

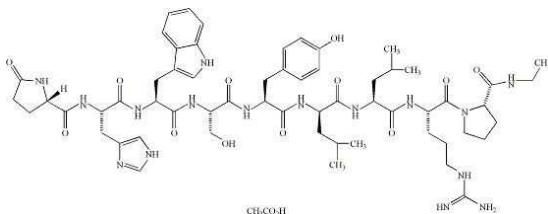
ELIGARD® 7.5mg, 22.5 mg, 30 mg, 45 mg
(leuprolide acetate for injectable suspension)

Rx Only

DESCRIPTION

ELIGARD® is a sterile polymeric matrix formulation of leuprolide acetate for subcutaneous injection. It is designed to deliver leuprolide acetate at a controlled rate over a one-, three-, four- or six-month therapeutic period.

Leuprolide acetate is a synthetic nonapeptide analog of naturally occurring gonadotropin releasing hormone (GnRH or LH-RH) that, when given continuously, inhibits pituitary gonadotropin secretion and suppresses testicular and ovarian steroidogenesis. The analog possesses greater potency than the natural hormone. The chemical name is 5-oxo-L-prolyl-L-histidyl-L-tryptophyl-L-seryl-L-tyrosyl-D-leucyl-L-leucyl-L-arginyl-N-ethyl-L-prolinamide acetate (salt) with the following structural formula:



ELIGARD® is prefilled and supplied in two separate, sterile syringes whose contents are mixed immediately prior to administration. The two syringes are joined and the single dose product is mixed until it is homogenous. ELIGARD® is administered subcutaneously, where it forms a solid drug delivery depot.

One syringe contains the ATRIGEL® Delivery System and the other contains leuprolide acetate. ATRIGEL® is a polymeric (non-gelatin containing) delivery system consisting of a biodegradable poly (DL-lactide-co-glycolide) (PLGH or PLG) polymer formulation dissolved in a biocompatible solvent, N-methyl-2-pyrrolidone (NMP).

Refer to Table 1 for the delivery system composition and constituted product formulation for each ELIGARD® product.

Table 1. ELIGARD® Delivery System Composition and Constituted Product Formulation

		ELIGARD® 7.5 mg	ELIGARD® 22.5 mg	ELIGARD® 30 mg	ELIGARD® 45 mg
ATRIGEL® Delivery System Syringe	Polymer	PLGH	PLG	PLG	PLG
	Polymer description	Copolymer containing carboxyl endgroups	Copolymer with hexanediol	Copolymer with hexanediol	Copolymer with hexanediol
	Polymer DL-lactide to Glycolide Molar Ratio	50:50	75:25	75:25	85:15
Constituted Product	Polymer delivered	82.5 mg	158.6 mg	211.5 mg	165 mg
	NMP delivered	160.0 mg	193.9 mg	258.5 mg	165 mg
	Leuprolide acetate delivered	7.5 mg	22.5 mg	30 mg	45 mg
	Approximate Leuprolide free base equivalent	7.0 mg	21 mg	28 mg	42 mg
	Approximate administered formulation weight	250 mg	375 mg	500 mg	375 mg
	Approximate injection volume	0.25 mL	0.375 mL	0.5 mL	0.375 mL

CLINICAL PHARMACOLOGY

Leuprolide acetate, an LH-RH agonist, acts as a potent inhibitor of gonadotropin secretion when given continuously in therapeutic doses. Animal and human studies indicate that after an initial stimulation, chronic administration of leuprolide acetate results in suppression of testicular and ovarian steroidogenesis. This effect is reversible upon discontinuation of drug therapy.

In humans, administration of leuprolide acetate results in an initial increase in circulating levels of luteinizing hormone (LH) and follicle stimulating hormone (FSH), leading to a transient increase in levels of the gonadal steroids (testosterone and dihydrotestosterone in males, and estrone and estradiol in premenopausal females). However, continuous administration of leuprolide acetate results in decreased levels of LH and FSH. In males, testosterone is reduced to below castrate threshold (≤ 50 ng/dL). These decreases occur within two to four weeks after initiation of treatment. Long-term studies have shown that continuation of therapy with leuprolide acetate maintains testosterone below the castrate level for up to seven years.

PHARMACODYNAMICS

Following the first dose of ELIGARD®, mean serum testosterone concentrations transiently increased, then fell to below castrate threshold (≤ 50 ng/dL) within three weeks for all ELIGARD® concentrations.

Continued monthly treatment with ELIGARD® 7.5 mg maintained castrate testosterone suppression throughout the study. No breakthrough of testosterone concentrations above castrate threshold (> 50 ng/dL) occurred at any time during the study once castrate suppression was achieved (Figure 1).

One patient received less than a full dose of ELIGARD® 22.5 mg at baseline, never suppressed and withdrew from the study at Day 73. Of the 116 patients remaining in the study, 115 (99%) had serum testosterone levels below the castrate threshold by Month 1 (Day 28). By Day 35, 116 (100%) had serum testosterone levels below the castrate threshold. Once testosterone suppression was achieved, one patient ($< 1\%$) demonstrated breakthrough (concentrations > 50 ng/dL after achieving castrate levels) following the initial injection; that patient remained below the castrate threshold following the second injection (Figure 2).

One patient withdrew from the ELIGARD® 30 mg study at Day 14. Of the 89 patients remaining in the study, 85 (96%) had serum testosterone levels below the castrate threshold by Month 1 (Day 28). By Day 42, 89 (100%) of patients attained castrate testosterone suppression. Once castrate testosterone suppression was achieved, three patients (3%) demonstrated breakthrough (concentrations > 50 ng/dL after achieving castrate levels) (Figure 3).

