

Dr. Steven Ponders received his medical degree from the University of Texas Medical Branch at Galveston, and he completed his residency in internal medicine at Baylor Medicine of College in Houston. Dr. Ponders is an active member of the HIV education community and is the recipient of several honors, including the 2017 Kuchling Humanitarian Award and the 2014 CURE Open Heart Award. An early advocate for patients with HIV, Dr. Ponders' story was featured in the movie *Dallas Buyer's Club*. He is currently in private practice in Dallas.

Clinical Conversations in HIV-Associated Wasting

A brief discussion with Steven Ponders, MD

INDICATIONS AND USAGE

Serostim® (somatropin) for injection is indicated for the treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight, and improve physical endurance. Concomitant antiretroviral therapy is necessary.

IMPORTANT RISK INFORMATION

CONTRAINDICATIONS

Serostim® should not be used in patients with acute critical illness, active malignancy, hypersensitivity to somatropin or any of its excipients, or diabetic retinopathy. Increased mortality has been reported in patients with acute critical illness due to complications following surgery, multiple accidental trauma, or acute respiratory failure. Preexisting malignancies should be inactive and treatment completed prior to instituting therapy. Serostim® should be discontinued if there is evidence of tumor recurrence. Systemic hypersensitivity reactions have been reported with postmarketing use of somatropin products.

Please see additional Important Risk Information throughout and enclosed Full Prescribing Information.

Serostim®
(somatropin) for injection

A brief discussion with Steven Pounders, MD

Q: Your work in caring for people living with HIV began before HAART was introduced. Can you tell us how the field of HIV care has changed over the past several decades?

A: My early years of working in HIV were intense. Patients were dying every week. Then HAART came around and suddenly things started to change. Treatments were better tolerated, and today medications have become even less toxic. As most of our patients living with HIV are doing so well with HAART, it does feel that problems with complications stemming from HIV have diminished. However, because some have fortunately survived for as long as they have, we still see HIV-related problems. We also see more of our patients getting chronic diseases, just like the rest of the population.

Q: How often do you see HIV-associated wasting among patients in your practice?

A: More than 90% of our patients have undetectable viral loads. While many of my patients struggle to lose weight, as does much of the general US population, I do have patients who need to gain the weight they have lost without trying. We have learned that with HIV, there are attacks on the lining in the gut very early on, which may cause problems with their immune systems and immune activation. This results in increased inflammation and activation, which interferes with nutrient absorption, resulting in loss of lean body mass and body weight.

Q: How do you think HIV-associated wasting is viewed today?

A: In our society so many people are overweight. People who lose weight unintentionally don't get a lot of sympathy from others. Most people think "Thin is in, thin is good." But for those with HIV-associated wasting, it places them at a higher risk for morbidity and mortality. When you are HIV-positive, a lower body mass index is not ideal. A person can even have a normal BMI, but it may be declining due to a loss of weight that is unexpected or unplanned. That is why we cannot rely only on BMI to determine wasting. We need to monitor any decrease in weight or BMI and really listen to patient concerns over time to ensure that we do not miss wasting syndrome.

To those who believe that wasting no longer exists, I would remind them that it continues to impact a range of patients both male and female. In fact, I diagnose patients with it on a regular basis. These include patients who have immune reconstitution, as defined by increasing T cells, and those with have undetectable viral loads. It also includes those who are recently diagnosed with HIV or living with HIV for many years, those who seem to tolerate their medications very well, and those who have no evidence of infections or are recovering from an acute infection.

Q: How do you diagnose HIV-associated wasting?

A: One of the first steps I take, especially in men, is to check their hormone profile. Then we look for vitamin deficiencies that can be corrected. They see a dietitian to ensure that their appetite is good and that they are getting the nutrition they need, and if warranted, we will try appetite stimulants or anabolic agents. We also screen for active infections.

We certainly want to get them therapeutically corrected if they are deficient in testosterone or other hormones. Even when we address all these factors, some patients do not regain the weight they have lost or they are still losing weight and lean body mass and have decreased energy for no apparent reason.

Q: What else do you look for?

A: I routinely ask general questions about fatigue and their daily routines. Are they able to do regular exercises? At first, some patients will only mention that they experience fatigue—fatigue meaning they can barely make it through the day. They cannot get their work done and they are not doing extracurricular activities or their regular exercise routines. Patients don't want to complain because they don't realize it can be fixed. They say, "Oh, my T cells are good. My viral load is down. I'm doing great." But they're not doing great.

If the physician doesn't know the patient is experiencing symptoms of HIV-associated wasting, he or she can't treat it. That's why it's important that we ask probing questions during visits.

Q: Can you tell us about a patient you've treated with Serostim® (somatropin) for injection?

A: My patient was a 40-year-old white male with a CD4-cell count of 410-640 cells/mm³ and an RNA viral load of 20 copies/mL. He began to develop problems with his memory and cognition. He could no longer work and had HIV-associated neurocognitive disorder.

Despite a head CT scan, MRI, and lumbar puncture, we found nothing but HIV. Then in the next year, he started to lose weight and became very fatigued. We checked all of the markers I recommended earlier. He needed testosterone, anabolics, and appetite stimulants. Over the next few months, he continued to lose weight and I was really getting more concerned about him. He used to go to the gym regularly and lift weights, and he was not able to do that any longer.

After excluding other reasons for weight loss, I started him on Serostim®. I saw him start to gain weight and gain some energy. He could go back to the gym and work out slowly and progressively. I still see him, and he is doing really well.

Q: In general, how are patients affected by Serostim® therapy?

A: When you face a life-threatening illness such as HIV, it is important to watch for a 5% or more loss of body weight because it does portend a poor prognostic signal. That's why it's important to get appropriate patients started on treatment with Serostim® and help them to understand how helpful it can be.

We are fortunate to have treatments like testosterone, nutritional supplements, and other options to help temporize and help improve the patient. With Serostim® we have been able to change the course of wasting in people living with HIV. When I see unexplained weight loss and decreased lean body mass and energy in a patient, I always consider the need to prescribe it.

IMPORTANT RISK INFORMATION (CONTINUED)

WARNINGS AND PRECAUTIONS

Acute Critical Illness: Increased mortality in patients with acute critical illness due to complications following open heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure has been reported after treatment with [pharmacologic amounts of] somatropin.

Patient Case

Clinician's observation: "We need to monitor any decrease in weight or BMI and really listen to patient concerns over time."

PATIENT PROFILE

40-year-old male diagnosed with HIV in 2006. Despite adherence to antiretrovirals, patient experienced progressive fatigue and weight loss, ultimately causing him to leave his job. An extensive workup was completed. The patient was initiated on several treatments: testosterone to address hypogonadism, and anabolics and appetite stimulants to counteract weight loss. He continued to lose weight and express concerns about fatigue. At that time, Serostim® (somatropin) for injection was initiated for HIV-associated wasting.

