

PRODUCT MONOGRAPH

Pr **REVLIMID**[®]

lenalidomide

5 mg, 10 mg, 15 mg, and 25 mg Capsules

Antineoplastic Agent
Immunomodulatory Agent

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Pr **REVLIMID**[®]

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PART I: HEALTH PROFESSIONAL INFORMATION

SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	Clinically Relevant Nonmedicinal Ingredients
oral	Capsule, 5 mg, 10 mg, 15 mg, 25 mg	lactose <i>For a complete listing see Dosage Forms, Composition and Packaging section.</i>

INDICATIONS AND CLINICAL USE

- REVLIMID[®] (lenalidomide) is indicated for the treatment of patients with transfusion-dependent anemia due to Low- or Intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities. Approval for this indication is based on red blood cell transfusion independence response rates. Overall survival benefit has not been demonstrated (see **CLINICAL TRIALS, Myelodysplastic Syndromes**).
- REVLIMID[®] in combination with dexamethasone is indicated for the treatment of multiple myeloma patients who have received at least one prior therapy.

Distribution restrictions

REVLIMID[®] is only available through a controlled distribution program called RevAid[®]. Under this program, only prescribers and pharmacists registered with the program are able to prescribe and dispense the product. In addition, REVLIMID[®] can only be dispensed to patients who are registered and meet all the conditions of the RevAid[®] program. Please call 1-888-RevAid1 (1-888-738-2431) or log onto www.RevAid.ca.

Geriatrics (> 65 years of age):

REVLIMID[®] has been used in clinical trials in subjects up to 95 years of age. Of the 353 subjects with multiple myeloma who received REVLIMID[®] /dexamethasone, 41.4% were > 65 years of age. No effect of age on the clinical efficacy was observed in the Phase 3 clinical trials. Some differences in clinical safety have been identified between the elderly and younger subjects (see **Special populations: Geriatrics > 65 years of age**).

Because elderly patients are more likely to have decreased renal function, and REVLIMID[®] is cleared by the kidney, monitoring of renal function and dose adjustments are recommended based on stage of renal impairment (see **WARNINGS AND PRECAUTIONS, Geriatrics and DOSAGE AND ADMINISTRATION, Starting Dose Adjustment for renal impairment**).

Pediatrics (< 18 years of age):

The safety and effectiveness of REVLIMID[®] in children and adolescents have not been established.

CONTRAINDICATIONS

- REVLIMID[®] (lenalidomide) is contraindicated in patients who are hypersensitive to it or to thalidomide or to any ingredient in the formulation or component of the container. For a complete listing, see **DOSAGE FORMS, COMPOSITION AND PACKAGING**.
- REVLIMID[®] is contraindicated in pregnant women and women at risk of becoming pregnant (see **WARNINGS AND PRECAUTIONS**). Lenalidomide is structurally related to thalidomide, a known human teratogen that causes severe and life-threatening birth defects. Lenalidomide induced malformations in monkeys similar to those described with thalidomide. If lenalidomide is taken during pregnancy, it may cause severe birth defects or death to the fetus (see **WARNINGS AND PRECAUTIONS**). Females of Child-Bearing Potential may be treated with REVLIMID[®] provided that adequate contraception, with two simultaneous effective methods of contraception, is used to prevent fetal exposure to the drug. The choice of the two simultaneously effective contraceptive methods will necessitate a risk/benefit discussion between the patient and a qualified physician experienced in the use of contraceptive methods (see **Serious Warnings and Precautions Box**).
- Breast feeding women
- REVLIMID[®] treatment should not be started in MDS patients whose platelet levels are less than $50 \times 10^9/L$ (see **ADVERSE REACTIONS, Clinical Trial Adverse Drug Reactions**).

WARNINGS AND PRECAUTIONS**Serious Warnings and Precautions**

REVLIMID[®] (lenalidomide) should be administered under the supervision of a qualified physician experienced in the use of cancer chemotherapeutic agents.

- Potential for human birth defects, stillbirths, and spontaneous abortions (see **Special Populations: Females of Child-Bearing Potential and Male patients**).
- Neutropenia and Thrombocytopenia (see **WARNINGS AND PRECAUTIONS, ADVERSE REACTIONS** and **DOSAGE AND ADMINISTRATION**).
- Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) (see **WARNINGS AND PRECAUTIONS**).
- Hepatotoxicity, including fatal cases (see **WARNINGS AND PRECAUTIONS, Hepatic**).
- Available only under a controlled distribution program called RevAid[®].

General

Patients should be informed to not give blood while taking REVLIMID[®] and for 4 weeks after stopping REVLIMID[®]. If a woman who is pregnant received their donated blood, her baby may be exposed to lenalidomide and may be born with birth defects.

In the treatment of MDS, patients without at least a minor erythroid response within 4 months of therapy initiation demonstrated by at least a 50% reduction in transfusion requirements or, if not transfused, a 1 g/dL rise in hemoglobin, should discontinue REVLIMID[®] treatment (see **DOSAGE AND ADMINISTRATION, Myelodysplastic Syndromes**).

In the treatment of multiple myeloma, consideration should be given to the dose of dexamethasone used in combination with REVLIMID (see **DOSAGE AND ADMINISTRATION, Dosing Considerations, Multiple Myeloma**). This is based on safety data from a Phase 3 study conducted in 445 patients with newly diagnosed multiple myeloma (unauthorized indication). With a median follow up of 72.3 weeks, an increased mortality was observed in the REVLIMID/ standard dose dexamethasone arm 19.3% (43/223) compared to the REVLIMID/low dose dexamethasone arm 6.8% (15/220). Considering that the patient population differs from the authorized indication, these results should be interpreted with caution.

Cardiovascular

In the two Phase 3 multiple myeloma studies, REVLIMID[®] was associated with an increased risk of cardiac disorders. The incidence of treatment emergent cardiac disorders was 18% and 11% in the REVLIMID[®]/dexamethasone and placebo/dexamethasone treatment groups, respectively. The rates of grade 3/4 cardiac events (9.1% versus 4.6%) and serious cardiac events (7.6% versus 3.4%) were higher in the REVLIMID[®]/dexamethasone group as compared to the control group. Treatment with REVLIMID[®]/dexamethasone resulted in a three-fold increase in the incidence of serious events of atrial fibrillation as compared with the placebo/dexamethasone (see **ADVERSE REACTIONS, Clinical Trial Adverse Reactions**). Patients with risk factors for developing atrial fibrillation (e.g. existing heart disease, electrolyte abnormalities, hypertension and infections) should be closely monitored.

The combination of REVLIMID[®] with dexamethasone is associated with an increased risk of venous thromboembolism (predominantly deep vein thrombosis (DVT) and pulmonary embolism (PE)) and arterial thromboembolism (predominantly myocardial infarction and cerebrovascular events) in patients with MM. The number of patients experiencing a serious DVT event was higher in the combination arm (7.1%; 25/353) as compared to those in the placebo/dexamethasone arm (3.1%; 11/350) (see **ADVERSE REACTIONS**).

Concomitant administration of erythropoietic agents or previous history of DVT may enhance the risk of thrombotic events. Therefore, erythropoietic agents, or other agents that may increase the risk of thrombosis, such as hormone replacement therapy and hormonal contraceptives, should be used with caution in patients receiving REVLIMID[®] in combination with dexamethasone. Patients and physicians are advised to be observant for the signs and symptoms of thromboembolism. Physicians should make the decision when to discontinue therapy of erythropoietic or other agents that may increase the risk of thrombosis based on best clinical practice. Patients should be instructed to seek medical care if they develop symptoms such as a

sudden shortness of breath, chest pain, arm or leg swelling. Prophylactic antithrombotic medications, such as low dose aspirin, low molecular weight heparins or warfarin, should be considered, especially in patients with additional thrombotic risk factors. The decision to take antithrombotic prophylactic measures should be made after careful assessment of an individual patient's underlying risk factors.

Myocardial infarction has been reported in patients receiving REVLIMID[®], particularly those with known risk factors. Consequently, patients with known risk factors should be closely monitored and action should be taken to minimize risk factors (e.g. smoking, hypertension, and hyperlipidemia).

Carcinogenesis and Mutagenesis

Carcinogenicity studies have not been conducted. Lenalidomide did not induce mutation in the Ames test, chromosome aberrations in cultured human peripheral blood lymphocytes, or mutation at the thymidine kinase (tk) locus of mouse lymphoma L5178Y cells. Lenalidomide did not increase morphological transformation in Syrian Hamster Embryo assay or induce micronuclei in the polychromatic erythrocytes of the bone marrow of male rats (see **TOXICOLOGY**).

Hematologic

REVLIMID[®] is associated with significant neutropenia and thrombocytopenia.

- **Myelodysplastic Syndromes**

Grade 3/4 neutropenia (75%) and thrombocytopenia (37%) are the most common, dose-limiting adverse events associated with the administration of lenalidomide. Patients on therapy for del 5q myelodysplastic syndromes must be adequately informed of the risk of thrombocytopenia and neutropenia and should have their complete blood counts monitored weekly for the first 8 weeks of therapy and at least monthly thereafter (see **Monitoring and Laboratory Tests**). Patients may require dose interruption and/or reduction. Patients may require use of blood product support and/or growth factors (see **DOSAGE AND ADMINISTRATION, CLINICAL TRIALS**).

Patients should be advised to promptly report febrile episodes as a dose reduction may be required. In cases of thrombocytopenia, patients and physicians should be observant for signs and symptoms of bleeding, including petechiae and epistaxes.

- **Multiple Myeloma**

In multiple myeloma patients, Grade 3 and 4 hematologic toxicities including neutropenia (35.4%) and thrombocytopenia (13.0%) were more frequent in subjects treated with the combination of REVLIMID[®] and dexamethasone than in subjects treated with dexamethasone alone (see **ADVERSE REACTIONS**).

Hepatic

Hepatic failure, including fatal cases, has occurred in patients treated with REVLIMID in combination with dexamethasone: acute hepatic failure, toxic hepatitis, cytolytic hepatitis, cholestatic hepatitis, and mixed cytolytic/cholestatic hepatitis have been reported (see **ADVERSE REACTIONS, Post-Market Adverse Drug Reactions**). The mechanism of severe drug-induced hepatotoxicity is unknown. Pre-existing viral liver disease, elevated baseline liver enzymes, and concomitant medications may be risk factors. Monitor liver enzymes periodically. Stop REVLIMID upon elevation of liver enzymes. After return to baseline values, treatment at a lower dose may be considered.

Immune

Angioedema and serious dermatologic reactions including Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) have been reported as rare cases from post-marketing experience. These events have the potential to be fatal. REVLIMID[®] discontinuation should be considered if skin rash \geq Grade 2 is exfoliative or bullous or if Stevens-Johnson syndrome or toxic epidermal necrolysis is suspected. REVLIMID[®] should not be resumed following discontinuation for these reactions.

Renal/Metabolic

Lenalidomide is primarily excreted unchanged by the kidney. Lower starting dose adjustment is recommended in patients with renal insufficiency in order to maintain an effective and safe level of REVLIMID[®]. Based on a pharmacokinetic study in subjects with renal impairment due to a nonmalignant condition, a REVLIMID[®] starting dose adjustment should be considered for patients with moderate or severe renal impairment and in patients on dialysis (patients with CrCL < 60 mL/min) (see **DOSAGE AND ADMINISTRATION** and **ACTION AND CLINICAL PHARMACOLOGY, Renal Insufficiency**).

Patients with multiple myeloma, progressive disease and/or advanced age are more likely to have decreased renal function. The risk of serious renal disorders and renal failure may be greater in patients with impaired renal function. Periodic monitoring of renal function and dose adjustments are recommended based on stage of renal impairment.

Sensitivity/Resistance

Lenalidomide capsules contain lactose. Patients with rare hereditary problems of glucose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this product.

Second Primary Malignancies

An increase of second primary malignancies (SPM) has been observed in clinical trials in previously treated myeloma patients receiving lenalidomide/dexamethasone (3.98 per 100 patient-years) compared to controls (1.38 per 100 patient-years). Non invasive SPM comprise basal cell or squamous cell skin cancers. Most of the invasive SPMs were solid tumor malignancies.

In clinical trials of newly diagnosed multiple myeloma, a 4-fold increased incidence of second primary malignancies has been observed in patients receiving REVLIMID[®] (7.0%) compared with controls (1.8%). Among invasive SPMs, cases of AML, MDS and solid tumors were observed in patients receiving REVLIMID[®] in combination with melphalan or immediately following high dose melphalan and autologous stem cell transplantation (ASCT); cases of B-cell malignancies (including Hodgkin's lymphoma) were observed in the clinical trials where patients received REVLIMID[®] in the post ASCT setting.

The risk of occurrence of SPM must be taken into account before initiating treatment with REVLIMID[®]. Physicians should carefully evaluate patients before and during treatment using standard cancer screening for occurrence of second primary malignancies and institute treatment as indicated.

Tumor Lysis Syndrome and Tumor Flare Reaction

Tumor Lysis Syndromes (TLS) and Tumor Flare Reaction (TFR) have been observed in patients with chronic lymphocytic leukemia (CLL) who were treated with REVLIMID[®]. There have been rare reports of TLS in patients with MM and TLS and TRF in non-Hodgkin's Lymphoma treated with REVLIMID[®]. Fatal instances of TLS have been reported during treatment with lenalidomide. Patients at risk for TLS are those with high tumor burden prior to treatment. Caution should be practiced when introducing these patients to REVLIMID[®]. These patients should be monitored closely and appropriate precautions taken.

Special Populations

1. Females of Child-Bearing Potential:

Females of Child-Bearing Potential are all females who are menstruating, amenorrheic from previous treatments, and/or perimenopausal.

Lenalidomide is an analogue of thalidomide, a known human teratogen that causes severe and life-threatening birth defects. An embryo-fetal development study in non-human primates indicates that lenalidomide produced malformations in the offspring of female monkeys given the drug during pregnancy, similar to birth defects observed in humans following exposure to thalidomide during pregnancy. The teratogenic effect of lenalidomide in humans cannot be ruled out. REVLIMID[®] may cause fetal harm when administered to a pregnant female. For Females of Child-Bearing Potential, REVLIMID[®] is contraindicated unless **ALL** of the following conditions are met:

- ✓ The patient is capable of understanding and carrying out instructions. (In some cases, the patient will need a competent support person to ensure RevAid[®] program compliance).
- ✓ The patient is willing and able to comply with the **two** mandatory, simultaneous and effective contraceptive measures or to commit to continually abstaining from heterosexual contact.

- ✓ The patient has a consultation with a health care professional, who has experience with the use of contraceptive methods, to discuss the best and most effective **two** simultaneous contraceptive methods to be used.
- ✓ The patient understands the cumulative risks of deep venous thrombosis, including, but not limited to, REVLIMID[®], dexamethasone, cancer and hormonal contraception.
- ✓ The patient knows the risk of possible contraceptive failure.
- ✓ The patient is willing and able to comply with the pregnancy testing requirements noted in detail below. This includes two negative pregnancy tests prior to the first dispense and on-going pregnancy tests throughout treatment.
- ✓ The patient is aware of the potential need for emergency contraception.
- ✓ The patient is informed of the risk of teratogenicity should a pregnancy occur.
- ✓ The patient knows and understands the need to consult her physician immediately if there is a risk of pregnancy.
- ✓ The patient acknowledges the importance of compliance with all the conditions of use.

Contraceptive Measures:

- All Females of Child-Bearing Potential (including those who normally do not use contraception due to a history of infertility, and those who have amenorrhea) must use the two simultaneous, effective methods of contraception:
 - For at least 4 weeks before starting REVLIMID[®] treatment.
 - During dose interruptions.
 - During REVLIMID[®] treatment.
 - For at least 4 weeks following the discontinuation of REVLIMID[®] treatment.
- The patient who chooses to abstain from heterosexual contact as a contraceptive measure, must commit to using 2 methods of contraception at the same time if abstinence is no longer practiced.
- The use of hormonal contraceptives is associated with an increased risk of thromboembolic disorders. Hormonal contraceptives are not recommended (see **WARNINGS AND PRECAUTIONS, Cardiovascular**).
- Any method of contraception can fail. It is, therefore, critically important that Females of Child-Bearing Potential use two effective methods of contraception simultaneously.
- If pregnancy does occur during treatment, the drug should be immediately discontinued. Under these conditions, the patient should be referred to an obstetrician/gynecologist experienced in reproductive toxicity, for further evaluation and counseling.
- Any suspected embryo-fetal exposure to REVLIMID[®] should be reported immediately by telephone to Celgene at 1-888-RevAid1 (1-888-738-2431)

- Female patients with a previous hysterectomy or bilateral oophorectomy are exempt from contraception use during REVLIMID[®] therapy.

Pregnancy Testing:

- Females of Child-Bearing Potential must not be given REVLIMID[®] until pregnancy is excluded. The patient must have two negative pregnancy tests before starting REVLIMID[®] therapy, as well as subsequent tests throughout the treatment.
- The first pregnancy test should be conducted seven to 14 days prior to the start of therapy.
- The second pregnancy test should be conducted 24 hours prior to dispensing and starting the drug.
- A pregnancy test should be conducted weekly during the first month of treatment, monthly thereafter during treatment (or every two weeks if menses are irregular) and 4 weeks after the discontinuation of treatment.
- The pregnancy test should be a blood test performed in a licensed laboratory. The dates and results of pregnancy tests should be documented.
- The pregnancy test should have a serum hCG sensitivity of at least 25 mIU/ml.
- Pregnancy testing and consultation with an obstetrician/gynecologist should also occur if a patient misses her period, or if there is any abnormal menstrual bleeding.

2. Pregnant Women:

- REVLIMID[®] is contraindicated in females who are, or may become, pregnant.
- REVLIMID[®] is contraindicated in Females of Child-Bearing Potential who are not using the two mandatory, simultaneous and effective methods of contraception or who are not continually abstaining from heterosexual sexual contact.
- If pregnancy does occur during treatment, the drug should be immediately discontinued. Under these conditions, the patient should be referred to an obstetrician/gynecologist experienced in reproductive toxicity, for further evaluation and counseling.
- Any suspected embryo-fetal exposure to REVLIMID[®] should be reported immediately by telephone to Celgene at 1-888-RevAid1 (1-888-738-2431).

3. Nursing Women:

REVLIMID[®] should not be used when a patient is breast-feeding (See **CONTRAINDICATIONS**).

The safe use of REVLIMID[®] during lactation has not been established.

4. Male Patients:

Lenalidomide is present in the semen of patients receiving the drug (see **ACTION AND CLINICAL PHARMACOLOGY**). Therefore, males receiving REVLIMID[®] must always use

a latex condom during any sexual contact with Females of Child-Bearing Potential even if they have undergone a successful vasectomy. The condom should be used:

- While the Male Patient is taking REVLIMID[®].
- During interruption of treatment.
- For four weeks after stopping REVLIMID[®].

Patients should not donate semen while taking REVLIMID[®] and for four weeks after stopping REVLIMID[®].

5. Pediatrics (< 18 years of age):

Safety and effectiveness in pediatric patients below the age of 18 have not been established. In the clinical trial program, no patients under 18 years of age were treated. For **ALL** sexually active Females of Child-Bearing Potential the use of two simultaneous effective methods of contraception is mandatory.

6. Geriatrics (> 65 years of age):

Elderly patients are more likely to have decreased renal function, and the risk of adverse reactions to REVLIMID[®] may be greater in patients with impaired renal function. Based on stage of renal impairment, lower REVLIMID[®] starting doses are recommended (see **Renal/Metabolic** and **DOSAGE AND ADMINISTRATION, Starting Dose Adjustment for Renal Impairment**).

- **Myelodysplastic Syndromes**

REVLIMID[®] has been used in MDS clinical trials in patients up to 95 years of age. Of the 395 patients with MDS who were treated with 10 mg/day of REVLIMID[®], atrial fibrillation, constipation, confusion and dyspnea were reported in significantly more subjects > 65 than those ≤ 65 years of age. In the del 5q MDS single arm Phase 2 study, patients ≥ 65 years old experienced serious adverse events more frequently than younger patients (60.0% vs. 35.4%). Discontinuation of treatment was three-fold higher in patients ≥ 65 years of age compared to that of patients < 65 years (30.1% vs. 10.4%).

- **Multiple Myeloma**

REVLIMID[®] in combination with dexamethasone has been used in multiple myeloma (MM) clinical trials in patients up to 86 years of age.

In the REVLIMID[®]/dexamethasone arm (n=353), patients > 65 years of age were more likely than patients ≤ 65 years of age to experience serious events of cardiac disorders (15.8% versus 4.3%), including atrial fibrillation (6.8% versus 1.9%) as well as diarrhea (4.1% vs. 2.4%), fatigue (9.6% vs. 4.3%), pulmonary embolism (6.2% vs. 2.4%), and syncope (3.4% vs. 2.4%).

