

1. NAME OF THE MEDICINAL PRODUCT

RoActemra 20 mg/mL concentrate for solution for infusion

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

One mL concentrate contains 20 mg tocilizumab*.

Each vial contains 80 mg of tocilizumab* in 4 mL (20 mg/mL).

Each vial contains 200 mg of tocilizumab* in 10 mL (20 mg/mL).

Each vial contains 400 mg of tocilizumab* in 20 mL (20 mg/mL).

*humanised IgG1 monoclonal antibody produced in Chinese hamster ovary (CHO) cells by recombinant DNA technology.

Excipients with known effects

Each 80 mg vial contains 0.10 mmol (2.21 mg) sodium and 2 mg (0.5 mg/mL) polysorbate 80.

Each 200 mg vial contains 0.20 mmol (4.43 mg) sodium and 5 mg (0.5 mg/mL) polysorbate 80.

Each 400 mg vial contains 0.39 mmol (8.85 mg) sodium and 10 mg (0.5 mg/mL) polysorbate 80.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Concentrate for solution for infusion (sterile concentrate).

Clear to opalescent, colourless to pale yellow solution with a pH of 6.3-6.7 and an osmolality of 172-229 mOsm/kg.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Rheumatoid arthritis (RA)

RoActemra, in combination with methotrexate (MTX), is indicated for:

- the treatment of severe, active and progressive RA in adults not previously treated with MTX.
- the treatment of moderate to severe active RA in adult patients who have either responded inadequately to, or who were intolerant to, previous therapy with one or more disease-modifying anti-rheumatic drugs (DMARDs) or tumour necrosis factor (TNF) antagonists.

In these patients, RoActemra can be given as monotherapy in case of intolerance to MTX or where continued treatment with MTX is inappropriate.

RoActemra has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function when given in combination with MTX.

Coronavirus disease 2019 (COVID-19)

RoActemra is indicated for the treatment of COVID-19 in adults who are receiving systemic corticosteroids and require supplemental oxygen or mechanical ventilation.

Systemic juvenile idiopathic arthritis (sJIA)

RoActemra is indicated for the treatment of active sJIA in patients 2 years of age and older, who have responded inadequately to previous therapy with non-steroidal anti-inflammatory drugs (NSAIDs) and

systemic corticosteroids. RoActemra can be given as monotherapy (in case of intolerance to MTX or where treatment with MTX is inappropriate) or in combination with MTX.

Polyarticular juvenile idiopathic arthritis (pJIA)

RoActemra in combination with MTX is indicated for the treatment of pJIA (rheumatoid factor positive or negative and extended oligoarthritis) in patients 2 years of age and older, who have responded inadequately to previous therapy with MTX. RoActemra can be given as monotherapy in case of intolerance to MTX or where continued treatment with MTX is inappropriate.

Cytokine release syndrome (CRS)

RoActemra is indicated for the treatment of chimeric antigen receptor (CAR) T cell induced severe or life-threatening CRS in adults and paediatric patients 2 years of age and older.

4.2 Posology and method of administration

Treatment should be initiated by healthcare professionals experienced in the diagnosis and treatment of RA, COVID-19, sJIA, pJIA or CRS.

All patients treated with RoActemra must be given the Patient Card.

Posology

RA patients

The recommended posology is 8 mg/kg body weight, given once every four weeks.

For individuals whose body weight is more than 100 kg, doses exceeding 800 mg per infusion are not recommended (see section 5.2).

Doses above 1.2 g have not been evaluated in clinical trials (see section 5.1).

Dose adjustments due to laboratory abnormalities (see section 4.4)

- Liver enzyme abnormalities

Laboratory value	Action
> 1 to 3 × Upper Limit of Normal (ULN)	Modify the dose of the concomitant MTX if appropriate. For persistent increases in this range, reduce tocilizumab dose to 4 mg/kg or interrupt treatment until alanine aminotransferase (ALT) or aspartate aminotransferase (AST) have normalised. Restart with 4 mg/kg or 8 mg/kg, as clinically appropriate.
> 3 to 5 × ULN (confirmed by repeat testing, see section 4.4).	Interrupt tocilizumab dosing until < 3 × ULN and follow recommendations above for > 1 to 3 × ULN. For persistent increases > 3 × ULN, discontinue treatment.
> 5 × ULN	Discontinue treatment.

- Low absolute neutrophil count (ANC)

In patients not previously treated with tocilizumab, initiation is not recommended in patients with an absolute neutrophil count (ANC) below $2 \times 10^9/L$.

Laboratory Value (cells $\times 10^9/L$)	Action
ANC > 1	Maintain dose.
ANC 0.5 to 1	Interrupt tocilizumab dosing. When ANC increases $> 1 \times 10^9/L$ resume treatment at 4 mg/kg and increase to 8 mg/kg as clinically appropriate.
ANC < 0.5	Discontinue treatment.

- Low platelet count

Laboratory Value (cells $\times 10^3/\mu L$)	Action
50 to 100	Interrupt tocilizumab dosing. When platelet count $> 100 \times 10^3/\mu L$ resume treatment at 4 mg/kg and increase to 8 mg/kg as clinically appropriate.
< 50	Discontinue treatment.

COVID-19 patients

The recommended posology for treatment of COVID-19 is a single 60-minute intravenous infusion of 8 mg/kg body weight in patients who are receiving systemic corticosteroids and require supplemental oxygen or mechanical ventilation, see section 5.1. If clinical signs or symptoms worsen or do not improve after the first dose, one additional infusion of tocilizumab 8 mg/kg may be administered. The interval between the two infusions must be at least 8 hours.

For individuals whose body weight is more than 100 kg, doses exceeding 800 mg per infusion are not recommended (see section 5.2).

Administration of tocilizumab is not recommended in patients with COVID-19 who have any of the following laboratory abnormalities:

Laboratory test type	Laboratory value	Action
Liver enzyme	$> 10 \times ULN$	Administration of tocilizumab is not recommended
Absolute neutrophil count	$< 1 \times 10^9/L$	
Platelet count	$< 50 \times 10^3/\mu L$	

Cytokine Release Syndrome (CRS) (adults and paediatrics)

The recommended posology for treatment of CRS given as a 60-minute intravenous infusion is 8 mg/kg in patients weighing greater than or equal to 30 kg or 12 mg/kg in patients weighing less than 30 kg. Tocilizumab can be given alone or in combination with corticosteroids.

If no clinical improvement in the signs and symptoms of CRS occurs after the first dose, up to 3 additional doses of tocilizumab may be administered. The interval between consecutive doses must be at least 8 hours. Doses exceeding 800 mg per infusion are not recommended in CRS patients.

Patients with severe or life-threatening CRS frequently have cytopenias or elevated ALT or AST due to the underlying malignancy, preceding lymphodepleting chemotherapy or the CRS.

Special populations

Elderly

No dose adjustment is required in elderly patients > 65 years of age.

Renal impairment

No dose adjustment is required in patients with mild renal impairment. Tocilizumab has not been studied in patients with moderate to severe renal impairment (see section 5.2). Renal function must be monitored closely in these patients.

Hepatic impairment

Tocilizumab has not been studied in patients with hepatic impairment. Therefore, no dose recommendations can be made.

Paediatric population

sJIA patients

The recommended posology in patients above 2 years of age is 8 mg/kg once every 2 weeks in patients weighing greater than or equal to 30 kg or 12 mg/kg once every 2 weeks in patients weighing less than 30 kg. The dose must be calculated based on the patient's body weight at each administration. A change in dose should only be based on a consistent change in the patient's body weight over time.

The safety and efficacy of intravenous tocilizumab in children below 2 years of age has not been established. Currently available data are described in section 4.8, 5.1 and 5.2 but no recommendation on a posology can be made.

Dose interruptions of tocilizumab for the following laboratory abnormalities are recommended in sJIA patients in the tables below. If appropriate, the dose of concomitant MTX and/or other medicinal products should be modified or dosing stopped and tocilizumab dosing interrupted until the clinical situation has been evaluated. As there are many co-morbid conditions that may affect laboratory values in sJIA, the decision to discontinue tocilizumab for a laboratory abnormality should be based upon the medical assessment of the individual patient.

- Liver enzyme abnormalities

Laboratory Value	Action
> 1 to 3 × ULN	Modify the dose of the concomitant MTX if appropriate. For persistent increases in this range, interrupt tocilizumab until ALT/AST have normalised.
> 3 × ULN to 5 × ULN	Modify the dose of the concomitant MTX if appropriate. Interrupt tocilizumab dosing until < 3 × ULN and follow recommendations above for > 1 to 3 × ULN.
> 5 × ULN	Discontinue tocilizumab. The decision to discontinue treatment in sJIA for a laboratory abnormality must be based on the medical assessment of the individual patient.

- Low absolute neutrophil count (ANC)

Laboratory Value (cells $\times 10^9/L$)	Action
ANC > 1	Maintain dose.
ANC 0.5 to 1	Interrupt tocilizumab dosing. When ANC increases to $> 1 \times 10^9/L$ resume treatment.
ANC < 0.5	Discontinue tocilizumab. The decision to discontinue treatment in sJIA for a laboratory abnormality must be based on the medical assessment of the individual patient.

- Low platelet count

Laboratory Value (cells $\times 10^3/\mu L$)	Action
50 to 100	Modify the dose of the concomitant MTX if appropriate. Interrupt tocilizumab dosing. When platelet count is $> 100 \times 10^3/\mu L$ resume treatment.
< 50	Discontinue tocilizumab. The decision to discontinue treatment in sJIA for a laboratory abnormality must be based on the medical assessment of the individual patient.

There are insufficient clinical data to assess the impact of a tocilizumab dose reduction in sJIA patients who have experienced laboratory abnormalities.

Available data suggest that clinical improvement is observed within 6 weeks of initiation of treatment with tocilizumab. Continued therapy must be carefully reconsidered in a patient exhibiting no improvement within this timeframe.

pJIA patients

The recommended posology in patients above 2 years of age is 8 mg/kg once every 4 weeks in patients weighing greater than or equal to 30 kg or 10 mg/kg once every 4 weeks in patients weighing less than 30 kg. The dose must be calculated based on the patient's body weight at each administration. A change in dose should only be based on a consistent change in the patient's body weight over time.

The safety and efficacy of intravenous tocilizumab in children below 2 years of age has not been established. Currently available data are described in section 4.8, 5.1 and 5.2 but no recommendation on a posology can be made.

Dose interruptions of tocilizumab for the following laboratory abnormalities are recommended in pJIA patients in the tables below. If appropriate, the dose of concomitant MTX and/or other medicinal products should be modified or dosing stopped and tocilizumab dosing interrupted until the clinical situation has been evaluated. As there are many co-morbid conditions that may effect laboratory values in pJIA, the decision to discontinue tocilizumab for a laboratory abnormality should be based upon the medical assessment of the individual patient.

- Liver enzyme abnormalities

Laboratory Value	Action
> 1 to $3 \times \text{ULN}$	Modify the dose of the concomitant MTX if appropriate. For persistent increases in this range, interrupt tocilizumab until ALT/AST have normalised.
$> 3 \times \text{ULN}$ to $5 \times \text{ULN}$	Modify the dose of the concomitant MTX if appropriate. Interrupt tocilizumab dosing until $< 3 \times \text{ULN}$ and follow recommendations above for > 1 to $3 \times \text{ULN}$.
$> 5 \times \text{ULN}$	Discontinue tocilizumab. The decision to discontinue treatment in pJIA for a laboratory abnormality must be based on the medical assessment of the individual patient.

- Low absolute neutrophil count (ANC)

Laboratory Value (cells $\times 10^9/\text{L}$)	Action
ANC > 1	Maintain dose.
ANC 0.5 to 1	Interrupt tocilizumab dosing. When ANC increases to $> 1 \times 10^9/\text{L}$ resume treatment.
ANC < 0.5	Discontinue tocilizumab. The decision to discontinue treatment in pJIA for a laboratory abnormality must be based on the medical assessment of the individual patient.