RELEVANT MEDICAL HISTORY

- HIV+ (2006)
- HIV-associated neurocognitive disorder

SOCIAL HISTORY

- Exercised regularly prior to reports of fatigue and weight loss
- Employed prior to reports of fatigue and weight loss
- Reports no illicit drug use

WEIGHT HISTORY

- Height: 5'8"
- Premorbid weight: 146 lb
- Premorbid BMI: 22.2
- Weight at HIV-associated wasting diagnosis: 130 lb
- BMI at HIV-associated wasting diagnosis: 19.8

OVERVIEW OF SYMPTOMS AT TIME OF HIV-ASSOCIATED WASTING DIAGNOSIS

- Decreased physical endurance; no longer able to complete usual exercise routine
- Fatigue
- Poor appetite
- Unintentional weight loss

LABORATORY AND IMAGING RESULTS

- CD4-cell count: 410-640 cells/mm³
- Viral load: Less than 20 copies/mL
- Testosterone levels: Below normal range
- CT scan, MRI, and lumbar puncture: Normal
- No vitamin deficiencies

TREATMENT HISTORY

- Anabolic steroids
- Appetite stimulants
- Testosterone replacement therapy

This case study represents a real patient of Dr. Pounders, however, it may not be a complete representation of the individual's entire medical case or include his full experience with Serostim®. Certain details such as concomitant medications, dose adjustments, and adverse reactions may not be reflected. For more information obtained from clinical trials and unsolicited post-marketing reporting of adverse experiences, refer to the Important Risk Information throughout and see enclosed Full Prescribing Information.

IMPORTANT RISK INFORMATION (CONTINUED)

WARNINGS AND PRECAUTIONS (CONTINUED)

Concomitant Antiretroviral Therapy: Somatropin has been shown to potentiate HIV replication in vitro, however there was no increase in virus production when antiretroviral agents were added to the culture medium. All patients received antiretroviral therapy for the duration of treatment during Serostim® clinical trials and no significant increase in viral burden was observed.

Neoplasms: Patients with preexisting tumors should be monitored for progression or reoccurrence. Monitor patients on somatropin therapy carefully for preexisting nevi.

Please see additional Important Risk Information continued on the back and enclosed Full Prescribing Information.

Help your patients with HIV-associated wasting keep moving forward with Serostim® (somatropin) for injection

Serostim® is the only FDA-approved treatment to increase lean body mass and weight as well as improve physical endurance—3 key elements of HIV-associated wasting.



In clinical trials, after 12 weeks of treatment with Serostim®, patients with HIV-associated wasting experienced statistically significant increases in lean body mass and weight and clinically and statistically significant improvements in physical endurance.

IMPORTANT RISK INFORMATION (CONTINUED)

WARNINGS AND PRECAUTIONS (CONTINUED)

Impaired Glucose Tolerance/Diabetes: Cases of new onset impaired glucose tolerance, new onset type 2 diabetes, and exacerbation of preexisting diabetes have been reported in patients receiving Serostim®. Some patients developed diabetic ketoacidosis and diabetic coma. Patients with risk factors for hyperglycemia and glucose intolerance should be monitored closely and those using antidiabetic agents may require dose adjustment.

Intracranial Hypertension: Intracranial hypertension (IH) with papilledema, visual changes, headache, nausea, and/or vomiting has been reported. Funduscopic examination should be performed prior to initiating treatment with Serostim® and periodically during the course of treatment. If papilledema is observed, treatment should be stopped and restarted at a lower dose after IH-associated symptoms have resolved.

Severe Hypersensitivity: Serious systemic hypersensitivity reactions including anaphylactic reactions and angioedema have been reported with postmarketing use of somatropin products. Patients and caregivers should be informed that such reactions are possible and that prompt medical attention should be sought if an allergic reaction occurs.

Fluid Retention/Carpal Tunnel Syndrome: Swelling (particularly in the hands and feet), musculoskeletal discomfort, or carpal tunnel syndrome may occur during treatment with Serostim®. Symptoms may resolve spontaneously, with analgesic therapy, or after reducing the frequency of dosing. If symptoms of carpal tunnel do not resolve by decreasing the weekly number of doses, it is recommended that Serostim® treatment be discontinued.

Skin Atrophy: Rotate the injection site to avoid tissue atrophy.

Pancreatitis: Cases of pancreatitis have been reported rarely. Consider pancreatitis in patients who develop persistent severe abdominal pain.

ADVERSE REACTIONS

In clinical trials in HIV-associated wasting or cachexia the most common adverse reactions (incidence >10%) were increased tissue turgor, arthralgia, myalgia, and arthrosis, which may be responsive to dose reduction. Other common adverse reactions (incidence >5%) included nausea, fatigue, gynecomastia, paresthesia, generalized edema and hypoesthesia.

SPECIAL POPULATIONS:

Somatropin should be used during pregnancy only if clearly needed and with caution in nursing mothers because it is not known whether somatropin is excreted in human milk. The safety and effectiveness of somatropin in patients with hepatic or renal impairment or in patients aged 65 years and over have not been evaluated in clinical studies.

Please see the enclosed Prescribing Information for full disclosure.



EMD Serono is a business of Merck KGaA, Darmstadt, Germany
©2020 EMD Serono, Inc. US/SER/0217/0007[1]d[2]. All rights reserved.



HIGHLIGHTS OF PRESCRIBING INFORMATION

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

SEROSTIM (somatropin) for injection, for subcutaneous use

Initial U.S. Approval: 1987

INDICATIONS AND USAGE

SEROSTIM is indicated for the treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight, and improve physical endurance (1)

DOSAGE AND ADMINISTRATION

- The recommended dose of SEROSTIM is 0.1 mg/kg subcutaneously (SC) daily (up to 6 mg) at bedtime for HIV patients with wasting or cachexia (2.1)
- Injection sites, which may be located on thigh, upper arm, abdomen or buttock, should be rotated to avoid local irritation (2.2)

DOSAGE FORMS AND STRENGTHS

- Single-dose administration (to be administered with Sterile Water for Injection) (3):
SEROSTIM 5 mg/ vial
SEROSTIM 6 mg/ vial
- Multi-dose administration (to be administered with Bacteriostatic Water for Injection):
SEROSTIM 4 mg/ vial

CONTRAINDICATIONS

- Acute Critical Illness (4)
- Active Malignancy (4)
- Diabetic Retinopathy (4)
- Hypersensitivity to somatropin or excipients (4)

WARNINGS AND PRECAUTIONS

- Acute Critical Illness: Increased mortality in patients with acute critical illness following open heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure has been reported after treatment with pharmacologic amounts of somatropin (5.1)

- Concomitant Antiretroviral Therapy: In vitro experimental systems have demonstrated the potential to potentiate HIV replication. No significant somatropin-associated increase in viral load was observed in clinical trials. HIV patients should be maintained on antiretroviral therapy for the duration of SEROSTIM treatment (5.2)
- Neoplasms: Monitor all patients with a history of any neoplasm routinely while on somatropin therapy for progression, recurrences, or development of a tumor (5.3)
- Impaired Glucose Tolerance/Diabetes: May be unmasked. Periodically monitor glucose levels. Dose adjustment of concurrent antihyperglycemic drugs in diabetics may be required (5.4)
- Intracranial Hypertension: Exclude preexisting papilledema. May develop and is usually reversible after discontinuation or dose reduction (5.5)
- Hypersensitivity: Serious hypersensitivity reactions may occur. In the event of an allergic reaction, seek prompt medical attention (5.6)
- Fluid Retention (edema, arthralgia)/Carpal Tunnel Syndrome: May occur frequently. Reduce dose as necessary (5.7)
- Pancreatitis: Consider pancreatitis in patients with persistent severe abdominal pain (5.9)

ADVERSE REACTIONS

Most common adverse reactions include (incidence >10%) tissue turgor (edema, myalgia, hypoesthesia) and musculoskeletal discomfort (arthralgia, pain in extremities) (6)

To report SUSPECTED ADVERSE REACTIONS, contact EMD Serono at 1-800-283-8088 ext 5563 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

DRUG INTERACTIONS

- Inhibition of 11 β -Hydroxysteroid Dehydrogenase Type 1: May require the initiation of glucocorticoid replacement therapy. Patients treated with glucocorticoid replacement for previously diagnosed hypoadrenalism may require an increase in their maintenance doses (7.1)
- Cytochrome P450-Metabolized Drugs: Monitor carefully if used with somatropin (7.2)
- Oral Estrogen: Larger doses of somatropin may be required in women (7.3)
- Insulin and/or Oral/Injectable Hypoglycemic Agents: May require adjustment (7.4)

See 17 for PATIENT COUNSELING INFORMATION.