Monitoring and Laboratory Tests

Complete blood cell count (CBC), including white blood cell count with differential,

hemoglobin, platelets, blood chemistries including SGOT/AST, SGPT/ALT, direct bilirubin, creatinine, creatinine clearance (CrCL), and thyroid function should be monitored at baseline and throughout treatment with REVLIMID[®].

Twelve (12) lead ECGs were mandatory in pivotal studies. Patients with irregularly irregular heart rates at the time of follow-up should receive an additional ECG and evaluation for atrial fibrillation. If atrial fibrillation is detected, the patient should be treated in accordance with current medical practice in order to prevent potentially serious consequences.

- **Myelodysplastic Syndromes**

For MDS patients, complete blood count with differential, platelet count, hemoglobin, and hematocrit should be monitored weekly for the first 8 weeks of REVLIMID[®] treatment and monthly thereafter or when deemed necessary for cytopenias.

- **Multiple Myeloma**

For multiple myeloma patients, complete blood count with differential, platelet count, hemoglobin, and hematocrit should be monitored bi-weekly (every two weeks) for the first 12 weeks of REVLIMID[®] treatment and monthly thereafter or when deemed necessary for cytopenias.

Geriatric patients should be closely monitored for cardiac and renal function.

ADVERSE REACTIONS

Adverse Drug Reaction Overview

Phase 2 Single Arm Open Label del 5q Myelodysplastic Syndromes Study

Phase 3 Three arm, Double-Blind, Randomized, Placebo-controlled del 5q MDS Study

The Phase 2 study enrolled 148 patients, and the Phase 3 study enrolled 205 patients (69 each in the 10 mg REVLIMID[®] cyclic regimen and 5 mg continuous regimen, and 67 in the placebo group).

In the Phase 2 study, all 148 patients received at least one dose of 10 mg REVLIMID[®] and at least one adverse event was reported in all (100%) of these patients. In the Phase 3 study, a total of 194 patients received at least one dose of REVLIMID[®] including placebo-treated patients who crossed over to REVLIMID[®] in the open-label portion of the Phase 3 study. All REVLIMID-treated patients (100%) experienced at least one adverse event during the entire study (double-blind and open-label phases).

The most common adverse events reported in REVLIMID[®]-treated patients in Phase 2 and Phase 3 studies, respectively, were: neutropenia (66% and 77%) and thrombocytopenia (65% and 46%) (see **Serious Warnings and Precautions** Box). Severe myelosuppression generally occurred

early in the course of treatment with 62% of grade 3 or 4 hematologic adverse events occurring within the initial 8 weeks of treatment. In the Phase 3 study, there were two patients with baseline platelet levels from $25 \times 10^9/L$ – $50 \times 10^9/L$ who were treated with REVLIMID. Both patients did not achieve 182-day RBC transfusion independence. Both patients had bleeding events and received platelet transfusions. Both patients subsequently died (> 30 days after the last dose of REVLIMID); one patient had AML progression and the other, progressive worsening of general condition (see **CONTRAINDICATIONS**). Other most common adverse events in Phase 2 and Phase 3 studies, respectively, include diarrhea (61%, 35%), pruritus (45%, 25%), rash (40%, 18%), and fatigue (42%, 18%). These adverse events occurred most frequently during the first two cycles of treatment.

The most common serious adverse events reported in REVLIMID[®]-treated patients were pneumonia (10%, 3%), neutropenia (7%, 6%), thrombocytopenia (4%, 6%), anemia (5%, 3%), and febrile neutropenia (5%, 2%). The serious adverse events are consistent with the known safety profile of REVLIMID[®].

Due to adverse events, REVLIMID[®] was discontinued in 32% and 13% of patients in the Phase 2 study and Phase 3 study, respectively. The most frequent adverse events leading to discontinuation in Phase 2 were thrombocytopenia (6.8%) and neutropenia (4.1%) followed by acute myeloid leukemia (2.7% in Phase 2 study and 2.9% in Phase 3 study). Dose interruption occurred in 72% and 38% of patients, mainly due to adverse events of neutropenia (24% and 17%) and thrombocytopenia (29% and 12%) in Phase 2 and Phase 3 studies, respectively. Approximately half of the REVLIMID[®]-treated patients had at least one adverse event leading to dose reduction. In addition to dose modifications, granulocyte colony-stimulating factors and platelet transfusions were used to manage patients who developed neutropenia, fever in association with neutropenia, and thrombocytopenia. A total of 18% (27/148) received platelet transfusions in the Phase 2 study. Evidence of bleeding was reported in 7 (25.9%) of the 27 subjects at the time of platelet transfusion.

The entire treatment period was up to 253 weeks in Phase 2 and up to 158.7 weeks in Phase 3. There were 12 deaths in the Phase 2 study and 10 deaths in the Phase 3 study during the treatment phase of the study plus 30 days. The most commonly reported causes of death were disease progression or disease-related events (sepsis) or cardiovascular (heart failure) findings.

Phase 3 Randomized Double Blind Placebo-Controlled Studies in Previously Treated Multiple Myeloma Patients

Overall, the adverse event data demonstrate that the addition of REVLIMID[®] to dexamethasone was accomplished with only a minimal increase in toxicity. The incidences of lethargy, neutropenia, thrombocytopenia, anemia NOS, leukopenia NOS, lymphopenia, diarrhea NOS, constipation, dry mouth, rash NOS, dry skin, tremor, dizziness, dysgeusia, muscle cramp, back pain, dyspnea NOS, nasopharyngitis, pharyngitis, upper respiratory tract infection NOS, pneumonia NOS, anorexia, hypokalemia, hypocalcemia, hypomagnesemia, vision blurred, and DVT were higher in the REVLIMID[®]/dexamethasone group than in the placebo/dexamethasone group.

Based on pooled data from two studies, all subjects experienced at least one adverse event when on REVLIMID[®]/dexamethasone combination treatment. A greater proportion of patients in the REVLIMID[®]/dexamethasone group than in the placebo/dexamethasone group had grade 3/4 (83.3% vs. 69.7%) and serious (57.2% vs. 46.6%) adverse events. More patients taking REVLIMID[®]/dexamethasone had experienced an adverse event leading to dose reduction/interruption (76.5% vs. 57.7%) and drug discontinuation (24.9% vs. 18.0%). The incidences of serious cardiac and DVT events were 7.6% and 7.1% in the REVLIMID[®]/dexamethasone group as compared to 3.4% and 3.1% in the placebo/dexamethasone group, respectively (see **WARNINGS AND PRECAUTIONS**).

Treatment-emergent cardiac disorders of any kind were reported more frequently among subjects treated with REVLIMID[®]/dexamethasone (18.1%; 64/353) than in subjects treated with placebo/dexamethasone (11.1%, 39/350). A total of 33 serious cardiac events were reported in 27 REVLIMID[®]/dexamethasone subjects compared to 15 events in 12 placebo/dexamethasone subjects. Serious cardiac disorders included atrial fibrillation (12 vs. 2 subjects), cardiac failure congestive (5 vs. 0 subjects), acute myocardial infarction (3 vs. 0 subjects), coronary artery disease (3 vs. 0 subjects), atrial flutter (2 vs. 0 subjects), arteriospasm coronary (1 vs. 0 subjects), acute coronary syndrome (1 vs. 0 subjects), and pulmonary edema NOS (1 vs 4 subjects). For serious events of atrial fibrillation, the exposure adjusted incidence density was three-fold higher for the REVLIMID[®]/dexamethasone group than for the placebo/dexamethasone group (0.033 versus 0.010 events per person per year). If atrial fibrillation is detected, the patient should be treated in accordance with current medical practice in order to prevent potentially serious consequences

Cardiac adverse events leading to the discontinuation of study medication were atrial fibrillation (2/353) and acute myocardial infarction (2/353) in the REVLIMID[®]/dexamethasone arm; and pulmonary edema NOS (3/350) in the placebo/dexamethasone arm.

Approximately 39% of subjects in the REVLIMID[®]/dexamethasone group required a reduction in their REVLIMID[®] dose, and approximately 31% of subjects required a reduction in their dexamethasone dose. Approximately 11% of subjects in the placebo/dexamethasone group required a reduction in their placebo dose and approximately 16% required a reduction in their dexamethasone dose.

Ten deaths were considered to be REVLIMID[®]/dexamethasone related: 3 due to cerebrovascular accident, 1 due to pneumonia, 1 due to leukoencephalopathy, 1 due to pulmonary embolism,

1 due to cardiac arrest, 1 due to pneumonia NOS/respiratory failure, 1 due to pancytopenia/pneumonia NOS/sepsis NOS and 1 due to sudden death of unknown causes.

Four deaths were considered placebo/dexamethasone related: 1 due to brain edema/pulmonary edema NOS, 1 due to pulmonary edema NOS, 1 due to pneumonia NOS, and 1 of unknown cause.

One case of hypersensitivity pneumonitis-like syndrome was reported with REVLIMID[®] use. The patient was dosed with REVLIMID[®] in cycles of 25 mg/d on days 1 to 21, followed by 7 days off. Dexamethasone was cycled at 40 mg/d on days 1–4, 9–12, and 17–20, followed by 7 days off. Treatment cycles were repeated every 28 days. In the case of unexpected respiratory symptoms such as dyspnea on exertion, crackles on physical examination, radiological bilateral ground-glass opacities and non-resolving pneumonia, REVLIMID[®] should be discontinued until further investigation excludes hypersensitivity pneumonitis-like syndrome.

Clinical Trial Adverse Drug Reactions

Phase 2 Single Arm Open Label del 5q Myelodysplastic Syndromes Study

Phase 3 Three arm, Double-Blind, Randomized, Placebo-controlled del 5q MDS Study

Table 1 summarizes the adverse reactions and grade 3/4 adverse reactions that were reported in $\geq 5\%$ of the REVLIMID[®] treated patients in the del 5q MDS uncontrolled and placebo-controlled clinical studies.

Table 1: Summary of adverse events reported in $\geq 5\%$ and Grade 3/4 adverse events reported in $\geq 1\%$ of the REVLIMID[®] treated patients in the del 5q MDS uncontrolled and placebo-controlled studies

System organ class/ Preferred term**	Uncontrolled Trial		Placebo-controlled Trial			
	All AEs REVLIMID [®] 10mg (N=148) %	Gr 3/4 AEs REVLIMID [®] 10mg (N=148) %	All AEs* (REVLIMID [®] 10 and 5 mg QD) (N=138) %	All AEs* Placebo (N=67) %	All Gr 3/4 AEs (REVLIMID [®] 10 and 5 mg QD) (n=138) %	All Gr 3/4 AEs Placebo (N=67) %
Patients With At Least One Adverse Event	(100.0)	94	100	96	92	43
Blood And Lymphatic System Disorders	86	82	86	31	82	27
Neutropenia	66	65	77	18	75	15
Thrombocytopenia	65	55	46	3	37	1
Anemia	26	16	8	9	4	9
Leukopenia	14	10	12	4	11	0
Febrile Neutropenia	8	7	3	0	2	0
Pancytopenia	5	3	1	0	1	0
Granulocytopenia	1	1	0	0	0	0
Skin And Subcutaneous Tissue Disorders	82	14	57	16	5	1
Pruritus	45	3	25	4	1	0
Rash	41	7	18	1	2	0
Dry Skin	14	0	10	1	0	0
Night Sweats	11	0	2	0	0	0

Table 1: Summary of adverse events reported in $\geq 5\%$ and Grade 3/4 adverse events reported in $\geq 1\%$ of the REVLIMID[®] treated patients in the del 5q MDS uncontrolled and placebo-controlled studies

System organ class/ Preferred term**	Uncontrolled Trial		Placebo-controlled Trial			
	All AEs REVLIMID [®] 10mg (N=148) %	Gr 3/4 AEs REVLIMID [®] 10mg (N=148) %	All AEs* (REVLIMID [®] 10 and 5 mg QD) (N=138) %	All AEs* Placebo (N=67) %	All Gr 3/4 AEs (REVLIMID [®] 10 and 5 mg QD) (n=138) %	All Gr 3/4 AEs Placebo (N=67) %
Hyperhidrosis	9	1	3	0	0	0
Ecchymosis	7	0	0	1	0	0
Erythema	8	0	2	1	0	0
Skin Lesion	5	0	1	0	0	0
Alopecia	7	0	1	0	0	0
Gastrointestinal Disorders	83	17	62	45	8	3
Diarrhea	65	7	35	18	3	0
Nausea	28	5	20	9	1	0
Constipation	26	1	20	7	1	0
Abdominal Pain	19	2	11	6	0	0
Vomiting	14	2	9	6	1	0
Abdominal Pain Upper	9	1	7	1	1	0
Dry Mouth	9	0	7	3	0	0
Toothache	8	0	3	0	2	0
Flatulence	6	0	2	0	0	0
Dysphagia	5	1	1	0	0	0
Dyspepsia	4	0	6	1	0	0
General Disorders And Administration Site Conditions	80	18	57	40	7	3
Fatigue	42	6	18	7	1	1
Edema Peripheral	32	3	15	7	1	0
Pyrexia	26	3	14	6	1	0
Asthenia	13	2	12	8	0	1
Edema	13	0	4	0	0	0
Pain	8	1	2	0	1	0
Chest Pain	5	0	0	6	0	0
Chills	6	2	1	0	0	0
Multi-organ failure	1	1	0	0	0	0
Respiratory, Thoracic And Mediastinal Disorders	70	18	35	19	5	4
Cough	26	0	11	6	0	0
Dyspnea	26	5	8	7	2	3
Epistaxis	15	1	5	3	0	0
Dyspnea Exertional	11	1	3	1	0	0
Sinus Congestion	5	0	0	0	0	0
Rhinorrhea	5	0	0	0	0	0
Oropharyngeal Pain	18	0	6	1	0	0
Pulmonary Embolism	4	3	4	0	3	0
Pleural Effusion	3	2	1	4	0	1
Respiratory Distress	2	2	0	0	0	0
Hypoxia	1	1	1	0	1	0
Pneumonitis	1	1	0	0	0	0
Pulmonary Hypertension	1	1	0	0	0	0

Table 1: Summary of adverse events reported in $\geq 5\%$ and Grade 3/4 adverse events reported in $\geq 1\%$ of the REVLIMID[®] treated patients in the del 5q MDS uncontrolled and placebo-controlled studies

System organ class/ Preferred term**	Uncontrolled Trial		Placebo-controlled Trial			
	All AEs REVLIMID [®] 10mg (N=148) %	Gr 3/4 AEs REVLIMID [®] 10mg (N=148) %	All AEs* (REVLIMID [®] 10 and 5 mg QD) (N=138) %	All AEs* Placebo (N=67) %	All Gr 3/4 AEs (REVLIMID [®] 10 and 5 mg QD) (n=138) %	All Gr 3/4 AEs Placebo (N=67) %
Pulmonary Edema	3	1	1	0	0	0
Musculoskeletal And Connective Tissue Disorders	68	14	50	22	6	0
Arthralgia	26	2	7	1	0	0
Back Pain	27	6	9	6	2	0
Muscle Spasms	24	2	17	9	0	0
Pain In Extremity	20	3	7	1	1	0
Musculoskeletal Pain	14	2	9	4	0	0
Myalgia	13	0	5	3	0	0
Neck Pain	5	0	3	0	0	0
Bone Pain	5	0	1	0	0	0
Muscular Weakness	5	0	1	0	0	0
Periarthritis	3	1	1	0	0	0
Infections And Infestations	79	31	62	34	12	4
Upper Respiratory Tract Infection	33	2	11	6	1	0
Nasopharyngitis	18	0	12	7	0	0
Urinary Tract Infection	16	2	9	6	1	0
Bronchitis	14	1	12	4	1	0
Pneumonia	14	9	4	4	3	1
Sinusitis	14	1	2	1	0	0
Influenza	9	2	3	1	0	0
Pharyngitis	18	0	3	0	0	0
Rhinitis	9	1	3	0	0	0
Cellulitis	8	2	1	0	0	0
Gastroenteritis	5	2	3	0	1	0
Sepsis	5	5	0	0	0	0
Bacteremia	1	1	0	0	0	0
Fungal Infection	3	1	0	0	0	0
Infection	3	1	2	0	0	0
Klebsiella Sepsis	1	1	0	0	0	0
Respiratory Tract Infection	3	1	1	0	1	0
Nervous System Disorders	61	18	38	25	3	1
Dizziness	25	3	10	4	0	0
Headache	22	2	14	9	1	0
Hypoesthesia	7	0	1	0	0	0
Dysgeusia	7	0	1	0	0	0
Peripheral Neuropathy	8	0	1	0	1	0
Paresthesia	8	1	7	4	0	0
Syncope	3	1	1	0	0	0
Peripheral Sensory Neuropathy	5	0	2	0	0	0
Transient Ischemic Attack	2	2	0	0	0	0
Cerebrovascular Accident	1	1	1	0	1	0

Table 1: Summary of adverse events reported in ≥ 5% and Grade 3/4 adverse events reported in ≥ 1% of the REVLIMID® treated patients in the del 5q MDS uncontrolled and placebo-controlled studies

System organ class/ Preferred term**	Uncontrolled Trial		Placebo-controlled Trial			
	All AEs REVLIMID® 10mg (N=148) %	Gr 3/4 AEs REVLIMID® 10mg (N=148) %	All AEs* (REVLIMID® 10 and 5 mg QD) (N=138) %	All AEs* Placebo (N=67) %	All Gr 3/4 AEs (REVLIMID® 10 and 5 mg QD) (n=138) %	All Gr 3/4 AEs Placebo (N=67) %
Depressed Level of Consciousness	1	1	0	0	0	0
Metabolism And Nutrition Disorders	48	16	24	19	9	7
Decreased Appetite	18	2	9	3	1	0
Hypokalemia	15	5	4	0	1	0
Hypomagnesaemia	7	1	2	0	0	0
Dehydration	7	1	1	0	0	0
Hypocalcemia	5	0	1	0	0	0
Hyperglycemia	5	1	1	3	1	0
Hyponatremia	5	3	0	1	0	1
Iron Overload	3	3	5	3	3	3
Investigations	38	10	22	10	4	0
Alanine Aminotransferase Increased	9	3	8	3	2	0
Aspartate Aminotransferase Increased	4	1	1	0	1	0
Blood Creatinine Increased	4	1	1	0	0	0
Weight Decreased	8	0	6	1	0	0
Vascular Disorders	33	12	23	10	7	1
Hypertension	9	5	7	0	0	0
Deep Vein Thrombosis	5	5	4	1	4	1
Hypotension	5	1	1	1	1	0
Hematoma	3	1	7	3	0	0
Psychiatric Disorders	31	3	19	13	2	3
Insomnia	13	0	9	7	1	0
Depression	9	1	2	4	0	1
Anxiety	5	0	4	3	0	0
Psychosomatic Disease	1	1	0	0	0	0
Renal And Urinary Disorders	22	4	8	4	2	1
Dysuria	8	0	2	3	0	0
Renal Failure	5	2	1	0	1	0
Cardiac Disorders	22	11	10	9	5	0
Palpitations	7	0	3	4	0	0
Cardiac Failure Congestive	5	4	1	0	1	0
Atrial Fibrillation	3	3	1	3	1	0
Cardiac Failure	1	1	3	1	1	0
Myocardial Infarction	1	1	1	0	1	0
Acute Myocardial Infarction	0	0	1	0	1	0
Neoplasms Benign, Malignant and Unspecified (Including Cysts and Polyps)	20	14	9	3	6	1
Acute Leukemia	5	0	0	0	0	0

Table 1: Summary of adverse events reported in $\geq 5\%$ and Grade 3/4 adverse events reported in $\geq 1\%$ of the REVLIMID[®] treated patients in the del 5q MDS uncontrolled and placebo-controlled studies

System organ class/ Preferred term**	Uncontrolled Trial		Placebo-controlled Trial			
	All AEs REVLIMID [®] 10mg (N=148) %	Gr 3/4 AEs REVLIMID [®] 10mg (N=148) %	All AEs* (REVLIMID [®] 10 and 5 mg QD) (N=138) %	All AEs* Placebo (N=67) %	All Gr 3/4 AEs (REVLIMID [®] 10 and 5 mg QD) (n=138) %	All Gr 3/4 AEs Placebo (N=67) %
Acute Myeloid Leukemia	3	3	4	3	2	1
Endocrine Disorders	11	1	3	0	0	0
Hypothyroidism	9	1	1	0	0	0
Hepatobiliary Disorders	7	2	4	1	1	0
Cholecystitis	1	1	1	0	0	0
Ear and Labyrinth Disorders	16	1	6	3	0	0
Ear Pain	5	0	0	0	0	0
Eye Disorders	30	3	6	5	1	0
Conjunctivitis	6	0	3	0	0	0
Vision Blurred	5	0	1	0	0	0
Cataract	3	1	2	1	0	0
Injury, Poisoning and Procedural Complications	36	5	14	10	4	0
Contusion	12	0	2	1	0	0
Fall	10	2	4	0	2	0
Skin Laceration	5	1	1	0	0	0
Femoral Neck Fracture	1	1	0	0	0	0
Femur Fracture	1	1	0	0	0	0

* Adverse events with frequency $\geq 1\%$ in the 10 mg. Grade 3 and 4 are based on National Cancer Institute Common Toxicity Criteria version 2.