One patient at Day 1 and another patient at Day 29 were withdrawn from the ELIGARD® 45 mg study. Of the 109 patients remaining in the study, 108 (99.1%) had serum testosterone levels below the castrate threshold by Month 1 (Day 28). One patient did not achieve castrate suppression and was withdrawn from the study at Day 85. Once castrate testosterone suppression was achieved, one patient ($< 1\%$) demonstrated breakthrough (concentrations > 50 ng/dL after achieving castrate levels) (Figure 4).

Leuprolide acetate is not active when given orally.

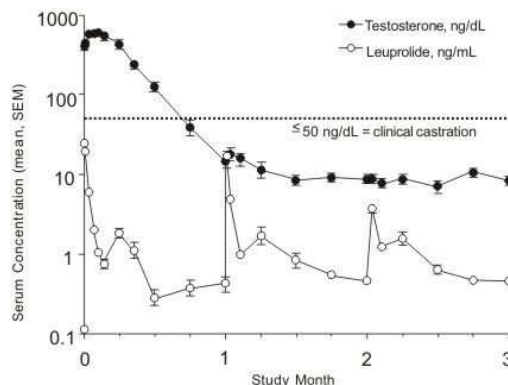
PHARMACOKINETICS

Absorption

ELIGARD® 7.5 mg

The pharmacokinetics/pharmacodynamics observed during three once-monthly injections in 20 patients with advanced prostate cancer is shown in Figure 1. Mean serum leuprolide concentrations following the initial injection rose to 25.3 ng/mL (C_{max}) at approximately 5 hours after injection. After the initial increase following each injection, serum concentrations remained relatively constant (0.28 – 2.00 ng/mL).

Figure 1 Pharmacokinetic/Pharmacodynamic Response (N=20) to ELIGARD® 7.5 mg – Patients Dosed Initially and at Months 1 and 2

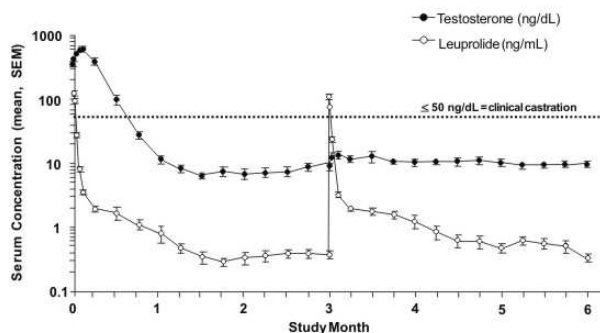


A reduced number of sampling timepoints resulted in the apparent decrease in C_{max} values with the second and third doses of ELIGARD® 7.5 mg (Figure 1).

ELIGARD® 22.5 mg

The pharmacokinetics/pharmacodynamics observed during two injections every three months (ELIGARD® 22.5 mg) in 22 patients with advanced prostate cancer is shown in Figure 2. Mean serum leuprolide concentrations rose to 127 ng/mL and 107 ng/mL at approximately 5 hours following the initial and second injections, respectively. After the initial increase following each injection, serum concentrations remained relatively constant (0.2 – 2.0 ng/mL).

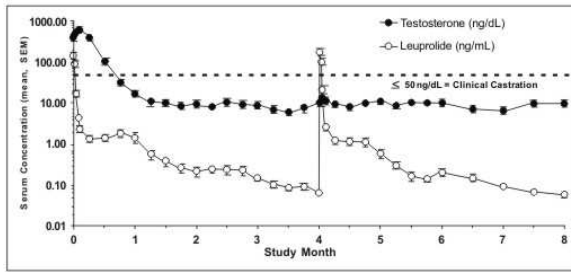
Figure 2 Pharmacokinetic/Pharmacodynamic Response (N=22) to ELIGARD® 22.5 mg – Patients Dosed Initially and at Month 3



ELIGARD® 30 mg

The pharmacokinetics/pharmacodynamics observed during injections administered initially and at four months (ELIGARD® 30 mg) in 24 patients with advanced prostate cancer is shown in Figure 3. Mean serum leuprolide concentrations following the initial injection rose rapidly to 150 ng/mL (C_{max}) at approximately 3.3 hours after injection. After the initial increase following each injection, mean serum concentrations remained relatively constant (0.1 – 1.0 ng/mL).

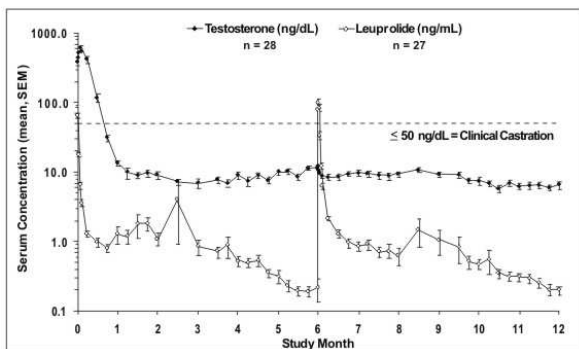
Figure 3 Pharmacokinetic/Pharmacodynamic Response (N=24) to ELIGARD® 30 mg – Patients Dosed Initially and at Month 4



ELIGARD® 45 mg

The pharmacokinetics/pharmacodynamics observed during injections administered initially and at six months (ELIGARD® 45 mg) in 27 patients with advanced prostate cancer is shown in Figure 4. Mean serum leuprolide concentrations rose to 82.0 ng/mL and 102 ng/mL (C_{max}) at approximately 4.5 hours following the initial and second injections, respectively. After the initial increase following each injection, mean serum concentrations remained relatively constant (0.2 – 2.0 ng/mL).

