About PANHEMATIN

PANHEMATIN is supplied as a sterile, lyophilized, black powder in single-dose dispensing vials containing 350 mg hemin, 240 mg sodium carbonate, and 335 mg sorbitol. When mixed as directed with Sterile Water for Injection, USP, each 48 mL provides the equivalent of approximately 336 mg hematin (7 mg/mL).

Prior to reconstitution, PANHEMATIN should be stored at room temperature (68°-77°F). PANHEMATIN contains no preservative, and it undergoes rapid chemical decomposition in solution. Therefore, PANHEMATIN should not be reconstituted until immediately before use.

Indication

PANHEMATIN® is a hemin for injection indicated for the amelioration of recurrent attacks of acute intermittent porphyria temporally related to the menstrual cycle in susceptible women, after initial carbohydrate therapy is known or suspected to be inadequate. (See Limitations of Use on page 5 of this brochure.)

Important Safety Information

- Do not use in patients with known hypersensitivity to PANHEMATIN.
- Phlebitis is possible. Utilize a large arm vein or a central venous catheter for administration to minimize the risk of phlebitis.
Dosing PANHEMATIN® (hemin for injection)

PANHEMATIN should only be used by or in consultation with physicians experienced in the management of porphyrias. For intravenous infusion only.

Dosing recommendation:
- IV infusion of 1-4 mg/kg/day over 30+ minutes for 3-14 days based on clinical signs
- The standard dose in clinical practice is 3 to 4 mg/kg/day
- In more severe cases, the dose may be repeated no earlier than every 12 hours
- No more than 6 mg/kg per 24-hour period

Preparing PANHEMATIN

Step 1 - Calculate Dose of Reconstituted PANHEMATIN for Infusion

When PANHEMATIN is reconstituted with 48 ml Sterile Water for Injection, USP, it contains the equivalent of ~336 mg hematin at a concentration of 7 mg/mL.

\[
\text{mL to infuse} = \frac{\text{Prescribed Dosage (mg/kg) x Patient Weight (kg)}}{7 \text{ mg/mL Concentration of Reconstituted PANHEMATIN}}
\]

Step 2 - Reconstitute PANHEMATIN

PANHEMATIN must be reconstituted immediately before use, because it contains no preservative and undergoes rapid chemical decomposition in solution.

1. Using aseptic technique, remove caps from Sterile Water for Injection, USP bottle and PANHEMATIN vial. Clean rubber stoppers* with alcohol wipes.
2. Using the 60 mL syringe, withdraw 48 mL Sterile Water for Injection from bottle.
3. Inject the Sterile Water into the PANHEMATIN dispensing vial. Do not add other drug or chemical agent to a PANHEMATIN fluid admixture.
4. Immediately after adding diluent, shake the PANHEMATIN vial for 2-3 minutes to aid dissolution. Reconstituted PANHEMATIN is not transparent.

*The vial stopper of PANHEMATIN contains natural rubber latex, which may cause allergic reactions.

Important Safety Information
- Do not use in patients with known hypersensitivity to PANHEMATIN.
- Phlebitis is possible. Utilize a large arm vein or a central venous catheter for administration to minimize the risk of phlebitis.
- Elevated iron and serum ferritin may occur. Monitor iron and serum ferritin in patients receiving multiple administrations of PANHEMATIN.
Administering PANHEMATIN® (hemin for injection)

Refer to page 5 for a list of supplies needed to infuse PANHEMATIN.

Step 1 – Establish an IV Line

1. Protect patient’s clothing with a towel or pad.
2. Use a large arm vein or central venous catheter to avoid the possibility of phlebitis.
3. Connect primary tubing to the 250 mL bag of 0.9% Sodium Chloride for Injection, USP, and prime.
4. Verify blood return and flush IV to verify patency, then attach the line.
5. Start the sodium chloride infusion at a “keep vein open” (KVO) rate.

Important Safety Information
- PANHEMATIN has transient and mild anticoagulant effect. Avoid concurrent anticoagulant therapy.
- Reversible renal shutdown has been observed with an excessive hematin dose (12.2 mg/kg in a single infusion). Strictly follow recommended dosage guidelines.
- PANHEMATIN may carry a risk of transmitting infectious agents, e.g., viruses, and theoretically, the Creutzfeldt-Jakob disease (CJD) agent.
Step 2 - Infuse PANHEMATIN® (hemin for injection)

Verify the dose of PANHEMATIN the patient will be receiving. Use an infusion pump to ensure accuracy of dosing and administration time.

