

▼ This medicinal product is subject to additional monitoring in Australia. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse events at <https://www.tga.gov.au/reporting-problems>.

AUSTRALIAN PI – ILUVIEN (FLUOCINOLONE ACETONIDE) INTRAVITREAL IMPLANT IN APPLICATOR

1 NAME OF THE MEDICINE

ILUVIEN *fluocinolone acetonide* 190 micrograms intravitreal implant in applicator.

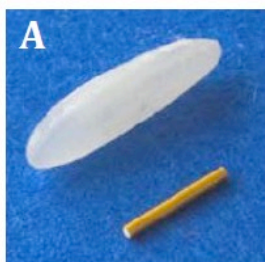
2 QUALITATIVE AND QUANTITATIVE COMPOSITION

ILUVIEN® is a non-biodegradable intravitreal implant in a drug delivery system containing 0.19 mg fluocinolone acetonide, designed to release fluocinolone acetonide for 36 months.

For the full list of excipients, see Section 6.1 List of excipients.

3 PHARMACEUTICAL FORM

ILUVIEN is a sterile non-bioerodable intravitreal implant which is inside a single use applicator with a 25 gauge needle. The implant is a light brown colour and cylindrical in shape with dimensions 3.5 mm long x 0.37 mm in diameter. The applicator is packaged in a plastic tray sealed with a lid.



A: ILUVIEN® implant compared to a grain of rice
B: ILUVIEN® applicator with 25-gauge needle

4 CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

ILUVIEN is indicated for the treatment of diabetic macular oedema (DME) in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure (IOP).

4.2 DOSE AND METHOD OF ADMINISTRATION

For ophthalmic intravitreal injection.

The recommended dose is one ILUVIEN implant in the affected eye. Administration in both eyes concurrently has not been studied and is not recommended (see Section 4.4 Special warnings and precautions for use).

An additional implant may be administered after 12 months if the patient experiences decreased vision or an increase in retinal thickness secondary to recurrent or worsening diabetic macular oedema (see Section 5.1 Pharmacodynamic properties).

Retreatments should not be administered unless the potential benefits outweigh the risks.

Paediatric Population

There is no relevant use of intravitreally administered fluocinolone acetonide in the paediatric population in diabetic macular oedema (DME).

The safety and efficacy of fluocinolone acetonide in the paediatric population has not been established.

Special Populations

No dosage adjustments are necessary in elderly patients, or those with renal or hepatic impairment.

Method of Administration

FOR INTRAVITREAL USE ONLY.

Treatment with ILUVIEN is for intravitreal use only and should be administered by an ophthalmologist experienced in intravitreal injections. The intravitreal injection procedure should be carried out under controlled aseptic conditions, which include use of sterile gloves, a sterile drape, and a sterile eyelid speculum (or equivalent). Adequate anaesthesia and a broad-spectrum microbicide should be given prior to the injection. Further information is provided in the Healthcare Professional materials available from the Sponsor.

The injection procedure for ILUVIEN is as follows:

1. Preoperative antibiotic drops may be administered at the discretion of the treating ophthalmologist.
2. Just prior to injection, administer topical anaesthesia over the injection site (inferotemporal quadrant recommended) as one drop followed by either a cotton-tipped applicator soaked in anaesthetic or as subconjunctival administration of adequate anaesthesia.
3. Administer 2-3 drops of adequate topical antiseptic into the lower fornix. The lids may be scrubbed with cotton-tipped applicators soaked with an adequate topical antiseptic. Place a sterile lid speculum. Have the subject look up and apply a cotton-tipped applicator soaked with an adequate antiseptic to the injection site. Allow 30-60 seconds for the topical antiseptic to dry prior to injection of ILUVIEN.
4. The exterior of the tray should **not** be considered sterile. An assistant (non-sterile) should remove the tray from the carton and examine the tray and lid for damage. If damaged, do not use unit.

If **acceptable, the assistant should peel the lid from the tray without** touching the interior surface.

5. Visually check through the viewing window of the preloaded applicator to ensure that there is a drug implant inside.
6. Remove the applicator from the tray with sterile gloved hands **touching only the sterile interior tray surface and applicator**.

The protective cap on the needle should not be removed until ILUVIEN is ready to be injected.

Prior to injection, the applicator tip must be kept above the horizontal plane to ensure that the implant is properly positioned within the applicator.

