

PRODUCT MONOGRAPH
INCLUDING PATIENT MEDICATION INFORMATION

Pr **CRYSVITA™**

Burosumab Injection

Solution for Subcutaneous Injection

10 mg/mL

20 mg/mL

30 mg/mL

Fibroblast growth factor 23 (FGF23) Inhibitor

ATC Code: M05BX05

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PART I: HEALTH PROFESSIONAL INFORMATION

1. INDICATIONS

CRYSVITA (Burosumab Injection) is indicated for the treatment of X-linked hypophosphataemia (XLH) in adult and pediatric patients 1 year of age and older.

Treatment should be initiated and monitored by a health professional experienced in the management of patients with metabolic bone diseases.

1.1 Pediatrics

Pediatrics (> 1 year of age): Based on the data submitted and reviewed by Health Canada in patients aged 1-12 at the time of enrollment, the safety and efficacy of CRYSVITA in pediatric patients has been established; therefore, Health Canada has authorized an indication for pediatric use. Data were collected from a small number of patients who entered adolescence during clinical trials. Dosing in adolescents (aged 13-17) was derived using modeling and simulation of adult and pediatric PK and PD data.

1.2 Geriatrics

Geriatrics (> 65 years of age): Clinical studies with CRYSVITA did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients.

2 CONTRAINDICATIONS

- CRYSVITA is contraindicated in patients who are hypersensitive to this drug or to any ingredient in the formulation, including any non-medicinal ingredient, or component of the container. For a complete listing, see Dosage Forms, Strengths, Composition and Packaging.
- Do not use CRYSVITA with oral phosphate and active vitamin D analogues.
- Do not initiate CRYSVITA treatment if serum phosphorus is within or above the normal range for age.
- CRYSVITA is contraindicated in patients with severe renal impairment or end stage renal disease because these conditions are associated with abnormal mineral metabolism.

3 DOSAGE AND ADMINISTRATION

3.1 Dosing Considerations

Discontinue oral phosphate and vitamin D analogues at least 1 week prior to initiation of treatment. Fasting serum phosphorus concentration should be below the reference range for age prior to initiation of treatment.

3.2 Recommended Dose and Dosage Adjustment

Pediatric Patients with X-linked Hypophosphataemia (1 to less than 18 years of age)

The recommended starting dose regimen is 0.8 mg/kg of body weight, rounded to the nearest 10 mg, administered every two weeks. The minimum starting dose is 10 mg up to a maximum dose of 90 mg.

After initiation of treatment with CRYSVITA, measure fasting serum phosphorus every 4 weeks for the first 3 months of treatment, and thereafter as appropriate. If serum phosphorus is within the lower limit of the reference range for age, continue treatment with the same dose. Follow the dose adjustment schedule below to maintain serum phosphorus within the reference range for age. Patient weight should be checked periodically to ensure proper total dose for patient weight is being administered.

Dose increase:

If serum phosphorus is below the reference range for age, the dose may be increased stepwise in 0.4 mg/kg intervals up to a maximum of 2 mg/kg, administered every two weeks. Calculated dose should be rounded to the nearest 10 mg with a maximum dose of 90 mg. Reassess fasting serum phosphorus level 4 weeks after dose adjustment. Do not adjust CRYSVITA dose more frequently than every 4 weeks.

Dose decrease:

If serum phosphorus is above the reference range for age, withhold the next dose and reassess the serum phosphorus level in 4 weeks. The patient must have serum phosphorus below the reference range for age to reinitiate CRYSVITA. Once serum phosphorus is below the reference range for age, treatment may be restarted at half the dose level previously administered. Reassess serum phosphorus level 4 weeks after dose adjustment. If the level is below the reference range for age after the re-initiation dose, the dose can be gradually increased according to the Dose Increase instructions.

Adult Patients with X-linked Hypophosphataemia (18 years of age and older)

The recommended dose regimen in adults is 1 mg/kg of body weight, rounded to the nearest 10 mg up to a maximum dose of 90 mg, administered every four weeks. Dose recalculation should be performed if there are changes in patient weight of $\pm 10\%$.

After initiation of treatment with CRYSVITA, measure fasting serum phosphorus on a monthly basis, measured 2 weeks post-dose, for the first 3 months of treatment, and thereafter as appropriate. If serum phosphorus is within the normal range, continue with the same dose.

Dose increase:

CRYSVITA should not be administered at doses greater than 1 mg/kg in adults.

Dose decrease:

If serum phosphorus is above the normal range, withhold the next dose and reassess the serum phosphorus level after 4 weeks. The patient must have serum phosphorus below the normal range to be able to reinitiate CRYSVITA. Once serum phosphorus is below the normal range, treatment may be restarted at half the previous starting dose up to a maximum dose of 40 mg every 4 weeks. Reassess serum phosphorus 2 weeks after any change in dose. Do not adjust CRYSVITA dose more frequently than every 4 weeks.

3.3 Administration

CRYSVITA is administered by subcutaneous injection and should be administered by a health professional.

Injection sites should be rotated with each injection administered at a different anatomic location (upper arms, upper thighs, buttocks, or any quadrant of abdomen) than the previous injection.

Do not inject into moles, scars, or areas where the skin is tender, bruised, red, hard, or not intact. If a given dose on a dosing day requires multiple vials of CRYSVITA, contents from two vials can be combined for injection. The maximum volume of CRYSVITA per injection is 1.5 mL. If multiple injections are required on a given dosing day administer at different injection sites. Monitor for signs of reactions.

Visually inspect CRYSVITA for particulate matter and discoloration prior to administration. CRYSVITA is a sterile, preservative-free, clear to slightly opalescent, and colourless to pale brown-yellow solution for subcutaneous injection. Do not use if the solution is discoloured or cloudy or if the solution contains any particles or foreign particulate matter.

3.4 Missed Dose

If a patient misses a dose, resume CRYSVITA as soon as possible at prescribed dose and begin new dosing schedule based on date at resumption of dosing.

4 OVERDOSAGE

There have been no reports of overdose with CRYSVITA. In clinical trials, the maximum dose tested in pediatric patients was 2 mg/kg to a maximum of 90 mg, and maximum intended dose tested in adult patients was 1 mg/kg to a maximum of 90 mg. In non-XLH adult and juvenile cynomolgus monkeys, the main adverse effects consisted of ectopic mineralization in multiple tissues and organs, which were observed at doses of burosumab that resulted in increased serum phosphorus levels compared to baseline and control levels (0.3, 3, and 30 mg/kg in adult animals and 3 mg/kg in juvenile animals). In adult animals, ectopic mineralization was associated with secondary adverse effects on kidney and heart at ≥ 3 mg/kg and 30 mg/kg, respectively. Adverse effects on bone associated with increased serum phosphorus included thickening of long bones and decreases in femur and vertebral bone strength in adult animals at 30 mg/kg [see NON-CLINICAL TOXICOLOGY].

