

Helixate® FS

Antihemophilic Factor (Recombinant)

Formulated with Sucrose

ZLB Behring

Rx only

DESCRIPTION

Helixate® FS Antihemophilic Factor (Recombinant) is a sterile, stable, purified, nonpyrogenic, dried concentrate that has been manufactured using recombinant DNA technology. Helixate FS is intended for use in the treatment of classical hemophilia (hemophilia A), and is produced by Baby Hamster Kidney (BHK) cells into which the human factor VIII (FVIII) gene has been introduced.¹ The cell culture medium contains Human Plasma Protein Solution (HPPS) and recombinant insulin, but does not contain any proteins derived from animal sources. Helixate FS is a highly purified glycoprotein consisting of multiple peptides including an 80 kD and various extensions of the 90 kD subunit. It has the same biological activity as FVIII derived from human plasma. Compared to its predecessor product HELIXATE® Antihemophilic Factor (Recombinant), Helixate FS incorporates a revised purification and formulation process that eliminates the addition of Albumin (Human).

The purification process includes an effective solvent/detergent virus inactivation step in addition to the use of the classical purification methods of ion exchange chromatography, monoclonal antibody immunoaffinity chromatography, along with other chromatographic steps designed to purify recombinant FVIII and remove contaminating substances.

Additionally, the manufacturing process was investigated for its capacity to decrease the infectivity of an experimental agent of transmissible spongiform encephalopathy (TSE), considered as a model for the vCJD and CJD agents.^{19,27} Several of the individual production and raw material preparation steps in the Helixate FS manufacturing process have been shown to decrease TSE infectivity of that experimental model agent. TSE reduction steps included the Fraction II+III separation step for Human Plasma Protein Solution (6.0 log₁₀) and an anion exchange chromatography step (3.6 log₁₀). These studies provide reasonable assurance that low levels of CJD/vCJD agent infectivity, if present in the starting material, would be removed.

Helixate FS is formulated with sucrose (0.9–1.3%), glycine (21–25 mg/mL), and histidine (18–23 mM) as stabilizers in the final container in place of Albumin (Human) as used in HELIXATE, and is then lyophilized. The final product also contains calcium chloride (2–3 mM), sodium (27–36 mEq/L), chloride (32–40 mEq/L), polysorbate 80 (64–96 µg/mL), imidazole (NMT 20 µg/1000 IU), tri-n-butyl phosphate (NMT 5 µg/1000 IU), and copper (NMT 0.6 µg/1000 IU). The product contains no preservatives. The amount of sucrose in each vial is 28 mg. Intravenous administration of sucrose contained in Helixate FS will not affect blood glucose levels.

Each vial of Helixate FS contains the labeled amount of recombinant FVIII in international units (IU). One IU, as defined by the World Health Organization standard for blood coagulation FVIII, human, is approximately equal to the level of FVIII activity found in 1 mL of fresh pooled human plasma.

Helixate FS must be administered by the intravenous route.

CLINICAL PHARMACOLOGY

Pharmacokinetic studies were conducted in 20 patients with severe hemophilia A in North America. In this comparative pharmacokinetic study, Helixate FS was shown to be similar to its predecessor product HELIXATE. Mean FVIII recovery measured 10 minutes following infusion was 2.1 ± 0.3 %/IU/kg for Helixate FS and 2.4 ± 0.7 %/IU/kg for HELIXATE. The two recoveries were not statistically different (confidence interval 0.815–1.01). The mean biological half-life of recombinant FVIII formulated with sucrose (FVIII-FS) is similar to HELIXATE with a mean of approximately 13 hours, which has previously been shown to be similar to plasma-derived Antihemophilic Factor (AHF). The activated partial thromboplastin time shortened appropriately with both rFVIII and rFVIII-FS. The recovery and half-life data for rFVIII-FS were unchanged after 24 weeks of exclusive treatment indicating continued efficacy and no evidence of FVIII inhibition. The mean FVIII recovery measured 10 minutes following a dose of rFVIII-FS in 37 patients (after 24 weeks of treatment with rFVIII-FS) was 2.1%/IU/kg, which was unchanged from FVIII recovery determined at baseline and at weeks 4 and 12.