**Preferred Terms are coded using the MedDRA dictionary. A patient with multiple occurrences of an AE is counted only once in the Preferred Term category.

The frequency of undesirable effects was calculated using the CIOMS IV working group recommendation criteria:

Very common	$\geq 1/10$ ($\geq 10\%$)
Common (frequent)	$\geq 1/100$ and $< 1/10$ ($\geq 1\%$ and $< 10\%$)
Uncommon (infrequent)	$\geq 1/1000$ and $< 1/100$ ($\geq 0.1\%$ and $< 1\%$)
Rare	$\geq 1/10,000$ and $< 1/1000$ ($\geq 0.01\%$ and $< 0.1\%$)
Very rare	$< 1/10,000$ ($< 0.01\%$)

The following lists all adverse events reported in under 5% of patients in the study. All reactions listed as “Uncommon” occurred in 1/148 (uncontrolled trial) and 1/138 (controlled trial) patients.

Blood and Lymphatic Systems Disorders:

Common: lymphadenopathy, granulocytopenia, polycythemia, splenomegaly

Uncommon: autoimmune thrombocytopenia, coagulopathy, eosinophilia, hemolytic anemia, hyperglobulinemia, leukocytosis, lymphocytosis, lymphopenia, monocytosis, myelosuppression/bone marrow failure, thrombocytopenia, thrombocytosis

Cardiac Disorders:

Common: tachycardia, angina pectoris, bradycardia, pericardial effusion

Uncommon: cardio-respiratory arrest, cardiomyopathy, mitral valve incompetence, tachyarrhythmia

Congenital, Familial and Genetic Disorders:

Uncommon: pseudoxanthoma elasticum

Ear and Labyrinth Disorders:

Common: tinnitus, vertigo, ear discomfort, deafness, middle ear effusion

Uncommon: hearing impaired, hypoacusis,

Endocrine Disorders:

Common: hyperthyroidism

Uncommon: Addison's disease, goiter

Eye Disorders:

Common: eye pruritus, dry eye, macular degeneration, conjunctival hemorrhage, diplopia, eye hemorrhage, eyelid edema, visual disturbance, eye pain, eye irritation, abnormal sensation eye, chalazion, conjunctival hyperaemia, visual impairment, vitreous floaters

Uncommon: acquired night blindness, blindness transient, chorioretinal atrophy, dacryocanaliculitis, diabetic retinopathy, eye discharge, eye disorder, hyphema, keratopathy, ocular hypertension, ocular icterus, photopsia, amaurosis fugax, keratoconjunctivitis sicca, lacrimation increased, visual acuity reduced

Gastrointestinal Disorders:

Common: stomatitis, abdominal distension, abdominal discomfort, gingival bleeding, gastroesophageal reflux disease, hemorrhoidal hemorrhage, mouth ulceration, lower abdominal pain, colonic polyp, gastritis, gastrointestinal upset, irritable bowel syndrome, abdominal tenderness, aphthous stomatitis, dental discomfort, diverticulitis, diverticulum, frequent bowel movements, hemorrhoids, intestinal spasm, oral pain, rectal hemorrhage, gastrointestinal hemorrhage, gingival pain, glossodynia, hematochezia, melena

Uncommon: abdominal mass, anal hemorrhage, aptyalism, cheilitis, colitis ischemic, feces discolored, gastric erosions, gingival disorder, gingival hyperplasia, gingivitis, intestinal perforation, lip dry, lip hemorrhage, lower gastrointestinal hemorrhage, odynophagia, esophagitis, oral mucosal blistering, oral mucosal petechiae, oral soft tissue disorder, periodontitis, perirectal abscess, pruritus ani, regurgitation of food, stomach discomfort, tooth disorder, tooth impacted, anal fissure, esophagitis, gastric disorder, gastrointestinal pain, intussusception, lip swelling, oral dysesthesia, tooth loss

General Disorders and Administration Site Conditions:

Common: influenza-like illness, feeling cold, impaired healing, inflammation, lethargy, malaise, mucosal inflammation, multi-organ failure, pitting edema, mass, non-cardiac chest pain, generalised edema, tenderness

Uncommon: atrophy, chest tightness, disease progression, injection site bruising, injection site hemorrhage, injection site irritation, injection site reaction, intermittent pyrexia, mucosal dryness, sudden death, thirst, general physical health deterioration, hyperthermia, induration, injection site swelling, local swelling, necrosis, ulcer, venipuncture site thrombosis

Hepatobiliary Disorders:

Common: hyperbilirubinemia, cholelithiasis

Uncommon: cholecystitis, hepatic infarction, jaundice, cytolytic hepatitis, hepatic steatosis, hepatomegaly, hepatosplenomegaly, liver disorder

Immune System Disorders:

Common: hypersensitivity, seasonal allergy

Uncommon: hypogammaglobulinaemia

Infections and Infestations:

Common: herpes simplex, oral candidiasis, skin infection, tooth abscess, candidal infection, fungal infection, sinusitis acute, abscess, bladder infection, ear infection, furuncle, hordeolum, rash pustular, skin and subcutaneous tissue abscess, skin fungal infection, vaginosis fungal, viral infection, oral herpes, herpes zoster, cystitis, laryngitis, tooth infection, eye infection, clostridial infection, erysipelas, gastroenteritis viral, onychomycosis

Uncommon: bronchial infection, central line infection, encephalitis herpes, enterobacter sepsis, enterococcal infection, eye infection staphylococcal, eyelid infection, fungal rash, gastrointestinal infection NOS, helicobacter gastritis, infected skin ulcer, infusion site infection, kidney infection, lobar pneumonia, pneumonia klebsiella, sialoadenitis, skin candida, soft tissue infection, staphylococcal sepsis, systemic candida, tinea, vaginal candidiasis, pyelonephritis, osteomyelitis, otitis externa, septic shock, tinea versicolour, urosepsis, uterine infection, wound infection, wound infection staphylococcal

Injury, Poisoning and Procedural Complications:

Common: excoriation/abrasion, limb injury, spinal compression fracture, transfusion reaction, post procedural pain, rib fracture, wound, injury, joint injury, radius fracture, wrist fracture

Uncommon: confusion postoperative, eye injury, facial bones fracture, femoral neck fracture, femur fracture, joint dislocation, joint sprain, meniscus lesion, muscle strain, nerve injury, open wound, overdose, post procedural hemorrhage, spinal fracture, tendon injury, vaccination complication, back injury, chest injury, fat embolism, head injury, wound complication

Investigations:

Common: liver function tests abnormal, blood alkaline phosphatase increased, blood glucose increased, weight increased, blood bilirubin decreased, blood uric acid increased, neutrophil count decreased, blood thyroid stimulating hormone increased, blood lactate dehydrogenase increased, hemoglobin increased, transaminases increased

Uncommon: alanine aminotransferase decreased, basophil count increased, blood bilirubin increased, blood cholesterol increased, blood in stool, blood estrogen decreased, blood potassium decreased, blood pressure increased, blood urea increased, body temperature increased, ejection fraction decreased, electrocardiogram abnormal, electrocardiogram QT prolonged, fecal occult blood positive, fibrinolysis increased, heart rate increased, international normalized ratio

increased, intraocular pressure increased, low density lipoprotein increased, lymph node palpable, prostatic specific antigen increased, troponin I increased, urine analysis abnormal, aortic bruit, blood albumin decreased, blood folate decreased, HLA marker study positive, prothrombin level decreased, pulse pressure decreased

Metabolism and Nutrition Disorders:

Common: hyperuricemia, hyponatremia, hemochromatosis, diabetes mellitus, gout, hypercholesterolemia, fluid retention, hypoalbuminemia, hypoglycemia, lactose intolerance

Uncommon: diabetes mellitus non-insulin-dependent, failure to thrive, hyperkalemia, hypernatremia, hypophosphatemia, hypercalcemia, increased appetite

Musculoskeletal and Connective Tissue Disorders:

Common: arthritis, flank pain, joint swelling, musculoskeletal stiffness, musculoskeletal discomfort, musculoskeletal pain, peri-arthritis, arthritis aggravated, chest wall pain, limb discomfort, osteopenia, osteoporosis, pain in jaw, musculoskeletal chest pain, osteoarthritis

Uncommon: Dupuytren's contracture, groin pain, intervertebral disc degeneration, joint range of motion decreased, joint stiffness, local swelling, localized osteoarthritis, muscle weakness, night cramps, nodule on extremity, rheumatoid arthritis aggravated, sensation of heaviness, tendon disorder, tendonitis, fibromyalgia, rotator cuff syndrome

Neoplasms, Benign, Malignant and Unspecified (includes Cysts and Polyps):

Common: basal cell carcinoma, squamous cell carcinoma, seborrheic keratosis

Uncommon: angiomyolipoma, colon cancer, keratoacanthoma, lung cancer metastatic, lymphoma cutis, thymoma, breast cancer, histiocytosis hemaphagic, leukemia, myelodysplastic syndrome

Nervous System Disorders:

Common: tremor, balance impaired, memory impairment, sciatica, somnolence, ageusia, burning sensation, disturbance in attention, mental impairment, neuropathy, polyneuropathy, sensory disturbance, vasovagal attack, dysesthesia, restless leg syndrome, trigeminal neuralgia, amnesia, sinus headache, presyncope, migraine

Uncommon: aphasia, areflexia, ataxia, carpal tunnel syndrome, cervical radiculopathy, dementia, depressed level of consciousness, hypertensive encephalopathy, hypotonia, intracranial hemorrhage, muscle spasticity, neuropathic pain, parosmia, peripheral motor neuropathy, retinal migraine, senile dementia, sleep apnea syndrome, speech disorder, subarachnoid hemorrhage, torticollis, visual field defect, hemiparesis, hypogeusia

Psychiatric Disorders:

Common: agitation, dyssomnia, mental status changes, mood alteration, sleep disorder, depressed mood, nightmare

Uncommon: abnormal dreams, confusional state, decreased interest, hallucination, mania, nervousness, restlessness, eating disorder, panic attack

Renal and Urinary Disorders:

Common: micturition urgency, urinary frequency, urinary incontinence, renal impairment, pollakiuria

Uncommon: azotemia, bladder disorder, hematuria, nephrolithiasis, nocturia, oliguria,

proteinuria, renal failure acute, urethral caruncle, urinary retention, renal colic

Reproductive System and Breast Disorders:

Common: metrorrhagia, vaginal hemorrhage, breast pain, dysmenorrhea

Uncommon: amenorrhea, benign prostatic hyperplasia, female genital tract fistula, genital rash, gynecomastia, nipple exudate bloody, prostatism, erectile dysfunction, genital pain, vaginal inflammation, vulvovaginal burning sensation

Respiratory, Thoracic and Mediastinal Disorders:

Common: nasal congestion, crackles lung, lung infiltration, asthma, chronic obstructive airways disease exacerbated, dyspnea exacerbated, hoarseness, productive cough, rhinitis allergic, sinus pain, dysphonia, hemoptysis, rales, dry throat, emphysema, postnasal drip

Uncommon: choking, dyspnea paroxysmal nocturnal, hiccups, laryngitis NOS, nasal disorder, nasal mucosal disorder, nasal passage irritation, oropharyngeal swelling, orthopnea, paranasal sinus hypersecretion, pharyngeal ulceration, pharyngolaryngeal pain, pleurisy, pulmonary congestion, pulmonary mass, respiratory failure, rhinitis seasonal, sinus disorder, sneezing, throat tightness, diaphragmalgia, sputum discoloured, upper respiratory tract inflammation

Skin and Subcutaneous Tissue Disorders:

Common: rash pruritic, urticaria, face edema, pruritus generalized, rash erythematous, rash papular, decubitus ulcer, dermatitis allergic, exanthem, periorbital edema, pigmentation disorder, rash macular, rosacea, skin discoloration, skin irritation, swelling face, skin ulcer, stasis dermatitis, acne, purpura, exfoliative rash, skin disorder, skin fissures

Uncommon: acute febrile neutrophilic dermatosis, angioneurotic edema, cold sweat, dermatitis medicamentosa, eczema, epidermal cyst, folliculitis, hair disorder, ingrowing nail, skin burning sensation, skin nodule, xeroderma, blood blister, intertrigo, prurigo, pyoderma gangrenosum, rash maculo-papular, rash vesicular, scar pain, skin exfoliation

Surgical and Medical Procedures

Uncommon: nasal sinus drainage

Vascular Disorders:

Common: petechiae, flushing, arterial aneurysm, peripheral coldness, thrombophlebitis, thrombosis, phlebitis, pallor, varicose vein, aortic stenosis, hot flush

Uncommon: hemorrhage NOS, lymphedema, peripheral ischemia, Raynaud's phenomenon, thrombophlebitis superficial, necrosis ischemic

Phase 3 Randomized Double Blind Placebo-Controlled Studies in Previously Treated Multiple Myeloma Patients

Data were evaluated from 703 subjects who received at least one dose of REVLIMID[®]/dexamethasone (353 subjects) or placebo/dexamethasone (350 subjects). Table 2 summarizes the number and percentage of subjects with Grade 1-4 adverse events reported in $\geq 5\%$ of subjects in either treatment (see Table 2).

**Table 2: Summary of adverse events reported in $\geq 5\%$
of the subjects in the Controlled Multiple Myeloma Studies**

System organ class/ Preferred term	REVLIMID® /dexamethasone (N=353)	PLACEBO /dexamethasone (N=350)
Subjects With At Least One Adverse Event	353 (100.0)	350 (100.0)
General Disorders And Administration Site Conditions	303 (85.8)	278 (79.4)
Fatigue	161 (45.6)	147 (42.0)
Asthenia	103 (29.2)	94 (26.9)
Pyrexia	100 (28.3)	83 (23.7)
Edema Peripheral	95 (26.9)	75 (21.4)
Edema NOS	37 (10.5)	33 (9.4)
Chest Pain	30 (8.5)	21 (6.0)
Lethargy	26 (7.4)	8 (2.3)
Pain NOS	25 (7.1)	27 (7.7)
Gastrointestinal Disorders	284 (80.5)	244 (69.7)
Constipation	149 (42.2)	77 (22.0)
Diarrhea NOS	137 (38.8)	98 (28.0)
Nausea	92 (26.1)	76 (21.7)
Dyspepsia	59 (16.7)	51 (14.6)
Vomiting NOS	42 (11.9)	32 (9.1)
Abdominal Pain NOS	37 (10.5)	22 (6.3)
Abdominal Pain Upper	29 (8.2)	20 (5.7)
Dry Mouth	27 (7.6)	13 (3.7)
Stomatitis	22 (6.2)	19 (5.4)
Flatulence	20 (5.7)	16 (4.6)
Abdominal Distension	15 (4.2)	20 (5.7)
Musculoskeletal And Connective Tissue Disorders	282 (79.9)	246 (70.3)
Muscle Cramp	121 (34.3)	76 (21.7)
Back Pain	91 (25.8)	67 (19.1)
Arthralgia	63 (17.8)	63 (18.0)
Muscle Weakness NOS	56 (15.9)	56 (16.0)
Bone Pain	51 (14.4)	40 (11.4)
Pain In Limb	41 (11.6)	33 (9.4)
Myalgia	37 (10.5)	38 (10.9)
Chest Wall Pain	28 (7.9)	21 (6.0)
Nervous System Disorders	275 (77.9)	221 (63.1)
Headache	94 (26.6)	85 (24.3)
Dizziness	83 (23.5)	59 (16.9)
Tremor	75 (21.2)	26 (7.4)
Dysgeusia	54 (15.3)	34 (9.7)
Paraesthesia	51 (14.4)	47 (13.4)
Hypoaesthesia	37 (10.5)	26 (7.4)
Peripheral Neuropathy NOS	31 (8.8)	23 (6.6)
Neuropathy NOS	23 (6.5)	14 (4.0)
Respiratory, Thoracic And Mediastinal Disorders	258 (73.1)	213 (60.9)
Cough	90 (25.5)	86 (24.6)
Dyspnea NOS	85 (24.1)	60 (17.1)
Nasopharyngitis	65 (18.4)	31 (8.9)
Pharyngitis	53 (15.0)	34 (9.7)
Bronchitis NOS	41 (11.6)	30 (8.6)
Epistaxis	28 (7.9)	29 (8.3)
Hoarseness	22 (6.2)	17 (4.9)

**Table 2: Summary of adverse events reported in $\geq 5\%$
of the subjects in the Controlled Multiple Myeloma Studies**

System organ class/ Preferred term	REVLIMID® /dexamethasone (N=353)	PLACEBO /dexamethasone (N=350)
Hiccups	21 (5.9)	17 (4.9)
Dyspnea Exertional	18 (5.1)	18 (5.1)
Infections And Infestations	243 (68.8)	200 (57.1)
Upper Respiratory Tract Infection NOS	87 (24.6)	55 (15.7)
Pneumonia NOS	49 (13.9)	30 (8.6)
Urinary Tract Infection NOS	31 (8.8)	19 (5.4)
Sinusitis NOS	30 (8.5)	17 (4.9)
Oral Candidiasis	22 (6.2)	19 (5.4)
Herpes Simplex	21 (5.9)	18 (5.1)
Respiratory Tract Infection NOS	18 (5.1)	11 (3.1)
Blood And Lymphatic System Disorders	224 (63.5)	120 (34.3)
Neutropenia	152 (43.1)	23 (6.6)
Anemia NOS	119 (33.7)	83 (23.7)
Thrombocytopenia	80 (22.7)	37 (10.6)
Leukopenia NOS	30 (8.5)	7 (2.0)
Lymphopenia	20 (5.7)	6 (1.7)
Psychiatric Disorders	209 (59.2)	207 (59.1)
Insomnia	129 (36.5)	133 (38.0)
Depression	45 (12.7)	37 (10.6)
Anxiety	35 (9.9)	33 (9.4)
Confusional State	33 (9.3)	24 (6.9)
Irritability	24 (6.8)	16 (4.6)
Mood Alteration NOS	10 (2.8)	28 (8.0)
Skin And Subcutaneous Tissue Disorders	202 (57.2)	158 (45.1)
Rash NOS	76 (21.5)	35 (10.0)
Sweating Increased	34 (9.6)	25 (7.1)
Dry Skin	33 (9.3)	16 (4.6)
Pruritus	26 (7.4)	18 (5.1)
Contusion	21 (5.9)	17 (4.9)
Night Sweats	18 (5.1)	17 (4.9)
Face Edema	15 (4.2)	20 (5.7)
Metabolism And Nutrition Disorders	188 (53.3)	148 (42.3)
Anorexia	57 (16.1)	36 (10.3)
Hyperglycemia NOS	57 (16.1)	50 (14.3)
Hypokalemia	52 (14.7)	21 (6.0)
Hypocalcaemia	34 (9.6)	10 (2.9)
Hypomagnesaemia	27 (7.6)	10 (2.9)
Appetite Decreased NOS	25 (7.1)	14 (4.0)
Dehydration	25 (7.1)	14 (4.0)
Investigations	156 (44.2)	129 (36.9)
Weight Decreased	68 (19.3)	53 (15.1)
Weight Increased	20 (5.7)	29 (8.3)
Vascular Disorders	127 (36.0)	80 (22.9)
Deep Vein Thrombosis	32 (9.1)	15 (4.3)
Hypertension NOS	30 (8.5)	22 (6.3)
Hypotension NOS	26 (7.4)	16 (4.6)
Eye Disorders	121 (34.3)	91 (26.0)
Vision Blurred	60 (17.0)	40 (11.4)

**Table 2: Summary of adverse events reported in $\geq 5\%$
of the subjects in the Controlled Multiple Myeloma Studies**

System organ class/ Preferred term	REVLIMID [®] /dexamethasone (N=353)	PLACEBO /dexamethasone (N=350)
Endocrine Disorders	32 (9.1)	22 (6.3)
Cushingoid	21 (5.9)	16 (4.6)

System organ classes and preferred terms are coded using the MedDRA dictionary.

