

## **Mylan Fingolimod Educational Material for Healthcare Professionals**

**July 9, 2019**

Fingolimod is a sphingosine 1-phosphate receptor (S1P) modulator indicated for the treatment of patients with the relapsing-remitting form of multiple sclerosis (MS). Fingolimod has been shown to reduce the frequency of clinical exacerbations and to delay the progression of physical disability due to MS.

Mylan is providing the following information concerning potential risks to consider when prescribing fingolimod.

### **Bradyarrhythmia**

#### **(Conduction defects and bradycardia complicated by hypotension)**

Initiation of fingolimod treatment results in a reversible decrease in heart rate that may also be associated with AV conduction delays.

Symptoms of decreased heart rate usually happen within the first 6 hours of the first dose. The heart rate gradually recovers by 8 to 10 hours post-dose, although not to baseline levels. The heart rate returns to baseline progressively over approximately one month during chronic treatment. Bradycardia can be asymptomatic or some patients might experience mild to moderate symptoms, including hypotension, dizziness, fatigue, palpitations, dyspnea, arrhythmia, and/or chest pain or chest discomfort, which resolve within the first 24 hours of treatment.

Patients treated with fingolimod may also experience transient AV conduction delays. The conduction abnormalities are usually transient and asymptomatic, and resolve within the first 24 hours of treatment. The patient may occasionally require treatment with atropine or isoproterenol to treat the resultant abnormalities.

Patients with some preexisting conditions (e.g., ischemic heart disease, history of myocardial infarction, congestive heart failure, history of cardiac arrest, cerebrovascular disease, uncontrolled hypertension, history of symptomatic bradycardia, history of recurrent syncope, severe untreated sleep apnea, AV block, sinoatrial heart block) may poorly tolerate the fingolimod-induced bradycardia, or experience serious rhythm disturbances after the first dose of fingolimod. Prior to initiate fingolimod treatment, these patients should have a cardiac evaluation by a physician appropriately trained to conduct such evaluation, and, if treated with fingolimod, should be monitored overnight with continuous ECG in a medical facility after the first dose.

If patient experiences symptoms of slow heart rate (such as dizziness, tiredness, feeling like heart is beating slowly or skipping beats, or chest pain), the health care professional monitoring the patient can help manage these symptoms.

#### Recommendations for first dose monitoring:

- For all patients, obtain an electrocardiogram (ECG) and measure blood pressure prior to and 6-hours after the first dose of fingolimod
- Monitor all patients for signs and symptoms of bradyarrhythmia, with hourly pulse and blood pressure measurements, for at least 6 hours after the first dose
- If symptoms of bradyarrhythmia or atrioventricular (AV) block occur, initiate appropriate management, with continued monitoring (e.g., continuous ECG monitoring) until the symptoms have resolved
- If the ECG at 6 hours after the first dose shows a QTc interval  $\geq 500$  msec, patients should be monitored overnight
- Should a patient require pharmacological intervention during the first dose observation period, continuous overnight monitoring (e.g., continuous ECG monitoring) in a medical facility should be

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instituted and the first dose monitoring strategy should be repeated when the second dose of fingolimod is administered

- First-dose monitoring is also recommended if fingolimod treatment is interrupted  $\geq 1$  day within first 2 weeks or  $>7$  days during weeks 3 and 4, or  $>14$  days after the first month of treatment because effects on heart rate and AV conduction may occur upon re-initiation
- Extended monitoring, until the finding has resolved, may be required:
  - if the heart rate at 6 hours post-dose is  $<45$  bpm in adults,  $<55$  bpm in pediatric patients aged 12 years and above, or  $<60$  bpm in pediatric patients aged 10 to below 12 years, or is the lowest value post-dose,
  - if the ECG at 6 hours after the first dose shows new-onset second-degree or higher grade AV block

### Contraindications:

- Patients who in the last 6 months had myocardial infarction, unstable angina pectoris, stroke/transient ischemic attack, decompensated heart failure (requiring inpatient treatment), or New York Heart Association Class III/IV heart failure
- Patients with severe cardiac arrhythmias requiring anti-arrhythmic treatment with Class Ia or Class III anti-arrhythmic drugs
- Patients with second-degree Mobitz type II atrioventricular (AV) block or third-degree AV block, or sick-sinus syndrome, if they do not have a pacemaker
- Patients with a baseline QTc interval  $\geq 500$  msec

