Indication
Activase® (alteplase) is indicated for the treatment of acute ischemic stroke. Exclude intracranial hemorrhage as the primary cause of stroke signs and symptoms prior to initiation of treatment. Initiate treatment as soon as possible but within 3 hours after symptom onset.

Important Safety Information

Contraindications
Do not administer Activase to treat acute ischemic stroke in the following situations in which the risk of bleeding is greater than the potential benefit: current intracranial hemorrhage (ICH); subarachnoid hemorrhage; active internal bleeding; recent (within 3 months) intracranial or intraspinal surgery or serious head trauma; presence of intracranial conditions that may increase the risk of bleeding (e.g., some neoplasms, arteriovenous malformations, or aneurysms); bleeding diathesis; and current severe uncontrolled hypertension.

Please see select Important Safety Information throughout and the full Prescribing Information below.
### Clinical presentation of acute ischemic stroke (AIS)

**Common symptoms of anterior stroke include**

- Aphasia
- Disturbed consciousness
- Dysarthria
- Facial palsy
- Hemisensory deficits
- Homolateral motor deficit

**Common symptoms of posterior stroke include**

- Diplopia
- Dizziness
- Dysarthria
- Dysphagia
- Dystaxia

---

*The symptoms listed for anterior and posterior strokes are not exhaustive, nor are they mutually exclusive. Symptoms alone are not sufficient to diagnose the location of the occlusion, which should be confirmed using brain imaging.*

1.
Conditions that may mimic stroke

- Bell’s palsy
- Complicated migraine
- Conversion disorder/psychogenic conditions
- Hypertensive encephalopathy
- Hypoglycemia
- Infection/abscess
- Seizures
- Tumor
EMS management of patients with suspected stroke

<table>
<thead>
<tr>
<th>On scene</th>
<th>In transit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage CABs (chest compressions-airway-breathing)—give ventilatory assistance, if needed</td>
<td>Rapid transport to the closest IV alteplase–capable hospital,* which may involve air medical transport or bypass of hospitals without IV alteplase capabilities</td>
</tr>
<tr>
<td>Perform prehospital stroke assessment</td>
<td>Notify the receiving hospital that a patient with suspected stroke is en route</td>
</tr>
<tr>
<td>Establish and record exact time when the patient was last seen normal, as opposed to when the patient was found with neurological deficits</td>
<td>Check and record blood glucose to assess for hypoglycemia</td>
</tr>
<tr>
<td>Obtain the name of a family contact and their phone number</td>
<td>Establish cardiac monitoring and IV access, if possible</td>
</tr>
<tr>
<td>Ascertain the patient’s medical history, including relevant surgeries, medications, and allergies; particular attention should be paid to potential stroke risk factors, such as hypertension, diabetes, previous strokes, recent surgeries, and smoking</td>
<td></td>
</tr>
</tbody>
</table>

*If no such centers exist, patient should be brought to the most appropriate institution that provides emergency stroke care.

EMS=emergency medical services; IV=intravenous.
Prehospital stroke assessments

Recommendation from the AHA/ASA 2018 Guideline

Ensure that patients with a known or suspected stroke are rapidly identified and assessed by use of a validated and standardized instrument for stroke screening, such as the Face, Arm, Speech Test (FAST) scale, Los Angeles Prehospital Stroke Screen (LAPSS), or Cincinnati Prehospital Stroke Scale (CPSS) (Class I; Level of Evidence B-NR).

Examples of other prehospital stroke assessments include the Los Angeles Motor Scale (LAMS), the Rapid Arterial Occlusion Evaluation (RACE) scale, and the Vision, Aphasia, and Neglect (VAN) screening tool.

AHA/ASA=American Heart Association/American Stroke Association; Class I=procedure is considered effective (strong strength; benefit is greater than risk); Level of Evidence B-NR=data from 1 or more nonrandomized studies or meta-analyses of such studies.
1a. Level of Consciousness (LOC)

0 = Alert; keenly responsive
1 = Not alert, but arousalable by minor stimulation
2 = Not alert; requires repeated stimulation to attend or is obtunded and requires strong or painful stimulation to make movements
3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flaccid, and areflexic

The investigator must choose a response if full evaluation is prevented by such obstacles as an endotracheal tube, language barrier, orotracheal trauma/bandages, etc. A score of 3 is given only if the patient makes no movement (other than reflexive posturing) in response to noxious stimuli.

1b. LOC Questions

Ask the patient: “What month is it?” “How old are you?”

0 = Answers both questions correctly
1 = Answers 1 question correctly
2 = Answers neither question correctly

Score only the initial answer (there is no credit for being close). Patients unable to speak due to intubation, orotracheal trauma, severe dysarthria, language barrier, etc. are scored 1. Aphasic and stuporous patients are scored 2.
1c. LOC Commands

Ask the patient to: “Open and close your eyes.” “Grip and release your hand.”

0 = Performs both tasks correctly
1 = Performs 1 task correctly
2 = Performs neither task correctly

Substitute another 1-step command if the hands cannot be used. Credit is given if an unequivocal attempt is made but not completed due to weakness. If the patient does not respond to the command, the task should be demonstrated to him or her (pantomime) and the results scored (ie, follows none, 1, or 2 commands). Patients with trauma, amputation, or other physical impediments should be given suitable 1-step commands. Only the first attempt is scored.

2. Best Gaze (only horizontal movement tested)

Establish eye contact and ask the patient to: “Follow my finger.”

0 = Normal
1 = Partial gaze palsy
2 = Forced deviation or total gaze paresis is not overcome by oculocephalic maneuver

Appropriate for aphasic patients. Score voluntary or reflexive horizontal eye movements (do not perform caloric test). Test patients with ocular trauma, bandages, preexisting blindness, etc, for reflexive movement and a choice made by the investigator. Patients with conjugate deviation of the eyes (overcome by voluntary or reflexive activity) and those with isolated peripheral nerve paresis (cranial nerve III, IV, or VI) are scored 1.
3. **Visual Fields**

Use confrontation, finger counting, or visual threat. Confront upper/lower quadrants of visual field.

- **0** = No visual loss
- **1** = Partial hemianopsia
- **2** = Complete hemianopsia
- **3** = Bilateral hemianopsia

Test patients with unilateral blindness or enucleation in remaining eye. Patients with clear-cut asymmetry, including quadrantanopia, are scored 1. Blind patients are scored 3. Test again using double simultaneous stimulation. Score 1 for extinction and record under item 11.

4. **Facial Palsy**

Through words or pantomime, encourage the patient to:
- “Show me your teeth.” “Raise your eyebrows.” “Close your eyes.”

- **0** = Normal symmetrical movements
- **1** = Minor paralysis (flattened nasolabial fold, asymmetry on smiling)
- **2** = Partial paralysis (total or near-total paralysis of lower face)
- **3** = Complete paralysis of one or both sides

If possible, remove facial bandages, orotracheal tube, tape, etc, before testing. In poorly responsive patients, score symmetry of grimace in response to noxious stimuli.
5. **Motor Arm**

Alternately position the patient's arms. Extend each arm with palms down (90 degrees if sitting, 45 degrees if supine).

- **0** = No drift
- **1** = Drift
- **2** = Some effort vs gravity
- **3** = No effort vs gravity
- **4** = No movement
- **UN** = Amputation or joint fusion

Test each arm in turn (nonparetic arm first). Drift is scored if arm falls before 10 seconds. Score untestable (UN) only for patients with amputations or joint fusions of the shoulder.

6. **Motor Leg**

Alternately position the patient's legs. Extend each leg (30 degrees, always while supine).

- **0** = No drift
- **1** = Drift
- **2** = Some effort vs gravity
- **3** = No effort vs gravity
- **4** = No movement
- **UN** = Amputation or joint fusion

Test each leg in turn (nonparetic leg first). Drift is scored if leg falls before 5 seconds. Score UN only for patients with amputations or joint fusions of the hip.
7. **Limb Ataxia**

Ask patient (eyes open) to: “Touch your finger to your nose.”
“Touch your heel to your shin.”

0 = Absent
1 = Present in 1 limb
2 = Present in 2 limbs

**UN** = Amputation or joint fusion

Perform finger-nose-finger and heel-shin tests on both sides to determine unilateral cerebellar lesion. Score 0 for patients who are paralyzed or cannot understand the commands. Score 1 or 2 only if ataxia is disproportionate to weakness. Score **UN** only for patients with amputation or joint fusions.