Figure 4 Pharmacokinetic/Pharmacodynamic Response (N=27) to ELIGARD® 45 mg – Patients Dosed Initially and at Month 6



There was no evidence of significant accumulation during repeated dosing. Nondetectable leuprolide plasma concentrations have been occasionally observed during ELIGARD® administration, but testosterone levels were maintained at castrate levels.

Distribution

The mean steady-state volume of distribution of leuprolide following intravenous bolus administration to healthy male volunteers was 27 L.¹ In vitro binding to human plasma proteins ranged from 43% to 49%.

¹Sennello LT et al. Single-dose pharmacokinetics of leuprolide in humans following intravenous and subcutaneous administration. *J Pharm Sci* 1986; 75(2): 158–160.

Metabolism

In healthy male volunteers, a 1-mg bolus of leuprolide administered intravenously revealed that the mean systemic clearance was 8.34 L/h, with a terminal elimination half-life of approximately 3 hours based on a two compartment model.¹

No drug metabolism study was conducted with ELIGARD®. Upon administration with different leuprolide acetate formulations, the major metabolite of leuprolide acetate is a pentapeptide (M-1) metabolite.

Excretion

No drug excretion study was conducted with ELIGARD®.

Special Populations

Geriatrics

The majority of the patients (approximately 70%) studied in the clinical trials were age 70 and older.

Pediatrics

The safety and effectiveness of ELIGARD® in pediatric patients have not been established (see **CONTRAINDICATIONS**).

Race

In patients studied, mean serum leuprolide concentrations were similar regardless of race. Refer to Table 2 for distribution of study patients by race.

Table 2. Race Characterization of Study Patients

Race	ELIGARD® 7.5 mg	ELIGARD® 22.5 mg	ELIGARD® 30 mg	ELIGARD® 45 mg
White	26	19	18	17
Black	-	4	4	7
Hispanic	2	2	2	3

Renal and Hepatic Insufficiency

The pharmacokinetics of ELIGARD® in hepatically and renally impaired patients have not been determined.

Drug-Drug Interactions

No pharmacokinetic drug-drug interaction studies were conducted with ELIGARD®.

CLINICAL STUDIES

One open-label, multicenter study was conducted with each ELIGARD® formulation (7.5 mg, 22.5 mg, 30 mg, and 45 mg) in patients with Jewett stage A through D prostate cancer who were treated with at least a single injection of study drug (Table 3). These studies evaluated the achievement and maintenance of castrate serum testosterone suppression over the duration of therapy (Figures 5–8). During the AGL9904 study using ELIGARD® 7.5 mg, once testosterone suppression was achieved, no patients (0%) demonstrated breakthrough (concentration >50 ng/dL) at any time in the study.

During the AGL9909 study using ELIGARD® 22.5 mg, once testosterone suppression was achieved, only one patient (< 1%) demonstrated breakthrough following the initial injection; that patient remained below the castrate threshold following the second injection.

During the AGL0001 study using ELIGARD® 30 mg, once testosterone suppression was achieved, three patients (3%) demonstrated breakthrough. In the first of these patients, a single serum testosterone concentration of 53 ng/dL was reported on the day after the second injection. In this patient, castrate suppression was reported for all other timepoints. In the second patient, a serum testosterone concentration of 66 ng/dL was reported immediately prior to the second injection. This rose to a maximum concentration of 147 ng/dL on the second day after the second injection. In this patient, castrate suppression was again reached on the seventh day after the second injection and was maintained thereafter. In the final patient, serum testosterone concentrations > 50 ng/dL were reported at 2 and at 8 hours after the second injection. Serum testosterone concentration rose to a maximum of 110 ng/dL on the third day after the second injection. In this patient, castrate suppression was again reached eighteen days after the second injection and was maintained until the final day of the study, when a single serum testosterone concentration of 55 ng/dL was reported.

During the AGL0205 study using ELIGARD® 45 mg, once testosterone suppression was achieved, one patient (<1%) demonstrated breakthrough. This patient reached castrate suppression at Day 21 and remained suppressed until Day 308 when his testosterone level rose to 112 ng/dL. At Month 12 (Day 336), his testosterone was 210 ng/dL.

Table 3. Summary of ELIGARD® Clinical Studies

	7.5 mg	22.5 mg	30 mg	45 mg	
Study number	AGL9904	AGL9909	AGL0001	AGL0205	
Total Number of patients	120 (117 completed)	117* (111 completed [†])	90 (82 completed [‡])	111 (103 completed [§])	
Jewett Stages	Stage A	2	2	5	
	Stage B	-	19	38	43
	Stage C	89	60	16	19
	Stage D	31	36	34	44
Treatment	6 monthly injections	1 injection (4 patients)	1 injection (5 patients)	1 injection (5 patients)	
		2 injections, one every three months (113 patients)	2 injections, one every four months (85 patients)	2 injections, one every six months (106 patients)	
Duration of therapy	6 months	6 months	8 months	12 months	
Mean testosterone concentration (ng/dL)	Baseline	361.3	367.1	385.5	367.7
	Day 2	574.6 (Day 3)	588.0	610.0	588.6
	Day 14	Below Baseline (Day 10)	Below Baseline	Below Baseline	Below Baseline
	Day 28	21.8	27.7 (Day 21)	17.2	16.7
	Conclusion	6.1	10.1	12.4	12.6
	Number of patients below castrate threshold (≤ 50 ng/dL)	Day 28	112 of 119 (94.1%)	115 of 116 (99%)	85 of 89 (96%)
Day 35		-	116 (100%)	-	-
Day 42		119 (100%)	-	89 (100%)	-
Conclusion		117 [¶] (100%)	111 (100%)	81 (99%)	102 (99%)

*One patient received less than a full dose at Baseline, never suppressed, and was withdrawn at Day 73 and given an alternate treatment.

