## 1. NAME OF THE MEDICINAL PRODUCT

DARZALEX FASPRO® 1800 mg solution for injection

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each 15 mL vial of solution for injection contains 1800 mg of daratumumab (120 mg daratumumab per mL).

Daratumumab is a human monoclonal IgG1κ antibody against CD38 antigen, produced in a mammalian cell line (Chinese Hamster Ovary) using recombinant DNA technology.

Excipient with known effect

Each 15 mL vial of solution for injection contains 735.1 mg of sorbitol

For the full list of excipients, see section 6.1.

## 3. PHARMACEUTICAL FORM

Solution for injection.
The solution is clear to opalescent, colourless to yellow.

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Multiple myeloma

DARZALEX FASPRO® is indicated:

- DARZALEX FASPRO® is indicated as monotherapy for the treatment of patients with multiple myeloma who have received at least three prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double refractory to a PI and an immunomodulatory agent.
- DARZALEX FASPRO® is indicated in combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least one prior therapy.
- DARZALEX FASPRO® is indicated in combination with lenalidomide and dexamethasone, or bortezomib, melphalan and prednisone for the treatment of adult patients with newly diagnosed multiple myeloma who are ineligible for autologous stem cell transplant.
- DARZALEX FASPRO® in combination with bortezomib, lenalidomide and dexamethasone for the treatment of adult patients with newly diagnosed multiple myeloma.
- DARZALEX FASPRO® in combination with pomalidomide and dexamethasone for the treatment of adult patients with multiple myeloma who have received one prior therapy containing a proteasome inhibitor and lenalidomide and were lenalidomide-refractory, or who have received at least two prior therapies that included lenalidomide and a proteasome inhibitor and have demonstrated disease progression on or after the last therapy (see section 5.1).

AL amyloidosis

DARZALEX FASPRO® is indicated in combination with cyclophosphamide, bortezomib and dexamethasone for the treatment of adult patients with newly diagnosed systemic AL amyloidosis.

### 4.2 Posology and method of administration

DARZALEX FASPRO® subcutaneous formulation is not intended for intravenous administration and should be given by subcutaneous injection only, using the doses specified.

DARZALEX FASPRO® should be administered by a healthcare professional, and the first dose should be administered in an environment where resuscitation facilities are available.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

It is important to check the vial labels to ensure that the appropriate formulation (intravenous or subcutaneous formulation) and dose is being given to the patient as prescribed.

For patients currently receiving daratumamab intravenous formulation, DARZALEX FASPRO® solution for subcutaneous injection may be used as an alternative to the intravenous daratumumab formulation starting at the next scheduled dose.

Pre- and post-injection medicinal products should be administered to reduce the risk of infusion-related reactions (IRRs) with daratumumab. See below "Recommended concomitant medicinal products" and section 4.4.

Posology

*Multiple myeloma*
*Dosing schedule in combination with lenalidomide and dexamethasone or pomalidomide and dexamethasone (4-week cycle regimen) and for monotherapy*

The recommended dose is 1800 mg of DARZALEX FASPRO® solution for subcutaneous injection administered over approximately 3-5 minutes according to the following dosing schedule in table 1.

**Table 1: DARZALEX FASPRO® dosing schedule in combination with lenalidomide and dexamethasone (Rd), pomalidomide and dexamethasone (Pd) (4-week cycle dosing regimen) and monotherapy**

| Weeks | Schedule |
|---|---|
| Weeks 1 to 8 | weekly (total of 8 doses) |
| Weeks 9 to 24[a] | every two weeks (total of 8 doses) |
| Week 25 onwards until disease progression[b] | every four weeks |

[a] First dose of the every-2-week dosing schedule is given at week 9.
[b] First dose of the every-4-week dosing schedule is given at week 25.

Dexamethasone should be administered at 40 mg/week (or a reduced dose of 20 mg/week for patients > 75 years).

For dose and schedule of medicinal products administered with DARZALEX FASPRO® solution for subcutaneous injection, see section 5.1 and the corresponding Summary of Product Characteristics.

*Dosing schedule in combination with bortezomib, melphalan and prednisone (6-week cycle regimens)*

The recommended dose is 1800 mg of DARZALEX FASPRO® solution for subcutaneous injection administered over approximately 3-5 minutes according to the following dosing schedule in table 2.

**Table 2: DARZALEX FASPRO® dosing schedule in combination with bortezomib, melphalan and prednisone ([VMP]; 6-week cycle dosing regimen)**

| Weeks | Schedule |
|---|---|
| Weeks 1 to 6 | weekly (total of 6 doses) |
| Weeks 7 to 54[a] | every three weeks (total of 16 doses) |
| Week 55 onwards until disease progression[b] | every four weeks |

[a] First dose of the every-3-week dosing schedule is given at week 7.
[b] First dose of the every-4-week dosing schedule is given at week 55.

Bortezomib is given twice weekly at weeks 1, 2, 4 and 5 for the first 6-week cycle, followed by **once** weekly at weeks 1, 2, 4 and 5 for eight more 6-week cycles. For information on the VMP dose and dosing schedule when administered with DARZALEX FASPRO® solution for subcutaneous injection, see section 5.1.

*Dosing schedule in combination with bortezomib, lenalidomide and dexamethasone (4-week cycle regimens) for treatment of newly diagnosed patients eligible for autologous stem cell transplant (ASCT)*

The recommended dose is 1800 mg of DARZALEX FASPRO® solution for subcutaneous injection administered over approximately 3-5 minutes according to the following dosing schedule in table 3.

**Table 3: DARZALEX FASPRO® dosing schedule in combination with bortezomib, lenalidomide and dexamethasone ([VRd]; 4-week cycle dosing regimen)**

| Treatment phase | Weeks | Schedule |
|---|---|---|



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

| | | |
|---|---|---|
| Induction | Weeks 1 to 8 | weekly (total of 8 doses) |
| | Weeks 9 to 16[a] | every two weeks (total of 4 doses) |
| Stop for high dose chemotherapy and ASCT | | |
| Consolidation | Weeks 17 to 24[b] | every two weeks (total of 4 doses) |
| Maintenance | Week 25 onwards until disease progression[c] | every four weeks |

[a] First dose of the every-2-week dosing schedule is given at week 9.
[b] Week 17 corresponds to re-initiation of treatment following recovery from ASCT.
[c] DARZALEX FASPRO® can be discontinued for patients who have achieved MRD negativity that is sustained for 12 months and have been treated on maintenance for at least 24 months.

Dexamethasone should be administered at 40 mg on days 1-4 and days 9-12 of each 28-day cycle during induction and consolidation (cycles 1-6).

For dose and schedule of medicinal products administered with DARZALEX FASPRO® solution for subcutaneous injection, see section 5.1 and the corresponding Summary of Product Characteristics.

*Dosing schedule in combination with bortezomib, lenalidomide and dexamethasone (3-week cycle regimens) for treatment of newly diagnosed patients who are ineligible for ASCT*

The recommended dose is 1800 mg of DARZALEX solution for subcutaneous injection administered over approximately 3-5 minutes according to the following dosing schedule in table 4.

**Table 4: DARZALEX dosing schedule in combination with bortezomib, lenalidomide and dexamethasone ([VRd]; 3-week cycle dosing regimen)**

| **Weeks** | **Schedule** |
|---|---|
| Weeks 1 to 6 | weekly (total of 6 doses) |
| Weeks 7 to 24[a] | every three weeks (total of 6 doses) |
| Week 25 onwards until disease progression[b] | every four weeks |

[a] First dose of the every-3-week dosing schedule is given at week 7.
[b] First dose of the every-4-week dosing schedule is given at week 25.

Dexamethasone should be administered at 20 mg on days 1, 2, 4, 5, 8, 9, 11, and 12 of each 21-day cycle of cycles 1-8. For patients > 75 years or underweight (BMI < 18.5), dexamethasone may be administered at 20 mg on days 1, 4, 8, and 11. During cycle 9 and beyond, dexamethasone should be administered at 40 mg (or at 20 mg for patients > 75 years or with a BMI < 18.5) on days 1, 8, 15, and 22 of each 28 day (4 week) cycle.

For dose and schedule of medicinal products administered with DARZALEX solution for subcutaneous injection, see section 5.1 and the corresponding Summary of Product Characteristics.

*Dosing schedule in combination with bortezomib and dexamethasone (3-week cycle regimen)*

The recommended dose is 1800 mg of DARZALEX FASPRO® solution for subcutaneous injection administered over approximately 3-5 minutes according to the following dosing schedule in table 5.

**Table 5: DARZALEX FASPRO® dosing schedule in combination with bortezomib and dexamethasone (Vd) (3-week cycle dosing regimen)**

| **Weeks** | **Schedule** |
|---|---|
| Weeks 1 to 9 | weekly (total of 9 doses) |
| Weeks 10 to 24[a] | every three weeks (total of 5 doses) |
| Week 25 onwards until disease progression[b] | every four weeks |

[a] First dose of the every-3-week dosing schedule is given at week 10.
[b] First dose of the every-4-week dosing schedule is given at week 25.

Dexamethasone should be administered at 20 mg on days 1, 2, 4, 5, 8, 9, 11 and 12 of the first 8 bortezomib treatment cycles or a reduced dose of 20 mg/week for patients > 75 years, underweight (BMI < 18.5), poorly controlled diabetes mellitus or prior intolerance to steroid therapy.

For dose and schedule of medicinal products administered with DARZALEX FASPRO® solution for subcutaneous injection, see section 5.1 and the corresponding Summary of Product Characteristics.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

*AL amyloidosis*
*Dosing schedule in combination with bortezomib, cyclophosphamide and dexamethasone (4-week cycle regimens)*

The recommended dose is 1800 mg of DARZALEX FASPRO® solution for subcutaneous injection administered over approximately 3-5 minutes according to the following dosing schedule in table 6.

**Table 6: DARZALEX FASPRO® dosing schedule for AL amyloidosis in combination with bortezomib, cyclophosphamide and dexamethasone ([VCd];4-week cycle dosing regimen)[a]**

| Weeks | Schedule |
|---|---|
| Weeks 1 to 8 | weekly (total of 8 doses) |
| Weeks 9 to 24[b] | every two weeks (total of 8 doses) |
| Week 25 onwards until disease progression[c] | every four weeks |

[a] In the clinical study, DARZALEX FASPRO® was given until disease progression or a maximum of 24 cycles (~ 2 years) from the first dose of study treatment.
[b] First dose of the every-2-week dosing schedule is given at week 9.
[c] First dose of the every-4-week dosing schedule is given at week 25.

For dose and schedule of medicinal products administered with DARZALEX FASPRO® solution for subcutaneous injection, see section 5.1 and the corresponding Summary of Product Characteristics.

*Missed dose*
If a planned dose of DARZALEX FASPRO® is missed, the dose should be administered as soon as possible and the dosing schedule should be adjusted accordingly, maintaining the treatment interval.

*Dose modifications*
No dose reductions of DARZALEX FASPRO® are recommended. Dose delay may be required to allow recovery of blood cell counts in the event of haematological toxicity (see section 4.4). For information concerning medicinal products given in combination with DARZALEX FASPRO®, see corresponding Summary of Product Characteristics.

In clinical studies, no modification to rate or dose of DARZALEX FASPRO® solution for subcutaneous injection was required to manage IRRs.

Recommended concomitant medicinal products

*Pre-injection medicinal product*
Pre-injection medicinal products (oral or intravenous) should be administered to reduce the risk of IRRs to all patients 1-3 hours prior to every administration of DARZALEX FASPRO® solution for subcutaneous injection as follows:

- Corticosteroid (long-acting or intermediate-acting)
  - Monotherapy:
    Methylprednisolone 100 mg, or equivalent. Following the second injection, the dose of corticosteroid may be reduced to methylprednisolone 60 mg.
  - Combination therapy:
    Dexamethasone 20 mg (or equivalent), administered prior to every DARZALEX FASPRO® solution for subcutaneous injection. When dexamethasone is the background-regimen specific corticosteroid, the dexamethasone treatment dose will instead serve as pre-injection medicinal product on DARZALEX FASPRO® administration days (see section 5.1). Additional background regimen specific corticosteroids (e.g. prednisone) should not be taken on DARZALEX FASPRO® administration days when patients have received dexamethasone (or equivalent) as a pre-injection medicinal product.
- Antipyretics (paracetamol 650 to 1000 mg).
- Antihistamine (oral or intravenous diphenhydramine 25 to 50 mg or equivalent).

*Post-injection medicinal product*
Post-injection medicinal products should be administered to reduce the risk of delayed IRRs as follows:

- Monotherapy:
  Oral corticosteroid (20 mg methylprednisolone or equivalent dose of an intermediate-acting or long-acting corticosteroid in accordance with local standards) should be administered on each of the two days following all injections (beginning the day after the injection).


DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

- Combination therapy:
  Consider administering low-dose oral methylprednisolone (≤ 20 mg) or equivalent the day after the DARZALEX FASPRO® injection. However, if a background regimen specific corticosteroid (e.g. dexamethasone, prednisone) is administered the day after the DARZALEX FASPRO® injection, additional post-injection medicinal products may not be needed (see section 5.1).

If the patient experiences no major IRRs after the first three injections, post-injection corticosteroids (excluding any background regimen corticosteroids) may be discontinued.

Additionally, for patients with a history of chronic obstructive pulmonary disease, the use of post-injection medicinal products including short and long acting bronchodilators, and inhaled corticosteroids should be considered. Following the first four injections, if the patient experiences no major IRRs, these inhaled post-injection medicinal products may be discontinued at the discretion of the physician.

*Prophylaxis for herpes zoster virus reactivation*
Anti-viral prophylaxis should be considered for the prevention of herpes zoster virus reactivation.

Special populations

*Renal impairment*
No formal studies of daratumumab in patients with renal impairment have been conducted. Based on population pharmacokinetic (PK) analyses no dose adjustment is necessary for patients with renal impairment (see section 5.2).

*Hepatic impairment*
No formal studies of daratumumab in patients with hepatic impairment have been conducted.
No dose adjustments are necessary for patients with hepatic impairment (see section 5.2).

*Elderly*
No dose adjustments are considered necessary (see section 5.2).

*Paediatric population*
The safety and efficacy of DARZALEX FASPRO® in children aged below 18 years of age have not been established.
No data are available.

*Body weight (> 120 kg)*
Limited number of patients with body weight > 120 kg have been studied using flat-dose (1800 mg) DARZALEX FASPRO® solution for subcutaneous injection and efficacy in these patients has not been established. No dose adjustment based on body weight can currently be recommended (see sections 4.4 and 5.2).

Method of administration

DARZALEX FASPRO® subcutaneous formulation is not intended for intravenous administration and should be given by subcutaneous injection only, using the doses specified. See section 6.6 for special precautions prior to administration.

To avoid needle clogging, attach the hypodermic injection needle or subcutaneous infusion set to the syringe immediately prior to injection.

**Inject 15 mL DARZALEX FASPRO® solution for subcutaneous injection into the subcutaneous tissue of the abdomen approximately 7.5 cm to the right or left of the navel over approximately 3-5 minutes.** Do not inject DARZALEX FASPRO® solution for subcutaneous injection at other sites of the body as no data are available.
Injection sites should be rotated for successive injections.

DARZALEX FASPRO® solution for subcutaneous injection should never be injected into areas where the skin is red, bruised, tender, hard or areas where there are scars.

Pause or slow down delivery rate if the patient experiences pain. In the event pain is not alleviated by slowing down the injection, a second injection site may be chosen on the opposite side of the abdomen to deliver the remainder of the dose.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

During treatment with DARZALEX FASPRO® solution for subcutaneous injection, do not administer other medicinal products for subcutaneous use at the same site as DARZALEX FASPRO®.

## 4.3 Contraindications

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

## 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.

Infusion-related reactions

DARZALEX FASPRO® solution for subcutaneous injection can cause severe and/or serious IRRs, including anaphylactic reactions. In clinical studies, approximately 7% (102/1380) of patients experienced an IRR. Most IRRs occurred following the first injection and were grade 1-2. IRRs occurring with subsequent injections were seen in 1% of patients (see section 4.8).

The median time to onset of IRRs following DARZALEX FASPRO® injection was 2.9 hours (range 0.08-83 hours). The majority of IRRs occurred on the day of treatment. Delayed IRRs have occurred in 1% of patients.

Signs and symptoms of IRRs may include respiratory symptoms, such as nasal congestion, cough, throat irritation, allergic rhinitis, wheezing as well as pyrexia, chest pain, pruritus, chills, vomiting, nausea, hypotension and blurred vision. Severe reactions have occurred, including bronchospasm, hypoxia, dyspnoea, hypertension, tachycardia and ocular adverse reactions (including choroidal effusion, acute myopia and acute angle closure glaucoma) (see section 4.8).

Patients should be pre-medicated with antihistamines, antipyretics, and corticosteroids as well as monitored and counselled regarding IRRs, especially during and following the first and second injections. If an anaphylactic reaction or life-threatening (grade 4) reactions occur, appropriate emergency care should be initiated immediately. DARZALEX FASPRO® therapy should be discontinued immediately and permanently (see sections 4.2 and 4.3).

To reduce the risk of delayed IRRs, oral corticosteroids should be administered to all patients following DARZALEX FASPRO® injection (see section 4.2). Patients with a history of chronic obstructive pulmonary disease may require additional post-injection medicinal products to manage respiratory complications. The use of post-injection medicinal products (e.g. short- and long-acting bronchodilators and inhaled corticosteroids) should be considered for patients with chronic obstructive pulmonary disease. If ocular symptoms occur, interrupt DARZALEX FASPRO® and seek immediate ophthalmologic evaluation prior to restarting DARZALEX FASPRO® (see section 4.2).

Neutropenia/thrombocytopenia

DARZALEX FASPRO® may increase neutropenia and thrombocytopenia induced by background therapy (see section 4.8).
Complete blood cell counts should be monitored periodically during treatment according to manufacturer's prescribing information for background therapies. Patients with neutropenia should be monitored for signs of infection. DARZALEX FASPRO® delay may be required to allow recovery of blood cell counts. In lower body weight patients receiving DARZALEX FASPRO® subcutaneous formulation, higher rates of neutropenia were observed; however, this was not associated with higher rates of serious infections. No dose reduction of DARZALEX FASPRO® is recommended. Consider supportive care with transfusions or growth factors.

Interference with indirect antiglobulin test (indirect Coombs test)

Daratumumab binds to CD38 found at low levels on red blood cells (RBCs) and may result in a positive indirect Coombs test. Daratumumab-mediated positive indirect Coombs test may persist for up to 6 months after the last daratumumab administration. It should be recognised that daratumumab bound to RBCs may mask detection of antibodies to minor antigens in the patient's serum. The determination of a patient's ABO and Rh blood type are not impacted.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

Patients should be typed and screened prior to starting daratumumab treatment. Phenotyping may be considered prior to starting daratumumab treatment as per local practice. Red blood cell genotyping is not impacted by daratumumab and may be performed at any time.

In the event of a planned transfusion blood transfusion centres should be notified of this interference with indirect antiglobulin tests (see section 4.5). If an emergency transfusion is required, non-cross-matched ABO/RhD-compatible RBCs can be given per local blood bank practices.

Interference with determination of complete response

Daratumumab is a human IgG kappa monoclonal antibody that can be detected on both, the serum protein electrophoresis (SPE) and immunofixation (IFE) assays used for the clinical monitoring of endogenous M-protein (see section 4.5). This interference can impact the determination of complete response and of disease progression in some patients with IgG kappa myeloma protein.

