HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use DUPIXENT safely and effectively. See full prescribing information for DUPIXENT.

DUPIXENT® (dupilumab) injection, for subcutaneous use
Initial U.S. Approval: 2017

RECENT MAJOR CHANGES

Indications and Usage, Eosinophilic Esophagitis (1.4) 01/2024
Dosage and Administration (2.6) 01/2024
Warnings and Precautions (5.2) 01/2024

INDICATIONS AND USAGE

DUPIXENT is an interleukin-4 receptor alpha antagonist indicated:

Atopic Dermatitis

for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe AD whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids. (1.1)

Asthma

as an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma. (1.2)

Limitations of Use: Not for the relief of acute bronchospasm or status asthmaticus. (1.2)

Chronic Rhinosinusitis with Nasal Polyposis

as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP). (1.3)

Eosinophilic Esophagitis

for the treatment of adult and pediatric patients aged 1 year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE). (1.4)

Prurigo Nodularis

for the treatment of adult patients with prurigo nodularis (PN). (1.5)

DOSAGE AND ADMINISTRATION

Atopic Dermatitis

Dosage in Adults (2.3):

Recommended dosage is an initial dose of 600 mg (two 300 mg injections), followed by 300 mg given every other week (Q2W).

Dosage in Pediatric Patients 6 Months to 5 Years of Age (2.3):

<table>
<thead>
<tr>
<th>Body Weight</th>
<th>Initial and Subsequent Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to less than 15 kg</td>
<td>200 mg (one 200 mg injection) every 4 weeks (Q4W)</td>
</tr>
<tr>
<td>15 to less than 30 kg</td>
<td>300 mg (one 300 mg injection) every 4 weeks (Q4W)</td>
</tr>
</tbody>
</table>

Dosage in Pediatric Patients 6 Years to 17 Years of Age (2.3):

<table>
<thead>
<tr>
<th>Body Weight</th>
<th>Initial Loading Dose</th>
<th>Subsequent Dosage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 to less than 30 kg</td>
<td>600 mg (two 300 mg injections)</td>
<td>300 mg Q4W</td>
</tr>
<tr>
<td>30 to less than 60 kg</td>
<td>400 mg (two 200 mg injections)</td>
<td>200 mg Q2W</td>
</tr>
<tr>
<td>60 kg or more</td>
<td>600 mg (two 300 mg injections)</td>
<td>300 mg Q2W</td>
</tr>
</tbody>
</table>

* Q2W – every other week; Q4W – every 4 weeks

Asthma

Dosage in Adult and Pediatric Patients 12 Years and Older (2.4):

<table>
<thead>
<tr>
<th>Initial Loading Dose</th>
<th>Subsequent Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>400 mg (two 200 mg injections)</td>
<td>200 mg every 2 weeks (Q2W)</td>
</tr>
<tr>
<td>Or</td>
<td></td>
</tr>
<tr>
<td>600 mg (two 300 mg injections)</td>
<td>300 mg every 2 weeks (Q2W)</td>
</tr>
</tbody>
</table>

Dosage for patients with oral corticosteroid-dependent asthma or with co-morbid moderate-to-severe atopic dermatitis or adults with co-morbid chronic rhinosinusitis with nasal polyposis

| 600 mg (two 300 mg injections) | 300 mg every 2 weeks (Q2W) |

Dosage in Pediatric Patients 6 Years to 11 Years of Age (2.4):

<table>
<thead>
<tr>
<th>Body Weight</th>
<th>Initial Dose and Subsequent Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 to less than 30 kg</td>
<td>300 mg every 4 weeks (Q4W)</td>
</tr>
<tr>
<td>≥30 kg</td>
<td>200 mg every other week (Q2W)</td>
</tr>
</tbody>
</table>

For pediatric patients 6 to 11 years old with asthma and co-morbid moderate-to-severe atopic dermatitis, follow the recommended dosage as per Table 2 which includes an initial loading dose. (2.3)

Chronic Rhinosinusitis with Nasal Polyposis (2.5):

Recommended dosage for adult patients is 300 mg given every other week (Q2W).

Eosinophilic Esophagitis (2.6):

<table>
<thead>
<tr>
<th>Body Weight</th>
<th>Recommended Dosage in Adult and Pediatric Patients 1 Year and Older, Weighing at Least</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 kg</td>
<td></td>
</tr>
<tr>
<td>15 to less than 30 kg</td>
<td>200 mg every other week (Q2W)</td>
</tr>
<tr>
<td>30 to less than 40 kg</td>
<td>300 mg every other week (Q2W)</td>
</tr>
<tr>
<td>40 kg or more</td>
<td>300 mg every week (QW)</td>
</tr>
</tbody>
</table>

Prurigo Nodularis (2.7):

Recommended dosage for adult patients is an initial dose of 600 mg (two 300 mg injections), followed by 300 mg given every other week (Q2W).

DOSE FORMS AND STRENGTHS

Single-Dose Pre-Filled Syringe with Needle Shield (3):

- Injection: 300 mg/2 mL
- Injection: 200 mg/1.14 mL

Single-Dose Pre-Filled Pen (3):

- Injection: 300 mg/2 mL
- Injection: 200 mg/1.14 mL

CONTRAINDICATIONS

Known hypersensitivity to dupilumab or any excipients in DUPIXENT. (4)

WARNINGS AND PRECAUTIONS

- Hypersensitivity: Hypersensitivity reactions including anaphylaxis, serum sickness, angioedema, urticaria, rash, erythema nodosum, and erythema multiforme have occurred. Discontinue DUPIXENT in the event of a hypersensitivity reaction. (5.1)
- Conjunctivitis and Keratitis: Advise patients to report new onset or worsening eye symptoms to their healthcare provider. Consider ophthalmological examination, as appropriate. (5.2)
- Eosinophilic Conditions: Be alert to vasculitic rash, worsening pulmonary symptoms, and/or neuropathy, especially upon reduction of oral corticosteroids. (5.3)
- Reduction of Corticosteroid Dosage: Do not discontinue systemic, topical, or inhaled corticosteroids abruptly upon initiation of DUPIXENT. Decrease steroids gradually, if appropriate. (5.5)
- Arthralgia: Advise patients to report new onset or worsening joint symptoms to their healthcare provider. If symptoms persist or worsen, consider rheumatological evaluation and/or discontinuation of DUPIXENT. (5.7)
- Parasitic (Helminth) Infections: Treat pre-existing helminth infections before initiating DUPIXENT. If patients become infected while receiving DUPIXENT and do not respond to anti-helminth treatment, discontinue DUPIXENT until the infection resolves. (5.8)
- Vaccinations: Avoid use of live vaccines. (5.9)

ADVERSE REACTIONS

Most common adverse reactions are:

- Atopic Dermatitis (incidence ≥1%): injection site reactions, conjunctivitis, blepharitis, oral herpes, keratitis, eye pruritus, other herpes simplex virus infection, dry eye, and eosinophilia. (6.1)
- Asthma (incidence ≥1%): injection site reactions, oropharyngeal pain, and eosinophilia. (6.1)
- Chronic Rhinosinusitis with Nasal Polyposis (incidence ≥1%); injection site reactions, eosinophilia, insomnia, toothache, gastritis, arthralgia, and conjunctivitis. (6.1)
- Eosinophilic Esophagitis (incidence ≥2%): injection site reactions, upper respiratory tract infections, arthralgia, and herpes viral infections. (6.1)
- Prurigo Nodularis (incidence ≥2%): nasopharyngitis, conjunctivitis, herpes infection, dizziness, myalgia, and diarrhea. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Regeneron at 1-844-387-4936 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 01/2024
DUPIXENT is administered by subcutaneous injection.

1 INDICATIONS AND USAGE

1.1 Atopic Dermatitis

DUPIXENT is indicated for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe atopic dermatitis (AD) whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids.

1.2 Asthma

DUPIXENT is indicated as an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma [see Clinical Studies (14)].

Limitations of Use

DUPIXENT is not indicated for the relief of acute bronchospasm or status asthmaticus.

1.3 Chronic Rhinosinusitis with Nasal Polyposis

DUPIXENT is indicated as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).

1.4 Eosinophilic Esophagitis

DUPIXENT is indicated for the treatment of adult and pediatric patients aged 1 year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE).

1.5 Prurigo Nodularis

DUPIXENT is indicated for the treatment of adult patients with prurigo nodularis (PN).

2 DOSAGE AND ADMINISTRATION

2.1 Important Administration Instructions

DUPIXENT is administered by subcutaneous injection. DUPIXENT is intended for use under the guidance of a healthcare provider. Provide proper training to patients and/or caregivers on the preparation and administration of DUPIXENT prior to use according to the "Instructions for Use".

Use of Pre-filled Pen or Pre-filled Syringe

The DUPIXENT pre-filled pen is for use in adult and pediatric patients aged 2 years and older.

The DUPIXENT pre-filled syringe is for use in adult and pediatric patients aged 6 months and older.

A caregiver or patient 12 years of age and older may inject DUPIXENT using the pre-filled syringe or pre-filled pen. In pediatric patients 12 to 17 years of age, administer DUPIXENT under the supervision of an adult. In pediatric patients 6 months to less than 12 years of age, administer DUPIXENT by a caregiver.

2.2 Vaccination Prior to Treatment

Consider completing all age-appropriate vaccinations as recommended by current immunization guidelines prior to initiating treatment with DUPIXENT [see Warnings and Precautions (5.9)].

2.3 Recommended Dosage for Atopic Dermatitis

Dosage in Adults

The recommended dosage of DUPIXENT for adult patients is an initial dose of 600 mg given every 2 weeks (Q2W), followed by 300 mg given every other week (Q2W).

Dosage in Pediatric Patients 6 Months to 5 Years of Age

The recommended dosage of DUPIXENT for pediatric patients 6 months to 5 years of age is specified in Table 1.

Table 1: Dosage of DUPIXENT in Pediatric Patients 6 Months to 5 Years of Age with Atopic Dermatitis

<table>
<thead>
<tr>
<th>Body Weight</th>
<th>Initial* and Subsequent Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to less than 15 kg</td>
<td>200 mg (one 200 mg injection) every 4 weeks (Q4W)</td>
</tr>
<tr>
<td>15 to less than 30 kg</td>
<td>300 mg (one 300 mg injection) every 4 weeks (Q4W)</td>
</tr>
</tbody>
</table>

* For pediatric patients 6 months to 5 years of age with AD, no initial loading dose is recommended.

Dosage in Pediatric Patients 6 Years to 17 Years of Age

The recommended dosage of DUPIXENT for pediatric patients 6 years to 17 years of age is specified in Table 2.
AD, follow the recommended dosage as per Table 2 which includes an initial loading dose for pediatric patients 6 to 11 years of age with asthma and co-morbid moderate-to-severe atopic dermatitis or adults with co-morbid chronic obstructive pulmonary disease. Concomitant Topical Therapies DUPIXENT can be used with or without topical corticosteroids. Topical calcineurin inhibitors may be used, but should be reserved for problem areas only, such as the face, neck, intertriginous and genital areas.

2.4 Recommended Dosage for Asthma
Dosage in Adult and Pediatric Patients 12 Years and Older

The recommended dosage of DUPIXENT for adult and pediatric patients 12 years of age and older is specified in Table 3.

Table 3: Dosage of DUPIXENT in Adult and Pediatric Patients 12 Years and Older with Asthma

<table>
<thead>
<tr>
<th>Body Weight</th>
<th>Initial Loading Dose</th>
<th>Subsequent Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 to less than 30 kg</td>
<td>600 mg (two 300 mg injections)</td>
<td>300 mg every 4 weeks (Q4W)</td>
</tr>
<tr>
<td>30 to less than 60 kg</td>
<td>400 mg (two 200 mg injections)</td>
<td>200 mg every other week (Q2W)</td>
</tr>
<tr>
<td>60 kg or more</td>
<td>600 mg (two 300 mg injections)</td>
<td>300 mg every other week (Q2W)</td>
</tr>
</tbody>
</table>

Concomitant Topical Therapies
If an every 4 week dose is missed, administer the injection within 7 days from the missed dose and then resume the patient’s original schedule. If the missed dose is not administered within 7 days, wait until the next dose on the original schedule.

If an every 4 week dose is missed, administer the injection within 7 days from the missed dose and then resume the patient’s original schedule. If the missed dose is not administered within 7 days, administer the dose, starting a new schedule based on this date.

2.5 Recommended Dosage for Chronic Rhinosinusitis with Nasal Polyposis
The recommended dosage of DUPIXENT for adult patients is 300 mg given every other week.

2.6 Recommended Dosage for Eosinophilic Esophagitis
The recommended dosage of DUPIXENT for adult and pediatric patients 1 year of age and older, weighing at least 15 kg, is specified in Table 5.

Table 5: Dosage of DUPIXENT in Adult and Pediatric Patients 1 Year of Age and Older with Eosinophilic Esophagitis

<table>
<thead>
<tr>
<th>Body Weight</th>
<th>Recommended Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 to less than 30 kg</td>
<td>200 mg every other week (Q2W)</td>
</tr>
<tr>
<td>30 to less than 40 kg</td>
<td>300 mg every other week (Q2W)</td>
</tr>
<tr>
<td>40 kg or more</td>
<td>300 mg every week (QW)</td>
</tr>
</tbody>
</table>

2.7 Recommended Dosage for Prurigo Nodularis
The recommended dosage of DUPIXENT for adult patients is an initial dose of 600 mg (two 300 mg injections) followed by 300 mg given every other week (Q2W).

2.8 Missed Doses
If a weekly dose is missed, administer the dose as soon as possible, and start a new weekly schedule from the date of the last administered dose.

If an every other week dose is missed, administer the injection within 7 days from the missed dose and then resume the patient’s original schedule. If the missed dose is not administered within 7 days, wait until the next dose on the original schedule.

If an every 4 week dose is missed, administer the injection within 7 days from the missed dose and then resume the patient’s original schedule. If the missed dose is not administered within 7 days, administer the dose, starting a new schedule based on this date.

2.9 Preparation for Use
Before injection, remove DUPIXENT from the refrigerator and allow DUPIXENT to reach room temperature (45 minutes for the 300 mg/1.14 mL pre-filled syringe or pre-filled pen, and 30 minutes for the 200 mg/1.14 mL pre-filled syringe or pre-filled pen) without removing the needle cap. After removal from the refrigerator, DUPIXENT must be used within 14 days or discarded.

Inspect DUPIXENT visually for particulate matter and discoloration prior to administration. DUPIXENT is a clear to slightly opalescent, colorless to pale yellow solution. Do not use if the liquid contains visible particulate matter, is discolored or cloudy (other than clear to slightly opalescent, colorless to pale yellow). DUPIXENT does not contain preservatives; therefore, discard any unused product remaining in the pre-filled syringe or pre-filled pen.

3 DOSAGE FORMS AND STRENGTHS
DUPIXENT is a clear to slightly opalescent, colorless to pale yellow solution in a:

Single-dose pre-filled syringe with needle shield:
- Injection: 300 mg/2 mL
- Injection: 200 mg/1.14 mL

Single-dose pre-filled pen as:
- Injection: 300 mg/2 mL
- Injection: 200 mg/1.14 mL

4 CONTRAINDICATIONS
DUPIXENT is contraindicated in patients who have known hypersensitivity to dupilumab or any excipients of DUPIXENT [see Warnings and Precautions (5.1)].

5 WARNINGS AND PRECAUTIONS
5.1 Hypersensitivity
Hypersensitivity reactions, including anaphylaxis, serum sickness or serum sickness-like reactions, angioedema, generalized urtica, rash, erythema nodosum, and erythema multiforme have been reported. If a clinically significant hypersensitivity reaction occurs, institute appropriate therapy and discontinue DUPIXENT [see Adverse Reactions (6.1, 6.2) and Clinical Pharmacology (12.6)].

