

HIGHLIGHTS OF PRESCRIBING INFORMATION

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

FORTEO (teriparatide [rDNA origin] injection) for subcutaneous use
Initial U.S. Approval: 2002

WARNING: POTENTIAL RISK OF OSTEOSARCOMA
See full prescribing information for complete boxed warning.

- In rats, teriparatide caused an increase in the incidence of osteosarcoma, a malignant bone tumor. (5.1, 13.1)
- Because of the uncertain relevance of the rat osteosarcoma finding to humans, prescribe FORTEO only for patients for whom potential benefits outweigh potential risk. (5.1)
- FORTEO should not be prescribed for patients at increased baseline risk for osteosarcoma (e.g., those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, pediatric and young adult patients with open epiphyses, or prior external beam or implant radiation therapy involving the skeleton). (5.1)

RECENT MAJOR CHANGES

Indications and Usage, Treatment of Men and Women with Glucocorticoid-Induced Osteoporosis (1.3) MM/200X
Dosage and Administration, Treatment of Men and Women with Glucocorticoid-Induced Osteoporosis (2.3) MM/200X

INDICATIONS AND USAGE

FORTEO is recombinant human parathyroid hormone analog (1-34), [rhPTH(1-34)] indicated for:

- Treatment of postmenopausal women with osteoporosis at high risk for fracture (1.1)
- Increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture (1.2)
- Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture (1.3)

DOSAGE AND ADMINISTRATION

- Recommended dose is 20 mcg subcutaneously once a day (2.1, 2.2, 2.3)
- Administer as a subcutaneous injection into the thigh or abdominal wall (2.4)
- Administer initially under circumstances in which the patient can sit or lie down if symptoms of orthostatic hypotension occur (2.4)
- Use of the drug for more than 2 years during a patient's lifetime is not recommended (2.5)

DOSAGE FORMS AND STRENGTHS

Multi-dose prefilled delivery device (pen) containing 28 daily doses of 20 mcg (3)

CONTRAINDICATIONS

- Patients with hypersensitivity to teriparatide or to any of its excipients (4)

WARNINGS AND PRECAUTIONS

- Patients with Paget's disease of bone, pediatric and young adult patients with open epiphyses, and patients with prior external beam or implant radiation involving the skeleton: Should not be treated with FORTEO (5.1, 8.4)
- Treatment duration: Use of FORTEO for more than 2 years during a patient's lifetime is not recommended. (5.2)
- Patients with bone metastases, history of skeletal malignancies, metabolic bone diseases other than osteoporosis, or hypercalcemic disorders: Should not be treated with FORTEO (5.3, 5.4, 5.5)
- Laboratory alterations: FORTEO may increase serum calcium, urinary calcium, and serum uric acid (5.5, 5.6)
- Urolithiasis: Use with caution in patients with active or recent urolithiasis because of risk of exacerbation (5.6)
- Orthostatic hypotension: Transient orthostatic hypotension may occur with initial doses of FORTEO (5.7)

ADVERSE REACTIONS

Most common adverse reactions (>10%) include: arthralgia, pain, and nausea (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Eli Lilly and Company at 1-800-545-5979 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

DRUG INTERACTIONS

Digoxin: Use FORTEO with caution in patients receiving digoxin. Transient hypercalcemia may predispose patients to digitalis toxicity (5.8, 7.1, 12.3)

USE IN SPECIFIC POPULATIONS

- Pregnancy: Based on animal studies, may cause fetal harm (8.1)
- Nursing Mothers: Discontinue nursing or FORTEO, taking into account the importance of treatment to the mother (8.3)
- Pediatric Use: FORTEO should not be used in pediatric and young adult patients with open epiphyses due to increased baseline risk of osteosarcoma (5.1, 8.4)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide

Revised: MM/20XX

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FULL PRESCRIBING INFORMATION

WARNING: POTENTIAL RISK OF OSTEOSARCOMA

In male and female rats, teriparatide caused an increase in the incidence of osteosarcoma (a malignant bone tumor) that was dependent on dose and treatment duration. The effect was observed at systemic exposures to teriparatide ranging from 3 to 60 times the exposure in humans given a 20-mcg dose. Because of the uncertain relevance of the rat osteosarcoma finding to humans, prescribe FORTEO® only for patients for whom the potential benefits are considered to outweigh the potential risk. FORTEO should not be prescribed for patients who are at increased baseline risk for osteosarcoma (including those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, pediatric and young adult patients with open epiphyses, or prior external beam or implant radiation therapy involving the skeleton) [see *Warnings and Precautions (5.1), Adverse Reactions (6.2), and Nonclinical Toxicology (13.1)*].

1 INDICATIONS AND USAGE

1.1 Treatment of Postmenopausal Women with Osteoporosis at High Risk for Fracture

FORTEO is indicated for the treatment of postmenopausal women with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. In postmenopausal women with osteoporosis, FORTEO reduces the risk of vertebral and nonvertebral fractures [see *Clinical Studies (14.1)*].

1.2 Increase of Bone Mass in Men with Primary or Hypogonadal Osteoporosis at High Risk for Fracture

FORTEO is indicated to increase bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy [see *Clinical Studies (14.2)*].

1.3 Treatment of Men and Women with Glucocorticoid-Induced Osteoporosis at High Risk for Fracture

FORTEO is indicated for the treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5 mg or greater of prednisone) at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy [see *Clinical Studies (14.3)*].

2 DOSAGE AND ADMINISTRATION

2.1 Treatment of Postmenopausal Women with Osteoporosis at High Risk for Fracture

The recommended dose is 20 mcg subcutaneously once a day.

2.2 Increase of Bone Mass in Men with Primary or Hypogonadal Osteoporosis at High Risk for Fracture

The recommended dose is 20 mcg subcutaneously once a day.

2.3 Treatment of Men and Women with Glucocorticoid-Induced Osteoporosis at High Risk for Fracture

The recommended dose is 20 mcg subcutaneously once a day.

2.4 Administration

- FORTEO should be administered as a subcutaneous injection into the thigh or abdominal wall. There are no data available on the safety or efficacy of intravenous or intramuscular injection of FORTEO.
- FORTEO should be administered initially under circumstances in which the patient can sit or lie down if symptoms of orthostatic hypotension occur [see *Warnings and Precautions (5.7)*].

- Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit. FORTEO is a clear and colorless liquid. Do not use if solid particles appear or if the solution is cloudy or colored.
- Patients and caregivers who administer FORTEO should receive appropriate training and instruction on the proper use of the FORTEO delivery device from a qualified health professional [see *Patient Counseling Information (17.5)*].

2.5 Treatment Duration

The safety and efficacy of FORTEO have not been evaluated beyond 2 years of treatment. Consequently, use of the drug for more than 2 years during a patient's lifetime is not recommended.

3 DOSAGE FORMS AND STRENGTHS

Multi-dose prefilled delivery device (pen) for subcutaneous injection containing 28 daily doses of 20 mcg.

4 CONTRAINDICATIONS

Do not use FORTEO in patients with:

- Hypersensitivity to teriparatide or to any of its excipients. Reactions have included angioedema and anaphylaxis [see *Adverse Reactions (6.2)*].

5 WARNINGS AND PRECAUTIONS

5.1 Osteosarcoma

In male and female rats, teriparatide caused an increase in the incidence of osteosarcoma (a malignant bone tumor) that was dependent on dose and treatment duration [see *Boxed Warning and Nonclinical Toxicology (13.1)*]. FORTEO should not be prescribed for patients at increased baseline risk of osteosarcoma.

These include:

- Paget's disease of bone. Unexplained elevations of alkaline phosphatase may indicate Paget's disease of bone.
- Pediatric and young adult patients with open epiphyses.
- Prior external beam or implant radiation therapy involving the skeleton.