7. To reduce the amount of air administered with the implant, the administration procedure requires two steps. Before injecting the needle in the eye, push the button down and slide it to the first stop (at the curved black marks alongside the button track). At the first stop, release the button and it will move to the UP position. If the button does not rise to the UP position, do not proceed with this unit.
8. Optimal placement of the implant is inferior to the optic disc and posterior to the equator of the eye. Measure 4 millimeters inferotemporal from the limbus with the aid of calipers.
9. Carefully remove the protective cap from the needle and inspect the tip to ensure it is not bent.
10. Gently displace the conjunctiva so that after withdrawing the needle, the conjunctival and scleral needle entry sites will not align. Care should be taken to avoid contact between the needle and the lid margin or lashes. Inject the needle in the eye. To release the implant, while the button is in the UP position, advance the button by sliding it forward to the end of the button track and remove the needle. Note: Ensure that the button reaches the end of the track before removing the needle.
11. Remove the lid speculum and perform indirect ophthalmoscopy to verify placement of the implant, adequate central retinal artery perfusion and absence of any other complications. Scleral depression may enhance visualisation of the implant. Examination should include a check for perfusion of the optic nerve head immediately after the injection. Immediate IOP measurement may be performed at the discretion of the ophthalmologist.

Following the procedure, patients should be monitored for potential complications such as endophthalmitis, increased IOP, retinal detachments, and vitreous haemorrhages or detachments. Biomicroscopy with tonometry should be performed between two and seven days after the implant injection.

Thereafter it is recommended that patients are monitored at least quarterly for potential complications, due to the extended duration of release of fluocinolone acetonide, of approximately 36 months (see Section 4.4 Special warnings and precautions for use).

4.3 CONTRAINDICATIONS

An intravitreal implant with ILUVIEN is contraindicated in the presence of pre-existing glaucoma or active or suspected ocular or periocular infection including most viral diseases of the cornea and conjunctiva, including active epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella, mycobacterial infections, and fungal diseases.

ILUVIEN is contraindicated in patients with hypersensitivity to the active substance or to any of the excipients listed in Section 6.1 List of excipients.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Intravitreal Injection-related effects

Intravitreal injections have been associated with endophthalmitis, elevation in IOP, retinal detachments and vitreous haemorrhages or detachments. Patients should be instructed to report without delay any symptoms suggestive of endophthalmitis.

Steroid-related effects

Use of intravitreal corticosteroids may cause cataracts, increased IOP, glaucoma and may increase the risk of secondary infections.

Corticosteroids are not recommended to be used in patients with a history of ocular herpes simplex because of the potential for reactivation of the viral infection.

Patient Monitoring

Patient monitoring within two to seven days following the injection may permit early identification and treatment of ocular infection, increase in IOP or other complication. It is recommended that intra-ocular pressure be monitored at least quarterly thereafter.

The risk of raised intra-ocular pressure from ILUVIEN can be reliably predicted from a patient's response to other topical or intra-ocular steroids. A trial of ocular steroids prior to the use of ILUVIEN is recommended. ILUVIEN is not recommended in patients who develop ocular hypertension that cannot be controlled with topical treatment.

Concurrent Administration

The safety and efficacy of ILUVIEN administered to both eyes concurrently have not been studied. It is recommended that an implant is not administered to both eyes at the same visit. Concurrent treatment of both eyes is not recommended until the patient's systemic and ocular response to the first implant is known (see Section 4.2 Dose and method of administration).

Phase 3 Diabetic Macular Oedema (FAME) Studies

In the DME studies, 80% of phakic subjects treated with fluocinolone acetonide underwent cataract surgery (See Section 4.8 Adverse effects (Undesirable effects)). Phakic patients should be closely monitored for signs of cataract after treatment.

In DME, 38% of patients treated with fluocinolone acetonide required treatment with IOP-lowering medication (see Section 4.8 Adverse effects (Undesirable effects)). The rise in IOP is normally manageable with IOP lowering medications.

Implant Migration

There is a potential for implants to migrate into the anterior chamber, especially in patients with posterior capsular abnormalities, such as tears. This should be taken into consideration when examining patients complaining of visual disturbance after treatment.

Use in the elderly

No dosage adjustments are necessary in elderly patients.

Paediatric use

There is no relevant use of ILUVIEN in the paediatric population in diabetic macular oedema (DME).

Effects on laboratory tests

Interactions with laboratory tests have not been established.

4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS

Specific drug-drug interaction studies were not conducted with fluocinolone acetonide. However, given that fluocinolone acetonide is administered as an intravitreal implant and systemic exposure following its administration is extremely low, the likelihood of drug-drug interactions is unlikely.

