

HIGHLIGHTS OF PRESCRIBING INFORMATION

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

SUBLOCADE (buprenorphine extended-release) injection, for subcutaneous use CIII
Initial U.S. Approval: 2002

WARNING: RISK OF SERIOUS HARM OR DEATH WITH INTRAVENOUS ADMINISTRATION; SUBLOCADE RISK EVALUATION AND MITIGATION STRATEGY

See full prescribing information for complete boxed warning.

- Serious harm or death could result if administered intravenously. (5.1)
- SUBLOCADE is only available through a restricted program called the SUBLOCADE REMS Program. Healthcare settings and pharmacies that order and dispense SUBLOCADE must be certified in this program and comply with the REMS requirements. (5.2)

INDICATIONS AND USAGE

SUBLOCADE contains buprenorphine, a partial opioid agonist, and is indicated for the treatment of moderate to severe opioid use disorder in patients who have initiated treatment with a transmucosal buprenorphine-containing product, followed by dose adjustment for a minimum of 7 days. (1)

SUBLOCADE should be used as part of a complete treatment program that includes counseling and psychosocial support. (1)

DOSAGE AND ADMINISTRATION

Prescription use of this product is limited under the Drug Addiction Treatment Act. (2.1)

SUBLOCADE should only be prepared and administered by a healthcare provider. (2.2)

SUBLOCADE is administered monthly only by subcutaneous injection in the abdominal region. (2.2)

The recommended dose of SUBLOCADE is two monthly initial doses of 300 mg followed by 100 mg monthly maintenance doses. (2.3)

Increasing the maintenance dose to 300 mg monthly may be considered for patients in which the benefits outweigh the risks. (2.3)

Examine the injection site for signs of infection or evidence of tampering or attempts to remove the depot. (2.5)

See Full Prescribing Information for administration instructions. (2.6)

DOSAGE FORMS AND STRENGTHS

Injection: 100 mg/0.5 mL and 300 mg/1.5 mL provided in a prefilled syringe with a 19 Gauge 5/8-inch needle. (3)

CONTRAINDICATIONS

Hypersensitivity to buprenorphine or any other ingredients in SUBLOCADE. (4)

WARNINGS AND PRECAUTIONS

Addiction, Abuse, and Misuse: Buprenorphine can be abused in a manner similar to other opioids. Monitor patients for conditions indicative of diversion or progression of opioid dependence and addictive behaviors. (5.3)

Respiratory Depression: Life-threatening respiratory depression and death have occurred in association with buprenorphine. Warn patients of the potential danger of self-administration of benzodiazepines or other CNS depressants while under treatment with SUBLOCADE. (5.4, 5.5)

Neonatal Opioid Withdrawal Syndrome: Neonatal opioid withdrawal syndrome (NOWS) is an expected and treatable outcome of prolonged use of opioids during pregnancy. (5.6)

Adrenal Insufficiency: If diagnosed, treat with physiologic replacement of corticosteroids, and wean patient off of the opioid. (5.7)

Risk of Opioid Withdrawal With Abrupt Discontinuation: If treatment with SUBLOCADE is discontinued, monitor patients for several months for withdrawal and treat appropriately. (5.8)

Risk of Hepatitis, Hepatic Events: Monitor liver function tests prior to and during treatment. (5.9)

Risk of Withdrawal in Patients Dependent on Full Agonist Opioids: Verify that patient is clinically stable on transmucosal buprenorphine before injecting SUBLOCADE. (5.11)

Treatment of Emergent Acute Pain: Treat pain with a non-opioid analgesic whenever possible. If opioid therapy is required, monitor patients closely because higher doses may be required for analgesic effect. (5.12)

ADVERSE REACTIONS

Adverse reactions commonly associated with SUBLOCADE (in ≥5% of subjects) were constipation, headache, nausea, injection site pruritus, vomiting, increased hepatic enzymes, fatigue, and injection site pain. (6)

To report SUSPECTED ADVERSE REACTIONS, contact Indivior Inc. at 1-877-782-6966 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

CYP3A4 Inhibitors and Inducers: Monitor patients starting or ending CYP3A4 inhibitors or inducers for potential over- or under-dosing. (7)

Serotonergic Drugs: If concomitant use is warranted, monitor for serotonin syndrome, particularly during treatment initiation, and during dose adjustment of the serotonergic drug. (7)

USE IN SPECIFIC POPULATIONS

Lactation: Buprenorphine passes into the mother's milk. (8.2)

Geriatric Patients: Monitor for sedation or respiratory depression. (8.5)

Moderate to Severe Hepatic Impairment: Not recommended. (5.14, 8.6)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 11/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

WARNING: RISK OF SERIOUS HARM OR DEATH WITH INTRAVENOUS ADMINISTRATION; SUBLOCADE RISK EVALUATION AND MITIGATION STRATEGY

1 INDICATIONS AND USAGE

2 DOSAGE AND ADMINISTRATION

- 2.1 Drug Addiction Treatment Act
- 2.2 Important Dosing and Administration Information
- 2.3 Recommended Dosing
- 2.4 Patient Selection
- 2.5 Clinical Supervision
- 2.6 Instructions for Use
- 2.7 Limits on Distribution
- 2.8 Removal of the Depot

3 DOSAGE FORMS AND STRENGTHS

4 CONTRAINDICATIONS

5 WARNINGS AND PRECAUTIONS

- 5.1 Risk of Serious Harm or Death With Intravenous Administration
- 5.2 SUBLOCADE Risk Evaluation and Mitigation Strategy (REMS) Program
- 5.3 Addiction, Abuse, and Misuse
- 5.4 Risk of Respiratory and Central Nervous System (CNS) Depression
- 5.5 Managing Risks From Concomitant Use of Benzodiazepines or Other CNS Depressants With Buprenorphine
- 5.6 Neonatal Opioid Withdrawal Syndrome
- 5.7 Adrenal Insufficiency
- 5.8 Risk of Opioid Withdrawal With Abrupt Discontinuation of SUBLOCADE Treatment
- 5.9 Risk of Hepatitis, Hepatic Events
- 5.10 Hypersensitivity Reactions
- 5.11 Precipitation of Opioid Withdrawal in Patients Dependent on Full Agonist Opioids
- 5.12 Risks Associated With Treatment of Emergent Acute Pain
- 5.13 Use in Opioid Naïve Patients
- 5.14 Use in Patients With Impaired Hepatic Function
- 5.15 Use in Patients at Risk for Arrhythmia
- 5.16 Impairment of Ability to Drive or Operate Machinery

- 5.17 Orthostatic Hypotension
- 5.18 Elevation of Cerebrospinal Fluid Pressure
- 5.19 Elevation of Intrahepatic Bile Duct Pressure
- 5.20 Effects in Acute Abdominal Conditions
- 5.21 Unintentional Pediatric Exposure

6 ADVERSE REACTIONS

- 6.1 Clinical Trials Experience
- 6.2 Postmarketing Experience

7 DRUG INTERACTIONS

8 USE IN SPECIFIC POPULATIONS

- 8.1 Pregnancy
- 8.2 Lactation
- 8.3 Females and Males of Reproductive Potential
- 8.4 Pediatric Use
- 8.5 Geriatric Use
- 8.6 Hepatic Impairment
- 8.7 Renal Impairment

9 DRUG ABUSE AND DEPENDENCE

- 9.1 Controlled Substance
- 9.2 Abuse
- 9.3 Dependence

10 OVERDOSAGE

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY

- 12.1 Mechanism of Action
- 12.2 Pharmacodynamics
- 12.3 Pharmacokinetics

13 NONCLINICAL TOXICOLOGY

- 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

14 CLINICAL STUDIES

- 14.1 Study 13-0002, NCT02044094
- 14.2 Study 13-0001, NCT02357901

16 HOW SUPPLIED/STORAGE AND HANDLING

17 PATIENT COUNSELING INFORMATION

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

1 **FULL PRESCRIBING INFORMATION**

**WARNING: RISK OF SERIOUS HARM OR DEATH WITH INTRAVENOUS ADMINISTRATION;
SUBLOCADE RISK EVALUATION AND MITIGATION STRATEGY**

- **Serious harm or death could result if administered intravenously. SUBLOCADE forms a solid mass upon contact with body fluids and may cause occlusion, local tissue damage, and thrombo-embolic events, including life threatening pulmonary emboli, if administered intravenously. (5.1)**
- **Because of the risk of serious harm or death that could result from intravenous self-administration, SUBLOCADE is only available through a restricted program called the SUBLOCADE REMS Program. Healthcare settings and pharmacies that order and dispense SUBLOCADE must be certified in this program and comply with the REMS requirements. (5.2)**

2 **1 INDICATIONS AND USAGE**

3 SUBLOCADE is indicated for the treatment of moderate to severe opioid use disorder in patients who
4 have initiated treatment with a transmucosal buprenorphine-containing product, followed by dose
5 adjustment for a minimum of 7 days.

6 SUBLOCADE should be used as part of a complete treatment plan that includes counseling and
7 psychosocial support.

8 **2 DOSAGE AND ADMINISTRATION**

9 **2.1 Drug Addiction Treatment Act**

10 Under the Drug Addiction Treatment Act (DATA) codified at 21 U.S.C. 823(g), prescription use of this
11 product in the treatment of opioid dependence is limited to healthcare providers who meet certain
12 qualifying requirements, and who have notified the Secretary of Health and Human Services (HHS) of
13 their intent to prescribe this product for the treatment of opioid dependence and have been assigned a
14 unique identification number that must be included on every prescription.

15 **2.2 Important Dosing and Administration Information**

16 FOR ABDOMINAL SUBCUTANEOUS INJECTION ONLY. DO NOT ADMINISTER SUBLOCADE
17 INTRAVENOUSLY OR INTRAMUSCULARLY [see Warnings and Precautions (5.1), Dosage and
18 Administration (2.6)].

- Only healthcare providers should prepare and administer SUBLOCADE.
- Administer SUBLOCADE monthly with a minimum of 26 days between doses.
- Initiating treatment with SUBLOCADE as the first buprenorphine product has not been studied. Initiate SUBLOCADE treatment only following induction and dose-adjustment with a transmucosal buprenorphine-containing product [see Dosage and Administration (2.4)].
- Administer each injection only using the syringe and safety needle included with the product [see Dosage and Administration (2.6)].

26 **2.3 Recommended Dosing**

27 The recommended dose of SUBLOCADE following induction and dose adjustment with transmuscosal
28 buprenorphine is 300 mg monthly for the first two months followed by a maintenance dose of 100 mg
29 monthly.

30 The maintenance dose may be increased to 300 mg monthly for patients who tolerate the 100 mg dose,
31 but do not demonstrate a satisfactory clinical response, as evidenced by self-reported illicit opioid use or
32 urine drug screens positive for illicit opioid use.

33 A patient who misses a dose should receive the next dose as soon as possible, with the following dose
34 given no less than 26 days later. Occasional delays in dosing up to 2 weeks are not expected to have a
35 clinically significant impact on treatment effect.

36 **2.4 Patient Selection**

37 Patients appropriate for SUBLOCADE are adults who have initiated treatment on a transmucosal
38 buprenorphine-containing product delivering the equivalent of 8 to 24 mg of buprenorphine daily. The
39 patient may only be transitioned to SUBLOCADE after a minimum of 7 days.

40 Initiation of treatment with transmucosal buprenorphine-containing products should be based on
41 instructions in their appropriate product label. One SUBOXONE® (buprenorphine and naloxone) 8 mg/2
42 mg sublingual tablet provides equivalent buprenorphine exposure to one SUBUTEX® (buprenorphine
43 HCl) 8 mg sublingual tablet or one Bunavail® (buprenorphine and naloxone) 4.2mg/0.7 mg buccal film or
44 one Zubsolv® (buprenorphine and naloxone) 5.7 mg/1.4 mg sublingual tablet.

45 **2.5 Clinical Supervision**

46 Periodic assessment is necessary to determine effectiveness of the treatment plan and overall patient
47 progress. When evaluating the patient, examine the injection site for signs of infection or evidence of
48 tampering or attempts to remove the depot.

49 Due to the chronic nature of opioid use disorder, the need for continuing medication-assisted treatment
50 should be re-evaluated periodically. There is no maximum recommended duration of maintenance
51 treatment. For some patients, treatment may continue indefinitely. If considering stopping treatment,
52 the clinical status of the patient should be considered.

53

54 If SUBLOCADE is discontinued, its extended-release characteristics should be considered and the patient
55 should be monitored for several months for signs and symptoms of withdrawal and treated
56 appropriately. After steady-state has been achieved (4-6 months), patients discontinuing SUBLOCADE
57 may have detectable plasma levels of buprenorphine for twelve months or longer. The correlation
58 between plasma concentrations of buprenorphine and those detectable in urine is not known.

59 **2.6 Instructions for Use**

60 IMPORTANT INFORMATION:

- 61
- 62 • For abdominal subcutaneous injection only [see *Warnings and Precautions (5.1)*].
 - 63 • To be prepared and administered by a healthcare provider only.
 - 64 • Please read the instructions carefully before handling the product.
 - As a universal precaution, always wear gloves.

- 65
- Remove SUBLOCADE from the refrigerator prior to administration. The product requires at least
- 66 15 minutes to reach room temperature. Do not open the foil pouch until the patient has arrived
- 67 for his or her injection.
- Discard SUBLOCADE if left at room temperature for longer than 7 days.
- 68
- Do not attach the needle until time of administration.
- 69
- 70

71 **STEP 1: GETTING READY**

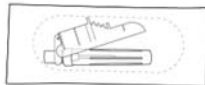
72 Remove the foil pouch and safety needle from the carton. Open the pouch and remove the syringe.

73 Discard the oxygen absorber pack. It is not needed.

74 **Figure 1**



syringe



safety
needle

75

76

77 **STEP 2: CHECK THE LIQUID CLARITY**

78 Check that the medication does not contain contaminants or particles. SUBLOCADE ranges from

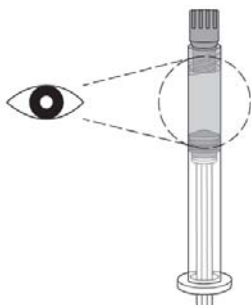
79 colorless to yellow to amber. Variations of color within this range do not affect the potency of the

80 product.

81 Parenteral drug products should be inspected visually for particulate matter and discoloration prior to

82 administration, whenever solution and container permit.