Patients should be encouraged to enroll in the voluntary FORTEO Patient Registry, which is designed to collect information about any potential risk of osteosarcoma in patients who have taken FORTEO. Enrollment information can be obtained by calling 1-866-382-6813, or by visiting www.forteoregistry.rti.org

5.2 Treatment Duration

The safety and efficacy of FORTEO have not been evaluated beyond 2 years of treatment. Consequently, use of the drug for more than 2 years during a patients' lifetime is not recommended.

5.3 Bone Metastases and Skeletal Malignancies

Patients with bone metastases or a history of skeletal malignancies should not be treated with FORTEO.

5.4 Metabolic Bone Diseases

Patients with metabolic bone diseases other than osteoporosis should not be treated with FORTEO.

5.5 Hypercalcemia and Hypercalcemic Disorders

FORTEO has not been studied in patients with pre-existing hypercalcemia. These patients should not be treated with FORTEO because of the possibility of exacerbating hypercalcemia. Patients known to have an underlying hypercalcemic disorder, such as primary hyperparathyroidism, should not be treated with FORTEO.

5.6 Urolithiasis or Pre-existing Hypercalciuria

In clinical trials, the frequency of urolithiasis was similar in patients treated with FORTEO and placebo. However, FORTEO has not been studied in patients with active urolithiasis. If active urolithiasis or pre-existing hypercalciuria are suspected, measurement of urinary calcium excretion should be considered. FORTEO should be used with caution in patients with active or recent urolithiasis because of the potential to exacerbate this condition.

5.7 Orthostatic Hypotension

FORTEO should be administered initially under circumstances in which the patient can sit or lie down if symptoms of orthostatic hypotension occur. In short-term clinical pharmacology studies with teriparatide, transient episodes of symptomatic orthostatic hypotension were observed in 5% of patients. Typically, an event began within 4 hours of dosing and spontaneously resolved within a few minutes to a few hours. When transient orthostatic hypotension occurred, it happened within the first several doses, it was relieved by placing the person in a reclining position, and it did not preclude continued treatment.

5.8 Drug Interactions

Hypercalcemia may predispose patients to digitalis toxicity. Because FORTEO transiently increases serum calcium, patients receiving digoxin should use FORTEO with caution [see *Drug Interactions (7.1) and Clinical Pharmacology (12.3)*].

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

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

Treatment of Osteoporosis in Men and Postmenopausal Women

The safety of FORTEO in the treatment of osteoporosis in men and postmenopausal women was assessed in two randomized, double-blind, placebo-controlled trials of 1382 patients (21% men, 79% women) aged 28 to 86 years (mean 67 years). The median durations of the trials were 11 months for men and 19 months for women, with 691 patients exposed to FORTEO and 691 patients to placebo. All patients received 1000 mg of calcium plus at least 400 IU of vitamin D supplementation per day.

The incidence of all cause mortality was 1% in the FORTEO group and 1% in the placebo group. The incidence of serious adverse events was 16% in FORTEO patients and 19% in placebo patients. Early discontinuation due to adverse events occurred in 7% of FORTEO patients and 6% of placebo patients.

Table 1 lists adverse events from the two principal osteoporosis trials in men and postmenopausal women that occurred in $\geq 2\%$ of FORTEO-treated and more frequently than placebo-treated patients.

Table 1. Percentage of Patients with Adverse Events Reported by at Least 2% of FORTEO-Treated Patients and in More FORTEO-Treated Patients than Placebo-Treated Patients from the Two Principal Osteoporosis Trials in Women and Men
Adverse Events are Shown Without Attribution of Causality

	FORTEO N=691	Placebo N=691
Event Classification	(%)	(%)
Body as a Whole		
Pain	21.3	20.5
Headache	7.5	7.4
Asthenia	8.7	6.8
Neck pain	3.0	2.7
Cardiovascular		
Hypertension	7.1	6.8
Angina pectoris	2.5	1.6
Syncope	2.6	1.4
Digestive System		
Nausea	8.5	6.7
Constipation	5.4	4.5
Diarrhea	5.1	4.6
Dyspepsia	5.2	4.1
Vomiting	3.0	2.3
Gastrointestinal disorder	2.3	2.0
Tooth disorder	2.0	1.3
Musculoskeletal		
Arthralgia	10.1	8.4
Leg cramps	2.6	1.3
Nervous System		
Dizziness	8.0	5.4
Depression	4.1	2.7
Insomnia	4.3	3.6
Vertigo	3.8	2.7
Respiratory System		
Rhinitis	9.6	8.8
Cough increased	6.4	5.5
Pharyngitis	5.5	4.8
Dyspnea	3.6	2.6
Pneumonia	3.9	3.3
Skin and Appendages		
Rash	4.9	4.5
Sweating	2.2	1.7

111 Immunogenicity — In the clinical trial, antibodies that cross-reacted with teriparatide were detected in 3% of women (15/541)
112 receiving FORTEO. Generally, antibodies were first detected following 12 months of treatment and diminished after withdrawal of
113 therapy. There was no evidence of hypersensitivity reactions or allergic reactions among these patients. Antibody formation did not
114 appear to have effects on serum calcium, or on bone mineral density (BMD) response.

115 Laboratory Findings

116 Serum Calcium — FORTEO transiently increased serum calcium, with the maximal effect observed at approximately 4 to
117 6 hours post-dose. Serum calcium measured at least 16 hours post-dose was not different from pretreatment levels. In clinical trials,
118 the frequency of at least 1 episode of transient hypercalcemia in the 4 to 6 hours after FORTEO administration was increased from 2%
119 of women and none of the men treated with placebo to 11% of women and 6% of men treated with FORTEO. The number of patients
120 treated with FORTEO whose transient hypercalcemia was verified on consecutive measurements was 3% of women and 1% of men.

121 Urinary Calcium — FORTEO increased urinary calcium excretion, but the frequency of hypercalciuria in clinical trials was
122 similar for patients treated with FORTEO and placebo [see *Clinical Pharmacology (12.2)*].

123 Serum Uric Acid — FORTEO increased serum uric acid concentrations. In clinical trials, 3% of FORTEO patients had serum
124 uric acid concentrations above the upper limit of normal compared with 1% of placebo patients. However, the hyperuricemia did not
125 result in an increase in gout, arthralgia, or urolithiasis.

126 Renal Function — No clinically important adverse renal effects were observed in clinical studies. Assessments included
127 creatinine clearance; measurements of blood urea nitrogen (BUN), creatinine, and electrolytes in serum; urine specific gravity and pH;
128 and examination of urine sediment.

129 Studies in Men and Women with Glucocorticoid-Induced Osteoporosis

130 The safety of FORTEO in the treatment of men and women with glucocorticoid-induced osteoporosis was assessed in a
131 randomized, double-blind, active-controlled trial of 428 patients (19% men, 81% women) aged 22 to 89 years (mean 57 years) treated
132 with ≥ 5 mg per day prednisone or equivalent for a minimum of 3 months. The duration of the trial was 18 months with 214 patients
133 exposed to FORTEO and 214 patients exposed to oral daily bisphosphonate (active control). All patients received 1000 mg of calcium
134 plus 800 IU of vitamin D supplementation per day.

135 The incidence of all cause mortality was 4% in the FORTEO group and 6% in the active control group. The incidence of
136 serious adverse events was 21% in FORTEO patients and 18% in active control patients, and included pneumonia (3% FORTEO, 1%
137 active control). Early discontinuation because of adverse events occurred in 15% of FORTEO patients and 12% of active control
138 patients, and included dizziness (2% FORTEO, 0% active control).

139 Adverse events reported at a higher incidence in the FORTEO group and with at least a 2% difference in FORTEO-treated
140 patients compared with active control-treated patients were: nausea (14%, 7%), gastritis (7%, 3%), pneumonia (6%, 3%), dyspnea
141 (6%, 3%), insomnia (5%, 1%), anxiety (4%, 1%), and herpes zoster (3%, 1%), respectively.

142 **6.2 Postmarketing Experience**

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

- 146 • Osteosarcoma: Cases of bone tumor and osteosarcoma have been reported rarely in the postmarketing period. The
147 causality to FORTEO use is unclear. Long term osteosarcoma surveillance studies are ongoing [see *Warnings and*
148 *Precautions (5.1)*]
- 149 • Hypercalcemia: Hypercalcemia greater than 13.0 mg/dL has been reported with FORTEO use.