4.6 FERTILITY, PREGNANCY AND LACTATION

Effects on fertility

There are no human data on the effect of ILUVIEN on fertility. The effects of intravitreally administered fluocinolone acetonide on fertility were not assessed in animal studies. However, effects on either male or female fertility are unlikely since the systemic exposure to fluocinolone acetonide following intravitreal administration is very low.

Use in pregnancy – Pregnancy Category C

There are no studies of ILUVIEN in pregnant women. Administration of fluocinolone acetonide to pregnant rats and rabbits produced embryofetal lethality and/or malformations. Other corticosteroids have also been shown to be teratogenic in multiple laboratory animal species. Although fluocinolone acetonide is undetectable in the systemic circulation after local, intraocular treatment, fluocinolone is nonetheless a potent corticosteroid and even very low levels of systemic exposure may present some risk to the developing foetus. As a precautionary measure it is preferable to avoid the use of ILUVIEN during pregnancy.

Use in lactation.

It is not known whether intravitreally administered fluocinolone acetonide is excreted in human milk. There are no data on the effects of intravitreally administered fluocinolone acetonide on the breastfed infant, or the effects on milk production. Systematically administered corticosteroids are detected in human milk. A decision should be made on whether to discontinue breastfeeding or to abstain from fluocinolone acetonide treatment taking into account the potential benefit of ILUVIEN to the mother and the potential benefit of breastfeeding to the infant.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

ILUVIEN's effects on ability to drive and use machines were not assessed during clinical development and hence are unknown.

4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)

Summary of the safety profile

Intravitreally administered fluocinolone acetonide was evaluated in 768 subjects (375 in the 0.2 µg/day/ILUVIEN group; 393 in the 0.5 µg/day group) with diabetic macular oedema across the two Phase 3 clinical trials. The most frequently reported adverse drug reactions included cataract operation, cataract and increased IOP.

In the Phase 3 studies, 38.4% of subjects treated with ILUVIEN and 14.1% of subjects receiving sham treatment required IOP-lowering medication. In addition, 4.8% of subjects treated with ILUVIEN and 0.5% of subjects in the sham group required IOP-lowering surgeries. The use of IOP-lowering medication was similar in subjects who received two or more treatments with ILUVIEN.

Table 1. Common (≥1.0%) Drug-Related Adverse Events in the Study Eye by Treatment Group (Integrated FAME Studies: Safety Population)

Adverse Event	Treatment Group	
	Sham (N=185) n (%)	0.2 µg/day fluocinolone acetonide (N=375) n (%)
Eye Disorders SOC		
Cataract	36 (19.5)	133 (35.5)
Cataract nuclear	2 (1.1)	5 (1.3)
Cataract subcapsular	7 (3.8)	24 (6.4)
Conjunctival haemorrhage	2 (1.1)	6 (1.6)
Eye irritation	1 (0.5)	10 (2.7)
Eye pain	4 (2.2)	7 (1.9)
Glaucoma or open angle glaucoma ¹	1 (0.5)	14 (3.7)
Lacrimation increased	3 (1.6)	0
Myodesopsia	0	36 (9.6)
Ocular hypertension	1 (0.5)	8 (2.1)
Vision blurred	2 (1.1)	6 (1.6)
Visual acuity reduced	0	5 (1.3)
Vitreous haemorrhage	2 (1.1)	7 (1.9)
Investigations SOC		
Intraocular pressure increased	8 (4.3)	101 (26.9)
Surgical and Medical Procedures SOC		
Cataract operation	18 (9.7)	160 (42.7)
Glaucoma surgery	1 (0.5)	5 (1.3)
Trabeculectomy	0	10 (2.7)
Vitrectomy	0	5 (1.3)

¹ Includes the total number of unique subjects who experienced glaucoma or open-angle glaucoma.

Two cases of endophthalmitis were reported in subjects treated with ILUVIEN during the Phase 3 studies. This represents an incidence rate of 0.2% (2 cases divided by 1,022 injections).

While the majority of subjects in the DME clinical trials received only one implant (see Section 5.1 Pharmacodynamic properties), the long-term safety implications of retention of the non-bioerodable implant inside the eye are not known. In the FAME clinical trials, 3-year data show that events such as cataract, increased intraocular pressure (IOP) and floaters occurred only slightly more frequently in subjects receiving 2 or more implants. This is considered a function of the increased exposure to the drug rather than an effect of the implant itself. In non-clinical studies, there were no indications of an increase in safety issues other than lens changes in the rabbit eyes with 2-4 implants over 24 months. The implant is made of polyimide and is essentially similar to an intraocular lens haptic; it is therefore expected to remain inert inside the eye.