Hepatitis B virus (HBV) reactivation

Hepatitis B virus reactivation, in some cases fatal, has been reported in patients treated with DARZALEX FASPRO®. HBV screening should be performed in all patients before initiation of treatment with DARZALEX FASPRO®.
For patients with evidence of positive HBV serology, monitor for clinical and laboratory signs of HBV reactivation during, and for at least six months following the end of DARZALEX FASPRO® treatment. Manage patients according to current clinical guidelines. Consider consulting a hepatitis disease expert as clinically indicated.
In patients who develop reactivation of HBV while on DARZALEX FASPRO®, suspend treatment with DARZALEX FASPRO® and institute appropriate treatment. Resumption of DARZALEX FASPRO® treatment in patients whose HBV reactivation is adequately controlled should be discussed with physicians with expertise in managing HBV.

Body weight (> 120 kg)

There is a potential for reduced efficacy with DARZALEX FASPRO® solution for subcutaneous injection in patients with body weight > 120 kg (see sections 4.2 and 5.2).

Excipients

This medicinal product contains sorbitol (E420). Patients with hereditary fructose intolerance (HFI) should not be given this medicinal product.

This medicinal product also contains less than 1 mmol (23 mg) sodium per dose, that is to say essentially ‘sodium-free’.

## 4.5 Interaction with other medicinal products and other forms of interaction

No interaction studies have been performed.

As an IgG1κ monoclonal antibody, renal excretion and hepatic enzyme-mediated metabolism of intact daratumumab are unlikely to represent major elimination routes. As such, variations in drug-metabolising enzymes are not expected to affect the elimination of daratumumab. Due to the high affinity to a unique epitope on CD38, daratumumab is not anticipated to alter drug-metabolising enzymes.

Clinical pharmacokinetic assessments with daratumumab intravenous or subcutaneous formulations and lenalidomide, pomalidomide, thalidomide, bortezomib, melphalan, prednisone, carfilzomib, cyclophosphamide and dexamethasone indicated no clinically-relevant drug-drug interaction between daratumumab and these small molecule medicinal products.

Interference with indirect antiglobulin test (indirect Coombs test)

Daratumumab binds to CD38 on RBCs and interferes with compatibility testing, including antibody screening and cross matching (see section 4.4). Daratumumab interference mitigation methods include treating reagent RBCs with dithiothreitol (DTT) to disrupt daratumumab binding or other locally validated methods. Since the Kell blood group system is also sensitive to DTT treatment, Kell-negative units should be supplied after ruling



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

out or identifying alloantibodies using DTT-treated RBCs. Alternatively, phenotyping or genotyping may also be considered (see section 4.4).

Interference with serum protein electrophoresis and immunofixation tests

Daratumumab may be detected on serum protein electrophoresis (SPE) and immunofixation (IFE) assays used for monitoring disease monoclonal immunoglobulins (M protein). This can lead to false positive SPE and IFE assay results for patients with IgG kappa myeloma protein impacting initial assessment of complete responses by International Myeloma Working Group (IMWG) criteria. In patients with persistent very good partial response, where daratumumab interference is suspected, consider using a validated daratumumab-specific IFE assay to distinguish daratumumab from any remaining endogenous M protein in the patient's serum, to facilitate determination of a complete response.

## 4.6 Fertility, pregnancy and lactation

Women of child-bearing potential/contraception

Women of child-bearing potential should use effective contraception during, and for 3 months after cessation of daratumumab treatment.

Pregnancy

There are no or limited amount of data from the use of daratumumab in pregnant women. Animal studies are insufficient with respect to reproductive toxicity (see section 5.3). DARZALEX FASPRO® is not recommended during pregnancy and in women of childbearing potential not using contraception.

Breast-feeding

It is unknown whether daratumumab is excreted in human milk.
A risk to newborns/infants cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from DARZALEX FASPRO® therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman.

Fertility

No data are available to determine potential effects of daratumumab on fertility in males or females (see section 5.3).

## 4.7 Effects on ability to drive and use machines

DARZALEX FASPRO® has no or negligible influence on the ability to drive and use machines. However, fatigue has been reported in patients taking daratumumab and this should be taken into account when driving or using machines.

## 4.8 Undesirable effects

Summary of the safety profile

The most frequent adverse reactions of any grade (≥ 20% patients) with daratumumab (either intravenous or subcutaneous formulations) when administered either as monotherapy or combination treatment were IRRs, fatigue, nausea, diarrhoea, constipation, pyrexia, cough, neutropenia, thrombocytopenia, anaemia, oedema peripheral, peripheral neuropathy, upper respiratory tract infection, musculoskeletal pain and COVID-19. Serious adverse reactions were pneumonia, bronchitis, upper respiratory tract infection, sepsis, pulmonary oedema, influenza, pyrexia, dehydration, diarrhoea, atrial fibrillation and syncope.

The safety profile of the DARZALEX FASPRO® subcutaneous formulation was similar to that of intravenous formulation with the exception of a lower rate of IRRs. In the phase III study MMY3012, neutropenia was the only adverse reaction reported at ≥ 5% higher frequency for DARZALEX FASPRO® subcutaneous formulation compared to intravenous daratumumab (grade 3 or 4: 13% vs 8%, respectively).



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

Tabulated list of adverse reactions

Table 7 summarises the adverse reactions that occurred in patients receiving DARZALEX FASPRO® subcutaneous formulation or intravenous formulation of daratumumab.

The data reflects exposure to DARZALEX FASPRO® subcutaneous formulation (1800 mg) in 1187 patients with multiple myeloma (MM). The data includes 260 patients from a phase III active-controlled study (MMY3012) who received DARZALEX FASPRO® solution for subcutaneous injection as monotherapy, 149 patients from a phase III active-controlled study (MMY3013) who received DARZALEX FASPRO® subcutaneous formulation in combination with pomalidomide and dexamethasone (D-Pd), 351 patients from a phase III active-controlled study (MMY3014) who received DARZALEX FASPRO® subcutaneous formulation in combination with bortezomib, lenalidomide and dexamethasone (D-VRd), and 197 newly diagnosed multiple myeloma patients for whom transplant was not planned as initial therapy or who were ineligible for transplant from a phase III active-controlled study (MMY3019) who received DARZALEX FASPRO® subcutaneous formulation in combination with bortezomib, lenalidomide and dexamethasone (D-VRd). The data also reflects three open-label, clinical studies in which patients received DARZALEX FASPRO® solution for subcutaneous injection either as monotherapy (N=31, MMY1004 and MMY1008) and MMY2040 in which patients received DARZALEX FASPRO® solution for subcutaneous injection in combination with either bortezomib, melphalan and prednisone (D-VMP, n=67), lenalidomide and dexamethasone (D-Rd, n=65) or bortezomib, lenalidomide and dexamethasone (D-VRd, n=67). Additionally, data reflect exposure to 193 patients with newly diagnosed AL amyloidosis from a phase III active-controlled study (AMY3001) in which patients received DARZALEX FASPRO® subcutaneous formulation in combination with bortezomib, cyclophosphamide and dexamethasone (D-VCd).

The safety data also reflects exposure to intravenous daratumumab (16 mg/kg) in 2324 patients with multiple myeloma including 1910 patients who received intravenous daratumumab in combination with background regimens and 414 patients who received intravenous daratumumab as monotherapy. Post-marketing adverse reactions are also included.

Frequencies are defined as very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1000 to < 1/100), rare (≥ 1/10000 to < 1/1000) and very rare (< 1/10000).

**Table 7: Adverse reactions in multiple myeloma and AL amyloidosis patients treated with intravenous daratumumab or subcutaneous daratumumab**

| System organ class | Adverse reaction | Frequency | Incidence (%) | |
|---|---|---|---|---|
| | | | Any grade | Grade 3-4 |
| **Infections and infestations** | Upper respiratory tract infection[a] | Very common | 45 | 3 |
| | COVID-19[a, g] | | 26 | 7 |
| | Pneumonia[a] | | 19 | 11 |
| | Bronchitis[a] | | 14 | 1 |
| | Urinary tract infection | Common | 8 | 1 |
| | | | | |
| | Sepsis[a] | | 4 | 4 |
| | Cytomegalovirus infection[a] | Uncommon | < 1 | < 1[#] |
| | Hepatitis B Virus reactivation[a] | | < 1 | < 1 |
| **Blood and lymphatic system disorders** | Neutropenia[a] | Very common | 43 | 37 |
| | Thrombocytopenia[a] | | 32 | 19 |
| | Anaemia[a] | | 27 | 11 |
| | Lymphopenia[a] | | 13 | 10 |
| | Leukopenia[a] | | 11 | 6 |
| **Immune system disorders** | Hypogammaglobulinemia[a] | Common | 3 | < 1[#] |
| | Anaphylactic reaction[b] | Rare | - | - |
| **Metabolism and nutrition disorders** | Hypokalaemia[a] | Very common | 11 | 3 |
| | Decreased appetite | | 10 | 1 |
| | Hyperglycaemia | Common | 7 | 3 |
| | Hypocalcaemia | | 6 | 1 |
| | Dehydration | | 2 | 1[#] |
| **Psychiatric disorders** | Insomnia | Very common | 17 | 1[#] |
| **Nervous system disorders** | Peripheral neuropathy | Very common | 33 | 4 |
| | Headache | | 10 | < 1[#] |



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

| | | | | |
|---|---|---|---|---|
| | Dizziness | Common | 9 | < 1[#] |
| | Paraesthesia | | 9 | < 1 |
| | Syncope | | 3 | 2[#] |
| **Cardiac disorders** | Atrial fibrillation | Common | 4 | 1 |
| **Vascular disorders** | Hypertension[a] | Common | 9 | 4 |
| **Respiratory, thoracic and mediastinal disorders** | Cough[a] | Very common | 22 | < 1[#] |
| | Dyspnoea[a] | | 18 | 2 |
| | Pulmonary oedema[a] | Common | 1 | < 1 |
| **Gastrointestinal disorders** | Diarrhoea | Very common | 33 | 5 |
| | Constipation | | 29 | 1 |
| | Nausea | | 22 | 1[#] |
| | Abdominal pain[a] | | 13 | 1 |
| | Vomiting | | 13 | 1[#] |
| | Pancreatitis[a] | Common | 1 | 1 |
| **Skin and subcutaneous tissue disorders** | Rash | Very common | 12 | 1[#] |
| | Pruritus | Common | 6 | < 1[#] |
| **Musculoskeletal and connective tissue disorders** | Musculoskeletal pain[a] | Very common | 35 | 3 |
| | Arthralgia | | 14 | 1 |
| | Muscle spasms | | 12 | < 1[#] |
| **General disorders and administration site conditions** | Fatigue | Very common | 24 | 4 |
| | Oedema peripheral[a] | | 24 | 1 |
| | Pyrexia | | 22 | 1 |
| | Asthenia | | 19 | 2 |
| | Chills | Common | 8 | < 1[#] |
| | Injection site reactions[d,e] | | 8 | 0 |
| **Injury, poisoning and procedural complications** | Infusion-related reactions[c] | | | |
| | Daratumumab intravenous[f] | Very common | 39 | 5 |
| | Daratumumab subcutaneous[e] | Common | 7 | 1 |

[#] No grade 4.

[a] Indicates a grouping of terms.

[b] Based on post-marketing adverse reactions.

[c] Infusion-related reactions includes terms determined by investigators as related to infusion/injection of daratumumab.

[d] Injection site reactions includes terms determined by investigators as related to injection of daratumumab.

[e] Frequency based on daratumumab subcutaneous studies only (N=1380).

[f] Frequency based on daratumumab intravenous studies only (N=2324).

[g] Incidence is based on a subset of patients who received at least one dose of study treatment on or after 01 February 2020 (the start of the COVID-19 pandemic) from studies MMY3003, MMY3006, MMY3008 and MMY3013, and all patients from studies MMY3014 and MMY3019 (N=984).

Note: Based on 3704 multiple myeloma and AL amyloidosis patients treated with daratumumab intravenous or daratumumab subcutaneous

Description of selected adverse reactions

*Infusion-related reactions (IRRs)*

In clinical studies (monotherapy and combination treatments; N=1380) with DARZALEX FASPRO® subcutaneous formulation, the incidence of any grade IRRs was 6.4% with the first injection of DARZALEX FASPRO® (1800 mg, week 1), 0.3% with the week 2 injection, and 1.2% with subsequent injections. Grades 3 and 4 IRRs were seen in 0.7% and 0.1% of patients, respectively.

Signs and symptoms of IRR may include respiratory symptoms, such as nasal congestion, cough, throat irritation, allergic rhinitis, wheezing as well as pyrexia, chest pain, pruritus, chills, vomiting, nausea, blurred vision and hypotension. Severe reactions have occurred, including bronchospasm, hypoxia, dyspnoea, hypertension, tachycardia and ocular adverse reactions (including choroidal effusion, acute myopia and acute angle closure glaucoma) (see section 4.4).

*Injection site reactions (ISRs)*

In clinical studies (N=1380) with DARZALEX FASPRO® subcutaneous formulation, the incidence of any grade injection site reaction was 7.8%. There were no grade 3 or 4 ISRs. The most common (> 1%) ISR at the site of injection was erythema and rash.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

*Infections*
In patients with multiple myeloma receiving daratumumab as monotherapy, the overall incidence of infections was similar between DARZALEX FASPRO® subcutaneous formulation (52.9%) *versus* intravenous daratumumab groups (50.0%). Grade 3 or 4 infections also occurred at similar frequencies between DARZALEX FASPRO® subcutaneous formulation (11.7%) and intravenous daratumumab (14.3%). Most infections were manageable and rarely led to treatment discontinuation. Pneumonia was the most commonly reported grade 3 or 4 infection across studies. In active-controlled studies, discontinuations from treatment due to infections occurred in 1-4% of patients. Fatal infections were primarily due to pneumonia and sepsis.

In patients with multiple myeloma receiving intravenous daratumumab combination therapy, the following were reported:
Grade 3 or 4 infections:
Relapsed/refractory patient studies: DVd: 21%, Vd: 19%; DRd: 28%, Rd: 23%; DPd: 28%
Newly diagnosed patient studies: D-VMP: 23%, VMP: 15%; DRd: 32%, Rd: 23%.
Grade 5 (fatal) infections:
Relapsed/refractory patient studies: DVd: 1%, Vd: 2%; DRd: 2%, Rd: 1%; DPd: 2%
Newly diagnosed patient studies: D-VMP: 1%, VMP: 1%; DRd: 2%, Rd: 2%.

In patients with multiple myeloma receiving DARZALEX FASPRO® subcutaneous formulation combination therapy, the following were reported:
Grade 3 or 4 infections: DPd: 28%, Pd: 23%; D-VRd (transplant eligible): 35%, VRd (transplant eligible): 27%; D-VRd (transplant ineligible):40%, VRd (transplant ineligible): 32%
Grade 5 (fatal) infections: DPd: 5%, Pd: 3%; D-VRd (transplant eligible): 2%, VRd (transplant eligible): 3%; D-VRd (transplant ineligible):8%, VRd (transplant ineligible): 6%
Key: D=daratumumab; Vd=bortezomib-dexamethasone; Rd=lenalidomide-dexamethasone; Pd=pomalidomide-dexamethasone; VMP=bortezomib-melphalan-prednisone; VRd=bortezomib-lenalidomide-dexamethasone.

In patients with AL amyloidosis receiving DARZALEX FASPRO® subcutaneous formulation combination therapy, the following were reported:
Grade 3 or 4 infections: D-VCd: 17%, VCd:10%
Grade 5 infections: D-VCd: 1%, VCd: 1%
Key: D=daratumumab; VCd=bortezomib-cyclophosphamide-dexamethasone

*Haemolysis*
There is a theoretical risk of haemolysis. Continuous monitoring for this safety signal will be performed in clinical studies and post-marketing safety data.

*Cardiac disorders and AL amyloidosis-related cardiomyopathy*
The majority of patients in AMY3001 had AL amyloidosis-related cardiomyopathy at baseline (D-VCd 72% *vs*. VCd 71%). Grade 3 or 4 cardiac disorders occurred in 11% of D-VCd patients compared to 10% of VCd patients, while serious cardiac disorders occurred in 16% *vs*. 13% of D-VCd and VCd patients, respectively. Serious cardiac disorders occurring in ≥ 2% of patients included cardiac failure (D-VCd 6.2% *vs*. VCd 4.3%), cardiac arrest (D-VCd 3.6% *vs*. VCd 1.6%) and atrial fibrillation (D-VCd 2.1% *vs*. VCd 1.1%). All D-VCd patients who experienced serious or fatal cardiac disorders had AL amyloidosis-related cardiomyopathy at baseline. The longer median duration of treatment in the D-VCd arm compared to the VCd arm (9.6 months *vs*. 5.3 months, respectively) should be taken into consideration when comparing the frequency of cardiac disorders between the two treatment groups. Exposure-adjusted incidence rates (number of patients with the event per 100 patient-months at risk) of overall grade 3 or 4 cardiac disorders (1.2 *vs*. 2.3), cardiac failure (0.5 *vs*. 0.6), cardiac arrest (0.1 *vs*. 0.0) and atrial fibrillation (0.2 *vs*. 0.1) were comparable in the D-VCd arm *vs*. the VCd arm, respectively.

With a median follow-up of 11.4 months, overall deaths (D-VCd 14% *vs*. VCd 15%) in study AMY3001 were primarily due to AL amyloidosis-related cardiomyopathy in both treatment arms.

Other special populations

In the phase III study MMY3007, which compared treatment with D-VMP to treatment with VMP in patients with newly diagnosed multiple myeloma who are ineligible for autologous stem cell transplant, safety analysis of the subgroup of patients with an ECOG performance score of 2 (D-VMP: n=89, VMP: n=84), was consistent with the overall population (see section 5.1).


DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

*Elderly patients*
Of the 4238 patients who received daratumumab (n=1422 subcutaneous; n=2816 intravenous) at the recommended dose, 38% were 65 to less than 75 years of age, and 15% were 75 years of age or older. No overall differences in effectiveness were observed based on age. The incidence of serious adverse reactions was higher in older than in younger patients. Among patients with relapsed and refractory multiple myeloma (n=1976), the most common serious adverse reactions that occurred more frequently in elderly (≥ 65 years of age) were pneumonia and sepsis. Among patients with newly diagnosed multiple myeloma who were ineligible for autologous stem cell transplant (n=777), the most common serious adverse reaction that occurred more frequently in elderly (≥ 75 years of age) was pneumonia. Among patients with newly diagnosed multiple myeloma who were eligible for autologous stem cell transplant (n=351), the most common serious adverse reaction that occurred more frequently in elderly (≥ 65 years of age) was pneumonia. Among patients with newly diagnosed multiple myeloma for whom transplant was not planned as initial therapy or who were ineligible for autologous stem cell transplant (n=197), the most common serious adverse reaction that occurred more frequently in elderly (≥ 65 years of age) was pneumonia. Among patients with newly diagnosed AL amyloidosis (n=193), the most common serious adverse reaction that occurred more frequently in elderly (≥ 65 years of age) was pneumonia.

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 via the national reporting system.

Pusat Farmakovigilans/MESO Nasional
Direktorat Pengawasan Keamanan, Mutu, dan Ekspor Impor Obat, Narkotika, Psikotropika, Prekursor, dan Zat Adiktif
Badan Pengawas Obat dan Makanan Republik Indonesia
Address: Jl. Percetakan Negara No. 23, Jakarta Pusat, 10560
Email: pv-center@pom.go.id
Website: https://e-meso.pom.go.id/

### 4.9 Overdose

Symptoms and signs

There has been no experience of overdose in clinical studies.

Treatment

There is no known specific antidote for daratumumab overdose. In the event of an overdose, the patient should be monitored for any signs or symptoms of adverse reactions and appropriate symptomatic treatment should be instituted immediately.

