For your adult patients with incontinence due to neurogenic detrusor overactivity (NDO) refractory to an anticholinergic, **BOTOX® DELIVERS.**

**INDICATION**
Detrusor Overactivity Associated With a Neurologic Condition
BOTOX® for injection is indicated for the treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury [SCI], multiple sclerosis [MS]) in adults who have an inadequate response to or are intolerant of an anticholinergic medication.

**IMPORTANT SAFETY INFORMATION, INCLUDING BOXED WARNING**

**Distant Spread of Toxin Effect**
Postmarketing reports indicate that the effects of BOTOX® and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These may include asthenia, generalized muscle weakness, diplopia, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence, and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening, and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity, but symptoms can also occur in adults treated for spasticity and other conditions, particularly in those patients who have an underlying condition that would predispose them to these symptoms. In unapproved uses, including spasticity in children, and in approved indications, cases of spread of effect have been reported at doses comparable to those used to treat cervical dystonia and at lower doses.

Please see additional Important Safety Information inside. Please see accompanying full Prescribing Information, including Boxed Warning.
More than half of patients with the following neurologic conditions may have detrusor overactivity (DO)\(^1,2\):

- Multiple sclerosis (MS)
- Parkinson’s disease (PD)
- Spinal cord injury (SCI)
- Stroke

Many patients with UI associated with a neurologic condition are inadequately managed with anticholinergics\(^3\)

- 71% of patients with a neurologic condition stop taking at least one oral medication within 12 months, according to a 5-year observational study\(^3\)

Patients with NDO may be using clean intermittent catheterization (CIC)\(^1\)

- In BOTOX\(^\circledR\) pivotal trials for urinary incontinence (UI) due to NDO, more than half of all patients were using CIC at baseline\(^1\)
- BOTOX\(^\circledR\) patients must be willing and able to perform CIC to empty the bladder\(^4\)

BOTOX\(^\circledR\) for injection is indicated for the treatment of\(^4\):

- Urinary incontinence due to detrusor overactivity associated with a neurologic condition (eg, SCI, MS)
- In adults who have an inadequate response to or are intolerant of an anticholinergic medication

IMPORTANT SAFETY INFORMATION (cont.)

CONTRAINDICATIONS
BOTOX\(^\circledR\) is contraindicated in the presence of infection at the proposed injection site(s) and in individuals with known hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation.

Intradetrusor injection of BOTOX\(^\circledR\) is contraindicated in patients with detrusor overactivity associated with a neurologic condition who have acute urinary tract infection, and in patients with acute urinary retention who are not routinely performing clean intermittent self-catheterization (CIC).

WARNINGS AND PRECAUTIONS
Lack of Interchangeability Between Botulinum Toxin Products
The potency Units of BOTOX\(^\circledR\) are specific to the preparation and assay method utilized. They are not interchangeable with other preparations of botulinum toxin products and, therefore, Units of biological activity of BOTOX\(^\circledR\) cannot be compared to nor converted into Units of any other botulinum toxin products assessed with any other specific assay method.

Spread of Toxin Effect
See Boxed Warning.

Please see additional Important Safety Information on the following pages.
Please see accompanying full Prescribing Information, including Boxed Warning.
**Phase 3 Trials Study Design**

**Two double-blind, placebo-controlled, randomized, multicenter studies**

**Key patient characteristics**

- Adults with UI due to detrusor overactivity associated with a neurologic condition
  - Diagnosed with MS (n=381) or SCI (n=310)
  - Spontaneously voiding or using catheterization
  - 4.5 daily UI episodes (about 32/week) on average at baseline
  - Had an inadequate response to or were intolerant of an anticholinergic medication

**Study methodology**

- 691 patients in 2 studies (study 1, n=416; study 2, n=275) were randomized (1:1:1) into one of 3 arms: placebo, BOTOX® 200 U, or BOTOX® 300 U

**Primary efficacy endpoint**

- Weekly UI episodes

**Select secondary efficacy endpoints**

- Maximum cystometric capacity (MCC)
- Maximum detrusor pressure (MDP) during first involuntary detrusor contraction (IDC)

**BOTOX® approved at 200 U for the treatment of urinary incontinence due to NDO in adults who have an inadequate response to or are intolerant of an anticholinergic medication**

- BOTOX® 300 U showed a higher rate of certain adverse events and no clinically meaningful difference in efficacy

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*Mean baseline Expanded Disability Status Scale (EDSS) score of 5.1 (EDSS score of 5.0 = ambulatory without aid or rest for approximately 200 m; disability severe enough to impair full day activities).
† Neurologic injury was at or below thoracic level (T1). 68% of SCI patients were classified as ASIA A: complete SCI with no motor or sensory function preserved in the sacral segments S4-S5.
‡ Patient qualification for retreatment was based on loss of effect on incontinent episode frequency: 50% of effect in study 1; 70% of effect in study 2. Patients could not qualify for retreatment before week 12.
BOTOX® Significantly Reduced UI Episodes

Treatment with BOTOX® 200 U reduced weekly mean UI episodes by up to 67% (-22 episodes) from baseline at week 6\(^1\)

- Placebo: up to 36% reduction (-13 episodes)

Mean change from baseline in weekly number of UI episodes\(^1,4\)

![Graph showing mean change from baseline in weekly number of UI episodes for Study 1 and Study 2.]

**Study 1**

- Placebo (n=146)
- BOTOX® 200 U (n=134)

**Study 2**

- Placebo (n=91)
- BOTOX® 200 U (n=91)

Baseline mean weekly UI frequency

- BOTOX®: 32.3 episodes; Placebo: 28.3 episodes
- BOTOX®: 32.7 episodes; Placebo: 36.8 episodes

‡ Mean change from baseline based on LOCF analysis.

**IMPORTANT SAFETY INFORMATION (cont.)**

**WARNINGS AND PRECAUTIONS (cont.)**

**Hypersensitivity Reactions**

Serious and/or immediate hypersensitivity reactions have been reported. These reactions include anaphylaxis, serum sickness, urticaria, soft-tissue edema, and dyspnea. If such a reaction occurs, further injection of BOTOX® should be discontinued and appropriate medical therapy immediately instituted. One fatal case of anaphylaxis has been reported in which lidocaine was used as the diluent, and consequently the causal agent cannot be reliably determined.

**Pre-Existing Neuromuscular Disorders**

Individuals with peripheral motor neuropathic diseases, amyotrophic lateral sclerosis, or neuromuscular junctional disorders (eg, myasthenia gravis or Lambert-Eaton syndrome) should be monitored particularly closely when given botulinum toxin. Patients with neuromuscular disorders may be at increased risk of clinically significant effects including severe dysphagia and respiratory compromise from therapeutic doses of BOTOX®.

**Pulmonary Effects of BOTOX® in Patients With Compromised Respiratory Status Treated for Detrusor Overactivity Associated With a Neurologic Condition**

Patients with compromised respiratory status treated with BOTOX® for detrusor overactivity associated with a neurologic condition should be monitored closely.
**BOTOX® Delivered Long-lasting Response**

BOTOX® patients experienced a median 10-month duration of response (up to 48 weeks) based on patient qualification for retreatment¹,⁴

- Placebo: median of 4 months (up to 18 weeks)

Duration of response: time to patient qualification for retreatment¹,⁴

**Study 1**

![Graph showing percentage of patients not qualified for retreatment over duration of response (days)]

- Placebo (n=149)
- BOTOX® 200 U (n=135)

Starting at week 12, patients could qualify for retreatment⁴

**Study 2**

![Graph showing percentage of patients not qualified for retreatment over duration of response (days)]

- Placebo (n=92)
- BOTOX® 200 U (n=92)

Starting at week 12, patients could qualify for retreatment⁴

Retreatment qualification criteria¹,⁴

- A minimum of 12 weeks had elapsed since the first treatment
- The patient requested treatment and met a UI threshold at time of request
  - A return to more than 50% of baseline UI episodes in study 1
  - A return to more than 70% of baseline UI episodes in study 2

**IMPORTANT SAFETY INFORMATION (cont.)**

**WARNINGS AND PRECAUTIONS (cont.)**

**Autonomic Dysreflexia and Urinary Retention in Patients Treated for Detrusor Overactivity Associated With a Neurologic Condition**

Autonomic dysreflexia associated with intradetrusor injections of BOTOX® could occur in patients treated for detrusor overactivity associated with a neurologic condition and may require prompt medical therapy. In clinical trials, the incidence of autonomic dysreflexia was greater in patients treated with BOTOX® 200 Units compared with placebo (1.5% versus 0.4%, respectively).

In clinical trials, 30.6% of patients (33/108) who were not using clean intermittent catheterization (CIC) prior to injection, required catheterization for urinary retention following treatment with BOTOX® 200 Units as compared to 6.7% of patients (7/104) treated with placebo. The median duration of post-injection catheterization for these patients treated with BOTOX® 200 Units (n=108) was 289 days (minimum 1 day to maximum 530 days) as compared to a median duration of 358 days (minimum 2 days to maximum 379 days) for patients receiving placebo (n=104).

Please see additional Important Safety Information on the following pages. Please see accompanying full Prescribing Information, including Boxed Warning.
**BOTOX® Significantly Increased Cystometric Capacity**

**BOTOX® patients showed a mean increase in maximum cystometric capacity of up to 63% (+150.8 mL) at week 6**
- Placebo: up to 5% (+12.1 mL)

**Maximum cystometric capacity at baseline and week 6†**

<table>
<thead>
<tr>
<th>Study 1</th>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Placebo (n=129)</strong></td>
<td><strong>Placebo (n=85)</strong></td>
</tr>
<tr>
<td>Baseline</td>
<td>Baseline</td>
</tr>
<tr>
<td>259.1 mL</td>
<td>253.8 mL</td>
</tr>
<tr>
<td><strong>+5%</strong></td>
<td><strong>+1%</strong></td>
</tr>
<tr>
<td>+12.1 mL</td>
<td>+2.8 mL</td>
</tr>
<tr>
<td>Week 6</td>
<td>Week 6</td>
</tr>
<tr>
<td>271.2 mL</td>
<td>256.6 mL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>BOTOX® 200 U (n=123)</strong></th>
<th><strong>BOTOX® 200 U (n=88)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>Baseline</td>
</tr>
<tr>
<td>253.8 mL</td>
<td>239.6 mL</td>
</tr>
<tr>
<td><strong>+54%</strong></td>
<td><strong>+63%</strong></td>
</tr>
<tr>
<td>+135.9 mL*</td>
<td>+150.8 mL*</td>
</tr>
<tr>
<td>Week 6</td>
<td>Week 6</td>
</tr>
<tr>
<td>389.7 mL</td>
<td>390.4 mL</td>
</tr>
</tbody>
</table>

*P<.001

† Change from baseline represented by LS mean change based on an LOCF analysis using an ANCOVA model.

**IMPORTANT SAFETY INFORMATION (cont.)**

**WARNINGS AND PRECAUTIONS (cont.)**

*Autonomic Dysreflexia and Urinary Retention in Patients Treated for Detrusor Overactivity Associated With a Neurologic Condition (cont.)*

Among patients not using CIC at baseline, those with MS were more likely to require CIC post-injection than those with SCI.

Due to the risk of urinary retention, only patients who are willing and/or able to initiate catheterization post-treatment, if required, should be considered for treatment.

In patients who are not catheterizing, post-void residual (PVR) urine volume should be assessed within 2 weeks post-treatment and periodically as medically appropriate up to 12 weeks. Catheterization should be instituted if PVR urine volume exceeds 200 mL and continued until PVR falls below 200 mL. Patients should be instructed to contact their physician if they experience difficulty in voiding as catheterization may be required.

