ARAVA® (leflunomide), tablets, for oral use

Initial U.S. Approval: 1998

WARNING: EMBRYO-FETAL TOXICITY and HEPATOTOXICITY

See full prescribing information for complete boxed warning.

Embryo-Fetal Toxicity
- Teratogenicity and embryolethality occurred in animals administered leflunomide. (5.1, 8.1)
- Exclude pregnancy prior to initiating ARAVA therapy. (5.1, 8.3)
- Advise use of effective contraception in females of reproductive potential during treatment and during a drug elimination procedure. (5.1, 5.3, 8.3)
- Stop ARAVA and use an accelerated drug elimination procedure if the patient becomes pregnant. (5.1, 5.3, 8.1)

Hepatotoxicity
- Severe liver injury and fatal liver failure have been reported. (5.2)
- Avoid ARAVA use in patients with pre-existing liver disease, or those with serum alanine aminotransferase (ALT) >2×ULN. (5.2, 8.6)
- Use caution when ARAVA is given with other potentially hepatotoxic drugs. (5.2)
- Monitor ALT levels. Interrupt ARAVA treatment if ALT elevation >3 fold ULN. If likely leflunomide-induced, start accelerated drug elimination procedure and monitor liver tests weekly until normalized. (5.2, 5.3)

CONTRAINDICATIONS
- Pregnancy: (4, 5.1, 8.1)
- Severe hepatic impairment. (4, 5.2)
- Hypersensitivity to ARAVA or any of its inactive components. (4)
- Current teriflunomide treatment. (4)

WARNINGS AND PRECAUTIONS
- After stopping ARAVA, it is recommended that an accelerated drug elimination procedure be used to reduce the plasma concentrations of the active metabolite, teriflunomide. (5.3)
- Severe infections (including sepsis), pancreatitis, agranulocytosis and thrombocytopenia: Stop ARAVA and use accelerated elimination procedure. Do not start ARAVA in patients with active infection. Monitor CBCs during treatment with ARAVA. (5.4)
- Stevens-Johnson syndrome and toxic epidermal necrolysis: Stop ARAVA and use accelerated elimination procedure. (5.5)
- Peripheral neuropathy: If patient develops symptoms consistent with peripheral neuropathy, evaluate patient and consider discontinuing ARAVA. (5.7)
- Interstitial lung disease: May be fatal. New onset or worsening symptoms may necessitate discontinuation of Arava and initiation of accelerated elimination procedure. (5.8)
- Increased blood pressure: Monitor and treat. (5.10)

ADVERSE REACTIONS
- The most commonly reported adverse reactions (≥10%) regardless of relation to ARAVA treatment were diarrhea, respiratory infection, nausea, headache, rash, abnormal liver enzymes, dyspepsia. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact sanofi-aventis U.S. LLC at 1-800-633-1610 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

DRUG INTERACTIONS
- Drugs metabolized by CYP2C8 and OAT3 transporters: Monitor patients because teriflunomide may increase exposure of ethinylestradiol and levonorgestrel. Choose an appropriate oral contraceptive. (7)
- Drugs metabolized by CYP1A2: Monitor patients because teriflunomide may decrease exposure of these drugs. (7)
- Warfarin: Monitor INR as teriflunomide may decrease INR. (7)
- Drugs metabolized by BCRP and OATP1B1/B3 transporters: Monitor patients because teriflunomide may increase exposure of these drugs. (7)
- Rosuvastatin: The dose of rosvustatin should not exceed 10 mg once daily in patients taking ARAVA. (7)

ADVERSE REACTIONS

Use in Specific Populations
- Lactation: Discontinue breastfeeding. (8.2)
- Safety and effectiveness in pediatric patients <12 years of age has not been established. (8.4)

See 17 for PATIENT COUNSELING INFORMATION

Revised: 02/2016

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**WARNING: EMBRYO-FETAL TOXICITY and HEPATOTOXICITY**

**Embryo-Fetal Toxicity**
ARAVA is contraindicated for use in pregnant women because of the potential for fetal harm. Teratogenicity and embryo-lethality occurred in animals administered leflunomide at doses lower than the human exposure level. Exclude pregnancy before the start of treatment with ARAVA in females of reproductive potential. Advise females of reproductive potential to use effective contraception during ARAVA treatment and during an accelerated drug elimination procedure after ARAVA treatment. Stop ARAVA and use an accelerated drug elimination procedure if the patient becomes pregnant. (see Contraindications (4), Warnings and Precautions (5.3, 5.4), and Use in Specific Populations (8.3)).

**5.2 Hepatotoxicity**
Severe liver injury, including fatal liver failure, has been reported in patients treated with ARAVA. ARAVA is contraindicated in patients with severe hepatic impairment. Concomitant use of ARAVA with other potentially hepatotoxic drugs may increase the risk of liver injury. Patients with pre-existing acute or chronic liver disease, or those with serum alanine aminotransferase (ALT) >2 x ULN before initiating treatment, are at increased risk and should not be treated with ARAVA. Monitor ALT levels at least monthly for six months after starting ARAVA, and thereafter every 6-8 weeks. If leflunomide-induced liver injury is suspected, stop ARAVA treatment, start an accelerated drug elimination procedure, and monitor liver tests weekly until normalized. (see Contraindications (4), Warnings and Precautions (5.2, 5.3), Use in Specific Populations (8.6)).

**Embryo-Fetal Toxicity**
ARAVA is contraindicated for use in pregnant women because of the potential for fetal harm. Teratogenicity and embryo-lethality occurred in animals administered leflunomide at doses lower than the human exposure level. Exclude pregnancy before the start of treatment with ARAVA in females of reproductive potential. Advise females of reproductive potential to use effective contraception during ARAVA treatment and during an accelerated drug elimination procedure after ARAVA treatment. Stop ARAVA and use an accelerated drug elimination procedure if the patient becomes pregnant. (see Contraindications (4), Warnings and Precautions (5.1, 5.3), Use in Specific Populations (8.1), 8.3), and Clinical Pharmacology (12.3))

**2.2 Evaluation and Testing Prior to Starting ARAVA**

**5.4 Immunosuppression, Bone Marrow Suppression, and Risk of Serious Infections**
ARAVA is not recommended for patients with severe immunodeficiency, bone marrow dysplasia, or severe, uncontrolled infections. If a serious infection occurs, consider interrupting ARAVA therapy and initiating the accelerated drug elimination procedure (see Warnings and Precautions (5.3), Medications Affecting Immune Function (10.1), Immunosuppression (5.4), and Use in Specific Populations (8.1)).