Revised: 06/2019

FULL PRESCRIBING INFORMATION: CONTENTS*

1	INDICATIONS AND USAGE	8	USE IN SPECIFIC POPULATIONS
2	DOSAGE AND ADMINISTRATION	8.1	Pregnancy
2.1	HIV-associated wasting or cachexia	8.3	Nursing Women
2.2	Preparation and Administration	8.4	Pediatric Use
3	DOSAGE FORMS AND STRENGTHS	8.5	Geriatric Use
4	CONTRAINDICATIONS	8.6	Hepatic Impairment
5	WARNINGS AND PRECAUTIONS	8.7	Renal Impairment
5.1	Acute Critical Illness	8.8	Gender Effect
5.2	Concomitant Antiretroviral Therapy	10	OVERDOSAGE
5.3	Neoplasms	11	DESCRIPTION
5.4	Impaired Glucose Tolerance/Diabetes	12	CLINICAL PHARMACOLOGY
5.5	Intracranial Hypertension	12.1	Mechanism of Action
5.6	Severe Hypersensitivity	12.2	Pharmacodynamics
5.7	Fluid Retention/Carpal Tunnel Syndrome	12.3	Pharmacokinetics
5.8	Lipoatrophy	13	NONCLINICAL TOXICOLOGY
5.9	Pancreatitis	13.1	Carcinogenesis, Mutagenesis, Impairment of Fertility
6	ADVERSE REACTIONS	14	CLINICAL STUDIES
6.1	Clinical Trials Experience	16	HOW SUPPLIED/STORAGE AND HANDLING
6.2	Post-Marketing Experience	16.1	How Supplied
7	DRUG INTERACTIONS	16.2	Storage and Handling
7.1	11 β -Hydroxysteroid Dehydrogenase Type 1	17	PATIENT COUNSELING INFORMATION
7.2	Cytochrome P450-metabolized drugs		
7.3	Oral Estrogen		
7.4	Insulin and/or Other Oral/Injectable Hypoglycemic Agents		

*Sections or subsections omitted from the full prescribing information are not listed

FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

SEROSTIM (somatropin) is indicated for the treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight, and improve physical endurance. Concomitant antiretroviral therapy is necessary.

2 DOSAGE AND ADMINISTRATION

SEROSTIM is administered by subcutaneous injection.

SEROSTIM therapy should be carried out under the regular guidance of a physician who is experienced in the diagnosis and management of HIV infection.

2.1 HIV-associated wasting or cachexia

The usual starting dose of SEROSTIM is 0.1 mg/kg subcutaneously once daily (up to a total dose of 6 mg). SEROSTIM should be administered subcutaneously once daily at bedtime according to the following body weight-based dosage recommendations:

Weight Range	Dose
>55kg (>121 lb)	6 mg* SC daily
45-55 kg (99-121 lb)	5 mg* SC daily
35-45 kg (75-99 lb)	4 mg* SC daily
<35 kg (<75 lb)	0.1 mg/kg SC daily

*Based on an approximate daily dosage of 0.1 mg/kg.

Treatment with SEROSTIM 0.1 mg/kg every other day was associated with fewer side effects, and resulted in a similar improvement in work output, as compared with SEROSTIM 0.1 mg/kg daily. Therefore, a starting dose of SEROSTIM 0.1 mg/kg every other day should be considered in patients at increased risk for adverse effects related to recombinant human growth hormone therapy (i.e., glucose intolerance). In general, dose reductions (i.e., reducing the total daily dose or the number of doses per week) should be considered for side effects potentially related to recombinant human growth hormone therapy.

Most of the effect of SEROSTIM on work output and lean body mass was apparent after 12 weeks of treatment. The effect was maintained during an additional 12 weeks of therapy. There are no safety or efficacy data available from controlled studies in which patients were treated with SEROSTIM continuously for more than 48 weeks. There are no safety or efficacy data available from trials in which patients with HIV wasting or cachexia were treated intermittently with SEROSTIM.

2.2 Preparation and Administration

Each vial of SEROSTIM 5 mg or 6 mg is reconstituted with 0.5 to 1 mL Sterile Water for Injection, USP.

Each vial of SEROSTIM 4 mg is reconstituted in 0.5 to 1 mL of Bacteriostatic Water for Injection, USP (0.9% Benzyl Alcohol preserved). For patients sensitive to Benzyl Alcohol, SEROSTIM may be reconstituted with Sterile Water for Injection, USP [see *Pediatric Use* (8.4)].

When SEROSTIM is reconstituted with Sterile Water for Injection, USP, the reconstituted solution should be used immediately and any unused portion should be discarded.

When SEROSTIM is reconstituted with Bacteriostatic Water for Injection, USP (0.9% Benzyl Alcohol preserved) the reconstituted solution may be refrigerated (2-8°C/36-46°F) for up to 14 days.

Approximately 10% mechanical loss can be associated with reconstitution and administration from multi-dose vials.

To reconstitute SEROSTIM, inject the diluent into the vial of SEROSTIM aiming the liquid against the glass vial wall. Swirl the vial with a GENTLE rotary motion until contents are dissolved completely. DO NOT SHAKE. Parenteral drug products should always be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit. SEROSTIM MUST NOT BE INJECTED if the solution is cloudy or contains particulate matter. Use it only if it is clear and colorless.

SEROSTIM can be administered using (1) a standard sterile, disposable syringe and needle, (2) a compatible SEROSTIM needle-free injection device or (3) a compatible SEROSTIM needle injection device. For proper use, refer to the Instructions for Use provided with the administration device.

Injection sites, which may be located on the thigh, upper arm, abdomen or buttock, should be rotated to avoid local irritation.

3 DOSAGE FORMS AND STRENGTHS

Single-use administration (to be reconstituted with Sterile Water for Injection):

- SEROSTIM 5 mg per vial
- SEROSTIM 6 mg per vial

Multi-use administration (to be reconstituted with Bacteriostatic Water for Injection):

- SEROSTIM 4 mg per vial

4 CONTRAINDICATIONS

• Acute Critical Illness

Growth hormone therapy should not be initiated in patients with acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure [see *Warnings and Precautions* (5.1)].

• Active Malignancy

In general, somatropin is contraindicated in the presence of active malignancy. Any preexisting malignancy should be inactive and its treatment complete prior to instituting therapy with somatropin. Somatropin should be discontinued if there is evidence of recurrent activity [see *Warnings and Precautions* (5.3)].

• Hypersensitivity

SEROSTIM is contraindicated in patients with a known hypersensitivity to somatropin or any of its excipients. Systemic hypersensitivity reactions have been reported with postmarketing use of somatropin products [see *Warnings and Precautions* (5.6)].