Seventy-one patients with severe hemophilia A, ages 12–59, who had been previously treated with other recombinant and with plasma-derived AHF products, were enrolled in 6-month studies of home therapy with rFVIII-FS in Europe and North America. A total of 3995 infusions have been administered under this portion of the study, or 7.4 million units of rFVIII-FS. Treatment of 659 bleeding episodes during the study period required 951 infusions of rFVIII-FS. The majority of bleeding episodes (89.5%) were treated successfully with one or two infusions, using a mean dosage of approximately 28 IU/kg per treatment infusion. Regularly scheduled treatment accounted for 76% of infusions administered on study. Nine patients have received rFVIII-FS on 11 occasions for surgical procedures. The procedures included removal of a brain tumor, two total knee replacements, two joint synovectomies (one with Achilles tendon lengthening), two circumcisions, a hernia repair, and three teeth extractions. Hemostasis was satisfactory in all cases.

In clinical studies, Helixate FS has been used in the treatment of bleeding episodes in previously untreated patients (PUPs) and minimally treated (MTP) pediatric patients. In ongoing studies, 61 PUPs/MTPs have been treated with Helixate FS. Bleeding episodes were treated effectively with one or two infusions of rFVIII-FS. Ten patients have developed inhibitors. In these trials, approximately half of the patients have achieved 20 or more exposure days, and the incidence of inhibitor formation (15%) is consistent with that observed in other pediatric studies using plasma-derived and recombinant factor VIII products.²⁵

INDICATIONS AND USAGE

Helixate FS is indicated for the treatment of classical hemophilia (hemophilia A) in which there is a demonstrated deficiency of activity of the plasma clotting factor FVIII. Helixate FS provides a means of temporarily replacing the missing clotting factor in order to correct or prevent bleeding episodes, or in order to perform emergency or elective surgery in hemophiliacs.

In clinical studies with the predecessor product HELIXATE, some patients who developed inhibitors on study continued to manifest a clinical response when inhibitor titers were less than 10 Bethesda Units (BU) per mL. When an inhibitor is present, the dosage requirement for FVIII is variable. The dosage can be determined only by clinical response, and by monitoring circulating FVIII levels after treatment (see **DOSE AND ADMINISTRATION**). Because Helixate FS has similar biological activity to HELIXATE it can be used in the same manner.

Helixate FS does not contain von Willebrand's factor and therefore is not indicated for the treatment of von Willebrand's disease.

CONTRAINDICATIONS

Known intolerance or allergic reactions to constituents of the preparation.

Known hypersensitivity to mouse or hamster protein may be a contraindication to the use of Helixate FS.

WARNINGS

None.

PRECAUTIONS

General

Helixate® FS Antihemophilic Factor (Recombinant) is intended for the treatment of bleeding disorders arising from a deficiency in FVIII. This deficiency should be proven prior to administering Helixate FS.

The development of circulating neutralizing antibodies to FVIII may occur during the treatment of patients with hemophilia A. Inhibitor formation is especially common in young children with severe hemophilia during their first years of treatment, or in patients of any age who have received little previous treatment with FVIII. Nonetheless, inhibitor formation may occur at any time in the treatment of a patient with hemophilia A. Patients treated with any AHF preparation, including Helixate FS, should be carefully monitored for the development of antibodies to FVIII by appropriate clinical observation and laboratory tests, according to the recommendation of the patient's hemophilia treatment center.

Among patients treated with antihemophilic factor concentrates, cases of hypotension, urticaria, and chest tightness in association with hypersensitivity reactions have been reported in the literature.¹¹⁻¹² Very rare cases of allergic and anaphylactic reactions have been reported with the predecessor product HELIXATE® Antihemophilic Factor (Recombinant), particularly in very young patients or patients who have previously reacted to other FVIII concentrates (see **ADVERSE REACTIONS—Post-marketing experience**). Serious anaphylactic reactions require immediate emergency treatment with resuscitative measures such as the administration of epinephrine and oxygen.

Formation of Antibodies to Mouse and Hamster Protein

Assays to detect seroconversion to mouse and hamster protein were conducted on all patients in clinical studies. No patient has developed specific antibodies to these proteins after commencing study, and no animal protein associated serious allergic reactions have been observed with rFVIII-FS infusions. Although no such reactions were observed, patients should be made aware of the possibility of a hypersensitivity reaction to mouse and/or hamster protein, and alerted to the early signs of such a reaction (e.g., hives, localized or generalized urticaria, wheezing, and hypotension). Patients should be advised to discontinue use of the product and contact their physician if such symptoms occur.