150 Adverse events reported since market introduction that were temporally (but not necessarily causally) related to FORTEO
151 therapy include the following:

- 152 • Allergic Reactions: Anaphylactic reactions, drug hypersensitivity, angioedema, urticaria
- 153 • Investigations: Hyperuricemia
- 154 • Respiratory System: Acute dyspnea, chest pain
- 155 • Musculoskeletal: Muscle spasms of the leg or back
- 156 • Other: Injection site reactions including injection site pain, swelling and bruising; oro-facial edema
- 157

158 **7 DRUG INTERACTIONS**

159 **7.1 Digoxin**

160 A single FORTEO dose did not alter the effect of digoxin on the systolic time interval (from electrocardiographic Q-wave
161 onset to aortic valve closure, a measure of digoxin's calcium-mediated cardiac effect). However, because FORTEO may transiently
162 increase serum calcium, FORTEO should be used with caution in patients taking digoxin [see *Warnings and Precaution (5.8) and*
163 *Clinical Pharmacology (12.3)*].

165 **7.2 Hydrochlorothiazide**

166 The coadministration of hydrochlorothiazide 25 mg with teriparatide did not affect the serum calcium response to teriparatide
167 40 mcg. The effect of coadministration of a higher dose of hydrochlorothiazide with teriparatide on serum calcium levels has not been
168 studied [see *Clinical Pharmacology (12.3)*].

169 **7.3 Furosemide**

170 Coadministration of intravenous furosemide (20 to 100 mg) with teriparatide 40 mcg in healthy people and patients with mild,
171 moderate, or severe renal impairment (CrCl 13 to 72 mL/min) resulted in small increases in the serum calcium (2%) and 24-hour urine
172 calcium (37%) responses to teriparatide that did not appear to be clinically important [see *Clinical Pharmacology (12.3)*].

173 **8 USE IN SPECIFIC POPULATIONS**

174 **8.1 Pregnancy**

175 Pregnancy Category C — There are no adequate and well-controlled studies of FORTEO in pregnant women. In animal
176 studies, teriparatide increased skeletal deviations and variations in mouse offspring at doses more than 60 times the equivalent human
177 dose and produced mild growth retardation and reduced motor activity in rat offspring at doses more than 120 times the equivalent
178 human dose. FORTEO should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

179 In animal studies, pregnant mice received teriparatide during organogenesis at subcutaneous doses 8 to 267 times the human
180 dose. At doses ≥ 60 times the human dose, the fetuses showed an increased incidence of skeletal deviations or variations (interrupted
181 rib, extra vertebra or rib). When pregnant rats received subcutaneous teriparatide during organogenesis at doses 16 to 540 times the
182 human dose, the fetuses showed no abnormal findings.

183 In a perinatal/postnatal study, pregnant rats received subcutaneous teriparatide from organogenesis through lactation. Mild
184 growth retardation in female offspring at doses ≥ 120 times the human dose (based on surface area, mcg/m²). Mild growth retardation
185 in male offspring and reduced motor activity in both male and female offspring occurred at maternal doses 540 times the human dose.
186 There were no developmental or reproductive effects in mice or rats at doses 8 or 16 times the human dose, respectively.

187 Exposure multiples were normalized based on body surface area (mcg/m²). Actual animal doses: mice (30 to
188 1000 mcg/kg/day); rats (30 to 1000 mcg/kg/day).

189 **8.3 Nursing Mothers**

190 It is not known whether teriparatide is excreted in human milk. Because of the potential for tumorigenicity shown for
191 teriparatide in animal studies, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account
192 the importance of the drug to the mother.

193 **8.4 Pediatric Use**

194 The safety and efficacy of FORTEO have not been established in any pediatric population. FORTEO should not be prescribed
195 in patients at an increased baseline risk of osteosarcoma which include pediatric and young adult patients with open epiphyses.
196 Therefore, FORTEO is not indicated for use in pediatric or young adult patients with open epiphyses [see *Warnings and Precautions*
197 (5.1)].

198 **8.5 Geriatric Use**

199 Of the patients receiving FORTEO in the osteoporosis trial of 1637 postmenopausal women, 75% were 65 years of age and
200 over and 23% were 75 years of age and over. Of the patients receiving FORTEO in the osteoporosis trial of 437 men, 39% were
201 65 years of age and over and 13% were 75 years of age and over. No overall differences in safety or effectiveness were observed
202 between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses
203 between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

204 **8.6 Hepatic Impairment**

205 No studies have been performed in patients with hepatic impairment. [see *Clinical Pharmacology (12.3)*].

206 **8.7 Renal Impairment**

207 In 5 patients with severe renal impairment (CrCl < 30 mL/min), the AUC and T_{1/2} of teriparatide were increased by 73% and
208 77%, respectively. Maximum serum concentration of teriparatide was not increased [see *Clinical Pharmacology (12.3)*].

209 **10 OVERDOSAGE**

210 Incidents of overdose in humans have not been reported in clinical trials. Teriparatide has been administered in single doses of
211 up to 100 mcg and in repeated doses of up to 60 mcg/day for 6 weeks. The effects of overdose that might be expected include a
212 delayed hypercalcemic effect and risk of orthostatic hypotension. Nausea, vomiting, dizziness, and headache might also occur.

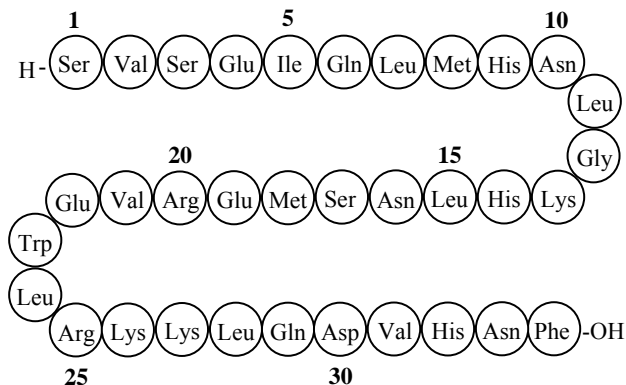
213 In postmarketing spontaneous reports, there have been cases of medication errors in which the entire contents (up to 800 mcg)
214 of the FORTEO delivery device (pen) have been administered as a single dose. Transient events reported have included nausea,
215 weakness/lethargy and hypotension. In some cases, no adverse events occurred as a result of the overdose. No fatalities associated
216 with overdose have been reported.

217 **Overdose Management** — There is no specific antidote for teriparatide. Treatment of suspected overdose should include
218 discontinuation of FORTEO, monitoring of serum calcium and phosphorus, and implementation of appropriate supportive measures,
219 such as hydration.

220 11 DESCRIPTION

221 FORTEO (teriparatide [rDNA origin] injection) contains recombinant human parathyroid hormone (1-34), and is also called
222 rhPTH (1-34). It has an identical sequence to the 34 N-terminal amino acids (the biologically active region) of the 84-amino acid
223 human parathyroid hormone.

224 Teriparatide has a molecular weight of 4117.8 daltons and its amino acid sequence is shown below:



225 Teriparatide (rDNA origin) is manufactured using a strain of *Escherichia coli* modified by recombinant DNA technology.
226 FORTEO is supplied as a sterile, colorless, clear, isotonic solution in a glass cartridge which is pre-assembled into a disposable
227 delivery device (pen) for subcutaneous injection. Each prefilled delivery device is filled with either 3.3 mL to deliver 3 mL or 2.7 mL
228 to deliver 2.4 mL. Each mL contains 250 mcg teriparatide (corrected for acetate, chloride, and water content), 0.41 mg glacial acetic
229 acid, 0.1 mg sodium acetate (anhydrous), 45.4 mg mannitol, 3 mg Metacresol, and Water for Injection. In addition, hydrochloric acid
230 solution 10% and/or sodium hydroxide solution 10% may have been added to adjust the product to pH 4.

