PRODUCT MONOGRAPH
INCLUDING PATIENT MEDICATION INFORMATION

PRSPINRAZATM

(nusinersen injection)

Solution for intrathecal injection 2.4 mg/mL nusinersen as nusinersen sodium

Other drugs for disorders of the musculo-skeletal system

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PRINZRAZATM
(nusinersen injection)

PART I: HEALTH PROFESSIONAL INFORMATION

SUMMARY PRODUCT INFORMATION

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<thead>
<tr>
<th>Route of Administration</th>
<th>Pharmaceutical Form/Strength</th>
<th>Nonmedicinal Ingredients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrathecal by lumbar puncture</td>
<td>Solution for intrathecal injection 2.4 mg/mL</td>
<td>sodium dihydrogen phosphate dihydrate, disodium phosphate, sodium chloride, potassium chloride, calcium chloride dihydrate, magnesium chloride hexahydrate, water for injection</td>
</tr>
</tbody>
</table>

INDICATIONS AND CLINICAL USE

SPINRAZA (nusinersen) is indicated for the treatment of 5q Spinal Muscular Atrophy (SMA).

The efficacy and safety data supporting the use of SPINRAZA for the treatment of SMA were from:

- a completed randomized, controlled trial and an ongoing open-label clinical trial that included patients with infantile-onset SMA
- a completed randomized, controlled trial and completed open-label clinical trials in children with later-onset SMA and,
- an ongoing open-label clinical trial in presymptomatic infants with genetically diagnosed SMA (see CLINICAL TRIALS).

Knowledge of the disease natural history and the use of management strategies that assist the patient in coping with the manifestations of SMA, which may include decline in motor function, serious respiratory complications and feeding difficulties remain necessary for the overall management of the disease. Treatment with SPINRAZA should only be initiated by healthcare professionals who are experienced in the management of SMA.

There are limited data in patients over the age of 18 years (see CLINICAL TRIALS).

**Adult:** There are limited data from patients over 18 years of age. SPINRAZA has been studied in patients ranging in age from newborn to 19 years (see CLINICAL TRIALS).

**Geriatrics (> 65 years of age):**
There are no data from patients over the age of 65.

CONTRAINDICATIONS

- SPINRAZA (nusinersen) is contraindicated in patients with known or suspected hypersensitivity to nusinersen or to any of the ingredients in the formulation or component of the container.
WARNINGS AND PRECAUTIONS

General
The route of administration for SPINRAZA (nusinersen) is intrathecal injection by lumbar puncture and should be administered by healthcare professionals who are experienced in performing lumbar puncture procedures. Patients should be evaluated for the presence of potential contraindications for lumbar puncture (e.g., skin infection near site of lumbar puncture, suspicion of increased intracranial pressure due to a cerebral mass, uncorrected coagulopathy, acute spinal cord trauma), and all necessary precautions should be taken to avoid serious procedural complications (see DOSAGE AND ADMINISTRATION; ADVERSE REACTIONS, Postmarket Adverse Events).

Hematologic
Coagulation abnormalities and thrombocytopenia, including acute severe thrombocytopenia, have been observed after intravenous or subcutaneous administration of some antisense oligonucleotides.

In a combined analysis of the sham-controlled studies for patients with infantile-onset and later-onset SMA, 24 of 146 (16%) SPINRAZA-treated patients developed a platelet level below the lower limit of normal, compared to 10 of 72 (14%) sham-controlled patients. In the sham-controlled study in patients with later-onset SMA (Study 2), two SPINRAZA-treated patients developed platelet counts less than 50,000 cells per microliter, with a lowest level of 10,000 cells per microliter recorded on study day 28.

Patients may be at increased risk of bleeding complications due to the risk of thrombocytopenia and coagulation abnormalities with SPINRAZA.

Perform a platelet count and coagulation laboratory testing at baseline and as clinically indicated (see WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests).

Neurologic

Hydrocephalus
There have been reports of communicating hydrocephalus not related to meningitis or bleeding in patients treated with nusinersen in the post-marketing setting. Some patients were implanted with a ventriculo-peritoneal shunt. In patients with decreased consciousness, an evaluation for hydrocephalus should be considered. The benefits and risks of nusinersen treatment in patients with a ventriculo-peritoneal shunt are unknown at present and the maintenance of treatment needs to be carefully considered.

Renal
Renal toxicity, including potentially fatal glomerulonephritis, has been observed after intravenous or subcutaneous administration of some antisense oligonucleotides. SPINRAZA is found in high concentrations in the kidney, localized mainly in proximal tubule cells, and is excreted by the kidney (see ACTION AND CLINICAL PHARMACOLOGY).

In a combined analysis of the sham-controlled studies for patients with infantile-onset and later-onset SMA, 71 of 123 (58%) of SPINRAZA-treated patients had elevated urine protein, compared to 22 of 65 (34%) sham-controlled patients.
Conduct quantitative spot urine protein testing (preferably using a first morning urine specimen) at baseline and as clinically indicated. For urinary protein concentration greater than 0.2 g/L, consider repeat testing and further evaluation.

**Cardiovascular**
(See ADVERSE REACTIONS)

**Carcinogenesis and Mutagenesis**
(see TOXICOLOGY).

**Sexual Function/Reproduction**
The effects of SPINRAZA on labor and delivery are not known.

**Special Populations:**

**Pregnant Women:**

There are no data from clinical studies on the use of SPINRAZA during pregnancy in humans and the effects of SPINRAZA on labor and delivery are not known. Because the potential developmental risk associated with the use of SPINRAZA in pregnant women is not known, the use of SPINRAZA during pregnancy is not recommended.

In animal studies administration of nusinersen by subcutaneous injection to mice and rabbits during pregnancy did not have toxic effects on embryo-fetal development (see TOXICOLOGY).

**Nursing Women:**

It is not known if nusinersen is present in human breast milk.

There are no data on the use of SPINRAZA during lactation in humans and the effects of nusinersen on the breastfed infant are not known.

**Pediatrics:**

In repeated dose toxicity studies in juvenile cynomolgus monkeys, following intrathecal administration of nusinersen (0.3, 1, or 3 mg/dose for 14 weeks or 0.3, 1, 3 or 4 mg/dose for 53 weeks) or vehicle control, brain histopathology (neuronal vacuolation and necrosis/cellular debris in the hippocampus) was observed at the mid- (1 mg/dose) and high doses (3 mg or 4 mg/dose), specifically in the inferior region of the hippocampus. Possible neurobehavioral deficits were observed on a learning and memory test at the high dose in the 53-week monkey study. The no-observed adverse effect level (NOAEL) dose for neurohistopathology in monkeys (0.3 mg/dose) is approximately equivalent to the human dose when calculated on a yearly basis and corrected for the species difference in CSF volume. The clinical significance of these observations in monkeys is not known.

**Monitoring and Laboratory Tests**
Conduct the following laboratory tests at baseline and as clinically indicated:
- Platelet count (see WARNINGS AND PRECAUTIONS, Hematologic)
• Prothrombin time; activated partial thromboplastin time (see WARNINGS AND PRECAUTIONS, Hematologic)
• Quantitative spot urine testing (see WARNINGS AND PRECAUTIONS, Renal)

ADVERSE REACTIONS

Adverse Drug Reaction Overview

The safety of SPINRAZA (nusinersen) was evaluated in infants with SMA in a phase 3 randomized, double-blind, sham-controlled study of symptomatic infants (1 to 7 months of age at study entry, SPINRAZA n=80, control n=41); an ongoing open-label phase 2 study in symptomatic infants (1 to 7 months of age at study entry, n=20); and, an ongoing open-label phase 2 study in pre-symptomatic infants genetically diagnosed with SMA (3 to 42 days old at first dose, n=20). The safety of SPINRAZA in patients with later-onset SMA was evaluated in a phase 3 randomised, double-blind, sham-controlled study (2 to 9 years of age at study entry, SPINRAZA n=84, control n=42); and completed open-label phase 1 and phase 2 studies of patients who were 2 to 16 years of age at first dose (n=56).