### **Liver transaminase elevation**

Elevations of liver enzymes, mostly alanine aminotransaminase (ALT), may occur in patients receiving fingolimod. Recent (i.e., within last 6 months) transaminase and bilirubin levels should be referred before initiating the fingolimod therapy. Elevations 3- and 5-fold the upper limit of normal have occurred with fingolimod. The majority occurred within 6 to 9 months and returned to normal within 2 months after discontinuing fingolimod. Recurrence of liver transaminase elevations can occur with rechallenge. Patients with preexisting liver disease may be at increased risk of developing elevated liver enzymes when taking fingolimod.

Fingolimod exposure doubles in patients with severe hepatic impairment. Thus, the risk of adverse reactions is greater in them. Such patients should be closely monitored.

### Recommendations for the treatment:

- Obtain transaminase and bilirubin levels prior to initiating treatment if no recent (i.e. within the last 6 months) result is available, every 3 months during the first year of treatment and periodically thereafter in the absence of symptoms or when symptoms suggestive of hepatic injury develop
- If liver transaminases rise above 5 times the ULN, more frequent monitoring should be instituted, including serum bilirubin and alkaline phosphatase (ALP) measurement
- Monitor the levels of liver enzymes and bilirubin in patients who develop symptoms suggestive of hepatic dysfunction, such as unexplained nausea, vomiting, abdominal pain, fatigue, anorexia, or jaundice and/or dark urine
- Fingolimod therapy should be discontinued if significant liver injury is confirmed

### Contraindication:

Patients with severe hepatic impairment (Child-Pugh Class C)

## Macular edema

Macular edema, a vision problem that can cause some of the same vision symptoms as an MS attack (optic neuritis), or no symptoms. Fingolimod increases the risk of macular edema. If it happens, macular edema usually starts in the first 3 to 4 months after starting fingolimod therapy. Some patients may present with blurred vision or decreased visual acuity, but in others it might be asymptomatic and the condition gets diagnosed on routine ophthalmologic examination. Macular edema generally improves or resolved with or without treatment after drug discontinuation, but some patients might have residual visual acuity loss even after resolution of macular edema.

### Recommendations for the treatment:

- An ophthalmic evaluation should be performed 3-4 months after treatment initiation in all patients, and at any time in any patient complaining of visual disturbances
- Patients with diabetes mellitus or a history of uveitis are at increased risk of macular edema and should undergo an ophthalmic evaluation prior to initiating fingolimod therapy and have regular ophthalmic evaluations while receiving fingolimod therapy
- Fingolimod be discontinued if a patient develops macular edema. A decision on whether or not fingolimod therapy should be re-initiated after resolution of macular edema needs to take into account the potential benefits and risks for the individual patient
- Encourage the patients who receive fingolimod to contact their healthcare provider if they experience blurriness, shadows, or a blind spot in the center of vision; sensitivity to light; or unusually colored vision.

## Infections

### **(Opportunistic infections such as progressive multifocal leukoencephalopathy (PML), varicella zoster virus (VZV) infections, herpes viral infections and fungal infections)**

Fingolimod causes a dose-dependent reduction of peripheral lymphocyte count to 20-30% of baseline values. This is due to the reversible sequestration of lymphocytes in lymphoid tissues. Because elimination of fingolimod after discontinuation of the therapy may take up to 2 months, peripheral lymphocyte counts gradually recovers to baseline values. Fingolimod thus increases the risk of infections, including opportunistic infections during treatment and for up to 2 months after discontinuation of treatment. Continuous monitoring is recommended for infections during this period.

During fingolimod treatment, serious infections have been reported with opportunistic pathogens, including viruses (e.g., John Cunningham virus [JCV] causing PML, herpes simplex viruses 1 and 2, varicella zoster virus [VZV]), fungi (e.g., cryptococci), bacteria (e.g., atypical mycobacteria), and Kaposi's sarcoma). Suspension of fingolimod therapy should be considered if a patient develops a serious infection.