8. **Sensory**

Test as many body parts as possible (arms [not hands], legs, trunk, face) for sensation using pinprick or noxious stimulus (in the obtunded or aphasic patient).

0 = Normal
1 = Mild-to-moderate sensory loss
2 = Severe to total sensory loss

Score sensory loss due to stroke only. Stuporous and aphasic patients are scored 0 or 1. Patients with brain-stem stroke and bilateral sensory loss, quadriplegic patients who do not respond, and comatose patients (item 1a = 3) are scored 2. A score of 2 is only given when severe or total loss of sensation is clearly demonstrated.
9. **Best Language**

Using pictures and a sentence list (see following cards), ask the patient to:
“Describe what you see in this picture.” “Name the items in this picture.”
“Read these sentences.”

- 0 = No aphasia
- 1 = Mild-to-moderate aphasia
- 2 = Severe aphasia
- 3 = Mute, global aphasia

Patients with visual loss can be asked to identify and describe objects placed in their hand. Intubated patients should be asked to write their answers. The examiner must choose a score for stuporous or uncooperative patients. Comatose patients (item 1a = 3) are scored 3. A score of 3 is only given if the patient is mute and unable to follow 1-step commands.
NIHSS testing card—picture description

(NIHSS information on pages 6-17)

NIHSS testing card—naming list

(NIHSS information on pages 6-17)

You know how.

Down to earth.

I got home from work.

Near the table in the dining room.

They heard him speak on the radio last night.
NIHSS\textsuperscript{8} (cont’d)
(NIHSS information on pages 6-17)

10. Dysarthria

Using a simple word list (see next card), ask the patient to:
“Read these words.” “Repeat these words.”

0 = Normal articulation
1 = Mild-to-moderate dysarthria
2 = Severe dysarthria
UN = Intubated or other physical barrier

Patients with severe aphasia can be scored based on the clarity of articulation of their spontaneous speech. Score UN only for patients who are intubated or have other physical barriers to speech. Do not tell patients why they are being tested.
MAMA
TIP-TOP
FIFTY-FIFTY
THANKS
HUCKLEBERRY
BASEBALL PLAYER
11. Extinction and Inattention

Sufficient information to determine these scores may have been obtained during the prior testing.

0 = No abnormality
1 = Visual, tactile, auditory, spatial, or personal inattention
2 = Profound hemi-inattention or extinction to more than 1 modality

Lack of patient response and inattention may already be evident from the previous items. Score 0 if the patient has a severe visual loss preventing visual double simultaneous stimulation but the response to cutaneous stimuli is normal, or if the patient has aphasia but does appear to attend to both sides. The presence of visual or spatial neglect or anosognosia may also be evidence of abnormality.
Not all deficits may be detected by the NIHSS\textsuperscript{9}

Studies indicate that the NIHSS scores lesion-specific deficits unevenly; for example:

- The NIHSS scoring system is heavily biased toward anterior circulation and left-hemisphere strokes\textsuperscript{9}
- Cranial nerve signs and ataxia, typical of posterior circulation strokes, receive fewer points or are excluded entirely\textsuperscript{10}
- Right-hemisphere strokes are often underestimated, as only 2 points are directed toward neglect, compared to 7 toward language\textsuperscript{11}

Due to this uneven scoring, it is therefore possible that, depending on the location of the infarct, some patients may have a low NIHSS score but still have persistent neurological deficits.\textsuperscript{9}
Differentiate between disabling and nondisabling deficits

For each patient, all neurological deficits present at the time of the treatment decision should be considered in the context of individual risk and benefit, as well as the patient’s baseline functional status.\textsuperscript{4}

Activase® (alteplase) clinical trials enrolled patients with a measurable neurological deficit, defined as impairment of language, motor function, cognition, gaze, vision, or neglect.\textsuperscript{12,13}

Deficits considered by the AHA/ASA to be disabling\textsuperscript{12}:

- Complete hemianopsia ($\geq 2$ on NIHSS question 3)
- Severe aphasia ($\geq 2$ on NIHSS question 9)
- Visual or sensory extinction ($\geq 1$ on NIHSS question 11)
- Any weakness limiting sustained effort against gravity ($\geq 2$ on NIHSS question 5 or 6)
- Any deficits that lead to a total NIHSS score $>5$
- Any remaining deficit the patient or practitioner considers potentially disabling (clinical judgment is required)
Determine if your patients’ deficits are disabling

Consider asking your patients the following questions:

• Will you be able to return to work as normal?
• Will you be able to perform your everyday activities and hobbies?
• Do you consider any of your symptoms to be disabling? (For example, in patients with hand weakness: “Will weakness of your hand affect your daily life?”)

Consider the following questions about your patients:

• Can they sit on the edge of the bed? Are they ambulatory?
• Are they able to hold a conversation?
Quantify the level of disability

Measurement of a patient’s ability to perform activities of daily living, including instrumental activities, should be a treatment consideration. The modified Rankin Scale measures the ability of a patient to function independently without assistance.

**Modified Rankin Scale**:  

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No symptoms at all</td>
</tr>
<tr>
<td>1</td>
<td>No significant disability despite symptoms; able to carry out all usual duties and activities</td>
</tr>
<tr>
<td>2</td>
<td>Slight disability; unable to carry out all previous activities but able to look after own affairs without assistance</td>
</tr>
<tr>
<td>3</td>
<td>Moderate disability; requiring some help but able to walk without assistance</td>
</tr>
<tr>
<td>4</td>
<td>Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance</td>
</tr>
<tr>
<td>5</td>
<td>Severe disability; bedridden, incontinent, and requiring constant nursing care and attention</td>
</tr>
<tr>
<td>6</td>
<td>Dead</td>
</tr>
</tbody>
</table>
AHA/ASA 2018 Guideline: Immediate diagnostic tests for all patients with suspected AIS

- Brain imaging by noncontrast computed tomography (CT) or magnetic resonance imaging (MRI)
- Blood glucose
- Blood pressure
- Oxygen saturation
- Platelet count
- Troponin assessment
- Prothrombin time (PT)/international normalized ratio (INR)
- Activated partial thromboplastin time (aPTT)
- Electrocardiogram

*Although it is desirable to know the results of these tests before administering alteplase, fibrinolytic therapy should not be delayed while awaiting results unless: 1) there is clinical suspicion of a bleeding abnormality or thrombocytopenia, 2) the patient has received heparin or warfarin, or 3) the patient has received other anticoagulants (direct thrombin inhibitors or direct factor Xa inhibitors).
Blood glucose management in patients with AIS

Recommendations from AHA/ASA 2018 Guideline

• Evidence indicates that persistent in-hospital hyperglycemia during the first 24 hours after AIS is associated with worse outcomes than normoglycemia, and thus, it is reasonable to treat hyperglycemia to achieve blood glucose levels in a range of 140 to 180 mg/dL and to closely monitor to prevent hypoglycemia (Class IIa; Level of Evidence C-LD)

• Hypoglycemia (blood glucose <60 mg/dL) should be treated in patients with AIS (Class I; Level of Evidence C-LD)

Class IIa=procedure can be considered effective (moderate strength; benefit can be greater than risk); Level C-LD=limited data available to support the recommendation.
Recommendations from AHA/ASA 2018 Guideline

If patients are otherwise eligible for acute reperfusion therapy except that BP is >185/110 mm Hg, administer:

- Labetalol 10-20 mg IV over 1-2 minutes, may repeat 1 time; or
- Nicardipine 5 mg/h IV, titrate up by 2.5 mg/h every 5-15 minutes, maximum 15 mg/h; when desired BP reached, adjust to maintain proper BP limits; or
- Clevidipine 1-2 mg/h IV, titrate by doubling the dose every 2-5 min until desired BP reached, maximum 21 mg/h; or
- Other agents (eg, hydralazine, enalaprilat) may also be considered

If BP is not maintained ≤185/110 mm Hg, do not administer alteplase.
BP management in patients with AIS

- In patients with AIS, early treatment of hypertension is indicated when required by comorbid conditions (e.g., concomitant acute coronary event, acute heart failure, aortic dissection, postthrombolysis symptomatic intracranial hemorrhage, or preeclampsia/eclampsia). Lowering BP initially by 15% is probably safe (Class I; Level of Evidence C-EO).