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antineoplastic agents, monoclonal antibodies and antibody drug conjugates, CD38 (Clusters of Differentiation 38) inhibitors, ATC code: L01FC01.

DARZALEX FASPRO® solution for subcutaneous injection contains recombinant human hyaluronidase (rHuPH20). rHuPH20 works locally and transiently to degrade hyaluronan ((HA), a naturally occurring glycoaminoglycan found throughout the body) in the extracellular matrix of the subcutaneous space by cleaving the linkage between the two sugars (N-acetylglucosamine and glucuronic acid) which comprise HA. rHuPH20 has a half-life in skin of less than 30 minutes. Hyaluronan levels in subcutaneous tissue return to normal within 24 to 48 hours because of the rapid biosynthesis of hyaluronan.

Mechanism of action

Daratumumab is an IgG1κ human monoclonal antibody (mAb) that binds to the CD38 protein expressed on the surface of cells in a variety of haematological malignancies, including clonal plasma cells in multiple myeloma


DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

and AL amyloidosis, as well as other cell types and tissues. CD38 protein has multiple functions such as receptor mediated adhesion, signalling and enzymatic activity.

Daratumumab has been shown to potently inhibit the *in vivo* growth of CD38-expressing tumour cells. Based on *in vitro* studies, daratumumab may utilise multiple effector functions, resulting in immune mediated tumour cell death. These studies suggest that daratumumab can induce tumour cell lysis through complement-dependent cytotoxicity, antibody-dependent cell-mediated cytotoxicity, and antibody-dependent cellular phagocytosis in malignancies expressing CD38. A subset of myeloid derived suppressor cells (CD38+MDSCs), regulatory T cells (CD38+$T_{regs}$) and B cells (CD38+$B_{regs}$) are decreased by daratumumab mediated cell lysis. T cells (CD3+, CD4+, and CD8+) are also known to express CD38 depending on the stage of development and the level of activation. Significant increases in CD4+ and CD8+ T cell absolute counts, and percentages of lymphocytes, were observed with daratumumab treatment in peripheral whole blood and bone marrow. In addition, T-cell receptor DNA sequencing verified that T-cell clonality was increased with daratumumab treatment, indicating immune modulatory effects that may contribute to clinical response.

Daratumumab induced apoptosis *in vitro* after Fc mediated cross-linking. In addition, daratumumab modulated CD38 enzymatic activity, inhibiting the cyclase enzyme activity and stimulating the hydrolase activity. The significance of these *in vitro* effects in a clinical setting, and the implications on tumour growth, are not well-understood.

Pharmacodynamic effects

*Natural killer (NK) cell and T-cell count*
NK cells are known to express high levels of CD38 and are susceptible to daratumumab mediated cell lysis. Decreases in absolute counts and percentages of total NK cells (CD16+CD56+) and activated (CD16+$CD56^{dim}$) NK cells in peripheral whole blood and bone marrow were observed with daratumumab treatment. However, baseline levels of NK cells did not show an association with clinical response.

Immunogenicity

In multiple myeloma and AL amyloidosis patients treated with subcutaneous daratumumab in monotherapy and combination clinical studies, less than 1% of patients developed treatment-emergent anti-daratumumab antibodies and 7 patients tested positive for neutralising antibodies.

In multiple myeloma and AL amyloidosis patients, the incidence of treatment-emergent non-neutralising anti-rHuPH20 antibodies was 8.9% (115/1298) in patients who received either monotherapy DARZALEX FASPRO® subcutaneous formulation or combination DARZALEX FASPRO® subcutaneous formulation and 1 patient tested positive for neutralising antibodies. The anti-rHuPH20 antibodies did not appear to impact daratumumab exposures. The clinical relevance of the development of anti-daratumumab or anti-rHuPH20 antibodies after treatment with DARZALEX FASPRO® subcutaneous formulation is not known.

Clinical experience of DARZALEX FASPRO® solution for subcutaneous injection (subcutaneous formulation)

*Monotherapy – relapsed/refractory multiple myeloma*
MMY3012, an open-label, randomised, phase III non-inferiority study, compared efficacy and safety of treatment with DARZALEX FASPRO® solution for subcutaneous injection (1800 mg) *vs*. intravenous (16 mg/kg) daratumumab in patients with relapsed or refractory multiple myeloma who had received at least 3 prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent (IMiD) or who were double-refractory to a PI and an IMiD. Treatment continued until unacceptable toxicity or disease progression.

A total of 522 patients were randomised: 263 to the DARZALEX FASPRO® subcutaneous formulation arm and 259 to the intravenous daratumumab arm. The baseline demographic and disease characteristics were similar between the two treatment groups. The median patient age was 67 years (range: 33-92 years), 55% were male and 78% were Caucasian. The median patient weight was 73 kg (range: 29 – 138 kg) Patients had received a median of 4 prior lines of therapy. A total of 51% of patients had prior autologous stem cell transplant (ASCT), 100% of patients were previously treated with both PI(s) and IMiD(s) and most patients were refractory to a prior systemic therapy, including both PI and IMiD (49%).

The study met its co-primary endpoints of overall response rate (ORR) by the IMWG response criteria (table 8) and maximum $C_{trough}$ at pre-dose cycle 3 day 1, (see section 5.2).



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

**Table 8: Key results from study MMY3012**

| | Subcutaneous daratumumab (N=263) | Intravenous daratumumab (N=259) |
|---|---|---|
| **Primary endpoint** | | |
| Overall response (sCR+CR+VGPR+PR), n (%)[a] | 108 (41.1%) | 96 (37.1%) |
| 95% CI (%) | (35.1%, 47.3%) | (31.2%, 43.3%) |
| Ratio of response rates (95% CI)[b] | | 1.11 (0.89, 1.37) |
| CR or better, n (%) | 5 (1.9%) | 7 (2.7%) |
| Very good partial response (VGPR) | 45 (17.1%) | 37 (14.3%) |
| Partial response (PR) | 58 (22.1%) | 52 (20.1%) |
| **Secondary endpoint** | | |
| Rate of infusion-related reaction, n (%)[c] | 33 (12.7%) | 89 (34.5%) |
| Progression-free survival, months | | |
| Median (95% CI) | 5.59 (4.67, 7.56) | 6.08 (4.67, 8.31) |
| Hazard ratio (95% CI) | | 0.99 (0.78, 1.26) |

[a] Based on intent-to-treat population.

[b] p-value < 0.0001 from Farrington-Manning test for non-inferiority hypothesis.

[c] Based on safety population. P-value< 0.0001 from Cochran-Mantel-Haenszel Chi-Squared test.

After a median follow-up of 29.3 months, the median OS was 28.2 months (95% CI: 22.8, NE) in the DARZALEX FASPRO® subcutaneous formulation arm and was 25.6 months (95% CI: 22.1, NE) in the intravenous daratumumab arm.

Safety and tolerability results, including in lower weight patients, were consistent with the known safety profile for DARZALEX FASPRO® subcutaneous formulation and intravenous daratumumab.

Results from the modified-CTSQ, a patient reported outcome questionnaire that assesses patient satisfaction with their therapy, demonstrated that patients receiving DARZALEX FASPRO® subcutaneous formulation had greater satisfaction with their therapy compared with patients receiving intravenous daratumumab. However, open-label studies are subject to bias.

*Combination therapies in multiple myeloma*

*Combination treatment with bortezomib, lenalidomide and dexamethasone (VRd) in patients with newly diagnosed multiple myeloma eligible for autologous stem cell transplant (ASCT)*
Study MMY3014 was an open-label, randomised, active-controlled phase III study that compared induction and consolidation treatment with DARZALEX FASPRO® subcutaneous formulation (1800 mg) in combination with bortezomib, lenalidomide and dexamethasone (D-VRd), followed by maintenance with DARZALEX FASPRO® in combination with lenalidomide, to treatment with bortezomib, lenalidomide and dexamethasone (VRd), followed by maintenance with lenalidomide, in patients 70 years of age and younger with newly diagnosed multiple myeloma eligible for ASCT until documented disease progression or unacceptable toxicity. An emergency short course of corticosteroid (equivalent of dexamethasone 40 mg/day for a maximum 4 days) was permitted before treatment. Patients received DARZALEX FASPRO® subcutaneous formulation (1800 mg) administered subcutaneously once weekly (days 1, 8, 15, and 22) for cycles 1-2 followed by once every two weeks (days 1 and 15) for cycles 3-6. For maintenance (cycles 7+), patients received DARZALEX FASPRO® subcutaneous formulation (1800 mg) once every four weeks. Patients who achieved MRD negativity that was sustained for 12 months and had been treated on maintenance for at least 24 months discontinued treatment with DARZALEX FASPRO® subcutaneous formulation (1800 mg). Bortezomib was administered by subcutaneous (SC) injection at a dose of 1.3 mg/m$^2$ body surface area twice weekly for two weeks (days 1, 4, 8, and 11) of repeated 28-day (4-week) cycles 1-6. Lenalidomide was administered orally at 25 mg daily on days 1 to 21 during cycles 1-6. For maintenance (cycles 7+), patients received 10 mg lenalidomide daily on days 1-28 (continuously) of each cycle until documented disease progression or unacceptable toxicity. Dexamethasone (oral or intravenous) was administered at 40 mg on days 1-4 and days 9-12 of cycles 1-6. On the days of DARZALEX FASPRO® subcutaneous formulation (1800 mg) injection, the dexamethasone dose was administered orally or intravenously as a pre-injection medicinal product. Dose adjustments for bortezomib, lenalidomide and dexamethasone were applied according to manufacturer's prescribing information.

A total of 709 patients were randomised: 355 to the D-VRd arm and 354 to the VRd arm. The baseline demographic and disease characteristics were similar between the two treatment groups. The median age was 60 (range: 31 to 70 years). The majority were male (59%), 64% had an ECOG performance score of 0, 31% had an ECOG performance score of 1 and 5% had an ECOG performance score of 2. Additionally, 51% had ISS stage I,

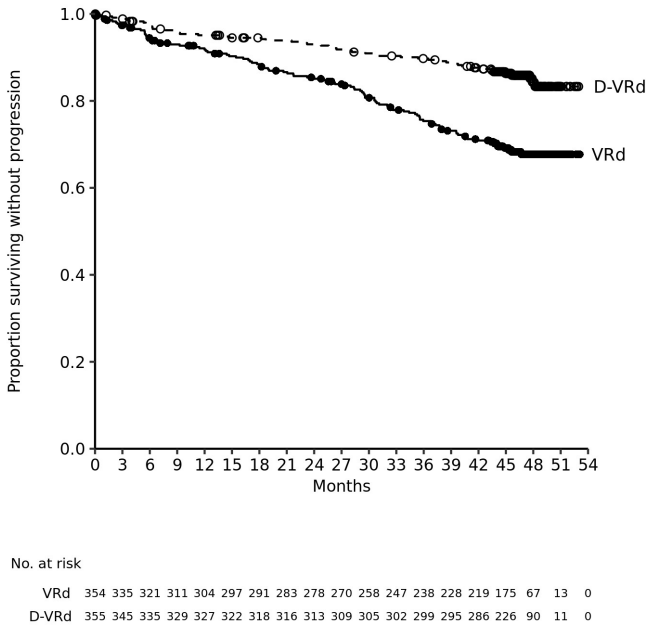


DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

34% had ISS stage II, 15% had ISS stage III disease, 75% had a standard cytogenetic risk, 22% had a high cytogenetic risk (del17p, t[4;14], t[14;16]), and 3% had an indeterminate cytogenetic risk.

With a median follow-up of 47.5 months, the primary analysis of PFS in study MMY3014 demonstrated an improvement in PFS in the D-VRd arm as compared to the VRd arm (HR=0.42; 95% CI: 0.30, 0.59; p<0.0001). The median PFS was not reached in either arm.

**Figure 1: Kaplan-Meier curve of PFS in study MMY3014**




Additional efficacy results from study MMY3014 are presented in table 9 below.

**Table 9: Efficacy results from study MMY3014[a]**

| | **D-VRd (n=355)** | **VRd (n=354)** | **Odds ratio (95% CI)[d]** |
|---|---|---|---|
| **Overall response (sCR+CR+VGPR+PR) n(%)[a]** | 343 (96.6%) | 332 (93.8%) | |
| Stringent complete response (sCR) | 246 (69.3%) | 158 (44.6%) | |
| Complete response (CR) | 66 (18.6%) | 90 (25.4%) | |
| Very good partial response (VGPR) | 26 (7.3%) | 68 (19.2%) | |
| Partial response (PR) | 5 (1.4%) | 16 (4.5%) | |
| CR or better (sCR+CR) | 312 (87.9%) | 248 (70.1%) | 3.13 (2.11, 4.65) |
| 95% CI (%) | (84.0%, 91.1%) | (65.0%, 74.8%) | |
| P-value[b] | | | < 0.0001 |
| **Overall MRD negativity rate[a,c]** | 267 (75.2%) | 168 (47.5%) | 3.40 (2.47, 4.69) |
| 95% CI (%) | (70.4%, 79.6%) | (42.2%, 52.8%) | |
| P-value[b] | | | < 0.0001 |

D-VRd=daratumumab-bortezomib-lenalidomide-dexamethasone; VRd=bortezomib-lenalidomide-dexamethasone; MRD=minimal residual disease; CI=confidence interval

[a] Based on intent-to-treat population

[b] p-value from Cochran Mantel-Haenszel Chi-Squared test

[c] Patients achieved both MRD negativity (threshold of $10^{-5}$) and CR or better

[d] Mantel-Haenszel estimate of the common odds ratio for stratified tables is used

*Combination treatment with bortezomib, lenalidomide and dexamethasone (VRd) in patients with newly diagnosed multiple myeloma for whom ASCT is not planned as initial therapy or who are ineligible for ASCT*
Study MMY3019 was an open-label, randomised, active-controlled phase III study that compared treatment with DARZALEX FASPRO® subcutaneous formulation (1800 mg) in combination with bortezomib, lenalidomide and dexamethasone (D-VRd) to treatment with bortezomib, lenalidomide and dexamethasone (VRd) in patients with newly diagnosed multiple myeloma for whom ASCT was not planned as initial therapy or who were not eligible for ASCT. An emergency short course of corticosteroid (equivalent of dexamethasone 40 mg/day for a



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maximum 4 days) was permitted before treatment. Patients received DARZALEX FASPRO® subcutaneous formulation (1800 mg) administered subcutaneously once weekly (days 1, 8, and 15) for cycles 1 to 2 followed by once every three weeks for cycles 3 to 8, and once every four weeks in cycle 9 and beyond until documented disease progression or unacceptable toxicity. Bortezomib was administered by subcutaneous injection at a dose of 1.3 mg/m$^2$ body surface area twice weekly (days 1, 4, 8, and 11) of repeated 21-day (3-week) cycles 1-8. Lenalidomide was administered orally at 25 mg daily on days 1 to 14 during cycles 1-8 and on days 1-21 during cycle 9 and beyond. Dexamethasone was administered orally at 20 mg on days 1, 2, 4, 5, 8, 9, 11, and 12 of each 21-day (3-week ) cycle during cycles 1-8 (or at 20 mg on days 1, 4, 8, and 11 for patients > 75 years or with a body mass index [BMI] <18.5) and at 40 mg on days 1, 8, 15, and 22 of each 28-day (4-week) cycle during cycle 9 and beyond (or at 20 mg weekly for patients > 75 years or with a BMI < 18.5). On the days of DARZALEX FASPRO® subcutaneous formulation (1800 mg) injection, the dexamethasone dose was administered orally or intravenously as a pre-injection medication. Dose adjustments for bortezomib, lenalidomide and dexamethasone were applied according to manufacturer's prescribing information.

A total of 395 patients were randomised: 197 to the D-VRd arm and 198 to the VRd arm. The baseline demographic and disease characteristics were similar between the two treatment groups. The median age was 70 (range: 31 to 80 years). Fifty percent were male, 39% had an ECOG performance score of 0, 51% had an ECOG performance score of 1 and 9% had an ECOG performance score of 2. Eighteen percent were less than 70 years of age and transplant ineligible and 27% were less than 70 years of age and were transplant deferred. Additionally, 34% had ISS stage I, 38% had ISS stage II, 28% had ISS stage III disease, 75% had a standard cytogenetic risk, 13% had a high cytogenetic risk (del17p, t[4;14], t[14;16]), and 11% had an indeterminate cytogenetic risk.

With a median follow-up of 22.3 months, the primary analysis of MRD in study MMY3019 demonstrated an improvement in overall MRD negativity rate (by NGS at or below $10^{-5}$) for patients reaching CR or better in the D-VRd arm as compared to the VRd arm. Overall MRD negativity rates were 53.3% (95% CI: 46.1, 60.4) in the D-VRd arm and 35.4% (95% CI: 28.7, 42.4) in the VRd arm (odds ratio [D-VRd versus VRd] 2.07 with 95% CI: 1.38, 3.10; p=0.0004).

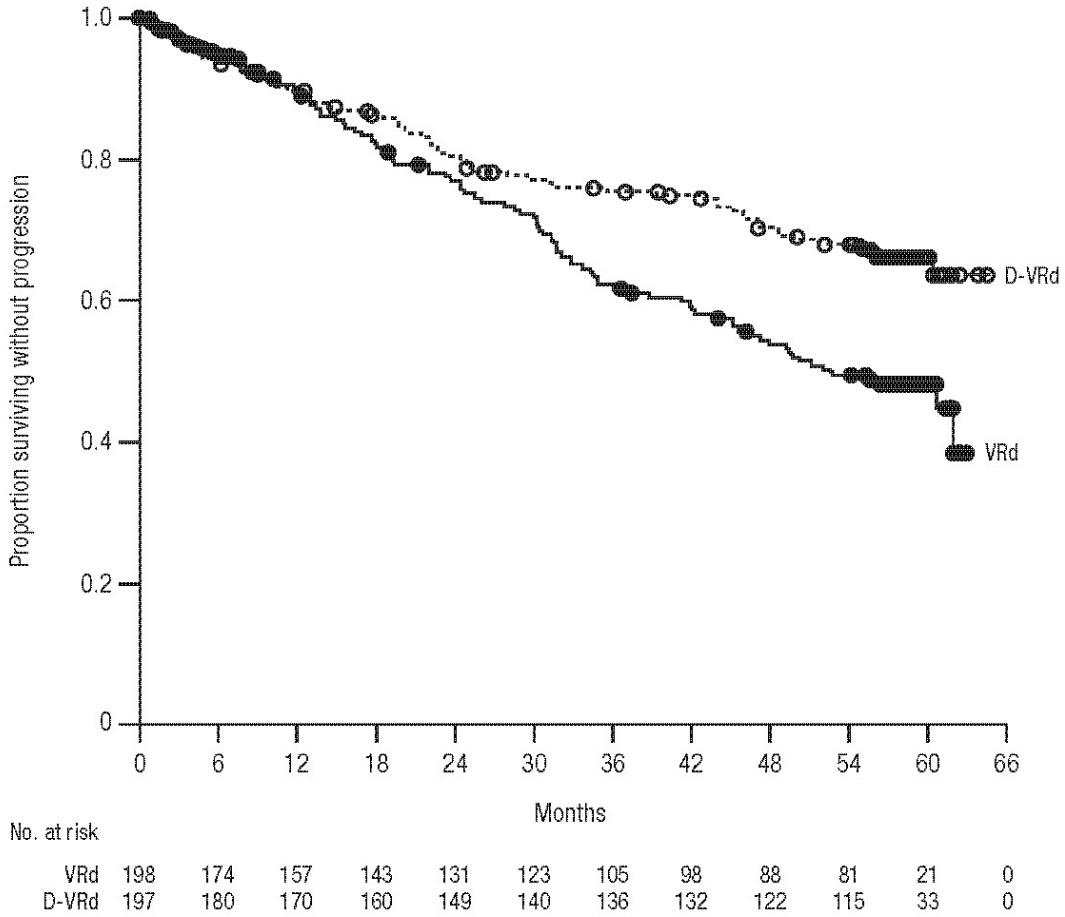
At the time of primary MRD analysis, an improvement in overall CR or better rate was observed in the D-VRd arm as compared to the VRd arm. Overall CR or better rates were 76.6% (95% CI: 70.1, 82.4) in the D-VRd arm and 59.1% (95% CI: 51.9, 66.0) in the VRd arm (odds ratio [D-VRd versus VRd] 2.31; 95% CI: 1.48, 3.60; p=0.0002).