Infuse the reconstituted PANHEMATIN immediately. PANHEMATIN contains no preservative and undergoes rapid chemical decomposition in solution.

1. Attach the 0.45-micron filter to the IV tubing, since undissolved particulate matter is difficult to see in PANHEMATIN. If the tubing is not vented, attach a vented spike adapter, and then insert the spike into the evacuated PANHEMATIN vial.

2. Prime the IV and filter system with PANHEMATIN. Attach IV line to the “Y” site on the primary infusion line, and stop the saline infusion.

3. Open the clamp on the IV tubing and begin infusion. The prescribed dose of PANHEMATIN should be infused over a period of at least 30 minutes.

4. After the full dose has been given, stop the infusion. Disconnect the PANHEMATIN at the “Y” site, and remove the vial and PANHEMATIN tubing. Rinse the vein with 100 mL 0.9% Sodium Chloride for Injection, USP. Discard any remaining PANHEMATIN solution.

Important Safety Information

- Most common adverse reactions in >1% of patients are headache, pyrexia, infusion site reactions, and phlebitis.
- To report SUSPECTED ADVERSE REACTIONS, contact Recordati Rare Diseases Inc. at 1-888-575-8344, or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.
- Avoid CYP inducing drugs such as estrogens, barbituric acid derivatives and steroid metabolites which induce δ-aminolevulinic acid synthetase 1 (ALAS 1) through a feedback mechanism.

Please see Full Prescribing Information at the end of this brochure.
**Supply List**

### Reconstitution

1. Vial of PANHEMATIN® (hemin for injection)
2. Bottle Sterile Water for Injection, USP
3. 60 mL syringe with 18-20 gauge needle
4. Alcohol wipes
5. Protective gloves

### Infusion

1. Vial of reconstituted PANHEMATIN
2. Infusion pump
3. Primary infusion set (including IV administration tubing with “Y” site)
4. 250 mL IV bag of 0.9% Sodium Chloride for Injection, USP
5. Sterile 0.45-micron or smaller filter
6. IV tubing with vented spike, or vented spike adapter
7. Huber needle and injection cap
8. Central line dressing kit
9. Saline flush syringe
10. Alcohol wipes
11. Protective gloves
12. IV bag label

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**PANHEMATIN® (hemin for injection)**

**Indications and Usage**

PANHEMATIN® is a hemin for injection indicated for the amelioration of recurrent attacks of acute intermittent porphyria temporally related to the menstrual cycle in susceptible women, after initial carbohydrate therapy is known or suspected to be inadequate.

**Limitations of Use**

- Before administering PANHEMATIN, consider an appropriate period of carbohydrate loading (i.e., 400 g glucose/day for 1 to 2 days).
- Attacks of porphyria may progress to a point where irreversible neuronal damage has occurred. PANHEMATIN therapy is intended to prevent an attack from reaching the critical stage of neuronal degeneration. PANHEMATIN is not effective in repairing neuronal damage.

**Important Safety Information**

- Do not use in patients with known hypersensitivity to PANHEMATIN.
- Phlebitis is possible. Utilize a large arm vein or a central venous catheter for administration to minimize the risk of phlebitis.
- Elevated iron and serum ferritin may occur. Monitor iron and serum ferritin in patients receiving multiple administrations of PANHEMATIN.
- PANHEMATIN has transient and mild anticoagulant effect. Avoid concurrent anticoagulant therapy.
- Reversible renal shutdown has been observed with an excessive hematin dose (12.2 mg/kg in a single infusion). Strictly follow recommended dosage guidelines.
- PANHEMATIN may carry a risk of transmitting infectious agents, e.g., viruses, and theoretically, the Creutzfeldt-Jakob disease (CJD) agent.
- Most common adverse reactions in >1% of patients are headache, pyrexia, infusion site reactions, and phlebitis.
- **To report SUSPECTED ADVERSE REACTIONS, contact Recordati Rare Diseases Inc. at 1-888-575-8344, or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.**
- Avoid CYP inducing drugs such as estrogens, barbituric acid derivatives and steroid metabolites which induce δ-aminolevulinic acid synthetase 1 (ALAS1) through a feedback mechanism.
How to Order PANHEMATIN® (hemin for injection)

Contact:
- Your primary wholesaler, or
- ASD Healthcare
  - Phone: 1-800-746-6273
  - Fax: 1-800-547-9413
  - Email: asd.customerservice@asdhealthcare.com

Ordering tips:
- Orders placed Monday - Thursday by 6:30 pm central time:
  - Sent UPS Next Day Air Saver for mid-afternoon delivery
- Orders placed Friday by 6:00 pm central time:
  - Sent UPS Next Day Air Saver for Monday mid-afternoon delivery
  - For next day delivery, Saturday delivery must be requested
- Earlier, same day, and weekend delivery are available with an additional shipping cost
- Include any specific delivery instructions when ordering

Additional Phone Numbers
For assistance with insurance questions, patient assistance program, or copay assistance program, call: 1-866-209-7604.