83 **Figure 2**



84

85

86 **STEP 3: ATTACH THE SAFETY NEEDLE**

87 Remove the cap from the syringe and the safety needle supplied in the carton from its sterile package.

88 Gently twist the needle clockwise until it is tight and firmly attached.

89 Do not remove the plastic cover from the needle.

90 **Figure 3**



91

92

93 **STEP 4: PREPARE THE ABDOMINAL INJECTION SITE**

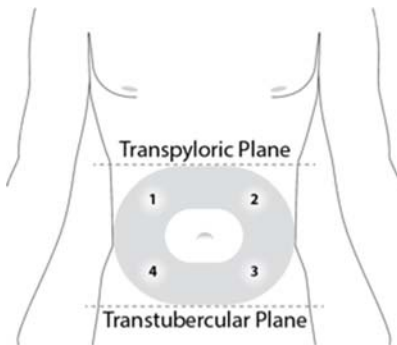
94 Choose an injection site on the abdomen between the transpyloric and transtuberular planes with
95 adequate subcutaneous tissue that is free of skin conditions (e.g., nodules, lesions, excessive pigment).
96 It is recommended that the patient is in the supine position.

97 Do not inject into an area where the skin is irritated, reddened, bruised, infected or scarred in any way.

98 Clean the injection site well with an alcohol swab.

99 To avoid irritation, rotate injection sites following a pattern similar to the illustration in Figure 4. Record
100 the location of the injection to ensure that a different site is used at the time of the next injection.

101 **Figure 4**



102

103

104 **STEP 5: REMOVE EXCESS AIR FROM SYRINGE**

105 Hold the syringe upright for several seconds to allow air bubbles to rise. Due to the viscous nature of the
106 medication, bubbles will not rise as quickly as those in an aqueous solution.

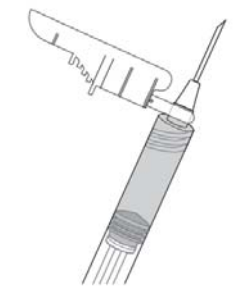
107 Remove needle cover and slowly depress the plunger to push out the excess air from the syringe.

- 108
- Small bubbles may remain in the medication. Large air gaps, however, can be minimized by
109 pulling back on the plunger rod to pop air bubbles prior to expelling the air very slowly. Air
110 should be expelled very carefully to avoid loss of medication.

111 If medication is seen at the needle tip, pull back slightly on the plunger to prevent medication spillage.

112 **Figure 5**

113



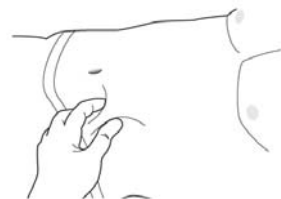
114

115

116 **STEP 6: PINCH THE INJECTION SITE**

117 Pinch the skin around the injection area. Be sure to pinch enough skin to accommodate the size of the
118 needle. Lift the adipose tissue from the underlying muscle to prevent accidental intramuscular injection.

119 **Figure 6**



120

121

122 **STEP 7: INJECT THE MEDICATION**

123 SUBLOCADE is for subcutaneous injection only. Do not inject intravenously or intramuscularly [see
124 *Warnings and Precautions (5.1)*].

125 Insert needle fully into the abdominal subcutaneous tissue. Actual angle of injection will depend on the
126 amount of subcutaneous tissue.

127 Use a slow, steady push to inject the medication. Continue pushing until all of the medication is given.

128 **Figure 7**

129



130

131

132 **STEP 8: WITHDRAW THE NEEDLE**

133 Withdraw the needle at the same angle used for insertion and release the pinched skin.

134 Do not rub the injection area after the injection. If there is bleeding, apply a gauze pad or bandage but
135 use minimal pressure.

136 **Figure 8**



137

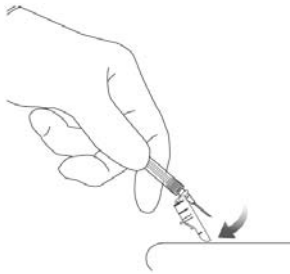
138

139 **STEP 9: LOCK THE NEEDLE GUARD AND DISCARD THE SYRINGE**

140 Lock the needle guard into place by pushing it against a hard surface such as a table (Figure 9).

141 Dispose of all syringe components in a secure sharps disposal container.

142 **Figure 9**



143

144 **STEP 10: INSTRUCT THE PATIENT**

145 Advise the patient that they may have a lump for several weeks that will decrease in size over time.
146 Instruct the patient not to rub or massage the injection site and to be aware of the placement of any
147 belts or clothing waistbands.

148 **2.7 Limits on Distribution**

149 SUBLOCADE is subject to a risk evaluation and mitigation strategy (REMS) program that includes, among
150 other elements, a restricted distribution system. The purpose of the restricted distribution system is to
151 ensure that SUBLOCADE is only administered by a health care provider [see *Warnings and Precautions*
152 (5.2)].

153 **2.8 Removal of the Depot**

154 In the event the depot must be removed, it can be surgically excised under local anesthesia within 14
155 days of injection. Only the most recently-injected depot can be removed.

156 The removed depot should be handled with adequate security, accountability, and proper disposal, per
157 facility procedure for a Schedule III drug product and pharmaceutical biohazardous waste, and per

158 applicable federal, state, and local regulations.

159 The residual plasma concentrations from previous injections will decrease gradually over subsequent
160 months [see *Clinical Pharmacology (12.3)*].

161 Patients who have the depot removed should be monitored for signs and symptoms of withdrawal and
162 treated appropriately [see *Warnings and Precautions (5.8)*].

163 **3 DOSAGE FORMS AND STRENGTHS**

164 SUBLOCADE is available in dosage strengths of 100 mg/0.5 mL and 300 mg/1.5 mL buprenorphine. Each
165 dose is a clear, colorless to yellow to amber solution provided in a prefilled syringe with a 19 gauge 5/8-
166 inch needle.

167 **4 CONTRAINDICATIONS**

168 SUBLOCADE should not be administered to patients who have been shown to be hypersensitive to
169 buprenorphine or any component of the ATRIGEL® delivery system [see *Warnings and Precautions*
170 *(5.10)*].

171 **5 WARNINGS AND PRECAUTIONS**

172 **5.1 Risk of Serious Harm or Death With Intravenous Administration**

173 Intravenous injection presents significant risk of serious harm or death as SUBLOCADE forms a solid
174 mass upon contact with body fluids. Occlusion, local tissue damage, and thrombo-embolic events,
175 including life threatening pulmonary emboli, could result if administered intravenously [see *Warnings*
176 *and Precautions (5.2), Drug Abuse and Dependence (9.2)*]. Do not administer intravenously or
177 intramuscularly.

178 **5.2 SUBLOCADE Risk Evaluation and Mitigation Strategy (REMS) Program**

179 SUBLOCADE is available only through a restricted program called the SUBLOCADE REMS Program
180 because of the risk of serious harm or death that could result from intravenous self-administration. The
181 goal of the REMS is to mitigate serious harm or death that could result from intravenous self-
182 administration by ensuring that healthcare settings and pharmacies are certified and only dispense
183 SUBLOCADE directly to a healthcare provider for administration by a health care provider.

184 Notable requirements of the SUBLOCADE REMS Program include the following:

- 185 • Healthcare Settings and Pharmacies that order and dispense SUBLOCADE must be certified in
186 the SUBLOCADE REMS Program.
- 187 • Certified Healthcare Settings and Pharmacies must establish processes and procedures to verify
188 SUBLOCADE is provided directly to a healthcare provider for administration by a healthcare
189 provider, and the drug is not dispensed to the patient.
- 190 • Certified Healthcare Settings and Pharmacies must not distribute, transfer, loan, or sell
191 SUBLOCADE.

192 Further information is available at www.SublocadeREMS.com or call 1-866-258-3905.

193 **5.3 Addiction, Abuse, and Misuse**

194 SUBLOCADE contains buprenorphine, a Schedule III controlled substance that can be abused in a
195 manner similar to other opioids. Buprenorphine is sought by people with opioid use disorder and is
196 subject to criminal diversion. Monitor all patients for progression of opioid use disorder and addictive
197 behaviors [see *Drug Abuse and Dependence (9.2)*].

198 **5.4 Risk of Respiratory and Central Nervous System (CNS) Depression**

199 Buprenorphine has been associated with life-threatening respiratory depression and death. Many, but
200 not all, postmarketing reports regarding coma and death involved misuse by self-injection or were
201 associated with the concomitant use of buprenorphine and benzodiazepines or other CNS depressants,
202 including alcohol. Warn patients of the potential danger of self-administration of benzodiazepines or
203 other CNS depressants while under treatment with SUBLOCADE [see *Warnings and Precautions (5.5)*,
204 *Drug Interactions (7)*, *Patient Counseling Information (17)*].

205 Use SUBLOCADE with caution in patients with compromised respiratory function (e.g., chronic
206 obstructive pulmonary disease, cor pulmonale, decreased respiratory reserve, hypoxia, hypercapnia, or
207 pre-existing respiratory depression).

208 Due to its extended-release characteristics, if SUBLOCADE is discontinued as a result of compromised
209 respiratory function, monitor patients for ongoing buprenorphine effects for several months.

210 **5.5 Managing Risks From Concomitant Use of Benzodiazepines Or Other CNS Depressants With**
211 **Buprenorphine**

212 Concomitant use of buprenorphine and benzodiazepines or other CNS depressants increases the risk of
213 adverse reactions including overdose, respiratory depression, and death. Medication-assisted
214 treatment of opioid use disorder, however, should not be categorically denied to patients taking these
215 drugs. Prohibiting or creating barriers to treatment can pose an even greater risk of morbidity and
216 mortality due to the opioid use disorder alone.

217
218 As a routine part of orientation to buprenorphine treatment, educate patients about the risks of
219 concomitant use of benzodiazepines, sedatives, opioid analgesics, and alcohol.

220
221 Develop strategies to manage use of prescribed or illicit benzodiazepines or other CNS depressants at
222 initiation of buprenorphine treatment, or if it emerges as a concern during treatment. Adjustments to
223 induction procedures and additional monitoring may be required. There is no evidence to support dose
224 limitations or arbitrary caps of buprenorphine as a strategy to address benzodiazepine use in
225 buprenorphine-treated patients. However, if a patient is sedated at the time of buprenorphine dosing,
226 delay or omit the buprenorphine dose if appropriate.

227
228 Cessation of benzodiazepines or other CNS depressants is preferred in most cases of concomitant use
229 with buprenorphine. In some cases, monitoring in a higher level of care for taper may be appropriate. In
230 others, gradually tapering a patient off of a prescribed benzodiazepine or other CNS depressant or
231 decreasing to the lowest effective dose may be appropriate.

232
233 For patients in buprenorphine treatment, benzodiazepines are not the treatment of choice for anxiety
234 or insomnia. Before co-prescribing benzodiazepines, ensure that patients are appropriately diagnosed
235 and consider alternative medications and non-pharmacologic treatments to address anxiety or

236 insomnia. Ensure that other healthcare providers prescribing benzodiazepines or other CNS depressants
237 are aware of the patient's buprenorphine treatment and coordinate care to minimize the risks
238 associated with concomitant use.

239
240 In addition, take measures to confirm that patients are taking their medications as prescribed and are
241 not diverting or supplementing with illicit drugs. Toxicology screening should test for prescribed and
242 illicit benzodiazepines [see *Drug Interactions (7)*].

243 **5.6 Neonatal Opioid Withdrawal Syndrome**

244 Neonatal opioid withdrawal syndrome (NOWS) is an expected and treatable outcome of prolonged use
245 of opioids during pregnancy, whether that use is medically-authorized or illicit. Unlike opioid withdrawal
246 syndrome in adults, NOWS may be life-threatening if not recognized and treated in the neonate.
247 Healthcare professionals should observe newborns for signs of NOWS and manage accordingly [see *Use*
248 *in Specific Populations (8.1)*].

249 Advise pregnant women receiving opioid addiction treatment with SUBLOCADE of the risk of neonatal
250 opioid withdrawal syndrome and ensure that appropriate treatment will be available [see *Use in Specific*
251 *Populations (8.1)*]. This risk should be balanced against the risk of untreated opioid addiction which
252 often results in continued or relapsing illicit opioid use and is associated with poor pregnancy outcomes.
253 Therefore, prescribers should discuss the importance of management of opioid addiction throughout
254 pregnancy.

255 **5.7 Adrenal Insufficiency**

256 Cases of adrenal insufficiency have been reported with opioid use, more often following greater than
257 one month of use. Presentation of adrenal insufficiency may include non-specific symptoms and signs
258 including nausea, vomiting, anorexia, fatigue, weakness, dizziness, and low blood pressure. If adrenal
259 insufficiency is suspected, confirm the diagnosis with diagnostic testing as soon as possible. If adrenal
260 insufficiency is diagnosed, treat with physiologic replacement doses of corticosteroids. Wean the patient
261 off the opioid to allow adrenal function to recover and continue corticosteroid treatment until adrenal
262 function recovers. Other opioids may be tried as some cases reported use of a different opioid without
263 recurrence of adrenal insufficiency. The information available does not identify any particular opioids as
264 being more likely to be associated with adrenal insufficiency.

265 **5.8 Risk of Opioid Withdrawal With Abrupt Discontinuation of SUBLOCADE Treatment**

266 Buprenorphine is a partial agonist at the mu-opioid receptor and chronic administration produces
267 physical dependence of the opioid type, characterized by withdrawal signs and symptoms upon abrupt
268 discontinuation. The withdrawal syndrome is milder than that seen with full agonists and may be
269 delayed in onset [see *Drug Abuse and Dependence (9.3)*].

270 Withdrawal signs and symptoms were not observed in the month following discontinuation of
271 SUBLOCADE. Considering the long half-life, any withdrawal signs and symptoms that may occur would
272 be expected to be delayed [see *Clinical Pharmacology (12.2)*]. Model simulations indicate that steady-
273 state buprenorphine plasma concentrations decreased slowly over time following the last injection and
274 remained at therapeutic levels for 2 to 5 months on average, depending on the dosage administered
275 (100 or 300 mg, respectively).

276 Patients who elect to discontinue treatment with SUBLOCADE should be monitored for withdrawal signs

277 and symptoms. Consider transmucosal buprenorphine if needed to treat withdrawal after discontinuing
278 SUBLOCADE.