231 Each cartridge, pre-assembled into a delivery device, delivers 20 mcg of teriparatide per dose each day for up to 28 days.

233 12 CLINICAL PHARMACOLOGY

234 12.1 Mechanism of Action

235 Endogenous 84-amino acid parathyroid hormone (PTH) is the primary regulator of calcium and phosphate metabolism in bone
236 and kidney. Physiological actions of PTH include regulation of bone metabolism, renal tubular reabsorption of calcium and phosphate,
237 and intestinal calcium absorption. The biological actions of PTH and teriparatide are mediated through binding to specific high-
238 affinity cell-surface receptors. Teriparatide and the 34 N-terminal amino acids of PTH bind to these receptors with the same affinity
239 and have the same physiological actions on bone and kidney. Teriparatide is not expected to accumulate in bone or other tissues.

240 The skeletal effects of teriparatide depend upon the pattern of systemic exposure. Once-daily administration of teriparatide
241 stimulates new bone formation on trabecular and cortical (periosteal and/or endosteal) bone surfaces by preferential stimulation of
242 osteoblastic activity over osteoclastic activity. In monkey studies, teriparatide improved trabecular microarchitecture and increased
243 bone mass and strength by stimulating new bone formation in both cancellous and cortical bone. In humans, the anabolic effects of
244 teriparatide manifest as an increase in skeletal mass, an increase in markers of bone formation and resorption, and an increase in bone
245 strength. By contrast, continuous excess of endogenous PTH, as occurs in hyperparathyroidism, may be detrimental to the skeleton
246 because bone resorption may be stimulated more than bone formation.

247 12.2 Pharmacodynamics

248 Pharmacodynamics in Men and Postmenopausal Women with Osteoporosis

249 **Effects on Mineral Metabolism** — Teriparatide affects calcium and phosphorus metabolism in a pattern consistent with the
250 known actions of endogenous PTH (e.g., increases serum calcium and decreases serum phosphorus).

251 **Serum Calcium Concentrations** — When teriparatide 20 mcg is administered once daily, the serum calcium concentration
252 increases transiently, beginning approximately 2 hours after dosing and reaching a maximum concentration between 4 and 6 hours
253 (median increase, 0.4 mg/dL). The serum calcium concentration begins to decline approximately 6 hours after dosing and returns to
254 baseline by 16 to 24 hours after each dose.

255 In a clinical study of postmenopausal women with osteoporosis, the median peak serum calcium concentration measured 4 to
256 6 hours after dosing with FORTEO (teriparatide 20 mcg) was 2.42 mmol/L (9.68 mg/dL) at 12 months. The peak serum calcium
257 remained below 2.76 mmol/L (11.0 mg/dL) in >99% of women at each visit. Sustained hypercalcemia was not observed.

258 In this study, 11.1% of women treated with FORTEO had at least 1 serum calcium value above the upper limit of normal
259 [2.64 mmol/L (10.6 mg/dL)] compared with 1.5% of women treated with placebo. The percentage of women treated with FORTEO
260 whose serum calcium was above the upper limit of normal on consecutive 4- to 6-hour post-dose measurements was 3.0% compared
261 with 0.2% of women treated with placebo. In these women, calcium supplements and/or FORTEO doses were reduced. The timing of
262 these dose reductions was at the discretion of the investigator. FORTEO dose adjustments were made at varying intervals after the
263 first observation of increased serum calcium (median 21 weeks). During these intervals, there was no evidence of progressive
264 increases in serum calcium.

265 In a clinical study of men with either primary or hypogonadal osteoporosis, the effects on serum calcium were similar to those
266 observed in postmenopausal women. The median peak serum calcium concentration measured 4 to 6 hours after dosing with FORTEO
267 was 2.35 mmol/L (9.44 mg/dL) at 12 months. The peak serum calcium remained below 2.76 mmol/L (11.0 mg/dL) in 98% of men at
268 each visit. Sustained hypercalcemia was not observed.

269 In this study, 6.0% of men treated with FORTEO daily had at least 1 serum calcium value above the upper limit of normal
270 [2.64 mmol/L (10.6 mg/dL)] compared with none of the men treated with placebo. The percentage of men treated with FORTEO
271 whose serum calcium was above the upper limit of normal on consecutive measurements was 1.3% (2 men) compared with none of
272 the men treated with placebo. Although calcium supplements and/or FORTEO doses could have been reduced in these men, only
273 calcium supplementation was reduced [see *Warnings and Precautions (5.5) and Adverse Reactions (6.1)*].

274 In a clinical study of women previously treated for 18 to 39 months with raloxifene (n=26) or alendronate (n=33), mean serum
275 calcium >12 hours after FORTEO injection was increased by 0.09 to 0.14 mmol/L (0.36 to 0.56 mg/dL), after 1 to 6 months of
276 FORTEO treatment compared with baseline. Of the women pretreated with raloxifene, 3 (11.5%) had a serum calcium >2.76 mmol/L
277 (11.0 mg/dL), and of those pretreated with alendronate, 3 (9.1%) had a serum calcium >2.76 mmol/L (11.0 mg/dL). The highest serum
278 calcium reported was 3.12 mmol/L (12.5 mg/dL). None of the women had symptoms of hypercalcemia. There were no placebo
279 controls in this study.

280 In the study of patients with glucocorticoid-induced osteoporosis, the effects of FORTEO on serum calcium were similar to
281 those observed in postmenopausal women with osteoporosis not taking glucocorticoids.

282 *Urinary Calcium Excretion* — In a clinical study of postmenopausal women with osteoporosis who received 1000 mg of
283 supplemental calcium and at least 400 IU of vitamin D, daily FORTEO increased urinary calcium excretion. The median urinary
284 excretion of calcium was 4.8 mmol/day (190 mg/day) at 6 months and 4.2 mmol/day (170 mg/day) at 12 months. These levels were
285 0.76 mmol/day (30 mg/day) and 0.3 mmol/day (12 mg/day) higher, respectively, than in women treated with placebo. The incidence
286 of hypercalciuria (>7.5 mmol Ca/day or 300 mg/day) was similar in the women treated with FORTEO or placebo.

287 In a clinical study of men with either primary or hypogonadal osteoporosis who received 1000 mg of supplemental calcium
288 and at least 400 IU of vitamin D, daily FORTEO had inconsistent effects on urinary calcium excretion. The median urinary excretion
289 of calcium was 5.6 mmol/day (220 mg/day) at 1 month and 5.3 mmol/day (210 mg/day) at 6 months. These levels were 0.5 mmol/day
290 (20 mg/day) higher and 0.2 mmol/day (8.0 mg/day) lower, respectively, than in men treated with placebo. The incidence of
291 hypercalciuria (>7.5 mmol Ca/day or 300 mg/day) was similar in the men treated with FORTEO or placebo.

292 *Phosphorus and Vitamin D* — In single-dose studies, teriparatide produced transient phosphaturia and mild transient
293 reductions in serum phosphorus concentration. However, hypophosphatemia (<0.74 mmol/L or 2.4 mg/dL) was not observed in
294 clinical trials with FORTEO.

295 In clinical trials of daily FORTEO, the median serum concentration of 1,25-dihydroxyvitamin D was increased at 12 months
296 by 19% in women and 14% in men, compared with baseline. In the placebo group, this concentration decreased by 2% in women and
297 increased by 5% in men. The median serum 25-hydroxyvitamin D concentration at 12 months was decreased by 19% in women and
298 10% in men compared with baseline. In the placebo group, this concentration was unchanged in women and increased by 1% in men.

299 In the study of patients with glucocorticoid-induced osteoporosis, the effects of FORTEO on serum phosphorus were similar
300 to those observed in postmenopausal women with osteoporosis not taking glucocorticoids.