System organ classes and preferred terms are listed in descending order of frequency for the Overall column. A subject with multiple occurrences of an AE is counted only once in the AE category.

Table 3 summarizes the Grade 3/4 adverse events reported in $\geq 2\%$ of subjects in either treatment group.

Table 3: Incidence of grade 3/4 adverse events reported in $\geq 2\%$ of subjects in Either Treatment Group

Preferred term**	REVLIMID®/ dexamethasone (N=353)	PLACEBO/ dexamethasone N=(350)
Subjects With At Least One Grade 3 / 4 AE	294	244
Neutropenia	125 (35.4)	12 (3.4)
Thrombocytopenia	46 (13.0)	22 (6.3)
Anemia NOS	38 (10.8)	21 (6.0)
Pneumonia NOS	32 (9.1)	19 (5.4)
Deep Vein Thrombosis	28 (7.9)	12 (3.4)
Hyperglycemia NOS	27 (7.6)	27 (7.7)
Fatigue	23 (6.5)	17 (4.9)
Hypokalemia	20 (5.7)	5 (1.4)
Muscle Weakness NOS	20 (5.7)	11 (3.1)
Asthenia	17 (4.8)	18 (5.1)
Hypocalcaemia	16 (4.5)	6 (1.7)
Atrial Fibrillation	14 (4.0)	4 (1.1)
Leukopenia NOS	14 (4.0)	1 (0.3)
Pulmonary Embolism	14 (2.0)	3 (0.9)
Diarrhea NOS	11 (3.1)	4 (1.1)
Lymphopenia	11 (3.1)	4 (1.1)
Depression	10 (2.8)	6 (1.7)
Dyspnea NOS	10 (2.8)	10 (2.9)
Hypophosphatemia	10 (2.8)	0 (0.0)
Syncope	10 (2.8)	4 (1.1)
Bone Pain	8 (2.3)	5 (1.4)
Confusional State	8 (2.3)	10 (2.9)
Constipation	8 (2.3)	2 (0.6)
Febrile Neutropenia	8 (2.3)	0 (0.0)
Dizziness	7 (2.0)	3 (0.9)
Nausea	7 (2.0)	2 (0.6)
Neuropathy NOS	7 (2.0)	4 (1.1)
Dehydration	6 (1.7)	8 (2.3)
Hypertension NOS	6 (1.7)	7 (2.0)
Pyrexia	5 (1.4)	12 (3.4)
Renal Failure NOS	5 (1.4)	11 (3.1)
Respiratory Tract Infection NOS	4 (1.1)	7 (2.0)
Hypotension NOS	3 (0.8)	7 (2.0)

*Adverse events with frequency $\geq 1\%$ in the 10 mg. Grade 3 and 4 are based on National Cancer Institute Common Toxicity Criteria version 2.

**Preferred Terms are coded using the MedDRA dictionary. A patient with multiple occurrences of an AE is counted only once in the Preferred Term category.

In 2 pivotal studies of patients with multiple myeloma who had been treated with 1 prior therapy, the following **serious adverse events (considered related to study drug treatment)** were reported:

The frequency of undesirable effects was calculated using the CIOMS IV working group recommendation criteria:

Very common	$\geq 1/10$ ($\geq 10\%$)
Common (frequent)	$\geq 1/100$ and $< 1/10$ ($\geq 1\%$ and $< 10\%$)
Uncommon (infrequent)	$\geq 1/1000$ and $< 1/100$ ($\geq 0.1\%$ and $< 1\%$)
Rare	$\geq 1/10,000$ and $< 1/1000$ ($\geq 0.01\%$ and $< 0.1\%$)
Very rare	$< 1/10,000$ ($< 0.01\%$)

Blood and Lymphatic system disorders:

Common: febrile neutropenia, neutropenia, anemia NOS, thrombocytopenia

Uncommon: pancytopenia, lymphadenopathy

Cardiac disorders:

Common: atrial fibrillation

Uncommon: cardiac failure congestive, atrial flutter

Endocrine disorders:

Uncommon: adrenal insufficiency NOS

Eye disorders:

Uncommon: blindness

Gastrointestinal disorders:

Uncommon: abdominal pain NOS, constipation, caecitis, diarrhea NOS, gastrointestinal hemorrhage NOS, peptic ulcer hemorrhage

General disorders and administration site conditions:

Common: pyrexia

Uncommon: general physical health deterioration, asthenia, edema peripheral

Infections and infestations:

Common: pneumonia NOS

Uncommon: cellulitis, sepsis NOS, bronchopneumonia NOS, herpes zoster ophthalmic, *Pneumocystis carinii* pneumonia, septic shock, urinary tract infection NOS, bursitis infective NOS, *Clostridium difficile* sepsis, *Enterobacter* bacteremia, *Escherichia* sepsis, herpes zoster, lobar pneumonia NOS, meningitis, neutropenic sepsis, pneumonia bacterial NOS, pneumonia pneumococcal, pneumonia primary atypical, respiratory tract infection NOS, sinusitis NOS, subacute endocarditis, upper respiratory tract infection NOS

Investigations:

Uncommon: international normalized ratio increased, blood creatinine increased, hemoglobin decreased, weight decreased, white blood cell count decreased

Metabolism and nutrition disorders:

Common: hyperglycemia NOS

Uncommon: dehydration, hypocalcaemia, hypokalemia

Musculoskeletal and connective tissue disorders:

Uncommon: muscle weakness NOS, myopathy steroid, back pain, spondylitis NOS

Neoplasms benign, malignant and unspecified (incl. cysts and polyps):

Uncommon: basal cell carcinoma, squamous cell carcinoma, glioblastoma multiforme, fibrous histiocytoma, breast carcinoma in situ, bronchoalveolar carcinoma, lung adenocarcinoma, prostate cancer, and transitional cell carcinoma*

* Each solid tumor listed as “Uncommon” above occurred in 1/353 patients.

Nervous system disorders:

Common: cerebrovascular accident

Uncommon: cerebral ischemia, dizziness, leukoencephalopathy, memory impairment, intracranial hemorrhage NOS, intracranial venous sinus thrombosis NOS, polyneuropathy NOS, somnolence

Psychiatric disorders:

Uncommon: depression, confusional state, delusion NOS, insomnia

Renal and urinary disorders:

Uncommon: renal failure NOS, renal failure acute, Fanconi syndrome acquired, hematuria, renal tubular necrosis, urinary retention

Respiratory, thoracic and mediastinal disorders:

Common: pulmonary embolism

Skin and subcutaneous tissue disorders:

Uncommon: skin discoloration

Vascular disorders:

Uncommon: venous thrombosis NOS limb, phlebitis NOS, hypotension NOS, peripheral ischemia, circulatory collapse, hypertension NOS, orthostatic hypotension, phlebitis superficial

Post-Market Adverse Drug Reactions

Approximately 177,499 patients were exposed to REVLIMID[®] through 31 December 2010 across Celgene- and non-Celgene-sponsored clinical studies and in the commercial environment, including approximately 133,799 in multiple myeloma, 27,787 in myelodysplastic syndromes, and 15,913 in other indications.

The following adverse drug reactions have been identified from the worldwide post-marketing experience with REVLIMID[®] and are not listed under **Clinical Trial Adverse Drug Reactions**. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure:

Allergic reactions: angioedema, Stevens-Johnson syndrome, toxic epidermal necrolysis

Gastrointestinal Disorders: pancreatitis

General Disorders and Administrative Site Conditions: drug ineffective, drug intolerance, swelling, chills, edema, gait disturbance, feeling abnormal

Hepatobiliary Disorders: hepatic failure, acute hepatic failure, toxic hepatitis, cytolytic hepatitis, hepato-renal failure, cholestasis, cholestatic hepatitis, and mixed cytolytic/cholestatic hepatitis

Injury, Poisoning and Procedural Complications: hip fracture, fall

Investigations: RBC count decreased, platelet count decreased, WBC count decreased, blood pressure decreased, full blood count abnormal, hematocrit decreased, transient abnormal liver laboratory tests (predominantly transaminases). Treatment should be interrupted and restarted at a lower dose once levels return to baseline. Successful re-challenge without recurrence of liver laboratory elevation was reported in some patients.

Metabolism and Nutrition Disorders: tumor lysis syndrome (TLS) and tumor flare reaction (TFR)

Musculoskeletal Disorders: pain in extremity

Neoplasms benign, malignant and unspecified: multiple myeloma, leukemia, acute leukemia, acute myeloid leukemia, neoplasm progression, myelodysplastic syndromes

Nervous System Disorders: balance disorder, hypoesthesia

Renal Disorders: renal impairment

Reproductive System and Breast Disorders: breast mass, breast pain, erectile dysfunction

Respiratory, Thoracic and Mediastinal Disorders: dyspnea, interstitial pneumonitis, dysphonia, cough

Skin and Subcutaneous Tissue Disorders: pruritus, rash maculo-papular, skin exfoliation, erythema, swelling face, hyperhidrosis, urticaria, rash generalized

DRUG INTERACTIONS

Overview

In vitro lenalidomide is not a substrate, inhibitor or inducer of cytochrome P450 enzymes. Hence co-administration of cytochrome P450 substrates or inhibitors with REVLIMID[®] (lenalidomide) is not likely to result in clinically relevant drug-drug interactions.

Drug-Drug Interactions

Table 4: Established or Potential Drug-Drug Interactions

Proper name	Ref	Effect	Clinical comment
digoxin	CT	When co-administered with REVLIMID [®] , the digoxin AUC was not significantly different, however, the digoxin C _{max} was increased by 14%.	Periodic monitoring of digoxin plasma levels, in accordance with clinical judgment and based on standard clinical practice in patients receiving this medication, is recommended during administration of REVLIMID [®] .
warfarin	CT	Co-administration of multiple doses of 10 mg of REVLIMID [®] had no effect on the single dose pharmacokinetics of R- and S- warfarin . Co-administration of single 25-mg dose of warfarin had no effect on the pharmacokinetics of total lenalidomide.	Expected changes in laboratory assessments of PT and INR were observed after warfarin administration, but these changes were not affected by concomitant REVLIMID [®] administration. Periodic monitoring of warfarin plasma levels, in accordance with clinical judgment and based on standard clinical practice in patients receiving this medication, is recommended during administration of REVLIMID [®] .

Legend: CT = Clinical Trial; INR = International Normalized Ratio; PT = Prothrombin Time

The risk of DVT, and PE may potentially be increased with the simultaneous use of erythropoietic agents or Hormone Replacement Therapy in menopause.

Hormonal contraceptives are not recommended due to the increased risk of venous thromboembolic disease.

Drug-Food Interactions

REVLIMID[®] is absorbed equally well with or without food.

Drug-Herb Interactions

Interactions with herbal products have not been established.

Drug-Laboratory Interactions

Interactions with laboratory tests have not been established.

Drug-Lifestyle Interactions

REVLIMID[®] may be associated with dizziness and fatigue. Therefore, patients are advised to be cautious when operating machinery, or when driving.

DOSAGE AND ADMINISTRATION

Dosing Considerations

The capsules should be taken orally at about the same time each day. The capsules should not be broken, chewed, opened or handled extensively. The capsules should be swallowed whole, preferably with water, either with or without food.

- **Myelodysplastic Syndromes**

The recommended starting dose of REVLIMID[®] for MDS patients is 10 mg daily for the first 21 days of repeated 28-day cycles. Dosing is continued or modified based upon clinical and laboratory findings.

Patients without at least a minor erythroid response within 4 months of therapy initiation demonstrated by at least a 50% reduction in transfusion requirements or, if not transfused, a 1 g/dL rise in hemoglobin, should discontinue REVLIMID[®] treatment.

- **Multiple Myeloma**

The recommended starting dose of REVLIMID[®] for multiple myeloma patients is 25 mg/day administered as a single 25 mg capsule on Days 1-21 of repeated 28-day cycles. Consideration should be given to the dose of dexamethasone used in combination with REVLIMID. In a Phase 3 clinical trial in newly diagnosed patients with MM (unauthorized indication), patients randomized to the REVLIMID/standard dose dexamethasone arm received REVLIMID 25 mg/day, Days 1-21 every 28 days plus dexamethasone 40 mg/day on Days 1-4, 9-12, and 17-20 of each 28-day cycle for the first 4 cycles of therapy and then 40 mg/day orally on Days 1-4 every 28 days. Patients randomized to the REVLIMID/low dose dexamethasone arm received REVLIMID 25 mg/day, Days 1-21 every 28 days plus low dose dexamethasone 40 mg/day once weekly on Days 1, 8, 15, and 22 every 28 days (see **WARNINGS AND PRECAUTIONS, General**). Dosing is continued or modified based upon clinical and laboratory findings.

Recommended Dose and Dosage Adjustment

- **Myelodysplastic Syndromes**

The dose of REVLIMID[®] was reduced or interrupted at least once due to an adverse event in 124 (83.8%) of the 148 patients; the median time to the first dose reduction or interruption was 22 days (mean, 48 days; range, 2-468 days), and the median duration of the first dose interruption was 22 days (mean, 31 days; range, 2-331 days). A second dose reduction or interruption due to adverse events was required in 73 (49.3%) of the 148 patients. The median interval between the first and second dose reduction or interruption was 71 days (mean, 117 days; range, 15-568 days) and the median duration of the second dose interruption was 23 days (mean, 35 days; range, 2-295 days). Among the 124 patients that had a dose reduction/interruption, the median dose per day was 4.3 mg (min=0.4, max=10.0) (see **CLINICAL TRIALS**).

Thrombocytopenia

Patients who are dosed initially at 10 mg and who experience thrombocytopenia should have their dosage adjusted as indicated in the following tables.

<i>If thrombocytopenia develops WITHIN 4 weeks of starting treatment at 10 mg daily</i>	
If baseline $\geq 100,000/\text{mcL}$	
When Platelets	Recommended Course
Fall to $<50,000/\text{mcL}$	Interrupt REVLIMID® treatment
Return to $\geq 50,000/\text{mcL}$	Resume REVLIMID® at 5 mg daily
If baseline $<100,000/\text{mcL}$	
When Platelets	Recommended Course
Fall to 50% of the baseline value	Interrupt REVLIMID® treatment
If baseline $\geq 60,000/\text{mcL}$ and returns to $\geq 50,000/\text{mcL}$	Resume REVLIMID® at 5 mg daily
If baseline $<60,000/\text{mcL}$ and returns to $\geq 30,000/\text{mcL}$	Resume REVLIMID® at 5 mg daily

<i>If thrombocytopenia develops AFTER 4 weeks of starting treatment at 10 mg daily</i>	
When Platelets	Recommended Course
$<30,000/\text{mcL}$ or $<50,000/\text{mcL}$ with platelet transfusions	Interrupt REVLIMID® treatment
Return to $\geq 30,000/\text{mcL}$ (without hemostatic failure)	Resume REVLIMID® at 5 mg daily

Patients who experience thrombocytopenia at 5 mg daily should have their dosage adjusted as follows:

<i>If thrombocytopenia develops during treatment at 5 mg daily</i>	
When Platelets	Recommended Course
$<30,000/\text{mcL}$ or $<50,000/\text{mcL}$ with platelet transfusions	Interrupt REVLIMID® treatment
Return to $\geq 30,000/\text{mcL}$ (without hemostatic failure)	Resume REVLIMID® at 5 mg every other day

Neutropenia

Patients who are dosed initially at 10 mg and experience neutropenia [Absolute Neutrophil Count (ANC)] should have their dosage adjusted as indicated in the following tables.

<i>If neutropenia develops WITHIN 4 weeks of starting treatment at 10 mg daily</i>	
If baseline ANC $\geq 1,000/\text{mcL}$	
When Neutrophils	Recommended Course
Fall to $<750/\text{mcL}$	Interrupt REVLIMID® treatment
Return to $\geq 1,000/\text{mcL}$	Resume REVLIMID® at 5 mg daily
If baseline ANC $<1,000/\text{mcL}$	
When Neutrophils	Recommended Course

Fall to <500/mcL	Interrupt REVLIMID® treatment
Return to ≥500/mcL	Resume REVLIMID® at 5 mg daily

<i>If neutropenia develops AFTER 4 weeks of starting treatment at 10 mg daily</i>	
When Neutrophils	Recommended Course
<500/mcL for ≥7 days or <500/mcL associated with fever (≥38.5°C)	Interrupt REVLIMID® treatment
Return to ≥500/mcL	Resume REVLIMID® at 5 mg daily

Patients who experience neutropenia at 5 mg daily should have their dosage adjusted as follows:

<i>If neutropenia develops during treatment at 5 mg daily</i>	
When Neutrophils	Recommended Course
<500/mcL for ≥7 days or <500/mcL associated with fever (≥38.5°C)	Interrupt REVLIMID® treatment
Return to ≥500/mcL	Resume REVLIMID® at 5 mg every other day

Multiple Myeloma

Patients on therapy for Multiple Myeloma should have their complete blood counts monitored every 2 weeks for the first 12 weeks and then monthly thereafter. Patients may require dose interruption and/or reduction.

Dose modification guidelines, as summarized below are recommended to manage Grade 3 or 4 neutropenia or thrombocytopenia or other Grade 3 or 4 toxicity judged to be related to REVLIMID®.

Platelet counts

Thrombocytopenia

When Platelets	Recommended Course
Fall to <30,000/mcL	Interrupt REVLIMID® treatment, follow CBC weekly
Return to ≥30,000/mcL	Restart REVLIMID® at 15 mg daily
For each subsequent drop <30,000/mcL	Interrupt REVLIMID® treatment
Return to ≥30,000/mcL	Resume REVLIMID® at 5 mg less than the previous dose. Do not dose below 5 mg daily

Neutrophil counts (ANC)

Neutropenia

When Neutrophils	Recommended Course
Fall to <1000/mcL	Interrupt REVLIMID [®] treatment, add G-CSF, follow CBC weekly
Return to $\geq 1,000$ /mcL and neutropenia is the only toxicity	Resume REVLIMID [®] at 25 mg daily.
Return to $\geq 1,000$ /mcL and if other toxicity	Resume REVLIMID [®] at 15 mg daily
For each subsequent drop <1,000/mcL	Interrupt REVLIMID [®] treatment
Return to $\geq 1,000$ /mcL	Resume REVLIMID [®] at 5 mg less than the previous dose. Do not dose below 5 mg daily

Other Grade 3/4 Toxicities

For other Grade 3/4 toxicities judged to be related to REVLIMID[®], hold treatment and restart at next lower dose level when toxicity has resolved to \leq Grade 2.

Starting Dose Adjustment for Renal Impairment:

Since lenalidomide is primarily excreted unchanged by the kidney, starting dose adjustment is recommended in patients with renal insufficiency in order to maintain an effective and safe level of REVLIMID[®]. No dose adjustments are required for patients with CrCL ≥ 60 mL/min. A REVLIMID[®] starting dose adjustment should be considered for patients with CrCL < 60 mL/min.

- **Myelodysplastic Syndromes**

The recommendations for initial starting doses for patients with MDS are as follows:

Renal Function (CrCL)	Myelodysplastic Syndromes Dose
Mild Renal Impairment ($90 > \text{CrCL} \geq 60$ mL/min)	10 mg (Normal Dose) Every 24 hours
Moderate Renal Impairment ($30 \leq \text{CrCL} < 60$ mL/min)	5 mg Every 24 hours
Severe Renal Impairment (CrCL < 30 mL/min, not requiring dialysis)	5 mg Every 48 hours
End Stage Renal Disease (CrCL < 30 mL/min, requiring dialysis)	5 mg 3 times a week following each dialysis

- **Multiple Myeloma**

The recommendations for initial starting doses for patients with MM are as follows while maintaining a 21 out of 28 day treatment cycle:

Renal Function (CrCL)	Multiple Myeloma Dose
Mild Renal Impairment ($90 > \text{CrCL} \geq 60$ mL/min)	25 mg (Normal Dose) Every 24 hours
Moderate Renal Impairment	10 mg ^a

($30 \leq \text{CrCL} < 60 \text{ mL/min}$)	Every 24 hours
Severe Renal Impairment ($\text{CrCL} < 30 \text{ mL/min}$, not requiring dialysis)	15 mg Every 48 hours
End Stage Renal Disease ($\text{CrCL} < 30 \text{ mL/min}$, requiring dialysis)	5 mg, Once daily. On dialysis days the dose should be administered following dialysis

^{a.} The dose may be escalated to 15 mg every 24 hours after 2 cycles if patient is not responding to treatment and is tolerating the drug.

After initiation of REVLIMID[®] therapy, subsequent REVLIMID[®] dose modification should be based on individual patient treatment tolerance, as described elsewhere in this section.

