Lenalidomide Accord

Hard Capsules

Prescribing Information

Lenalidomide Accord 2.5, 5, 7.5, 10, 15, 20, 25 mg hard capsules

Please refer to the Summary of Product Characteristics (SmPC) before prescribing.

Presentation: Each tablet contains 2.5, 5, 7.5, 10, 15, 20, or 25 mg of lenalidomide.

Indications: *Multiple myeloma (MM):* Monotherapy for the maintenance treatment of adult patients with newly diagnosed MM who have undergone autologous stem cell transplantation: Combination therapy with dexamethasone, or bortezomib and dexamethasone, or melphalan and prednisone is indicated for the treatment of adult patients with previously untreated MM who are not eligible for transplant: Combination with dexamethasone for the treatment of MM in adult patients who have received at least one prior therapy. *Myelodysplastic syndromes (MDS):* Monotherapy for the treatment of adult patients with transfusion dependent anaemia due to low- or intermediate-1-risk myelodysplastic syndromes (MS) associated with an isolated deletion 5q cytogenetic abnormality when other therapeutic options are insufficient or inadequate. *Mantle cell lymphoma (MCL):* Monotherapy for the treatment of adult patients with relapsed or refractory MCL. *Follicular lymphoma (FL):* Combination with rituximab (anti-CD20 antibody) for the treatment of adult patients with previously treated FL (Grade 1 – 3a).

Dosage and Administration: Treatment should be supervised by a physician experienced in the use of anti- cancer therapies. For all indications, dose is modified based upon clinical and laboratory findings. See SmPC for details of dose adjustments. Dose adjustments, during treatment and restart of treatment, are recommended to manage Grade 3 or 4 thrombocytopenia, neutropenia, or other Grade 3 or 4 toxicity judged to be related to lenalidomide. In case of neutropenia, the use of growth factors in patient management should be considered. If less than 12 hours has elapsed since missing a dose, the patient can take the dose. If more than 12 hours has elapsed since missing a dose at the normal time, the patient should not take the dose, but take the next dose at the normal time on the following day. *Newly diagnosed multiple myeloma (NDMM): Lenalidomide maintenance in patients who have undergone autologous stem cell transplantation (ASCT):* Maintenance should be initiated after adequate haematologic recovery following ASCT in patients without evidence of progression. Lenalidomide must not be started if the ANC is $< 1.0 \times 10^9$/L, and/or platelet counts are $< 75 \times 10^9$/L. Recommended starting dose is lenalidomide 10 mg orally once daily continuously (on days 1 to 28 of repeated 28-day cycles) given until disease progression or intolerance. After 3 maintenance cycles, dose can be increased to 15 mg orally once daily if tolerated. *Lenalidomide in combination with dexamethasone until disease progression in patients who are not eligible for transplant*: Treatment must not be started if the Absolute Neutrophil Count (ANC) is $< 1.0 \times 10^9$/L, and/or platelet counts are $< 50 \times 10^9$/L. Recommended starting dose of lenalidomide is 25 mg orally once daily on days 1 to 21 of repeated 28-day cycles. Recommended dose of dexamethasone is 40 mg orally once daily on days 1, 8, 15 and 22 of repeated 28-day cycles. Patients may continue lenalidomide and dexamethasone therapy until disease progression or intolerance. *Lenalidomide in combination with bortezomib and dexamethasone followed by lenalidomide and dexamethasone until disease progression in patients who are not eligible for transplant: Initial treatment: Lenalidomide in combination with bortezomib and dexamethasone:* Treatment must not be started if the ANC is $< 1.0 \times 10^9$/L, and/or platelet counts are $< 50 \times 10^9$/L. Recommended starting dose is lenalidomide 25 mg orally once daily days 1-14 of each 21-day cycle in combination with bortezomib and dexamethasone. Bortezomib should be administered via subcutaneous injection (1.3 mg/m2 body surface area) twice weekly on days 1, 4, 8 and 11 of each 21-day cycle. Up to eight 21-day treatment cycles (24 weeks of initial treatment) are recommended. *Continued treatment: Lenalidomide in combination with dexamethasone until progression:* Continue lenalidomide 25 mg orally once daily on days 1-21 of repeated 28-day cycles in combination with dexamethasone. Treatment should be continued until disease progression or unacceptable toxicity. *Lenalidomide in combination with melphalan and prednisone followed by lenalidomide maintenance in patients who are not eligible for transplant:* Treatment must not be started if the ANC is $< 1.5 \times 10^9$/L, and/or platelet counts are $< 75 \times 10^9$/L. Recommended starting dose is lenalidomide 10 mg orally once daily on days 1 to 21 of repeated 28-day cycles for up to 9 cycles, melphalan 0.18 mg/kg orally on days 1 to 4 of repeated 28-day cycles, prednisone 2 mg/kg orally on days 1 to 4 of repeated 28-day cycles. Patients who complete 9 cycles or who are unable to complete the combination therapy due to intolerance are treated with lenalidomide monotherapy as follows: 10 mg orally once daily on days 1 to 21 of repeated 28-day cycles given until disease progression. *MM with at least one prior therapy:* Treatment must not be started if the ANC $< 1.0 \times 10^9$/L, and/or platelet counts $< 75 \times 10^9$/L or, dependent on bone marrow infiltration by plasma cells, platelet counts < 30 x 109/L. Recommended starting dose of lenalidomide is 25 mg orally once daily on days 1 to 21 of repeated 28-day cycles. Recommended dose of dexamethasone is 40 mg