• Diabetic Retinopathy

Somatropin is contraindicated in patients with active proliferative or severe non-proliferative diabetic retinopathy.

5 WARNINGS AND PRECAUTIONS

5.1 Acute Critical Illness

Increased mortality in patients with acute critical illness due to complications following open heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure has been reported after treatment with pharmacologic amounts of somatropin. Two placebo-controlled clinical trials in non-growth hormone deficient adult patients (n=522) with these conditions revealed a significant increase in mortality (42% vs. 19%) among somatropin-treated patients (doses 5.3-8 mg/day) compared to those receiving placebo [see *Contraindications* (4)].

5.2 Concomitant Antiretroviral Therapy

In some experimental systems, somatropin has been shown to potentiate HIV replication in vitro at concentrations ranging from 50-250 ng/mL. There was no increase in virus production when the antiretroviral agents, zidovudine, didanosine or lamivudine were added to the culture medium. Additional in vitro studies have shown that somatropin does not interfere with the antiviral activity of zalcitabine or stavudine. In the controlled clinical trials, no significant somatropin-associated increase in viral burden was observed. However, the protocol required all participants to be on concomitant antiretroviral therapy for the duration of the study. In view of the potential for acceleration of virus replication, it is recommended that HIV patients be maintained on antiretroviral therapy for the duration of SEROSTIM treatment.

5.3 Neoplasms

Because malignancies are more common in HIV positive individuals, the risks and benefits of starting somatropin in HIV positive patients should be carefully considered before initiating SEROSTIM treatment and patients should be monitored carefully for the development of neoplasms if treatment with somatropin is initiated.

Monitor all patients with a history of any neoplasm routinely while on somatropin therapy for progression or recurrence of the tumor [see *Contraindications* (4)].

Monitor patients on somatropin therapy carefully for increased growth, or potential malignant changes of preexisting nevi.

5.4 Impaired Glucose Tolerance/Diabetes

Hyperglycemia may occur in HIV infected individuals due to a variety of reasons. In wasting patients, treatment with SEROSTIM 0.1 mg/kg daily and 0.1 mg/kg every other day for 12 weeks was associated with approximately 10 mg/dL and 6 mg/dL increases in mean fasting blood glucose concentrations, respectively. The increases occurred early in treatment. Patients with other risk factors for glucose intolerance should be monitored closely during SEROSTIM therapy.

During safety surveillance of patients with HIV-associated wasting, cases of new onset impaired glucose tolerance, new onset type 2 diabetes mellitus and exacerbation of preexisting diabetes mellitus have been reported in patients receiving SEROSTIM. Some patients developed diabetic ketoacidosis and diabetic coma. In some patients, these conditions improved when SEROSTIM was discontinued, while in others, the glucose intolerance persisted. Some of these patients required initiation or adjustment of antidiabetic treatment while on SEROSTIM.

In clinical trials of SEROSTIM conducted in HIV patients with lipodystrophy (an unapproved indication), evidence of dose-dependent glucose intolerance and related adverse reaction was observed at doses of 4 mg SEROSTIM daily and 4 mg SEROSTIM every other day for 12 weeks [see *Adverse Reactions* (6.1)].

5.5 Intracranial Hypertension

Intracranial hypertension (IH) with papilledema, visual changes, headache, nausea, and/or vomiting has been reported in a small number of patients treated with somatropin products. Symptoms usually occurred within the first eight (8) weeks after the initiation of somatropin therapy. In all reported cases, IH-associated signs and symptoms rapidly resolved after cessation of therapy or a reduction of the somatropin dose. Funduscopic examination should be performed routinely before initiating treatment with somatropin to exclude preexisting papilledema, and periodically during the course of somatropin therapy. If papilledema is observed by funduscopy during somatropin treatment, treatment should be stopped. If somatropin-induced IH is diagnosed, treatment with somatropin can be restarted at a lower dose after IH-associated signs and symptoms have resolved.

5.6 Severe Hypersensitivity

Serious systemic hypersensitivity reactions including anaphylactic reactions and angioedema have been reported with postmarketing use of somatropin products. Patients and caregivers should be informed that such reactions are possible and that prompt medical attention should be sought if an allergic reaction occurs [see *Contraindications (4)*].

5.7 Fluid Retention/Carpal Tunnel Syndrome

Increased tissue turgor (swelling, particularly in the hands and feet) and musculoskeletal discomfort (pain, swelling and/or stiffness) may occur during treatment with SEROSTIM, but may resolve spontaneously, with analgesic therapy, or after reducing the frequency of dosing [see *Dosage and Administration (2.1)*].

Carpal tunnel syndrome may occur during treatment with SEROSTIM. If the symptoms of carpal tunnel syndrome do not resolve by decreasing the weekly number of doses of SEROSTIM, it is recommended that treatment be discontinued.

5.8 Lipoatrophy

When somatropin is administered subcutaneously at the same site over a long period of time, tissue atrophy may result. This can be avoided by rotating the injection site [see *Dosage and Administration (2.2)*].

5.9 Pancreatitis

Cases of pancreatitis have been reported rarely in children and adults receiving somatropin treatment, with some evidence supporting a greater risk in children compared with adults. Published literature indicates that girls who have Turner syndrome may be at greater risk than other somatropin-treated children. Pancreatitis should be considered in any somatropin-treated patient, especially a child who develops abdominal pain.

6 ADVERSE REACTIONS

The following important adverse reactions are also described elsewhere in the labeling:

Acute Critical Illness [see *Warnings and Precautions (5.1)*]

Neoplasms [see *Warnings and Precautions (5.3)*]

Impaired glucose tolerance and diabetes mellitus [see *Warnings and Precautions (5.4)*]

Intracranial hypertension [see *Warnings and Precautions (5.5)*]

Severe hypersensitivity [see *Warnings and Precautions (5.6)*]

Fluid retention/Carpal tunnel syndrome [see *Warnings and Precautions (5.7)*]

Lipoatrophy [see *Warnings and Precautions (5.8)*]

Pancreatitis [see *Warnings and Precautions (5.9)*]

6.1 Clinical Trials Experience

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

Clinical trials in HIV-associated wasting or cachexia:

In the 12-week, placebo-controlled Clinical Trial 2, 510 patients were treated with SEROSTIM. The most common adverse reactions judged to be associated with SEROSTIM were musculoskeletal discomfort and increased tissue turgor (swelling, particularly of the hands or feet), and were more frequently observed when SEROSTIM 0.1 mg/kg was administered on a daily basis [Table 1 and *Warnings and Precautions (5)*]. These symptoms often subsided with continued treatment or dose reduction. Approximately 23% of patients receiving SEROSTIM 0.1 mg/kg daily and 11% of patients receiving 0.1 mg/kg every other day required dose reductions. Discontinuations as a result of adverse reactions occurred in 10.3% of patients receiving SEROSTIM 0.1 mg/kg daily and 6.6% of patients receiving 0.1 mg/kg every other day. The most common reasons for dose reduction and/or drug discontinuation were arthralgia, myalgia, edema, carpal tunnel syndrome, elevated glucose levels, and elevated triglyceride levels.

Clinical adverse reactions which occurred during the first 12 weeks of study in at least

5% of the patients in either active treatment group and at an incidence greater than placebo are listed below, without regard to causality assessment.

