AUSTRALIAN PI – KYMRIAH® (TISAGENLECLEUCEL) SUSPENSION

WARNING

CYTOKINE RELEASE SYNDROME

Cytokine Release Syndrome (CRS), including fatal or life threatening reactions, occurred in patients receiving KYMRIAH. Do not administer KYMRIAH to patients with active infection or inflammatory disorders. Implement CRS management to treat severe or life threatening CRS with tocilizumab as per current guidelines, see section 4.4 Special warnings and precautions.

IMMUNE EFFECTOR CELL-ASSOCIATED NEUROTOXICITY SYNDROME

Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS), which may be fatal or life-threatening, has occurred following treatment with KYMRIAH, including concurrently with CRS, after CRS resolution, or in the absence of CRS. Monitor for neurologic events after treatment with KYMRIAH. Provide supportive care and/or corticosteroids as needed.

1 NAME OF THE MEDICINE

T Cells – Tisagenlecleucel, cryopreserved – T - Kymriah

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Tisagenlecleucel: Autologous T-cells genetically modified *ex vivo* using a lentiviral vector encoding an anti-CD19 chimeric antigen receptor (CAR).

1 or more infusion bags containing a total of 1.2 x 10^6 to 6.0 x 10^8 CAR-positive viable T cells in 10 to 50 mL. The quantitative information regarding total cells in the product is presented in the Certificate of Analysis.

For the full list of excipients, see Section 6.1 List of excipients.

3 PHARMACEUTICAL FORM

Cell suspension.

Appearance: colourless to slightly yellow suspension of cells.

4 CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Kymriah is a genetically modified autologous immunocellular therapy indicated for:

- the treatment of paediatric and young adult patients up to 25 years of age with B-cell precursor acute lymphoblastic leukaemia (ALL) that is refractory, in relapse post-transplant, or in second or later relapse.

- the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) after two or more lines of systemic therapy. Kymriah is not indicated for patients with primary central nervous system lymphoma.

4.2 DOSE AND METHOD OF ADMINISTRATION

Manufacture and release of Kymriah usually takes about 3 to 4 weeks.

Kymriah must be administered in a treatment centre that has been qualified by the sponsor. Therapy should be initiated under the direction of and supervised by a healthcare professional experienced in the treatment of haematological malignancies and trained for Kymriah administration and management of patients treated with Kymriah.

A minimum of two doses of tocilizumab per patient for use in the event of cytokine release syndrome and emergency equipment must be available on site prior to infusion. The treatment centre should have timely access to additional doses of tocilizumab (see section 4.4 Special Warnings and Precautions for Use, Management of Cytokine Release Syndrome Associated With Kymriah).

For autologous use only.

Dosage

Kymriah is provided as a single, one-time treatment. The amount of tisagenlecleucel provided by the manufacturing facility equates to the dose to be used for each patient, and is within the target dose range indicated below.

Dosage in paediatric and young adult B-cell ALL patients:

- For patients 50 kg and below: 0.2 to 5.0 x 10^6 CAR-positive viable T-cells/kg body weight.
- For patients above 50 kg: 0.1 to 2.5 x 10^8 CAR-positive viable T-cells (non-weight based).

Dosage in DLBCL patients:

- 0.6 to 6.0 x 10^8 CAR-positive viable T-cells (non-weight based).

Pre-treatment conditioning (lymphodepleting chemotherapy)

Lymphodepleting chemotherapy is recommended to be administered before Kymriah infusion unless the white blood cell (WBC) count within one week prior to infusion is ≤1,000 cells/microliter. Kymriah is recommended to be infused 2 to 14 days after completion of the lymphodepleting chemotherapy. The availability of Kymriah must be confirmed prior to starting the lymphodepleting regimen. If there is a delay of more than 4 weeks between completing lymphodepleting chemotherapy and the Kymriah infusion and the WBC count is >1,000 cells/microliter, then the patient should be re-treated with lymphodepleting chemotherapy prior to receiving Kymriah.

B-cell ALL: *The recommended lymphodepleting chemotherapy regimen is:*

- Fludarabine (30 mg/m^2 IV daily for 4 days) and cyclophosphamide (500 mg/m^2 IV daily for 2 days starting with the first dose of fludarabine).

If the patient experienced a previous Grade 4 haemorrhagic cystitis with cyclophosphamide, or demonstrated a chemorefractory state to a cyclophosphamide-containing regimen administered shortly before lymphodepleting chemotherapy, then the following should be used:

- Cytarabine (500 mg/m^2 IV daily for 2 days) and etoposide (150 mg/m^2 IV daily for 3 days starting with the first dose of cytarabine)

DLBCL: *The recommended lymphodepleting chemotherapy regimen is:*

- Fludarabine (25 mg/m^2 IV daily for 3 days) and cyclophosphamide (250 mg/m^2 IV daily for 3 days starting with the first dose of fludarabine).

If the patient experienced a previous Grade 4 haemorrhagic cystitis with cyclophosphamide, or demonstrated a chemorefractory state to a cyclophosphamide-containing regimen administered shortly before lymphodepleting chemotherapy, then the following should be used:

- Bendamustine (90 mg/m^2 IV daily for 2 days).

Method of administration

For intravenous use only. Do not use a leukocyte depleting filter.

Premedication

To minimize potential acute infusion reactions, it is recommended to pre-medicate patients with paracetamol and diphenhydramine or another H1 antihistamine within approximately 30 to 60 minutes prior to Kymriah infusion. The prophylactic use of systemic corticosteroids should be avoided as it may interfere with the activity of Kymriah (see section 4.4 Special Warnings and Precautions for Use, Cytokine Release Syndrome).

Clinical assessment prior to infusion

Kymriah treatment should be delayed in certain patients with safety risk factors as detailed in section 4.4 Special Warning and Precautions for Use.

Precautions to be taken before handling or administering Kymriah

Kymriah contains genetically-modified human blood cells. Local biosafety guidelines applicable for handling and disposal of such products should be followed (see Special Precautions for Disposal).

Kymriah is prepared from autologous blood of the patient collected by leukapheresis. Patient leukapheresis material and Kymriah may carry a risk of transmitting infectious viruses to healthcare professionals handling the product. Accordingly, healthcare professionals should employ appropriate precautions (wearing gloves and glasses) when handling leukapheresis material or Kymriah to avoid potential transmission of infectious diseases as for any human derived materials.

Preparation for infusion

Patient identity confirmation: Prior to Kymriah infusion, the patient's identity must be matched with the patient identifiers on the Kymriah infusion bag(s).

Inspection and thawing of the infusion bag(s): The timing of thaw of Kymriah and infusion should be coordinated. The infusion start time should be confirmed in advance, and adjusted for thaw so that Kymriah is available for infusion when the recipient is ready.

The infusion bag should be placed inside a second bag in case of a leak and to protect ports from contamination during the thawing process. The infusion bag(s) should be examined for any breaks or cracks prior to thawing.

Kymriah should be thawed at 37°C using either water bath or dry thaw method until there is no visible ice in the infusion bag. The infusion bag should be removed immediately from the thawing device and should not be stored at 37°C after thawing is completed.

Inspect the contents of the thawed infusion bag for any visible cell clumps. If visible cell clumps remain, gently mix the contents of the bag. Small clumps of cellular material should disperse with gentle manual mixing. Do not infuse Kymriah if clumps are not dispersed.

If the Kymriah bag appears to have been damaged or to be leaking, it should not be infused, and should be disposed of according to local biosafety procedures.

Once Kymriah has been thawed and is at room temperature (20°C to 25°C), it should be infused within 30 minutes to maintain maximum product viability, including any interruption during the infusion.

If more than one infusion bag has been received for the treatment dose, the second bag should not be thawed until after the contents of the first bag have been safely infused.

Administration

Kymriah should not be manipulated. For example, Kymriah should **not** be washed (spun down and resuspended in new media) prior to infusion. All contents of the infusion bag(s) should be infused to complete a single dose.

Kymriah should be administered as an IV infusion through latex free tubing without a leukocyte depleting filter, approximately at 10 to 20 mL per minute by gravity flow. Sodium chloride 9 mg/mL (0.9%) solution for injection should be used to prime the tubing prior to infusion as well as to rinse it afterwards. When the full volume of Kymriah has been infused, Kymriah infusion bag should be rinsed with 10 to 30 mL sodium chloride 9 mg/mL (0.9%) solution for injection by back priming to assure as many cells as possible are infused into the patient.

In clinical trials intravenous push was an alternate method for the administration of low volumes of Kymriah.

Monitoring after infusion

- Following infusion with Kymriah patients should be monitored 2-3 times per week for at least the first week for signs and symptoms of potential cytokine release syndrome, neurological events and other toxicities. Physicians should consider hospitalisation at the first signs/symptoms of cytokine release syndrome and/or neurological events.
- Instruct patients to remain within proximity (ie within 2 hours travel) of the qualified clinical facility for at least 4 weeks following infusion.

Dosage adjustment in:

Renal and hepatic impairment

As a cell based therapy and based on the mechanism of action, renal and hepatic impairment is not expected to impact tisagenlecleucel expansion and cellular kinetics; hence no formal renal and hepatic impairment studies were performed.

Geriatric patients (65 years of age or above)

DLBCL: No dose adjustment is required in patients over 65 years of age (see Cellular Kinetics; Special Populations).

Special Populations:

Paediatric patients

B-cell ALL: No formal studies have been performed in paediatric patients below 3 years of age.

DLBCL: No formal studies have been performed in paediatric patients below 18 years of age.

Geriatric patients (65 years of age or above)

B-cell ALL: The safety and efficacy of Kymriah in this population has not been established.

Patients seropositive for hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (HIV)

There is no experience with manufacturing Kymriah for patients with a positive test for HIV or with active HBV or active HCV infection. Leukapheresis material from patients with HIV, active HCV or active HBV will not be accepted for Kymriah manufacturing. Perform screening for HIV, HBV, and HCV in accordance with institutional procedures before collection of cells for manufacturing.

Active central nervous system (CNS) leukaemia or lymphoma

There is limited experience of use of Kymriah in patients with active CNS leukaemia and active CNS lymphoma. Therefore the risk/benefit of Kymriah has not been established in these populations.

Concomitant diseases

Patients with active CNS disorder or inadequate renal, hepatic, pulmonary or cardiac function were excluded from the studies. These patients are likely to be more vulnerable to the consequences of the adverse reactions described after Kymriah infusion and require special attention.

4.3 CONTRAINDICATIONS

Kymriah is contraindicated in patients with known hypersensitivity to tisagenlecleucel or to any component of the product formulation, (see section 6.1) including dimethyl sulfoxide (DMSO) or dextran 40 (see section 4.4 Special warnings and precautions for use).

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Reasons to delay treatment

Due to the risks associated with Kymriah treatment, infusion should be withheld until resolution of any of the following conditions:

- Unresolved serious adverse reactions (especially pulmonary reactions, cardiac reactions or hypotension) from preceding chemotherapies.
- Active uncontrolled infection.
- Active Graft Versus Host Disease (GVHD).