[†]All non-evaluable patients who attained castration by Day 28 maintained castration at each timepoint up to and including the time of withdrawal.

[‡]One patient withdrew on Day 14. All 7 non-evaluable patients who had achieved castration by Day 28 maintained castration at each timepoint, up to and including the time of withdrawal.

[§]Two patients were withdrawn prior to the Month 1 blood draw. One patient did not achieve castration and was withdrawn on Day 85. All 5 non-evaluable patients who attained castration by Day 28, maintained castration at each timepoint up to and including the time of withdrawal.

[¶]Two patients withdrew for reasons unrelated to drug.

Figure 5 ELIGARD® 7.5 mg Mean Serum Testosterone Concentrations (n=117)

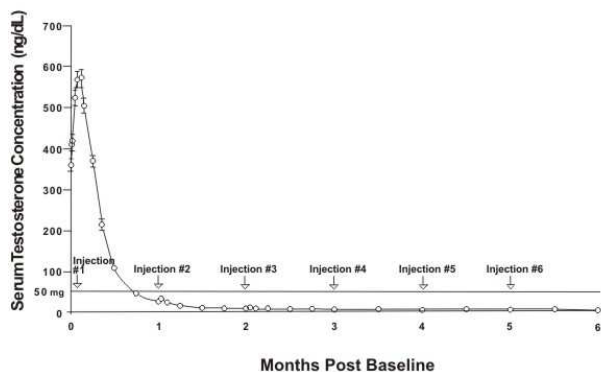


Figure 6 ELIGARD® 22.5 mg Mean Serum Testosterone Concentrations (n=111)

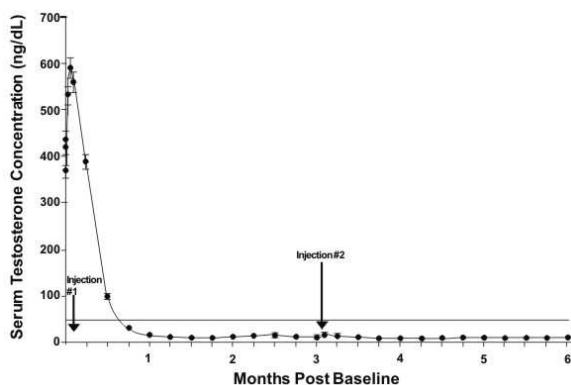


Figure 7 ELIGARD® 30 mg Mean Serum Testosterone Concentrations (n=90)

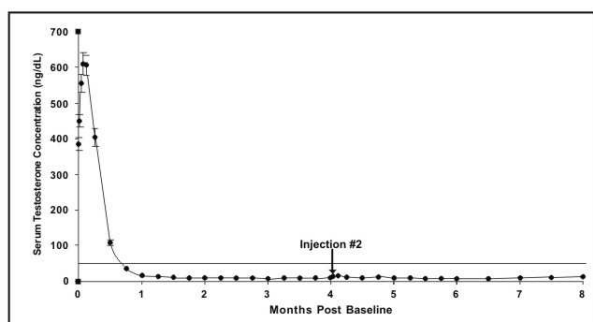
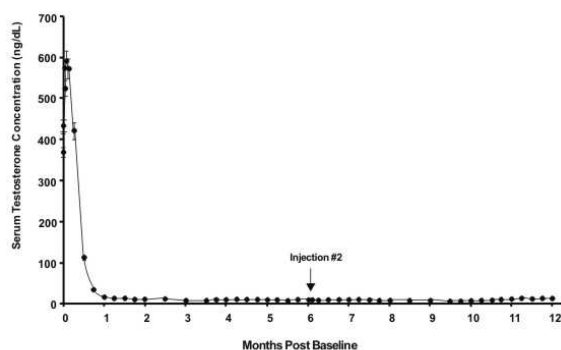


Figure 8 ELIGARD® 45 mg Mean Serum Testosterone Concentrations (n=103)



Serum PSA decreased in all patients in all studies whose Baseline values were elevated above the normal limit. Refer to Table 4 for a summary of the effectiveness of ELIGARD® in reducing serum PSA values.

Table 4 Effect of ELIGARD® on Patient Serum PSA Values

ELIGARD®	7.5 mg	22.5 mg	30 mg	45 mg
Mean PSA Reduction at Study Conclusion	94%	98%	86%	97%
Patients with Normal PSA at Study Conclusion*	94%	91%	93%	95%

*Among patients who presented with elevated levels at Baseline

Other secondary efficacy endpoints evaluated included WHO performance status, bone pain, urinary pain and urinary signs and symptoms. Refer to Table 5 for a summary of these endpoints.