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orally once daily on days 1 to 4, 9 to 12, and 17 to 20 of each 28-day cycle for the first 4 cycles of therapy and then 40 mg once daily on days 1 to 4 every 28 days. Prescribing physicians should carefully evaluate which dose of dexamethasone to use, taking into account the condition and disease status of the patient. *MDS:* Treatment must not be started if the ANC < 0.5 x 10^9/L and or platelet counts < 25 x 10^9 L. Recommended starting dose of lenalidomide is 10 mg orally once daily on days 1 to 21 of repeated 28-day cycles. *Discontinuation of lenalidomide:* Patients without at least a minor erythroid response within 4 months of therapy initiation, demonstrated by at least a 50% reduction in transfusion requirements or, if not transfused, a 1g/dl rise in haemoglobin, should discontinue lenalidomide treatment. *MCL:* Recommended starting dose of lenalidomide is 25 mg orally once daily on days 1 to 21 of repeated 28- day cycles. *FL:* Treatment must not be started if the ANC is < 1 x 10^9/L, and/or platelet count < 50 x 10^9/L, unless secondary to lymphoma infiltration of bone marrow. Recommended starting dose of lenalidomide is 20 mg, orally once daily on days 1 to 21 of repeated 28-day cycles for up to 12 cycles of treatment. Recommended starting dose of rituximab is 375 mg/m2 intravenously (IV) every week in Cycle 1 (days 1, 8, 15, and 22) and day 1 of every 28-day cycle for cycles 2 through 5. *MCL or FL: Tumour lysis syndrome (TLS):* All patients should receive TLS prophylaxis (allopurinol, rasburicase or equivalent) and be well hydrated during the first week of the first cycle or for a longer period if clinically indicated. Lenalidomide may be continued (maintain dose) in patients with laboratory TLS or Grade 1 clinical TLS, or at the physician's discretion, reduce dose by one level and continue lenalidomide. In patients with Grade 2 to 4 clinical TLS, interrupt lenalidomide and obtain a chemistry panel weekly or as clinically indicated. *Tumour flare reaction (TFR):* At the physician's discret-ion, lenalidomide may be continued in patients with Grade 1 or 2 TFR without interruption or modification. Therapy with nonsteroidal anti-inflammatory drugs (NSAIDs), limited duration corticosteroids, and/or narcotic analgesics may be administered. In patients with Grade 3 or 4 TFR, withhold treatment with lenalidomide and initiate therapy with NSAIDs, corticosteroids and/or narcotic analgesics. *All indications:* For other Grade 3 or 4 toxicities related to lenalidomide, treatment should be stopped and only restarted at next lower dose level when toxicity has resolved. Lenalidomide interruption or discontinuation should be considered for Grade 2 or 3 skin rash. Lenalidomide must be discontinued for angioedema, anaphylactic reaction, Grade 4 rash, exfoliative or bullous rash, or if Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN) or Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) is suspected should not be resumed following discontinuation from these reactions.*Paediatric population:* Should not be used in children and adolescents from birth to less than 18 years because of safety concerns. *Elderly:* More likely to have decreased renal function, care should be taken in dose selection and it would be prudent to monitor renal function. Please refer to SmPC for further information of experience in elderly patients for each indication. Patients with renal impairment: Lenalidomide is primarily excreted by the kidney; patients with greater degrees of renal impairment can have impaired treatment tolerance. Care should be taken in dose selection and monitoring of renal function is advised. Dose adjustments for patients with moderate or severe impaired renal function or end stage renal disease are recommended at the start of therapy and throughout treatment, based on individual patient treatment tolerance. *Patients with hepatic impairment:* No specific dose recommendations. *Method of administration:* Should be taken orally at about the same time on the scheduled days. The capsules should be swallowed whole, preferably with water, with or without food