- In patients with BP ≥220/120 mm Hg who did not receive IV alteplase or endovascular therapy and have no comorbid conditions requiring acute antihypertensive treatment, the benefit of initiating or reinitiating treatment of hypertension within the first 48 to 72 hours is uncertain. It might be reasonable to lower BP by 15% during the first 24 hours after onset of stroke (Class IIb; Level of Evidence C-EO).

Level C-EO = consensus of expert opinion based on clinical experience.

Please see select Important Safety Information throughout and the full Prescribing Information below.
IV alteplase (0.9 mg/kg, maximum dose 90 mg over 60 minutes with initial 10% of dose given as bolus over 1 minute) is recommended for selected patients who may be treated within 3 hours of ischemic stroke symptom onset or patient last known well or at baseline state (Class I; Level of Evidence A).

In patients eligible for IV alteplase, benefit of therapy is time dependent, and treatment should be initiated as quickly as possible (Class I; Level of Evidence A).
Activase® (alteplase) is also recommended for patients prior to mechanical thrombectomy

AHA/ASA 2018 Guideline

Patients eligible for IV alteplase should receive IV alteplase even if endovascular therapies are being considered (Class I; Level of Evidence A).

SVIN 2015 Recommendations

Endovascular mechanical thrombectomy, in addition to treatment with IV rtPA in eligible patients, is recommended for anterior circulation LVO ischemic strokes in patients presenting within 6 hours after symptom onset (Class I; Level of Evidence A).

LVO=large vessel occlusion; rtPA=recombinant tissue plasminogen activator;
SVIN=Society of Vascular and Interventional Neurology.

Please see select Important Safety Information throughout and the full Prescribing Information below.
Since 2015, the Joint Commission has required DTN of ≤60 minutes in 50% of all eligible AIS patients receiving Activase® (alteplase)\textsuperscript{17}

Target: Stroke has established a more aggressive goal\textsuperscript{18}:

- DTN within 60 minutes in at least 75% of patients
- DTN within 45 minutes in at least 50% of patients

\*Initiate treatment with Activase as soon as possible but within 3 hours after symptom onset.\textsuperscript{13}

ED=emergency department; NIH=National Institutes of Health.
Patient selection for Activase therapy\textsuperscript{13}

- Activase is indicated for the treatment of AIS
- Exclude intracranial hemorrhage as the primary cause of stroke signs and symptoms prior to initiation of treatment
- Initiate treatment as soon as possible but within 3 hours after symptom onset

Please see select Important Safety Information throughout and the full Prescribing Information below.
Contraindications to Activase® (alteplase) therapy

Do not administer Activase to treat AIS in the following situations in which the risk of bleeding is greater than the potential benefit:

- Current intracranial hemorrhage
- Subarachnoid hemorrhage
- Active internal bleeding
- Recent (within 3 months) intracranial or intraspinal surgery or serious head trauma
- Presence of intracranial conditions that may increase the risk of bleeding (e.g., some neoplasms, arteriovenous malformations, or aneurysms)
- Bleeding diathesis*
- Current severe uncontrolled hypertension

*The 2018 AHA/ASA Guideline advises against treatment with IV alteplase in patients:
- With a platelet count <100,000/mm³, INR >1.7, aPTT >40 seconds, or PT >15 seconds
- Who have a history of warfarin use and an INR >1.7 and/or a PT >15 seconds
- Who have received a treatment dose of low-molecular-weight heparin within the previous 24 hours
- Who are taking direct thrombin inhibitors or direct factor Xa inhibitors, unless the laboratory tests are normal or the patient has not received a dose of these agents for >48 hours
The recommended dose of Activase is 0.9 mg/kg (not to exceed 90-mg total dose) infused intravenously over 60 minutes with 10% of the total dose administered as an initial bolus over 1 minute.

FDA=Food and Drug Administration.

Please see select Important Safety Information throughout and the full Prescribing Information below.
Overall management of BP in patients treated with Activase® (alteplase)

Recommendations from AHA/ASA 2018 Guideline

To maintain BP ≤180/105 mm Hg, monitor BP:
- Every 15 minutes for 2 hours from the start of alteplase therapy;
- Then every 30 minutes for 6 hours; and
- Then every hour for 16 hours

If systolic BP is >180-230 mm Hg or diastolic BP is >105-120 mm Hg, administer:
- Labetalol 10 mg IV followed by continuous IV infusion 2-8 mg/min; or
- Nicardipine 5 mg/h IV, titrate up to desired effect by 2.5 mg/h every 5-15 minutes (maximum 15 mg/h); or
- Clevidipine 1-2 mg/h IV, titrate by doubling the dose every 2-5 min until desired BP reached (maximum 21 mg/h)

If BP is not controlled or diastolic BP >140 mm Hg, consider IV sodium nitroprusside.
Monitor BP every 15 minutes during the 1-hour infusion\textsuperscript{4,13}

- Once IV alteplase is given, the BP must be maintained at or below 180/105 mm Hg to limit the risk of intracranial hemorrhage
- Administer antihypertensive medications to maintain BP at or below these levels

Perform neurological assessments\textsuperscript{4}

The use of a stroke rating scale, preferably the NIHSS, is recommended.
- Repeat every 15 minutes during the 1-hour infusion to monitor for neurological deterioration

Please see select Important Safety Information throughout and the full Prescribing Information below.
Check for major and/or minor bleeding
All body secretions should be tested for occult blood.\textsuperscript{19}
• Major bleeding: intracranial, retroperitoneal, gastrointestinal, or genitourinary hemorrhages\textsuperscript{20}
• Minor bleeding: gums, venipuncture sites, hematuria, hemoptysis, skin hematomas, or ecchymosis\textsuperscript{20}
• Arterial and venous punctures should be minimized and checked frequently\textsuperscript{13,19}

Discontinue infusion and obtain an emergency CT scan if the patient develops severe headache, acute hypertension, nausea, or vomiting or has a worsening neurological examination.\textsuperscript{4}

Monitor for signs of hypersensitivity\textsuperscript{13}
If signs of hypersensitivity occur, such as an anaphylactoid reaction or development of angioedema, discontinue the Activase infusion and promptly institute appropriate therapy.

Please see select Important Safety Information throughout and the full Prescribing Information below.
Patient monitoring post–Activase administration

Continue to monitor for neurological deterioration\(^4\)
- Every 15 minutes for the first hour after the infusion is stopped
- Every 30 minutes for the next 6 hours
- Hourly from the eighth postinfusion hour until 24 hours after the infusion is stopped

Continue to check for major and/or minor bleeding\(^{20}\)

Continue to monitor and control BP\(^4\)
- Every 15 minutes for the first hour after the infusion is stopped
- Every 30 minutes for the next 6 hours
- Hourly from the eighth postinfusion hour until 24 hours after the infusion is stopped

Obtain a follow-up CT scan or MRI at 24 hours before starting anticoagulants or antiplatelet agents.\(^4\)

Continue to monitor for signs of hypersensitivity\(^{13}\)
Indication

Activase® (alteplase) is indicated for the treatment of acute ischemic stroke (AIS). Exclude intracranial hemorrhage as the primary cause of stroke signs and symptoms prior to initiation of treatment. Initiate treatment as soon as possible but within 3 hours after symptom onset.

Important Safety Information

Contraindications

Do not administer Activase to treat acute ischemic stroke in the following situations in which the risk of bleeding is greater than the potential benefit: current intracranial hemorrhage (ICH); subarachnoid hemorrhage; active internal bleeding; recent (within 3 months) intracranial or intraspinal surgery or serious head trauma; presence of intracranial conditions that may increase the risk of bleeding (e.g., some neoplasms, arteriovenous malformations, or aneurysms); bleeding diathesis; and current severe uncontrolled hypertension.
**Important Safety Information**

**Warnings and Precautions**

**Bleeding**

Activase can cause significant, sometimes fatal internal or external bleeding, especially at arterial and venous puncture sites. Avoid intramuscular injections and trauma to the patient. Perform venipunctures carefully and only as required. Fatal cases of hemorrhage associated with traumatic intubation in patients administered Activase have been reported. The concomitant administration of heparin and aspirin with and following infusions of Activase for the treatment of AIS during the first 24 hours after symptom onset has not been investigated. Because heparin, aspirin, or Activase may cause bleeding complications, carefully monitor for bleeding, especially at arterial puncture sites. Hemorrhage can occur 1 or more days after administration of Activase, while patients are still receiving anticoagulant therapy. If serious bleeding occurs, terminate the Activase infusion, and treat properly.