Table 5 Secondary Efficacy Endpoints

		ELIGARD® 7.5 mg	ELIGARD® 22.5 mg	ELIGARD® 30 mg	ELIGARD® 45 mg
Baseline	WHO Status = 0 [†]	88%	94%	90%	90%
	WHO Status = 1 [†]	11%	6%	10%	7%
	WHO Status = 2 [‡]				3%
	Mean Bone Pain [§] (range)	1.22 (1–9)	1.20 (1–9)	1.20 (1–7)	1.38 (1–7)
	Mean Urinary Pain (range)	1.12 (1–5)	1.02 (1–2)	1.01 (1–2)	1.22 (1–8)
	Mean Urinary Signs and Symptoms (range)	Low	1.09 (1–4)	Low	Low
	Number of Patients with Prostate Abnormalities	102 (85%)	96 (82%)	66 (73%)	89 (80%)
		Month 6	Month 6	Month 8	Month 12
Follow-up	WHO Status = 0	Unchanged	96%	87%	94%
	WHO Status = 1	Unchanged	4%	12%	5%
	WHO Status = 2			1%	1%
	Mean Bone Pain (range)	1.26 (1–7)	1.22 (1–5)	1.19 (1–8)	1.31 (1–8)
	Mean Urinary Pain (range)	1.07 (1–8)	1.10 (1–8)	1.00 (1–1)	1.07 (1–5)
	Mean Urinary Signs and Symptoms (range)	Modestly Decreased	1.18 (1–7)	Modestly Decreased	Modestly Decreased
	Number of Patients with Prostate Abnormalities	77 (64%)	76 (65%)	54 (60%)	60 (58%)

*WHO Status = 0 classified as "fully active."

†WHO Status = 1 classified as "restricted in strenuous activity but ambulatory and able to carry out work of a light or sedentary nature."

‡WHO Status = 2 classified as "ambulatory but unable to carry out work activities."

§Pain score scale: 1 (no pain) to 10 (worst pain possible).

INDICATIONS AND USAGE

ELIGARD® is indicated for the palliative treatment of advanced prostate cancer.

CONTRAINDICATIONS

- ELIGARD® is contraindicated in patients with hypersensitivity to GnRH, GnRH agonist analogs or any of the components of ELIGARD®. Anaphylactic reactions to synthetic GnRH or GnRH agonist analogs have been reported in the literature.²
- ELIGARD® is contraindicated in women and in pediatric patients and was not studied in women or children. Moreover, leuprolide acetate can cause fetal harm when administered to a pregnant woman. Major fetal abnormalities were observed in rabbits but not in rats after administration of leuprolide acetate throughout gestation. There were increased fetal mortality and decreased fetal weights in rats and rabbits. The effects on fetal mortality are expected consequences of the alterations in hormonal levels brought about by this drug. The possibility exists that spontaneous abortion may occur.

²MacLeod TL et al. Anaphylactic reaction to synthetic luteinizing hormone releasing hormone. Fertil Steril 1987 Sept; 48(3): 500–502.

WARNINGS

ELIGARD® 7.5 mg 22.5 mg 30 mg, like other LH-RH agonists, causes a transient increase in serum concentrations of testosterone during the first week of treatment. ELIGARD® 45 mg causes a transient increase in serum concentrations of testosterone during the first two weeks of treatment. Patients may experience worsening of symptoms or onset of new signs and symptoms during the first few weeks of treatment, including bone pain, neuropathy, hematuria, or bladder outlet obstruction. Isolated cases of ureteral obstruction and/or spinal cord compression, which may contribute to paralysis with or without fatal complications, have been observed in the palliative treatment of advanced prostate cancer using LH-RH agonists (see **PRECAUTIONS**).

If spinal cord compression or ureteral obstruction develops, standard treatment of these complications should be instituted.

PRECAUTIONS

General

Patients with metastatic vertebral lesions and/or with urinary tract obstruction should be closely observed during the first few weeks of therapy (see **WARNINGS** section).

Laboratory Tests

Response to ELIGARD® should be monitored by measuring serum concentrations of testosterone and prostate specific antigen periodically.

In the majority of patients, testosterone levels increased above Baseline during the first week, declining thereafter to Baseline levels or below by the end of the second or third week. Castrate levels were generally reached within two to four weeks.

Castrate testosterone levels were maintained for the duration of the treatment with ELIGARD® 7.5 mg. No increases to above the castrate level occurred in any of the patients.

Castrate levels were generally maintained for the duration of treatment with ELIGARD® 22.5 mg.

Once castrate levels were achieved with ELIGARD® 30 mg, most (86/89) patients remained suppressed throughout the study.

Once castrate levels were achieved with ELIGARD® 45 mg, only one patient (< 1%) experienced a breakthrough, with testosterone levels > 50 ng/dL.

Results of testosterone determinations are dependent on assay methodology. It is advisable to be aware of the type and precision of the assay methodology to make appropriate clinical and therapeutic decisions.

Drug Interactions

See **PHARMACOKINETICS**.

Drug/Laboratory Test Interactions

Therapy with leuprolide acetate results in suppression of the pituitary-gonadal system. Results of diagnostic tests of pituitary gonadotropic and gonadal functions conducted during and after leuprolide therapy may be affected.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Two-year carcinogenicity studies were conducted with leuprolide acetate in rats and mice. In rats, a dose-related increase of benign pituitary hyperplasia and benign pituitary adenomas was noted at 24 months when the drug was administered subcutaneously at high daily doses (0.6 to 4 mg/kg). There was a significant but not dose-related increase of pancreatic islet-cell adenomas in females and of testicular interstitial cell adenomas in males (highest incidence in the low dose group). In mice, no leuprolide acetate-induced tumors or pituitary abnormalities were observed at a dose as high as 60 mg/kg for two years. Patients have been treated with leuprolide acetate for up to three years with doses as high as 10 mg/day and for two years with doses as high as 20 mg/day without demonstrable pituitary abnormalities. No carcinogenicity studies have been conducted with ELIGARD®.

