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)
1 Bottle Sterile Water for Injection, USP
1 60 mL syringe with 18-20 gauge needle
2 Alcohol wipes
1 Protective gloves

Infusion

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

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.
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• 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.
Important Phone Numbers

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

For assistance with insurance questions and patient financial assistance programs, call: **1-866-209-7604**

To order, contact your wholesaler or ASD directly: **1-800-746-6273**

You are encouraged to report adverse events to the FDA. Visit www.fda.gov/MedWatch, or call: **1-800-FDA-1088**

To view a demonstration video of the information in this brochure, go to: www.Panhematin.com.
HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use PANHEMATIN safely and effectively. See full prescribing information for PANHEMATIN.

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

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<thead>
<tr>
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<tr>
<td>1 mg</td>
<td>1.84 mL</td>
</tr>
<tr>
<td>2 mg</td>
<td>3.68 mL</td>
</tr>
<tr>
<td>3 mg</td>
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ADVERSE REACTIONS

PANHEMATIN is not effective in repairing neuronal damage due to progression of porphyria attacks. (1)

• 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)

WARNINGS AND PRECAUTIONS

Most common adverse reactions in >1% of patients are headache, pyrexia, infusion site reactions, and phlebitis. (6.1)

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.

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.

Revised: 12/2016

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The dose of PANHEMATIN is 1 to 4 mg/kg/day of hematin for 3 to 14 days based on the clinical signs. The standard dose in clinical practice is 3 to 4 mg/kg/day. In more severe cases this dose may be repeated no earlier than every 12 hours. Do not exceed 6 mg/kg of hematin in any 24 hour period. After reconstitution each mL of PANHEMATIN contains the equivalent of approximately 7 mg of hematin (see dosage calculation table below).

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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

2.2 Preparation and Administration

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

Reconstitute PANHEMATIN by aseptically adding 48 mL of Sterile Water for Injection, USP, to the dispensing vial. Shake the vial well for a period of 2 to 3 minutes to aid dissolution.

PANHEMATIN may be administered directly from the vial. After the first withdrawal from the vial, discard any solution remaining.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit. Since reconstituted PANHEMATIN is not transparent, any undissolved particulate matter is difficult to see when inspected visually. Therefore, terminal filtration through a sterile 0.45 micron or smaller filter is recommended.

Do not add other drug or chemical agent to a PANHEMATIN fluid admixture.

Infuse the dose over a period of at least 30 minutes via a separate line.

After the infusion, flush the vein with 100 mL of 0.9% NaCl.

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Uroporphyrin
Coproporphyrin
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

Immune 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 large veins such as vein cave

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

7 DRUG INTERACTIONS

PANHEMATIN therapy is intended to limit the rate of porphyria/heme biosynthesis possibly by inhibiting the enzyme 8-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 50% 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 dosing 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 [see Warnings and Precautions (5.4)]. Treatment of this case consisted of ethacrynic acid and mannitol.

11 DESCRIPTION

PANHEMATIN (hemin for injection) is an enzyme inhibitor derived from processed red blood cells. Hemin for injection was known previously as hematin. The term hematin has been used to describe the chemical reaction product of heme and sodium carbonate. Hemin and hematin are iron containing metahemoporphyrin complexes with either bound chloride or hydroxide ions, respectively. Chemically hemin is represented as chloro[7,12-diethynyl-3.8.13.17-tetramethyl-21H,23H-porphine-2,18-dipropanoato(2-)-N1,N3,N3,N3] iron. The structural formula for hemin is:

PANHEMATIN is formulated as a sterile, lyophilized powder for intravenous administration after reconstitution. Each dispensing vial of PANHEMATIN contains the equivalent of 350 mg hemin, 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.
PANHEMATIN therapy for the acute porphyrias is not curative. After discontinuation of PANHEMATIN treatment, 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-jaundiced 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 mechanism by which hematin produces symptomatic improvement in patients with acute episodes of the hepatic porphyrias has not been elucidated.