301 *Effects on Markers of Bone Turnover* — Daily administration of FORTEO to men and postmenopausal women with
302 osteoporosis in clinical studies stimulated bone formation, as shown by increases in the formation markers serum bone-specific
303 alkaline phosphatase (BSAP) and procollagen I carboxy-terminal propeptide (PICP). Data on biochemical markers of bone turnover
304 were available for the first 12 months of treatment. Peak concentrations of PICP at 1 month of treatment were approximately 41%
305 above baseline, followed by a decline to near-baseline values by 12 months. BSAP concentrations increased by 1 month of treatment
306 and continued to rise more slowly from 6 through 12 months. The maximum increases of BSAP were 45% above baseline in women
307 and 23% in men. After discontinuation of therapy, BSAP concentrations returned toward baseline. The increases in formation markers
308 were accompanied by secondary increases in the markers of bone resorption: urinary N-telopeptide (NTX) and urinary
309 deoxypyridinoline (DPD), consistent with the physiological coupling of bone formation and resorption in skeletal remodeling.
310 Changes in BSAP, NTX, and DPD were lower in men than in women, possibly because of lower systemic exposure to teriparatide in
311 men.

312 In the study of patients with glucocorticoid-induced osteoporosis, the effects of FORTEO on serum markers of bone turnover
313 were similar to those observed in postmenopausal women with osteoporosis not taking glucocorticoids.

12.3 Pharmacokinetics

Absorption — Teriparatide is absorbed after subcutaneous injection; the absolute bioavailability is approximately 95% based on pooled data from 20-, 40-, and 80- mcg doses. The rates of absorption and elimination are rapid. The peptide reaches peak serum concentrations about 30 minutes after subcutaneous injection of a 20-mcg dose and declines to non-quantifiable concentrations within 3 hours.

Distribution — Systemic clearance of teriparatide (approximately 62 L/hr in women and 94 L/hr in men) exceeds the rate of normal liver plasma flow, consistent with both hepatic and extra-hepatic clearance. Volume of distribution, following intravenous injection, is approximately 0.12 L/kg. Intersubject variability in systemic clearance and volume of distribution is 25% to 50%. The half-life of teriparatide in serum is 5 minutes when administered by intravenous injection and approximately 1 hour when administered by subcutaneous injection. The longer half-life following subcutaneous administration reflects the time required for absorption from the injection site.

Metabolism and Excretion — No metabolism or excretion studies have been performed with teriparatide. However, the mechanisms of metabolism and elimination of PTH(1-34) and intact PTH have been extensively described in published literature. Peripheral metabolism of PTH is believed to occur by non-specific enzymatic mechanisms in the liver followed by excretion via the kidneys.

Pediatric Patients — Pharmacokinetic data in pediatric patients are not available [see *Warnings and Precautions (5.1)*].

Geriatric Patients — No age-related differences in teriparatide pharmacokinetics were detected (range 31 to 85 years).

Gender — Although systemic exposure to teriparatide was approximately 20% to 30% lower in men than women, the recommended dose for both genders is 20 mcg/day.

Race — The populations included in the pharmacokinetic analyses were 98.5% Caucasian. The influence of race has not been determined.

Renal Impairment — No pharmacokinetic differences were identified in 11 patients with mild or moderate renal impairment [creatinine clearance (CrCl) 30 to 72 mL/min] administered a single dose of teriparatide. In 5 patients with severe renal impairment (CrCl<30 mL/min), the AUC and T_{1/2} of teriparatide were increased by 73% and 77%, respectively. Maximum serum concentration of teriparatide was not increased. No studies have been performed in patients undergoing dialysis for chronic renal failure [see *Use in Specific Populations (8.7)*].

Hepatic Impairment — No studies have been performed in patients with hepatic impairment. Non-specific proteolytic enzymes in the liver (possibly Kupffer cells) cleave PTH(1-34) and PTH(1-84) into fragments that are cleared from the circulation mainly by the kidney [see *Use in Specific Populations (8.6)*].

Drug Interactions

Digoxin — In a study of 15 healthy people administered digoxin daily to steady state, a single FORTEO dose did not alter the effect of digoxin on the systolic time interval (from electrocardiographic Q-wave onset to aortic valve closure, a measure of digoxin's calcium-mediated cardiac effect). However, sporadic case reports have suggested that hypercalcemia may predispose patients to digitalis toxicity. Because FORTEO may transiently increase serum calcium, FORTEO should be used with caution in patients taking digoxin [see *Drug Interactions (7.1)*].

Hydrochlorothiazide — In a study of 20 healthy people, the coadministration of hydrochlorothiazide 25 mg with teriparatide did not affect the serum calcium response to teriparatide 40 mcg. The 24-hour urine excretion of calcium was reduced by a clinically unimportant amount (15%). The effect of coadministration of a higher dose of hydrochlorothiazide with teriparatide on serum calcium levels has not been studied [see *Drug Interactions (7.2)*].

Furosemide — In a study of 9 healthy people and 17 patients with mild, moderate, or severe renal impairment (CrCl 13 to 72 mL/min), coadministration of intravenous furosemide (20 to 100 mg) with teriparatide 40 mcg resulted in small increases in the serum calcium (2%) and 24-hour urine calcium (37%) responses to teriparatide that did not appear to be clinically important [see *Drug Interactions (7.3)*].

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis — Two carcinogenicity bioassays were conducted in Fischer 344 rats. In the first study, male and female rats were given daily subcutaneous teriparatide injections of 5, 30, or 75 mcg/kg/day for 24 months from 2 months of age. These doses resulted in systemic exposures that were, respectively, 3, 20, and 60 times higher than the systemic exposure observed in humans following a subcutaneous dose of 20 mcg (based on AUC comparison). Teriparatide treatment resulted in a marked dose-related increase in the incidence of osteosarcoma, a rare malignant bone tumor, in both male and female rats. Osteosarcomas were observed at all doses and the incidence reached 40% to 50% in the high-dose groups. Teriparatide also caused a dose-related increase in osteoblastoma and osteoma in both sexes. No osteosarcomas, osteoblastomas or osteomas were observed in untreated control rats. The bone tumors in rats occurred in association with a large increase in bone mass and focal osteoblast hyperplasia.

The second 2-year study was carried out in order to determine the effect of treatment duration and animal age on the development of bone tumors. Female rats were treated for different periods between 2 and 26 months of age with subcutaneous doses

of 5 and 30 mcg/kg (equivalent to 3 and 20 times the human exposure at the 20-mcg dose, based on AUC comparison). The study showed that the occurrence of osteosarcoma, osteoblastoma and osteoma was dependent upon dose and duration of exposure. Bone tumors were observed when immature 2-month old rats were treated with 30 mcg/kg/day for 24 months or with 5 or 30 mcg/kg/day for 6 months. Bone tumors were also observed when mature 6-month old rats were treated with 30 mcg/kg/day for 6 or 20 months. Tumors were not detected when mature 6-month old rats were treated with 5 mcg/kg/day for 6 or 20 months. The results did not demonstrate a difference in susceptibility to bone tumor formation, associated with teriparatide treatment, between mature and immature rats.

The relevance of these animal findings to humans is uncertain.

Mutagenesis — Teriparatide was not genotoxic in any of the following test systems: the Ames test for bacterial mutagenesis; the mouse lymphoma assay for mammalian cell mutation; the chromosomal aberration assay in Chinese hamster ovary cells, with and without metabolic activation; and the in vivo micronucleus test in mice.

Impairment of Fertility — No effects on fertility were observed in male and female rats given subcutaneous teriparatide doses of 30, 100, or 300 mcg/kg/day prior to mating and in females continuing through gestation Day 6 (16 to 160 times the human dose of 20 mcg based on surface area, mcg/m²).

13.2 Animal Toxicology

In single-dose rodent studies using subcutaneous injection of teriparatide, no mortality was seen in rats given doses of 1000 mcg/kg (540 times the human dose based on surface area, mcg/m²) or in mice given 10,000 mcg/kg (2700 times the human dose based on surface area, mcg/m²).