Carcinogenesis, Mutagenesis, and Impairment of Fertility

In vitro evaluation of the mutagenic potential of rFVIII failed to demonstrate reverse mutation or chromosomal aberrations at doses substantially greater than the maximum expected clinical dose. In vivo evaluation of rFVIII in animals using doses ranging between 10 and 40 times the expected clinical maximum also indicated that rFVIII does not possess a mutagenic potential. Long-term investigations of carcinogenic potential in animals have not been performed.

Pediatric Use

Helixate® FS Antihemophilic Factor (Recombinant) is appropriate for use in pediatric patients of all ages, including neonates, infants, children, and adolescents. Safety and efficacy studies have been performed in previously untreated and minimally treated pediatric patients (n=62). Helixate FS is similar to HELIXATE in its biological activity and may be used in pediatric patients in the same manner as HELIXATE.

Geriatric Use

Clinical studies with Helixate FS did not include sufficient numbers of patients aged 65 and over to be able to determine whether they respond differently from younger patients. However, clinical experience with HELIXATE and other AHF products has not identified differences between the elderly and younger patients. As with any patient receiving Helixate FS, dose selection for an elderly patient should be individualized.

Pregnancy Category C

Animal reproduction studies have not been conducted with Helixate FS. It is also not known whether Helixate FS can cause fetal harm when administered to a pregnant woman or affect reproduction capacity. Helixate FS should be used during pregnancy and lactation only if clearly indicated.

ADVERSE REACTIONS

During the clinical studies conducted in previously treated patients (PTPs), 109 adverse events were reported in the course of 4160 infusions (2.6%). Only 13 events were reported by the investigator as at least remotely related to study drug. Another 7 events were nonassessable. Thus 20 events in 11 patients were considered to be either nonassessable or at least remotely related to Helixate FS administration, for an incidence of 0.5% relative to the number of infusions administered. Events that were at least remotely drug-related included: local injection site reactions (2), dizziness (2), rash (2), unusual taste in the mouth (1), mild increase in blood pressure (1), pruritus (1), depersonalization (1), nausea (1), and rhinitis (1). No FVIII inhibitors have developed in the 72 PTPs with severe hemophilia A who have received Helixate FS for a mean of 54 exposure days.

In clinical studies with previously untreated patients (PUPs) and minimally treated (MTP) pediatric patients, 18 adverse events were reported by the clinical investigators as at least possibly related to the study drug including the expected complication of inhibitor development in 8 patients (included in the 10 patients discussed under **CLINICAL PHARMACOLOGY**), a forearm bleed following venipuncture, constipation, adenopathy, rash, anemia and pallor in one inhibitor patient with gastroenteritis, and serous otitis media.

Post-marketing experience

The following events are principally derived from post-marketing experience and publications,¹⁴ and accurate rate estimates are generally not possible. Among patients treated with its predecessor product HELIXATE, very rare cases of serious allergic reactions and anaphylactic reactions have been reported, particularly in very young patients or patients who had previously reacted to other FVIII concentrates. Individual cases of hypotension have been very rarely reported. Rare cases of urticaria have also been reported. Although such serious reactions have not been reported with the use of Helixate FS, it is likely that these may also occur. Rare cases of dyspnea have been reported with Helixate FS.

DOSE AND ADMINISTRATION

Each bottle of Helixate FS has the rFVIII potency in international units stated on the label based on the one-stage assay methodology. The reconstituted product must be administered within 3 hours after reconstitution.