5.2 Conjunctivitis and Keratitis
Conjunctivitis and keratitis adverse reactions have been reported in clinical trials. Conjunctivitis and keratitis occurred more frequently in AD subjects who received DUPIXENT compared to those who received placebo. Conjunctivitis was the most frequently reported eye disorder. Most subjects with conjunctivitis or keratitis recovered or were recovering during the treatment period [see Adverse Reactions (6.1)]. Among subjects with asthma, the frequencies of conjunctivitis and keratitis were similar between DUPIXENT and placebo [see Adverse Reactions (6.1)]. In subjects with CRSwNP, the frequency of conjunctivitis was 2% in the DUPIXENT group compared to 1% in the placebo group in the 24-week safety pool; these subjects recovered. There were no cases of keratitis reported in the CRSwNP development program [see Adverse Reactions (6.1)]. Among subjects with asthma, the frequencies of conjunctivitis and keratitis were similar between DUPIXENT and placebo [see Adverse Reactions (6.1)]. In subjects with eosinophilic esophagitis, the frequency of conjunctivitis was 4% in the DUPIXENT group compared to 1% in the placebo group; these subjects recovered or were recovering during the treatment period. There were no cases of keratitis reported in the new development program [see Adverse Reactions (6.1)]. Conjunctivitis and keratitis adverse events have also been reported with DUPIXENT in postmarketing settings, predominantly in AD patients. Some patients reported visual disturbances (e.g., blurred vision) associated with conjunctivitis or keratitis. Advise patients or their caregivers to report new onset or worsening eye symptoms to their healthcare provider. Consider ophthalmological examination for patients who develop conjunctivitis that does not resolve following standard treatment or signs and symptoms suggestive of keratitis, as appropriate [see Adverse Reactions (6.1)].

5.3 Eosinophilic Conditions
Patients being treated for asthma may present with serious systemic eosinophilia sometimes presenting with clinical features of eosinophilic pneumonia or vasculitis consistent with eosinophilic granulomatosis with polyangiitis, conditions which are often treated with systemic corticosteroid therapy. These events may be associated with the reduction of oral corticosteroid therapy. Healthcare providers should be alert to vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in their patients with eosinophilia. Cases of eosinophilic pneumonia were reported in adult subjects who participated in the asthma development program and cases of vasculitis consistent with eosinophilic granulomatosis with polyangiitis have been reported with DUPIXENT in adult subjects who participated in the asthma development program as well as in adult subjects with co-morbid asthma in the CRSwNP development program. A causal association between DUPIXENT and these conditions has not been established.

5.4 Acute Asthma Symptoms or Deteriorating Disease
DUPIXENT should not be used to treat acute asthma symptoms or acute exacerbations. Do not use DUPIXENT to treat acute bronchospasm or status asthmaticus. Patients should seek medical advice if their asthma remains uncontrolled or worsens after initiation of treatment with DUPIXENT.

5.5 Risk Associated with Abrupt Reduction of Corticosteroid Dosage
A discontinuation syndrome has been observed in patients with asthma who were tapered off systemic corticosteroids. The condition may be associated with withdrawal symptoms and symptoms of eosinophilia. The condition can be treated with systemic corticosteroids or systemic corticosteroids, depending on the severity of the condition. The discontinuation syndrome may be associated with the reduction of DUPIXENT dosage or discontinuation of DUPIXENT.

5.6 Eosinophilia
Eosinophilia may be a transient or prolonged adverse reaction to DUPIXENT. The eosinophilia may be associated with eosinophilic pneumonia, vasculitis, and other eosinophilic disorders. The eosinophilia may be associated with the reduction of DUPIXENT dosage or discontinuation of DUPIXENT.

5.7 Interactions of DUPIXENT with Other Medications
DUPIXENT may interfere with the binding of DUPIXENT to the IL-4Rα receptor and reduce the efficacy of other medications that bind to the IL-4Rα receptor. Therefore, DUPIXENT should not be used in combination with other medications that bind to the IL-4Rα receptor.

5.8 Treatment during Pregnancy and Lactation
DUPIXENT is not indicated for use in pregnant or breastfeeding women. It is unknown if DUPIXENT is excreted in breast milk. Therefore, DUPIXENT should not be used in pregnant or breastfeeding women.

5.9 Treatment of Patients with a History of Severe Asthma
DUPIXENT is not indicated for use in patients with a history of severe asthma. DUPIXENT should not be used in patients with a history of severe asthma.

5.10 Treatment of Patients with Severe Asthma
DUPIXENT is not indicated for use in patients with severe asthma. DUPIXENT should not be used in patients with severe asthma.

5.11 Treatment of Patients with Oral Corticosteroid-Dependent Asthma
DUPIXENT is not indicated for use in patients with oral corticosteroid-dependent asthma. DUPIXENT should not be used in patients with oral corticosteroid-dependent asthma.

5.12 Treatment of Patients with Status Asthmaticus
DUPIXENT is not indicated for use in patients with status asthmaticus. DUPIXENT should not be used in patients with status asthmaticus.

5.13 Treatment of Patients with Acute Bronchospasm
DUPIXENT is not indicated for use in patients with acute bronchospasm. DUPIXENT should not be used in patients with acute bronchospasm.

5.14 Treatment of Patients with Acute Exacerbation of Asthma
DUPIXENT is not indicated for use in patients with acute exacerbation of asthma. DUPIXENT should not be used in patients with acute exacerbation of asthma.

5.15 Treatment of Patients with Acute Bronchospasm or Status Asthmaticus
DUPIXENT is not indicated for use in patients with acute bronchospasm or status asthmaticus. DUPIXENT should not be used in patients with acute bronchospasm or status asthmaticus.

5.16 Treatment of Patients with Acute Exacerbation of Asthma
DUPIXENT is not indicated for use in patients with acute exacerbation of asthma. DUPIXENT should not be used in patients with acute exacerbation of asthma.
5.6 Patients with Co-morbid Asthma

Advises patients with co-morbid asthma to not adjust or stop their asthma treatments without consultation with their physicians.

5.7 Arthralgia

Arthralgia has been reported with the use of DUPIXENT with some patients reporting gait disturbances or decreased mobility associated with joint symptoms. For patients with arthralgia, it is unknown if DUPIXENT treatment will impact the safety or effectiveness of these vaccines. Limited data are available regarding coadministration of DUPIXENT with non-live vaccines [see Clinical Pharmacology (12.2)].

5.8 Parasitic (Helminth) Infections

Patients with known helminth infections were excluded from participation in clinical studies. It is unknown if DUPIXENT will influence the immune response against helminth infections. In the event the patient becomes infected while receiving treatment with DUPIXENT, treatment with DUPIXENT is not recommended until the infection resolves.

6.1 Clinical Trials Experience

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

Adults with Atopic Dermatitis

Three randomized, double-blind, placebo-controlled, multicenter trials (SOLO 1, SOLO 2, and CHRONOS) and one dose-ranging trial (AD-1021) evaluated the safety of DUPIXENT in subjects with moderate-to-severe AD. The safety population had a mean age of 38 years; 41% of subjects were female, 67% were White, 24% were Asian, and 6% were Black. In terms of co-morbid conditions, 48% of the subjects had asthma, 49% had allergic rhinitis, 37% had food allergy, and 27% had allergic conjunctivitis. In these 4 trials, 1472 subjects were treated with subcutaneous injections of DUPIXENT, with or without concomitant topical corticosteroids (TCS). A total of 739 subjects were treated with DUPIXENT for at least 1 year in the development program for moderate-to-severe AD.

SOLO 1, SOLO 2, and AD-1021 compared the safety of DUPIXENT monotherapy to placebo through Week 16. CHRONOS compared the safety of DUPIXENT + TCS to placebo + TCS through Week 52.

DUPIXENT 300 mg Q2W is a multicenter, open-label extension (OLE) trial which assessed the long-term safety of repeat doses of DUPIXENT through 260 weeks of treatment in adults with moderate-to-severe AD who had previously participated in controlled trials of DUPIXENT or had been screened for SOLO 1 or SOLO 2. The safety data in AD-1225 reflect exposure to DUPIXENT 200 mg QW, 300 mg QW and 300 mg QW in 2677 subjects, including 2254 exposed for at least 52 weeks, 1224 exposed for at least 100 weeks, 561 exposed for at least 148 weeks and 179 exposed for at least 260 weeks.

Weeks 0 to 16 (SOLO 1, SOLO 2, CHRONOS, and AD-1021)

In DUPIXENT monotherapy trials (SOLO 1, SOLO 2, and AD-1021) through Week 16, the proportion of subjects who discontinued treatment because of adverse events was 1.9% in both the DUPIXENT 300 mg Q2W and placebo groups. Table 6 summarizes the adverse reactions that occurred at a rate of at least 1% in the DUPIXENT 300 mg Q2W monotherapy groups, and in the DUPIXENT + TCS group, all at a higher rate than in their respective comparator groups during the first 16 weeks of treatment.
disease was reported in 9 (5%) pediatric subjects and skin papilloma was reported in 4 (2%) pediatric subjects treated with DUPIXENT ± TCS. These cases did not lead to study drug discontinuation [see Use in Specific Populations (8.4)].

Atopic Dermatitis with Hand and/or Foot Involvement

The safety of DUPIXENT was assessed in a 16-week, multicenter, randomized, double-blind, parallel-group, placebo-controlled trial (LIBerty-AD-HAFT) in 133 adult and pediatric subjects 12 to 17 years of age with atopic dermatitis with moderate-to-severe hand and/or foot involvement [see Clinical Studies (14.1)]. In this trial 67 subjects received DUPIXENT and 66 subjects received placebo. DUPIXENT-treated subjects received the recommended dosage based on their age and body weight [see Dosage and Administration (2.3)]. The safety profile of DUPIXENT in these subjects through Week 16 was consistent with the safety profile from studies in adult and pediatric subjects 6 months of age and older with moderate-to-severe AD.

Chronic Rhinosinusitis with Nasal Polyposis

SINUS-24 and SINUS-52 treated with DUPIXENT and at a higher rate than in their respective comparator groups without DUPIXENT treatment discontinuation.

In DRI12544 and QUEST, the proportion of subjects who discontinued treatment due to adverse events was 4% of the placebo group, 3% of the DUPIXENT 200 mg Q2W group, and 6% of the DUPIXENT 300 mg Q2W group.

Table 7 summarizes the adverse reactions that occurred at a rate of at least 1% in subjects treated with DUPIXENT and at a higher rate than in their respective comparator groups in DRI12544 and QUEST.

Table 7: Adverse Reactions Occurring in ≥1% of the DUPIXENT Groups in DRI12544 and QUEST and Greater than Placebo (6 Month Safety Pool)

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>DUPIXENT 200 mg Q2W</th>
<th>DUPIXENT 300 mg Q2W</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection site reactions a</td>
<td>111 (14%)</td>
<td>144 (18%)</td>
<td>50 (6%)</td>
</tr>
<tr>
<td>Oropharyngeal pain</td>
<td>13 (2%)</td>
<td>19 (2%)</td>
<td>7 (1%)</td>
</tr>
<tr>
<td>Eosinophilia b</td>
<td>17 (2%)</td>
<td>16 (2%)</td>
<td>2 (&lt;1%)</td>
</tr>
</tbody>
</table>

a Injection site reactions cluster includes erythema, edema, pruritus, pain, and inflammation.
b Eosinophilia = blood eosinophils ≥3,000 cells/mL or deemed by the investigator to be an adverse event. None met the criteria for serious eosinophilic conditions [see Warnings and Precautions (5.4)].

Injection site reactions were most common with the loading (initial) dose.

The safety profile of DUPIXENT through Week 52 was generally consistent with the safety profile observed at Week 24.

Pediatric Subjects 6 to 11 Years of Age with Asthma

The safety of DUPIXENT was assessed in 405 pediatric subjects 6 to 11 years of age with moderate-to-severe asthma (VOYAGE). The safety profile of DUPIXENT in these subjects through Week 52 was similar to the safety profile from studies in adult and pediatric subjects 12 years of age and older with moderate-to-severe asthma with the addition of helmint infections. Helmint infections were reported in 2.2% (6 subjects) in the DUPIXENT group and 2.7% (1 subject) in the placebo group. The majority of cases were enterobiasis, reported in 1.8% (5 subjects) in the DUPIXENT group and none in the placebo group. There was one case of ascariasis in the DUPIXENT group. All helmint infection cases were mild to moderate and subjects recovered with anti-helmint treatment without DUPIXENT treatment discontinuation.

Chronic Rhinosinusitis with Nasal Polyposis

A total of 722 adult subjects with chronic rhinosinusitis with nasal polyposis (CRSwNP) were evaluated in 2 randomized, placebo-controlled, multicenter trials of 24 to 52 weeks duration (SINUS-24 and SINUS-52). The safety pool consisted of data from the first 24 weeks of treatment from both studies. In the safety pool, the proportion of subjects who discontinued treatment due to adverse events was 5% of the placebo group and 2% of the DUPIXENT 300 mg Q2W group.

Table 8 summarizes the adverse reactions that occurred at a rate of at least 1% in subjects treated with DUPIXENT and at a higher rate than in their respective comparator group in SINUS-24 and SINUS-52.

Table 8: Adverse Reactions Occurring in ≥1% of the DUPIXENT Group in SINUS-24 and SINUS-52 and Greater than Placebo (24-Week Safety Pool)

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>DUPIXENT 300 mg Q2W</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection site reactions c</td>
<td>28 (6%)</td>
<td>12 (4%)</td>
</tr>
<tr>
<td>Conjunctivitis c</td>
<td>7 (2%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>14 (3%)</td>
<td>5 (2%)</td>
</tr>
<tr>
<td>Gastritis</td>
<td>7 (2%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Insomnia</td>
<td>6 (1%)</td>
<td>0 (&lt;1%)</td>
</tr>
<tr>
<td>Eosinophilia</td>
<td>5 (1%)</td>
<td>1 (&lt;1%)</td>
</tr>
<tr>
<td>Toothache</td>
<td>5 (1%)</td>
<td>1 (&lt;1%)</td>
</tr>
</tbody>
</table>

a Injection site reactions cluster includes injection site reaction, pain, bruising and swelling.
b Conjunctivitis cluster includes conjunctivitis, allergic conjunctivitis, bacterial conjunctivitis, viral conjunctivitis, giant papillary conjunctivitis, eye irritation, and eye inflammation.

The safety profile of DUPIXENT through Week 52 was generally consistent with the safety profile observed at Week 24.

Eosinophilic Esophagitis

Adults and Pediatric Subjects 12 Years of Age and Older with EoE

A total of 239 adult and pediatric subjects 12 years of age and older, weighing at least 40 kg, with EoE were evaluated in a randomized, double-blind, parallel-group, multicenter, placebo-controlled trial, including two 24-week treatment periods (Study EoE-1 Parts A and B) and received either DUPIXENT 300 mg QW or placebo [see Clinical Studies (14.4)].

Table 9 summarizes the adverse reactions that occurred at a rate of at least 2% in subjects treated with DUPIXENT and at a higher rate than in their respective comparator group in Parts A and B. Safety profile through Week 16 of Study EoE-2 Part A was generally similar to the safety profile in adult and pediatric subjects 12 years of age and older with EoE. In Part B, a helmint infection was reported in one DUPIXENT-treated subject.

Pediatric Subjects 6 to 11 Years of Age with EoE

A total of 61 pediatric subjects 1 to 11 years of age, weighing at least 15 kg, with EoE were evaluated in a randomized, blinded, parallel-group, multicenter trial, including an initial 16-week placebo-controlled treatment period (Study EoE-2 Part A) and a 36-week extended active treatment period (Study EoE-2 Part B). Subjects in Part A received a weight-based dosing regimen of DUPIXENT or placebo [see Clinical Studies (14.4)]. All subjects in Part B completed Part A and received active treatment with weight-based dosing regimens of DUPIXENT in Part B (N=47).

The safety profile of DUPIXENT through Week 16 of Study EoE-2 Part A was generally similar to the safety profile in adult and pediatric subjects 12 years of age and older with EoE. In Part B, a helmint infection was reported in one DUPIXENT-treated subject.

Prurigo Nodularis

A total of 309 adult subjects with prurigo nodularis (PN) were evaluated in two 24-week randomized, double-blind, placebo-controlled, multicenter trials (PRIME and PRIME2). The safety pool included data from the 24-week treatment and 12-week follow-up periods from both trials.

The proportion of subjects who discontinued treatment due to adverse events was 3% of the placebo group and 0% of the DUPIXENT 300 mg Q2W group.
The safety population had a mean age of 49 years; 65% of subjects were female, 56% were White, 34% were Asian, and 6% were Black or African American. Subjects with co-morbid conditions included 43% of subjects with a history of atopy (defined as having a medical history of AD, allergic rhinitis/hinconjunctivitis, asthma, or food allergy), 8% of subjects with a history of hypothyroidism and 9% of subjects with a history of diabetes mellitus type 2. Table 10 summarizes the adverse reactions that occurred at a rate of at least 2% in subjects treated with DUPIXENT and at a higher rate than in their respective comparator group in PRIME and PRIME2.