- Significant clinical worsening of leukaemia burden or rapid progression of lymphoma with unstable clinical presentation following lymphodepleting chemotherapy.

Patient information

Prior to infusion, the patient should read the information from 'Patient Education Leaflet". In particular, the patient should be carefully educated to inform their doctor immediately if cytokine release syndrome (CRS), neurological symptoms or other toxicities occur after infusion with Kymriah, and be informed that they should stay within 2 hours distance of where they are given Kymriah treatment for at least 4 weeks. Ensure that patients understand the risk of manufacturing failure. In case of a manufacturing failure, a second manufacturing of KYMRIAH may be attempted. In addition, while the patient awaits the product, additional chemotherapy (not the lymphodepletion) may be necessary and may increase the risk of adverse events during the pre-infusion period.

Blood, organ, tissue and cell donation

Patients treated with Kymriah should not donate blood, organs, tissues, sperms, oocytes and other cells.

Active central nervous system (CNS) leukaemia or lymphoma

There is limited experience of use of Kymriah in patients with active CNS leukaemia and active CNS lymphoma. Therefore the risk/benefit of Kymriah has not been established in these populations.

Cytokine release syndrome

Cytokine release syndrome (CRS), including fatal or life threatening events, occurred frequently after Kymriah infusion. In all but 4 cases, development of CRS occurred between 1 to 10 days (median onset 3 days) after Kymriah infusion in paediatric and young adult B-cell ALL patients and between 1 and 9 days (median onset 3 days) after Kymriah infusion in adult DLBCL patients. The median time to resolution of CRS was 8 days in B-cell ALL and 7 days in DLBCL patients.

Signs and symptoms of CRS may include high fever, hypotension, hypoxia, dyspnoea, tachypnoea, arrhythmia (including tachycardia), fatigue, headache, rigors, myalgia, arthralgia, nausea, vomiting, diarrhoea, diaphoresis, rash and anorexia. Organ dysfunction, including cardiac insufficiency, renal insufficiency and liver injury with accompanying elevated aspartate aminotransferase (AST), elevated alanine aminotransferase (ALT) or elevated total bilirubin may also be observed. In addition, disseminated intravascular coagulation (DIC) with low fibrinogen levels, capillary leak syndrome (CLS), macrophage activation syndrome (MAS) and haemophagocytic lymphohistiocytosis (HLH) may occur in the setting of CRS. Patients should be closely monitored for signs or symptoms of these events including fever.

Risk factors for severe CRS in paediatric and young adult B-cell ALL patients are high pre-infusion tumour burden, uncontrolled or accelerating tumour burden following lymphodepleting chemotherapy, active infection and early onset of fever or CRS following Kymriah infusion. High tumour burden prior to Kymriah infusion was identified as a risk factor for developing severe CRS in adult DLBCL patients.

Prior to administration of Kymriah in paediatric and young adult B-cell ALL patients, efforts should be made to lower and control the patient's tumour burden.

In all indications, appropriate prophylactic and therapeutic treatment for infections should be provided, and complete resolution of any existing infections should be ensured. Infections may also occur during CRS and may increase the risk of a fatal event.

Management of Cytokine Release Syndrome Associated with Kymriah

To reduce the risk of or manage CRS complications (see above), patients treated with Kymriah may receive anti-interleukin-6 based intervention (e.g. tocilizumab) with or without a corticosteroid-based therapy. CRS management strategies may be implemented based on the most recent American Society of Clinical Oncology (ASCO) guideline, and/or appropriate local institutional / academic guidelines.

A minimum of two doses of tocilizumab per patient must be available on site prior to Kymriah infusion. The treatment centre should have timely access to additional doses of tocilizumab. Tisagenlecleucel continues to expand and persist following administration of tocilizumab and corticosteroids. Patients with medically significant cardiac dysfunction should be managed by standards of critical care; measures such as echocardiography should be considered. Tumour Necrosis Factor (TNF) antagonists are not recommended for management of Kymriah associated CRS.

Neurological toxicities

Neurological toxicities (including immune effector cell-associated neurotoxicity syndrome (ICANS), in particular encephalopathy, confusional state and/or delirium, occur frequently with Kymriah and can be severe or life threatening. Other manifestations include depressed level of consciousness, seizures, aphasia and speech disorder. The majority of neurological events occurred within 8 weeks following Kymriah infusion and were transient. The median time to onset of the first neurological events occurring at any time following Kymriah infusion was 8 days for B-cell ALL (range: 2-489) and the median time to resolution was 7 days. The median time to onset of the first neurological events occurring at any time following Kymriah infusion was 6 days for DLBCL (range: 1-323) and the median time to resolution was 13 days.

Neurological events can be concurrent with CRS, following resolution of CRS or in the absence of CRS.

Patients should be monitored for neurological events. To reduce the risk of neurological toxicities (including ICANS) (see above), patients treated with Kymriah may receive supportive treatment.

Infections and febrile neutropenia

Patients with active, uncontrolled infection should not start Kymriah treatment until the infection is resolved. Prior to Kymriah infusion, infection prophylaxis should follow standard guidelines based on the degree of preceding immunosuppression.

Serious infections, including life threatening or fatal infections, occurred in patients after Kymriah infusion. Patients should be monitored for signs and symptoms of infection and treated appropriately. As appropriate, prophylactic antibiotics should be administered and surveillance testing should be employed prior to and during treatment with Kymriah. Infections are known to complicate the course and management of concurrent CRS. In immunosuppressed patients, opportunistic infections of the central nervous system, in some cases with late onset (including progressive multifocal leukoencephalopathy due to John Cunningham virus reactivation), have been reported. Appropriate diagnostic evaluations should be performed in patients with neurological adverse events.

Febrile neutropenia was frequently observed in patients after Kymriah infusion and may be concurrent with CRS. In the event of febrile neutropenia, infection should be evaluated and managed appropriately with broad spectrum antibiotics, fluids and other supportive care, as medically indicated.

In patients achieving complete remission following Kymriah, resulting low immunoglobulin levels can increase the risk for infections. In patients with low immunoglobulin levels pre-emptive measures such as immunoglobulin replacement and rapid attention to signs and symptoms of infection should be implemented according to age and standard specific guidelines.

Prolonged cytopenias

Patients may continue to exhibit cytopenias for several weeks following lymphodepleting chemotherapy and Kymriah and should be managed per standard guidelines. The majority of patients who had cytopenias at day 28 following Kymriah treatment resolved to Grade 2 or below within three months after treatment. Prolonged neutropenia has been associated with increased risk of infection. Myeloid growth factors, particularly granulocyte macrophage-colony stimulating factor (GM-CSF), have the potential to worsen CRS symptoms and are not recommended during the first 3 weeks after Kymriah infusion and until CRS has resolved.

Secondary malignancies

Patients treated with Kymriah may develop secondary malignancies or recurrence of their cancer. T-cell malignancies have occurred following treatment of haematologic malignancies with BCMA- and CD19- directed genetically modified autologous T-cell immunotherapies, including Kymriah. Mature T-cell malignancies, including CAR-positive tumours, may present as soon as weeks following infusion, and may include fatal outcomes.

Patients should be monitored life-long for secondary malignancies, including those of T-cell origin. In the event that a secondary malignancy occurs, the company should be contacted (see section 8 Sponsor) to obtain instructions on patient samples to collect for testing.

Hypogammaglobulinemia

Hypogammaglobulinemia and agammaglobulinemia can occur in patients after Kymriah infusion. Immunoglobulin levels should be monitored after treatment with Kymriah. In patients with low immunoglobulin levels pre-emptive measures such as infection precautions, antibiotic prophylaxis and immunoglobulin replacement should be taken according to age and standard guidelines.

Live vaccines

The safety of immunization with live vaccines during or following Kymriah treatment has not been studied. Vaccination with live vaccines is not recommended for at least 6 weeks prior to the start of lymphodepleting chemotherapy, during Kymriah treatment, and until immune recovery following treatment with Kymriah.

Tumour lysis syndrome

Tumour lysis syndrome (TLS), which may be severe, has been observed. To minimize risk of TLS, patients with elevated uric acid or high tumour burden should receive allopurinol, or an alternative prophylaxis, prior to Kymriah infusion. Signs and symptoms of TLS should be monitored and events managed according to standard guidelines.

Concomitant disease

Patients with active CNS disorder or inadequate renal, hepatic, pulmonary or cardiac function were excluded from the studies. These patients are likely to be more vulnerable to the consequences of the adverse reactions described after Kymriah infusion (see section 4.8 Adverse Effects) and require special attention.

Prior stem cell transplantation

It is not recommended that patients undergo allogeneic stem cell transplant (SCT) within 4 months prior to Kymriah because of the potential risk of Kymriah worsening graft versus host disease (GVHD). Leukapheresis for Kymriah manufacturing should be performed at least 12 weeks after allogeneic SCT.

HIV, Hepatitis B, Hepatitis C and viral reactivation

It is not recommended that patients receive Kymriah if they have viral hepatitis because of the potential risk of viral reactivation. It is not recommended that patients receive Kymriah if they have HIV because of the possible effect on loss of HIV viral suppression and the theoretical risk of recombination events.

Viral Reactivation

Viral reactivation, e.g. Hepatitis B virus (HBV) reactivation, in some cases resulting in fulminant hepatitis, hepatic failure and death, can occur in patients treated with drugs directed against B cells.

Prior treatment with an anti-CD19 therapy

There is limited experience with Kymriah in patients exposed to prior CD19-directed therapy. Kymriah is not recommended if the patient has relapsed with CD19-negative leukaemia after prior anti-CD19 therapy.

Use in the elderly

B-cell ALL: The safety and efficacy of Kymriah in this population has not been established.

DLBCL: The safety and efficacy of KYMRIAH have been established in geriatric patients (See Clinical Trials). No dose adjustment is required in patients over 65 years of age (see Cellular Kinetics; Special Populations).

Paediatric use

B-cell ALL: No formal studies have been performed in paediatric patients below 3 years of age.

DLBCL: No formal studies have been performed in paediatric patients below 18 years of age.

Effects on laboratory tests

Due to limited and short spans of identical genetic information between the lentiviral vector used to create Kymriah and HIV, some commercial HIV nucleic acid tests (NAT) may give a false positive result post-treatment with Kymriah.

Content of dextran 40 and dimethyl sulfoxide (DMSO)

This medicinal product contains 11 mg dextran 40 and 82.5 mg dimethyl sulfoxide (DMSO) per mL. Serious hypersensitivity reactions, including anaphylaxis have been reported (see section 4.8 Adverse effects (undesirable effects)). Each of these excipients are known to possibly cause anaphylactic reaction following parenteral administration. All patients should be observed closely during the infusion period.

4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS

No cellular kinetic or biodynamic drug interaction studies with tisagenlecleucel have been performed.

The co-administration of agents known to inhibit T-cell function has not been formally studied. The co-administration of agents known to stimulate T-cell function has not been investigated and the effects are unknown.