279 **5.9 Risk of Hepatitis, Hepatic Events**

280 Cases of cytolytic hepatitis and hepatitis with jaundice have been observed in individuals receiving
281 buprenorphine in clinical trials and through postmarketing adverse event reports. The spectrum of
282 abnormalities ranges from transient asymptomatic elevations in hepatic transaminases to case reports
283 of death, hepatic failure, hepatic necrosis, hepatorenal syndrome, and hepatic encephalopathy. In many
284 cases, the presence of pre-existing liver enzyme abnormalities, infection with hepatitis B or hepatitis C
285 virus, concomitant usage of other potentially hepatotoxic drugs, and ongoing injecting drug use may
286 have played a causative or contributory role. In other cases, insufficient data were available to
287 determine the etiology of the abnormality. Withdrawal of buprenorphine has resulted in amelioration of
288 acute hepatitis in some cases, however, in other cases no dose reduction was necessary. The possibility
289 exists that buprenorphine had a causative or contributory role in the development of the hepatic
290 abnormality in some cases. In one subject in the SUBLOCADE clinical program, surgical removal was
291 followed by improvement in liver enzymes.

292
293 Liver function tests, prior to initiation of treatment, are recommended to establish a baseline. Monthly
294 monitoring of liver function during treatment, particularly with 300 mg maintenance dose, is also
295 recommended. An etiological evaluation is recommended when a hepatic adverse event is suspected.

296 **5.10 Hypersensitivity Reactions**

297 Cases of hypersensitivity to buprenorphine-containing products have been reported both in clinical trials
298 and in the postmarketing experience. Cases of bronchospasm, angioneurotic edema, and anaphylactic
299 shock have been reported. The most common signs and symptoms include rashes, hives, and pruritus. A
300 history of hypersensitivity to buprenorphine is a contraindication to the use of SUBLOCADE [see
301 *Contraindications (4)*].

302 **5.11 Precipitation of Opioid Withdrawal in Patients Dependent on Full Agonist Opioids**

303 Because of the partial opioid agonist properties of buprenorphine, buprenorphine may precipitate
304 opioid withdrawal signs and symptoms in persons who are currently physically dependent on full opioid
305 agonists such as heroin, morphine, or methadone before the effects of the full opioid agonist have
306 subsided. Verify that patients have tolerated and are dose adjusted on transmucosal buprenorphine
307 before subcutaneously injecting SUBLOCADE.

308 **5.12 Risks Associated With Treatment of Emergent Acute Pain**

309 While on SUBLOCADE, situations may arise where patients need acute pain management, or may
310 require anesthesia. Treat patients receiving SUBLOCADE with a non-opioid analgesic whenever possible.
311 Patients requiring opioid therapy for analgesia may be treated with a high-affinity full opioid analgesic
312 under the supervision of a physician, with particular attention to respiratory function. Higher doses may
313 be required for analgesic effect. Therefore, a higher potential for toxicity exists with opioid
314 administration. If opioid therapy is required as part of anesthesia, patients should be continuously
315 monitored in an anesthesia care setting by persons not involved in the conduct of the surgical or
316 diagnostic procedure. The opioid therapy should be provided by individuals specifically trained in the
317 use of anesthetic drugs and the management of the respiratory effects of potent opioids, specifically the

318 establishment and maintenance of a patent airway and assisted ventilation.

319 Advise patients of the importance of instructing their family members, in the event of emergency, to
320 inform the treating healthcare provider or emergency room staff that the patient is physically
321 dependent on an opioid and that the patient is being treated with SUBLOCADE [see *Patient Counseling*
322 *Information (17)*].

323 The above guidance should also be considered for any patient who has been treated with SUBLOCADE
324 within the last 6 months.

325 **5.13 Use in Opioid Naïve Patients**

326 There have been reported deaths of opioid naïve individuals who received a 2 mg dose of
327 buprenorphine as a sublingual tablet. SUBLOCADE is not appropriate for use in opioid naïve patients.

328 **5.14 Use in Patients With Impaired Hepatic Function**

329 In a pharmacokinetic study with transmucosal buprenorphine, buprenorphine plasma levels were found
330 to be higher and the half-life was found to be longer in subjects with moderate and severe hepatic
331 impairment, but not in subjects with mild hepatic impairment. The effect of hepatic impairment on the
332 pharmacokinetics of SUBLOCADE has not been studied.

333 Because of the long-acting nature of the product, adjustments to dosages of SUBLOCADE are not rapidly
334 reflected in plasma buprenorphine levels. Because buprenorphine levels cannot be rapidly decreased,
335 patients with pre-existing moderate to severe hepatic impairment are not candidates for treatment with
336 SUBLOCADE.

337 Patients who develop moderate to severe hepatic impairment while being treated with SUBLOCADE
338 should be monitored for several months for signs and symptoms of toxicity or overdose caused by
339 increased levels of buprenorphine [see *Use in Specific Populations (8.6)*, *Clinical Pharmacology (12.3)*].

340 **5.15 Use in Patients at Risk for Arrhythmia**

341 Buprenorphine has been observed to prolong the QTc interval in some patients participating in clinical
342 trials. Consider these observations in clinical decisions when prescribing buprenorphine to patients with
343 hypokalemia, hypomagnesemia, or clinically unstable cardiac disease, including unstable atrial
344 fibrillation, symptomatic bradycardia, unstable congestive heart failure, or active myocardial ischemia.
345 Periodic electrocardiographic (ECG) monitoring is recommended in these patients. Avoid the use of
346 buprenorphine in patients with a history of Long QT Syndrome or an immediate family member with this
347 condition or those taking Class IA antiarrhythmic medications (e.g., quinidine, procainamide,
348 disopyramide) or Class III antiarrhythmic medications (e.g., sotalol, amiodarone, dofetilide), or other
349 medications that prolong the QT interval [see *Clinical Pharmacology (12.2)*].

350 **5.16 Impairment of Ability to Drive or Operate Machinery**

351 SUBLOCADE may impair the mental or physical abilities required for the performance of potentially
352 dangerous tasks such as driving a car or operating machinery especially during the first few days
353 following treatment and dose adjustment. Buprenorphine plasma levels accumulate during the first two
354 months and are maintained with the 100 mg maintenance dose; further accumulation occurs with the
355 300 mg maintenance dose, which achieves steady-state after the fourth monthly injection. Caution
356 patients about driving or operating hazardous machinery until they are reasonably certain that

357 SUBLOCADE does not adversely affect their ability to engage in such activities.

358 **5.17 Orthostatic Hypotension**

359 Buprenorphine may produce orthostatic hypotension in ambulatory patients.

360 **5.18 Elevation of Cerebrospinal Fluid Pressure**

361 Buprenorphine may elevate cerebrospinal fluid pressure and should be used with caution in patients
362 with head injury, intracranial lesions, and other circumstances when cerebrospinal pressure may be
363 increased. Buprenorphine can produce miosis and changes in the level of consciousness that may
364 interfere with patient evaluation.

365 **5.19 Elevation of Intracholedochal Pressure**

366 Buprenorphine has been shown to increase intracholedochal pressure, as do other opioids, and thus
367 should be administered with caution to patients with dysfunction of the biliary tract.

368 **5.20 Effects in Acute Abdominal Conditions**

369 Buprenorphine may obscure the diagnosis or clinical course of patients with acute abdominal
370 conditions.

371 **5.21 Unintentional Pediatric Exposure**

372 Buprenorphine can cause severe, possibly fatal, respiratory depression in children who are accidentally
373 exposed to it.

374 **6 ADVERSE REACTIONS**

375 *The following adverse reactions are discussed in more detail in other sections of the labeling:*

- 376 • Addiction, Abuse, and Misuse [see Warnings and Precautions (5.3)]
- 377 • Respiratory and CNS Depression [see Warnings and Precautions (5.4)]
- 378 • Neonatal Opioid Withdrawal Syndrome [see Warnings and Precautions (5.6)]
- 379 • Adrenal Insufficiency [see Warnings and Precautions (5.7)]
- 380 • Opioid Withdrawal [see Warnings and Precautions (5.8, 5.11)]
- 381 • Hepatitis, Hepatic Events [see Warnings and Precautions (5.9)]
- 382 • Hypersensitivity Reactions [see Warnings and Precautions (5.10)]
- 383 • Orthostatic Hypotension [see Warnings and Precautions (5.17)]
- 384 • Elevation of Cerebrospinal Fluid Pressure [see Warnings and Precautions (5.18)]
- 385 • Elevation of Intracholedochal Pressure [see Warnings and Precautions (5.19)]

386 **6.1 Clinical Trials Experience**

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

390 The safety of SUBLOCADE was evaluated in 848 opioid-dependent subjects (see Table 1). In these

391 studies, there was a total of 557 subjects who received at least 6 monthly SC injections of SUBLOCADE
 392 and 138 subjects who received 12 monthly SC injections. Adverse events led to premature
 393 discontinuation in 4% of the group receiving SUBLOCADE compared with 2% in the placebo group (13-
 394 0001, NCT02357901).

395 In the Phase 3 open-label study (13-0003, NCT02510014), adverse events leading to drug dose
 396 reductions were reported in 7.3% of subjects receiving SUBLOCADE.

397 **Table 1. Total Subjects Exposed to SUBLOCADE**

Study 13-0001 (NCT02357901) Up to 6 Injections			Study 13-0003 (NCT02510014)				Total Subjects Exposed To SUBLOCADE
SUBLOCADE 300/100 mg	SUBLOCADE 300/300 mg	Placebo	Roll-Over Up to 6 Injections			De-Novo Up to 12 Injections	
			From SUBLOCADE 300/100 mg To SUBLOCADE 300/Flex†	From SUBLOCADE 300/300 mg To SUBLOCADE 300/Flex†	From Placebo To SUBLOCADE 300/Flex†	SUBLOCADE 300/Flex	
N = 203	N = 201	N = 100*	N = 112‡	N = 113‡	N = 32	N = 412	N = 848

398 *Not included in total subjects exposed to SUBLOCADE

399 † FLEX = 300 mg initial dose with an option to receive either 100 mg or 300 mg for subsequent dosing per clinician's discretion

400 ‡ = Not included in total unique subjects exposed to SUBLOCADE, already accounted for in Study 13-0001 section of table

401 Table 2 shows the non-injection site-related adverse reactions (ADRs) for the groups receiving
 402 SUBLOCADE 300/300 mg (6 doses of 300 mg SC injections) 300/100 mg (300 mg SC injections for the
 403 first two doses followed by 4 doses of 100 mg SC injections) and placebo (volume-matched ATRIGEL®
 404 delivery system subcutaneous injections) reported following administration in the 6 month, double-
 405 blind, placebo-controlled study. The systemic safety profile for SUBLOCADE, given by a healthcare
 406 provider in clinical trials, was consistent with the known safety profile of transmucosal buprenorphine.
 407 Common adverse reactions associated with buprenorphine included constipation, nausea, vomiting,
 408 abnormal liver enzymes, headache, sedation and somnolence. Dose dependent hepatic effects observed
 409 in the Phase 3, double-blind study (13-0001, NCT02357901) included the incidence of ALT more than 3
 410 times the upper limit of normal (> 3 × ULN) in 12.4%, 5.4%, and 4.0% of the SUBLOCADE 300/300-mg,
 411 SUBLOCADE 300/100-mg, and placebo groups, respectively. The incidence of AST > 3 × ULN was 11.4%,
 412 7.9%, and 1.0%, respectively. Adverse drug reactions [by MedDRA Preferred Terms (PT)] reported in at
 413 least 2% of subjects receiving SUBLOCADE are grouped by System Organ Class (SOC).

414 **Table 2. Adverse Reactions for Phase 3 Double-Blind Study: ≥2% of Subjects Receiving SUBLOCADE**

System Organ Class Preferred Term	PLACEBO Count (%)	SUBLOCADE 300/100 mg Count (%)	SUBLOCADE 300/300 mg Count (%)
Total	N = 100	N = 203	N = 201
Gastrointestinal disorders	12 (12%)	51 (25.1%)	45 (22.4%)
Constipation	0	19 (9.4)	16 (8)
Nausea	5 (5)	18 (8.9)	16 (8)
Vomiting	4 (4)	19 (9.4)	11 (5.5)

System Organ Class Preferred Term	PLACEBO	SUBLOCADE	SUBLOCADE
	Count (%)	300/100 mg Count (%)	300/300 mg Count (%)
General disorders and administration site conditions	17 (17%)	40 (19.7%)	49 (24.4%)
Fatigue	3 (3)	8 (3.9)	12 (6)
Investigations*	2 (2%)	21 (10.3%)	19 (9.5%)
Alanine aminotransferase increased (ALT)	0	2 (1)	10 (5)
Aspartate aminotransferase increased (AST)	0	7 (3.4)	9 (4.5)
Blood creatine phosphokinase increased (CPK)	1 (1)	11 (5.4)	5 (2.5)
Gamma-glutamyl transferase increased (GGT)	1 (1)	6 (3)	8 (4)
Nervous system disorders	7 (7%)	35 (17.2%)	25 (12.4%)
Headache	6 (6)	19 (9.4)	17 (8.5)
Sedation	0	7 (3.4)	3 (1.5)
Dizziness	2 (2)	5 (2.5)	3 (1.5)
Somnolence	0	10 (4.9)	4 (2)

415 *There were no cases of serious liver injury attributed to study drug.

416 Table 3 shows the injection site-related adverse events reported by ≥ 2 subjects in the Phase 3 studies.
417 Most injection site adverse drug reactions (ADRs) were of mild to moderate severity, with one report of
418 severe injection site pruritus. None of the injection site reactions were serious. One reaction, an
419 injection site ulcer, led to study treatment discontinuation.