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 established in five open-label studies, one compassionate-use multi-center open-label non-comparative study, case reports in patients who had acute intermittent porphyria, and an observational study investigating patient reported outcomes in 108 patients with acute porphyrias.

In these initial 5 open-label studies, 99 patients with acute porphyrias (72 with AIP) were treated with 3-4 mg/kg/day of heminin once or twice daily. Of the 99 patients in these studies, 30 received prior or concomitant glucose 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). Seventy-four percent of the AIP patients in the observational study investigating patient reported outcomes assessed PANHEMATIN therapy as very successful in the treatment of abdominal pain and other symptoms.

Watson et al. studied the use of hematin treatment in 15 patients with acute porphyrias, of whom 11 were with AIP. Seven patients were female and four were male with an age range of 18-65 years with biochemical evidence of AIP. Preparations of 4 mg/kg IV of hematin were infused at 12-24 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 50%-100% reduction in urinary ALA and PBG levels.

Pierach et al. 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 porphyria 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.

McCull et al. reported the use of 4 mg/kg of hematin IV given either every 12 or 24 hours for three to five days in the treatment of 13 attacks of acute porphyria in eight patients. Seven of these 8 patients had AIP. Five patients with AIP were female and two were male with a mean age of 25 years (range 19-31 years). All patients had biochemistry and clinical evidence of an attack of acute porphyria at the time of hematin administration. All patients had a chemical response of approximately 50% reduction in urinary ALA and PBG from pre-treatment values. In addition, clinical response was seen after hematin treatment in a total of 7 attacks in 5 AIP patients.

Lamon et al. reported on 12 patients with acute porphyrias, of whom 11 were with AIP. These AIP patients received 190 infusions of approximately 2 to 4 mg/kg of hematin IV given every 12 or 24 hours for 3 to 13 days as 20 separate courses of treatment, when high carbohydrate intake (300 g for a minimum of 72 hours) and supportive measures were unsuccessful. Urinary ALA and PBG levels were collected as well as clinical signs and symptoms of AIP recorded. Out of 20 treatment courses for acute attacks, there was a clinical response in 14. All patients had significant reductions in ALA and/or PBG levels after hematin treatment (p-value in the range from less than 0.001 to 0.05).

In another observational study by Lamon et al. seven patients with acute attacks of porphyria were administered 11 hematin courses (each course: 1 mg/kg every 24 hours for 3 to 13 days). Before and during hematin administration, patients were maintained on a 250-300 g/24H carbohydrate diet. Patients had elevated urinary ALA and PBG treatment and clinical evidence of an acute attack. Chemical response of a decrease in ALA and PBG occurred in every patient (except one PBG value in one patient) when treatment lasted 5 days or longer (p<0.001).

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.

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.

An observational study investigated patient reported outcomes in 108 patients with acute porphyrias. Out 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.

Hemin therapy effectiveness was assessed alongside 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 a 4.4 (p=0.0781), high carbohydrate diets a 4.7 (p=0.0021), and pain medications a 4.2 (p=0.0049).

Hemin therapy was well tolerated in all patients. There were no serious or life-threatening adverse events, although little or no response was noted at the time of treatment. Some patients experienced prolonged abdominal pain and other symptoms. Some neurological symptoms have improved weeks to months after therapy although little or no response was noted at the time of treatment. In some cases, remission was prolonged. Some neurological symptoms have improved weeks to months after therapy although little or no response was noted at the time of treatment. In some cases, remission was prolonged. Some neurological symptoms have improved weeks to months after therapy although little or no response was noted at the time of treatment. In some cases, remission was prolonged. Some neurological symptoms have improved weeks to months after therapy although little or no response was noted at the time of treatment. In some cases, remission was prolonged. Some neurological symptoms have improved weeks to months after therapy although little or no response was noted at the time of treatment. In some cases, remission was prolonged.