Contraindications: Hypersensitivity to the active substance or to any of the excipients: Women who are pregnant: Women of childbearing potential (unless all of the conditions of the Pregnancy Prevention Programme (PPP) are met).

Warnings and Precautions: When given in combination with other medicinal products, the corresponding SmPC must also be consulted. *Pregnancy warning:* Lenalidomide is structurally related to thalidomide, which is a known human teratogenic active substance that causes severe life-threatening birth defects. The conditions of the PPP must be fulfilled for all patients unless there is reliable evidence that the patient or female partner of a male patient does not have childbearing potential, i.e. she meets at least one of the criteria listed in the SmPC. *Counselling:* For women of childbearing potential, lenalidomide is contraindicated unless she is informed, acknowledges and understands all of the information listed in the SmPC. For male patients taking lenalidomide, pharmacokinetic data has demonstrated that lenalidomide is present in human semen at extremely low levels during treatment and is undetectable in human semen 3 days after stopping the substance in the healthy subject. As a precaution and taking into account special populations with prolonged elimination time such as renal impairment, all male patients taking lenalidomide must meet the conditions listed in the SmPC. The prescriber must ensure that for women of childbearing potential: The patient complies with the conditions of the PPP, including confirmation that they have an adequate level of understanding and has acknowledged the aforementioned conditions. *Contraception:* Women of