Description of selected adverse reactions

The long-term use of corticosteroids may cause cataracts and increased IOP. The frequencies stated below reflect the findings in all patients in the DME studies. The observed frequencies in patients with chronic DME were not significantly different to those in the overall population.

The incidence of cataract in phakic subjects was approximately 82% in ILUVIEN treated subjects and 50% in sham treated subjects in the Phase 3 clinical trials. 80% of phakic subjects treated with ILUVIEN required cataract surgery by Year 3 compared to 27% of the sham treated subjects, with most subjects requiring surgery by 21 months. Posterior subcapsular cataract is the most common type of corticosteroid-related cataract. Surgery for this type of cataract is more difficult and may be associated with greater risk of surgical complications.

In the DME studies, subjects with a baseline IOP of > 21 mm Hg were excluded. The incidence of increased IOP was 37%, and 38% of subjects required IOP-lowering medication, with half of these requiring at least two medications to control the IOP. The use of IOP-lowering medication was similar in subjects who received retreatment with an additional implant during the study. Additionally, 5.6% (21/375) of subjects who received an implant required a surgical or laser procedure to control the IOP (trabeculoplasty 5 (1.3%), trabeculectomy 10 (2.7%), endocycloablation 2 (0.5%), and other surgical procedures 6 (1.6%)).

Twenty four percent of subjects in the sham treated group were treated at any time with either anti-coagulant or anti-platelet medications as compared to 27% in the ILUVIEN treated subjects. Subjects treated with ILUVIEN concomitantly or within 30 days of cessation of treatment with anti-coagulant or anti-platelet medications experienced a slightly higher incidence of conjunctival haemorrhage versus the sham treated subjects (0.5% sham and 2.7% ILUVIEN treated). The only other event reported at a higher incidence rate in the ILUVIEN treated subjects was eye operation complication (0% sham and 0.3% ILUVIEN treated).

The following reactions have been identified during post-marketing use of ILUVIEN in clinical practice. Because they are reported voluntarily, estimates of frequency cannot be made. The reactions, which have been chosen for inclusion due to either their seriousness, frequency of reporting (reporting rate > 0.05%), possible causal connection to ILUVIEN, or a combination of these factors.

Infections and infestations	Endophthalmitis
Eye disorders	Cataract, increased IOP Glaucoma, vitreous haemorrhage, conjunctival haemorrhage, reduced visual acuity, vitreous floaters, ocular hypertension, visual impairment
Surgical and medical procedures	Cataract operation, Intraocular lens implant, trabeculectomy, glaucoma surgery, trabeculectomy
Product Issues	Device dislocation
General disorders and administration site conditions	Device dislocation (implant migration)

Reporting of adverse events

Reporting suspected adverse reactions after registration of the medicinal product is important. It allows continued monitoring of the benefit-risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions at www.tga.gov.au/reporting-problems and drugsafety-sta@stbiopharma.com.

4.9 OVERDOSE

No case of overdose has been reported.

For information on the management of overdose, contact the Poisons Information Centre on 13 11 26 (Australia).

5 PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES

Pharmacotherapeutic group: Anti-inflammatory agents, corticosteroids, plain.

ATC code: S01BA15

Mechanism of action

Corticosteroids inhibit inflammatory responses to a variety of inciting agents including multiple inflammatory cytokines. They inhibit oedema, fibrin deposition, capillary dilation, leukocyte migration, capillary proliferation, fibroblast proliferation, deposition of collagen, and scar formation associated with inflammation. Corticosteroids have also been shown to reduce levels of vascular endothelial growth factor, a protein which increases vascular permeability and causes oedema.

Corticosteroids are thought to act by inhibition of phospholipase A₂ via induction of inhibitory proteins collectively called lipocortins. It is postulated that these proteins control biosynthesis of potent mediators of inflammation such as prostaglandins and leukotrienes by inhibiting release of the common precursor, arachidonic acid. Arachidonic acid is released from membrane phospholipids by phospholipase A₂.