**2.2 Evaluation and Testing Prior to Starting ARAVA**
For patients with pre-existing acute or chronic liver disease, or those with serum alanine aminotransferase (ALT) >2 x ULN before initiating treatment, are at increased risk and should not be treated with ARAVA. Monitor ALT levels at least monthly for six months after starting ARAVA, and thereafter every 6-8 weeks. If leflunomide-induced liver injury is suspected, stop ARAVA treatment, start an accelerated drug elimination procedure, and monitor liver tests weekly until normalized. (see Contraindications (4), Warnings and Precautions (5.2, 5.3), Use in Specific Populations (8.6)).

**5.2 Hepatotoxicity**
Severe liver injury, including fatal liver failure, has been reported in some patients treated with ARAVA. Patients with pre-existing acute or chronic liver disease, or those with serum alanine aminotransferase (ALT) >2 x ULN before initiating treatment, should not be treated with ARAVA. Use caution when ARAVA is given with other potentially hepatotoxic drugs. Monitoring of ALT levels is recommended at least monthly for six months after starting ARAVA, and thereafter every 6-8 weeks. If ALT elevations >3 fold ULN occur, interrupt ARAVA therapy and reevaluate the case. If ARAVA is reinstituted, the patient should be monitored closely for disease activity and liver function tests weekly until normalized (see Warnings and Precautions (5.3, 5.4)). If ARAVA-induced liver injury is likely because some other cause has been found, resumption of ARAVA therapy may be considered. If ARAVA and methotrexate are given concomitantly, follow the American College of Rheumatology (ACR) guidelines for monitoring methotrexate toxicity with ALT, AST, and serum albumin testing. (see Warnings and Precautions (5.5)).

**5.4 Immunosuppression, Bone Marrow Suppression, and Risk of Serious Infections**
ARAVA is not recommended for patients with severe immunodeficiency, bone marrow dysplasia, or severe, uncontrolled infections. If a serious infection occurs, consider interrupting ARAVA therapy and initiating the accelerated drug elimination procedure (see Warnings and Precautions (5.3), Medications Affecting Immune Function (10.1), Immunosuppression (5.4), and Use in Specific Populations (8.1)).

**Elimination can be accelerated by the following procedures:**
1) Administer chlorothiazide 8 grams orally 3 times daily for 11 days.
2) Alternatively, administer 50 grams of activated charcoal powder (made into a suspension) orally every 12 hours for 11 days. Verify plasma teriflunomide concentrations of less than 0.02 mg/mL (0.02 µg/mL) by at least 14 days apart. If plasma teriflunomide concentrations are higher than 0.02 mg/L, repeat chlorothiazide and/or activated charcoal treatment.

The duration of accelerated drug elimination treatment may be modified based on the clinical status and tolerability of the elimination procedure. The procedure may be repeated as needed, based on teriflunomide concentrations and clinical status.

Use of the accelerated drug elimination procedure may potentially result in return of disease activity if the patient had been responding to ARAVA treatment.

**5.5 Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis, and Drug Reactions with Labial and/or Oral Mucous Membrane Ulcers**

**5.5 Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis, and Drug Reactions with Labial and/or Oral Mucous Membrane Ulcers**

**5.5 Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis, and Drug Reactions with Labial and/or Oral Mucous Membrane Ulcers**

Rare cases of Stevens-Johnson syndrome and toxic epidermal necrolysis, and drug reaction with eosinophilia and systemic symptoms (DRESS) have been reported in patients receiving ARAVA. If a patient taking ARAVA develops any of these conditions, stop ARAVA treatment and perform an accelerated drug elimination procedure (see Warnings and Precautions (5.3)).
5.6 Malignancy and Lymphoproliferative Disorders
The risk of malignancy, particularly lymphoproliferative disorders, is increased with the use of some immunosuppression medications. There is a potential for immunosuppression with ARAVA. No apparent increase in the incidence of malignancies and lymphoproliferative disorders was reported in the clinical trials of ARAVA, but larger dosages and longer-term studies would be needed to determine whether there is an increased risk of malignancy or lymphoproliferative disorders with ARAVA.

5.7 Peripheral Neuropathy
Cases of peripheral neuropathy have been reported in patients receiving ARAVA and in clinical studies with teriflunomide, the active metabolite of leflunomide. Most patients recovered after discontinuation of treatment, but some patients had persistent symptoms. Age older than 60 years, concomitant neurotoxic medications, and diabetes may increase the risk for peripheral neuropathy. If a patient taking ARAVA develops a peripheral neuropathy, consider discontinuing ARAVA therapy and performing an accelerated drug elimination procedure [see Dosage and Administration (5.3)].

5.8 Interstitial Lung Disease
Interstitial lung disease and worsening of pre-existing interstitial lung disease have been reported during treatment with ARAVA and has been associated with fatal outcomes [see Adverse Reactions (6.2)]. The risk of ARAVA-associated interstitial lung disease is increased in patients with a history of interstitial lung disease. Interstitial lung disease is a potentially fatal disorder that may occur acutely at any time during therapy and has a variable clinical presentation. New onset or worsening pulmonary symptoms, such as cough and dyspnea, with or without associated fever, may be a reason for discontinuation of ARAVA therapy and for further investigation as appropriate. If discontinuation of ARAVA is necessary, consider performing an accelerated drug elimination procedure [see Warnings and Precautions (5.3)].

5.9 Vaccinations
No clinical data are available on the efficacy and safety of vaccinations during ARAVA treatment. Vaccination with live vaccines is, however, not recommended. The long half-life of the active metabolite of ARAVA should be considered when contemplating administration of a live vaccine after stopping ARAVA.

Table 1. Liver Enzyme Elevations >3-fold Upper Limits of Normal (ULN) in Patients with RA in Trials 1, 2, and 3

<table>
<thead>
<tr>
<th></th>
<th>Trial 1 (n=118)</th>
<th>Trial 2 (n=92)</th>
<th>Trial 3 (n=501)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALT (SGPT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;3-fold ULN</td>
<td>8(4.4)</td>
<td>2(1.5)</td>
<td>13(2.6)</td>
</tr>
<tr>
<td>Reversed to ≤ 2-fold ULN</td>
<td>8</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Timing of Elevation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–3 Months</td>
<td>6</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>4–6 Months</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>7–9 Months</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10–12 Months</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
</tbody>
</table>

MTX = methotrexate, PL = placebo, SSZ = sulfasalazine, ULN = Upper limit of normal
*Only 10% of patients in Trial 3 received folate. All patients in Trial 1 received folate.

In a 6 month study of 263 patients with persistent active rheumatoid arthritis despite methotrexate therapy, and with normal LFTs, ARAVA was administered to a group of 130 patients starting at 10 mg per day and increased to 20 mg as needed. An increase in ALT greater than or equal to three times the ULN was observed in 3.8% of patients compared to 0.8% in 133 patients continued on methotrexate placebo.