Missed Dose

If less than 12 hours has elapsed since missing a dose, the patient can take the dose. If more than 12 hours has elapsed since missing a dose at the normal time, the patient should not take the dose, but take the next dose at the normal time on the following day. Patients should not take 2 doses at the same time.

OVERDOSAGE

For management of a suspected drug overdose, contact your regional Poison Control Centre.

Information on overdosage of REVLIMID[®] is limited. No cases of overdose have been reported during the clinical studies. The highest single dose of lenalidomide that has been ingested in humans in healthy volunteers is 400 mg and the highest multiple dose is 200 mg/day, administered as 100 mg twice daily for six days. There is no known specific antidote for REVLIMID[®] overdosage and treatment must be symptomatic. In the event of an overdosage, frequent monitoring of the patient's vital signs and blood counts over the following 2 weeks along with close patient monitoring are indicated. Appropriate supportive care should be administered.

ACTION AND CLINICAL PHARMACOLOGY

Mechanism of Action

The mechanism of action of lenalidomide remains to be fully characterized; however, multiple mechanisms of action have been identified that affect cancer cells and their microenvironment.

Lenalidomide increases hemoglobin expression by erythroid cells; inhibits proliferation of certain hematopoietic tumor cells (including tumor cells with or without deletions of chromosome 5 and MM tumor cells); enhances T cell and Natural Killer cell number and activity; inhibits angiogenesis by blocking the migration and adhesion of endothelial cells and the formation of microvessels; and inhibits production of pro-inflammatory cytokines (e.g., TNF- α and IL-6) by monocytes.

Pharmacodynamics

In healthy volunteers, multiple dosing with lenalidomide appeared to have an effect upon the immune response. The highest dose was 200 mg/day. Dosing occurred once on the morning of Days 1 and 8 and twice daily on Days 2 to 7 inclusive. Statistically significant dose-related decrease in both CD4 and CD8 blood counts was observed from Day 4 onwards. For CD4 counts, the magnitude of the decreases was relatively constant (approximately 300/mm³) on Days 4, 6 and 8, with values approaching 433/mm³. The decrease in mean CD8 counts were up to 242/mm³ on Day 8, with levels still considerably lower than the baseline value at the post-study assessment.

- **Myelodysplastic Syndromes**

Treatment with lenalidomide in MDS patients is associated with apoptosis of dysplastic cells in the bone marrow of these patients. Whether long-term REVLIMID[®] therapy affects the CD4 and CD8 counts in MDS patients is not yet known.

- **Multiple Myeloma**

Treatment with lenalidomide in MM patients is associated with the induction of antiproliferative effects and apoptosis in malignant myeloma cells due to direct antitumor activity, the alteration of the bone marrow microenvironment, and immune modulation.

Pharmacokinetics

The pharmacokinetics of lenalidomide were evaluated in a single-blind, placebo-controlled, ascending single oral-dose study (see Table 5). Single oral doses of 5, 20, 50, 100, 200 and 400 mg were administered in the fasted state. Nineteen subjects entered the study and 15 completed the study.

Table 5: Summary of Pharmacokinetic Parameters in a healthy male volunteers
Geometric Mean

Dose	C _{max} (ng/mL)	t _{1/2} (h)	AUC _(0-∞) (ng·h/mL)	Apparent Oral Clearance (mL/min)	Apparent Volume of distribution (L)
5 mg	66.2	3.24	276	302	84.6
20 mg	373	3.66	1391	240	76.0
50 mg	808	3.46	2546	327	98.1
100 mg	1735	4.71	5997	278	113
200 mg	3519	5.16	12111	275	123
400 mg	4586	8.72	21895	304	230

No formal bioavailability studies were performed in humans.

The pharmacokinetics of lenalidomide were evaluated in MDS subjects who received a single 10 mg dose of REVLIMID or multiple doses of REVLIMID (see Table 6).

Table 6: Pharmacokinetic Parameters for Lenalidomide in MDS Subjects

Parameter	Single 10 mg Dose (N = 12)	Multiple Doses (N = 24)
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C _{max} (ng/mL)	179 (33.6)	185 (38.7)
AUC ₅ (ng•h/mL)	543 (27.5)	563 (32.5)
t _{1/2,z} (h)	3.72 (19.5)	NA

Geometric mean (CV%) data are presented for all parameters; AUC = area under the concentration versus time curve from time zero to 5 hours; C_{max} = maximum concentration; t_{1/2,z} = terminal half-life

Absorption:

Lenalidomide, in healthy volunteers, is rapidly absorbed following oral administration with maximum plasma concentrations occurring between 0.625 and 1.5 hours post-dose.

Co-administration with food does not alter the extent of absorption (AUC) but does reduce the maximal plasma concentration (C_{max}) by 36%. The pharmacokinetic disposition of lenalidomide is linear. C_{max} and AUC increase proportionately with increases in dose. Multiple dosing at the recommended dose-regimen does not result in drug accumulation.

In patients with low- or intermediate-1-risk MDS, a single 10 mg oral dose of lenalidomide is rapidly absorbed with the C_{max} observed at around 1 hour post-dose. There is no accumulation of lenalidomide in plasma with multiple doses at 10 mg per day. The mean exposure (AUC_∞) in MDS patients is approximately 57% higher than healthy male subjects, possibly related to reduced renal function associated with the MDS disease state and secondary to increased age in this patient population. In two subjects with 30 ≤ CrCL < 50 mL/min, the 5-hour exposure (AUC) on Day 14 was increased by more than 70%, compared with the subjects with CrCL > 80 mL/min.

In MM patients maximum plasma concentrations occurred between 0.5 and 4.0 hours post-dose both on Days 1 and 28. AUC and C_{max} values increase proportionally with dose following single and multiple doses. Exposure (AUC) in multiple myeloma patients was 57% higher than in healthy male volunteers.

Distribution:

In vitro (¹⁴C)-lenalidomide binding to plasma proteins is approximately 23-29%.

Lenalidomide is present in semen (<0.01% of the dose) after the administration of 25 mg/day. Lenalidomide is undetectable in the semen of healthy volunteers three days after discontinuation of the drug.

Metabolism:

The metabolism and disposition of lenalidomide in humans has not yet been evaluated. In healthy volunteers, approximately two-thirds of lenalidomide is eliminated unchanged through urinary excretion. Half-life of elimination is approximately 3 hours.

In vitro in human liver preparations lenalidomide does not undergo oxidative (Cytochrome P450) or conjugative metabolism. Non-enzymatic hydrolysis of lenalidomide occurs in aqueous media and plasma. In vitro lenalidomide does not inhibit or induce cytochrome P450 enzymes,

suggesting that clinically relevant drug-drug interactions with cytochrome P450 substrates are unlikely.

Excretion:

In healthy volunteers, approximately two-thirds of lenalidomide is eliminated unchanged through urinary excretion. The process exceeds the glomerular filtration rate and therefore active secretion may have some contribution in the overall renal excretion of lenalidomide. Half-life of elimination is approximately 3 hours. Lenalidomide is a weak substrate, but not an inhibitor of P-glycoprotein, suggesting that drug-drug interactions are unlikely with P-glycoprotein substrates and inhibitors.

In MDS patients, urinary excretion of unchanged lenalidomide in 24 hours post-dose averages approximately 65% of the administered dose.

Special Populations and Conditions

Pediatrics: No pharmacokinetic data are available in patients below the age of 18 years.

Geriatrics: Pharmacokinetic studies have not been carried out in the geriatric population.

Gender: The effects of gender on the pharmacokinetics of lenalidomide have not been studied.

Race: Pharmacokinetic differences due to race have not been studied.

Hepatic Insufficiency: The pharmacokinetics of lenalidomide in patients with hepatic impairment has not been studied.

Renal Insufficiency: The pharmacokinetics of lenalidomide were studied in patients with renal impairment due to nonmalignant conditions. In this study, 5 patients with mild renal function impairment (CrCL 56-74 mL/min), 6 patients with moderate renal function impairment (CrCL 33-46 mL/min), 6 patients with severe renal function impairment (CrCL 17-29 mL/min), and 6 patients with end stage renal disease requiring dialysis were administered a single oral 25 mg dose of REVLIMID[®]. As a control group comparator, 7 healthy subjects of similar age with normal renal function (CrCL 83-145 mL/min) were also administered a single oral 25 mg dose of REVLIMID[®]. The pharmacokinetic parameters of lenalidomide were similar in patients with mild impairment and healthy subjects. Patients with moderate and severe renal impairment had a 3-fold increase in half-life and up to 75% decrease in clearance compared to healthy subjects. Patients with end stage renal disease on hemodialysis had an approximately 4.5-fold increase in half-life and an 80% decrease in clearance compared to healthy subjects. Approximately 30% of the drug in the body was removed by a 4-hour dialysis session.

Mean AUC_∞ was increased by 137%, 274% and 372% in patients with moderate, severe and end stage renal disease, respectively, as compared to that of normal and mild groups combined (n=12). Renal impairment had no effect on oral absorption (C_{max} and t_{max}).

After a single 10 mg dose of REVLIMID in MDS patients with mild renal impairment,

the drug exposure (AUC_{0-∞}) was increased by 55% and the apparent total clearance was reduced by 35% compared to those observed in MDS patients with normal renal function. In two MDS patients with moderate renal impairment, lenalidomide exposure after multiple doses was increased to a greater degree (C_{max} increased by 41-51% and AUC_{0-∞} by 74-95%) while renal clearance was decreased by 65-92%. A starting dose adjustment is recommended for MDS patients with moderate renal impairment (**see DOSAGE AND ADMINISTRATION, Starting Dose Adjustment for Renal Impairment, Myelodysplastic Syndromes**).

STORAGE AND STABILITY

Store at 15-30°C.

SPECIAL HANDLING INSTRUCTIONS

Currently, no published data are available regarding the cutaneous absorption of lenalidomide. Most health care institutions recommend that latex gloves be worn while handling chemotherapeutic agents. Health care providers may consider wearing gloves when directly handling REVLIMID[®] (lenalidomide) capsules, along with standard hand washing. Females who could become pregnant, or who plan to become pregnant can handle REVLIMID[®] capsules if they are using latex gloves.

Patients should be instructed to not extensively handle or open the capsules and to maintain storage of capsules in blister packs until ingestion wherever possible. If there is contact with non-intact REVLIMID[®] capsules or the powder contents, the exposed area should be washed with soap and water.

Repackaging of REVLIMID[®] must only be done on exceptional circumstances. This should only be done by pharmacists.

DOSAGE FORMS, COMPOSITION AND PACKAGING

Each capsule contains lenalidomide, lactose anhydrous, microcrystalline cellulose, croscarmellose sodium, and magnesium stearate. The additional composition of the different capsule strengths is provided in the table below.

5 mg	REV, 5 mg	Gelatin, titanium dioxide	White opaque	28 count blisters
10 mg	REV, 10 mg	Gelatin, FD&C blue #2, yellow iron oxide, titanium dioxide	Blue/green opaque and pale yellow opaque	28 count blisters
15 mg	REV, 15 mg	Gelatin, FD&C blue #2, titanium dioxide	Powder blue opaque and white opaque	21count blisters
25 mg	REV, 25 mg	Gelatin, titanium dioxide	White opaque	21count blisters

*Imprint is in black ink

PART II: SCIENTIFIC INFORMATION

PHARMACEUTICAL INFORMATION

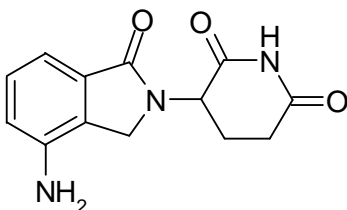
Drug Substance

Proper name: lenalidomide

Chemical name: 3-(4-amino-1-oxo 1,3-dihydro-2*H*-isoindol-2-yl) piperidine-2,6-dione

Molecular formula and molecular mass: C₁₃H₁₃N₃O₃, 259.3

Structural formula:



Physicochemical properties: Lenalidomide is an off-white to pale-yellow solid powder. It is soluble in organic solvent/water mixtures, and buffered aqueous solvents. Lenalidomide is more soluble in organic solvents and low pH solutions. Solubility was significantly lower in less acidic buffers. Lenalidomide has an asymmetric carbon atom and can exist as the optically active forms S(-) and R(+), and is produced as a racemic mixture with a net optical rotation of zero.

CLINICAL TRIALS

Myelodysplastic Syndromes (MDS) with a Deletion 5q Cytogenetic Abnormality

Two studies were conducted in support of the efficacy and safety of REVLIMID[®] (lenalidomide) in the treatment of transfusion dependent anemia due to Low- or Intermediate-1- risk MDS with a 5q (q31-33) cytogenetic abnormality in isolation or with additional cytogenetic abnormalities

Study demographics and trial design

The first study was a Phase 2, multicenter, open-label, single-arm study that was conducted to confirm the efficacy and safety of REVLIMID[®] in subjects with an International Prognostic Scoring System (IPSS) diagnosis of Low- or Intermediate-1-risk MDS associated with a 5q (q31-33) cytogenetic abnormality (del 5q) in isolation or with additional cytogenetic abnormalities, and RBC transfusion dependent anemia. REVLIMID[®] was dosed orally as 10 mg once daily continuously or 10 mg once daily for 21 days every 28 days. The study was not designed nor powered to prospectively compare the efficacy of the two dosing regimens. Sequential dose reductions to 5 mg daily and 5 mg every other day, as well as dose delays, were allowed for toxicity. This study enrolled 148 patients who had RBC transfusion dependent anemia. RBC-transfusion dependence was defined as

having received ≥ 2 units of RBCs within 8 weeks prior to study treatment. The study enrolled patients with absolute neutrophil counts (ANC) $\geq 500/\text{mm}^3$, platelet counts $\geq 50,000/\text{mm}^3$, serum creatinine ≤ 2.5 mg/dL, serum SGOT/AST or SGPT/ALT ≤ 3.0 x upper limit of normal (ULN), and serum direct bilirubin ≤ 2.0 mg/dL.

The second study was a Phase 3, multicenter, randomized, double-blind, placebo-controlled study comparing 2 doses of oral REVLIMID[®] versus placebo in RBC transfusion-dependent subjects with Low- or Intermediate-1-risk IPSS MDS associated with a del 5q cytogenetic abnormality with or without additional cytogenetic abnormalities. This study was conducted in 2 phases: a double-blind treatment phase (up to maximum of 52 weeks) in which 205 subjects were randomized to receive either 10 mg REVLIMID[®] for 21 days of a 28-day cycle (cyclic), 5 mg REVLIMID[®] continuously, or placebo; and an open-label extension phase (maximum of 105 weeks). Subjects who successfully completed the double blind phase and subjects who did not have at least a minor erythroid response (50% reduction in RBC transfusions) by week 16 of double blind treatment were unblinded and eligible to receive open label REVLIMID[®] in either the 5 mg or 10 mg dosing regimens.

Baseline patient and disease-related characteristics for subjects in the IIT populations of the two studies are summarized below.

Table 7: Baseline Demographic and Disease-Related Characteristics

Parameter	Phase 2 Study (N=148)	Phase 3 Study (n = 205)
Age (years)		
Mean	70.0	67.3
SD	10.5	10.66
Median	71.0	68.0
Min, Max	37.0, 95.0	36.0, 86.0
Age distribution		
	n (%)	n (%)
< 65	48 (32.4)	82 (40.0)
> 65	100 (67.6)	123 (60.0)
Gender		
	n (%)	n (%)
Male	51 (34.5)	49 (23.9)
Female	97 (65.5)	156 (76.1)
Race		
	n (%)	n (%)
White	143 (96.6)	202 (98.5)
Other	5 (3.4)	3 (1.5)
Duration of MDS (years)		
Mean	3.4	3.6
SD	3.29	3.57
Median	2.5	2.6
Min, Max	0.1, 20.7	0.2, 29.2
Del 5 (q31-33) Cytogenetic Abnormality		
	n (%)	n (%)
Yes	148 (100.0)	191 (93.2)
Other cytogenetic abnormalities	37 (25.2)	-
IPSS Score [a] from central review		
	n (%)	n (%)
Low (0)	49 (33.1)	70 (34.1)
Intermediate-1 (0.5-1.0)	69 (46.6)	74 (36.1)
Intermediate-2 (1.5-2.0)	7 (4.7)	10 (4.9)
High (>=2.5)	2 (1.4)	1 (0.5)
Missing	21 (14.2)	50 (24.4)
FAB Classification [b] from central review		
	n (%)	n (%)
RA	78 (52.7)	107 (52.2)
RARS	16 (10.8)	24 (11.7)
RAEB	30 (20.3)	22 (10.7)
CMML	3 (2.0)	3 (1.5)

[a] IPSS Risk Category: Low (combined score = 0), Intermediate-1 (combined score = 0.5 to 1.0), Intermediate-2 (combined score = 1.5 to 2.0), High (combined score \geq 2.5); Combined score = (Marrow blast score + Karyotype score + Cytopenia score)

[b] French-American-British (FAB) classification of MDS.

Study results

The International Working Group (IWG) defined criteria for a major erythroid response is transfusion independence for at least 8 consecutive weeks (56 days). In the Phase 2 study, transfusion independence was defined as a period of at least 56 consecutive days during which no transfusions were given and the Hgb concentration rose by at least 1 g/dL. In the Phase 3 study, the primary efficacy endpoint extended the transfusion independence period to 6 months (182 days).

An overview of the efficacy results for the Intent to Treat (ITT) populations is presented in Table 8 below. The primary endpoint results for the phase 3 study are provided (transfusion

independence at 182 days), but for comparison purposes across studies the results by IWG criteria are shown. Results for the 5mg group are not displayed.

RBC-transfusion independence rates were unaffected by age or gender.

Table 8: Efficacy results for REVLIMID® in del 5q MDS (ITT populations)

Efficacy parameter	Phase 2 study	Phase 3 study (double-blind and open-label phases)	
	Revlimid® 10 mg N = 148	Revlimid® 10 mg N=69	Placebo N=67
Transfusion independence			
Number (%) transfusion independent (56 days) ^a	97 (65.5)	42 (60.9)	5 (7.5)
Number (%) transfusion independent (182 days) [^]	86 (58.1)	37 (53.6)	4 (6.0)
Median Hgb increase (g/dL)^b (Min, Max)	5.6 (2.2, 40.7)	6.2 (1.8, 10.0)	2.6 (1.5, 4.4)
Median Time to transfusion independence (weeks)^c (Min, Max)	4.1 (0.3, 49.0)	4.6 (0.3, 14.7)	0.3 (0.3, 24.1)

CI = Confidence interval; Cont = continuous (28 days of a 28-day cycle); Cyc = cyclic (21 days of a 28-day cycle); Hgb = Hemoglobin; ITT = Intent to treat; Max = Maximum; Min = Minimum; MITT = Modified intent to treat; RBC = Red blood cell; SD = Standard deviation; nr = not reported.

- * Based on RBC-transfusion independence response for subjects in the double-blind phase who became RBC-transfusion independent for at least 56 days
- [^] RBC-transfusion independence response for subjects in the double-blind phase who became RBC-transfusion independent for at least 182 days (MDS-004 primary endpoint)
- ^a The absence of the intravenous infusion of any RBC transfusion during any consecutive “rolling” 56 days during the treatment period and an increase in Hgb of at least 1 g/dL from the minimum during the screening/baseline period to the maximum during the transfusion-independent period, excluding the first 30 days after the last transfusion before the transfusion-free period.
- ^b Change from baseline in Hgb concentration to maximum value during response period, where response period was defined as the time from 30 days after the last transfusion prior to achieving transfusion independence to the next transfusion or to the last assessment for subjects who did not receive a subsequent transfusion during the study period.
- ^c Measured from the day of the first dose of study drug to the first day of the first 56-day RBC transfusion-free period.

Multivariate analysis reveals that, compared to baseline, either a decrease in the ANC by 75 percent (in patients not neutropenic at baseline) or a decrease in the platelet count by 50 percent (regardless of the platelet count at baseline) within the first 8 weeks of the initiation of REVLIMID® is a predictor of red blood cell transfusion independence response.

Red blood cell transfusion independence correlated with decrease in platelet and/or neutrophil count (p=0.018 and p=0.005, respectively). The median decrease from baseline in absolute neutrophil counts was $1.73 \times 10^9/L$ (Min, Max: $1.28 \times 10^9/L$, $20.35 \times 10^9/L$). The median decrease in platelet levels from maximum at baseline to the minimum during the study was $171 \times 10^9/L$ (Min, Max: $32 \times 10^9/L$, $1393 \times 10^9/L$). Cytopenias were seen early in treatment (before onset of response) or after treatment failure. During the transfusion independence response, white blood cell counts and platelet counts showed initial decreases in the first 2 months and then were maintained at clinically acceptable levels. In the 51 out of 81 (75%) responders, treatment

related grade 4 neutropenia and/or thrombocytopenia were resolved alongside the adjustment of the dose to a lower level (see **DOSAGE AND ADMINISTRATION**).