### Table 10: Adverse Reactions Occurring in ≥2% of the DUPIXENT Group in PRIME and PRIME2 and Greater than Placebo

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>PRIME and PRIME2</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasopharyngitis (^a)</td>
<td>8 (5%)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Conjunctivitis (^a)</td>
<td>6 (4%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Herpes infection (^b)</td>
<td>5 (3%)</td>
<td>0%</td>
</tr>
<tr>
<td>Dizziness (^c)</td>
<td>5 (3%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Myalgia (^d)</td>
<td>5 (3%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>4 (3%)</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

\(^a\) Nasopharyngitis includes pharyngitis
\(^b\) Conjunctivitis includes conjunctivitis and allergic conjunctivitis.
\(^c\) Herpes infection includes oral herpes, genital herpes simplex, herpes zoster and ophthalmic herpes zoster
\(^d\) Dizziness includes dizziness postural, vertigo and vertigo positional

**Myalgia includes musculoskeletal pain and musculoskeletal chest pain**

### Specific Adverse Reactions

**Conjunctivitis and Keratitis**

In adult subjects with AD, conjunctivitis was reported in 10% (34 per 100 subject-years) in the 300 mg Q2W dose group and in 2% of the placebo group (8 per 100 subject-years) during the 16-week treatment period of the monotherapy trials (SOLO 1, SOLO 2, and AD-1021). During the 52-week treatment period of concomitant therapy AD trial (CHRONOS), conjunctivitis was reported in 16% of the DUPIXENT 300 mg Q2W + TCS group (20 per 100 subject-years) and in 9% of the placebo + TCS group (10 per 100 subject-years). During the long-term OLE trial with data through 260 weeks (AD-1225), conjunctivitis was reported in 21% of the DUPIXENT group (12 per 100 subject-years).

In DUPIXENT AD monotherapy trials (SOLO 1, SOLO 2, and AD-1021) through Week 16, keratitis was reported in <1% of the DUPIXENT group (1 per 100 subject-years) and in 9% of the placebo group (0 per 100 subject-years). In the 52-week DUPIXENT + topical corticosteroids (TCS) AD trial (CHRONOS), keratitis was reported in 4% of the DUPIXENT + TCS group (4 per 100 subject-years) and in 2% of the placebo + TCS group (2 per 100 subject-years). Conjunctivitis and keratitis occurred more frequently in AD subjects who received DUPIXENT. Conjunctivitis was the most frequently reported eye disorder. During the long-term OLE trial with data through 260 weeks (AD-1225), keratitis was reported in 3% of the DUPIXENT group (1 per 100 subject-years). Most subjects with conjunctivitis or keratitis recovered or were recovering during the treatment period.

Among subjects with asthma, the frequency of conjunctivitis and keratitis was similar between DUPIXENT and placebo.

In subjects with CRSwNP, the frequency of conjunctivitis was 2% in the DUPIXENT group compared to 1% in the placebo group in the 24-week safety pool; these subjects recovered.

In the 52-week CRSwNP study (SINUS-52), the frequency of conjunctivitis was 3% in the DUPIXENT subjects and 1% in the placebo subjects; all of these subjects recovered. There were no cases of keratitis reported in the CRSwNP development program [see Warnings and Precautions (5.2)].

Among subjects with EoE, there were no reports of conjunctivitis and keratitis in the DUPIXENT group in the 16-week AD monotherapy trials [see Warnings and Precautions (5.2)]. In the 36-week active treatment extension period of Study EoE-2 Part B, conjunctivitis was reported in 4% of DUPIXENT-treated pediatric subjects with EoE.

Among subjects with PN, the frequency of conjunctivitis was 4% in the DUPIXENT group compared to 1% in the placebo group; all of these subjects recovered or were recovering during the treatment period. There were no cases of keratitis reported in the PN development program [see Warnings and Precautions (5.2)].

### Eczema Herpeticum and Herpes Zoster

The rate of eczema herpeticum was similar in the placebo and DUPIXENT groups in the AD trials. The rates remained stable through 260 weeks in the long-term OLE trial (AD-1225). Herpes zoster was reported in <1% of the DUPIXENT groups (1 per 100 subject-years) and in <1% of the placebo group (1 per 100 subject-years) in the 16-week AD monotherapy trials. In the 52-week DUPIXENT + TCS AD trial, herpes zoster was reported in 1% of the DUPIXENT + TCS group (1 per 100 subject-years) and 2% of the placebo + TCS group (2 per 100 subject-years). During the long-term OLE trial with data through 260 weeks (AD-1225), 2.0% of DUPIXENT-treated subjects reported herpes zoster (0.94 per 100 subject-years of follow up). Among asthma subjects the frequency of herpes zoster was similar between DUPIXENT and placebo. Among subjects with CRSwhNP or EoE there were no reported cases of herpes zoster or eczema herpeticum.

### Hypersensitivity Reactions

Hypersensitivity reactions were reported in <1% of DUPIXENT-treated subjects. These included anaphylaxis, serum sickness or serum sickness-like reactions, generalized urticaria, rash, erythema nodosum, and erythema multiforme [see Contraindications (4), Warnings and Precautions (5.1), and Clinical Pharmacology (12.6)].

**Eosinophils**

DUPIXENT-treated subjects with AD, asthma, and CRSwhNP had a greater initial increase from baseline in blood eosinophil count compared to subjects treated with placebo. In adult subjects with AD (SOLO 1, SOLO 2, and AD-1021), the mean and median increases in blood eosinophils from baseline to Week 4 were 478 and 90 cells/mcL, respectively. In pediatric subjects <6 years old with AD, the mean and median increases from baseline to week 4 were 478 and 90 cells/mcL, respectively.

In adult and pediatric subjects 12 years of age and older with asthma (DR12544 and QUEST), the mean and median increases in blood eosinophils from baseline to Week 4 were 150 and 50 cells/mcL, respectively.

An increase from baseline in blood eosinophil count was not observed in adult and pediatric subjects 12 years of age and older with EoE treated with DUPIXENT as compared to placebo (Study EoE-1). In pediatric subjects 1 to 11 years of age with EoE (Study EoE-2 Part A), blood eosinophil counts were generally consistent with those observed in Study EoE-1.

In subjects with PN (PRIME and PRIME2), the mean and median decrease in blood eosinophils from baseline to Week 4 were 150 and 50 cells/mcL, respectively.

Across the trials for AD, asthma, and CRSwhNP, indications, the incidence of treatment-emergent eosinophilia (>500 cells/mcL) was similar in DUPIXENT and placebo groups. In the trials for the PN indication, the incidence of treatment-emergent eosinophilia (>500 cells/mcL) was lower in DUPIXENT than in the placebo group.

Treatment-emergent eosinophilia (>5,000 cells/mcL) was reported in <3% of DUPIXENT-treated subjects and <0.5% in placebo-treated subjects (SOLO 1, SOLO 2, and AD-1021; DR12544, QUEST, and VOYAGE; SINUS-24 and SINUS-52; PRIME and PRIME2). Blood eosinophil counts declined to near baseline or remained below baseline levels (PRIME and PRIME2) during study treatment. In study AD-1539, treatment-emergent eosinophilia (>5,000 cells/mcL) was reported in 8% of DUPIXENT-treated subjects and 0% in placebo-treated subjects [see Warnings and Precautions (5.3)].

**Cardiovascular**

In the 1-year placebo-controlled trial in adult and pediatric subjects 12 years of age and older with asthma (QUEST), cardiovascular thromboembolic events (cardiovascular deaths, non-fatal myocardial infarctions, and non-fatal strokes) were reported in 1 (0.2%) of the DUPIXENT 200 mg Q2W group, 4 (0.6%) of the DUPIXENT 300 mg Q2W group, and 2 (0.3%) of the placebo group.

In the 1-year placebo-controlled trial in subjects with AD (CHRONOS), cardiovascular thromboembolic events (cardiovascular deaths, non-fatal myocardial infarctions, and non-fatal strokes) were reported in 0 (0.0%) of the DUPIXENT group and 0 (0.0%) of the placebo group. In the 1-year placebo-controlled trial in subjects with CRSwhNP (SINUS-52), there were no cases of cardiovascular thromboembolic events (cardiovascular deaths, non-fatal myocardial infarctions, and non-fatal strokes) reported in any treatment arm.

In the 24-week placebo-controlled trial in subjects with CRSwhNP (SINUS-24), cardiovascular thromboembolic events (cardiovascular deaths, non-fatal myocardial infarctions, and non-fatal strokes) were reported in any treatment arm.

### 6.2 Postmarketing Experience

The following adverse reactions have been identified following post-approval use of DUPIXENT. 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.

**Immune system disorders:** angioedema [see Warnings and Precautions (5.1)]

**Skin and subcutaneous tissue disorders:** Facial skin reactions, including erythema, rash, scaling, edema, papules, pruritus, burning, and pain

### 8 USE IN SPECIFIC POPULATIONS

#### 8.1 Pregnancy

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to DUPIXENT during pregnancy.

Pregnancy Exposure Registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to DUPIXENT during pregnancy. Healthcare providers and patients may call 1-877-311-8972 or go to https://mothertobaby.org/ongoing-study/dupixent/ to enroll in or to obtain information about the registry.
A total of 107 pediatric subjects 12 to 17 years of age with moderate-to-severe asthma were enrolled in QUEST and received either 200 mg (N=21) or 300 mg (N=18) DUPIXENT (or matching placebo either 200 mg [N=34] or 300 mg [N=34]) Q2W. Asthma exacerbations and lung function were assessed in both pediatric subjects 12 to 17 years of age and adults. For both the 200 mg and 300 mg Q2W doses, improvements in FEV1, (LS mean change from baseline at Week 12) were observed (0.36 L and 0.27 L, respectively). For the 200 mg Q2W dose, subjects had a reduction in the rate of severe exacerbations that was consistent with adults. Dupilumab exposure was higher in pediatric subjects 12 to 17 years of age than that in adults at the respective dose level which was mainly accounted for by difference in body weight [see Clinical Pharmacology (12.3)].

The adverse event profile in pediatric subjects 12 to 17 years of age was generally similar to the adults [see Adverse Reactions (6.1)].

Pediatric Subjects 6 to 11 Years of Age:
A total of 408 pediatric subjects 6 to 11 years of age with moderate-to-severe asthma were enrolled in VOYAGE, which evaluated doses of 100 mg Q2W or 200 mg Q2W. Improvement in asthma exacerbations and lung function were demonstrated [see Clinical Studies (14.2)]. The effectiveness of DUPIXENT 300 mg Q4W in subjects 6 to 11 years of age with body weight 15 to <30 kg was extrapolated from efficacy of 100 mg Q2W in VOYAGE with support from population pharmacokinetics analyses showing higher drug exposure levels with 300 mg Q4W [see Clinical Pharmacology (12.3)]. Subjects who completed the treatment period of the VOYAGE study could participate in the open-label extension study (LS214422). Eighteen subjects (≥15 to <30 kg) out of 365 subjects were exposed to 300 mg Q4W in this study, and the safety profile in these eighteen subjects was consistent with that seen in VOYAGE. Additional safety for DUPIXENT 300 mg Q4W is based upon available safety information from the pediatric AD indication [see Adverse Reactions (6.1) and Clinical Pharmacology (12.3)].

Safety and effectiveness in pediatric patients younger than 6 years of age with asthma have not been established.

CRSwNP
Safety and effectiveness in pediatric patients younger than 18 years of age with CRSwNP have not been established.

EoE
The safety and effectiveness of DUPIXENT for the treatment of EoE have been established in pediatric subjects 1 year of age and older, weighing at least 15 kg. Use of DUPIXENT in this population is supported by an adequate well-controlled study in adults and 72 pediatric subjects 12 to 17 years of age (Study EoE-1), a clinical study in 61 pediatric subjects 6 to 11 years of age (Study EoE-2), and pharmacokinetic data in adults and pediatric subjects 1 to 17 years of age. The safety of DUPIXENT in pediatric subjects 1 to 17 years of age was similar to adults [see Adverse Reactions (6.1), Clinical Pharmacology (12.3), and Clinical Studies (14.4)].

Safety and effectiveness in pediatric patients younger than 1 year of age, or weighing less than 15 kg, with EoE have not been established.

Prurigo Nodularis
Safety and effectiveness in pediatric patients younger than 18 years of age with PN have not been established.

8.5 Geriatric Use
Of the 1539 subjects with AD exposed to DUPIXENT in a dose-ranging study and placebo-controlled trials, 70 subjects were 65 years or older. Clinical trials of DUPIXENT 300 mg Q4W in EoE did not include sufficient numbers of subjects aged 65 years and over to determine whether they respond differently from younger subjects [see Clinical Pharmacology (12.3)]. Of the 1977 subjects with asthma exposed to DUPIXENT, a total of 240 subjects were 65 years or older. Efficacy and safety in this age group was similar to the overall study population. Of the 440 subjects with CRSwNP exposed to DUPIXENT, a total of 79 subjects were 65 years or older. Efficacy and safety in this age group were similar to the overall study population.

Clinical studies of DUPIXENT in EoE did not include sufficient numbers of subjects aged 65 years and over to determine whether they respond differently from younger adult subjects. Of the 152 subjects with PN exposed to DUPIXENT, a total of 37 were 65 years or older including 8 subjects 75 years or older. Clinical trials did not include a sufficient number of subjects 65 years of age and older to determine whether they respond differently from younger adult subjects.

10 OVERDOSAGE
There is no specific treatment for DUPIXENT overdose. In the event of overdosage, contact Poison Control (1-800-222-1222) for the latest recommendations and monitor the patient for any signs or symptoms of adverse reactions and institute appropriate symptomatic treatment immediately.

11 DESCRIPTION
Dupilumab, an interleukin-4 receptor alpha antagonist, is a human monoclonal antibody of the IgG4 subclass that binds to the IL-4Rα subunit and inhibits IL-4 and IL-13 signaling. Dupilumab has an approximate molecular weight of 147 kDa. Dupilumab is produced by recombinant DNA technology in Chinese Hamster Ovary cell suspension culture.

DUPIXENT (dupilumab) Injection is supplied as a sterile, preservative-free, clear to slightly opalescent, colorless to pale yellow solution for subcutaneous injection. DUPIXENT is provided as either a single-dose pre-filled syringe with needle shield or a single-dose pre-filled pen in a siliconized Type-1 clear glass syringe. The needle cap is not made with natural rubber latex.
Each 300 mg pre-filled syringe or pre-filled pen delivers 300 mg dupilumab in 2 mL which also contains L-arginine hydrochloride (10.5 mg), L-histidine (6.2 mg), polysorbate 80 (4 mg), sodium acetate (1.5 mg), and water for injection, pH 5.9.

Each 200 mg pre-filled syringe or pre-filled pen delivers 200 mg dupilumab in 1.14 mL which also contains L-arginine hydrochloride (12 mg), L-histidine (3.5 mg), polysorbate 80 (2.3 mg), sodium acetate (1.2 mg), sucrose (57 mg), and water for injection, pH 5.9.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action
Dupilumab is a human monoclonal IgG4 antibody that inhibits interleukin-4 (IL-4) and interleukin-13 (IL-13) signaling by specifically binding to the IL-4Rα subunit shared by the IL-4 and IL-13 receptor complexes. Dupilumab inhibits IL-4 signaling via the Type I receptor and both IL-4 and IL-13 signaling through the Type II receptor.

Inflammation driven by IL-4 and IL-13 is an important component in the pathogenesis of asthma, AD, CRSwNP, EoE, and PN. Multiple IL-4/IL-13Rα (e.g., mast cells, eosinophils, macrophages, lymphocytes, epithelial cells, goblet cells) and inflammatory mediators (e.g., histamine, eicosanoids, leukotrienes, cytokines, chemokines) are involved in inflammation. Blocking IL-4Rα with dupilumab inhibits IL-4 and IL-13 cytokine-induced inflammatory responses, including the release of proinflammatory cytokines, chemokines, nitric oxide, and IgE. The mechanism of dupilumab action has not been definitively established.

12.2 Pharmacodynamics
Consistent with inhibition of IL-4 and IL-13 signaling, dupilumab treatment decreased certain biomarkers of inflammation. In asthma subjects, fractional exhaled nitric oxide (FeNO) and circulating concentrations of eotaxin-3, total IgE, specific IgE to house dust mite, and total IgE, and total IgE to grass pollen were measured. A statistically significant reduction in FeNO was observed as early as 1 week post dose. The median percent reduction (IQR) from baseline at Week 2 was 35% and 24% in DRI12544 and QUEST, respectively, and in the overall safety population, the mean FeNO level decreased to 20 ppb.