Clinical trials

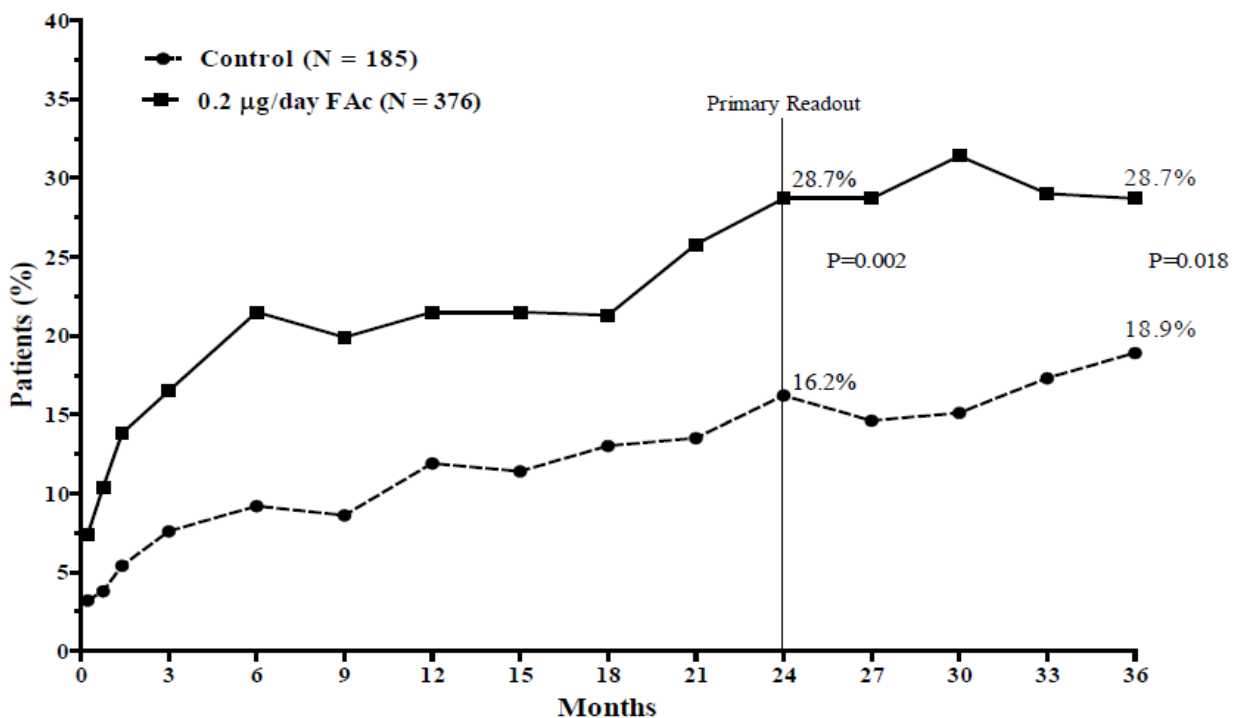
The efficacy of ILUVIEN was assessed in two three year, randomized (2:1, active: sham), multicenter, double-masked, parallel-groups studies that enrolled patients with diabetic macular oedema (DME) that had previously been treated with laser photocoagulation.

The primary efficacy endpoint in both trials was the proportion of subjects in whom BCVA had improved by 15 letters or more from baseline after 24 months of follow-up.

The safety and efficacy of ILUVIEN was assessed in two randomized, multicenter, double-masked, parallel-group studies enrolling subjects with diabetic macular oedema who had previously been treated with laser photocoagulation at least once, each involving three years of follow-up. There were 74.4% of subjects treated with 1 implant, 21.6% with 2 implants, 3.5% with 3 implants and 0.5% with 4 implants and 0% > 4 implants). In clinical trials, around 25% of patients received repeated treatment, with no major difference in outcome. Patients with vision loss and retinal thickening were eligible for re-treatment with fluocinolone acetonide at 12 months, where vision loss was defined as reduction of 5 or more letters in visual acuity and retinal thickening was defined as a minimum increase of 50 microns at the centre of the fovea as per optical coherence tomography (OCT).

