Ex-factory price Imnovid: € 6000
14x4mg; 14x3mg; 14x2mg; 14x1mg
Ex-factory price Imnovid: € 9000
21x4mg; 21x3mg; 21x 2mg; 21x1mg

Abbreviated Prescribing Information: ▼ Imnovid® (pomalidomide) 1 mg, 2 mg, 3 mg, 4 mg hard capsules. Refer to the Summary of Product Characteristics (SmPC) before prescribing. **Name of medicine:** Imnovid 1 mg, 2 mg, 3 mg, 4 mg hard capsules. **Active ingredients**: pomalidomide. **List of excipients:** Capsule content: Mannitol (E421), Starch, pregelatinised, Sodium stearyl fumarate. Capsule shell: 1 mg capsule shell contains gelatin, titanium dioxide (E171), indigotine (E132) and yellow iron oxide (E172) and white and black ink. 2 mg capsule shell contains gelatin, titanium dioxide (E171), indigotine (E132), yellow iron oxide (E172), erythrosin (E127) and white ink. 3 mg capsule shell contains gelatin, titanium dioxide (E171), indigotine (E132), yellow iron oxide (E172), and white ink. 4 mg capsule shell contains gelatin, titanium dioxide (E171), brilliant blue FCF (E133) indigotine (E132) and white ink. Printing ink: 1 mg capsule shell contains: white ink - shellac, titanium dioxide (E171), simethicone, propylene glycol (E1520) and ammonium hydroxide (E527). Black ink - shellac, iron oxide black (E172), propylene glycol (E1520) and ammonium hydroxide (E527). 2 mg capsule shell contains: white ink – shellac, titanium dioxide (E171), simethicone, propylene glycol (E1520) and ammonium hydroxide (E527). 3 mg capsule shell contains: white ink – shellac, titanium dioxide (E171), simethicone, propylene glycol (E1520) and ammonium hydroxide (E527). 4 mg capsule shell contains: white ink – shellac, titanium dioxide (E171), simethicone, propylene glycol (E1520) and ammonium hydroxide (E527). **Available dosage form:** Hard capsules containing pomalidomide 1 mg, 2 mg, 3 mg and 4 mg. **Authorised Indication(s):** Imnovid in combination with bortezomib and dexamethasone is indicated in the treatment of adult patients with multiple myeloma who have received at least one prior treatment regimen including lenalidomide. Imnovid in combination with dexamethasone is indicated in the treatment of adult patients with relapsed and refractory multiple myeloma who have received at least two prior treatment regimens, including both lenalidomide and bortezomib, and have demonstrated disease progression on the last therapy. **Dosage regimens and routes of administration:** *Imnovid in combination with bortezomib and dexamethasone*. The recommended starting dose of Imnovid is 4 mg orally once daily on Days 1 to 14 of repeated 21-day treatment cycles. The recommended starting dose of bortezomib is 1.3 mg/m^2 intravenous or subcutaneous once daily on Days 1, 4, 8, 11 (Cycle 1-8) and on Days 1, 8 (Cycle 9 and onwards) of repeated 21-day treatment cycles. The recommended dose of dexamethasone is 20 mg orally once daily on Days 1, 2, 4, 5, 8, 9, 11,12 (Cycle 1-8) and on Days 1, 2, 8, 9 (Cycle 9 and onwards) of repeated 21-day treatment cycles. *Imnovid in combination with dexamethasone*. The recommended starting dose of Imnovid is 4 mg once daily taken orally on Days 1 to 21 of repeated 28-day treatment cycles. The recommended dose of dexamethasone is 40 mg orally once daily on Days 1, 8, 15 and 22 of each 28-day treatment cycle. **Reference to special groups of patients:** *Paediatric population.* There is no relevant use of Imnovid in the paediatric population in the indication of multiple myeloma. *Older people. Imnovid in combination with bortezomib and dexamethasone*. No dose adjustment is required for pomalidomide. For information on bortezomib given in combination with Imnovid, refer to the respective current SmPC. For patients >75 years of age, the starting dose of dexamethasone is: (Cycles 1 to 8) 10 mg once daily on Days 1, 2, 4, 5, 8, 9, 11 and 12 of each 21-day cycle; (Cycles 9 and onwards) 10 mg once daily on Days 1, 2, 8 and 9 of each 21-day cycle. *Imnovid in combination with dexamethasone*. No dose adjustment is required for pomalidomide. For patients >75 years of age, the starting dose of dexamethasone is 20 mg once daily on Days 1, 8, 15 and 22 of each 28-day treatment cycle. *Renal impairment.* No dose adjustment of pomalidomide is required for patients with renal impairment. On haemodialysis days, patients should take their pomalidomide dose following haemodialysis. *Hepatic impairment.