**Human Albumin and Transmission of Viral Diseases**

This product contains albumin, a derivative of human blood. Based on effective donor screening and product manufacturing processes, it carries an extremely remote risk for transmission of viral diseases. A theoretical risk for transmission of Creutzfeldt-Jakob disease (CJD) is also considered extremely remote. No cases of transmission of viral diseases or CJD have ever been reported for albumin.
**BOTOX® Significantly Reduced Detrusor Pressure**

BOTOX® patients showed a mean reduction in maximum detrusor pressure at the first involuntary detrusor contraction of up to 45% (-28.1 cmH₂O) at week 6:

- Placebo: up to 6% (-3.7 cmH₂O)

Mean change in maximum detrusor pressure during first involuntary detrusor contraction at week 6:

### Study 1

<table>
<thead>
<tr>
<th>Drug</th>
<th>Mean Change from Baseline (cmH₂O)</th>
<th>% Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>57.4</td>
<td></td>
</tr>
<tr>
<td>BOTOX® 200 U</td>
<td>63.1</td>
<td>45%</td>
</tr>
</tbody>
</table>

### Study 2

<table>
<thead>
<tr>
<th>Drug</th>
<th>Mean Change from Baseline (cmH₂O)</th>
<th>% Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>43.7</td>
<td></td>
</tr>
<tr>
<td>BOTOX® 200 U</td>
<td>65.6</td>
<td>44%</td>
</tr>
</tbody>
</table>

*P < .001

† Change from baseline represented by LS mean change based on an LOCF analysis using an ANCOVA model.

**IMPORTANT SAFETY INFORMATION (cont.)**

**ADVERSE REACTIONS**

The following adverse reactions to BOTOX® for injection are discussed in greater detail in the following sections: Spread of Toxin Effect (see Boxed Warning) and Hypersensitivity Reactions (see Contraindications and Warnings and Precautions).

**Detrusor Overactivity Associated With a Neurologic Condition**

The most frequently reported adverse reactions within 12 weeks of BOTOX® injection for detrusor overactivity associated with a neurologic condition include urinary tract infection (BOTOX® 24%, placebo 17%), urinary retention (BOTOX® 17%, placebo 3%), hematuria (BOTOX® 4%, placebo 3%), fatigue (BOTOX® 4%, placebo 1%), and insomnia (BOTOX® 2%, placebo 0%).

Please see additional Important Safety Information on the following pages.

Please see accompanying full Prescribing Information, including Boxed Warning.
Most Commonly Reported AEs and Patient CIC Usage

Most commonly reported adverse events (AEs) within the first 12 weeks\(^4\text{‡}\)

<table>
<thead>
<tr>
<th>Adverse reactions</th>
<th>BOTOX(^\circ) 200 U (n=262)</th>
<th>Placebo (n=272)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary tract infection (UTI)</td>
<td>64 (24%)</td>
<td>47 (17%)</td>
</tr>
<tr>
<td>Urinary retention</td>
<td>45 (17%)</td>
<td>8 (3%)</td>
</tr>
<tr>
<td>Hematuria</td>
<td>10 (4%)</td>
<td>8 (3%)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>10 (4%)</td>
<td>3 (1%)</td>
</tr>
<tr>
<td>Insomnia</td>
<td>4 (2%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

- UTI was not required to be symptomatic; it was defined as a positive urine culture\(^1\)
- Urinary retention was not defined and was determined at the discretion of the investigator\(^1\)

No change was observed in the overall safety profile with repeat dosing.\(^4\)

Proportion of patients using CIC: baseline CIC and \textit{de novo} CIC following treatment\(^1,4\)

<table>
<thead>
<tr>
<th>Timepoint</th>
<th>BOTOX(^\circ) 200 U</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIC prior to treatment*</td>
<td>119/227 (52.4%)</td>
<td>139/241 (57.7%)</td>
</tr>
<tr>
<td>CIC initiated at any time during complete treatment cycle†</td>
<td>33/108 (30.6%)</td>
<td>7/104 (6.7%)</td>
</tr>
</tbody>
</table>

* CIC status during the baseline period.
† Catheterizing for urinary retention.

- In the clinical trials, CIC was initiated at the discretion of the investigator\(^1\)
- In patients who are not catheterizing, post-void residual (PVR) urine volume should be assessed within 2 weeks post-treatment and periodically as medically appropriate up to 12 weeks. Catheterization should be instituted if PVR urine volume exceeds 200 mL and continued until PVR falls below 200 mL. Patients should be instructed to contact their physician if they experience difficulty in voiding, as catheterization may be required\(^4\)

\textbf{IMPORTANT SAFETY INFORMATION (cont.)}

\textbf{ADVERSE REACTIONS (cont.)}

\textbf{Detrusor Overactivity Associated With a Neurologic Condition (cont.)}

The following adverse event rates were reported at any time following initial injection and prior to reinjection or study exit (median duration of 44 weeks of exposure): urinary tract infections (49%), urinary retention (17%), fatigue (6%), constipation (4%), muscular weakness (4%), dysuria (4%), fall (3%), gait disturbance (3%), insomnia (3%), and muscle spasm (2%).

Please see additional Important Safety Information on the following pages.
Dosing and administration for the treatment of neurogenic detrusor overactivity

**Pretreatment**
- Prophylactic antibiotics (except aminoglycosides) 1 to 3 days pretreatment
- Patients should discontinue antiplatelet therapy at least 3 days before the injection procedure; patients on anticoagulant therapy need to be managed appropriately to decrease the risk of bleeding
- Reconstitute 200 U of BOTOX® per label; use immediately after reconstitution in the syringe
- Patients must be asymptomatic for UTI at the time of treatment; BOTOX® treatment is contraindicated in the setting of an acute UTI

**Treatment**
- Patient options for anesthesia should be discussed: no anesthesia, local anesthetic with or without sedation, or general anesthesia
- Administer prophylactic antibiotics (except aminoglycosides) on the day of treatment
- Recommended dose for NDO is 200 U BOTOX® as 1-cc (~6.7 U) injections and should not be exceeded
- In treating adult patients for one or more indications, the maximum cumulative dose should generally not exceed 360 U in a 3-month interval
- Use caution when BOTOX® treatment is used in the presence of inflammation at the proposed injection site(s) or when excessive weakness or atrophy is present in the target muscle(s)
- Instill the bladder with enough saline to achieve adequate visualization; overdistention should be avoided
- The injection needle should be filled (primed) with approximately 1 mL of reconstituted BOTOX® prior to the start of the injections (depending on needle length) to remove any air

1. Using a flexible or rigid cystoscope, insert needle approximately 2 mm into the detrusor (avoiding the trigone)
2. Space injections approximately 1 cm apart
   - Administer 30 injections of 1 cc each (30 cc total), evenly distributed across the detrusor
     - If you encounter a small amount of bleeding from an injection site, it should not interfere with the procedure
     - For the final injection, inject approximately 1 mL of sterile normal saline so the full dose is delivered

The dosing and administration of BOTOX® is a detailed process. The information on this page and the following page contain highlights only and are not meant to be a substitute for appropriate training or review of full Prescribing Information.

Please see additional Important Safety Information on the following pages. Please see accompanying full Prescribing Information, including Boxed Warning.
**Post-treatment Protocol**

| 30 mins | **IMMEDIATELY POSTINJECTION** | Immediately drain the saline used for bladder wall visualization⁴ |
| 1-3 days | **30 MINUTES POSTINJECTION** | Observe the patient for at least 30 minutes postinjection⁴ |
| 2 weeks | - During this period, safety monitoring and assessments should be done according to your facility’s accepted practices (eg, monitoring of blood pressure, pulse rate, and ensuring the patient has emptied the bladder before leaving the site)¹ |
| 12 weeks | **ONE TO 3 DAYS POSTINJECTION** | One to 3 days after treatment, provide postprocedural prophylactic antibiotics (except aminoglycosides)⁴ |
| 10 months | **2 TO 12 WEEKS POSTINJECTION** | Assess PVR volume within 2 weeks post-treatment (or earlier as medically appropriate) for patients who are not catheterizing⁴ |
|          |   | Continue to assess PVR volume periodically as medically appropriate up to 12 weeks post-treatment⁴ |
|          | **RETREATMENT CONSIDERATIONS** | Reinjection may be considered upon diminishing clinical effect of the previous BOTOX® injection (median time to qualification for retreatment in the double-blind, placebo-controlled clinical studies was approximately 10 months [42 to 48 weeks] for BOTOX® 200 U) but no sooner than 12 weeks from the prior bladder injection procedure⁴ |

The potency Units of BOTOX® (onabotulinumtoxinA) for injection are specific to the preparation and assay method utilized. They are not interchangeable with other preparations of botulinum toxin products, and, therefore, units of biological activity of BOTOX® cannot be compared to nor converted into units of any other botulinum toxin products assessed with any other specific assay method.⁴

**IMPORTANT SAFETY INFORMATION (cont.)**

**ADVERSE REACTIONS (cont.)**

**Post Marketing Experience**

There have been spontaneous reports of death, sometimes associated with dysphagia, pneumonia, and/or other significant debility or anaphylaxis, after treatment with botulinum toxin. There have also been reports of adverse events involving the cardiovascular system, including arrhythmia and myocardial infarction, some with fatal outcomes. Some of these patients had risk factors including cardiovascular disease. The exact relationship of these events to the botulinum toxin injection has not been established.
BOTOX® treatment for NDO is generally well covered by private and public payers.\(^7\)

<table>
<thead>
<tr>
<th>Coverage and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Established J-code for BOTOX® for over 20 years</strong>(^1)</td>
</tr>
<tr>
<td>- J-code = J0585</td>
</tr>
<tr>
<td>- Acquisition cost for 200 U = $1050</td>
</tr>
<tr>
<td><strong>Selecting a procedural code is a clinical decision</strong></td>
</tr>
<tr>
<td>- Currently no specific CPT® code exists for BOTOX® bladder injections</td>
</tr>
<tr>
<td>- AUA states that in absence of an established code, CPT code 53899 [unlisted procedure, urinary system] may be used</td>
</tr>
</tbody>
</table>

**Simplify reimbursement with Allergan resources**

**BOTOX® Reimbursement Solutions**
- 20 years of experience in BOTOX® reimbursement for therapeutic uses
- Provides urology offices with comprehensive support for insurance verification, prior authorization, and claims appeals
- Verification of coverage and benefits for each of your patients
- Click on **BOTOXReimbursementSolutions.com** for a wide range of online tools
- Call the BOTOX® Reimbursement Solutions Support Center at **1-800-44-BOTOX** (1-800-442-6869), Option 4, for direct access to Reimbursement Counselors

**Reimbursement Business Managers**
- On-site education, training, and support
- Knowledge of your local payers’ policies
- Use the Reimbursement Business Manager Lookup feature at **BOTOXReimbursementSolutions.com**

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**IMPORTANT SAFETY INFORMATION (cont.)**

**DRUG INTERACTIONS**
No formal drug interaction studies have been conducted with BOTOX® (onabotulinumtoxinA) for injection. Co-administration of BOTOX® and aminoglycosides or other agents interfering with neuromuscular transmission (e.g. curare-like compounds) should only be performed with caution as the effect of the toxin may be potentiated. Use of anticholinergic drugs after administration of BOTOX® may potentiate systemic anticholinergic effects.

Please see additional Important Safety Information on the following pages. Please see accompanying full Prescribing Information, including Boxed Warning.
BOTOX® DELIVERS.

Significantly Reduced UI Episodes

Treatment with BOTOX® 200 U reduced weekly mean UI episodes by up to 67% (-22 episodes) from baseline vs up to 36% (-13 episodes) for placebo by week 6.1,4

Long-lasting Response

BOTOX® patients experienced a median 10-month duration of response (up to 48 weeks) vs 4 months (up to 18 weeks) for placebo based on patient qualification for retreatment.*

Significantly Improved Urodynamic Parameters

BOTOX® patients showed a mean increase from baseline in maximum cystometric capacity of up to 63% (+150.8 mL) vs up to 5% (+12.1 mL) for placebo.4

IMPORTANT SAFETY INFORMATION (cont.)