In case of overdose, it is recommended that serum phosphorus levels, serum calcium levels and renal function be measured immediately and monitored periodically until resolution to normal/baseline levels. In case of hyperphosphataemia, withhold CRYSVITA and initiate appropriate medical treatment.

For management of a suspected drug overdose, contact your regional poison control centre.

5 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING

Table 1: Dosage Forms, Strengths, Composition and Packaging

Route of Administration	Dosage Form / Strength/Composition	Non-Medicinal Ingredients
Subcutaneous Injection	Solution for Injection 10 mg/mL, 20 mg/mL or 30 mg/mL	D-sorbitol, L-histidine, L-methionine, polysorbate 80, water for injection (USP), and hydrochloric acid may be used to adjust pH.

6 DESCRIPTION

CRYSVITA (Burosumab Injection) for subcutaneous administration is supplied as a sterile, preservative-free, clear to slightly opalescent, and colourless to pale brown-yellow solution in a single-use vial.

7 WARNINGS AND PRECAUTIONS

General

Hyperphosphataemia and Risk of Ectopic Mineralization

Increases in serum phosphorus to above the upper limit of normal may be associated with an increased risk of ectopic mineralization, most commonly nephrocalcinosis. For patients already taking CRYSVITA, dose interruption and/or dose reduction may be required based on the patient's serum phosphorus levels [see DOSAGE AND ADMINISTRATION]. Periodic monitoring for signs of ectopic mineralization (e.g., renal ultrasound) should be performed.

Injection Site Reactions

Administration of CRYSVITA may result in local injection site reactions, especially in pediatric patients. Discontinue CRYSVITA if severe injection site reactions occur and administer appropriate medical treatment [see ADVERSE REACTIONS].

Vitamin D Decrease

During burosumab treatment, monitoring of 25-hydroxy vitamin D (25(OH)D) concentration is advised. If vitamin D levels decrease below the normal range, vitamin D supplementation may be needed. Active vitamin D analogues are contraindicated.

Driving and Operating Machinery

Patients experiencing dizziness while taking burosumab should not drive or operate machinery.

Immune

Hypersensitivity

Hypersensitivity reactions (e.g. rash, urticaria, facial swelling) have been reported in patients with CRYSVITA. Discontinue CRYSVITA if serious hypersensitivity reactions occur and initiate appropriate medical treatment [see ADVERSE REACTIONS].

Immunogenicity

As with all therapeutic proteins, there is potential for immunogenicity. Due to the limitation of the anti-drug antibody assay used in clinical trials, antibodies to burosumab could not be evaluated in the majority of patients due to serum burosumab levels ≥ 3750 ng/mL. It is unknown whether burosumab is associated with development of anti-drug and/or neutralizing antibodies or what effects these antibodies may have on the safety or efficacy profile.

Monitoring and Laboratory Tests

Serum phosphorus must be lower than the normal reference range prior to initiation of burosumab. Serum phosphorus should be monitored and dosage adjusted as detailed for the

pediatric and adult populations [see 3 DOSAGE AND ADMINISTRATION]. Serum calcium, creatinine and parathyroid hormone and urine calcium should be monitored periodically.

Sexual Health

Fertility

There are no available data on the effects of CRYSVITA on human fertility to inform a drug-associated risk of adverse fertility outcomes. In addition, no dedicated fertility studies have been conducted in animals. In a 40-week repeat-dose toxicity study conducted in cynomolgus monkeys, no adverse effects on female reproductive organs or menstrual length were observed at doses up to 30 mg/kg. In male monkeys, minimal mineralization in the rete testis or seminiferous tubules associated with hyperphosphatemia was observed at doses ≥ 3 mg/kg. Semen analysis did not show any adverse effects at any dose [see 15 NON-CLINICAL TOXICOLOGY].

7.1 Special Populations

7.1.1 Pregnant Women

There are no available data on CRYSVITA use in pregnant women to inform a drug-associated risk of adverse developmental outcomes. In utero, burosumab exposure in non-XLH pregnant cynomolgus monkeys did not result in teratogenic effects. Adverse effects, such as fetal loss and pre-term birth, were observed in pregnant cynomolgus monkeys. Fetal loss was observed at an exposure higher than that provided by the maximum recommended human dose of 1 mg/kg and was accompanied by maternal hyperphosphatemia and placental mineralization. Pre-term birth was observed at an exposure less than that provided by the maximum recommended human dose. In addition, burosumab was detected in serum from monkey fetuses indicating transport across the placenta [see 15 NON-CLINICAL TOXICOLOGY].

Animal studies are not always predictive of human response; therefore, it is unknown whether CRYSVITA can cause fetal harm when administered to a pregnant woman. Serum phosphorus should be monitored throughout pregnancy [see DOSAGE AND ADMINISTRATION]. Report pregnancies to the KKL Adverse Event reporting line at 1-833-229-1036.

7.1.2 Breast-feeding

CRYSVITA has not been studied in lactating women. It is unknown if the drug is excreted in human milk. Because many drugs are excreted in human milk precaution should be exercised.

7.1.3 Pediatrics

Safety and efficacy of CRYSVITA have been established in pediatric patients aged 1-12 years [see 8 ADVERSE REACTIONS and 14 CLINICAL STUDIES]. Efficacy in pediatric patients with XLH is based on open label studies of 52 pediatric patients 5 to 12 years of age (Study UX023-CL201), and in 13 pediatric patients 1 to 4 years of age (Study UX023-CL205) evaluating serum phosphorus and radiographic findings. Dosing in adolescents (age 13-17) was derived using modeling and simulation of adult and pediatric PK and PD data.

Safety and efficacy for CRYSVITA in pediatric patients with XLH below the age of 1 have not been established.

7.1.4 Geriatrics

Clinical studies of CRYSVITA did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients.

8 ADVERSE REACTIONS

8.1 Adverse Reaction Overview

Overall, 65 pediatric XLH patients aged 1-12 have been exposed to CRYSVITA for a mean duration of 108 weeks (min 40.9, max 150.0). Common adverse reactions in pediatric patients are presented in Table 2. No pediatric patients discontinued due to adverse events.

