

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use Victoza safely and effectively. See full prescribing information for Victoza.

Victoza® (liraglutide [rDNA origin] injection), solution for subcutaneous use
Initial U.S. Approval: 2010

WARNING: RISK OF THYROID C-CELL TUMORS

See full prescribing information for complete boxed warning.

- Liraglutide causes thyroid C-cell tumors at clinically relevant exposures in rodents. It is unknown whether Victoza causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be determined by clinical or nonclinical studies (5.1).
- Victoza is contraindicated in patients with a personal or family history of MTC or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) (5.1).

RECENT MAJOR CHANGES

Indications and Usage: Important Limitations of Use (1.1)	04/2013
Warnings and Precautions: Pancreatitis (5.2)	04/2013

INDICATIONS AND USAGE

Victoza is a glucagon-like peptide-1 (GLP-1) receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (1).

Important Limitations of Use (1.1):

- Not recommended as first-line therapy for patients inadequately controlled on diet and exercise (5.1).
- Has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis (5.2).
- Not for treatment of type 1 diabetes mellitus or diabetic ketoacidosis.
- Has not been studied in combination with prandial insulin.

DOSAGE AND ADMINISTRATION

- Administer once daily at any time of day, independently of meals (2).
- Inject subcutaneously in the abdomen, thigh or upper arm (2).
- The injection site and timing can be changed without dose adjustment (2).
- Initiate at 0.6 mg per day for one week. This dose is intended to reduce gastrointestinal symptoms during initial titration, and is not effective for glycemic control. After one week, increase the dose to 1.2 mg. If the 1.2 mg dose does not result in acceptable glycemic control, the dose can be increased to 1.8 mg (2).

DOSAGE FORMS AND STRENGTHS

- Solution for subcutaneous injection, pre-filled, multi-dose pen that delivers doses of 0.6 mg, 1.2 mg, or 1.8 mg (6 mg/mL, 3 mL) (3).

CONTRAINDICATIONS

Do not use in patients with a personal or family history of medullary thyroid carcinoma or in patients with Multiple Endocrine Neoplasia syndrome type 2 (4).

Do not use if history of serious hypersensitivity to Victoza or any product components (4).

WARNINGS AND PRECAUTIONS

- Thyroid C-cell tumors in animals: Counsel patients regarding the risk of medullary thyroid carcinoma and the symptoms of thyroid tumors (5.1).
- Pancreatitis: Postmarketing reports, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis. Discontinue promptly if pancreatitis is suspected. Do not restart if pancreatitis is confirmed. Consider other antidiabetic therapies in patients with a history of pancreatitis (5.2).
- Serious hypoglycemia: Can occur when Victoza is used with an insulin secretagogue (e.g. a sulfonylurea) or insulin. Consider lowering the dose of the insulin secretagogue or insulin to reduce the risk of hypoglycemia (5.3).
- Renal Impairment: Has been reported postmarketing, usually in association with nausea, vomiting, diarrhea, or dehydration which may sometimes require hemodialysis. Use caution when initiating or escalating doses of Victoza in patients with renal impairment (5.4).
- Hypersensitivity: Postmarketing reports of serious hypersensitivity reactions (e.g., anaphylactic reactions and angioedema). The patient should discontinue Victoza and other suspect medications and promptly seek medical advice (5.5).
- Macrovascular outcomes: There have been no studies establishing conclusive evidence of macrovascular risk reduction with Victoza or any other antidiabetic drug (5.6).

ADVERSE REACTIONS

- The most common adverse reactions, reported in ≥5% of patients treated with Victoza and more commonly than in patients treated with placebo, are: headache, nausea, diarrhea and anti-liraglutide antibody formation (6).
- Immunogenicity-related events, including urticaria, were more common among Victoza-treated patients (0.8%) than among comparator-treated patients (0.4%) in clinical trials (6).

To report SUSPECTED ADVERSE REACTIONS, contact Novo Nordisk Inc. at 1-877-484-2869 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Victoza delays gastric emptying. May impact absorption of concomitantly administered oral medications. Use caution (7).

