The recommended dose of PRALUENT in patients with HeFH undergoing LDL apheresis is 150 mg once every 2 weeks. PRALUENT can be administered without regard to timing of apheresis. (2.1)

**CONTRAINDICATIONS**

History of a serious hypersensitivity reaction to PRALUENT. (4)

**WARNINGS AND PRECAUTIONS**

Allergic Reactions: Hypersensitivity reactions (e.g., pruritus, rash, urticaria), including some serious events (e.g., hypersensitivity vasculitis and hypersensitivity reactions requiring hospitalization), have been reported with PRALUENT treatment. If signs or symptoms of serious allergic reactions occur, discontinue treatment with PRALUENT, treat according to the standard of care, and monitor until signs and symptoms resolve. (5.1)

**ADVERSE REACTIONS**

The most commonly occurring adverse reactions (≥25% of patients treated with PRALUENT and occurring more frequently than with placebo) are nasopharyngitis, injection site reactions, and influenza. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Sanofi at 1-800-633-1610 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

**INDICATIONS AND USAGE**

The recommended starting dose of PRALUENT is 75 mg once every 2 weeks administered subcutaneously, since the majority of patients achieve sufficient LDL-C reduction with this dosage. An alternative starting dosage for patients who prefer less frequent dosing is 300 mg once every 4 weeks (monthly). (2.1)

If the LDL-C response is inadequate, the dosage may be adjusted to the maximum dosage of 150 mg administered every 2 weeks. (2.1)
6.2 Immunogenicity

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

In a pool of ten placebo-controlled and active-controlled trials, 4.8% (147/3033) of patients treated with PRALUENT 75 mg and/or 150 mg every 2 weeks (Q2W) had anti-drug antibodies (ADA) newly detected at least once after initiating treatment compared with 0.6% (10/1708) of patients treated with control. For 1.3% (57/3033) of patients treated with PRALUENT and 0.5% (81/1708) of patients treated with control, ADA were detected in at least 2 samples separated by at least 12 weeks or were detected only at the last sampling point. Patients treated with PRALUENT 75 mg and/or 150 mg Q2W who ever developed ADA had a higher incidence of injection site reactions compared with patients who never had ADA detected (10.2% vs 5.9%). In the same pool, 1.2% (36/3033) of patients treated with PRALUENT 75 mg and/or 150 mg Q2W had neutralizing antibodies (NAb) detected at least once, and 0.3% (9/3033) exhibited some attenuation in efficacy. No patients treated with control developed NAb. The long-term consequences of continuing PRALUENT treatment in the presence of persistent NAb are unknown.

In a separate clinical study of patients treated with PRALUENT 75 mg Q2W or 300 mg every 4 weeks (including some patients with dose adjustment to 150 mg Q2W), the incidence of detecting ADA and NAb was qualitatively similar to the results from the pooled trials described above.

6.3 Postmarketing Experience

The following adverse reactions have been reported during postapproval use of PRALUENT. 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.

- General disorders and administration site conditions
- Flu-like illness

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 PRALUENT during pregnancy. To enroll in or to obtain information about the registry:

Please contact 1-877-311-8972 or go to https://mothertobaby.org/ongoing-study/praluent/.

Risk Summary

There are no available data on use of PRALUENT in pregnant women to inform a drug-associated risk. In animal reproduction studies, there were no effects on embryo-fetal development when rats were subcutaneously administered alirocumab during organogenesis at dose exposures up to 12-fold the exposure at the maximum recommended human dose of 150 mg every two weeks. In monkeys, suppression of the humoral immune response was observed in infants when alirocumab was administered during organogenesis to parturition at dose exposures 13-fold the exposure at the maximum recommended human dose of 150 mg every two weeks. No additional effects on pregnancy or neonatal/infant development were observed at dose exposures up to 81-fold the maximum recommended human dose of 150 mg every two weeks. No effects on the placenta were observed at levels below levels observed at maternal doses up to 81-fold the exposure at the maximum recommended human dose of 150 mg every two weeks. There are no data on the effect of PRALUENT on the fetal-placental unit. In monkeys, fetal weights were decreased at doses that were 12-fold the maximum recommended human dose of 150 mg every two weeks. The effect of PRALUENT on the placenta was not determined in this species. In humans, there is no clinical experience with PRALUENT in the third trimester of pregnancy. Women treated with PRALUENT during pregnancy may have an increased risk of preterm delivery, placental abruption, and fetal death compared to controls. It is not known whether PRALUENT can cause fetal harm when administered to a pregnant woman.
In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2%–4% and 15%–20%, respectively.

