

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use SPINRAZA® safely and effectively. See full prescribing information for SPINRAZA.

SPINRAZA (nusinersen) injection, for intrathecal use
Initial U.S. Approval: 2016

RECENT MAJOR CHANGES

Dosage and Administration, Important Preparation and Administration Instructions (2.2) 11/2017

INDICATIONS AND USAGE

SPINRAZA is a survival motor neuron-2 (SMN2)-directed antisense oligonucleotide indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients (1)

DOSAGE AND ADMINISTRATION

SPINRAZA is administered intrathecally (2.1)

Dosing Information (2.1)

- The recommended dosage is 12 mg (5 mL) per administration
- Initiate SPINRAZA treatment with 4 loading doses; the first three loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose; a maintenance dose should be administered once every 4 months thereafter

Important Preparation and Administration Instructions (2.2)

- Allow to warm to room temperature prior to administration
- Administer within 4 hours of removal from vial
- Prior to administration, remove 5 mL of cerebrospinal fluid
- Administer as intrathecal bolus injection over 1 to 3 minutes

Laboratory Testing and Monitoring to Assess Safety (2.3)

- At baseline and prior to each dose, obtain a platelet count, coagulation laboratory testing, and quantitative spot urine protein testing

DOSAGE FORMS AND STRENGTHS

Injection: 12 mg/5 mL (2.4 mg/mL) in a single-dose vial (3)

CONTRAINDICATIONS

None.

WARNINGS AND PRECAUTIONS

- *Thrombocytopenia and Coagulation Abnormalities:* Increased risk for bleeding complications; testing required at baseline and before each dose (5.1, 2.3)
- *Renal Toxicity:* Quantitative spot urine protein testing required at baseline and prior to each dose (5.2, 2.3)

ADVERSE REACTIONS

The most common adverse reactions that occurred in at least 20% of SPINRAZA-treated patients and occurred at least 5% more frequently than in control patients were lower respiratory infection, upper respiratory infection, and constipation (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Biogen at 1-800-456-2255 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

See 17 for PATIENT COUNSELING INFORMATION.

Revised: 12/2017

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

SPINRAZA is indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients.

2 DOSAGE AND ADMINISTRATION

2.1 Dosing Information

SPINRAZA is administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures.

Recommended Dosage

The recommended dosage is 12 mg (5 mL) per administration.

Initiate SPINRAZA treatment with 4 loading doses. The first three loading doses should be administered at 14-day intervals. The 4th loading dose should be administered 30 days after the 3rd dose. A maintenance dose should be administered once every 4 months thereafter.

Missed Dose

If a loading dose is delayed or missed, administer SPINRAZA as soon as possible, with at least 14-days between doses and continue dosing as prescribed. If a maintenance dose is delayed or missed, administer SPINRAZA as soon as possible and continue dosing every 4 months.

2.2 Important Preparation and Administration Instructions

SPINRAZA is for intrathecal use only.

Prepare and use SPINRAZA according to the following steps using aseptic technique. Each vial is intended for single dose only.

Preparation

- Store SPINRAZA in the carton in a refrigerator until time of use.
- Allow the SPINRAZA vial to warm to room temperature (25° C/77° F) prior to administration. Do not use external heat sources.
- Inspect the SPINRAZA vial for particulate matter and discoloration prior to administration. Do not administer SPINRAZA if visible particulates are observed or if the liquid in the vial is discolored.
- Withdraw 12 mg (5 mL) of SPINRAZA from the single-dose vial into a syringe and discard unused contents of the vial.
- Administer SPINRAZA within 4 hours of removal from vial.

Administration

- Consider sedation as indicated by the clinical condition of the patient.

- Consider ultrasound or other imaging techniques to guide intrathecal administration of SPINRAZA, particularly in younger patients.
- Prior to administration, remove 5 mL of cerebrospinal fluid.
- Administer SPINRAZA as an intrathecal bolus injection over 1 to 3 minutes using a spinal anesthesia needle [see *Dosage and Administration (2.1)*]. Do not administer SPINRAZA in areas of the skin where there are signs of infection or inflammation [see *Adverse Reactions (6.3)*].

2.3 Laboratory Testing and Monitoring to Assess Safety

Conduct the following laboratory tests at baseline and prior to each dose of SPINRAZA and as clinically needed [see *Warnings and Precautions (5.1, 5.2)*]:

- Platelet count
- Prothrombin time; activated partial thromboplastin time
- Quantitative spot urine protein testing

3 DOSAGE FORMS AND STRENGTHS

Injection: 12 mg/5 mL (2.4 mg/mL) nusinersen as a clear and colorless solution in a single-dose vial.