In a long-term study, skeletally mature ovariectomized female monkeys (N=30 per treatment group) were given either daily subcutaneous teriparatide injections of 5 mcg/kg or vehicle. Following the 18-month treatment period, the monkeys were removed from teriparatide treatment and were observed for an additional 3 years. The 5 mcg/kg dose resulted in systemic exposures that were approximately 6 times higher than the systemic exposure observed in humans following a subcutaneous dose of 20 mcg (based on AUC comparison). Bone tumors were not detected by radiographic or histologic evaluation in any monkey in the study.

14 CLINICAL STUDIES

14.1 Treatment of Osteoporosis in Postmenopausal Women

The safety and efficacy of once-daily FORTEO, median exposure of 19 months, were examined in a double-blind, multicenter, placebo-controlled clinical study of 1637 postmenopausal women with osteoporosis (FORTEO 20 mcg, n=541).

All women received 1000 mg of calcium and at least 400 IU of vitamin D per day. Baseline and endpoint spinal radiographs were evaluated using the semiquantitative scoring. Ninety percent of the women in the study had 1 or more radiographically diagnosed vertebral fractures at baseline. The primary efficacy endpoint was the occurrence of new radiographically diagnosed vertebral fractures defined as changes in the height of previously undeformed vertebrae. Such fractures are not necessarily symptomatic.

Effect on Fracture Incidence

New Vertebral Fractures — FORTEO, when taken with calcium and vitamin D and compared with calcium and vitamin D alone, reduced the risk of 1 or more new vertebral fractures from 14.3% of women in the placebo group to 5.0% in the FORTEO group. This difference was statistically significant (p<0.001); the absolute reduction in risk was 9.3% and the relative reduction was 65%. FORTEO was effective in reducing the risk for vertebral fractures regardless of age, baseline rate of bone turnover, or baseline BMD (see Table 2).

Table 2. Effect of FORTEO on Risk of Vertebral Fractures in Postmenopausal Women with Osteoporosis

	Percent of Women With Fracture			
	FORTEO (N=444)	Placebo (N=448)	Absolute Risk Reduction (%, 95% CI)	Relative Risk Reduction (%, 95% CI)
New fracture (≥1)	5.0 ^a	14.3	9.3 (5.5-13.1)	65 (45-78)
1 fracture	3.8	9.4		
2 fractures	0.9	2.9		
≥3 fractures	0.2	2.0		

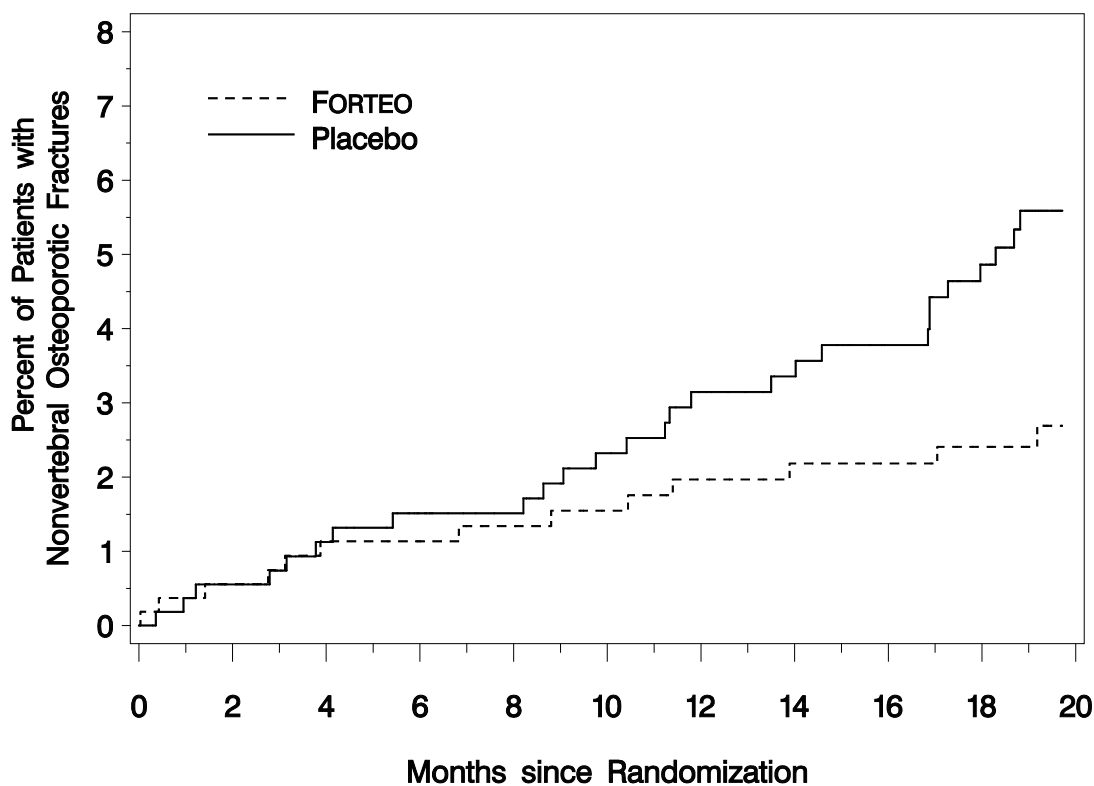
^a p≤0.001 compared with placebo.

New Nonvertebral Osteoporotic Fractures — FORTEO significantly reduced the risk of any nonvertebral fracture from 5.5% in the placebo group to 2.6% in the FORTEO group (p<0.05). The absolute reduction in risk was 2.9% and the relative reduction was 53%. The incidence of new nonvertebral fractures in the FORTEO group compared with the placebo group was ankle/foot (0.2%),

413 0.7%), hip (0.2%, 0.7%), humerus (0.4%, 0.4%), pelvis (0%, 0.6%), ribs (0.6%, 0.9%), wrist (0.4%, 1.3%), and other sites (1.1%,
414 1.5%), respectively.

415 The cumulative percentage of postmenopausal women with osteoporosis who sustained new nonvertebral fractures was lower
416 in women treated with FORTEO than in women treated with placebo (see Figure 1).

417
418 **Figure 1. Cumulative Percentage of Postmenopausal Women with Osteoporosis Sustaining New Nonvertebral**
419 **Osteoporotic Fractures**



420
421 Effect on Bone Mineral Density (BMD)
422 FORTEO increased lumbar spine BMD in postmenopausal women with osteoporosis. Statistically significant increases were
423 seen at 3 months and continued throughout the treatment period. Postmenopausal women with osteoporosis who were treated with
424 FORTEO had statistically significant increases in BMD from baseline to endpoint at the lumbar spine, femoral neck, total hip, and
425 total body (see Table 3).

Table 3. Mean Percent Change in BMD from Baseline to Endpoint^a in Postmenopausal Women with Osteoporosis, Treated with FORTEO or Placebo for a Median of 19 Months

	FORTEO N=541	Placebo N=544
Lumbar spine BMD	9.7 ^b	1.1
Femoral neck BMD	2.8 ^c	-0.7
Total hip BMD	2.6 ^c	-1.0
Trochanter BMD	3.5 ^c	-0.2
Intertrochanter BMD	2.6 ^c	-1.3
Ward's triangle BMD	4.2 ^c	-0.8
Total body BMD	0.6 ^c	-0.5
Distal 1/3 radius BMD	-2.1	-1.3
Ultradistal radius BMD	-0.1	-1.6

^a Intent-to-treat analysis, last observation carried forward.

^b p<0.001 compared with placebo.

^c p<0.05 compared with placebo.

FORTEO treatment increased lumbar spine BMD from baseline in 96% of postmenopausal women treated. Seventy-two percent of patients treated with FORTEO achieved at least a 5% increase in spine BMD, and 44% gained 10% or more.

Both treatment groups lost height during the trial. The mean decreases were 3.61 and 2.81 mm in the placebo and FORTEO groups, respectively.

Bone Histology

The effects of teriparatide on bone histology were evaluated in iliac crest biopsies of 35 postmenopausal women treated for 12 to 24 months with calcium and vitamin D and teriparatide 20 or 40 mcg/day. Normal mineralization was observed with no evidence of cellular toxicity. The new bone formed with teriparatide was of normal quality (as evidenced by the absence of woven bone and marrow fibrosis).

