PANHEMATIN®
(HEMIN FOR INJECTION)
Dosing, preparation, and infusion instructions

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.
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.

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PANHEMATIN is available as a sterile, lyophilized powder for reconstitution for injection. Each vial contains the equivalent of 350 mg hemin, 240 mg sodium carbonate and 335 mg of 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). (3)

CONTRAINDICATIONS
Do not use in patients with known hypersensitivity to PANHEMATIN. (4)

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)

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.

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* Sections or subsections omitted from the full prescribing information are not listed.

• 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).

<table>
<thead>
<tr>
<th>Dosage Calculation Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 mg hematin equivalent = 0.14 mL PANHEMATIN</td>
</tr>
<tr>
<td>2 mg hematin equivalent = 0.28 mL PANHEMATIN</td>
</tr>
<tr>
<td>3 mg hematin equivalent = 0.42 mL PANHEMATIN</td>
</tr>
<tr>
<td>4 mg hematin equivalent = 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

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.

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.
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 infused 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 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 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 Creuzfeldt-Jacob disease (vCJD) agent, and theoretically the Creuzfeldt-Jacob disease (CJD) 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 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 160 patients were treated with hematin for acute attacks, prophylaxis or both. Of these, 11% of patients were administered hemin for treatment of 305 acute porphyria attacks and to 40 patients for prophylaxis. The majority (92%) of patients were Caucasian. Most (72%) were female; all adult patients had a mean age ± SD of 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 of PANHEMATIN intravenously for 1 to 9 doses. For prophylaxis patients, the most common dosages 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 N (% of Total Adverse Events)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections and infestations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cellulitis</td>
<td>3 (1.5%)</td>
<td>2 (1.0%)</td>
</tr>
<tr>
<td>Nervous System Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>18 (9.2%)</td>
<td>5 (2.6%)</td>
</tr>
<tr>
<td>Vascular Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phlebitis / Infusion 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>
</tr>
<tr>
<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>
</tr>
<tr>
<td>Pyrexia</td>
<td>9 (4.6%)</td>
<td>6 (3.1%)</td>
</tr>
<tr>
<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.
In another study by Lamon et al. seven patients with acute attacks of porphyria were treated with 3-4 mg/kg/day of hemin 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). A 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. studied the use of hemin 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 hemin 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 hemin infusion. All patients also demonstrated a chemical response based on 58%-100% reduction in urinary ALA and PBG levels.

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

McColl et al. reported the use of 4 mg/kg of hemin 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 porphyria at the time of hemin administration. All patients had a clinical response of approximately 50% reduction in urinary ALA and PBG from pre-treatment values. In addition, clinical response was seen after hemin 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 hemin 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 hemin treatment (p-value in the range of less than 0.001 to 0.05).

In another study by Lamon et al. seven patients with acute attacks of porphyria were administered 11 hemin courses (each course: 1 mg/kg every 24 hours for 3 to 10 days). Before and during hemin 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).

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 hemin. The patients were administered hemin 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 (17 patients who had elevated urinary ALA and PBG levels prior to hemin treatment, and 21 patients were treated for up to 3 acute attacks prior to receiving prophyactic treatment). Prophylaxis treatment varied greatly in frequency with the most common hemin regimen given once a week. Clinical response was achieved if the physician determined that the admitted 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 hemin prophylaxis for >1 month, 21 (68%) did not require subsequent hemin treatment for acute attacks.

Open-Label Study
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 hemin 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). A clinical response was defined by improvement of symptoms and reduction in pain. All patients also demonstrated a chemical response based on 58%-100% reduction in urinary ALA and PBG levels.

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 hemin. The patients were administered hemin 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 (17 patients who had elevated urinary ALA and PBG levels prior to hemin treatment, and 21 patients were treated for up to 3 acute attacks prior to receiving prophyactic treatment). Prophylaxis treatment varied greatly in frequency with the most common hemin regimen given once a week. Clinical response was achieved if the physician determined that the admitted 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 hemin prophylaxis for >1 month, 21 (68%) did not require subsequent hemin treatment for acute attacks.

Case Reports
In 334 courses, patients received hemin 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, hemin 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 doses of at least 3 mg/kg/day and only 3 patients (2.7%) received a dose of hemin 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 porphyria. Out of 108 patients, 90 patients were with AIP and reported the following: 55% of patients reported having received hemin 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 along with glucose infusions, high carbohydrate diets, and pain medications on a scale from zero being least effective to 10 highly effective. Hemin 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
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).

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:
Xella 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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