With a median follow-up of 39 months, an interim analysis of PFS in Study MMY3019 demonstrated an improvement in PFS in the D-VRd arm as compared to the VRd arm (HR=0.61; 95% CI: 0.42, 0.90; p=0.0104). The median PFS had not been reached in either arm. With more mature PFS data at the final PFS analysis, treatment effect for PFS was improved with a hazard ratio of 0.57 (95% CI: 0.41, 0.79). The median PFS had not been reached in the D-VRd arm and was 52.6 months in the VRd arm.

**Figure 2: Kaplan-Meier curve of PFS at final analysis in study MMY3019**



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054




At the time of interim PFS analysis, an improvement in 1-year sustained MRD negativity rate (by NGS at or below $10^{-5}$) for patients reaching CR or better was observed in the D-VRd arm as compared to the VRd arm. Sustained MRD negativity rates were 42.6% (95% CI: 35.6, 49.9) in the D-VRd arm and 25.3% (95% CI: 19.4, 31.9) in the VRd arm (odds ratio [D-VRd versus VRd] 2.18 with 95% CI: 1.42, 3.34; p=0.0003).

Additional efficacy results from Study MMY3019 are presented in table 10 below.

**Table 10: Efficacy results from the final PFS analysis of study MMY3019[a]**

| | **D-VRd (n=197)** | **VRd (n=198)** |
|---|---|---|
| **Overall MRD negativity rate[b]** | 120 (60.9%) | 78 (39.4%) |
| Odds ratio (95% CI)[c] | 2.37 (1.58, 3.55) | |
| Sustained MRD negativity rate[d] | 96 (48.7%) | 52 (26.3%) |
| Odds ratio (95% CI)[c] | 2.63 (1.73, 4.00) | |
| Overall CR or better (sCR+CR) | 160 (81.2%) | 122 (61.6%) |
| Odds ratio (95% CI)[c] | 2.73 (1.71, 4.34) | |
| Overall response (sCR+CR+VGPR+PR) n (%)[a] | 191 (97.0%) | 184 (92.9%) |
| Stringent complete response (sCR) | 128 (65.0%) | 88 (44.4%) |
| Complete response (CR) | 32 (16.2%) | 34 (17.2%) |
| Very good partial response (VGPR) | 23 (11.7%) | 50 (25.3%) |
| Partial response (PR) | 8 (4.1%) | 12 (6.1%) |

D-VRd=daratumumab-bortezomib-lenalidomide-dexamethasone;
VRd=bortezomib-lenalidomide-dexamethasone; MRD=minimal residual disease; CI=confidence interval

[a] Based on intent-to-treat population, median follow-up of 59 months

[b] Patients achieved both MRD negativity (threshold of at or below $10^{-5}$) and CR or better

[c] Mantel-Haenszel estimate of the common ratio for stratified tables is used. The stratification factors are: ISS staging (I, II, III), age/transplant eligibility (< 70 years ineligible, or age< 70 years and refusal to transplant, or age ≥ 70 years) as randomised. An odds ratio > 1 indicates an advantage for D-VRd.

[d] Sustained MRD negativity is defined as MRD negative and confirmed by at least 1 year apart without MRD positive in between.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

*Combination therapies in multiple myeloma*
MMY2040 was an open-label study evaluating the efficacy and safety of DARZALEX FASPRO® subcutaneous formulation 1800 mg:

- in combination with bortezomib, melphalan, and prednisone (D-VMP) in patients with newly diagnosed multiple myeloma (MM) who are ineligible for transplant. Bortezomib was administered by subcutaneous injection at a dose of 1.3 mg/m$^2$ body surface area twice weekly at weeks 1, 2, 4 and 5 for the first 6-week cycle (cycle 1; 8 doses), followed by once weekly administrations at weeks 1, 2, 4 and 5 for eight more 6-week cycles (cycles 2-9; 4 doses per cycle). Melphalan at 9 mg/m$^2$, and prednisone at 60 mg/m$^2$ were orally administered on days 1 to 4 of the nine 6-week cycles (cycles 1-9). DARZALEX FASPRO® subcutaneous formulation was continued until disease progression or unacceptable toxicity.
- in combination with lenalidomide and dexamethasone (D-Rd) in patients with relapsed or refractory MM. Lenalidomide (25 mg once daily orally on days 1-21 of repeated 28-day [4-week] cycles) was given with low dose dexamethasone 40 mg/week (or a reduced dose of 20 mg/week for patients > 75 years or BMI < 18.5). DARZALEX FASPRO® subcutaneous formulation was continued until disease progression or unacceptable toxicity.
- in combination with bortezomib, lenalidomide, and dexamethasone (D-VRd) in patients with newly diagnosed MM who are transplant eligible. Bortezomib was administered by subcutaneous injection at a dose of 1.3 mg/m$^2$ body surface area twice weekly at weeks 1 and 2. Lenalidomide was administered orally at 25 mg once daily on days 1-14; low dose dexamethasone was administered 40 mg/week in 3-week cycles. Total treatment duration was 4 cycles.

A total of 199 patients (D-VMP: 67; D-Rd: 65; D-VRd: 67) were enrolled. Efficacy results were determined by computer algorithm using IMWG criteria. The study met its primary endpoint ORR for D-VMP and D-Rd and the primary endpoint VGPR or better for D-VRd (see table 11).

**Table 11: Efficacy results from study MMY2040**

| | **D-VMP (n=67)** | **D-Rd (n=65)** | **D-VRd (n=67)** |
|---|---|---|---|
| Overall response (sCR+CR+VGPR+PR), n (%)[a] | 60 (89.6%) | 61 (93.8%) | 65 (97.0%) |
| 90% CI(%) | (81.3%, 95.0%) | (86.5%, 97.9%) | (90.9%, 99.5%) |
| Stringent complete response (sCR) | 13 (19.4%) | 12 (18.5%) | 6 (9.0%) |
| Complete response (CR) | 19 (28.4%) | 13 (20.0%) | 5 (7.5%) |
| Very good partial response (VGPR) | 20 (29.9%) | 26 (40.0%) | 37 (55.2%) |
| Partial response (PR) | 8 (11.9%) | 10 (15.4%) | 17 (25.4%) |
| | | | |
| VGPR or better (sCR + CR + VGPR) | 52 (77.6%) | 51 (78.5%) | 48 (71.6%) |
| 90% CI(%) | (67.6%, 85.7%) | (68.4%, 86.5%) | (61.2%, 80.6%) |

D-VMP=Daratumumab-bortezomib-melphalan-prednisone; D-Rd=Daratumumab-lenalidomide-dexamethasone; D-VRd=Daratumumab-bortezomib-lenalidomide-dexamethasone; Daratumumab=DARAZALEX subcutaneous formulation; CI=confidence interval.

[a] Based on treated subjects.

*Combination treatment with pomalidomide and dexamethasone (Pd)*
Study MMY3013 was an open-label, randomised, active-controlled phase III study that compared treatment with DARZALEX FASPRO® subcutaneous formulation (1800 mg) in combination with pomalidomide and low-dose dexamethasone (D-Pd) to treatment with pomalidomide and low-dose dexamethasone (Pd) in patients with multiple myeloma who had received at least one prior line of therapy with lenalidomide and a proteasome inhibitor (PI). Pomalidomide (4 mg once daily orally on days 1-21 of repeated 28-day [4-week] cycles) was given with low dose oral or intravenous dexamethasone 40 mg/week (or a reduced dose of 20 mg/week for patients > 75 years). On DARZALEX FASPRO® subcutaneous formulation administration days, 20 mg of the dexamethasone dose was given as a pre-administration medicinal product and the remainder given the day after the administration. For patients on a reduced dexamethasone dose, the entire 20 mg dose was given as a DARZALEX FASPRO® subcutaneous formulation pre-administration medicinal product. Dose adjustments for pomalidomide and dexamethasone were applied according to manufacturer's prescribing information. Treatment was continued in both arms until disease progression or unacceptable toxicity.

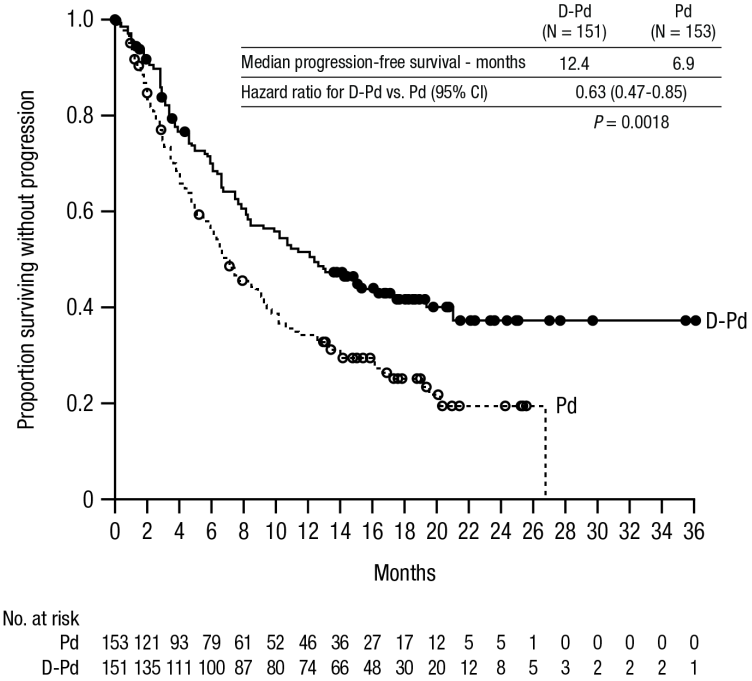
A total of 304 patients were randomised: 151 to the D-Pd arm and 153 to the Pd arm. Patients with documented evidence of disease progression on or after the last regimen were included in the study. Patients who had ≥ grade 3 rash during prior therapy were excluded as per the pomalidomide Summary of Product Characteristics. The baseline demographic and disease characteristics were similar between the two treatment groups. The median patient age was 67 years (range 35 to 90 years), 18% were ≥ 75 years, 53% were male, and 89%


DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

Caucasian. Patients had received a median of 2 prior lines of therapy. All patients received a prior treatment with a proteasome inhibitor (PI) and lenalidomide, and 56% of patients received prior stem cell transplantation (ASCT). Ninety-six percent (96%) of patients received prior treatment with bortezomib. The majority of patients were refractory to lenalidomide (80%), a PI (48%), or both an immunomodulator and a PI (42%). Eleven percent of patients received 1 prior line of therapy; all were refractory to lenalidomide and 32.4% were refractory to both lenalidomide and a PI. Efficacy was evaluated by progression free survival (PFS) based on International Myeloma Workin
g Group (IMWG) criteria.

With a median follow-up of 16.9 months, the primary analysis of PFS in study MMY3013 showed a statistically significant improvement in the D-Pd arm as compared to the Pd arm; the median PFS was 12.4 months in the D-Pd arm and 6.9 months in the Pd arm (HR [95% CI]: 0.63 [0.47, 0.85]; p-value = 0.0018), representing a 37% reduction in the risk of disease progression or death for patients treated with D-Pd *versus* Pd.

**Figure 3: Kaplan-Meier curve of PFS in study MMY3013**




An additional planned follow-up analysis of OS after a median follow-up of 39.6 months was performed. At OS maturity of 57%, the median OS was 34.4 months in the D-Pd arm and 23.7 months in the Pd arm (HR [95% CI]: 0.82 [0.61, 1.11]).

Additional efficacy results from study MMY3013 are presented in table 12 below.

**Table 12: Efficacy results from study MMY3013[a]**

| | **D-Pd (n=151)** | **Pd (n=153)** |
|---|---|---|
| **Overall response (sCR+CR+VGPR+PR) n(%)[a]** | 104 (68.9%) | 71 (46.4%) |
| P-value[b] | < 0.0001 | |
| Stringent complete response (sCR) | 14 (9.3%) | 2 (1.3%) |
| Complete response (CR) | 23 (15.2%) | 4 (2.6%) |
| Very good partial response (VGPR) | 40 (26.5%) | 24 (15.7%) |
| Partial response (PR) | 27 (17.9%) | 41 (26.8%) |
| **MRD negativity rate[c] n(%)** | 13 (8.7%) | 3 (2.0%) |
| 95% CI (%) | (4.7%, 14.3%) | (0.4%, 5.6%) |
| P-value[d] | 0.0102 | |

D-Pd=daratumumab-pomalidomide-dexamethasone; Pd=pomalidomide-dexamethasone; MRD=minimal residual disease; CI=confidence interval.

[a] Based on intent-to-treat population.

[b] p-value from Cochran Mantel-Haenszel Chi-Squared test adjusted for stratification factors.

[c] MRD Negative rate is based on the intent-to-treat population and a threshold of $10^{-5}$.

[d] p-value from Fisher's exact test.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

In responders, the median time to response was 1 month (range: 0.9 to 9.1 months) in the D-Pd group and 1.9 months (range: 0.9 to 17.3 months) in the Pd group. The median duration of response had not been reached in the D-Pd group (range: 1 to 34.9+ months) and was 15.9 months (range: 1+ to 24.8 months) in the Pd group.

*Combination treatment with bortezomib, cyclophosphamide and dexamethasone in patients with AL amyloidosis*
Study AMY3001, an open-label, randomised, active-controlled phase III study, compared treatment with DARZALEX FASPRO® subcutaneous formulation (1800 mg) in combination with bortezomib, cyclophosphamide and dexamethasone (D-VCd) to treatment with bortezomib, cyclophosphamide and dexamethasone (VCd) alone in patients with newly diagnosed systemic AL amyloidosis. Randomisation was stratified by AL amyloidosis Cardiac Staging System, countries that typically offer autologous stem cell transplant (ASCT) for patients with AL amyloidosis, and renal function.

All patients enrolled in study AMY3001 had newly diagnosed AL amyloidosis with at least one affected organ, measurable hematologic disease, cardiac stage I-IIIA (based on European Modification of Mayo 2004 cardiac stage), and NYHA class I-IIIA. Patients with NYHA class IIIB and IV were excluded.

Bortezomib (SC; 1.3 mg/m$^2$ body surface area), cyclophosphamide (oral or IV; 300 mg/m$^2$ body surface area; max dose 500 mg), and dexamethasone (oral or IV; 40 mg or a reduced dose of 20 mg for patients > 70 years or body mass index [BMI] < 18.5 or those who have hypervolemia, poorly controlled diabetes mellitus or prior intolerance to steroid therapy) were administered weekly on days 1, 8, 15, and 22 of repeated 28-day [4-week] cycles. On the days of DARZALEX FASPRO® dosing, 20 mg of the dexamethasone dose was given as a pre-injection medicinal product and the remainder given the day after DARZALEX FASPRO® administration. Bortezomib, cyclophosphamide and dexamethasone were given for six 28-day [4-week] cycles in both treatment arms, while DARZALEX FASPRO® treatment was continued until disease progression, start of subsequent therapy, or a maximum of 24 cycles (~2 years) from the first dose of study treatment. Dose adjustments for bortezomib, cyclophosphamide and dexamethasone were applied according to manufacturer's prescribing information.

A total of 388 patients were randomised: 195 to the D-VCd arm and 193 to the VCd arm. The baseline demographic and disease characteristics were similar between the two treatment groups. The majority (79%) of patients had lambda free light chain disease. The median patient age was 64 years (range: 34 to 87); 47% were ≥ 65 years; 58% were male; 76% Caucasian, 17% Asian, and 3% African American; 23% had AL amyloidosis Clinical Cardiac stage I, 40% had stage II, 35% had stage IIIA, and 2% had stage IIIB. All patients had one or more affected organs and the median number of organs involved was 2 (range: 1-6) and 66% of patients had 2 or more organs involved. Vital organ involvement was: 71% cardiac, 59% renal and 8% hepatic. Patients with grade 2 sensory or grade 1 painful peripheral neuropathy were excluded. The primary efficacy endpoint was hematologic complete response (HemCR) rate as determined by the Independent Review Committee assessment based on International Concensus Criteria. Study AMY3001 demonstrated an improvement in HemCR in the D-VCd arm as compared to the VCd arm. Efficacy results are summarised in table 13.

**Table 13: Efficacy results from study AMY3001[a]**

| | **D-VCd (n=195)** | **VCd (n=193)** | **P value** |
|---|---|---|---|
| Hematologic complete response (HemCR), n (%) | 104 (53.3%) | 35 (18.1%) | < 0.0001[b] |
| Very good partial response (VGPR), n (%) | 49 (25.1%) | 60 (31.1%) | |
| Partial response (PR), n (%) | 26 (13.3%) | 53 (27.5%) | |
| Hematologic VGPR or better (HemCR + VGPR), n (%) | 153 (78.5%) | 95 (49.2%) | < 0.0001[b] |
| Major organ deterioration progression-free survival (MOD-PFS), Hazard ratio with 95% CI[c] | 0.58 (0.36, 0.93) | | 0.0211[d] |

D-VCd=daratumumab-bortezomib-cyclophosphamide-dexamethasone; VCd=bortezomib-cyclophosphamide-dexamethasone.

[a] Based on intent-to-treat population.

[b] p-value from Cochran Mantel-Haenszel Chi-Squared test.

[c] MOD-PFS defined as hematologic progression, major organ (cardiac or renal) deterioration or death.

[d] Nominal p-value from inverse probability censoring weighted log-rank test.

In responders, the median time to HemCR was 60 days (range: 8 to 299 days) in the D-VCd group and 85 days (range: 14 to 340 days) in the VCd group. The median time to VGPR or better was 17 days (range: 5 to 336 days) in the D-VCd group and 25 days (range: 8 to 171 days) in the VCd group. The median duration of HemCR had not been reached in either arm.

The median follow-up for the study is 11.4 months. The median major organ deterioration progression-free survival (MOD-PFS) was not reached for patients in either arm.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

Overall survival (OS) data were not mature. A total of 56 deaths were observed [n=27 (13.8%) D-VCd *vs*. n=29 (15%) VCd group].