420 **Table 3. Injection Site Adverse Drug Reactions Reported by ≥ 2 Subjects in the Phase 3 Double-Blind**
421 **Study**

Preferred term, n (%)	13-0001 (Ph3DB)			13-0003 (Ph3OL)				All Phase 3*
	SUBLOCADE 300/300 (N = 201)	SUBLOCADE 300/100 (N = 203)	Placebo (N = 100)	Roll-over		De-novo		
				SUBLOCADE 300 → SUBLOCADE 300/Flex (N = 113)	SUBLOCADE 100 → SUBLOCADE 300/Flex (N = 112)	Placebo → SUBLOCADE 300/Flex (N = 32)	SUBLOCADE 300/Flex (N = 412)	Total SUBLOCADE (N = 848)
Subjects with any injection site reactions	38 (18.9%)	28 (13.8%)	9 (9.0%)	6 (5.3%)	13 (11.6%)	2 (6.3%)	61 (14.8%)	140 (16.5%)
Injection site pain	12 (6.0%)	10 (4.9%)	3 (3.0%)	4 (3.5%)	2 (1.8%)	2 (6.3%)	33 (8.0%)	61 (7.2%)
Injection site pruritus	19 (9.5%)	13 (6.4%)	4 (4.0%)	2 (1.8%)	6 (5.4%)	1 (3.1%)	17 (4.1%)	56 (6.6%)
Injection site erythema	6 (3.0%)	9 (4.4%)	0	1 (0.9%)	4 (3.6%)	0	21 (5.1%)	40 (4.7%)
Injection site induration	2 (1.0%)	2 (1.0%)	0	0	1 (0.9%)	0	7 (1.7%)	12 (1.4%)

Injection site bruising	2 (1.0%)	2 (1.0%)	0	0	0	0	2 (0.5%)	6 (0.7%)
Injection site swelling	1 (0.5%)	2 (1.0%)	0	1 (0.9%)	1 (0.9%)	0	1 (0.2%)	6 (0.7%)
Injection site discomfort	1 (0.5%)	1 (0.5%)	0	0	0	0	3 (0.7%)	5 (0.6%)
Injection site reaction	1 (0.5%)	0	0	0	3 (2.7%)	0	1 (0.2%)	5 (0.6%)
Injection site cellulitis	0	1 (0.5%)	0	0	0	0	2 (0.5%)	3 (0.4%)
Injection site infection	1 (0.5%)	0	1 (1.0%)	0	0	0	2 (0.5%)	3 (0.4%)

*Patients received SUBOXONE film for a run-in period before they switched to SUBLOCADE injection.

422 Longer-term experience

423 In an interim analysis of the ongoing open-label long-term safety study (13-0003), safety was evaluated
424 for up to 12 injections over the course of a year (see Table 1). Adverse events were reported for 432 of
425 669 subjects during the treatment period. The overall adverse event profile was similar to the double-
426 blind trial described above.

427 **6.2 Postmarketing Experience**

428 The most frequently reported systemic postmarketing adverse event observed with buprenorphine
429 sublingual tablets was drug misuse or abuse. The most frequently reported systemic postmarketing
430 adverse event with buprenorphine/naloxone sublingual tablets and film was peripheral edema.

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

434 Serotonin syndrome: Cases of serotonin syndrome, a potentially life-threatening condition, have been
435 reported during concomitant use of opioids with serotonergic drugs.

436 Adrenal insufficiency: Cases of adrenal insufficiency have been reported with opioid use, more often
437 following greater than one month of use.

438 Anaphylaxis: Anaphylaxis has been reported with ingredients contained in SUBLOCADE.

439 Androgen deficiency: Cases of androgen deficiency have occurred with chronic use of opioids [see
440 *Clinical Pharmacology (12.2)*].

441 **7 DRUG INTERACTIONS**

442 Table 4 includes clinically significant drug interactions with SUBLOCADE.

443 **Table 4. Clinically Significant Drug Interactions**

Benzodiazepines and Other Central Nervous System (CNS) Depressants	
<i>Clinical Impact:</i>	Due to additive pharmacologic effects, the concomitant use of benzodiazepines or other CNS depressants, including alcohol, increases the risk of respiratory depression, profound sedation, coma, and death.
<i>Intervention:</i>	Cessation of benzodiazepines or other CNS depressants is preferred in most cases of concomitant use. In some cases, monitoring in a higher level of care for

	<p>taper may be appropriate. In others, gradually tapering a patient off of a prescribed benzodiazepine or other CNS depressant or decreasing to the lowest effective dose may be appropriate. Similarly, cessation of other CNS depressants is preferred when possible.</p> <p>Before co-prescribing benzodiazepines for anxiety or insomnia, ensure that patients are appropriately diagnosed and consider alternative medications and non-pharmacologic treatments [see <i>Warnings and Precautions (5.4, 5.5)</i>].</p>
<i>Examples:</i>	Alcohol, non-benzodiazepine sedatives/hypnotics, anxiolytics, tranquilizers, muscle relaxants, general anesthetics, antipsychotics, and other opioids.
Inhibitors of CYP3A4	
<i>Clinical Impact:</i>	<p>The effects of co-administered CYP3A4 inhibitors on buprenorphine exposure in subjects treated with SUBLOCADE have not been studied and the effects may be dependent on the route of administration; however, such interactions have been established in studies using transmucosal buprenorphine. Buprenorphine is metabolized to norbuprenorphine primarily by CYP3A4; therefore, potential interactions may occur when SUBLOCADE is given concurrently with agents that affect CYP3A4 activity.</p> <p>The concomitant use of sublingual buprenorphine and CYP3A4 inhibitors (e.g., ketoconazole) can increase the plasma concentration of buprenorphine, resulting in increased or prolonged opioid effects.</p>
<i>Intervention:</i>	<p>Patients who transfer to SUBLOCADE treatment from a regimen of transmucosal buprenorphine used concomitantly with CYP3A4 inhibitors [e.g., azole antifungals such as ketoconazole, macrolide antibiotics such as erythromycin, and HIV protease inhibitors (e.g., ritonavir, indinavir, and saquinavir)] should be monitored to ensure that the plasma buprenorphine level provided by SUBLOCADE is adequate. If patients already on SUBLOCADE require newly-initiated treatment with CYP3A4 inhibitors, the patients should be monitored for signs and symptoms of over-medication. Within 2 weeks of SUBLOCADE administration, if signs and symptoms of buprenorphine toxicity or overdose occur but the concomitant medication cannot be reduced or discontinued, it may be necessary to remove the depot and treat the patient with a formulation of buprenorphine that permits dose adjustments. Conversely, if a patient has been stabilized on SUBLOCADE in the setting of concomitant medication that is a CYP3A4 inhibitor, and the concomitant medication is discontinued, the patient should be monitored for withdrawal. If the dose of SUBLOCADE is not adequate in the absence of the concomitant medication, that patient should be transitioned back to a formulation of buprenorphine that permits dose adjustments.</p>
<i>Examples:</i>	Macrolide antibiotics (e.g., erythromycin), azole-antifungal agents (e.g., ketoconazole), protease inhibitors (e.g., ritonavir)
CYP3A4 Inducers	

<i>Clinical Impact:</i>	<p>The effects of co-administered CYP3A4 inducers on buprenorphine exposure in subjects treated with SUBLOCADE have not been studied.</p> <p>Buprenorphine is metabolized to norbuprenorphine primarily by CYP3A4; therefore, potential interactions may occur when SUBLOCADE is given concurrently with agents that affect CYP3A4 activity.</p> <p>CYP3A4 inducers may induce the metabolism of buprenorphine and, therefore, may cause increased clearance of the drug which could lead to a decrease in buprenorphine plasma concentrations, lack of efficacy or, possibly, development of an abstinence syndrome.</p>
<i>Intervention:</i>	<p>Patients who transfer to SUBLOCADE treatment from a regimen of transmucosal buprenorphine used concomitantly with CYP3A4 inducers should be monitored to ensure that the plasma buprenorphine level provided by SUBLOCADE is adequate. If patients already on SUBLOCADE require newly-initiated treatment with CYP3A4 inducers, the patients should be monitored for withdrawal. If the dose of SUBLOCADE is not adequate in the absence of the concomitant medication, and the concomitant medication cannot be reduced or discontinued, that patient should be transitioned back to a formulation of buprenorphine that permits dose adjustments. Conversely, if a patient has been stabilized on SUBLOCADE in the setting of concomitant medication that is a CYP3A4 inducer, and the concomitant medication is discontinued, the patient should be monitored for signs and symptoms of over-medication. Within 2 weeks of SUBLOCADE administration, if the dose provided by SUBLOCADE is excessive in the absence of the concomitant inducer, it may be necessary to remove the SUBLOCADE and treat the patient with a formulation of buprenorphine that permits dose adjustments [see <i>Clinical Pharmacology (12.3)</i>].</p>
<i>Examples:</i>	Rifampin, carbamazepine, phenytoinphenobarbital
Antiretrovirals: Non-nucleoside reverse transcriptase inhibitors (NNRTIs)	
<i>Clinical Impact:</i>	<p>Non-nucleoside reverse transcriptase inhibitors (NNRTIs) are metabolized principally by CYP3A4. Efavirenz, nevirapine, and etravirine are known CYP3A inducers, whereas delavirdine is a CYP3A inhibitor. Significant pharmacokinetic interactions between NNRTIs (e.g., efavirenz and delavirdine) and sublingual buprenorphine have been shown in clinical studies, but these pharmacokinetic interactions did not result in any significant pharmacodynamic effects.</p>
<i>Intervention:</i>	<p>Patients who are on chronic treatment with SUBLOCADE should be monitored for increase or decrease in therapeutic effects if NNRTIs are added to their treatment regimen.</p>
<i>Examples:</i>	Efavirenz, nevirapine, etravirine, delavirdine
Antiretrovirals: Protease inhibitors (PIs)	
<i>Clinical Impact:</i>	<p>Studies have shown some antiretroviral protease inhibitors (PIs) with CYP3A4 inhibitory activity (nelfinavir, lopinavir/ritonavir, ritonavir) have little effect on</p>

	sublingual buprenorphine pharmacokinetic and no significant pharmacodynamic effects. Other PIs with CYP3A4 inhibitory activity (atazanavir and atazanavir/ritonavir) resulted in elevated levels of buprenorphine and norbuprenorphine after sublingual administration, and patients in one study reported increased sedation. Symptoms of opioid excess have been found in postmarketing reports of patients receiving sublingual buprenorphine and atazanavir with and without ritonavir concomitantly.
<i>Intervention:</i>	If treatment with atazanavir with and without ritonavir must be initiated in a patient already treated with SUBLOCADE, the patient should be monitored for signs and symptoms of over-medication. It may be necessary to remove the depot and treat the patient with a sublingual buprenorphine product that permits rapid dose adjustments.
<i>Examples:</i>	Atazanavir, ritonavir
Antiretrovirals: Nucleoside reverse transcriptase inhibitors (NRTIs)	
<i>Clinical Impact:</i>	Nucleoside reverse transcriptase inhibitors (NRTIs) do not appear to induce or inhibit the P450 enzyme pathway, thus no interactions with buprenorphine are expected.
<i>Intervention:</i>	None
Serotonergic Drugs	
<i>Clinical Impact:</i>	The concomitant use of opioids with other drugs that affect the serotonergic neurotransmitter system has resulted in serotonin syndrome.
<i>Intervention:</i>	If concomitant use is warranted, carefully monitor the patient for signs and symptoms of serotonin syndrome, particularly during treatment initiation, and during dose adjustment of the serotonergic drug.
<i>Examples:</i>	Selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), triptans, 5-HT ₃ receptor antagonists, drugs that affect the serotonin neurotransmitter system (e.g., mirtazapine, trazodone, tramadol), monoamine oxidase (MAO) inhibitors (those intended to treat psychiatric disorders and also others, such as linezolid and intravenous methylene blue).
Monoamine Oxidase Inhibitors (MAOIs)	
<i>Clinical Impact:</i>	MAOI interactions with opioids may manifest as serotonin syndrome or opioid toxicity (e.g., respiratory depression, coma).
<i>Intervention:</i>	The use of SUBLOCADE is not recommended for patients taking MAOIs or within 14 days of stopping such treatment.
<i>Examples:</i>	Phenelzine, tranylcypromine, linezolid
Muscle Relaxants	
<i>Clinical Impact:</i>	Buprenorphine may enhance the neuromuscular blocking action of skeletal

	muscle relaxants and produce an increased degree of respiratory depression.
<i>Intervention:</i>	Monitor patients receiving muscle relaxants and SUBLOCADE for signs of respiratory depression that may be greater than otherwise expected and decrease the dosage of the muscle relaxant as necessary.
Diuretics	
<i>Clinical Impact:</i>	Opioids can reduce the efficacy of diuretics by inducing the release of antidiuretic hormone.
<i>Intervention:</i>	Monitor patients for signs of diminished diuresis and/or effects on blood pressure and increase the dosage of the diuretic as needed.
Anticholinergic Drugs	
<i>Clinical Impact:</i>	The concomitant use of anticholinergic drugs may increase the risk of urinary retention and/or severe constipation, which may lead to paralytic ileus.
<i>Intervention:</i>	Monitor patients for signs of urinary retention or reduced gastric motility when SUBLOCADE is used concomitantly with anticholinergic drugs.

444 **8 USE IN SPECIFIC POPULATIONS**

445 **8.1 Pregnancy**

446 Risk Summary

447 The data on use of buprenorphine, the active ingredient in SUBLOCADE, in pregnancy, are limited;
 448 however, these data do not indicate an increased risk of major malformations specifically due to
 449 buprenorphine exposure. There are limited data from randomized clinical trials in women maintained on
 450 buprenorphine that were not designed appropriately to assess the risk of major malformations [see
 451 *Human Data*].

452 Observational studies have reported congenital malformations among buprenorphine-exposed
 453 pregnancies, but were also not designed appropriately to assess the risk of congenital malformations
 454 specifically due to buprenorphine exposure [see *Human Data*].

455 In published animal reproduction studies with NMP, an excipient in SUBLOCADE, preimplantation losses,
 456 delayed ossification, reduced fetal weight, developmental delays and reduced cognitive function were
 457 reported at doses equivalent to the doses of NMP via SUBLOCADE. Decreased pup survival at 2 times
 458 the dose of NMP and malformation and postimplantation losses were reported at 3 times the dose of
 459 NMP via SUBLOCADE. In animal reproduction studies with SUBLOCADE, SUBLOCADE administered
 460 subcutaneously to pregnant rats and rabbits during the period of organogenesis at a buprenorphine
 461 dose equivalent to 38 and 15 times, respectively, the maximum recommended human dose (MRHD) of
 462 300 mg caused embryoletality, which appeared to be attributable primarily to the SUBLOCADE vehicle.
 463 In addition, reduced fetal body weights, increased visceral malformations and skeletal malformations
 464 were observed in rats and rabbits at a buprenorphine dose equivalent to 38 and 15 times, respectively,
 465 the MRHD. These effects were also observed with the SUBLOCADE vehicle alone, but the skeletal and
 466 visceral malformations in rat appear at least partially attributable to buprenorphine [see *Animal Data*].
 467 Based on animal data, advise pregnant women of the potential risk to a fetus.