In VOYAGE 1 and 2, dupilumab was associated with a statistically significant reduction in median percent reduction from baseline at Week 2 of 60% and 55% in VOYAGE 1 and 2, respectively.

Approximately 10% of VOYAGE subjects discontinued treatment due to adverse events.

12.3 Pharmacokinetics
The pharmacokinetics of dupilumab is similar in subjects with AD, asthma, CRSwNP, EoE, and PN.

Absorption
Following an initial subcutaneous (SC) dose of 600 mg, 400 mg, or 300 mg, dupilumab reached peak mean ± SD concentrations (Cmax) of 70.1±24.1 mcg/mL, 41.8±12.4 mcg/mL, or 30.5±9.39 mcg/mL, respectively, by approximately 1 week post dose.

12.4 Dose Linearity
Dupilumab exhibited nonlinear target-mediated pharmacokinetics with exposures increasing in a greater than dose-proportional manner. The systemic exposure increased by approximately 1.5 times (up to 19 weeks) and 2.5 times (up to 32 weeks) longer in pediatric subjects 6 to 11 years of age and pediatric subjects 6 months to 17 years of age, weighing at least 40 kg, with EoE receiving 300 mg QW. The mean ± SD steady-state trough concentration of dupilumab was 29.5±9.0 mcg/mL and 46.7±26.9 mcg/mL, respectively, for 300 mg or 200 mg administered Q2W.

Approximately 6% of subjects with AD who received DUPIXENT 300 mg Q2W for 12 weeks developed antibodies to DUPIXENT; approximately 2% exhibited persistent ADA responses, and approximately 5% had neutralizing antibodies. Similar results were observed in pediatric subjects 6 years and older with a body weight ≥15 kg, the mean ± SD steady-state trough concentration was 174±66.2 mcg/mL.

The systemic exposure in pediatric subjects 1 to 11 years of age with a body weight ≥40 kg receiving 300 mcg QW is expected to be comparable to pediatric subjects 6 to 11 years of age.

Drug Interaction Studies
An effect of dupilumab on the PK of co-administered medications is not expected. Based on the population analysis, co-administered medications had no effect on DUPIXENT pharmacokinetics in subjects with moderate-to-severe asthma.

Cytochrome P450 Substrates
The effects of dupilumab on the pharmacokinetics of midazolam (metabolized by CYP3A4), warfarin (metabolized by CYP2C9), omeprazole (metabolized by CYP2C19), metoprolol (metabolized by CYP2D6), and caffeine (metabolized by CYP1A2) were evaluated in a study with 12-13 evaluable subjects with AD (a SC loading dose of 600 mg followed by 300 mg SC weekly for six weeks). No clinically significant changes in AUC were observed. The largest effect was observed for metoprolol (CYP2D6) with an increase in AUC of 9%.

12.6 Immune-mediated toxicity
The observed incidence of anti-drug antibodies is highly dependent on the sensitivity and specificity of the assay. Differences in assay methods preclude meaningful comparisons of the incidence of anti-drug antibodies in the studies described below with the incidence of anti-drug antibodies in other studies, including those of DUPIXENT or other dupilumab products.

Atopic Dermatitis
Approximately 6% of subjects with AD who received DUPIXENT 300 mg Q2W for 52 weeks developed antibodies to DUPIXENT; approximately 2% exhibited persistent ADA responses, and approximately 1% had neutralizing antibodies. Similar results were observed in pediatric subjects 6 months to 11 years of age with AD who received either DUPIXENT 200 mg Q2W, 200 mg Q4W, or 300 mg Q4W. Approximately 16% of pediatric subjects 12 to 17 years of age with AD who received DUPIXENT 300 mg or 200 mg Q2W for 16 weeks developed antibodies to DUPIXENT; approximately 3% exhibited persistent ADA responses, and approximately 5% had neutralizing antibodies.

Asthma
Approximately 5% of subjects with asthma who received DUPIXENT 300 mg Q2W for 52 weeks developed antibodies to DUPIXENT; approximately 2% exhibited persistent ADA responses, and approximately 2% had neutralizing antibodies. Similar results were observed in pediatric subjects 6 to 17 years of age with asthma who were receiving either DUPIXENT 200 mg or 300 mg Q4W for 52 weeks. Approximately 5% of these subjects developed antibodies to DUPIXENT; approximately 2% exhibited persistent ADA responses, and approximately 2% had neutralizing antibodies.

Immunogenicity
Development of antibodies to dupilumab was associated with lower dupilumab concentrations. A few subjects who had high antibody titers also had no detectable serum dupilumab concentrations.

Specific Populations
Age
Based on population pharmacokinetic analysis, age did not affect dupilumab clearance in adults and in pediatric subjects 6 to 17 years of age. In pediatric subjects 6 months to 5 years of age, clearance increased with age.

Geriatric Patients
In subjects who are 65 years and older, the mean ± SD steady-state trough concentrations of dupilumab were 69.4±31.4 mcg/mL and 166±62.3 mcg/mL, respectively, for 300 mg administered Q2W and weekly, and 39.7±21.7 mcg/mL for 200 mg administered Q2W.

Pediatric Patients
EOSINOPHILIC ESOPHAGITIS
In Study EoE-1, dupilumab pharmacokinetics were investigated in 35 pediatric subjects 12 to 17 years of age with EoE. The mean ± SD steady-state trough concentration of dupilumab was 107±51.6 mcg/mL and 46.7±26.9 mcg/mL, respectively, for 300 mg or 200 mg administered Q2W.

The systemic exposure in pediatric subjects 12 to 17 years of age with a body weight ≥40 kg receiving 300 mcg QW is expected to be comparable to pediatric subjects 6 to 11 years of age.

Drug Interaction Studies
An effect of dupilumab on the PK of co-administered medications is not expected. Based on the population analysis, co-administered medications had no effect on DUPIXENT pharmacokinetics in subjects with moderate-to-severe asthma.

Cytochrome P450 Substrates
The effects of dupilumab on the pharmacokinetics of midazolam (metabolized by CYP3A4), warfarin (metabolized by CYP2C9), omeprazole (metabolized by CYP2C19), metoprolol (metabolized by CYP2D6), and caffeine (metabolized by CYP1A2) were evaluated in a study with 12-13 evaluable subjects with AD (a SC loading dose of 600 mg followed by 300 mg SC weekly for six weeks). No clinically significant changes in AUC were observed. The largest effect was observed for metoprolol (CYP2D6) with an increase in AUC of 9%.

12.6 Immune-mediated toxicity
The observed incidence of anti-drug antibodies is highly dependent on the sensitivity and specificity of the assay. Differences in assay methods preclude meaningful comparisons of the incidence of anti-drug antibodies in the studies described below with the incidence of anti-drug antibodies in other studies, including those of DUPIXENT or of other dupilumab products.

Atopic Dermatitis
Approximately 6% of subjects with AD who received DUPIXENT 300 mg Q2W for 52 weeks developed antibodies to DUPIXENT; approximately 2% exhibited persistent ADA responses, and approximately 1% had neutralizing antibodies. Similar results were observed in pediatric subjects 6 months to 11 years of age with AD who received either DUPIXENT 200 mg Q2W, 200 mg Q4W, or 300 mg Q4W. Approximately 16% of pediatric subjects 12 to 17 years of age with AD who received DUPIXENT 300 mg or 200 mg Q2W for 16 weeks developed antibodies to DUPIXENT; approximately 3% exhibited persistent ADA responses, and approximately 5% had neutralizing antibodies.

Asthma
Approximately 5% of subjects with asthma who received DUPIXENT 300 mg Q2W for 52 weeks developed antibodies to DUPIXENT; approximately 2% exhibited persistent ADA responses, and approximately 2% had neutralizing antibodies. Similar results were observed in pediatric subjects 6 to 17 years of age with asthma who were receiving either DUPIXENT 200 mg or 300 mg Q4W for 52 weeks. Approximately 5% of these subjects developed antibodies to DUPIXENT; approximately 2% exhibited persistent ADA responses, and approximately 2% had neutralizing antibodies.
observed in pediatric subjects 6 to 11 years of age with asthma who received either DUPIXENT 100 mg Q2W or 200 mg Q2W up to 52 weeks.

Approximately 9% of subjects with asthma who received DUPIXENT 200 mg Q2W for 52 weeks developed antibodies to DUPIXENT; approximately 4% exhibited persistent ADA responses, and approximately 4% had neutralizing antibodies.

Chronic Rhinosinusitis with Nasal Polyps

Approximately 5% of subjects with CRSwNP who received DUPIXENT 300 mg Q2W for 52 weeks developed antibodies to DUPIXENT; approximately 2% exhibited persistent ADA responses, and approximately 3% had neutralizing antibodies.

Eosinophilic Esophagitis

Approximately 1% of subjects with EoE who received DUPIXENT 300 mg Q2W for 24 weeks developed antibodies to DUPIXENT; approximately 1% exhibited persistent ADA responses, and approximately 3% had neutralizing antibodies.

The antibody titers detected in subjects who received DUPIXENT were mostly low. In subjects who received DUPIXENT, development of high titer antibodies to DUPIXENT was associated with lower serum dupilumab concentrations [see Clinical Pharmacology (12.3)].

Two adult subjects with AD who experienced high titer antibody responses developed serum sickness or serum sickness-like reactions during DUPIXENT therapy [see Warnings and Precautions (5.1)].

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Animal studies have not been conducted to evaluate the carcinogenic or mutagenic potential of dupilumab.

No effects on fertility parameters such as reproductive organs, menstrual cycle length, or sperm analysis were observed in sexually mature mice that were subcutaneously administered a homologous antibody against IL-4Rα at doses up to 200 mg/kg/week.

14 CLINICAL STUDIES

14.1 Atopic Dermatitis

Adults with Atopic Dermatitis

Three randomized, double-blind, placebo-controlled trials (SOLO 1 (NCT02277743), SOLO 2 (NCT02277769), and CHRONOS (NCT02260986)) enrolled a total of 2119 adult subjects 18 years of age and older with moderate-to-severe AD not adequately controlled by topical medication(s). Disease severity was defined by an Investigator's Global Assessment (IGA) score ≥3 in the overall assessment of AD lesions on a severity scale of 0 to 4, an Eczema Area and Severity Index (EASI) score ≥16 on a scale of 0 to 72, and a minimum body surface area involvement of ≥10%. At baseline, 59% of subjects were male, 67% were White, 52% of subjects had a baseline IGA score of 3 (moderate AD), and 48% of subjects had a baseline IGA of 4 (severe AD). The baseline mean EASI score was 33 and the baseline weekly averaged Peak Pruritus Numeric Rating Scale (NRS) was 7 on a scale of 0-10.

In all three trials, subjects in the DUPIXENT group received subcutaneous injections of DUPIXENT 600 mg at Week 0, followed by 300 mg every other week (Q2W). In the monotherapy trials (SOLO 1 and SOLO 2), subjects received DUPIXENT or placebo for 16 weeks.

In the concomitant therapy trial (CHRONOS), subjects received DUPIXENT or placebo with concomitant topical corticosteroids (TCS) and as needed topical calcineurin inhibitors for problem areas only, such as the face, neck, intertriginous and genital areas for 52 weeks.

All three trials assessed the primary endpoint, the change from baseline to Week 16 in the Peak Pruritus NRS from baseline to Week 16.

Treatment effects in subgroups (weight, age, gender, race, and prior treatment, including immunosuppressants) in SOLO 1, SOLO 2, and CHRONOS were generally consistent with the results in the overall study population.

<table>
<thead>
<tr>
<th>Table 11: Efficacy Results of DUPIXENT with or without Concomitant TCS at Week 16 (FAS) in Adult Subjects 18 Years of Age and Older with Moderate-to-Severe AD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOLO 1</strong></td>
</tr>
<tr>
<td><strong>DUPIXENT</strong></td>
</tr>
<tr>
<td><strong>300 mg Q2W</strong></td>
</tr>
<tr>
<td><strong>Placebo</strong></td>
</tr>
<tr>
<td><strong>Number of Subjects randomized (FAS)</strong></td>
</tr>
<tr>
<td><strong>IGA 0 or □</strong></td>
</tr>
<tr>
<td><strong>EASI-75</strong></td>
</tr>
<tr>
<td><strong>EASI-90</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 12: Efficacy Results (IGA 0 or 1) of DUPIXENT with Concomitant TCS at Week 16 and 52 in Adult Subjects 18 Years of Age and Older with Moderate-to-Severe AD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DUPIXENT</strong></td>
</tr>
<tr>
<td><strong>300 mg Q2W</strong></td>
</tr>
<tr>
<td><strong>Number of Subjects</strong></td>
</tr>
<tr>
<td><strong>Responder</strong></td>
</tr>
<tr>
<td><strong>Responder at Week 16 but Non-responder at Week 52</strong></td>
</tr>
<tr>
<td><strong>Non-responder at Week 16 or Non-responder at Week 52</strong></td>
</tr>
<tr>
<td><strong>Overall Responder Rate</strong></td>
</tr>
</tbody>
</table>

The primary analyses of the efficacy endpoints, subjects who received rescue treatment or with missing data were considered non-responders.

In CHRONOS, of the 421 subjects, 353 had been on study for 52 weeks at the time of data analysis. Of these 353 subjects, responders at Week 52 represent a mixture of subjects who maintained their efficacy from Week 16 (e.g., 53% of DUPIXENT IGA 0 or 1 responders at Week 16 remained responders at Week 52) and subjects who were non-responders at Week 16 who later responded to treatment (e.g., 24% of DUPIXENT IGA 0 or 1 non-responders at Week 16 became responders at Week 52).

Table 12: Efficacy Results (IGA 0 or 1) of DUPIXENT with Concomitant TCS at Week 16 and 52 in Adult Subjects 18 Years of Age and Older with Moderate-to-Severe AD |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Subjects</strong></td>
</tr>
<tr>
<td><strong>Responder</strong></td>
</tr>
<tr>
<td><strong>Responder at Week 16 but Non-responder at Week 52</strong></td>
</tr>
<tr>
<td><strong>Non-responder at Week 16 or Non-responder at Week 52</strong></td>
</tr>
<tr>
<td><strong>Overall Responder Rate</strong></td>
</tr>
</tbody>
</table>

a In CHRONOS, of the 421 randomized and treated subjects, 68 subjects (16%) had not been on study for 52 weeks at the time of data analysis.

b Responder was defined as a subject with an IGA of 0 or 1 (“clear” or “almost clear”) and a reduction of ≥2 points on a 0-4 IGA scale.

c Subjects who received rescue treatment or with missing data were considered non-responders.
In SOLO 1, SOLO 2, and CHRONOS, a third randomized treatment arm of DUPIXENT 300 mg QW did not demonstrate additional treatment benefit over DUPIXENT 300 mg Q2W.

Subjects in SOLO 1 and SOLO 2 who had an IGA 0 or 1 with a reduction of ≥2 points were re-randomized into SOLO CONTINUE (NCT02395133). SOLO CONTINUE evaluated multiple DUPIXENT monotherapy dose regimens for maintaining treatment response. The study included subjects randomized to continue with DUPIXENT 300 mg Q2W (62 subjects) or switch to placebo (31 subjects) for 36 weeks. IGA 0 or 1 responses at Week 36 were as follows: 33 (53%) in the Q2W group and 3 (10%) in the placebo group.

Pediatric Subjects 12 to 17 Years of Age with Atopic Dermatitis

The efficacy of DUPIXENT monotherapy in pediatric subjects 12 to 17 years of age was evaluated in a multicenter, randomized, double-blind, placebo-controlled trial (AD-1526; NCT03054428) in 251 pediatric subjects 12 to 17 years of age, with moderate-to-severe AD defined by an IGA score ≥3 (scale of 0 to 4), an EASI score ≥16 (scale of 0 to 72), and a minimum BSA involvement of ≥10%. Eligible subjects enrolled into this trial had previous inadequate response to topical medication.

Subjects in the DUPIXENT group with baseline weight of <60 kg received an initial dose of 400 mg at Week 0, followed by 200 mg Q2W for 16 weeks. Subjects with baseline weight of ≥60 kg received an initial dose of 600 mg at Week 0, followed by 300 mg Q2W for 16 weeks. Subjects were permitted to receive rescue treatment at the discretion of the investigator. Subjects who received rescue treatment were considered non-responders.