A total of 260 patients were exposed to SPINRAZA in the clinical trials for a total duration of 6 to 1538 days (median 449 days); 227 patients were exposed for at least 6 months and 181 were exposed for at least 12 months. In the controlled study in symptomatic infants, 58 patients were exposed to SPINRAZA for at least 6 months and 28 patients were exposed for at least 12 months. In the controlled study in symptomatic, later-onset patients, 83 patients were exposed to SPINRAZA for at least 6 months and 54 patients were exposed for at least 12 months. The nature of the adverse events reported during all clinical trials suggests that the majority may have been related to SMA disease or the lumbar puncture procedure.

Clinical Trial Adverse Drug 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 drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.

The safety of SPINRAZA in infants and children with SMA was assessed in two phase 3 randomized, double blind, sham controlled studies (Study 1 and Study 2), in an open label phase 2 study in symptomatic infants (Study 3), an open label study in pre-symptomatic infants genetically diagnosed with SMA (Study 4) and in patients aged 2 to 16 years (at first dose) in an integrated analysis of 4 open label studies (Studies 5, 6, 7 and 8), with a total of 260 SMA patients assessed and total time on study from 6 to 1538 days (median 449 days).

In Study 1, 121 patients were dosed, of whom 80 patients received SPINRAZA (median exposure 280 days) and 41 patients received sham control (median exposure 187 days).

In Study 2, 126 patients were dosed, of whom 84 patients received SPINRAZA (median exposure 451 days) and 42 patients received sham control (median exposure 450 days).
Adverse events reported at an incidence at least 5% higher in patients treated with SPINRAZA compared to sham-control in Studies 1 and 2 are summarized in Tables 1 and 2, respectively. Events reported across open-label studies 3, 4, 5, 6, 7, and 8 were consistent with those observed in Studies 1 and 2.

The adverse events are presented as MedDRA preferred terms under the MedDRA system organ class (SOC) (MedDRA Version 18.1).

The adverse events are listed by system organ class and are presented in order of decreasing seriousness.

**Table 1: Treatment Emergent Adverse Events\(^1\) Reported with an Incidence of at Least 5% Higher in Patients Treated with SPINRAZA\(^2\) Compared to Sham-control in the controlled clinical trial in patients with infantile-onset SMA**

<table>
<thead>
<tr>
<th>System Organ Class</th>
<th>Preferred term</th>
<th>Control N=41</th>
<th>SPINRAZA N=80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any adverse event</td>
<td></td>
<td>40 (98)</td>
<td>77 (96)</td>
</tr>
<tr>
<td>Infections and infestations</td>
<td>Upper respiratory tract infection</td>
<td>9 (22%)</td>
<td>24 (30%)</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
<td>7 (17%)</td>
<td>23 (29%)</td>
</tr>
<tr>
<td></td>
<td>Nasopharyngitis</td>
<td>4 (10%)</td>
<td>15 (19%)</td>
</tr>
<tr>
<td></td>
<td>Respiratory tract infection</td>
<td>2 (5%)</td>
<td>9 (11%)</td>
</tr>
<tr>
<td></td>
<td>Urinary tract infection</td>
<td>0 (0%)</td>
<td>7 (9%)</td>
</tr>
<tr>
<td></td>
<td>Bronchitis</td>
<td>1 (2%)</td>
<td>6 (8%)</td>
</tr>
<tr>
<td></td>
<td>Upper respiratory tract congestion</td>
<td>1 (2%)</td>
<td>6 (8%)</td>
</tr>
<tr>
<td></td>
<td>Bronchitis viral</td>
<td>0 (0%)</td>
<td>5 (6%)</td>
</tr>
<tr>
<td></td>
<td>Influenza</td>
<td>0 (0%)</td>
<td>5 (6%)</td>
</tr>
<tr>
<td></td>
<td>Ear infection</td>
<td>1 (2%)</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>Constipation</td>
<td>9 (22%)</td>
<td>28 (35%)</td>
</tr>
<tr>
<td></td>
<td>Teething</td>
<td>3 (7%)</td>
<td>14 (18%)</td>
</tr>
</tbody>
</table>

\(^1\) Frequency category based upon SPINRAZA treated adverse event.

\(^2\) Adverse events which are verbally communicated, such as those which commonly occur in the setting of lumbar puncture procedure, could not be assessed due to the infantile patient population.

**Table 2: Treatment Emergent Adverse Events\(^1\) Reported with an Incidence of at Least 5% Higher in Patients Treated with SPINRAZA\(^2\) Compared to Sham-control in the controlled clinical trial in patients with later-onset SMA**

<table>
<thead>
<tr>
<th>System Organ Class</th>
<th>Preferred term</th>
<th>Control N=42</th>
<th>SPINRAZA N=84</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any adverse event</td>
<td></td>
<td>42 (100)</td>
<td>78 (93%)</td>
</tr>
<tr>
<td>General disorders and administration site conditions</td>
<td>Pyrexia</td>
<td>15 (36%)</td>
<td>36 (43%)</td>
</tr>
<tr>
<td>System Organ Class</td>
<td>Preferred term</td>
<td>Control N=42</td>
<td>SPINRAZA N=84</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------</td>
<td>--------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Nervous system disorders</td>
<td>Headache*</td>
<td>3 (7%)</td>
<td>24 (29%)</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>Vomiting*</td>
<td>5 (12%)</td>
<td>24 (29%)</td>
</tr>
<tr>
<td>Respiratory, thoracic and mediastinal disorders</td>
<td>Epistaxis</td>
<td>0</td>
<td>6 (7%)</td>
</tr>
<tr>
<td>Musculoskeletal and connective tissue disorders</td>
<td>Back pain*</td>
<td>0</td>
<td>21 (25%)</td>
</tr>
</tbody>
</table>

* Frequency category based upon SPINRAZA treated adverse event.
* Adverse events considered related to the lumbar puncture procedure. These events can be considered manifestations of post-lumbar puncture syndrome.

**QTc interval abnormalities**
Across the sham-controlled studies in 247 patients with SMA who received either SPINRAZA or sham-control, QTc values >500 ms with a change from baseline values >60 ms were observed in 4 (2.4%) of patients receiving SPINRAZA. There were no patients with an adverse event of QTc prolongation and there was no increase in the incidence of cardiac adverse events associated with delayed ventricular repolarization in patients treated with SPINRAZA compared to the sham control.

**Effect on growth**
A reduction in growth, as measured by height, was suggested in the controlled clinical trial in patients with infantile-onset SMA treated with SPINRAZA. It is not known if any effect of SPINRAZA on growth would be reversible upon discontinuation of treatment.

**Rash**
Cases of rash were reported in the controlled clinical trial in patients with infantile-onset SMA. One patient developed painless lesions on the forearm, leg and foot, over an 8-week period 8 months after starting treatment with SPINRAZA. The lesions were initially red macular skin lesions that ulcerated and scabbed over in 4 weeks. The patient continued to have recurring painless ulcerative lesions in acral distribution. A second patient developed red macular lesions on the hands 10 months after starting treatment with SPINRAZA, which resolved over a period of 3 months. In both cases there was spontaneous resolution of the rash while the patients continued to receive SPINRAZA.