- Low platelet count

Laboratory Value (cells $\times 10^3/\mu\text{L}$)	Action
50 to 100	Modify the dose of the concomitant MTX if appropriate. Interrupt tocilizumab dosing. When platelet count is $> 100 \times 10^3/\mu\text{L}$ resume treatment.
< 50	Discontinue tocilizumab. The decision to discontinue treatment in pJIA for a laboratory abnormality must be based on the medical assessment of the individual patient.

Reduction of tocilizumab dose due to laboratory abnormalities has not been studied in pJIA patients.

Available data suggest that clinical improvement is observed within 12 weeks of initiation of treatment with tocilizumab. Continued therapy must be carefully reconsidered in a patient exhibiting no improvement within this timeframe.

CRS

Tocilizumab may be used in paediatric patients (2 years of age and older) at the same posology as in adults in CRS. See section 4.2 Posology and method of administration, Cytokine Release Syndrome (CRS) (adults and paediatrics) subsection.

Method of administration

After dilution, this medicinal product should be administered as an intravenous infusion over 1 hour. If signs and symptoms of an infusion-related reaction occur, the infusion needs to be slowed or stopped and appropriate medicinal product/supportive care must be administered immediately (see section 4.4).

RA, sJIA, pJIA, CRS and COVID-19 patients ≥ 30 kg

This medicinal product needs to be diluted to a final volume of 100 mL with sterile, non-pyrogenic sodium chloride 9 mg/mL (0.9 %) solution for injection using aseptic technique.

For instructions on dilution of the medicinal product before administration, see section 6.6.

sJIA, pJIA and CRS patients < 30 kg

This medicinal product needs to be diluted to a final volume of 50 mL with sterile, non-pyrogenic sodium chloride 9 mg/mL (0.9 %) solution for injection using aseptic technique.

For instructions on dilution of the medicinal product before administration, see section 6.6.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

Active, severe infections with the exception of COVID-19 (see section 4.4).

4.4 Special warnings and precautions for use

Traceability

In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded.

RA, pJIA and sJIA patients

Infections

Serious and sometimes fatal infections have been reported in patients receiving immunosuppressive agents including tocilizumab (see section 4.8). Treatment must not be initiated in patients with active infections (see section 4.3). Administration of tocilizumab must be interrupted if a patient develops a serious infection until the infection is controlled (see section 4.8). Healthcare professionals should exercise caution when considering the use of this medicinal product in patients with a history of recurring or chronic infections or with underlying conditions (e.g. diverticulitis, diabetes and interstitial lung disease) which may predispose patients to infections.

Vigilance for the timely detection of serious infection is recommended for patients receiving biological treatments as signs and symptoms of acute inflammation may be lessened, associated with suppression of the acute phase reaction. The effects of tocilizumab on C-reactive protein (CRP), neutrophils and signs and symptoms of infection must be considered when evaluating a patient for a potential infection. Patients (which includes younger children with sJIA or pJIA who may be less able to communicate their symptoms) and parents/guardians of sJIA or pJIA patients should be instructed to contact their healthcare professional immediately when any symptoms suggesting infection appear, in order to assure rapid evaluation and appropriate treatment.

Tuberculosis (TB)

As recommended for other biological treatments, RA, pJIA and sJIA patients should be screened for latent TB infection prior to starting tocilizumab therapy. Patients with latent TB must be treated with standard anti-mycobacterial therapy before initiating treatment. Prescribers are reminded of the risk of false negative tuberculin skin and interferon-gamma TB blood test results, especially in patients who are severely ill or immunocompromised.

Patients should be instructed to seek medical advice if signs/symptoms (e.g., persistent cough, wasting/weight loss, low grade fever) suggestive of a tuberculosis infection occur during or after therapy with this medicinal product.

Viral reactivation

Viral reactivation (e.g. hepatitis B virus) has been reported with biologic therapies for RA. In clinical trials with tocilizumab, patients who screened positive for hepatitis were excluded.

Complications of diverticulitis

Events of diverticular perforations as complications of diverticulitis have been reported uncommonly with tocilizumab in RA patients (see section 4.8). This medicinal product should be used with caution in patients with previous history of intestinal ulceration or diverticulitis. Patients presenting with symptoms potentially indicative of complicated diverticulitis, such as abdominal pain, haemorrhage and/or unexplained change in bowel habits with fever must be evaluated promptly for early identification of diverticulitis, which can be associated with gastrointestinal perforation.

Hypersensitivity reactions

Serious hypersensitivity reactions have been reported in association with infusion of tocilizumab (see section 4.8). Such reactions may be more severe, and potentially fatal in patients who have experienced hypersensitivity reactions during previous infusions even if they have received premedication with steroids and antihistamines. Appropriate treatment should be available for immediate use in the event of an anaphylactic reaction during treatment. If an anaphylactic reaction or other serious hypersensitivity / serious infusion-related reaction occurs, administration of tocilizumab must be stopped immediately and treatment should be permanently discontinued.

Active hepatic disease and hepatic impairment

Treatment with tocilizumab, particularly when administered concomitantly with MTX, may be associated with elevations in hepatic transaminases, therefore, caution should be exercised when considering treatment of patients with active hepatic disease or hepatic impairment (see sections 4.2 and 4.8).

Hepatotoxicity

Transient or intermittent mild and moderate elevations of hepatic transaminases have been reported commonly with tocilizumab treatment (see section 4.8). An increased frequency of these elevations was observed when potentially hepatotoxic medicinal products (e.g. MTX) were used in combination with tocilizumab. When clinically indicated, other liver function tests including bilirubin should be considered.

Serious drug-induced liver injury, including acute liver failure, hepatitis and jaundice, have been observed with tocilizumab (see section 4.8). Serious hepatic injury occurred between 2 weeks to more than 5 years after initiation of treatment. Cases of liver failure resulting in liver transplantation have been reported. Patients must be advised to immediately seek medical help if they experience signs and symptoms of hepatic injury.

Caution should be exercised when considering initiation of treatment in patients with elevated ALT or AST $> 1.5 \times \text{ULN}$. In RA, pJIA and sJIA patients with baseline ALT or AST $> 5 \times \text{ULN}$, treatment is not recommended.

In RA, pJIA and sJIA patients, ALT/AST should be monitored every 4 to 8 weeks for the first 6 months of treatment followed by every 12 weeks thereafter. For recommended modifications,

including tocilizumab discontinuation, based on transaminases levels see section 4.2. For ALT or AST elevations $> 3\text{--}5 \times \text{ULN}$, confirmed by repeat testing, treatment must be interrupted.

Haematological abnormalities

Decreases in neutrophil and platelet counts have occurred following treatment with tocilizumab 8 mg/kg in combination with MTX (see section 4.8). There may be an increased risk of neutropenia in patients who have previously been treated with a TNF antagonist.

In patients not previously treated with tocilizumab, initiation is not recommended in patients with an ANC below $2 \times 10^9/\text{L}$. Caution should be exercised when considering initiation of treatment in patients with a low platelet count (i.e. platelet count below $100 \times 10^3/\mu\text{L}$). In RA, pJIA and sJIA patients who develop an ANC $< 0.5 \times 10^9/\text{L}$ or a platelet count $< 50 \times 10^3/\mu\text{L}$, continued treatment is not recommended.

Severe neutropenia may be associated with an increased risk of serious infections, although there has been no clear association between decreases in neutrophils and the occurrence of serious infections in clinical trials with tocilizumab to date.

In RA patients, neutrophils and platelets should be monitored 4 to 8 weeks after start of therapy and thereafter according to standard clinical practice. For recommended dose modifications based on ANC and platelet counts, see section 4.2.

In pJIA and sJIA patients, neutrophils and platelets should be monitored at the time of second infusion and thereafter according to good clinical practice, see section 4.2.

Lipid parameters

Elevations in lipid parameters including total cholesterol, low-density lipoprotein (LDL), high-density lipoprotein (HDL) and triglycerides were observed in patients treated with tocilizumab (see section 4.8). In the majority of patients, there was no increase in atherogenic indices, and elevations in total cholesterol responded to treatment with lipid lowering agents.

In RA, pJIA and sJIA patients, assessment of lipid parameters should be performed 4 to 8 weeks following initiation of therapy. Patients should be managed according to local clinical guidelines for management of hyperlipidaemia.

Neurological disorders

Physicians should be vigilant for symptoms potentially indicative of new-onset central demyelinating disorders. The potential for central demyelination with tocilizumab is currently unknown.

Malignancy

The risk of malignancy is increased in patients with RA. Immunomodulatory medicinal products may increase the risk of malignancy. The clinical data are insufficient to assess the potential incidence of malignancy following exposure to tocilizumab. Long-term safety evaluations are ongoing.

Vaccinations

Live and live attenuated vaccines should not be given concurrently with this medicinal product as clinical safety has not been established. In a randomised open-label trial, adult RA patients treated with tocilizumab and MTX were able to mount an effective response to both the 23-valent pneumococcal polysaccharide and tetanus toxoid vaccines which was comparable to the response seen in patients on MTX only. It is recommended that all patients, particularly pJIA and sJIA patients, be brought up to date with all immunisations in agreement with current immunisation guidelines prior to initiating therapy. The interval between live vaccinations and initiation of therapy should be in accordance with current vaccination guidelines regarding immunosuppressive agents.

Cardiovascular risk

RA patients have an increased risk for cardiovascular disorders and must have risk factors (e.g. hypertension, hyperlipidaemia) managed as part of usual standard of care.

Combination with TNF antagonists

There is no experience with the use of tocilizumab with TNF antagonists or other biological treatments for RA, pJIA or sJIA patients. This medicinal product is not recommended for use with other biological agents.

COVID-19 patients

- The efficacy of this medicinal product has not been established in the treatment of COVID-19 patients who do not have elevated CRP levels, see section 5.1.
- This medicinal product must not be administered to COVID-19 patients who are not receiving systemic corticosteroids as an increase in mortality cannot be excluded in this subgroup, see section 5.1.

Infections

In COVID-19 patients, this medicinal product should not be administered if they have any other concurrent severe active infection. Healthcare professionals should exercise caution when considering the use of tocilizumab in patients with a history of recurring or chronic infections or with underlying conditions (e.g. diverticulitis, diabetes, and interstitial lung disease) which may predispose patients to infections.

Hepatotoxicity

Patients hospitalised with COVID-19 may have elevated ALT or AST levels. Multi-organ failure with involvement of the liver is recognised as a complication of severe COVID-19. The decision to administer tocilizumab should balance the potential benefit of treating COVID-19 against the potential risks of acute treatment with tocilizumab. In COVID-19 patients with elevated ALT or AST above $10 \times \text{ULN}$, administration of tocilizumab treatment is not recommended. In COVID-19 patients, ALT /AST should be monitored according to current standard clinical practices.

Haematological abnormalities

In COVID-19 patients who develop an ANC $< 1 \times 10^9/\text{L}$ or a platelet count $< 50 \times 10^3/\mu\text{L}$, administration of treatment is not recommended. Neutrophil and platelet counts should be monitored according to current standard clinical practices, see section 4.2.

Paediatric population

sJIA Patients

Macrophage activation syndrome (MAS) is a serious life-threatening disorder that may develop in sJIA patients. In clinical trials, tocilizumab has not been studied in patients during an episode of active MAS.

Sodium

After dilution with 0.9 % sodium chloride solution, this medicinal product contains 230.6 mg sodium per maximum dose of 800 mg, equivalent to 11.5 % of the WHO recommended maximum daily intake of 2 g sodium for an adult.