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Thrombocytopenia and Coagulation Abnormalities

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

In a clinical study, 6 of 56 (11%) SPINRAZA-treated patients with normal or above normal platelet levels at baseline developed a platelet level below the lower limit of normal, compared to 0 of 28 sham-procedure control patients. No patient had a platelet count less than 50,000 cells per microliter in this study and no patient developed a sustained low platelet count despite continued drug exposure.

Because of the risk of thrombocytopenia and coagulation abnormalities from SPINRAZA, patients may be at increased risk of bleeding complications.

Perform a platelet count and coagulation laboratory testing at baseline and prior to each administration of SPINRAZA and as clinically needed.

5.2 Renal Toxicity

Renal toxicity, including potentially fatal glomerulonephritis, has been observed after administration of some antisense oligonucleotides.

SPINRAZA is present in and excreted by the kidney [see *Clinical Pharmacology (12.3)*]. In a clinical study (mean treatment exposure 7 months), 17 of 51 (33%) SPINRAZA-treated patients had elevated urine protein, compared to 5 of 25 (20%) sham-control patients. In a group of later-onset SMA patients (mean treatment exposure 34 months), 36 of 52 (69%) had elevated urine protein. No elevations in serum creatinine or cystatin C were observed in these studies. Conduct quantitative spot urine protein testing (preferably using a first morning urine specimen) at baseline and prior to each dose of SPINRAZA. For urinary protein concentration greater than 0.2 g/L, consider repeat testing and further evaluation.

6 ADVERSE REACTIONS

The following serious adverse reactions are described in detail in other sections of the labeling:

- Thrombocytopenia and Coagulation Abnormalities [see *Warnings and Precautions (5.1)*]
- Renal Toxicity [see *Warnings and Precautions (5.2)*]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of SPINRAZA cannot be directly compared to rates in clinical trials of other drugs and may not reflect the rates observed in practice.

The data described below reflect exposure to SPINRAZA in 173 patients (50% male, 82% Caucasian), including 120 exposed for at least 6 months and 83 exposed for at least 1 year. The safety of SPINRAZA was studied in infants with symptomatic SMA, approximately 1 month to 8 months of age at study entry; in a sham-controlled trial (n=80 for SPINRAZA, n=41 for control); in open-label studies in presymptomatic and symptomatic infants (n=37), and in open-label studies in later onset patients (n=56, 2 to 15 years of age at study entry). In the controlled study in symptomatic infants, 41 patients were exposed for at least 6 months and 19 patients were exposed for at least 12 months.

In the controlled study, 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%).

In the controlled study, the most common adverse reactions that occurred in at least 20% of SPINRAZA-treated patients and occurred at least 5% more frequently than in control patients were lower respiratory infection, upper respiratory infection, and constipation. Serious adverse reactions of atelectasis were more frequent in SPINRAZA-treated patients (14%) than in control

patients (5%). Because patients in the controlled study were infants, adverse reactions that are verbally reported could not be assessed in this study.

Table 1. Adverse Reactions that Occurred in at Least 5% of SPINRAZA Patients and Occurred at Least 5% More Frequently or At Least 2 Times as Frequently Than in Control Patients in the Controlled Study in Infants with Symptomatic SMA

Adverse Reactions	SPINRAZA 12 mg ¹	Sham-Procedure Control
	N=80 %	N=41 %
Lower respiratory infection ²	43	29
Upper respiratory infection ³	39	34
Constipation	30	22
Teething	14	7
Upper respiratory tract congestion	6	2
Aspiration	5	2
Ear infection	5	2
Scoliosis	5	2

¹ Four loading doses followed by 12 mg (5 mL) once every 4 months

² Includes pneumonia, bronchiolitis, pneumonia viral, respiratory syncytial virus bronchiolitis, lower respiratory tract infection, pneumonia bacterial, bronchitis, bronchitis viral, pneumonia moraxella, pneumonia parainfluenzae viral, lower respiratory tract infection viral, lung infection, pneumonia influenza, pneumonia pseudomonal, pneumonia respiratory syncytial viral

³ Includes upper respiratory tract infection, nasopharyngitis, rhinitis, pharyngitis, or tracheitis

In an open-label clinical study in infants with symptomatic SMA, severe hyponatremia was reported in a patient treated with SPINRAZA requiring salt supplementation for 14 months.