**Hyponatremia**
One patient treated with SPINRAZA in an open-label study including patients with infantile onset SMA had a serious adverse event of hyponatremia requiring daily salt supplementation for 14 months.
**Immunogenicity**

The immunogenic response to nusinersen was determined by the evaluation of anti-drug antibodies (ADA) in patients with baseline and post-baseline plasma samples (n=229). Overall, the incidence of ADAs were low, with 13 (6%) patients developing treatment-emergent ADAs, of which 2 were transient, 5 were considered to be persistent, and 6 were unconfirmed at the last data cut. There were insufficient data to evaluate the effect of ADAs on clinical response, adverse events, or the pharmacokinetic profile of nusinersen.

**Post-market Adverse Events**

Adverse events associated with the lumbar puncture procedure used for administration of SPINRAZA, including serious infection, have occurred in the post market setting. SPINRAZA should be administered by healthcare professionals who are experienced in performing lumbar puncture procedures (see WARNINGS AND PRECAUTIONS, General; DOSAGE AND ADMINISTRATION). Hydrocephalus and aseptic meningitis have also been observed.

**DRUG INTERACTIONS**

No clinical studies of interactions with other medicines have been performed. Nusinersen is metabolized via nucleases and not by the cytochrome P450 (CYP450) system. *In vitro* studies indicated that nusinersen is not an inducer or inhibitor of CYP450 mediated metabolism.

*In vitro* studies indicated that the likelihood for interactions with nusinersen due to competition with or inhibition of transporters is low.

The co-administration of other intrathecal agents with SPINRAZA has not been evaluated and the safety of these combinations is not known.

**DOSAGE AND ADMINISTRATION**

**Dosing Considerations**

SPINRAZA (nusinersen) is only for intrathecal use by lumbar puncture. SPINRAZA should not be administered by intravenous, intramuscular, subcutaneous or epidural routes.

Treatment should be administered by health care professionals experienced in performing lumbar punctures.

SPINRAZA has not been studied in patients with renal impairment.

SPINRAZA has not been studied in patients with hepatic impairment. SPINRAZA is not metabolized via the cytochrome P450 enzyme system in the liver, therefore dosage adjustment is unlikely to be required in patients with hepatic impairment (see DRUG INTERACTIONS and ACTION AND CLINICAL PHARMACOLOGY, Special Populations and Conditions).

**Recommended Dose**

The recommended dose is 12 mg (5 mL).

**Loading doses**

Initiate treatment as early as possible after diagnosis with 4 loading doses. The first 3 loading doses should be administered at 14-day intervals (e.g., Day 0, Day 14, Day 28). The fourth
A loading dose should be administered approximately 30 days after the third loading dose (e.g., Day 63).

**Maintenance doses**
Following the fourth loading dose, a maintenance dose should be administered once every 4 months.

**Missed Dose**
If a loading dose is delayed or missed SPINRAZA should be administered as soon as possible, with at least 14 days between doses, and dosing should continue at the prescribed frequency.

If a maintenance dose is delayed or missed SPINRAZA should be administered as soon as possible and dosing should continue at the prescribed frequency.

**Administration**

**Preparation of dose**
1. The vial should be taken out of the refrigerator and allowed to warm to room temperature (25°C/77°F) without using external heat sources, prior to administration. The solution must be visually inspected prior to use. Only clear and colorless solutions, free from particles, can be used. Do not administer SPINRAZA if visible particles are observed or if the solution in the vial is discolored. Use of external filters is not required.
2. Aseptic technique must be used when preparing and administering SPINRAZA.
3. Just prior to administration insert the syringe needle into the vial through the center of the over-seal and withdraw 12 mg (5 mL) of SPINRAZA from the vial into the syringe. SPINRAZA must not be diluted. If a vial remains unopened and the solution has not been used, it should be returned back to the refrigerator.

**Administration of dose**
1. Sedation may be required to administer SPINRAZA, as indicated by the clinical condition of the patient.
2. Ultrasound (or other imaging techniques) may be considered to guide intrathecal administration of SPINRAZA, particularly in younger patients.
3. Prior to administration, removal of 5 mL of cerebral spinal fluid is recommended.
4. Administer SPINRAZA as an intrathecal bolus injection over 1 to 3 minutes, using a spinal anesthesia needle. Do not administer SPINRAZA in areas of the skin where there are signs of infection or inflammation.
5. Once drawn in to the syringe, if the solution is not used within 6 hours, it must be discarded.

**OVERDOSAGE**
No cases of overdose associated with adverse reactions were reported in clinical studies.

In case of overdose with SPINRAZA the patient should be advised to seek medical attention if they experience any signs or symptoms of adverse reactions.

For management of a suspected drug overdose, contact your regional Poison Control Centre.
Mechanism of Action
SPINRAZA (nusinersen) is an antisense oligonucleotide (ASO) specifically designed to treat SMA, an autosomal recessive progressive neuromuscular disease, caused by mutations in the chromosome 5q. These mutations lead to loss of function of the survival motor neuron 1 (SMN1) gene, resulting in deficiency of SMN protein. The SMN2 gene also produces SMN protein but at low levels. In patients with SMA, fewer SMN2 gene copies are associated with earlier age of onset and increased severity of symptoms.

SPINRAZA binds to a specific site in the SMN2 pre-messenger ribonucleic acid (pre-mRNA) to increase the proportion of exon 7 inclusion in SMN2 messenger ribonucleic acid (mRNA) transcripts made, which can be translated into the functional full length SMN protein.

Pharmacodynamics
Autopsy samples from treated infants had higher levels of SMN2 mRNA containing exon 7 in the thoracic spinal cord compared to untreated SMA infants.

Pharmacokinetics
Single- and multiple-dose pharmacokinetics of nusinersen, administered via intrathecal injection, were determined in pediatric patients diagnosed with SMA.

Absorption: Intrathecal injection of nusinersen into the cerebrospinal fluid (CSF) allows nusinersen to be distributed from the CSF to the target central nervous system (CNS) tissues. Following intrathecal administration trough plasma concentrations of nusinersen were relatively low compared to the trough CSF concentration. Median plasma Tmax values ranged from 1.7 to 6.0 hours. Mean plasma Cmax and AUC values increased approximately dose proportionally over the evaluated dose range up to 12 mg. There is no accumulation in plasma exposure measures (Cmax and AUC) after multiple doses.

Distribution: Autopsy data from patients (n=3) showed that following intrathecal administration, nusinersen was broadly distributed within the CNS and peripheral tissues such as skeletal muscle, liver, and kidney.

Metabolism/Biotransformation: Nusinersen is metabolized slowly via exonuclease (3’- and 5’) mediated hydrolysis and is not a substrate for, or inhibitor or inducer of CYP450 enzymes.

Elimination: The mean terminal elimination half-life is estimated at 135 to 177 days in CSF and 63 to 87 days in plasma. Following slow metabolism in tissues, the primary route of elimination is likely by urinary excretion of nusinersen and its chain-shortened metabolites. During the first 24 hours after dosing, only 0.5% of the administered dose was recovered in urine.

Special Populations and Conditions:

Gender: Population pharmacokinetic analysis showed that gender does not affect the pharmacokinetics of nusinersen.