childbearing potential must use at least one effective method of contraception for at least 4 weeks before lenalidomide therapy, during therapy, and until at least 4 weeks after therapy and in case of dose interruption unless the patient commits to absolute and continuous abstinence. If not on effective contraception, the patient must be referred to a healthcare professional so that contraception can be initiated. Please see SmPC for examples of suitable methods of contraception, and those that are not recommended. *Pregnancy testing:* Medically supervised pregnancy tests with a minimum sensitivity of 25 mIU/mL must be performed for women of childbearing potential, including those who practice absolute and continuous abstinence. Ideally, pregnancy testing, issuing a prescription and dispensing should occur on the same day. Dispensing of lenalidomide to women of childbearing potential should occur within 7 days of the prescription. Please see SmPC for details of pregnancy testing prior to starting treatment, during follow-up and at end of treatment. *Additional precautions:* Patients should be instructed never to give this medicinal product to another person and to return any unused capsules to their pharmacist at the end of treatment for safe disposal. Patients should not donate blood, semen or sperm during treatment (including during dose interruptions) and for at least 7 days following discontinuation of lenalidomide. Healthcare professionals and caregivers should wear disposable gloves when handling the blister or capsule. Women who are pregnant or suspect they may be pregnant should not handle the blister or capsule. *Other special warnings and precautions for use: Myocardial infarction:* This has been reported in patients receiving lenalidomide, particularly in those with known risk factors and within the first 12 months when used in combination with dexamethasone. Patients with known risk factors – including prior thrombosis – should be closely monitored, and action should be taken to try to minimize all modifiable risk factors (e.g. smoking, hypertension, and hyperlipidaemia). *Venous and arterial thromboembolic events:* In patients with MM, the combination of lenalidomide with dexamethasone is associated with an increased risk of venous thromboembolism. The risk of venous thromboembolism was seen to a lesser extent with lenalidomide in combination with melphalan and prednisone. In patients with MM, MS and MCL, treatment with lenalidomide monotherapy was associated with a lower risk of venous thromboembolism than in patients with MM treated with lenalidomide in combination therapy. In patients with MM, the combination of lenalidomide with dexamethasone is associated with an increased risk of arterial thromboembolism and was seen to a lesser extent with lenalidomide in combination with melphalan and prednisone. The risk of arterial thromboembolism is lower in patients with multiple myeloma treated with lenalidomide monotherapy than in patients with MM treated with lenalidomide in combination therapy. Patients with known risk factors for thromboembolism – including prior thrombosis – should be closely monitored. Action should be taken to try to minimize all modifiable risk factors (e.g. smoking, hypertension, and hyperlipidaemia). Concomitant administration of erythropoietic agents or previous history of thromboembolic events may also increase thrombotic risk in these patients. Therefore, erythropoietic agents, or other agents that may increase the risk of thrombosis, such as hormone replacement therapy, should be used with caution in MM patients receiving lenalidomide with dexamethasone. A haemoglobin concentration above 12 g/dl should lead to discontinuation of erythropoietic agents. Patients and physicians are advised to be observant for the signs and symptoms of thromboembolism. Patients should be instructed to seek medical care if they develop symptoms such as shortness of breath, chest pain, arm or leg swelling. Prophylactic antithrombotic medicines should be recommended, after assessment of individual underlying risk factors, especially in patients with additional thrombotic risk factors. If the patient experiences any thromboembolic events, treatment must be discontinued and standard anticoagulation therapy started. Once stabilised on the anticoagulation treatment and any complications of the thromboembolic event have been managed, lenalidomide treatment may be restarted at the original dose dependent upon a benefit risk assessment. The patient should continue anticoagulation therapy during the course of lenalidomide treatment. *Pulmonary hypertension:* Some fatal cases have been reported in patients treated with lenalidomide. Patients should be evaluated for signs and symptoms of underlying cardiopulmonary disease prior to initiating and during lenalidomide therapy. *Neutropenia and thrombocytopenia:* The major dose limiting toxicities of lenalidomide include neutropenia and thrombocytopenia. A complete blood cell count, including white blood cell count with differential count, platelet count, haemoglobin, and haematocrit should be performed at baseline, every week for the first 8 weeks of lenalidomide treatment and monthly thereafter to monitor for cytopenias. In MCL patients, the monitoring scheme should be every 2 weeks in cycles 3 and 4, and then at the start of each cycle. In FL, the monitoring scheme should be weekly for the first 3 weeks of cycle 1 (28 days), every 2 weeks during cycles 2 through 4, and then at the start of each cycle thereafter. A dose interruption and/or a dose reduction may be required. In case of neutropenia, the physician should consider the use of growth factors. Patients should be advised to promptly report febrile episodes. Patients and physicians are advised to be observant for signs and symptoms of bleeding, including petechiae