468 The estimated background risk of major birth defects and miscarriage for the indicated population is
469 unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In
470 the U.S. general population, the estimated background risk of major birth defects and miscarriage in
471 clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively.

472 SUBLOCADE should be used during pregnancy only if the potential benefit justifies the potential risk to
473 the fetus.

474 Clinical Considerations

475 *Disease-associated maternal and embryo-fetal risk*

476 Untreated opioid addiction in pregnancy is associated with adverse obstetrical outcomes such as low
477 birth weight, preterm birth, and fetal death. In addition, untreated opioid addiction often results in
478 continued or relapsing illicit opioid use.

479 *Fetal/neonatal adverse reactions*

480 Neonatal opioid withdrawal syndrome may occur in newborn infants of mothers who are receiving
481 treatment with SUBLOCADE.

482 Neonatal opioid withdrawal syndrome presents as irritability, hyperactivity and abnormal sleep pattern,
483 high pitched cry, tremor, vomiting, diarrhea, and/or failure to gain weight. Signs of neonatal withdrawal
484 usually occur in the first days after birth. The duration and severity of neonatal opioid withdrawal
485 syndrome may vary. Observe newborns for signs of neonatal opioid withdrawal syndrome and manage
486 accordingly [*see Warnings and Precautions (5.3)*].

487 *Labor or Delivery*

488 Opioid-dependent women on buprenorphine maintenance therapy may require additional analgesia
489 during labor. As with all opioids, use of buprenorphine prior to delivery may result in respiratory
490 depression in the newborn. Closely monitor neonates for signs of respiratory depression. An opioid
491 antagonist such as naloxone should be available for reversal of opioid induced respiratory depression in
492 the neonate.

493 Data

494 *Human Data*

495 Studies have been conducted to evaluate neonatal outcomes in women exposed to buprenorphine
496 during pregnancy. Limited data on malformations from trials, observational studies, case series, and
497 case reports on buprenorphine use in pregnancy do not indicate an increased risk of major
498 malformations specifically due to buprenorphine. Pregnancy in an opioid dependent woman poses
499 challenges to treating physicians and potential hazards for the fetus including control of illicit drug,
500 nicotine and alcohol use, infections, premature birth, abortion, low birth weight, toxemia, third
501 trimester bleeding, malpresentation, puerperal morbidity, fetal distress, meconium aspiration, narcotic
502 withdrawal, postnatal growth deficiency, microcephaly, (neuro-) developmental disorders and increased
503 neonatal mortality.

504 A multicenter, double-blind, double-dummy, flexible-dose study in 175 pregnant women [Maternal
505 Opioid Treatment: Human Experimental Research (MOTHER)] was conducted to study outcomes in
506 neonates born to mothers using methadone or buprenorphine, including the number of neonates
507 requiring treatment for NOWS, the Peak NOWS score, the total amount of morphine needed to treat

508 NOWS, the length of hospital stay for neonates, and neonatal head circumference. The authors found
509 that 18% of pregnant women in the methadone group and 33% in the buprenorphine group
510 discontinued treatment over the course of the pregnancy. They reported no significant difference in the
511 incidence of NOWS, but in the prenatally buprenorphine-exposed condition, the duration of treatment
512 for NOWS was shorter, duration of hospital stays were shorter and the amount of morphine required
513 was significantly less; however, methodological concerns limit the conclusions that may be made.

514 *Animal Data*

515 Preimplantation losses, delayed ossification and reduced fetal body weights were reported in published
516 studies following treatment of pregnant rats during organogenesis with NMP, an excipient in
517 SUBLOCADE, via inhalation at approximately equivalent doses of NMP delivered by SUBLOCADE. Fetal
518 malformations and resorptions have also been reported following oral administration of 3 times the
519 MDD of NMP delivered by SUBLOCADE at the MDD based on a body surface area comparison.

520 Post-implantation loss and increased cardiovascular and skull malformations were demonstrated in
521 pregnant rabbits administered oral NMP, an excipient in SUBLOCADE, at doses 3.2 times the human
522 MDD of NMP via SUBLOCADE in the absence of maternal toxicity. No adverse effects were reported at
523 an oral dose equivalent to the MDD via SUBLOCADE based on a body surface area comparison.

524 Decreased pup survival was noted following oral treatment of pregnant rats prior to and during
525 gestation and lactation with NMP, an excipient in SUBLOCADE at doses 1.8 times the MDD.

526 Developmental delays and impaired cognitive function were reported in pups born to pregnant rats
527 treated with NMP via inhalation during gestation at doses equivalent to the MDD of NMP via
528 SUBLOCADE based on a body surface area comparison.

529 In an embryofetal development study in rats, SUBLOCADE administered subcutaneously to pregnant
530 animals before mating and again on GD 7 during the period of organogenesis resulted in increased post-
531 implantation loss, which correlated with higher mean number of resorptions and decreased number of
532 viable fetuses per litter, and decreased mean fetal body weights at 900 mg/kg (approximately 38 times
533 the maximum recommended human dose [MRHD] of 300 mg of SUBLOCADE on an AUC basis); however,
534 similar effects were observed with an equivalent level of ATRIGEL® delivery system alone, indicating
535 they may be attributable to the vehicle. Dose-related increases in incidences of skeletal malformations
536 of the head and visceral malformations were observed with SUBLOCADE with significant changes at 900
537 mg/kg (approximately 38 times the MRHD on an AUC basis). Although similar effects were observed
538 with equivalent levels of ATRIGEL® delivery system, the incidence of skeletal malformations, primarily
539 skull malformations, was higher in the SUBLOCADE groups suggesting that buprenorphine contributed
540 to the increased incidence. Based on these results, the NOAEL for developmental toxicity was 300
541 mg/kg (approximately 15 times the MRHD on an AUC basis).

542 In an embryofetal development study in rabbits, administration of a single subcutaneous injection of
543 SUBLOCADE to pregnant animals on Gestation Day 7 during the period of organogenesis resulted an
544 increased litter incidence of skeletal malformations at 155 mg/kg (approximately 7 times the MRHD on
545 an AUC basis), which appear to be buprenorphine-related adverse effects. There was also an increased
546 litter incidence of external malformations, visceral, and skeletal malformations and variations at 390
547 mg/kg SUBLOCADE (approximately 15 times the MRHD on an AUC basis); however, similar effects were
548 observed with an equivalent level of the ATRIGEL® delivery system, indicating they may be attributable
549 to the vehicle. In addition, increased post-implantation loss, which correlated with increased mean
550 number of resorptions and decreased mean number of viable fetuses, and decreased fetal body weights
551 were observed at 390 mg/kg (approximately 15 times the MRHD on an AUC basis); however, similar

552 findings were also observed with an equivalent level of the ATRIGEL® delivery system alone. Based on
553 these results, the NOAEL for developmental toxicity for SUBLOCADE was 78 mg/kg (approximately 3
554 times the MRHD on an AUC basis).

555 In a pre- and postnatal development study in rats, SUBLOCADE was administered subcutaneously to
556 pregnant animals once during implantation (on Gestation Day 7) and once during weaning (on Lactation
557 Day 7). There were no adverse effects on offspring survival, sexual maturation, behavioral assessment,
558 or reproductive performance at up to 300 mg/kg (approximately 10 times the MRHD on an mg/m² basis)

559 **8.2 Lactation**

560 Risk Summary

561 Based on two studies in 13 lactating women maintained on buprenorphine treatment, buprenorphine
562 and its metabolite norbuprenorphine are present in low levels in human milk and infant urine. Available
563 data have not shown adverse reactions in breastfed infants. Caution should be exercised when
564 SUBLOCADE is administered to a nursing woman. The developmental and health benefits of
565 breastfeeding should be considered along with the mother's clinical need for SUBLOCADE and any
566 potential adverse effects on the breastfed child from the drug or from the underlying maternal
567 condition.

568 Clinical Considerations

569 Advise breastfeeding women taking buprenorphine products to monitor the infant for increased
570 drowsiness and breathing difficulties.

571 Data

572 Data were consistent from two studies (N=13) of breastfeeding infants whose mothers were maintained
573 on sublingual doses of buprenorphine ranging from 2.4 to 24 mg/day, showing that the infants were
574 exposed to less than 1% of the maternal daily dose.

575 In a study of six lactating women who were taking a median sublingual buprenorphine dose of 0.29
576 mg/kg/day 5 to 8 days after delivery, breast milk provided a median infant dose of 0.42 mcg/kg/day of
577 buprenorphine and 0.33 mcg/kg/day of norbuprenorphine, equal to 0.2% and 0.12%, respectively, of the
578 maternal weight-adjusted dose (relative dose/kg (%)) of norbuprenorphine was calculated from the
579 assumption that buprenorphine and norbuprenorphine are equipotent).

580 Data from a study of seven lactating women who were taking a median sublingual buprenorphine dose
581 of 7 mg/day an average of 1.12 months after delivery indicated that the mean milk concentrations (C_{avg})
582 of buprenorphine and norbuprenorphine were 3.65 mcg/L and 1.94 mcg/L respectively. Based on the
583 study data, and assuming milk consumption of 150 mL/kg/day, an exclusively breastfed infant would
584 receive an estimated mean absolute infant dose (AID) of 0.55 mcg/kg/day of buprenorphine and 0.29
585 mcg/kg/day of norbuprenorphine, or a mean relative infant dose (RID) of 0.38% and 0.18%, respectively,
586 of the maternal weight-adjusted dose.

587 **8.3 Females and Males of Reproductive Potential**

588 Human Data

589 Chronic use of opioids may cause reduced fertility in females and males of reproductive potential. It is
590 not known whether these effects on fertility are reversible [see *Adverse Reactions (6.2)*].

591 Animal Data

592 *Infertility*

593 Male

594 Male fertility may be reduced based on animal data demonstrating adverse effects of SUBLOCADE on
595 sperm parameters [see *Nonclinical Toxicology (13.1)*].

596 **8.4 Pediatric Use**

597 The safety and effectiveness of SUBLOCADE have not been established in pediatric patients.

598 **8.5 Geriatric Use**

599 Clinical studies of SUBLOCADE did not include sufficient numbers of subjects aged 65 and over to
600 determine whether they responded differently than younger subjects. Other reported clinical
601 experience with buprenorphine has not identified differences in responses between geriatric and
602 younger patients.

603 Due to possible decreased hepatic, renal, or cardiac function and of concomitant disease or other drug
604 therapy in geriatric patients, the decision to prescribe SUBLOCADE should be made cautiously in
605 individuals 65 years of age or older and these patients should be monitored for signs and symptoms of
606 toxicity or overdose.

607 **8.6 Hepatic Impairment**

608 The effect of hepatic impairment on the pharmacokinetics of SUBLOCADE has not been studied.

609 The effect of hepatic impairment on the pharmacokinetics of sublingual buprenorphine has been
610 evaluated in a pharmacokinetic study. While no clinically significant changes have been observed in
611 subjects with mild hepatic impairment, the plasma levels have been shown to be higher and half-life
612 values have been shown to be longer for buprenorphine in subjects with moderate and severe hepatic
613 impairment.

614 Because of the long-acting nature of the product, adjustments to dosages of SUBLOCADE are not rapidly
615 reflected in plasma buprenorphine levels. Because buprenorphine levels cannot be rapidly adjusted,
616 patients with pre-existing moderate to severe hepatic impairment are not candidates for treatment with
617 SUBLOCADE.

618 Patients who develop moderate to severe hepatic impairment while being treated with SUBLOCADE
619 should be monitored for signs and symptoms of toxicity or overdose caused by increased levels of
620 buprenorphine. If signs and symptoms of toxicity or overdose occur within 2 weeks of SUBLOCADE
621 administration, removal of the depot may be required [see *Dosage and Administration (2.8)*, *Warnings*
622 *and Precautions (5.9)*, *Clinical Pharmacology (12.3)*].

623 **8.7 Renal Impairment**

624 Clinical studies of SUBLOCADE did not include subjects with renal impairment. No differences in
625 buprenorphine pharmacokinetics were observed between 9 dialysis-dependent and 6 normal patients
626 following IV administration of 0.3 mg buprenorphine.

627 **9 DRUG ABUSE AND DEPENDENCE**

628 **9.1 Controlled Substance**

629 SUBLOCADE contains buprenorphine, a Schedule III substance under the Controlled Substances Act.

630 Under the Drug Addiction Treatment Act (DATA) codified at 21 U.S.C. 823(g), prescription use of this
631 product in the treatment of opioid dependence is limited to healthcare providers who meet certain
632 qualifying requirements, and who have notified the Secretary of Health and Human Services (HHS) of
633 their intent to prescribe this product for the treatment of opioid dependence and have been assigned a
634 unique identification number that must be included on every prescription.

635 **9.2 Abuse**

636 SUBLOCADE contains buprenorphine, a Schedule III controlled substance that can be abused similar to
637 other opioids. Patients who continue to misuse, abuse, or divert buprenorphine products or other
638 opioids should be provided with or referred for more intensive and structured treatment. Abuse of
639 buprenorphine poses a risk of overdose and death. This risk is increased with the abuse of
640 buprenorphine and alcohol and other substances, especially benzodiazepines.

641 SUBLOCADE is distributed through a restricted distribution system, which is intended to prevent the
642 direct distribution to a patient. SUBLOCADE should only be dispensed directly to a healthcare provider
643 for administration by a healthcare provider. It is supplied in prefilled syringes and is intended for
644 administration only by subcutaneous injection by a healthcare provider. The entire contents of the
645 prefilled syringe should be administered. After administration, a small amount (approximately 0.1 mL) of
646 SUBLOCADE will remain in the needle and syringe and should be properly disposed of [*see How*
647 *Supplied/Storage and Handling (16)*].

648 SUBLOCADE is injected as a liquid, and the subsequent precipitation of the poly (DL-lactide-co-glycolide)
649 polymer creates a solid depot which contains buprenorphine. After initial formation of the depot,
650 buprenorphine is released via diffusion from, and the biodegradation of, the depot. Clinical monitoring
651 for evidence at the injection site of tampering or attempting to remove the depot should be ongoing
652 throughout treatment. No accounts of subjects removing or attempting to remove the depot after
653 administration of SUBLOCADE were reported in premarketing studies.

654 **9.3 Dependence**

655 Buprenorphine is a partial agonist at the mu-opioid receptor and chronic administration produces
656 physical dependence of the opioid type, characterized by moderate withdrawal signs and symptoms
657 upon abrupt discontinuation. The withdrawal syndrome is typically milder than seen with full agonists
658 and may be delayed in onset [*see Warnings and Precautions (5.11)*].