* A study in subjects with hepatic impairment has not been conducted with pomalidomide. Patients with serum total bilirubin > 1.5 x ULN were excluded from clinical studies. Hepatic impairment has a modest effect on the pharmacokinetics of pomalidomide. No adjustment of the starting dose of pomalidomide is required for patients with hepatic impairment as defined by the Child-Pugh criteria. However, patients with hepatic impairment should be carefully monitored for adverse reactions and dose reduction or interruption of pomalidomide should be used as needed. For information on other medicinal products given in combination with Imnovid, refer to the respective current SmPC. **Contraindications:** Pregnancy. Women of childbearing potential, except when all the conditions for Pregnancy Prevention Programme have been met. Male patients unable to follow or comply with the required contraceptive measures. Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of the SmPC. For information on other medicinal products given in combination with Imnovid, refer to the respective current SmPC**Warnings:** *Pregnancy warning.* Pomalidomide must not be taken during pregnancy, since a teratogenic effect is expected. The conditions of the Pregnancy Prevention Programme (PPP) must be fulfilled for all patients unless there is reliable evidence that the patient does not have childbearing potential. Refer to Section 4.4 of SmPC for a full list of the criteria for women of non-childbearing potential. *Counselling.* For women of childbearing potential, pomalidomide is contraindicated unless all of the following are met: she understands the expected teratogenic risk to the unborn child, she understands the need for effective contraception, without interruption, at least 4 weeks before starting treatment, throughout the entire duration of treatment, and at least 4 weeks after the end of treatment, even if a woman of childbearing potential has amenorrhea she must follow all the advice on effective contraception, she should be capable of complying with effective contraceptive measures, she is informed and understands the potential consequences of pregnancy and the need to rapidly consult if there is a risk of pregnancy, she understands the need to commence the treatment as soon as pomalidomide is dispensed following a negative pregnancy test, she understands the need and accepts to undergo pregnancy testing at least every 4 weeks except in case of confirmed tubal sterilisation, she acknowledges that she understands the hazards and necessary precautions associated with the use of pomalidomide. The prescriber must ensure that for women of childbearing potential: The patient complies with the conditions of the PPP, including confirmation that she has an adequate level of understanding, the patient has acknowledged the aforementioned conditions. For male patients taking pomalidomide, pharmacokinetic data has demonstrated that pomalidomide is present in human semen. As a precaution, all male patients taking pomalidomide must meet the following conditions: he understands the expected teratogenic risk if engaged in sexual activity with a pregnant woman or a woman of childbearing potential, he understands the need for the use of a condom if engaged in sexual activity with a pregnant woman or a woman of childbearing potential not using effective contraception, throughout treatment duration, during dose interruption and for 7 days after dose interruptions and/or cessation of treatment. Vasectomised males should wear a condom if engaged in sexual activity with a pregnant woman or a woman of childbearing potential as seminal fluid may still contain pomalidomide in the absence of spermatozoa, he understands that if his female partner becomes pregnant whilst he is taking pomalidomide or 7 days after he has stopped taking pomalidomide, he should inform his treating physician immediately and that it is recommended to refer the female partner to a physician specialised or experienced in teratology for evaluation and advice. *Contraception.