DRUG INTERACTIONS (cont.)

The effect of administering different botulinum neurotoxin products at the same time or within several months of each other is unknown. Excessive neuromuscular weakness may be exacerbated by administration of another botulinum toxin prior to the resolution of the effects of a previously administered botulinum toxin. Excessive weakness may also be exaggerated by administration of a muscle relaxant before or after administration of BOTOX®.

Please see accompanying full Prescribing Information, including Boxed Warning.

* Patient qualification for retreatment was based on loss of effect on incontinent episode frequency: 50% of effect in study 1; 70% of effect in study 2. Patients could not qualify for retreatment before week 12.1,4

References:
2.2 Preparation and Dilution Technique

1.5 Primary Axillary Hyperhidrosis

1.4 Cervical Dystonia

1.3 Upper Limb Spasticity

1.2 Chronic Migraine

INDICATIONS AND USAGE

FULL PRESCRIBING INFORMATION: CONTENTS*

HIGHLIGHTS OF PRESCRIBING INFORMATION

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

BOTOX (onabotulinumtoxinA) for injection, for intramuscular, intradetrusor, or intradermal use

Initial U.S. Approval: 1989

WARNING: DISTANT SPREAD OF TOXIN EFFECT

See full prescribing information for complete boxed warning.

The effects of BOTOX and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These symptoms may have been reported to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults, particularly in those patients who have an underlying condition that would predispose them to these symptoms. (5.2)

RECENT MAJOR CHANGES

• Indications and Usage, Detrusor Overactivity associated with a Neurologic Condition (1.1) 8/2011

DOSAGE AND ADMINISTRATION

BOTOX is an acetylcholine release inhibitor and a neuromuscular blocking agent indicated for:

• Treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication (1.1)

• Prophylaxis of headaches in adult patients with chronic migraine (≥15 days per month with headache lasting 4 hours a day or longer) (1.2)

• Treatment of upper limb spasticity in adult patients (1.3)

• Treatment of cervical dystonia in adult patients, to reduce the severity of abnormal head and neck pain (1.4)

• Treatment of severe axial hyperhidrosis that is inadequately managed by topical agents in adult patients (1.5)

• Treatment of blepharospasm associated with dystonia in patients ≥12 years of age (1.6)

• Treatment of strabismus in patients ≥12 years of age (1.6)

Important limitations:

• Safety and effectiveness of BOTOX have not been established for the prophylaxis of episodic migraine (14 headache days or fewer per month). (1.2)

• Safety and effectiveness of BOTOX have not been established for the treatment of upper limb spasticity in pediatric patients, and for the treatment of lower limb spasticity in adult and pediatric patients. (1.3)

• Safety and effectiveness of BOTOX for hyperhidrosis in body areas other than axillary have not been established. (1.5)

DOSE AND ADMINISTRATION

• Indication specific dosage and administration recommendations should be followed; Do not exceed a total dose of 360 Units administered in a 3 month interval (2.1)

• See Preparation and Dilution Technique for instructions on BOTOX reconstitution, storage, and preparation before injection (2.2)

• Detrusor Overactivity associated with a Neurologic Condition: Recommended total dose 200 Units, as 1 mL (~6.7 Units) injections across 30 sites into the detrusor (2.3)

• Chronic Migraine: Recommended total dose 155 Units, as 0.1 mL (5 Units) injections per each site divided across 7 head/neck muscles (2.4)

FULL PRESCRIBING INFORMATION: CONTENTS*

WARNING: DISTANT SPREAD OF TOXIN EFFECT

1 INDICATIONS AND USAGE

1.1 Detrusor Overactivity associated with a Neurologic Condition

1.2 Chronic Migraine

1.3 Upper Limb Spasticity

1.4 Cervical Dystonia

1.5 Primary Axillary Hyperhidrosis

1.6 Blepharospasm and Strabismus

2 DOSAGE AND ADMINISTRATION

2.1 Instructions for Safe Use

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4.1 Known Hypersensitivity to Botulinum Toxin

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See 17 for PATIENT COUNSELING INFORMATION and Medication Guide

Revised: 11/2011

HIGHLIGHTS OF PRESCRIBING INFORMATION

• Safety and effectiveness of BOTOX have not been established for the prophylaxis of episodic migraine (14 headache days or fewer per month). (1.2)

• Safety and effectiveness of BOTOX have not been established for the treatment of upper limb spasticity in pediatric patients, and for the treatment of lower limb spasticity in adult and pediatric patients. (1.3)

• Safety and effectiveness of BOTOX for hyperhidrosis in body areas other than axillary have not been established. (1.5)

• Upper Limb Spasticity: Select dose based on muscles affected, severity of muscle activity, prior response to treatment, and adverse event history; Electromyographic guidance recommended (2.5)

• Cervical Dystonia: Base dosing on the patient's head and neck position, localization of pain, muscle hypertrophy, patient response, and adverse event history; use lower initial dose in botulinum toxin naïve patients (2.6)

• Axillary Hyperhidrosis: 50 Units per axilla (2.7)

• Blepharospasm: 1.25 Units-2.5 Units into each of 3 sites per affected eye (2.8)

• Strabismus: 1.25 Units-2.5 Units initially in any one muscle (2.9)

DOSE FORMS AND STRENGTHS

Single-use, sterile 100 Units or 200 Units vacuum-dried powder for reconstitution only with sterile, non-preserved 0.9% Sodium Chloride Injection USP prior to injection (3)

CONTRAINDICATIONS

• Hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation (4.1, 5.4, 6)

• Infection at the proposed injection site (4.2)

• Intradetrusor Injections: Acute Urinary Tract Infection and/or Acute Urinary Retention (4.3)

WARNINGS AND PRECAUTIONS

• Potency Units of BOTOX not interchangeable with other preparations of botulinum toxin products (4.4, 11)

• Spread of toxin effects; swallowing and breathing difficulties can lead to death. Seek immediate medical attention if respiratory, speech or swallowing difficulties occur (5.2, 5.5)

• Care should be taken when injecting in or near vulnerable anatomic structures (5.3)

• Concomitant neuromuscular disorder may exacerbate clinical effects of treatment (5.6)

• Use with caution in patients with compromised respiratory function (5.5, 5.7, 5.10)

• Corneal exposure and ulceration due to reduced blinking may occur (5.11)

• Corneal exposure and ulceration due to reduced blinking may occur with BOTOX treatment of blepharospasm (5.8)

• Retrobulbar hemorrhages and compromised retinal circulation may occur with BOTOX treatment of strabismus (5.9)

• Bronchitis and upper respiratory tract infections in patients treated for upper limb spasticity (5.10)

• Urinary retention: Post-void residual urine volume should be monitored in patients treated for detrusor overactivity associated with a neurologic condition who do not catheterize routinely, particularly patients with MS. (5.11)

ADVERSE REACTIONS

The most common adverse reactions (≥5% and ≠placebo) are (6.1):

• Detrusor Overactivity associated with a neurologic condition: urinary tract infection, urinary retention

• Chronic Migraine: neck pain, headache

• Spasticity: pain in extremity

• Cervical Dystonia: dysphagia, upper respiratory infection, neck pain, headache, increased cough, flu syndrome, back pain, rhinitis

• Axillary Hyperhidrosis: injection site pain and hemorrhage, non-axillary sweating, pharyngitis, flu syndrome

To report SUSPECTED ADVERSE REACTIONS, contact Allergan at 1-800-433-8871 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

• Patients receiving concomitant treatment of BOTOX and aminoglycosides or other agents interfering with neuromuscular transmission (e.g., curare-like agents), or muscle relaxants, should be observed closely because the effect of BOTOX may be potentiated (7)

USE IN SPECIFIC POPULATIONS

• Pregnancy: Based on animal data, may cause fetal harm (8.1)

• Pediatric Use: Safety and efficacy are not established in patients under 18 years of age for the prophylaxis of headaches in chronic migraine, the treatment of detrusor overactivity associated with a neurologic condition, upper limb spasticity, and axillary hyperhidrosis, in patients under 16 years of age for the treatment of cervical dystonia, and in patients under 12 years of age for the treatment of blepharospasm and strabismus (8.4)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide

Revised: 11/2011
5 WARNINGS AND PRECAUTIONS

5.1 Lack of Interchangeability between Botulinum Toxin Products

5.2 Spread of Toxin Effect

5.3 Injections In or Near Vulnerable Anatomic Structures

5.4 Hypersensitivity Reactions

5.5 Dysphagia and Breathing Difficulties in Treatment of Cervical Dystonia

5.6 Pre-Existing Neuromuscular Disorders

5.7 Pulmonary Effects of BOTOX in Patients with Compromised Respiratory Status Treated for Spasticity or for Detrusor Overactivity associated with a Neurologic Condition

5.8 Corneal Exposure and Ulceration in Patients Treated with BOTOX for Blepharospasm

5.9 Retrobulbar Hemorrhages in Patients Treated with BOTOX for Strabismus

5.10 Bronchitis and Upper Respiratory Tract Infections in Patients Treated for Spasticity

5.11 Autonomic Dysreflexia and Urinary Retention in Patients Treated for Detrusor Overactivity associated with a Neurologic Condition

5.12 Human Albumin and Transmission of Viral Diseases

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

6.2 Immunogenicity

6.3 Post-Marketing Experience

7 DRUG INTERACTIONS

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

8.3 Nursing Mothers

FULL PRESCRIBING INFORMATION

WARNING: DISTANT SPREAD OF TOXIN EFFECT

Postmarketing reports indicate that the effects of BOTOX and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These may include asthenia, generalized muscle weakness, diplopia, paresis, dysphagia, dysphonia, dysarthria, urinary incontinence and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults treated for spasticity and other conditions, particularly in those patients who have an underlying condition that would predispose them to these symptoms. In unapproved uses, including spasticity in children, and in approved indications, cases of spread of effect have been reported at doses comparable to those used to treat cervical dystonia and at lower doses. [See Warnings and Precautions (5.2)]

1 INDICATIONS AND USAGE

1.1 Detrusor Overactivity associated with a Neurologic Condition

BOTOX (onabotulinumtoxinA) for injection is indicated for the treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., SCI, MS) in adults who have an inadequate response to or are intolerant of an anticholinergic medication.

1.2 Chronic Migraine

BOTOX is indicated for the prophylaxis of headaches in adult patients with chronic migraine (≥15 days per month with headache lasting 4 hours a day or longer).

Important limitations

Safety and effectiveness have not been established for the prophylaxis of episodic migraine (14 headache days or fewer per month) in seven placebo-controlled studies.

1.3 Upper Limb Spasticity

BOTOX is indicated for the treatment of upper limb spasticity in adult patients, to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris) and finger flexors (flexor digitorum profundus and flexor digitorum sublimis).

Important limitations

Safety and effectiveness of BOTOX have not been established for the treatment of other upper limb muscle groups, or for the treatment of lower limb spasticity. Safety and effectiveness of BOTOX have not been established for the treatment of spasticity in pediatric patients under age 18 years. BOTOX has not been shown to improve upper extremity functional abilities, or range of motion at a joint affected by a fixed contracture. Treatment with BOTOX is not intended to substitute for usual standard of care rehabilitation regimens.

1.4 Cervical Dystonia

BOTOX is indicated for the treatment of adults with cervical dystonia, to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

1.5 Primary Axillary Hyperhidrosis

BOTOX is indicated for the treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents.

Important limitations

The safety and effectiveness of BOTOX for hyperhidrosis in other body areas have not been established. Weakness of hand muscles and blepharoptosis may occur in patients who receive BOTOX for palmar hyperhidrosis and facial hyperhidrosis, respectively. Patients should be evaluated for potential causes of secondary hyperhidrosis (e.g., hyperthyroidism) to avoid symptomatic treatment of hyperhidrosis without the diagnosis and/or treatment of the underlying disease.