GENERAL APPROACH TO TREATMENT AND ASSESSMENT OF TREATMENT EFFICACY

The dosages described below are presented as general guidance. It should be emphasized that the dosage of Helixate FS required for hemostasis must be individualized according to the needs of the patient, the severity of the deficiency, the severity of the hemorrhage, the presence of inhibitors, and the FVIII level desired. It is often critical to follow the course of therapy with FVIII level assays. The clinical effect of FVIII is the most important element in evaluating the effectiveness of treatment. It may be necessary to administer more FVIII than estimated in order to attain satisfactory clinical results. If the calculated dose fails to attain the expected FVIII levels, or if bleeding is not controlled after administration of the calculated dosage, the presence of a circulating inhibitor in the patient should be suspected. Its presence should be substantiated and the inhibitor level quantitated by appropriate laboratory tests. When an inhibitor is present, the dosage requirement for FVIII could be extremely variable among different patients, and the optimal treatment can be determined only by the clinical response. Some patients with low-titer inhibitors (<10 BU) can be successfully treated with FVIII preparations without a resultant anamnestic rise in inhibitor titer. FVIII levels and clinical response to treatment must be assessed to insure adequate response. Use of alternative treatment products, such as Factor IX Complex concentrates, Antihemophilic Factor (Porcine), recombinant Factor VIIa or Anti-Inhibitor Coagulant Complex, may be necessary for patients with anamnestic responses to FVIII treatment and/or high-titer inhibitors.

Calculation of Dosage

The *in vivo* percent elevation in FVIII level can be estimated by multiplying the dose of Helixate FS per kilogram of body weight (IU/kg) by 2% per IU per kg. This method of calculation is based on clinical findings with the use of plasma-derived and recombinant AHF products²³ and is illustrated in the following examples: (see next page)

$$\text{Expected \% factor VIII increase} = \frac{\# \text{ units administered} \times 2\%/\text{IU/kg}}{\text{body weight (kg)}}$$

$$\text{Example for a 70 kg adult: } \frac{1400 \text{ IU} \times 2\%/\text{IU/kg}}{70 \text{ kg}} = 40\%$$

or

$$\text{Dosage required (IU)} = \frac{\text{body weight (kg)} \times \text{desired \% FVIII increase}}{2\%/\text{IU/kg}}$$

$$\text{Example for a 15 kg child: } \frac{15 \text{ kg} \times 100\%}{2\%/\text{IU/kg}} = 750 \text{ IU required}$$

The dosage necessary to achieve hemostasis depends upon the type and severity of the bleeding episode, according to the following general guidelines:

Hemorrhagic event	Therapeutically necessary plasma level of FVIII activity	Dosage necessary to maintain the therapeutic plasma level
Minor hemorrhage (superficial, early hemorrhages, hemorrhages into joints)	20–40%	10–20 IU per kg Repeat dose if evidence of further bleeding.
Moderate to major hemorrhage (hemorrhages into muscles, hemorrhages into the oral cavity, definite hemarthroses, known trauma)	30–60%	15–30 IU per kg Repeat one dose at 12–24 hours if needed.

Surgery (minor surgical procedures)

Major to life-threatening hemorrhage (intracranial, intraabdominal or intrathoracic hemorrhages, gastrointestinal bleeding, central nervous system bleeding, bleeding in the retropharyngeal or retroperitoneal spaces, or ilioasos sheath)	80–100%	Initial dose 40–50 IU per kg Repeat dose 20–25 IU per kg every 8–12 hours.
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Fractures Head trauma

Surgery Major surgical procedures	~100%	Preoperative dose 50 IU/kg Verify ~100% activity prior to surgery. Repeat as necessary after 6 to 12 hours initially, and for 10 to 14 days until healing is complete.
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Prophylaxis

AHF concentrates may also be administered on a regular schedule for prophylaxis of bleeding, as reported by Nilsson et al.¹⁰

Instructions for Use

Reconstitution and product administration must be done with caution. Percutaneous puncture with a needle contaminated with blood can transmit infectious viruses including HIV (AIDS) and hepatitis. Obtain immediate medical attention if injury occurs. Place needles in a sharps container after single use. Discard all equipment, including any reconstituted Helixate® FS Antihemophilic Factor (Recombinant) product, in accordance with biohazard procedures.