Please see select Important Safety Information throughout and the full Prescribing Information below.
Warnings and Precautions

Bleeding (cont’d)

In the following conditions, the risks of bleeding with Activase® (alteplase) are increased and should be weighed against the anticipated benefits: recent major surgery or procedure; cerebrovascular disease; recent intracranial hemorrhage; recent gastrointestinal or genitourinary bleeding; recent trauma; hypertension; acute pericarditis; subacute bacterial endocarditis; hemostatic defects including those secondary to severe hepatic or renal disease; significant hepatic dysfunction; pregnancy; diabetic hemorrhagic retinopathy or other hemorrhagic ophthalmic conditions; septic thrombophlebitis or occluded AV cannula at seriously infected site; advanced age; and patients currently receiving oral anticoagulants, or any other condition in which bleeding constitutes a significant hazard or would be particularly difficult to manage because of its location.
Warnings and Precautions

Hypersensitivity

Hypersensitivity, including urticarial/anaphylactic reactions, have been reported after administration of Activase. Rare fatal outcome for hypersensitivity was reported. Angioedema has been observed during and up to 2 hours after infusion in patients treated for acute ischemic stroke and acute myocardial infarction. In many cases, patients received concomitant angiotensin-converting enzyme inhibitors. Monitor patients during and for several hours after infusion for hypersensitivity. If signs of hypersensitivity occur, e.g. anaphylactoid reaction or angioedema develops, discontinue the Activase infusion and promptly institute appropriate therapy (e.g., antihistamines, intravenous corticosteroids, epinephrine).

Please see select Important Safety Information throughout and the full Prescribing Information below.
**Important Safety Information**

**Warnings and Precautions**

*Thromboembolism*

The use of thrombolytics can increase the risk of thrombo-embolic events in patients with high likelihood of left heart thrombus, such as patients with mitral stenosis or atrial fibrillation. Activase® (alteplase) has not been shown to treat adequately underlying deep vein thrombosis in patients with PE. Consider the possible risk of re-embolization due to the lysis of underlying deep venous thrombi in this setting.

*Cholesterol Embolization*

Cholesterol embolism, sometimes fatal, has been reported rarely in patients treated with thrombolytic agents; the true incidence is unknown. It is associated with invasive vascular procedures (e.g., cardiac catheterization, angiography, vascular surgery) and/or anticoagulant therapy.
Warnings and Precautions

Coagulation Tests May Be Unreliable During Activase Therapy

Coagulation tests and/or measures of fibrinolytic activity may be unreliable during Activase therapy unless specific precautions are taken to prevent *in vitro* artifacts. When present in blood at pharmacologic concentrations, Activase remains active under *in vitro* conditions, which can result in degradation of fibrinogen in blood samples removed for analysis.

Adverse Reactions

The most frequent adverse reaction associated with Activase AIS therapy is bleeding.

Please see select Important Safety Information throughout and the full Prescribing Information below.
References


2. Lewandowski C, Santhakumar S. Posterior circulation stroke. Presented at: ACEP; October 2000; Chicago, IL.


11. Woo D, Broderick JP, Kothari RU, et al. Does the National Institutes of Health Stroke Scale favor left hemisphere strokes?


**FULL PRESCRIBING INFORMATION**: CONTENTS*

1 INDICATIONS AND USAGE
  1.1 Acute Ischemic Stroke
  1.2 Acute Myocardial Infarction
  1.3 Pulmonary Embolism

2 DOSAGE AND ADMINISTRATION
  2.1 Acute Ischemic Stroke
  2.2 Acute Myocardial Infarction
  2.3 Pulmonary Embolism
  2.4 Preparation for Administration
  2.5 Administration

3 DOSAGE FORMS AND STRENGTHS

4 CONTRAINDICATIONS
  4.1 Acute Ischemic Stroke
  4.2 Acute Myocardial Infarction or Pulmonary Embolism

5 WARNINGS AND PRECAUTIONS
  5.1 Bleeding
  5.2 Hypersensitivity
  5.3 Thromboembolism
  5.4 Cholesterol Embolization
  5.5 Coagulation Tests May Be Unreliable during Activase Therapy

6 ADVERSE REACTIONS
  6.1 Clinical Trials Experience
  6.2 Post-Marketing Experience

7 DRUG INTERACTIONS

8 USE IN SPECIFIC POPULATIONS
  8.1 Pregnancy
  8.2 Lactation
  8.3 Pediatric Use
  8.4 Geriatric Use

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY
  12.1 Mechanism of Action
  12.2 Pharmacodynamics
  12.3 Pharmacokinetics

13 NONCLINICAL TOXICOLOGY
  13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

14 CLINICAL STUDIES
  14.1 Acute Ischemic Stroke (AIS)
  14.2 Acute Myocardial Infarction (AMI)
  14.3 Acute Massive Pulmonary Embolism (PE)

16 HOW SUPPLIED/STORAGE AND HANDLING
  16.1 How Supplied
  16.2 Stability and Storage

17 PATIENT COUNSELING INFORMATION
  * Sections or subsections omitted from the Full Prescribing Information are not listed.
FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

1.1 Acute Ischemic Stroke

Activase is indicated for the treatment of acute ischemic stroke.

Exclude intracranial hemorrhage as the primary cause of stroke signs and symptoms prior to initiation of treatment [see Contraindications (4.1)]. Initiate treatment as soon as possible but within 3 hours after symptom onset.

1.2 Acute Myocardial Infarction

Activase is indicated for use in acute myocardial infarction (AMI) for the reduction of mortality and reduction of the incidence of heart failure.

**Limitation of Use:** The risk of stroke may outweigh the benefit produced by thrombolytic therapy in patients whose AMI puts them at low risk for death or heart failure.

1.3 Pulmonary Embolism

Activase is indicated for the lysis of acute massive pulmonary embolism, defined as:

- Acute pulmonary emboli obstructing blood flow to a lobe or multiple lung segments.
- Acute pulmonary emboli accompanied by unstable hemodynamics, e.g., failure to maintain blood pressure without supportive measures.

2 DOSAGE AND ADMINISTRATION

2.1 Acute Ischemic Stroke

Administer Activase as soon as possible but within 3 hours after onset of symptoms.

The recommended dose is 0.9 mg/kg (not to exceed 90 mg total dose), with 10% of the total dose administered as an initial intravenous bolus over 1 minute and the remainder infused over 60 minutes.

During and following Activase administration for the treatment of acute ischemic stroke, frequently monitor and control blood pressure.

In patients without recent use of oral anticoagulants or heparin, Activase treatment can be initiated prior to the availability of coagulation study results. Discontinue Activase if the pretreatment International Normalized Ratio (INR) is greater than 1.7 or the activated partial thromboplastin time (aPTT) is elevated [see Contraindications (4.1)].

2.2 Acute Myocardial Infarction

Administer Activase as soon as possible after the onset of symptoms.

The recommended total doses for acute myocardial infarction (AMI) is based on patient weight, not to exceed 100 mg, regardless of the selected administration regimen (accelerated or 3 hour, described below).
There are two Activase dose regimens (accelerated and 3-hour) for use in the management of AMI; there are no controlled studies to compare clinical outcomes with these regimens [see Clinical Studies (14.2)].

**Accelerated Infusion**

The recommended accelerated infusion dose consists of an IV bolus [see Dosage and Administration (2.5)] followed by an IV infusion as set forth in Table 1.

<table>
<thead>
<tr>
<th>Patient weight</th>
<th>Intravenous Bolus</th>
<th>First 30 min</th>
<th>Next 60 min</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 67 kg</td>
<td>15 mg</td>
<td>50 mg</td>
<td>35 mg</td>
</tr>
<tr>
<td>≤ 67 kg</td>
<td>15 mg</td>
<td>0.75 mg/kg</td>
<td>0.50 mg/kg</td>
</tr>
</tbody>
</table>

The safety and efficacy of accelerated infusion of Activase have only been investigated with concomitant administration of heparin and aspirin [see Clinical Studies (14.2)].