Renal and Hepatic Insufficiency: The pharmacokinetics of nusinersen in patients with renal impairment or hepatic impairment have not been studied.
STORAGE AND STABILITY

Store refrigerated at 2°C to 8°C (36°F to 46°F). Do not freeze.

SPINRAZA should be protected from light and kept in the original carton until time of use. If no refrigeration is available, SPINRAZA may be stored in its original carton, protected from light at or below 30°C for up to 14 days.

Prior to administration, unopened vials of SPINRAZA can be removed from and returned to the refrigerator if necessary. If removed from the original carton, the total combined time out of refrigeration and secondary packaging should not exceed 30 hours, at a temperature that does not exceed 25°C (77°F).

Once in the syringe, if the solution is not used within 6 hours, it must be discarded.

Discard any unused solution left in a vial.

DOSAGE FORMS, COMPOSITION AND PACKAGING

Single-use solution for intrathecal injection containing 5 mL of a 2.4 mg/mL clear and colorless solution of nusinersen.

**Composition**

SPINRAZA is formulated at a pH of approximately 7.2 and contains:

- Artificial cerebral spinal fluid contents per 5 mL;
- Sodium dihydrogen phosphate dihydrate (0.25 mg),
- Disodium phosphate (0.49 mg),
- Sodium chloride (45.83 mg),
- Potassium chloride (1.12 mg),
- Calcium chloride dihydrate (1.03 mg),
- Magnesium chloride hexahydrate (0.82 mg)
- Water for injection

Sodium hydroxide and hydrochloric acid may be used for pH adjustment.

**Packaging**

SPINRAZA is supplied as 5mL in a Type I vial with bromobutyl rubber stopper and an aluminium over-seal and plastic cap. Pack size: one vial per carton.
PART II: SCIENTIFIC INFORMATION

PHARMACEUTICAL INFORMATION

Drug Substance

Proper name: nusinersen

Molecular formula and molecular mass: The molecular formula of SPINRAZA is $\text{C}_{234}\text{H}_{323}\text{N}_{61}\text{O}_{128}\text{P}_{17}\text{S}_{17}\text{Na}_{17}$ and the molecular weight is 7501.0 amu

Structural formula:

Physicochemical properties: Nusinersen is a fully modified 2′-O-2-methoxyethyl antisense oligonucleotide designed to bind to a specific sequence in the intron downstream of Exon 7 of the SMN2 transcript. SPINRAZA is a sterile, preservative-free solution that contains 2.4 mg/mL nusinersen in artificial cerebral spinal fluid. SPINRAZA contains 12.6 mg nusinersen sodium equivalent to 12 mg nusinersen free acid in 5 mL per vial.

pH of approximately 7.2.
## Study demographics and trial design

### Table 3 - Summary of patient demographics for clinical trials

<table>
<thead>
<tr>
<th>Study #</th>
<th>Trial design</th>
<th>Dosage and duration</th>
<th>Study subjects (n = number)</th>
<th>Population studied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study 1</td>
<td>Phase 3, Randomized, double-blind, multiple-dose, sham-procedure controlled in subjects with symptomatic infantile-onset SMA</td>
<td>12 mg scaled equivalent dose or sham-procedure (2:1) Loading dose: Days 1, 15, 29, 64 Maintenance dose: Days 183 and 302</td>
<td>121</td>
<td>Most likely to develop Type I SMA Median age at symptom onset 8 weeks (range 1 to 20 weeks) SMN2 gene copies: 2 (120), 3 (1) Median age at first dose: 175 days (range 30 to 262 days) Gender: - 45% male - 55% female</td>
</tr>
<tr>
<td>Study 2</td>
<td>Phase 3, Randomized, double-blind, multiple-dose, sham-procedure controlled in subjects with symptomatic later-onset SMA</td>
<td>12 mg scaled equivalent dose or sham-procedure (2:1) Loading dose: Days 1, 29 and 85 Maintenance dose: Day 274</td>
<td>126</td>
<td>Median age at symptom onset: 11 months (range: 6 to 20 months) SMN2 gene copies: 2 (10), 3 (111), 4 (3), unknown (2) Median age at enrollment: 3 years (range 2 to 9) Gender: - 47% male - 53% female</td>
</tr>
<tr>
<td>Study #</td>
<td>Trial design</td>
<td>Dosage and duration¹</td>
<td>Study subjects (n = number)</td>
<td>Population studied</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Study 3 (CS3A)</td>
<td>Phase 2, open label, multiple-dose in subjects with symptomatic infantile-onset SMA [ongoing]</td>
<td>Cohort 1: 6 mg scaled equivalent loading dose and 12 mg maintenance dose Cohort 2: 12 mg scaled equivalent loading dose and 12 mg maintenance dose Loading dose: Days 1, 15, and 85 Maintenance dose: Day 253 and every 4 months thereafter.</td>
<td>20</td>
<td>Most likely to develop Type I or Type II SMA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Median age at symptom onset 56 days (range: 21 to 154 days)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SMN2 gene copies: 2 (17), 3 (2), unknown (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Median age at enrollment: 155 days (range 36 to 210)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Gender:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 60% male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 40% female</td>
</tr>
<tr>
<td>Study 4 (NURTURE; CS5; SM201)</td>
<td>Phase 2, open label study in pre symptomatic infants genetically diagnosed with SMA [ongoing]</td>
<td>12 mg scaled equivalent loading and maintenance doses of nusinersen on day 1, 15, 29, 64, 183, 302, 421, 540, 659, and 778.</td>
<td>20</td>
<td>Most likely to develop Type I or II SMA.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SMN2 gene copies: 2 (13), 3 (7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Median age at first dose: 19 days (range 3 - 42 days)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Gender:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 55% male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 45% female</td>
</tr>
<tr>
<td>Study 5 (CS2)</td>
<td>Phase 1, open-label, dose-escalation, multiple dose in subjects with symptomatic later-onset SMA</td>
<td>3, 6, 9, and 12 mg nusinersen. 2 doses on days 1 and 85 (9mg cohort) or 3 doses on days 1, 29, and 85 (3, 6 and 12 mg cohorts).</td>
<td>56</td>
<td>Diagnosed with Type II or III SMA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Median age at symptom onset: 14 months (range: 3 to 60 months)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SMN2 gene copies: 2 copies (1), 3 copies (46), 4 copies (8), 5 copies (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Median age at first dose: 6.21 years (range 2.1 to 16.0 years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Gender:</td>
</tr>
<tr>
<td>Study 6 (CS12)</td>
<td>Phase 1, open-label, multiple-dose, single-arm in subjects with symptomatic later-onset SMA [ongoing extension for patients completing Study CS2, or Studies CS1 and CS10]</td>
<td>12 mg scaled equivalent loading and maintenance doses of nusinersen on days 1, 169, 351, and 533</td>
<td>20</td>
<td>Most likely to develop Type I or II SMA.</td>
</tr>
</tbody>
</table>
Study 7 (CS1)  
Phase 1, open-label, escalating dose in subjects with symptomatic later-onset SMA  
single dose of 1, 3, 6, or 9 mg  
- 46% male  
- 54% female

Study 8 (CS10)  
Phase 1, open-label, single dose in subjects with symptomatic later-onset SMA  
single dose of 6 or 9 mg

The efficacy of SPINRAZA (nusinersen) was demonstrated in 2 phase 3, randomized, double-blind, sham-procedure controlled clinical trials, one in symptomatic patients with infantile-onset SMA (Study 1) and the other in later-onset SMA (Study 2). This is further supported by ongoing and completed open-label clinical trials conducted in patients with infantile-onset SMA, patients with later-onset SMA, and patients with presymptomatic genetically diagnosed SMA (Study 3, 4, 5, 6, 7 and 8).

