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.
• 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: service@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)

DOSE 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.

ADVERSE REACTIONS

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: 05/2020

Dosage Calculation Table

| Dose of PANHEMATIN (mg/kg/day) | Equivalent Hematin (mg) | mL PANHEMATIN
|-------------------------------|-------------------------|-----------------
| 1                             | 1.45                    | 14.5 mL PANHEMATIN
| 2                             | 2.9                       | 29 mL PANHEMATIN
| 3                             | 4.35                    | 43.5 mL PANHEMATIN
| 4                             | 5.8                      | 58 mL PANHEMATIN

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* Sections or subsections omitted from the full prescribing information are not listed.
Table 1: Adverse Reactions in >1% of Patients Treated with PANHEMATIN

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.

### 5.1 Risk of Phlebitis
A large arm vein or a central venous catheter should be utilized for the administration of PANHEMATIN to minimize the risk of phlebitis.

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. [See Dosage and Administration (2.2)]

### 5.2 Iron and Serum Ferritin

Because increased levels of iron and serum ferritin have been reported in post-marketing experience, physicians must monitor iron and serum ferritin in patients receiving multiple administrations of PANHEMATIN [See Adverse Reactions (6.2)]. In case of elevated iron or serum ferritin levels, consider iron chelation therapy.

### 5.3 Anticoagulant Effects

Because PANHEMATIN has exhibited transient, mild anticoagulant effects during clinical studies, avoid concurrent anticoagulant therapy. The extent and duration of the hypocoagulable state induced by PANHEMATIN has not been established.

### 5.4 Renal Effects

Recommended dosage guidelines should be strictly followed. Reversible renal shutdown has been observed in a case where an excessive hematid 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 dosages 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 Creutzfeldt-Jacob disease (TtCJD) agent. 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 hematin for acute attacks, prophylaxis or both. Of those, 111 patients were administered hematin for treatment of 305 acute porphyria attacks including 60 patients for prophylaxis. The majority (92%) of patients were Caucasian. Most (72%) patients were administered hematin for treatment of 305 acute porphyria attacks and to prevent the occurrence of new attacks.

Because clinical trials are conducted under widely varying conditions, adverse reaction frequencies below may not reflect the rates observed in practice.

#### 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.

### 7 DRUG INTERACTIONS

PANHEMATIN therapy is intended to limit the rate of porphyria/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 (e.g., certain 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, nursing mothers should be encouraged to nurse their infants only if the potential benefit justifies the potential risk to the infant.

#### 8.3 Pediatric Use

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

#### 8.4 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 OVERDOSE

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 designate the chemical reaction product of heme and sodium carbonate solution. Hemin and hematin are iron containing metalloporphyrin complexes with either bound chloride or hydroxide ions, respectively. Chemically hemin is represented as chloro[7,12-diethylenyl]-8,13,17-tetramethyl-21H,23H-porphine-2,18-dipropanoato(2-)N\textsuperscript{3},N\textsuperscript{2},N\textsuperscript{4},N\textsuperscript{7}] iron. The structural formula for hematin is:

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 treatment, acute attacks 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 heme in non-jaundiced human patients, an
increase in fecal urobilinogen can be observed which is roughly proportional to the
amount of heme administered. This suggests an enterohepatic pathway as at least one
route of elimination. Bilirubin metabolites are also excreted in the urine following heme
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 bacterial 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, 1-5 99 patients with acute porphyrias (72 with AIP)
were treated with 3-4 mg/kg/day of heme 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).

Watson et al.1 studied the use of heme 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 19-45 years with biochemical evidence of AIP. Preparations of 4 mg/kg IV of
heme 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 heme infusion. All patients also demonstrated a chemical response based on 58%-100% reduction in
urinary ALA and PBG levels.

Pierach et al.2 examined the use of 2 to 4 mg/kg of heme IV in 57 patients with acute porphyrias,
of whom 43 were with AIP. Out of 82 individual acute intermittent porphyria attacks with 476 heme 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 heme treatment.

McColl et al.3 reported the use of 4 mg/kg of heme 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 biochemical and clinical
evidence of an attack of acute porphyrin at the time of heme 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 heme treatment in a total of 7 attacks in 5 AIP patients.

Lamon et al.4 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 heme 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 heme treatment (p-value in the range from less than 0.001 to 0.05).

In another study by Lamon et al.5 seven patients with acute attacks of porphyria were
administered 11 heme courses (each course: 1 mg/kg every 24 hours for 3 to 13 days).
Before and during heme administration, patients were maintained on a 250-300 g/24-
high 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).

Before and during heme administration, patients were maintained on a 250-300 g/24-
high 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).

In 234 courses, patients received heme 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, heme 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
heme 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. Out of 108 patients, 90 patients were with AIP and reported the following:
• 55% reported having received heme 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.

Heme therapy effectiveness was assessed along with glucose infusions, high
right carbohydrate diets, and pain medications on a scale from zero being least effective to 10
highly effective. Heme 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).

15 REFERENCES

1. Watson, CJ, et al., Use of Hemin in the Acute Attack of the “Inducible” Hepatic
2. Pierach CA, Bossenmaier I, Cardinal R, Weiner M, Watson CJ. Hemin therapy in
porphyrias in the USA: features of 108 subjects from porphyrias consortium. Am J

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.

Figure 1: Efficacy Data on Hemin in Acute Intermittent Porphyria from 5 Open-Label Studies
• Advise a female patient to inform the prescriber if she is pregnant or planning to become pregnant.