Polysorbate 80 (E 433)

This medicinal product contains 2 mg of polysorbate 80 in each 80 mg vial, 5 mg of polysorbate 80 in each 200 mg vial and 10 mg polysorbate 80 in each 400 mg vial, which is equivalent to 0.5 mg/mL. Polysorbates may cause allergic reactions. Patients' known allergies shall be taken into consideration.

4.5 Interaction with other medicinal products and other forms of interaction

Interaction trials have only been performed in adults.

Concomitant administration of a single dose of 10 mg/kg tocilizumab with 10-25 mg MTX once weekly had no clinically significant effect on MTX exposure.

Population pharmacokinetic analyses did not detect any effect of MTX, NSAIDs or corticosteroids on tocilizumab clearance.

The expression of hepatic CYP450 enzymes is suppressed by cytokines, such as IL-6, that stimulate chronic inflammation. Thus, CYP450 expression may be reversed when potent cytokine inhibitory therapy, such as tocilizumab, is introduced.

In vitro trials with cultured human hepatocytes demonstrated that IL-6 caused a reduction in CYP1A2, CYP2C9, CYP2C19 and CYP3A4 enzyme expression. Tocilizumab normalises expression of these enzymes.

In a trial in RA patients, levels of simvastatin (CYP3A4) were decreased by 57 % one week following a single dose of tocilizumab, to the level similar to, or slightly higher than, those observed in healthy subjects.

When starting or stopping therapy with tocilizumab, patients taking medicinal products which are individually adjusted and are metabolised via CYP450 3A4, 1A2 or 2C9 (e.g. methylprednisolone, dexamethasone, (with the possibility for oral glucocorticoid withdrawal syndrome), atorvastatin, calcium channel blockers, theophylline, warfarin, phenprocoumon, phenytoin, ciclosporin, or benzodiazepines) must be monitored as doses may need to be increased to maintain therapeutic effect. Given its long elimination half-life ($t_{1/2}$), the effect of tocilizumab on CYP450 enzyme activity may persist for several weeks after stopping therapy.

4.6 Fertility, pregnancy and lactation

Women of childbearing potential

Women of childbearing potential have to use effective contraception during and up to 3 months after treatment.

Pregnancy

There are no adequate data from the use of tocilizumab in pregnant women. A trial in animals has shown an increased risk of spontaneous abortion/embryo-foetal death at a high dose (see section 5.3). The potential risk for humans is unknown.

RoActemra should not be used during pregnancy unless clearly necessary.

Breast-feeding

It is unknown whether tocilizumab is excreted in human milk. The excretion of tocilizumab in milk has not been studied in animals. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from RoActemra therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman.

Fertility

Available non-clinical data do not suggest an effect on fertility under tocilizumab treatment.

4.7 Effects on ability to drive and use machines

RoActemra has minor influence on the ability to drive and use machines, e.g. dizziness (see section 4.8).

4.8 Undesirable effects

Summary of the safety profile

RA, sJIA, pJIA and CRS

The most commonly reported adverse reactions are upper respiratory tract infections, nasopharyngitis, headache, hypertension and increased ALT.

The most serious adverse reactions are serious infections, complications of diverticulitis, and hypersensitivity reactions.

COVID-19

The most commonly reported adverse reactions are hepatic transaminases increased, constipation, and urinary tract infection.

Tabulated list of adverse reactions

Adverse reactions from clinical trials and/or post-marketing experience with tocilizumab based on spontaneous case reports, literature cases and cases from non-interventional trial programs are listed in Table 1 and in Table 2 by MedDRA system organ class (SOC). The corresponding frequency category for each adverse reaction is based on the following convention: very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1\ 000$ to $< 1/100$), rare ($\geq 1/10\ 000$ to $< 1/1\ 000$), very rare ($< 1/10\ 000$), and frequency not known (cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

RA patients

Table 1. List of adverse reactions occurring in patients with RA receiving tocilizumab as monotherapy or in combination with MTX or other DMARDs in the double-blind controlled period or during post-marketing experience

MedDRA SOC	Frequency categories with preferred terms				
	Very common	Common	Uncommon	Rare	Very rare
Infections and infestations	Upper respiratory tract infections	Cellulitis, Pneumonia, Oral herpes simplex, Herpes zoster	Diverticulitis		
Blood and lymphatic system disorders		Leukopenia, Neutropenia, Hypofibrinogenaemia			
Immune system disorders				Anaphylaxis (fatal) ^{1, 2, 3}	
Endocrine disorders			Hypothyroidism		
Metabolism and nutrition disorders	Hypercholesterolaemia*		Hypertriglyceridaemia		
Nervous system disorders		Headache, Dizziness			
Eye disorders		Conjunctivitis			
Vascular disorders		Hypertension			
Respiratory, thoracic and mediastinal disorders		Cough, Dyspnoea			

MedDRA SOC	Frequency categories with preferred terms				
	Very common	Common	Uncommon	Rare	Very rare
Gastroin- testinal disorders		Abdominal pain, Mouth ulceration, Gastritis	Stomatitis, Gastric ulcer		
Hepatobi- liary disorders				Drug-induced liver injury, Hepatitis, Jaundice, :	Hepatic failure
Skin and subcutane- ous tissue disorders		Rash, Pruritus, Urticaria		Stevens- Johnson- Syndrome ³	
Renal and urinary disorders			Nephroli- thiasis		
General disorders and administra- tion site conditions		Peripheral oedema, Hypersensitiv ity reactions			
Investiga- tions		Hepatic transaminases increased, Weight increased, Total bilirubin increased*			

* Includes elevations collected as part of routine laboratory monitoring (see text below)

¹ See section 4.3

² See section 4.4

³ This adverse reaction was identified through post-marketing surveillance but not observed in controlled clinical trials. The frequency category was estimated as the upper limit of the 95 % confidence interval calculated on the basis of the total number of patients exposed to tocilizumab in clinical trials.

Patients with COVID-19

The safety evaluation of this medicinal product in COVID-19 was based on 3 randomised, double-blind, placebo-controlled trials (Trials ML42528, WA42380, and WA42511). A total of 974 patients were exposed to tocilizumab in these trials. Collection of safety data from the RECOVERY trial was limited and is not presented here.

The following adverse reactions, listed by MedDRA SOC in Table 2, have been adjudicated from events which occurred in at least 3 % of tocilizumab treated patients and more commonly than that in patients on placebo in the pooled safety-evaluable population from clinical Trials ML42528, WA42380, and WA42511.

Table 2. List of adverse reactions¹ identified from the pooled safety-evaluable population from tocilizumab clinical trials in COVID-19 patients²

MedDRA SOC Class	Preferred Terms and frequency Common
Infections and infestations	Urinary tract infection
Metabolism and nutrition disorders	Hypokalaemia
Psychiatric disorders	Anxiety, Insomnia
Vascular disorders	Hypertension
Gastrointestinal disorders	Constipation, Diarrhoea, Nausea
Hepatobiliary disorders	Hepatic transaminases increased

¹ Patients are counted once for each category regardless of the number of reactions

² Includes adjudicated reactions reported in Trials WA42511, WA42380 and ML42528

Patients with sJIA or pJIA

Adverse reactions in the sJIA and pJIA patients treated with tocilizumab are listed in the Table 3 and presented by MedDRA SOC. The corresponding frequency category for each adverse reaction is based on the following convention: very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$) or uncommon ($\geq 1/1\ 000$ to $< 1/100$).

Table 3. List of adverse reactions occurring in clinical trial patients with sJIA or pJIA receiving tocilizumab as monotherapy or in combination with MTX.

MedDRA SOC	Preferred term (PT)	Frequency		
Infections and Infestations		Very Common	Common	Uncommon
	Upper Respiratory Tract Infections	pJIA, sJIA		
	Nasopharyngitis	pJIA, sJIA		
Nervous system disorders				
	Headache	pJIA	sJIA	
Gastrointestinal Disorders				
	Nausea		pJIA	
	Diarrhoea		pJIA, sJIA	
General disorders and administration site conditions				
	Infusion related reactions		pJIA ¹ , sJIA ²	
Investigations				
	Hepatic transaminases increased		pJIA	
	Decrease in neutrophil count	sJIA	pJIA	
	Platelet count decreased		sJIA	pJIA
	Cholesterol increased		sJIA	pJIA

1. Infusion-related reaction events in pJIA patients included but were not limited to headache, nausea and hypotension

2. Infusion-related reaction events in sJIA patients included but were not limited to rash, urticaria, diarrhoea, epigastric discomfort, arthralgia and headache

Description of selected adverse reactions

RA patients

Infections

In the 6-month controlled trials the rate of all infections reported with tocilizumab 8 mg/kg plus DMARD treatment was 127 events per 100 patient years compared to 112 events per 100 patient years in the placebo plus DMARD group. In the long-term exposure population, the overall rate of infections with tocilizumab was 108 events per 100 patient years exposure.

In 6-month controlled clinical trials, the rate of serious infections with tocilizumab 8 mg/kg plus DMARDs was 5.3 events per 100 patient years exposure compared to 3.9 events per 100 patient years exposure in the placebo plus DMARD group. In the monotherapy trial, the rate of serious infections was 3.6 events per 100 patient years of exposure in the tocilizumab group and 1.5 events per 100 patient years of exposure in the MTX group.

In the long-term exposure population, the overall rate of serious infections (bacterial, viral and fungal) was 4.7 events per 100 patient years. Reported serious infections, some with fatal outcome, included active tuberculosis, which may present with intrapulmonary or extrapulmonary disease, invasive pulmonary infections, including candidiasis, aspergillosis, coccidioidomycosis and pneumocystis jirovecii, pneumonia, cellulitis, herpes zoster, gastroenteritis, diverticulitis, sepsis and bacterial arthritis. Cases of opportunistic infections have been reported.

Interstitial lung disease

Impaired lung function may increase the risk for developing infections. There have been post-marketing reports of interstitial lung disease (including pneumonitis and pulmonary fibrosis), some of which had fatal outcomes.

Gastrointestinal perforation

During the 6-month controlled clinical trials, the overall rate of gastrointestinal perforation, was 0.26 events per 100 patient years with tocilizumab therapy. In the long-term exposure population the overall rate of gastrointestinal perforation was 0.28 events per 100 patient years. Reports of gastrointestinal perforation on treatment were primarily reported as complications of diverticulitis including generalised purulent peritonitis, lower gastrointestinal perforation, fistulae and abscess.

Infusion related reactions

In the 6-month controlled trials adverse events associated with infusion (selected events occurring during or within 24 hours of infusion) were reported by 6.9 % of patients in the tocilizumab 8 mg/kg plus DMARD group and 5.1 % of patients in the placebo plus DMARD group. Events reported during the infusion were primarily episodes of hypertension; events reported within 24 hours of finishing an infusion were headache and skin reactions (rash, urticaria). These events were not treatment limiting.

The rate of anaphylactic reactions (occurring in a total of 8/4 009 patients, 0.2 %) was several fold higher with the 4 mg/kg dose, compared to the 8 mg/kg dose. Clinically significant hypersensitivity reactions associated with tocilizumab and requiring treatment discontinuation were reported in a total of 56 out of 4 009 patients (1.4 %) treated during the controlled and open label clinical trials. These reactions were generally observed during the second to fifth infusions of tocilizumab (see section 4.4). Fatal anaphylaxis has been reported after marketing authorisation during treatment with tocilizumab (see section 4.4).

Immunogenicity

A total of 2 876 patients have been tested for anti-tocilizumab antibodies in the 6-month controlled clinical trials. Of the 46 patients (1.6 %) who developed anti-tocilizumab antibodies, 6 had an associated medically significant hypersensitivity reaction, of which 5 led to permanent discontinuation of treatment. Thirty patients (1.1 %) developed neutralising antibodies.