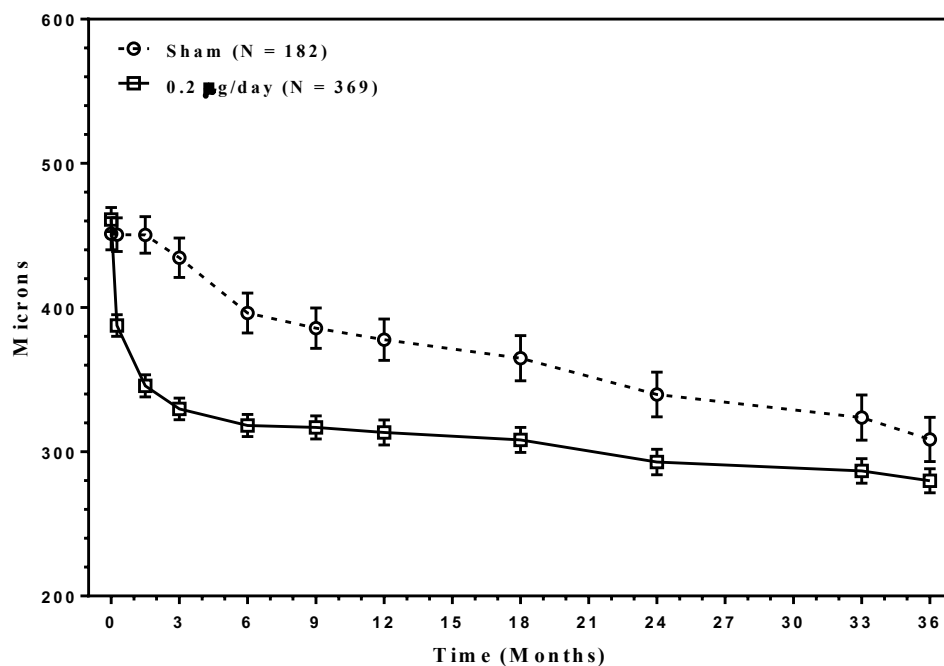
The primary efficacy endpoint in both trials was the proportion of subjects whose vision improved by 15 letters or greater after 24 months. In each of these trials, the primary endpoint was met for ILUVIEN (see Figure 1 for the integrated results of the primary efficacy endpoint). This benefit was maintained at month 36, where the proportion of subjects whose vision improved by 15 letters or greater in the integrated dataset was statistically significantly greater for ILUVIEN (28.7%) than for the control (18.9%) ($p=0.018$). A statistically significant difference was seen as early as week 3 ($p=0.011$) in the integrated dataset.

Figure 1: Percentage of Subjects with BCVA \geq 15 Letter Improvement Over Baseline, Integrated Phase 3 studies (integrated, ITT population)



Reduction in retinal thickness was rapid and maintained over 36 months in patients treated with ILUVIEN (Figure 2).

Figure 2. Mean (\pm SEM) Change from Baseline in Center Point Thickness by Treatment Group (Integrated Phase 3 [FAME] Studies: Full Analysis Population)



5.2 PHARMACOKINETIC PROPERTIES

Absorption

ILUVIEN 190 micrograms intravitreal implant releases very small amounts of fluocinolone acetonide directly into the vitreous humour. In the 24-month repeat-dose toxicity study, absorption into the systemic circulation was not detectable (>200 pg/mL) in rabbits administered intravitreal implants releasing fluocinolone acetonide at 0.2, 0.5 or 1.0 μ g/day.

Distribution

In a 24 month intravitreal repeat dos toxicity study, fluocinolone acetonide concentrations in aqueous humour of pigmented rabbits were generally below the limit of quantitation (200 pg/mL) at the majority of time points. Vitreous humour, lens, choroid, pigmented epithelium and iris/ciliary body had measurable concentrations of fluocinolone acetonide at all time points. Fluocinolone acetonide levels fell below 200 pg/mL in the cornea and retina, typically after Day 89.

Following a small initial peak release, near steady vitreous humour, lens, cornea, retina, choroid and pigmented epithelium and iris/ciliary body tissue concentrations of fluocinolone acetonide were maintained for up to the 24 months in pigmented rabbits administered fluocinolone acetonide insert (0.2, 0.5 or 1.0 μ g/day) intravitreally. The left and right eye mean tissue concentrations declined very gradually with elimination half-lives ($t_{1/2}$) generally exceeding 2000 hours. In general, ocular tissue fluocinolone acetonide concentrations increased with the dose level and at the mid and high dose levels, concentrations were seen to increase following administration of the second fluocinolone acetonide insert at 12 months.

Metabolism

No drug metabolism/elimination studies have been conducted. There are also no reports of metabolite effects or systemic effects from fluocinolone acetonide or other corticosteroids administered intravitreally. The metabolism of corticosteroids is primarily by hepatic mechanisms. Ocular metabolism of fluocinolone acetonide released from the implant is not expected and is most likely that fluocinolone acetonide is eliminated by distribution into the systemic circulation, producing very low levels over a prolonged period of time.