There have been 175 adult XLH patients exposed to CRYSVITA for a mean duration of 61 weeks (min 12, max 184). Common adverse reactions in adults are presented in Table 3. In clinical trials, 3 adults discontinued from treatment with burosumab due to adverse events.

8.2 Clinical Trial Adverse Reactions

Because clinical trials are conducted under very specific conditions, the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.

Adverse Reactions in Pediatric Patients with XLH

The safety data described below reflect exposure to CRYSVITA in 65 pediatric XLH patients aged 1-12 that included 52 exposed for at least 64 weeks (Study UX023-CL201) and 13 exposed for at least 40 weeks (Study UX023-CL205). Overall, the patient population was 1-12 years (mean age 7.4 years), 51% male, and 89% white/Caucasian. Starting doses were 0.1-0.6 mg/kg in CL201 and 0.8 mg/kg in CL205, and dosing was adjusted towards a target serum phosphorus level of 3.5-5.0 mg/dL. In Study UX023-CL201, 26 of the patients received CRYSVITA at a mean dose of 1.05 mg/kg (range 0.4 – 2.0 mg/kg) every 2 weeks at Week 64; the other 26 patients received CRYSVITA every 4 weeks. In Study UX023-CL205, patients received CRYSVITA at a mean dose of 0.89 mg/kg (range 0.8 – 1.2 mg/kg) every 2 weeks at Week 40. Adverse reactions reported in more than 10% of CRYSVITA-treated pediatric patients are shown in Table 2.

Table 2: Adverse Reactions Reported in More than 10% of Pediatric Patients Receiving CRYSVITA in Studies UX023-CL201 and UX023-CL205

Adverse Reaction (MedDRA 18.1)	UX023-CL201 [ages 5-12] (N=52) n (%)	UX023-CL205 [ages 1-4] (N=13) n (%)	Overall (N=65) n (%)
Headache	38 (73)	1 (8)	39 (60)
Injection site reaction ¹	35 (67)	3 (23)	38 (59)
Pain in extremity	24 (46)	3 (23)	27 (42)
Vitamin D decreased ²	19 (37)	2 (15)	21 (32)

Adverse Reaction (MedDRA 18.1)	UX023-CL201 [ages 5-12] (N=52) n (%)	UX023-CL205 [ages 1-4] (N=13) n (%)	Overall (N=65) n (%)
Rash ³	14 (27)	1 (8)	15 (23)
Toothache	12 (23)	2 (15)	14 (22)
Myalgia	9 (17)	1 (8)	10 (15)
Tooth abscess	8 (15)	3 (23)	11 (17)
Dizziness ⁴	8 (15)	0 (0)	8 (12)

n = number of patients with an event; N = total number of patients who received at least one dose of CRYSVITA

¹ Injection site reaction includes: injection site reaction, injection site erythema, injection site pruritus, injection site swelling, injection site pain, injection site rash, injection site bruising, injection site discoloration, injection site discomfort, injection site hematoma, injection site hemorrhage, injection site induration, injection site macule, and injection site urticaria

² Vitamin D decreased includes: vitamin D deficiency, blood 25-hydroxycholecalciferol decreased, and vitamin D decreased

³ Rash includes: rash, rash pruritic, rash maculo-papular, and rash pustular

⁴ Dizziness includes: dizziness, and dizziness exertional

Hypersensitivity reactions

In pediatric patients, the most frequent potential hypersensitivity events were rash (22%), injection site rash (6%), and urticaria (5%).

Hyperphosphataemia

In pediatric studies, there were no events of hyperphosphataemia reported.

Injection Site Reactions (ISR)

In pediatric studies, approximately 58% of the patients had a local reaction (e.g. injection site urticaria, erythema, rash, swelling, bruising, pain, pruritus, and hematoma) at the site of CRYSVITA injection. Injection site reactions were generally mild in severity, occurred within 1 day of injection, and lasted approximately 1 to 3 days.

Adverse Reactions in Adult Patients with XLH

The safety data described below reflect the results of a randomized, double-blind, placebo-controlled Phase 3 study in adults with XLH (Study UX023-CL303: CRYSVITA = 68, Placebo = 66) aged 20-63 years (mean age 41 years), of whom most were white/Caucasian (81%) and female (65%). Patients started on a dose of 1 mg/kg subcutaneously every 4 weeks and had a mean dose of 0.95 mg/kg (range of weight-adjusted dose after rounding 0.3 – 1.2 mg/kg) at Week 24. Adverse reactions reported in more than 5% of CRYSVITA-treated patients and ≥2 patients than with placebo from the 24-week placebo-controlled portion of UX023-CL303 are shown in Table 3.

Table 3: Adverse Reactions Occurring in More Than 5% of CRYSVITA-Treated Adult Patients and in at Least 2 Patients More Than with Placebo from the 24-Week Placebo-Controlled Period of Study UX023-CL303

Adverse Reaction (MedDRA 18.1)	CRYSVITA (N=68) n (%)	Placebo (N=66) n (%)
Back pain	10 (15)	6 (9)
Headache ¹	9 (13)	6 (9)
Tooth infection ²	9 (13)	6 (9)
Restless legs syndrome	8 (12)	5 (8)
Vitamin D decreased ³	8 (12)	3 (5)
Dizziness	7 (10)	4 (6)
Constipation	6 (9)	0 (0)
Muscle spasm	5 (7)	2 (3)
Blood phosphorus increased ⁴	4 (6)	0 (0)

n = number of patients with an event; N = total number of patients who received at least one dose of CRYSVITA or placebo

¹ Headache includes: headache, and head discomfort

² Tooth infection includes: tooth abscess, and tooth infection

³ Vitamin D decreased includes: vitamin D deficiency, blood 25-hydroxycholecalciferol decreased, and vitamin D decreased

⁴ Blood phosphorus increased includes: blood phosphorus increased, and hyperphosphataemia

Hypersensitivity Reactions

In the double-blind period of UX023-CL303 in adults, approximately 6% of patients in both the CRYSVITA and placebo treatment groups experienced a hypersensitivity event. The events were mild or moderate and did not require discontinuation.

Hyperphosphataemia

In the double-blind period of UX023-CL303, 7% of patients in the CRYSVITA treatment group experienced hyperphosphataemia meeting the protocol-specified criteria for dose reduction (either a single serum phosphorus greater than 5.0 mg/dL or serum phosphorus greater than 4.5 mg/dL [the upper limit of normal for adults] on two occasions). The hyperphosphataemia was managed with dose reduction. The dose for all patients meeting the protocol-specified criteria was reduced 50 percent to 0.5 mg/kg. A single patient required a second dose reduction to 0.25 mg/kg for continued hyperphosphataemia.