Neutrophils

In the 6-month controlled trials decreases in neutrophil counts below $1 \times 10^9/L$ occurred in 3.4 % of patients on tocilizumab 8 mg/kg plus DMARDs compared to < 0.1 % of patients on placebo plus

DMARDs. Approximately half of the patients who developed an ANC $< 1 \times 10^9/\text{L}$ did so within 8 weeks after starting therapy. Decreases below $0.5 \times 10^9/\text{L}$ were reported in 0.3 % patients receiving tocilizumab 8 mg/kg plus DMARDs. Infections with neutropenia have been reported.

During the double-blind controlled period and with long-term exposure, the pattern and incidence of decreases in neutrophil counts remained consistent with what was seen in the 6-month controlled clinical trials.

Platelets

In the 6-month controlled trials decreases in platelet counts below $100 \times 10^3/\mu\text{L}$ occurred in 1.7 % of patients on tocilizumab 8 mg/kg plus DMARDs compared to < 1 % on placebo plus DMARDs. These decreases occurred without associated bleeding events.

During the double-blind controlled period and with long-term exposure, the pattern and incidence of decreases in platelet counts remained consistent with what was seen in the 6-month controlled clinical trials.

Very rare reports of pancytopenia have occurred in the post-marketing setting.

Hepatic transaminase elevations

During the 6-month controlled trials transient elevations in ALT/AST $> 3 \times \text{ULN}$ were observed in 2.1 % of patients on tocilizumab 8 mg/kg compared to 4.9 % of patients on MTX and in 6.5 % of patients who received 8 mg/kg tocilizumab plus DMARDs compared to 1.5 % of patients on placebo plus DMARDs.

The addition of potentially hepatotoxic medicinal products (e.g. MTX) to tocilizumab monotherapy resulted in increased frequency of these elevations. Elevations of ALT/AST $> 5 \times \text{ULN}$ were observed in 0.7 % of tocilizumab monotherapy patients and 1.4 % of tocilizumab plus DMARD patients, the majority of whom were discontinued permanently from tocilizumab treatment. During the double-blind controlled period, the incidence of indirect bilirubin greater than the upper limit of normal, collected as a routine laboratory parameter, is 6.2 % in patients treated with 8 mg/kg tocilizumab + DMARD. A total of 5.8 % of patients experienced an elevation of indirect bilirubin of > 1 to $2 \times \text{ULN}$ and 0.4 % had an elevation of $> 2 \times \text{ULN}$.

During the double-blind controlled period and with long-term exposure, the pattern and incidence of elevation in ALT/AST remained consistent with what was seen in the 6-month controlled clinical trials.

Lipid parameters

During the 6-month controlled trials, increases of lipid parameters such as total cholesterol, triglycerides, LDL cholesterol, and/or HDL cholesterol have been reported commonly. With routine laboratory monitoring it was seen that approximately 24 % of patients receiving tocilizumab in clinical trials experienced sustained elevations in total cholesterol $\geq 6.2 \text{ mmol/L}$ with 15 % experiencing a sustained increase in LDL to $\geq 4.1 \text{ mmol/L}$. Elevations in lipid parameters responded to treatment with lipid-lowering agents.

During the double-blind controlled period and with long-term exposure, the pattern and incidence of elevations in lipid parameters remained consistent with what was seen in the 6-month controlled trials.

Skin reactions

Rare reports of Stevens-Johnson Syndrome have occurred in the post-marketing setting.

COVID-19 patients

Infections

In the pooled safety-evaluable population from Trials ML42528, WA42380, and WA42511, the rates of infection/serious infection events were balanced between COVID-19 patients receiving tocilizumab (30.3 %/18.6 %, n = 974) versus placebo (32.1 %/22.8 %, n = 483).

The safety profile observed in the baseline systemic corticosteroids treatment group was consistent with the safety profile of tocilizumab from the overall population presented in Table 2. In this subgroup, infections and serious infections occurred in 27.8 % and 18.1 % of patients treated with intravenous tocilizumab and in 30.5 % and 22.9 % of patients treated with placebo, respectively.

Laboratory abnormalities

The incidence of laboratory abnormalities was generally similar between patients with COVID-19 who received one or two doses of tocilizumab-intravenous compared with those who received placebo in the randomised, double-blind, placebo-controlled trials with few exceptions. Decreases in platelets and neutrophils and elevations of ALT and AST were more frequent among patients receiving tocilizumab-intravenous versus placebo (see section 4.2 and 4.4).

Paediatric population

In general, the adverse reactions in pJIA and sJIA patients were similar in type to those seen in RA patients, see section 4.8.

Description of selected adverse reactions in pJIA patients

The safety profile of intravenous tocilizumab in pJIA has been studied in 188 patients from 2 to 17 years of age. The total patient exposure was 184.4 patient years. The frequency of adverse reactions in pJIA patients can be found in Table 3. The types of adverse reactions in pJIA patients were similar to those seen in RA and sJIA patients. When compared to the adult RA population, events of nasopharyngitis, headache, nausea, and decreased neutrophil count were more frequently reported in the pJIA population. Events of cholesterol increased were less frequently reported in the pJIA population than in the adult RA population.

Infections

The rate of infections in the tocilizumab all exposure population was 163.7 per 100 patient years. The most common events observed were nasopharyngitis and upper respiratory tract infections. The rate of serious infections was numerically higher in patients weighing < 30 kg treated with 10 mg/kg tocilizumab (12.2 per 100 patient years) compared to patients weighing ≥ 30 kg, treated with 8 mg/kg tocilizumab (4.0 per 100 patient years). The incidence of infections leading to dose interruptions was also numerically higher in patients weighing < 30 kg treated with 10 mg/kg tocilizumab (21.4 %) compared to patients weighing ≥ 30 kg, treated with 8 mg/kg tocilizumab (7.6 %).

Infusion-related reactions

In pJIA patients, infusion-related reactions are defined as all events occurring during or within 24 hours of an infusion. In the tocilizumab all exposure population, 11 patients (5.9 %) experienced infusion-related reactions during the infusion and 38 patients (20.2 %) experienced an event within 24 hours of an infusion. The most common events occurring during infusion were headache, nausea and hypotension and within 24 hours of infusion were dizziness and hypotension. In general, the adverse reactions observed during or within 24 hours of an infusion were similar in nature to those seen in RA and sJIA patients, see section 4.8.

No clinically significant hypersensitivity reactions associated with tocilizumab and requiring treatment discontinuation were reported.

Immunogenicity

One patient in the 10 mg/kg < 30 kg group developed positive anti-tocilizumab antibodies without developing a hypersensitivity reaction and subsequently withdrew from the trial.

Neutrophils

During routine laboratory monitoring in the tocilizumab all exposure population, a decrease in neutrophil count below $1 \times 10^9/\text{L}$ occurred in 3.7 % of patients.

Platelets

During routine laboratory monitoring in the tocilizumab all exposure population, 1 % of patients had a decrease in platelet count to $\leq 50 \times 10^3/\mu\text{L}$ without associated bleeding events.

Hepatic transaminase elevations

During routine laboratory monitoring in the tocilizumab all exposure population, elevation in ALT or AST $\geq 3 \times \text{ULN}$ occurred in 3.7 % and < 1 % of patients, respectively.

Lipid parameters

During routine laboratory monitoring in the intravenous tocilizumab Trial WA19977 3.4 % and 10.4 % of patients experienced a post-baseline elevation of their LDL-cholesterol value to $\geq 130 \text{ mg/dL}$ and total cholesterol value to $\geq 200 \text{ mg/dL}$ at any time during the trial treatment, respectively.

Description of selected adverse reactions in sJIA patients

The safety profile of intravenous tocilizumab in sJIA has been studied in 112 patients from 2 to 17 years of age. In the 12 week double-blind, controlled phase, 75 patients received treatment with tocilizumab (8 mg/kg or 12 mg/kg based upon body weight). After 12 weeks or at the time of switching from placebo to tocilizumab, due to disease worsening, patients were treated in the open label extension phase.

In general, the adverse reactions in sJIA patients were similar in type to those seen in RA patients. The frequency of adverse reactions in sJIA patients can be found in Table 3. When compared to the adult RA population, patients with sJIA experienced a higher frequency of nasopharyngitis, decrease in neutrophil counts, hepatic transaminases increased, and diarrhoea. Events of cholesterol increased were less frequently reported in the sJIA population than in the adult RA population.

Infections

In the 12 week controlled phase, the rate of all infections in the intravenous tocilizumab group was 344.7 per 100 patient years and 287.0 per 100 patient years in the placebo group. In the open label extension phase (Part II), the overall rate of infections remained similar at 306.6 per 100 patient years.

In the 12 week controlled phase, the rate of serious infections in the intravenous tocilizumab group was 11.5 per 100 patient years. At one year in the open label extension phase the overall rate of serious infections remained stable at 11.3 per 100 patient years. Reported serious infections were similar to those seen in RA patients with the addition of varicella and otitis media.

Infusion-related reactions

Infusion-related reactions are defined as all events occurring during or within 24 hours of an infusion. In the 12 week controlled phase, 4 % of patients from the tocilizumab group experienced events occurring during infusion. One event (angioedema) was considered serious and life-threatening, and the patient was discontinued from trial treatment.

In the 12 week controlled phase, 16 % of patients in the tocilizumab group and 5.4 % of patients in the placebo group experienced an event within 24 hours of infusion. In the tocilizumab group, the events included, but were not limited to rash, urticaria, diarrhoea, epigastric discomfort, arthralgia and headache. One of these events, urticaria, was considered serious.

Clinically significant hypersensitivity reactions associated with tocilizumab and requiring treatment discontinuation, were reported in 1 out of 112 patients (< 1 %) treated with tocilizumab during the controlled and up to and including the open label clinical trial.

Immunogenicity

All 112 patients were tested for anti-tocilizumab antibodies at baseline. Two patients developed positive anti-tocilizumab antibodies with one of these patients having a hypersensitivity reaction leading to withdrawal. The incidence of anti-tocilizumab antibody formation might be underestimated because of interference of tocilizumab with the assay and higher tocilizumab concentration observed in children compared to adults.

Neutrophils

During routine laboratory monitoring in the 12 week controlled phase, a decrease in neutrophil counts below $1 \times 10^9/L$ occurred in 7 % of patients in the tocilizumab group, and no decreases in the placebo group.

In the open label extension phase, decreases in neutrophil counts below $1 \times 10^9/L$, occurred in 15 % of the tocilizumab group.

Platelets

During routine laboratory monitoring in the 12 week controlled phase, 3 % of patients in the placebo group and 1 % in the tocilizumab group had a decrease in platelet count to $\leq 100 \times 10^3/\mu L$.

In the open label extension phase, decreases in platelet counts below $100 \times 10^3/\mu L$, occurred in 3 % of patients in the tocilizumab group, without associated bleeding events.

Hepatic transaminase elevations

During routine laboratory monitoring in the 12 week controlled phase, elevation in ALT or AST $\geq 3 \times ULN$ occurred in 5 % and 3 % of patients, respectively, in the tocilizumab group, and 0 % in the placebo group.

In the open label extension phase, elevation in ALT or AST $\geq 3 \times ULN$ occurred in 12 % and 4 % of patients, respectively, in the tocilizumab group.

Immunoglobulin G

IgG levels decrease during therapy. A decrease to the lower limit of normal occurred in 15 patients at some point in the trial.

Lipid parameters

During routine laboratory monitoring in the 12 week controlled phase (Trial WA18221), 13.4 % and 33.3 % of patients experienced a post-baseline elevation of their LDL-cholesterol value to ≥ 130 mg/dL and total cholesterol value to ≥ 200 mg/dL at any time during trial treatment, respectively.

In the open label extension phase (Trial WA18221), 13.2 % and 27.7 % of patients experienced a post-baseline elevation of their LDL-cholesterol value to ≥ 130 mg/dL and total cholesterol value to ≥ 200 mg/dL at any time during trial treatment, respectively.

