the intravenous treatment group). Patients with baseline Grade ≥ 2 peripheral neuropathy or neuropathic pain, or platelet counts < 50,000/μL were excluded. A total of 218 patients were evaluable for response.

Stratification factors were based on the number of lines of prior therapy the patient had received (1 previous line versus more than 1 line of therapy), and international staging system (ISS) stage (incorporating beta$_2$-microglobulin and albumin levels; Stages I, II, or III).

The baseline demographic and others characteristics of the two treatment groups are summarized as follows: the median age of the patient population was approximately 64 years of age (range 38-88 years), primarily male (subcutaneous: 50%, intravenous: 64%); the primary type of myeloma is IgG (subcutaneous: 65% IgG, 26% IgA, 8% light chain; intravenous: 72% IgG, 19% IgA, 8% light chain), ISS staging I/II/III (%) was 27, 41, 32 for both subcutaneous and intravenous, Karnofsky performance status score was ≤ 70% in 22% of subcutaneous and 16% of intravenous, creatinine clearance was 67.5 mL/min in subcutaneous and 73 mL/min in intravenous, the median years from diagnosis was 2.68 and 2.93 in subcutaneous and intravenous respectively and the proportion of patients with more than one prior line of therapy was 38% in subcutaneous and 35% in intravenous.

This study met its primary (non-inferiority) objective that single agent subcutaneous VELCADE retains at least 60% of the overall response rate after 4 cycles relative to single agent intravenous VELCADE. The results are provided in Table 14.

Table 14: Summary of Efficacy Analyses in the Relapsed Multiple Myeloma Study of VELCADE Subcutaneous vs. Intravenous

	Subcutaneous VELCADE	Intravenous VELCADE
Intent to Treat Population	**n=148**	**n=74**
Primary Endpoint		
Response Rate at 4 cycles		
ORR (CR+PR) n(%)	63 (43)	31 (42)
Ratio of Response Rates (95% CI)	1.01 (0.73, 1.40)	
CR n (%)	11 (7)	6 (8)
PR n (%)	52 (35)	25 (34)
nCR n (%)	9 (6)	4 (5)
Secondary Endpoints		
Response Rate at 8 cycles		
ORR (CR+PR)	78 (53)	38 (51)
CR n (%)	17 (11)	9 (12)
PR n (%)	61 (41)	29 (39)
nCR n (%)	14 (9)	7 (9)
Median Time to Progression, months	10.4	9.4
Median Progression Free Survival, months	10.2	8.0
1-year Overall Survival (%)[a]	72.6	76.7

[a] Median duration of follow up is 11.8 months

A Randomized Phase 2 Dose-Response Study in Relapsed Multiple Myeloma

An open-label, multicenter study randomized 54 patients with multiple myeloma who had progressed or relapsed on or after front-line therapy to receive VELCADE 1 mg/m^2 or 1.3 mg/m^2 intravenous bolus twice weekly for 2 weeks on Days 1, 4, 8, and 11 followed by a 10-day rest period (Days 12 to 21). The median duration of time between diagnosis of multiple myeloma and first dose of VELCADE on this trial was 2.0 years, and patients had received a median of 1 prior line of treatment (median of 3 prior therapies). A single complete response was seen at each dose. The overall response rates (CR + PR) were 30% (8/27) at 1 mg/m^2 and 38% (10/26) at 1.3 mg/m^2.

A Phase 2 Open-Label Extension Study in Relapsed Multiple Myeloma

Patients from the two phase 2 studies, who in the investigators' opinion would experience additional clinical benefit, continued to receive VELCADE beyond 8 cycles on an extension study. Sixty-three (63) patients from the phase 2 multiple myeloma studies were enrolled and received a median of 7 additional cycles of VELCADE therapy for a total median of 14 cycles (range 7 to 32). The overall median dosing intensity was the same in both the parent protocol and extension study. Sixty-seven percent (67%) of patients initiated the extension study at the same or higher dose intensity at which they completed the parent protocol, and 89% of patients maintained the standard 3-week dosing schedule during the extension study. No new cumulative or new long-term toxicities were observed with prolonged VELCADE treatment. [*see Adverse Reactions (6.1)*]

14.2 Mantle Cell Lymphoma

A Phase 2 Single-arm Clinical Study in Relapsed Mantle Cell Lymphoma After Prior Therapy

The safety and efficacy of VELCADE in relapsed or refractory mantle cell lymphoma were evaluated in an open-label, single-arm, multicenter study of 155 patients with progressive disease who had received at least 1 prior therapy. The median age of the patients was 65 years (42, 89), 81% were male, and 92% were Caucasian.