Injection Site Reactions (ISR)

In the double-blind period of UX023-CL303, approximately 12% of patients in both the CRYSVITA and placebo treatment groups had a local reaction (e.g. injection site reaction, erythema, rash, bruising, pain, pruritus, and hematoma) at the site of the injection. Injection site reactions were generally mild in severity, occurred within 1 day of injection, lasted approximately 1 to 3 days, required no treatment, and resolved in almost all instances.

Restless Leg Syndrome (RLS)

In the double-blind period of UX023-CL303, approximately 12% of the CRYSVITA treatment group had worsening of baseline restless leg syndrome (RLS) or new onset RLS of mild to moderate severity; these events did not lead to dose discontinuation. Non-serious RLS has also been reported in other repeat dose adult XLH studies; in one case, worsening baseline RLS

was attributed to dose limiting toxicity and led to drug discontinuation and subsequent resolution of the event.

Spinal Stenosis

Spinal stenosis (sometimes with cord compression) is known to occur in adults with XLH. In CRYSVITA clinical trials, 6 patients (of 176) underwent spinal surgery. It is unknown if CRYSVITA is associated with new or exacerbated spinal stenosis or spinal cord compression.

8.3 Less Common Clinical Trial Adverse Reactions

Not applicable due to size of trials; see Tables 2 and 3.

8.4 Post-Market Adverse Reactions

No post-market data was available.

9 DRUG INTERACTIONS

9.1 Overview

Drug interaction studies have not been conducted with CRYSVITA.

9.2 Drug-Drug Interactions

Interactions with other drugs have not been established.

9.3 Drug-Food Interactions

Interactions with food have not been established.

9.4 Drug-Herb Interactions

Interactions with herbal products have not been established.

9.5 Drug-Laboratory Test Interactions

Interactions with laboratory tests have not been established.

10 ACTION AND CLINICAL PHARMACOLOGY

10.1 Mechanism of Action

X-linked hypophosphataemia is caused by excess fibroblast growth factor 23 (FGF23) which suppresses renal tubular phosphate reabsorption and the renal production of 1,25 dihydroxy-vitamin D. Burosumab binds to and inhibits the biological activity of FGF23 increasing renal phosphate reabsorption and increasing the serum concentration of 1,25 dihydroxy-vitamin D.

10.2 Pharmacodynamics

Following SC administration of burosumab in XLH patients, higher burosumab concentrations were associated with greater increase of serum phosphorus levels. The increase in serum

phosphorus was reversible and returned to near baseline following systemic elimination of burosumab.

Ratio of renal tubular maximum reabsorption rate of phosphate to glomerular filtration rate (T_mP/GFR) showed dose-dependent increases from baseline [see CLINICAL STUDIES].

Elevation in serum total FGF23 was observed after initiation of burosumab treatment. The clinical implication of elevated total FGF23 serum concentrations is unknown.

10.3 Pharmacokinetics

Burosumab exhibited linear pharmacokinetics following SC injections within the dose range of 0.1 to 1 mg/kg.

Absorption: Following single SC administrations of burosumab, within the dose range of 0.1 to 1 mg/kg, the mean T_{max} values ranged from 8 to 11 days. The mean (±SD) steady-state trough concentration of burosumab following SC dosing once every 4 weeks was 5.8 (±3.4) mcg/mL. Based on population PK estimates, the systemic accumulation is estimated to be 1.6-fold for the once every 4-week dosing regimen.

Distribution: The apparent volume of distribution of burosumab is estimated to be 8 L based on population PK model estimates for a patient of 70 kg of body weight.

Metabolism: The exact pathway through which burosumab is metabolized has not been characterized. As a human monoclonal antibody, burosumab is expected to be degraded into small peptides and amino acids via catabolic pathways in the same manner as endogenous IgG.

Elimination: The apparent clearance was estimated to be 0.290 L/day based on population PK model estimates for a patient of 70 kg of body weight. The estimated half-life of burosumab was approximately 19 days.

Special Populations and Conditions

Pediatrics: Following SC dosing once every two weeks, the mean (±SD) steady-state trough concentration was 15.8 (±9.4) mcg/mL in pediatric patients 5-12 years of age, and 11.2 (±4.6) mcg/mL in pediatric patients 1-4 years of age. Based on population PK estimates, the systemic accumulation is estimated to be 2.5-fold for the once every 2-week dosing regimen.

Population pharmacokinetic analysis indicated that clearance and volume of distribution of burosumab increases when body weight increases. Age was found not to significantly influence burosumab PK. The apparent volume of distribution was estimated to be 3.4 L and the apparent clearance was estimated to be 0.136 L/day based on population PK model estimates for a patient of 30 kg of body weight.

Hepatic Insufficiency: No studies have been conducted to determine the effect of hepatic impairment on the pharmacokinetics of burosumab.

Renal Insufficiency: No studies have been conducted to determine the effect of renal impairment on the pharmacokinetics of burosumab.

11 STORAGE, STABILITY AND DISPOSAL

CRYSVITA vials must be stored in the original carton until the time of use under refrigerated conditions at 36°F to 46°F (2°C to 8°C). Keep CRYSVITA vial in the original carton to protect from light until time of use.

Do not freeze or shake CRYSVITA.

Do not use CRYSVITA beyond the expiration date stamped on the carton.

CRYSVITA vials are single-use only. Discard any unused product.

12 SPECIAL HANDLING INSTRUCTIONS

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

PART II: SCIENTIFIC INFORMATION

13 PHARMACEUTICAL INFORMATION

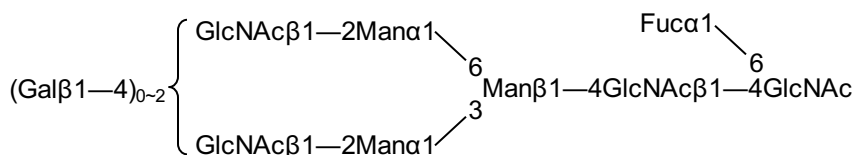
Drug Substance

Proper name: Burosumab

Chemical name: Immunoglobulin G1, anti-(human Fibroblast Growth Factor 23 (FGF23) antigen) (human monoclonal burosumab heavy chain), disulfide with human monoclonal burosumab kappa/light chain, dimer

Molecular formula and molecular mass: Burosumab is a human Immunoglobulin G subclass 1 (IgG1), anti-(human fibroblast growth factor 23 (FGF23) antigen) antibody produced by recombinant DNA technology using Chinese hamster ovary (CHO) mammalian cell culture. Burosumab is composed of two heavy chain (γ 1-chain) molecules and two LC (κ -chain) molecules. Each heavy chain (H-chain) has an N-linked carbohydrate moiety at asparagine 297 (Asn297). The molecular weight calculated by mass spectrometry is approximately 147 kilodaltons (kDa).