Cases of rash were reported in patients treated with SPINRAZA. One patient, 8 months after starting SPINRAZA treatment, developed painless red macular lesions on the forearm, leg, and foot over an 8-week period. The lesions ulcerated and scabbed over within 4 weeks, and resolved over several months. A second patient developed red macular skin lesions on the cheek and hand ten months after the start of SPINRAZA treatment, which resolved over 3 months. Both cases continued to receive SPINRAZA and had spontaneous resolution of the rash.

SPINRAZA may cause a reduction in growth as measured by height when administered to infants, as suggested by observations from the controlled study. It is unknown whether any effect of SPINRAZA on growth would be reversible with cessation of treatment.

The most common adverse events in the open-label studies in later onset patients were headache (50%), back pain (41%) and post lumbar puncture syndrome (41%). Most of these events occurred within 5 days of lumbar puncture. Other adverse events in these patients were consistent with adverse reactions observed in the controlled study.

6.2 Immunogenicity

The immunogenic response to nusinersen was determined in 126 patients with baseline and post-baseline plasma samples evaluated for anti-drug antibodies (ADAs). Five (4%) patients developed treatment-emergent ADAs, of which 3 were transient and 2 were considered to be persistent. There are insufficient data to evaluate an effect of ADAs on clinical response, adverse events, or the pharmacokinetic profile of nusinersen.

The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. In addition, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors including assay methodology, sample handling, timing of sample collection, concomitant medications and underlying disease. For these reasons, comparison of the incidence of antibodies to SPINRAZA in the studies described below with the incidence of antibodies in other studies or to other products may be misleading.

6.3 Postmarketing Experience

The following adverse reactions have been identified during post-approval use of SPINRAZA. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Serious infections (including meningitis) and hydrocephalus have occurred in patients treated with SPINRAZA via lumbar puncture.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

There are no adequate data on the developmental risk associated with the use of SPINRAZA in pregnant women. No adverse effects on embryofetal development were observed in animal studies in which nusinersen was administered by subcutaneous injection to mice and rabbits during pregnancy (*see Data*).

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively. The background risk of major birth defects and miscarriage for the indicated population is unknown.

Data

Animal Data

When nusinersen (0, 3, 10, or 25 mg/kg) was administered subcutaneously to male and female mice every other day prior to and during mating and continuing in females throughout organogenesis, no adverse effects on embryofetal development were observed. Subcutaneous administration of nusinersen (0, 6, 12.6, or 25 mg/kg) to pregnant rabbits every other day throughout organogenesis produced no evidence of embryofetal developmental toxicity.

8.2 Lactation

Risk Summary

There are no data on the presence of nusinersen in human milk, the effects on the breastfed infant, or the effects of the drug on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for SPINRAZA and any potential adverse effects on the breastfed infant from SPINRAZA or from the underlying maternal condition.

8.4 Pediatric Use

The safety and effectiveness of SPINRAZA in pediatric patients from newborn to 17 years have been established [*see Clinical Studies (14.1)*].