* Women of childbearing potential must use at least one effective method of contraception for at least 4 weeks before therapy, during therapy, and until at least 4 weeks after pomalidomide therapy and even in case of dose interruption unless the patient commits to absolute and continuous abstinence confirmed on a monthly basis. If not established on effective contraception, the patient must be referred to an appropriately trained health care professional for contraceptive advice in order that contraception can be initiated. The following can be considered to be examples of suitable methods of contraception: implant, levonorgestrel-releasing intrauterine system, medroxyprogesterone acetate depot, tubal sterilisation, sexual intercourse with a vasectomised male partner only; vasectomy must be confirmed by two negative semen analyses, ovulation inhibitory progesterone-only pills (i.e. desogestrel). Because of the increased risk of venous thromboembolism in patients with multiple myeloma taking pomalidomide and dexamethasone, combined oral contraceptive pills are not recommended. If a patient is currently using combined oral contraception the patient should switch to one of the effective methods listed above. The risk of venous thromboembolism continues for 4–6 weeks after discontinuing combined oral contraception. The efficacy of contraceptive steroids may be reduced during cotreatment with dexamethasone. Implants and levonorgestrel-releasing intrauterine systems are associated with an increased risk of infection at the time of insertion and irregular vaginal bleeding. Prophylactic antibiotics should be considered particularly in patients with neutropenia. Insertion of copper-releasing intrauterine devices is not recommended due to the potential risks of infection at the time of insertion and menstrual blood loss which may compromise patients with severe neutropenia or severe thrombocytopenia. *Pregnancy testing.* According to local practice, medically supervised pregnancy tests with a minimum sensitivity of 25 mIU/ml must be performed for women of childbearing potential as outlined below. This requirement includes women of childbearing potential who practice absolute and continuous abstinence. Ideally, pregnancy testing, issuing a prescription and dispensing should occur on the same day. Dispensing of pomalidomide to women of childbearing potential should occur within 7 days of the prescription. *Prior to starting treatment.* A medically supervised pregnancy test should be performed during the consultation, when pomalidomide is prescribed, or in the 3 days prior to the visit to the prescriber once the patient had been using effective contraception for at least 4 weeks. The test should ensure the patient is not pregnant when she starts treatment with pomalidomide. *Follow-up and end of treatment.* A medically supervised pregnancy test should be repeated at least every 4 weeks, including at least 4 weeks after the end of treatment, except in the case of confirmed tubal sterilisation. These pregnancy tests should be performed on the day of the prescribing visit or in the 3 days prior to the visit to the prescriber. *Men.* Pomalidomide is present in human semen during treatment. As a precaution and taking into account special populations with potentially prolonged elimination time such as hepatic impairment, all male patients taking pomalidomide should use condoms throughout treatment duration, during dose interruption and for 7 days after cessation of treatment if their partner is pregnant or of childbearing potential and does not use effective contraception. Male patients should not donate semen or sperm during treatment (including during dose interruptions) and for 7 days following discontinuation of pomalidomide. *Additional precautions.* Patients should be instructed never to give this medicinal product to another person and to return any unused capsules to their pharmacist at the end of treatment. Patients should not donate blood, semen or sperm during treatment (including during dose interruptions) and for 7 days following discontinuation of pomalidomide. *Haematological events.* Neutropenia was the most frequently reported Grade 3 or 4 haematologic adverse reaction in patients with relapsed/refractory multiple myeloma followed by anaemia and thrombocytopenia. Patients should be monitored for haematologic adverse reactions, especially neutropenia. Patients should be advised to promptly report febrile episodes. Physicians should observe for signs of bleeding including epistaxes, especially with use of concomitant medication known to increase the risk of bleeding. Complete blood counts should be monitored at baseline, weekly for the first 8 weeks and monthly thereafter. A dose modification may be required (see section 4.2). Patients may require use of blood product support and /or growth factors. *Thromboembolic events.