Safety and effectiveness of BOTOX have not been established for the treatment of axillary hyperhidrosis in pediatric patients under age 18.

1.6 Blepharospasm and Strabismus

BOTOX is indicated for the treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above.

2 DOSAGE AND ADMINISTRATION

2.1 Instructions for Safe Use

The potency Units of BOTOX (onabotulinumtoxinA) for injection are specific to the preparation and assay method utilized. They are not interchangeable with other preparations of botulinum toxin products and, therefore, units of biological activity of BOTOX cannot be compared to nor converted into units of any other botulinum toxin products assessed with any other specific assay method [see Warnings and Precautions (5.1) and Description (11)].

Indication specific dosage and administration recommendations should be followed. In treating adult patients for one or more indications, the maximum cumulative dose should generally not exceed 360 Units, in a 3 month interval.

The safe and effective use of BOTOX depends upon proper storage of the product, selection of the correct dose, and proper reconstitution and administration techniques. Physicians administering BOTOX must understand the relevant neuromuscular and/or orbital anatomy of the area involved and any alterations to the anatomy due to prior surgical procedures. An understanding of standard electromyographic techniques is also required for treatment of strabismus and of upper limb spasticity, and may be useful for the treatment of cervical dystonia.

Use caution when BOTOX treatment is used in the presence of inflammation at the proposed injection site(s) or when excessive weakness or atrophy is present in the target muscle(s).

2.2 Preparation and Dilution Technique

BOTOX is supplied in single-use 100 Units and 200 Units per vial. Prior to injection, reconstitute each vacuum-dried vial of BOTOX with sterile, non-preserved 0.9% Sodium Chloride Injection USP. Draw up the proper amount of diluent in the appropriate size syringe (see Table 1, or for specific instructions for detrusor overactivity associated with a neurologic condition see Section 2.3), and slowly inject the diluent into the vial. Discard the vial if a vacuum does not pull the diluent into the vial. Gently mix BOTOX with the saline by rotating the vial. Record the date and time of reconstitution on the space on the label. BOTOX should be administered within 24 hours after reconstitution. During this time period, reconstituted BOTOX should be stored in a refrigerator (2° to 8°C).

8.4 Pediatric Use

8.5 Geriatric Use

10 OVERdosage

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY

A 12.1 Mechanism of Action

12.3 Pharmacokinetics

13 NONclINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

13.2 Animal Toxicology

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14.1 Detrusor Overactivity associated with a Neurologic Condition

14.2 Chronic Migraine

14.3 Upper Limb Spasticity

14.4 Cervical Dystonia

14.5 Primary Axillary Hyperhidrosis

14.6 Blepharospasm

14.7 Strabismus

16 how Supplied/Storage and Handling

17 PATIENT COUNSELING INFORMATION

17.1 Swallowing, Speaking or Breathing Difficulties, or Other Unusual Symptoms

17.2 Ability to Operate Machinery or Vehicles

17.3 Voiding Difficulties after Bladder Injections

* Sections or subsections omitted from the full prescribing information are not listed
### 2.3 Detrusor Overactivity associated with a Neurologic Condition

Patients should not have an acute urinary tract infection prior to treatment. Prophylactic antibiotics (except aminoglycosides, see Drug Interactions (7)) should be administered 1-3 days pre-treatment, on the treatment day, and 1-3 days post-treatment.

Patients should discontinue anti-platelet therapy at least 3 days before the injection procedure. Patients on anti-coagulant therapy need to be managed appropriately to decrease the risk of bleeding.

Appropriate caution should be exercised when performing a cystoscopy. An intravesical instillation of diluted local anesthetic with or without sedation, or general anesthesia may be used prior to injection, per local site practice. If a local anesthetic instillation is performed, the bladder should be drained and irrigated with sterile saline before injection.

The recommended dose is 200 Units of BOTOX per treatment, and should not be exceeded.

Reconstitute a 200 Unit vial of BOTOX with 6 mL of 0.9% non-preserved saline solution and mix the vial gently. Draw 2 mL from the vial into each of three 10 mL syringes. Complete the reconstitution by adding 8 mL of 0.9% non-preserved saline solution into each of the 10 mL syringes, and mix gently. This will result in three 10 mL syringes each containing 10 mL (~67 Units in each), for a total of 200 Units of reconstituted BOTOX. Use immediately after reconstitution in the syringe. Dispose of any unused saline.

Alternatively, reconstitute two 100 Unit vials of BOTOX, each with 6 mL of 0.9% non-preserved saline solution and mix the vials gently. Draw 4 mL from each vial into each of two 10 mL syringes. Draw the remaining 2 mL from each vial into a third 10 mL syringe. Complete the reconstitution by adding 6 mL of 0.9% non-preserved saline solution into each of the 10 mL syringes, and mix gently. This will result in three 10 mL syringes each containing 10 mL (~67 Units in each), for a total of 200 Units of reconstituted BOTOX. Use immediately after reconstitution in the syringe. Dispose of any unused saline.

Reconstituted BOTOX (200 Units/30 mL) is injected into the detrusor muscle via a flexible or rigid cystoscope, avoiding the trigone. The bladder should be instilled with enough saline to achieve adequate visualization for the injections, but over-distension should be avoided.

The injection needle should be filled (primed) with approximately 1 mL of reconstituted BOTOX prior to the start of injections (depending on the needle length) to remove any air.

The needle should be inserted approximately 2 mm into the detrusor, and 30 injections of 1 mL (~6.7 Units) each (total volume of 30 mL) should be spaced approximately 1 cm apart (see Figure 1). For the final injection, approximately 1 mL of sterile normal saline should be injected so the full dose is delivered. After the injections are given, the saline used for bladder wall visualization should be drained. The patient should be observed for at least 30 minutes post-injection.

Patients should be considered for re-injection when the clinical effect of the previous injection diminishes (median time to qualification for re-treatment in the double-blind, placebo-controlled clinical studies was 295-337 days [42-48 weeks] for BOTOX 200 Units), but no sooner than 12 weeks from the prior bladder injection.

### 2.4 Chronic Migraine

The recommended dilution is 200 Units/4 mL or 100 Units/2 mL, with a final concentration of 5 Units per 0.1 mL (see Table 1). The recommended dose for treating chronic migraine is 155 Units administered intramuscularly (IM) using a sterile 30-gauge, 0.5 inch needle as 0.1 mL (5 Units) injections per each site. Injections should be divided across 7 specific head/neck muscle areas as specified in the diagrams and Table 2 below. A one inch needle may be needed in the neck region for patients with thick neck muscles. With the exception of the procerus muscle, which should be injected at one site (midline), all muscles should be injected bilaterally with half the number of injection sites administered to the left, and half to the right side of the head and neck. The recommended re-treatment schedule is every 12 weeks.

### Table 1: Dilution Instructions for BOTOX Vials (100 Units and 200 Units)

<table>
<thead>
<tr>
<th>Added to Unit Vial</th>
<th>Resulting Dose Units per 0.1 mL</th>
<th>Added to 200 Unit Vial</th>
<th>Resulting Dose Units per 0.1 mL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 mL</td>
<td>10 Units</td>
<td>1 mL</td>
<td>20 Units</td>
</tr>
<tr>
<td>2 mL</td>
<td>5 Units</td>
<td>2 mL</td>
<td>10 Units</td>
</tr>
<tr>
<td>4 mL</td>
<td>2.5 Units</td>
<td>4 mL</td>
<td>5 Units</td>
</tr>
<tr>
<td>8 mL</td>
<td>1.25 Units</td>
<td>8 mL</td>
<td>2.5 Units</td>
</tr>
<tr>
<td>10 mL</td>
<td>10 Units</td>
<td>2 mL</td>
<td>2 Units</td>
</tr>
</tbody>
</table>

*Preservative-free 0.9% Sodium Chloride Injection, USP Only

Note: These dilutions are calculated for an injection volume of 0.1 mL. A decrease or increase in the BOTOX dose is also possible by administering a smaller or larger injection volume - from 0.05 mL (50% decrease in dose) to 0.15 mL (50% increase in dose).

An injection of BOTOX is prepared by drawing into an appropriately sized sterile syringe an amount of the properly reconstituted toxin slightly greater than the intended dose. Air bubbles in the syringe barrel are expelled and the syringe is attached to an appropriate injection needle. Patency of the needle should be confirmed. A new, sterile, needle and syringe should be used to enter the vial on each occasion for removal of BOTOX.

Reconstituted BOTOX should be clear, colorless, and free of particulate matter. Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration and whenever the solution and the container permit.

### Table 2: BOTOX Dosing by Muscle for Chronic Migraine

<table>
<thead>
<tr>
<th>Head/Neck Area</th>
<th>Recommended Dose (Number of Sites*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frontalis</td>
<td>20 Units divided in 4 sites</td>
</tr>
<tr>
<td>Corrugator</td>
<td>10 Units divided in 2 sites</td>
</tr>
<tr>
<td>Procerus</td>
<td>5 Units in 1 site</td>
</tr>
<tr>
<td>Occipitalis</td>
<td>30 Units divided in 6 sites</td>
</tr>
<tr>
<td>Temporals</td>
<td>40 Units divided in 8 sites</td>
</tr>
<tr>
<td>Trapezius</td>
<td>30 Units divided in 6 sites</td>
</tr>
<tr>
<td>Cervical Paraspinal Muscle Group*</td>
<td>20 Units divided in 4 sites</td>
</tr>
<tr>
<td>Total Dose:</td>
<td>155 Units divided in 31 sites</td>
</tr>
</tbody>
</table>

* Each IM injection site = 0.1 mL = 5 Units BOTOX

* Dose distributed bilaterally

### 2.5 Upper Limb Spasticity

Dosing in initial and sequential treatment sessions should be tailored to the individual based on the size, number and location of muscles involved, severity of spasticity, the presence of local muscle weakness, the patient’s response to previous treatment, or adverse event history with BOTOX. In clinical trials, doses ranging from 75 Units to 360 Units were divided among selected muscles at a given treatment session.

### Figure 1: Injection Pattern for Detrusor Overactivity associated with a Neurologic Condition

Dome

Bladder base

Opening of left ureter

Trigone

Diagrams 1-4: Recommended Injection Sites (A thru G) for Chronic Migraine

A. Corrugator: 5 U each side
B. Procerus: 5 U (one site)
C. Frontalis: 10 U each side
D. Temporals: 20 U each side
E. Occipitalis: 15 U each side
F. Cervical paraspinal: 10 U each side
G. Trapezius: 15 U each side

### Table 2: BOTOX Dosing by Muscle for Chronic Migraine

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* Each IM injection site = 0.1 mL = 5 Units BOTOX

* Dose distributed bilaterally

### 2.5 Upper Limb Spasticity

Dosing in initial and sequential treatment sessions should be tailored to the individual based on the size, number and location of muscles involved, severity of spasticity, the presence of local muscle weakness, the patient’s response to previous treatment, or adverse event history with BOTOX. In clinical trials, doses ranging from 75 Units to 360 Units were divided among selected muscles at a given treatment session.
Table 3: BOTOX Dosing by Muscle for Upper Limb Spasticity

<table>
<thead>
<tr>
<th>Muscle</th>
<th>Recommended Dose Total Dosage (Number of Sites)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biceps Brachii</td>
<td>100 Units-200 Units divided in 4 sites</td>
</tr>
<tr>
<td>Flexor Carpi Radialis</td>
<td>12.5 Units-50 Units in 1 site</td>
</tr>
<tr>
<td>Flexor Carpi Ulnaris</td>
<td>12.5 Units-50 Units in 1 site</td>
</tr>
<tr>
<td>Flexor Digitsorum Profundus</td>
<td>30 Units-50 Units in 1 site</td>
</tr>
<tr>
<td>Flexor Digitsorum Sublunaris</td>
<td>30 Units-50 Units in 1 site</td>
</tr>
</tbody>
</table>

The recommended dilution is 200 Units/4 mL or 100 Units/2 mL with 0.9% non-preserved sterile saline (see Table 1). The lowest recommended starting dose should be used, and no more than 50 Units per site should generally be administered. An appropriately sized needle (e.g., 25-30 gauge) may be used for superficial muscles, and a longer 22 gauge needle may be used for deeper musculature. Localization of the involved muscles with electromyographic guidance or nerve stimulation techniques is recommended.