Data
Animal data
In Sprague Dawley rats, no effects on embryo-fetal development were observed when alirocumab was administered up to 75 mg/kg/dose by the subcutaneous route on gestation days 6 and 12 at exposures 12-fold the maximum recommended human dose of 150 mg every two weeks, based on serum AUC.

In cynomolgus monkeys, suppression of the humoral immune response to keyhole limpet hemocyanin (KLH) antigen was observed in infant monkeys at 4 to 6 months of age when alirocumab was dosed during organogenesis to parturition at 15 mg/kg/week and 75 mg/kg/week by the subcutaneous route, corresponding to 13-fold and 81-fold the human exposure at the maximum recommended human dose of 150 mg every two weeks, based on serum AUC. The lowest dose tested in the monkey resulted in humoral immune suppression; therefore it is unknown if this effect would be observed at clinical exposure.

No study designed to challenge the immune system of infant monkeys was conducted. No additional embryo-fetal, prenatal or postnatal effects were observed in infant monkeys, and no maternal effects were observed, when alirocumab was dosed at up to 75 mg/kg/week by the subcutaneous route, corresponding to maternal exposure of 81-fold the exposure at the maximum recommended human dose of 150 mg every two weeks, based on serum AUC.

8.2 Lactation
Risk Summary
There is no information regarding the presence of alirocumab in human milk, the effects on the breastfed infant, or the effects on milk production. The development and health benefits of breastfeeding should be considered along with the mother’s clinical need for PRALUENT and any potential adverse effects on the breastfed infant from PRALUENT or from the underlying maternal condition. Human IgG is present in human milk, but published data suggest that breastmilk IgG antibodies do not enter the neonatal and infant circulation in substantial amounts.

8.4 Pediatric Use
Safety and efficacy in pediatric patients have not been established.

8.5 Geriatric Use
In controlled studies, 1158 patients treated with PRALUENT were ≥65 years of age and 241 patients treated with PRALUENT were ≥75 years of age. 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.

8.6 Renal Impairment
No dose adjustment is needed for patients with mild or moderately impaired renal function. No data are available in patients with severe renal impairment. [See Clinical Pharmacology (12.3)].

8.7 Hepatic Impairment
No dose adjustment is needed for patients with mild or moderate hepatic impairment. No data are available in patients with severe hepatic impairment. [See Clinical Pharmacology (12.3)].

11 DESCRIPTION
Alirocumab is a human monoclonal antibody (lgG1 isotype) that targets proprotein convertase subtilisin kexin type 9 (PCSK9). Alirocumab is a PCSK9 inhibitor produced by recombinant DNA technology in Chinese Hamster Ovary cell suspension culture. Alirocumab consists of two disulfide-linked human heavy chains, each covalently linked through a human kappa chain to a human Fc region. The heavy chain is located in each heavy chain within the CH2 domain of the Fc constant region of the molecule. The variable domains of the heavy and light chains combine to form the PCSK9 binding site within the antibody. Alirocumab has an approximate molecular weight of 146 kDa.

PRALUENT is a sterile, preservative-free, clear, colorless to pale yellow solution for subcutaneous injection. PRALUENT 75 mg/mL or 150 mg/mL solution for subcutaneous injection in a single-dose pre-filled pen or single-dose pre-filled syringe is supplied in a sterilized 3 mL Type-1 clear glass syringe. The needle shield is made with natural rubber latex.