Live vaccines

The safety of immunisation with live vaccines during or following Kymriah treatment has not been studied. Vaccination with live vaccines is not recommended for at least 6 weeks prior to the start of lymphodepleting chemotherapy, during Kymriah treatment, and until immune recovery following treatment with Kymriah.

Concomitant therapy with tocilizumab and corticosteroids

Administration of tocilizumab and corticosteroids as per the cytokine release syndrome treatment algorithm does not impact the expansion and persistence of CAR-T cells.

4.6 FERTILITY, PREGNANCY AND LACTATION

Effects on fertility

There are no animal or human data available on the effect of Kymriah on male or female fertility. Effects of Kymriah on male and female fertility have not been evaluated in animal studies.

Use in pregnancy – Pregnancy Category C

Risk summary

There are no available data with Kymriah use in pregnant women. No animal studies have been conducted with Kymriah to assess whether it can cause fetal harm when administered to a pregnant woman. Kymriah has the potential to be transferred to the fetus via the placenta and could cause fetal toxicity, including B-cell lymphocytopenia.

Kymriah is not recommended during pregnancy and in women of child-bearing potential not using contraception.

If a patient intends to become pregnant after receiving Kymriah, the patient should be apprised of the potential risks to the fetus.

Pregnant women who have received Kymriah may have hypogammaglobulinemia. Assessment of immunoglobulin levels is indicated in newborns of mothers treated with Kymriah.

Use in lactation

There are no data regarding the presence of Kymriah in human milk, the effect on the breast-fed child or the effects of Kymriah on milk production. A risk to the newborn/infant cannot be excluded. Women who are breast-feeding should be advised of the potential risk to the breast-fed infant.

Following administration of Kymriah, breast-feeding should be discussed with the treating physician.

Females and males of reproductive potential

There is a potential for Kymriah to cause fetal toxicity.

Pregnancy testing

The pregnancy status of females of reproductive potential should be verified prior to starting treatment with Kymriah.

Contraception

Females of reproductive potential should use highly effective contraception (i.e., methods that result in less than 1% pregnancy rates) after Kymriah administration.

Sexually active males who have received Kymriah should use a condom during intercourse with a female of reproductive potential or a pregnant woman.

Pregnancy or fathering a child after Kymriah therapy should be discussed with the treating physician.

See the prescribing information for lymphodepleting chemotherapy for information on the need for effective contraception in patients who receive the lymphodepleting chemotherapy.

There are insufficient exposure data to provide a recommendation concerning the duration of contraception following treatment with Kymriah.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Due to the potential for neurological toxicities, patients receiving Kymriah are at risk of altered or decreased consciousness or coordination, and seizures in the 8 weeks following infusion. Patients are advised to refrain from driving and engaging in hazardous occupations or activities such as operating heavy or potentially dangerous machinery during this initial period.

4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)

Pediatric and young adult B-cell ALL (13-Apr-2018 data-cut)

The adverse reactions described in this section were characterized in 79 patients infused with Kymriah in the multi-center pivotal clinical study CCTL019B2202 (N=79).

The most common non-haematological adverse reactions (≥40%) were cytokine release syndrome (77%), infections (72%), hypogammaglobulinemia (53%) and pyrexia (42%).

The most common haematological laboratory abnormalities were decreased white blood cells (100%), decreased haemoglobin (100%), decreased neutrophils (98%), decreased lymphocytes (98%) and decreased platelets (97%).

Grade 3 and Grade 4 adverse reactions were reported in 89% of patients.

The most common (>40%) Grade 3 and Grade 4 non-haematological adverse reaction was CRS (48%).

The most common (>40%) Grade 3 and Grade 4 haematological laboratory abnormalities were white blood cells decreased (97%), neutrophils decreased (95%), lymphocytes decreased (96%), platelets decreased (77%), and haemoglobin decreased (48%).

Grade 3 or 4 adverse events were more often observed within the initial 8 weeks post-infusion (82% of patients) compared to after 8 weeks post-infusion (51% of patients).

Six fatalities not related to disease progression occurred following Kymriah infusion, of which 1 death occurred within 30 days of infusion due to cerebral haemorrhage. Three deaths were due to infections (encephalitis, lower respiratory tract bacterial infection and mycosis), 1 due to hepatobiliary disease, and 1 death was due to unknown reason.

Tabulated summary of adverse drug reactions from B2202

Adverse drug reactions from B2202 in Table 1 are listed by MedDRA system organ class. Within each system organ class, the adverse drug reactions are ranked by frequency, with the most frequent reactions first. Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness. In addition, the corresponding frequency category for each adverse drug reaction is based on the following convention (CIOMS III): very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000).

Table 1 Adverse drug reactions at any time post Kymriah infusion by primary system organ class, ADR term and maximum CTCAE grade in study B2202 Safety Set (13-Apr-2018 data-cut)

B2202, N=79	All grades		Grade 3		Grade 4		Frequency category (All grades)
	n	%	n	%	n	%	
Blood and lymphatic system disorders							
Febrile neutropenia	27	34	25	32	2	3	Very common
Anaemia	25	32	9	11	0	0	Very common
Haemorrhage[11]	25	32	6	8	2	3	Very common
Neutropenia	11	14	2	3	7	9	Very common
Thrombocytopenia	9	11	3	4	6	8	Very common
Haemophagocytic lymphohistiocytosis	5	6	2	3	1	1	Common
Coagulopathy	5	6	2	3	0	0	Common
Leukopenia	3	4	1	1	1	1	Common
Lymphopenia	2	3	2	3	0	0	Common
Pancytopenia	2	3	2	3	0	0	Common
Cardiac disorders							
Tachycardia[24]	19	24	2	3	1	1	Very common
Cardiac failure[4]	7	9	4	5	2	3	Common
Cardiac arrest	3	4	0	0	3	4	Common
Eye disorders							
Visual impairment	2	3	0	0	0	0	Common
Gastrointestinal disorders							
Vomiting	25	32	1	1	0	0	Very common
Diarrhoea	23	29	1	1	0	0	Very common
Nausea	21	27	2	3	0	0	Very common
Abdominal pain[1]	14	18	2	3	0	0	Very common
Constipation	14	18	0	0	0	0	Very common
Stomatitis	3	4	1	1	0	0	Common
Abdominal distension	3	4	0	0	0	0	Common
Ascites	3	4	0	0	0	0	Common
Dry mouth	1	1	0	0	0	0	Common
General disorders and administration site conditions							
Pyrexia	33	42	8	10	2	3	Very common
Pain[18]	20	25	2	3	0	0	Very common
Oedema[17]	15	19	1	1	0	0	Very common
Fatigue[9]	18	23	0	0	0	0	Very common
Chills	7	9	0	0	0	0	Common
Asthenia	3	4	0	0	0	0	Common
Multiple organ dysfunction syndrome	2	3	0	0	2	3	Common

B2202, N=79	All grades		Grade 3		Grade 4		Frequency category (All grades)
	n	%	n	%	n	%	
Influenza like illness	2	3	0	0	0	0	Common
Hepatobiliary disorders							
Hyperbilirubinaemia	5	6	1	1	0	0	Common
Immune system disorders							
Cytokine release syndrome	61	77	17	22	21	27	Very common
Hypogammaglobulinaemia[14]	42	53	10	13	0	0	Very common
Infusion related reaction	5	6	1	1	0	0	Common
Graft versus host disease	2	3	2	3	0	0	Common
Infections and infestations							
Infections - pathogen unspecified[15]	45	57	14	18	7	9	Very common
Viral infectious disorders[25]	30	38	15	19	2	3	Very common
Bacterial infectious disorders[3]	23	29	12	15	1	1	Very common
Fungal infectious disorders[10]	12	15	4	5	3	4	Very common
Investigations							
White blood cell decreased*	79	100	5	6	72	91	Very common
Haemoglobin decreased*	79	100	38	48	0	0	Very common
Neutrophil count decreased*	77	98	6	8	69	87	Very common
Lymphocyte count decreased*	77	98	20	25	56	71	Very common
Platelet count decreased*	77	98	13	17	48	61	Very common
Aspartate aminotransferase increased	19	24	8	10	3	4	Very common
Alanine aminotransferase increased	18	23	7	9	0	0	Very common
Blood bilirubin increased	13	17	9	11	0	0	Very common
International normalised ratio increased	9	11	0	0	0	0	Very common
Blood fibrinogen decreased	7	9	1	1	1	1	Common
Activated partial thromboplastin time prolonged	4	5	1	1	0	0	Common
Prothrombin time prolonged	3	4	0	0	0	0	Common
Fibrin D dimer increased	2	3	1	1	0	0	Common
Weight decreased	2	3	1	1	0	0	Common
Blood alkaline phosphatase increased	1	1	0	0	0	0	Common
Metabolism and nutrition disorders							
Decreased appetite	30	38	11	14	1	1	Very common
Hypokalaemia	20	25	9	11	2	3	Very common
Hypophosphataemia	18	23	8	10	1	1	Very common
Hypocalcaemia	16	20	5	6	0	0	Very common
Hypoalbuminaemia[17]	11	14	1	1	0	0	Very common
Hyperuricaemia	9	11	1	1	0	0	Very common
Hyperglycaemia	8	10	4	5	0	0	Very common
Fluid overload	7	9	5	6	0	0	Common
Hyperferritinaemia[13]	8	10	2	3	0	0	Very common
Hypomagnesaemia	6	8	0	0	0	0	Common
Tumour lysis syndrome	5	6	4	5	1	1	Common
Hyperphosphataemia	5	6	0	0	1	1	Common
Hypercalcaemia	3	4	2	3	0	0	Common
Hyperkalaemia	3	4	1	1	1	1	Common
Hypernatraemia	3	4	1	1	1	1	Common
Hyponatraemia	3	4	0	0	0	0	Common
Hypermagnesaemia	2	3	0	0	0	0	Common
Musculoskeletal and connective tissue disorders							
Back pain	10	13	3	4	0	0	Very common
Arthralgia	11	14	1	1	0	0	Very common
Myalgia	10	13	0	0	0	0	Very common
Musculoskeletal pain	5	6	0	0	0	0	Common
Nervous system disorders							
Headache[12]	28	35	2	3	0	0	Very common
Encephalopathy[8]	24	30	7	9	0	0	Very common
Tremor	6	8	0	0	0	0	Common
Seizure[21]	5	6	3	4	0	0	Common
Dizziness	4	5	0	0	0	0	Common
Peripheral neuropathy[19]	3	4	0	0	0	0	Common