5.10 Blood Pressure Monitoring
In placebo-controlled studies with the active metabolite of ARAVA, teriflunomide, elevations in blood pressure were observed in some subjects. Blood pressure should be checked before starting treatment with ARAVA and monitored periodically thereafter [see Adverse Reactions (6.1)].

ADVERSE REACTIONS
The following serious adverse reactions are described elsewhere in the labeling:
- Hepatotoxicity [see Warnings and Precautions (5.2)]
- Immunosuppression [see Warnings and Precautions (5.4)]
- Bone marrow suppression [see Warnings and Precautions (5.4)]
- Stevens-Johnson syndrome and toxic epidermal necrolysis [see Warnings and Precautions (5.5)]
- Peripheral neuropathy [see Warnings and Precautions (5.7)]
- Intestinal lung disease [see Warnings and Precautions (5.8)]

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

In clinical studies (Trials 1, 2, and 3), 1,865 patients were treated with ARAVA administered as either monotherapy or in combination with methotrexate or sulfasalazine. Patients ranged in age from 19 to 85 years, with an overall median age of 58 years. The mean duration of RA was 6 years ranging from 0 to 45 years.

Elevation of Liver Enzymes
Treatment with ARAVA was associated with elevations of liver enzymes, primarily ALT and AST, in a significant number of patients; these effects were generally reversible. Most transaminase elevations were mild (<2-fold ULN) and usually resolved while continuing treatment. Marked elevations (>3-fold ULN) occurred infrequently and reversed with dose reduction or discontinuation of treatment. Table 1 shows liver enzyme elevations seen with monthly monitoring in clinical trials Trial 1 and Trial 2. It was notable that the absence of folate use in Trial 3 was associated with a considerably greater incidence of liver enzyme elevation on methotrexate.

<table>
<thead>
<tr>
<th>ARAVA 20 mg/day (n=118)</th>
<th>PL 7.5 – 15 mg/wk (n=182)</th>
<th>MTX 7.5 – 15 mg/wk (n=498)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
<td>27%</td>
<td>12%</td>
</tr>
<tr>
<td>Headache</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Nausea</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Rash</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>Abnormal Liver Enzymes</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>Alopecia</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>Hypertension1</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Athero-sclerosis</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Back Pain</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>GI/Abdominal Pain</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Most Common Adverse Reactions
The most common adverse reactions in ARAVA-treated patients with RA include diarrhea, elevated liver enzymes (ALT and AST), alopecia, and rash. Table 2 displays the most common adverse reactions in the controlled studies in patients with RA at one year (>5% in any ARAVA treatment group).

Table 2. Percentage Of Patients With Adverse Events >5% In Any ARAVA Treated Group in all RA Studies in Patients with RA

<table>
<thead>
<tr>
<th>Placebo-Controlled Trials</th>
<th>Active-Controlled Trials</th>
<th>All RA Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARAVA 20 mg/day (n=513)</td>
<td>PL 2.0 g/day (n=133)</td>
<td></td>
</tr>
<tr>
<td>20 mg/day (n=501)</td>
<td>MTX 7.5 – 15 mg/wk (n=498)</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>27%</td>
<td>12%</td>
</tr>
<tr>
<td>Headache</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Nausea</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Rash</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>Abnormal Liver Enzymes</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>Alopecia</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Athero-sclerosis</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Back Pain</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>GI/Abdominal Pain</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Table 2. Percentage Of Patients With Adverse Events ≥5% In Any ARAVA Treated Group in all RA Studies in Patients with RA (continued)

<table>
<thead>
<tr>
<th></th>
<th>Placebo-Controlled Trials</th>
<th>Active-Controlled Trials</th>
<th>All RA Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ARAVA 20 mg/day (n=315)</td>
<td>ARAVA 20 mg/day (n=501)</td>
<td>ARAVA (n=1339)</td>
</tr>
<tr>
<td></td>
<td>PL (n=210)</td>
<td>MTX 7.5 – 15 mg/wk (n=182)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSZ 2.0 g/day (n=133)</td>
<td>MTX 7.5 – 15 mg/wk (n=498)</td>
<td></td>
</tr>
<tr>
<td>Allergic Reaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td>5%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>5%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Mouth Ulcer</td>
<td>5%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Pruritus</td>
<td>5%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Rhinitis</td>
<td>5%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Tenosynovitis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MTX = methotrexate, PL = placebo, SSZ = sulfaalazine
*Only 10% of patients in Trial 3 received folate. All patients in Trial 1 received folate; none in Trial 2 received folate.
†Includes all controlled and uncontrolled trials with ARAVA (duration up to 12 months).
††Hypertension as a pre-existing condition was overrepresented in all ARAVA treatment groups in phase III trials.

Adverse events during a second year of treatment with ARAVA in clinical trials were consistent with those observed during the first year of treatment and occurred at a similar or lower incidence. Less Common Adverse Reactions

In addition, in controlled clinical trials, the following adverse events in the ARAVA treatment group occurred at a higher incidence than in the placebo group. These adverse events were deemed possibly related to the study drug.

Blood and Lymphatic System: leucocytosis, thrombocytopenia;
Cardiovascular: chest pain, palpitation, thrombophelitis of the leg, varicose vein;
Eye: blurred vision, eye disorder, papilledema, retinal disorder, retinal hemorrhage;
Gastrointestinal: alkaline phosphatase increased, anorexia, bilirubinemia, flatulence, gamma-GT increased, salivary gland enlarged, sene throat, vomiting, dry mouth;
General Disorders: malaise;
Immun System: anaphylactic reaction;
Infection: abscess, flu syndrome, vaginal moniliasis;
Nervous System: dizziness, headache, somnolence;
Respiratory System: dyspnea;

6.2 Post Marketing Experience

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

Blood and Lymphatic System: leucocytosis, thrombocytopenia;
Cardiovascular: chest pain, palpitation, thrombophelitis of the leg, varicose vein;
Eye: blurred vision, eye disorder, papilledema, retinal disorder, retinal hemorrhage;
Gastrointestinal: alkaline phosphatase increased, anorexia, bilirubinemia, flatulence, gamma-GT increased, salivary gland enlarged, sene throat, vomiting, dry mouth;
General Disorders: malaise;
Immun System: anaphylactic reaction;
Infection: abscess, flu syndrome, vaginal moniliasis;
Nervous System: dizziness, headache, somnolence;
Respiratory System: dyspnea;

7 Drug Interactions

Following oral administration, leflunomide is metabolized to an active metabolite, teriflunomide, which is responsible for essentially all of leflunomide's in vivo activity. Drug interaction studies have been conducted with both ARAVA (leflunomide) and with its active metabolite, teriflunomide, where the metabolite was directly administered to the test subjects.