Healthcare providers should be vigilant for clinical symptoms or MRI findings suggestive of PML and suspend fingolimod until PML has been excluded. Cases of PML have been reported 2-3 years after fingolimod treatment.

Patients should contact their healthcare provider if they have fever, tiredness, body aches, chills, nausea, vomiting, or headache accompanied by fever, neck stiffness, sensitivity to light, nausea, and/or confusion. These may be symptoms of meningitis, an infection of the lining around the brain and the spine. Perform prompt diagnostic evaluation in patients with symptoms and signs consistent with meningitis, and initiate appropriate treatment if diagnosed. Cryptococcal meningitis (sometimes fatal) has been reported 2-3 years after fingolimod treatment.

### Recommendation before initiating fingolimod:

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- Obtain a recent complete blood count (CBC) (i.e. within 6 months or after discontinuation of prior therapy) before initiating treatment. Treatment with fingolimod should not be initiated when lymphocyte counts are consistently below the normal range.
- Treatment should not be initiated when there are signs and symptoms of a severe active bacterial, fungal or viral infection. Instruct patients to promptly report symptoms or signs suggestive of any infection, during and for up to 2 months after discontinuation of treatment, to facilitate early diagnosis and initiation of appropriate treatments
- Patients without a history of chicken pox or without vaccination against varicella zoster virus (VZV) should be tested for antibodies to VZV. VZV vaccination of antibody negative patients should be considered prior to commencing treatment with fingolimod, following which initiation of treatment with fingolimod should be postponed for one month to allow for full effect of vaccination to occur.
- The use of live attenuated vaccines during fingolimod treatment and for two months after discontinuing treatment is not recommended due to the risk of infection from the vaccine

### Contraindications:

- Patients with increased risk for opportunistic infections, including those who are immunocompromised due to treatment (e.g. antineoplastic, immunosuppressive or immunomodulating therapies, total lymphoid irradiation or bone marrow transplantation) or disease (e.g. immunodeficiency syndrome).
- Patients with severe active infections including active chronic bacterial, fungal or viral infections (e.g., hepatitis, tuberculosis).

## **Hemophagocytic syndrome**

Hemophagocytic syndrome (HPS) with fatal outcome has been reported with fingolimod treatment in the context of infection.

HPS is a very rare and potentially life-threatening hyper-inflammatory syndrome, that has been described in association with infections (primary or reactivation of virus infections e.g. Epstein Barr Virus), malignancies (e.g. lymphoma), immune deficiency and a variety of autoimmune diseases (e.g. lupus). Because fingolimod is a selective immunosuppressant, its effect on the immune system increases the risk of infections that may result in HPS.

The cytopathological feature of HPS is the activation of well differentiated macrophages with prominent hemophagocytosis in hematopoietic organs or lymph nodes. HPS can be diagnosed based on the clinical and laboratory findings (consist of progressive cytopenia, markedly elevated serum ferritin levels, hypertriglyceridemia, hypofibrinogenemia, coagulopathy, hepatic cytolysis and hyponatremia.)

### Recommendation:

- Instruct patients to report possible symptoms of HPS. Symptoms and signs often associated with HPS are:
  - fever, asthenia, hepato-splenomegaly and adenopathy which may be associated with more severe manifestations such as hepatic failure or respiratory distress.
  - progressive cytopenia, markedly elevated serum ferritin levels, hypertriglyceridemia, hypofibrinogenemia, coagulopathy, hepatic cytolysis and hyponatremia.
- An early diagnosis of HPS is recommended in order to improve the prognosis by early initiation of treatment of the HPS and/or the underlying condition, e.g. a viral infection

## **Reproductive toxicity**

Fingolimod may cause fetal harm if taken during conception or pregnancy.

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### Recommendation for treatment:

- Women of childbearing potential should be counseled on the potential risk to the fetus and advised to use effective contraception during and for at least 2 months following discontinuation of fingolimod therapy
- The use of fingolimod in women who are or may become pregnant should only be considered if the potential benefit justifies the potential risk to the fetus.