For medical questions, call Recordati Rare Diseases Medical Information: 1-888-575-8344

To view a demonstration video of the information in this brochure, go to: www.Panhematin.com.
PANHEMATIN®
(hemin for injection)

For intravenous infusion only.

Initial U.S. Approval: 1983

INDICATIONS AND USAGE
PANHEMATIN is a hemin for injection indicated for amelioration of recurrent attacks of acute intermittent porphyria temporally related to the menstrual cycle in susceptible women, after initial carbohydrate therapy is known or suspected to be inadequate. (1)

Limitations of Use
- Before administering PANHEMATIN, consider an appropriate period of carbohydrate loading (i.e., 400 g glucose/day for 1 to 2 days). (1)
- PANHEMATIN is not effective in repairing neuronal damage due to progression of porphyria attacks. (1)

DOSAGE AND ADMINISTRATION

For intravenous infusion only.

- **Dose (2.1)**
  - 1 to 4 mg/kg/day for 3 to 14 days based on the clinical signs. The standard dose in clinical practice is 3 to 4 mg/kg/day.
  - Repeat dose in more severe cases no earlier than every 12 hours. Do not exceed 6 mg/kg in any 24 hour period.
- **Administration (2.2)**
  - Use sterile 0.45 micron or smaller filter to remove any undissolved particulate matter.
  - The dose may be administered directly from the vial over a period of at least 30 minutes.
  - After the infusion, flush the vein with 100 mL of 0.9% NaCl.

Dosage Calculation Table

<table>
<thead>
<tr>
<th>Hematin Equivalent</th>
<th>PANHEMATIN mL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 mg</td>
<td>0.14 mL PANHEMATIN</td>
</tr>
<tr>
<td>2 mg</td>
<td>0.28 mL PANHEMATIN</td>
</tr>
<tr>
<td>3 mg</td>
<td>0.42 mL PANHEMATIN</td>
</tr>
<tr>
<td>4 mg</td>
<td>0.56 mL PANHEMATIN</td>
</tr>
</tbody>
</table>

Monitor urinary concentrations of the following compounds during PANHEMATIN therapy. Effectiveness is demonstrated by a decrease in one or more of the following compounds:
- ALA - δ-aminolevulinic acid
- PBG - porphobilinogen
- Uroporphyrin
- Coproporphyrin

WARNINGS AND PRECAUTIONS
- Phlebitis is possible. Utilize a large arm vein or a central venous catheter for administration to minimize the risk of phlebitis. (5.1)
- Elevated iron and serum ferritin may occur. Monitor iron and serum ferritin in patients receiving multiple administrations of PANHEMATIN. (5.2)
- PANHEMATIN has transient and mild anticoagulant effect. Avoid concurrent anticoagulant therapy. (5.3)
- Reversible renal shutdown has been observed with an excessive hematin dose (12.2 mg/kg in a single infusion). Strictly follow recommended dosage guidelines. (5.4)
- PANHEMATIN may carry a risk of transmitting infectious agents, e.g., viruses, and theoretically, the Creutzfeldt-Jakob disease (CJD) agent. (5.5)

DRUG INTERACTIONS
- Avoid CYP inducing drugs such as estrogens, barbituric acid derivatives and steroid metabolites which induce δ-aminolevulinic acid synthetase 1 (ALAS1) through a feedback mechanism. (7)

See 17 for PATIENT COUNSELING INFORMATION.
6.2 Postmarketing Experience
The following adverse reactions associated with the use of PANHEMATIN were identified in open-label clinical trials or postmarketing reports. Because these reactions were reported voluntarily from a population of uncertain size, it is not always possible to estimate their frequency reliably or to establish a causal relationship to drug exposure.