CRS patients

The safety of tocilizumab in CRS has been evaluated in a retrospective analysis of data from clinical trials, where 51 patients were treated with intravenous tocilizumab 8 mg/kg (12 mg/kg for patients less than 30 kg) with or without additional high-dose corticosteroids for severe or life-threatening CAR T cell-induced CRS. A median of 1 dose of tocilizumab (range, 1-4 doses) was administered.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions (see details below).

Ireland

HPRA Pharmacovigilance

Website: www.hpra.ie

Malta

ADR Reporting Website: <https://medicinesauthority.gov.mt/adrportal>

4.9 Overdose

There are limited data available on overdose with tocilizumab. One case of accidental overdose was reported in which a patient with multiple myeloma received a single dose of 40 mg/kg. No adverse reactions were observed.

No serious adverse reactions were observed in healthy volunteers who received a single dose up to 28 mg/kg, although dose limiting neutropenia was observed.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Immunosuppressants, Interleukin inhibitors; ATC code: L04AC07.

Mechanism of action

Tocilizumab binds specifically to both soluble and membrane-bound IL-6 receptors (sIL-6R and mIL-6R). Tocilizumab has been shown to inhibit sIL-6R and mIL-6R-mediated signalling. IL-6 is a pleiotropic pro-inflammatory cytokine produced by a variety of cell types including T- and B-cells, monocytes and fibroblasts. IL-6 is involved in diverse physiological processes such as T-cell activation, induction of immunoglobulin secretion, induction of hepatic acute phase protein synthesis and stimulation of haemopoiesis. IL-6 has been implicated in the pathogenesis of diseases including inflammatory diseases, osteoporosis and neoplasia.

Pharmacodynamic effects

In clinical trials with RA patients treated with tocilizumab, rapid decreases in CRP, erythrocyte sedimentation rate (ESR), serum amyloid A (SAA) and fibrinogen were observed. Consistent with the effect on acute phase reactants, treatment with tocilizumab was associated with reduction in platelet count within the normal range. Increases in haemoglobin levels were observed, through tocilizumab decreasing the IL-6 driven effects on hepcidin production to increase iron availability. In treated patients, decreases in the levels of CRP to within normal ranges were seen as early as week 2, with decreases maintained while on treatment.

In healthy subjects administered tocilizumab in doses from 2 to 28 mg/kg, absolute neutrophil counts decreased to their lowest 3 to 5 days following administration. Thereafter, neutrophils recovered towards baseline in a dose dependent manner. Rheumatoid arthritis patients demonstrated a similar pattern of absolute neutrophil counts following tocilizumab administration (see section 4.8).

In COVID-19 patients with one dose of tocilizumab 8 mg/kg administered intravenously, decreases in the levels of CRP to within normal ranges were seen as early as day 7.

RA patients

Clinical efficacy and safety

The efficacy of tocilizumab in alleviating the signs and symptoms of RA was assessed in five randomised, double-blind, multi-centre trials. Trials I-V enrolled patients ≥ 18 years of age with active RA diagnosed according to the American College of Rheumatology (ACR) criteria and who had at least eight tender and six swollen joints at baseline.

In Trial I, tocilizumab was administered intravenously every four weeks as monotherapy. In Trials II, III and V, tocilizumab was administered intravenously every four weeks in combination with MTX vs.

placebo and MTX. In Trial IV, tocilizumab was administered intravenously every 4 weeks in combination with other DMARDs vs. placebo and other DMARDs. The primary endpoint for each of the five trials was the proportion of patients who achieved an ACR 20 response at week 24.

Trial I evaluated 673 patients who had not been treated with MTX within six months prior to randomisation and who had not discontinued previous MTX treatment as a result of clinically important toxic effects or lack of response. The majority (67 %) of patients were MTX-naïve. Doses of 8 mg/kg of tocilizumab were given every four weeks as monotherapy. The comparator group was weekly MTX (dose titrated from 7.5 mg to a maximum of 20 mg weekly over an eight-week period).

Trial II, a two-year trial with planned analyses at week 24, week 52 and week 104, evaluated 1 196 patients who had an inadequate clinical response to MTX. Doses of 4 or 8 mg/kg of tocilizumab or placebo were given every four weeks as blinded therapy for 52 weeks in combination with stable MTX (10 mg to 25 mg weekly). After week 52, all patients could receive open-label treatment with tocilizumab 8 mg/kg. Of the patients who completed the trial who were originally randomised to placebo + MTX, 86 % received open-label tocilizumab 8 mg/kg in year 2. The primary endpoint at week 24 was the proportion of patients who achieved an ACR 20 response. At week 52 and week 104 the co-primary endpoints were prevention of joint damage and improvement in physical function.

Trial III evaluated 623 patients who had an inadequate clinical response to MTX. Doses of 4 or 8 mg/kg tocilizumab or placebo were given every four weeks, in combination with stable MTX (10 mg to 25 mg weekly).

Trial IV evaluated 1 220 patients who had an inadequate response to their existing rheumatologic therapy, including one or more DMARDs. Doses of 8 mg/kg tocilizumab or placebo were given every four weeks in combination with stable DMARDs.

Trial V evaluated 499 patients who had an inadequate clinical response or were intolerant to one or more TNF antagonist therapies. The TNF antagonist therapy was discontinued prior to randomisation. Doses of 4 or 8 mg/kg tocilizumab or placebo were given every four weeks in combination with stable MTX (10 mg to 25 mg weekly).

Clinical response

In all trials, patients treated with tocilizumab 8 mg/kg had statistically significant higher ACR 20, 50, 70 response rates at 6 months compared to control (Table 4). In Trial I, superiority of tocilizumab 8 mg/kg was demonstrated against the active comparator MTX.

The treatment effect was similar in patients independent of rheumatoid factor status, age, gender, race, number of prior treatments or disease status. Time to onset was rapid (as early as week 2) and the magnitude of response continued to improve with duration of treatment. Continued durable responses were seen for over 3 years in the open label extension Trials I-V.

In patients treated with tocilizumab 8 mg/kg, significant improvements were noted on all individual components of the ACR response including: tender and swollen joint counts; patients and physician global assessment; disability index scores; pain assessment and CRP compared to patients receiving placebo plus MTX or other DMARDs in all trials.

Patients in Trials I – V had a mean Disease Activity Score (DAS28) of 6.5–6.8 at baseline. Significant reduction in DAS28 from baseline (mean improvement) of 3.1-3.4 were observed in tocilizumab-treated patients compared to control patients (1.3-2.1). The proportion of patients achieving a DAS28 clinical remission (DAS28 < 2.6) was significantly higher in patients receiving tocilizumab (28-34 %) compared to 1-12 % of control patients at 24 weeks. In Trial II, 65 % of patients achieved a DAS28 < 2.6 at week 104 compared to 48 % at 52 weeks and 33 % of patients at week 24.

In a pooled analysis of Trials II, III and IV, the proportion of patients achieving an ACR 20, 50 and 70 response was significantly higher (59 % vs. 50 %, 37 % vs. 27 %, 18 % vs. 11 %, respectively) in the tocilizumab 8 mg/kg plus DMARD vs. the tocilizumab 4 mg/kg plus DMARD group ($p < 0.03$).

Similarly, the proportion of patients achieving a DAS28 remission ($\text{DAS28} < 2.6$) was significantly higher (31 % vs. 16 % respectively) in patients receiving tocilizumab 8 mg/kg plus DMARD than in patients receiving tocilizumab 4 mg/kg plus DMARD ($p < 0.0001$).

Table 4. ACR responses in placebo-/MTX-/DMARDs-controlled trials (% patients)

	Trial I AMBITION		Trial II LITHE		Trial III OPTION		Trial IV TOWARD		Trial V RADIATE	
week	TCZ 8 mg/k g	MT X	TCZ 8 mg/k g + MT X	PBO + MT X	TCZ 8 mg/k g + MT X	PBO + MT X	TCZ 8 mg/kg + DMAR D	PBO + DMAR D	TCZ 8 mg/k g + MT X	PBO + MTX
	n = 286	n = 284	n = 398	n = 393	n = 205	n = 204	n = 803	n = 413	n = 170	n = 158
ACR 20										
24	70 %** *	52 %	56 %** *	27 %	59 %** *	26 %	61 %** *	24 %	50 %** *	10 %
52			56 %** *	25 %						
ACR 50										
24	44 %**	33 %	32 %** *	10 %	44 %** *	11 %	38 %** *	9 %	29 %** *	4 %
52			36 %** *	10 %						
ACR 70										
24	28 %**	15 %	13 %** *	2 %	22 %** *	2 %	21 %** *	3 %	12 %**	1 %
52			20 %** *	4 %						

ACR - American College of Rheumatology (ACR) criteria

TCZ - Tocilizumab

MTX - Methotrexate

PBO - Placebo

DMARD - Disease modifying anti-rheumatic drug

** - $p < 0.01$, TCZ vs. PBO + MTX/DMARD

*** - $p < 0.0001$, TCZ vs. PBO + MTX/DMARD

Major clinical response

After 2 years of treatment with tocilizumab plus MTX, 14 % of patients achieved a major clinical response (maintenance of an ACR 70 response for 24 weeks or more).

Radiographic response

In Trial II, in patients with an inadequate response to MTX, inhibition of structural joint damage was assessed radiographically and expressed as change in modified Sharp score and its components, the erosion score and joint space narrowing score. Inhibition of joint structural damage was shown with significantly less radiographic progression in patients receiving tocilizumab compared to control (Table 5).

In the open-label extension of Trial II the inhibition of progression of structural joint damage in tocilizumab plus MTX-treated patients was maintained in the second year of treatment. The mean change from baseline at week 104 in total Sharp-Genant score was significantly lower for patients randomised to tocilizumab 8 mg/kg plus MTX ($p < 0.0001$) compared with patients who were randomised to placebo plus MTX.

Table 5. Radiographic mean changes over 52 weeks in Trial II

	PBO + MTX (+ TCZ from week 24) n = 393	TCZ 8 mg/kg + MTX n = 398
Total Sharp-Genant score	1.13	0.29*
Erosion score	0.71	0.17*
JSN score	0.42	0.12**

PBO - Placebo
MTX - Methotrexate
TCZ - Tocilizumab
JSN - Joint space narrowing
* - $p \leq 0.0001$, TCZ vs. PBO + MTX
** - $p < 0.005$, TCZ vs. PBO + MTX

Following 1 year of treatment with tocilizumab plus MTX, 85 % of patients (n = 348) had no progression of structural joint damage, as defined by a change in the Total Sharp Score of zero or less, compared with 67 % of placebo plus MTX-treated patients (n = 290) ($p \leq 0.001$). This remained consistent following 2 years of treatment (83 %; n = 353). Ninety-three percent (93 %; n = 271) of patients had no progression between week 52 and week 104.

Health-related and quality of life outcomes

Tocilizumab-treated patients reported an improvement in all patient-reported outcomes (Health Assessment Questionnaire Disability Index - HAQ-DI), Short Form-36 and Functional Assessment of Chronic Illness Therapy questionnaires. Statistically significant improvements in HAQ-DI scores were observed in patients treated with tocilizumab compared with patients treated with DMARDs. During the open-label period of Trial II, the improvement in physical function has been maintained for up to 2 years. At week 52, the mean change in HAQ-DI was -0.58 in the tocilizumab 8 mg/kg plus MTX group compared with -0.39 in the placebo + MTX group. The mean change in HAQ-DI was maintained at week 104 in the tocilizumab 8 mg/kg plus MTX group (-0.61).

Haemoglobin levels

Statistically significant improvements in haemoglobin levels were observed with tocilizumab compared with DMARDs ($p < 0.0001$) at week 24. Mean haemoglobin levels increased by week 2 and remained within normal range through to week 24.