Structural formula: Based upon the molecular weight observed, main N-Glycan structures were resolved as shown in the figure below. The major carbohydrate species on each site are typical sialylated biantennary structures with core fucose.



Physicochemical properties: Burosumab has Complementarity Determining Regions (CDRs) derived from mouse anti-human Fibroblast Growth Factor 23 (FGF23). It binds to excess FGF23 in biological fluid. The Mechanism of Action (MoA) of KRN23 is neutralization of excess FGF23 that can inhibit an interaction between soluble FGF23 and FGF23 receptor complex on the cell surface.

Product Characteristics

Burosumab is intended for subcutaneous injection and is supplied as a sterile, preservative-free, clear to slightly opalescent and colourless to pale brown-yellow solution in a single-use vial. Each vial of burosumab contains 10 mg, 20 mg, or 30 mg of burosumab in 1 mL solution containing D-sorbitol (45.91 mg), L-histidine (1.55 mg), L-methionine (1.49 mg), polysorbate 80 (0.5 mg) in water for injection, USP.

14 CLINICAL TRIALS

14.1 Trial Design and Study Demographics

Table 4: Summary of Patient Demographics for Clinical Trials in X-linked Hypophosphataemia

Study #	Trial Design	Dosage, Route of Administration and Duration	Study Subjects (n)	Mean Age (Range)	Sex
UX023-CL201	Randomized, Phase 2, open-label dose finding study	Starting doses of 0.1 mg/kg, 0.2 mg/kg, or 0.3 mg/kg Q2W, or 0.2 mg/kg, 0.4 mg/kg, or 0.6 mg/kg Q4W. Doses titrated to target serum phosphorus with max dose 2.0 mg/kg. SC injections, 64 weeks (ongoing).	52 Prepubescent XLH patients	8.5 years old (5 – 12)	24 male 28 female
UX023-CL205	Open-label, Phase 2 study	Subcutaneous 0.8 mg/kg every two weeks with titration up to 1.2 mg/kg based on serum phosphorus measurements for up to 40 weeks.	13 pediatric XLH patients	2.9 years old (1 – 4)	9 male 4 female
UX023-CL303	Phase 3, Randomized, double-blind, placebo-controlled followed by open-label extension	Subcutaneous 1 mg/kg every 4 weeks for 24 weeks placebo-controlled treatment, followed by open-label treatment for all subjects up to 48 weeks	134 adult XLH patients	40 years old (19 – 66)	47 male 87 female
UX023-CL304	Open-label, single-arm, phase 3 study	Subcutaneous 1.0 mg/kg every four weeks	14 adult XLH patients	40 years old (25 – 52)	6 male 8 female

Pediatric X-linked Hypophosphataemia

CRYSVITA has been evaluated in 65 pediatric patients with XLH. For the purposes of CRYSVITA clinical trials in pediatric XLH patients aged 1-12, the normal range for serum phosphorus used was 3.2-6.1 mg/dL and the normal range for serum ALP was 297-385 U/L.

UX023-CL201:

UX023-CL201 is a randomized, open-label study in 52 prepubescent XLH patients, 5 to 12 years old, which compared treatment with CRYSVITA administered every 2 weeks versus every 4 weeks. All 52 patients completed at least 64 weeks on study; no patient discontinued. Burosumab dose was adjusted to target a fasting serum phosphorus concentration of 3.5 to 5.0 mg/dL. Twenty-six of 52 patients received CRYSVITA every two weeks at an average dose of 0.73 (range: 0.3, 1.5), 0.98 (range: 0.4, 2.0) and 1.04 (range: 0.4, 2.0) mg/kg at weeks 16, 40 and 60 respectively, and up to a maximum dose of 2.0 mg/kg. The remaining 26 patients received CRYSVITA every four weeks. Ninety-six percent had received oral phosphate and active vitamin D analogues for a mean duration of 7 (2.4) years. Oral phosphate and active vitamin D analogues were discontinued prior to study enrolment. Ninety-four percent of patients had radiographic evidence of rickets at baseline.

UX023-CL205:

UX023-CL205 is a 64-week open-label study in 13 pediatric XLH patients, 1 to 4 years old. All patients completed at least 40 weeks on study; no patients discontinued. All patients had radiographic evidence of rickets at baseline and had received oral phosphate and active vitamin D analogues for a mean duration of 16.9 (13.9) months. Oral phosphate and active vitamin D analogues were discontinued prior to study enrolment.

Adult X-linked Hypophosphataemia

For the purposes of CRYSVITA clinical trials in adult patients with XLH, the normal range for serum phosphorus used was 2.5-4.5 mg/dL, with a dose-limiting toxicity threshold of >6.5 mg/dL.

UX023-CL303:

UX023-303 is a randomized, double-blind, placebo-controlled study in 134 adult XLH patients. The study comprised a 24-week placebo-controlled treatment period followed by a 24-week open-label period in which patients randomized to placebo switched to CRYSVITA; all patients remained blinded to their original treatment assignment. One patient in the CRYSVITA group discontinued treatment during the 24-week placebo-controlled treatment period, 7 patients discontinued during the second 24-week period with 126 patients completing 48 weeks of treatment. Oral phosphate and active vitamin D analogues were not allowed during the study.

UX023-CL304:

UX023-CL304 is a 48-week, open-label, single-arm study in 14 adult XLH patients to assess the effects of CRYSVITA on improvement of osteomalacia as determined by histologic and histomorphometric evaluation of iliac crest bone biopsies. Patients received 1 mg/kg CRYSVITA every four weeks. Oral phosphate and active vitamin D analogues were not allowed during the study.

14.2 Study Results

Pediatric X-linked Hypophosphataemia

Serum Phosphorus

In pediatric patients receiving open label CRYSVITA titrated to a target serum phosphorus range of 3.5-5.0 mg/dL, mean serum phosphorus levels were within the normal range for children (3.2-6.1 mg/dL in these trials) at the times of efficacy assessments (Table 5).