Clinical Trial in Infantile-Onset SMA
This study was a phase 3, multicenter, randomized, double-blind, sham-procedure controlled study conducted in 121 symptomatic infants ≤ 7 months of age at the time of first dose or sham procedure, diagnosed with SMA (symptom onset before 6 months of age). The median age of onset of clinical signs and symptoms of SMA was 6.5 weeks (range 2-18) and 8 weeks (range 1-20) for SPINRAZA treated versus sham control patients respectively. Patients in this study were deemed most likely to develop type I SMA. At baseline, the mean total motor milestone score was 1.37 (range 0-6), the median CHOP INTEND score was 28 (range 8-50.5), and the median CMAP amplitudes were 0.20 (range 0.00-0.87) and 0.30 (range 0.00-1.50) for the ulnar nerve and peroneal nerves, respectively. The median age when patients received their first dose was 164.5 days (range 52-242) for treated patients, and 205 days (range 30-262) for sham control. Patients were randomized 2:1 to either SPINRAZA or sham-control, with a length of treatment ranging from 6 to 442 days (median 258). Patients randomized to the SPINRAZA group received 4 loading doses of 12 mg nusinersen intrathecal injection, administered by lumbar puncture, on Days 1, 15, 29 and 64, followed by maintenance doses administered at 4-month intervals on Days 183 and 302. In the sham-control group patients received a dermal puncture at all scheduled dosing visits.

Baseline disease characteristics were largely similar in the SPINRAZA treated patients and sham-control patients except that SPINRAZA treated patients at baseline had a higher percentage compared to sham-control patients of paradoxical breathing (89% vs 66%), pneumonia or respiratory symptoms (35% vs 22%), swallowing or feeding difficulties (51% vs 29%) and requirement for respiratory support (26% vs 15%).

A planned interim analysis was conducted based on patients with the opportunity to reach a 6 month evaluation. The primary endpoint assessed at the interim analysis was the proportion of motor milestone responders: patients achieving a pre-defined level of improvement in motor milestones according to Section 2 of the Hammersmith Infant Neurologic Exam (HINE).
treatment responder was defined as any patient with at least 2 point increase [or maximal score of 4] in ability to kick, or at least a 1 point increase in the motor milestones of head control, rolling, sitting, crawling, standing or walking. To be classified as a responder, patients needed to exhibit improvement in more categories of motor milestones than worsening. Of the 78 patients who were eligible for the interim analysis, a statistically significantly greater proportion of patients achieved the definition of a motor milestone responder in the SPINRAZA group (41%) compared to the sham-control group (0%), p<0.0001.

At the final analysis, time to death or permanent ventilation (≥ 16 hours ventilation/day continuously for > 21 days in the absence of an acute reversible event or tracheostomy) was assessed as the primary endpoint. Statistically significant effects on event-free survival, overall survival, the proportion of patients achieving the definition of a motor milestone responder, and the percentage of patients with at least a 4 point improvement from baseline in CHOP-INTEND score were observed in patients in the SPINRAZA group compared to those in the sham-control group (Table 4).

A 47% reduction in the risk of death or permanent ventilation was observed in the ITT population (p=0.0046). Median time to death or permanent ventilation was not reached in SPINRAZA group, and was 22.6 weeks in the sham-control group. A statistically significant 62.8% reduction in the risk of death was also observed (p=0.0041) (Figure 3).

In the efficacy set, 51% of patients in the SPINRAZA group achieved the definition of motor milestone responder compared to 0% in the sham control group at the final analysis (p<0.0001). The proportion of responders increased over time in patients in the SPINRAZA group with 41% responders at 6 months (compared to 5% in sham-control), 45% at 10 months (compared to 0% in sham-control), and 54% at 13 months (compared to 0% in sham-control). Overall, 49 (67%) of SPINRAZA compared to 5 (14%) of sham-control patients met the protocol-defined criteria for a motor milestone responder. Eleven (61%) patients in the SPINRAZA group and 3 (25%) patients in the sham-control group experienced at least a 1 point improvement in total motor milestone score. Zero (0%) patients in the SPINRAZA group and 3 (25%) patients in the sham-control group experienced at least 1 point worsening in total motor milestone score (Figure 1).

In the efficacy set (ES), 18 (25%) patients in the SPINRAZA group and 12 (32%) patients in the sham-control group required permanent ventilation. Of these patients, 6 (33%) in the SPINRAZA group and 0 (0%) in the sham-control group met the protocol-defined criteria for a motor milestone responder. Eleven (61%) patients in the SPINRAZA group and 3 (25%) patients in the sham-control group experienced at least a 1 point improvement in total motor milestone score. Zero (0%) patients in the SPINRAZA group and 3 (25%) patients in the sham-control group experienced at least a 1 point worsening in total motor milestone score.

A statistically significant greater percentage of patients in the ES receiving SPINRAZA (71%) compared to sham-control (3%) achieved a least a 4 point improvement from baseline in CHOP-INTEND score (p<0.0001). Consistently, 3% of patients receiving SPINRAZA and 46% of patients receiving sham-control experienced at least a 4 point worsening from baseline in CHOP-INTEND score.
Figure 1. Distribution of the net change from baseline in HINE total motor milestone score by percent of patients in the Efficacy Set

*For subjects who were alive and ongoing in the study, the change in total motor milestone score was calculated at the later of Day 183, Day 302, or Day 394.

Table 4: Primary and secondary endpoints at final analysis – Study 1

<table>
<thead>
<tr>
<th>Efficacy Parameter</th>
<th>SPINRAZA-treated Patients</th>
<th>Sham-control Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Survival</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Event-free survival¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients who died or received permanent ventilation</td>
<td>31 (39%)</td>
<td>28 (68%)</td>
</tr>
<tr>
<td>Hazard ratio (95% CI)</td>
<td></td>
<td>0.53 (0.32 -0.89)</td>
</tr>
<tr>
<td>p-value²</td>
<td></td>
<td>p = 0.0046</td>
</tr>
<tr>
<td><strong>Overall survival¹</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients who died</td>
<td>13 (16%)</td>
<td>16 (39%)</td>
</tr>
<tr>
<td>Hazard Ratio (95% CI)</td>
<td></td>
<td>0.37 (0.18 – 0.77)</td>
</tr>
<tr>
<td>p-value²</td>
<td></td>
<td>p=0.0041</td>
</tr>
<tr>
<td><strong>Motor function</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor milestones³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion achieving pre-defined motor milestone responder criteria (HINE section 2)⁴,⁵</td>
<td>37 (51%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td></td>
<td>P&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>Efficacy Parameter</td>
<td>SPINRAZA-treated Patients</td>
<td>Sham-control Patients</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Proportion at Day 183&lt;sup&gt;6&lt;/sup&gt;</td>
<td>41%</td>
<td>5%</td>
</tr>
<tr>
<td>Proportion at Day 302&lt;sup&gt;6&lt;/sup&gt;</td>
<td>45%</td>
<td>0%</td>
</tr>
<tr>
<td>Proportion at Day 394&lt;sup&gt;6&lt;/sup&gt;</td>
<td>54%</td>
<td>0%</td>
</tr>
<tr>
<td>Proportion with improvement in total motor milestone score</td>
<td>49 (67%)</td>
<td>5 (14%)</td>
</tr>
<tr>
<td>Proportion with worsening in total motor milestone score</td>
<td>1 (1%)</td>
<td>8 (22%)</td>
</tr>
</tbody>
</table>

**CHOP-INTEND<sup>3</sup>**

| Proportion achieving a 4-point improvement | 52 (71%) | 1 (3%) |
| Proportion achieving a 4-point worsening | 2 (3%)   | 17 (46%) |
| Proportion with any improvement | 53 (73%) | 1 (3%) |
| Proportion with any worsening | 5 (7%) | 18 (49%) |

<sup>1</sup>At the final analysis, event-free survival and overall survival were assessed using the Intent to Treat population (ITT SPINRAZA n=80; Sham-control n=41).