No data is available to suggest the association between fingolimod and male reproductive toxicity.

### **Skin Cancer**

Vigilance for basal cell carcinoma and other cutaneous neoplasms is recommended with skin examination every 6 to 12 months and referral to a dermatologist if suspicious lesions are detected

- Caution patients against exposure to sunlight without protection
- Ensure patients are not receiving concomitant phototherapy with UV-B-radiation or PUVA-photochemotherapy

Fingolimod has an immunosuppressive effect and can increase the risk of developing lymphomas and other malignancies, particularly those of the skin and serious opportunistic infections. Closely monitor patients during treatment, especially those with concurrent conditions or known factors, such as previous immunosuppressive therapy. If this risk is suspected, discontinuation of fingolimod should be considered by the physician on a case-by-case basis.

### **Missing Information:**

#### **Use of fingolimod in pregnant women**

There are no adequate data on the developmental risk associated with the use of fingolimod in pregnant women. However, animal studies have shown that fingolimod induced reproductive toxicity including fetal loss and teratogenicity when given to pregnant animals.

There is a registry that monitors pregnancy outcomes in women exposed to fingolimod during pregnancy or conception. Healthcare providers are encouraged to enroll pregnant patients to the Mylan Fingolimod Pregnancy Registry.

The use of fingolimod in pregnant women should only be considered if the potential benefit justifies the potential risk to the fetus.

#### ***Pregnancy Registry***

Since there are no adequate and well-controlled studies of fingolimod in pregnant women, Mylan established a pregnancy registry to collect information about the effects of fingolimod during pregnancy. Physicians are encouraged to register patients who become pregnant while exposed to fingolimod or within 2 months after stopping therapy.

Innomar Strategies Inc. is managing The Mylan-Fingolimod Pregnancy Registry on behalf of Mylan. Healthcare providers with an eligible patient, can contact Innomar Strategies Inc. by calling 1-888-246-5830, sending a fax to 1-833-677-0484 or sending an e-mail to MylanFPR@innomar-strategies.com.

#### **Use of fingolimod in lactating women**

Fingolimod is excreted in the milk of animals treated during lactation. There are no data on the presence of fingolimod in human milk, the effects on the breastfed infant, or the effects of the drug on milk production.

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The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for fingolimod and any potential adverse effects on the breastfed infant from fingolimod or from the underlying maternal condition.

### **Patient Counseling**

Prescribers should inform patients about the benefits and risks of fingolimod before a decision is made to prescribe. Patients should be instructed to read the consumer information and should be handed over the patient educational material. Patients should be given an opportunity to discuss the contents of the consumer information with their physician or healthcare professional and to obtain answers to any questions they may have.

### **Reporting Adverse Events**

Healthcare providers should report all suspected adverse events associated with the use of Mylan-fingolimod. Please contact 1-844-596-9526.

## **Summary of Recommendations:**

| Timing  | Check if done   | Recommendation   |
|---|---|--|
| <b>Considerations prior to initiating treatment</b> |   | Availability of suitable resources to manage symptomatic bradycardia before the first dose of fingolimod is administered   |
|   |   | Obtain an electrocardiogram (ECG) prior to the first dose of fingolimod and at the end of the observation period   |
|   |   | Obtain a recent (i.e. within 6 months) CBC   |
|   |   | Obtain a recent (i.e. within 6 months) liver transaminase and bilirubin levels   |
|   |   | Obtain results of baseline ophthalmologic examination  |
|   |   | Counsel women of childbearing age on potential for adverse fetal outcomes and need for contraception   |
|   |   | Consider serology for patients without a history of chicken pox or without vaccination against varicella zoster virus (VZV). If patient is antibody negative, VZV vaccine should be considered.  |
|   |   | Do not begin fingolimod therapy on patients who get VZV vaccination within one month   |
|   |   | Vigilance for basal cell carcinoma and other cutaneous neoplasms is recommended with skin examination prior to treatment initiation and referral to a dermatologist if suspicious lesions are detected. Caution patients against exposure to sunlight without protection   |
| <b>Treatment initiation (first dose)</b>            |   | Fingolimod treatment is <b>contraindicated</b> in patients <ol style="list-style-type: none"><li>with recent (within last 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization or Class III/IV heart failure</li><li>with a history or presence of Mobitz Type II 2nd or 3rd degree AV block or sick sinus syndrome, unless patient has a functioning pacemaker</li><li>with a baseline QTc interval <math>\geq 500</math> msec</li><li>receiving treatment with Class Ia or III anti-arrhythmic drugs</li></ol> |
|   |   | Monitor blood pressure and pulse hourly  |
|   |   | Observe all patients for signs and symptoms of bradycardia for a period of at least 6 hours after the first dose of fingolimod   |
|   |   | Obtain an ECG prior to treatment initiation and 6 hours after the dose administration  |
|   | Continue observation beyond 6 hours (until resolution) if: <ul style="list-style-type: none"><li>the lowest post-dose heart rate is observed at end of the observation period</li></ul> |  |