Mutagenicity studies have been performed with leuprolide acetate using bacterial and mammalian systems and with ELIGARD® 7.5 mg in bacterial systems. These studies provided no evidence of a mutagenic potential.

Pregnancy

Teratogenic Effects

Pregnancy category X

(see **CONTRAINDICATIONS**).

Pediatric Use

ELIGARD® is contraindicated in pediatric patients and was not studied in children (see **CONTRAINDICATIONS**).

ADVERSE REACTIONS

The safety of all ELIGARD® formulations was evaluated in clinical trials involving patients with advanced prostate cancer. In addition, the safety of ELIGARD® 7.5 mg was evaluated in 8 surgically castrated males (Table 7). ELIGARD®, like other LH-RH analogs, caused a transient increase in serum testosterone concentrations during the first one to two weeks of treatment. Therefore, potential exacerbations of signs and symptoms of the disease during the first weeks of treatment are of concern in patients with vertebral metastases and/or urinary obstruction or hematuria. If these conditions are aggravated, it may lead to neurological problems such as weakness and/or paresthesia of the lower limbs or worsening of urinary symptoms (see **WARNINGS** and **PRECAUTIONS**).

During the clinical trials, injection sites were closely monitored. Refer to Table 6 for a summary of reported injection site events.

Table 6 Reported Injection Site Adverse Events

	7.5 mg	22.5 mg	30 mg	45 mg
Study Number	AGL9904	AGL9909	AGL0001	AGL0205
Number of patients	120	117	90	111
Treatment	1 injection every month up to 6 months	1 injection every 3 months up to 6 months	1 injection every 4 months up to 8 months	1 injection every 6 months up to 12 months
Number of injections	716	230	175	217
Transient burning/stinging	248 (34.6%) injections; 84% reported as mild	50 (21.7%) injections; 86% reported as mild	35 (20%) injections; 100% reported as mild	35 (16%) injections; 91.4% reported as mild*
Pain (generally brief and mild)	4.3% of injections (18.3% of patients)	3.5% of injections (6.0% of patients)	2.3% of injections† (3.3% of patients)	4.6% of injections‡

Table 6 Reported Injection Site Adverse Events (continued)

	7.5 mg	22.5 mg	30 mg	45 mg
Erythema (generally brief and mild)	2.6% of injections (12.5% of patients)	0.9% of injections§ (1.7% of patients)	1.1% of injections (2.2% of patients)	
Bruising (Mild)	2.5% of injections (11.7% of patients)	1.7% of injections (3.4% of patients)		2.3% of injections¶
Pruritis	1.4% of injections (9.2% of patients)	0.4% of injections (0.9% of patients)		
Induration	0.4% of injections (2.5% of patients)			
Ulceration	0.1% of injections (> 0.8% of patients)			

*Following injection of ELIGARD® 30 mg, three of the 35 burning/stinging events were reported as moderate.

†A single event reported as moderate pain resolved within two minutes and all 3 mild pain events resolved within several days following injection of ELIGARD® 30 mg.

‡Transient pain was reported as mild in intensity in nine of ten (90%) events and moderate in intensity in one of ten (10%) events following injection of ELIGARD® 45 mg.

§Erythema was reported following 2 injections of ELIGARD® 22.5 mg. One report characterized the erythema as mild and it resolved within 7 days. The other report characterized the erythema as moderate and it resolved within 15 days. Neither patient experienced erythema at multiple injections.

¶Mild bruising was reported following 5 (2.3%) study injections and moderate bruising was reported following 2 (<1%) study injections of ELIGARD® 45 mg.

These localized adverse events were non-recurrent over time. No patient discontinued therapy due to an injection site adverse event.

The following possibly or probably related systemic adverse events occurred during clinical trials with ELIGARD®, and were reported in > 2% of patients (Table 7). Often, causality is difficult to assess in patients with metastatic prostate cancer. Reactions considered not drug-related are excluded.

Table 7 Summary of Possible or Probably Related Systemic Adverse Events Reported by > 2% of Patients treated with ELIGARD®

		7.5 mg	7.5 mg	22.5 mg	30 mg	45 mg
Study Number		AGL9904	AGL9802	AGL9909	AGL0001	AGL0205
Number of patients		120	8	117	90	111
Treatment		1 injection every month up to 6 months	1 injection (surgically castrated patients)	1 injection every 3 months up to 6 months	1 injection every 4 months up to 8 months	1 injection every 6 months up to 12 months
Body System	Adverse Event	Number (Percent)				
Body as a Whole	Malaise and Fatigue	21 (17.5%)		7 (6.0%)	12 (13.3%)	13 (11.7%)
	Weakness					4 (3.6%)
Nervous System	Dizziness	4 (3.3%)			4 (4.4%)	
Vascular	Hot flashes/sweats	68 (56.7%)*	2 (25.0%)*	66 (56.4%)*	66 (73.3%)*	64 (57.7%)*
Renal/Urinary	Urinary frequency			3 (2.6%)	2 (2.2%)	
	Nocturia				2 (2.2%)	
Gastrointestinal	Nausea			4 (3.4%)	2 (2.2%)	
	Gastroenteritis/colitis	3 (2.5%)				
Skin	Pruritis			3 (2.6%)		
	Clamminess				4 (4.4%)*	
	Night sweats				3 (3.3%)*	3 (2.7%)*
	Alopecia				2 (2.2%)	
Musculoskeletal	Arthralgia			4 (3.4%)		
	Myalgia				2 (2.2%)	5 (4.5%)
	Pain in limb					3 (2.7%)