Table 5: Serum Phosphorus in children 1-12 years receiving CRYSVITA every 2 weeks in study UX023-CL201 (5-12 year olds) and study UX023-CL205 (1-4 year olds)

Serum Phosphorus:	CL201 (n=26)	CL205 (n=13)
Baseline mean, mg/dL (SD)	2.4 (0.40)	2.5 (0.28)
Week 40 mean, mg/dL (SD)	3.3 (0.40)	3.5 (0.49)
Week 64 mean, mg/dL (SD)	3.4 (0.45)	

Radiographic Evaluation of Rickets

Radiographs from 52 CRYSVITA-treated XLH patients in Study UX023-201 and 13 patients in Study UX023-CL205 were examined to assess XLH related rickets using the 10-point Thacher Rickets Severity Score (RSS) and the 7-point Radiographic Global Impression of Change (RGI-C). The RSS score is assigned based on single images of the wrist and knee from a single time point with higher scores indicating higher rickets severity. The RGI-C score is assigned based on side-by-side comparisons of wrist and knee radiographs from two time points with higher scores indicating greater improvement in rickets. A RGI-C score of +2.0 was defined as radiographic evidence of substantial healing.

Table 6: Rickets Response in Children 1-12 years Receiving CRYSVITA Every 2 Weeks in Study UX023-CL201 and Study UX023-CL205

Endpoint Timepoint	CRYSVITA Every 2 Weeks	
	UX023-CL201 (N=26)	UX023-CL205 (N=13)
RSS Total Score		
Baseline Mean (SD)	1.9 (1.17)	2.9 (1.37)
LS Mean change from baseline in total score ^a (reduction indicates improvement) with 95% CI		
Week 40	-1.1 (-1.28, -0.85)	-1.7 (-2.03, -1.44)
RGI-C Global Score		
LS Mean score ^a (positive indicates healing) with 95% CI		
Week 40	+1.7 (+1.48, +1.84)	+2.3 (+2.16, +2.51)

a) The estimates of LS means and 95% CI (confidence interval) are from the generalized estimation equation model accounting for baseline RSS, visits and regimen and its interaction for UX023-CL201 and from ANCOVA model accounting for age and baseline RSS. Reduced RSS score indicates improvement in rickets severity.

In Trial CL201, 18 out of 26 patients receiving CRYSVITA every two weeks achieved a RGI-C score of $\geq +2.0$. In Trial CL205, all 13 patients achieved a RGI-C global score $\geq +2.0$.

Serum Alkaline Phosphatase Activity

For Study UX023-CL201, mean (SD) serum total alkaline phosphatase activity was 462 (110) U/L at baseline and decreased to 395 (95) U/L at Week 40 (-12.6%) in the patients who received CRYSVITA every 2 weeks.

For Study UX023-CL205, mean (SD) serum total alkaline phosphatase activity was 549 (194) U/L at baseline and decreased to 335 (88) U/L at Week 40 (mean change: -36%).

Adult X-linked Hypophosphataemia

Serum Phosphorus

In Study UX023-CL303 at baseline, mean (SD) serum phosphorus was 1.9 (0.32) and 2.0 (0.30) mg/dL in the placebo and CRYSVITA groups respectively. During the initial 24 weeks of treatment, mean (SD) serum phosphorus across the midpoints of dose intervals (2 weeks post dose, at time of peak effect) was 2.1 (0.30) and 3.2 (0.53) mg/dL in the placebo and CRYSVITA groups, and mean (SD) serum phosphorus across the ends of dose intervals (trough effect) was 2.1 (0.30) and 2.7 (0.45) mg/dL in the placebo and CRYSVITA groups (see Table 7).

Table 7: Proportion of Adult Patients Achieving Mean Serum Phosphorus Levels Above the LLN at the Midpoint of the Dose Interval in the 24-Week Placebo-Controlled Period of Study UX023-CL303

	Placebo (N = 66)	CRYSVITA (N = 68)
Achieved Mean Serum Phosphorus > LLN Across Midpoints of Dose Intervals Through Week 24 - n (%)	5 (8%)	64 (94%)
95% CI	(3.3, 16.5)	(85.8, 97.7)
p-value ^a		< 0.0001

The 95% CIs are calculated using the Wilson score method.

^a P-value is from Cochran-Mantel-Haenszel (CMH) testing for association between achieving the primary endpoint and treatment group, adjusting for randomization stratifications.

In the initial CRYSVITA group, mean serum phosphorus concentrations remained at or above LLN through 48 weeks of treatment. In patients who crossed over from placebo to CRYSVITA at week 24, mean serum phosphorus concentrations increased above the LLN at the first visit after the first CRYSVITA administration (Week 26) and remained at or above the LLN throughout CRYSVITA treatment.

XLH-Associated Stiffness

Study UX023-CL303 investigated CRYSVITA for the management of XLH associated stiffness measured by the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC). The scores on each domain of the index are normalized and range from 0-100 with a higher score indicating poorer functioning. At 24 weeks, mean (SD) WOMAC stiffness score declined from 61.4 (20.77) to 60.4 (21.83) in the placebo group and from 64.7 (20.25) to 53.7 (20.76) in the CRYSVITA group [LS Mean (SE): CRYSVITA -7.9 (3.03) versus Placebo 0.5 (3.14), p-value =0.0106].

Radiographic Evaluation of Osteomalacia

In Study UX023-CL303, a skeletal survey was conducted at baseline to identify osteomalacia-related fractures and pseudofractures. Osteomalacia-related fractures are defined as atraumatic lucencies extending across both bone cortices and pseudofractures are defined as atraumatic lucencies extending across one cortex. The active fractures and pseudofractures were predominantly located in the femurs, tibia/fibula, and metatarsals of the feet. Assessment of these active fracture/pseudofracture sites at week 24 demonstrated a higher rate of complete healing in the CRYSVITA group compared to placebo as shown in [Table 8](#).

Table 8: Comparison of Fracture Healing with CRYSVITA vs Placebo in UX023-CL303: Comparison of Fracture Healing with CRYSVITA vs Placebo in UX023-CL303

	Active Fractures		Active Pseudofractures		Total Fractures	
	Placebo n (%)	CRYSVITA n (%)	Placebo n (%)	CRYSVITA n (%)	Placebo n (%)	CRYSVITA n (%)
No. of fractures at baseline	13	14	78	51	91	65
Healed at week 24^a	0 (0%)	7 (50.0%)	7 (9.0%)	21 (41.2%)	7 (7.7%)	28 (43.1%)

a. Percent based on baseline

During the open-label period where all patients received CRYSVITA, the patients who continued receiving CRYSVITA showed additional healing in Active Fractures, Active Pseudofractures and Total Fractures. Patients who started receiving CRYSVITA in the open-label period showed higher rate of complete healing in Active Fractures, Active Pseudofractures and Total Fractures compared to when they received placebo.