In the Phase 2 ITT population, major cytogenetic responses (complete resolution of all cytogenetic abnormalities compared with baseline) were observed in 44.2% (53/120) and minor cytogenetic responses ($\geq 50\%$ reduction in the proportion of hematopoietic cells with cytogenetic abnormalities compared with baseline) were observed in 24.2% (29/120) of the patients who were evaluable for cytogenetic response. Cytogenetic responses were assessed during the study at month 6, month 12 and when clinically indicated.

Among the 147 patients who had hematopoietic cells from bone marrow aspirate specimens available for cytogenetic testing, 110 (74.8%) had an MDS clone with an isolated del 5q cytogenetic abnormality, and 37 (25.2%) had an MDS clone with a del 5q abnormality and with additional cytogenetic abnormalities. Seventy-four (67%) of the 110 subjects with an isolated del 5q abnormality and 21 (57%) of the 37 subjects with a del 5q abnormality and an additional cytogenetic abnormality achieved RBC-transfusion independence.

Progression to Acute Myeloid Leukemia (AML)

In the Phase 3 study, the median duration of follow-up for all patients who received treatment with REVLIMID regardless of randomized group, dose or study phase, was 35.2 months (2.9 years; range: 0.4, 70.8 months; n=194). Overall, the incidence of progression to AML during the entire study period was 30.2%. In all subjects who received REVLIMID, the incidence of progression to AML or death was 59.8% (116/194 subjects).

The risk of progression to AML over time, taking the competing risk of death without AML into account, in the Phase 2 study (ITT population, N = 147) and Phase 3 study (subjects randomized to REVLIMID, N = 138) is 0.146 and 0.152 at 2 years, 0.1741 and 0.2151 at 3 years, and 0.2216 and 0.2974 at 5 years (cumulative incidence function, Gray's test: $p = 0.2259$). In the Kaplan-Meier analysis of risk of progression to AML over time, the median time to progression to AML was 57 months in subjects randomized to placebo; the median time to progression to AML in subjects randomized to REVLIMID had not been reached by the data cutoff date (30 Jun 2011). AML was defined as the presence of $\geq 30\%$ bone marrow blasts according to FAB classification.

Patients without at least a minor erythroid response within 4 months of therapy initiation demonstrated by at least a 50% reduction in transfusion requirements or, if not transfused, a 1 g/dL rise in hemoglobin, should discontinue REVLIMID[®] treatment (see **DOSAGE AND ADMINISTRATION, Dosing Considerations**).

Phase 3 Randomized Double Blind Placebo-Controlled Studies in Previously Treated Multiple Myeloma Patients

Two randomized studies (Study MM-009 and MM-010) were conducted to evaluate the efficacy and safety of REVLIMID® in multiple myeloma subjects who had received at least one prior therapy. These multi-center, multi-national, double-blind, placebo-controlled studies compared REVLIMID® plus oral pulse high-dose dexamethasone therapy (REVLIMID®/dexamethasone) to dexamethasone therapy alone (placebo/dexamethasone), in subjects with MM who had received at least one prior treatment.

In both studies, subjects in the (REVLIMID®/dexamethasone) group took 25 mg of REVLIMID® orally once daily on Days 1 to 21 and a matching placebo capsule once daily on Days 22 to 28 of each 28-day cycle. Subjects in the placebo/dexamethasone group took 1 placebo capsule on Days 1 to 28 of each 28-day cycle. Subjects in both treatment groups took 40 mg of dexamethasone orally once daily on Days 1 to 4, 9 to 12, and 17 to 20 of each 28-day cycle for the first 4 cycles of therapy. The dose of dexamethasone was reduced to 40 mg orally once daily on Days 1 to 4 of each 28-day cycle after the first 4 cycles of therapy. In both studies, treatment was to continue until disease progression.

Dose adjustments were allowed based on clinical and laboratory findings. Sequential dose reductions to 15 mg daily, 10 mg daily and 5 mg daily were allowed for toxicity (see **DOSAGE AND ADMINISTRATION**).

Table 9 summarizes the baseline patient and disease characteristics in the two studies. In both studies, baseline demographic and disease-related characteristics were comparable between the REVLIMID®/dexamethasone and placebo/dexamethasone groups.

Table 9: Baseline Demographic and Disease-Related Characteristics

	MM-009 (Cutoff: 28 Jun 2005)		MM-010 (Cutoff: 03 Aug 2005)	
	REVLIMID®/ dexamethasone (N=177)	PLACEBO/ dexamethasone (N=176)	REVLIMID®/ dexamethasone (N=176)	PLACEBO/ dexamethasone (N=175)
Patient Characteristics				
Age (years)				
Median	64.0	62.0	63.0	64.0
Min, Max	36.0, 86.0	37.0, 85.0	33.0, 84.0	40.0, 82.0

	MM-009 (Cutoff: 28 Jun 2005)		MM-010 (Cutoff: 03 Aug 2005)	
	REVLIMID®/ dexamethasone (N=177)	PLACEBO/ dexamethasone (N=176)	REVLIMID®/ dexamethasone (N=176)	PLACEBO/ dexamethasone (N=175)
Sex				
Male	106 (59.9%)	104 (59.1%)	104 (59.1%)	103 (58.9%)
Female	71 (40.1%)	72 (40.9%)	72 (40.9%)	72 (41.1%)
Race/Ethnicity				
White	141 (79.7%)	148 (84.1%)	172 (97.7%)	175 (100.0%)
Other	36 (20.3%)	28 (15.9%)	4 (2.3%)	0 (0%)
ECOG Performance Status 0-1	157 (88.7%)	168 (95.5%)	150 (85.2%)	144 (82.3%)
Disease Characteristics				
Baseline Multiple Myeloma Stage [b]				
I	6 (3.4%)	5 (2.8%)	11 (6.3%)	8 (4.6%)
II	56 (31.6%)	55 (31.3%)	50 (28.4%)	57 (32.6%)
III	114 (64.4%)	116 (65.9%)	115 (65.3%)	110 (62.9%)
Missing	1 (0.6%)	0 (0%)	0 (0%)	0 (0%)
Median (min, max) Baseline β ₂ -microglobulin levels (mg/L)	3.65 (1.1, 45.0)	3.30 (1.3, 15.2)	3.35 (1, 14.4)	3.25 (1.3, 25.3)
Number of Prior Therapies				
No. of Prior Antimyeloma Therapies				
1	68 (38.4%)	67 (38.1%)	56 (31.8%)	57 (32.6%)
≥ 2	109 (61.6%)	109 (61.9%)	120 (68.2%)	118 (67.4%)
Types of Prior Therapies				
Stem Cell Transplantation	61.0%	60.2%	56.3%	53.7%
Thalidomide	41.8%	45.5%	30.1%	38.3%
Dexamethasone	80.8%	70.5%	65.9%	68.6%
Bortezomib	10.7%	11.4%	4.5%	4.0%
Melphalan	33.3%	30.7%	56.3%	52.0%
Doxorubicin	54.8%	51.1%	55.7%	56.6%

[a] More than one category could be selected. Therefore, percentages may total to more than 100%.

[b] Baseline multiple myeloma stage was determined based on the Durrie-Salmon staging criteria.

The efficacy and safety of the treatments were monitored at clinic visits that were scheduled at screening/baseline (within 28 days of Day 1 of Cycle 1), on Days 1, 8, and 15 of Cycle 1, on Days 1 and 15 of Cycles 2 and 3, on Day 1 of each subsequent cycle, and at treatment discontinuation. After discontinuation from the study, subjects are contacted every 6 months to obtain data on survival, the cause of death, and subsequent antimyeloma therapy.

The primary efficacy endpoint in both studies was time to progression (TTP). TTP was defined as the time from randomization to the first occurrence of progressive disease or death due to progressive disease. The secondary efficacy endpoints were the myeloma response rate; the time to the first symptomatic skeletal-related event (SRE); the time to the first decrease in the ECOG performance status; and overall survival (OS). The response to therapy was assessed using the Myeloma Response Determination Criteria. The time to SRE was not analyzed due to the small number of observations available.

The median durations of observation at the time of the pre-planned analyses were 17 months for Study MM-009 and 16.5 months for Study MM-010.

Results

Protocol-specified Analysis of TTP (Primary Endpoint)

In both studies, TTP was significantly longer in the REVLIMID[®]/dexamethasone group than in the placebo/dexamethasone group ($p < 0.001$).

At the time of the preplanned interim analysis, the predetermined stopping criteria for superiority in the primary efficacy endpoint, TTP (as defined in the protocol), had been surpassed, with $p < 0.001$ in favor of the REVLIMID[®]/dexamethasone treatment group. Both studies showed that the combination of REVLIMID[®]/dexamethasone was significantly superior to dexamethasone alone for TTP.

Subjects in the placebo/dexamethasone group were permitted to receive treatment with the REVLIMID[®]/dexamethasone combination after unblinding.

Table 10: Summary of Time to Progression

	Statistics	MM-009 (Cutoff: 28 Jun 2005)		MM-010 (Cutoff: 03 Aug 2005)	
		REVLIMID [®] / dexamethasone (N=177)	PLACEBO/ dexamethasone (N=176)	REVLIMID [®] / dexamethasone (N=176)	PLACEBO/ dexamethasone (N=175)
TTP [a]	N	177	176	176	175
Progressed	n (%)	92 (52.0)	132 (75.0)	82 (46.6)	142 (81.1)
Censored	n (%)	85 (48.0)	44 (25.0)	94 (53.4)	33 (18.9)
Overall TTP (wk)	Median [b]	48.1	20.1	48.7	20.1
	[95% CI] [c]	[36.9, 61.4]	[16.7, 23.1]	[40.9, 72.1]	[18.1, 20.7]
	Mean [b]	39.0	20.6	38.0	22.9
	SD	28.55	19.17	27.08	19.03
	Min, Max	0.0, 106.9	0.0, 93.1	0.1, 93.4	0.3, 90.1
Hazard Ratio [95% CI] [d]		0.354 [0.270, 0.466]		0.351 [0.266, 0.463]	
Log-rank Test p-Value [e]		< 0.001		< 0.001	

NE, not estimable

[a] Time to progression was calculated as the time from randomization to the first occurrence of any of the following events: 1) disease progression based on the myeloma response criteria developed by Bladé et al, 2) discontinuation from the treatment phase due to disease progression according to the investigator whether or not confirmed by the Bladé et al criteria (TTP was measured to the last date of visit), or death due to disease progression during the treatment period (TTP was measured to the date of death if death occurred on or before treatment discontinuation). The TTP was censored at the date of the last response assessment for subjects who 1) had not progressed at the time of the analysis, 2) withdrew from the treatment phase before documented progression, including those who died of causes not related to multiple myeloma, or 3) were given another antimyeloma therapy without documented progression or experienced intolerable adverse events (for these subjects, the date of their last response assessment prior to taking other antimyeloma therapy was used as the censor date).

[b] The median is based on the Kaplan-Meier estimate, and the mean is the univariate mean without adjusting for censoring (i.e., the mean values represent mean TTP documented to date as of the data cutoff date, without consideration of the fact that a substantial number of subjects who had not yet progressed were continuing in the study).

[c] Ninety-five percent confidence interval (CI) about the median overall TTP

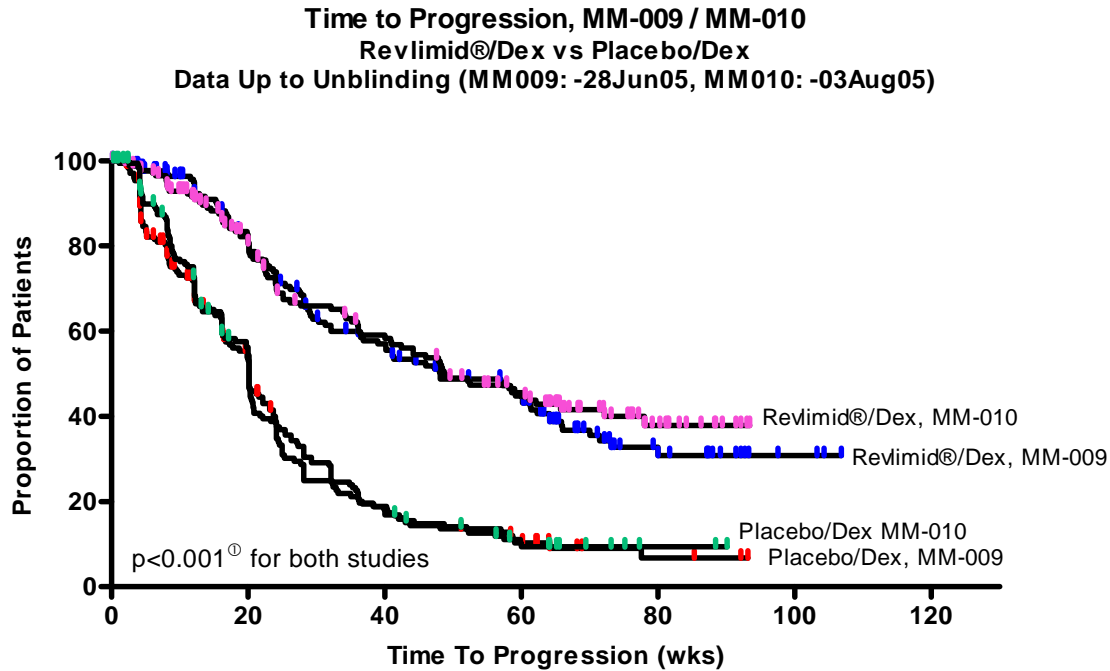
[d] Based on a proportional hazards model comparing the hazard functions associated with the treatment groups (REVLIMID[®]/dexamethasone:placebo/dexamethasone)

[e] The p-value is based on a 2-tailed unstratified log-rank test of survival curve differences between the treatment groups.

Superiority of REVLIMID[®]/dexamethasone over placebo/dexamethasone was also observed regardless of gender, age (≤ 65 years and > 65 years), prior therapy (with high-dose chemotherapy and SCT or without such therapy), or the number of prior antimyeloma regimens (1 vs > 1).

Figure 1 depicts the Kaplan-Meier estimates of TTP as of the dates on which the studies were unblinded.

Figure 1: Kaplan-Meier Estimate of Time to Progression



[ⓐ] p-value from log-rank test

Progression Free Survival (PFS) - Sensitivity Analysis

The analysis of PFS, which differed from the protocol-specified primary TTP analysis in that all deaths, regardless of causality, were considered as events confirmed the results that were observed with the protocol-specified analysis of TTP. Highly significant differences between treatment groups ($p < 0.001$) in favor of the REVLIMID[®]/dexamethasone combination, were observed in both studies (see Table 11).

Table 11: Summary of Progression-free Survival (Sensitivity Analysis)

	Statistics	MM-009 (Cutoff: 28 Jun 2005)		MM-010 (Cutoff: 03 Aug 2005)	
		REVLIMID [®] / dexamethasone (N=177)	PLACEBO/ dexamethasone (N=176)	REVLIMID [®] / dexamethasone (N=176)	PLACEBO/ dexamethasone (N=175)
PFS [a] Time	N	177	176	176	175
Progressed	n (%)	93 (52.5)	134 (76.1)	95 (54.0)	148 (84.6)
Censored	n (%)	84 (47.5)	42 (23.9)	81 (46.0)	27 (15.4)
Overall PFS (wk)	Median [b]	48.0	20.1	44.1	20.1
	[95% CI] [c]	[36.9, 61.4]	[16.4, 23.1]	[34.3, 59.0]	[16.1, 20.4]
	Mean [b]	39.1	20.6	37.7	22.9
	SD	28.52	19.16	27.11	19.01
	Min, Max	0.0, 106.9	0.0, 93.1	0.1, 93.4	0.3, 90.1
Hazard Ratio [95% CI] [d]		2.820 [2.148, 3.701]		2.459 [1.891, 3.199]	
Log-rank Test p-Value [e]		< 0.001		< 0.001	

NE, not estimable

- [a] Calculated as the time from randomization to documented progression or death due to any cause, whichever occurred first. If withdrawal due to adverse events or change of therapy occurred before documented progression or death, then these observations were censored at the last progression assessment date.
- [b] The median is based on the Kaplan-Meier estimate, and the mean is the univariate mean without adjusting for censoring (i.e., the mean values represent mean PFS documented to date as of the data cutoff date, without consideration of the fact that a substantial number of subjects who had not yet progressed were continuing in the study).
- [c] Ninety-five percent confidence interval (CI) about the median overall PFS.
- [d] Based on a proportional hazards model comparing the hazard functions associated with the treatment groups (REVLIMID[®]/dexamethasone:placebo/dexamethasone)
- [e] The p-value is based on a 1-tailed unstratified log-rank test of survival curve differences between the treatment groups.

Myeloma Response Rate (Secondary Endpoint)

In both studies, the myeloma response rates were significantly higher in the REVLIMID[®]/dexamethasone group than in the placebo/dexamethasone group both for the overall comparison of response categories ($p < 0.001$) and for the dichotomous comparison of Complete Response (CR) + Remission Response (RR) + Partial Response (PR) ($p < 0.001$) (see Table 12). The overall response rates in Study 009 were consistent with those in Study 010, with 61.0% (108/177) of the REVLIMID[®]/dexamethasone-treated subjects in Study 009 and 60.2% (106/176) of the REVLIMID[®]/dexamethasone-treated subjects in Study 010 achieving a CR, RR plus PR.

Table 12: Summary of Myeloma Response Rates Based on Best Response Assessments (Studies MM-009 and MM-010)

Response [a, b]	Study MM-009 (Cutoff: 28 Jun 2005)		Study MM-010 (Cutoff: 03 Aug 2005)	
	REVLIMID [®] / dexamethasone (N=177)	PLACEBO/ dexamethasone (N=176)	REVLIMID [®] / dexamethasone (N=176)	PLACEBO/ dexamethasone (N=175)
Complete Response (CR)	25 (14.1%) [g]	1 (0.6%)	28 (15.9%) [g]	6 (3.4%)
Partial Response (PR)	31 (17.5%)	18 (10.2%)	32 (18.2%)	20 (11.4%)
Stable Disease (SD)	54 (30.5%)	102 (58.0%)	53 (30.1%)	97 (55.4%)
Progressive Disease (PD)	5 (2.8%)	25 (14.2%)	3 (1.7%)	25 (14.3%)
Not Evaluable (NE) [c]	10 (5.6%)	14 (8.0%)	14 (8.0%)	11 (6.3%)
p-value [d]	< 0.001		< 0.001	
Dichotomized Response				
CR, RR, or PR	108 (61.0%)	35 (19.9%)	106 (60.2%)	42 (24.0%)
SD, PD, or NE	69 (39.0%)	141 (80.1%)	70 (39.8%)	133 (76.0%)
p-value [e]	< 0.001		< 0.001	
Odds Ratio [f] [95% CI]	6.31 [3.91, 10.17]		4.80 [3.03, 7.59]	

[a] Response is based on the review of all myeloma assessment data using Bladé et al criteria.

[b] Response is the highest assessment of response during the treatment phase of the study.

[c] Includes subjects who did not have any response assessment data as of the data cutoff date and those whose only assessment was “response not evaluable.” This category was not included in the Wilcoxon rank sum test.

[d] Probability from Wilcoxon rank sum test

[e] Probability from continuity-corrected Pearson chi square test

[f] Odds ratio (REVLIMID[®]:placebo)

[g] Significantly higher in the REVLIMID[®]/dexamethasone group than in the placebo/dexamethasone group (p < 0.003, continuity-corrected Pearson chi square test)

Based on subgroup analyses, the myeloma response rate (CR + RR + PR) and CR rate were significantly higher in the REVLIMID[®]/dexamethasone group than in the placebo/dexamethasone group regardless of gender, age (≤ 65 years or > 65 years), prior therapy (with high-dose chemotherapy and SCT or without such therapy; or number of prior antimyeloma regimens (1 vs ≥ 1)). The myeloma response rate (CR + RR + PR) and the CR rate were also significantly higher in the REVLIMID[®]/dexamethasone group than in the placebo/dexamethasone group both in subjects who had a baseline serum $\beta 2$ -microglobulin level of ≤ 2.5 mg/L and in those who had a baseline $\beta 2$ -microglobulin level of > 2.5 mg/L.