Each 75 mg/mL pre-filled pen or pre-filled syringe contains 75 mg alirocumab, histidine (8 mM), polysorbate 20 (0.1 mg), sucrose (100 mg), and Water for Injection USP, to pH 6.0.

Each 150 mg/mL pre-filled pen or pre-filled syringe contains 150 mg alirocumab, histidine (6 mM), polysorbate 20 (0.1 mg), sucrose (100 mg), and Water for Injection USP, to pH 6.0.

12 CLINICAL PHARMACOLOGY
12.1 Mechanism of Action
Alirocumab is a human monoclonal antibody that binds to proprotein convertase subtilisin kexin type 9 (PCSK9). PCSK9 binds to the low-density lipoprotein receptors (LDLR) on the surface of hepatocytes to promote LDLR degradation within the liver. LDLR is the primary receptor that clears circulating LDL; therefore the decrease in LDLR levels by alirocumab at the surface of hepatocytes to promote LDLR degradation within the liver. LDLR is the primary receptor that clears circulating LDL, therefore the decrease in LDLR levels by alirocumab at the surface of hepatocytes to promote LDLR degradation within the liver.

12.2 Pharmacokinetics
Alirocumab reduced free PCSK9 in a concentration-dependent manner. Following a single subcutaneous administration of alirocumab 75 or 150 mg, maximal suppression of free PCSK9 occurred within 4 to 8 hours. Free PCSK9 concentrations returned to baseline when alirocumab concentrations decreased below the limit of quantification.

12.3 Absorption
After subcutaneous (SC) administration of 75 mg to 300 mg alirocumab, median times to maximum serum concentrations (Cmax) were 1–3 hours. The pharmacokinetics of alirocumab after single SC administration of 75 mg into the abdomen, upper arm, or thigh were similar. The absolute bioavailability of alirocumab after SC administration was about 85% as determined by population pharmacokinetics analysis. A slightly greater than dose proportional increase was observed, with a 2.1-fold to 2.7-fold increase in total alirocumab concentrations for a 2-fold increase in dose from 75 mg every 2 weeks to 150 mg every 2 weeks.

Monthly dose normalized exposure with 300 mg every 4 weeks treatment was similar to that of 150 mg every 2 weeks. Steady state was reached after 2 to 3 doses with an accumulation ratio up to a maximum of about 2-fold.

Distribution
Following IV administration, the volume of distribution was about 0.04 to 0.05 L/kg indicating that alirocumab is distributed primarily in the circulating system.

12.4 Metabolism and Elimination
Specific metabolism studies were not conducted, because alirocumab is a protein. Alirocumab is primarily cleaved by specific peptidases and individual amino acids. In clinical studies where alirocumab was administered in combination with atorvastatin or rosuvastatin, no relevant changes in statin concentrations were observed in the presence of repeated administration of alirocumab, indicating that cytochrome P450 enzymes (mainly CYP3A4 and CYP2C9) and transporter proteins such as P-gp and OATP were not affected by alirocumab.

Two elimination phases were observed for alirocumab. At low concentrations, the elimination is predominately through saturable binding to target (PCSK9), while at higher exposures the elimination of alirocumab is largely through a non-saturable proteolytic pathway.

Based on a population pharmacokinetic analysis, the median apparent half-life of alirocumab at steady state was 17 to 20 days in patients receiving alirocumab at subcutaneous doses of 75 mg Q2W or 150 mg Q2W.

Specific Populations
A population pharmacokinetic analysis was conducted on data from 2799 subjects. Age, body weight, gender, race, and creatinine clearance were found not to significantly influence alirocumab pharmacokinetics. No dose adjustments are recommended for these demographics.

Pediatric
PRALUENT has not been studied in pediatric patients [see Use in Specific Populations (8.4)].

13 NONCLINICAL TOXICOLOGY
13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility
Carcinogenicity studies have not been conducted with alirocumab. The mutagenic potential of alirocumab has not been evaluated; however, monoclonal antibodies are not expected to alter DNA or chromosomes.