<sup>2</sup>Based on log-rank test stratified by disease duration

<sup>3</sup>At the final analysis, CHOP-INTEND and motor milestone analyses were conducted using the Efficacy Set (SPINRAZA n=73; Sham-control n=37).

<sup>4</sup>Assessed at the later of Day 183, Day 302, and Day 394 Study Visit

<sup>5</sup>According to HINE section 2: ≥2 point increase [or maximal score] in ability to kick, OR ≥1 point increase in the motor milestones of head control, rolling, sitting, crawling, standing or walking, AND improvement in more categories of motor milestones than worsening), defined as a responder for this primary analysis.

<sup>6</sup>The proportion of motor milestones responders at Day 183, Day 302, and Day 394 are based on efficacy sets at those visits.
Figure 2: Event-Free Survival in the Intent to Treat Set – Study 1

![Event-Free Survival Graph]

Hazard Ratio of SPINRAZA to Sham: 0.53

Figure 3: Overall Survival (ITT) – Study 1

![Overall Survival Graph]

HR of SPINRAZA to sham: 0.372
Clinical Trial in Later-Onset SMA

Study 2 was a phase 3, randomized, double-blind, sham-procedure controlled study in 126 symptomatic children with later-onset SMA (symptom onset after 6 months of age). Patients were randomized 2:1 to either SPINRAZA or sham-control, with a length of treatment ranging from 324 to 482 days (median 450). No patients in either treatment group discontinued treatment.

The median age at screening was 3 years (range 2-9), and the median age of onset of clinical signs and symptoms of SMA was 11 months (range 6-20). The majority of patients (88%) have 3 copies of the SMN2 gene (8% have 2 copies, 2% have 4 copies, and 2% have an unknown copy number). At baseline, patients had a mean HFMSE score of 21.6, a mean Revised Upper Limb Module (RULM) of 19.1, all had achieved independent sitting, and no patients had achieved independent walking. Patients in this study were deemed most likely to develop type II or III SMA.

Baseline disease characteristics were generally similar with the exception of an imbalance in the proportion of patients who had ever achieved the ability to stand without support (13% of patients in the SPINRAZA group and 29% in sham-control) or walk with support (24% of patients in the SPINRAZA group and 33% in sham-control).

A planned interim analysis was conducted when all patients had completed their Month 6 assessment and at least 39 patients had completed their Month 15 assessment. The primary endpoint assessed at the time of interim analysis was change from baseline score at Month 15 on the HFMSE. The primary analysis was conducted in the ITT population which included all subjects who were randomized and received at least 1 dose of SPINRAZA or at least 1 sham procedure (SPINRAZA: n=84; sham-control: n=42). Post-baseline HFMSE data for patients without a Month 15 visit were imputed using the multiple imputation method. A statistically significant improvement from baseline HFMSE score was observed in SPINRAZA treated patients compared to the sham-control patients (SPINRAZA vs. sham-control: 4.0 vs. -1.9; p=0.0000002).

Results from the final analysis are consistent with those from the interim analysis, showing a statistically significant improvement in HFMSE scores from baseline to Month 15 in the SPINRAZA group compared to the sham-control group (3.9 vs. -1.0; p=0.0000001) (Table 5, Figure 4).

An analysis of the subset of patients in the ITT population who had observed values at Month 15 demonstrated consistent, statistically significant results. Of those with observed values at Month 15 a higher proportion of SPINRAZA-treated subjects had improvement (73% vs 41%, respectively) and a lower proportion had worsening (23% vs 44%, respectively) in total HFMSE scores compared to sham-control treated subjects (Figure 5).

Among patients in the ITT population, 56.8% of patients in the SPINRAZA group achieved a 3-point or greater increase from baseline in the HFMSE score at baseline compared to 26.3% in the sham-control group, for a difference of 30.5% in favor of the SPINRAZA group (p=0.0006).
At the final analysis, all secondary endpoints including functional measures and WHO motor milestone achievement were formally statistically tested and are described in Table 5.

The proportion of subjects achieving new WHO motor milestones (without worsening in any baseline motor milestones) in the SPINRAZA group and sham-control groups was 19.7% and 5.9%, respectively, for a difference of 13.8% (p = 0.0811). At 15 months, 1 of the 66 (2%) subjects in the SPINRAZA group compared to 9 of 34 (26%) subjects in the sham-control group had lost at least 1 motor milestone.

The number of new motor milestones achieved per subject at Month 15 was higher in the SPINRAZA group, with a least squares mean difference of 0.4 between the 2 groups (nominal p = 0.0001).

Although SPINRAZA-treated patients with a longer time from symptom onset to initiation of treatment experienced benefit compared to sham-controlled patients, initiation of treatment sooner after symptom onset resulted in earlier and greater improvement in motor function.

There was a greater improvement in Revised Upper Limb Module (RULM) Test scores from baseline to Month 15 in the SPINRAZA group (least squares mean change of 4.2) than in the sham-control group (least squares mean change of 0.5), with a least squares mean difference of 3.7 between the 2 groups (nominal p = 0.0000001). Among patients with observed values at Month 15, a higher proportion of SPINRAZA treated subjects had improvement (79% vs 68%, respectively) and a lower proportion had worsening (14% vs 21%, respectively) in RULM score compared to sham-control (Figure 6).

**Figure 4: Mean change from baseline in HFMSE score over time at final analysis (ITT) – Study 2**

1Data for patients without a Month 15 visit were imputed using the multiple imputation method
2Error bars denote +/- standard error
Table 5: Primary and secondary endpoints at final analysis – Study 2