14.2 Treatment to Increase Bone Mass in Men with Primary or Hypogonadal Osteoporosis

The safety and efficacy of once-daily FORTEO, median exposure of 10 months, were examined in a double-blind, multicenter, placebo-controlled clinical study of 437 men with either primary (idiopathic) or hypogonadal osteoporosis (FORTEO 20 mcg, n=151). All men received 1000 mg of calcium and at least 400 IU of vitamin D per day. The primary efficacy endpoint was change in lumbar spine BMD.

FORTEO increased lumbar spine BMD in men with primary or hypogonadal osteoporosis. Statistically significant increases were seen at 3 months and continued throughout the treatment period. FORTEO was effective in increasing lumbar spine BMD regardless of age, baseline rate of bone turnover, and baseline BMD. The effects of FORTEO at additional skeletal sites are shown in Table 4.

FORTEO treatment for a median of 10 months increased lumbar spine BMD from baseline in 94% of men treated. Fifty-three percent of patients treated with FORTEO achieved at least a 5% increase in spine BMD, and 14% gained 10% or more.

Table 4. Mean Percent Change in BMD from Baseline to Endpoint^a in Men with Primary or Hypogonadal Osteoporosis, Treated with FORTEO or Placebo for a Median of 10 Months

	FORTEO N=151	Placebo N=147
Lumbar spine BMD	5.9 ^b	0.5
Femoral neck BMD	1.5 ^c	0.3
Total hip BMD	1.2	0.5
Trochanter BMD	1.3	1.1
Intertrochanter BMD	1.2	0.6
Ward's triangle BMD	2.8	1.1
Total body BMD	0.4	-0.4
Distal 1/3 radius BMD	-0.5	-0.2
Ultradistal radius BMD	-0.5	-0.3

^a Intent-to-treat analysis, last observation carried forward.

^b p<0.001 compared with placebo.

^c p<0.05 compared with placebo.

14.3 Treatment of Men and Women with Glucocorticoid-Induced Osteoporosis

The efficacy of FORTEO for treating glucocorticoid-induced osteoporosis was assessed in a randomized, double-blind, active-controlled trial of 428 patients (19% men, 81% women) aged 22 to 89 years (mean 57 years) treated with ≥5 mg/day prednisone or equivalent for a minimum of 3 months. The duration of the trial was 18 months with 214 patients exposed to FORTEO. In the FORTEO group, the baseline median glucocorticoid dose was 7.5 mg/day and the median duration of glucocorticoid use was 1.5 years. The mean (SD) baseline lumbar spine BMD was 0.85 ± 0.13 g/cm² and lumbar spine BMD T-score was -2.5 ± 1 (number of standard deviations below the mean BMD value for healthy adults). A total of 30% of patients had prevalent vertebral fracture(s) and 43% had prior non-vertebral fracture(s). The patients had chronic rheumatologic, respiratory or other diseases that required sustained glucocorticoid therapy. All patients received 1000 mg of calcium plus 800 IU of vitamin D supplementation per day.

Because of differences in mechanism of action (anabolic vs. anti-resorptive) and lack of clarity regarding differences in BMD as an adequate predictor of fracture efficacy, data on the active comparator are not presented.

Effect on Bone Mineral Density (BMD)

In patients with glucocorticoid-induced osteoporosis, FORTEO increased lumbar spine BMD compared with baseline at 3 months through 18 months of treatment. In patients treated with FORTEO, the mean percent change in BMD from baseline to endpoint was 7.2% at the lumbar spine, 3.6% at the total hip, and 3.7% at the femoral neck (p<0.001 all sites). The relative treatment effects of FORTEO were consistent in subgroups defined by gender, age, geographic region, body mass index, underlying disease, prevalent vertebral fracture, baseline glucocorticoid dose, prior bisphosphonate use, and glucocorticoid discontinuation during trial.

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

The FORTEO delivery device (pen) is available in the following package sizes:

- 3 mL prefilled delivery device NDC 0002-8971-01 (MS8971).
- 2.4 mL prefilled delivery device NDC 0002-8400-01 (MS8400).

16.2 Storage and Handling

- The FORTEO delivery device should be stored under refrigeration at 2° to 8°C (36° to 46°F) at all times.
- Recap the delivery device when not in use to protect the cartridge from physical damage and light.
- During the use period, time out of the refrigerator should be minimized; the dose may be delivered immediately following removal from the refrigerator.
- Do not freeze. Do not use FORTEO if it has been frozen.

17 PATIENT COUNSELING INFORMATION

See Medication Guide.

17.1 Potential Risk of Osteosarcoma and Voluntary FORTEO Patient Registry

Patients should be made aware that in rats, teriparatide caused an increase in the incidence of osteosarcoma (a malignant bone tumor) that was dependent on dose and treatment duration. Patients should be encouraged to enroll in the voluntary FORTEO Patient

Registry, which is designed to collect information about any potential risk of osteosarcoma in patients who have taken FORTEO. Enrollment information can be obtained by calling 1-866-382-6813, or by visiting www.forteoregistry.rti.org.

17.2 Orthostatic Hypotension

FORTEO should be administered initially under circumstances where the patient can immediately sit or lie down if symptoms occur. Patients should be instructed that if they feel lightheaded or have palpitations after the injection, they should sit or lie down until the symptoms resolve. If symptoms persist or worsen, patients should be instructed to consult a physician before continuing treatment [see *Warnings and Precautions (5.7)*].

17.3 Hypercalcemia

Although symptomatic hypercalcemia was not observed in clinical trials, physicians should instruct patients taking FORTEO to contact a health care provider if they develop persistent symptoms of hypercalcemia (e.g., nausea, vomiting, constipation, lethargy, muscle weakness).

17.4 Other Osteoporosis Treatment Modalities

Patients should be informed regarding the roles of supplemental calcium and/or vitamin D, weight-bearing exercise, and modification of certain behavioral factors such as cigarette smoking and/or alcohol consumption.

17.5 Use of Delivery Device (Pen)

Patients and caregivers who administer FORTEO should be instructed on how to properly use the delivery device (refer to *User Manual*), properly dispose of needles, and be advised not to share their delivery device with other patients. The contents of the delivery device should NOT be transferred to a syringe.

Each FORTEO delivery device can be used for up to 28 days including the first injection from the delivery device. After the 28-day use period, discard the FORTEO delivery device, even if it still contains some unused solution.

17.6 Availability of Medication Guide and User Manual

Patients should read the *Medication Guide* and delivery device (pen) *User Manual* before starting therapy with FORTEO and re-read them each time the prescription is renewed. Patients need to understand and follow the instructions in the FORTEO delivery device *User Manual*. Failure to do so may result in inaccurate dosing.

Literature revised Month DD, YYYY

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www.forteo.com**

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Medication Guide

**FORTEO® (for-TAY-o)
teriparatide (rDNA origin)
injection**

Read this Medication Guide before you start taking FORTEO and each time you get a refill. There may be new information. Also, read the User Manual that comes with the FORTEO delivery device (pen) for information on how to use the device to inject your medicine the right way. This Medication Guide does not take the place of talking with your healthcare provider about your medical condition or your treatment.

What is the most important information I should know about FORTEO?

- During the drug testing process, the medicine in FORTEO caused some rats to develop a bone cancer called osteosarcoma. In people, osteosarcoma is a serious but rare cancer. Osteosarcoma has been reported rarely in people who took FORTEO. It is not known if people who take FORTEO have a higher chance of getting osteosarcoma.
- You should not take FORTEO for more than 2 years over your lifetime.
- There is a voluntary Patient Registry for people who take FORTEO. The purpose of the registry is to collect information about the possible risk of osteosarcoma in people who take FORTEO. For information about how to sign up for this patient registry, call 1-866-382-6813 or go to www.forteoregistry.rti.org.

What is FORTEO?