Effect of potent CYP and transporter inducers

Leflunomide is metabolized by CYP450 metabolizing enzymes. Concomitant use of ARAVA and rifampin, a potent inducer of CYP and transporters, increased the plasma concentration of teriflunomide by 40%. However, when co-administered with the metabolite, teriflunomide, rifampin did not affect the pharmacokinetics. No dosage adjustment is recommended for ARAVA when coadministered with rifampin. Because of the potential for ARAVA concentrations to continue to increase with multiple dosing, caution should be used if patients are to be receiving both ARAVA and rifampin (see Clinical Pharmacology (12.2)).

Effect on CYP2C8 substrates

Teriflunomide is an inhibitor of CYP2C8 in vivo. In patients taking ARAVA, exposure of drugs metabolized by CYP2C8 (e.g., paxilaxef, pioglitazone, repaglinide, rosiglitazone) may be increased. Monitor these patients and adjust the dose of the concomitant drug(s) as required (see Clinical Pharmacology (12.3)).

Effect on organic anion transporter 3 (OAT3) substrates

Teriflunomide inhibits the activity of OAT3 in vivo. In patients taking ARAVA, exposure of drugs which are OAT3 substrates (e.g., eflocef, cilomitrine, ciprofloxacin, penicillin G, ketoprofen, lusoside, leflunomide, zidovudine) may be increased. Monitor these patients and adjust the dose of the concomitant drug(s) as required (see Clinical Pharmacology (12.3)).

Effect on BCRP and organic anion transporting polypeptide B1 and B3 (OATP1B1/1B3) substrates

Teriflunomide inhibits the activity of BCRP and OATPIB1/B3 in vivo. For a patient taking ARAVA, the dose of rosuvastatin should not exceed 10 mg once daily. For other substrates of BCRP (e.g., milodrotone) and drugs in the OATP family (e.g., methotrexate, rifampin), especially HMG-CoA reductase inhibitors (e.g., atorvastatin, nateglinide, pravastatin, repagluride, and simvastatin), consider reducing the dose of these drugs and monitor patients closely for signs and symptoms of increased exposures to the drugs while patients are taking ARAVA (see Clinical Pharmacology (12.3)).

8 Use in Specific Populations

8.1 Pregnancy

Pregnancy Exposure Registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to ARAVA during pregnancy. Health care providers and patients are encouraged to report pregnancies by calling 1-877-311-9672 or visit http://www.pregnancystudy.org/participate-in-a-study/

Risk Summary

ARAVA is contraindicated for use in pregnant women because of the potential for fetal harm. In animal reproduction studies, oral administration of leflunomide during organogenesis at a dose of 1/10 of and equivalent to the maximum recommended human dose (MRHD) based on AUC, respectively in rats and rabbits, caused teratogenicity (rats and rabbits) and embryo-lethality (rabs) (see Data). Pregnancy exposure registry data are not available at this time to inform the presence or absence of drug-associated risk with the use of ARAVA during pregnancy. The background risk of major birth defects and miscarriage for the indicated population is unknown. The background risk in the U.S. general population of major birth defects is 2–4% and of miscarriage is 15–20% of clinically recognized pregnancies. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, stop treatment with ARAVA, apprise the patient of the potential hazard to a fetus, and perform the accelerated drug elimination procedure to achieve teriflunomide concentrations of less than 0.02 mg/L [0.02 mcg/mL] (see Warnings and Precautions (5.3)).

Clinical Considerations

Fetal/Neonatal adverse reactions

Levering the plasma concentration of the active metabolite, teriflunomide, by instituting an accelerated drug elimination procedure as soon as pregnancy is detected may decrease the risk to the fetus from ARAVA. The accelerated drug elimination procedure includes verification that the plasma teriflunomide concentration is less than 0.02 mg/L [0.02 mcg/mL] (see Warnings and Precautions (5.3) and Clinical Pharmacology (12.3)).

Data

Animal Data

In an embryofetal development study, pregnant rats administered leflunomide during organogenesis from gestation days 7 to 19 at a dose approximately 1/10 of the MRHD (on an AUC basis at a maternal oral dose of 15 mg/kg), teratogenic effects, most notably anophthalmia or microphthalmia and internal malformations were observed. Under these exposure conditions, leflunomide also caused a decrease in postnatal survival of 1/10 of the MRHD (on an AUC basis at a maternal oral dose of 15 mg/kg), teratogenic effects were observed. Under these exposure conditions, leflunomide also decreased a decrease in postnatal body weight and an increase in embryolethality with a decrease in fetal body weight for surviving fetuses. In an embryofetal development study, pregnant rabbits administered leflunomide during organogenesis from gestation days 8 to 18 at a dose approximately equivalent to the MRHD (on an AUC basis at a maternal oral dose of 10 mg/kg), a teratogenic finding of fused, dysplastic sternebrae was observed. Leflunomide was not teratogenic in rats and rabbits at doses approximately 1/100 and 1/100 of the MRHD, respectively (on an AUC basis at maternal oral dose of 1 mg/kg in both rats and rabbits).

In a pre- and post-natal development study, when female rats were treated with leflunomide at a dose that was approximately 1/100 of the MRHD (on an AUC basis at a maternal dose of 1.25 mg/kg) beginning 14 days before mating and continuing until the end of lactation, the offspring exhibited marked (greater than 90%) decreases in postnatal survival.
8.2 Lactation
Risk Summary
Clinical trial studies have not been conducted to assess the presence of ARAVA in human milk, the effects of ARAVA on the breast-fed child, or the effects of ARAVA on milk production. Because of the potential for serious adverse reactions in a breastfed infant from ARAVA, advise a nursing woman to discontinue breastfeeding during treatment with ARAVA.

8.3 Females and Males of Reproductive Potential
ARAVA may cause fetal harm when administered during pregnancy. Advise females of the potential risk to the fetus. Advise females to notify their healthcare provider immediately if pregnancy occurs or is suspected during treatment [see Use In Specific Populations (8.1)].

Women receiving ARAVA treatment who wish to become pregnant should discontinue ARAVA and undergo an accelerated drug elimination procedure to achieve plasma teriflunomide concentrations of less than 0.02 mg/L [see Warnings and Precautions (5.3)].

Teriflunomide is extensively bound to plasma protein (98-99%) and is mainly distributed in plasma. The volume of distribution is 11 L after a single intravenous (IV) administration.

The active metabolite of teriflunomide, leflunomide, has a median half-life of 18-19 days in healthy volunteers. The elimination of teriflunomide can be accelerated by administration of chloroethyramine or activated charcoal. Without use of an accelerated drug elimination procedure, it may take up to 2 years to reach plasma teriflunomide concentrations of less than 0.02 mg/L, due to individual variation in drug clearance [see Warnings and Precautions (5.3)]. After a single IV administration of the metabolite (teriflunomide), the total body clearance of teriflunomide was 30.5 mL/h.