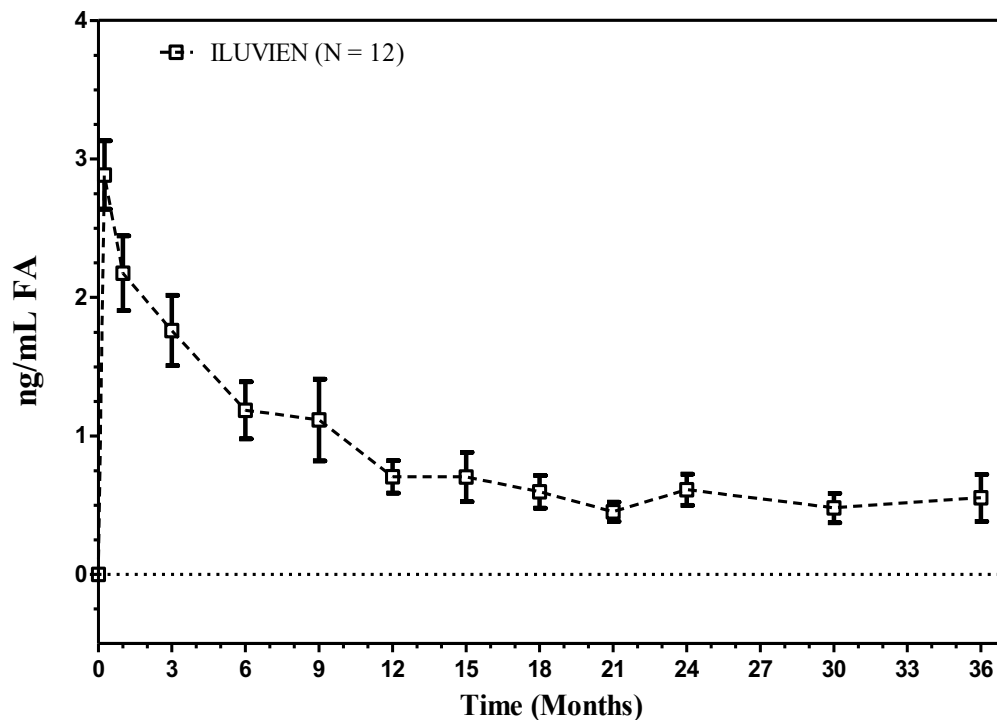
The most active organ for metabolism of corticosteroids is the liver, and these low levels of fluocinolone acetonide are most likely metabolised by hepatic esterification. Because of the very limited systemic exposure expected from the fluocinolone acetonide insert, meaningful levels of fluocinolone acetonide metabolites or parent drug are not likely to occur. This is supported by the fact that plasma and urine levels of fluocinolone acetonide in rabbits were consistently below the limit of quantitation (200 pg/mL) in the 24-month intravitreal repeat dose study despite exaggerated dosing (of up to 1.0 µg/day). Furthermore, plasma levels of fluocinolone acetonide in patients treated with the drug product were below the limit of detection (<100 pg/mL) at all times for both doses of 0.2 and 0.5 µg/day (FAMOUS Study).

Clinical pharmacokinetic studies

In a human pharmacokinetic study of ILUVIEN, fluocinolone acetonide concentrations in plasma were below the lower limit of quantitation of the assay (100 pg/mL) at all post-administration time points from Day 7 through Month 36 following intravitreal administration of a 0.2 µg/day or 0.5 µg/day fluocinolone acetonide insert.

In a human pharmacokinetic study (FAMOUS Study) fluocinolone acetonide concentrations in plasma were below the lower limit of quantitation of the assay (100 pg/mL) at all time points from Day 1 through Month 36 indicating negligible systemic exposure. The maximal aqueous humour fluocinolone acetonide concentrations were observed on Day 7 for most of the subjects. Aqueous humour fluocinolone acetonide concentrations decreased over the first 3–6 months and remained essentially the same through Month 36 for subjects who were not retreated (Figure 3). Subjects who were retreated experienced a second fluocinolone acetonide peak concentration similar to that following the initial dose. After retreatment, aqueous humour concentrations of fluocinolone acetonide returned to levels approximately similar to those observed at the time of first treatment.