Blood and Lymphatic System Disorders: thrombocytopenia, coagulopathy (including prolonged prothrombin time and prolonged partial thromboplastin time), and hemolysis

Immunologic System Disorders: hypersensitivity reactions including a report of infusion-related anaphylactoid reaction presenting as circulatory collapse

Vascular Disorders: injection site venous thrombosis including some that occurred in fatal cases

General Disorders and Administration Site Conditions: infusion site reactions (such as erythema, pain, bleeding and extravasation)

Metabolism and Nutrition Disorders: iron overload and serum ferritin increased

[See Warnings and Precautions (5.2)]

7 DRUG INTERACTIONS
PANHEMATIN therapy is intended to limit the rate of porphyrin/heme biosynthesis possibly by inhibiting the enzyme δ-aminolevulinic acid synthetase 1 (ALAS1) [See Clinical Pharmacology (12.1)]. Most of the heme synthesized in liver is used for the production of cytochrome P450 (CYP) enzymes. Therefore, avoid CYP inducing drugs (such as estrogens, barbituric acid derivatives and steroid metabolites) while on PANHEMATIN therapy, because these drugs increase the activity of ALAS leading to induction of ALAS1 through a feedback mechanism.

8 USE IN SPECIFIC POPULATIONS
8.1 Pregnancy
Risk Summary
About 30% of the women with acute intermittent porphyria experience an acute attack of porphyria in pregnancy and/or the puerperium. It is most severe in early pregnancy and the puerperium, and can result in fatal outcome. Although anecdotal evidence suggests safe use of hematin during pregnancy, the available human data is not sufficient to establish the presence or absence of drug-associated risk. Animal reproduction studies have not been conducted with hematin. It is also not known whether hematin can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. PANHEMATIN should be given to a pregnant woman only if clearly needed.

Avoid administering hematin in severe pre-eclampsia because of a theoretical risk of potentiation of the coagulation disorder [see Warnings and Precautions (5.3)].

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

8.2 Lactation
Risk Summary
It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, the developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for PANHEMATIN and any potential adverse effects on the breastfed child from PANHEMATIN or from the underlying maternal condition.

8.4 Pediatric Use
Safety and effectiveness in pediatric patients under 16 years of age have not been established.

8.5 Geriatric Use
Clinical data for subjects aged 65 and over was not sufficient to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in response between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dose range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

10 OVERDOSAGE
Reversible renal shutdown has been observed in a case where an excessive hematin dose (12.2 mg/kg) was administered in a single infusion. Oliguria and increased nitrogen retention occurred although the patient remained asymptomatic. No worsening of renal function has been seen with administration of recommended doses of hematin.

5.4 Renal Effects
Recommended dosage guidelines should be strictly followed. Reversible renal shutdown has been observed in a case where an excessive hematin dose (12.2 mg/kg) was administered in a single infusion. Oliguria and increased nitrogen retention occurred although the patient remained asymptomatic. No worsening of renal function has been seen with administration of recommended doses of hematin.

5.5 Transmissible Infectious Agents
Because PANHEMATIN is made from human blood, it may carry a risk of transmitting infectious agents, e.g., viruses, the variant Creutzfeldt-Jacob disease (vCJD) agent, and transfusion-transmitted infections, the acquired immunodeficiency syndrome (AIDS) agent (HIV). The risk that this product may transmit an infectious agent has been reduced by screening blood donors for prior exposure to certain viruses, by testing for the presence of certain current virus infections, and by inactivating certain viruses. Despite these measures, this product can still potentially transmit disease. There is also the possibility that unknown infectious agents may be present in the product.

All infections thought by a physician possibly to have been transmitted by this product should be reported by the physician or other healthcare provider to Recordati Rare Diseases at 1-888-575-8344.

6 ADVERSE REACTIONS
The most common adverse reactions (occurring in >1% of patients) are: headache, pyrexia, infusion site reactions, and phlebitis.

6.1 Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. The safety of PANHEMATIN use was evaluated in a compassionate use study. A total of 130 patients were treated with hemin for acute attacks, prophylaxis or both. Of those, 111 patients were administered hemin for treatment of 305 acute porphyria attacks and to 40 patients for prophylaxis. The majority (82%) of patients were Caucasian. Most (72%) were female; all adult patients had a mean age £ 40.3 ± 12.3 years. Proportionally more females (15 out of 19) received prophylaxis or a combination of acute treatment and prophylaxis (19 out of 21). For the treatment of acute attacks, patients received 2 to 4 mg/kg/day PANHEMATIN intravenously for 1 to 9 doses. For prophylaxis patients, the most common doses were weekly or biweekly infusions. Table 1 summarizes adverse reactions occurring in >1% of patients treated with PANHEMATIN, categorized by body system and order of decreasing frequency.