Table 1: Controlled Clinical Trial 2 Adverse Reactions Occurring in at least 5% of Patients in one of the Treatment Groups, and at an Incidence Greater than Placebo

	Placebo	0.1 mg/ kg every other day SEROSTIM	0.1 mg/ kg daily SEROSTIM
	Patients (n=247)	Patients (n=257)	Patients (n=253)
Body System Preferred Term	%	%	%
Musculoskeletal System Disorders			
Arthralgia	11.3	24.5	36.4
Myalgia	11.7	17.9	30.4
Arthrosis	3.6	7.8	10.7
Gastrointestinal System Disorders			
Nausea	4.9	5.4	9.1
Body As A Whole – General Disorders			
Edema Peripheral	2.8	11.3	26.1
Fatigue	4.5	3.5	5.1
Endocrine Disorders			
Gynecomastia	0.4	3.5	5.5
Central and Peripheral Nervous System Disorders			
Paresthesia	4.5	7.4	7.9
Hypoesthesia	2.4	1.6	5.1
Metabolic and Nutritional Disorders			
Edema Generalized	1.2	1.2	5.9

Adverse reactions that occurred in 1% to less than 5% of trial participants receiving SEROSTIM during the first 12 weeks of Clinical Trial 2 thought to be related to SEROSTIM included dose dependent edema, periorbital edema, carpal tunnel syndrome, hyperglycemia and hypertriglyceridemia.

During the 12-week, placebo-controlled portion of Clinical Trial 2, the incidence of hyperglycemia reported as an adverse reaction was 3.6% for the placebo group, 1.9% for the 0.1 mg/kg every other day group and 3.2% for the 0.1 mg/kg daily group. One case of diabetes mellitus was noted in the 0.1 mg/kg daily group during the first 12-weeks of therapy. In addition, during the extension phase of Clinical Trial 2, two patients converted from placebo to full dose SEROSTIM, and 1 patient converted from placebo to half-dose SEROSTIM, were discontinued because of the development of diabetes mellitus.

The types and incidences of adverse reactions reported during the Clinical Trial 2 extension phase were not different from, or greater in frequency than those observed during the 12-week, placebo-controlled portion of Clinical Trial 2.

Adverse reactions from treatment with SEROSTIM in clinical trials in HIV lipodystrophy

SEROSTIM was evaluated for the treatment of patients with HIV lipodystrophy in two double-blind, placebo-controlled trials that excluded patients with a history of diabetes, impaired fasting glucose or impaired glucose (approximately 20% of the patients screened were excluded from study enrollment as a result of a diagnosis of diabetes or glucose intolerance). The studies included a 12-week double-blind, placebo-controlled, parallel group "induction" phase followed by maintenance phases of different durations (12 and 24 weeks, respectively). In the initial 12-week treatment periods of the two, placebo-controlled clinical trials, 406 patients were treated with SEROSTIM. Clinical adverse reactions which occurred during the first 12 weeks of both studies combined in at least 5% of the patients in either of the two active treatment groups are listed by treatment group in Table 2, without regard to causality assessment. The most common adverse reactions judged to be associated with SEROSTIM were edema, arthralgia, pain in extremity, hypoesthesia, myalgia, and blood glucose increased, all of which were more frequently observed when SEROSTIM 4 mg was administered on a daily basis compared with alternate days. These symptoms often subsided with dose reduction. During the 12-week induction phase, 1) approximately 26% of patients receiving SEROSTIM 4 mg daily and 19% of patients receiving SEROSTIM 4 mg every other day required dose reductions; and 2) discontinuations as a result of adverse reactions occurred in 13% of patients receiving SEROSTIM 4 mg daily and 5% of

patients receiving SEROSTIM 4 mg every other day. The most common reasons for dose reduction and/or drug discontinuation were peripheral edema, hyperglycemia (including blood glucose increased, blood glucose abnormal, and hyperglycemia), and arthralgia.

Table 2: Controlled HIV Lipodystrophy Studies 1 and 2 Combined –Adverse Reactions with >5% Incidence in Either Active Treatment Arm

	Placebo	SEROSTIM 4 mg every other day ¹	SEROSTIM 4 mg daily
	Patients (n=159)	Patients (n=80)	Patients (n=326)
System Organ Class			
Preferred Term	%	%	%
Musculoskeletal and connective tissue disorders			
Arthralgia	11.9	27.8	37.1
Pain in extremity	3.8	5.0	19.3
Myalgia	3.8	2.5	12.6
Musculoskeletal stiffness	1.9	3.8	8.0
Joint stiffness	1.3	3.8	7.7
Joint swelling	0.6	5.0	6.1
General disorders and administration site conditions			
Edema peripheral	3.8	18.8	45.4
Fatigue	1.9	6.3	8.9
Nervous system disorders			
Hypoesthesia	0.6	8.8	15.0
Paraesthesia	2.5	12.5	11.0
Investigations (Laboratory Evaluations)			
Blood glucose increased ²	2.5	3.8	13.8
Metabolism and nutrition disorders			
Hyperglycemia ²	0.6	8.8	7.1
Fluid retention	0.6	2.5	5.2
Gastrointestinal disorders			
Nausea	2.5	1.3	6.1

¹ Study 22388 only
² similar terms were grouped together and reported below

Glucose metabolism related adverse reactions: During the initial 12-week treatment periods of Studies 1 and 2, the incidence of glucose-related adverse reactions was 4% for the placebo group, 13% for the 4 mg every other day group and 22% for the 4 mg daily group.

Twenty-three patients discontinued due to hyperglycemia while receiving SEROSTIM during any phase of these studies (3.2% in the 12-week induction phases and 2.1% in the extension phases).

Breast-Related Terms: When grouped together, breast-related adverse reactions (e.g. nipple pain, gynecomastia, breast pain/mass/tenderness/swelling/edema/hypertrophy) had an incidence of 1% for the placebo group, 3% for the SEROSTIM 4 mg every other day group and 6% for the SEROSTIM 4 mg daily group.

Adverse reactions that occurred in 1% to less than 5% of trial participants receiving SEROSTIM during the first 12 weeks of HIV Lipodystrophy Studies 1 and 2 thought to be related to SEROSTIM include carpal tunnel syndrome, Tinel's sign and facial edema.

The adverse reactions reported for SEROSTIM 4 mg every other day during the maintenance phase of HIV Lipodystrophy Study 1 (Week 12 to Week 24) were similar in frequency and quality to those observed after treatment with SEROSTIM 4 mg every other day during the 12-week induction phase.

IGF-1 serum concentrations increased statistically in SEROSTIM-treated patients when compared to placebo (Table 3). In the SEROSTIM treated patients at baseline, the proportion of subjects with serum IGF-1 SDS levels $\geq +2$ was approximately 10 to 20%, while with treatment with either dose regimen of SEROSTIM the percentage increased to 80 to 90% by Week 12.