Reconstitution

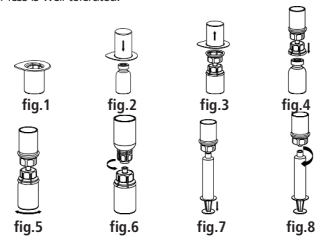
Always wash your hands before performing the following procedures:

Vacuum Transfer

- Warm the unopened diluent and the concentrate to a temperature not to exceed 37°C, 99°F.
- Place the product vial, diluent vial and Mix2Vial™ on a flat surface.
- Ensure product and diluent vial flip caps are removed and the stoppers are treated with an aseptic solution and allowed to dry prior to opening the Mix2Vial package.
- Open the Mix2Vial package by peeling away the lid (Fig. 1). Leave the Mix2Vial in the clear package. Place the diluent vial on an even surface and hold the vial tight. Grip the Mix2Vial together with the package and snap the blue end onto the diluent stopper (Fig. 2).
- Carefully remove the clear package from the Mix2Vial set. Make sure that you only pull up the package and not the Mix2Vial set (Fig. 3).
- With the product vial firmly on a surface, invert the diluent vial with the set attached and snap the transparent adapter onto the product vial stopper (Fig. 4). The diluent will automatically transfer into the product vial.
- With the diluent and product vial still attached, gently swirl the product vial to ensure the product is fully dissolved (Fig. 5). Do not shake vial.
- With one hand grasp the product-side of the Mix2Vial set and with the other hand grasp the blue diluent-side of the Mix2Vial set and unscrew the set into two pieces (Fig. 6).
- Draw air into an empty, sterile syringe. While the product vial is upright, screw the syringe to the Mix2Vial set. Inject air into the product vial. While keeping the syringe plunger pressed, invert the system upside down and draw the concentrate into the syringe by pulling the plunger back slowly (Fig. 7).
- Now that the concentrate has been transferred into the syringe, firmly grasp the barrel of the syringe (keeping the syringe plunger facing down) and unscrew the syringe from the Mix2Vial set (Fig. 8). Attach the syringe to an administration set made with microbore tubing. Use of other administration sets without microbore tubing may result in a larger retention of the solution within the administration set.
- If the same patient is to receive more than one bottle, the contents of two bottles may be drawn into the same syringe through a separate unused Mix2Vial set before attaching the vein needle.
- Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

Rate of Administration

The rate of administration should be adapted to the response of the individual patient, but administration of the entire dose in 5 to 10 minutes or less is well tolerated.



HOW SUPPLIED

Helixate® FS Antihemophilic Factor (Recombinant) is supplied in the following single use bottles. A suitable volume of Sterile Water for Injection, USP and Mix2Vial™ filter transfer set are provided. The actual potency is printed on the label and the carton.

NDC Number	Approximate FVIII Activity (IU)	Dosage	Diluent (mL)
0053-8130-01	250	L - Low	2.5
0053-8130-02	500	M - Mid	2.5
0053-8130-04	1000	H - High	2.5

STORAGE

Helixate FS stored in a refrigerator at 2–8°C (36–46°F) is stable for the period indicated by the expiration date on the label. Within this period Helixate FS may be stored at room temperature, not to exceed 25°C (77°F), for up to 3 months, such as in home treatment situations. Do not freeze. Do not use beyond the expiration date indicated on the bottle. Protect from extreme exposure to light and store the lyophilized powder in the carton prior to use.