Table 1: Adverse Reactions in >1% of Patients Treated with PANHEMATIN

<table>
<thead>
<tr>
<th>System Organ Class</th>
<th>Preferred Term</th>
<th>Adverse Events</th>
<th>Description</th>
<th>Total</th>
<th>Possibly or Probably Related to Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Infections and infestations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cellulitis</td>
<td>3 (1.5%)</td>
<td>2 (1.0%)</td>
</tr>
<tr>
<td>Nervous System Disorders</td>
<td></td>
<td></td>
<td>Headache</td>
<td>18 (9.2%)</td>
<td>5 (2.6%)</td>
</tr>
<tr>
<td>Vascular Disorders</td>
<td></td>
<td></td>
<td>Phlebitis / Injection site phlebitis</td>
<td>7 (3.6%)</td>
<td>6 (3.1%)</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td></td>
<td></td>
<td>Rash</td>
<td>3 (1.5%)</td>
<td>3 (1.5%)</td>
</tr>
<tr>
<td>General Disorders and Administration Site Conditions</td>
<td></td>
<td></td>
<td>Pyrexia</td>
<td>9 (4.6%)</td>
<td>6 (3.1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Catheter-related Complication</td>
<td>7 (3.6%)</td>
<td>3 (1.5%)</td>
</tr>
</tbody>
</table>

PANHEMATIN is formatted as a sterile, lyophilized powder for intravenous administration after reconstitution. Each dispensing vial of PANHEMATIN contains the equivalent of 350 mg hematin, 240 mg sodium carbonate and 335 mg of sorbitol. The pH may have been adjusted with hydrochloric acid. When mixed as directed with Sterile Water for Injection, USP, each 48 mL provides the equivalent of approximately 336 mg hematin (7 mg/mL). The product contains no preservatives.
12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Heme acts to limit the hepatic and/or marrow synthesis of porphyrin. This action is likely due to the inhibition of δ-aminolevulinic acid synthetase, the enzyme which limits the rate of the porphyrin/heme biosynthetic pathway. The exact mechanism by which hemin produces symptomatic improvement in patients with acute episodes of the hepatic porphyrias has not been elucidated.

PANHEMATIN therapy for the acute porphyrias is not curative. After discontinuation of PANHEMATIN therapy, symptoms generally return although in some cases remission is prolonged. Some neurological symptoms have improved weeks to months after therapy although little or no response was noted at the time of treatment.

12.3 Pharmacokinetics

Following intravenous administration of hematin in non-judicied human patients, an increase in fecal urobilinogen can be observed which is roughly proportional to the amount of hematin administered. This suggests an enterohepatic pathway as at least one route of elimination. Bilirubin metabolites are also excreted in the urine following hematin injections.

Other aspects of human pharmacokinetics have not been defined.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

PANHEMATIN was not mutagenic in bacteria systems in vitro and was not clastogenic in mammalian systems in vitro and in vivo. No data are available on potential for carcinogenicity or impairment of fertility in animals.

14 CLINICAL STUDIES

The effectiveness of PANHEMATIN for the amelioration of recurrent attacks of acute intermittent porphyria was evaluated in five open-label studies, one compassionate-use study, case reports, and an observational study investigating patient reported outcomes in patients with acute porphyrias.

Open-Label Studies

In these initial 5 open-label studies, 1699 patients with acute porphyrias (72 with AIP) were treated with 3-4 mg/kg/day of hematin once or twice daily. Of the 99 patients in these studies, 30 received prior or concomitant glucagon administration. Patients experienced a clinical response in 85.5% (141/165) of treatment courses (Figure 1). Clinical response was defined by improvement of symptoms and reduction in pain. All patients experienced a chemical response which was defined as normalization of urinary aminolevulinic acid (ALA) and porphobilinogen (PBG).

Watson et al.1 studied the use of hematin in treatment in 15 patients with acute porphyrias, of whom 43 were with AIP. Out of 82 individual acute intermittent porphyrin attacks with 476 hematin infusions (82 treatment courses) administered, a clinical response was seen in 74 (90%) acute attacks. A chemical response was seen for those patients who had elevated urinary ALA and PBG levels prior to hematin treatment.

McColl et al.2 reported the use of 4 mg/kg of hematin IV in 13 attacks of acute porphyria in eight patients. Seven of these 8 patients had AIP. Five patients with AIP and female were two male with an age range of 19-45 years with biochemical evidence of AIP. Preparations of 4 mg/kg IV of hematin were infused at 12- or 24-hour intervals for 1 to 4 days after trials of glucose of various durations and dosages in all patients. All patients, with exception of one, experienced a clear clinical response most of which was rapid after hematin infusion. All patients also demonstrated a chemical response based on 58%-100% reduction in urinary ALA and PBG levels.