659 Due to the long-acting nature of SUBLOCADE, withdrawal signs and symptoms may not be evident
660 immediately following the discontinuation of treatment.

661 Neonatal opioid withdrawal syndrome (NOWS) is an expected and treatable outcome of prolonged use
662 of opioids during pregnancy [*see Warnings and Precautions (5.6)*].

663 **10 OVERDOSAGE**

664 Clinical Presentation

665 The manifestations of acute overdose include pinpoint pupils, sedation, hypotension, respiratory
666 depression, and death.

667 Treatment of Overdose

668 In the event of overdose, the respiratory and cardiac status of the patient should be monitored
669 carefully. When respiratory or cardiac functions are depressed, primary attention should be given to the
670 re-establishment of adequate respiratory exchange through provision of a patent airway and institution
671 of assisted or controlled ventilation. Oxygen, IV fluids, vasopressors, and other supportive measures
672 should be considered as indicated. Naloxone may be of value for the management of buprenorphine
673 overdose. Higher than normal doses and repeated administration may be necessary.

674 Clinicians should consider the potential role and contribution of buprenorphine, other opioids, and
675 other CNS depressant drugs in a patient's clinical presentation. Clinical data are limited with regards to
676 the possible surgical removal of the depot. Two cases of surgical removal were reported in premarketing
677 clinical studies.

678 **11 DESCRIPTION**

679 SUBLOCADE (buprenorphine extended-release) injection is a clear, viscous, colorless to yellow to amber,
680 sterile solution for subcutaneous injection only. It is designed to deliver buprenorphine at a controlled
681 rate over a one month period.

682 The active ingredient in SUBLOCADE is buprenorphine free base, a mu-opioid receptor partial agonist
683 and a kappa-opioid receptor antagonist.

684 Buprenorphine is dissolved in the ATRIGEL® delivery system at 18% by weight.

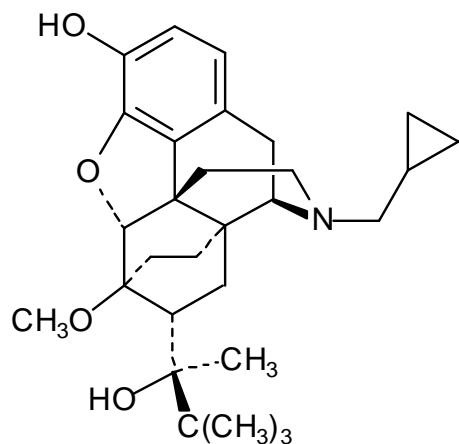
685 The ATRIGEL® delivery system is a biodegradable 50:50 poly(DL-lactide-co-glycolide) polymer and a
686 biocompatible solvent, *N*-methyl-2-pyrrolidone (NMP).

687 SUBLOCADE is provided in dosage strengths of 100 mg and 300 mg. Table 5 presents the delivered
688 amounts of the raw materials and the approximate delivered volume for the two dosage strengths.

689 **Table 5. Amounts of Raw Materials and Delivered Volume for the Dosage Strengths**

Raw Materials in SUBLOCADE	100 mg Dosage	300 mg Dosage
Buprenorphine	100 mg	300 mg
Poly(DL-lactide-co-glycolide)	178 mg	533 mg
<i>N</i> -methyl-2-pyrrolidone	278 mg	833 mg
Approximate Delivered Volume	0.5 mL	1.5 mL

690 The molecular weight of buprenorphine free base is 467.6, and its molecular formula is C₂₉H₄₁NO₄.
691 Chemically, buprenorphine is (2S)-2-[17-(Cyclopropylmethyl)-4,5α-epoxy-3-hydroxy-6-methoxy-6α,14-
692 ethano-14α-morphinan-7α-yl]-3,3-dimethylbutan-2-ol. The structural formula is:



693

694 12 CLINICAL PHARMACOLOGY

695 12.1 Mechanism of Action

696 SUBLOCADE Injection contains buprenorphine. Buprenorphine is a partial agonist at the mu- opioid
 697 receptor and an antagonist at the kappa-opioid receptor.

698 12.2 Pharmacodynamics

699 Mu-Opioid Receptor Occupancy and Association With Opioid Blockade

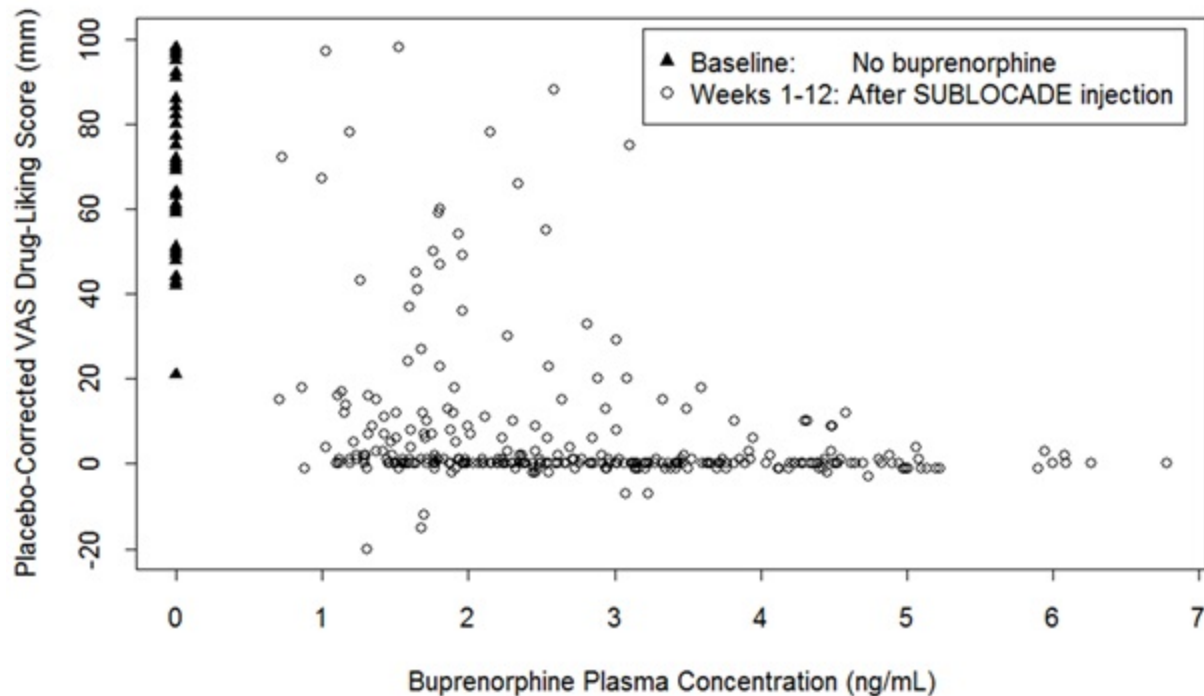
700 In a Positron Emission Tomography (PET) study with SUBLOCADE in 2 subjects (one subject
 701 receiving 200 mg SC injections and one subject receiving 300 mg SC injections) with opioid use disorder,
 702 75 to 92% occupancy of the mu-opioid receptors in the brain was maintained for 28 days following the
 703 last dose under steady-state conditions.

704 The opioid blockade study evaluated the blockade of subjective opioid effects, pharmacokinetics (PK)
 705 and safety of SC injections of SUBLOCADE. Stabilization doses of SL buprenorphine prior to injection of
 706 SUBLOCADE failed to provide full blockade of subjective effects of hydromorphone 18 mg IM. After
 707 SUBLOCADE injections at Weeks 0 and 4, on average, subjective effects of both 6 mg and 18 mg doses of
 708 hydromorphone were blocked; however, wide variability was seen across subjects. Complete blockade
 709 continued throughout the 8 weeks of observation that followed the 2nd SUBLOCADE injection [see
 710 *Clinical Studies (14.1)*].

711 Figure 10 illustrates the relationship between buprenorphine plasma level and drug liking after 18 mg
 712 hydromorphone IM.

713 **Figure 10. Drug Liking VAS vs. Plasma Buprenorphine Concentration Following 18 mg Hydromorphone** 714 **Challenges**

715



716

717 Exposure-response relationships were assessed for illicit opioid use, based on urine samples negative for
 718 illicit opioids combined with self-reports negative for illicit opioid use, and withdrawal symptoms using
 719 data obtained from 489 opioid dependent patients in the double-blind Phase 3 Study (13-0001).

720 The observed plateau for maximal response was reached at buprenorphine plasma concentrations of
 721 approximately 2-3 ng/mL for illicit opioid use and 4 ng/mL for opioid withdrawal symptoms.

722 Population PK/PD modeling indicated that patients using opioids by the injectable route at baseline may
 723 require higher buprenorphine exposure compared to patients not using opioids by the injectable route
 724 at baseline.

725 Cardiac Electrophysiology

726 Serial ECGs were collected following a single dose and at steady-state to evaluate the effect of
 727 SUBLOCADE on the QT interval in five clinical studies including the Phase 3 study. In a Phase 3 study,
 728 seven patients had an increase from baseline QTc greater than 60 msec at any time [2/203 patients
 729 (1.0%) in the 300 mg/100 mg group and 5/201 patients (2.0%) in the 300 mg/300 mg group] and one
 730 patient in the 300 mg/300 mg group was found to have a QTc greater than 500 msec. These QTc findings
 731 were all sporadic and transient and none led to aberrant ventricular rhythm. Review of ECG and adverse
 732 event data provided no evidence for syncope, seizure, or ventricular tachycardia or fibrillation.

733 Physiological Effects

734 Buprenorphine in IV (2, 4, 8, 12 and 16 mg) and sublingual (12 mg) doses have been administered to
 735 opioid-experienced subjects who were not physically dependent to examine cardiovascular, respiratory,
 736 and subjective effects at doses comparable to those used for treatment of opioid dependence.
 737 Compared to placebo, there were no statistically significant differences among any of the treatment
 738 conditions for blood pressure, heart rate, respiratory rate, O₂ saturation, or skin temperature across
 739 time. Systolic BP was higher in the 8 mg group than placebo (3 hour AUC values). Minimum and

740 maximum effects were similar across all treatments. Subjects remained responsive to low voice and
 741 responded to computer prompts. Some subjects showed irritability, but no other changes were
 742 observed. The respiratory effects of sublingual buprenorphine were compared with the effects of
 743 methadone in a double-blind, parallel group, dose ranging comparison of single doses of buprenorphine
 744 sublingual solution (1, 2, 4, 8, 16, or 32 mg) and oral methadone (15, 30, 45, or 60 mg) in non-
 745 dependent, opioid-experienced volunteers. In this study, hypoventilation not requiring medical
 746 intervention was reported more frequently after buprenorphine doses of 4 mg and higher than after
 747 methadone. Both drugs decreased O₂ saturation to the same degree.

748 In clinical studies conducted with SUBLOCADE at doses ranging from 50 to 300 mg, no incidences of
 749 temperature elevations, or clinically significant lowering of oxygen saturation were observed.

750 Androgen Deficiency

751 Chronic use of opioids may influence the hypothalamic-pituitary-gonadal axis, leading to androgen
 752 deficiency that may manifest as low libido, impotence, erectile dysfunction, amenorrhea, or infertility.
 753 The causal role of opioids in the clinical syndrome of hypogonadism is unknown because the various
 754 medical, physical, lifestyle, and psychological stressors that may influence gonadal hormone levels have
 755 not been adequately controlled for in studies conducted to date. Patients presenting with symptoms of
 756 androgen deficiency should undergo laboratory evaluation.

757 **12.3 Pharmacokinetics**

758 Absorption

759 The pharmacokinetics (PK) of buprenorphine following subcutaneous injection of SUBLOCADE was
 760 evaluated in subjects with opioid use disorder after single doses (50 mg to 200 mg) and repeated doses
 761 (50 to 300 mg) separated by 28 days for up to 12 injections.

762 After SUBLOCADE injection, an initial buprenorphine peak was observed and the median T_{max} occurred
 763 at 24 hours after injection. After the initial buprenorphine peak, the plasma buprenorphine
 764 concentrations decreased slowly to a plateau. Steady-state was achieved at 4-6 months. Observed
 765 mean buprenorphine concentrations levels for C_{avg}, C_{max} and C_{min} are presented in Table 6.

766 **Table 6. Comparison of Buprenorphine Mean Pharmacokinetic Parameters Between SUBUTEX and**
 767 **SUBLOCADE**

Pharmacokinetic parameters	SUBUTEX daily stabilization		SUBLOCADE		
	12 mg (steady-state)	24 mg (steady-state)	300 mg# (1 st injection)	100 mg* (steady-state)	300 mg* (steady-state)
Mean					
C _{avg,ss} (ng/mL)	1.71	2.91	2.19	3.21	6.54
C _{max,ss} (ng/mL)	5.35	8.27	5.37	4.88	10.12
C _{min,ss} (ng/mL)	0.81	1.54	1.25	2.48	5.01

768 #Exposure after 1 injection of 300 mg SUBLOCADE following 24 mg SUBUTEX stabilization

769 *Steady-state exposure after 4 injections of 100 mg or 300 mg SUBLOCADE, following 2 injections of 300 mg
 770 SUBLOCADE

771

772 Distribution

773 Buprenorphine is approximately 96% protein bound, primarily to alpha and beta globulin.

774 Elimination

775 Buprenorphine is metabolized and eliminated in urine and feces. The apparent terminal plasma half-life
776 of buprenorphine following subcutaneous injection of SUBLOCADE ranged between 43 to 60 days as a
777 result of the slow release of buprenorphine from the subcutaneous depot.

778 *Metabolism*

779 Buprenorphine is metabolized to its major metabolite, norbuprenorphine, primarily by CYP3A4.
780 Norbuprenorphine can further undergo glucuronidation. Norbuprenorphine has been found to bind
781 opioid receptors *in vitro*; however, it has not been studied clinically for opioid-like activity.
782 Norbuprenorphine steady-state plasma concentrations in humans after subcutaneous injection of
783 SUBLOCADE are low compared to buprenorphine (AUC norbuprenorphine/buprenorphine ratio of 0.20
784 to 0.40).