and epistaxis, especially in patients receiving concomitant medicinal products susceptible to induce bleeding. Coadministration of lenalidomide with other myelosuppressive agents should be undertaken with caution. Please refer to SmPC for further information on neutropenia and thrombocytopenia for specific indications. *Thyroid disorders:* Cases of hypothyroidism and hyperthyroidism have been reported. Optimal control of co- morbid conditions influencing thyroid function is recommended before start of treatment. Baseline and ongoing monitoring of thyroid function is recommended. *Peripheral neuropathy:* Lenalidomide is structurally related to thalidomide, which is known to induce severe peripheral neuropathy. There was no increase in peripheral neuropathy observed with lenalidomide in combination with dexamethasone or melphalan and prednisone or lenalidomide monotherapy or with long term use of lenalidomide for the treatment of newly diagnosed MM.The combination of lenalidomide with intravenous bortezomib and dexamethasone in MM patients is associated with a higher frequency of peripheral neuropathy. The frequency was lower when bortezomib was administered subcutaneously. For additional information see the SmPC for bortezomib. TFR and TLS: Because lenalidomide has anti-neoplastic activity the complications of TLS may occur. TLS and TFR, including fatal cases have been reported. The patients at risk of and TFR are those with high tumour burden prior to treatment. Caution should be practiced when introducing these patients to lenalidomide. These patients should be monitored closely, especially during the first cycle or dose- escalation, and appropriate precautions taken. *MCL:* Careful monitoring and evaluation for TFR is recommended. Patients with high MCL International Prognostic Index (MIPI) at diagnosis or bulky disease (at least one lesion that is ≥ 7 cm in the longest diameter) at baseline may be at risk of TFR. TFR may mimic progression of disease (PD). Corticosteroids, NSAIDs and/or narcotic analgesics for management of TFR symptoms may be considered. The decision to take therapeutic measures for TFR should be made after careful clinical assessment of the individual patient. *FL:* Careful monitoring and evaluation for TFR is recommended. Tumour flare may mimic PD. Patients who experienced Grade 1 and 2 TFR were treated with corticosteroids, NSAIDs and/or narcotic analgesics for management of TFR symptoms. The decision to take therapeutic measures for TFR should be made after careful clinical assessment of the individual patient. Careful monitoring and evaluation for TLS is recommended. Patients should be well hydrated and receive TLS prophylaxis, in addition to weekly chemistry panels during the first cycle or longer, as clinically indicated. *Tumour burden: MCL:* Lenalidomide is not recommended for the treatment of patients with high tumour burden if alternative treatment options are available. *Early death:* Patients with high tumour burden at baseline are at increased risk of early death. *Adverse events:* The main reason for treatment withdrawal for patients with high tumour burden during treatment with lenalidomide is adverse events. Patients with high tumour burden should therefore be closely monitored for adverse reactions including signs of TFR. *Allergic reactions and severe skin reactions*: Cases of allergic reactions including angioedema, anaphylactic reaction and severe cutaneous reactions including SJS, TEN and DRESS have been reported in patients treated with lenalidomide. Patients should be advised of the signs and symptoms of these reactions and should be told to seek medical attention immediately if they develop these symptoms. Lenalidomide must be discontinued for angioedema, anaphylactic reaction, exfoliative or bullous rash, or if SJS, TEN or DRESS is suspected, and should not be resumed following discontinuation for these reactions. Interruption or discontinuation of lenalidomide should be considered for other forms of skin reaction depending on severity. Patients who had previous allergic reactions while treated with thalidomide should be monitored closely, as a possible cross- reaction between lenalidomide and thalidomide has been reported. Patients with a history of severe rash associated with thalidomide treatment should not receive lenalidomide. *Second primary malignancies:* An increase of second primary malignancies (SPM) has been observed. Non-invasive SPM comprise basal cell or squamous cell skin cancers. Most of the invasive SPMs were solid tumour malignancies. The increased risk of secondary primary malignancies associated with lenalidomide is relevant also in the context of NDMM after stem cell transplantation. Though this risk is not yet fully characterized, it should be kept in mind when considering and using lenalidomide in this setting. The risk of occurrence of hematologic SPM must be taken into account before initiating treatment with lenalidomide either in combination with melphalan or immediately following high-dose melphalan and ASCT. Physicians should carefully evaluate patients before and during treatment using standard cancer screening for occurrence of SPM and institute treatment as indicated. Please consult the SmPC for further details. Physicians should monitor patients for the development of SPMs. Both the potential benefit of lenalidomide and the risk of SPMs should be considered when considering treatment with lenalidomide. *Hepatic disorders:* Fatal cases, have been reported in patients treated with lenalidomide in combination therapy: acute hepatic failure, toxic hepatitis, cytolytic hepatitis, cholestatic hepatitis, and mixed cytolytic/cholestatic hepatitis have been reported. The mechanisms of severe drug-induced hepatotoxicity remain unknown although, in some cases, pre-existing viral liver disease, elevated