B2202, N=79	All grades		Grade 3		Grade 4		Frequency category (All grades)
	n	%	n	%	n	%	
Speech disorder[23]	2	3	1	1	0	0	Common
Motor dysfunction[16]	1	1	0	0	0	0	Common
Neuralgia	1	1	0	0	0	0	Common
Psychiatric disorders							
Delirium[6]	15	19	3	4	0	0	Very common
Anxiety	13	17	2	3	0	0	Very common
Sleep disorder[22]	9	11	0	0	0	0	Very common
Renal and urinary disorders							
Acute kidney injury[2]	17	22	3	4	8	10	Very common
Respiratory, thoracic and mediastinal disorders							
Cough[5]	21	27	0	0	0	0	Very common
Hypoxia	20	25	10	13	6	8	Very common
Dyspnoea[7]	15	19	3	4	8	10	Very common
Pulmonary oedema	12	15	6	8	1	1	Very common
Nasal congestion	9	11	0	0	0	0	Very common
Pleural effusion	8	10	2	3	1	1	Very common
Tachypnoea	8	10	4	5	0	0	Very common
Oropharyngeal pain	8	10	0	0	0	0	Very common
Acute respiratory distress syndrome	3	4	0	0	3	4	Common
Lung infiltration	1	1	1	1	0	0	Common
Skin and subcutaneous tissue disorders							
Rash[20]	14	18	1	1	0	0	Very common
Pruritus	7	9	0	0	0	0	Common
Erythema	5	6	0	0	0	0	Common
Hyperhidrosis	3	4	0	0	0	0	Common
Night sweats	1	1	0	0	0	0	Common
Vascular disorders							
Hypotension	23	29	8	10	8	10	Very common
Hypertension	15	19	4	5	0	0	Very common
Capillary leak syndrome	2	3	1	1	0	0	Common
Thrombosis	2	3	1	1	0	0	Common
Flushing	1	1	0	0	0	0	Common

1) Abdominal pain includes PTs of Abdominal pain, Abdominal pain upper
2) Acute kidney injury includes PTs of Acute kidney injury, Anuria, Azotaemia, Blood creatinine increased, Renal failure, Renal tubular dysfunction, Renal tubular necrosis
3) Bacterial infectious disorders includes HLGT of Bacterial infectious disorders
4) Cardiac failure includes PTs of Cardiac failure, Cardiac failure congestive, Left ventricular dysfunction, Right ventricular dysfunction
5) Cough includes PTs of Cough, Productive cough
6) Delirium includes PTs of Agitation, Delirium, Hallucination, Hallucination visual, Irritability, Restlessness
7) Dyspnoea includes PTs of Acute respiratory failure, Dyspnoea, Respiratory distress, Respiratory failure
8) Encephalopathy includes PTs of Automatism, Cognitive disorder, Confusional state, Depressed level of consciousness, Disturbance in attention, Encephalopathy, Lethargy, Memory impairment, Mental status changes, Somnolence
9) Fatigue includes PTs of Fatigue, Malaise
10) Fungal infectious disorders includes HLGT of Fungal infectious disorders
11) Haemorrhage includes PTs of Anal haemorrhage, Catheter site haemorrhage, Cerebral haemorrhage, Conjunctival haemorrhage, Contusion, Cystitis haemorrhagic, Disseminated intravascular coagulation, Epistaxis, Gastrointestinal haemorrhage, Gingival bleeding, Haemarthrosis, Haematemesis, Haematuria, Haemoptysis, Heavy menstrual bleeding, Melaena, Mouth haemorrhage, Peritoneal haematoma, Petechiae, Pharyngeal haemorrhage, Purpura, Retinal haemorrhage, Vaginal haemorrhage
12) Headache includes PTs of Headache, Migraine
13) Hyperferritinaemia includes PT of Serum ferritin increased
14) Hypogammaglobulinaemia includes PTs of Blood immunoglobulin A decreased, Blood immunoglobulin G decreased, Blood immunoglobulin M decreased, Hypogammaglobulinaemia, Immunodeficiency, Immunodeficiency common variable, Immunoglobulins decreased
15) Infections – pathogen unspecified include HLGT of Infections pathogen unspecified
16) Motor dysfunction includes PT of Muscle spasms
17) Oedema includes PTs of Face oedema, Generalised oedema, Localised oedema, Oedema peripheral
18) Pain includes PTs of Pain, Pain in extremity
19) Peripheral neuropathy includes PTs of Hyperaesthesia, Hypoaesthesia, Paraesthesia
20) Rash includes PTs of Dermatitis, Rash, Rash maculo-papular, Rash papular, Rash pruritic
21) Seizure includes PTs of Generalised tonic-clonic seizure, Seizure
22) Sleep disorder includes PTs of Insomnia, Nightmare, Sleep disorder
23) Speech disorder includes PTs of Aphasia, Dysarthria

24) Tachycardia includes PTs of Sinus tachycardia, Tachycardia
25) Viral infectious disorders includes HLGTs of Viral infectious disorders
* Frequency is based on laboratory values. Patients are counted only for the worst grade observed post baseline.

Diffuse Large B-Cell Lymphoma (11-Dec-2018 data-cut)

The adverse reactions described in this section were characterised in 115 patients, infused with Kymriah, in one global multi-centre international study, i.e. the ongoing pivotal clinical study CCTL019C2201.

The most common non-haematological adverse reactions were CRS (57%), infections (58%), pyrexia (35%), diarrhoea (31%), nausea (29%), hypotension (25%) and fatigue (27%).

The most common haematological laboratory abnormalities were lymphocytes decreased (100%), haemoglobin decreased (99%), white blood cells decreased (99%), neutrophils decreased (97%), and platelet decreased (95%).

Grade 3 and Grade 4 adverse reactions were reported in 88% of patients. The most common Grade 3 and Grade 4 non-haematological adverse reaction was infections (34%) and CRS (23%).

The most common (>25%) Grade 3 and Grade 4 haematological laboratory abnormalities were lymphocyte count decreased (95%), neutrophil count decreased (82%), white blood cell count decreased (78%), haemoglobin decreased (59%), and platelet count decreased (56%).

Grade 3 or 4 adverse events were more often observed within the initial 8 weeks post-infusion (82% of patients) compared to after 8 weeks post-infusion (48% of patients).

Twelve fatalities not related to disease progression occurred following Kymriah infusion, all after 30 days from infusion. Of those, there were 2 deaths due to multiple organ dysfunction syndrome, 2 deaths (unspecified) and one death each due to AML, cardiopulmonary failure, cerebral haemorrhage, chronic kidney disease, duodenal ulcer haemorrhage, neuroendocrine carcinoma, pulmonary haemorrhage and sepsis.

Tabulated summary of adverse drug reactions from C2201

Adverse drug reactions from C2201 in Table 2 are listed by MedDRA system organ class. Within each system organ class, the adverse drug reactions are ranked by frequency, with the most frequent reactions first. Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness. In addition, the corresponding frequency category for each adverse drug reaction is based on the following convention (CIOMS III): very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000).

Table 2 Adverse drug reactions at any time post Kymriah infusion by primary system organ class, ADR term and maximum CTCAE grade in study C2201 Safety Set (11-Dec-2018 data-cut)

C2201, N=115	All grades		Grade 3		Grade 4		Frequency category (All grades)
	n	%	n	%	n	%	
Blood and lymphatic system disorders							
Anaemia	55	48	42	37	3	3	Very common
Haemorrhage[13]	25	22	4	4	5	4	Very common
Neutropenia	23	20	7	6	16	14	Very common
Febrile neutropenia	19	17	16	14	3	3	Very common
Thrombocytopenia	15	13	3	3	11	10	Very common
Leukopenia	4	4	2	2	0	0	Common
Pancytopenia	4	4	2	2	1	1	Common
Haemophagocytic lymphohistiocytosis	2	2	0	0	1	1	Common
B-cell aplasia	1	1	1	1	0	0	Uncommon
Lymphopenia	1	1	0	0	0	0	Uncommon
Cardiac disorders							
Tachycardia[30]	16	14	4	4	0	0	Common
Atrial fibrillation	6	5	2	2	0	0	Common
Cardiac arrest	3	3	0	0	3	3	Common
Cardiac failure[5]	1	1	0	0	1	1	Uncommon
Ventricular extrasystoles	1	1	0	0	0	0	Uncommon
Eye disorders							
Visual impairment[34]	7	6	0	0	0	0	Common
Gastrointestinal disorders							
Diarrhoea	36	31	1	1	0	0	Very common
Nausea	33	29	1	1	0	0	Very common
Constipation	19	17	1	1	0	0	Very common
Abdominal pain[1]	12	10	2	2	0	0	Very common
Vomiting	10	9	1	1	0	0	Common
Stomatitis	7	6	0	0	0	0	Common
Dry mouth	6	5	0	0	0	0	Common
Abdominal distension	4	4	2	2	0	0	Common
Ascites	3	3	0	0	0	0	Common
General disorders and administration site conditions							
Pyrexia	40	35	6	5	0	0	Very common
Fatigue[11]	31	27	7	6	0	0	Very common
Oedema[21]	26	23	2	2	0	0	Very common
Pain[23]	16	14	3	3	0	0	Very common
Chills	14	12	0	0	0	0	Very common
Influenza like illness	10	9	1	1	0	0	Common
Asthenia	8	7	0	0	0	0	Common
Multiple organ dysfunction syndrome	3	3	0	0	3	3	Common
Hepatobiliary disorders							
Hyperbilirubinaemia	3	3	3	3	0	0	Common
Immune system disorders							
Cytokine release syndrome	66	57	17	15	9	8	Very common

C2201, N=115	All grades		Grade 3		Grade 4		Frequency category (All grades)
	n	%	n	%	n	%	
Hypogammaglobulinaemia[16]	20	17	7	6	0	0	Very common
Infusion related reaction	3	3	0	0	0	0	Common
Infections and infestations							
Infections - pathogen unspecified[18]	55	48	23	20	7	6	Very common
Bacterial infectious disorders[4]	20	17	9	8	0	0	Very common
Fungal infectious disorders[12]	13	11	5	4	1	1	Very common
Viral infectious disorders[33]	13	11	2	2	0	0	Very common
Investigations							
Lymphocytes count decreased*	115	100	33	29	76	66	Very common
White blood cell decreased*	114	99	40	35	50	44	Very common
Haemoglobin decreased*	114	99	68	59	0	0	Very common
Neutrophil count decreased*	112	97	24	21	70	61	Very common
Platelet count decreased*	109	95	16	14	48	42	Very common
Weight decreased	14	12	4	4	0	0	Very common
Aspartate aminotransferase increased	5	4	0	0	1	1	Common
Blood alkaline phosphate increased	5	4	1	1	0	0	Common
Fibrin D dimer increased	5	4	1	1	0	0	Common
Serum ferritin increased	5	4	1	1	0	0	Common
Blood fibrinogen decreased	4	4	4	4	0	0	Common
Blood bilirubin increased	3	3	2	2	0	0	Common
Activated partial thromboplastin time prolonged	2	2	2	2	0	0	Common
Metabolism and nutrition disorders							
Hypokalaemia	26	23	10	9	0	0	Very common
Hypophosphataemia	19	17	15	13	0	0	Very common
Hypomagnesaemia	19	17	0	0	0	0	Very common
Decreased appetite	16	14	4	3	0	0	Very common
Hyponatraemia	9	8	4	3	1	1	Common
Hypocalcaemia	6	5	0	0	0	0	Common
Hypercalcaemia	5	4	0	0	1	1	Common
Hypoalbuminaemia	5	4	3	3	0	0	Common
Hyperglycaemia	5	4	2	2	0	0	Common
Fluid overload	3	3	1	1	0	0	Common
Hyperferritinaemia[15]	5	4	1	1	0	0	Common
Hyperkalaemia	3	3	0	0	0	0	Common
Hyperuricaemia	2	2	0	0	2	2	Common
Tumour lysis syndrome	2	2	1	1	1	1	Common
Hypermagnesaemia	1	1	1	1	0	0	Uncommon
Hypernatraemia	1	1	0	0	0	0	Uncommon
Hyperphosphataemia	1	1	0	0	0	0	Uncommon
Musculoskeletal and connective tissue disorders							
Arthralgia	16	14	0	0	0	0	Very common
Back pain	6	5	1	1	0	0	Common
Myalgia	6	5	0	0	0	0	Common
Musculoskeletal pain	5	4	0	0	0	0	Common