**3-Hour Infusion**

For patients weighing ≥ 65 kg, the recommended dose is 100 mg administered as 60 mg in the first hour (6-10 mg administered as a bolus), 20 mg over the second hour, and 20 mg over the third hour. For smaller patients (< 65 kg), a dose of 1.25 mg/kg administered over 3 hours may be used. Weight-based doses are shown in Table 2.

<table>
<thead>
<tr>
<th>Patient weight</th>
<th>Bolus</th>
<th>Rest of 1st hour</th>
<th>2nd hour</th>
<th>3rd hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 65 kg</td>
<td>6-10 mg</td>
<td>50-54 mg</td>
<td>20 mg</td>
<td>20 mg</td>
</tr>
<tr>
<td>&lt; 65 kg</td>
<td>0.075 mg/kg</td>
<td>0.675 mg/kg</td>
<td>0.25 mg/kg</td>
<td>0.25 mg/kg</td>
</tr>
</tbody>
</table>

**2.3 Pulmonary Embolism (PE)**

The recommended dose is 100 mg administered by IV infusion over 2 hours.

Institute parenteral anticoagulation near the end of or immediately following the Activase infusion when the partial thromboplastin time or thrombin time returns to twice normal or less.

**2.4 Preparation for Administration**

**Reconstitution**

Use only the accompanying Sterile Water for Injection (SWFI), USP without preservatives. Do not use Bacteriostatic Water for Injection, USP.

Reconstitute using aseptic technique. Do not add other medication to solutions containing Activase. Reconstitute Activase no more than 8 hours before use, as it contains no antibacterial preservatives [see How Supplied/Storage and Handling (16.2)].
Slight foaming is not unusual; let stand undisturbed for several minutes to allow large bubbles to dissipate. Inspect parenteral drug products for particulate matter and discoloration prior to administration whenever solution and container permit.

Activase may be administered as reconstituted at 1 mg/mL or further diluted immediately before administration in an equal volume of 0.9% Sodium Chloride Injection, USP, or 5% Dextrose Injection, USP, to yield a concentration of 0.5 mg/mL, using either polyvinyl chloride bags or glass vials.

Avoid excessive agitation during dilution; mix by gently swirling and/or slow inversion.

**50 mg Vials**

**DO NOT USE IF VACUUM IS NOT PRESENT.**

Using a large bore needle (e.g., 18 gauge) and a syringe, reconstitute by adding the contents of the accompanying 50 mL vial of SWFI to the 50 mg vial of Activase, directing the SWFI stream into the lyophilized cake.

**100 mg Vials**

THE 100 mg VIALS DO NOT CONTAIN VACUUM.

Using the transfer device provided, reconstitute by adding the contents of the accompanying 100 mL vial of SWFI to the 100 mg vial of Activase.

1. Use aseptic technique.
2. Remove the protective flip-caps from one vial of Activase and one vial of SWFI.
3. Open the package containing the transfer device by peeling the paper label off the package.
4. Remove the protective cap from one end of the transfer device and keeping the vial of SWFI upright, insert the piercing pin vertically into the center of the stopper of the vial of SWFI.
5. Remove the protective cap from the other end of the transfer device. **DO NOT INVERT THE VIAL OF SWFI.**
6. Hold the vial of Activase upside down, position it so that the center of the stopper is directly over the exposed piercing pin of the transfer device, and push the vial of Activase down so that the piercing pin is inserted through the center of the Activase vial stopper.
7. Invert the two vials so that the vial of Activase is on the bottom (upright) and the vial of SWFI is upside-down, allowing the SWFI to flow down through the transfer device. Allow the entire contents of the vial of SWFI to flow into the Activase vial (approximately 0.5 cc of SWFI will remain in the diluent vial).
8. Remove the transfer device and the empty SWFI vial from the Activase vial and discard.
9. Swirl gently to dissolve the Activase powder. **DO NOT SHAKE.**

**Preparation of Bolus Dose**

- Prepare the bolus dose in one of the following ways: Remove the appropriate volume from the vial of reconstituted (1 mg/mL) Activase using a syringe and needle. If this method is used with the 50 mg vials, the syringe should not be primed with air and the needle should be inserted into the Activase vial stopper. If the 100 mg vial is used, the needle should be inserted away from the puncture mark made by the transfer device.
- Remove the appropriate volume from a port (second injection site) on the infusion line after the infusion set is primed.
• Program an infusion pump to deliver the appropriate volume as a bolus at the initiation of the infusion

2.5 Administration

Following bolus dose, if indicated [see Dosage and Administration (2.1, 2.2)]:

• 50 mg vials - administer using either a polyvinyl chloride bag or glass vial and infusion set.
• 100 mg vials - remove from the vial any quantity of drug in excess of that specified for patient treatment [see Dosage and Administration (2.1, 2.2)]. Insert the spike end of an infusion set through the same puncture site created by the transfer device in the stopper of the vial of reconstituted Activase. Peel the clear plastic hanger from the vial label. Hang the Activase vial from the resulting loop.

Activase is for intravenous administration only. Extravasation of Activase infusion can cause ecchymosis or inflammation. If extravasation occurs, terminate the infusion at that IV site and apply local therapy.

Do not add any other medication to infusion solutions containing Activase.

3 DOSAGE FORMS AND STRENGTHS

• 50 mg lyophilized powder per single use vial with 50 mL SWFI USP for reconstitution
• 100 mg lyophilized powder per single use vial with 100 mL SWFI USP for reconstitution

4 CONTRAINDICATIONS

4.1 Acute Ischemic Stroke

Do not administer Activase to treat acute ischemic stroke in the following situations in which the risk of bleeding is greater than the potential benefit [see Warnings and Precautions (5.1)]:

• Current intracranial hemorrhage
• Subarachnoid hemorrhage
• Active internal bleeding
• Recent (within 3 months) intracranial or intraspinal surgery or serious head trauma
• Presence of intracranial conditions that may increase the risk of bleeding (e.g., some neoplasms, arteriovenous malformations, or aneurysms)
• Bleeding diathesis
• Current severe uncontrolled hypertension.

4.2 Acute Myocardial Infarction or Pulmonary Embolism

Do not administer Activase for treatment of AMI or PE in the following situations in which the risk of bleeding is greater than the potential benefit [see Warnings and Precautions (5.1)]:

• Active internal bleeding
• History of recent stroke
• Recent (within 3 months) intracranial or intraspinal surgery or serious head trauma
• Presence of intracranial conditions that may increase the risk of bleeding (e.g. some neoplasms, arteriovenous malformations, or aneurysms)
5 WARNINGS AND PRECAUTIONS

5.1 Bleeding

Activase can cause significant, sometimes fatal, internal or external bleeding, especially at arterial and venous puncture sites. Avoid intramuscular injections and trauma to the patient while on Activase. Perform venipunctures carefully and only as required. To minimize bleeding from noncompressible sites, avoid internal jugular and subclavian venous punctures. If an arterial puncture is necessary during Activase infusion, use an upper extremity vessel that is accessible to manual compression, apply pressure for at least 30 minutes, and monitor the puncture site closely.

Because of the higher risk of intracranial hemorrhage in patients treated for acute ischemic stroke, limit treatment to facilities that can provide timely access to appropriate evaluation and management of intracranial hemorrhage.

Fatal cases of hemorrhage associated with traumatic intubation in patients administered Activase have been reported.

Aspirin and heparin have been administered concomitantly with and following infusions of Activase in the management of acute myocardial infarction and pulmonary embolism, but the concomitant administration of heparin and aspirin with and following infusions of Activase for the treatment of acute ischemic stroke during the first 24 hours after symptom onset has not been investigated. Because heparin, aspirin, or Activase may cause bleeding complications, carefully monitor for bleeding, especially at arterial puncture sites. Hemorrhage can occur 1 or more days after administration of Activase, while patients are still receiving anticoagulant therapy.