baseline liver enzymes, and possibly treatment with antibiotics might be risk factors. Abnormal liver function tests were commonly reported and were generally asymptomatic and reversible upon dosing interruption. Once parameters have returned to baseline, treatment at a lower dose may be considered. Lenalidomide is excreted by the kidneys. It is important to dose adjust patients with renal impairment in order to avoid plasma levels which may increase the risk for higher haematological adverse reactions or hepatotoxicity. Monitoring of liver function is recommended, particularly when there is a history of or concurrent viral liver infection or when lenalidomide is combined with medicinal products known to be associated with liver dysfunction. *Infection with or without neutropenia:* Patients with MM are prone to develop infections including pneumonia. A higher rate of infections was observed with lenalidomide in combination with dexamethasone than with MPT in patients with NDMM who are not eligible for transplant, and with lenalidomide maintenance compared to placebo in patients with NDMM who had undergone ASCT. Grade ≥ 3 infections occurred within the context of neutropenia in less than one-third of the patients. Patients with known risk factors for infections should be closely monitored. All patients should be advised to seek medical attention promptly at the first sign of infection (e.g. cough, fever, etc) thereby allowing for early management to reduce severity. *Viral reactivation:* Cases (some fatal) have been reported in patients receiving lenalidomide, including serious cases of herpes zoster or hepatitis B virus (HBV) reactivation. Some of the cases of herpes zoster reactivation resulted in disseminated herpes zoster, meningitis herpes zoster or ophthalmic herpes zoster requiring a temporary hold or permanent discontinuation of the treatment with lenalidomide and adequate antiviral treatment. Reactivation of hepatitis B has been reported rarely in patients receiving lenalidomide who have previously been infected with the hepatitis B virus. Some of these cases have progressed to acute hepatic failure resulting in discontinuation of lenalidomide and adequate antiviral treatment. Hepatitis B virus status should be established before initiating treatment with lenalidomide. For patients who test positive for HBV infection, consultation with a physician with expertise in the treatment of hepatitis B is recommended. Caution should be exercised when lenalidomide is used in patients previously infected with HBV, including patients who are anti-HBc positive but HBsAg negative. These patients should be closely monitored for signs and symptoms of active HBV infection throughout therapy. *NDMM patients:* There was a higher rate of intolerance (Grade 3 or 4 adverse eve nts, serious adverse events, discontinuation) in patients aged >75 years, ISS stage III, ECOG PS≤2 or CLcr<60 mL/min when lenalidomide is given in combination. Patients should be carefully assessed for their ability to tolerate lenalidomide in combination, with consideration to age, ISS stage III, ECOG PS≤2 or CLcr<60 mL/min. *Cataract:* This has been reported with a higher frequency in patients receiving lenalidomide in combination with dexamethasone particularly when used for a prolonged time. Regular monitoring of visual ability is recommended. *Progressive multifocal leukoencephalopathy (PML):* Fatal cases have been reported several months to several years after starting the treatment with lenalidomide. Cases have generally been reported in patients taking concomitant dexamethasone or prior treatment with other immunosuppressive chemotherapy. Physicians should monitor patients at regular intervals and should consider PML in the differential diagnosis in patients with new or worsening neurological symptoms, cognitive or behavioural signs. Patients should also be advised to inform their partner or caregivers about their treatment, since they may notice symptoms that the patient is not aware of. The evaluation for PML should be based on neurological examination, magnetic resonance imaging of the brain, and cerebrospinal fluid analysis for JC virus (JCV) DNA by polymerase chain reaction (PCR) or a brain biopsy with testing for JCV. A negative JCV PCR does not exclude PML. Additional follow-up and evaluation may be warranted if no alternative diagnosis can be established. If PML is suspected, further dosing must be suspended until PML has been excluded. If PML is confirmed, lenalidomide must be permanently discontinued. *Lactose:* Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. *Effects on ability to drive and use machines:* Lenalidomide has minor or mode-rate influence on the ability to drive and use machines. Fatigue, dizziness, somnolence, vertigo and blurred vision have been reported. Therefore, caution is recommended when driving or operating machines.

Fertility, Pregnancy & Lactation: Due to the teratogenic potential, lenalidomide must be prescribed under a PPP unless there is reliable evidence that the patient does not have childbearing potential. *Women of childbearing potential/ Contraception in males and females:* Effective method of contraception should be used. If pregnancy occurs in a woman treated with lenalidomide or in a partner of a male patient taking lenalidomide, treatment must be stopped and the woman should be referred to a physician specialised or experienced in teratology for evaluation and advice. Lenalidomide is present in human semen at extremely low levels during treatment and is undetectable in human semen 3 days after stopping the substance in the healthy subject. As a

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precaution all male patients taking lenalidomide should use condoms throughout treatment duration, during dose interruption and for 1 week after cessation of treatment if their partner is pregnant or of childbearing potential and has no contraception. *Pregnancy:* Lenalidomide is contraindicated during pregnancy as it is structurally related to thalidomide, a teratogenic substance that causes severe life-threatening birth defects. *Breast-feeding:* It is not known whether lenalidomide is excreted in breast milk. Therefore, breast-feeding should be discontinued during therapy with lenalidomide.