Table 3: Change from Baseline to Week 12 in Serum IGF-1 SDS After Treatment with SEROSTIM 4 mg daily vs. Placebo (Modified ITT Population; Studies 1 and 2 Combined)

		Placebo	SEROSTIM 4 mg every other day	SEROSTIM 4 mg daily
Time Point	Statistic	(n=145)	(n=79)	(n=290)
Baseline	Mean (SD)	0.4 (1.4)	1.3 (2.1)	0.0 (1.6)
	Range	(-2.5, 4.8)	(-2.0, 13.7)	(-3.0, 11.9)
Week 12	Mean (SD)	0.8 (1.6)	5.1 (3.4)	6.1 (5.0)
	Range	(-2.6, 6.7)	(-0.7, 17.2)	(-1.8, 29.2)
Change from Baseline to	Mean (SD)	0.4 (1.3)	3.9 (3.1)	6.1 (4.6)
	Range	(-2.9, 7.7)	(-9.4, 11.8)	(-2.4, 24.3)
Week 12	p-value ^(b)	<0.001	<0.001	<0.001
	Mean ^(a) diff (SEM)		3.5 (0.5)	5.7 (0.4)
	p-value ^(c)		<0.001	<0.001

^(a) Proportionally weighted least squares means from a two-way ANOVA model on raw data including effects for treatment, sex, and the treatment by sex interaction.
^(b) P-value from a Wilcoxon Signed Rank test on the change from baseline to Week 12.
^(c) P-value from a two-way ANOVA model on ranked data including effects for treatment, sex, and the treatment by sex interaction.

As with all therapeutic proteins, there is potential for immunogenicity. The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies to SEROSTIM with the incidence of antibodies to other products may be misleading.

After 12 weeks of treatment, none of the 651 study participants with HIV-associated wasting treated with SEROSTIM for the first time developed detectable antibodies to growth hormone (> 4 pg binding). Patients were not rechallenged. Data beyond 3 months is not available.

6.2 Post-Marketing Experience

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

Hypersensitivity: Serious systemic hypersensitivity reactions including anaphylactic reactions and angioedema have been reported with postmarketing use of somatropin products [see *Warnings and Precautions* (5.6)].

Endocrine:

- new onset impaired glucose tolerance
- new onset type 2 diabetes mellitus
- exacerbation of preexisting diabetes mellitus
- diabetic ketoacidosis
- diabetic coma

In some patients, these conditions improved when SEROSTIM was discontinued, while in others the glucose intolerance persisted. Some of these patients required initiation or adjustment of antidiabetic treatment while on SEROSTIM [see *Warnings and Precautions* (5.4)].

Gastrointestinal: Pancreatitis [see *Warnings and Precautions* (5.9)].

7 DRUG INTERACTIONS

Formal drug interaction studies have not been conducted. No data are available on drug interactions between SEROSTIM and HIV protease inhibitors or the non-nucleoside reverse transcriptase inhibitors.

7.1 11 β -Hydroxysteroid Dehydrogenase Type 1

The microsomal enzyme 11 β -hydroxysteroid dehydrogenase type 1 (11 β HSD-1) is required for conversion of cortisone to its active metabolite, cortisol, in hepatic and adipose tissue. Somatropin inhibits 11 β HSD-1. Patients treated with glucocorticoid replacement for previously diagnosed hypoadrenalism may require an increase in their maintenance or stress doses following initiation of somatropin treatment; this may be especially true for patients treated with cortisone acetate and prednisone since conversion of these drugs to their biologically active metabolites is dependent on the activity of 11 β HSD-1.

7.2 Cytochrome P450–metabolized drugs

Limited published data indicate that somatropin treatment increases cytochrome P450 (CYP450)-mediated antipyrine clearance in man. These data suggest that somatropin administration may alter the clearance of compounds metabolized by CYP450 liver enzymes (e.g., corticosteroids, sex steroids, anticonvulsants, cyclosporine). Therefore, careful monitoring is advised when somatropin is administered in combination with drugs metabolized by CYP450 liver enzymes. However, formal drug interaction studies have not been conducted.

7.3 Oral Estrogen

Because oral estrogens may reduce the serum IGF-1 response to somatropin treatment, girls and women receiving oral estrogen replacement may require greater somatropin dosages [see *Dosage and Administration* (2)].

7.4 Insulin and/or Other Oral/Injectable Hypoglycemic Agents

Patients with diabetes mellitus who receive concomitant treatment with somatropin may require adjustment of their doses of insulin and/or other hypoglycemic agents [see *Warnings and Precautions* (5.4)].

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Reproduction studies have been performed in rats and rabbits. Doses up to 5 to 10 times the human dose, based on body surface area, have revealed no evidence of impaired fertility or harm to the fetus due to SEROSTIM. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, SEROSTIM should be used during pregnancy only if clearly needed.

8.3 Nursing Women

It is not known whether SEROSTIM is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SEROSTIM is administered to a nursing woman.

8.4 Pediatric Use

Safety and effectiveness in pediatric patients with HIV have not been established. Available evidence suggests that somatropin clearance is similar in adults and children, but no pharmacokinetic studies have been conducted in children with HIV.

In two small studies, 11 children with HIV-associated failure to thrive were treated subcutaneously with human growth hormone. In one study, five children (age range, 6 to 17 years) were treated with 0.04 mg/kg/day for 26 weeks. In a second study, six children (age range, 8 to 14 years) were treated with 0.07 mg/kg/day for 4 weeks. Treatment appeared to be well tolerated in both studies. The preliminary data collected on a limited number of patients with HIV-associated failure to thrive appear to be consistent with safety observations in growth hormone-treated adults with HIV wasting.

Benzyl alcohol, a component of this product, has been associated with serious adverse events and death, particularly in pediatric patients. The "gasping syndrome," (characterized by central nervous system depression, metabolic acidosis, gasping respirations, and high levels of benzyl alcohol and its metabolites found in the blood and urine) has been associated with benzyl alcohol dosages >99 mg/kg/day in neonates and low-birth weight neonates. Additional symptoms may include gradual neurological deterioration, seizures, intracranial hemorrhage, hematologic abnormalities, skin breakdown, hepatic and renal failure, hypotension, bradycardia, and cardiovascular collapse. Practitioners administering this and other medications containing benzyl alcohol should consider the combined daily metabolic load of benzyl alcohol from all sources.

8.5 Geriatric Use

Clinical studies with SEROSTIM did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Elderly patients may be more sensitive to the action of somatropin, and therefore, may be more prone to develop adverse reactions. A lower starting dose and smaller dose increments should be considered for older patients [see *Dosage and Administration* (2)].

8.6 Hepatic Impairment

No studies have been conducted for SEROSTIM in patients with hepatic impairment [see *Clinical Pharmacology* (12.3)].

8.7 Renal Impairment

Subjects with chronic renal failure tend to have decreased somatropin clearance compared to those with normal renal function. However, no studies have been conducted for SEROSTIM in patients with renal impairment [see *Clinical Pharmacology* (12.3)].

8.8 Gender Effect

Biomedical literature indicates that a gender-related difference in the mean clearance of r-hGH could exist (clearance of r-hGH in males > clearance of r-hGH in females). However, no gender-based analysis is available for SEROSTIM in normal volunteers or patients infected with HIV.

10 OVERDOSAGE

Short-Term

Acute overdosage could lead initially to hypoglycemia and subsequently to hyperglycemia.

Long-Term

Long-term overdosage could result in signs and symptoms of acromegaly consistent with the known effects of excess growth hormone.

11 DESCRIPTION

SEROSTIM is a human growth hormone (hGH) produced by recombinant DNA technology. SEROSTIM has 191 amino acid residues and a molecular weight of 22,125 daltons. Its amino acid sequence and structure are identical to the dominant form of human pituitary growth hormone. SEROSTIM is produced by a mammalian cell line (mouse C127) that has been modified by the addition of the hGH gene. SEROSTIM is secreted directly through the cell membrane into the cell-culture medium for collection and purification.