Juvenile Animal Toxicity Data

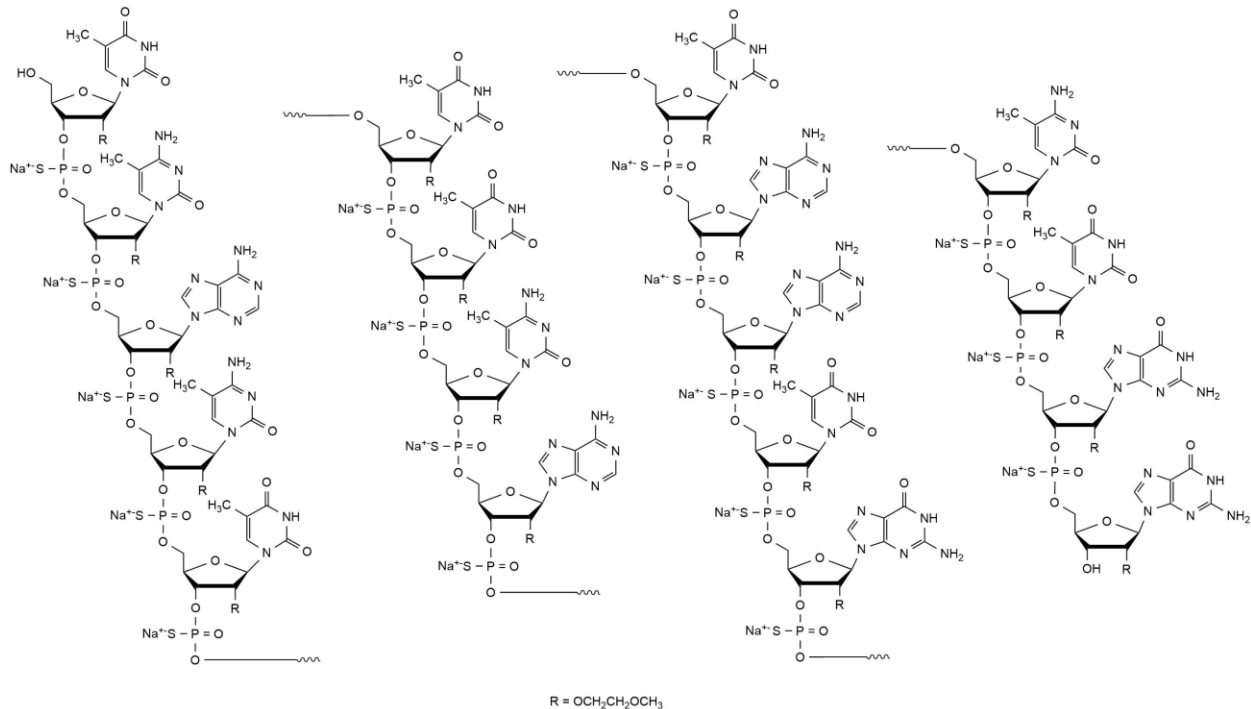
In intrathecal toxicity studies in juvenile monkeys, administration of nusinersen (0, 0.3, 1, or 3 mg/dose for 14 weeks and 0, 0.3, 1, or 4 mg/dose for 53 weeks) resulted in brain histopathology (neuronal vacuolation and necrosis/cellular debris in the hippocampus) at the mid and high doses and acute, transient deficits in lower spinal reflexes at the high dose in each study. In addition, possible neurobehavioral deficits were observed on a learning and memory test at the high dose in the 53-week monkey study. The no-effect 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.

8.5 Geriatric Use

SMA is largely a disease of children and young adults; therefore, there is no geriatric experience with SPINRAZA.

11 DESCRIPTION

SPINRAZA contains nusinersen, which is a modified antisense oligonucleotide, where the 2'-hydroxy groups of the ribofuranosyl rings are replaced with 2'-O-2-methoxyethyl groups and the phosphate linkages are replaced with phosphorothioate linkages. Nusinersen binds to a specific sequence in the intron downstream of exon 7 of the *SMN2* transcript. The structural formula is:



SPINRAZA is supplied as a sterile, preservative-free, colorless solution for intrathecal use in a single-dose glass vial. Each 1 mL solution contains 2.4 mg of nusinersen (equivalent to 2.53 mg of nusinersen sodium salt). Each 1 mL also contains calcium chloride dihydrate (0.21 mg) USP, magnesium chloride hexahydrate (0.16 mg) USP, potassium chloride (0.22 mg) USP, sodium chloride (8.77 mg) USP, sodium phosphate dibasic anhydrous (0.10 mg) USP, sodium phosphate monobasic dihydrate (0.05 mg) USP, and Water for Injection USP. The product may contain hydrochloric acid or sodium hydroxide to adjust pH. The pH is ~7.2.

The molecular formula of SPINRAZA is C₂₃₄H₃₂₃N₆₁O₁₂₈P₁₇S₁₇Na₁₇ and the molecular weight is 7501.0 daltons.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

SPINRAZA is an antisense oligonucleotide (ASO) designed to treat SMA caused by mutations in chromosome 5q that lead to SMN protein deficiency. Using in vitro assays and studies in transgenic animal models of SMA, SPINRAZA was shown to increase exon 7 inclusion in *SMN2* messenger ribonucleic acid (mRNA) transcripts and production of full-length SMN protein.

12.2 Pharmacodynamics

Autopsy samples from patients (n=3) had higher levels of *SMN2* messenger ribonucleic acid (mRNA) containing exon 7 in the thoracic spinal cord compared to untreated SMA infants.

Cardiac Electrophysiology

In 121 patients with spinal muscular atrophy who received either SPINRAZA or sham-control, QTcF values >500 ms and change from baseline values >60 ms were observed in 5% of patients receiving SPINRAZA. Compared to the sham-control, there was no increase in the incidence of cardiac adverse reactions associated with delayed ventricular repolarization in patients treated with SPINRAZA.