Leflunomide, the active metabolite of leflunomide, is eliminated by direct biliary excretion of unchanged drug as well as renal excretion of metabolites. Over 21 days, 60.1% of the administered dose is excreted via feces (57.3%) and urine (22.6%). After an accelerated elimination procedure with cholestyramine, an additional 23.1% was recovered (mostly in feces).

Studies with both hemodialysis and CAPD (chronic ambulatory peritoneal dialysis) indicate that teriflunomide is not dialyzable. Studies with both hemodialysis and CAPD (chronic ambulatory peritoneal dialysis) indicate that teriflunomide is not dialyzable.

Specific Populations
Teratogenicity has not been shown to cause a consistent change in the in vivo pharmacokinetics of teriflunomide.

Smoking: A population based pharmacokinetic analysis of the clinical trial data indicates that smokers have a 38% increase in clearance over nonsmokers; however, no difference in clinical efficacy was seen between smokers and nonsmokers.

Drug Interaction Studies
Drug interaction studies have been conducted with both ARAVA (leflunomide) and with its active metabolite, teriflunomide, where the metabolite was directly administered to the test subjects.

The Potential Effect of Other Drugs on ARAVA
- Potent CYP and transporter inducers: Following concomitant administration of a single dose of ARAVA to subjects receiving multiple doses of rifampicin, teriflunomide peak concentrations were increased (~40%) over those seen when ARAVA was given alone [see Drug Interactions (7)].
  - An in vivo interaction study with ARAVA and cimetidine (non-specific weak CYP inhibitor) has demonstrated a lack of a significant impact on teriflunomide exposure.

The Potential Effect of ARAVA on Other Drugs
- CYP2C8 Substrates
  - There was an increase in mean repaglinide C_max and AUC (1.7- and 2.4-fold, respectively), following repeated doses of teriflunomide and a single dose of 0.25 mg repaglinide, suggesting that teriflunomide is an inhibitor of CYP2C8 in vivo. The magnitude of interaction could be higher at the recommended repaglinide dose [see Drug Interactions (7)].
- CYP1A2 Substrates
  - Repeated doses of teriflunomide decreased mean C_max and AUC of caffeine by 18% and 55%, respectively, suggesting that teriflunomide may be a weak inducer of CYP1A2 in vivo.
- OATs Substrates
  - There was an increase in mean cefaclor C_max and AUC (1.43- and 1.54-fold, respectively), following repeated doses of teriflunomide, suggesting that teriflunomide is an inhibitor of organic anion transporter 3 (OAT3) in vivo [see Drug Interactions (7)].
- BCRP and OATP1B1/1B3 Substrates
  - There was an increase in mean rosuvastatin C_max and AUC (2.65- and 2.51-fold, respectively), following repeated doses of teriflunomide, suggesting that teriflunomide is an inhibitor of BCRP transporter and organic anion transporting polypeptide 1B1 and 1B3 (OATP1B1/1B3) [see Drug Interactions (7)].
- Oral Contraceptives
  - There was an increase in mean ethinylestradiol C_max and AUC (1.58- and 1.54-fold, respectively), and levonorgestrel C_max and AUC (1.65- and 1.41-fold, respectively) following repeated doses of teriflunomide [see Drug Interactions (7)].

Teriflunomide did not affect the pharmacokinetics of bupropion (a CYP2B6 substrate), midazolam (a CYP3A4 substrate), S-warfarin (a CYP2C9 substrate), omeprazole (a CYP2C19 substrate), and metoprolol (a CYP2D6 substrate).

Absorption
Following oral administration, peak teriflunomide concentrations occurred between 6-12 hours after dosing. Due to the very long half-life of teriflunomide (18-19 days), a loading dose of 100 mg for 3 days was used in clinical studies to facilitate the rapid attainment of steady-state teriflunomide concentrations. Without a loading dose, it is estimated that attainment of steady-state plasma concentrations would require about 2 months of dosing. The resulting plasma concentrations following both loading doses and continued clinical dosing indicate that plasma teriflunomide concentrations are dose proportional.

Effect of Food
Co-administration of leflunomide tablets with a high fat meal did not have a significant impact on teriflunomide plasma concentrations.

Distribution
Teriflunomide is extensively bound to plasma protein (>98%) and is mainly distributed in plasma. The volume of distribution is 11 L after a single intravenous (IV) administration.

Elimination
Teriflunomide, the active metabolite of leflunomide, has a median half-life of 18-19 days in healthy volunteers. The elimination of teriflunomide can be accelerated by administration of chloroethyramine or activated charcoal. Without use of an accelerated drug elimination procedure, it may take up to 2 years to reach plasma teriflunomide concentrations of less than 0.02 mg/L, due to individual variation in drug clearance [see Warnings and Precautions (5.3)]. After a single IV administration of the metabolite (teriflunomide), the total body clearance of teriflunomide was 30.5 mL/h.

Leflunomide is a isoxazole immunomodulatory agent that inhibits dihydroorotate dehydrogenase (a mitochondrial enzyme involved in de novo pyrimidine synthesis) and has antiproliferative activity. Leflunomide is an isoxazole immunomodulatory agent that inhibits dihydroorotate dehydrogenase (a mitochondrial enzyme involved in de novo pyrimidine synthesis) and has antiproliferative activity.

8.4 Pediatric Use
The safety and effectiveness of ARAVA in the treatment of polycystic ovary syndrome, juvenile idiopathic arthritis (JIA), and asthma in pediatric subjects has not been established.

The safety and effectiveness of ARAVA in the treatment of juvenile idiopathic arthritis (JIA) was evaluated in a single multicenter, double-blind, active-controlled trial in 94 pediatric patients [1.1 randomization] with polycystic ovary syndrome (JIA) as defined by the American College of Rheumatology (ACR). In this population, ARAVA treatment was found not to be effective.

74 patients with polycystic ovary syndrome JIA ranging in age from 3-17 years (47 patients from the active-controlled study and 27 from an open-label safety and pharmacokinetic study). The most common adverse events included abdominal pain, diarrhea, nausea, vomiting, oral ulcers, upper respiratory tract infections, alopecia, rash, headache, and dizziness. Less common adverse events included anemia, hypertension, and weight loss. Fourteen pediatric patients experienced ALT and/or AST elevations, nine between 1.2 and 3-fold the upper limit of normal, five between 3 and 8-fold the upper limit of normal.

8.5 Geriatric Use
The total number of subjects in controlled clinical trials (Trials 1, 2, and 3) of ARAVA, 234 subjects were 65 years and over (see Clinical Studies [14]). No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. No dosage adjustment is needed in patients over 65.

8.6 Hepatic Impairment
Dedicated studies of the effect of hepatic impairment on leflunomide pharmacokinetics have not been conducted. Given the need to metabolize leflunomide into the active species, the role of the liver in drug elimination/recycling, and the possible risk of increased hepatic toxicity, the use of ARAVA in patients with hepatic impairment is not recommended.