Tocilizumab versus adalimumab in monotherapy

Trial VI (WA19924), a 24-week double-blinded trial that compared tocilizumab monotherapy with adalimumab monotherapy, evaluated 326 patients with RA who were intolerant of MTX or where continued treatment with MTX was considered inappropriate (including MTX inadequate responders). Patients in the tocilizumab arm received an intravenous infusion of tocilizumab (8 mg/kg) every 4 weeks (q4w) and a subcutaneous placebo injection every 2 weeks (q2w). Patients in the adalimumab arm received an adalimumab subcutaneous injection (40 mg) q2w plus an intravenous placebo infusion q4w. A statistically significant superior treatment effect was seen in favour of tocilizumab over adalimumab in control of disease activity from baseline to week 24 for the primary endpoint of change in DAS28 and for all secondary endpoints (Table 6).

Table 6. Efficacy results for Trial VI (WA19924)

	ADA + Placebo (IV) n = 162	TCZ + Placebo (SC) n = 163	p-value ^(a)
Primary endpoint - mean change from baseline at week 24			
DAS28 (adjusted mean)	-1.8	-3.3	
Difference in adjusted mean (95 % CI)	-1.5 (-1.8, -1.1)		< 0.0001
Secondary endpoints - percentage of responders at week 24 ^(b)			
DAS28 < 2.6, n (%)	17 (10.5)	65 (39.9)	< 0.0001
DAS28 ≤ 3.2, n (%)	32 (19.8)	84 (51.5)	< 0.0001
ACR 20 response, n (%)	80 (49.4)	106 (65.0)	0.0038
ACR 50 response, n (%)	45 (27.8)	77 (47.2)	0.0002
ACR 70 response, n (%)	29 (17.9)	53 (32.5)	0.0023

^a p-value is adjusted for region and duration of RA for all endpoints and additionally baseline value for all continuous endpoints.

^b Non-responder Imputation used for missing data. Multiplicity controlled using Bonferroni-Holm Procedure

IV = intravenous

SC = subcutaneous

TCZ = tocilizumab

ADA = adalimumab

The overall clinical adverse event profile was similar between tocilizumab and adalimumab. The proportion of patients with serious adverse events was balanced between the treatment groups (tocilizumab 11.7 % vs. adalimumab 9.9 %). The types of adverse reactions in the tocilizumab arm were consistent with the known safety profile of tocilizumab and adverse reactions were reported at a similar frequency compared with Table 1. A higher incidence of infections and infestations was reported in the tocilizumab arm (48 % vs. 42 %), with no difference in the incidence of serious infections (3.1 %). Both trial treatments induced the same pattern of changes in laboratory safety parameters (decreases in neutrophil and platelet counts, increases in ALT, AST and lipids), however, the magnitude of change and the frequency of marked abnormalities was higher with tocilizumab compared with adalimumab. Four (2.5 %) patients in the tocilizumab arm and two (1.2 %) patients in the adalimumab arm experienced CTC grade 3 or 4 neutrophil count decreases. Eleven (6.8 %) patients in the tocilizumab arm and five (3.1 %) patients in the adalimumab arm experienced ALT increases of CTC grade 2 or higher. The mean LDL increase from baseline was 0.64 mmol/L (25 mg/dL) for patients in the tocilizumab arm and 0.19 mmol/L (7 mg/dL) for patients in the adalimumab arm. The safety observed in the tocilizumab arm was consistent with the known safety profile of tocilizumab and no new or unexpected adverse reactions were observed (see Table 1).

MTX naïve, early RA

Trial VII (WA19926), a 2-year trial with the planned primary analysis at week 52 evaluated 1 162 MTX-naïve adult patients with moderate to severe, active early RA (mean disease duration ≤ 6 months). Approximately 20 % of patients had received prior treatment with DMARDs other than MTX. This trial evaluated the efficacy of intravenous tocilizumab 4 or 8 mg/kg every 4 weeks/MTX combination therapy, intravenous tocilizumab 8 mg/kg monotherapy and MTX monotherapy in reducing the signs and symptoms and rate of progression of joint damage for 104 weeks. The primary endpoint was the proportion of patients achieving DAS28 remission (DAS28 < 2.6) at week 24. A significantly higher proportion of patients in the tocilizumab 8 mg/kg + MTX and tocilizumab monotherapy groups met the primary endpoint compared with MTX alone. The tocilizumab 8 mg/kg + MTX group also showed statistically significant results across the key secondary endpoints. Numerically greater responses compared with MTX alone were observed in the tocilizumab 8 mg/kg monotherapy group in all secondary endpoints, including radiographic endpoints. In this trial, ACR/EULAR remission (Boolean and Index) were also analysed as pre-specified exploratory endpoints, with higher responses observed in the tocilizumab groups. The results from Trial VII are shown in Table 7.

Table 7. Efficacy Results for Trial VII (WA19926) on MTX-naïve, early RA patients

	TCZ 8 mg/kg + MTX n = 290	TCZ 8 mg/kg + placebo n = 292	TCZ 4 mg/kg + MTX n = 288	Placebo + MTX n = 287
Primary endpoint				
DAS28 Remission				
week 24 n (%)	130 (44.8)***	113 (38.7)***	92 (31.9)	43 (15.0)
Key secondary endpoints				
DAS 28 remission				
week 52 n (%)	142 (49.0)***	115 (39.4)	98 (34.0)	56 (19.5)
ACR				
week 24 ACR 20, n (%)	216 (74.5)*	205 (70.2)	212 (73.6)	187 (65.2)
ACR 50, n (%)	165 (56.9)**	139 (47.6)	138 (47.9)	124 (43.2)
ACR 70, n (%)	112 (38.6)**	88 (30.1)	100 (34.7)	73 (25.4)
week 52 ACR 20, n (%)	195 (67.2)*	184 (63.0)	181 (62.8)	164 (57.1)
ACR 50, n (%)	162 (55.9)**	144 (49.3)	151 (52.4)	117 (40.8)
ACR 70, n (%)	125 (43.1)**	105 (36.0)	107 (37.2)	83 (28.9)
HAQ-DI (adjusted mean change from baseline)				
week 52	-0.81*	-0.67	-0.75	-0.64
Radiographic endpoints (mean change from baseline)				
week 52 mTSS	0.08***	0.26	0.42	1.14
Erosion Score	0.05**	0.15	0.25	0.63
JSN	0.03	0.11	0.17	0.51
Radiographic Non-Progression n (%) (change from baseline in mTSS of ≤ 0)	226 (83)‡	226 (82)‡	211 (79)	194 (73)
Exploratory endpoints				
week 24: ACR/EULAR Boolean Remission, n (%)	47 (18.4)‡	38 (14.2)	43 (16.7)‡	25 (10.0)
ACR/EULAR Index Remission, n (%)	73 (28.5)‡	60 (22.6)	58 (22.6)	41 (16.4)
week 52: ACR/EULAR Boolean Remission, n (%)	59 (25.7)‡	43 (18.7)	48 (21.1)	34 (15.5)
ACR/EULAR Index Remission, n (%)	83 (36.1)‡	69 (30.0)	66 (29.3)	49 (22.4)

mTSS - modified Total Sharp Score

JSN - Joint space narrowing

TCZ – tocilizumab

MTX – methotrexate

ACR - American College of Rheumatology (ACR) criteria

All efficacy comparisons vs Placebo + MTX. ***p ≤ 0.0001; **p < 0.001; *p < 0.05;

‡p-value < 0.05 vs. Placebo + MTX, but endpoint was exploratory (not included in the hierarchy of statistical testing and has therefore not been controlled for multiplicity)

COVID-19

Clinical efficacy

RECOVERY (randomised evaluation of COVID-19 therapy) collaborative group trial in hospitalised adults diagnosed with COVID-19

RECOVERY was a large, randomised, controlled, open-label, multi-centre platform trial conducted in the United Kingdom to evaluate the efficacy and safety of potential treatments in hospitalised adult patients with severe COVID-19. All eligible patients received usual care and underwent an initial (main) randomisation. Eligible patients for the trial had clinically suspected or laboratory-confirmed SARS-CoV-2 infection and no medical contraindications to any of the treatments. Patients with clinical evidence of progressive COVID-19 (defined as oxygen saturation < 92 % on room air or receiving oxygen therapy, and CRP $\geq$ 75 mg/L) qualified for a second randomisation to receive either intravenous tocilizumab or usual care alone.

Efficacy analyses were performed in the intent-to-treat (ITT) population comprising 4116 patients who were randomised with 2022 patients in the tocilizumab + usual care arm and 2 094 patients in the usual care alone arm. The baseline demographic and disease characteristics of the ITT population were well balanced across treatment arms. The mean age of participants was 63.6 years (standard deviation [SD] 13.6 years). The majority of patients were male (67 %) and White (76 %). The median (range) level of CRP was 143 mg/L (75-982).

At baseline, 0.2 % (n = 9) of patients were not on supplemental oxygen, 45 % of patients required low flow oxygen, 41 % of patients required non-invasive ventilation or high-flow oxygen and 14 % of patients required invasive mechanical ventilation; 82 % were reported receiving systemic corticosteroids (defined as patients who initiated treatment with systemic corticosteroids either prior to or at the time of randomisation). The most common comorbidities were diabetes (28.4 %), heart disease (22.6 %) and chronic lung disease (23.3 %).

The primary outcome was time to death through Day 28. The hazard ratio comparing the tocilizumab + usual care arm to the usual care alone arm was 0.85 (95 % CI: 0.76 to 0.94), a statistically significant result (p = 0.0028). The probabilities of dying by Day 28 were estimated to be 30.7 % and 34.9 % in the tocilizumab and usual care arms, respectively. The risk difference was estimated to be -4.1 % (95 % CI: -7.0 % to -1.3 %), consistent with the primary analysis. The hazard ratio among the pre-specified subgroup of patients receiving systemic corticosteroids at baseline was 0.79 (95 % CI: 0.70 to 0.89), and for the pre-specified subgroup not receiving systemic corticosteroids at baseline was 1.16 (95 % CI: 0.91 to 1.48).

The median time to hospital discharge was 19 days in the tocilizumab+ usual care arm and > 28 days in the usual care arm (hazard ratio [95 % CI] = 1.22 [1.12 to 1.33]).

Among patients not requiring invasive mechanical ventilation at baseline, the proportion of patients who required mechanical ventilation or died by Day 28 was 35 % (619/1754) in the tocilizumab + usual care arm and 42 % (754/1800) in the usual care alone arm (risk ratio [95 % CI] = 0.84, [0.77 to 0.92] p < 0.0001).

Paediatric population with sJIA

Clinical efficacy

The efficacy of tocilizumab for the treatment of active sJIA was assessed in a 12 week randomised, double-blind, placebo-controlled, parallel group, two arm trial. Patients included in the trial had a total disease duration of at least 6 months and active disease but were not experiencing an acute flare requiring corticosteroid doses of more than 0.5 mg/kg prednisone equivalent. Efficacy for the treatment of macrophage activation syndrome (MAS) has not been investigated.

Patients (treated with or without MTX) were randomised (tocilizumab:placebo = 2:1) to one of two treatment groups, 75 patients received tocilizumab infusions every two weeks, either 8 mg/kg for patients ≥ 30 kg or 12 mg/kg for patients < 30 kg and 37 patients were assigned to receiving placebo infusions every two weeks. Corticosteroid tapering was permitted from week six for patients who achieved a JIA ACR 70 response. After 12 weeks or at the time of escape, due to disease worsening, patients were treated in the open label phase at weight appropriate dosing.

Clinical response

The primary endpoint was the proportion of patients with at least 30 % improvement in the JIA ACR core set (JIA ACR 30 response) at week 12 and absence of fever (no temperature recording ≥ 37.5 °C in the preceding 7 days). Eighty-five percent (64/75) of tocilizumab treated patients and 24.3 % (9/37) of placebo treated patients achieved this endpoint. These proportions were highly significantly different ($p < 0.0001$).