12.3 Pharmacokinetics

Absorption

Intrathecal injection of SPINRAZA 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 T_{max} values ranged from 1.7 to 6.0 hours. Mean plasma C_{max} and AUC values increased approximately dose-proportionally up to a dose of 12 mg.

Distribution

Autopsy data from patients (n=3) showed that SPINRAZA administered intrathecally was distributed within the CNS and peripheral tissues, such as skeletal muscle, liver, and kidney.

Elimination

Metabolism

Nusinersen is metabolized via exonuclease (3'- and 5')-mediated hydrolysis and is not a substrate for, or inhibitor or inducer of CYP450 enzymes.

Excretion

The mean terminal elimination half-life is estimated to be 135 to 177 days in CSF, and 63 to 87 days in plasma. The primary route of elimination is likely by urinary excretion for nusinersen and its chain-shortened metabolites. At 24 hours, only 0.5% of the administered dose was recovered in the urine.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Long-term studies in animals to evaluate the carcinogenic potential of nusinersen have not been performed.

Mutagenesis

Nusinersen demonstrated no evidence of genotoxicity in in vitro (Ames and chromosomal aberration in CHO cells) and in vivo (mouse micronucleus) assays.

Impairment of Fertility

When nusinersen (0, 3, 10, or 25 mg/kg) was administered by subcutaneous injection to mice every other day prior to and during mating and continuing in females throughout organogenesis, no adverse effects on male or female fertility were observed.

14 CLINICAL STUDIES

The efficacy of SPINRAZA was demonstrated in a double-blind, sham-procedure controlled clinical trial in symptomatic infantile-onset SMA patients and was supported by open-label clinical trials conducted in presymptomatic and symptomatic SMA patients.

14.1 Clinical Trial in Infantile-Onset SMA

This study was a multicenter, randomized, double-blind, sham-procedure controlled study in 121 symptomatic infants ≤ 7 months of age at the time of first dose, diagnosed with SMA (symptom onset before 6 months of age). Patients were randomized 2:1 to receive either SPINRAZA or sham injection.

A planned interim efficacy analysis was conducted based on patients who died, withdrew, or completed at least 183 days of treatment. Of the 82 patients included in the interim analysis, 44% were male and 56% were female. Age at first treatment ranged from 30 to 262 days (median 181). Eighty-seven (87%) of subjects were Caucasian, 2% were Black, and 4% were Asian. Length of treatment ranged from 6 to 442 days (median 261 days). Baseline demographics were balanced between the SPINRAZA and control groups with the exception of age at first treatment (median age 175 vs. 206 days, respectively). The SPINRAZA and control groups were balanced with respect to gestational age, birth weight, disease duration, and SMN2 copy number (2 copies in 98% of subjects in both groups). Median disease duration was 14 weeks. There was some imbalance in age at symptom onset with 88% of subjects in the SPINRAZA group and 77% in the control group experiencing symptoms within the first 12 weeks of life.

The primary endpoint assessed at the time of interim analysis was the proportion of responders: patients with an improvement in motor milestones according to Section 2 of the Hammersmith Infant Neurologic Exam (HINE). This endpoint evaluates seven different areas of motor milestone development, with a maximum score between 2-4 points for each, depending on the milestone, and a total maximum score of 26. A treatment responder was defined as any patient with at least a 2-point increase (or maximal score of 4) in ability to kick (consistent with improvement by at least 2 milestones), or at least a 1-point increase in the motor milestones of head control, rolling, sitting, crawling, standing or walking (consistent with improvement by at least 1 milestone). To be classified as a responder, patients needed to exhibit improvement in more categories of motor milestones than worsening. Of the 82 patients who were eligible for the interim analysis, a statistically significantly greater percentage of patients achieved a motor milestone response in the SPINRAZA group compared to the sham-control group (see [Table 2](#)). Figure 1 is a descriptive display of the distribution of net change from baseline in the total motor milestone score for Section 2 of the HINE.

Although not statistically controlled for multiple comparisons at the interim analysis, the study also assessed treatment effects on the Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), which is an evaluation of motor skills in patients with infantile-onset SMA. The CHOP-INTEND results are displayed in Table 2.