Overall Survival (Secondary endpoint)

Based on pooled data from Study 009 and Study 010 at the time of un-blinding, overall survival (OS) was significantly longer ($p < 0.001$); among the REVLIMID[®]/dexamethasone-treated subjects than among the placebo/dexamethasone -treated subjects. Subjects in the placebo/dexamethasone group were permitted to receive treatment with the REVLIMID[®]/dexamethasone combination after un-blinding. As of January 2007, OS was significantly longer ($p = 0.015$) among the REVLIMID[®]/dexamethasone-treated subjects than among the placebo/dexamethasone -treated subjects (see Table 13), however the data are confounded by the effects of the crossover of placebo/dexamethasone subjects to REVLIMID[®]. A total of 146 patients (96 from Study MM-009 and 50 from Study MM-010) rolled over to receive REVLIMID[®] before study un-blinding. After study un-blinding, a total of 19 patients (5 from Study MM-009 and 14 from Study MM-010) crossed over to receive REVLIMID[®]/dexamethasone.

Table13: Summary of Overall Survival as of January 2007: Intent-To-Treat Population

Overall Survival (OS) Statistics	Pooled Data	
	REVLIMID [®] / dexamethasone N=353	PLACEBO/ dexamethasone N=351
Died n (%)	152 (43.1)	180 (51.3)
Median OS time since randomization, weeks [a]	149.7	133.3
95% CI [b]	[141.6, NE]	[111.0, 151.7]
Mean ± SD	101.5 ± 51.39	92.4 ± 53.86
Min, Max	1.1, 183.1	0.0, 187.9
Hazard rate ratio [c]	0.765 [0.616, 0.949]	
p-value [d]	0.015	
3-yr survival rate (95% CI)	47% (40-54%)	43% (37-49%)

Notes: The median in this table is based on Kaplan-Meier estimate, and the mean is the univariate mean without adjusting for censoring.

NE= Not Estimable

[a] For subjects who died during the follow-up phase and whose death dates are not available, the follow-up visit dates are used as the event date.

[b] 95% confidence intervals about the median survival time.

[c] Based on a proportional hazards model comparing the hazard functions associated with the treatment groups (REVLIMID[®]/dexamethasone: Placebo/dexamethasone)

[d] The p-value is based on a two-tailed unstratified log rank test of survival curve differences between the treatment groups.

Figure 2: Overall Survival Data from CC-5013-MM-009; January 2007

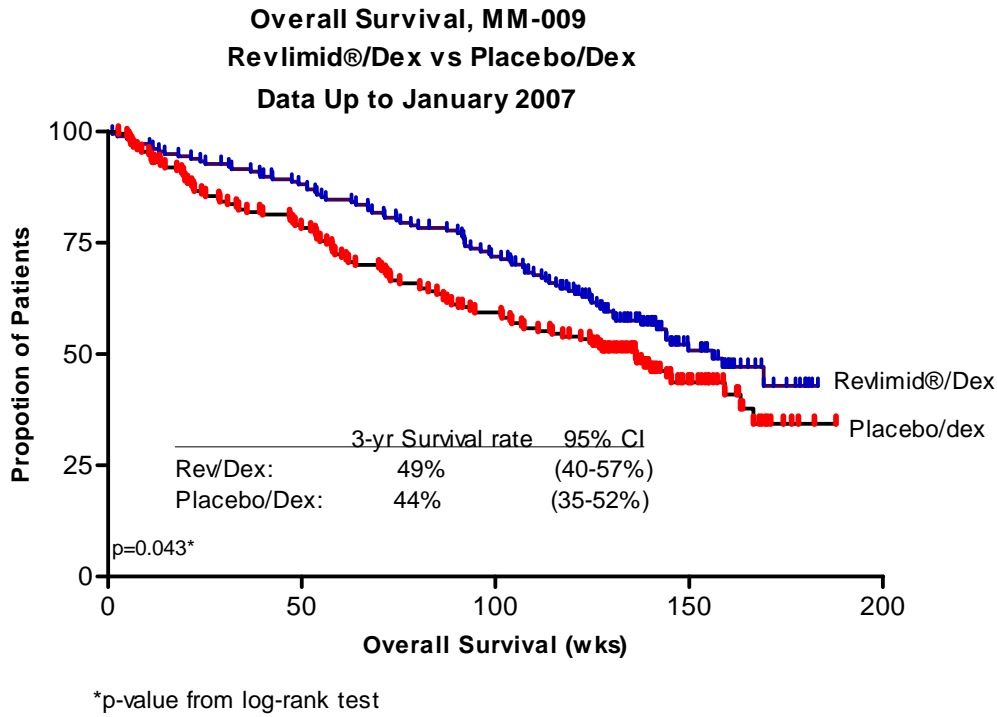
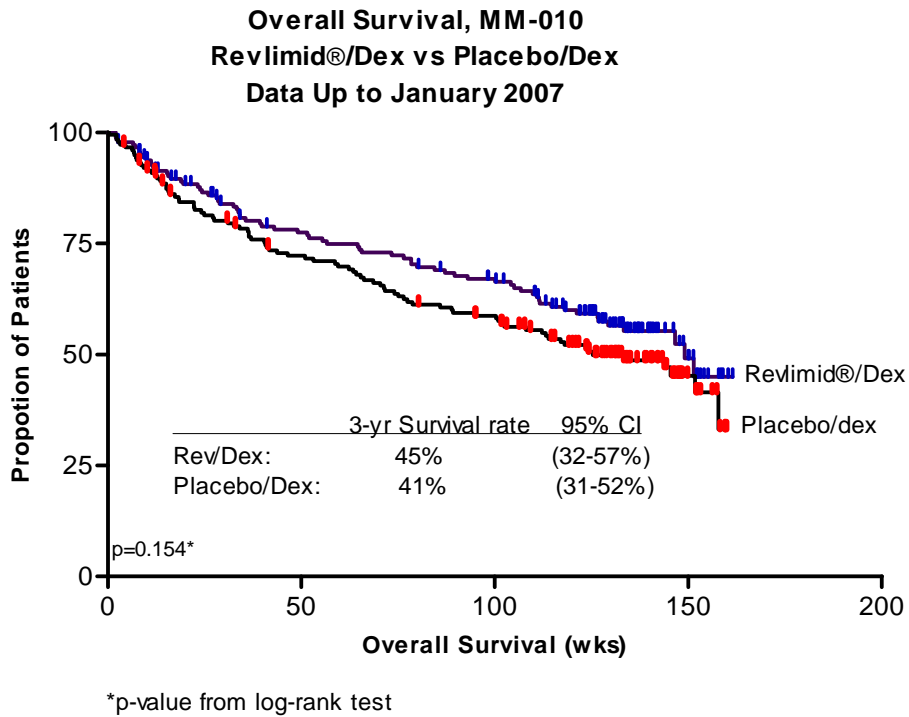


Figure 3: Overall Survival Data from CC-5013-MM-010; January 2007



Time to First Worsening of ECOG Performance Status (Secondary Endpoint)

The time to the first worsening of the ECOG performance status score was significantly longer for the REVLIMID[®]/dexamethasone-treated subjects than for the placebo/dexamethasone-treated subjects in Study 009 ($p = 0.012$). No significant difference in the time to first worsening in the ECOG performance status score was observed between the REVLIMID[®]/dexamethasone and placebo/dexamethasone groups in Study 010.

DETAILED PHARMACOLOGY

Non-Clinical Pharmacology

REVLIMID[®] (lenalidomide) is a potent and orally effective antineoplastic, immunomodulatory, and antiangiogenic drug. The pharmacological properties of lenalidomide were characterized in both in vitro and in vivo non-GLP studies examining the complex set of pathological conditions associated with myelodysplastic syndromes (MDS) and for the potential to produce any adverse secondary pharmacological effects. The results of these studies demonstrate that lenalidomide affects many biological processes associated with MDS. Specifically, lenalidomide induces fetal hemoglobin expression upon CD34⁺ hematopoietic stem cell differentiation in a model of erythroid progenitor differentiation; inhibits proliferation of various hematopoietic tumor cell lines, in particular those with cytogenetic defects of chromosome 5 and multiple myeloma (MM) plasma tumor cells; and inhibits angiogenesis in vitro by blocking the formation of microvessels and endothelial cell tubes, as well as the migration and adhesion of endothelial cells and in vivo by reducing the microvessel density in the rat mesenteric window model and in the beige-nude-xid mouse MM tumor model. In addition, lenalidomide stimulates T-cell proliferation and interleukin (IL)-2 and interferon-gamma production; and increases natural killer (NK) and NK T cell number and activity; and inhibits the secretion of pro-inflammatory cytokines including tumor necrosis factor-alpha, IL-1 β , IL-6 and IL-12, and increases the secretion of anti-inflammatory cytokine IL-10 from peripheral blood mononuclear cells.

Some of the cellular effects listed above (T cell stimulation, inhibition of tumor cell proliferation, and inhibition of endothelial cell migration) are associated with modulation of the Akt pathway, suggesting that this core signaling pathway may be a key molecular target of lenalidomide.

In rats and monkeys, lenalidomide is cleared at a moderate rate from the systemic circulation, and is rapidly absorbed, with oral bioavailability of $\geq 50\%$ in rats and monkeys. In animals, systemic exposure increased with increasing doses, with no notable accumulation on multiple dosing of lenalidomide.

The plasma protein binding of lenalidomide is low (19 to 29% bound) in nonclinical species as well as humans. ¹⁴C-Lenalidomide-derived radioactivity is extensively distributed into tissues in rats. Very limited distribution of radioactivity occurs into the central nervous system (less than 5% of levels in blood).

Lenalidomide is not subject to cytochrome P450 mediated metabolism in vitro. It undergoes hydrolysis in aqueous media, and animal and human plasma. The enantiomers of lenalidomide undergo facile interconversion in animal and human plasma in vitro.

The excretion of radioactivity following oral dosing of ¹⁴C-lenalidomide to rats and monkeys is rapid and occurs *via* both the urine and feces. In both rats and monkeys, the major component of the excreted radioactivity is the parent compound (50 to 58% of the dose). The remaining radioactive dose is excreted as multiple metabolites comprising isomeric forms of hydrolytic metabolites (5 to 10% of the dose), an N-acetyl conjugate (less than 3% of the dose) and isomers of a glucose conjugate (less than 13% of the dose). Thus, multiple clearance mechanisms contribute to the overall elimination of lenalidomide in animal models.

Lenalidomide does not inhibit or induce cytochrome P450 isoforms *in vitro*, and hence is not likely to precipitate drug-drug interactions when administered with cytochrome P450 substrates. *In vivo* in both rats and monkeys, chronic administration of lenalidomide did not result in the induction of cytochrome P450 enzymes. *In vitro* lenalidomide is a weak substrate, but is not an inhibitor of P-glycoprotein. Hence clinically relevant drug-drug interactions between lenalidomide and P-glycoprotein substrates or inhibitors are unlikely.

Non-Clinical Safety Pharmacology

Results of safety pharmacology studies have shown that lenalidomide did not induce behavioral or autonomic changes when administered orally to male rats at doses up to 2000 mg/kg, did not produce major inhibition of the cloned human cardiac potassium channel (hERG) (IC₅₀ > 786.7 μM) *in vitro*, and did not induce any biologically significant cardiovascular or respiratory changes when administered intravenously to anesthetized dogs at doses up to 20 mg/kg.

TOXICOLOGY

Study Title	Findings
Single dose intravenous toxicity study in the mouse	No deaths after a single intravenous administration of 40 mg/kg were observed in mice.
Single dose oral toxicity study in the mouse	No deaths after a single oral dose of 2000 mg/kg were observed in mice.
Single dose intravenous toxicity study in the rat	No deaths after a single intravenous administration of 40 mg/kg were observed in rats.
Single dose oral toxicity study in the rat	No deaths after a single oral dose of 2000 mg/kg were observed in rats.
7 day oral (gavage) range-finding toxicity study in the mouse	High dose females exhibited slightly elevated liver weights (p<0.05). NOAEL = 1000 mg/kg/day.
7 day oral (gavage) range finding toxicity study in the rat	Decreased red blood cell indices in treated males. Increased urea and creatinine in treated males at 500 and 2000 mg/kg. Increased kidney weights in males at 500 and 2000 mg/kg. NOAEL = < 500 mg/kg/day.

Study Title	Findings
28 day oral (gavage) toxicity study in the rat	Bodyweight and feed consumption decreased in high dose males. Unidentified crystals were noted in the urine of treated animals. At week 4, increased incidence of proteinuria and hematuria in high dose males. White powder deposit was noted in the urine of the mid and high dose animals. Moderate to severe tubular necrosis or nephropathy noted in the high dose rats. Slight decrease in red blood cell parameters for high dose males. NOAEL = 300 mg/kg/day.
13 week oral (gavage) toxicity study in the rat	Decreased body weight gains and unidentified crystals in the urine at the mid and high dose. NOAEL = 75 mg/kg/day.
26 week (with a 4 week treatment-free recovery period) oral (gavage administration) toxicity study in the rat	Male and female rats were administered 0, 75, 150 or 300 mg/kg/day for 26 weeks. In this study, there were 3 non-treatment related deaths; 1 male at 300 mg/kg and 2 females from control and 150 mg/kg groups. No treatment-related clinical signs were observed during the treatment and treatment-free periods. Hematology, clinical chemistry, urinalysis, ophthalmoscopic findings were unaffected by treatment. At the end of treatment, there were slight decreases of 16% and 9% in group mean unadjusted liver weight and organ to body weight ratio in males dosed with 300 mg/kg/day. Microscopically, a treatment-related increase in the incidence of pelvic mineralization was seen in the kidney at all doses. After 4 weeks, recovery from this effect was observed in the high dose group. The NOAEL was 75 mg/kg/day.
28 day oral (gavage) toxicity study in the monkey.	One animal sacrificed in moribund condition. Animal exhibited increased urea, creatinine & bilirubin. Lesions in bone marrow & lymphocytic system, kidneys, GI tract & liver. Minor atrophy of the thymus, spleen and peripheral lymph nodes and altered hematopoiesis were noted. NOAEL was not achieved.
28 day oral (gavage) toxicity study in the monkey	No treatment related effects. NOAEL = 2 mg/kg/day.
13 week oral (gavage) toxicity study in the monkey	The top dose of 2/mg/kg/day was the NOAEL. Evidence of pharmacodynamic activity was noted at all dose levels.
52 week oral (gavage administration) toxicity study in the monkey	A number of animals administered 4 and 6 mg/kg/day were terminated early due to toxicity on Day 135. In these animals, treatment-related findings consisted of severely reduced RBC, WBC, and platelet counts, hemorrhage in multiple organs, gastrointestinal tract inflammation and lymphoid and bone marrow atrophy. For animals administered 1 and 2 mg/kg/day, mild, but inconsistent, suppression of white blood cell count at 2 mg/kg/day was observed. Histology at 52 weeks showed atrophy of the thymus at both doses. After 7 weeks of recovery, platelet and WBC counts were similar to control; the effects on the thymus were partially reversed. The NOAEL in this study was 1 mg/kg/day.
Fertility and early Embryonic Development	A fertility and early embryonic development study in rats, with administration of lenalidomide up to 500 mg/kg, produced no parental toxicity and no adverse effects on fertility.

Study Title	Findings
Embryo-fetal development studies:	Embryofetal developmental toxicity studies were conducted in rats, rabbits and monkeys. In monkeys, malformations were observed in the offspring of female monkeys who received lenalidomide doses as low as 0.5 mg/kg/day during pregnancy. Exposure in monkeys at this dose (AUC of 378 ng•hr/mL) was 0.17-times the exposure from a human clinical dose of 25 mg/day (AUC of 2215 ng•hr/mL). The observed malformations ranged from stiff and slightly malrotated hindlimbs at 0.5 mg/kg/day lenalidomide up to severe external malformations, such as bent, shortened, malformed, malrotated, and/or absent part of the extremities, oligo- or polydactyly at 4 mg/kg/day lenalidomide. These external malformations had correlated skeletal finding and were similar to those seen with the positive control thalidomide treatment.
	In rabbits, the maternal and developmental NOAELs for lenalidomide were 3 mg/kg/day. Exposure of rabbits at this dose (AUC of 2858 ng•hr/mL) was 2.3 fold higher than in patients administered 10 mg of lenalidomide based on AUC. Exposure in patients administered 25 mg of lenalidomide was approximately the same as in rabbits at the NOAEL dose based on AUC. Lenalidomide has been shown to have an embryocidal effect in rabbits at a dose of 50 mg/kg. Developmental toxicity at the 10 and 20 mg/kg/day dose levels was characterized by slightly reduced fetal body weights, increased incidences of post implantation loss, and gross external findings in the fetuses associated with morbidity and pharmacotoxic effects of lenalidomide (purple discoloration of the skin on the entire body).
Pre- and Post-Natal Development:	A pre- and post-natal development study in rats revealed few adverse effects in the offspring of female rats treated with lenalidomide at doses up to 500 mg/kg (approximately 600 times and 240 times the human dose of 10 and 25 mg, respectively based on body surface area). Exposures to lenalidomide at these doses were ≥ 128-fold and 50-fold higher than in patients administered 10 mg and 25 mg, respectively based on AUC. The male offspring exhibited slightly delayed sexual maturation, and the female offspring had slightly lower body weight gains during gestation when bred to male offspring.
Carcinogenicity	Carcinogenicity studies with lenalidomide have not been conducted.
Mutagenicity	Lenalidomide did not induce mutation in the Ames test, chromosome aberrations in cultured human peripheral blood lymphocytes, or mutation at the thymidine kinase (tk) locus of mouse lymphoma L5178Y cells. Lenalidomide did not increase morphological transformation in Syrian Hamster Embryo assay or induce micronuclei in the polychromatic erythrocytes of the bone marrow of male rats.

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PART III: CONSUMER INFORMATION

MYELODYSPLASTIC SYNDROME

PrREVLIMID®
lenalidomide

This leaflet is part III of a three-part "Product Monograph" published when REVLIMID® (lenalidomide) was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about REVLIMID®. Contact your doctor or pharmacist if you have any questions about the drug.

ABOUT THIS MEDICATION

REVLIMID® can only be given to patients who are registered in and meet all conditions of the RevAid® program. RevAid® is a controlled distribution program of REVLIMID®.

What the medication is used for:

REVLIMID® is used in the treatment of patients who require blood transfusions due to myelodysplastic syndromes (MDS with a chromosome problem in which part of chromosome 5 is missing. This type of MDS is known as deletion 5q MDS.

What it does:

The details of how REVLIMID® works in deletion 5q MDS are still being studied. When patients with deletion 5q MDS are treated with REVLIMID®, abnormal cells in their bone marrow are often eliminated and replaced by normal-appearing cells. REVLIMID® can also directly stimulate the production of red blood cells by the bone marrow. These effects can improve anemia, and reduce or eliminate the need for transfusions in patients with MDS.

When it should not be used:

- **REVLIMID® may cause birth defects. In order to take this drug you must meet the following conditions:**
 1. Females who can get pregnant:
 - Discuss contraception (birth control) with your health care provider.
 - Use at least two effective methods of contraception at the same time.
 - Use these two effective methods of contraception:
 - For at least 4 weeks before starting REVLIMID® treatment
 - During interruptions of REVLIMID® treatment
 - During REVLIMID® treatment
 - For at least 4 weeks after stopping REVLIMID® treatment
 - Do not take REVLIMID® if you are breastfeeding.

- Do not take REVLIMID® if you are pregnant, plan to become pregnant, or become pregnant during REVLIMID® treatment.
- You must have two negative pregnancy tests before starting treatment:
 - The first 7-14 days prior to starting treatment
 - The second within 24 hours of starting treatment.
- You must have negative pregnancy tests during treatment:
 - Once weekly for the first 4 weeks
 - Once every 4 weeks (or once every 2 weeks if your period is irregular) for the duration of treatment and during treatment interruption
- You must have a final pregnancy test 4 weeks after stopping REVLIMID®.

2. Males:

- Use a latex condom every time you have sexual intercourse with a woman who is pregnant or can get pregnant while you are taking, during interruptions of treatment, and for 4 weeks after stopping REVLIMID®. This must be done even if you have undergone a successful vasectomy.
- Do not donate sperm while taking REVLIMID® and for 4 weeks after stopping REVLIMID®.

3. All Patients:

REVLIMID® may cause birth defects and any method of birth control can fail. You should contact your doctor immediately if you think you or your female partner may be pregnant. You should also contact your doctor if you miss your period or experience unusual menstrual bleeding.

- Do not take REVLIMID® if you are allergic to lenalidomide or thalidomide or any of the other ingredients in REVLIMID®. REVLIMID® contains lactose.
- REVLIMID® treatment should not be started in patients whose platelet levels are less than 50 x 10⁹/L.
- Do not give blood while you take REVLIMID® and for 4 weeks after stopping REVLIMID®.
- Do not share REVLIMID® with other people.
- Do not take REVLIMID® if you are not enrolled in or do not meet the requirements of the RevAid® controlled distribution program.