<table>
<thead>
<tr>
<th></th>
<th>SPINRAZA-treated Patients</th>
<th>Sham-control Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HFMSE score</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change from baseline in total</td>
<td>3.9 (95% CI: 3.0, 4.9)</td>
<td>-1.0 (95% CI: -2.5, 0.5)</td>
</tr>
<tr>
<td>HFMSE score at 15 months(^1,2,3)</td>
<td>p=0.0000001</td>
<td></td>
</tr>
<tr>
<td>Proportion of patients who</td>
<td>56.8% (95% CI: 45.6, 68.1)</td>
<td>26.3% (95% CI: 12.4, 40.2)</td>
</tr>
<tr>
<td>achieved at least a 3 point</td>
<td>p=0.0006(^5)</td>
<td></td>
</tr>
<tr>
<td>improvement from baseline to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>month 15(^1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RULM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean change from baseline to</td>
<td>4.2 (95% CI: 3.4, 5.0)</td>
<td>0.5 (95% CI: -0.6, 1.6)</td>
</tr>
<tr>
<td>month 15 in total RULM score</td>
<td>p=0.0000001(^6)</td>
<td></td>
</tr>
<tr>
<td>(^1,2,3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WHO motor milestones</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients who</td>
<td>19.7% (95% CI: 10.9, 31.3)</td>
<td>5.9% (95% CI: 0.7, 19.7)</td>
</tr>
<tr>
<td>achieved new motor milestones at 15 months(^4)</td>
<td>p=0.0811</td>
<td></td>
</tr>
<tr>
<td>Mean number of new motor</td>
<td>0.2 (range -1 to 2, 95%</td>
<td>-0.2 (range -1 to 1, 95%</td>
</tr>
<tr>
<td>milestones attained(^2,3,4)</td>
<td>CI: 0.1, 0.3)</td>
<td>CI: -0.4, 0.0)(^3)</td>
</tr>
<tr>
<td>(^2) Least squares mean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^3) Negative value indicates worsening, positive value indicates improvement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^4) Assessed using the Month 15 Efficacy Set (SPINRAZA n=66; Sham control n=34; analyses are based on imputed data when there are missing data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^5) Based on logistic regression with adjustment for each subject's age at screening and HFMSE score at baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^6) Nominal p value</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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1 Assessed using the Intent to Treat population (SPINRAZA n=84; Sham-control n=42); data for patients without a Month 15 visit were imputed using the multiple imputation method.  
2 Least squares mean.  
3 Negative value indicates worsening, positive value indicates improvement.  
4 Assessed using the Month 15 Efficacy Set (SPINRAZA n=66; Sham control n=34; analyses are based on imputed data when there are missing data.  
5 Based on logistic regression with adjustment for each subject's age at screening and HFMSE score at baseline  
6 Nominal p value
Ongoing and completed open-label clinical trials
The results of the controlled trial in infantile-onset SMA patients were supported by data from completed and ongoing phase 1 and phase 2 open-label, uncontrolled trials conducted in symptomatic patients with infantile-onset SMA (n=20, age range 37 days to 223 days at first
dose); in patients with later-onset SMA (n=56, age range 2 to 15 years at first dose); and, in
presymptomatic genetically diagnosed patients (n=20, age range 3 to 42 days at first dose). Most
of the patients included in these studies had or were likely to develop type I, type II or type III
SMA. Some patients achieved milestones such as ability to sit unassisted, stand, or walk when
they would otherwise be unexpected to do so, maintained milestones at ages when they would be
expected to be lost, and survived to ages unexpected, when considering the number of SMN2
gene copies of patients enrolled in the studies and the disease natural history.

When treatment with SPINRAZA was initiated prior to symptom onset in patients with
genetically diagnosed SMA (study 4), patients achieved milestones unexpected in Type 1 or
Type 2 SMA.

At the interim analysis of Study 4, 18 of the 20 patients completed the Day 64 visit, thereby
composing the Efficacy Set (2 SMN2 gene copies, n=13; 3 SMN2 gene copies, n=5). The
primary endpoint assessed at the time of the interim analysis was time to death or respiratory
intervention (defined as invasive or noninvasive ventilation for ≥6 hours/day continuously for ≥7
consecutive days OR tracheostomy). At the planned interim analysis, no patients had met the
primary endpoint of death or respiratory intervention (Figure 7).

Patients achieved milestones unexpected in Type 1 or 2 SMA. Compared to baseline,
improvements in HINE motor milestones were achieved in 16 (89%) of patients in the efficacy
set at the interim analysis. Twelve patients were sitting independently, 9 were standing with or
without support, and 6 were walking with or without support. Sixteen patients (89%)
demonstrated a ≥ 4 point improvement in CHOP INTEND total score, 7 of which achieved the
maximum total CHOP INTEND score of 64. One patient (6%) experienced a ≥ 4 point decrease
in CHOP INTEND total score.

The proportion of patients developing clinically manifested SMA was assessed amongst patients
who reached the Day 365 visit at the interim analysis (n=9). The protocol-defined criteria for
clinically manifested SMA included age-adjusted weight below the fifth WHO percentile, a
decrease of 2 or more major weight growth curve percentiles, the placement of a percutaneous
gastric tube, and/or the inability to achieve expected age-appropriate WHO milestones
(independent sitting, standing with assistance, and hands-and-knees crawling). Five (56%)
patients were gaining weight and achieving WHO milestones. Although 4 (44%) patients (each
with 2 SMN2 gene copies) met the protocol-defined criteria for clinically manifested SMA, these
patients were gaining weight, and achieving WHO milestones, including independent sitting,
inconsistent with Type 1 SMA.

It is not known whether ongoing, continuous treatment with SPINRAZA will be required to
maintain or prevent loss of motor function that is achieved during treatment.

Page 25 of 33
Figure 7: Probability of Survival Versus Study Days in Study 1 (treated and sham-control), 3 and 4 - ITT

Figure 8: Change in Motor Milestones Versus Study Days for Study 1 (treated and sham-control, IES), 3 (IES) and 4 (ITT)
**TOXICOLOGY**

In repeat-dose toxicity studies (14-weeks and 53-weeks) intrathecal administration of nusinersen to juvenile cynomolgus monkeys resulted in transient deficits in lower spinal reflexes which occurred at the highest dose levels in each study (3 or 4 mg per dose; equivalent to 30 or 40 mg per IT dose in patients). These effects were observed within several hours post-dose and generally resolved within 48 hours. Neuronal vacuolation and necrosis/cellular debris in the hippocampus were also observed at the mid- and high doses (see WARNINGS AND PRECAUTIONS, Pediatrics).

Reproductive toxicology studies were conducted using subcutaneous administration of SPINRAZA in mice and rabbits. No impact on male or female fertility, embryo-fetal development, or pre/post-natal development was observed.

**Carcinogenicity and Mutagenicity**

Long-term carcinogenicity studies have not been conducted.

SPINRAZA demonstrated no evidence of genotoxicity, in *in vitro* assays (Ames and chromosomal aberration in CHO cells) or in *in vivo* assays (mouse micronucleus).
REFERENCES

1. Finkel RS. Electrophysiological and motor function scale association in a pre-symptomatic infant with spinal muscular atrophy type I. Neuromuscul Disord. 2013;23(2):112-5.


READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE

PATIENT MEDICATION INFORMATION
SPINRAZA
nusinersen injection

Read this carefully before you or your child start receiving SPINRAZA and before each dose. This leaflet is a summary and will not tell you everything about this drug. Talk to your healthcare professional about you or your child’s medical condition and treatment and ask if there is any new information about SPINRAZA. Keep this leaflet. You may need to read it again.

What is SPINRAZA used for?
SPINRAZA is used to treat a genetic disease called 5q Spinal Muscular Atrophy (SMA). SMA is caused by a problem with the 5q chromosome. This problem leads to a shortage of a particular protein called survival motor neuron (SMN). The shortage of SMN protein results in the loss of nerve cells in the spine that leads to weakness of the muscles in the shoulders, hips, thighs and upper back. It may also weaken the muscles used for breathing and swallowing.

SPINRAZA may be given to children, adolescents or adults:
- There is limited experience of SPINRAZA in people over 18 years of age.
- There is no experience of SPINRAZA in people over 65 years of age.

How does SPINRAZA work?
SPINRAZA is one of a group of medicines called anti-sense oligonucleotides (ASO). SPINRAZA works by helping the body to produce more of the SMN protein that people with SMA need. This may reduce the loss of nerve cells and improve muscle strength.

What are the ingredients in SPINRAZA?
Medicinal ingredients: nusinersen
Non-medicinal ingredients: calcium chloride dihydrate, disodium phosphate, magnesium chloride hexahydrate, potassium chloride, sodium chloride, sodium dihydrogen phosphate dihydrate, water for injection. Sodium hydroxide and hydrochloric acid may be used for pH adjustment.