8.7 Renal Impairment
Dedicated studies of the effect of renal impairment on leflunomide pharmacokinetics have not been conducted. Given that the kidney plays an important role in drug elimination, caution should be used when ARAVA is administered to these patients.

10 OVERDOSAGE
There have been reports of chronic overdose in patients taking ARAVA at daily dose up to five times the recommended daily dose and reports of acute overdose in adults and children. Adverse events were consistent with the safety profile for ARAVA [see Adverse Reactions (6)]. The most frequent adverse events observed were diarrhea, abdominal pain, leukopenia, anemia and elevated liver function tests. In the event of a significant overdose or toxicity, perform an accelerated drug elimination procedure to accelerate elimination [see Warnings and Precautions (5.3)].

11 DESCRIPTION
ARAVA (leflunomide) is a pyrimidine synthesis inhibitor. The chemical name for leflunomide is N-(4-fluoromethylphenyl)-5-methylisoxazole-4-carboxylic acid. It has an empirical formula C_14H_7F_N_2_O_2, a molecular weight of 270.2 and the following structural formula:

ARAVA is available for oral administration as tablets containing 10, 20, or 100 mg of active drug. Combined with leflunomide are the following inactive ingredients: colloidal silicon dioxide, crospovidone, titanium dioxide, and yellow ferric oxide (20 mg tablet only).

12 CLINICAL PHARMACOLOGY
12.1 Mechanism of Action
Leflunomide is an oxazole immunomodulatory agent that inhibits dihydroorotate dehydrogenase (a mitochondrial enzyme involved in de novo pyrimidine synthesis) and has antiproliferative activity. Several in vivo and in vitro experimental models have demonstrated an anti-inflammatory effect.

12.2 Pharmacokinetics
Following oral administration, leflunomide is metabolized to an active metabolite, teriflunomide, which is responsible for essentially all of leflunomide’s in vivo activity. Plasma concentrations of the parent drug, leflunomide, have been occasionally seen at very low concentrations. Studies of the pharmacokinetics of leflunomide have primarily examined the plasma concentrations of the active metabolite, teriflunomide.
13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

No evidence of carcinogenicity was observed in a 2-year bioassay in rats at oral doses of leflunomide up to the maximally tolerated dose of 6 mg/kg (approximately 1/40 the maximum human teriflunomide systemic exposure based on AUC). However, male mice in a 2-year bioassay exhibited an increased incidence in lymphomas at an oral dose of 15 mg/kg, the highest dose studied (1.7 times the human teriflunomide exposure based on AUC). Female mice, in the same study, exhibited a dose-related increased incidence of bronchoalveolar adenomas and carcinomas combined beginning at 1.5 mg/kg (approximately 1/10 the human teriflunomide exposure based on AUC). The significance of the findings in mice relative to the clinical use of ARAVA is not known.

Leflunomide had no effect on fertility or reproductive performance in either male or female rats at oral doses up to 4.0 mg/kg (approximately 1/30 the human teriflunomide exposure based on AUC) [see Use in Specific Populations (8.1, 8.6)].

14 CLINICAL STUDIES

The efficacy of ARAVA in the treatment of rheumatoid arthritis (RA) was demonstrated in three controlled trials showing reduction in signs and symptoms, and inhibition of structural damage. In two placebo controlled trials, efficacy was demonstrated for improvement in physical function. In these trials, efficacy was evaluated by:

1. Reduction of signs and symptoms

   Relief of signs and symptoms was assessed using the American College of Rheumatology (ACR) 20 Responder Index, a composite of clinical, laboratory, and functional measures in rheumatoid arthritis. An "ACR20 Responder" is a patient who has ≥20% improvement in tender joint counts, swollen joint counts and in 3 of the following 5 criteria: physician global assessment, patient global assessment, functional ability measure (Modified Health Assessment Questionnaire [MHAQ]), visual analog pain scale, and erythrocyte sedimentation rate or C-reactive protein. An "ACR20 Responder at Endpoint" is a patient who completed the study and was an ACR20 Responder at the completion of the study.

2. Inhibition of structural damage

   Inhibition of structural damage compared to control was assessed using the Sharp Score, a composite score of X-ray erosions and joint space narrowing in hands/wrists and forefeet.

3. Improvement in physical function

   Improvement in physical function was assessed using the Health Assessment Questionnaire (HAQ) and the Medical Outcomes Survey Short Form (SF-36).

In all ARAVA trials, participants were at least 18 years of age and in ARA functional class of I, II or III who received an initial loading dosage of 100 mg Leflunomide per day for three days, followed by 20 mg per day thereafter.

Exclusion criteria included patients with a history of hypersensitivity to the study medication; women who were pregnant or breastfeeding and men or women of child bearing age and potential who had not received contraceptives for at least 4 weeks before entering the study and to be maintained throughout the study and for at least 6 months after discontinuing treatment; Patients with a history of inflammatory disease, impaired renal function or liver impairment, cardiac failure, congenital or acquired immunodeficiency, impaired coagulation, or a history of recent major traumatic injury; patients taking intra-articular or systemic concomitant medications which could affect the safety and/or efficacy of the study medication.

Trial 1

Trial 1, a 2 year study, randomized 482 patients with active RA of at least 6 months duration to leflunomide 20 mg/day (n=182), methotrexate 7.5 mg/week increasing to 15 mg/week (n=182), or placebo (n=118). All patients received folate 1 mg BID. The primary analysis was at 52 weeks. Overall, 235 of the 508 randomized treated patients (46 in primary data analysis and an additional 26 patients), continued into a second 12 months of double-blind treatment (98 leflunomide, 101 methotrexate, 38 placebo). Leflunomide dosage decreased to 20 mg/day and the methotrexate dose could be increased to a maximum of 20 mg/week. In total, 190 patients (83 leflunomide, 80 methotrexate, 27 placebo) completed 2 years of double-blind treatment.

Trial 2

Trial 2 randomized 358 patients with active RA to leflunomide 20 mg/day (n=133), sulfasalazine 2.0 g/day (n=133), or placebo (n=92). Treatment duration was 24 weeks. An extension of the study was an optional 6-month blinded continuation of Trial 2 without the placebo arm, resulting in a 12-month comparison of leflunomide and sulfasalazine. Of the 168 patients who completed 12 months of treatment, 146 patients (87%) entered a 1-year extension study of double blind active treatment; (80 leflunomide, 60 sulfasalazine, 26 placebo/sulfasalazine). Patients continued on the same daily dosage of leflunomide or sulfasalazine that they had been taking at the completion of Trial 2. A total of 121 patients (53 leflunomide, 47 sulfasalazine, 21 placebo/sulfasalazine) completed the 2 years of double-blind treatment.