SEROSTIM is a sterile lyophilized powder intended for subcutaneous injection after reconstitution to its liquid form.

Vials of SEROSTIM contain either 4 mg, 5 mg, or 6 mg. Each vial contains the following:

	Vials		
	4 mg	5 mg	6 mg
Component			
Somatropin	4 mg	5 mg	6 mg
Sucrose	27.3 mg	34.2 mg	41 mg
Phosphoric acid	0.9 mg	1.2 mg	1.4 mg

Each 4 mg multi-vial is supplied in a combination package with Bacteriostatic Water for Injection, USP (0.9% Benzyl Alcohol). The pH is adjusted with sodium hydroxide of phosphoric acid to give a pH of 7.4 to 8.5 after reconstitution.

Each 5 mg single-use vial is supplied in a combination package with Sterile Water for Injection, USP. The pH is adjusted with sodium hydroxide or phosphoric acid to give a pH of 6.5 to 8.5 after reconstitution.

Each 6 mg single-use vial is supplied in a combination package with Sterile Water for Injection, USP. The pH is adjusted with sodium hydroxide of phosphoric acid to give a pH of 7.4 to 8.5 after reconstitution.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

SEROSTIM is an anabolic and anticatabolic agent which exerts its influence by interacting with specific receptors on a variety of cell types including myocytes, hepatocytes, adipocytes, lymphocytes, and hematopoietic cells. Some, but not all of its effects, are mediated by insulin-like growth factor-1 (IGF-1).

12.2 Pharmacodynamics

Effects on Protein, Lipid and Carbohydrate Metabolism

A one-week study in 6 patients with HIV-associated wasting has shown that treatment with SEROSTIM 0.1 mg/kg/day improved nitrogen balance, increased protein-sparing lipid oxidation, and had little effect on overall carbohydrate metabolism.

Decreases in trunk fat and total body fat, and increases in lean body mass were observed during two double-blind, placebo-controlled studies wherein SEROSTIM vs. placebo were administered daily for 12 weeks to patients with HIV Lipodystrophy [see *Clinical Studies* (14)].

Effects on Nitrogen and Mineral Retention

In the one-week study in 6 patients with HIV-associated wasting, treatment with SEROSTIM resulted in the retention of phosphorus, potassium, nitrogen, and sodium. The ratio of retained potassium and nitrogen during SEROSTIM therapy was consistent with retention of these elements in lean tissue.

Physical Performance

Cycle ergometry work output and treadmill performance were examined in separate 12-week, placebo-controlled trials [see *Clinical Studies* (14)]. In both studies, work output improved significantly in the group receiving SEROSTIM 0.1 mg/kg/day subcutaneously vs placebo. Isometric muscle performance, as measured by grip strength dynamometry, declined, probably as a result of a transient increase in tissue turgor known to occur with SEROSTIM therapy.

12.3 Pharmacokinetics

Absorption: The absolute bioavailability after subcutaneous administration was determined to be 70 to 90%. The mean $t_{1/2}$ after subcutaneous administration is significantly longer than that seen after intravenous administration in normal male volunteers down-regulated with somatostatin (approximately 4.0 hrs. vs. 0.6 hrs.), indicating that the subcutaneous absorption of somatotropin is a rate-limiting process.

Distribution: The steady-state volume of distribution (Mean \pm SD) following intravenous administration of somatotropin in normal male volunteers is 12.0 ± 1.08 L.

Metabolism: Although the liver plays a role in the metabolism of GH, GH is primarily cleaved in the kidney. GH undergoes glomerular filtration and, after cleavage within the renal cells, the peptides and amino acids are returned to the systemic circulation.

Elimination: The $t_{1/2}$ in nine patients with HIV-associated wasting with an average weight of 56.7 ± 6.8 kg, given a fixed dose of 6.0 mg somatotropin subcutaneously was 4.28 ± 2.15 hrs, similar to that observed in normal male volunteers. The renal clearance of r-hGH after subcutaneous administration in nine patients with HIV-associated wasting was 0.0015 ± 0.0037 L/h. No significant accumulation of r-hGH appears to occur after 6 weeks of daily dosing as indicated.

Specific Populations:

Pediatric: Available evidence suggests that r-hGH clearances are similar in adults and children, but no pharmacokinetic studies have been conducted in children with HIV.

Gender: Biomedical literature indicates that a gender-related difference in the mean clearance of r-hGH could exist (clearance of r-hGH in males > clearance of r-hGH in females). However, no gender-based analysis is available in normal volunteers or patients infected with HIV.

Race: No studies have been conducted to determine the effect of race on the pharmacokinetics of SEROSTIM.

Renal Impairment: Subjects with chronic renal failure tend to have decreased somatotropin clearance compared to those with normal renal function. However, no studies have been conducted to determine the effect of renal impairment on the pharmacokinetics of SEROSTIM.

Hepatic Impairment: No studies have been conducted to determine the effect of hepatic impairment on the pharmacokinetic of SEROSTIM.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term animal studies for carcinogenicity have not been performed with SEROSTIM. There is no evidence from animal studies to date of SEROSTIM-induced mutagenicity or impairment of fertility.

14 CLINICAL STUDIES

HIV-Associated Wasting or Cachexia

The clinical efficacy of SEROSTIM in HIV-associated wasting or cachexia was assessed in two placebo-controlled trials. All study subjects received concomitant antiretroviral therapy. There was no increase in the incidence of Kaposi's sarcoma (KS), lymphoma, or in the progression of cutaneous Kaposi's sarcoma in clinical studies of SEROSTIM. Patients with internal KS lesions were excluded from the studies. Potential effects on other malignancies are unknown.

Clinical Trial 1:

A 12-week, randomized, double-blind, placebo-controlled study followed by an open-label extension phase enrolled 178 patients with severe HIV wasting taking nucleoside analogue therapy (pre-HAART era). The primary endpoint was body weight. Body composition was assessed using dual energy X-ray absorptiometry (DXA) and physical function was assessed by treadmill exercise testing. Patients meeting the inclusion/exclusion criteria were treated with either placebo or SEROSTIM 0.1 mg/kg daily. Ninety-six percent (96%) were male. The average baseline CD4 count/microliter was 85. The results from one hundred forty (140) evaluable patients were analyzed (those completing the 12-week course of treatment and who were at least 80% compliant with study drug). After 12 weeks of therapy, the mean difference in weight increase between the SEROSTIM-treated group and the placebo-treated group was 1.6 kg (3.5 lb). Mean difference in lean body mass (LBM) change between the SEROSTIM-treated group and the placebo-treated group was 3.1 kg (6.8 lbs) as measured by DXA. Mean increase in weight and LBM, and mean decrease in body fat, were significantly greater in the SEROSTIM-treated group than in the placebo group ($p=0.011$, $p<0.001$, $p<0.001$, respectively) after 12 weeks of treatment (Figure 1). There were no significant changes with continued treatment beyond 12 weeks suggesting that the original gains of weight and LBM were maintained (Figure 1).

Treatment with SEROSTIM resulted in a significant increase in physical function as assessed by treadmill exercise testing. The median treadmill work output increased by 13% ($p=0.039$) at 12 weeks in the group receiving SEROSTIM (Figure 2). There was no improvement in the placebo-treated group at 12 weeks. Changes in treadmill performance were significantly correlated with changes in LBM.