USE IN SPECIFIC POPULATIONS

- Limited data in patients with renal or hepatic impairment. (8.6, 8.7).

See 17 for PATIENT COUNSELING INFORMATION and FDA-Approved Medication Guide.

Revised: 04/2013

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*Sections or subsections omitted from the full prescribing information are not listed.

FULL PRESCRIBING INFORMATION

WARNING: RISK OF THYROID C-CELL TUMORS

Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be ruled out by clinical or nonclinical studies. Victoza is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Based on the findings in rodents, monitoring with serum calcitonin or thyroid ultrasound was performed during clinical trials, but this may have increased the number of unnecessary thyroid surgeries. It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate human risk of thyroid C-cell tumors. Patients should be counseled regarding the risk and symptoms of thyroid tumors [see *Contraindications (4), Warnings and Precautions (5.1) and Nonclinical Toxicology (13.1)*].

1 INDICATIONS AND USAGE

Victoza is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

1.1 Important Limitations of Use

- Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise.
- Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza. Victoza has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for pancreatitis while using Victoza. Other antidiabetic therapies should be considered in patients with a history of pancreatitis.
- Victoza is not a substitute for insulin. Victoza should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings.
- The concurrent use of Victoza and prandial insulin has not been studied.

2 DOSAGE AND ADMINISTRATION

Victoza can be administered once daily at any time of day, independently of meals, and can be injected subcutaneously in the abdomen, thigh or upper arm. The injection site and timing can be changed without dose adjustment.

For all patients, Victoza should be initiated with a dose of 0.6 mg per day for one week. The 0.6 mg dose is a starting dose intended to reduce gastrointestinal symptoms during initial titration, and is not effective for glycemic control. After one week at 0.6 mg per day, the dose should be increased to 1.2 mg. If the 1.2 mg dose does not result in acceptable glycemic control, the dose can be increased to 1.8 mg.

When initiating Victoza, consider reducing the dose of concomitantly administered insulin secretagogues (such as sulfonylureas) to reduce the risk of hypoglycemia [*see Warnings and Precautions (5.3) and Adverse Reactions (6)*].

When using Victoza with insulin, administer as separate injections. Never mix. It is acceptable to inject Victoza and insulin in the same body region but the injections should not be adjacent to each other.

Victoza solution should be inspected prior to each injection, and the solution should be used only if it is clear, colorless, and contains no particles.

If a dose is missed, the once-daily regimen should be resumed as prescribed with the next scheduled dose. An extra dose or increase in dose should not be taken to make-up for the missed dose.

Based on the elimination half-life, patients should be advised to reinitiate Victoza at 0.6 mg if more than 3 days have elapsed since the last Victoza dose. This approach will mitigate any gastrointestinal symptoms associated with reinitiation of treatment. Upon reinitiation, Victoza should be titrated at the discretion of the prescribing healthcare provider.

3 DOSAGE FORMS AND STRENGTHS

Solution for subcutaneous injection, pre-filled, multi-dose pen that delivers doses of 0.6 mg, 1.2 mg, or 1.8 mg (6 mg/mL, 3 mL).

4 CONTRAINDICATIONS

Do not use in patients with a personal or family history of medullary thyroid carcinoma (MTC) or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).

Do not use in patients with a prior serious hypersensitivity reaction to Victoza or to any of the product components.

5 WARNINGS AND PRECAUTIONS

5.1 Risk of Thyroid C-cell Tumors

Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors (adenomas and/or carcinomas) at clinically relevant exposures in both genders of rats and mice [*see Nonclinical Toxicology (13.1)*]. Malignant thyroid C-cell carcinomas were detected in rats and mice. A statistically significant increase in cancer was observed in rats receiving liraglutide at 8-times clinical exposure compared to controls. It is unknown whether Victoza will cause thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors could not be determined by clinical or nonclinical studies [*see Boxed Warning, Contraindications (4)*].