Figure 3: Fluocinolone acetonide Levels in Human Aqueous Humour in Subjects Receiving 1 Implant (FAMOUS Study)



5.3 PRECLINICAL SAFETY DATA

Genotoxicity

Fluocinolone acetonide was not genotoxic *in vitro* in the bacterial reverse mutation (Ames) test (*S. typhimurium* and *E. coli*) and the mouse lymphoma TK assay *in vitro*, or in the *in vivo* mouse bone marrow micronucleus assay.

Carcinogenicity

Long-term animal studies have not been conducted to determine the carcinogenic potential of fluocinolone acetonide insert.

No carcinogenicity data are available for intravitreally administered fluocinolone acetonide. However, intravitreally administered fluocinolone acetonide was not detectable systemically in rabbits for up to 24 months (at ocular exposures up to 11 fold higher than the clinical dose of 0.2 µg/day, based on vitreous humour volume) and thus no systemic effects are anticipated.

Local Effects

Local effects (focal degenerative lesions affecting fibers in the posterior polar and posterior cortical regions of the lens) were observed in rabbits at doses of intravitreal fluocinolone acetonide in excess of the clinically used dose. Local effects (focal retinal scarring) were also seen in rabbits treated with both placebo and fluocinolone acetonide containing device. This scarring was not seen clinically in humans and is postulated to be due to anatomical differences between the rabbit and human eye.

6 PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

ILUVIEN contains the following excipients: polyvinyl alcohol.

The drug delivery system consists of: PMDA/ODA copolymer tubing, MED-1137 RTV silicone adhesive, polyvinyl alcohol.

6.2 INCOMPATIBILITIES

Incompatibilities were either not assessed or not identified as part of the registration of this medicine.

6.3 SHELF LIFE

ILUVEIN has a shelf life of 2 years. After first opening the lid, use immediately.

In Australia, information on the shelf life can be found on the public summary of the Australian Register of Therapeutic Goods (ARTG). The expiry date can be found on the packaging.

6.4 SPECIAL PRECAUTIONS FOR STORAGE

Store below 25°C. Do not refrigerate or freeze.

Do not open the sealed tray until just before application.

6.5 NATURE AND CONTENTS OF CONTAINER

The implant is supplied in a single use applicator with a 25 gauge needle. Each sterile applicator contains a light brown 3.5 mm long cylindrical implant. The applicator is packaged in a plastic tray sealed with a lid.

6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

Dispose of the applicator safely in a biohazard sharps container.

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

6.7 PHYSICOCHEMICAL PROPERTIES

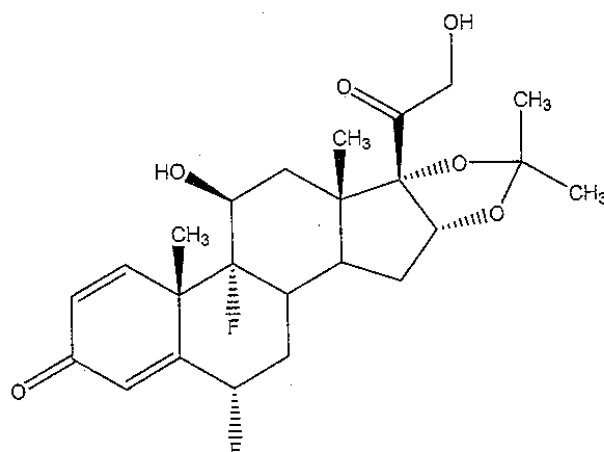
Chemical structure

Chemical Name: (6 α , 11 β , 16 α)-6,9-difluoro-11,21-dihydroxy-16,17-[(1-methylethylidene)bis-(oxy)]-pregna-1,4-diene-3,20-dione

Molecular Weight: 452.50 g/mol

Molecular Formula: C₂₄H₃₀F₂O₆

Structural Formula:



CAS number

CAS Registry No: 67-73-2

Fluocinolonide is a white or almost white, microcrystalline powder, practically insoluble in water, soluble in methanol, ethanol, chloroform and acetone, and sparingly soluble in ether.

7 MEDICINE SCHEDULE (POISONS STANDARD)

Prescription Only Medicine (S4)

8 SPONSOR

Specialised Therapeutics Alim Pty Ltd
Level 2, 17 Cotham Road
Kew Victoria 3101
Australia
Website: www.stbiopharma.com
Phone: 1300 798 820
Fax: 1800 798 829

9 DATE OF FIRST APPROVAL

29 July 2019

ILUVIEN 190 micrograms: AUST R 306543

10 DATE OF REVISION

SUMMARY TABLE OF CHANGES

Section Changed	Summary of new information