C2201, N=115	All grades		Grade 3		Grade 4		Frequency category (All grades)
	n	%	n	%	n	%	
Nervous system disorders							
Headache[14]	24	21	1	1	0	0	Very common
Encephalopathy[10]	18	16	8	7	5	4	Very common
Dizziness[8]	14	12	2	2	0	0	Very common
Peripheral neuropathy[24]	10	9	0	0	0	0	Common
Motor dysfunction[19]	7	6	1	1	0	0	Common
Tremor[32]	7	6	0	0	0	0	Common
Speech disorder[29]	5	4	1	1	0	0	Common
Neuralgia[20]	3	3	1	1	0	0	Common
Seizure[27]	3	3	1	1	0	0	Common
Ataxia[3]	2	2	1	1	0	0	Common
Ischaemic cerebral infarction	1	1	1	1	0	0	Uncommon
Psychiatric disorders							
Anxiety	12	10	1	1	0	0	Very common
Sleep disorder[28]	12	10	0	0	0	0	Very common
Delirium[7]	6	5	3	3	0	0	Common
Renal and urinary disorders							
Acute kidney injury[2]	19	17	4	4	3	3	Very common
Respiratory, thoracic and mediastinal disorders							
Dyspnoea[9]	24	21	5	4	2	2	Very common
Cough[6]	20	17	0	0	0	0	Very common
Hypoxia	9	8	3	3	1	1	Common
Oropharyngeal pain[22]	9	8	1	1	0	0	Common
Pleural effusion	6	5	2	2	0	0	Common
Nasal congestion	5	4	0	0	0	0	Common
Pulmonary oedema[25]	3	3	1	1	0	0	Common
Tachypnoea	3	3	0	0	0	0	Common
Skin and subcutaneous tissue disorders							
Rash[26]	13	11	0	0	0	0	Very common
Night sweats	6	5	0	0	0	0	Common
Pruritus	5	4	0	0	0	0	Common
Hyperhidrosis	4	4	0	0	0	0	Common
Erythema	2	2	1	1	0	0	Common
Vascular disorders							
Hypotension[17]	29	25	7	6	3	3	Very common
Thrombosis[31]	7	6	3	3	0	0	Common
Hypertension	5	4	2	2	1	1	Common
Capillary leak syndrome	1	1	0	0	0	0	Uncommon

1) Abdominal pain includes PTs of Abdominal discomfort, Abdominal pain, Abdominal pain upper

2) Acute kidney injury includes PTs of Acute kidney injury, Blood creatinine abnormal, Blood creatinine increased

3) Ataxia includes PTs of Ataxia, Dysmetria

4) Bacterial infectious disorders includes HLGT of Bacterial infectious disorders

5) Cardiac failure includes PT of Cardiac failure congestive

6) Cough includes PTs of Cough, Productive cough, Upper-airway cough syndrome

7) Delirium includes PTs of Agitation, Delirium, Irritability

8) Dizziness includes PTs of Dizziness, Presyncope, Syncope

9) Dyspnoea includes PTs of Dyspnoea, Dyspnoea exertional, Respiratory distress, Respiratory failure

10) Encephalopathy includes PTs of Cognitive disorder, Confusional state, Disturbance in attention, Encephalopathy, Lethargy, Memory impairment, Mental status changes, Metabolic encephalopathy, Somnolence, Thinking abnormal

11) Fatigue includes PTs of Fatigue, Malaise

12) Fungal infectious disorders includes HLGT of Fungal infectious disorders

13) Haemorrhage includes PTs of Anal haemorrhage, Blood urine present, Cerebral haemorrhage, Contusion, Cystitis haemorrhagic, Disseminated intravascular coagulation, Duodenal ulcer haemorrhage, Epistaxis, Eye contusion,

	Gastrointestinal haemorrhage, Haematemesis, Haematochezia, Haematuria, Large intestinal haemorrhage, Melaena, Mouth haemorrhage, Petechiae, Pharyngeal haemorrhage, Post procedural haemorrhage, Pulmonary Haemorrhage, Purpura, Retinal haemorrhage, Traumatic haematoma, Tumour haemorrhage, Upper gastrointestinal haemorrhage
14)	Headache includes PTs of Headache, Migraine
15)	Hyperferritinaemia includes PT of Serum ferritin increased
16)	Hypogammaglobulinaemia includes PTs of Blood immunoglobulin G decreased, Hypogammaglobulinaemia, Immunodeficiency, Immunoglobulins decreased
17)	Hypotension includes PTs of Hypotension, Orthostatic hypotension
18)	Infections - pathogen unspecified includes HLGT of Infections - pathogen unspecified
19)	Motor dysfunction includes PTs of Muscle spasms, Muscle twitching, Myoclonus, Myopathy
20)	Neuralgia includes PTs of Neuralgia, Sciatica
21)	Oedema includes PTs of Face oedema, Fluid retention, Generalised oedema, Localised oedema, Oedema peripheral, Peripheral swelling
22)	Oropharyngeal pain includes PTs of Oral pain, Oropharyngeal pain
23)	Pain includes PTs of Pain, Pain in extremity
24)	Peripheral neuropathy includes PTs of Hyperaesthesia, Hypoaesthesia, Neuropathy peripheral, Paraesthesia, Peripheral sensory neuropathy
25)	Pulmonary oedema includes PTs of Acute pulmonary oedema, Pulmonary oedema
26)	Rash includes PTs of Dermatitis, Dermatitis acneiform, Dermatitis contact, Rash, Rash maculo-papular, Rash papular, Rash pruritic
27)	Seizure includes PTs of Seizure, Status epilepticus
28)	Sleep disorder includes PTs of Insomnia, Sleep disorder
29)	Speech disorder includes PTs of Aphasia, Dysarthria, Speech disorder
30)	Tachycardia includes PTs of Sinus tachycardia, Supraventricular tachycardia, Tachycardia
31)	Thrombosis includes PTs of Deep vein thrombosis, Embolism, Pulmonary embolism, Thrombosis, Vena cava thrombosis, Venous thrombosis
32)	Tremor includes PTs of Dyskinesia, Tremor
33)	Viral infectious disorders includes HLGT of Viral infectious disorders
34)	Visual impairment includes PTs of Vision blurred, Visual impairment
* Frequency is based on laboratory values. Patients are counted only for the worst grade observed post baseline.	

Adverse drug reactions from spontaneous reports and literature cases (frequency not known)

The following adverse drug reactions have been derived from post-marketing experience with Kymriah via spontaneous case reports, literature cases, expanded access programs, and clinical studies other than the global registration trials. 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 tisagenlecleucel exposure.

Frequency not known: anaphylactic reaction/infusion related reaction, neurotoxicity, immune effector cell-associated neurotoxicity syndrome (ICANS), and secondary malignancy of T-cell origin.

Description of selected adverse drug reactions

Cytokine release syndrome (CRS)

In the ongoing clinical study in paediatric and young adult B-cell ALL (N=79), CRS reactions classified based on the PENN Grading system for CRS (Porter et al 2015) were reported in 77% of patients (48% with Grade 3 or 4) with a median time to onset of 3 days and a median CRS duration of 8 days. Two deaths occurred within 30 days of Kymriah infusion, including one patient, who died from progressive leukaemia in the setting of possible CRS and one patient, who experienced fatal intracranial haemorrhage that developed during the course of resolved CRS, abdominal compartment syndrome, coagulopathy and renal failure.

In the ongoing clinical study in DLBCL (N=115), CRS was reported in 57% of patients, (23% with Grade 3 or 4), with a median time to onset of 3 days and a median duration of 7 days.

Of the 61 patients with r/r ALL who had CRS, 31 (51%) received tocilizumab. Ten (16%) patients received two doses of tocilizumab, 3 (5%) patients received three doses of tocilizumab, and 16 (26%) patients received addition of corticosteroids (e.g., methylprednisolone).

Of the 66 patients with r/r DLBCL who had CRS, 19 (29%) received systemic tocilizumab or corticosteroids. Eight (12%) patients received a single dose of tocilizumab, 10 (15%) patients received two doses of tocilizumab, and 11 (17%) patients received corticosteroids in addition to tocilizumab. One patient with r/r DLBCL received corticosteroids for CRS without concomitant tocilizumab.

Cytokine release syndrome was graded per the Penn criteria in the paediatric and young adult B-cell ALL and DLBCL trials as follows: Grade 1: mild reactions, requiring supportive care; Grade 2: moderate reactions, requiring intravenous therapies; Grade 3: severe reactions, requiring low dose vasopressors or supplemental oxygen; Grade 4: life threatening reactions, requiring high dose vasopressors or intubation; Grade 5: death.

For clinical management of CRS, see section 4.4 Special Warnings and Precautions for Use.

Infections and febrile neutropenia

In B-cell ALL patients severe infections (Grade 3 or 4), which can be life-threatening or fatal, occurred in 48% of patients after Kymriah infusion. The overall incidence was 72% (unspecified 57%, bacterial 27%, viral 38% and fungal 15%) (see Special Warnings and Precautions for Use). Forty three percent of the patients experienced an infection of any type within 8 weeks after Kymriah infusion.

In DLBCL patients severe infections (Grade 3 or 4), which can be life-threatening or fatal, occurred in 34% of patients. The overall incidence (all grades) was 58% (unspecified 48%, bacterial 15%, fungal 11% and viral 11%) (see Special Warnings and Precautions for Use). Thirty seven percent of the patients experienced an infection of any type within 8 weeks.

Severe febrile neutropenia (Grade 3 or 4) was observed in 34% of paediatric and young adult B-cell ALL patients and 17% of DLBCL patients. See Special Warnings and Precautions for Use for the management of febrile neutropenia before Kymriah and after Kymriah infusion.

Hematopoietic cytopenias not resolved by day 28

Cytopenias are very common based on prior chemotherapies and Kymriah therapy.

All paediatric and young B-cell ALL patients, had a Grade 3 or 4 cytopenia at any time post Kymriah infusion. Grade 3 and 4 cytopenias not resolved by day 28 after Kymriah infusion were based on laboratory findings included a decreased count of white blood cells (57%), neutrophils (54%), lymphocytes (44%), thrombocytes (42%) and decreased haemoglobin (13%).