Trial 3

Trial 3 randomized 999 patients with active RA to leflunomide 20 mg/day (n=501) or methotrexate at 7.5 mg/week increasing to 15 mg/week (n=498). Folate supplementation was used in 10% of patients. Treatment duration was 52 weeks. Of the 736 patients who completed 52 weeks of treatment in study Trial 3, 612 (83%) entered the double-blind, 1-year extension study (292 leflunomide, 320 methotrexate). Patients continued on the same daily dosage of leflunomide or methotrexate that they had been taking at the completion of Trial 3. There were 535 patients (236 leflunomide, 277 methotrexate) who completed 2 years of double-blind treatment.

Clinical Trial Results

The ACR20 Responder at Endpoint rates are shown in Figure 1. ARAVA was statistically significantly superior to placebo in reducing the signs and symptoms of RA by the primary efficacy analysis. ACR20 Responder at Endpoint, in study Trial 1 (at the primary 12 months endpoint) and Trial 2 (at 6 month endpoint). ACR20 Responder at Endpoint rates with ARAVA treatment were consistent across the 6 and 12 month studies (41 – 49%). No consistent differences were demonstrated between leflunomide and methotrexate or between leflunomide and sulfasalazine. ARAVA treatment effect was evident by 1 month, stabilized by 3 – 6 months, and continued throughout the course of treatment as shown in Figure 1.

Figure 1. Percentage of ACR20 Responders at Endpoint in Patients with Active RA in Trials 1, 2, and 3

% ACR 20 Responder at Endpoint

<table>
<thead>
<tr>
<th>Trials</th>
<th>ARAVA vs. Placebo</th>
<th>Methotrexate vs. Placebo</th>
<th>ARAVA vs. Methotrexate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trial 1</td>
<td>12, 32</td>
<td>8, 30</td>
<td>-19, -7</td>
</tr>
<tr>
<td>Trial 2</td>
<td>4, 16</td>
<td>7, 33</td>
<td>-8, 16</td>
</tr>
<tr>
<td>Trial 3</td>
<td>-19, -7</td>
<td>-8, 16</td>
<td>-6, 16</td>
</tr>
</tbody>
</table>

Comparisons 95% Confidence Interval p Value

Table 3: Treatment Comparisons: Clinical Response

<table>
<thead>
<tr>
<th>Comparisons</th>
<th>95% Confidence Interval</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trial 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARAVA vs. Placebo</td>
<td>(12, 32)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Methotrexate vs. Placebo</td>
<td>(8, 30)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>ARAVA vs. Methotrexate</td>
<td>(-4, 16)</td>
<td>NS</td>
</tr>
<tr>
<td>Trial 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARAVA vs. Placebo</td>
<td>(7, 33)</td>
<td>0.0026</td>
</tr>
<tr>
<td>Sulfasalazine vs. Placebo</td>
<td>(4, 29)</td>
<td>0.0121</td>
</tr>
<tr>
<td>ARAVA vs. Sulfasalazine</td>
<td>(-8, 16)</td>
<td>NS</td>
</tr>
<tr>
<td>Trial 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARAVA vs. Methotrexate</td>
<td>(-19, -7)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

Figure 2. ACR20 Responders over Time in Patients with Active RA in Trial 1

*Last Observation Carried Forward.
Table 3. Summary of ACR Response Rates in Patients with Active RA in Trials 1, 2, and 3

<table>
<thead>
<tr>
<th>Study and Treatment Group</th>
<th>ACR20</th>
<th>ACR50</th>
<th>ACR70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo-Controlled Studies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trial 1 (12 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARAVA (n=178)†</td>
<td>52‡</td>
<td>34‡</td>
<td>20‡</td>
</tr>
<tr>
<td>Placebo (n=118)†</td>
<td>26</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Methotrexate (n=180)†</td>
<td>46</td>
<td>23</td>
<td>9</td>
</tr>
<tr>
<td>Trial 2 (6 months)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ARAVA (n=130)†</td>
<td>55‡</td>
<td>33‡</td>
<td>10‡</td>
</tr>
<tr>
<td>Placebo (n=91)†</td>
<td>29</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Sulfasalazine (n=132)†</td>
<td>57</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>Non-Placebo Active-Controlled Studies</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Trial 3 (12 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARAVA (n=495)†</td>
<td>51</td>
<td>31</td>
<td>10</td>
</tr>
<tr>
<td>Methotrexate (n=489)†</td>
<td>65</td>
<td>44</td>
<td>16</td>
</tr>
</tbody>
</table>

*Intent to treat (ITT) analysis using last observation carried forward (LOCF) technique for patients who discontinued early.
†n is the number of ITT patients for whom adequate data were available to calculate the indicated rates.
‡p < 0.001 ARAVA vs placebo
§p < 0.02 ARAVA vs placebo

Table 4 shows the results of the components of the ACR response criteria for Trial 1, Trial 2 and Trial 3. ARAVA was significantly superior to placebo in all components of the ACR Response criteria in study Trial 1 and Trial 2. In addition, Arava was significantly superior to placebo in improving morning stiffness, a measure of RA disease activity, not included in the ACR Response criteria. No consistent differences were demonstrated between ARAVA and the active comparators.

Table 4. Mean Change in the Components of the ACR Responder Index in Patients with Active RA in Trials 1, 2, and 3

<table>
<thead>
<tr>
<th>Components</th>
<th>Placebo-Controlled Studies</th>
<th>Non-placebo Controlled Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trial 1 (12 months)</td>
<td>Trial 2 Non-US (6 months)</td>
</tr>
<tr>
<td>Tender joint count†</td>
<td>-7.7</td>
<td>-6.6</td>
</tr>
<tr>
<td>Swollen joint count†</td>
<td>-5.7</td>
<td>-5.4</td>
</tr>
<tr>
<td>Patient global assessment‡</td>
<td>-2.1</td>
<td>-1.5</td>
</tr>
<tr>
<td>Physician global assessment‡</td>
<td>-2.8</td>
<td>-2.4</td>
</tr>
<tr>
<td>Physical function/disability</td>
<td>-0.29</td>
<td>-0.15</td>
</tr>
<tr>
<td>Erythrocyte Sedimentation rate</td>
<td>-6.26</td>
<td>-6.48</td>
</tr>
<tr>
<td>C-reactive protein</td>
<td>-0.62</td>
<td>-0.50</td>
</tr>
<tr>
<td>Not included in the ACR Responder Index</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morning Stiffness (min)</td>
<td>-101.4</td>
<td>-88.7</td>
</tr>
</tbody>
</table>

*Last Observation Carried Forward; Negative Change Indicates Improvement
†Based on 28 joint count
‡Visual Analog Scale - 0=Best; 10=Worst

Maintenance of effect
After completing 12 months of treatment, patients continuing on study treatment were evaluated for an additional 12 months of double-blind treatment (total treatment period of 2 years). ACR Responder rates at 12 months were maintained over 2 years in most patients continuing a second year of treatment. Improvement from baseline in the individual components of the ACR responder criteria was also sustained in most patients during the second year of Arava treatment in all three trials.