What the medicinal ingredient is:

lenalidomide

What the important nonmedicinal ingredients are:

Each capsule contains lactose anhydrous, microcrystalline cellulose, croscarmellose sodium, and magnesium stearate. The additional composition of the different capsule strengths is provided in the table below.

Strength	Imprint	Composition	Colour	Package size
5 mg	REV, 5 mg	Gelatin, titanium dioxide	White opaque	28 count blisters
10 mg	REV, 10 mg	Gelatin, FD&C blue #2, yellow iron oxide, titanium dioxide	Blue/green and pale yellow	28 count blisters

What dosage forms it comes in:

Capsules. Each capsule contains 5 mg or 10 mg lenalidomide.

INTERACTIONS WITH THIS MEDICATION

Tell your healthcare provider about all the medicines you take including prescription and nonprescription medicines, vitamins and herbal supplements. It is possible that REVLIMID® and other medicines may affect each other causing serious side effects. Drugs that may interact with REVLIMID® include: digoxin, Hormonal Replacement Therapy, and Hormonal Contraception (estrogens and progestins).

Know the medicines you take. Keep a list of them to show your healthcare provider and pharmacist.

PROPER USE OF THIS MEDICATION

Dosage: Myelodysplastic Syndrome: Starting dose: 10 mg daily on days 1-21 of 28-day cycles.

Your doctor may change the dosage during treatment, and will decide the total duration of therapy that you need. If you don't respond within 4 months of starting REVLIMID®, your doctor may decide to stop the treatment. It all depends on your response to the treatment.

Take REVLIMID® exactly as prescribed.

Swallow REVLIMID® capsules whole with water once a day. You should try to take it at about the same time each day.

Do not break, chew, or open your capsules.

Females who could become pregnant, or who plan to become pregnant can handle REVLIMID® capsules if they are using latex gloves. You will have regular blood tests during your treatment with REVLIMID®. You should have your blood tested every week during your first 8 weeks of treatment, and at least monthly after that. Your healthcare provider may adjust your dose of REVLIMID® or interrupt your treatment based on the results of your blood tests and on your general condition.

Overdose:

In case of drug overdose, contact a health care practitioner, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

Missed Dose:

If less than 12 hours have passed since missing a dose, take the dose. If more than 12 hours have passed since missing a dose at the normal time, do not take the dose. Take the next dose at the normal time on the following day. Do **not** take 2 doses at the same time.

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions

REVLIMID® should only be prescribed by a doctor experienced in the use of anti-cancer drugs and registered with the RevAid® controlled distribution program.

Serious side effects may occur with the use of REVLIMID® and could include:

- birth defects (deformed babies) or death of an unborn baby and spontaneous abortion.
- decrease in the production of blood cells resulting in very low levels of white blood cells (neutropenia) and of platelets (thrombocytopenia)
- blood clots in the veins (Deep Vein Thrombosis) and in the lung (Pulmonary Embolism)
- Liver problems. Treatment with REVLIMID may lead to a higher risk of liver problems which may cause death

REVLIMID® is only available under a controlled distribution program called RevAid®.

BEFORE you use REVLIMID® talk to your doctor or pharmacist if you:

- are pregnant or are planning to get pregnant
- are breastfeeding
- have kidney problems
- have liver problems
- have blood problems
- have or have had heart problems (irregular heart beat, heart attack)
- smoke, have high blood pressure or high cholesterol levels

REVLIMID® is not recommended for use in children under 18 years of age.

SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Like all medicines, REVLIMID® can have side effects. The following are the most commonly reported side effects (≥ 10%):

Very Common: decrease in white blood cells, decrease in platelets, diarrhea, itchy skin, rash, tiredness, nausea, infection of the nasal passages, constipation, joint pain, back pain, swelling of arms and/or legs, fever, cough, dizziness, difficulty breathing, headache, decrease in red blood cells, muscle cramp, infection of the pharynx, upper respiratory tract infection, nose bleed, lack or loss of strength, dry skin, abdominal pain, pain in arm or leg, urinary tract infection, pneumonia, loss of appetite, decrease in blood potassium level, swelling, bronchitis, difficulty sleeping, sinus infection, vomiting, night sweats, muscle pain

The following are commonly reported side effects (≥1% and ≤ 10%):

Common: fall, pain, increased sweating, bruise, upper abdominal pain, loose stools, arm and/or leg swelling, acquired decreased thyroid activity, high blood pressure, difficult or painful urination, dry mouth, toothache, allergy (rhinitis), flu, decreased sensitivity to stimulation, ruptured blood vessels, skin redness, chest pain, rigors, foot pain, distortion of sense of taste, loss of sensation in limbs, decrease in blood magnesium level, weight loss, infection under the skin, depression, skin lesion, flatulence, sensation of pricking, tingling, or creeping on the skin, heart palpitations, acute leukemia, hair loss, ear pain, dry eye, eye redness, eye pain.

Tell your doctor or pharmacist if you experience a side effect which is not listed above or any of the listed side effects that bother you or does not go away.

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom / Effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Very common	Fever / Neutropenia (decrease in white blood cells)		√	
Very common	Bleeding from the gums or other sites or abnormal bleeding / Thrombocytopenia (decrease in platelets that help with blood clotting)		√	
Very common	Chest or other infections / Pneumonia, Sepsis, Flu, Various Infections		√	

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom / Effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Very common	Tiredness / Anemia (decrease in red blood cells), Fatigue, Acute Leukemia, Pancytopenia (decrease in platelet, red blood cell and white blood cell counts)		√	
Very common	Difficulty breathing, breathlessness / Pulmonary Embolism (blood clot in or around the lungs), Heart failure, Pleural Effusion (excess fluid around the lungs), Hypoxia (decrease in oxygen to the body), Pneumonitis (inflammation of the lungs), Pulmonary Hypertension (increased blood pressure in vessels around or in the lungs), Pulmonary edema (build up of fluid in spaces outside blood vessels of the lungs)			√
Common	Nausea / Hyponatremia (decrease in sodium levels in the blood)		√	
Common	Skin rash		√	
Common	Muscle weakness / Asthenia (lack or loss of strength), Hypokalemia (decrease in potassium levels in blood)		√	
Common	Swelling of arms or legs / Edema peripheral, Kidney failure, Blood creatinine increase (decreased kidney function)			√
Common	Back pain	√		
Common	Loose or frequent bowel movements / Diarrhea	√		
Common	Arm pain with arm or leg swelling / Deep Vein Thrombosis (blood clots that form in your blood vessels)			√
Common	Dizziness or fainting	√		
Common	Headache / High blood pressure	√		
Common	Joint pain and muscle cramps	√		

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom / Effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Common	Chest palpitations, awareness of abnormal heart rhythm / Atrial fibrillation (abnormal or irregular heartbeats)			√
Common	Itchy skin	√		
Common	Pain	√		
Common	Chest pain / Angina		√	
Common	Vomiting	√		
Common	Difficulty moving limbs, walking or speaking / stroke and mini-stroke			√
Common	Confusion / Psychosomatic Disease (disorder having physical symptoms but originating from mental or emotional causes)		√	
Common	Dry mouth, excessive thirst, dark yellow urine / Dehydration		√	
Common	Difficulty swallowing / Dysphagia		√	
Common	Fall		√	
Common	Increased sweating		√	
Common	Loss of appetite / Anorexia		√	

These are not all the possible side effects possible with the use of REVLIMID®. Ask your healthcare provider or pharmacist for more information.

HOW TO STORE IT

Store REVLIMID® at 15-30°. Keep out of the reach of children. Contact RevAid to return any unused REVLIMID capsules.

REPORTING SUSPECTED SIDE EFFECTS

You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:

- Report online at www.healthcanada.gc.ca/medeffect
- Call toll-free at 1-866-234-2345
- Complete a Canada Vigilance Reporting Form and:
 - Fax toll-free to 1-866-678-6789, or
 - Mail to: Canada Vigilance Program
Health Canada
Postal Locator 0701D
Ottawa, Ontario
K1A 0K9

Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines are available on the MedEffect™ Canada Web site at www.healthcanada.gc.ca/medeffect.

NOTE: Should you require information related to the management of side effects, contact your health professional. The Canada Vigilance Program does not provide medical advice.

MORE INFORMATION

This document plus the full product monograph, prepared for health professionals can be found at: <http://www.RevAid.ca> or by contacting the sponsor, Celgene, at: 1-888-RevAid1 (1-888-738-2431).

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PART III: CONSUMER INFORMATION MULTIPLE MYELOMA

Pr **REVLIMID**[®] lenalidomide

This leaflet is part III of a three-part "Product Monograph" published when **REVLIMID**[®] (lenalidomide) was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about **REVLIMID**[®]. Contact your doctor or pharmacist if you have any questions about the drug.

ABOUT THIS MEDICATION

REVLIMID[®] can only be given to patients who are registered in and meet all conditions of the RevAid[®] program. RevAid[®] is a controlled distribution program of **REVLIMID**[®].

What the medication is used for:

REVLIMID[®] is used with dexamethasone to treat patients with multiple myeloma who have already had another treatment. Multiple myeloma is a cancer of plasma cells. Plasma cells are found in the bone marrow. Plasma cells produce a protein called antibodies. Some antibodies can attack and kill disease causing germs. Patients with this type of cancer may have low blood cell counts and immune problems giving them a higher chance for getting infections such as pneumonia. The bones can be affected leading to bone pain and breaks (fractures).

What it does:

REVLIMID[®] works in multiple ways within the bone marrow to stop or slow the growth of cancerous myeloma cells.

When it should not be used:

- **REVLIMID**[®] may cause birth defects. In order to take this drug you must meet the following conditions:
1. Females who can get pregnant:
 - Discuss contraception (birth control) with your health care provider.
 - Use at least two effective methods of contraception at the same time.
 - Use these two effective methods of contraception:
 - For at least 4 weeks before starting **REVLIMID**[®] treatment
 - During interruptions of **REVLIMID**[®] treatment
 - During **REVLIMID**[®] treatment
 - For at least 4 weeks after stopping **REVLIMID**[®] treatment
 - Do not take **REVLIMID**[®] if you are breastfeeding.
 - Do not take **REVLIMID**[®] if you are pregnant, plan to become pregnant, or become pregnant during **REVLIMID**[®] treatment.

- You must have two negative pregnancy tests before starting treatment:
 - The first 7-14 days prior to starting treatment
 - The second within 24 hours of starting treatment.
 - You must have negative pregnancy tests during treatment:
 - Once weekly for the first 4 weeks
 - Once every 4 weeks (or once every 2 weeks if your period is irregular) for the duration of treatment and during treatment interruption
 - You must have a final pregnancy test 4 weeks after stopping **REVLIMID**[®].
2. Males:
 - Use a latex condom every time you have sexual intercourse with a woman who is pregnant or can get pregnant while you are taking, during interruptions of treatment, and for 4 weeks after stopping **REVLIMID**[®]. This must be done even if you have undergone a successful vasectomy.
 - Do not donate sperm while taking **REVLIMID**[®] and for 4 weeks after stopping **REVLIMID**[®].
 3. All Patients:

REVLIMID[®] may cause birth defects and any method of birth control can fail. You should contact your doctor immediately if you think you or your female partner may be pregnant. You should also contact your doctor if you miss your period or experience unusual menstrual bleeding.

- Do not take **REVLIMID**[®] if you are allergic to lenalidomide or thalidomide or any of the other ingredients in **REVLIMID**[®]. **REVLIMID**[®] contains lactose.
- Do not give blood while you take **REVLIMID**[®] and for 4 weeks after stopping **REVLIMID**[®].
- Do not share **REVLIMID**[®] with other people.
- Do not take **REVLIMID**[®] if you are not enrolled in or do not meet the requirements of the RevAid[®] controlled distribution program.

What the medicinal ingredient is: lenalidomide

What the important nonmedicinal ingredients are:

Each capsule contains lactose anhydrous, microcrystalline cellulose, croscarmellose sodium, and magnesium stearate. The additional composition of the different capsule strengths is provided in the table below.

Strength	Imprint	Composition	Colour	Package size
5 mg	REV, 5 mg	Gelatin, titanium dioxide	White opaque	28 count blisters
10 mg	REV, 10 mg	Gelatin, FD&C blue #2, yellow iron oxide, titanium dioxide	Blue/green and pale yellow	28 count blisters
15 mg	REV, 15 mg	Gelatin, FD&C blue #2, titanium dioxide	Powder blue opaque and white opaque	21 count blisters
25 mg	REV, 25 mg	Gelatin, titanium dioxide	White opaque	21 count blisters

What dosage forms it comes in:

Capsules. Each capsule contains 5 mg, 10 mg, 15 mg, or 25 mg of lenalidomide.

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions

REVLIMID® should only be prescribed by a doctor experienced in the use of anti-cancer drugs and registered with the RevAid® controlled distribution program.

Serious side effects may occur with the use of REVLIMID® and could include:

- birth defects (deformed babies) or death of an unborn baby and spontaneous abortion.
- decrease in the production of blood cells resulting in very low levels of white blood cells (neutropenia) and of platelets (thrombocytopenia)
- blood clots in the veins (Deep Vein Thrombosis) and in the lung (Pulmonary Embolism)
- Liver problems. Treatment with REVLIMID may lead to a higher risk of liver problems which may cause death

REVLIMID® is only available under a controlled distribution program called RevAid®.

BEFORE you use REVLIMID® talk to your doctor or pharmacist if you:

- are pregnant or are planning to get pregnant
- are breastfeeding
- have kidney problems
- have liver problems
- have blood problems
- have or have had heart problems (irregular heart beat, heart attack)
- smoke, have high blood pressure or high cholesterol levels

REVLIMID® is not recommended for use in children under 18 years of age.

Second cancers such as skin cancers or other invasive solid tumor cancers have been reported in a small number of patients while taking REVLIMID® or after treatment with REVLIMID® is completed. Patients should talk to their doctors if they have any concerns about their own increased risk of having other cancers.

INTERACTIONS WITH THIS MEDICATION

Tell your healthcare provider about all the medicines you take including prescription and nonprescription medicines, vitamins and herbal supplements. It is possible that REVLIMID® and other medicines may affect each other causing serious side effects.

Drugs that may interact with REVLIMID® include: digoxin, Hormonal Replacement Therapy, and Hormonal Contraception (estrogens and progestins).

Know the medicines you take. Keep a list of them to show your healthcare provider and pharmacist.

PROPER USE OF THIS MEDICATION

Dosage: Multiple Myeloma: Starting dose: 25 mg daily on days 1-21 of 28 day cycles in combination with dexamethasone.

Your doctor may change the dosage during treatment, and will decide the total duration of therapy that you need. It all depends on your response to the treatment.

Take REVLIMID® exactly as prescribed.

Swallow REVLIMID® capsules whole with water once a day. You should try to take it at about the same time each day.

Do not break, chew, or open your capsules.

Females who could become pregnant, or who plan to become pregnant can handle REVLIMID® capsules if they are using latex gloves. You will have regular blood tests during your treatment with REVLIMID®. You should have your blood tested once every two weeks during your first 12 weeks of treatment, and at least monthly after that. Your healthcare provider may adjust your dose of REVLIMID® or interrupt your treatment based on the results of your blood tests and on your general condition.

Overdose:

In case of drug overdose, contact a health care practitioner, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

Missed Dose:

If less than 12 hours have passed since missing a dose, take the dose. If more than 12 hours have passed since missing a dose at the normal time, do not take the dose. Take the next dose at the normal time on the following day. Do **not** take 2 doses at the same time.

SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Like all medicines, REVLIMID® can have side effects. The following are the most commonly reported side effects (≥ 10%):

Very Common: chest and other infections, tiredness/lethargy, fever, muscle weakness, joint pain and muscle cramps, pain, abdominal pain, difficulty breathing/breathlessness, hard stools / difficult to pass, difficulty sleeping, diarrhea, bleeding from gums or other sites, numbness / abnormal sensations, dizziness, swelling of arms or legs, cough, blurred vision, headache, nausea, skin rash, back pain, loss of appetite, weight loss, frequent hunger with excessive thirst and urination, taste altered, chest palpitations/awareness of abnormal heart rhythm, chest pain, swelling, mouth pain, general feeling of discomfort or uneasiness, sore throat, shaking, confusion, weight gain, depression, arm pain with arm or leg swelling, vomiting, reduced sense of touch, irritability

The following are commonly reported side effects (≥1% and ≤ 10%):

Common: “pins and needles” in hands and feet, bruise, increased sweating, dry skin, inflammation mouth, frequent urination, high blood pressure (headache), hoarse voice, dry mouth, stuffy nose, itchy skin, lightheadedness or dizziness, dehydration (dry mouth, excessive thirst, dark yellow urine), mood changes, hiccups, flatulence, runny nose, swelling face, sweating increased, skin redness, dizziness or fainting, muscle spasm, fever with shaking, heartburn, face redness, balance impaired, canker sores, loose stools, bone pain, skin cancer, skin discoloration, decreased urination, hot flashes, painful urination, toothache, hair loss, increased tears, skin lesions, skin wound, decreased sex drive, nervousness, difficulty moving limbs, walking or speaking (stroke), dry eye, eye redness, fall, hives, memory impairment, difficulty swallowing, eye itch, rash, ringing in ears, allergic reaction, bedsores, blood in urine, deafness, increased hair growth, walking abnormally, increased appetite, mental status changes, non-coordinated muscle movement, painful or frequent urination, pale skin, urgent need to urinate, wheezing, wound

Tell your doctor or pharmacist if you experience a side effect which is not listed above or any of the listed side effects that bother you or does not go away.

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom / Effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Very common	Fever / Neutropenia (decrease in white blood cells)		√	
Very Common	Muscle weakness / Asthenia (lack or loss of strength), Hypokalemia (decrease in potassium levels in blood), Hypophosphatemia (decrease in phosphate levels in blood)		√	
Very common	Tiredness / Anemia (decrease in red blood cells), Fatigue		√	
Very common	Bleeding from the gums or other sites or abnormal bleeding / Thrombocytopenia (decrease in platelets that help with blood clotting)		√	
Very common	Chest or other infections / Pneumonia, Various Infections		√	
Very Common	Arm pain with arm or leg swelling / Deep Vein Thrombosis (blood clots that form in your blood vessels)			√
Common	Frequent hunger, excessive thirst or urination / Hyperglycemia (high blood sugar)			√
Common	Difficulty breathing, breathlessness / Pulmonary Embolism (blood clot in or around the lungs) / Heart Failure / Pulmonary edema			√
Common	Lightheadedness, dizziness or fainting / Hypotension (low blood pressure)	√		
Common	Chest palpitations, awareness of abnormal heart rhythm / Atrial fibrillation (abnormal or irregular heartbeats)			√
Common	“Pins and needles” in hands and feet / Hypocalcaemia (low blood calcium)		√	
Common	Loose or frequent bowel movements / Diarrhea	√		

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom / Effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Common	Depression		√	
Common	Bone Pain	√		
Common	Confusion		√	
Common	Constipation	√		
Common	Numbness, abnormal sensations / Neuropathy (a disease of the nerves)		√	
Common	Nausea		√	
Common	Headache / High blood pressure	√		
Common	Dry mouth, excessive thirst, dark yellow urine / Dehydration		√	
Common	Rapid swelling of the skin, face and lips / Angioedema			√
Rare	Red rash across face and body / Stevens-Johnson Syndrome / Toxic Epidermal Necrolysis			√

These are not all the possible side effects possible with the use of REVLIMID®. Ask your healthcare provider or pharmacist for more information.

HOW TO STORE IT

Store REVLIMID® at 15-30°. Keep out of the reach of children. Contact RevAid to return any unused REVLIMID capsules.

REPORTING SUSPECTED SIDE EFFECTS

You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:

- Report online at www.healthcanada.gc.ca/medeffect
- Call toll-free at 1-866-234-2345
- Complete a Canada Vigilance Reporting Form and:
 - Fax toll-free to 1-866-678-6789, or
 - Mail to: Canada Vigilance Program
Health Canada
Postal Locator 0701D
Ottawa, Ontario
K1A 0K9

Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines are available on the MedEffect™ Canada Web site at www.healthcanada.gc.ca/medeffect.

NOTE: Should you require information related to the management of side effects, contact your health professional. The Canada Vigilance Program does not provide medical advice.

MORE INFORMATION

This document plus the full product monograph, prepared for health professionals can be found at: <http://www.RevAid.ca> or by contacting the sponsor, Celgene, at: 1-888-RevAid1 (1-888-738-2431).

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