* Patients receiving pomalidomide either in combination with bortezomib and dexamethasone or in combination with dexamethasone have developed venous thromboembolic events (predominantly deep vein thrombosis and pulmonary embolism) and arterial thrombotic events (myocardial infarction and cerebrovascular accident). Patients with known risk factors for thromboembolism – including prior thrombosis – should be closely monitored. Action should be taken to try to minimize all modifiable risk factors (e.g. smoking, hypertension, and hyperlipidaemia). Patients and physicians are advised to be observant for the signs and symptoms of thromboembolism. Patients should be instructed to seek medical care if they develop symptoms such as shortness of breath, chest pain, arm or leg swelling. Anti-coagulation therapy (unless contraindicated) is recommended, (such as acetylsalicylic acid, warfarin, heparin or clopidogrel), especially in patients with additional thrombotic risk factors. A decision to take prophylactic measures should be made after a careful assessment of an individual patient's underlying risk factors. In clinical studies, patients received prophylactic acetylsalicylic acid or alternative anti-thrombotic therapy. The use of erythropoietic agents carries a risk of thrombotic events including thromboembolism. Therefore, erythropoietic agents, as well as other agents that may increase the risk of thromboembolic events, should be used with caution. *Peripheral neuropathy.* Patients with ongoing ≥ Grade 2 peripheral neuropathy were excluded from clinical studies with pomalidomide. Appropriate caution should be exercised when considering the treatment of such patients with pomalidomide. *Significant cardiac dysfunction.* Patients with significant cardiac dysfunction (congestive heart failure [NY Heart Association Class III or IV]; myocardial infarction within 12 months of starting study; unstable or poorly controlled angina pectoris) were excluded from clinical studies with pomalidomide. Cardiac events, including congestive cardiac failure, pulmonary oedema and atrial fibrillation have been reported mainly in patients with pre-existing cardiac disease or cardiac risk factors. Appropriate caution should be exercised when considering the treatment of such patients with pomalidomide, including periodic monitoring for signs or symptoms of cardiac events. *Tumour lysis syndrome.* Tumour lysis syndrome may occur. The patients at greatest risk of tumour lysis syndrome are those with high tumour burden prior to treatment. These patients should be monitored closely, and appropriate precautions taken. *Second Primary Malignancies.* Second primary malignancies, such as non-melanoma skin cancer, have been reported in patients receiving pomalidomide. Physicians should carefully evaluate patients before and during treatment using standard cancer screening for occurrence of second primary malignancies and institute treatment as indicated. *Allergic reactions and severe skin reactions.* Patients should be advised of angioedema and Stevens-Johnson syndrome (SJS), Toxic Epidermal Necrolysis (TEN) and Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) signs and symptoms by their prescribers and should be told to seek medical attention immediately if they develop these symptoms. Pomalidomide must be discontinued for exfoliative or bullous rash, or if SJS, TEN or DRESS is suspected, and should not be resumed following discontinuation for these reactions. Patients with a prior history of serious allergic reactions associated with thalidomide or lenalidomide were excluded from clinical studies, may be at higher risk of hypersensitivity and should not receive pomalidomide. Pomalidomide interruption or discontinuation should be considered for Grade 2-3 skin rash. Pomalidomide must be discontinued permanently for angioedema. *Dizziness and confusion.* Dizziness and confusional state have been reported with pomalidomide. Patients must avoid situations where dizziness or confusion may be a problem and not to take other medications that may cause dizziness or confusion without adequate medical advice. *Interstitial lung disease (ILD).