SPINRAZA comes in the following dosage forms:
Single-use solution in a vial for intrathecal injection containing 5 mL of a 12 mg / 5 mL (2.4 mg / mL) clear and colorless solution of nusinersen. Pack size: one vial per carton.

Do not use SPINRAZA if:
- You or your child has or may have an allergy or hypersensitivity to nusinersen or to any of the ingredients in the formulation or component of the container.

To help avoid side effects and ensure proper use, talk to your healthcare professional before you are given SPINRAZA. Talk about any health conditions or problems you may have.
**Warnings you should know about:**

**Lumbar puncture**
- There are known reasons why you or your child should not have a lumbar puncture. These may include:
  - a skin infection near site of lumbar puncture
  - the possibility that you or your child has a brain tumour and increased pressure in the skull
  - uncontrolled problems with blood clotting
  - injury or damage to the spinal cord (only short duration and not ongoing)

**Pregnancy, breastfeeding and fertility**
There is no experience of the use of SPINRAZA in pregnant women. Ask your doctor for advice about taking SPINRAZA if you:
- are pregnant
- breast-feeding
- think you may be pregnant or are planning to have a baby.

**Blood clotting problems and risk of bleeding**
After receiving medicines similar to SPINRAZA, some patients had:
- abnormal blood clotting
- abnormal and/or severely low levels of platelets (blood cells responsible for stopping bleeding).

In a SPINRAZA clinical trial, some patients had lower than normal levels of platelets. The lower levels of platelets came and went and the patients did not have abnormal blood clotting.

You may be at risk of bleeding complications while you are taking SPINRAZA. Your doctor will monitor your blood clotting by testing your blood. You will be tested before starting treatment with SPINRAZA and any other time your doctor thinks is necessary.

**Risk of kidney damage**
After receiving medicines similar to SPINRAZA, some patients had:
- higher levels of protein in their urine
- an increased risk of toxicity in the kidneys
- inflammation of the kidneys, which has caused death.

In a SPINRAZA clinical trial, some patients had higher levels of protein in their urine. SPINRAZA was also found in high concentrations in the kidneys. SPINRAZA leaves the body (is excreted) through the kidneys. It is important that your kidneys work well while you are taking SPINRAZA.

Your doctor will monitor how your kidneys are working by testing your urine. Your urine will be tested before you start treatment with SPINRAZA and any other time your doctor thinks is necessary.

**Tell your healthcare professional about all the medicines you take, including any drugs, vitamins, minerals, natural supplements or alternative medicines.**
At this time, there are no known medicines that interact with SPINRAZA. It is unknown if SPINRAZA can be used safely with other drugs that are administered into the spine (intrathecal).

**How SPINRAZA is given:**
- SPINRAZA is given by injection to the lower back.
- This injection is called a lumbar puncture and is done by inserting a needle in the space around the spinal cord.
- This will be done by a healthcare provider experienced in doing lumbar punctures.
- The injection will take 1 to 3 minutes
- You or your child may also be given a medicine to make you relax or sleep during the injection.
- Ask your health care provider, if you have any questions about how SPINRAZA is given.

Your doctor will tell you how long you or your child needs to keep receiving SPINRAZA. Don’t stop treatment with SPINRAZA unless your doctor tells you to.

**Usual dose:**
The dose of SPINRAZA is 12 mg. You or your child will receive SPINRAZA based on the schedule below:

- The first 3 doses of SPINRAZA will be administered 14 days apart: on Day 0, Day 14 and Day 28.
- The 4th dose will be administered about a month later, for example on Day 63.
- And then once every 4 months.

**Overdose:**
There is no experience with overdose with SPINRAZA.

If you think you have been given too much SPINRAZA, contact your healthcare professional immediately, even if there are no symptoms.

**Missed Dose:**
If you or your child is unable to receive SPINRAZA as planned, speak with your doctor to ensure that SPINRAZA can be given as soon as possible.

**What are possible side effects from using SPINRAZA?**

Like all medicines, SPINRAZA can cause side effects, although not everybody gets them. Contact your doctor or nurse if you notice any of these side effects. Do not try to treat them yourself.

When SPINRAZA was tested in clinical trials, most side effects seemed to be:
- continued symptoms of the disease (SMA), such as:
  - breathing problems, muscle weakness, joint and bone problems, or digestive problems
  - sinus and/or throat infections, colds
  - lung infections like bronchitis and pneumonia
- side effects of the lumbar puncture:
experienced during or within a few days after SPINRAZA is given

The side effects reported that were likely continued symptoms of the disease included:

- Chest infections (such as pneumonia)
  - wheezing, shortness of breath, chest pain, feeling tired, coughing - sometimes with mucus
- Constipation
- Cough
- Curving of the back or spine (scoliosis)
- Diarrhea
- Difficulty breathing or being unable to breathe
  - signs may include rapid or shallow breathing, an increase in heart rate, and a blush-tinge of the skin, fingertips or lips
  - may be caused by a collapsed lung or part of a lung
- Difficulty swallowing or being unable to swallow
- Ear infection leading to pain or loss of balance
- Feeling nauseous or throwing up
- Fever
- Heart-burn
- Infections of the nose, throat or upper airways
  - blocked, stuffy or runny nose, sneezing and coughing, a sore or scratchy throat and watery or itchy eyes
- Nose bleed (epistaxis)
- Pain
- Permanent shortening of a muscle or joint
- Rash on forearms, legs, feet, hands
- Reduction in growth
- Stiffness of muscles or joints
- Stomach flu
- Yeast / fungus infection in mouth (oral thrush)
  - White patches usually on tongue or inner cheeks

The side effects that were likely a result of the lumbar puncture included:

- Back-pain
- Dizziness
- Feeling nauseous or throwing up
- Headache
- Pain during the injection
- Serious infections

Additional side effects included:

- Hydrocephalus (a buildup of too much fluid around the brain)
  - symptoms may include increase in head size or bulging soft spot on top of the head (fontanel) in infants, decreased consciousness, persistent nausea, vomiting or headache
• Aseptic meningitis (meningitis that is not caused by an infection)
  o symptoms may include headache, photophobia, neck stiffness, nausea, vomiting

Tell your doctor if you experience any of the side effects listed above. **Contact your doctor if you or your child has any side effect that bothers you or that does not go away.**

These are not all the possible side effects you may feel when taking SPINRAZA. If you experience any side effects not listed here, or have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, contact your healthcare professional.

### Reporting Side Effects
You can help improve the safe use of health products for Canadians by reporting serious and unexpected side effects to Health Canada. Your report may help to identify new side effects and change the product safety information.

**3 ways to report:**
- By calling 1-866-234-2345 (toll-free);
- By completing a Consumer Side Effect Reporting Form and sending it by:
  - Fax to 1-866-678-6789 (toll-free), or
  - Mail to: Canada Vigilance Program
    Health Canada, Postal Locator 1908C
    Ottawa, ON
    K1A 0K9

**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.

### Storage:
SPINRAZA will be managed and stored by healthcare professionals. Below are some of the guidelines for storing SPINRAZA:
- Refrigerate at 2°C to 8°C.
- May be stored at up to 30°C for up to 14 days.
- Protect from freezing.
- Protect SPINRAZA from light and keep it in the original carton until it is needed.
- Keep out of reach and sight of children.

**If you want more information about SPINRAZA:**
- Talk to your healthcare professional

This leaflet was prepared by Biogen Canada Inc.  
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