In AD-1526, the mean age was 14.5 years, the median weight was 59.4 kg, 41% of subjects were female, 66% were White, 15% were Asian, and 12% were Black. At baseline, 46% of subjects had an IGA score of 3 (moderate AD), 54% had an IGA score of 4 (severe AD), the mean BSA involvement was 57%, and 42% had received prior systemic immunosuppressants. Also, at baseline, the mean EASI score was 36, and the weekly averaged Peak Pruritus NRS was 8 on a scale of 0-10. Overall, 92% of subjects had at least one co-morbid allergic condition; 66% had allergic rhinitis, 54% had asthma, and 61% had food allergies.

The primary endpoint was the proportion of subjects with an IGA 0 (clear) or 1 (almost clear) and at least a 2-point improvement from baseline to Week 16. Other evaluated outcomes included the proportion of subjects with EASI-75 or EASI-90 (improvement of at least 75% or 90% in EASI from baseline, respectively), and reduction in itch as measured by the Peak Pruritus NRS (≥4-point improvement).

The efficacy results at Week 16 for AD-1526 are presented in Table 13.

### Table 13: Efficacy Results of DUPIXENT in AD-1526 at Week 16 (FAS) in Pediatric Subjects 12 to 17 Years of Age with Moderate-to-Severe AD

<table>
<thead>
<tr>
<th>IGA 0 or 1&lt;sup&gt;a&lt;/sup&gt;&lt;sup&gt;b&lt;/sup&gt;</th>
<th>DUPIXENT&lt;sup&gt;c&lt;/sup&gt; 200 mg (≤60 kg) or 300 mg (&gt;60 kg) Q2W&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Placebo N=85&lt;sup&gt;e&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>IGA 0 or 1&lt;sup&gt;a&lt;/sup&gt;&lt;sup&gt;b&lt;/sup&gt;</td>
<td>24%</td>
<td>2%</td>
</tr>
<tr>
<td>EASI-75&lt;sup&gt;c&lt;/sup&gt;</td>
<td>42%</td>
<td>8%</td>
</tr>
<tr>
<td>EASI-90&lt;sup&gt;c&lt;/sup&gt;</td>
<td>23%</td>
<td>2%</td>
</tr>
<tr>
<td>Peak Pruritus NRS (≥4-point improvement)&lt;sup&gt;f&lt;/sup&gt;</td>
<td>37%</td>
<td>5%</td>
</tr>
</tbody>
</table>

<sup>a</sup> Full Analysis Set (FAS) includes all subjects randomized.
<sup>b</sup> Responder was defined as a subject with an IGA 0 or 1 ("clear" or "almost clear") and a reduction of ≥2 points on a 0-4 IGA scale.
<sup>c</sup> Subjects who received rescue treatment or with missing data were considered as non-responders (59% and 21% in the placebo and DUPIXENT arms, respectively).
<sup>d</sup> At Week 0, subjects received 400 mg (baseline weight <60 kg) or 600 mg (baseline weight ≥60 kg) of DUPIXENT.

A greater proportion of subjects randomized to DUPIXENT achieved an improvement in the Peak Pruritus NRS compared to placebo (defined as ≥4-point improvement at Week 4). See Figure 2.

---

The efficacy of DUPIXENT monotherapy in pediatric subjects 6 to 11 years of age was evaluated in a multicenter, randomized, double-blind, placebo-controlled trial (AD-1652; NCT03345914) in 367 subjects 6 to 11 years of age, with AD defined by an IGA score of 4 (scale of 0 to 4), an EASI score ≥16 (scale of 0 to 72), and a minimum BSA involvement of ≥15%. Eligible subjects enrolled into this trial had previous inadequate response to topical medication. Enrollment was stratified by baseline weight (<30 kg; ≥30 kg).

Subjects in the DUPIXENT Q4W + TCS group received an initial dose of 600 mg on Day 1, followed by 300 mg Q4W from Week 4 to Week 12, regardless of weight. Subjects in the DUPIXENT Q2W + TCS group with baseline weight of <30 kg received an initial dose of 200 mg on Day 1, followed by 100 mg Q2W from Week 2 to Week 14, and subjects with baseline weight of ≥30 kg received an initial dose of 400 mg on Day 1, followed by 200 mg Q2W from Week 2 to Week 14. Subjects were permitted to receive rescue treatment at the discretion of the investigator. Subjects who received rescue treatment were considered non-responders.

In AD-1652, the mean age was 8.5 years, the median weight was 29.8 kg, 50% of subjects were female, 69% were White, 17% were Black, and 8% were Asian. At baseline, the mean BSA involvement was 58%, and 17% had received prior systemic non-steroidal immunosuppressants. Also, at baseline the mean EASI score was 37.9, and the weekly averaged Peak Pruritus NRS was 4.3 on a scale of 0-10. Overall, 92% of subjects had at least one co-morbid allergic condition; 64% had food allergies, 63% had other allergies, 60% had allergic rhinitis, 54% had asthma, and 47% had asthma.

The primary endpoint was the proportion of subjects with an IGA 0 (clear) or 1 (almost clear) at Week 16. Other evaluated outcomes included the proportion of subjects with EASI-75 or EASI-90 (improvement of at least 75% or 90% in EASI from baseline, respectively), and reduction in itch as measured by the Peak Pruritus NRS (≥4-point improvement).

Table 14 presents the results by baseline weight strata for the approved dose regimens.

### Table 14: Efficacy Results of DUPIXENT with Concomitant TCS in AD-1652 at Week 16 (FAS) in Pediatric Subjects 6 to 11 Years of Age with AD

<table>
<thead>
<tr>
<th>IGA 0 or 1&lt;sup&gt;a&lt;/sup&gt;</th>
<th>DUPIXENT&lt;sup&gt;c&lt;/sup&gt; 300 mg Q4W + TCS&lt;sup&gt;f&lt;/sup&gt; (N=59)</th>
<th>Placebo + TCS (N=62)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 kg</td>
<td>30%</td>
<td>39%</td>
</tr>
<tr>
<td>≥30 kg</td>
<td>30%</td>
<td>28%</td>
</tr>
<tr>
<td>EASI-75&lt;sup&gt;e&lt;/sup&gt;</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>EASI-90&lt;sup&gt;e&lt;/sup&gt;</td>
<td>46%</td>
<td>36%</td>
</tr>
<tr>
<td>Peak Pruritus NRS (&lt;4-point improvement)&lt;sup&gt;f&lt;/sup&gt;</td>
<td>54%</td>
<td>61%</td>
</tr>
</tbody>
</table>

<sup>a</sup> Full Analysis Set (FAS) includes all subjects randomized.
<sup>b</sup> Responder was defined as a subject with an IGA 0 or 1 ("clear" or "almost clear").
<sup>c</sup> Subjects who received rescue treatment or with missing data were considered as non-responders.
<sup>d</sup> At Day 1, subjects received 600 mg of DUPIXENT.
<sup>e</sup> At Day 1, subjects received 200 mg (baseline weight <30 kg) or 400 mg (baseline weight ≥30 kg) of DUPIXENT.

A greater proportion of subjects randomized to DUPIXENT + TCS achieved an improvement in the Peak Pruritus NRS compared to placebo + TCS (defined as ≥4-point improvement at Week 16). See Figure 3.
Pediatric Subjects 6 Months to 5 Years of Age with Atopic Dermatitis

The efficacy and safety of DUPIXENT use concomitantly with TCS in pediatric subjects was evaluated in a multicenter, randomized, double-blind, placebo-controlled trial (AD-1539: NCT03594434) in 162 subjects 6 months to 5 years of age, with moderate-to-severe AD defined by an IGA score of ≥2 (scale of 0 to 4), an EASI score ≥16 (scale of 0 to 72), and a minimum BSA involvement of ≥10%. Eligible subjects enrolled into this trial had previous inadequate response to topical medication. Enrollment was stratified by baseline weight (≥15 kg and <30 kg) or 300 mg (15 to <30 kg) DUPIXENT every other week (Q2W) or 200 mg (N=154) or 300 mg (N=157) DUPIXENT every 4 weeks following an initial dose of 400 mg, 600 mg or placebo (N=158), respectively. The primary endpoint was mean change from baseline to Week 12 in FEV1.

Subjects enrolled in AD-1539 were randomized to receive a loading dose of 200 mg on Day 1, followed by 200 mg Q4W from Week 4 to Week 12, and subjects with baseline weight of ≥15 kg received an initial dose of 300 mg on Day 1, followed by 300 mg Q4W from Week 4 to Week 12. Subjects were permitted to receive rescue treatment at the discretion of the investigator. Subjects who received rescue treatment were considered non-responders.

In AD-1539, the mean age was 3.8 years, the median weight was 16.5 kg, 39% of subjects were female, 66% were White, 19% were Black, and 6% were Asian. At baseline, the mean BSA involvement was 58%, and 23% of subjects had received prior systemic immunosuppressants. Also, at baseline the mean EASI score was 34.1, and the weekly average of daily worst scratch/itch score was 7.6 on a scale of 0-10. Overall, 81.4% of subjects had at least one co-morbid allergic condition; 68.3% had food allergies, 52.8% had other allergies, 44.1% had allergic rhinitis, and 25.5% had asthma.

The primary endpoint was the proportion of subjects with an IGA 0 (clear) or 1 (almost clear) at Week 16. Other evaluated outcomes included the proportion of subjects with EASI-75 or EASI-90 (improvement of at least 75% or 90% in EASI from baseline, respectively), and reduction in itch as measured by the Worst Scratch/itch NRS (≥4-point improvement).

The efficacy results at Week 16 for AD-1539 are presented in Table 15.

| Table 15: Efficacy Results of DUPIXENT with Concomitant TCS in AD-1539 at Week 16 (FAS) in Pediatric Subjects 6 Months to 5 Years of Age with Moderate-to-Severe AD |
|-----------------|----------------|-----------------|-----------------|
| **Treatment**   | **Placebo**   | **Difference vs. Placebo (95% CI)** |
| **EASI-75**     | 53%           | 11%             | 42% (29%, 55%)  |
| **EASI-90**     | 25%           | 3%              | 23% (12%, 33%)  |
| **Worst Scratch/itch NRS (≥4-point improvement)** | 48% | 9% | 39% (26%, 52%) |

CI = confidence interval

- **a** In the primary analyses of the efficacy endpoints, subjects who received rescue treatment or with missing data were considered non-responders.
- **b** Full Analysis Set (FAS) includes all subjects randomized.
- **c** Responder was defined as a subject with an IGA 0 or 1 (“clear” or “almost clear”).
- **d** Subjects who received rescue treatment (63% and 19% in the placebo and DUPIXENT arms, respectively) or with missing data were considered as non-responders.
- **e** At Day 1, subjects received 200 mg (5 to <15 kg) or 300 mg (15 to <30 kg) of DUPIXENT.

14.2 Asthma

The asthma development program for patients aged 12 years and older included three randomized, double-blind, placebo-controlled, parallel-group, multicenter trials (DRI12544 (NCT01854047), QUEST (NCT02414854), and VENTURE (NCT02528214)) of 24 to 52 weeks in treatment duration which enrolled a total of 2888 subjects. Subjects enrolled in QUEST and VENTURE were required to have a history of 1 or more asthma exacerbations that required treatment with systemic corticosteroids or emergency department visit or hospitalization for the treatment of asthma in the year prior to trial entry.

Subjects entered in VENTURE required dependence on daily oral corticosteroids in addition to rescue therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist. In all 3 trials, subjects were enrolled without requiring a minimum baseline blood eosinophil count. In QUEST and VENTURE, subjects with screening blood eosinophil level of ≥1500 cells/mcL (<1.3% cells) were excluded. DUPIXENT was administered as add-on to background asthma treatment. Subjects continued oral or high-dose inhaled corticosteroid therapy throughout the duration of the studies, except in VENTURE in which OCS dose was tapered as described below.

DRI12544

DRI12544 was a 24-week dose-ranging study which included 776 adult subjects (18 years of age and older). DUPIXENT compared with placebo was evaluated in adult subjects with moderate-to-severe asthma on a medium or high-dose inhaled corticosteroid and a long acting beta agonist. Subjects were randomized to receive either 200 mg (N=150) or 300 mg (N=157) DUPIXENT every 4 weeks following an initial dose of 400 mg, 600 mg or placebo (N=158), respectively. The primary endpoint was mean change from baseline to Week 12 in FEV1 (L) in subjects with baseline blood eosinophilia ≥300 cells/mcL. Additional endpoints included percent change from baseline in FEV1, and annualized rate of severe asthma exacerbation events during the 24-week placebo-controlled treatment period. Results were evaluated in the overall population and subgroups based on baseline blood eosinophil count (≥300 cells/mcL, and <300 cells/mcL). Additional secondary endpoints included responder rates in the pattern reported Asthma Control Questionnaire (ACQ-5) and Asthma Quality of Life Questionnaire, Standardized Version (AQoL(S)) scores.
**QUEST**

QUEST was a 52-week study which included 1902 adult and pediatric subjects (12 years of age and older). DULPIXENT compared with placebo was evaluated in 107 pediatric subjects 12 to 17 years of age and 1795 adult subjects with moderate-to-severe asthma on a medium or high-dose inhaled corticosteroid (ICS) and a minimum of one and up to two additional controller medications. Subjects were randomized to receive either 200 mg (N=831) or 300 mg (N=633) DULPIXENT Q2W (or matching placebo for either 200 mg [N=317] or 300 mg [N=321] Q2W) following an initial dose of 400 mg, 600 mg or placebo, respectively. The primary endpoints were the annualized rate of severe exacerbation events during the 52-week placebo-controlled period and change from baseline in pre-bronchodilator FEV1 at Week 12 in the overall population (unrestricted by minimum baseline blood eosinophil count). Additional secondary endpoints included annualized severe exacerbation rates and FEV1, in subjects with different baseline levels of blood eosinophils as well as responder rates in the ACQ-5 and AQLQ(S) scores.

VENTURE

VENTURE was a 24-week oral corticosteroid-reduction study in 210 adult and pediatric subjects 15 years of age and older with asthma who required daily oral corticosteroids in addition to regular use of high dose inhaled corticosteroids plus an additional controller. After optimizing the OCS dose during the screening period, subjects received 300 mg DULPIXENT (N=103) or placebo (N=107) once Q2W for 24 weeks following an initial dose of 600 mg or placebo. Subjects continued to receive their existing asthma medicine during the study; however, their OCS dose was reduced every 4 weeks during the OCS reduction phase (Week 4-20), as long as asthma control was maintained. The primary endpoint was the percent reduction of oral corticosteroid dose at Weeks 20 to 24 compared to the baseline dose, while maintaining asthma control in the overall population (unrestricted by minimum baseline blood eosinophil count). Additional secondary endpoints included the annualized rate of severe exacerbation events during treatment period and responder rate in the ACQ-5 and AQLQ(S) scores.

The demographics and baseline characteristics of these 3 trials are included in Table 17 below.