Bone Histomorphometry

In Study UX023-CL304, after 48 weeks of treatment, histomorphometric improvement in osteomalacia was observed in ten patients as demonstrated by decreases in proxy measures. Osteoid volume/Bone volume (OV/BV) changed from a mean (SD) score of 26.1% (12.4) at baseline to 11.2% (6.5), a reduction of 57% (n=11). Osteoid thickness (O.Th) declined from a mean (SD) of 17.2 (4.1) micrometers to 11.6 (3.1) micrometers, a reduction of 33% (n=11). Mineralization lag time (MLt) declined from a mean (SD) of 594 (675) days to 156 (77) days, a reduction of 74% (n=6).

15 NON-CLINICAL TOXICOLOGY

General Toxicology

In 40-week repeat-dose toxicity studies conducted in normal, non-XLH adult and juvenile cynomolgus monkeys, burosumab was administered intravenously once every two weeks at doses of 0.03, 0.3, 3, and 30 mg/kg in adults and 0.03, 0.3, and 3 mg/kg in juvenile animals. In these studies, burosumab was also administered subcutaneously at the high dose. Burosumab increased serum concentrations of phosphorus and 1,25 dihydroxy vitamin D in a dose-dependent manner. The main adverse effects consisted of ectopic mineralization in multiple tissues and organs, which were observed at doses of burosumab that resulted in increased serum phosphorus levels compared to baseline and control levels (0.3, 3, and 30 mg/kg in adult animals and 3 mg/kg in juvenile animals). Ectopic mineralization was predominantly observed in the kidneys, lungs, eye, sciatic nerve, and heart in adults and in the kidneys in juvenile animals. In adults, ectopic mineralization in the kidneys and heart were associated with secondary adverse effects (e.g., degeneration/necrosis of collecting tubules and interstitial fibrosis in the kidneys at ≥ 3 mg/kg and increased heart rate, depressed ST on ECG in one animal at 30 mg/kg, and effects on cardiac function in the heart at 30 mg/kg). Mineralization was also observed in connective tissue of subcutaneous tissue, skeletal muscle, and/or articular capsule, resulting in swelling, accumulated material, and white masses in extremities. Bone effects observed in adult and juvenile cynomolgus monkeys administered burosumab included changes in biomarkers of bone turnover and increases in cortical bone thickness, total and/or cortical bone density, and total and/or cortical bone content. In adults, thickening of long bones was accompanied by histopathological findings, including hyperostosis of cortical bone at 30 mg/kg. Decreases in femur and vertebral bone strength were also observed in adults at 30 mg/kg. In juvenile animals, burosumab administration did not adversely affect bone development as no effects on bone strength, vertebra height, and femur length were observed. There were also no effects on growth plate thickness.

Based on findings of ectopic mineralization, the no-observed-adverse-effect level (NOAEL) for the general toxicity of burosumab in cynomolgus monkeys was 0.03 mg/kg in adult males, 0.3 mg/kg in adult females, and 0.3 mg/kg in juvenile animals (males and females). The adult male NOAEL of 0.03 mg/kg corresponded to an exposure less than (0.13-fold) the predicted adult human exposure at the dose of 1 mg/kg every 4 weeks, and the adult female NOAEL of 0.3 mg/kg corresponded to an exposure equivalent to the predicted human exposure. The NOAEL of 0.3 mg/kg in juvenile animals also corresponded to an exposure less than the predicted exposures in pediatric patients following dosing every 2 weeks (0.38-fold the exposure in 1 to <5 year olds with mean dose of 0.77 mg/kg and 0.29-fold the exposure in 5 to ≤ 12 year olds with mean dose of 1.31 mg/kg).

Carcinogenicity

The carcinogenic potential of burosumab has not been evaluated in long term animal studies.

Genotoxicity

Studies have not been performed to evaluate the genotoxic potential of burosumab.

Reproductive and Developmental Toxicology

No dedicated fertility studies have been performed in animals to evaluate the effects of burosumab.

In the 40-week repeat-dose toxicity study conducted in non-XLH adult cynomolgus monkeys, no adverse effects on female reproductive organs or menstrual length were observed at doses up

to the highest doses tested (exposures up to 65-fold the predicted adult human exposure at the dose of 1 mg/kg every 4 weeks). In male monkeys, minimal mineralization of the rete testis or seminiferous tubules associated with hyperphosphatemia was observed at doses ≥ 3 mg/kg, but not at doses up to 0.3 mg/kg (exposures less than [0.79-fold] the predicted adult human exposure). Semen analysis did not show any adverse effects at any dose.

In an enhanced pre- and post-natal developmental study conducted in non-XLH cynomolgus monkeys, burosumab was administered intravenously at doses of 0.3, 3, or 30 mg/kg once every two weeks from gestation day 20 of pregnancy to parturition or cesarean section on gestation day 133, which includes the period of organogenesis. The doses corresponded to maternal exposures that were 0.9-, 7- and 64-fold the predicted adult human exposure at the dose of 1 mg/kg every 4 weeks. In maternal animals, burosumab increased serum concentrations of phosphorus and 1,25 dihydroxy vitamin D in a dose-dependent manner and resulted in similar changes in biomarkers of bone turnover and bone architecture as those observed in the repeat-dose toxicity studies. In addition, ectopic mineralization of maternal tissues (similar to those noted above), including in the placenta, and shortened gestation period were observed at ≥ 3 mg/kg, an increased incidence of embryo/fetal losses (excluding stillbirths) was observed at 30 mg/kg, and increased incidences of pre-term births were observed at all doses. Burosumab administration, however, did not result in teratogenic effects or on adverse developmental effects in offspring, including in bone as no clear effects on bone strength, vertebra height, femur length, and bone histomorphometry parameters were observed. A NOAEL for the general toxicity and reproductive toxicity of burosumab in maternal cynomolgus monkeys could not be identified on the basis that an increased incidence of pre-term birth was observed at all doses. The NOAEL for the developmental toxicity of burosumab was 3 mg/kg (maternal exposure 7-fold greater than the predicted adult human exposure) based on an increased incidence of fetal losses observed at 30 mg/kg. Burosumab was detected in serum from fetuses indicating transport across the placenta. Hyperphosphatemia but no ectopic mineralization was present in fetuses and offspring at the maternal dose of 30 mg/kg.