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|  |  | <ul style="list-style-type: none"> <li>heart rate is &lt; 45 bpm</li> <li>new onset of 2nd degree or higher AV block</li> </ul>  |
|  |  | <p>Overnight observation in a medical facility with continuous ECG monitoring should be initiated in:</p> <ul style="list-style-type: none"> <li>Patients at a higher risk for symptomatic bradycardia or bradyarrhythmia due to coexisting medical conditions</li> <li>Patients receiving concurrent therapies that slow heart rate or AV conduction should be evaluated with possibility of switching off these drugs prior to initiation of fingolimod. In patients who cannot switch, this observation is recommended.</li> <li>Patients with prolonged QTc interval at baseline or during the observation period, or taking drugs with known risk of torsades de pointes or at additional risk for QT prolongation</li> </ul> |
| <b>During treatment</b>                |  | Monitor blood pressure regularly   |
|  |  | Encourage patients to report symptoms of infection (and HPS) as soon as possible   |
|  |  | <p>Vigilance for basal cell carcinoma and other cutaneous neoplasms is recommended with skin examination every 6 to 12 months and referral to a dermatologist if suspicious lesions are detected</p> <p><input type="checkbox"/> Caution patients against exposure to sunlight without protection</p> <p><input type="checkbox"/> Ensure patients are not receiving concomitant phototherapy with UV-B-radiation or PUVA-photochemotherapy</p>   |
|  |  | Fingolimod has an immunosuppressive effect and can increase the risk of developing lymphomas and other malignancies, particularly those of the skin and serious opportunistic infections. Closely monitor patients during treatment, especially those with concurrent conditions or known factors, such as previous immunosuppressive therapy. If this risk is suspected, discontinuation of fingolimod should be considered by the physician on a case-by-case basis.   |
|  |  | Advise patients to avoid live attenuated vaccines  |
|  |  | Perform ophthalmologic examination 3-4 months after starting fingolimod, and at any time if patient reports visual disturbances. Perform regular follow-up ophthalmologic evaluations in patients with diabetes mellitus or a history of uveitis.  |
|  |  | Counsel women of childbearing potential about the importance of contraception use  |
|  |  | Monitor liver enzymes, particularly in patients who develop symptoms suggestive of hepatic dysfunction every 3 months during the 1 <sup>st</sup> year of treatment and periodically thereafter   |
|  |  | Monitor CBC count regularly  |
|  |  | Discontinue treatment if pregnancy occurred and report the event   |
|  |  | Cases of seizures, including status epilepticus, have been reported  |
|  |  | Monitor patients for any cardiac symptoms  |
| <b>After treatment discontinuation</b> |  | Encourage patients to report symptoms of infection (and HPS) for up to 2 months  |
|  |  | If fingolimod therapy is discontinued for more than 14 days after the first month of treatment, the effects on heart rate and AV conduction may recur on reintroduction of fingolimod treatment and the same precautions (first dose monitoring) as for initial dosing should apply. Within the first 2 weeks of treatment, first dose procedures are recommended after interruption of one day or more. During week 3 and 4 of treatment, first dose procedures are recommended after treatment interruption of more than 7 days.   |

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|  |  | Counsel women of childbearing potential on need for continuing contraception for 2 months |
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