All adult patients with DLBCL had Grade 3 and 4 cytopenias at any time post Kymriah infusion. Grade 3 and 4 cytopenias not resolved by day 28 after Kymriah infusion based on laboratory findings included a decreased count of thrombocytes (39%), lymphocytes (29%), neutrophils (25%), white blood cells (21%) and decreased haemoglobin (14%).

Neurotoxic events

The majority of neurotoxic events occurred within 8 weeks following infusion and were transient.

In paediatric and young adult B-cell ALL patients, manifestations of encephalopathy and/or delirium occurred in 39% of patients (13% Grade 3 or 4) within 8 weeks after Kymriah infusion. In DLBCL patients, these occurred in 20% of patients (11% were Grade 3 or 4) within 8 weeks after Kymriah infusion.

The other most common neurological event at any time post Kymriah infusion was headache (35% in paediatric and young adult B-cell ALL patients and 21% in DLBCL patients).

For clinical management of neurological toxicities, see section 4.4 Warnings and precautions.

Reporting suspected adverse effects

Reporting suspected adverse reactions after registration of the medicinal product is important. It allows continued monitoring of the benefit-risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions at www.tga.gov.au/reporting-problems.

4.9 OVERDOSE

For information on the management of overdose, contact the Poisons Information Centre on 13 11 26 (Australia).

5 BIOLOGICAL PROPERTIES

5.1 BIODYNAMIC PROPERTIES

ATC code: L01XL04.

Mechanism of action

Tisagenlecleucel is an autologous, immunocellular cancer therapy that involves reprogramming a patient's own T-cells with a transgene encoding a chimeric antigen receptor (CAR) to identify and eliminate CD19 expressing cells. CD19 is expressed by malignant and normal B cells. The CAR is comprised of a murine single chain antibody fragment that recognizes CD19 and is fused to intracellular signalling domains from 4-1BB (CD137) and CD3 zeta. The CD3 zeta component is critical for initiating T-cell activation and antitumor activity while 4-1BB enhances the expansion and persistence of tisagenlecleucel. Upon binding to CD19 expressing cells, the CAR transmits a signal to promote T-cell expansion, activation, target cell elimination and persistence of tisagenlecleucel.

Biodynamic effects

Cardiac electrophysiology

Kymriah is a cell product and is not expected to prolong the QT interval; hence no formal QT study was conducted.

Clinical trials

Acute Lymphoblastic Leukaemia (ALL)

The safety and efficacy of Kymriah treatment in patients with relapsed and refractory (r/r) paediatric and young adults B-cell ALL, were evaluated in one pivotal study (B2202) and two supportive studies

(B2205J and B2101J) with a total of 160 patients treated. All patients had leukapheresis products collected and cryopreserved prior to or during study entry.

Pivotal study B2202 used tisagenlecleucel exclusively sourced from the Novartis registered manufacturing facility. A small number of tisagenlecleucel batches (3/29) were manufactured at Novartis for study B2205J and no batches came from Novartis for study B2101J. A formal comparability study of Novartis-made tisagenlecleucel batches and other manufacturing sites has not taken place.

CCTL019B2202 (25-April-2017 data-cut)

The pivotal study (B2202) is a multicenter, single-arm, open label, phase II study in paediatric and young adult patients with r/r B-cell acute lymphoblastic leukaemia. Of 92 patients enrolled, 75 received infusion with Kymriah; for 7 patients (8%) Kymriah could not be manufactured; reasons for discontinuation prior to Kymriah infusion included death (n=7; 8%) or adverse events (n=3; 3%) while awaiting Kymriah manufacturing in the clinical study.

The 75 infused patients included 43 males and 32 females of median age 11 years (range: 3-23 years). Seventy-seven percent of patients were White, 8% were Asian, and 15% were of other races. Six (8%) had primary refractory disease, 40 (53%) had one prior stem cell transplantation, 6 patients (8%) had two stem cell transplantations. Treatment consisted of lymphodepleting chemotherapy (fludarabine 30 mg/m^2 daily for 4 days and cyclophosphamide 500 mg/m^2 daily for 2 days) followed by a single dose of KYMRIAH. Among the 75 patients who received Kymriah infusion, a total of 65 and 72 received bridging chemotherapy and lymphodepleting chemotherapy respectively after enrollment and prior to the Kymriah infusion (see Table 3).

Table 3 Study B2202: Baseline population information

	N=75 n (%)
Age (years)	
Mean (standard deviation)	12.0 (5.28)
Median (minimum – maximum)	11.0 (3 – 23)
Age category (years) - n (%)	
<10 years	31 (41.3)
≥10 years and <18 years	31 (41.3)
≥18 years	13 (17.3)
Sex - n (%)	
Male	43 (57.3)
Female	32 (42.7)
Disease status (%)	
Primary refractory[1]	6 (8.0)
Relapsed disease[2]	69 (92.0)
Prior stem-cell transplantation - n (%)	
0	29 (38.7)
1	40 (53.3)
2	6 (8.0)

[1]Primary refractory: Never had a morphologic complete remission (CR) prior to the study;
[2]Relapsed disease: Had at least one relapse prior to the study

Efficacy was established through the primary endpoint of overall remission rate (ORR), within 3 months post infusion, as determined by Independent Review Committee (IRC) assessment. Secondary endpoints included duration of remission (DOR) and the proportion of patients who achieved complete remission (CR) or complete remission with incomplete blood count (Cri) with minimal residual disease (MRD) <0.01% by flow cytometry (MRD-negative). The ORR at 3 months was 81% (61/75). The median time from Kymriah infusion to the data cut-off date was 13.11 months (range:

2.1 to 23.5). See Table 4 and Figure 1 and Figure 2 for efficacy results from this study. Fifty-seven of 61 responders achieved CR/CRi by the Day 28 assessment. ORR was consistent across all subgroups. Seven patients who received Kymriah infusion went to transplant while in remission. Seventy six percent of patients were hospitalized at the time of infusion and 24% were not hospitalized at the time of Kymriah infusion.

Health related quality of life (HRQoL) were evaluated by PedsQL™ and EQ-5D questionnaires completed by patients aged 8 and above. Among patients responding, the mean change from baseline in the PedsQL total score was 13.5 at Month 3 and 16.9 at Month 6 and 27.2 at Month 12, and the mean change from baseline in the EQ VAS score was 16.5 at Month 3 and 15.9 at Month 6 and 24.7 at Month 12, indicating overall clinically meaningful improvement in HRQoL following Kymriah infusion.

Table 4 B2202: Efficacy results in paediatric and young adult patients with relapsed/refractory B-cell Acute Lymphoblastic Leukaemia (ALL)

Primary Endpoint	**N=75**
Overall Remission Rate (ORR) [1,2], n (%)	61 (81.3)
95% CI	(70.7, 89.4)
	p<0.0001
CR [3], n (%)	45 (60.0)
CRi [4], n (%)	16 (21.3)
NR[5], n (%)	6 (8.0)
Not evaluable, n (%)	8 (10.7)
Key Secondary Endpoint	**N=75**
CR or CRi with MRD negative bone marrow [6,7], n (%)	61 (81.3)
95% CI	(70.7, 89.4)
	p<0.0001
Duration of remission (DOR)[8]	**N=61**
% event free probability at 6 months	79.5
Median (months) (95% CI)	Not reached (8.6, NE[9])
Other Secondary Endpoint	**N=75**
Overall survival (OS)	
% survival probability at 6 months	90.3
% survival probability at 12 months	76.4
Median (months) (95% CI)	19.1 (15.2, NE[9])

[1] Requires remission status to be maintained for at least 28 days without clinical evidence of relapse.
[2] Nominal one-sided exact p-value based on H0: ORR ≤ 20% vs. Ha: ORR >20%.
[3] CR (complete remission) was defined as <5% of blasts in the bone marrow, circulating blasts in blood should be <1%, no evidence of extramedullary disease, and full recovery of peripheral blood counts (platelets >100,000/microliter and absolute neutrophil counts [ANC] >1,000/microliter) without blood transfusion.
[4] CRi (complete remission with incomplete blood count recovery) was defined as <5% of blasts in the bone marrow, no evidence of extramedullary disease, and without full recovery of peripheral blood counts with or without blood transfusion.
[5] NR = No Response
[6] MRD (minimal residual disease) negative was defined as MRD by flow cytometry <0.01%.
[7] Norminal one-sided exact p-value based on H0: Rate of MRD negative remission ≤ 15% vs. Ha: > 15%.
[8] DOR was defined as time since onset of CR or CRi to relapse or death due to underlying indication, whichever is earlier (N=61)
[9] NE= Not estimable

Figure 1 B2202: Duration of remission (DOR)

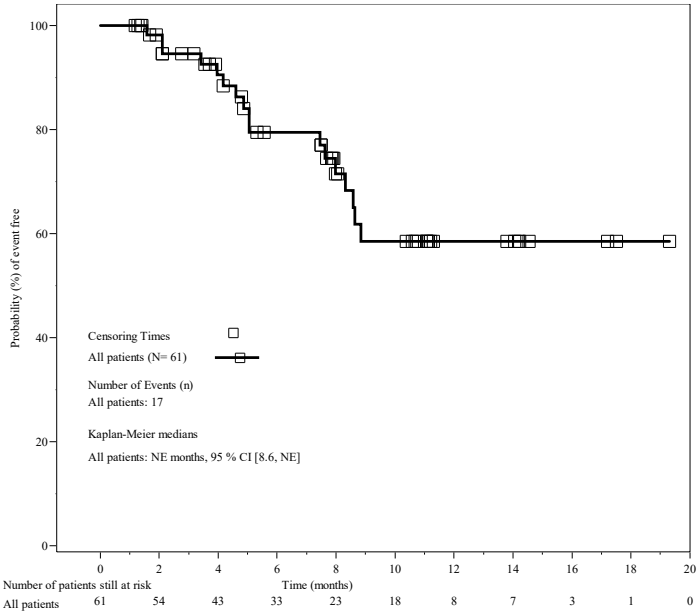
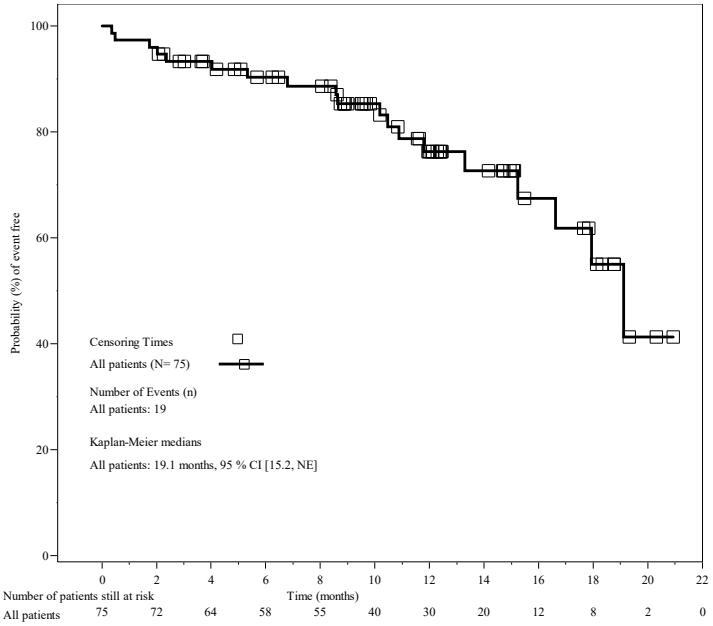


Figure 2 B2202: Overall Survival (OS)



Diffuse large B-cell lymphoma (DLBCL)

CCTL019C2201 (08-Dec-17 data-cut)

The pivotal study (C2201) is a multicentre, single-arm, open label, phase II study in adult patients with relapsed or refractory DLBCL. Of 165 patients enrolled, 111 patients received infusion with Kymriah (4 infusions were pending at the time of analysis); Twelve out of 165 patients did not receive Kymriah due to manufacturing failure. Other reasons for discontinuation prior to Kymriah infusion included death (n=16), physician decision/primary disease progression (n=16), adverse event (n=3), subject decision (n=3) or adverse events (n=2) while awaiting Kymriah manufacturing in the clinical trial.