Radiographic Response
The change from baseline to endpoint in progression of structural disease, as measured by the Sharp X-ray score, is displayed in Figure 3. ARAVA was statistically significantly superior to placebo in inhibiting the progression of disease by the Sharp Score. No consistent differences were demonstrated between leflunomide and methotrexate or between leflunomide and sulfasalazine.
Comparisons  95% Confidence Interval  p Value

<table>
<thead>
<tr>
<th>Trial</th>
<th>Comparison</th>
<th>CI</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ARAVA vs. Placebo</td>
<td>(-4.0, -1.1)</td>
<td>0.0007</td>
</tr>
<tr>
<td></td>
<td>Methotrexate vs. Placebo</td>
<td>(-2.6, -0.2)</td>
<td>0.0196</td>
</tr>
<tr>
<td></td>
<td>ARAVA vs. Methotrexate</td>
<td>(-2.3, 0.0)</td>
<td>0.0499</td>
</tr>
<tr>
<td>2</td>
<td>ARAVA vs. Placebo</td>
<td>(-6.2, -1.8)</td>
<td>0.0004</td>
</tr>
<tr>
<td></td>
<td>Sulfasalazine vs. Placebo</td>
<td>(-6.9, 0.0)</td>
<td>0.0484</td>
</tr>
<tr>
<td></td>
<td>ARAVA vs. Sulfasalazine</td>
<td>(-3.3, 1.2)</td>
<td>NS</td>
</tr>
<tr>
<td>3</td>
<td>ARAVA vs. Methotrexate</td>
<td>(-2.2, 7.4)</td>
<td>NS</td>
</tr>
</tbody>
</table>

Physical Function Response
The Health Assessment Questionnaire (HAQ) assesses a patient's physical function and degree of disability. The mean change from baseline in functional ability as measured by the HAQ Disability Index (HAQ DI) in the 6 and 12 month placebo and active controlled trials is shown in Figure 4. ARAVA was statistically significantly superior to placebo in improving physical function. Superiority to placebo was demonstrated consistently across all eight HAQ DI subscales (dressing, arising, eating, walking, hygiene, reach, grip and activities) in both placebo controlled studies.

The Medical Outcomes Survey Short Form 36 (SF-36), a generic health-related quality of life questionnaire, further addresses physical function. In Trial 1, at 12 months, ARAVA provided statistically significant improvements compared to placebo in the Physical Component Summary (PCS) Score.

Figure 4. Change in Functional Ability Measure in Patients with Active RA in Trials 1, 2, and 3*

<table>
<thead>
<tr>
<th>Comparison</th>
<th>95% Confidence Interval</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trial 1</td>
<td>ARAVA vs. Placebo</td>
<td>(-0.58, -0.29)</td>
</tr>
<tr>
<td></td>
<td>ARAVA vs. Methotrexate</td>
<td>(-0.34, -0.07)</td>
</tr>
<tr>
<td>Trial 2</td>
<td>ARAVA vs. Placebo</td>
<td>(-0.67, -0.36)</td>
</tr>
<tr>
<td></td>
<td>ARAVA vs. Sulfasalazine</td>
<td>(-0.33, -0.03)</td>
</tr>
<tr>
<td>Trial 3</td>
<td>ARAVA vs. Methotrexate</td>
<td>(0.01, 0.16)</td>
</tr>
</tbody>
</table>

Maintenance of effect
The improvement in physical function demonstrated at 6 and 12 months was maintained over two years. In those patients continuing therapy for a second year, this improvement in physical function as measured by HAQ and SF-36 (PCS) was maintained.

17 PATIENT COUNSELING INFORMATION

Embro-Fetal Toxicity
Advise females of reproductive potential
• Of the potential for fetal harm if ARAVA is taken during pregnancy.
• To notify their healthcare provider immediately if a pregnancy occurs or is suspected.
• To use effective contraception during treatment with ARAVA and until the active metabolite (teriflunomide) plasma concentration is verified to be less than 0.02 mg/L [see Warnings and Precautions (5.1, 5.3), Use in Specific Populations (8.1, 8.3), Clinical Pharmacology (12.3)].

Pregnancy Exposure Registry
There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to ARAVA during pregnancy [see Use in Specific Populations (8.1)].

Lactation
Advise nursing women to discontinue breastfeeding during treatment with ARAVA [see Use in Specific Populations (8.2)].

Advis patients of the possibility of rare, serious skin reactions. Instruct patients to promptly report if they develop a skin rash or mucous membrane lesions.

Advise patients of the potential hepatotoxic effects of ARAVA and of the need for monitoring liver enzymes. Instruct patients to report if they develop symptoms such as unusual tiredness, abdominal pain or jaundice.

Advise patients that they may develop a lowering of their blood counts and should have frequent hematologic monitoring. This is particularly important for patients who are receiving other immunosuppressive therapy concurrently with ARAVA, who have recently discontinued such therapy before starting treatment with ARAVA, or who have had a history of a significant hematologic abnormality. Instruct patients to promptly report if they notice symptoms consistent with pancytopenia, such as easy bruising or bleeding, recurrent infections, fever, paleness or unusual tiredness.

Inform patients about the early warning signs of interstitial lung disease and ask them to contact their physician promptly if these symptoms appear or worsen during therapy.

Release date: February 2016
sanofi-aventis U.S. LLC
Bridgewater, NJ 08807
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LEF-FPLR-SL-FEB16 Rx Only

16 HOW SUPPLIED/STORAGE AND HANDLING

How Supplied
ARAVA (leflunomide) Tablets

<table>
<thead>
<tr>
<th>Strength</th>
<th>Quantity</th>
<th>NDC Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 mg</td>
<td>30 count bottle</td>
<td>0088-2193-30</td>
<td>White, round film-coated tablet embossed with &quot;ZBN&quot; on one side.</td>
</tr>
<tr>
<td>20 mg</td>
<td>30 count bottle</td>
<td>0088-2161-30</td>
<td>Light yellow, triangular film-coated tablet embossed with &quot;ZBO&quot; on one side.</td>
</tr>
<tr>
<td>100 mg</td>
<td>3 count blister pack</td>
<td>0088-2162-33</td>
<td>White, round film-coated tablet embossed with &quot;ZBP&quot; on one side.</td>
</tr>
</tbody>
</table>

Store at 25°C (77°F); excursions permitted to 15 to 30°C (59 to 86°F) [see USP Controlled Room Temperature]. Protect from light.