If serious bleeding occurs, terminate the Activase infusion and treat appropriately. In the following conditions, the risks of bleeding with Activase therapy for all approved indications are increased and should be weighed against the anticipated benefits:

- Recent major surgery or procedure, (e.g., coronary artery bypass graft, obstetrical delivery, organ biopsy, previous puncture of noncompressible vessels)
- Cerebrovascular disease
- Recent intracranial hemorrhage
- Recent gastrointestinal or genitourinary bleeding
- Recent trauma
- Hypertension: systolic BP above 175 mm Hg or diastolic BP above 110 mm Hg
- Acute pericarditis
- Subacute bacterial endocarditis
- Hemostatic defects including those secondary to severe hepatic or renal disease
- Significant hepatic dysfunction
- Pregnancy
- Diabetic hemorrhagic retinopathy, or other hemorrhagic ophthalmic conditions
- Septic thrombophlebitis or occluded AV cannula at seriously infected site
Advanced age [see Use in Specific Populations (8.5)]

- Patients currently receiving anticoagulants (e.g., warfarin sodium)

Any other condition in which bleeding constitutes a significant hazard or would be particularly difficult to manage because of its location.

5.2 Hypersensitivity

Hypersensitivity, including urticarial / anaphylactic reactions, have been reported after administration of Activase (e.g., laryngeal edema, rash and shock). Rare fatal outcome for hypersensitivity was reported. Angioedema has been observed during and up to 2 hours after Activase infusion in patients treated for acute ischemic stroke and acute myocardial infarction. In many cases, patients received concomitant angiotensin-converting enzyme inhibitors [see Drug Interactions (7)].

Monitor patients treated with Activase during and for several hours after infusion for hypersensitivity. If signs of hypersensitivity occur, e.g. anaphylactoid reaction or angioedema develops, discontinue the Activase infusion and promptly institute appropriate therapy (e.g., antihistamines, intravenous corticosteroids, epinephrine).

5.3 Thromboembolism

The use of thrombolytics can increase the risk of thrombo-embolic events in patients with high likelihood of left heart thrombus, such as patients with mitral stenosis or atrial fibrillation. Activase has not been shown to treat adequately underlying deep vein thrombosis in patients with PE. Consider the possible risk of re-embolization due to the lysis of underlying deep venous thrombi in this setting.

5.4 Cholesterol Embolization

Cholesterol embolism has been reported rarely in patients treated with thrombolytic agents; the true incidence is unknown. Cholesterol embolism may present with livedo reticularis, “purple toe” syndrome, acute renal failure, gangrenous digits, hypertension, pancreatitis, myocardial infarction, cerebral infarction, spinal cord infarction, retinal artery occlusion, bowel infarction, or rhabdomyolysis and can be fatal. It is associated with invasive vascular procedures (e.g., cardiac catheterization, angiography, vascular surgery) and/or anticoagulant therapy.

5.5 Coagulation Tests May Be Unreliable during Activase Therapy

Coagulation tests and measures of fibrinolytic activity may be unreliable during Activase therapy, unless specific precautions are taken to prevent in vitro artifacts. When present in blood at pharmacologic concentrations, Activase remains active under in vitro conditions, which can result in degradation of fibrinogen in blood samples removed for analysis.

6 ADVERSE REACTIONS

The following adverse reactions are discussed in greater detail in the other sections of the label:

- Bleeding [see Contraindications (4), Warnings and Precautions (5.1)]
- Hypersensitivity [see Warnings and Precautions (5.2)]
- Thromboembolism [see Warnings and Precautions (5.3)]
- Cholesterol Embolization [see Warnings and Precautions (5.4)]
6.1 Clinical Trials Experience

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

The most frequent adverse reaction associated with Activase in all approved indications is bleeding.

Bleeding

Acute Ischemic Stroke (AIS)

In clinical studies in patients with AIS (Studies 1 and 2) the incidence of intracranial hemorrhage, especially symptomatic intracranial hemorrhage, was higher in Activase-treated patients than in placebo patients. A dose-finding study of Activase suggested that doses greater than 0.9 mg/kg may be associated with an increased incidence of intracranial hemorrhage.

The incidence of all-cause 90-day mortality, intracranial hemorrhage, and new ischemic stroke following Activase treatment compared to placebo are presented in Table 3 as a combined safety analysis (n=624) for Studies 1 and 2. These data indicate a significant increase in intracranial hemorrhage following Activase treatment, particularly symptomatic intracranial hemorrhage within 36 hours. There was no increase in the incidences of 90-day mortality or severe disability in Activase-treated patients compared to placebo.

| Table 3
Combined Safety Outcomes for Studies 1 and 2 |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo (n=312)</td>
</tr>
<tr>
<td>All-Cause 90-day Mortality</td>
</tr>
<tr>
<td>Total ICH</td>
</tr>
<tr>
<td>Symptomatic</td>
</tr>
<tr>
<td>Asymptomatic</td>
</tr>
<tr>
<td>Symptomatic Intracranial Hemorrhage within 36 hours</td>
</tr>
<tr>
<td>New Ischemic Stroke (3-months)</td>
</tr>
</tbody>
</table>

\(^a\) Within trial follow-up period. Symptomatic intracranial hemorrhage was defined as the occurrence of sudden clinical worsening followed by subsequent verification of intracranial hemorrhage on CT scan. Asymptomatic intracranial hemorrhage was defined as intracranial hemorrhage detected on a routine repeat CT scan without preceding clinical worsening.

\(^b\) Fisher’s Exact Test.
Bleeding events other than intracranial hemorrhage were noted in the studies of AIS and were consistent with the general safety profile of Activase. In Studies 1 and 2, the frequency of bleeding requiring red blood cell transfusions was 6.4% for Activase-treated patients compared to 3.8% for placebo (p=0.19).

Although exploratory analyses of Studies 1 and 2 suggest that severe neurological deficit (National Institutes of Health Stroke Scale [NIHSS > 22]) at presentation was associated with an increased risk of intracranial hemorrhage, efficacy results suggest a reduced but still favorable clinical outcome for these patients.

**Acute Myocardial Infarction (AMI)**

For the 3-hour infusion regimen in the treatment of AMI, the incidence of significant internal bleeding (estimated as > 250 mL blood loss) has been reported in studies in over 800 patients (Table 4). These data do not include patients treated with the Activase accelerated infusion.

<table>
<thead>
<tr>
<th>Total Dose ≤100 mg</th>
<th>Gastrointestinal</th>
<th>Genitourinary</th>
<th>Ecchymosis</th>
<th>Retroperitoneal</th>
<th>Epistaxis</th>
<th>Gingival</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>4%</td>
<td>1%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td></td>
</tr>
</tbody>
</table>

The incidence of intracranial hemorrhage in AMI patients treated with Activase is presented in Table 5.

<table>
<thead>
<tr>
<th>Dose</th>
<th>Number of Patients</th>
<th>Intracranial Hemorrhage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 mg, 3-hour</td>
<td>3272</td>
<td>0.4</td>
</tr>
<tr>
<td>≤ 100 mg, accelerated</td>
<td>10,396</td>
<td>0.7</td>
</tr>
<tr>
<td>150 mg</td>
<td>1779</td>
<td>1.3</td>
</tr>
<tr>
<td>1-1.4 mg/kg</td>
<td>237</td>
<td>0.4</td>
</tr>
</tbody>
</table>

A dose of 150 mg or greater should not be used in the treatment of AMI because it has been associated with an increase in intracranial bleeding.

**Pulmonary Embolism (PE)**

For acute massive pulmonary embolism, bleeding events were consistent with the general safety profile observed with Activase treatment of AMI patients receiving the 3-hour infusion regimen.
6.2 Post-Marketing Experience

The following adverse reactions have been identified during post-approval use of Activase. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. These reactions are frequent sequelae of the underlying disease, and the effect of Activase on the incidence of these events is unknown.

*Acute Ischemic Stroke:* Cerebral edema, cerebral herniation, seizure, new ischemic stroke, embolism. These events may be life threatening and may lead to death.

*Acute Myocardial Infarction:* Arrhythmias, AV block, cardiogenic shock, heart failure, cardiac arrest, recurrent ischemia, myocardial reinfarction, myocardial rupture, electromechanical dissociation, pericardial effusion, pericarditis, mitral regurgitation, cardiac tamponade, thromboembolism, pulmonary edema. These events may be life threatening and may lead to death. Nausea and/or vomiting, hypotension and fever have also been reported.

*Pulmonary Embolism:* Pulmonary reembolization, pulmonary edema, pleural effusion, thromboembolism, hypotension. These events may be life threatening and may lead to death. Fever has also been reported.