CAUTION

⚠ only

REFERENCES

- Lawn RM, Vehar GA: The molecular genetics of hemophilia. *Sci Am* 254(3):48–54, 1986.
- Scharrer I, Bray GL, Neutzling O: Incidence of inhibitors in haemophilia A patients — a review of recent studies of recombinant and plasma-derived factor VIII concentrates. *Haemophilia* 5(3):145–154, 1999.
- Lusher JM, Arkin S, Abildgaard CF, et al: Recombinant factor VIII for the treatment of previously untreated patients with hemophilia A: safety, efficacy, and development of inhibitors. *N Engl J Med* 328(7):453–459, 1993.
- Schwarzinger I, Pabinger I, Korninger C, et al: Incidence of inhibitors in patients with severe and moderate hemophilia A treated with factor VIII concentrates. *Am J Hematol* 24(3):241–5, 1987.
- Ehrenforth S, Kreuz W, Scharrer I, et al: Incidence of development of factor VIII and factor IX inhibitors in hemophiliacs. *Lancet* 339(8793):594–8, 1992.
- Kasper CK: Complications of hemophilia A treatment: factor VIII inhibitors. *Ann NY Acad Sci* 614:97–105, 1991.
- Abildgaard CF, Simone JV, Corrigan JJ, et al: Treatment of hemophilia with glycine-precipitated Factor VIII. *N Engl J Med* 275(9):471–5, 1966.
- Schwartz RS, Abildgaard CF, Aledort LM, et al: Human recombinant DNA-derived antihemophilic factor (factor VIII) in the treatment of hemophilia A. Recombinant Factor VIII Study Group. *N Engl J Med* 323(26):1800–5, 1990.
- White GC 2nd, Courter S, Bray GL, et al: A multicenter study of recombinant factor VIII (Recombine) in previously treated patients with hemophilia A. The Recombinate Previously Treated Patient Study Group. *Thromb Haemost* 77(4):660–667, 1997.
- Nilsson IM, Berntorp E, Löfqvist T, et al: Twenty-five years' experience of prophylactic treatment in severe haemophilia A and B. *J Intern Med* 232(1):25–32, 1992.
- Brettler DB, Forsberg AD, Levine PH, et al: The use of porcine factor VIII concentrate (Hyate:C) in the treatment of patients with inhibitor antibodies to factor VIII. A multicenter US experience. *Arch Intern Med* 149(6): 1381–5, 1989.
- Eyster ME, Bowman HS, Haverstick JN: Adverse reactions to factor VIII infusions. *Ann Intern Med* 87(2):248, 1977.
- Brettler DB, Levine PH: Factor concentrates for treatment of hemophilia: which one to choose? *Blood* 73(8):2067–73, 1989.
- Pernod G, Armani C, Barro C, et al: Anaphylaxis following the use of a plasma-derived immunopurified Monoclate-P®, and the recombinant Recombinate® and Kogenate® factor VIII: a therapeutic challenge. *Haemophilia* 5(2):143–4, 1999.
- Kimberlin RH, Walker CA: Characteristics of a short incubation model of scrapie in the golden hamster. *J Gen Virol* 34(2):295–304, 1977.
- Kimberlin RH, Walker CA: Evidence that the transmission of one source of scrapie agent to hamsters involves separation of agent strains from a mixture. *J Gen Virol* 39(3):487–96, 1978.
- Kimberlin RH, Walker CA: Pathogenesis of scrapie (strain 263K) in hamsters infected intracerebrally, intraperitoneally or intraocularly. *J Gen Virol* 67(2):255–63, 1986.
- Prusiner SB, et al: Further purification and characterization of scrapie prions. *Biochemistry* 21(26):6942–50, 1982.
- Kascsak RJ, et al: Mouse polyclonal and monoclonal antibody to scrapie-associated fibril proteins. *J Virol* 61(12):3688–93, 1987.
- Rubenstein R, et al: Scrapie-infected spleens: analysis of infectivity, scrapie-associated fibrils, and protease-resistant proteins. *J Infect Dis* 164(1):29–35, 1991.
- Taylor DM, Fernie K: Exposure to autoclaving or sodium hydroxide extends the dose-response curve of the 263K strain of scrapie agent in hamsters. *J Gen Virol* 77(4):811–13, 1996.
- Stenland CJ, et al: Partitioning of human and sheep forms of the pathogenic prion protein during the purification of therapeutic proteins from human plasma. *Transfusion* 42(11):1497–500, 2002.
- Lee DC, Miller JL, Petteway SR: Pathogen safety of manufacturing processes for biological products: special emphasis on KOGENATE® Bayer. *Haemophilia* 8(Suppl. 2):6–9, 2002.
- Lee DC, Stenland CJ, Hartwell RC, et al: Monitoring plasma processing steps with a sensitive Western blot assay for the detection of the prion protein. *J Virol Methods* 84(1):77–89, 2000.
- Lee DC, Stenland CJ, Miller JL, et al: A direct relationship between the partitioning of the pathogenic prion protein and transmissible spongiform encephalopathy infectivity during the purification of plasma proteins. *Transfusion* 41(4):449–55, 2001.
- Cai K, Miller JL, Stenland CJ, et al: Solvent-dependent precipitation of prion protein. *Biochim Biophys Acta* 1597(1):28–35, 2002.
- Trejo SR, Hotta JA, Lebing W, et al: Evaluation of virus and prion reduction in a new intravenous immunoglobulin manufacturing process. *Vox Sang* 84(3):176–87, 2003.

Product Website: www.hemophiliamoms.com

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