In the clinical trials, there have been 6 reported cases of thyroid C-cell hyperplasia among Victoza-treated patients and 2 cases in comparator-treated patients (1.3 vs. 1.0 cases per 1000 patient-years). One comparator-treated patient with MTC had pre-treatment serum calcitonin concentrations >1000 ng/L suggesting pre-existing disease. All of these cases were diagnosed after thyroidectomy, which was prompted by abnormal results on routine, protocol-specified measurements of serum calcitonin. Five of the six Victoza-treated patients had elevated calcitonin concentrations at baseline and throughout the trial. One Victoza and one non-Victoza-treated patient developed elevated calcitonin concentrations while on treatment.

Calcitonin, a biological marker of MTC, was measured throughout the clinical development program. The serum calcitonin assay used in the Victoza clinical trials had a lower limit of quantification (LLOQ) of 0.7 ng/L and the upper limit of the reference range was 5.0 ng/L for women and 8.4 ng/L for men. At Weeks 26 and 52 in the clinical trials, adjusted mean serum calcitonin concentrations were higher in Victoza-treated patients compared to placebo-treated patients but not compared to patients receiving active comparator. At these timepoints, the adjusted mean serum calcitonin values (~ 1.0 ng/L) were just above the LLOQ with between-group differences in adjusted mean serum calcitonin values of approximately 0.1 ng/L or less. Among patients with pre-treatment serum calcitonin below the upper limit of the reference range, shifts to above the upper limit of the reference range which persisted in subsequent measurements occurred most frequently among patients treated with Victoza 1.8 mg/day. In trials with on-treatment serum calcitonin measurements out to 5-6 months, 1.9% of patients treated with Victoza 1.8 mg/day developed new and persistent calcitonin elevations above the upper limit of the reference range compared to 0.8-1.1% of patients treated with control medication or the 0.6 and 1.2 mg doses of Victoza. In trials with on-treatment serum calcitonin measurements out to 12 months, 1.3% of patients treated with Victoza 1.8 mg/day had new and persistent elevations of calcitonin from below or within the reference range to above the upper limit of the reference range, compared to 0.6%, 0% and 1.0% of patients treated with Victoza 1.2 mg, placebo and active control, respectively. Otherwise, Victoza did not produce consistent dose-dependent or time-dependent increases in serum calcitonin.

Patients with MTC usually have calcitonin values >50 ng/L. In Victoza clinical trials, among patients with pre-treatment serum calcitonin <50 ng/L, one Victoza-treated patient and no comparator-treated patients developed serum calcitonin >50 ng/L. The Victoza-treated patient who developed serum calcitonin >50 ng/L had an elevated pre-treatment serum calcitonin of 10.7 ng/L that increased to 30.7 ng/L at Week 12 and 53.5 ng/L at the end of the 6-month trial. Follow-up serum calcitonin was 22.3 ng/L more than 2.5 years after the last dose of Victoza. The largest increase in serum calcitonin in a comparator-treated patient was seen with glimepiride in a patient whose serum calcitonin increased from 19.3 ng/L at baseline to 44.8 ng/L at Week 65 and 38.1 ng/L at Week 104. Among patients who began with serum calcitonin <20 ng/L, calcitonin elevations to >20 ng/L occurred in 0.7% of Victoza-treated patients, 0.3% of placebo-treated patients, and 0.5% of active-comparator-treated patients, with an incidence of 1.1% among patients treated with 1.8 mg/day of Victoza. The clinical significance of these findings is unknown.

Counsel patients regarding the risk for MTC and the symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea or persistent hoarseness). It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate the potential risk of MTC, and such monitoring may increase the risk of unnecessary procedures, due to low test specificity for serum calcitonin and a high background incidence of thyroid disease. Patients with thyroid nodules noted on physical examination or neck imaging obtained for other reasons should be referred to an endocrinologist for further evaluation. Although routine monitoring of serum calcitonin is of uncertain value in patients treated with Victoza, if serum calcitonin is measured and found to be elevated, the patient should be referred to an endocrinologist for further evaluation.

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