Repeat BOTOX treatment may be administered when the effect of a previous injection has diminished, but generally no sooner than 12 weeks after the previous injection. The degree and pattern of muscle spasticity at the time of re-injection may necessitate alterations in the dose of BOTOX and muscles to be injected.

2.6 Cervical Dystonia
A double-blind, placebo-controlled study enrolled patients who had extended histories of receiving and tolerating BOTOX injections, with prior individualized adjustment of dose. The mean BOTOX dose administered to patients in this study was 236 Units (25th to 75th percentile range of 198 Units to 300 Units). The BOTOX dose was divided among the affected muscles (see Clinical Studies (14.4)).

Dosing in initial and sequential treatment sessions should be tailored to the individual patient based on the patient's neck position, localization of pain, muscle hypertrophy, patient response, and adverse event history. The initial dose for a patient without prior use of BOTOX should be at a lower dose, with subsequent dosing adjusted based on individual response. Limiting the total dose injected into the sternocleidomastoid muscle to 100 Units or less may decrease the occurrence of dysphagia (see Warnings and Precautions (5.2, 5.5, 5.6)).

The recommended dilution is 200 Units/2 mL, 200 Units/4 mL, 100 Units/1 mL, or 100 Units/2 mL with 0.9% non-preserved sterile saline, depending on volume and number of injection sites desired to achieve treatment objectives (see Table 1). In general, no more than 50 Units per site should be administered. An appropriately sized needle (e.g., 25-30 gauge) may be used for superficial muscles, and a longer 22 gauge needle may be used for deeper musculature. Localization of the involved muscles with electromyographic guidance may be useful.

Clinical improvement generally begins within the first two weeks after injection with maximum clinical benefit at approximately six weeks post-injection. In the double-blind, placebo-controlled study most subjects were observed to have returned to pre-treatment status by 3 months post-treatment.

2.7 Primary Axillary Hyperhidrosis
The recommended dose is 50 Units per axilla. The hyperhidrotic area to be injected should be defined using standard staining techniques, e.g., Minor’s Iodine-Starch Test. The recommended dilution is 100 Units/4 mL with 0.9% preservative-free sterile saline (see Dilution Table). Using a 30 gauge needle, 50 Units of BOTOX (2 mL) is injected intradermally in 0.1 to 0.2 mL aliquots to each axilla evenly distributed in multiple sites (10-15) approximately 1-2 cm apart.

Repeat injections for hyperhidrosis should be administered when the clinical effect of a previous injection diminishes.

Instructions for the Minor’s Iodine-Starch Test Procedure:
Patients should shave underarms and abstain from use of over-the-counter deodorants or antiperspirants for 24 hours prior to the test. Patient should be resting comfortably without exercise, hot drinks for approximately 30 minutes prior to the test. Dry the underarm area and then immediately paint it with iodine solution. Allow the area to dry, then lightly sprinkle the area with starch powder. Gently blow off any excess starch powder. The hyperhidrotic area will develop a deep blue-black color over approximately 10 minutes. Each injection site has a ring of effect of up to approximately 2 cm in diameter. To minimize the area of no effect, the injection sites should be evenly spaced as shown in Figure 2.

Each dose is injected to a depth of approximately 2 mm and at a 45° angle to the skin surface, with the bevel side up to minimize leakage and to ensure the injections remain intradermal. If injection sites are marked in ink, do not inject BOTOX directly through the ink mark to avoid a permanent tattoo effect.

2.8 Blepharospasm
For blepharospasm, reconstituted BOTOX is injected using a sterile, 27-30 gauge needle without electromyographic guidance. The initial recommended dose is 1.25 Units-2.5 Units (0.05 mL to 0.1 mL volume at each site) injected into the medial and lateral pre-tarsal orbicularis oculi of the upper lid and into the lateral pre-tarsal orbicularis oculi of the lower lid. Avoiding injection near the levator palpebrae superioris may reduce the complication of ptosis. Avoiding medial lower lid injections, and thereby reducing diffusion into the inferior oblique, may reduce the complication of diplopia. Ecchymosis occurs easily in the soft eyelid tissues. This can be prevented by applying pressure at the injection site immediately after the injection.

The recommended dilution to achieve 1.25 Units is 100 Units/8 mL; for 2.5 Units it is 100 Units/4 mL (see Table 1).

In general, the initial effect of the injections is seen within three days and reaches a peak at one to two weeks post-treatment. Each treatment lasts approximately three months, following which the procedure can be repeated. At repeat treatment sessions, the dose may be increased up to two-fold if the response from the initial treatment is considered insufficient, usually defined as an effect that does not last longer than two months. However, there appears to be little benefit obtainable from injecting more than 5 Units per site. Some tolerance may be found when BOTOX is used in treating blepharospasm if treatments are given any more frequently than every three months, and is rare to have the effect be permanent.

The cumulative dose of BOTOX treatment for blepharospasm in a 30-day period should not exceed 200 Units.

2.9 Strabismus
BOTOX is intended for injection into extracocular muscles utilizing the electrical activity recorded from the tip of the injection needle as a guide to placement within the target muscle. Injection without surgical exposure or electromyographic guidance should not be attempted. Physicians should be familiar with electromyographic technique.

To prepare the eye for BOTOX injection, it is recommended that several drops of a local anesthetic and an ocular decongestant be given several minutes prior to injection.

The volume of BOTOX injected for treatment of strabismus should be between 0.05-0.15 mL per muscle.

The initial listed doses of the reconstituted BOTOX [see Dosage and Administration (2.2)] typically create paralysis of the injected muscles beginning one to two days after injection and increasing in intensity during the first week. The paralysis lasts for 2-6 weeks and gradually resolves over a similar time period. Overcorrections lasting over six months have been rare. About one half of patients will require subsequent doses because of inadequate paralytic response of the muscle to the initial dose, or because of mechanical factors such as large deviations or restrictions, or because of the lack of binocular motor fusion to stabilize the alignment.

Initial doses in Units
Use the lower listed doses for treatment of small deviations. Use the larger doses only for large deviations.

- For vertical muscles, and for horizontal strabismus of less than 20 prism diopters: 1.25 Units-2.5 Units in any one muscle.
- For horizontal strabismus of 20 prism diopters to 50 prism diopters: 2.5 Units-5 Units in any one muscle.
- For persistent VI nerve palsy of one month or longer duration: 1.25 Units-2.5 Units in the medial rectus muscle.

Subsequent doses for residual or recurrent strabismus
- It is recommended that patients be re-examined 7-14 days after each injection to assess the effect of that dose.
- Patients experiencing adequate paralysis of the target muscle that require subsequent injections should receive a dose comparable to the initial dose.
- Subsequent doses for patients experiencing incomplete paralysis of the target muscle may be increased up to two-fold compared to the previously administered dose.
- Subsequent injections should not be administered until the effects of the previous dose have dissipated as evidenced by substantial function in the injected and adjacent muscles.
• The maximum recommended dose as a single injection for any one muscle is 25 Units. The recommended dilution to achieve 1.25 Units is 100 Units/8 mL; for 2.5 Units it is 100 Units/4 mL (see Table 1).

3 DOSAGE FORMS AND STRENGTHS
Single-use, sterile 100 Units or 200 Units vacuum-dried powder for reconstitution only with sterile, non-preserved 0.9% Sodium Chloride Injection USP prior to injection.

4 CONTRAINDICATIONS
4.1 Known Hypersensitivity to Botulinum Toxin
BOTOX is contraindicated in patients who are hypersensitive to any botulinum toxin preparation or to any of the components in the formulation [see Warnings and Precautions (5.4)].

4.2 Injection at the Injection Site(s)
BOTOX is contraindicated in the presence of an infection at the proposed injection site(s).

4.3 Acute Urinary Tract Infection and/or Acute Urinary Retention
Intradetrusor injection of BOTOX is contraindicated in patients with detrusor overactivity associated with a neurologic condition who have acute urinary tract infection, and in patients with acute urinary retention who are not routinely performing clean intermittent self-catheterization (CIC).

5 WARNINGS AND PRECAUTIONS
5.1 Lack of Interchangeability between Botulinum Toxin Products
The potency Units of BOTOX are specific to the preparation and assay method utilized. They are not interchangeable with other preparations of botulinum toxin products and, therefore, units of biological activity of BOTOX cannot be compared to nor converted into units of any other botulinum toxin products assessed with any other specific assay method [see Dosage and Administration (2.1), Description (11)].

5.2 Spread of Toxin Effect
Postmarketing safety data from BOTOX and other approved botulinum toxins suggest that botulinum toxin effects may, in some cases, be observed beyond the site of local injection. The symptoms are consistent with the mechanism of action of botulinum toxin and may include asthenia, generalized muscle weakness, diplopia, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence, and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death related to spread of toxin effects. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults treated for spasticity and other conditions, and particularly in those patients who have an underlying condition that would predispose them to these symptoms. In unapproved uses, including spasticity in children, and in approved indications, symptoms consistent with spread of toxin effect have been reported at doses comparable to or lower than doses used to treat cervical dystonia. Patients or caregivers should be advised to seek immediate medical care if swallowing, speech or respiratory disorders occur.

No definitive serious adverse event reports of distant spread of toxin effect associated with dermatologic use of BOTOX/BOTOX® Cosmetic at the labeled dose of 20 Units (for glabellar lines) or 100 Units (for severe primary axillary hyperhidrosis) have been reported. No definitive serious adverse event reports of distant spread of toxin effect associated with BOTOX for blepharospasm at the recommended dose (30 Units and below), strabismus, or for chronic migraine at the labeled doses have been reported.

5.3 Injections In or Near Vulnerable Anatomic Structures
Care should be taken when injecting in or near vulnerable anatomic structures. Serious adverse events including fatal outcomes have been reported in patients who had received BOTOX injected directly into salivary glands, the oro-lingual-pharyngeal region, esophagus and stomach. Some patients had pre-existing dysphagia or significant debility. (Safety and effectiveness have not been established for indications pertaining to these injection sites.) Pneumothorax associated with injection procedure has been reported following the administration of BOTOX near the thorax. Caution is warranted when injecting in proximity to the lung, particularly the apices.

5.4 Hypersensitivity Reactions
Serious and/or immediate hypersensitivity reactions have been reported. These reactions include anaphylaxis, serum sickness, urticaria, soft tissue edema, and dyspnea. If such a reaction occurs, further injection of BOTOX should be discontinued and appropriate medical therapy immediately instituted. One fatal case of anaphylaxis has been reported in which lidocaine was used as the diluent, and consequently the causal agent cannot be reliably determined.

5.5 Dysphagia and Breathing Difficulties in Treatment of Cervical Dystonia
Treatment with BOTOX and other botulinum toxin products can result in swallowing or breathing difficulties. Patients with pre-existing swallowing or breathing difficulties may be more susceptible to these complications. In most cases, this is a consequence of weakening of muscles in the area of injection that are involved in breathing or swallowing. When distant effects occur, additional respiratory muscles may be involved [see Warnings and Precautions (5.2)].

Deaths as a complication of severe dysphagia have been reported after treatment with botulinum toxin. Dysphagia may persist for several months, and require use of a feeding tube to maintain adequate nutrition and hydration. Aspiration may result from severe dysphagia and is a particular risk when treating patients in whom swallowing or respiratory function is already compromised.