REFERENCES

1. Thacher, TD, Fischer, PR, Pettifor, JM, Lawson, JO, Manaster, BJ, and Reading, JC. 2000. "Radiographic scoring method for the assessment of the severity of nutritional rickets." *J Trop Pediatr* 46 (3):132-9.

READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE
PATIENT MEDICATION INFORMATION

CRYSVITA (kris-VEE-tuh)
Burosumab Injection

Read this carefully before you start taking **CRYSVITA** and each time you get a refill. This leaflet is a summary and will not tell you everything about this drug. Talk to your doctor about your medical condition and treatment and ask if there is any new information about **CRYSVITA**.

What is CRYSVITA ?

- CRYSVITA contains the active substance burosumab. This is a type of medicine called a human monoclonal antibody.
- CRYSVITA is used to treat X-linked hypophosphataemia (XLH). It is used in children one year of age and older and adults.
- XLH is a genetic disease. People with XLH have higher levels of a hormone called fibroblast growth factor 23 (FGF23). FGF23 lowers the amount of phosphate in the blood. The low level of phosphate may lead to bones that cannot grow and harden properly.

How does CRYSVITA work?

CRYSVITA attaches to FGF23 in the blood which stops FGF23 from working and increases the phosphate levels in the blood so that normal levels of phosphate can be achieved.

What are the ingredients in CRYSVITA?

Medicinal ingredients: Burosumab

Non-medicinal ingredients: D-sorbitol, L-histidine, L-methionine, polysorbate 80, water for injection (USP), and hydrochloric acid may be used to adjust pH.

CRYSVITA comes in the following dosage forms:

10 mg, 20 mg and 30 mg solution for injection

Do not use CRYSVITA if:

- You are allergic to burosumab or any of the other ingredients in this medication
- You are taking any phosphate or vitamin D supplements
- You already have a high level of phosphate in your blood (“hyperphosphataemia”)
- You have severe kidney disease or kidney failure

To help avoid side effects and ensure proper use, talk to your doctor before you take CRYSVITA. Talk about any health conditions or problems you may have, including if you:

- Are taking phosphates or vitamin D supplements

Other warnings you should know about:

Skin reactions

You may get skin reactions where the injection is given. If these reactions are severe, you should contact your health care professional right away.

Children under 1 Year

CRYSVITA should not be given to children under 1 year of age because the safety and effects of the medicine have not been studied in this age group.

Pregnancy and breast-feeding

If you are pregnant or breast-feeding, think you might be pregnant or are planning to have a baby, ask your health care professional or pharmacist for advice before taking this medicine. This is because it is not known if CRYSVITA will affect the baby.

It is not known if CRYSVITA passes into breast milk, and a risk to newborns or infants cannot be ruled out. You

should discuss this with your health care professional.

Tell your doctor about all the medicines you take, including any drugs, vitamins, minerals, natural supplements or alternative medicines. Studies to test how CRYSVITA interacts with other medicines have not been done.

How to take CRYSVITA:

CRYSVITA should be given by injection under the skin in the arm, abdomen, buttock or thigh by your health care professional or a trained healthcare provider.

Usual dose:

The dose is based on your body weight. Your health care professional will work out the right dose for you. CRYSVITA will be injected every two weeks in children and every four weeks for adults.

Tests and Checks

Your health care professional will sometimes check the phosphate level in your blood and your urine in order to reduce the risk of hyperphosphataemia (too much phosphate in the blood).

Your health care professional will perform these checks to make sure that you are getting the right dose and may change your dose if needed.

The maximum dose you will be given is 90 mg.

Overdose:

CRYSVITA is administered under the supervision of a health professional, who will check that the correct dose has been given and treat any overdose.

Missed Dose:

If a dose is missed, talk to your health care professional right away. The missed dose should be given as soon as possible, and your health care professional will re-arrange future doses accordingly.

What are possible side effects from using CRYSVITA?

Like all medicines, this medicine can cause side effects, although not everybody gets them.

Below are possible side effects you may feel when taking CRYSVITA. If you experience any side effects not listed here, contact your doctor.

Side effects in children may include:

- Tooth abscess (infection)
- Headache
- Toothache
- Rash
- Pain in muscles (myalgia) and hands and feet
- Reactions where the injection was given, which may include:
 - Redness or rash
 - Pain or itching
 - Swelling
 - Bleeding or bruising

These injection site reactions are usually mild and occur within a day after the injection and usually get better in around 1 to 3 days.

- Low vitamin D
- Dizziness

Side effects in adults may include:

- Back pain
- Headache
- Tooth infection

- Restless leg syndrome
- Constipation
- Low vitamin D
- Dizziness
- Muscle spasm

Serious side effects and what to do about them			
Symptom / effect	Talk to your doctor		Stop taking drug and get immediate medical help
	Only if severe	In all cases	
VERY COMMON Skin reactions	√		
Dizziness	√		
RARE Allergic reactions shortly after being given CRYSVITA: rash and itching all over the body, severe swelling of eyelids, mouth or lips, shortness of breath, rapid heartbeat, sweating		√	

If you have a troublesome symptom or that is not listed here or becomes bad enough to interfere with your daily activities, talk to your doctor.

<p>Reporting Side Effects</p> <p>You can report any suspected side effects associated with the use of health products to Health Canada by:</p> <ol style="list-style-type: none"> 1. Visiting the Web page on Adverse Reaction Reporting (http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/index-eng.php) for information on how to report online, by mail or by fax; or 2. Calling toll-free at 1-866-234-2345. <p><i>NOTE: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.</i></p>
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Storage:

CRYSVITA vials must be stored in the original carton until the time of use under refrigerated conditions at 36°F to 46°F (2°C to 8°C). Keep CRYSVITA vial in the original carton to protect from light until time of use.

Do not freeze or shake CRYSVITA.

Keep out of reach and sight of children.

If you want more information about CRYSVITA:

- Talk to your doctor
- Find the full product monograph that is prepared for healthcare professionals Patient Medication Information by visiting the [Health Canada Website](http://www.healthcanada.gc.ca); Kyowa Kirin Limited <http://international.kyowa-kirin.com/ca/crysvita/pm/> or by calling 1-833-388-5872.

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