There were no adverse effects on surrogate markers of fertility (e.g., estrous cyclicity, testicular volume, ejaculate volume, sperm motility, or total sperm count per ejaculate) in a 6-month chronic toxicity study in sexually-mature monkeys subcutaneously administered at 5, 15, and 75 mg/kg/week at systemic exposures up to 103-fold the 150 mg every 2 weeks subcutaneous clinical dose based on serum AUC. In addition, there were no adverse alirocumab-related anatomic pathology or histopathology findings in reproductive tissues in rat or monkey toxicity studies at systemic exposures up to 11-fold and 103-fold respectively, in the 6-month studies, compared to clinical systemic exposure following a 150 mg every 2 weeks subcutaneous dose based on serum AUC.

13.2 Animal Toxicology and/or Pharmacology
During a 13-week toxicity study of 75 mg/kg once weekly alirocumab in combination with 40 mg/kg once daily atorvastatin in adult monkeys, there were no effects of alirocumab on the humoral immune response to keyhole limpet hemocyanin (KLH) after one to two months at exposures 100-fold greater than the exposure at the maximum recommended human dose of 150 mg every two weeks, based on AUC.

14 CLINICAL STUDIES
The efficacy of PRALUENT was investigated in five double-blind placebo-controlled trials that enrolled 3499 patients; 36% were patients with heterozygous familial hypercholesterolemia (HeFH) and 54% were non-HF patients who had clinical atherothrombotic cardiovascular disease. Three of the five trials were conducted exclusively in patients with HeFH. All patients were receiving a maximally tolerated dose of a statin, with or without other lipid-modifying therapies. In the trials that enrolled patients with HeFH, the diagnosis of HeFH was made either by genotyping or clinical criteria (“definite FH” using either the Simon Broome or WHO/Dutch Lipid Network criteria). All trials were at least 52 weeks in duration using either the maximum efficacy endpoint measured at week 24 (mean percent change in LDL-C from baseline).

Three studies used an initial dose of 75 mg every 2 weeks (Q2W) followed by criteria-based up-titration to 150 mg Q2W at week 12 for patients who did not achieve their target LDL-C at week 8. The majority of patients (57% to 83%) who were treated for at least 12 weeks did not require up-titration. Two studies used only a 150 mg Q2W dose.

A sixth double-blind, placebo-controlled, 48-week trial enrolled 547 patients on maximally tolerated dose of a statin who received PRALUENT 300 mg every 4 weeks (Q4W), 75 mg every 2 weeks (Q2W) or placebo, with criteria-based adjustment to 150 mg Q2W in the PRALUENT arms at week 12. The primary efficacy endpoint was measured at week 24 (mean percent change in LDL-C from baseline).

2 patients in 2 double-blind, placebo-controlled trials was conducted in 62 patients with HeFH undergoing LDL apheresis who received PRALUENT 150 mg Q2W or placebo.

Study 1 was a multicenter, double-blind, placebo-controlled trial that randomly assigned 1553 patients to PRALUENT 150 mg Q2W and 788 patients to placebo. All patients were taking maximally tolerated doses of statins with or without other lipid-modifying therapy,
and required additional LDL-C reduction. The mean age was 61 years (range 18–89), 36% were women, 93% were Caucasian, 3% were Black, and 5% were Hispanic/Latino. Overall, 69% were non-HF patients with clinical atherosclerotic cardiovascular disease and 18% had HeFH. The average LDL-C at baseline was 122 mg/dL. The proportion of patients who prematurely discontinued study drug prior to the 24-week endpoint was 8% among those treated with PRALUENT and 6% among those treated with placebo.

At week 24, the treatment difference between PRALUENT and placebo in mean LDL-C percent change was -58% (95% CI: -61%, -56%; p-value: <0.0001).

For additional results see Table 2 and Figure 1.