Treatment of cervical dystonia with botulinum toxins may weaken neck muscles that serve as an accessory apparatus of ventilation. This may result in a critical loss of breathing capacity in patients with respiratory disorders who may have become dependent upon these accessory muscles. There have been postmarketing reports of serious breathing difficulties, including respiratory failure, in cervical dystonia patients.

Patients with smaller neck muscle mass and patients who require bilateral injections into the sternocleidomastoid muscle have been reported to be at greater risk for dysphagia. Limiting the dose injected into the sternocleidomastoid muscle may reduce the occurrence of dysphagia. Injections into the levator scapulae may be associated with an increased risk of upper respiratory infection and dysphagia.

Patients treated with botulinum toxin may require immediate medical attention should they develop problems with swallowing, speech or respiratory disorders. These reactions can occur within hours to weeks after injection with botulinum toxin [see Warnings and Precautions (5.2) and Adverse Reactions (6.1)].

5.6 Pre-Existing Neuromuscular Disorders
Individuals with peripheral motor neuropathic diseases, amyotrophic lateral sclerosis or neuromuscular junction disorders (e.g., myasthenia gravis or Lambert-Eaton syndrome) should be monitored particularly closely when given botulinum toxin. Patients with neuromuscular disorders may be at increased risk of clinically significant effects including severe dysphagia and respiratory compromise from therapeutic doses of BOTOX [see Adverse Reactions (6.1)].

5.7 Pulmonary Effects of BOTOX in Patients with Compromised Respiratory Status Treated for Spasticity or for Detrusor Overactivity associated with a Neurologic Condition
Patients with compromised respiratory status treated with BOTOX for upper limb spasticity should be monitored closely. In a double-blind, placebo-controlled, parallel group study in patients with stable reduced pulmonary function (defined as FEV1 40-80% of predicted value and FEV1/FVC ≤ 0.75), the event rate in change of Forced Vital Capacity ≥15% or ≥20% was generally greater in patients treated with BOTOX than in patients treated with placebo (see Table 4).

Table 4: Event rate per patient treatment cycle among patients with reduced lung function who experienced at least a 15% or 20% decrease in forced vital capacity from baseline at Week 1, 6, 12 post-injection with up to two treatment cycles with BOTOX or placebo

<table>
<thead>
<tr>
<th>Event Rate (%)</th>
<th>BOTOX 360 Units</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>≥15%</td>
<td>≥15%</td>
</tr>
<tr>
<td></td>
<td>≥20%</td>
<td>≥20%</td>
</tr>
<tr>
<td>Week 6</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Week 12</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>4%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Differences from placebo were not statistically significant.

In patients with reduced lung function, upper respiratory tract infections were also reported more frequently as adverse reactions in patients treated with BOTOX than in patients treated with placebo [see Warnings and Precautions (5.10)].

In an ongoing double-blind, placebo-controlled, parallel group study in adult patients with detrusor overactivity associated with a neurologic condition and restrictive lung disease of neuromuscular etiology [defined as FVC 50-80% of predicted value in patients with spinal cord injury between C5 and C8, or MS] the event rate in change of Forced Vital Capacity ≥15% or ≥20% was generally greater in patients treated with BOTOX than in patients treated with placebo (see Table 5).
Table 5: Number and percent of patients experiencing at least a 15% or 20% decrease in FVC from baseline at Week 2, 6, 12 post-injection with BOTOX or placebo

<table>
<thead>
<tr>
<th>Timepoint</th>
<th>BOTOX 200 Units</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≥15% (N=108)</td>
<td>≥20% (N=104)</td>
</tr>
<tr>
<td>Week 2</td>
<td>0/12 (0%)</td>
<td>0/12 (0%)</td>
</tr>
<tr>
<td>Week 6</td>
<td>2/11 (18%)</td>
<td>1/11 (9%)</td>
</tr>
<tr>
<td>Week 12</td>
<td>0/11 (0%)</td>
<td>0/11 (0%)</td>
</tr>
</tbody>
</table>

5.8 Corneal Exposure and Ulceration in Patients Treated with BOTOX for Blepharospasm

Reduced blinking from BOTOX injection of the orbicularis muscle can lead to corneal exposure, persistent epithelial defect, and corneal ulceration, especially in patients with VII nerve disorders. Vigorous treatment of any epithelial defect should be employed. This may require protective drops, ointment, therapeutic soft contact lenses, or closure of the eye by patching or other means.

5.9 Retrobulbar Hemorrhages in Patients Treated with BOTOX for Strabismus

During the administration of BOTOX for the treatment of strabismus, retrobulbar hemorrhages sufficient to compromise retinal circulation have occurred. It is recommended that appropriate instruments to decompress the orbit be accessible.

5.10 Bronchitis and Upper Respiratory Tract Infections in Patients Treated for Spasticity

Bronchitis was reported more frequently as an adverse reaction in patients treated for upper limb spasticity with BOTOX (3% at 251 Units-360 Units total dose), compared to placebo (1%). In patients with reduced lung function treated for upper limb spasticity, upper respiratory tract infections were also reported more frequently as adverse reactions in patients treated with BOTOX (11% at 360 Units total dose; 8% at 240 Units total dose) compared to placebo (6%).

5.11 Autonomic Dysreflexia and Urinary Retention in Patients Treated for Detrusor Overactivity associated with a Neurologic Condition

Autonomic dysreflexia associated with intradetrusor injections of BOTOX could occur in patients treated for detrusor overactivity associated with a neurologic condition and may require prompt medical therapy. In clinical trials, the incidence of autonomic dysreflexia was greater in patients treated with BOTOX 200 Units compared with placebo (1.5% versus 0.4%, respectively).

In double-blind, placebo-controlled trials, the proportion of subjects who were not using clean intermittent catheterization (CIC) prior to injection and who subsequently required catheterization for urinary retention following treatment with BOTOX or placebo is shown in Table 6. The duration of post-injection catheterization is also shown.

Table 6: Proportion of Patients not using CIC at baseline and then Catheterizing for Urinary Retention and Duration of Catheterization following injection in double-blind, placebo-controlled clinical trials

<table>
<thead>
<tr>
<th>Timepoint</th>
<th>BOTOX 200 Unit (N=108)</th>
<th>Placebo (N=104)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of Patients Catheterizing for Urinary Retention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At any time during treatment cycle</td>
<td>33 (30.6%)</td>
<td>7 (6.7%)</td>
</tr>
<tr>
<td>Median</td>
<td>2.86</td>
<td>3.58</td>
</tr>
<tr>
<td>Min, Max</td>
<td>1,530</td>
<td>2,379</td>
</tr>
</tbody>
</table>

Among patients not using CIC at baseline, those with MS were more likely to require CIC post-injection than those with SCI (see Table 7).

Table 7: Proportion of Patients by Etiology (MS and SCI) not using CIC at baseline and then Catheterizing for Urinary Retention following injection in double-blind, placebo-controlled clinical trials

<table>
<thead>
<tr>
<th>Timepoint</th>
<th>MS</th>
<th>SCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOTOX 200 Unit (N=86)</td>
<td>Placebo (N=88)</td>
<td>BOTOX 200 Unit (N=22)</td>
</tr>
<tr>
<td>At any time during complete treatment cycle</td>
<td>27 (31%)</td>
<td>4 (5%)</td>
</tr>
</tbody>
</table>

Due to the risk of urinary retention, only patients who are willing and/or able to initiate catheterization post-treatment, if required, should be considered for treatment.

In patients who are not catheterizing, post-void residual (PVR) urine volume should be assessed within 2 weeks post-treatment and periodically as medically appropriate up to 12 weeks. Catheterization should be instituted if PVR urine volume exceeds 200 mL and continued until PVR falls below 200 mL. Patients should be instructed to contact their physician if they experience difficulty in voiding as catheterization may be required.

5.12 Human Albumin and Transmission of Viral Diseases

This product contains albumin, a derivative of human blood. Based on effective donor screening and product manufacturing processes, it carries an extremely remote risk for transmission of viral diseases. A theoretical risk for transmission of Creutzfeldt-Jakob disease (CJD) is also considered extremely remote. No cases of transmission of viral diseases or CJD have ever been reported for albumin.

6 ADVERSE REACTIONS

The following adverse reactions to BOTOX (onabotulinumtoxinA) for injection are discussed in greater detail in other sections of the labeling:

- Spread of Toxin Effects [see Warnings and Precautions (5.2)]
- Hypersensitivity [see Contraindications (4.1) and Warnings and Precautions (5.4)]
- Dysphagia and Breathing Difficulties in Treatment of Cervical Dystonia [see Warnings and Precautions (5.5)]
- Bronchitis and Upper Respiratory Tract Infections in Patients Treated for Spasticity [see Warnings and Precautions (5.40)]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, the 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.

BOTOX and BOTOX Cosmetic contain the same active ingredient in the same formulation, but with different labeled Indications and Usage. Therefore, adverse reactions observed with the use of BOTOX Cosmetic also have the potential to be observed with the use of BOTOX.

In general, adverse reactions occur within the first week following injection of BOTOX and while generally transient, may have a duration of several months or longer. Localized pain, infection, inflammation, tenderness, swelling, erythema, and/or bleeding/bruising may be associated with the injection. Needle-related pain and/or anxiety may result in vasovagal responses (including e.g., syncope, hypotension), which may require appropriate medical therapy.

Local weakness of the injected muscle(s) represents the expected pharmacological action of botulinum toxin. However, weakness of nearby muscles may also occur due to spread of toxin [see Warnings and Precautions (5.2)].

Detrusor Overactivity associated with a Neurologic Condition

Table 8 presents the most frequently reported adverse reactions in double-blind, placebo-controlled studies within 12 weeks of injection for detrusor overactivity associated with a neurologic condition.

Table 8: Adverse Reactions Reported by >2% of BOTOX Treated Patients and More Frequent than in Placebo-treated Patients Within the First 12 Weeks after Intradetrusor Injection in Double-blind, Placebo-controlled Clinical Trials

<table>
<thead>
<tr>
<th>Adverse Reactions by Body Systems</th>
<th>BOTOX 200 Units (N=262)</th>
<th>Placebo (N=272)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections and infestations</td>
<td>64 (24%)</td>
<td>47 (17%)</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal and urinary disorders</td>
<td>45 (17%)</td>
<td>34 (12%)</td>
</tr>
<tr>
<td>Urinary retention</td>
<td>10 (4%)</td>
<td>6 (2%)</td>
</tr>
<tr>
<td>Hematuria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General disorders and administration site conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>10 (4%)</td>
<td>3 (1%)</td>
</tr>
<tr>
<td>Psychiatric disorders</td>
<td>1 (1%)</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td>4 (2%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (1%)</td>
<td></td>
</tr>
</tbody>
</table>

The following adverse reaction event rates with BOTOX 200 Units were reported at any time following initial injection and prior to re-injection or study exit (median duration of 44 weeks of exposure): urinary tract infections (49%), urinary retention (17%), fatigue (6%), constipation (4%), muscular weakness (4%), dysuria (4%), fall (3%), gait disturbance (3%), insomnia (3%), and muscle spasm (2%).

In the MS patients enrolled in the double-blind, placebo-controlled trials, the MS exacerbation annualization rate (i.e., number of MS exacerbation events per patient-year) was 0.23 for BOTOX and 0.20 for placebo.

No change was observed in the overall safety profile with repeat dosing.

Chronic Migraine

In double-blind, placebo-controlled chronic migraine efficacy trials (Study 1 and Study 2), the discontinuation rate was 12% in the BOTOX treated group and 10% in the placebo-treated group. Discontinuations due to an adverse event were 4% in the BOTOX group and 1% in the placebo group. The most frequent adverse events leading to discontinuation in the BOTOX group were neck pain, headache, worsening migraine, muscular weakness and eyelid ptosis.