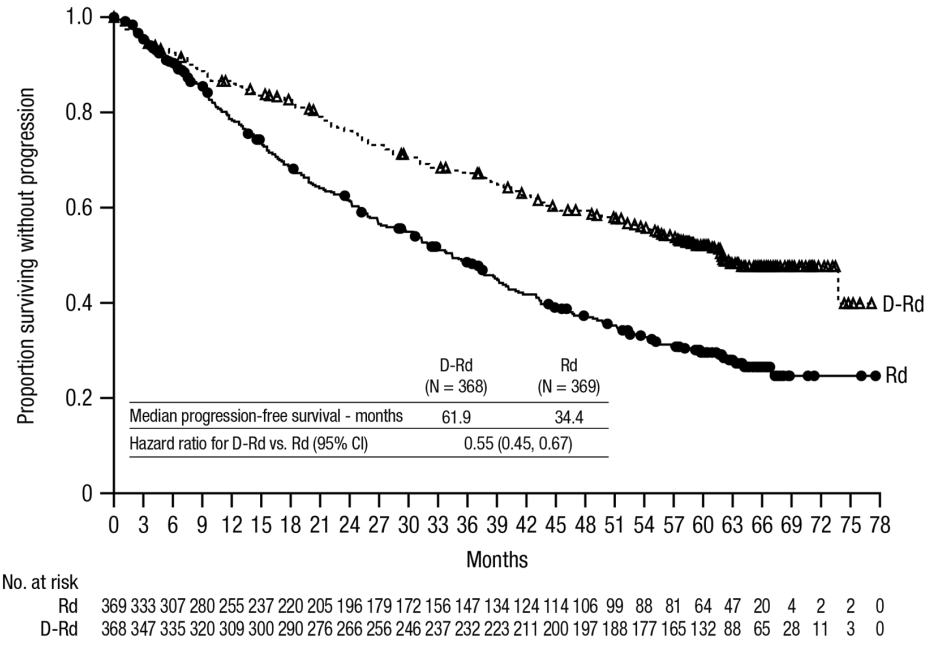
Clinical experience with daratumumab concentrate for solution for infusion (intravenous formulation)

*Newly diagnosed multiple myeloma*
*Combination treatment with lenalidomide and dexamethasone in patients ineligible for autologous stem cell transplant*
Study MMY3008, an open-label, randomised, active-controlled phase III study, compared treatment with intravenous daratumumab 16 mg/kg in combination with lenalidomide and low-dose dexamethasone (DRd) to treatment with lenalidomide and low-dose dexamethasone (Rd) in patients with newly diagnosed multiple myeloma. Lenalidomide (25 mg once daily orally on days 1-21 of repeated 28-day [4-week] cycles) was given with low dose oral or intravenous dexamethasone 40 mg/week (or a reduced dose of 20 mg/week for patients >75 years or body mass index [BMI] < 18.5). On intravenous daratumumab infusion days, the dexamethasone dose was given as a pre-infusion medicinal product. Dose adjustments for lenalidomide and dexamethasone were applied according to manufacturer's prescribing information. Treatment was continued in both arms until disease progression or unacceptable toxicity.

A total of 737 patients were randomised: 368 to the DRd arm and 369 to the Rd arm. The baseline demographic and disease characteristics were similar between the two treatment groups. The median age was 73 (range: 45-90) years, with 44% of the patients ≥ 75 years of age. The majority were white (92%), male (52%), 34% had an Eastern Cooperative Oncology Group (ECOG) performance score of 0, 49.5% had an ECOG performance score of 1 and 17% had an ECOG performance score of ≥ 2. Twenty-seven percent had International Staging System (ISS) stage I, 43% had ISS stage II and 29% had ISS stage III disease. Efficacy was evaluated by progression free survival (PFS) based on International Myeloma Working Group (IMWG) criteria and overall survival (OS).

With a median follow-up of 28 months, the primary analysis of PFS in study MMY3008 showed an improvement in the DRd arm as compared to the Rd arm; the median PFS had not been reached in the DRd arm and was 31.9 months in the Rd arm (hazard ratio [HR]=0.56; 95% CI: 0.43, 0.73; p < 0.0001), representing 44% reduction in the risk of disease progression or death in patients treated with DRd. Results of an updated PFS analysis after a median follow-up of 64 months continued to show an improvement in PFS for patients in the DRd arm compared with the Rd arm. Median PFS was 61.9 months in the DRd arm and 34.4 months in the Rd arm (HR=0.55; 95% CI: 0.45, 0.67).

**Figure 4: Kaplan-Meier curve of PFS in study MMY3008**

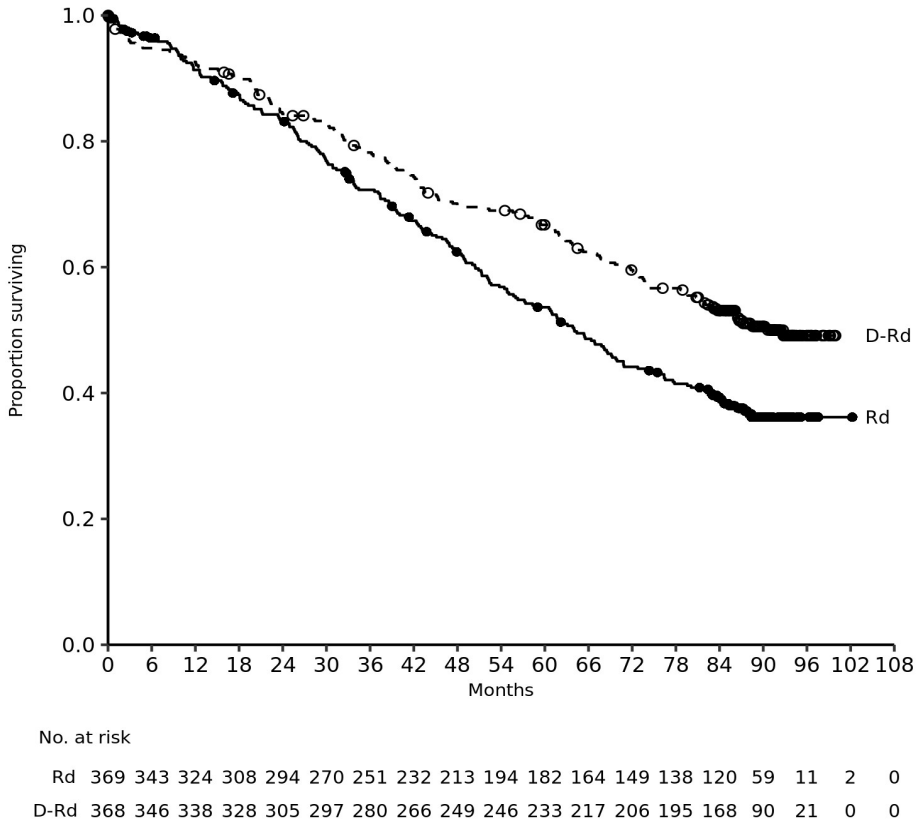



With a median follow-up of 56 months, DRd has shown an OS advantage over the Rd arm (HR=0.68; 95% CI: 0.53, 0.86; p=0.0013). Results of an updated OS analysis after a median of 89 months continued to show an


DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

improvement in OS for patients in the DRd arm compared to the Rd arm. Median OS was 90.3 months in the DRd arm and was 64.1 months in the Rd arm (HR= 0.67; 95% CI: 0.55, 0.82).

**Figure 5: Kaplan-Meier curve of OS in study MMY3008**




Additional efficacy results from study MMY3008 are presented in table 14 below.

**Table 14: Additional efficacy results from study MMY3008[a]**

| | **DRd (n=368)** | **Rd (n=369)** |
|---|---|---|
| Overall response (sCR+CR+VGPR+PR) n(%)[a] | 342 (92.9%) | 300 (81.3%) |
| p-value[b] | < 0.0001 | |
| Stringent complete response (sCR) | 112 (30.4%) | 46 (12.5%) |
| Complete response (CR) | 63 (17.1%) | 46 (12.5%) |
| Very good partial response (VGPR) | 117 (31.8%) | 104 (28.2%) |
| Partial response (PR) | 50 (13.6%) | 104 (28.2%) |
| CR or better (sCR + CR) | 175 (47.6%) | 92 (24.9%) |
| p-value[b] | < 0.0001 | |
| VGPR or better (sCR + CR + VGPR) | 292 (79.3%) | 196 (53.1%) |
| p-value[b] | < 0.0001 | |
| MRD negativity rate[a,c] n(%) | 89 (24.2%) | 27 (7.3%) |
| 95% CI (%) | (19.9%, 28.9%) | (4.9%, 10.5%) |
| Odds ratio with 95% CI[d] | 4.04 (2.55, 6.39) | |
| p-value[e] | < 0.0001 | |

DRd=daratumumab-lenalidomide-dexamethasone; Rd=lenalidomide-dexamethasone; MRD=minimal residual disease; CI=confidence interval.

[a] Based on intent-to-treat population.

[b] p-value from Cochran Mantel-Haenszel Chi-Squared test.

[c] Based on threshold of $10^{-5}$.

[d] Mantel-Haenszel estimate of the odds ratio for un-stratified tables is used. An odds ratio > 1 indicates an advantage for DRd.

[e] p-value from Fisher's exact test.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

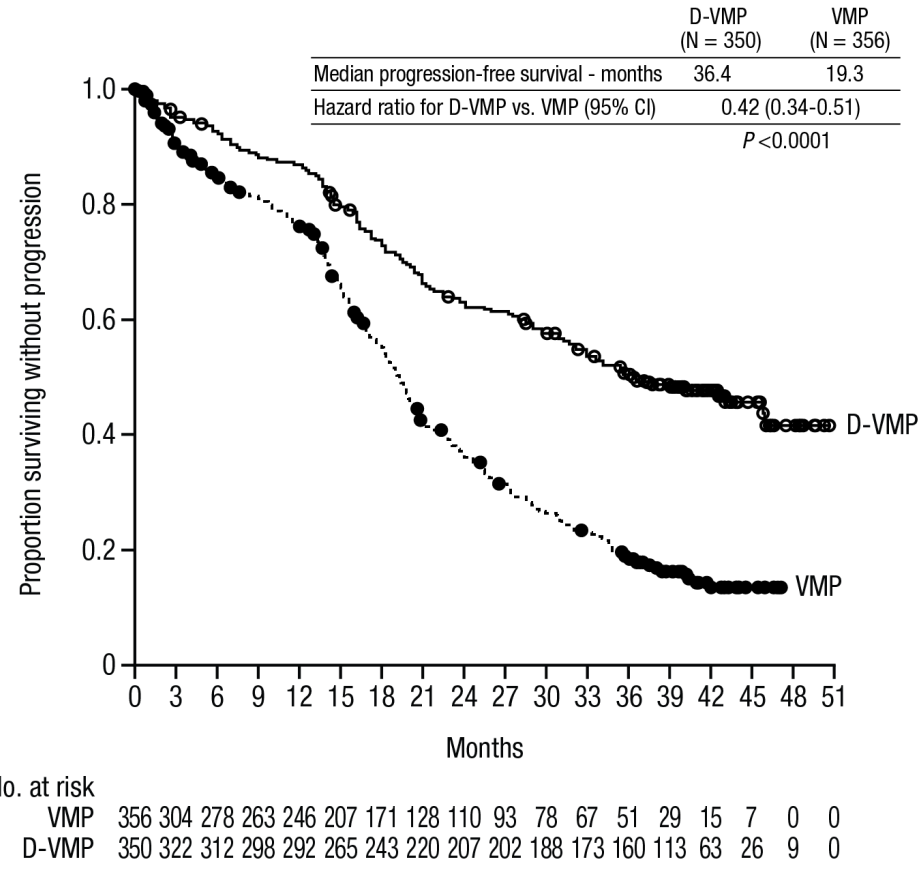
In responders, the median time to response was 1.05 months (range: 0.2 to 12.1 months) in the DRd group and 1.05 months (range: 0.3 to 15.3 months) in the Rd group. The median duration of response had not been reached in the DRd group and was 34.7 months (95% CI: 30.8, not estimable) in the Rd group.

*Combination treatment with bortezomib, melphalan and prednisone (VMP) in patients ineligible for autologous stem cell transplant*
Study MMY3007, an open-label, randomised, active-controlled phase III study, compared treatment with intravenous daratumumab 16 mg/kg in combination with bortezomib, melphalan and prednisone (D-VMP), to treatment with VMP in patients with newly diagnosed multiple myeloma. Bortezomib was administered by subcutaneous injection at a dose of 1.3 mg/m$^2$ body surface area twice weekly at weeks 1, 2, 4 and 5 for the first 6-week cycle (cycle 1; 8 doses), followed by once weekly administrations at weeks 1, 2, 4 and 5 for eight more 6-week cycles (cycles 2-9; 4 doses per cycle). Melphalan at 9 mg/m$^2$, and prednisone at 60 mg/m$^2$ were orally administered on days 1 to 4 of the nine 6-week cycles (cycles 1-9). Intravenous daratumumab treatment was continued until disease progression or unacceptable toxicity.

A total of 706 patients were randomised: 350 to the D-VMP arm and 356 to the VMP arm. The baseline demographic and disease characteristics were similar between the two treatment groups. The median age was 71 (range: 40-93) years, with 30% of the patients ≥ 75 years of age. The majority were white (85%), female (54%), 25% had an ECOG performance score of 0, 50% had an ECOG performance score of 1 and 25% had an ECOG performance score of 2. Patients had IgG/IgA/Light chain myeloma in 64%/22%/10% of instances, 19% had ISS stage I, 42% had ISS stage II, 38% had ISS stage III disease and 84% had standard risk cytogenetics. Efficacy was evaluated by PFS based on IMWG criteria and overall survival (OS).

With a median follow-up of 16.5 months, the primary analysis of PFS in study MMY3007 showed an improvement in the D-VMP arm as compared to the VMP arm; the median PFS had not been reached in the D-VMP arm and was 18.1 months in the VMP arm (HR=0.5; 95% CI: 0.38, 0.65; p < 0.0001). Results of an updated PFS analysis after a median follow-up of 40 months continued to show an improvement in PFS for patients in the D-VMP arm compared with the VMP arm. Median PFS was 36.4 months in the D-VMP arm and 19.3 months in the VMP arm (HR=0.42; 95% CI: 0.34, 0.51; p < 0.0001), representing a 58% reduction in the risk of disease progression or death in patients treated with D-VMP.

**Figure 6: Kaplan-Meier curve of PFS in study MMY3007**

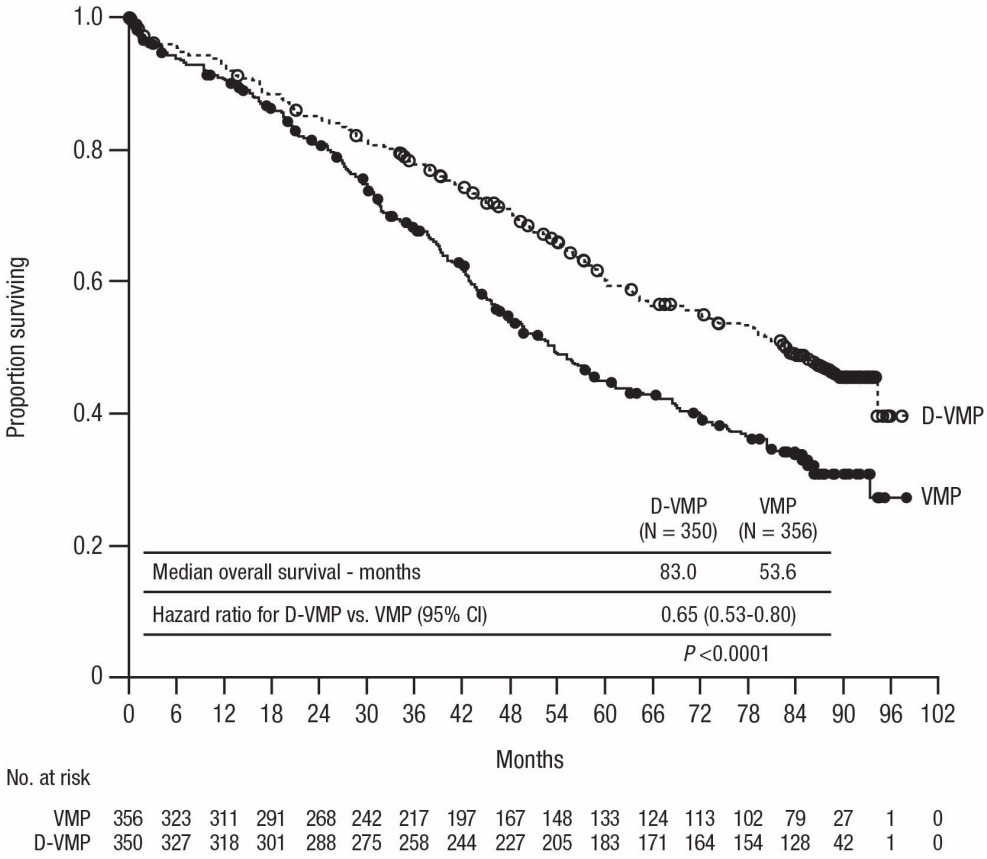





DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

After a median follow-up of 40 months, D-VMP has shown an OS advantage over the VMP arm (HR=0.60; 95% CI: 0.46, 0.80; p=0.0003), representing a 40% reduction in the risk of death in patients treated in the D-VMP arm. After a median follow-up of 87 months, the median OS was 83 months (95% CI: 72.5, NE) in the D-VMP arm and 53.6 months (95% CI: 46.3, 60.9) in the VMP arm.

**Figure 7: Kaplan-Meier curve of OS in study MMY3007**




Additional efficacy results from study MMY3007 are presented in table 15 below.

**Table 15: Additional efficacy results from study MMY3007[a]**

| | D-VMP (n=350) | VMP (n=356) |
|---|---|---|
| Overall response (sCR+CR+VGPR+PR) [n(%)] | 318 (90.9) | 263 (73.9) |
| p-value[b] | < 0.0001 | |
| Stringent complete response (sCR) [n(%)] | 63 (18.0) | 25 (7.0) |
| Complete response (CR) [n(%)] | 86 (24.6) | 62 (17.4) |
| Very good partial response (VGPR) [n(%)] | 100 (28.6) | 90 (25.3) |
| Partial response (PR) [n(%)] | 69 (19.7) | 86 (24.2) |
| MRD negativity rate (95% CI)[c] (%) | 22.3 (18.0, 27.0) | 6.2 (3.9, 9.2) |
| Odds ratio with 95% CI[d] | 4.36 (2.64, 7.21) | |
| p-value[e] | < 0.0001 | |

D-VMP=daratumumab-bortezomib-melphalan-prednisone; VMP=bortezomib-melphalan-prednisone; MRD=minimal residual disease; CI=confidence interval.

[a] Based on intent-to-treat population.

[b] p-value from Cochran Mantel-Haenszel Chi-Squared test.

[c] Based on threshold of $10^{-5}$.

[d] A Mantel-Haenszel estimate of the common odds ratio for stratified tables is used. An odds ratio > 1 indicates an advantage for D-VMP.

[e] p-value from Fisher's exact test.

In responders, the median time to response was 0.79 months (range: 0.4 to 15.5 months) in the D-VMP group and 0.82 months (range: 0.7 to 12.6 months) in the VMP group. The median duration of response had not been reached in the D-VMP group and was 21.3 months (range: 18.4, not estimable) in the VMP group.

A subgroup analysis was performed on patients at least 70 years old, or those 65-69 years old with ECOG performance score of 2, or aged less than 65 years of age with significant comorbidity or ECOG performance



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

score of 2 (D-VMP: n=273, VMP: n=270). The efficacy results in this subgroup were consistent with the overall population. In this subgroup, median PFS was not reached in the D-VMP group and was 17.9 months in the VMP group (HR=0.56; 95% CI: 0.42, 0.75; p < 0.0001). The overall response rate was 90% in the D-VMP group and 74% in theVMP group (VGPR rate:29% in D-VMP group and 26% in VMP group; CR: 22% in D-VMP group and 18% in VMP group; sCR rate: 20% in D-VMP group and 7% in VMP group). The safety results of this subgroup were consistent with the overall population. Furthermore, safety analysis of the subgroup of patients with an ECOG performance score of 2 (D-VMP: n=89, VMP: n=84), was also consistent with the overall population.