Median age of infused patients was 56 years (range 22 to 76 years), 76% of patients had Stage III-IV disease, 51% had received 3 or more prior lines of treatment for DLBCL. Forty-nine percent of patients had received prior stem cell transplant. Fifty-five percent of patients were refractory to last line of treatment. All patients had leukapheresis starting material collected and cryopreserved prior to or during study entry. The majority of patients 102/111 received bridging therapy while waiting for Kymriah and 103/111 received lymphodepleting chemotherapy prior to Kymriah infusion. Kymriah was given as a single dose intravenous infusion.

The efficacy of Kymriah was evaluated through the primary endpoint of best overall response rate (ORR), which includes complete response (CR) and partial response (PR) as determined by IRC assessment based on the Lugano Classification (Cheson et al 2014) as well as secondary endpoints including duration of response (DOR) (Table 5). The primary endpoint was assessed in 93 patients who received Kymriah manufactured at the Novartis U.S. facility and who have been followed for at least 3 months or discontinued earlier after Kymriah administration.

Among the 93 patients (Table 5) included in the primary analysis, the best ORR was 51.6% (48/93) with a 95% confidence interval (CI) of (41.0%, 62.1%). Thirty-seven patients (39.8%) achieved CR and 11 (11.8%) achieved PR. No patient who received Kymriah infusion went to transplant after achieving CR or PR.

Subgroup analyses demonstrated a homogeneous and consistent treatment effect across major demographic and prognostic subgroups regardless of prior lines of therapy (ORR 53.1% and 50.0% in patients with ≤2 lines of therapies and >2 lines of therapies, respectively), prior SCT (ORR of 50.0% and 53.7% in patients without or with previous SCT, respectively), relapsed or refractory disease (ORR 64.4% and 39.6%, respectively) or biological factors such as cell of origin (ORR 52.5% in non-GCB and 48.0% in GCB subtype) and double-hit/triple hit lymphoma with Bcl-2 and c-myc expression (ORR of 50.0% in patients with double-hit/triple hit lymphoma).

Table 5 C2201: Efficacy results in adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) who are ineligible for autologous stem cell transplant (08-Dec-17 cut-off)

Primary Endpoint	**N=93**
Overall Response Rate (ORR) (CR+PR) [1], n (%) 95% CI	48 (51.6) (41.0, 62.1)
CR, n (%)	37 (39.8)
PR, n (%)	11 (11.8)
Response at Month 3 ORR (%) CR (%)	 35 (37.6) 30 (32.3)
Response at Month 6 ORR (%) CR (%)	N=92 30 (32.6) 27 (29.3)
Duration of response (DOR)[2]	N=48
Median (months) (95% CI) % relapse free probability at 9 months % relapse free probability at 12 months	Not reached (10.0, NE[5]) 67.4 65.1

Other Secondary Endpoints	N=111
Overall survival (OS)[3]	
Median (months) (95% CI)	11.7 (6.6, NE[4])
% survival probability at 9 months	54.8
% survival probability at 12 months	49.0

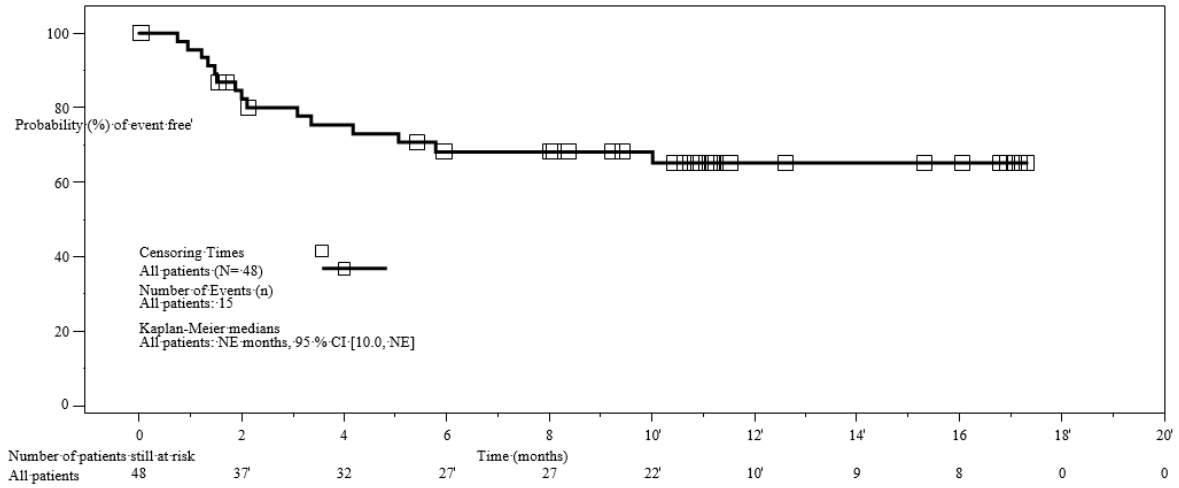
[1] ORR was calculated based on the first 93 patients who received Kymriah manufactured at the Novartis U.S. facility and have completed at least 3 months follow up, or discontinued earlier

[2] DOR was defined as time from achievement of CR or PR, whichever occurs first, to relapse or death due to DLBCL (N=48)

[3] OS was defined as time from date of Kymriah infusion to the date of death due to any cause (N=111)

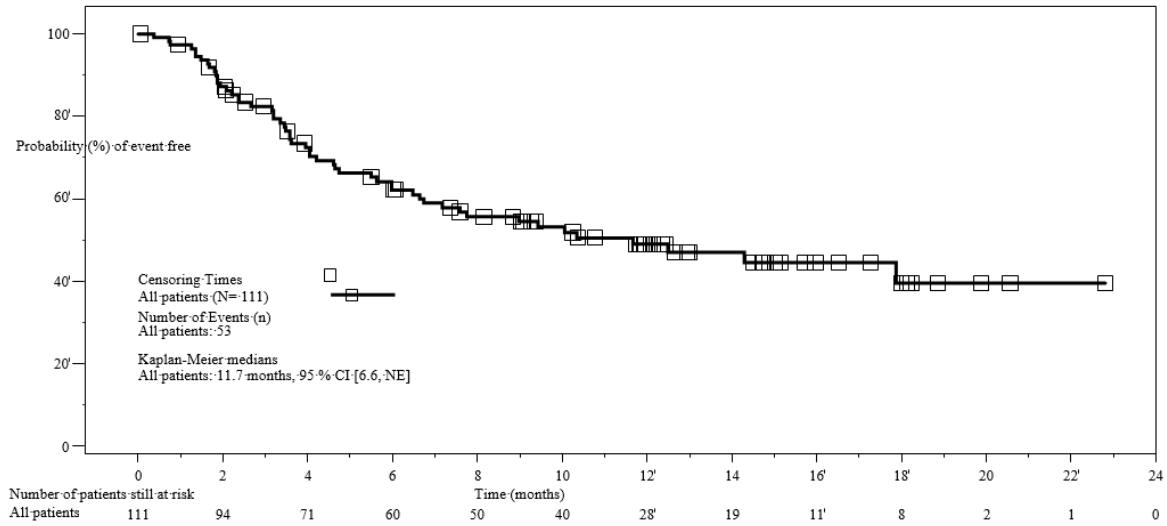
[4] Not estimable

Figure 3 Kaplan-Meier plot of duration of response (DOR) censoring HSCT by IRC assessment for main cohort patients (Efficacy Analysis Set) – 08-Dec-17 cut-off



- Efficacy analysis set (EAS) = All patients who receive CTL019 infusion at least 3 months prior to data-cut date.'
- Only patients who achieved best overall response (BOR) of CR or PR are included.
- Time is relative to onset of response, 1 month=30.4375 days.'

Figure 4 Kaplan-Meier plot of overall survival (OS) (Full analysis set) – 08-Dec-17 cut-off



- Full analysis set (FAS) = All patients who received an infusion of CTL019
- Time is relative to first CTL019 infusion date, 1 month=30.4375 days.

5.2 CELLULAR KINETICS

Following infusion of Kymriah into paediatric and young adult r/r B-cell ALL and r/r DLBCL patients, Kymriah typically exhibited an initial rapid expansion followed by a slower bi-exponential decline.

Cellular kinetics in paediatric B-cell ALL patients

A summary of cellular kinetic parameters of tisagenlecleucel is provided in Table 6 below.

The maximal expansion (C_{max}) was approximately 2-fold higher in CR/CRi patients (n=79) compared with non-responding (NR) patients (n=10) as measured by qPCR. Transgene persistence has been detected up to 784 days in peripheral blood (B2101J) and up to 617 days in responding patients in the in pooled studies B2202 and B2205J). Together these data, signify the potential role of expansion and persistence for eliciting a clinical response.

Table 6 **Cellular kinetic parameters of tisagenlecleucel in paediatric and young adult r/r B-cell ALL (B2202, B2205J)**

Parameter	Summary Statistics	Responding Patients N=80	Non-Responding Patients N=11
C_{max} (copies/µg)	Geometric mean (CV%),n	32,700 (163.4), 79	19,500 (123.7), 10
$T_{max‡}$ (day)	Median [min;max], n	9.83 [0.0111;27.8], 79	20.0 [0.0278;62.7], 10
$AUC_{0\text{-}28d}$ (copies/µg*day)	Geometric mean (CV%), n	300,000 (193.4), 78	210,000 (111.7), 8
T ½ (day)	Geometric mean (CV%), n	21.7 (196.8), 65	2.70 (154.4), 3

‡A total of 5patients had an early T_{max} (<1 days), the next lowest T_{max} occurs at 5.7 days. Early T_{max} may not be representative of the true maximal expansion, rather the amount of transgene present in the catheter from which sample was collected.

Cellular kinetics in DLBCL patients

A summary of cellular kinetic parameters of tisagenlecleucel in DLBCL patients is provided in Table 7 below.

Tisagenlecleucel undergoes significant *in vivo* expansion following infusion and demonstrated persistence of the CAR transgene up to 693 days in responding patients (CR/PR) with shorter persistence in non-responding patients up to 374 days.