The percent of patients achieving JIA ACR 30, 50, 70 and 90 responses are shown in Table 8.

Table 8. JIA ACR response rates at week 12 (% patients)

Response rate	Tocilizumab n = 75	Placebo n = 37
JIA ACR 30	90.7 % ¹	24.3 %
JIA ACR 50	85.3 % ¹	10.8 %
JIA ACR 70	70.7 % ¹	8.1 %
JIA ACR 90	37.3 % ¹	5.4 %

¹ $p < 0.0001$, tocilizumab vs. placebo

Systemic effects

In the tocilizumab treated patients, 85 % who had fever due to sJIA at baseline were free of fever (no temperature recording ≥ 37.5 °C in the preceding 14 days) at week 12 versus 21 % of placebo patients ($p < 0.0001$).

The adjusted mean change in the pain VAS after 12 weeks of tocilizumab treatment was a reduction of 41 points on a scale of 0 - 100 compared to a reduction of 1 for placebo patients ($p < 0.0001$).

Corticosteroid tapering

Patients achieving a JIA ACR 70 response were permitted corticosteroid dose reduction. Seventeen (24 %) tocilizumab treated patients versus 1 (3 %) placebo patient were able to reduce their dose of corticosteroid by at least 20 % without experiencing a subsequent JIA ACR 30 flare or occurrence of systemic symptoms to week 12 ($p = 0.028$). Reductions in corticosteroids continued, with 44 patients off oral corticosteroids at week 44, while maintaining JIA ACR responses.

Health related and quality of life outcomes

At week 12, the proportion of tocilizumab treated patients showing a minimally clinically important improvement in the Childhood Health Assessment Questionnaire – Disability Index (defined as an individual total score decrease of ≥ 0.13) was significantly higher than in placebo treated patients, 77 % versus 19 % ($p < 0.0001$).

Laboratory parameters

Fifty out of seventy-five (67 %) tocilizumab treated patients had a haemoglobin $< LLN$ at baseline. Forty (80 %) of these patients had an increase in their haemoglobin to within the normal range at week 12, in comparison to 2 out of 29 (7 %) of placebo treated patients with haemoglobin $< LLN$ at baseline ($p < 0.0001$).

Paediatric population with pJIA

Clinical efficacy

The efficacy of tocilizumab was assessed in a three-part Trial WA19977 including an open-label extension in children with active pJIA. Part I consisted of a 16-week active tocilizumab treatment lead-in period (n = 188) followed by Part II, a 24-week randomised double-blind placebo-controlled withdrawal period (n = 163), followed by Part III, a 64-week open-label period. In Part I, eligible patients ≥ 30 kg received tocilizumab at 8 mg/kg intravenous every 4 weeks for 4 doses. Patients < 30 kg were randomised 1:1 to receive either tocilizumab 8 mg/kg or 10 mg/kg intravenous every 4 weeks for 4 doses. Patients who completed Part I of the trial and achieved at least a JIA ACR 30 response at week 16 compared to baseline were eligible to enter the blinded withdrawal period (Part II) of the trial. In Part II, patients were randomised to tocilizumab (same dose received in Part I) or placebo in a 1:1 ratio, stratified by concurrent MTX use and concurrent corticosteroid use. Each patient continued in Part II of the trial until week 40 or until the patient satisfied JIA ACR 30 flare criteria (relative to week 16) and qualified for escape to tocilizumab therapy (same dose received in Part I).

Clinical response

The primary endpoint was the proportion of patients with a JIA ACR 30 flare at week 40 relative to week 16. Forty-eight percent (48.1 %, 39/81) of the patients treated with placebo flared compared with 25.6 % (21/82) of tocilizumab treated patients. These proportions were statistically significantly different ($p = 0.0024$).

At the conclusion of Part I, JIA ACR 30/50/70/90 responses were 89.4 %, 83.0 %, 62.2 %, and 26.1 %, respectively.

During the withdrawal phase (Part II), the percentage of patients achieving JIA ACR 30, 50, and 70 responses at week 40 relative to baseline are shown in Table 9. In this statistical analysis, patients who flared (and escaped to tocilizumab) during Part II or who withdrew, were classified as non-responders. An additional analyses of JIA ACR responses, considering observed data at week 40, regardless of flare status, showed that by week 40, 95.1 % of patients who had received continuous tocilizumab therapy, had achieved JIA ACR 30 or higher.

Table 9. JIA ACR response rates at week 40 relative to baseline (percentage of patients)

Response rate	Tocilizumab n = 82	Placebo n = 81
ACR 30	74.4 %*	54.3 %*
ACR 50	73.2 %*	51.9 %*
ACR 70	64.6 %*	42.0 %*

* $p < 0.01$, tocilizumab vs. placebo

The number of active joints was significantly reduced compared to baseline in patients receiving tocilizumab compared to placebo (adjusted mean changes of -14.3 vs -11.4, $p = 0.0435$). The physician's global assessment of disease activity, as measured on a 0-100 mm scale, showed a greater reduction in disease activity for tocilizumab compared to placebo (adjusted mean changes of -45.2 mm vs -35.2 mm, $p = 0.0031$).

The adjusted mean change in the pain VAS after 40 weeks of tocilizumab treatment was 32.4 mm on a 0-100 mm scale compared to a reduction of 22.3 mm for placebo patients (highly statistically significant; $p = 0.0076$).

The ACR response rates were numerically lower for patients with prior biologic treatment as shown in Table 10 below.

Table 10. Number and proportion of patients with a JIA ACR 30 flare and proportion of patients with JIA ACR 30/50/70/90 responses at week 40, by previous biologic use (ITT Population - trial Part II)

	Placebo		All TCZ	
Biologic use	Yes (n = 23)	No (n = 58)	Yes (n = 27)	No (n = 55)
JIA ACR 30 Flare	18 (78.3)	21 (36.2)	12 (44.4)	9 (16.4)
JIA ACR 30 Response	6 (26.1)	38 (65.5)	15 (55.6)	46 (83.6)
JIA ACR 50 Response	5 (21.7)	37 (63.8)	14 (51.9)	46 (83.6)
JIA ACR 70 Response	2 (8.7)	32 (55.2)	13 (48.1)	40 (72.7)
JIA ACR 90 Response	2 (8.7)	17 (29.3)	5 (18.5)	32 (58.2)

TCZ = tocilizumab

Patients randomised to tocilizumab had fewer ACR 30 flares and higher overall ACR responses than patients receiving placebo regardless of a history of prior biologic use.

CRS

The efficacy of tocilizumab for the treatment of CRS was assessed in a retrospective analysis of data from clinical trials of CAR T-cell therapies (tisagenlecleucel and axicabtagene ciloleucel) for haematological malignancies. Evaluable patients had been treated with tocilizumab 8 mg/kg. (12 mg/kg for patients < 30 kg) with or without additional high-dose corticosteroids for severe or life-threatening CRS; only the first episode of CRS was included in the analysis. The efficacy population for the tisagenlecleucel cohort included 28 males and 23 females (total 51 patients) of median age 17 years (range, 3–68 years). The median time from start of CRS to first dose of tocilizumab was 3 days (range, 0–18 days). Resolution of CRS was defined as lack of fever and off vasopressors for at least 24 hours. Patients were considered responders if CRS resolved within 14 days of the first dose of tocilizumab, if no more than 2 doses were needed, and no medicinal products other than tocilizumab and corticosteroids were used for treatment. Thirty-nine patients (76.5 %; 95 % CI: 62.5 %–87.2 %) achieved a response. In an independent cohort of 15 patients (range: 9–75 years old) with axicabtagene ciloleucel-induced CRS, 53 % responded.

The European Medicines Agency has waived the obligation to submit the results of trials with tocilizumab in all subsets of the paediatric population in treatment of cytokine release syndrome associated with CAR T-cell therapy.

COVID-19

The European Medicines Agency has deferred the obligation to submit the results of trials with tocilizumab in one or more subsets of the paediatric population in the treatment of COVID-19.

5.2 Pharmacokinetic properties

RA patients

The pharmacokinetics of tocilizumab were determined using a population pharmacokinetic analysis on a database composed of 3 552 RA patients treated with a one-hour infusion of 4 or 8 mg/kg tocilizumab every 4 weeks for 24 weeks or with 162 mg tocilizumab given subcutaneously either once a week or every other week for 24 weeks.

The following parameters (predicted mean $\pm$ SD) were estimated for a dose of 8 mg/kg tocilizumab given every 4 weeks: steady-state area under curve (AUC) = $38\,000 \pm 13\,000$ h $\mu\text{g/mL}$, trough concentration ($C_{\min}$) = 15.9 ± 13.1 $\mu\text{g/mL}$ and maximum concentration ($C_{\max}$) = 182 ± 50.4 $\mu\text{g/mL}$, and the accumulation ratios for AUC and $C_{\max}$ were small, 1.32 and 1.09, respectively. The accumulation ratio was higher for $C_{\min}$ (2.49), which was expected based on the non-linear clearance contribution at lower concentrations. Steady-state was reached following the first administration for $C_{\max}$ and after 8 and 20 weeks for AUC and $C_{\min}$, respectively. Tocilizumab AUC, $C_{\min}$ and $C_{\max}$ increased with increase of body weight. At body weight ≥ 100 kg, the predicted mean ($\pm$ SD)

steady-state AUC, $C_{\min}$ and $C_{\max}$ of tocilizumab were $50\,000 \pm 16\,800 \mu\text{g} \times \text{h/mL}$, $24.4 \pm 17.5 \mu\text{g/mL}$, and $226 \pm 50.3 \mu\text{g/mL}$, respectively, which are higher than mean exposure values for the patient population (i.e. all body weights) reported above. The dose-response curve for tocilizumab flattens at higher exposure, resulting in smaller efficacy gains for each incremental increase in tocilizumab concentration such that clinically meaningful increases in efficacy were not demonstrated in patients treated with $> 800 \text{ mg}$ of tocilizumab. Therefore, tocilizumab doses exceeding 800 mg per infusion are not recommended (see section 4.2).

COVID-19 patients

The pharmacokinetics of tocilizumab was characterised using a population pharmacokinetic analysis of a database composed of 380 adult COVID-19 patients in Trial WA42380 (COVACTA) and Trial CA42481 (MARIPOSA) that treated with a single infusion of 8 mg/kg tocilizumab or two infusions separated by at least 8 hours. The following parameters (predicted mean $\pm$ SD) were estimated for a dose of 8 mg/kg tocilizumab: area under curve over 28 days (AUC_{0-28}) = $18\,312$ ($5\,184$) $\text{hour} \times \mu\text{g/mL}$, concentration at Day 28 ($C_{\text{day}28}$) = 0.934 (1.93) $\mu\text{g/mL}$ and maximum concentration ($C_{\max}$) = 154 (34.9) $\mu\text{g/mL}$. The AUC_{0-28} , $C_{\text{day}28}$ and $C_{\max}$, following two doses of 8 mg/kg tocilizumab separated by 8 hours, were also estimated (predicted mean $\pm$ SD): $42\,240$ ($11\,520$) $\text{hour} \times \mu\text{g/mL}$ and 8.94 (8.5) $\mu\text{g/mL}$, and 296 (64.7) $\mu\text{g/mL}$ respectively.

Distribution

In RA patients the central volume of distribution was 3.72 L , the peripheral volume of distribution was 3.35 L resulting in a volume of distribution at steady-state of 7.07 L .

In COVID-19 adult patients, the central volume of distribution was 4.52 L , the peripheral volume of distribution was 4.23 L , resulting in a volume of distribution of 8.75 L .