**Table 17: Demographics and Baseline Characteristics of Asthma Trials**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>DRI12544 (N=776)</th>
<th>QUEST (N=1902)</th>
<th>VENTURE (N=210)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years) (SD)</td>
<td>49 (13)</td>
<td>48 (15)</td>
<td>51 (13)</td>
</tr>
<tr>
<td>% Female</td>
<td>63</td>
<td>63</td>
<td>61</td>
</tr>
<tr>
<td>% White</td>
<td>78</td>
<td>83</td>
<td>94</td>
</tr>
<tr>
<td>Duration of Asthma (years, mean ± SD)</td>
<td>22 (15)</td>
<td>21 (15)</td>
<td>20 (14)</td>
</tr>
<tr>
<td>Never smoked (%)</td>
<td>77</td>
<td>81</td>
<td>81</td>
</tr>
<tr>
<td>Mean exacerbations in previous year (mean ± SD)</td>
<td>2.2 (2.1)</td>
<td>2.1 (2.2)</td>
<td>2.1 (2.2)</td>
</tr>
<tr>
<td>High dose ICS use (%)</td>
<td>50</td>
<td>52</td>
<td>89</td>
</tr>
<tr>
<td>Pre-dose FEV1 (L) at baseline (mean ± SD)</td>
<td>1.84 (0.54)</td>
<td>1.78 (0.60)</td>
<td>1.58 (0.57)</td>
</tr>
<tr>
<td>Mean percent predicted FEV1 at baseline (mean ± SD)</td>
<td>61 (11)</td>
<td>58 (14)</td>
<td>52 (15)</td>
</tr>
<tr>
<td>% Reversibility (mean ± SD)</td>
<td>27 (15)</td>
<td>26 (22)</td>
<td>19 (23)</td>
</tr>
<tr>
<td>Atopic Medical History % Overall (AD %, NP %, AR %)</td>
<td>73</td>
<td>78</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>(8, 11, 62)</td>
<td>(10, 13, 69)</td>
<td>(8, 21, 56)</td>
</tr>
<tr>
<td>Mean FeNO ppb (mean ± SD)</td>
<td>39 (35)</td>
<td>35 (33)</td>
<td>38 (31)</td>
</tr>
<tr>
<td>Mean total IgE IU/mL (mean ± SD)</td>
<td>435 (754)</td>
<td>432 (747)</td>
<td>431 (776)</td>
</tr>
<tr>
<td>Mean baseline blood eosinophil count (mean ± SD) cells/mcL</td>
<td>350 (430)</td>
<td>360 (370)</td>
<td>350 (310)</td>
</tr>
</tbody>
</table>

ICS = inhaled corticosteroid; FEV1 = Forced expiratory volume in 1 second; AD = atopic dermatitis; NP = nasal polyposis; AR = allergic rhinitis; FeNO = fraction of exhaled nitric oxide

**Exacerbations**

DRI12544 and QUEST evaluated the frequency of severe asthma exacerbations defined as deterioration of asthma requiring the use of systemic corticosteroids for at least 3 days or hospitalization or emergency room visit due to asthma that required systemic corticosteroids. In the primary analysis population (subjects with baseline blood eosinophil count ≥300 cells/mcL in DRI12544 and the overall population in QUEST), subjects receiving either DULPIXENT 200 mg or 300 mg Q2W had significant reductions in the rate of asthma exacerbations compared to placebo. In the overall population in QUEST, the rate of severe exacerbations was 0.46 and 0.52 for DULPIXENT 200 mg Q2W and 300 mg Q2W, respectively, compared to matched placebo rates of 0.87 and 0.97. The rate ratio of severe exacerbations leading to hospitalizations and/or emergency room visits compared to placebo was 0.53 (95% CI: 0.28, 1.03) and 0.74 (95% CI: 0.32, 1.70) with DULPIXENT 200 mg Q2W and 300 mg Q2W, respectively.

In QUEST, the estimated rate ratio of exacerbations leading to hospitalizations and/or emergency room visits versus placebo was 0.53 (95% CI: 0.28, 1.03) and 0.74 (95% CI: 0.32, 1.70) with DULPIXENT 200 mg Q2W and 300 mg Q2W, respectively.

**Table 18: Rate of Severe Exacerbations in DRI12544 and QUEST**

<table>
<thead>
<tr>
<th>Trial</th>
<th>Treatment</th>
<th>Baseline Blood EOS ≥300 cells/mcL (primary analysis population, DRI12544)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Rate (95% CI)</td>
</tr>
<tr>
<td>DRI12544</td>
<td>65</td>
<td>0.20 (0.13, 0.68)</td>
</tr>
<tr>
<td></td>
<td>64</td>
<td>0.20 (0.08, 0.52)</td>
</tr>
<tr>
<td>Placebo</td>
<td>68</td>
<td>1.04 (0.57, 1.90)</td>
</tr>
<tr>
<td>QUEST</td>
<td>264</td>
<td>0.37 (0.29, 0.48)</td>
</tr>
<tr>
<td></td>
<td>148</td>
<td>1.08 (0.65, 1.38)</td>
</tr>
<tr>
<td>Placebo</td>
<td>277</td>
<td>0.40 (0.32, 0.51)</td>
</tr>
<tr>
<td>Placebo</td>
<td>142</td>
<td>1.24 (0.97, 1.57)</td>
</tr>
</tbody>
</table>

The time to first exacerbation was longer for the subjects receiving DULPIXENT compared to placebo in QUEST (Figure 8).

**Figure 4: Relative Risk in Annualized Event Rate of Severe Exacerbations across Baseline Blood Eosinophil Count (cells/mcL) in Subjects with Moderate-to-Severe Asthma (QUEST)**

**Figure 5: Relative Risk in Annualized Event Rate of Severe Exacerbations across Baseline FeNO Group (ppb) in Subjects with Moderate-to-Severe Asthma (QUEST)**

The response to baseline blood eosinophils and baseline FeNO for QUEST are shown for the overall population in Figure 4 and Figure 5, respectively. Elevation of FeNO can be a marker of the eosinophilic asthma phenotype when supported by clinical data. Pre-specified subgroup analyses of DRI12544 and QUEST demonstrated that there were greater reductions in severe exacerbations in subjects with higher baseline blood eosinophil levels (≥150 cells/mcL) or FeNO (≥25 ppb). In QUEST, reductions in exacerbations were significant in the subgroup of subjects with baseline blood eosinophil levels ≥150 cells/mcL. In subjects with baseline blood eosinophil count <150 cells/mcL or FeNO <25 ppb, similar severe exacerbation rates were observed between DULPIXENT and placebo.
Subjects with Moderate-to-Severe Asthma (QUEST)

Mean changes in FEV<sub>1</sub> with DUPIXENT and placebo.

In subjects with baseline blood eosinophil counts ≥300 cells/mL, the FEV<sub>1</sub> improvement versus placebo was 0.14 L (95% CI: 0.08, 0.19) and 0.13 L (95% CI: 0.08, 0.18) for DUPIXENT 200 mg Q2W and 300 mg Q2W, respectively. Results in subjects with baseline blood eosinophil counts ≥300 cells/mL in DRI12544 and QUEST are shown in Table 19.

Improvements in FEV<sub>1</sub> by baseline blood eosinophils and baseline FeNO for QUEST are shown in Figure 7 and 8, respectively. Subgroup analysis of DRI12544 and QUEST demonstrated greater improvement in subjects with higher baseline blood eosinophils (≥150 cells/mL) or FeNO (≥25 ppb). In subjects with baseline blood eosinophil count <150 cells/mL and FeNO <25 ppb, similar differences in FEV<sub>1</sub>, were observed between DUPIXENT and placebo.

Mean changes in FEV<sub>1</sub> over time in QUEST are shown in Figure 9.

### Table 19: Mean Change from Baseline and Difference vs Placebo in Pre-Bronchodilator FEV<sub>1</sub>, at Week 12 in Subjects with Moderate-to-Severe Asthma (DRI12544 and QUEST)

<table>
<thead>
<tr>
<th>Trial</th>
<th>Treatment</th>
<th>Baseline Blood EOS ≥300 cells/mL (primary analysis population, DRI12544)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>LS Mean Change from baseline (%)</td>
</tr>
<tr>
<td>DRI12544</td>
<td>DUPIXENT 200 mg Q2W</td>
<td>65</td>
<td>0.43 (25.9)</td>
</tr>
<tr>
<td></td>
<td>DUPIXENT 300 mg Q2W</td>
<td>64</td>
<td>0.39 (25.8)</td>
</tr>
<tr>
<td></td>
<td>Placebo</td>
<td>68</td>
<td>0.18 (10.2)</td>
</tr>
<tr>
<td>QUEST</td>
<td>DUPIXENT 200 mg Q2W</td>
<td>264</td>
<td>0.43 (29.0)</td>
</tr>
<tr>
<td></td>
<td>Placebo</td>
<td>148</td>
<td>0.21 (15.6)</td>
</tr>
<tr>
<td></td>
<td>DUPIXENT 300 mg Q2W</td>
<td>277</td>
<td>0.47 (32.5)</td>
</tr>
<tr>
<td></td>
<td>Placebo</td>
<td>142</td>
<td>0.22 (14.4)</td>
</tr>
</tbody>
</table>

*At the time of the database lock, not all subjects had completed Week 52.

### Lung Function

Significant increases in pre-bronchodilator FEV<sub>1</sub>, were observed at Week 12 for DRI12544 and QUEST in the primary analysis populations (subjects with baseline blood eosinophil count of ≥300 cells/mL in DRI12544 and the overall population in QUEST). In the overall population in QUEST, the FEV<sub>1</sub>, LS mean change from baseline was 0.32 L (21%) and 0.34 L (23%) for DUPIXENT 200 mg Q2W and 300 mg Q2W, respectively, compared to matched placebo means of 0.18 L (12%) and 0.21 L (14%). The mean treatment difference versus placebo was 0.14 L (95% CI: 0.08, 0.19) and 0.13 L (95% CI: 0.08, 0.18) for DUPIXENT 200 mg Q2W and 300 mg Q2W, respectively. Results in subjects with baseline blood eosinophil counts ≥300 cells/mL in DRI12544 and QUEST are shown in Table 19.

Improvements in pre-bronchodilator FEV<sub>1</sub>, demonstrated greater improvement in subjects with higher baseline blood eosinophils (≥150 cells/mL) or FeNO (≥25 ppb). In subjects with baseline blood eosinophil count <150 cells/mL and FeNO <25 ppb, similar differences in FEV<sub>1</sub>, were observed between DUPIXENT and placebo.

Mean changes in FEV<sub>1</sub>, over time in QUEST are shown in Figure 9.

### Additional Secondary Endpoints

ACQ-5 and AQLQ(S) were assessed in QUEST at 52 weeks. The responder rate was defined as an improvement in score of 0.5 or more (scale range 0-6 for ACQ-5 and 1-7 for AQLQ(S)).

- The ACQ-5 responder rate for DUPIXENT 200 mg and 300 mg Q2W in the overall population was 69% vs 62% placebo (odds ratio 1.37, 95% CI: 1.01, 1.86) and 69% vs 63% placebo (odds ratio 1.26, 95% CI: 0.94, 1.73), respectively, and the AQLQ(S) responder rates were 62% vs 54% placebo (odds ratio 1.61; 95% CI: 1.17, 2.21) and 62% vs 57% placebo (odds ratio 1.33; 95% CI: 0.98, 1.81), respectively.
- The ACQ-5 responder rate for DUPIXENT 200 mg and 300 mg Q2W in subjects with baseline blood eosinophils ≥300 cells/mL was 75% vs 67% placebo (odds ratio: 1.46; 95% CI: 0.90, 2.35) and 71% vs 64% placebo (odds ratio: 1.39; 95% CI: 0.88, 2.19), respectively, and the AQLQ(S) responder rates were 71% vs 55% placebo (odds ratio: 2.02; 95% CI: 1.24, 3.32) and 65% vs 55% placebo (odds ratio: 1.79; 95% CI: 1.13, 2.85), respectively.

### Oral Corticosteroid Reduction (VENTURE)

VENTURE evaluated the effect of DUPIXENT on reducing the use of maintenance oral corticosteroids. The baseline mean oral corticosteroid dose was 12 mg in the placebo group and 11 mg in the group receiving DUPIXENT. The primary endpoint was the percent reduction from baseline of the final oral corticosteroid dose at Week 24 while maintaining asthma control.

Compared with placebo, subjects receiving DUPIXENT achieved greater reductions in daily maintenance oral corticosteroid dose, while maintaining asthma control. The mean percent reduction in daily OCS dose from baseline was 70% (median 100%) in subjects receiving DUPIXENT (95% CI: 66%, 74%) compared to 50% (median 50%) in subjects receiving placebo (95% CI: 33%, 51%). Reductions of 50% or higher in the OCS dose were observed in 82 (80%) subjects receiving DUPIXENT compared to 53 (51%) in those receiving placebo. The proportion of subjects with a mean final dose less than 5 mg at Week 24 was 72% for DUPIXENT and 37% for placebo (odds ratio 4.85 95% CI: 2.39, 8.39). A total of 54 (52%) subjects receiving DUPIXENT versus 31 (29%) subjects in the placebo group had a 100% reduction in their OCS dose.

In this 24-week trial, asthma exacerbations (defined as a temporary increase in oral corticosteroid dose for at least 3 days) were lower in subjects receiving DUPIXENT compared with those receiving placebo (annualized rate 0.65 and 1.60 for the DUPIXENT and placebo group, respectively; rate ratio 0.41 [95% CI 0.26, 0.63] and improvement in pre-bronchodilator FEV<sub>1</sub>, from baseline to Week 24 was greater in subjects receiving DUPIXENT compared with those receiving placebo (LS mean difference for DUPIXENT versus placebo of 0.22 L [95% CI: 0.09 to 0.34 L]). Effects on lung function and on oral steroid and exacerbation reduction were similar irrespective of baseline blood eosinophil levels. The ACQ-5 and AQLQ(S) were also assessed in VENTURE and showed improvements similar to those in QUEST.

### Pediatric Subjects

Subjects aged 6 to 11 years of age with moderate-to-severe asthma on a medium or high-dose ICS and a second controller medication or high-dose ICS alone. Subjects were required to have a history of 1 or more asthma exacerbation(s) that required...
treatment with systemic corticosteroids or emergency department visit or hospitalization for the treatment of asthma in the year prior to trial entry. Subjects were randomized to DUXPENT (N=273) or matching placebo (N=135) every other week based on body weight <30 kg (100 mg Q2W) or ≥30 kg (200 mg Q2W). The effectiveness of DUXPENT 300 mg Q4W was extrapolated from efficacy of 100 mg Q2W in VOYAGE with support from population pharmacokinetic analyses showing higher drug exposure levels with 300 mg Q4W (see Pediatric Use (8.4) and Pharmacokinetics (12.3)).

The primary endpoint was the annualized rate of severe asthma exacerbation events during the 52-week placebo-controlled period. Severe asthma exacerbations were defined as deterioration of asthma requiring the use of systemic corticosteroids for at least 3 days or hospitalization or emergency room visit due to asthma that required systemic corticosteroids. The key secondary endpoint was the change from baseline in percent predicted pre-bronchodilator FEV₁ observed between DUXPENT and placebo.

Improvements were also observed for ACOG-7-IA and PAQLQ(S)-IA at Week 24 and were sustained at Week 52. Greater responder rates were observed for ACOG-7-IA and PAQLQ(S)-IA compared to placebo at Week 24. The responder rate was defined as an improvement in score of 0.5 or more (scale range 0-6 for ACOG-7-IA and 1-7 for PAQLQ(S)-IA) in the subgroup of subjects with baseline blood eosinophil count ≥300 cells/mcL, DUXPENT led to a higher proportion of subjects with a response in ACOG-7-IA (80.6% versus 64.3% for placebo) with an OR of 2.79 (95% CI: 1.43, 5.44), and in PAQLQ(S)-IA (72.8% versus 63.0% for placebo) with an OR of 1.84 (95% CI: 0.92, 3.65) at Week 24.

14.3 Chronic Rhinosinusitis with Nasal Polyposis
The chronic rhinosinusitis with nasal polyposis (CRSwithNP) development program included two randomized, double-blind, parallel-group, multicenter, placebo-controlled studies (SINUS-24 (NCT02912468) and SINUS-52 (NCT02898454)) in 724 adult subjects 18 years of age and older on background intranasal corticosteroids (INCS). These studies included subjects with CRSwithNP despite prior sino-nasal surgery or treatment with, or who were ineligible to receive or were intolerant to, systemic corticosteroids in the past 2 years. Subjects with chronic rhinosinusitis without nasal polyposis were not included in these trials. Rescue with systemic corticosteroids or surgery was allowed during the studies at the investigator's discretion. In SINUS-24, a total of 276 subjects were randomized to receive either 300 mg DUXPENT (N=143) or placebo (N=133) every other week for 24 weeks. In SINUS-52, 448 subjects were randomized to receive either 300 mg DUXPENT (N=150) every other week for 52 weeks, 300 mg DUXPENT (N=145) every other week until Week 24 followed by 300 mg DUXPENT every 4 weeks until Week 52, or placebo (N=153). All subjects had evidence of sinus opacification on the Lund Mackay (LMK) sinus CT scan and 73% to 90% of subjects had opacification of all sinuses. Subjects were stratified based on their histories of prior surgery and co-morbid asthma/nonsteroidal anti-inflammatory drug exacerbated respiratory disease (NSAID-ERD). A total of 63% of subjects reported previous sinus surgery, with a mean number of 2.0 prior surgeries, 74% used systemic corticosteroids in the previous 2 years with a mean number of 1.6 systemic corticosteroid courses in the previous 2 years; 59% had co-morbid asthma, and 28% had NSAID-ERD.