Pierach et al.3 examined the use of 2 to 4 mg/kg of hematin IV in 57 patients with acute porphyrias, of whom 43 were with AIP. Out of 82 individual acute intermittent porphyrin attacks with 476 hematin infusions (82 treatment courses) administered, a clinical response was seen in 74 (90%) acute attacks. A chemical response was seen for those patients who had elevated urinary ALA and PBG levels prior to hematin treatment.

Compassionate Use Study

In the compassionate use, multi-center, open-label, non-comparative study, 130 patients were enrolled with a diagnosis of acute porphyria and were treated with hematin. The patients were administered hematin for acute attacks [N=90 (69%)], prophylaxis [N=19 (15%)], or both [N=21 (16%)]. There was a subset of patients in the “both” group (acute attacks and prophylaxis) who were treated for acute attacks prior to receiving prophylactic treatment. Seventy-two percent of the patients were female and 28% were male. Hematin was administered to 111 patients (enrolled in the “acute attack” and the “both” treatment groups) for the treatment of 305 acute attacks and to 40 patients (enrolled in the “prophylaxis” and the “both” treatment groups) for prophylactic treatment. Out of the 40 patients who received prophylaxis, 19 received prophylaxis only and 21 patients were treated for up to 3 acute attacks prior to receiving prophylactic treatment. Prophylaxis treatment varied greatly in frequency with the most common hematin regimen given once a week. Clinical response was achieved if the physician determined that the admitting symptoms were resolved, there was a clinically acceptable response, or the patient went into remission.

A physician-assessed clinical response was achieved for all acute attacks in 81 (73%) of 111 patients. Ninety-four patients (85%) of 111 had ≥1 clinical response and 17 patients (15%) of 111 had no response. Among 31 of 40 patients who received hematin prophylaxis for >1 month, 21 (68%) did not require subsequent hematin treatment for acute attacks.

Case Reports

In 234 courses, patients received hematin therapy as normally prescribed by their physicians with the majority dosed between the recommended range of 3 mg/kg/day to 4 mg/kg/day for at least one course of treatment. In these patients, hematin treatment was administered immediately in 33% of recipients, within 1 day of symptom onset in 50%, and within 3 days in 75%. These groups were not mutually exclusive. Most patients [108[111 (97.3%)] received a dose of at least 3 mg/kg/day and only 3 patients (2.7%) received a dose of hematin less than 2 mg/kg/day. There were 6 patients (5.4%) who were administered doses exceeding 6 mg/kg/day for 1 or more treatment courses.

Observational Patient Reported Outcomes Study

An observational study investigated patient reported outcomes in 108 patients with acute porphyrias. Of 108 patients, 90 patients were with AIP and reported the following:

• 55% percent reported having received hematin during acute attacks, and 74% of these patients assessed PANHEMATIN therapy as very successful in the treatment of abdominal pain and other symptoms.
• 50% reported having received treatment with opiates during an acute attack, and 44% of these patients reported that opiates were effective.

Hematin therapy effectiveness was assessed along with glucose infusions, high carbohydrate diets, and pain medications on a scale from zero being least effective to 10 highly effective. Hematin infusions received a 7.9, glucose infusions 4.4 (p=0.0781), high carbohydrate diets a 4.7 (p=0.0021), and pain medications a 4.2 (p=0.0049).

15 REFERENCES


16 HOW SUPPLIED/STORAGE AND HANDLING

PANHEMATIN is supplied as a sterile, lyophilized black powder in single dose dispensing vials (NDC 55292-702-54) in a carton (NDC 55292-702-55). The vial stopper contains natural rubber latex.

Store lyophilized powder at 20-25°C (68-77°F).

17 PATIENT COUNSELING INFORMATION

• Advise the patient not to take drugs such as estrogens (e.g., oral contraceptives), barbiturates (drugs which help them to sleep and drugs sometimes used to treat epilepsy) or steroids (body hormone-like drugs), because this can trigger an attack or make the attack worse.
• Advise a female patient to inform the prescriber if she is pregnant or planning to become pregnant.

Manufactured by:
Xellia Pharmaceuticals USA, LLC
Raleigh, NC 27616

For:
Recordati Rare Diseases Inc.
Lebanon, NJ 08833, U.S.A.

U.S. Lic. No. 1899
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PP-PHT-US-0113