Table 2: Mean Percent Change from Baseline and Difference* from Placebo in Lipid Parameters at Week 24 in Study 1†

<table>
<thead>
<tr>
<th>Treatment Group</th>
<th>LDL-C</th>
<th>Total-C</th>
<th>Non-HDL-C</th>
<th>Apo B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PRALUENT (150 mg)</td>
<td>-58</td>
<td>-36</td>
<td>-49</td>
<td>-50</td>
</tr>
</tbody>
</table>

*a Difference is PRALUENT minus Placebo

†A pattern-mixture model approach was used with multiple imputation of missing post-treatment values based on a subject’s own baseline value and multiple imputation of missing on-treatment values based on a model including available on-treatment values.

Overall, 45% of these patients with HeFH also had clinical atherosclerotic cardiovascular disease. The average LDL-C at baseline was 141 mg/dL. Considering both trials together, the proportion of patients who prematurely discontinued study drug prior to the 24-week endpoint was 6% among those treated with PRALUENT and 4% among those treated with placebo.

At week 12, the treatment difference between PRALUENT 75 mg Q2W and placebo in mean LDL-C percent change was -48% (95% CI: -52%, -44%). At week 12, if additional LDL-C lowering was required based on pre-specified LDL-C criteria, PRALUENT was up-titrated to 150 mg Q2W for the remainder of the trial. The dose was up-titrated to 150 mg Q2W in 196 (42%) of 469 patients treated with PRALUENT for at least 12 weeks. At week 24, the mean treatment difference between PRALUENT and placebo in mean LDL-C percent change from baseline was -54% (95% CI: -59%, -50%, p-value: <0.0001). The LDL-C-lowering effect was sustained to week 52. For additional results see Table 3 and Figure 2.

Table 3: Mean Percent Change from Baseline and Difference* from Placebo in Lipid Parameters at Week 12 and Week 24 in Patients with HeFH (Studies 3 and 4 Pooled)†

<table>
<thead>
<tr>
<th>Treatment Group</th>
<th>LDL-C</th>
<th>Total-C</th>
<th>Non-HDL-C</th>
<th>Apo B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>PRALUENT (75 mg)</td>
<td>-43</td>
<td>-27</td>
<td>-38</td>
<td>-34</td>
</tr>
</tbody>
</table>

*a Difference is PRALUENT minus Placebo

†A pattern-mixture model approach was used with multiple imputation of missing post-treatment values based on a subject’s own baseline value and multiple imputation of missing on-treatment values based on a model including available on-treatment values.

Dose was up-titrated to 150 mg Q2W in 196 (42%) patients treated for at least 12 weeks.

Figure 1: Mean Percent Change from Baseline in LDL-C Over 52 Weeks in Patients on Maximally Tolerated Statin Treated with PRALUENT 150 mg Q2W and Placebo Q2W (Study 1)‡

*The means were estimated based on all randomized patients, with multiple imputation of missing data taking into account treatment adherence.

†Number of patients with observed data.

Study 2 was a multicenter, double-blind, placebo-controlled trial that randomly assigned 209 patients to PRALUENT and 107 patients to placebo. Patients were taking maximally tolerated doses of statins with or without other lipid-modifying therapy, and required additional LDL-C reduction. The mean age was 63 years (range 39–87), 34% were women, 82% were Caucasian, 16% were Black, and 11% had clinical atherosclerotic cardiovascular disease. Mean baseline LDL-C was 102 mg/dL. The proportion of patients who prematurely discontinued study drug prior to the 24-week endpoint was 11% among those treated with PRALUENT and 12% among those treated with placebo.

At week 12, if additional LDL-C lowering was required based on pre-specified LDL-C criteria, PRALUENT was up-titrated to 150 mg Q2W for the remainder of the trial. The dose was up-titrated to 150 mg Q2W in 196 (42%) of 469 patients treated with PRALUENT for at least 12 weeks. At week 24, the mean treatment difference between PRALUENT and placebo in mean LDL-C percent change from baseline was -54% (95% CI: -59%, -50%, p-value: <0.0001). The LDL-C-lowering effect was sustained to week 52. For additional results see Table 3 and Figure 2.