$AUC_{0\text{-}28d}$ and C_{max} were similar between responder (CR and PR) and non-responder patients (SD, PD, and patients with unknown response status) based on clinical response at month 3. The geometric mean estimate for expansion (C_{max}) in DLBCL patients was observed to be lower than that in paediatric ALL patients (geometric mean C_{max} (%CV): 5,530 (303.3) copies/microgram, n=86, Study C2201; 35,800 (157.4) copies/microgram, n=72, Study B2202).

A trend for longer half-life was noted in responding patients compared to non-responding patients geometric mean $T_{1/2}$: 91.3 days in responders, and 15.4 days in non-responders.

Table 7 **Cellular kinetic parameters of tisagenlecleucel in r/r DLBCL patients by clinical response at month 3**

Parameter	Summary Statistics	Responding Patients (CR and PR) N=35	Non-Responding Patients (SD/PD/Unknown) N=58
C_{max} (copies/µg)	Geometric mean (CV%), n	6210 (226.1), 35	5100 (372.6), 51
T_{max} (day)	Median [min;max], n	9.83 [5.78;16.8], 35	8.86 [3.04;27.7],51
$AUC_{0\text{-}28d}$ (copies/µg*day)	Geometric mean (CV%), n	64300 (156.1), 33	64800 (301.1), 42
$T_{½}$ (day)	Geometric mean (CV%), n	91.3 (200.7), 22	15.4 (156.0), 34
T_{last}	Median [min;max], n	289 [18.0; 693], 35	57.0 [16.0; 374], 48

Absorption

Not applicable. Kymriah is a T-cell immunocellular therapy and is administered via intravenous infusion.

Distribution

In paediatric and young adult B-cell ALL patients, Kymriah has been shown to be present in the blood as well as bone marrow beyond 2 years. The blood to bone marrow partitioning of Kymriah in bone marrow was 47.2% of that present in blood at Day 28 while at Months 3 and 6 it distributes at 68.3% and 69%, respectively, demonstrating high trafficking to bone marrow (Studies B2202 and B2205J). In addition, Kymriah also traffics and persists in cerebrospinal fluid in paediatric and young adult B-cell ALL patients (Study B2101J) for up to 1 year.

In DLBCL patients (Study C2201), Kymriah has been detected for up to 2 years in peripheral blood and up to Month 9 in bone marrow for complete responder patients. The blood to bone marrow

partitioning in bone marrow was nearly 70% of that present in blood at Day 28 and 50% at Month 3 in responder and non-responder patients.

Metabolism

Not applicable, Kymriah is an immunocellular therapy.

Excretion

The elimination profile of Kymriah includes a bi-exponential decline in peripheral blood and bone marrow.

Linearity/non-linearity

Dose and cellular kinetic parameters are independent, thus there is no apparent relationship with $AUC_{0\text{-}28d}$ and C_{max} with dose.

Special populations

Geriatric population (65 years of age or above)

The impact of age on cellular kinetics was evaluated across the age range of 22 to 76 years in DLBCL patients (Study C2201). The scatter plots of cellular kinetic parameters versus age revealed no relevant relationship between cellular kinetic parameters ($AUC_{0\text{-}28d}$ and C_{max}) with age. The $AUC_{0\text{-}28d}$ in patients with ≥65 years of age was observed to be 49.1% and 64.0% lower than patients ≥40 to <65 years and <40 years, respectively. However, the data should be interpreted with caution due to the high inter-individual variability associated with the parameter.

Gender

Gender is not a significant characteristic influencing tisagenlecleucel expansion in B-cell ALL and DLBCL patients.

Race/ethnicity

The majority of patients treated with Kymriah are Caucasian, therefore, there is limited evidence that race/ethnicity impact the expansion of Kymriah in paediatric and young adult ALL and DLBCL patients. In Studies B2202 and B2205J there were 79.8% of Caucasian, 7.7% of Asian and 12.5% of other ethnicities.

In Study C2201, there were 88% Caucasian, 5% Asian, 4% Black or African American patients and three patients (3%) of unknown race.

Body weight

In DLBCL patients, across the weight ranges (38.4 to 186.7 kg), the scatter plots of qPCR cellular kinetic parameters versus weight revealed no apparent relationship between cellular kinetic parameters with weight.

Renal impairment

Kymriah is a cell based product, and based on the mechanism of action renal impairment is not expected to impact tisagenlecleucel expansion and cellular kinetics; hence no formal renal impairment studies were performed.

Prior stem cell transplantation

Prior stem cell transplantation did not impact the expansion/persistence of tisagenlecleucel in paediatric and young adult B-cell ALL patients or adult DLBCL patients.

Hepatic impairment

Kymriah is a cell based product, and based on the mechanism of action hepatic impairment is not expected to impact tisagenlecleucel expansion and cellular kinetics; hence no formal hepatic impairment studies were performed.

Immunogenicity

Cell based therapeutics carry the potential for immunogenicity. Humoral immunogenicity of tisagenlecleucel was measured by determination of anti-murine CAR19 antibodies (anti-mCAR19) in serum pre- and post-administration. In paediatric and young adult ALL, the majority of patients (84.6%) tested positive for pre-dose anti-mCAR19, however, the pre-existing antibodies were not associated with an impact on clinical response nor have an impact on the expansion and persistence of tisagenlecleucel. Additionally treatment induced anti-mCAR19 antibodies were detected in 34.6 % of patients in the SCP pool. The treatment induced anti-mCAR19 antibodies did not impact cellular kinetics or clinical response.

In Study C2201, the majority of patients (91.4%) tested positive for pre-infusion humoral immunogenicity by the detection of anti-mCAR19 antibodies and 5% of patients had treatment-induced anti-mCAR19 antibodies detected. Anti-mCAR19 antibodies, both pre-existing and treatment-induced, were not associated with any apparent impact on clinical response nor have an impact on the in vivo initial expansion and persistence (C_{max} and $AUC_{0\text{-}28d}$) of tisagenlecleucel.

Cellular immunogenicity assessment was performed in paediatric and young adult ALL patients and r/r DLBCL patients to test for mCAR19 peptide-activated responses by stimulated intracellular interferon-gamma production. The cellular immunogenicity responses did not correlate with *in vivo* expansion and persistence and Month 3 response, for CD4 and CD8 T cell responses, for patients in both the indications.

As with any immunogenicity assay, the detection of anti-mCAR19 antibodies is highly dependent on assay sensitivity and specificity. Furthermore, the observed pre- and post-dose anti-mCAR19 may be influenced by several factors, including assay specifications, sample handling, timing of sample collection, prior therapy, administration of intravenous immunoglobulin or other concomitant medications as well as underlying disease. In addition, 90% of healthy volunteer samples screened during assay development were positive for anti-mCAR19 antibodies.

5.3 PRECLINICAL SAFETY DATA

Genotoxicity

Conventional genotoxicity assays have not been performed with tisagenlecleucel, and are not appropriate for cell therapy products. A genomic insertion site analysis of the lentiviral vector was performed on Kymriah products from 14 individual donors (12 patients and 2 healthy volunteers). There was no evidence for preferential integration near genes of concern or preferential outgrowth of cells harbouring integration sites of concern. However, a risk for insertional mutagenesis in mature T cells leading to oncogenic transformation cannot be excluded.

Carcinogenicity

Standard rodent carcinogenicity studies have not been performed with tisagenlecleucel. *In vitro* expansion studies with CAR-positive T-cells (Kymriah) from healthy donors and patients (Kymriah) showed no evidence for transformation and/or immortalization of T-cells. *In vivo* studies in immunocompromised mice did not show signs of abnormal cell growth or signs of clonal cell expansion for up to 7 months after cell injection.

6 PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

The cryo-media solution contains:

- Potassium 0.082 g/L
- Magnesium 0.012 g/L
- Sodium 2.43 g/L
- Aluminium 40.0 microgram/L
- Acetate 0.549 g/L
- Chloride 2.15 g/L
- Dextran 40 11.000 g/L
- Glucose 21.906 g/L
- Albumin (HSA) 52.400 g/L
- Dimethyl sulfoxide (DMSO) 82.500 g/L
- Dimethyl sulfone 0.03g/L
- D-gluconic acid 1.543 g/L
- Acetytriptophan 1.079 g/L
- Hydroxymethylfurfural 0.097mg/L
- Caprylate 0.630 g/L

This medicinal product contains 2.43 mg sodium per mL and 24.3 to 121.5 mg sodium per dose, equivalent to 1 to 6% of the WHO recommended maximum daily intake of 2 g sodium for an adult.

This medicinal product contains potassium, less than 1 mmol (39mg) per dose, ie essentially “potassium free.”

6.2 INCOMPATIBILITIES

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

6.3 SHELF LIFE

In Australia, information on the shelf life can be found on the public summary of the Australian Register of Therapeutic Goods (ARTG). The expiry date can be found on the packaging.

6.4 SPECIAL PRECAUTIONS FOR STORAGE

Kymriah must be stored in a temperature monitored system at ≤-120°C e.g. in the vapour phase liquid nitrogen. Do not thaw the product until it is ready to be used.

Store between 20 - 25°C	30 minutes
Store at 2°C to 8°C (Refrigerate. Do not freeze).	1 hour

6.5 NATURE AND CONTENTS OF CONTAINER

Container

Ethylene vinyl acetate (EVA) infusion bags with polyvinyl chloride (PVC) tubing and a luer spike interconnector closed by a luer-lock cap. Target volume 10 mL to 50 mL.

Pack size

Single dose unit.

6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

Any unused product or waste material should be disposed of in accordance with local requirements. Refer to local biosafety guidelines applicable for handling and disposal of products containing genetically-modified cells.

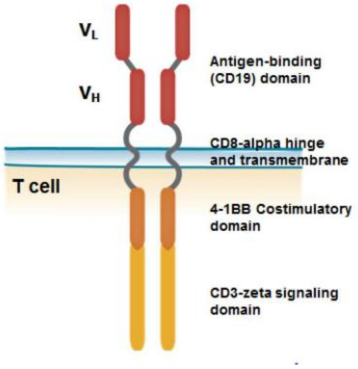
Kymriah products should be transported within the facility in closed, break-proof, leak-proof containers.

Solid and liquid waste: All material having been in contact with Kymriah should be handled and disposed of as potentially infectious waste in accordance with local hospital procedures.

6.7 PHYSICOCHEMICAL PROPERTIES

Chemical structure

The CAR-19 protein is comprised of a murine single chain antibody fragment, a CD8 hinge and transmembrane region, a 4-1BB (CD137) and CD3-zeta signalling domain



CAS number

Not established.

7 MEDICINE SCHEDULE (POISONS STANDARD)

Not determined.

8 SPONSOR

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9 DATE OF FIRST APPROVAL

19 Dec 2018

10 DATE OF REVISION

11 August 2025

SUMMARY TABLE OF CHANGES

Section Changed	Summary of new information
4.4	Update to warning on “Infections and febrile neutropenia”

Internal document code: kym110825i based on CDS 28-April-2025