7 DRUG INTERACTIONS

The interaction of Activase with other cardioactive or cerebroactive drugs has not been studied. Anticoagulants and antiplatelet drugs increase the risk of bleeding if administered prior to, during, or after Activase therapy.

In the post-marketing setting, there have been reports of angioedema in patients (primarily patients with AIS) receiving concomitant angiotensin-converting enzyme inhibitors. [see Warnings and Precautions (5.2)].

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Published studies and case reports on alteplase use in pregnant women are insufficient to inform a drug associated risk of adverse developmental outcomes. Alteplase is embryocidal in rabbits when intravenously administered during organogenesis at the clinical exposure for AMI, but no maternal or fetal toxicity was evident at lower exposure in pregnant rats or rabbits (see Data).

All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. The estimated background risk of major birth defects and miscarriage for the indicated populations is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

Clinical Considerations

*Maternal Adverse Reactions*

The most common complication of thrombolytic therapy is bleeding. Pregnancy may increase this risk [see Warnings and Precautions (5.1)].

Data
Animal Data

Alteplase is embryocidal in rabbits when administered intravenously during organogenesis in doses (3 mg/kg) approximately equal to the human exposure (based on AUC) at the dose for AMI. No maternal or fetal toxicity was evident at doses (1 mg/kg) approximately 0.3 times the human exposure. In pregnant rats, no maternal or fetal toxicity was evident at doses (1 mg/kg) approximately 0.6 times the human dose for AMI (based on body weight) dosed during the period of organogenesis.

8.2 Lactation

Risk Summary

There are no data on the presence of alteplase in human milk, the effects on the breastfed infant, or the effects on milk production.

8.4 Pediatric Use

Safety and effectiveness of Activase in pediatric patients have not been established.

8.5 Geriatric Use

Acute Ischemic Stroke

In exploratory, multivariate analyses of Studies 1 and 2, age greater than 77 years was one of several interrelated baseline characteristics associated with an increased risk of intracranial hemorrhage. Efficacy results suggest a reduced but still favorable clinical outcome for Activase-treated elderly [see Clinical Studies (14.1)].

Acute Myocardial Infarction

In a large trial of accelerated-infusion Activase that enrolled 41,021 patients with AMI to one of four thrombolytic regimens [see Clinical Studies (14.2)], patients over 75 years of age, a predefined subgroup, comprised 12% of enrollment. In these patients, the incidence of stroke was 4.0% for the Activase accelerated infusion group, 2.8% for streptokinase IV [SK (IV)], and 3.2% for streptokinase SQ [SK (SQ)]. The incidence of combined 30-day mortality or nonfatal stroke was 20.6% for accelerated infusion of Activase, 21.5% for SK (IV), and 22.0% for SK (SQ).

11 DESCRIPTION

Activase is a tissue plasminogen activator produced by recombinant DNA technology. It is a sterile, purified glycoprotein of 527 amino acids. It is synthesized using the complementary DNA (cDNA) for natural human tissue-type plasminogen activator obtained from a human melanoma cell line. Activase is a sterile, white to off-white, lyophilized powder for intravenous administration after reconstitution with Sterile Water for Injection, USP.
**Table 6**
Quantitative Composition of the Lyophilized Product

<table>
<thead>
<tr>
<th></th>
<th>100 mg Vial</th>
<th>50 mg Vial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alteplase</td>
<td>100 mg (58 million IU)</td>
<td>50 mg (29 million IU)</td>
</tr>
<tr>
<td>L-Arginine</td>
<td>3.5 g</td>
<td>1.7 g</td>
</tr>
<tr>
<td>Phosphoric Acid</td>
<td>1 g</td>
<td>0.5 g</td>
</tr>
<tr>
<td>Polysorbate 80</td>
<td>10 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>Vacuum</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Biological potency is determined by an in vitro clot lysis assay and is expressed in International Units (IU).

The reconstituted preparation results in a colorless to pale yellow transparent solution containing Activase 1 mg/mL at approximately pH 7.3. The osmolality of this solution is approximately 215 mOsm/kg.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Alteplase is a serine protease responsible for fibrin-enhanced conversion of plasminogen to plasmin. It produces limited conversion of plasminogen in the absence of fibrin.

When introduced into the systemic circulation at pharmacologic concentration, alteplase binds to fibrin in a thrombus and converts the entrapped plasminogen to plasmin. This initiates local fibrinolysis with limited systemic proteolysis.

12.2 Pharmacodynamics

Following administration of 100 mg Activase, there is a decrease (16%-36%) in circulating fibrinogen. In a controlled trial, 8 of 73 patients (11%) receiving Activase (1.25 mg/kg body weight over 3 hours) experienced a decrease in fibrinogen to below 100 mg/dL.

12.3 Pharmacokinetics

Alteplase in acute myocardial infarction (AMI) patients is rapidly cleared from the plasma with an initial half-life of less than 5 minutes. There is no difference in the dominant initial plasma half-life between the 3-hour and accelerated regimens for AMI. The plasma clearance of alteplase is 380-570 mL/min, primarily mediated by the liver. The initial volume of distribution approximates plasma volume.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term studies in animals have not been performed to evaluate the carcinogenic potential or the effect on fertility. Short-term studies, which evaluated tumorigenicity of Activase and effect on tumor metastases in rodents, were negative.
Studies to determine mutagenicity (Ames test) and chromosomal aberration assays in human lymphocytes were negative at all concentrations tested. Cytotoxicity, as reflected by a decrease in mitotic index, was evidenced only after prolonged exposure and only at the highest concentrations tested.

14 CLINICAL STUDIES

14.1 Acute Ischemic Stroke (AIS)

Two placebo-controlled, double-blind trials (Studies 1 and 2) were conducted in patients with AIS. Both studies enrolled patients with measurable neurological deficit who could complete screening and begin study treatment within 3 hours from symptom onset. A cranial computerized tomography (CT) scan was performed prior to treatment to rule out the presence of intracranial hemorrhage. Blood pressure was actively controlled (185/110 mm Hg or lower) for 24 hours.

Patients were randomized (1:1) to receive either 0.9 mg/kg Activase (maximum of 90 mg) or placebo. Activase was administered as a 10% initial IV bolus over 1 minute followed by continuous IV infusion of the remainder over 60 minutes. Study treatment was initiated prior to the availability of coagulation study results in patients without recent use of oral anticoagulants and/or heparin and was discontinued if the pretreatment prothrombin time (PT) was greater than 15 seconds or the activated partial thromboplastin time (aPTT) was elevated. Patients with prior aspirin use were included. Administration of anticoagulants and antiplatelet agents was prohibited for the first 24 hours following symptom onset.

Study 1 (n=291) evaluated neurological improvement at 24 hours after stroke onset. The primary endpoint, the proportion of patients with a 4 point or greater improvement in the National Institutes of Health Stroke Scale (NIHSS) score or complete recovery (NIHSS score of 0), was not significantly different between treatment groups. A prespecified secondary analysis suggested improved 3-month outcome associated with Activase treatment using the following stroke assessment scales: Barthel Index, Modified Rankin Scale, Glasgow Outcome Scale, and the NIHSS.