785 *Excretion*

786 A mass balance study of buprenorphine administered by IV infusion in humans showed complete
787 recovery of radiolabel in urine (30%) and feces (69%) collected up to 11 days after dosing. Almost all of
788 the dose was accounted for in terms of buprenorphine, norbuprenorphine, and two unidentified
789 buprenorphine metabolites. In urine, most of buprenorphine and norbuprenorphine were conjugated
790 (buprenorphine: 1% free and 9.4% conjugated; norbuprenorphine: 2.7% free and 11% conjugated). In
791 feces, almost all of the buprenorphine and norbuprenorphine were free (buprenorphine: 33% free and
792 5% conjugated; norbuprenorphine: 21% free and 2% conjugated).

793 Drug Interaction Studies

794 *CYP3A4 Inhibitors and Inducers*

795 The effects of co-administered CYP3A4 inhibitors and inducers on buprenorphine exposure in subjects
796 treated with SUBLOCADE have not been studied; however, such interactions have been established in
797 studies using transmucosal buprenorphine. The effects of buprenorphine may be dependent on the
798 route of administration.

799 Buprenorphine is metabolized to norbuprenorphine primarily by cytochrome CYP3A4; therefore,
800 potential interactions may occur when SUBLOCADE is given concurrently with agents that affect CYP3A4
801 activity. The effects of co-administered CYP3A4 inducers or inhibitors have been established in studies
802 using transmucosal buprenorphine. Patients who transfer to SUBLOCADE treatment from a regimen of
803 transmucosal buprenorphine used concomitantly with CYP3A4 inhibitors (e.g., ketoconazole), macrolide
804 antibiotics (e.g., erythromycin), or HIV protease inhibitors, or CYP3A4 inducer (e.g., phenobarbital,
805 carbamazepine, phenytoin, rifampicin) should be monitored to ensure that the plasma buprenorphine
806 level provided by SUBLOCADE is adequate and not excessive [*see Drug Interactions (7)*].

807 Buprenorphine has been found to be a CYP2D6 and CYP3A4 inhibitor and its major metabolite,
808 norbuprenorphine, has been found to be a moderate CYP2D6 inhibitor in *in vitro* studies employing
809 human liver microsomes. However, the plasma concentrations of buprenorphine and
810 norbuprenorphine resulting from therapeutic SUBLOCADE doses are not expected to significantly affect
811 metabolism of other co-medications.

812 Specific Populations

813 Based on population pharmacokinetic analyses, age, sex and race do not have a clinically meaningful

814 effect on PK of SUBLOCADE.

815 *Hepatic Impairment*

816 The effect of hepatic impairment on the pharmacokinetics of SUBLOCADE has not been studied.
817 However, the effect of hepatic impairment on the PK of buprenorphine has been evaluated in a study
818 using 2 mg/0.5 mg buprenorphine/naloxone sublingual tablet in subjects with various degrees of hepatic
819 impairment as indicated by Child-Pugh criteria. While no clinically relevant changes were observed in
820 subjects with mild hepatic impairment, buprenorphine plasma exposure was increased by 64% and
821 181% in subjects with moderate and severe hepatic impairment, respectively, compared to healthy
822 subjects [see *Use in Specific Populations (8.6)*].

823 *Renal Impairment*

824 The effect of renal impairment on the pharmacokinetics of SUBLOCADE has not been studied. Clinical
825 studies of SUBLOCADE did not include subjects with severe renal impairment.

826 Less than 1% is excreted as unchanged buprenorphine in urine following IV buprenorphine
827 administration. No differences in buprenorphine pharmacokinetics were observed between 9 dialysis-
828 dependent and 6 normal patients following IV administration of 0.3 mg buprenorphine [see *Use in*
829 *Specific Populations (8.7)*].

830 Population PK analyses indicated no notable relationship between creatinine clearance and steady-state
831 buprenorphine plasma concentrations.

832 *HCV infection*

833 In subjects with HCV infection but no sign of hepatic impairment, the changes in the mean C_{max} , AUC_{0-last} ,
834 and half-life values of buprenorphine were not clinically significant in comparison to healthy subjects
835 without HCV infection. No dose adjustment is needed in patients with HCV infection.

836 **13 NONCLINICAL TOXICOLOGY**

837 **13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility**

838 Carcinogenicity

839 Long-term studies in animals performed to evaluate carcinogenic potential of SUBLOCADE have not
840 been conducted. However, the carcinogenic potential of the active drug substance in SUBLOCADE,
841 buprenorphine, has been evaluated in Sprague-Dawley rats and CD-1 mice.

842 In the carcinogenicity study conducted in Sprague-Dawley rats, buprenorphine was administered in the
843 diet at doses of 0.6, 5.5, and 56 mg/kg/day (approximately 0.5, 5, and 50 times the recommended
844 human monthly SC dose of 300 mg of buprenorphine) for 27 months. A statistically significant dose-
845 related increase in Leydig cell tumors occurred. In an 86 week study in CD-1 mice, buprenorphine was
846 not carcinogenic at dietary doses up to 100 mg/kg/day (approximately 45 times the recommended
847 human monthly SC dose of 300 mg of buprenorphine).

848 NMP, an excipient in SUBLOCADE, produced an increase in hepatocellular adenomas and carcinomas in
849 male and female mice at 6 and 8 times the maximum daily dose (MDD) of NMP via SUBLOCADE. The
850 clinical significance of these findings is unclear. No tumors were noted at 1 and 1.3 times the MDD. In 2-
851 year inhalation and dietary studies in rats, NMP did not result in evidence of carcinogenicity.

852 Mutagenicity

853 No evidence of mutagenic potential for subcutaneous SUBLOCADE was found in *in vivo* subcutaneous
854 micronucleus test using rats' marrow.

855 Mutagenic potential for buprenorphine was studied in a series of tests utilizing gene, chromosome, and
856 DNA interactions in both prokaryotic and eukaryotic systems. Results were negative in yeast (*S.*
857 *cerevisiae*) for recombinant, gene convertant, or forward mutations; negative in *Bacillus subtilis* "rec"
858 assay, negative for clastogenicity in CHO cells, Chinese hamster bone marrow and spermatogonia cells,
859 and negative in the mouse lymphoma L5178Y assay.

860 Results were equivocal in the Ames test: negative in studies in two laboratories, but positive for frame
861 shift mutation at a high dose (5 mg/plate) in a third study. Results were positive in the Green-Tweets (*E.*
862 *coli*) survival test, positive in a DNA synthesis inhibition (DSI) test with testicular tissue from mice, for
863 both *in vivo* and *in vitro* incorporation of [3H]thymidine, and positive in unscheduled DNA synthesis
864 (UDS) test using testicular cells from mice.

865 Impairment of Fertility

866 In a fertility study in rats, female mating, fertility, and fecundity indices were unaffected by the SC
867 administration of SUBLOCADE up to 900 mg/kg buprenorphine (approximately 38 times the maximum
868 recommended human dose [MRHD] of 300 mg on an AUC basis). However, higher mean post-
869 implantation loss was observed with SUBLOCADE at 900 mg/kg buprenorphine and at an equivalent
870 level of ATRIGEL® alone, which correlated with higher mean number of resorptions and reduced mean
871 number of viable fetuses/litter size. Mean gravid uterine weight and mean final body weight were lower
872 with SUBLOCADE at 900 mg/kg buprenorphine and an equivalent level of ATRIGEL® alone, and
873 correlated with higher mean number of resorptions and lower fetal body weights. The NOAEL for female
874 fertility was 900 mg/kg and the NOAEL for female-mediated developmental parameters was 600 mg/kg
875 (approximately 25 times the MRHD on an AUC basis).

876 Male fertility and reproduction indices were lower as evidenced by abnormal sperm parameters (low
877 motility, low mean number of sperm, and higher percentage of abnormal sperm) with SUBLOCADE at
878 600 mg/kg and with an equivalent level of ATRIGEL®. The NOAEL for male fertility parameters, including
879 sperm analysis, and male-mediated developmental parameters was 300 mg/kg (approximately 32 times
880 the MRHD on an AUC basis).

881 Adverse effects on testes and male fertility were noted in published study in which rats were treated for
882 10 weeks with daily oral doses of NMP, an excipient in SUBLOCADE at greater than 11.6 times the MDD
883 and resulted in male-mediated adverse effects on offspring (decreased pup weight and survival) at daily
884 doses 3.5 times the MDD of NMP delivered by SUBLOCADE. No adverse effects were noted at oral doses
885 equivalent to the dose of NMP delivered by SUBLOCADE.

886 **14 CLINICAL STUDIES**

887 The key studies from the SUBLOCADE clinical development program that support its use in moderate to
888 severe OUD are a Phase 3 double-blind efficacy and safety study (13-0001, NCT02357901) and an opioid
889 blockade study (13-0002, NCT02044094).

890 **14.1 Study 13-0002, NCT02044094**

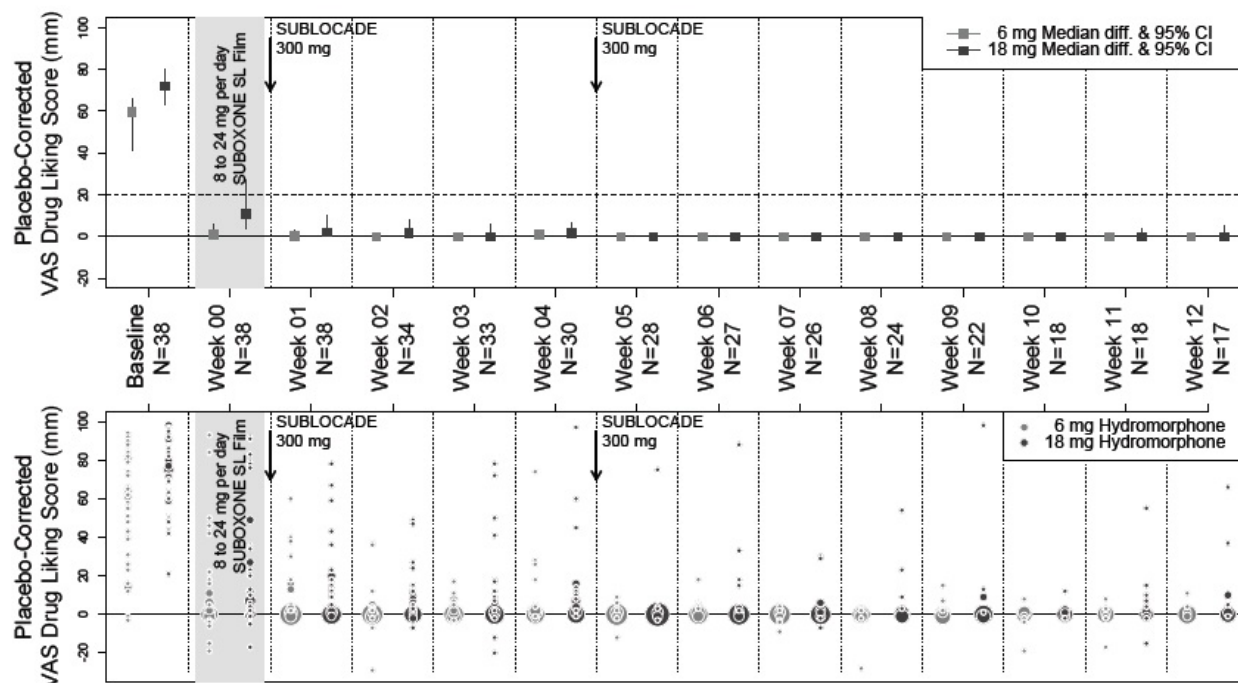
891 The opioid blockade study evaluated the blockade of subjective opioid effects, PK and safety of SC
892 injections of SUBLOCADE in 39 subjects with OUD (not treatment-seeking).

893 The peak (E_{max}) effect of "Drug Liking" Visual Analog Scale (VAS measurement after challenge with IM.

894 injections of 6 mg and 18 mg hydromorphone (HM) was not inferior (i.e., shown to be not substantially
 895 more likeable) compared to the E_{max} of “Drug Liking” VAS, measured after challenge with placebo (at
 896 weeks 1 through 4 following the first injection of 300 mg SUBLOCADE). The noninferiority (NI) margin,
 897 the largest difference allowed for the 6 or 18 mg HM VAS to exceed the placebo VAS (the maximum VAS
 898 recorded following IM injection of 0 mg HM) before being considered significant, was set at 20. Based
 899 on comparison to the historical response to opioid agonists in unblocked subjects, a difference of less
 900 than 20 points (on a unipolar scale) between the mean maximum response to hydromorphone and the
 901 mean maximum placebo response for the same challenge was considered to indicate near-complete
 902 blockade.

903 All 12 weeks of the treatment period demonstrated blockade for both 6 mg and 18 mg following
 904 SUBLOCADE injections. However, wide variation can be seen in isolated measurements from individual
 905 subjects, shown in the figure below. For comparison, stabilization doses of SL buprenorphine in Week 0
 906 failed to provide full blockade to 18 mg of HM. Complete blockade continued throughout the 8 weeks
 907 of observation that followed the 2nd SUBLOCADE injection.

908 **Figure 11: Median (95% Confidence Interval) of Placebo-Corrected Drug-Liking Scores by**
 909 **Hydromorphone Dose and by Week**



- 910
- 911 • Key to Figure: The grey shaded area indicates the period where subjects were stabilized with 8
 - 912 to 24 mg/day sublingual (SL) buprenorphine; the two vertical arrows represent treatment
 - 913 injections of SUBLOCADE, with 300 mg of buprenorphine.
 - 914 • The light grey and dark grey squares represent the median E_{max} drug-liking scores, placebo-
 - 915 corrected (VAS drug liking for that week’s 0 mg dose subtracted) during the hydromorphone
 - 916 challenge of 6 and 18 mg, respectively. This median Placebo-Corrected E_{max} is shown by
 - 917 treatment week, together with its 95% confidence interval (CI; vertical line). In some cases, 95%
 - 918 CI are not visible as the median was equal to the confidence limit. The horizontal line at 20 mm
 - 919 delineates the non-inferiority margin for opioid blockade. Next to median estimates, individual

920 data are summarized by circles, the area of which is proportional to the number of subjects at
 921 that location.

- 922 • The X axis shows how many weeks following injection #1 that each weeks' Placebo-Corrected
 923 Drug-Liking Score was measured. Beneath that treatment week indicator, is the number of
 924 subjects (N) who provided those VAS measurements for all three challenges with placebo, 6 and
 925 18 mg hydromorphone.