*Relapsed/refractory multiple myeloma*
Monotherapy:
The clinical efficacy and safety of intravenous daratumumab monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who had demonstrated disease progression on the last therapy, was demonstrated in two open-label studies.

In study MMY2002, 106 patients with relapsed and refractory multiple myeloma received 16 mg/kg intravenous daratumumab until disease progression. The median patient age was 63.5 years (range, 31 to 84 years), 11% of patients were ≥ 75 years of age, 49% were male and 79% were Caucasian. Patients had received a median of 5 prior lines of therapy. Eighty percent of patients had received prior autologous stem cell transplantation (ASCT). Prior therapies included bortezomib (99%), lenalidomide (99%), pomalidomide (63%) and carfilzomib (50%). At baseline, 97% of patients were refractory to the last line of treatment, 95% were refractory to both, a proteasome inhibitor (PI) and immunomodulatory agent (IMiD), 77% were refractory to alkylating agents, 63% were refractory to pomalidomide and 48% of patients were refractory to carfilzomib.

Efficacy results of the pre-planned interim analysis based on Independent Review Committee (IRC) assessment are presented in table 16 below.

**Table 16: IRC assessed efficacy results for study MMY2002**

| **Efficacy endpoint** | **Intravenous daratumumab 16 mg/kg N=106** |
|---|---|
| Overall response rate[1] (ORR: sCR+CR+VGPR+PR) [n (%)]<br>95% CI (%) | 31 (29.2)<br>(20.8, 38.9) |
| Stringent complete response (sCR) [n (%)] | 3 (2.8) |
| Complete response (CR) [n] | 0 |
| Very good partial response (VGPR) [n (%)] | 10 (9.4) |
| Partial response (PR) [n (%)] | 18 (17.0) |
| Clinical benefit rate (ORR+MR) [n (%)] | 36 (34.0) |
| Median duration of response [months (95% CI)] | 7.4 (5.5, NE) |
| Median time to response [months (range)] | 1 (0.9; 5.6) |

[1] Primary efficacy endpoint (International Myeloma Working Group criteria).
CI=confidence interval; NE=not estimable; MR=minimal response.

Overall response rate (ORR) in MMY2002 was similar regardless of type of prior anti-myeloma therapy.
At a survival update with a median duration of follow-up of 14.7 months, median OS was 17.5 months (95% CI: 13.7, not estimable).

In study GEN501, 42 patients with relapsed and refractory multiple myeloma received 16 mg/kg intravenous daratumumab until disease progression. The median patient age was 64 years (range, 44 to 76 years), 64% were male and 76% were Caucasian. Patients in the study had received a median of 4 prior lines of therapy. Seventy-four percent of patients had received prior ASCT. Prior therapies included bortezomib (100%), lenalidomide (95%), pomalidomide (36%) and carfilzomib (19%). At baseline, 76% of patients were refractory to the last line of treatment, 64% were refractory to both a PI and IMiD, 60% were refractory to alkylating agents, 36% were refractory to pomalidomide and 17% were refractory to carfilzomib.

Pre-planned interim analysis showed that treatment with daratumumab at 16 mg/kg led to a 36% ORR with 5% CR and 5% VGPR. The median time to response was 1 (range: 0.5 to 3.2) month. The median duration of response was not reached (95% CI: 5.6 months, not estimable).

At a survival update with a median duration of follow-up of 15.2 months, median OS was not reached (95% CI: 19.9 months, not estimable), with 74% of subjects still alive.

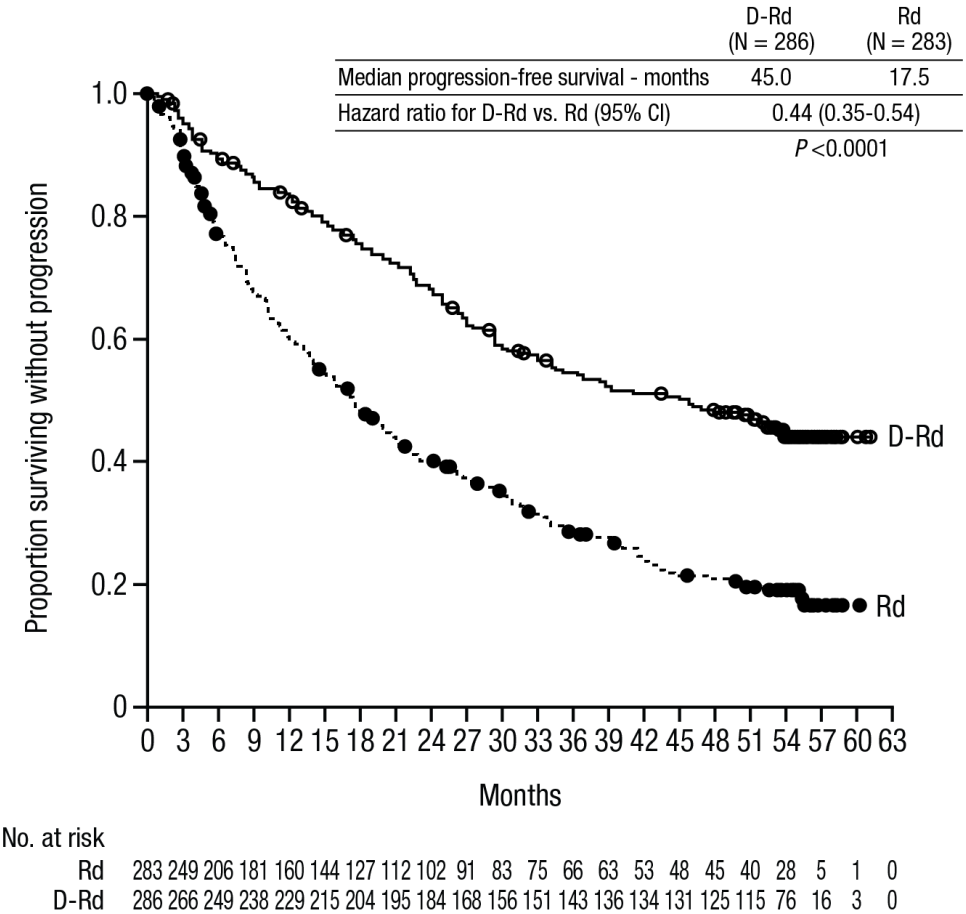

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*Combination treatment with lenalidomide*
Study MMY3003, an open-label, randomised, active-controlled phase III study, compared treatment with intravenous daratumumab 16 mg/kg in combination with lenalidomide and low-dose dexamethasone (DRd) to treatment with lenalidomide and low-dose dexamethasone (Rd) in patients with relapsed or refractory multiple myeloma who had received at least one prior therapy. Lenalidomide (25 mg once daily orally on days 1-21 of repeated 28-day [4-week] cycles) was given with low dose dexamethasone at 40 mg/week (or a reduced dose of 20 mg/week for patients > 75 years or BMI < 18.5). On intravenous daratumumab infusion days, 20 mg of the dexamethasone dose was given as a pre-infusion medicinal product and the remainder given the day after the infusion. Treatment was continued in both arms until disease progression or unacceptable toxicity.

A total of 569 patients were randomised; 286 to the DRd arm and 283 to the Rd arm. The baseline demographic and disease characteristics were similar between the intravenous daratumumab and the control arm. The median patient age was 65 years (range 34 to 89 years) and 11% were ≥ 75 years. The majority of patients (86%) received a prior PI, 55% of patients had received a prior IMiD, including 18% of patients who had received prior lenalidomide; and 44% of patients had received both a prior PI and IMiD. At baseline, 27% of patients were refractory to the last line of treatment. Eighteen percent (18%) of patients were refractory to a PI only, and 21% were refractory to bortezomib. Patients refractory to lenalidomide were excluded from the study.

With a median follow-up of 13.5 months, the primary analysis of PFS in study MMY3003 demonstrated an improvement in the DRd arm as compared to the Rd arm; the median PFS had not been reached in the DRd arm and was 18.4 months in the Rd arm (HR=0.37; 95% CI: 0.27, 0.52; p < 0.0001). Results of an updated PFS analysis after a median follow-up of 55 months continued to show an improvement in PFS for patients in the DRd arm compared with the Rd arm. Median PFS was 45.0 months in the DRd arm and 17.5 months in the Rd arm (HR=0.44; 95% CI: 0.35, 0.54; p < 0.0001), representing a 56% reduction in the risk of disease progression or death in patients treated with DRd (see figure 8).

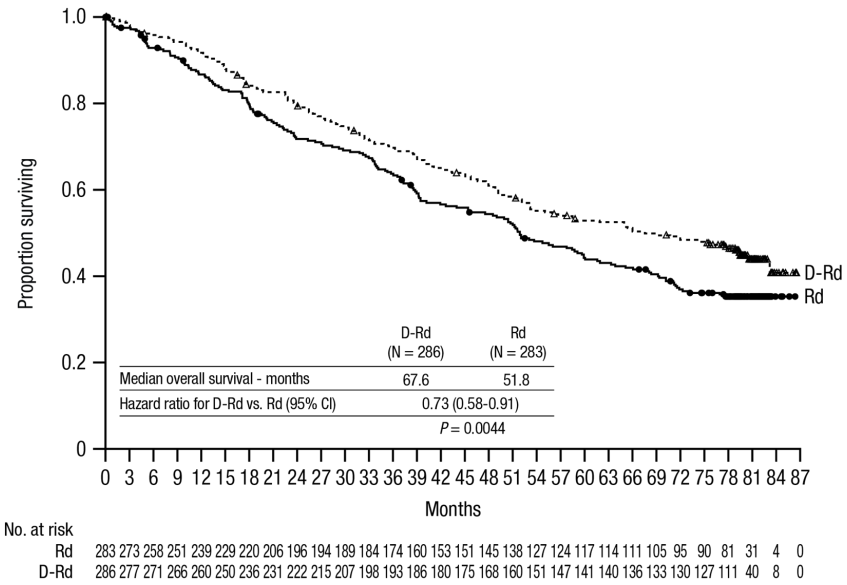
**Figure 8: Kaplan-Meier curve of PFS in study MMY3003**




After a median follow-up of 80 months, DRd has shown an OS advantage over the Rd arm (HR=0.73; 95% CI: 0.58, 0.91; p=0.0044). The median OS was 67.6 months in the DRd arm and 51.8 months in the Rd arm.


DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

**Figure 9: Kaplan-Meier curve of OS in study MMY3003**




Additional efficacy results from study MMY3003 are presented in table 17 below.

**Table 17: Additional efficacy results from study MMY3003**

| Response evaluable patient number | DRd (n=281) | Rd (n=276) |
|---|---|---|
| Overall response (sCR+CR+VGPR+PR) n(%) | 261 (92.9) | 211 (76.4) |
| p-value[a] | < 0.0001 | |
| Stringent complete response (sCR) | 51 (18.1) | 20 (7.2) |
| Complete response (CR) | 70 (24.9) | 33 (12.0) |
| Very good partial response (VGPR) | 92 (32.7) | 69 (25.0) |
| Partial response (PR) | 48 (17.1) | 89 (32.2) |
| Median Time to Response [months (95% CI)] | 1.0 (1.0, 1.1) | 1.3 (1.1, 1.9) |
| Median Duration of Response [months (95% CI)] | NE (NE, NE) | 17.4 (17.4, NE) |
| MRD negative rate (95% CI) [b] (%) | 21.0 (16.4, 26.2) | 2.8 (1.2, 5.5) |
| Odds ratio with 95% CI[c] | 9.31 (4.31, 20.09) | |
| P-value[d] | < 0.0001 | |

DRd=daratumumab-lenalidomide-dexamethasone; Rd=lenalidomide-dexamethasone; MRD=minimal residual disease; CI=confidence interval; NE=not estimable.

[a] p-value from Cochran Mantel-Haenszel Chi-Squared test.

[b] Based on Intent-to-treat population and threshold of $10^{-5}$.

[c] Mantel-Haenszel estimate of the common odds ratio is used. An odds ratio > 1 indicates an advantage for DRd.

[d] p-value is from a Fisher's exact test.

*Combination treatment with bortezomib*

Study MMY3004, an open-label, randomised, active-controlled phase III study, compared treatment with intravenous daratumumab 16 mg/kg in combination with bortezomib and dexamethasone (DVd), to treatment with bortezomib and dexamethasone (Vd) in patients with relapsed or refractory multiple myeloma who had received at least one prior therapy. Bortezomib was administered by subcutaneous injection or intravenous injection at a dose of 1.3 mg/m$^2$ body surface area twice weekly for two weeks (days 1, 4, 8, and 11) of repeated 21 day (3-week) treatment cycles, for a total of 8 cycles. Dexamethasone was administered orally at a dose of 20 mg on days 1, 2, 4, 5, 8, 9, 11, and 12 of each of the 8 bortezomib cycles (80 mg/week for two out of three weeks of the bortezomib cycle) or a reduced dose of 20 mg/week for patients > 75 years, BMI < 18.5, poorly controlled diabetes mellitus or prior intolerance to steroid therapy. On the days of intravenous daratumumab infusion, 20 mg of the dexamethasone dose was administered as a pre-infusion medicinal product. intravenous daratumumab treatment was continued until disease progression or unacceptable toxicity.

A total of 498 patients were randomised; 251 to the DVd arm and 247 to the Vd arm. The baseline demographic and disease characteristics were similar between the intravenous daratumumab and the control arm. The median patient age was 64 years (range 30 to 88 years) and 12% were ≥ 75 years. Sixty-nine percent (69%) of patients had received a prior PI (66% received bortezomib) and 76% of patients received an IMiD (42% received lenalidomide). At baseline, 32% of patients were refractory to the last line of treatment. Thirty-three percent

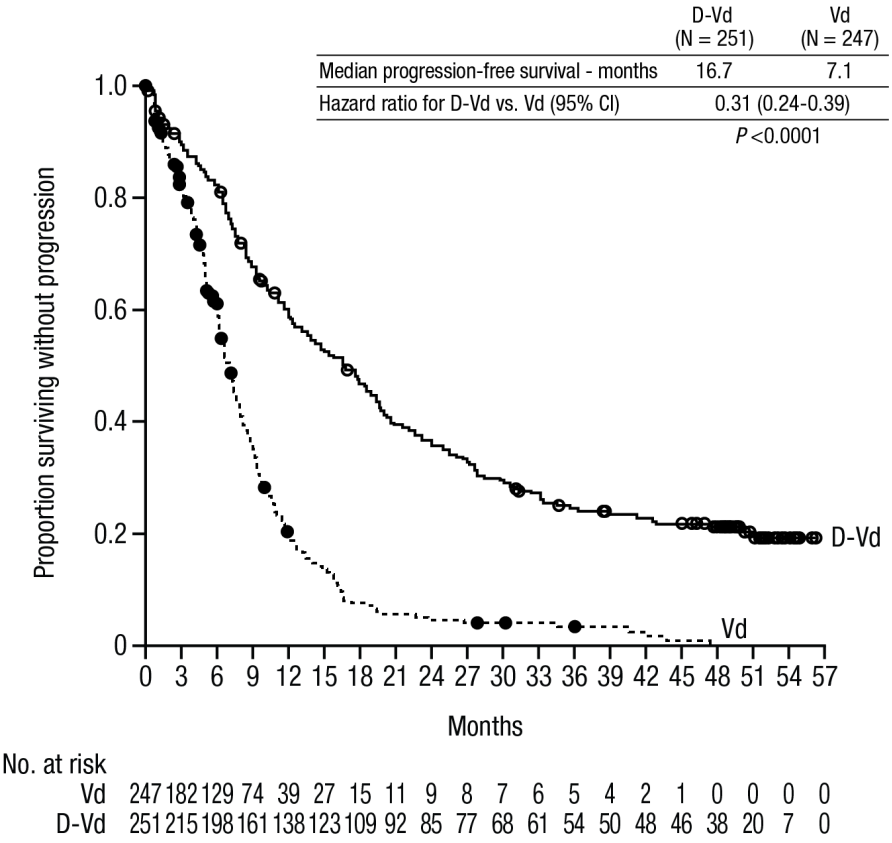


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(33%) of patients were refractory to an IMiD only, and 28% were refractory to lenalidomide. Patients refractory to bortezomib were excluded from the study.

With a median follow-up of 7.4 months, the primary analysis of PFS in study MMY3004 demonstrated an improvement in the DVd arm as compared to the Vd arm; the median PFS had not been reached in the DVd arm and was 7.2 months in the Vd arm (HR [95% CI]: 0.39 [0.28, 0.53]; p-value < 0.0001). Results of an updated PFS analysis after a median follow-up of 50 months continued to show an improvement in PFS for patients in the DVd arm compared with the Vd arm. Median PFS was 16.7 months in the DVd arm and 7.1 months in the Vd arm (HR [95% CI]: 0.31 [0.24, 0.39]; p-value < 0.0001), representing a 69% reduction in the risk of disease progression or death in patients treated with DVd *versus* Vd (see figure 10).

**Figure 10: Kaplan-Meier curve of PFS in study MMY3004**

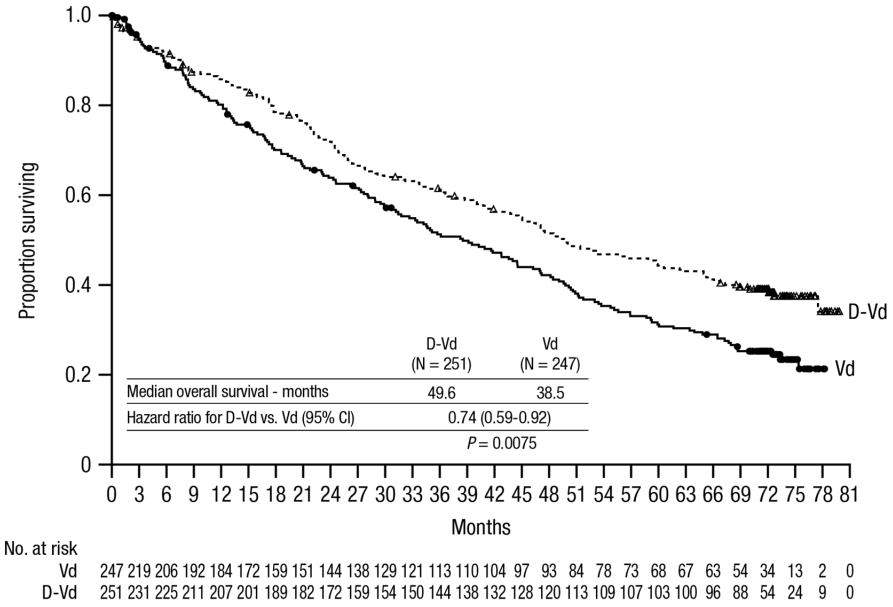



After a median follow-up of 73 months, DVd has shown an OS advantage over the Vd arm (HR=0.74; 95% CI: 0.59, 0.92; p=0.0075). The median OS was 49.6 months in the DVd arm and 38.5 months in the Vd arm.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

**Figure 11: Kaplan-Meier curve of OS in study MMY3004**




Additional efficacy results from study MMY3004 are presented in table 18 below.