Adverse Events include: *Adverse events which could be considered serious:* Pneumonia, lung infection, neutropenia, bronchitis, leucopenia, thrombocytopenia, gastroenteritis, upper respiratory tract infection, anaemia, renal failure, febrile neutropenia, venous thromboembolism (deep vein thrombosis, pulmonary embolism), neutropenic infection, rhinitis, urinary tract infection, lower respiratory tract infection, sepsis, bacteraemia, Herpes zoster, myelodysplastic syndrome, pancytopenia, hypokalaemia, peripheral neuropathy, cellulitis, enterocolitis infectious, basal cell carcinoma, squamous skin cancer, acute myeloid leukaemia, T-cell type acute leukaemia, TLS, haemorrhagic disorder, haemolysis, autoimmune haemolytic anaemia, coagulopathy hypersensitivity, hypothyroidism, diabetes mellitus, syncope, cerebrovascular accident, intracranial haemorrhage, intracranial venous sinus thrombosis, transient ischaemic attack, cerebral ischemia, cataracts, blindness, deafness, atrial fibrillation, bradycardia, arrhythmia, QT prolongation, myocardial infarction (including acute), tachycardia, congestive cardiac failure, cardiac failure, myocardial ischemia, vasculitis, dyspnoea, respiratory distress, hypoxia, gastrointestinal haemorrhage (including rectal haemorrhage, peptic ulcer haemorrhage), small intestinal obstruction, colitis, hepatocellular injury, hyperbilirubinaemia, acute hepatic failure, cholestasis, hepatotoxicity, DRESS, urinary retention, acquired Fanconi syndrome, renal tubular necrosis, erectile dysfunction, TFR, acute kidney injury, hepatitis B virus reactivation, acquired haemophilia, anaphylactic reaction, solid organ transplant rejection, hyperthyroidism, pulmonary hypertension, interstitial pneumonitis, pancreatitis, gastrointestinal perforation (including diverticular, intestinal and large intestine perforations), hepatitis toxic, cytolytic hepatitis, cholestatic hepatitis, mixed cytolytic/cholestatic hepatitis, angioedema, SJS, TEN, rhabdomyolysis.

Other Very Common adverse events: Influenza, sinusitis, nasopharyngitis, lymphopenia, paraesthesia, cough, diarrhoea, constipation, abdominal pain, nausea, vomiting, abnormal liver function tests, rashes (including dermatitis allergic), dry skin, muscle spasms, fatigue, asthenia, pyrexia, bacterial, viral and fungal infections (including opportunistic infections), pharyngitis, hyperglycaemia, hypoglycaemia, hypocalcaemia hyponatraemia, dehydration, decreased appetite, weight decreased, depression, insomnia, loss of libido, dizziness, tremor, dysgeusia, headache, blurred vision, hypotension, epistaxis, dyspepsia, dry mouth, stomatitis, alanine aminotransferase increased, aspartate aminotransferase increased, pruritus, muscular weakness, bone pain, musculoskeletal and connective tissue pain and discomfort (including back pain), pain in extremity, myalgia, arthralgia, oedema (including peripheral oedema), influenza like illness syndrome (including pyrexia, cough, pharyngitis, myalgia, musculoskeletal pain, headache and rigors), blood alkaline phosphatase increased.

Other Common adverse events: Rhinorrhoea, abdominal pain upper, hypomagnesaemia, hyperuricaemia, hypercalcaemia, hypophosphataemia gout, ataxia, balance impaired, neuralgia, dysaesthesia, reduced visual acuity, hypoacusis, tinnitus, hypertension, ecchymosis, dysphonia, pleuritic pain, dysphagia, haemorrhoidal haemorrhage, gingival bleeding, urticaria, hyperhidrosis, skin hyperpigmentation, eczema, erythema, joint swelling, haematuria, urinary incontinence, chest pain, lethargy, C-reactive protein increased, fall, confusion, iron overload, altered mood, haematoma, toothache, vertigo, night sweats, chills, oropharyngeal pain, neck pain, malaise.

See SmPC for details of other adverse events.

Presentation and Price: 2.5mg x 21 £3426.00, 5mg x 21 £3570.00, 7.5mg x 21 £3675.00, 10mg x 21 £3780.00, 15mg x 21 £3969.00, 20mg x 21 £4168.50, 25mg x 21 £4368.00

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Further information is available from: Accord-UK Ltd, Whiddon Valley,Barnstaple, Devon, EX32 8NS.

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Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
Adverse events should also be reported to Accord-UK LTD on 01271 385257 or email medinfo@accord-healthcare.com.