- FORTEO is a prescription medicine that is like a hormone made by the body called parathyroid hormone or PTH. FORTEO may help to form new bone, increase bone mineral density and bone strength.
- FORTEO can lessen the number of fractures of the spine and other bones in postmenopausal women with osteoporosis.
- The effect on fractures has not been studied in men.
- FORTEO is used in both men and postmenopausal women with osteoporosis who are at high risk for having fractures. FORTEO can be used by people who have had a fracture related to osteoporosis, or who have several risk factors for fracture, or who can not use other osteoporosis treatments.
- FORTEO is used in both men and women with osteoporosis due to use of glucocorticoid medicines, such as prednisone, for several months, who are at high risk for having broken bones (fractures). These include men and women with either a history of broken bones, who have several risk factors for fracture, or who can not use other osteoporosis treatments.

It is not known if FORTEO is safe and effective in children.

FORTEO should not be used in children and young adults whose bones are still growing.

Who should not use FORTEO?

Do not use FORTEO if you:

- are allergic to any of the ingredients in FORTEO. See the end of this Medication Guide for a complete list of the ingredients in FORTEO.

What should I tell my healthcare provider before taking FORTEO?

Before you take FORTEO, tell your healthcare provider if you:

- have the condition listed in the section “Who should not use FORTEO?”
- have Paget’s disease or other bone disease
- have cancer in your bones
- have trouble injecting yourself and do not have someone who can help you
- are a child or young adult whose bones are still growing
- have or have had kidney stones
- have had radiation therapy
- have or had too much calcium in your blood

- 52 • have any other medical conditions
- 53 • are pregnant or thinking about becoming pregnant. It is not known if FORTEO will harm your unborn
- 54 baby.
- 55 • are breast-feeding or plan to breast-feed. It is not known if FORTEO passes into your breast milk. You
- 56 and your doctor should decide if you will take FORTEO or breast feed. You should not do both.
- 57

58 **Tell your healthcare provider about all the medicines you take** including prescription and non-prescription
59 medicines, vitamins, and herbal supplements. Your healthcare provider needs this information to help keep you from
60 taking FORTEO with other medicines that may harm you.

- 61 • Especially tell your doctor if you take medicines that contain digoxin (Digoxin, Lanoxicaps, Lanoxin).

62 **How should I use FORTEO?**

- 63 • Inject FORTEO one time each day in your thigh or abdomen (lower stomach area). Talk to a healthcare
- 64 provider about how to rotate injection sites.
- 65 • Before you try to inject FORTEO yourself, a healthcare provider should teach you how to use the
- 66 FORTEO delivery device to give your injection the right way.
- 67 • Read the detailed User Manual at the end of this Medication Guide.
- 68 • You can take FORTEO with or without food or drink.
- 69 • The FORTEO delivery device has enough medicine for 28 days. It is set to give a 20 microgram dose of
- 70 medicine each day. Do not inject all the medicine in the FORTEO delivery device at any one time.
- 71 • Do not transfer the medicine from the FORTEO delivery device to a syringe. This can result in taking
- 72 the wrong dose of FORTEO. If you do not have pen needles to use with your FORTEO delivery device,
- 73 talk with your healthcare provider.
- 74 • FORTEO should look clear and colorless. Do not use FORTEO if it has particles in it, or if it is cloudy
- 75 or colored.
- 76 • Inject FORTEO right away after you take the delivery device out of the refrigerator.
- 77 • After each use, safely remove the needle, recap the delivery device, and put it back in the refrigerator
- 78 right away.
- 79 • You can take FORTEO at any time of the day. To help you remember to take FORTEO, take it at about
- 80 the same time each day.
- 81 • If you forget or can not take FORTEO at your usual time, take it as soon as you can on that day. Do not
- 82 take more than one injection in the same day.
- 83 • If you take more FORTEO than prescribed, call your healthcare provider. If you take too much
- 84 FORTEO, you may have nausea, vomiting, weakness or dizziness.
- 85

86 Follow your healthcare provider's instructions about other ways you can help your osteoporosis, such as exercise,
87 diet, and reducing or stopping your use of tobacco and alcohol. If your healthcare provider recommends calcium and
88 vitamin D supplements, you can take them at the same time you take FORTEO.

89 **What are the possible side effects of FORTEO?**

90 FORTEO can cause serious side effects including:

- 91 • See "What is the most important information I should know about FORTEO?"
- 92 • **Decrease in blood pressure when you change positions.** Some people feel dizzy, get a fast heartbeat, or feel
- 93 faint right after the first few doses. This usually happens within 4 hours of taking FORTEO and goes away
- 94 within a few hours. For the first few doses, take your injections of FORTEO in a place where you can sit or lie
- 95 down right away if you get these symptoms. If your symptoms get worse or do not go away, stop taking
- 96 FORTEO and call your healthcare provider.
- 97 • **Increased calcium in your blood.** Tell your healthcare provider if you have nausea, vomiting, constipation,
- 98 low energy, or muscle weakness. These may be signs there is too much calcium in your blood.
- 99

100 Common side effects of FORTEO include:

- 101 • nausea
- 102 • joint aches
- 103 • pain
- 104
- 105

106 Your healthcare provider may take samples of blood and urine during treatment to check your response to FORTEO.
107 Also, your healthcare provider may ask you to have follow-up tests of bone mineral density.

108
109 Tell your healthcare provider if you have any side effect that bothers you or that does not go away.

110
111 These are not all the possible side effects of FORTEO. For more information, ask your doctor or pharmacist.

112
113 Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

114 **How should I store FORTEO?**

- 115 • Keep your FORTEO delivery device in the refrigerator between 36° to 46°F (2° to 8°C).
- 116 • Do not freeze the FORTEO delivery device. Do not use FORTEO if it has been frozen.
- 117 • Do not use FORTEO after the expiration date printed on the delivery device and packaging.
- 118 • Throw away the FORTEO delivery device after 28 days even if it has medicine in it (see the User
119 Manual).

120 **Keep FORTEO and all medicines out of the reach of children.**

121 **General information about FORTEO**

122 Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use
123 FORTEO for a condition for which it was not prescribed. Do not give FORTEO to other people, even if they have
124 the same condition you have.

125
126 This Medication Guide summarizes the most important information about FORTEO. If you would like more
127 information, talk with your healthcare provider. You can ask your pharmacist or healthcare provider for information
128 about FORTEO that is written for healthcare professionals. For more information, go to www.FORTEO.com or call
129 Lilly at 1-866-436-7836.

130 **What are the ingredients in FORTEO?**

131
132 Active ingredient: teriparatide

133
134 Inactive ingredients: glacial acetic acid, sodium acetate (anhydrous), mannitol, metacresol, and water for injection.
135 In addition, hydrochloric acid solution 10% and/or sodium hydroxide solution 10% may have been added to adjust
136 the product to pH 4.

137 **What is Osteoporosis?**

138 Osteoporosis is a disease in which the bones become thin and weak, increasing the chance of having a broken bone.
139 Osteoporosis usually causes no symptoms until a fracture happens. The most common fractures are in the spine
140 (backbone). They can shorten height, even without causing pain. Over time, the spine can become curved or
141 deformed and the body bent over. Fractures from osteoporosis can also happen in almost any bone in the body, for
142 example, the wrist, rib, or hip. Once you have had a fracture, the chance for more fractures greatly increases.

143
144 The following risk factors increase your chance of getting fractures from osteoporosis:

- 145 • past broken bones from osteoporosis.
- 146 • very low bone mineral density (BMD).
- 147 • frequent falls.
- 148 • limited movement, such as using a wheelchair.
- 149 • medical conditions likely to cause bone loss, such as some kinds of arthritis.
- 150 • taking steroid medicines called glucocorticoids, such as prednisone.
- 151 • other medicines that may cause bone loss, for example: seizure medicines (such as phenytoin), blood
152 thinners (such as heparin), high doses of vitamin A.

153
154 *This Medication Guide has been approved by the U.S. Food and Drug Administration.*

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