Of the total, 75% had one or more extra-nodal sites of disease, and 77% were stage 4. In 91% of the patients, prior therapy included all of the following: an anthracycline or mitoxantrone, cyclophosphamide, and rituximab. A total of thirty seven percent (37%) of patients were refractory to their last prior therapy. An intravenous bolus injection of VELCADE 1.3 mg/m^2/dose was administered twice weekly for 2 weeks on Days 1, 4, 8, and 11 followed by a 10-day rest period (Days 12 to 21) for a maximum of 17 treatment cycles. Patients achieving a CR or CRu were treated for 4 cycles beyond first evidence of CR or CRu. The study employed dose modifications for toxicity. [*see Dosage and Administration (2.4, 2.5)*]

Responses to VELCADE are shown in Table 15. Response rates to VELCADE were determined according to the International Workshop Response Criteria (IWRC) based on independent radiologic review of CT scans. The median number of cycles administered across all patients was 4; in responding patients the median number of cycles was 8. The median time to response was 40 days (range 31 to 204 days). The median duration of follow-up was more than 13 months.

Table 15: Response Outcomes in a Phase 2 Mantle Cell Lymphoma Study

Response Analyses (N = 155)	**N (%)**	**95% CI**
Overall Response Rate (IWRC) (CR + CRu + PR)	48 (31)	(24, 39)
Complete Response (CR + CRu)	12 (8)	(4, 13)
CR	10 (6)	(3, 12)
CRu	2 (1)	(0, 5)
Partial Response (PR)	36 (23)	(17, 31)
Duration of Response	**Median**	**95% CI**
CR + CRu + PR (N = 48)	9.3 months	(5.4, 13.8)
CR + CRu (N = 12)	15.4 months	(13.4, 15.4)
PR (N=36)	6.1 months	(4.2, 9.3)

15 REFERENCES

1. Preventing Occupational Exposures to Antineoplastic and Other Hazardous Drugs in Health Care Settings. NIOSH Alert 2004-165.

2. OSHA Technical Manual, TED 1-0.15A, Section VI: Chapter 2. Controlling Occupational Exposure to Hazardous Drugs. OSHA, 1999. http://www.osha.gov/dts/osta/otm/otm_vi/otm_vi_2.html.

3. American Society of Health-System Pharmacists. ASHP guidelines on handling hazardous drugs. *Am J Health-Syst Pharm.* 2006;63:1172-1193.

4. Polovich, M., White, J. M., & Kelleher, L.O. (eds.) 2005. Chemotherapy and biotherapy guidelines and recommendations for practice (2nd. ed.) Pittsburgh, PA: Oncology Nursing Society.

16 HOW SUPPLIED/STORAGE AND HANDLING

VELCADE® (bortezomib) for Injection is supplied as individually cartoned 10 mL vials containing 3.5 mg of bortezomib as a white to off-white cake or powder.

NDC 63020-049-01
3.5 mg single use vial

Unopened vials may be stored at controlled room temperature 25ºC (77ºF); excursions permitted from 15 to 30ºC (59 to 86ºF) [see USP Controlled Room Temperature]. Retain in original package to protect from light.

Consider handling and disposal of VELCADE according to guidelines issued for cytotoxic drugs, including the use of gloves and other protective clothing to prevent skin contact[1-4].

17 PATIENT COUNSELING INFORMATION

Physicians are advised to discuss the following with patients prior to treatment with VELCADE:

Ability to Drive or Operate Machinery or Impairment of Mental Ability: VELCADE may cause fatigue, dizziness, syncope, orthostatic/postural hypotension. Advise patients not to drive or operate machinery if they experience any of these symptoms.

Dehydration/Hypotension: Patients receiving VELCADE therapy may experience vomiting and/or diarrhea. Advise patients how to avoid dehydration. Instruct patients to seek medical advice if they experience symptoms of dizziness, light headedness or fainting spells.

Pregnancy/Nursing: Advise patients to use effective contraceptive measures to prevent pregnancy during treatment with VELCADE. Instruct patients to report pregnancy to their physicians immediately. Advise patients that they should not receive VELCADE while pregnant or breast-feeding. If a patient wishes to restart breastfeeding after treatment, she should be advised to discuss the appropriate timing with her physician.

Concomitant Medications: Advise patients to speak with their physicians about any other medication they are currently taking.

Diabetic Patients: Advise patients to check their blood sugar frequently if using an oral antidiabetic medication and to notify their physicians of any changes in blood sugar level.

Peripheral Neuropathy: Advise patients to contact their physicians if they experience new or worsening symptoms of peripheral neuropathy such as tingling, numbness, pain, a burning feeling in the feet or hands, or weakness in the arms or legs.

Other: Instruct patients to contact their physicians if they develop a rash, experience shortness of breath, cough, or swelling of the feet, ankles, or legs, convulsion, persistent headache, reduced eyesight, an increase in blood pressure or blurred vision.

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