General disorders and administration site conditions

- Fatigue
- Insomnia
- Other

The following adverse reaction event rates with BOTOX 200 Units were reported at any time following initial injection and prior to re-injection or study exit (median duration of 44 weeks of exposure): urinary tract infections (49%), urinary retention (17%), fatigue (6%), constipation (4%), muscular weakness (4%), dysuria (4%), fall (3%), gait disturbance (3%), insomnia (3%), and muscle spasm (2%).

In the MS patients enrolled in the double-blind, placebo-controlled trials, the MS exacerbation annualization rate (i.e., number of MS exacerbation events per patient-year) was 0.23 for BOTOX and 0.20 for placebo.

No change was observed in the overall safety profile with repeat dosing.

Chronic Migraine

In double-blind, placebo-controlled chronic migraine efficacy trials (Study 1 and Study 2), the discontinuation rate was 12% in the BOTOX treated group and 10% in the placebo-treated group. Discontinuations due to an adverse event were 4% in the BOTOX group and 1% in the placebo group. The most frequent adverse events leading to discontinuation in the BOTOX group were neck pain, headache, worsening migraine, muscular weakness and eyelid ptosis.
The most frequently reported adverse reactions following injection of BOTOX for chronic migraine appear in Table 9.

Table 9: Adverse Reactions Reported by ≥2% of BOTOX treated Patients and More Frequent than in Placebo-treated Patients in Two Chronic Migraine Double-blind, Placebo-controlled Clinical Trials

<table>
<thead>
<tr>
<th>Adverse Reactions by Body Systems</th>
<th>BOTOX 155 Units-195 Units (N=687)</th>
<th>Placebo (N=692)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous system disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>32 (5%)</td>
<td>22 (3%)</td>
</tr>
<tr>
<td>Migraine</td>
<td>26 (4%)</td>
<td>18 (3%)</td>
</tr>
<tr>
<td>Facial paresis</td>
<td>15 (2%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Eye disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyelid ptosis</td>
<td>25 (4%)</td>
<td>2 (&lt;1%)</td>
</tr>
<tr>
<td>Infections and Infestations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td>17 (3%)</td>
<td>11 (2%)</td>
</tr>
<tr>
<td>Musculoskeletal and connective tissue disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck pain</td>
<td>60 (9%)</td>
<td>19 (3%)</td>
</tr>
<tr>
<td>Musculoskeletal stiffness</td>
<td>25 (4%)</td>
<td>6 (1%)</td>
</tr>
<tr>
<td>Muscular weakness</td>
<td>24 (4%)</td>
<td>2 (&lt;1%)</td>
</tr>
<tr>
<td>Myalgia</td>
<td>21 (3%)</td>
<td>6 (1%)</td>
</tr>
<tr>
<td>Musculoskeletal pain</td>
<td>18 (3%)</td>
<td>10 (1%)</td>
</tr>
<tr>
<td>Muscle spasms</td>
<td>13 (2%)</td>
<td>6 (1%)</td>
</tr>
<tr>
<td>General disorders and administration site conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection site pain</td>
<td>23 (3%)</td>
<td>14 (2%)</td>
</tr>
<tr>
<td>Vascular Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>11 (2%)</td>
<td>7 (1%)</td>
</tr>
</tbody>
</table>

Other adverse reactions that occurred more frequently in the BOTOX group compared to the placebo group at a frequency less than 1% and potentially BOTOX-related include: vertigo, dizziness, nausea, fever, anxiety, injection site pain and hemorrhage, non-axillary sweating, infection, pharyngitis, flu syndrome, headache, fever, neck or back pain, pruritus, and anxiety.

In two cases of VII nerve disorder, reduced blinking from BOTOX injection of the orbicularis muscle led to serious corneal exposure, persistent epithelial defect, corneal ulceration and a case of corneal perforation. Focal facial paralysis, syncope, and exacerbation of myasthenia gravis have also been reported after treatment of blepharospasm.

Strabismus

Extracocular muscles adjacent to the injection site can be affected, causing vertical deviation, especially with higher doses of BOTOX. The incidence rates of these adverse effects in 2058 adults who received a total of 3650 injections for horizontal strabismus was 17%.

The incidence of ptosis has been reported to be dependent on the location of the injected muscles, 1% after inferior rectus injections, 16% after horizontal rectus injections and 38% after superior rectus injections.

In a series of 5587 injections, retrobulbar hemorrhage occurred in 0.3% of cases.

6.2 Immunogenicity

As with all therapeutic proteins, there is a potential for immunogenicity. Formation of neutralizing antibodies to botulinum toxin type A may reduce the effectiveness of BOTOX treatment by inactivating the biological activity of the toxin.

In a long term, open-label study evaluating 326 cervical dystonia patients treated for an average of 9 treatment sessions with the current formulation of BOTOX, 4 (1.2%) patients had positive antibody tests. All 4 of these patients responded to BOTOX therapy at the time of the positive antibody test. However, 3 of these patients developed clinical resistance after subsequent treatment, while the fourth patient continued to respond to BOTOX therapy for the remainder of the study.

One patient among the 445 hyperhidrosis patients (0.2%), two patients among the 380 adult upper limb spasticity patients (0.5%), no patients among 406 migraine patients, and no patients among 475 detrusor overactivity patients with a neurologic condition patients with analyzed specimens developed the presence of neutralizing antibodies.

The data reflect the patients whose test results were considered positive or negative for neutralizing activity to BOTOX in a mouse protection assay. The results of these tests are highly dependent on the sensitivity and specificity of the assay. For these reasons, comparison of the incidence of neutralizing activity to BOTOX with the incidence reported to other products may be misleading.

The critical factors for neutralizing antibody formation have not been well characterized. The results from some studies suggest that BOTOX injections at more frequent intervals or at higher doses may lead to greater incidence of antibody formation. The potential for antibody formation may be minimized by injecting with the lowest effective dose given at the longest feasible intervals between injections.

6.3 Post-Marketing Experience

There have been spontaneous reports of death, sometimes associated with dysphagia, pneumonia, and/or other significant debility or anaphylaxis, after treatment with botulinum toxin [see Warnings and Precautions (5.4, 5.5)].

There have also been reports of adverse events involving the cardiovascular system, including arrhythmia and myocardial infarction, some with fatal outcomes. Some of these patients had risk factors including cardiovascular disease. The exact relationship of these events to the botulinum toxin injection has not been established.
New onset or recurrent seizures have also been reported, typically in patients who are predisposed to experiencing these events. The exact relationship of these events to the botulinum toxin injection has not been established.

The following adverse events have been identified during postapproval use of BOTOX: abdominal pain; anorexia; brachial plexopathy; diarrhea; dyspnea; facial palsy; facial paresthesia; hyperhidrosis; hypoaesthesia; localized numbness; malaise; muscle weakness; myalgia; paresthesia; pyrexia; radioculopathy; skin rash (including erythema multiforme, and psoriasisiform eruption); linitis; vertigo; visual disturbances; and vomiting.

Because these events 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.

7 DRUG INTERACTIONS

No formal drug interaction studies have been conducted with BOTOX (onabotulinumtoxinA) for injection.

Co-administration of BOTOX and aminoglycosides or other agents interfering with neuromuscular transmission (e.g., curare-like compounds) should only be performed with caution as the effect of the toxin may be potentiated.

Use of anticholinergic drugs after administration of BOTOX may potentiate systemic anticholinergic effects.

The effect of administering different botulinum neurotoxin products at the same time or within several months of each other is unknown. Excessive neuromuscular weakness may be exacerbated by administration of another botulinum toxin prior to the resolution of the effects of a previously administered botulinum toxin.

Excessive weakness may also be exaggerated by administration of a muscle relaxant before or after administration of BOTOX.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C.

There are no adequate and well-controlled studies in pregnant women. BOTOX should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

When BOTOX (4, 8, or 16 Units/kg) was administered intramuscularly to pregnant mice or rats two times during the period of organogenesis (on gestation days 5 and 13), reductions in fetal body weight and decreased fetal skeletal ossification were observed at the two highest doses. The no-effect dose for developmental toxicity in these studies (4 Units/kg) is approximately 1½ times the average human dose for upper limb spasticity of 360 Units on a body weight basis (Units/kg).

When BOTOX was administered intramuscularly to pregnant rats (0.125, 0.25, 0.5, 1, 4, or 8 Units/kg) or rabbits (0.063, 0.125, 0.25, or 0.5 Units/kg) daily during the period of organogenesis (total of 12 doses in rats, 13 doses in rabbits), reduced fetal body weights and decreased fetal skeletal ossification were observed at the two highest doses in rats and at the highest dose in rabbits. These doses were also associated with significant maternal toxicity, including abortions, early deliveries, and neonatal death. The developmental no-effect doses in these studies of 1 Unit/kg in rats and 0.25 Units/kg in rabbits are less than the average high human dose based on Units/kg.

When pregnant rats received single intramuscular injections (1, 4, or 16 Units/kg) at three different periods of development (prior to implantation, implantation, or organogenesis), no adverse effects on fetal development were observed. The developmental no-effect level for a single maternal dose in rats (16 Units/kg) is approximately 3 times the average high human dose based on Units/kg.

8.3 Nursing Mothers

It is not known whether BOTOX is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when BOTOX is administered to a nursing woman.

8.4 Pediatric Use

Urinary Incontinence due to Detrusor Overactivity associated with a Neurologic Condition

Safety and effectiveness in patients below the age of 18 years have not been established.

Prophylaxis of Headaches in Chronic Migraine

Safety and effectiveness in patients below the age of 18 years have not been established.

Spasticity

Safety and effectiveness in patients below the age of 18 years have not been established.

Axillary Hyperhidrosis

Safety and effectiveness in patients below the age of 18 years have not been established.

Cervical Dystonia

Safety and effectiveness in pediatric patients below the age of 16 years have not been established.

Blepharospasm and Strabismus

Safety and effectiveness in pediatric patients below the age of 12 years have not been established.

8.5 Geriatric Use

Clinical studies of BOTOX did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. There were too few patients over the age of 75 to enable any comparisons. In general, dose selection in an elderly patient should be cautious, usually starting at the low end of the dosage range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

10 OVERDOSAGE

Excessive doses of BOTOX (onabotulinumtoxinA) for injection may be expected to produce neuromuscular weakness with a variety of symptoms. Symptoms of overdose are likely not to be present immediately following injection. Should accidental injection or oral ingestion occur or overdose be suspected, the person should be medically supervised for several weeks for signs and symptoms of systemic muscular weakness which could be local, or distant from the site of injection [see Boxed Warning and Warnings and Precautions (5.2, 5.5)].

If the musculature of the oropharynx and esophagus are affected, aspiration may occur which may lead to development of aspiration pneumonia. If the respiratory muscles become paralyzed or sufficiently weakened, intubation and assisted respiration may be necessary until recovery takes place.

Supportive care could involve the need for a tracheostomy and/or prolonged mechanical ventilation, in addition to other general supportive care.

These patients should be considered for further medical evaluation and appropriate medical therapy immediately instituted, which may include hospitalization.

In the event of overdose, antitoxin raised against botulinum toxin is available from the Centers for Disease Control and Prevention (CDC) in Atlanta, GA. However, the antitoxin will not reverse any botulinum toxin-induced effects already apparent by the time of antitoxin administration. In the event of suspected or actual cases of botulinum toxin poisoning, please contact your local or state Health Department to process a request for antitoxin through the CDC. If you do not receive a response within 30 minutes, please contact the CDC directly at 1-770-488-7100. More information can be obtained at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5232a8.htm.

11 DESCRIPTION

BOTOX (onabotulinumtoxinA) for injection is a sterile, vacuum-dried purified botulinum toxin type A, produced from fermentation of Hall strain Clostridium botulinum type A, and intended for intramuscular, intradertrusor and intradermal use. It is purified from the culture solution by dialysis and a series of acid precipitations to a complex consisting of the neurotoxin, and several accessory proteins. The complex dissolves in sterile sodium chloride solution containing Albunin Human and is sterile filtered (0.2 microns) prior to filling and vacuum-drying.