The co-primary efficacy endpoints were change from baseline to Week 24 in bilateral endoscopic nasal polyps score (NPS; 0-8 scale) as graded by central blinded readers, and change from baseline to Week 24 in nasal congestion/obstruction score averaged over 28 days (NC; 0-3 scale), as determined by subjects using a daily diary. For NPS, polyps on each side of the nose were graded on a categorical scale (0=no polyps; 1=small polyps in the middle meatus not reaching below the inferior border of the middle turbinate; 2=polyps reaching below the lower border of the middle turbinate; 3=large polyps reaching the lower border of the inferior turbinate or polyps medial to the middle turbinate; 4=large polyps causing complete obstruction of the inferior nasal cavity). The total score was the sum of the right and left scores. Nasal congestion was rated daily by the subjects on a 0 to 3 categorical severity scale (0=no symptoms; 1=mild symptoms; 2=moderate symptoms; 3=severe symptoms).

In both studies, key secondary end-points at Week 24 included change from baseline: LMK sinuses CT scan score, daily loss of smell, and 22-item sino-nasal outcome test (SNOT-22). The LMK sinus CT scan score evaluated the opacification of each sinus using a 0 to 2 scale (0=normal; 1=partial opacification; 2=total opacification) deriving a maximum score of 12 per side and a total maximum score of 24 (higher scores indicate more opacification). Loss of smell was scored reflectively by the subject every morning on a 0-3 scale (0=no symptoms, 1=mild symptoms, 2=moderate symptoms, 3=severe symptoms). SNOT-22 includes 22 items assessing symptoms and symptom impact associated with CRSwithNP with each item scored from 0 (no problem) to 5 (problem as bad as it can be) with a global score ranging from 0 to 110. SNOT-22 had a 2 week recall period. In the pooled efficacy results, the reduction in the proportion of subjects treated with systemic corticosteroids and/or sino-nasal surgery (up to Week 52) were evaluated.

The demographics and baseline characteristics of these 2 trials are provided in Table 22 below.

---

### Table 20: Demographics and Baseline Characteristics for VOYAGE

<table>
<thead>
<tr>
<th>Parameter</th>
<th>VOYAGE (N=408)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years) (SD)</td>
<td>9 (2)</td>
</tr>
<tr>
<td>% Female</td>
<td>36</td>
</tr>
<tr>
<td>% White</td>
<td>88</td>
</tr>
<tr>
<td>Mean body weight (kg)</td>
<td>36</td>
</tr>
<tr>
<td>Mean exacerbations in previous year (± SD)</td>
<td>2.4 (2.2)</td>
</tr>
<tr>
<td>High dose ICS use (%)</td>
<td>44</td>
</tr>
<tr>
<td>Pre-dose FEV₁ (L) at baseline (± SD)</td>
<td>1.48 (0.41)</td>
</tr>
<tr>
<td>Mean percent predicted FEV₁ (%) (±SD)</td>
<td>78 (15)</td>
</tr>
<tr>
<td>Mean % Reversibility (± SD)</td>
<td>20 (21)</td>
</tr>
<tr>
<td>Atopic Medical History % Overall (AD %, AR %)</td>
<td>92 (36, 82)</td>
</tr>
<tr>
<td>Mean FeNO ppb (± SD)</td>
<td>28 (24)</td>
</tr>
<tr>
<td>% subjects with FeNO ppb ≥20</td>
<td>50</td>
</tr>
<tr>
<td>Median total IgE IU/mL (±SD)</td>
<td>792 (1093)</td>
</tr>
<tr>
<td>Mean baseline Eosinophil count (± SD) cells/mcL</td>
<td>502 (395)</td>
</tr>
</tbody>
</table>

ICS = inhaled corticosteroid; FEV₁ = Forced expiratory volume in 1 second; AD = atopic dermatitis; AR = allergic rhinitis; FeNO = fraction of exhaled nitric oxide

---

### Table 21: Efficacy Results of DUXPENT in VOYAGE

<table>
<thead>
<tr>
<th>Treatment</th>
<th>EOS ≥300 cells/mL*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annualized Severe Exacerbations Rate over 52 Weeks</strong></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Rate (95% CI)</td>
</tr>
<tr>
<td>DUXPENT 100 mg Q2W (&lt;30 kg)/200 mg Q2W (≥30 kg)</td>
<td>175</td>
</tr>
<tr>
<td>Placebo</td>
<td>84</td>
</tr>
<tr>
<td><strong>Mean Change from Baseline in Percent Predicted FEV₁, at Week 12</strong></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>LS mean ±Δ from Baseline</td>
</tr>
<tr>
<td>DUXPENT 100 mg Q2W (&lt;30 kg)/200 mg Q2W (≥30 kg)</td>
<td>168</td>
</tr>
<tr>
<td>Placebo</td>
<td>80</td>
</tr>
</tbody>
</table>
Table 22: Demographics and Baseline Characteristics of CRSwNP Trials (continued)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>SINUS-24 (N=276)</th>
<th>SINUS-52 (N=448)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years) (SD)</td>
<td>50 (13)</td>
<td>52 (12)</td>
</tr>
<tr>
<td>% Male</td>
<td>57</td>
<td>62</td>
</tr>
<tr>
<td>Mean CrSwNP duration (years) (SD)</td>
<td>11 (9)</td>
<td>11 (10)</td>
</tr>
<tr>
<td>Subjects with ≥1 prior surgery (%)</td>
<td>72</td>
<td>58</td>
</tr>
<tr>
<td>Subjects with systemic corticosteroid use in the previous 2 years (%)</td>
<td>65</td>
<td>80</td>
</tr>
<tr>
<td>Mean Bilateral endoscopic NPS a (SD), range 0-8</td>
<td>5.8 (1.3)</td>
<td>6.1 (1.2)</td>
</tr>
<tr>
<td>Mean Nasal congestion (NC) score a (SD), range 0-3</td>
<td>2.4 (0.6)</td>
<td>2.4 (0.6)</td>
</tr>
<tr>
<td>Mean LMK sinus CT total score a (SD), range 0-24</td>
<td>19 (4.4)</td>
<td>18 (3.8)</td>
</tr>
<tr>
<td>Mean loss of smell score a (AM), (SD) range 0-3</td>
<td>2.7 (0.5)</td>
<td>2.8 (0.5)</td>
</tr>
<tr>
<td>Mean SNOT-22 total score a (SD), range 0-110</td>
<td>49.4 (20.2)</td>
<td>51.9 (20.9)</td>
</tr>
</tbody>
</table>

Table 23: Results of the Primary Endpoints in CRSwNP Trials

<table>
<thead>
<tr>
<th>Primary Endpoints at Week 24</th>
<th>Placebo (n=133)</th>
<th>DUPLEXENT 300 mg Q2W (n=143)</th>
<th>LS mean difference vs. Placebo (95% CI)</th>
<th>Placebo (n=153)</th>
<th>DUPLEXENT 300 mg Q2W (n=295)</th>
<th>LS mean difference vs. Placebo (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scores</td>
<td>Baseline mean</td>
<td>LS mean change</td>
<td>Baseline mean</td>
<td>LS mean change</td>
<td>Baseline mean</td>
<td>LS mean change</td>
</tr>
<tr>
<td>NPS</td>
<td>5.86</td>
<td>-0.17</td>
<td>5.64</td>
<td>-1.89</td>
<td>-2.06</td>
<td>(-2.43, -1.69)</td>
</tr>
<tr>
<td>NC</td>
<td>2.45</td>
<td>-0.45</td>
<td>2.26</td>
<td>-1.34</td>
<td>-0.89</td>
<td>(-1.07, -0.71)</td>
</tr>
</tbody>
</table>

A reduction in score indicates improvement.
NPS = nasal polyps score; NC = nasal congestion/obstruction

Statistically significant efficacy was observed in SINUS-52 with regard to improvement in bilateral endoscopic NPS score at week 24 and week 52 (see Figure 11).

Figure 11: LS Mean Change from Baseline in Bilateral Nasal Polyps Score (NPS) up to Week 52 in Subjects 18 Years of Age and Older with CRSwNP (SINUS-24 - ITT Population)

Similar results were seen in SINUS-24 at Week 24. In the post-treatment period when subjects were off DUPLEXENT, the treatment effect diminished over time (see Figure 12).

At Week 52, the LS mean difference for nasal congestion in the DUPLEXENT group versus placebo was -0.98 (95% CI: -1.17, -0.79). In both studies, significant improvements in nasal congestion were observed as early as the first assessment at Week 4. The LS mean difference for nasal congestion at Week 4 in the DUPLEXENT group versus placebo was -0.41 (95% CI: -0.52, -0.30) in SINUS-24 and -0.37 (95% CI: -0.46, -0.27) in SINUS-52.

A significant decrease in the LMK sinus CT scan score was observed. The LS mean difference for LMK sinus CT scan score at Week 24 in the DUPLEXENT group versus placebo was -7.44 (95% CI: -8.35, -6.53) in SINUS-24 and -5.13 (95% CI: -5.80, -4.46) in SINUS-52. At Week 52, in SINUS-52 the LS mean difference for LMK sinus CT scan score in the DUPLEXENT group versus placebo was -6.94 (95% CI: -7.87, -6.01).

Dupilumab significantly improved the loss of smell compared to placebo. The LS mean difference for SNOT-22 at Week 24 in the DUPLEXENT group versus placebo was -1.12 (95% CI: -1.31, -0.93) in SINUS-24 and -0.98 (95% CI: -1.15, -0.81) in SINUS-52. At Week 52, the LS mean difference for loss of smell in the DUPLEXENT group versus placebo was -1.10 (95% CI: -1.31, -0.89). In both studies, significant improvements in daily loss of smell severity were observed as early as the first assessment at Week 4.

Dupilumab significantly decreased sino-nasal symptoms as measured by SNOT-22 compared to placebo. The LS mean difference for SNOT-22 at Week 24 in the DUPLEXENT group versus placebo was -21.12 (95% CI: -25.17, -17.06) in SINUS-24 and -17.36 (95% CI: -21.31, -13.41) in SINUS-52.
The effects of DUPIXENT on the primary endpoints of NPS and nasal congestion and the key secondary endpoint of LMK sinus CT scan score were consistent in subjects with prior surgery and without prior surgery.

In subjects with co-morbid asthma, improvements in pre-bronchodilator FEV1, were similar to subjects in the asthma program.

### 14.4 Eosinophilic Esophagitis

#### Adult and Pediatric Subjects 12 Years of Age and Older with EoE

A single randomized, double-blind, parallel-group, multicenter, placebo-controlled trial, including two 24-week treatment periods (Study EoE-1 Parts A and B) was conducted in adult and pediatric subjects 12 years of age and older, weighing at least 40 kg, with EoE (NCT03633617). In both parts, subjects were randomized to receive 300 mg DUPIXENT every week or placebo. Eligible subjects had ≥15 intraepithelial eosinophils per high-power field (eos/hpf) following a treatment course of a proton pump inhibitor (PPI) either prior to or during the screening period and symptoms of dysphagia as measured by the Dysphagia Symptom Questionnaire (DSQ). At baseline, 43% of subjects in Part A and 37% of subjects in Part B had a history of prior esophageal dilations.

Demographics and baseline characteristics were similar in Parts A and B. A total of 81 subjects (61 adults and 20 pediatric subjects) were enrolled in Part A and 159 subjects (107 adults and 52 pediatric subjects) were enrolled in Part B. The mean age in years was 32 years (range 13 to 62 years) in Part A and 28 years (range 12 to 66 years) in Part B. The majority of subjects were male (60% in Part A and 68% in Part B) and White (96% in Part A and 90% in Part B). The mean baseline DSQ score (SD) was 33.6 (12.4) in Part A and 37.2 (10.7) in Part B.

The coprimary efficacy endpoints in Parts A and B were the (1) proportion of subjects achieving histological remission defined as peak esophageal intraepithelial eosinophil count of ≤5 eos/hpf at Week 24; and (2) the absolute change in the subject-reported DSQ score from baseline to Week 24.

Efficacy results for Parts A and B are presented in Table 24.

#### Table 24: Efficacy Results of DUPIXENT at Week 24 in Adult and Pediatric Subjects 12 Years of Age and Older with EoE (Study EoE-1 Parts A and B)

<table>
<thead>
<tr>
<th>Study EoE-1 Part A</th>
<th>Study EoE-1 Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>DUPIXENT 300 mg QW³</td>
<td>Placebo³</td>
</tr>
<tr>
<td>N = 42</td>
<td>N = 39</td>
</tr>
<tr>
<td>25 (59.5)</td>
<td>2 (5.1)</td>
</tr>
<tr>
<td>Absolute change from baseline in DSQ score (0-84*), LS mean (SE)</td>
<td>-21.9 (2.5)</td>
</tr>
<tr>
<td>Placebo 300 mg QW³</td>
<td>Placebo³</td>
</tr>
<tr>
<td>N = 80</td>
<td>N = 79</td>
</tr>
<tr>
<td>47 (58.8)</td>
<td>5 (6.3)</td>
</tr>
<tr>
<td>Absolute change from baseline in DSQ score (0-84*), LS mean (SE)</td>
<td>-23.8 (1.9)</td>
</tr>
</tbody>
</table>

**Notes:**

- Total biweekly DSQ scores range from 0 to 84; higher scores indicate greater frequency and severity of dysphagia.
- For histological remission, the difference in percentages is estimated using the Cochran Mantel Haenszel method, adjusting for randomization stratification factors. For absolute change in DSQ score, the LS mean changes, standard errors, and differences are estimated using an ANCOVA model with treatment group, randomization stratification factors, and baseline measurement as covariates.

In Parts A and B, a greater proportion of subjects randomized to DUPIXENT achieved histological remission (peak esophageal intraepithelial eosinophil count ≤5 eos/hpf) compared to placebo. Treatment with DUPIXENT also resulted in a significant improvement in LS mean change in DSQ score compared to placebo at Week 24. The results of the anchor-based analyses that incorporated the subjects’ perspectives indicated that the observed improvement in dysphagia from Parts A and B is representative of a clinically meaningful within-subject improvement.

#### Pediatric Subjects 1 to 11 Years of Age, Weighing at Least 15 kg, with EoE

The efficacy and safety of DUPIXENT was evaluated in pediatric subjects 1 to 11 years of age, weighing at least 15 kg, with EoE in a randomized, blinded, parallel-group, multicenter trial (Study EoE-2 Part A and B; NCT03943551). Eligible subjects had ≥15 intraepithelial eosinophils per high-power field (eos/hpf) despite a treatment course of a proton pump inhibitor (PPI) either prior to or during the screening period and a history of EoE signs and symptoms. Part A evaluated weight-based dosing regimens of DUPIXENT, 200 mg Q2W (≥15 to <30 kg) and 300 mg Q2W (≥30 to <60 kg), or placebo in 61 subjects during the 16-week treatment period.

The recommended dosage of 300 mg QW for pediatric subjects 1 to 11 years of age weighing ≥20 kg is based on modeled pharmacokinetic data to provide comparable exposures to the 300 mg QW dosage in adult and pediatric subjects 12 years of age and older weighing >40 kg with EoE [see Dosage and Administration (2.6) and Pharmacokinetics (12.3)].

Forty-seven subjects who completed Part A were evaluated in the 36-week extended active treatment period (Study EoE-2 Part B). All subjects in Part B were treated with the weight-based dosing regimens of DUPIXENT described for Part A.

Of the total subjects evaluated in Part A, the mean age was 8 years, the median weight was 28 kg, and 75% were male. Seven percent identified as Hispanic or Latino; 85% identified as White, 12% as Black, 2% as Asian, and 2% identified as another racial subgroup.

The primary efficacy endpoint in Part A was the proportion of subjects achieving histological remission defined as peak esophageal intraepithelial eosinophil count of ≤5 eos/hpf at Week 16. Efficacy results for Part A are presented in Table 25.

#### Table 25: Efficacy Results of DUPIXENT at Week 16 in Subjects 1 to 11 Years of Age with EoE, Weighing at Least 15 kg (Study EoE-2 Part A)

<table>
<thead>
<tr>
<th>Study EoE-2 Part A</th>
<th>Study EoE-2 Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>DUPIXENT³</td>
<td>Placebo³</td>
</tr>
<tr>
<td>N = 32</td>
<td>N = 29</td>
</tr>
<tr>
<td>21 (65.6)</td>
<td>1 (3.4)</td>
</tr>
</tbody>
</table>

**Notes:**

- DUPIXENT was evaluated at tiered dosing regimens based on body weight: ≥15 to <30 kg (200 mg Q2W) and ≥30 to <60 kg (300 mg Q2W). The 300 mg Q2W dosing regimen is lower than the recommended dosage of DUPIXENT in subjects ≥40 kg [see Dosage and Administration (2.6)].
- The difference in percentages is estimated using the Mantel-Haenszel method, adjusting for baseline weight group (≥15 to <30 kg and ≥30 to <60 kg).