Table 7 Summary of Possible or Probably Related Systemic Adverse Events Reported by > 2% of Patients treated with ELIGARD® (continued)

		7.5 mg	7.5 mg	22.5 mg	30 mg	45 mg
Reproductive	Testicular atrophy	6 (5.0%)			4 (4.4%)*	8 (7.2%)*
	Gynecomastia				2 (2.2%)*	4 (3.6%)*
	Testicular pain				2 (2.2%)	
Psychiatric	Decreased libido				3 (3.3%)*	

In the patient populations studied with ELIGARD® 7.5 mg, a total of 86 hot flashes/sweats adverse events were reported in 70 patients. Of these, 71 events (83%) were mild; 14 (16%) were moderate; 1 (1%) was severe.

In the patient population studied with ELIGARD® 22.5 mg, a total of 84 hot flashes/sweats adverse events were reported in 66 patients. Of these, 73 events (87%) were mild; 11 (13%) were moderate; none were severe.

In the patient population studied with ELIGARD® 30 mg, a total of 75 hot flash adverse events were reported in 66 patients. Of these, 57 events (76%) were mild; 16 (21%) were moderate; 2 (3%) were severe.

In the patient population studied with ELIGARD® 45 mg, a total of 89 hot flash adverse events were reported in 64 patients. Of these, 62 events (70%) were mild; 27 (30%) were moderate; none were severe.

*Expected pharmacological consequences of testosterone suppression.

In addition, the following possibly or probably related systemic adverse events were reported by < 2% of the patients treated with ELIGARD® in these clinical studies.

Body System	Adverse Event
General	Sweating, insomnia, syncope, rigors, weakness, lethargy
Gastrointestinal	Flatulence, constipation, dyspepsia
Hematologic	Decreased red blood cell count, hematocrit and hemoglobin
Metabolic	Weight gain
Musculoskeletal	Tremor, backache, joint pain, muscle atrophy, limb pain
Nervous	Disturbance of smell and taste, depression, vertigo
Psychiatric	Insomnia, depression, loss of libido*
Renal/Urinary	Difficulties with urination, pain on urination, scanty urination, bladder spasm, blood in urine, urinary retention, urinary urgency, incontinence, nocturia, nocturia aggravated
Reproductive/Urogenital:	Testicular soreness/pain, impotence*, decreased libido*, gynecomastia*, breast soreness/tenderness*, testicular atrophy*, erectile dysfunction, penile disorder*, reduced penis size
Skin	Alopecia, clamminess, night sweats*, sweating increased*
Vascular	Hypertension, hypotension

*Expected pharmacological consequences of testosterone suppression.

Changes in Bone Density

Decreased bone density has been reported in the medical literature in men who have had orchiectomy or who have been treated with an LH-RH agonist analog.³ It can be anticipated that long periods of medical castration in men will have effects on bone density.

³Hatano T et al. Incidence of bone fracture in patients receiving luteinizing hormone-releasing hormone agonists for prostate cancer. *BJU International* 2000 86: 449-452.

Post-Marketing

Pituitary apoplexy

During post-marketing surveillance, rare cases of pituitary apoplexy (a clinical syndrome secondary to infarction of the pituitary gland) have been reported after the administration of gonadotropin-releasing hormone agonists. In a majority of these cases, a pituitary adenoma was diagnosed with a majority of pituitary apoplexy cases occurring within 2 weeks of the first dose, and some within the first hour. In these cases, pituitary apoplexy has presented as sudden headache, vomiting, visual changes, ophthalmoplegia, altered mental status, and sometimes cardiovascular collapse. Immediate medical attention has been required.

OVERDOSAGE

In clinical trials using daily subcutaneous injections of leuprolide acetate in patients with prostate cancer, doses as high as 20 mg/day for up to two years caused no adverse effects differing from those observed with the 1 mg/day dose.

DOSAGE AND ADMINISTRATION

ELIGARD® is administered subcutaneously and provides continuous release of leuprolide acetate over a one-, three-, four- or six-month treatment period (Table 8). The injection delivers the dose of leuprolide acetate incorporated in a polymer formulation.

Table 8 ELIGARD® Recommended Dosing

Dosage	7.5 mg	22.5 mg	30 mg	45 mg
Recommended dose	1 injection every month	1 injection every 3 months	1 injection every 4 months	1 injection every 6 months

Once mixed, ELIGARD® should be discarded if not administered within 30 minutes.

As with other drugs administered by subcutaneous injection, the injection site should vary periodically. The specific injection location chosen should be an area with sufficient soft or loose subcutaneous tissue. In clinical trials, the injection was administered in the upper- or mid-abdominal area. Avoid areas with brawny or fibrous subcutaneous tissue or locations that could be rubbed or compressed (i.e., with a belt or clothing waistband).