* ILD and related events (e.g. pneumonitis) have been observed with pomalidomide. Patients with patients with an acute onset or unexplained worsening of pulmonary symptoms should be carefully assessed to exclude ILD. During investigations, pomalidomide should be interrupted and if ILD is confirmed, treatment should be initiated. Pomalidomide should only be resumed after a thorough evaluation of the benefits and the risks. *Hepatic disorders.* Cases of hepatitis that resulted in discontinuation of pomalidomide have been observed. Patients liver function should be regularly monitoring for the first 6 months of treatment with pomalidomide and as clinically indicated thereafter. *Infections.* Reactivation of hepatitis B has been reported rarely in patients receiving pomalidomide in combination with dexamethasone who have previously been infected with the hepatitis B virus (HBV). Some of these cases have progressed to acute hepatic failure, resulting in discontinuation of pomalidomide. Hepatitis B virus status should be established before initiating treatment with pomalidomide. For patients who test positive for HBV infection, consultation with a physician with expertise in the treatment of hepatitis B is recommended. Caution should be exercised when pomalidomide in combination with dexamethasone is used in patients previously infected with HBV, including patients who are anti-HBc positive but HBsAg negative. These patients should be closely monitored for signs and symptoms of active HBV infection throughout therapy. *Sodium content.* Imnovid contains less than 1 mmol sodium (23 mg) per capsule, i.e. essentially 'sodiumfree'. *Haemorrhage.* Haemorrhagic disorders have been reported, especially in patients with high risk factors. For information on other medicinal products given in combination with Imnovid, refer to the respective current SmPC. **Clinically significant interactions:** Pomalidomide is not anticipated to cause clinically relevant pharmacokinetic drug-drug interactions due to P450 isoenzyme inhibition or induction or transporter inhibition when co-administered with substrates of these enzymes or transporters. Pomalidomide is partly metabolised by CYP1A2 and CYP3A4/5. It is also a substrate for P-glycoprotein. Co-administration of pomalidomide with the strong CYP3A4/5 and P-gp inhibitor ketoconazole, or the strong CYP3A4/5 inducer carbamazepine, had no clinically relevant effect on exposure to pomalidomide. Co-administration of the strong CYP1A2 inhibitor fluvoxamine with pomalidomide in the presence of ketoconazole, increased mean exposure to pomalidomide. by 107% with a 90 % confidence interval [91% to 124%] compared to pomalidomide plus ketoconazole. In a second study to evaluate the contribution of a CYP1A2 inhibitor alone to metabolism changes, co-administration of fluvoxamine alone with pomalidomide increased mean exposure to pomalidomide by 125% with a 90% confidence interval [98% to 157%] compared to pomalidomide alone. If strong inhibitors of CYP1A2 (e.g. ciprofloxacin, enoxacin and fluvoxamine) are co-administered with pomalidomide, reduce the dose of pomalidomide by 50%. *Dexamethasone.* Co-administration of multiple doses of up to 4 mg pomalidomide with 20 mg to 40 mg dexamethasone to patients with multiple myeloma had no effect on the pharmacokinetics of pomalidomide compared with pomalidomide administered alone. The effect of dexamethasone on warfarin is unknown. Close monitoring of warfarin concentration is advised during treatment. For information on other medicinal products given in combination with Imnovid, refer to the respective current SmPC. **Reported side effects:** *Imnovid in combination with bortezomib and dexamethasone*. The most commonly reported: neutropenia, thrombocytopenia, anaemia. The most frequently reported: peripheral sensory neuropathy. *Imnovid in combination with dexamethasone*. The most commonly reported: anaemia, neutropenia, thrombocytopenia, fatigue, pyrexia, oedema peripheral, pneumonia. Prescribers should consult the summary of product characteristics in relation to other side-effects. **Storage conditions:** This medicinal product does not require any special storage conditions. **Classification:** Medicinal product subject to medical prescription. **Marketing Authorisation Numbers:** 21 capsules: EU/1/13/850/001, EU/1/13/850/002, EU/1/13/850/003 and EU/1/13/850/004. 14 capsules: EU/1/13/850/005, EU/1/13/850/006, EU/1/13/850/007, EU/1/13/850/008. **Marketing Authorisation Holder:** Celgene Europe B.V., Winthontlaan 6 N, 3526 KV Utrecht. Netherlands. **Date of last revision:** 13/05/2019.