**Table 18: Additional efficacy results from study MMY3004**

| **Response evaluable patient number** | **DVd (n=240)** | **Vd (n=234)** |
|---|---|---|
| Overall response (sCR+CR+VGPR+PR) n(%) | 199 (82.9) | 148 (63.2) |
| P-value[a] | < 0.0001 | |
| Stringent complete response (sCR) | 11 (4.6) | 5 (2.1) |
| Complete response (CR) | 35 (14.6) | 16 (6.8) |
| Very good partial response (VGPR) | 96 (40.0) | 47 (20.1) |
| Partial response (PR) | 57 (23.8) | 80 (34.2) |
| Median time to response [months (range)] | 0.9 (0.8, 1.4) | 1.6 (1.5, 2.1) |
| Median duration of response [months (95% CI)] | NE (11.5, NE) | 7.9 (6.7, 11.3) |
| MRD negative rate (95% CI)[b] | 8.8% (5.6%, 13.0%) | 1.2% (0.3%, 3.5%) |
| Odds ratio with 95% CI[c] | 9.04 (2.53, 32.21) | |
| P-value[d] | 0.0001 | |

DVd=daratumumab- bortezomib-dexamethasone; Vd=bortezomib-dexamethasone; MRD=minimal residual disease; CI=confidence interval; NE=not estimable.

[a] p-value from Cochran Mantel-Haenszel Chi-Squared test.

[b] Based on Intent-to-treat population and threshold of $10^{-5}$.

[c] Mantel-Haenszel estimate of the common odds ratio is used. An odds ratio > 1 indicates an advantage for DVd.

[d] p-value is from Fisher's exact test.

Cardiac electrophysiology

Daratumumab as a large protein has a low likelihood of direct ion channel interactions. The effect of daratumumab on the QTc interval was evaluated in an open-label study for 83 patients (Study GEN501) with relapsed and refractory multiple myeloma following daratumumab infusions (4 to 24 mg/kg). Linear mixed PK-PD analyses indicated no large increase in mean QTcF interval (i.e. greater than 20 ms) at daratumumab $C_{max}$.

## 5.2 Pharmacokinetic properties

In patients with multiple myeloma, daratumumab exposure in a monotherapy study following the recommended 1800 mg administration of DARZALEX FASPRO® subcutaneous formulation (weekly for 8 weeks, biweekly for 16 weeks, monthly thereafter) as compared to 16 mg/kg intravenous daratumumab for the same dosing schedule, showed non-inferiority for the co-primary endpoint of maximum $C_{trough}$ (cycle 3 day 1 pre-dose), with mean ± SD of 593 ± 306 µg/mL compared to 522 ± 226 µg/mL for intravenous daratumumab, with a geometric mean ratio of 107.93% (90% CI: 95.74-121.67).



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

In a combination study, AMY3001, in patients with AL amyloidosis, the maximum $C_{trough}$ (cycle 3 day 1 pre-dose) was similar to that in multiple myeloma with mean ± SD of 597 ± 232 µg/mL following the recommended 1800 mg administration of DARZALEX FASPRO® subcutaneous formulation (weekly for 8 weeks, biweekly for 16 weeks, monthly thereafter).

Following the recommended dose of 1800 mg DARZALEX FASPRO® solution for subcutaneous injection, peak concentrations ($C_{max}$) increased 4.8-fold and total exposure ($AUC_{0\text{-}7\ days}$) increased 5.4-fold from first dose to last weekly dose ($8^{th}$ dose). Highest trough concentrations for DARZALEX FASPRO® solution for subcutaneous injection are typically observed at the end of the weekly dosing regimens for both monotherapy and combination therapy.

In patients with multiple myeloma, the simulated trough concentrations following 6 weekly doses of 1800 mg DARZALEX FASPRO® solution for subcutaneous injection for combination therapy were similar to 1800 mg DARZALEX FASPRO® solution for subcutaneous injection monotherapy.

In patients with newly diagnosed multiple myeloma eligible for ASCT, daratumumab exposure in a combination study with bortezomib, lenalidomide and dexamethasone (MMY3014) was similar to that in monotherapy, with the maximum $C_{trough}$ (cycle 3 day 1 pre-dose) mean ± SD of 526±209 µg/mL following the recommended 1800 mg administration of DARZALEX FASPRO® solution for subcutaneous injection (weekly for 8 weeks, biweekly for 16 weeks, monthly thereafter).

In patients with newly diagnosed multiple myeloma for whom ASCT was not planned as initial therapy or who were ineligible for ASCT, daratumumab exposure in a combination study with bortezomib, lenalidomide and dexamethasone (MMY3019) was similar to that in monotherapy and other combination therapies following similar dosing schedule, with the maximum $C_{trough}$ (cycle 3 day 1 pre-dose) mean ± SD of 407 ± 183 µg/mL following the recommended 1800 mg administration of DARZALEX FASPRO® solution for subcutaneous injection (weekly for 6 weeks, triweekly for 18 weeks, monthly thereafter).

In patients with multiple myeloma, daratumumab exposure in a combination study with pomalidomide and dexamethasone (study MMY3013) was similar to that in monotherapy, with the maximum $C_{trough}$ (cycle 3 day 1 pre-dose) mean ± SD of 537 ± 277 µg/mL following the recommended 1800 mg administration of DARZALEX FASPRO® solution for subcutaneous injection (weekly for 8 weeks, biweekly for 16 weeks, monthly thereafter).

Absorption and distribution

At the recommended dose of 1800 mg in multiple myeloma patients, the absolute bioavailability of DARZALEX FASPRO® solution for subcutaneous injection is 69%, with an absorption rate of 0.012 $hour^{-1}$, with peak concentrations occurring at 70 to 72 h ($T_{max}$). At the recommended dose of 1800 mg in AL amyloidosis patients, the absolute bioavailability was not estimated, the absorption rate constant was 0.77 $day^{-1}$ (8.31% CV) and peak concentrations occurred at 3 days.

The model predicted mean estimate of the volume of distribution for the central compartment was 5.25 L (36.9% CV) and peripheral compartment (V2) was 3.78 L in daratumumab monotherapy, and the modeled mean estimate of the volume of distribution for V1 was 4.36 L (28.0% CV) and V2 was 2.80 L when daratumumab was administered in combination with pomalidomide and dexamethasone in multiple myeloma patients. In AL amyloidosis patients, the model estimated apparent volume of distribution after subcutaneous administration is 10.8 L (3.1% CV). These results suggest that daratumumab is primarily localised to the vascular system with limited extravascular tissue distribution.

Metabolism and elimination

Daratumumab exhibits both concentration and time-dependent pharmacokinetics with parallel linear and nonlinear (saturable) elimination that is characteristic of target-mediated clearance. The population PK model estimated mean clearance value of daratumumab is 4.96 mL/h (58.7% CV) in daratumumab monotherapy and 4.32 mL/h (43.5% CV) when daratumumab is administered in combination with pomalidomide and dexamethasone in multiple myeloma patients. In AL amyloidosis patients, the apparent clearance after subcutaneous administration is 210 mL/day (4.1% CV). The model-based geometric mean for half-life associated with linear elimination is 20.4 days (22.4% CV) in daratumumab monotherapy and 19.7 days (15.3% CV) when daratumumab was administered in combination with pomalidomide and dexamethasone in multiple myeloma patients and 27.5 days (74.0% CV) in AL amyloidosis patients. For the monotherapy and combination regimens, the steady state is achieved at approximately 5 months into every 4 weeks dosage at the recommended dose and schedule (1800 mg; once weekly for 8 weeks, every 2 weeks for 16 weeks, and then every 4 weeks thereafter).



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

A population PK analysis was conducted using data from DARZALEX FASPRO® solution for subcutaneous injection monotherapy and combination therapy multiple myeloma studies, and the predicted PK exposures are summarised in table 19. Daratumumab exposures were similar between patients treated with DARZALEX FASPRO® solution for subcutaneous injection monotherapy and combination therapies.

**Table 19: Daratumumab exposure following administration of DARZALEX FASPRO® subcutaneous formulation (1800 mg) or intravenous daratumumab (16 mg/kg) monotherapy in patients with multiple myeloma**

| PK parameters | Cycles | subcutaneous daratumumab Median ($5^{th}$; $95^{th}$ percentile) | intravenous daratumumab Median ($5^{th}$; $95^{th}$ percentile) |
|---|---|---|---|
| $C_{trough}$ (µg/mL) | Cycle 1, 1st weekly dose | 123 (36; 220) | 112 (43; 168) |
| | Cycle 2, last weekly dose (cycle 3 day 1 $C_{trough}$) | 563 (177; 1063) | 472 (144; 809) |
| $C_{max}$ (µg/mL) | Cycle 1, 1st weekly dose | 132 (54; 228) | 256 (173; 327) |
| | Cycle 2, last weekly dose | 592 (234; 1114) | 688 (369; 1061) |
| $AUC_{0\text{-}7\ days}$ (µg/mL•day) | Cycle 1, 1st weekly dose | 720 (293; 1274) | 1187 (773; 1619) |
| | Cycle 2, last weekly dose | 4017 (1515; 7564) | 4019 (1740; 6370) |

The predicted PK expsosures for 526 patients with transplant eligible multiple myeloma who received DARZALEX FASPRO® solution for subcutaneous injection in combination with VRd are summarised in table 20.

**Table 20: Daratumumab exposure following administration of DARZALEX FASPRO® subcutaneous formulation (1800 mg) in combination with VRd in patients with transplant eligible multiple myeloma**

| PK parameters | Cycles | subcutaneous daratumumab Median ($5^{th}$; $95^{th}$ percentile) |
|---|---|---|
| $C_{trough}$ (µg/mL) | Cycle 1, 1st weekly dose | 113 (66; 171) |
| | Cycle 2, last weekly dose (cycle 3 day 1 $C_{trough}$) | 651 (413; 915) |
| $C_{max}$ (µg/mL) | Cycle 1, 1st weekly dose | 117 (67; 179) |
| | Cycle 2, last weekly dose | 678 (431; 958) |
| $AUC_{0\text{-}7\ days}$ (µg/mL•day) | Cycle 1, 1st weekly dose | 643 (322; 1027) |
| | Cycle 2, last weekly dose | 4637 (2941; 6522) |

A population PK analysis, using data from DARZALEX FASPRO® solution for subcutaneous injection combination therapy in AL amyloidosis patients, was conducted with data from 211 patients. At the recommended dose of 1800 mg, predicted daratumumab concentrations were slightly higher, but generally within the same range, in comparison with multiple myeloma patients.

**Table 21: Daratumumab exposure following administration of DARZALEX FASPRO® subcutaneous formulation (1800 mg) in patients with AL amyloidosis**

| PK parameters | Cycles | subcutaneous daratumumab Median ($5^{th}$; $95^{th}$ percentile) |
|---|---|---|
| $C_{trough}$ (µg/mL) | Cycle 1, 1st weekly dose | 138 (86; 195) |
| | Cycle 2, last weekly dose (cycle 3 day 1 $C_{trough}$) | 662 (315; 1037) |
| $C_{max}$ (µg/mL) | Cycle 1, 1st weekly dose | 151 (88; 226) |
| | Cycle 2, last weekly dose | 729 (390; 1105) |
| $AUC_{0\text{-}7\ days}$ (µg/mL•day) | Cycle 1, 1st weekly dose | 908 (482; 1365) |
| | Cycle 2, last weekly dose | 4855 (2562; 7522) |

Special populations

*Age and gender*
Based on population PK analyses in patients (33-92 years) receiving monotherapy or various combination therapies, age had no statistically significant effect on the PK of daratumumab. No individualisation is necessary for patients on the basis of age.



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

Gender had a statistically significant effect on PK parameters in patients with multiple myeloma but not in patients with AL amyloidosis. Slightly higher exposure in females were observed than males, but the difference in exposure is not considered clinically meaningful. No individualisation is necessary for patients on the basis of gender.

*Renal impairment*
No formal studies of DARZALEX FASPRO® subcutaneous formulation in patients with renal impairment have been conducted. Population PK analyses were performed based on pre-existing renal function data in patients with multiple myeloma receiving DARZALEX FASPRO® subcutaneous formulation monotherapy or various combination therapies in patients with multiple myeloma or AL amyloidosis. No clinically important differences in exposure to daratumumab were observed between patients with renal impairment and those with normal renal function.

*Hepatic impairment*
No formal studies of DARZALEX FASPRO® subcutaneous formulation in patients with hepatic impairment have been conducted.
Population PK analyses were performed in patients with multiple myeloma receiving DARZALEX FASPRO® subcutaneous formulation monotherapy or various combination therapies in patients with multiple myeloma and in AL amyloidosis. No clinically important differences in the exposure to daratumumab were observed between patients with normal hepatic function and mild hepatic impairment. There were very few patients with moderate and severe hepatic impairment to make meaningful conclusions for these populations.

*Race*
Based on the population PK analyses in patients receiving either DARZALEX FASPRO® subcutaneous formulation monotherapy or various combination therapies, the daratumumab exposure was similar across races.

*Body weight*
The flat-dose administration of DARZALEX FASPRO® subcutaneous formulation 1800 mg as monotherapy achieved adequate exposure for all body-weight subgroups. In patients with multiple myeloma, the mean cycle 3 day 1 $C_{trough}$ in the lower body-weight subgroup (≤ 65 kg) was 60% higher and in the higher body weight (> 85 kg) subgroup, 12% lower than the intravenous daratumumab subgroup. In some patients with body weight > 120 kg, lower exposure was observed which may result in reduced efficacy. However, this observation is based on limited number of patients.

In patients with AL amyloidosis, no meaningful differences were observed in $C_{trough}$ across body weight.

### 5.3 Preclinical safety data

Toxicology data have been derived from studies with daratumumab in chimpanzees and with a surrogate anti-CD38 antibody in cynomolgus monkeys. No chronic toxicity testing has been conducted.

No animal studies have been performed to establish the carcinogenic potential of daratumumab.

No animal studies have been performed to evaluate the potential effects of daratumumab on reproduction or development or to determine potential effects on fertility in males or females.

No carcinogenicity, genotoxicity, or fertility studies were conducted for recombinant human hyaluronidase. There were no effects on reproductive tissues and function and no systemic exposure of hyaluronidase in monkeys given 22000 U/kg/week subcutaneously (12 times higher than the human dose) for 39 weeks. As hyaluronidase is a recombinant form of the endogenous human hyaluronidase, no carcinogenity, mutagenesis, or effects on fertility are expected.

## 6. PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

Recombinant human hyaluronidase (rHuPH20)
L-histidine
L-histidine hydrochloride monohydrate
L-methionine
Polysorbate 20
Sorbitol



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

Water for injections

**6.2 Incompatibilities**

This medicinal product must not be used with other materials except those mentioned in section 6.6.

**6.3 Special precautions for storage**

Keep out of the sight and reach of children.
Store in a refrigerator (2 °C-8 °C) in the original carton to protect from light.
Do not freeze. Do not shake.

For storage conditions of the opened medicinal product (see section 6.4).

**6.4 Shelf life**

Unopened vial

3 years.

During the shelf-life, the product in unpunctured vials may be stored at ambient temperature (≤ 30 °C) for a single period of up to 24 hours. Once the product has been taken out of the refrigerator, it must not be returned to the refrigerator (see section 6.6).

Prepared syringe

If the syringe containing DARZALEX FASPRO® is not used immediately, store the DARZALEX FASPRO® solution for up to 24 hours refrigerated followed by up to 7 hours at 15°C–30°C and ambient light. Discard if stored more than 24 hours of being refrigerated or more than 7 hours of being at 15°C–30°C, if not used. If stored in the refrigerator, allow the solution to come to ambient temperature before administration.

**6.5 Nature and contents of container**

15 mL solution in a type 1 glass vial with an elastomeric closure and an aluminium seal with a flip-off button containing 1800 mg of daratumumab. Pack size of 1 vial.

**6.6 Special precautions for disposal and other handling**

DARZALEX FASPRO® solution for subcutaneous injection is for single use only and is ready to use.

DARZALEX FASPRO® solution for subcutaneous injection should be a clear to opalescent and colourless to yellow solution. Do not use if opaque particles, discolouration or other foreign particles are present.

DARZALEX FASPRO® solution for subcutaneous injection is compatible with polypropylene or polyethylene syringe material; polypropylene, polyethylene, or polyvinyl chloride (PVC) subcutaneous infusion sets; and stainless steel transfer and injection needles.

Unopened vial

Remove the DARZALEX FASPRO® solution for subcutaneous injection vial from refrigerated storage (2 °C-8 °C) and equilibrate to ambient temperature (≤30 °C). The unpunctured vial may be stored at ambient temperature and ambient light for a maximum of 24 hours in the original carton to protect from light. Keep out of direct sunlight. Do not shake.

For storage conditions of the prepared syringe, see *Shelf-life.*

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

**HOW SUPPLIED**
DARZALEX FASPRO® solution for injection
Box, 1 vial @ 15mL



DISETUJUI OLEH BPOM: 08/07/26 ID EREG100061VR12600054

Reg. No.:

**Date of first Authorisation:**
29 April 2024

**Prescription Drug**

HARUS DENGAN RESEP DOKTER

Manufactured by Cilag AG, Schaffhausen, Switzerland
Registered and Marketed by PT. SOHO Industri Pharmasi, a SOHO Global Health Company, Jakarta - Indonesia
For adverse event and product quality complaint, please contact pv.soho@sohoglobalhealth.com or (021) 460-5550

Based on EU SmPC 20250404

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**INFORMASI PRODUK UNTUK PASIEN**

**DARZALEX FASPRO® larutan untuk injeksi**
**Daratumumab**
**Hanya untuk pemakaian injeksi subkutan**

**Baca informasi ini secara seksama sebelum Anda mulai menggunakan obat ini karena mengandung informasi penting untuk Anda:**
- Simpan informasi produk ini. Anda mungkin perlu untuk membacanya lagi.
- Jika Anda memiliki pertanyaan lebih lanjut, tanyakan kepada dokter atau perawat Anda.
- Jika Anda mendapatkan efek samping, laporkan kepada dokter atau perawat Anda. Termasuk efek samping yang mungkin tidak tercantum dalam informasi produk ini. Lihat bagian 4.

**Apa yang ada dalam informasi produk ini**

1. Apa itu DARZALEX FASPRO® dan digunakan untuk apa
2. Apa saja yang harus Anda ketahui sebelum menggunakan DARZALEX FASPRO®
3. Bagaimana cara menggunakan DARZALEX FASPRO®
4. Efek samping yang mungkin terjadi
5. Bagaimana cara menyimpan DARZALEX FASPRO®
6. Isi kemasan dan Informasi lainnya


## 1. Apa itu DARZALEX FASPRO® dan digunakan untuk apa

**Apa itu DARZALEX FASPRO®**
DARZALEX FASPRO® adalah obat yang mengandung zat aktif daratumumab. Obat ini termasuk ke dalam kelompok obat yang disebut "antibodi monoklonal". Antibodi monoklonal adalah protein yang dirancang untuk mengenali dan menempel pada target tertentu di dalam tubuh. Daratumumab telah dirancang untuk menempel pada sel darah abnormal tertentu di tubuh Anda, sehingga sistem kekebalan Anda dapat menghancurkan sel-sel tersebut.

**Apa Kegunaan DARZALEX FASPRO®**
DARZALEX FASPRO® digunakan pada orang dewasa berusia 18 tahun keatas yang memiliki sejenis kanker yang disebut "*multiple myeloma*". Kanker ini merupakan kanker sumsum tulang.

DARZALEX FASPRO® juga digunakan pada orang dewasa berusia 18 tahun keatas, yang memiliki jenis kelainan darah yang disebut "AL amiloidosis." Pada AL amiloidosis, sel darah abnormal membuat protein abnormal dalam jumlah berlebihan yang disimpan di berbagai organ, menyebabkan organ-organ ini tidak berfungsi dengan baik.

## 2. Apa saja yang perlu Anda ketahui sebelum menggunakan DARZALEX FASPRO®

**Anda tidak boleh diberikan DARZALEX FASPRO®:**
- Jika Anda alergi terhadap daratumumab atau bahan lain dari obat ini (tercantum pada bagain 6).