Elimination

Following intravenous administration, tocilizumab undergoes a dual elimination from the circulation, one following a linear clearance and one following a concentration-dependent non-linear clearance. In RA patients, the linear clearance was 9.5 mL/h . In COVID-19 adult patients, the linear clearance was 17.6 mL/h in patients with baseline ordinal scale category 3 (OS 3, patients requiring supplemental oxygen), 22.5 mL/h in patients with baseline OS 4 (patients requiring high-flow oxygen or non-invasive ventilation), 29 mL/h in patients with baseline OS 5 (patients requiring mechanical ventilation), and 35.4 mL/h in patients with baseline OS 6 (patients requiring extracorporeal membrane oxygenation (ECMO) or mechanical ventilation and additional organ support). The concentration-dependent non-linear clearance plays a major role at low tocilizumab concentrations. Once the non-linear clearance pathway is saturated, at higher tocilizumab concentrations, clearance is mainly determined by the linear clearance.

In RA patients, the $t_{1/2}$ of tocilizumab was concentration-dependent. At steady-state following a dose of 8 mg/kg every 4 weeks, the effective $t_{1/2}$ decreased with decreasing concentrations within a dosing interval from 18 days to 6 days.

In COVID-19 patients, serum concentrations were below the limit of quantification after 35 days on average following one infusion of tocilizumab intravenous 8 mg/kg .

Linearity

Pharmacokinetic parameters of tocilizumab did not change with time. A more than dose-proportional increase in the AUC and $C_{\min}$ was observed for doses of 4 and 8 mg/kg every 4 weeks. $C_{\max}$ increased dose-proportionally. At steady-state, predicted AUC and $C_{\min}$ were 3.2 and 30 fold higher at 8 mg/kg as compared to 4 mg/kg , respectively.

Special populations

Renal impairment

No formal trial of the effect of renal impairment on the pharmacokinetics of tocilizumab has been conducted. Most of the patients in the population pharmacokinetic analysis had normal renal function or mild renal impairment. Mild renal impairment (creatinine clearance based on Cockcroft-Gault < 80 mL/min and ≥ 50 mL/min) did not impact the pharmacokinetics of tocilizumab.

Hepatic impairment

No formal trial of the effect of hepatic impairment on the pharmacokinetics of tocilizumab has been conducted.

Age, gender and ethnicity

Population pharmacokinetic analyses in RA and COVID-19 patients, showed that age, gender and ethnic origin did not affect the pharmacokinetics of tocilizumab.

Results of the population PK analysis for COVID-19 patients confirmed that body weight and disease severity are both covariates which have an appreciable impact on the linear clearance of tocilizumab.

sJIA Patients

The pharmacokinetics of tocilizumab were determined using a population pharmacokinetic analysis on a database composed of 140 sJIA patients treated with 8 mg/kg intravenous every 2 weeks (patients with a body weight ≥ 30 kg) 12 mg/kg intravenous every 2 weeks (patients with a body weight < 30 kg), 162 mg subcutaneous every week (patients weighing ≥ 30 kg), 162 mg subcutaneous every 10 days or every 2 weeks (patients weighing below 30 kg).

Table 11. Predicted mean $\pm$ SD PK parameters at steady-state after intravenous dosing in sJIA

Tocilizumab PK parameter	8 mg/kg Q2W ≥ 30 kg	12 mg/kg Q2W below 30 kg
$C_{\max}$ ($\mu\text{g/mL}$)	256 $\pm$ 60.8	274 $\pm$ 63.8
C_{trough} ($\mu\text{g/mL}$)	69.7 $\pm$ 29.1	68.4 $\pm$ 30.0
C_{mean} ($\mu\text{g/mL}$)	119 $\pm$ 36.0	123 $\pm$ 36.0
Accumulation $C_{\max}$	1.42	1.37
Accumulation C_{trough}	3.20	3.41
Accumulation C_{mean} or AUC_{τ}^*	2.01	1.95

* τ = 2 weeks for intravenous regimens

After intravenous dosing, approximately 90 % of the steady-state was reached by week 8 for both the 12 mg/kg (body weight < 30 kg) and 8 mg/kg Q2W (body weight ≥ 30 kg) regimens.

In sJIA patients, the central volume of distribution was 1.87 L and the peripheral volume of distribution was 2.14 L resulting in a volume of distribution at a steady-state of 4.01 L. The linear clearance estimated as a parameter in the population pharmacokinetic analysis, was 5.7 mL/h.

The half-life of tocilizumab in sJIA patients is up to 16 days for the two body weight categories (8 mg/kg for body weight ≥ 30 kg or 12 mg/kg for body weight < 30 kg) at week 12.

pJIA patients

The pharmacokinetics of tocilizumab in pJIA patients was characterised by a population pharmacokinetic analysis which included 237 patients who were treated with 8 mg/kg intravenous every 4 weeks (patients weighing ≥ 30 kg), 10 mg/kg intravenous every 4 weeks (patients weighing below 30 kg), 162 mg subcutaneous every 2 weeks (patients weighing ≥ 30 kg), or 162 mg subcutaneous every 3 weeks (patients weighing below 30 kg).

Table 12. Predicted mean $\pm$ SD PK parameters at steady-state after intravenous dosing in pJIA

Tocilizumab PK parameter	8 mg/kg Q4W $\geq$ 30 kg	10 mg/kg Q4W below 30 kg
$C_{\max}$ ($\mu\text{g/mL}$)	183 ± 42.3	168 ± 24.8
C_{trough} ($\mu\text{g/mL}$)	6.55 ± 7.93	1.47 ± 2.44
C_{mean} ($\mu\text{g/mL}$)	42.2 ± 13.4	31.6 ± 7.84
Accumulation $C_{\max}$	1.04	1.01
Accumulation C_{trough}	2.22	1.43
Accumulation C_{mean} or AUC_{τ}^*	1.16	1.05

* τ = 4 weeks for intravenous regimens

After intravenous dosing, approximately 90 % of the steady-state was reached by week 12 for the 10 mg/kg (body weight < 30 kg), and by week 16 for the 8 mg/kg (body weight $\geq$ 30 kg) dose.

The half-life of tocilizumab in pJIA patients is up to 16 days for the two body weight categories (8 mg/kg for body weight $\geq$ 30 kg or 10 mg/kg for body weight < 30 kg) during a dosing interval at steady-state.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional trials of safety pharmacology, repeated dose toxicity and genotoxicity.

Carcinogenicity trials were not performed because IgG1 monoclonal antibodies are not deemed to have intrinsic carcinogenic potential.

Available non-clinical data demonstrated the effect of IL-6 on malignant progression and apoptosis resistance to various cancer types. This data does not suggest a relevant risk for cancer initiation and progression under tocilizumab treatment. Additionally, proliferative lesions were not observed in a 6-month chronic toxicity trial in cynomolgus monkeys or in IL-6 deficient mice.

Available non-clinical data do not suggest an effect on fertility under tocilizumab treatment. Effects on endocrine active and reproductive system organs were not observed in a chronic cynomolgus monkey toxicity trial and reproductive performance was not affected in IL-6 deficient mice. Tocilizumab administered to cynomolgus monkeys during early gestation, was observed to have no direct or indirect harmful effect on pregnancy or embryonal-foetal development. However, a slight increase in abortion/embryonal-foetal death was observed with high systemic exposure ($> 100 \times$ human exposure) in the 50 mg/kg/day high-dose group compared to placebo and other low-dose groups. Although IL-6 does not seem to be a critical cytokine for foetal growth or the immunological control of the maternal/foetal interface, a relation of this finding to tocilizumab cannot be excluded.

Treatment with a murine analogue did not exert toxicity in juvenile mice. In particular, there was no impairment of skeletal growth, immune function and sexual maturation.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Sucrose

Polysorbate 80 (E 433)

Disodium phosphate dodecahydrate (for pH-adjustment)

Sodium dihydrogen phosphate dihydrate (for pH-adjustment)

Water for injections

6.2 Incompatibilities

This medicinal product must not be mixed with other medicinal products except those mentioned in section 6.6.

6.3 Shelf life

Unopened vial

3 years

Diluted product

After dilution, the prepared solution for infusion is physically and chemically stable in sodium chloride 9 mg/mL (0.9 %) solution for injection. It can be stored for 24 hours at 30 °C and for up to 2 weeks in a refrigerator at 2 °C - 8 °C.

From a microbiological point of view, the prepared solution for infusion must be used immediately. If not used immediately, in use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2 °C - 8 °C, unless dilution has taken place in controlled and validated aseptic conditions.

6.4 Special precautions for storage

Store vials in a refrigerator (2 °C - 8 °C). Do not freeze.

Keep the vial(s) in the outer carton in order to protect from light.

For storage conditions after dilution of the medicinal product see section 6.3.

6.5 Nature and contents of container

RoActemra is supplied in a vial (type I glass) with a stopper (butyl rubber) containing 4 mL, 10 mL or 20 mL concentrate. Pack sizes of 1 and 4 vials.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Instructions for dilution prior to administration

Parenteral medicinal products must be inspected visually for particulate matter or discolouration prior to administration. Only solutions which are clear to opalescent, colourless to pale yellow and free of visible particles should be diluted. Use a sterile needle and syringe to prepare the product.

Adult RA, CRS (≥ 30 kg) and COVID-19 patients

Withdraw a volume of sterile, non-pyrogenic sodium chloride 9 mg/mL (0.9 %) solution for injection from a 100 mL infusion bag, equal to the volume of concentrate required for the patients dose, under aseptic conditions. The required amount of concentrate (0.4 mL/kg) should be withdrawn from the vial

and placed in the 100 mL infusion bag. This should be a final volume of 100 mL. To mix the solution, gently invert the infusion bag to avoid foaming.

Paediatric population

sJIA, pJIA and CRS patients ≥ 30 kg

Withdraw a volume of sterile, non-pyrogenic sodium chloride 9 mg/mL (0.9 %) solution for injection from a 100 mL infusion bag, equal to the volume of concentrate required for the patients dose, under aseptic conditions. The required amount of concentrate (**0.4 mL/kg**) should be withdrawn from the vial and placed in the 100 mL infusion bag. This should be a final volume of 100 mL. To mix the solution, gently invert the infusion bag to avoid foaming.

sJIA and CRS patients < 30 kg

Withdraw a volume of sterile, non-pyrogenic sodium chloride 9 mg/mL (0.9 %) solution for injection from a 50 mL infusion bag, equal to the volume of concentrate required for the patients dose, under aseptic conditions. The required amount of concentrate (**0.6 mL/kg**) should be withdrawn from the vial and placed in the 50 mL infusion bag. This should be a final volume of 50 mL. To mix the solution, gently invert the infusion bag to avoid foaming.

pJIA patients < 30 kg

Withdraw a volume of sterile, non-pyrogenic sodium chloride 9 mg/mL (0.9 %) solution for injection from a 50 mL infusion bag, equal to the volume of concentrate required for the patients dose, under aseptic conditions. The required amount of concentrate (**0.5 mL/kg**) should be withdrawn from the vial and placed in the 50 mL infusion bag. This should be a final volume of 50 mL. To mix the solution, gently invert the infusion bag to avoid foaming.

When diluted with sodium chloride 9 mg/mL (0.9 %) solution for injection, RoActemra is compatible with intravenous infusion bags composed of polyvinyl chloride (PVC), polyethylene (PE), polypropylene (PP).

RoActemra is for single-use only.

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

7. MARKETING AUTHORISATION HOLDER

Roche Registration GmbH
Emil-Barell-Strasse 1
79639 Grenzach-Wyhlen
Germany

8. MARKETING AUTHORISATION NUMBERS

EU/1/08/492/001
EU/1/08/492/002
EU/1/08/492/003
EU/1/08/492/004
EU/1/08/492/005
EU/1/08/492/006

9. DATE OF FIRST AUTHORISATION/DATE OF LATEST RENEWAL

Date of first authorisation: 16 January 2009

Date of last renewal: 25 September 2013

10. DATE OF REVISION OF THE TEXT

12 February 2026

Detailed information on this medicinal product is available on the website of the European Medicines Agency <https://www.ema.europa.eu>.