Figure 2: Mean Percent Change from Baseline in LDL-C Over 52 Weeks in Patients with HeFH on Maximally-Tolerated Statin Treated with PRALUENT 75/150 mg Q2W and Placebo Q2W (Studies 3 and 4 Pooled)‡

*The means were estimated based on all randomized patients, with multiple imputation of missing data taking into account treatment adherence.

†Number of patients with observed data.

Study 5 was a multicenter, double-blind, placebo-controlled trial that randomly assigned 72 patients to PRALUENT 150 mg Q2W and 35 patients to placebo. Patients had HeFH with a baseline LDL-C ≥160 mg/dL while taking a maximally tolerated dose of statin with or without other lipid-modifying therapy. The mean age was 51 years (range 18–80), 47% were women, 88% were Caucasian, 2% were Black, and 6% were Hispanic/Latino. Overall, 50% had clinical atherosclerotic cardiovascular disease. The average LDL-C at baseline was 198 mg/dL. The proportion of patients who discontinued study drug prior to the 24-week endpoint was 10% among those treated with PRALUENT and 0% among those treated with placebo.

At week 24, the mean percent change from baseline in LDL-C was -43% with PRALUENT and -7% with placebo, and the treatment difference between PRALUENT and placebo in mean LDL-C percent change was -36% (95% CI: -49%, -24%, p-value: <0.0001).
Study 6 was a multi-center, double-blind, placebo-controlled trial that randomly assigned 312 patients to PRALUENT 300 mg Q4W, 78 patients to PRALUENT 75 mg Q2W, and 157 patients to placebo who had hypercholesterolemia and were taking concomitant statin. The mean age was 62 years (range 21–88), 37% were women, 88% were Caucasian, 10% were Black, and 2% were Hispanic/Latino. Of these, 64% of patients had clinical atherosclerotic cardiovascular disease and 8% had HeFH. The mean LDL-C at baseline was 113 mg/dL.

The proportion of patients who discontinued study drug prior to the 24-week endpoint was 9% among those treated with PRALUENT 300 mg Q4W, 13% among those treated with PRALUENT 75 mg Q2W and 13% among those treated with placebo.

At week 12, the treatment difference between PRALUENT 300 mg Q4W and placebo in mean percent change in LDL-C from baseline was -29% (97.5% CI: -42%, -16%), and the treatment difference between PRALUENT 75 mg Q2W and placebo in mean percent change in LDL-C was -34% (97.5% CI: -49%, -19%) (Figure 3).

**Figure 3: Mean Percent Change from Baseline in LDL-C up to Week 12 in Patients on Concomitant Statin Treated with PRALUENT 75 mg Q2W, PRALUENT 300 mg Q4W or Placebo**

*The means were estimated based on all randomized patients, with multiple imputation of missing data taking into account treatment adherence.*

At week 12, if additional LDL-C lowering was required based on pre-specified LDL-C criteria, PRALUENT was adjusted to 150 mg Q2W for the remainder of the trial. The dose was adjusted to 150 mg Q2W in approximately 20% of patients treated with PRALUENT 75 mg Q2W or 300 mg Q4W for at least 12 weeks. At week 24, the treatment difference between initial assignment to PRALUENT 300 mg Q4W and placebo in mean percent change in LDL-C from baseline was -39% (97.5% CI: -52%, -16%; p-value: <0.0001), and the treatment difference between initial assignment to PRALUENT 75 mg Q2W and placebo in mean percent change in LDL-C from baseline was -41% (97.5% CI: -57%, -25%).

Study 7 was a multicenter, double-blind, placebo-controlled trial that randomly assigned patients with HeFH who were undergoing LDL apheresis to PRALUENT 150 mg Q2W (N=41) or placebo (N=21). Patients were treated in combination with their usual LDL apheresis schedule for 6 weeks. The mean age was 53 years (range 27–79), 42% were women, 97% were Caucasian, 3% were Black, and 0% were Hispanic/Latino. The mean LDL-C at baseline, measured before the apheresis procedure, was 181 mg/dL. The proportion of patients who discontinued study drug prior to the 6-week endpoint was 2% among those treated with PRALUENT 150 mg Q2W and 5% among those treated with placebo. At week 6, the mean percent change from baseline in pre-apheresis LDL-C was -39% among those treated with PRALUENT 150 mg Q2W and 5% among those treated with placebo.