Jangan menggunakan DARZALEX FASPRO® jika kondisi di atas berlaku pada Anda. Jika Anda tidak yakin, bicarakan dengan dokter atau perawat Anda sebelum Anda diberikan DARZALEX FASPRO®.

**Peringatan dan Perhatian**
Bicaralah dengan dokter atau perawat Anda sebelum menggunakan DARZALEX FASPRO®.

<u>Reaksi terkait pemberian infus</u>
DARZALEX FASPRO® diberikan dengan suntikan secara subkutan menggunakan jarum kecil dengan menyuntikkan obat di bawah kulit Anda. Sebelum dan sesudah setiap suntikan, Anda akan diberi obat-obatan untuk membantu mengurangi kemungkinan adanya reaksi terkait pemberian infus (lihat "Obat-obatan yang diberikan selama pengobatan dengan DARZALEX FASPRO®" pada bagian 3).
Reaksi-reaksi ini kemungkinan besar terjadi pada pemberian suntikan pertama dan sebagian besar reaksi muncul di hari penyuntikan. Jika Anda pernah mengalami reaksi terkait pemberian infus sebelumnya, kecil

kemungkinannya reaksi ini untuk muncul kembali. Namun, reaksi yang tertunda dapat terjadi hingga 3-4 hari setelah penyuntikan. Dokter Anda mungkin memutuskan untuk tidak menggunakan DARZALEX FASPRO® jika Anda memiliki reaksi yang berat setelah penyuntikan diberikan.

Pada beberapa kasus, Anda mungkin mengalami reaksi alergi yang berat termasuk bengkak pada wajah, bibir, mulut, lidah atau tenggorokan, sulit menelan atau bernapas atau ruam gatal (biduran). Lihat bagian 4.

Segera beritahu dokter atau perawat Anda jika Anda mengalami reaksi terkait pemberian infus seperti yang tercantum pada bagian atas di bagian 4. Jika Anda mengalami reaksi terkait pemberian infus, Anda mungkin memerlukan obat-obatan lain untuk mengobati gejalanya, atau pemberian suntikan mungkin perlu dihentikan. Bila reaksi ini hilang, atau menjadi lebih baik, pemberian suntikan bisa dimulai lagi

Penurunan jumlah sel darah
DARZALEX FASPRO® dapat menurunkan jumlah hitung sel darah putih yang berfungsi membantu melawan infeksi, dan sel darah yang disebut platelet yang berfungsi membantu menggumpalkan darah. Beritahu penyedia layanan kesehatan Anda jika Anda mengalami demam atau memiliki tanda-tanda memar atau pendarahan.

Transfusi darah
Jika Anda memerlukan transfusi darah, Anda akan menjalani tes darah terlebih dulu untuk menyesuaikan dengan tipe darah Anda. DARZALEX FASPRO® bisa mempengaruhi hasil dari tes darah ini. Beritahu pada petugas yang melakukan tes bahwa Anda sedang menggunakan DARZALEX FASPRO®.

Hepatitis B
Beri tahu dokter Anda jika Anda pernah atau mungkin sekarang memiliki infeksi hepatitis B. Hal ini dikarenakan DARZALEX FASPRO® dapat menyebabkan virus hepatitis B menjadi aktif kembali. Dokter Anda akan memeriksa tanda-tanda infeksi ini sebelum, selama, dan beberapa saat setelah perawatan dengan DARZALEX FASPRO®. Beri tahu dokter Anda segera jika Anda mengalami kelelahan yang semakin memburuk atau kulit Anda atau bagian mata Anda yang berwarna putih menjadi menguning.

**Anak-anak dan remaja**
Jangan berikan DARZALEX FASPRO® pada anak-anak atau remaja di bawah usia 18 tahun. Hal ini dikarenakan belum diketahui bagaimana obat ini akan mempengaruhi mereka.

**Penggunaan obat-obatan lain dan DARZALEX FASPRO®**
Beritahu dokter atau perawat Anda jika Anda sedang mengonsumsi, baru saja mengonsumsi atau mungkin mengonsumsi obat-obatan lain. Hal ini termasuk obat-obatan yang didapatkan tanpa resep dan obat-obatan herbal.

**Kehamilan**
Jika Anda hamil, berpikir Anda mungkin sedang hamil atau berencana untuk memiliki bayi, mintalah petunjuk dokter Anda sebelum Anda diberikan obat ini.
Jika Anda hamil saat menjalani pengobatan ini, segera beritahu dokter atau perawat Anda. Anda dan dokter Anda akan memutuskan apakah manfaat pengobatan ini lebih besar daripada risikonya pada bayi Anda.

**Kontrasepsi**
Wanita yang sedang diberikan DARZALEX FASPRO® harus menggunakan kontrasepsi yang efektif selama pengobatan dan selama 3 bulan setelah pengobatan.

**Menyusui**
Anda dan dokter Anda akan memutuskan apakah manfaat menyusui lebih besar daripada risiko pada bayi Anda. Hal ini dikarenakan obat ini dapat masuk ke dalam air susu ibu dan belum diketahui bagaimana obat tersebut akan mempengaruhi bayi Anda.

**Mengemudi dan menggunakan mesin**
Anda mungkin akan merasa letih setelah menggunakan DARZALEX FASPRO® yang dapat mempengaruhi kemampuan Anda untuk mengemudi atau menggunakan peralatan mesin.

**DARZALEX FASPRO® larutan untuk injeksi subkutan mengandung natrium**
Obat ini mengandung kurang dari 1mmol natrium (23 mg) dalam 15 mL, artinya bisa dikatakan "bebas sodium".

**DARZALEX FASPRO® larutan untuk injeksi subkutan mengandung sorbitol**
Sorbitol adalah sumber fruktosa. Jika dokter Anda memberi tahu Anda bahwa Anda memiliki intoleransi terhadap gula tertentu atau jika Anda telah didiagnosis dengan intoleransi fruktosa herediter (HFI), suatu kelainan genetik langka dimana seseorang tidak dapat memecah fruktosa, bicarakan dengan dokter Anda sebelum Anda menggunakan obat ini.

## 3. Bagaimana DARZALEX FASPRO® diberikan

**Berapa banyak obat ini diberikan**
Dosis DARZALEX FASPRO® adalah 1800 mg.
DARZALEX FASPRO® dapat diberikan sendiri atau bersamaan dengan obat-obatan lain yang digunakan untuk mengobati multiple myeloma atau bersamaan dengan obat-obatan lain untuk mengobati AL amyloidosis.

DARZALEX FASPRO® biasanya diberikan sebagai berikut:
- seminggu sekali untuk 8 minggu pertama
- kemudian setiap 2 minggu sekali selama 16 minggu
- kemudian setiap 4 minggu setelah itu selama kondisi Anda tidak memburuk

Jika DARZALEX FASPRO diberikan bersama dengan obat-obatan lain dokter Anda dapat mengubah waktu antar dosis dan juga berapa banyak pengobatan yang akan Anda terima.

**Bagaimana obat ini diberikan**
DARZALEX FASPRO® akan diberikan kepada Anda oleh dokter atau perawat berupa suntikan di bawah kulit Anda (suntikan subkutan) selama kurang lebih 3 sampai 5 menit. Obat ini diberikan di daerah perut (abdomen), bukan di tempat lain, dan tidak di daerah abdomen di mana kulitnya memerah, memar, lunak, keras atau di mana ada bekas luka.

Jika Anda mengalami rasa sakit selama penyuntikan, dokter atau perawat dapat menghentikan penyuntikan dan memberi Anda sisa suntikan di area lain di perut Anda.

**Obat-obatan yang diberikan selama pengobatan dengan DARZALEX FASPRO®**
Anda mungkin diberi obat untuk menurunkan kemungkinan terkena *cacar api (herpes zooster)*

Sebelum setiap pemberian suntikan DARZALEX FASPRO®, Anda akan diberi obat-obatan yang membantu mengurangi kemungkinan reaksi terkait pemberian suntikan. Obat-obatan tersebut termasuk:
- Obat untuk reaksi alergi (anti histamin)
- Obat untuk peradangan (kortikosteroid)
- Obat-obatan untuk demam (seperti parasetamol/asetaminofen).

Setelah setiap pemberian suntikan DARZALEX FASPRO®, Anda akan diberi obat-obatan (seperti kortikosteroid) untuk menurunkan kemungkinan reaksi terkait suntikan.

**Pasien dengan masalah pernafasan**
Jika Anda memiliki masalah pernapasan, seperti asma atau Penyakit Paru Obstruktif Kronik (PPOK), Anda akan diberi obat yang dihirup untuk membantu masalah pernapasan Anda:
- Obat-obatan untuk membantu saluran udara di paru-paru tetap terbuka (bronkodilator)
- Obat-obatan untuk menurunkan pembengkakan dan iritasi di paru-paru Anda (kortikosteroid)

**Jika Anda diberi DARZALEX FASPRO® lebih dari yang seharusnya**
Obat ini akan diberikan oleh dokter atau perawat Anda. Jika pada kejadian yang sangat jarang terjadi Anda diberi dosis terlalu banyak (overdosis), dokter Anda akan memeriksa Anda untuk melihat efek samping yang mungkin terjadi.

**Jika Anda melupakan jadwal Anda untuk mendapatkan DARZALEX FASPRO®**
Hal sangat penting untuk menjalani seluruh jadwal pengobatan Anda untuk memastikan pengobatan Anda barhasil. Jika Anda melewatkan jadwal Anda, sesegera mungkin menggantinya.
Jika Anda memiliki pertanyaan lebih lanjut tentang penggunaan obat ini, tanyakan kepada dokter atau perawat Anda.

## 4. Efek samping

Seperti semua obat lainnya, obat ini dapat menyebabkan efek samping, meskipun tidak semua orang mengalaminya.

**Reaksi terkait infus**
Beritahu dokter atau perawat Anda segera jika Anda mendapatkan tanda-tanda reaksi terkait pemberian suntikan berikut dalam 3-4 hari setelah pemberian suntikan. Anda mungkin memerlukan obat-obatan lain, atau pemberian suntikan harus disela atau dihentikan.

Reaksi-reaksi tersebut termasuk gejala berikut:

Sangat umum (dapat dialami lebih dari 1 dari 10 orang):
- menggigil
- sakit tenggorokan, batuk
- merasa sakit (mual)
- muntah
- hidung gatal, berair atau tersumbat
- merasa sesak napas atau masalah pernafasan lainnya

Umum (mempengaruhi hingga 1 dari 10 orang) yaitu:
- Rasa tidak nyaman pada dada
- pusing atau kepala terasa ringan (hipotensi)
- gatal
- mengi

Jarang (mempengaruhi 1 dari 1000 orang):
- reaksi alergi yang parah termasuk bengkak pada wajah, bibir, mulut, lidah atau tenggorokan, sulit menelan atau bernapas atau ruam gatal (biduran). Lihat bagian 2.
- Sakit mata
- Pandangan kabur

Jika Anda mengalami salah satu dari reaksi terkait pemberian suntikan di atas, segera beritahu dokter atau perawat Anda.

**Reaksi di tempat suntikan**
Reaksi kulit di dekat tempat suntikan (lokal), termasuk reaksi di tempat suntikan, dapat terjadi dengan DARZALEX FASPRO® larutan untuk suntikan subkutan. Reaksi-reaksi ini umum terjadi (dapat mempengaruhi hingga 1 dari 10 orang). Gejala di tempat suntikan termasuk kemerahan pada kulit, gatal, bengkak, nyeri, memar, ruam, pendarahan.

**Efek samping lainnya**
**Sangat umum (dapat dialami lebih dari 1 dari 10 orang):**
- demam
- merasa sangat lelah
- diare
- konstipasi
- nyeri perut
- penurunan nafsu makan

- susah tidur
- sakit kepala
- kerusakan syaraf yang dapat menyebabkan kesemutan, mati rasa atau nyeri
- ruam
- kejang otot
- nyeri sendi
- pembengkakan pada tangan, kaki
- merasa lemah
- sakit punggung
- infeksi paru-paru (pneumonia)
- bronkitis
- infeksi saluran udara - seperti hidung, sinus atau tenggorokan
- jumlah hitung sel darah merah yang rendah yang membawa oksigen dalam darah (anemia)
- jumlah hitung sel darah putih yang rendah yang membantu melawan infeksi yang rendah (neutropenia, limfopenia, leukopenia)
- Jumlah hitung tipe sel darah yang disebut platelet yang rendah yang membantu proses penggumpalan darah yang rendah (*trombositopenia)*
- kadar kalium rendah dalam darah (hipokalemia)
- COVID-19

**Umum (dapat dialami hingga 1 dari 10 orang):**
- detak jantung tidak teratur (fibrilasi atrium)
- cairan yang tertimbun di paru-paru yang membuat Anda sesak napas
- infeksi saluran kemih
- infeksi yang parah di seluruh tubuh (sepsis)
- dehidrasi
- kadar gula yang tinggi dalam darah
- kadar kalsium yang rendah dalam darah
- Level yang rendah pada antibodi yang disebut 'imunoglobulin' di dalam darah yang membantu melawan infeksi (hipogammaglobulinemia)
- merasa pusing
- pingsan
- nyeri otot dada
- kedinginan
- gatal
- perasaan yang tidak biasa pada kulit (seperti kesemutan atau perasaan merangkak)
- radang pankreas
- tekanan darah tinggi

**Tidak umum (dapat dialami hingga 1 dari 100 orang)**
- radang hati/liver (hepatitis)
- infeksi virus herpes (cytomegalovirus)

Beritahukan ke dokter / perawat / apoteker apabila Anda mengalami efek samping setelah mendapatkan obat ini.

## 5. Bagaimana cara menyimpan DARZALEX FASPRO®

DARZALEX FASPRO® larutan untuk suntikan subkutan akan disimpan di rumah sakit atau klinik.
Jauhkan obat ini dari pandangan dan jangkauan anak-anak.
Jangan gunakan obat ini setelah masa kedaluwarsa yang tertera pada dus dan label setelah tulisan EXP. Tanggal kedaluwarsa mengacu pada hari terakhir pada bulan tersebut.
Simpan dalam suhu 2°C - 8°C. Jangan dibekukan. Jangan dikocok.
Simpan pada kemasan asli untuk melindungi dari cahaya.

Jangan membuang obat apa pun melalui air limbah atau limbah rumah tangga. Tenaga kesehatan Anda akan membuang obat-obatan yang tidak lagi digunakan. Langkah-langkah ini akan membantu melindungi lingkungan.

## 6. Isi kemasan dan informasi lainnya

**Apa kandungan DARZALEX FASPRO®**

- Zat aktif adalah daratumumab. Satu mL larutan mengandung 120 mg daratumumab. Tiap vial 15 mL larutan untuk injeksi mengandung 1800 mg daratumumab.
- Bahan kandungan lainnya adalah recombinant human hyaluronidase (rHuPH20), L-histidine, L-histidine hydrochloride monohydrate, L-methionine, polysorbate 20, sorbitol dan air untuk suntikan (lihat "DARZALEX FASPRO® mengandung sodium dan sorbitol" pada bagian 2.

**Seperti apa DARZALEX FASPRO® terlihat dan isi kemasannya**

DARZALEX FASPRO® larutan untuk injeksi subkutan adalah cairan tidak berwarna hingga kekuningan.
DARZALEX FASPRO® tersedia dalam kemasan dus berisi 1 vial kaca.

No. Reg:

**HARUS DENGAN RESEP DOKTER**

**Diproduksi oleh:** Cilag AG, Schaffhausen, Switzerland.

**Didaftarkan dan dipasarkan oleh:**
PT. SOHO Industri Pharmasi, a SOHO Global Health Company, Jakarta – Indonesia.

Untuk pelaporan efek samping dan keluhan kualitas produk, dapat menghubungi pv.soho@sohoglobalhealth.com atau (021) 460-5550

Informasi berikut ditujukan untuk profesional kesehatan saja:

DARZALEX FASPRO® larutan untuk suntikan subkutan harus diberikan oleh profesional kesehatan.

Untuk mencegah kesalahan pengobatan, penting untuk memeriksa label vial untuk memastikan bahwa formulasi (formulasi intravena atau subkutan) dan dosis yang diberikan ke pasien yang diresepkan. DARZALEX FASPRO® laurtan untuk suntikan harus diberikan hanya dengan suntikan subkutan, dengan spesifik dosis. DARZALEX FASPRO® tidak dimaksudkan untuk pemberian intravena.

DARZALEX FASPRO® larutan untuk suntikan subkutan hanya untuk sekali pakai dan siap digunakan.

- DARZALEX FASPRO® larutan untuk suntikan subkutan dapat digunakan dengan menggunakan alat suntik berbahan polipropilen atau polietilen; set infus subkutan berbahan polipropilen, polietilen, atau polivinil klorida (PVC); dan jarum transfer atau suntik berbahan stainless steel.
- DARZALEX FASPRO® larutan untuk suntikan subkutan harus berupa larutan tidak berwarna hingga kekuningan. Jangan digunakan jika ada partikel keruh, perubahan warna atau partikel asing lainnya.
- Keluarkan vial DARZALEX FASPRO® larutan untuk suntikan subkutan dari penyimpanan berpendingin [2°C–8°C] dan seimbangkan dengan suhu sekitar [15°C–30°C]. Vial yang belum ditusuk dengan jarum suntik dapat disimpan pada suhu dan cahaya ruang selama maksimal 24 jam. Jauhkan dari sinar matahari langsung. Jangan dikocok.
- Siapkan jarum suntik dalam kondisi aseptik yang terkontrol dan tervalidasi.
- Untuk menghindari penyumbatan jarum, pasang jarum suntik hipodermik atau set infus subkutan ke alat suntik, sesaat sebelum penyuntikan.

<u>Penyimpanan jarum suntik yang sudah disiapkan</u>

- Jika jarum suntik yang mengandung DARZALEX FASPRO® tidak segera digunakan, simpan larutan DARZALEX FASPRO® hingga 24 jam dalam lemari pendingin (suhu 2°C-8°C), kemudian 7 jam pada suhu

15°C-30°C dan cahaya ruang. Jika disimpan dalam pendingin, biarkan larutan mencapai suhu ruang sebelum diberikan.

Cara pemberian suntikan

- Suntikkan 15 mL DARZALEX FASPRO® larutan untuk suntikan subkutan ke dalam jaringan subkutan perut kira-kira 7,5 cm di sebelah kanan atau kiri pusar selama kurang lebih 3-5 menit. Jangan menyuntikkan DARZALEX FASPRO® larutan untuk suntikan subkutan di bagian lain dari tubuh karena tidak ada data terkait hal ini.
- Tempat penyuntikan harus dirotasi untuk penyuntikan yang berurutan.
- DARZALEX FASPRO® larutan untuk suntikan subkutan tidak boleh disuntikkan ke area kulit yang merah, memar, nyeri, keras atau area yang terdapat bekas luka.
- Jeda atau perlambat suntikan jika pasien mengalami nyeri. Jika rasa sakit tidak berkurang dengan memperlambat suntikan, tempat suntikan kedua dapat dipilih di sisi berlawanan dari perut untuk memberikan sisa dosis.
- Selama pengobatan dengan DARZALEX FASPRO® larutan untuk suntikan subkutan, jangan berikan obat lain untuk penggunaan subkutan di tempat yang sama dengan DARZALEX FASPRO®.
- Setiap produk obat atau bahan limbah yang tidak terpakai harus dibuang sesuai dengan peraturan setempat.

Ketertelusuran

Untuk meningkatkan ketertelusuran produk obat biologis, nama dagang dan nomor bets produk yang diberikan harus dicatat dengan jelas.

Berdasarkan EU SmPC 20250404

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