In Part B, histological remission was achieved at Week 52 in 17/32 subjects treated with DUPIXENT in Parts A and B and 8/15 subjects treated with placebo in Part A and DUPIXENT in Part B.

In Study EoE-2 Part A, an observer-reported outcome, the Pediatric EoE Sign/Symptom Questionnaire-Caregiver (PESQ-C), was used to measure signs of EoE. A greater decrease in the proportion of days with 1 or more signs of EoE (based on the PESQ-C) was observed for subjects treated with DUPIXENT compared to placebo after 16 weeks of treatment.

### 14.5 Prurigo Nodularis

The prurigo nodularis (PN) development program included two 24-week randomized, double-blind, placebo-controlled, multicenter, parallel-group trials (PRIME (NCT04183335) and PRIME II (NCT04825750)).
and PRIME 2 (NCT04202679) in 311 adult subjects 18 years of age and older with pruritus (WI-NRS ≥ 7 on a scale of 0 to 10) and greater than or equal to 20 nodular lesions, PRIME and PRIME 2 assessed the effect of DUXIPENT on pruritus improvement as well as its effect on PN lesions.

In these two trials, subjects received either subcutaneous DUXIPENT 600 mg (two 300 mg injections) on day 1, followed by 300 mg once every other week (Q2W) for 24 weeks, or matching placebo.

In these trials, the mean age was 49.5 years, the median weight was 71 kg, 65% of subjects were female, 57% were White, 6% were Black, and 34% were Asian. At baseline, the mean Worst Itch-Numeric Rating Scale (WI-NRS) was 8.5, 66% had 20 to 100 nodules (moderate), and 34% had greater than 100 nodules (severe). Eleven percent (11%) of subjects were taking stable doses of antidepressants at baseline and were instructed to continue taking these medications during the trial. Forty-three percent (43%) had a history of atopy (defined as having a medical history of AD, allergic rhinitis/rhinoconjunctivitis, asthma, or food allergy).

The WI-NRS is comprised of a single item, rated on a scale from 0 (“no itch”) to 10 (“worst imaginable itch”). Subjects were asked to rate the intensity of their worst pruritus (itch) over the past 24 hours using this scale. The Investigator’s Global Assessment for Prurigo Nodularis-Stage (IGA PN-S) is a scale that measures the approximate number of nodules using a 5-point scale from 0 (clear) to 4 (severe).

Efficacy was assessed with the proportion of subjects with improvement (reduction) in WI-NRS by ≥4 points, the proportion of subjects with IGA PN-S 0 or 1 (the equivalent of 0-5 nodules), and the proportion of subjects who achieved a response in both WI-NRS and IGA PN-S per the criteria described above.

The efficacy results for PRIME and PRIME2 are presented in Table 26 and Figures 14, 15 and 16.

Table 26: Efficacy Results of DUXIPENT in PRIME and PRIME2

<table>
<thead>
<tr>
<th></th>
<th>PRIME</th>
<th>PRIME2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Placebo (N=76)</td>
<td>DUXIPENT 300 mg Q2W (N=75)</td>
</tr>
<tr>
<td>Proportion of subjects with both an improvement (reduction) in WI-NRS by ≥4 points from baseline to Week 24 and an IGA PN-S 0 or 1 at Week 24</td>
<td>9.2%</td>
<td>38.7%</td>
</tr>
<tr>
<td>Proportion of subjects with improvement (reduction) in WI-NRS by ≥4 points from baseline at Week 24</td>
<td>18.4%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Proportion of subjects with IGA PN-S 0 or 1 at Week 24</td>
<td>18.4%</td>
<td>48.0%</td>
</tr>
<tr>
<td>Proportion of subjects with improvement (reduction) in WI-NRS by ≥4 points from baseline at Week 12</td>
<td>15.8%</td>
<td>44.0%</td>
</tr>
</tbody>
</table>

* Not adjusted for multiplicity in PRIME.

** Subjects who received rescue treatment earlier or had missing data were considered as non-responders.

Figure 14: Proportion of Adult Subjects with PN with Both WI-NRS ≥4-point Improvement and IGA PN-S 0 or 1 Over Time in PRIME and PRIME2

Figure 15: Proportion of Adult Subjects with PN with WI-NRS ≥4-point Improvement Over Time in PRIME and PRIME2

The efficacy data did not show differential treatment effect across demographic subgroups.

16 HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

DUXIPENT (dupilumab) Injection is a clear to slightly opalescent, colorless to pale yellow solution, supplied in single-dose pre-filled syringes with needle shield or pre-filled pens.

The pre-filled syringe with needle shield is designed to deliver:
- 300 mg of DUXIPENT in 2 mL solution (NDC 0024-5914-00)
- 200 mg of DUXIPENT in 1.14 mL solution (NDC 0024-5918-00)

The pre-filled pen is designed to deliver:
- 300 mg of DUXIPENT in 2 mL solution (NDC 0024-5915-02)
- 200 mg of DUXIPENT in 1.14 mL solution (NDC 0024-5919-02)

DUXIPENT is available in cartons containing 2 pre-filled syringes with needle shield or 2 pre-filled pens.
Storage and Handling

DUPIXENT is sterile and preservative-free. Discard any unused portion. Store refrigerated at 2°C to 8°C (36°F to 46°F) in the original carton to protect from light. If necessary, DUPIXENT may be kept at room temperature up to 25°C (77°F) for a maximum of 14 days. Do not store above 25°C (77°F). After removal from the refrigerator, DUPIXENT must be used within 14 days or discarded. Do not expose DUPIXENT to heat or direct sunlight. Do NOT freeze. Do NOT shake.

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the 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 DUPIXENT during pregnancy. Encourage participation and advise patients about how they may enroll in the registry [see Use in Specific Populations (8.1)].

Administration Instructions

Provide proper training to patients and/or caregivers on proper subcutaneous injection technique, including aseptic technique, and the preparation and administration of DUPIXENT prior to use. Advise patients to follow sharps disposal recommendations [see Dosage and Administration (2.1) and Instructions for Use].

Hypersensitivity

Advise patients to discontinue DUPIXENT and to seek immediate medical attention if they experience any symptoms of systemic hypersensitivity reactions [see Warnings and Precautions (5.1)].

Conjunctivitis and Keratitis

Advise patients to consult their healthcare provider if new onset or worsening eye symptoms develop [see Warnings and Precautions (5.2)].

Eosinophilic Conditions

Advise patients to notify their healthcare provider if they present with clinical features of eosinophilic pneumonia or vasculitis consistent with eosinophilic granulomatosis with polyangiitis [see Warnings and Precautions (5.3)].

Not for Acute Asthma Symptoms or Deteriorating Disease

Inform patients that DUPIXENT does not treat acute asthma symptoms or acute exacerbations. Inform patients to seek medical advice if their asthma remains uncontrolled or worsens after initiation of treatment with DUPIXENT [see Warnings and Precautions (5.4)].

Reduction in Corticosteroid Dosage

Inform patients to not discontinue systemic or inhaled corticosteroids except under the direct supervision of a healthcare provider. Inform patients that reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy [see Warnings and Precautions (5.5)].

Patients with Co-morbid Asthma

Advise patients with co-morbid asthma not to adjust or stop their asthma treatment without talking to their healthcare providers [see Warnings and Precautions (5.6)].

Arthralgia

Advise patients to report new onset or worsening joint symptoms to their healthcare provider [see Warnings and Precautions (5.7)].

Parasitic (Helminth) Infections

Advise patients to notify their healthcare provider if they present with clinical features consistent with helminthic infection [see Warnings and Precautions (5.8)].

Vaccinations

Advise patients that vaccination with live vaccines is not recommended immediately prior to and while they are receiving DUPIXENT. Instruct patients to inform their healthcare provider that they are taking DUPIXENT prior to a potential vaccination [see Warnings and Precautions (5.9)].

Manufactured by:
Regeneron Pharmaceuticals, Inc.
Tarrytown, NY 10591
U.S. License No. 1760
Marketed by:
sanofi-aventis U.S. LLC (Bridgewater, NJ 08807) and
Regeneron Pharmaceuticals, Inc. (Tarrytown, NY 10591)
For patent information: www.dupixent-patents.com
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What is DUPIXENT?
DUPIXENT® (DU-pix-ent)
• to treat adults and children 6 months of age and older with moderate-to-severe eczema (atopic dermatitis or AD) that is not well controlled with prescription therapies used on the skin (topical), or who cannot use topical therapies. DUPIXENT can be used with or without topical corticosteroids.
• with other asthma medicines for the maintenance treatment of moderate-to-severe asthma in adults and children 6 years of age and older whose asthma is not controlled with their current asthma medicines. DUPIXENT helps prevent severe asthma attacks (exacerbations) and can improve your breathing. DUPIXENT may also help reduce the amount of oral corticosteroids you need while preventing severe asthma attacks and improving your breathing.
• with other medicines for the maintenance treatment of chronic rhinosinusitis with nasal polyposis (CRSwNP) in adults whose disease is not controlled.
• to treat adults and children 1 year of age and older with eosinophilic esophagitis (EoE), who weigh at least 33 pounds (15 kg).
• to treat adults with prurigo nodularis (PN).
• DUPIXENT works by blocking two proteins that contribute to a type of inflammation that plays a major role in atopic dermatitis, asthma, chronic rhinosinusitis with nasal polyposis, eosinophilic esophagitis, and prurigo nodularis.
• It is not known if DUPIXENT is safe and effective in children with atopic dermatitis under 6 months of age.
• It is not known if DUPIXENT is safe and effective in children with asthma under 6 years of age.
• It is not known if DUPIXENT is safe and effective in children with chronic rhinosinusitis with nasal polyposis under 18 years of age.
• It is not known if DUPIXENT is safe and effective in children with eosinophilic esophagitis under 1 year of age, or who weigh less than 33 pounds (15 kg).
• It is not known if DUPIXENT is safe and effective in children with prurigo nodularis under 18 years of age.

Do not use DUPIXENT if you are allergic to dupilumab or to any of the ingredients in DUPIXENT. See the end of this Patient Information leaflet for a complete list of ingredients in DUPIXENT.

Before using DUPIXENT, tell your healthcare provider about all your medical conditions, including if you:
• have eye problems.
• have a parasitic (helminth) infection.
• are scheduled to receive any vaccinations. You should not receive a “live vaccine” right before and during treatment with DUPIXENT.
• are pregnant or plan to become pregnant. It is not known whether DUPIXENT will harm your unborn baby.
• are breastfeeding or plan to breastfeed. It is not known whether DUPIXENT passes into your breast milk.

Tell your healthcare provider about all of the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

Especially tell your healthcare provider if you:
• are taking oral, topical, or inhaled corticosteroid medicines
• have asthma and use an asthma medicine
• have atopic dermatitis, chronic rhinosinusitis with nasal polyposis, eosinophilic esophagitis, or prurigo nodularis
• have asthma and use an asthma medicine

Do not change or stop your corticosteroid medicine or other asthma medicine without talking to your healthcare provider. This may cause other symptoms that were controlled by the corticosteroid medicine or other asthma medicine to come back.

How should I use DUPIXENT?
• See the detailed “Instructions for Use” that comes with DUPIXENT for information on how to prepare and inject DUPIXENT and how to properly store and throw away (dispose of) used DUPIXENT pre-filled syringes and pre-filled pens.
• Use DUPIXENT exactly as prescribed by your healthcare provider.
• Your healthcare provider will tell you how much DUPIXENT to inject and how often to inject it.
• DUPIXENT comes as a single-dose pre-filled syringe with needle shield or as a pre-filled pen.
• The DUPIXENT pre-filled syringe is for use in adults and children 6 months of age and older.
• The DUPIXENT pre-filled pen is only for use in adults and children 2 years of age and older.
• DUPIXENT is given as an injection under the skin (subcutaneous injection).
• If your dose schedule is every week and you miss a dose of DUPIXENT: Give the DUPIXENT injection as soon as possible and start a new every week dose schedule from the time you remember to take your DUPIXENT injection.
• If your dose schedule is every other week and you miss a dose of DUPIXENT: Give the DUPIXENT injection within 7 days from the missed dose, then continue with your original schedule. If the missed dose is not given within 7 days, start a new every 4 week dose schedule from the time you remember to take your DUPIXENT injection.
• If you inject too much DUPIXENT, call your healthcare provider or Poison Help line at 1-800-222-1222 or go to the nearest hospital emergency room right away.
• Your healthcare provider may prescribe other medicines to use with DUPIXENT. Use the other prescribed medicines exactly as your healthcare provider tells you.
What are the possible side effects of DUPIXENT?

DUPIXENT can cause serious side effects, including:

- Allergic reactions. DUPIXENT can cause allergic reactions that can sometimes be severe. Stop using DUPIXENT and tell your healthcare provider or get emergency help right away if you get any of the following signs or symptoms:
  - breathing problems or wheezing
  - fast pulse
  - fever
  - general ill feeling
  - swollen lymph nodes
  - swelling of the face, lips, mouth, tongue, or throat
  - hives
  - itching
  - cramps in your stomach-area
  - fainting, dizziness, feeling lightheaded
  - joint pain
  - skin rash

- Eye problems. Tell your healthcare provider if you have any new or worsening eye problems, including eye pain or changes in vision, such as blurred vision. Your healthcare provider may send you to an ophthalmologist for an eye exam if needed.

- Inflammation of your blood vessels. Rarely, this can happen in people with asthma who receive DUPIXENT. This may happen in people who also take a steroid medicine by mouth that is being stopped or the dose is being lowered. It is not known whether this is caused by DUPIXENT. Tell your healthcare provider right away if you have:
  - rash
  - worsening shortness of breath
  - chest pain
  - a feeling of pins and needles or numbness of your arms or legs

- Joint aches and pain. Joint aches and pain can happen in people who use DUPIXENT. Some people have had trouble walking or moving due to their joint symptoms, and in some cases needed to be hospitalized. Tell your healthcare provider about any new or worsening joint symptoms. Your healthcare provider may stop DUPIXENT if you develop joint symptoms.

The most common side effects of DUPIXENT include:

- injection site reactions
- upper respiratory tract infections
- eye and eyelid inflammation, including redness, swelling, and itching, sometimes with blurred vision
- dry eye
- herpes virus infections
- common cold symptoms (nasopharyngitis)
- cold sores in your mouth or on your lips
- high count of a certain white blood cell (eosinophilia)
- dizziness
- muscle pain
- diarrhea
- pain in the throat (oropharyngeal pain)
- gastritis
- joint pain (arthralgia)
- trouble sleeping (insomnia)
- toothache
- parasitic (helminth) infections

The following additional side effects have been reported with DUPIXENT:

- facial rash or redness

Tell your healthcare provider if you have any side effect that bothers you or that does not go away. These are not all of the possible side effects of DUPIXENT.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store DUPIXENT?

- Store DUPIXENT in the refrigerator at 36°F to 46°F (2°C to 8°C).
- Store DUPIXENT in the original carton to protect from light.
- DUPIXENT can be stored at room temperature up to 77°F (25°C) up to 14 days. Throw away (dispose of) any DUPIXENT that has been left at room temperature for longer than 14 days.
- Do not heat or put DUPIXENT into direct sunlight.
- Do not freeze. Do not shake.

Keep DUPIXENT and all medicines out of the reach of children.

General information about the safe and effective use of DUPIXENT.

Medicines are sometimes prescribed for purposes other than those listed in a Patient Information leaflet. Do not use DUPIXENT for a condition for which it was not prescribed. Do not give DUPIXENT to other people, even if they have the same symptoms that you have. It may harm them. You can ask your pharmacist or healthcare provider for information about DUPIXENT that is written for health professionals.

What are the ingredients in DUPIXENT?

Active ingredient: dupilumab

Inactive ingredients: L-arginine hydrochloride, L-histidine, polysorbate 80, sodium acetate, sucrose, and water for injection.

REGENERON sanofi

Manufactured by: Regeneron Pharmaceuticals, Inc., Tarrytown, NY 10591 U.S. License No. 1760
Marketed by: sanofi-aventis U.S. LLC (Bridgewater, NJ 08807) and Regeneron Pharmaceuticals, Inc. (Tarrytown, NY 10591)

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For more information about DUPIXENT, go to www.DUPIXENT.com or call 1-844-DUPIXENT (1-844-387-4936).

This Patient Information has been approved by the U.S. Food and Drug Administration. Revised: January 2024