Mixing Procedure

IMPORTANT: Allow the product to reach room temperature before using. **Once mixed, the product must be administered within 30 minutes.**

Follow the instructions as directed to ensure proper preparation of ELIGARD® prior to administration: ELIGARD® is packaged in either thermoformed trays or pouches. Each carton contains:

- One sterile Syringe A pre-filled with the ATRIGEL® Delivery System
- One Syringe B pre-filled with leuprolide acetate powder
- One long white plunger rod for use with Syringe B
- One sterile needle
- Desiccant pack(s)

1. On a clean field, open all of the packages and remove the contents. Discard the desiccant pack(s).

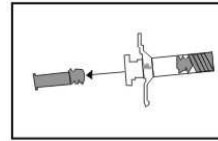


Figure 9

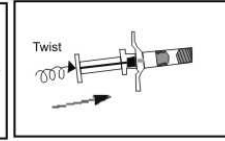


Figure 10

2. Pull out the blue-tipped short plunger rod and attached stopper from Syringe B and discard (Figure 9). Gently insert the long, white replacement plunger rod into the gray primary stopper remaining in Syringe B by twisting it in place (Figure 10).



Figure 11

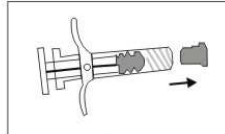


Figure 12

3. Unscrew the clear cap from Syringe A (Figure 11). Remove the gray rubber cap from Syringe B (Figure 12).

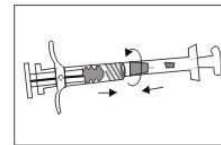


Figure 13

4. Join the two syringes together by pushing in and twisting until secure (Figure 13).

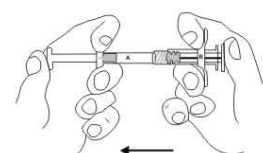
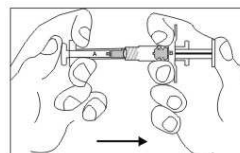


Figure 14

5. Inject the liquid contents of Syringe A into Syringe B containing the leuprolide acetate. Thoroughly mix the product by pushing the contents of both syringes back and forth between syringes (approximately 45 seconds) to obtain a uniform suspension (Figure 14). (7.5 mg PI, 22.5 mg PI, 30 mg PI, 45 mg PI) When thoroughly mixed, the suspension will appear light tan to tan (ELIGARD® 7.5 mg) or colorless to pale yellow (ELIGARD®, 22.5 mg, 30 mg and 45 mg) in color. **Please Note: Product must be mixed as described; shaking will not provide adequate mixing of the product.**



Figure 15

6. Hold the syringes vertically with Syringe B on the bottom. The syringes should remain securely coupled. Draw the entire mixed product into Syringe B (short, wide syringe) by depressing the Syringe A plunger and slightly withdrawing the Syringe B plunger. Uncouple Syringe A while continuing to push down on the Syringe A plunger (Figure 15). **Note: Small air bubbles will remain in the formulation – this is acceptable.**

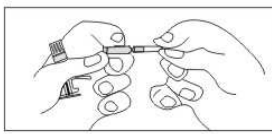


Figure 16

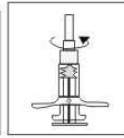


Figure 17

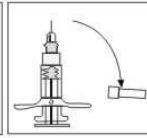


Figure 18

7. Hold Syringe B upright. Remove the cap on the bottom of the sterile needle cartridge by twisting it (Figure 16). Attach the needle cartridge to the end of Syringe B (Figure 17) by pushing in and turning the needle until it is firmly seated. Do not twist the needle onto the syringe until it is stripped. Pull off the clear needle cartridge cover prior to administration (Figure 18).

Administration Procedure

IMPORTANT: Allow the product to reach room temperature before using. **Once mixed, the product must be administered within 30 minutes.**

1. Choose an injection site on the abdomen, upper buttocks, or anywhere with adequate amounts of subcutaneous tissue that does not have excessive pigment, nodules, lesions, or hair. Since you can vary the injection site with a subcutaneous injection, choose an area that hasn't recently been used.
2. Cleanse the injection-site area with an alcohol swab.
3. Using the thumb and forefinger of your nondominant hand, grab and bunch the area of skin around the injection site.



4. Using your dominant hand, insert the needle quickly at a 90° angle. The approximate angle you use will depend on the amount and fullness of the subcutaneous tissue and the length of the needle. After the needle is inserted, release the skin with your nondominant hand.



5. Inject the drug using a slow, steady push. Press down on the plunger until the syringe is empty.
6. Withdraw the needle quickly at the same angle used for insertion.
7. Discard all components safely in an appropriate biohazard container.

HOW SUPPLIED

ELIGARD® is available in a single use kit. The kit consists of a two-syringe mixing system, a sterile needle (Table 9), a silicone desiccant pouch to control moisture uptake, and a package insert for constitution and administration procedures. Each syringe is individually packaged. One contains the ATRIGEL® Delivery System and the other contains leuprolide acetate. When constituted, ELIGARD® is administered as a single dose.

Table 9. ELIGARD® Needle specifications

ELIGARD® formulation	Gauge	Length
7.5 mg	20-gauge	½-inch
22.5 mg	20-gauge	½-inch
30 mg	20-gauge	5/8-inch
45 mg	18-gauge	5/8-inch

ELIGARD® 7.5 mg – NDC 0024-0793-75
 ELIGARD® 22.5 mg – NDC 0024-0222-05
 ELIGARD® 30 mg – NDC 0024-0610-30
 ELIGARD® 45 mg – NDC 0024-0605-45

Store at 2 – 8 °C (35.6 – 46.4 °F)

Manufactured by: TOLMAR, Inc.
 Fort Collins, CO 80526

for: TOLMAR Therapeutics, Inc.

Fort Collins, CO 80526

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