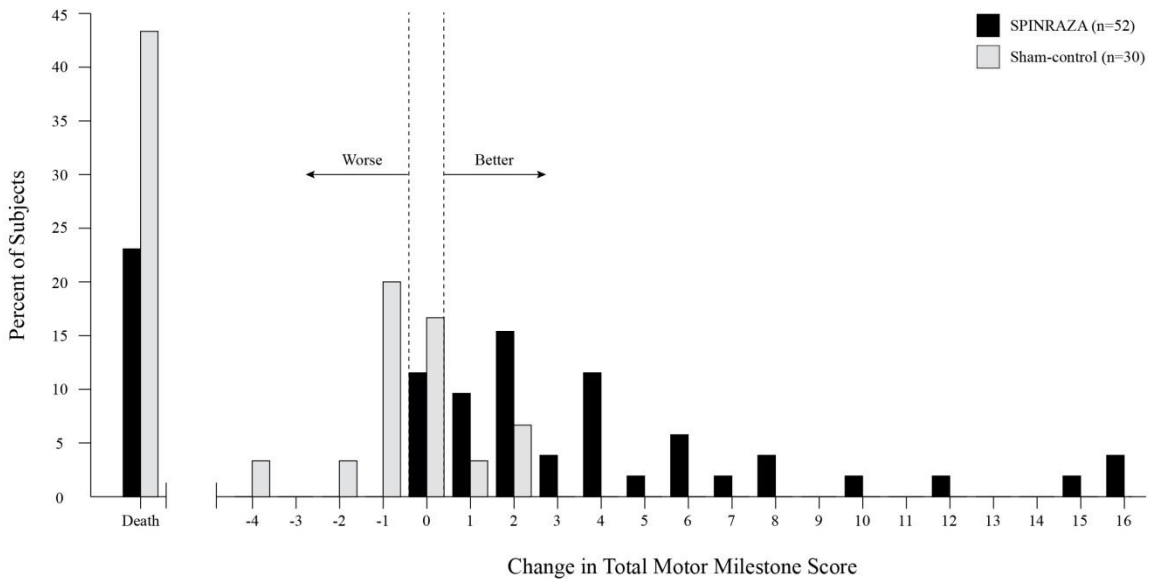
Table 2. Motor Milestone Response and CHOP-INTEND Results

Endpoint	SPINRAZA-treated patients (n=52) ¹	Sham-control patients (n=30) ¹
Motor Milestone (HINE Section 2)		
Achievement of a motor milestone response	21 (40%) p<0.0001	0 (0%)
CHOP-INTEND Improvement from Baseline²		
At least 4-points	33 (63%)	1 (3%)
CHOP-INTEND Worsening from Baseline²		
At least 4-points	2 (4%)	12 (40%)

¹Analyses included all subjects who were alive with the opportunity for at least a 6-month (Day 183) assessment and all subjects who died or withdrew from the study at the time of the interim analysis

²Not statistically controlled for multiple comparisons at interim analysis

Figure 1. Net Change from Baseline in Total Motor Milestone Score (HINE) by Percent of Subjects in the Interim 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.

The results of the controlled trial in infantile-onset SMA patients were supported by open-label uncontrolled trials conducted in symptomatic SMA patients who ranged in age from 30 days to

15 years at the time of first dose, and in presymptomatic patients, who ranged in age from 8 days to 42 days at the time of first dose. The patients in these studies had or were likely to develop Type 1, 2, or 3 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 considering the number of SMN2 gene copies of patients enrolled in the studies.

The overall findings of the controlled trial in infantile-onset SMA and the open-label uncontrolled trials support the effectiveness of SPINRAZA across the range of SMA patients, and appear to support the early initiation of treatment with SPINRAZA.

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

SPINRAZA injection is a sterile, clear and colorless solution supplied as a 12 mg/5 mL (2.4 mg/mL) solution in a single-dose glass vial free of preservatives. The NDC is 64406-058-01.

16.2 Storage and Handling

Store in a refrigerator between 2°C to 8°C (36°F to 46°F) in the original carton to protect from light. 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 (86°F) 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 should not exceed 30 hours at a temperature that does not exceed 25°C (77°F).

17 PATIENT COUNSELING INFORMATION

Thrombocytopenia and Coagulation Abnormalities

Inform patients and caregivers that SPINRAZA could increase the risk of bleeding. Inform patients and caregivers of the importance of obtaining blood laboratory testing at baseline and prior to each dose to monitor for signs of increased potential for bleeding. Instruct patients and caregivers to seek medical attention if unexpected bleeding occurs [*see Warnings and Precautions (5.1)*].

Renal Toxicity

Inform patients and caregivers that SPINRAZA could cause renal toxicity. Inform patients and caregivers of the importance of obtaining urine testing at baseline and prior to each dose to monitor for signs of potential renal toxicity [*see Warnings and Precautions (5.2)*].

49655-04

Manufactured for:

Biogen Inc.

Cambridge, MA 02142

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