Study 2 (n=333) assessed clinical outcome at 3 months. A favorable outcome was defined as minimal or no disability using four stroke assessment scales: Barthel Index (score of 95 or greater), Modified Rankin Scale (score of 1 or less), Glasgow Outcome Scale (score of 1), and NIHSS (score of 1 or less). The results comparing Activase- and placebo-treated patients for the four outcome scales together (Generalized Estimating Equations) and individually are presented in Table 7. In this study, depending upon the scale, the favorable outcome of minimal or no disability occurred in at least 11 per 100 more patients treated with Activase than those receiving placebo. Study results demonstrated consistent functional and neurological improvement within all four stroke scales as indicated by median scores. These results were consistent with the 3-month outcome treatment effects observed in Study 1.
### Table 7
Study 2 Three-Month Efficacy Outcomes

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Placebo (n=165)</th>
<th>Activase (n=168)</th>
<th>Absolute Difference (95% CI)</th>
<th>Odds Ratio b (95% CI)</th>
<th>p-Value c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized Estimating Equations (Multivariate)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.71 (1.15, 2.56)</td>
<td>0.02</td>
</tr>
<tr>
<td>Barthel Index</td>
<td>37.6%</td>
<td>50.0%</td>
<td>12.4% (3.0, 21.9)</td>
<td>1.66 (1.07, 2.57)</td>
<td>0.02</td>
</tr>
<tr>
<td>Modified Rankin Scale</td>
<td>26.1%</td>
<td>38.7%</td>
<td>12.6% (3.7, 21.6)</td>
<td>1.79 (1.12, 2.85)</td>
<td>0.02</td>
</tr>
<tr>
<td>Glasgow Outcome Scale</td>
<td>31.5%</td>
<td>44.0%</td>
<td>12.5% (3.3, 21.8)</td>
<td>1.71 (1.09, 2.68)</td>
<td>0.02</td>
</tr>
<tr>
<td>NIHSS</td>
<td>20.0%</td>
<td>31.0%</td>
<td>11.0% (2.6, 19.3)</td>
<td>1.79 (1.06, 2.96)</td>
<td>0.02</td>
</tr>
</tbody>
</table>

a Favorable Outcome is defined as recovery with minimal or no disability.

b Value greater than 1 indicates odds of recovery in favor of Activase treatment.

c p-Value for Odds Ratio is from Generalized Estimating Equations with logit link.

In a prespecified subgroup analysis of patients receiving aspirin prior to onset of stroke symptoms, the favorable outcome for Activase-treated patients was preserved.

### 14.2 Acute Myocardial Infarction (AMI)

Two Activase dose regimens have been studied in patients experiencing acute myocardial infarction [see Dosage and Administration (2.2)]. The comparative efficacy of these two regimens has not been evaluated.

**Accelerated Infusion in AMI Patients**

Accelerated infusion of Activase was studied in an international, multi-center trial that randomized 41,021 patients with AMI to four thrombolytic regimens (Study 3). Entry criteria included onset of chest pain within 6 hours of treatment and ST-segment elevation of ECG. The four treatment regimens included accelerated infusion of Activase (≤100 mg over 90 minutes) plus intravenous (IV) heparin (n=10,396); Streptokinase (1.5 million units over 60 minutes) plus IV heparin (SK [IV], n=10,410); Streptokinase plus subcutaneous (SQ) heparin (SK [SQ] n=9841). A fourth regimen combined Activase and Streptokinase (n=10,374). All patients received 160 mg chewable aspirin administered as soon as possible, followed by 160-325 mg daily. Bolus IV heparin 5000 U was initiated as soon as possible, followed by a 1000 U/hour continuous IV infusion for at least 48 hours; subsequent heparin therapy was at the physician’s discretion. Heparin SQ 12,500 U was administered 4 hours after initiation of SK therapy, followed by 12,500 U twice daily for 7 days or until discharge, whichever came first. Many of the patients randomized to receive SQ heparin...
received some IV heparin, usually in response to recurrent chest pain and/or the need for a medical procedure. Some received IV heparin on arrival to the emergency room prior to enrollment and randomization.

Key results from Study 3 are shown in Table 8. The incidence of 30-day mortality for Activase accelerated infusion was 1.0% lower than for either Streptokinase plus heparin regimen. The incidence of combined 30-day mortality or nonfatal stroke for the Activase accelerated infusion was 1.0% lower than for SK (IV) and 0.8% lower than for SK (SQ).

**Table 8**

Efficacy and Safety Results for Study 3

<table>
<thead>
<tr>
<th>Event</th>
<th>Accelerated Activase</th>
<th>SK (IV)</th>
<th>p-Value&lt;sup&gt;a&lt;/sup&gt;</th>
<th>SK (SQ)</th>
<th>p-Value&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day Mortality</td>
<td>6.3%</td>
<td>7.3%</td>
<td>0.003</td>
<td>7.3%</td>
<td>0.007</td>
</tr>
<tr>
<td>30-Day Mortality or Nonfatal Stroke</td>
<td>7.2%</td>
<td>8.2%</td>
<td>0.006</td>
<td>8.0%</td>
<td>0.036</td>
</tr>
<tr>
<td>24-Hour Mortality</td>
<td>2.4%</td>
<td>2.9%</td>
<td>0.009</td>
<td>2.8%</td>
<td>0.029</td>
</tr>
<tr>
<td>Any Stroke</td>
<td>1.6%</td>
<td>1.4%</td>
<td>0.32</td>
<td>1.2%</td>
<td>0.03</td>
</tr>
<tr>
<td>Intracerebral Hemorrhage</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.22</td>
<td>0.5%</td>
<td>0.02</td>
</tr>
</tbody>
</table>

<sup>a</sup> Two-tailed p-value is for comparison of Accelerated Activase to the respective SK control arm.

Subgroup analysis of patients by age, infarct location, time from symptom onset to thrombolytic treatment, and treatment in the U.S. or elsewhere showed consistently lower 30-day mortality on Activase.

For patients who were over 75 years of age, a predefined subgroup consisting of 12% of patients enrolled, the incidence of stroke was 4.0% for the Activase accelerated infusion group, 2.8% for SK (IV), and 3.2% for SK (SQ); the incidence of combined 30-day mortality or nonfatal stroke was 20.6% for accelerated infusion of Activase, 21.5% for SK (IV), and 22.0% for SK (SQ).

**3-Hour Infusion in AMI Patients**

In a double-blind, randomized trial (n=138) comparing 3-hour infusion of Activase to placebo (Study 4), patients infused with Activase within 4 hours of onset of symptoms experienced improved left ventricular function at Day 10 compared to the placebo group, when ejection fraction was measured by gated blood pool scan (53.2% vs. 46.4%, p=0.018). Relative to baseline (Day 1) values, the net changes in ejection fraction were +3.6% and -4.7% for the treated and placebo groups, respectively (p=0.0001). The treated group had a reduced incidence of clinical heart failure (14%) compared to the placebo group (33%) (p=0.009).

In a double-blind, randomized trial (n=5013) comparing 3-hour infusion of Activase to placebo (Study 5), patients infused with Activase within 5 hours of AMI symptom onset experienced improved 30-day survival compared to the placebo arm. At 1 month, the overall mortality rates were 7.2% for the Activase group and 9.8% for the placebo group (p=0.001). At 6 months, the overall mortality rate for Activase-treated patients was 10.4% compared to the placebo arm (13.1%, p=0.008).
14.3 Acute Massive Pulmonary Embolism (PE)

Study 6 was a comparative randomized trial (n=45) in which 59% of patients (n=22) treated with Activase (100 mg over 2 hours) experienced moderate or marked lysis of pulmonary emboli when assessed by pulmonary angiography 2 hours after treatment initiation. Activase-treated patients also experienced a significant reduction in pulmonary embolism-induced pulmonary hypertension within 2 hours of treatment (p=0.003). Pulmonary perfusion at 24 hours, as assessed by radionuclide scan, was significantly improved (p=0.002).

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

Activase is supplied as a sterile, lyophilized powder in 50 mg vials containing vacuum and in 100 mg vials without vacuum.

Each 50 mg Activase vial (29 million IU) is packaged with diluent for reconstitution (50 mL Sterile Water for Injection, USP): NDC 50242-044-13.

Each 100 mg Activase vial (58 million IU) is packaged with diluent for reconstitution (100 mL Sterile Water for Injection, USP), and one transfer device: NDC 50242-085-27.

16.2 Stability and Storage

Store lyophilized Activase at controlled room temperature not to exceed 30°C (86°F), or under refrigeration (2-8°C/36-46°F). Protect the lyophilized material during extended storage from excessive exposure to light. If stored between 2-30°C (36-86°F), Activase may be used within 8 hours following reconstitution. Discard any unused solution after administration is complete.

Do not use beyond the expiration date stamped on the vial.

17 PATIENT COUNSELING INFORMATION

Following Activase administration, patients are at increased risk of bleeding internally or externally. Advise patients to contact a health-care professional if they experience symptoms or signs consistent with bleeding (e.g., unusual bruising, pink or brown urine, red or black or tarry stools, coughing up blood, vomiting blood or blood that looks like coffee grounds), headache, or stroke symptoms.

Activase® (alteplase)
Manufactured by:
Genentech, Inc.
A Member of the Roche Group
1 DNA Way
South San Francisco, CA
94080-4990
U.S. License No. 1048

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