Figure 1: Mean Changes in Body Composition

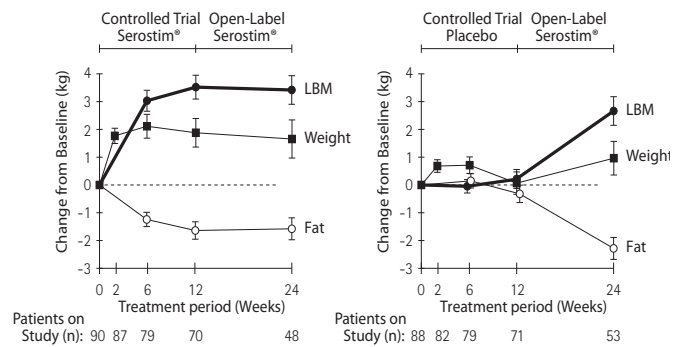
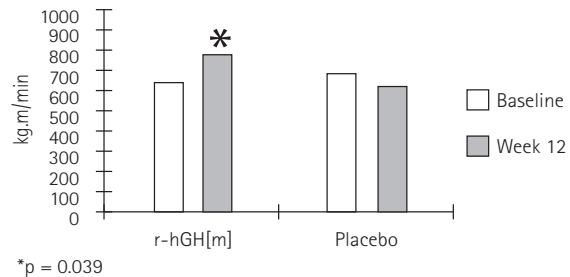


Figure 2: Median Treadmill Work Output



Clinical Trial 2:

A 12-week, randomized, double-blind, placebo-controlled study enrolled 757 patients with HIV-associated wasting, or cachexia. The primary efficacy endpoint was physical function as measured by cycle ergometry work output. Body composition was assessed using bioelectrical impedance spectroscopy (BIS) and also by dual energy X-ray absorptiometry (DXA) at a subset of centers. Patients meeting the inclusion/exclusion criteria were treated with either placebo, approximately 0.1 mg/kg every other day (qod) of SEROSTIM, or approximately 0.1 mg/kg daily at bedtime of SEROSTIM. All results were analyzed in intent-to-treat populations (for cycle ergometry work output, n=670). Ninety-one percent (91%) were male and 88% were on HAART anti-retroviral therapy. The average baseline CD4 count/ μ L was 446. Six hundred forty-six patients (646) completed the 12-week study and continued in the SEROSTIM treatment extension phase of the trial.

Clinical Trial 2 results are summarized in Tables 4 and 5:

Table 4: Mean (Median) of Cycle Work Output (kJ) Response after 12 weeks of Treatment ITT Population

	Placebo	Half-Dose SEROSTIM ^(b)	Full-Dose SEROSTIM ^(a)
Cycle work output (kJ)	n=222	n=230	n=218
Baseline	25.92 (25.05)	27.79 (26.65)	27.57 (26.30)
Change from baseline	-0.05 (-0.25)	2.48 (2.30)	2.52 (2.40)
Percent change from baseline	0.2%	8.9%	9.1%
Difference from Placebo			
Mean (2-sided 95% C.I.)	-	2.53 ^(c) (0.81, 4.25)	2.57 ^(c) (0.83, 4.31)
Median	-	2.55	2.65

^(a) approximately 0.1 mg/kg daily
^(b) approximately 0.1 mg/kg every other day
^(c) p<0.01

Table 5: Mean (Median) Change from Baseline for Lean Body Mass, Fat Mass and Body Weight

	Placebo		Half-Dose SEROSTIM ^(b)		Full-Dose SEROSTIM ^(a)	
	N	Mean (Median)	n	Mean (Median)	n	Mean (Median)
Lean body mass (kg) (by BIS)	222	0.97 (0.67)	223	3.89 (3.65)	205	5.84 (5.47)
Fat mass (kg) (by DXA)	94	0.03 (0.01)	100	-1.25 (-1.23)	85	-1.72 (-1.51)
Body weight (kg)	247	0.69 (0.68)	257	2.18 (2.15)	253	2.79 (2.65)
^(a) approximately 0.1 mg/kg daily						
^(b) approximately 0.1 mg/kg every other day						

The mean maximum cycle work output until exhaustion increased after 12 weeks by 2.57 kilojoules (kJ) in the SEROSTIM 0.1 mg/kg daily group ($p < 0.01$) and by 2.53 kJ in the SEROSTIM 0.1 mg/kg every other day group ($p < 0.01$) compared with placebo (Table 4). Cycle work output improved approximately 9% in both active treatment arms and decreased <1% in the placebo group. Lean body mass (LBM) and body weight (BW) increased, and fat mass decreased, in a dose-related fashion after treatment with SEROSTIM and placebo (Table 5). The LBM results obtained by BIS were confirmed with DXA.

Patients' perceptions of the impact of 12 weeks of treatment on their wasting symptoms as assessed by the Bristol-Meyers Anorexia/Cachexia Recovery Instrument improved with both doses of SEROSTIM in Clinical Trial 2.

Extension Phase: All patients (n=646) completing the 12-week placebo-controlled phase of Clinical Trial 2 continued SEROSTIM treatment into an extension phase. Five hundred and forty eight of these patients completed an additional 12 weeks of active treatment. In these patients, changes in cycle ergometry work output, LBM, BW, and fat mass either improved further or were maintained with continued SEROSTIM treatment.

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

SEROSTIM is available in the following forms:

- SEROSTIM single-use vials containing 5 mg with Sterile Water for Injection, USP. Package of 7 vials. NDC 44087-0005-7
- SEROSTIM single-use vials containing 6 mg with Sterile Water for Injection, USP. Package of 7 vials. NDC 44087-0006-7
- SEROSTIM multiple-use vials containing 4 mg with Bacteriostatic Water for Injection, USP (0.9% Benzyl Alcohol). Package of 7 vials. NDC 44087-0004-7

16.2 Storage and Handling

Before reconstitution: Vials of SEROSTIM and diluent should be stored at room temperature, (15°-30°C/59°-86°F). Expiration dates are stated on product labels.

Single-use vials: After reconstitution with Sterile Water for Injection, USP, the reconstituted solution should be used immediately and any unused portion should be discarded.

Multi-use vials: After reconstitution with Bacteriostatic Water for Injection, USP (0.9% Benzyl Alcohol), the reconstituted solution should be stored under refrigeration (2-8°C/36-46°F) for up to 14 days.

Avoid freezing reconstituted vials of SEROSTIM.

17 PATIENT COUNSELING INFORMATION

Patients being treated with SEROSTIM should be informed of the potential benefits and risks associated with treatment. Patients should be instructed to contact their physician should they experience any side effects or discomfort during treatment with SEROSTIM.

It is recommended that SEROSTIM be administered using sterile, disposable syringes and needles. Patients should be thoroughly instructed in the importance of proper disposal and cautioned against any reuse of needles and syringes. An appropriate container for the disposal of used syringes and needles should be employed.

Patients should be instructed to rotate injection sites to avoid localized tissue atrophy.

Never Share a SEROSTIM Pen or Needle Between Patients

Counsel patients that they should never share SEROSTIM or SEROSTIM injection devices with another person, even if the needle or nozzle is changed. Sharing of SEROSTIM or SEROSTIM injection devices between patients may pose a risk of transmission of infection.

Patients should be informed about the management of common side effects related to tissue turgor, glucose intolerance and musculoskeletal discomfort.

Manufactured for: EMD Serono, Inc., Rockland, MA 02370

US-SER-00033