At week 12, the mean percent change from baseline in pre-apheresis LDL-C was -48% (97.5% CI: -57%, -39%) and the treatment difference between initial assignment to PRALUENT 75 mg Q2W and placebo in mean percent change in LDL-C from baseline was -54% (97.5% CI: -61%, -48%), and the treatment difference between initial assignment to PRALUENT 300 mg Q4W and placebo in mean percent change in LDL-C from baseline was -39% (97.5% CI: -52%, -16%; p-value: <0.0001).

**16 HOW SUPPLIED/STORAGE AND HANDLING**

PRALUENT is a registered trademark of Sanofi-Aventis U.S. LLC, Bridgewater, NJ 08807

PRALUENT is designed to deliver 1 mL of 75 mg/mL or 150 mg/mL solution.

**Pack Size**

<table>
<thead>
<tr>
<th>Pack Size</th>
<th>75 mg/mL Pre-filled Pen</th>
<th>150 mg/mL Pre-filled Pen</th>
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<tr>
<td>Pack of 1 pen</td>
<td>NDC 0024-5901-01</td>
<td>NDC 0024-5902-01</td>
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<tr>
<td>Pack of 2 pens</td>
<td>NDC 0024-5901-02</td>
<td>NDC 0024-5902-02</td>
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**Pack Size**

<table>
<thead>
<tr>
<th>Pack Size</th>
<th>75 mg/mL Pre-filled Syringe</th>
<th>150 mg/mL Pre-filled Syringe</th>
</tr>
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<tbody>
<tr>
<td>Pack of 1 syringe</td>
<td>NDC 0024-5903-01</td>
<td>NDC 0024-5904-01</td>
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<tr>
<td>Pack of 2 syringes</td>
<td>NDC 0024-5903-02</td>
<td>NDC 0024-5904-02</td>
</tr>
</tbody>
</table>

**Storage**

Place in a refrigerator at 36°F to 46°F (2°C to 8°C) in the original carton in order to protect from light.

**Pharmacy**

Store in a refrigerator at 36°F to 46°F (2°C to 8°C) in the original carton in order to protect from light. Do not store above 77°F (25°C). After removal from the refrigerator, PRALUENT must be used within 30 days or discarded.

Do NOT freeze. Do NOT expose to extreme heat. Do NOT shake.

**17 PATIENT COUNSELING INFORMATION**

See FDA-Approved Patient Labeling (Patient Information and Instructions for Use).

**Pregnancy Registry**

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to PRALUENT during pregnancy. Encourage participation in the registry [see Use in Specific Populations (8.1)].

**Allergic Reactions**

- Advise patients to discontinue PRALUENT and seek prompt medical attention if any signs or symptoms of serious allergic reactions occur.

Instructions for Administration

- Instruct patients and caregivers to read the Patient Information and Instructions for Use (IFU) before the patient starts using PRALUENT, and each time the patient gets a refill as there may be new information they need to know.

- Provide guidance to patients and caregivers on proper subcutaneous injection technique, including aseptic technique, and how to use the pre-filled pen or pre-filled syringe correctly (see Instructions for Use leaflet). Inform patients that it may take up to 20 seconds to inject PRALUENT.

- The pre-filled pen or pre-filled syringe should be allowed to warm to room temperature for 30 to 40 minutes prior to use.

- Patients and caregivers should be cautioned that the pre-filled pen or pre-filled syringe must not be re-used and instructed in the technique of proper pen and syringe disposal in a puncture-resistant container. Do not recycle the container.

Manufactured by:

sanofi-aventis U.S. LLC

Bridgewater, NJ 08807

A SANOFI COMPANY

U.S. License # 1752

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