926
 927 **14.2 Study 13-0001, NCT02357901**

928 The efficacy of SUBLOCADE for the treatment of opioid use disorder was evaluated in a Phase 3, 24-
 929 week, randomized, double-blind, placebo-controlled, multicenter trial in treatment-seeking patients
 930 who met the DSM-5 criteria for moderate or severe opioid use disorder. Patients were randomized to
 931 one of following dosing regimens: 6 once-monthly 300 mg doses, 2 once-monthly 300 mg doses
 932 followed by 4 once-monthly 100 mg doses, or 6 once-monthly SC injections of placebo. All doses were
 933 administered by a physician or suitably qualified designee and were separated by 28 ± 2 days. In
 934 addition to study medication, all subjects received manual-guided psychosocial support at least once a
 935 week (Individual Drug Counseling = IDC).

936 Prior to the first dose, treatment was initiated with SUBOXONE® (buprenorphine/naloxone) sublingual
 937 film (SUBOXONE SL Film); doses were adjusted from 8/2mg to 24/6 mg per day over a period of 7-14
 938 days. Patients were randomized to SUBLOCADE injection or placebo after cravings and withdrawal
 939 symptoms were clinically controlled. After randomization, supplemental dosing with SUBOXONE SL Film
 940 was not permitted during the study.

941 Efficacy was evaluated over Weeks 5 through 24 based on weekly urine drug screens combined with
 942 self-reported use of illicit opioid use. A “grace period” was applied for Weeks 1 through 4 to allow
 943 patients to stabilize in treatment. During this period, opioid use, if it occurred, was not considered in the
 944 analysis. Missing urine drug screen samples and/or self-reports during Weeks 5-24 were counted as
 945 positive for illicit opioids.

946 A total of 504 patients were randomized 4:4:1:1 [203 subjects in the 300 mg/100 mg group, 201 patients
 947 in the 300 mg/300 mg group and 100 patients in the placebo group (2 groups of volume-matched
 948 placebo)]. Patients demographics and baseline characteristics are provided in Table 7.

949 **Table 7. Patient Demographics and Baseline Characteristics**

	SUBLOCADE 300/100 mg %	SUBLOCADE 300/300 mg %	Placebo %
Mean Age (years)	40.4	39.3	39.2
Sex			
Male	66.0	67.3	64.6
Female	34.0	32.7	35.4
Race or Ethnicity			
White	68.0	71.4	77.8
Black or African American	28.9	27.6	20.2
Hispanic or Latino	6.2	9.2	10.1
Substance Use At Screening			
Opioid Use - Injectable Route	43.3	40.8	50.5
Tobacco	91.8	92.3	92.9
Alcohol	78.4	79.1	80.8

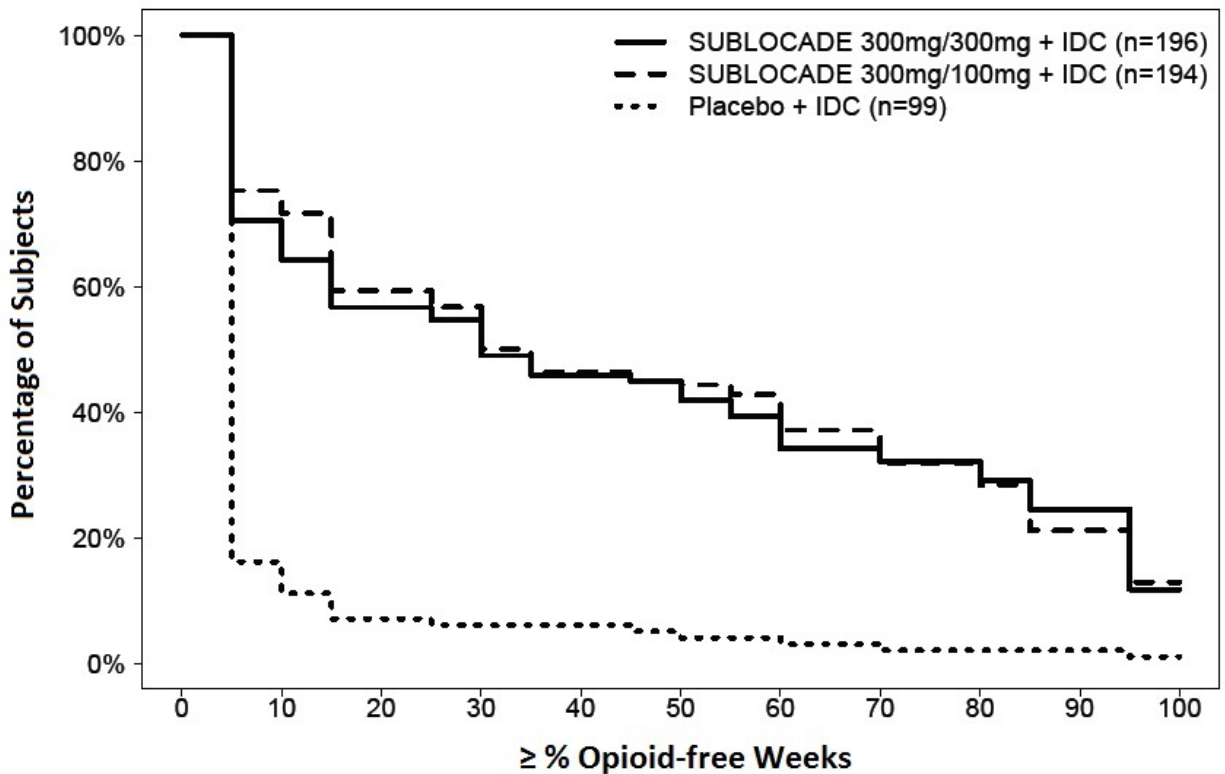
Drug Use History			
Cannabinoids	54.6	47.4	52.5
Cocaine	47.4	39.8	42.4
Amphetamine/Methamphetamine	25.3	14.8	19.2
Medical History			
Depression	14.4	11.2	13.1
Anxiety	9.3	9.7	10.1
Back Pain	14.9	16.3	13.1

950

951 Based on the cumulative distribution function (CDF) of the percentage of urine samples negative for
 952 illicit opioids combined with self-reports negative for illicit opioid use collected from Week 5 through
 953 Week 24 (Table 8), regardless of dose, SUBLOCADE was superior to the placebo group with statistical
 954 significance. The proportion of patients achieving treatment success (defined as patients with $\geq 80\%$
 955 opioid-free weeks) was statistically significantly higher in both groups receiving SUBLOCADE compared
 956 to the placebo group (28.4% [300 mg/100 mg], 29.1% [300 mg/300mg], 2% [placebo]).

957 For various percentages of opioid-free weeks, Table 8 shows the fraction of patients achieving that
 958 criterion. The table is cumulative, so that a patient whose percent of opioid-free weeks is, for example,
 959 50%, is also included at every level of opioid-free week percentage below 50%. Missing values and
 960 values after premature discontinuation were considered positive.

961 **Figure 12. Subjects Achieving Varying Percentages of Opioid-Free Weeks**



962

963

964 **Table 8. Cumulative Distribution Function of Percentage of Opioid-Free Weeks**

Percentage Opioid-Free Weeks	Number (%) of Subjects		
	SUBLOCADE 300mg/100mg + IDC (N = 194)	SUBLOCADE 300mg/300mg + IDC (N = 196)	Placebo + IDC (N = 99)
≥ 0%	194 (100.0)	196 (100.0)	99 (100.0)
≥ 10%	139 (71.6)	126 (64.3)	11 (11.1)
≥ 20%	115 (59.3)	111 (56.6)	7 (7.1)
≥ 30%	101 (52.1)	101 (51.5)	6 (6.1)
≥ 40%	90 (46.4)	90 (45.9)	6 (6.1)
≥ 50%	86 (44.3)	82 (41.8)	4 (4.0)
≥ 60%	78 (40.2)	70 (35.7)	4 (4.0)
≥ 70%	66 (34.0)	67 (34.2)	2 (2.0)
≥ 80%	55 (28.4)	57 (29.1)	2 (2.0)
≥ 90%	41 (21.1)	48 (24.5)	2 (2.0)
= 100%	25 (13)	23 (12)	1 (1.0)

965

966 **16 HOW SUPPLIED/STORAGE AND HANDLING**

967 SUBLOCADE is available as a sterile, clear, viscous, colorless to yellow to amber solution in a single dose,
968 prefilled syringe with safety needle.

969 SUBLOCADE, 100 mg/0.5 mL – NDC 12496-0100-1

970 SUBLOCADE, 300 mg/1.5 mL – NDC 12496-0300-1

971 **Storage and Handling**

972 Store refrigerated at 2 - 8°C (35.6 - 46.4°F).

973 Once outside the refrigerator this product may be stored in its original packaging at room temperature,
974 15 – 30°C (59 – 86°F), for up to 7 days prior to administration. Discard SUBLOCADE if left at room
975 temperature for longer than 7 days.

976 SUBLOCADE is a Schedule III drug product. Handle with adequate security and accountability. After
977 administration, syringes should be properly disposed, per facility procedure for a Schedule III drug
978 product, and per applicable federal, state, and local regulations.

979 Rx Only.

980 **17 PATIENT COUNSELING INFORMATION**

981 Advise the patient to read the FDA-approved patient labeling (Medication Guide).

982 SUBLOCADE Risk Evaluation and Mitigation Strategy (REMS)

983 Advise patients that because of the risk of serious harm or death due to intravenous self-administration,
984 SUBLOCADE is available only through a restricted program called the SUBLOCADE REMS Program.
985 Healthcare settings and pharmacies are certified and only dispense SUBLOCADE directly to a healthcare
986 provider for administration by healthcare providers [see Warnings and Precautions (5.2)].

987 Interaction With Benzodiazepines and Other CNS Depressants

988 Inform patients and caregivers that potentially fatal additive effects may occur if SUBLOCADE is used
989 with benzodiazepines or other CNS depressants, including alcohol. Counsel patients that such
990 medications should not be used concomitantly unless supervised by a healthcare provider [see *Warnings*
991 *and Precautions (5.5.44, 5.5), Drug Interactions (7)*].

992 Serotonin Syndrome

993 Inform patients that SUBLOCADE could cause a rare but potentially life-threatening condition resulting
994 from concomitant administration of serotonergic drugs. Warn patients of the symptoms of serotonin
995 syndrome and to seek medical attention right away if symptoms develop. Instruct patients to inform
996 their healthcare providers if they are taking, or plan to take serotonergic medications [see *Drug*
997 *Interactions (7)*].

998 Adrenal Insufficiency

999 Inform patients that SUBLOCADE could cause adrenal insufficiency, a potentially life-threatening
1000 condition. Adrenal insufficiency may present with non-specific symptoms and signs such as nausea,
1001 vomiting, anorexia, fatigue, weakness, dizziness, and low blood pressure. Advise patients to seek
1002 medical attention if they experience a constellation of these symptoms [see *Warnings and Precautions*
1003 *(5.7)*].

1004 Anaphylaxis

1005 Inform patients that anaphylaxis has been reported with buprenorphine. Advise patients how to
1006 recognize such a reaction and when to seek medical attention [see *Warnings and Precautions (5.10)*].

1007 Driving or Operating Heavy Machinery

1008 Caution patients that SUBLOCADE may impair the mental or physical abilities required for the
1009 performance of potentially dangerous tasks such as driving or operating hazardous machinery. Instruct
1010 patients not to drive or operate hazardous machinery until they are reasonably certain that SUBLOCADE
1011 does not adversely affect their ability to engage in such activities [see *Warnings and Precautions (5.16)*].

1012 Dependence and Withdrawal

1013 Inform patients that SUBLOCADE can cause drug dependence and that withdrawal signs and symptoms
1014 may occur when the medication is discontinued [see *Warnings and Precautions (5.8, 5.11)*].

1015 Orthostatic Hypotension

1016 Inform patients that, like other opioids, SUBLOCADE may produce orthostatic hypotension in
1017 ambulatory individuals [see *Warnings and Precautions (5.17)*].

1018 Long Duration of Action

1019 Inform patients that they may have detectable levels of buprenorphine for a prolonged period of time
1020 after treatment with SUBLOCADE. Considerations of drug-drug interactions, buprenorphine effects, and
1021 analgesia may continue to be relevant for several months after the last injection [see *Clinical*
1022 *Pharmacology (12.3)*].

1023 Drug Interactions

1024 Instruct patients to inform their healthcare providers of any other prescription medications, over the-
1025 counter medications, or herbal preparations that are prescribed or currently being used [see *Drug*

1026 *Interactions (7)*].

1027 Pregnancy

1028 *Neonatal Opioid Withdrawal Syndrome*

1029 Advise women that if they are pregnant while being treated with SUBLOCADE, the baby may have signs
1030 of withdrawal at birth and that withdrawal is treatable [see *Warnings and Precautions (5.6), Use in*
1031 *Specific Populations (8.1)*].

1032 *Embryofetal Toxicity*

1033 Advise women of childbearing potential who become pregnant or are planning to become pregnant to
1034 consult their healthcare provider regarding the possible effects of using SUBLOCADE during pregnancy
1035 [see *Use in Specific Populations (8.1)*].

1036 Lactation

1037 Warn patients that buprenorphine passes into breast milk. Advise the nursing mother taking
1038 buprenorphine to monitor the infant for increased drowsiness and breathing difficulties [see *Use in*
1039 *Specific Populations (8.2)*].

1040 Infertility

1041 Inform patients that chronic use of opioids may cause reduced fertility. It is not known whether these
1042 effects on fertility are reversible [see *Use in Specific Populations (8.3), Clinical Pharmacology (12.2)*].

1043 Emergency Analgesia

1044 Patients should be advised to instruct their family members to, in the event of emergency, inform the
1045 treating healthcare provider or emergency room staff that the patient is physically dependent on an
1046 opioid and that the patient is being treated with SUBLOCADE [see *Warnings and Precautions (5.12)*].

1047 Clinical Monitoring

1048 Tell your patients to seek emergency attention if they have signs or symptoms of respiratory or CNS
1049 depression or overdose [see *Warnings and Precautions (5.4, 5.5)*].

1050 Tell your patients not to tamper with or try to remove their depot [see *Dosage and Administration (2.8)*].

1051

1052 SUBLOCADE™ is a trademark of Indivior UK Limited.

1053

1054 Manufactured for Indivior Inc.
1055 North Chesterfield, VA 23235
1056 By AMRI
1057 Burlington, MA 01803