The primary release procedure for BOTOX uses a cell-based potency assay to determine the potency relative to a reference standard. The assay is specific to Allergan's products BOTOX and BOTOX Cosmetic. One Unit of BOTOX corresponds to the calculated median intraperitoneal lethal dose (LD₅₀) in mice. Due to specific details of this assay such as the vehicle, dilution scheme, and laboratory protocols, Units of biological activity of BOTOX cannot be compared to nor converted into Units of any other botulinum toxin or any toxin assessed with any other specific assay method. The specific activity of BOTOX is approximately 20 Units/nanogram of neurotoxin protein complex.

Each vial of BOTOX contains either 100 Units of Clostridium botulinum type A neurotoxin complex, 0.5 mg of Albumin Human, and 0.9 mg of sodium chloride; or 200 Units of Clostridium botulinum type A neurotoxin complex, 1 mg of Albumin Human, and 1.8 mg of sodium chloride in a sterile, vacuum-dried form without a preservative.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

BOTOX blocks neuromuscular transmission by binding to acceptor sites on motor or sympathetic nerve terminals, entering the nerve terminals, and inhibiting the release of acetylcholine. This inhibition occurs as the neurotoxin cleaves SNAP-25, a protein integral to the successful docking and release of acetylcholine from vesicles situated within nerve endings. When injected intramuscularly at therapeutic doses, BOTOX produces partial chemical denervation of the muscle resulting in a localized reduction in muscle activity. In addition, the muscle may atrophy, axonal sprouting may occur, and extrajunctional acetylcholine receptors may develop. There is evidence that reinnervation of the muscle may occur, thus slowly reversing muscle denervation produced by BOTOX.

When injected intradermally, BOTOX produces temporary chemical denervation of the sweat gland resulting in local reduction in sweating.
Following intradetrusor injection, BOTOX affects the efferent pathways of detrusor activity via inhibition of acetylcholine release. In addition, BOTOX is believed to inhibit afferent neurotransmitters and sensory pathways.

12.3 Pharmacokinetics

Using currently available analytical technology, it is not possible to detect BOTOX in the peripheral blood following intramuscular injection at the recommended doses.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Long term studies in animals have not been performed to evaluate the carcinogenic potential of BOTOX.

Mutagenesis

BOTOX was negative in a battery of in vitro (microbial reverse mutation assay, mammalian cell mutation assay, and chromosomal aberration assay) and in vivo (micronucleus assay) genetic toxicology assays.

Impairment of Fertility

In fertility studies of BOTOX (4, 8, or 16 Units/kg) in which either male or female rats were injected intramuscularly prior to mating and on the day of mating (3 doses, 2 weeks apart for males, 2 doses, 2 weeks apart for females) to untreated animals, reduced fertility was observed in males at the intermediate and high doses and in females at the high dose. The no-effect doses for reproductive toxicity (4 Units/kg in males, 8 Units/kg in females) are approximately equal to the average human dose for upper limb spasticity of 360 Units on a body weight basis (Units/kg).

13.2 Animal Toxicology

In a study to evaluate inadvertent peribladder administration, bladder stones were observed in 1 of 4 male monkeys that were injected with a total of 6.8 Units/kg divided into the prostatic urethra and proximal rectum (single administration). No bladder stones were observed in male or female monkeys following injection of up to 36 Units/kg (12X the human dose) directly to the bladder as either single or 4 repeat dose injections or in female rats for single injections up to 100 Units/kg (~33X the human dose).

14 CLINICAL STUDIES

14.1 Detrusor Overactivity associated with a Neurologic Condition

Two double-blind, placebo-controlled, randomized, multi-center clinical studies were conducted in patients with urinary incontinence due to detrusor overactivity associated with a neurologic condition who were either spontaneously voiding or using catheterization. A total of 691 spinal cord injury (T1 or below) or multiple sclerosis patients, who had an inadequate response to or were intolerant of at least one anticholinergic medication, were enrolled. These patients were randomized to receive either 200 Units of BOTOX (n=227), 300 Units of BOTOX (n=223), or placebo (n=241).

No significant improvements compared to placebo in the primary efficacy variable of change from baseline in weekly frequency of incontinence episodes were observed for BOTOX (200 Units) at the primary efficacy time point at week 6. Increases in maximum cystometric capacity and reductions in maximum detrusor pressure during the first involuntary detrusor contraction were also observed. These primary and secondary endpoints are shown in Tables 11 and 12, and Figures 3 and 4. No additional benefit of BOTOX 300 Units over 200 Units was demonstrated.

Table 11: Key Primary and Secondary Endpoints at Baseline and Change from Baseline in Study 1

<table>
<thead>
<tr>
<th></th>
<th>BOTOX 200 Units</th>
<th>Placebo</th>
<th>Treatment Difference*</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Frequency of Urinary Incontinence Episodes*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>134</td>
<td>146</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Baseline</td>
<td>32.3</td>
<td>28.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Change* at Week 2</td>
<td>-15.3</td>
<td>-10.0</td>
<td>-5.3</td>
<td>–</td>
</tr>
<tr>
<td>Mean Change* at Week 6 **</td>
<td>-19.9</td>
<td>-10.6</td>
<td>-9.2</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>Mean Change* at Week 12</td>
<td>-19.8</td>
<td>-8.8</td>
<td>-11.0</td>
<td>–</td>
</tr>
<tr>
<td>Maximum Cystometric Capacity (mL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>123</td>
<td>129</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Baseline</td>
<td>253.8</td>
<td>259.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Change* at Week 6 **</td>
<td>135.9</td>
<td>12.1</td>
<td>123.9</td>
<td>(89.1, 158.7)</td>
</tr>
<tr>
<td>Maximum Detrusor Pressure during First Involuntary Detrusor Contraction (cmH2O)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>41</td>
<td>103</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Baseline</td>
<td>63.1</td>
<td>57.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Change* at Week 6 **</td>
<td>-28.1</td>
<td>-3.7</td>
<td>-24.4</td>
<td>–</td>
</tr>
</tbody>
</table>

* Mean change, treatment difference and p-value are based on a LOCF analysis using an ANCOVA model with baseline weekly endpoint as covariate and treatment group, etiology at study entry (spinal cord injury or multiple sclerosis), concurrent anticholinergic therapy at screening, and investigator as factors.

** Primary Timepoint

* Primary endpoint

** Secondary endpoint

Table 12: Key Primary and Secondary Endpoints at Baseline and Change from Baseline in Study 2

<table>
<thead>
<tr>
<th>Weekly Frequency of Urinary Incontinence Episodes*</th>
<th>BOTOX 200 Units</th>
<th>Placebo</th>
<th>Treatment Difference*</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>91</td>
<td>91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Baseline</td>
<td>32.7</td>
<td>36.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Change* at Week 2</td>
<td>-18.0</td>
<td>-7.9</td>
<td>-10.1</td>
<td>–</td>
</tr>
<tr>
<td>Mean Change* at Week 6 **</td>
<td>-19.6</td>
<td>-10.8</td>
<td>-8.8</td>
<td>p&lt;0.003</td>
</tr>
<tr>
<td>Mean Change* at Week 12</td>
<td>-19.6</td>
<td>-10.7</td>
<td>-9.9</td>
<td>–</td>
</tr>
<tr>
<td>Maximum Cystometric Capacity (mL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>88</td>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Baseline</td>
<td>239.6</td>
<td>253.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Change* at Week 6 **</td>
<td>150.8</td>
<td>2.8</td>
<td>148.0</td>
<td>(1018, 194.2)</td>
</tr>
</tbody>
</table>

Maximum Detrusor Pressure during First Involuntary Detrusor Contraction (cmH2O)

<table>
<thead>
<tr>
<th>N</th>
<th>29</th>
<th>68</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Baseline</td>
<td>65.6</td>
<td>43.7</td>
</tr>
</tbody>
</table>
| Mean Change* at Week 6 ** | -28.7 | 2.1 | -30.7 | –

* Mean change, treatment difference and p-value are based on a LOCF analysis using an ANCOVA model with baseline weekly endpoint as covariate and treatment group, etiology at study entry (spinal cord injury or multiple sclerosis), concurrent anticholinergic therapy at screening, and investigator as factors.

** Primary Timepoint

* Primary endpoint

** Secondary endpoint

Figure 3: Mean Change from Baseline in Weekly Frequency of Urinary Incontinence Episodes During Treatment Cycle 1 in Study 1

Figure 4: Mean Change from Baseline in Weekly Frequency of Urinary Incontinence Episodes During Treatment Cycle 1 in Study 2

The median duration of response in the two pivotal studies, based on patient qualification for re-treatment was 295-337 days (42-48 weeks) for the 200 Unit dose group compared to 96-127 days (13-18 weeks) for placebo. Re-treatment was based on loss of effect on incontinence episode frequency (50% of effect in study 1; 70% of effect in study 2).
**14.2 Chronic Migraine**

_BOTOX_ was evaluated in two randomized, multi-center, 24-week, 2 injection cycle, placebo-controlled double-blind studies. Study 1 and Study 2 included chronic migraine adults who were not using any concurrent headache prophylaxis, and during a 28-day baseline period had ≥15 headache days lasting 4 hours or more, with ≥50% being migraine/probable migraine. In both studies, patients were randomized to receive placebo or 155 Units to 195 Units _BOTOX_ injections every 12 weeks for the 2-cycle, double-blind phase. Patients were allowed to use acute headache treatments during the study. _BOTOX_ treatment demonstrated statistically significant and clinically meaningful improvements from baseline compared to placebo for key efficacy variables (see Table 13).

**Table 13: Week 24 Key Efficacy Variables for Study 1 and Study 2**

<table>
<thead>
<tr>
<th>Efficacy per 28 days</th>
<th>Study 1</th>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BOTOX (N=341)</td>
<td>Placebo (N=338)</td>
</tr>
<tr>
<td>Change in frequency of headache days</td>
<td>-7.8*</td>
<td>-6.4</td>
</tr>
<tr>
<td>Change in total cumulative hours of headache on headache days</td>
<td>-107*</td>
<td>-70</td>
</tr>
</tbody>
</table>

* Significantly different from placebo (p≤0.05)

Patients treated with _BOTOX_ had a significantly greater mean decrease in frequency of headache days at most timepoints from Week 4 to Week 24 in Study 1 (Figure 5), and all timepoints from Week 4 to Week 24 in Study 2 (Figure 6), compared to placebo-treated patients.

**Figure 5: Mean Change from Baseline in Number of Headache Days for Study 1**

**Figure 6: Mean Change from Baseline in Number of Headache Days for Study 2**

**14.3 Upper Limb Spasticity**

The efficacy and safety of _BOTOX_ for the treatment of upper limb spasticity were evaluated in three randomized, multi-center, double-blind, placebo-controlled studies. Study 1 included 126 patients (64 _BOTOX_ and 62 placebo) with upper limb spasticity (Ashworth score of at least 3 for wrist flexor tone and at least 2 for finger flexor tone) who were at least 6 months post-stroke. _BOTOX_ (a total dose of 200 Units to 240 Units) and placebo were injected intramuscularly (IM) into the flexor digitorum profundus, flexor digitorum sublimis, flexor carpi radialis, flexor carpi ulnaris, and if necessary into the adductor pollicis and flexor pollicis longus (see Table 14). Use of an EMG/nerve stimulator was recommended to assist in proper muscle localization for injection. Patients were followed for 12 weeks.

**Table 14: Study Medication Dose and Injection Sites in Study 1**

<table>
<thead>
<tr>
<th>Muscles Injected</th>
<th>Volume (mL)</th>
<th><em>BOTOX</em> (Units)</th>
<th>Number of Injection Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrist</td>
<td>Flexor Carpi Radialis</td>
<td>1</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Flexor Carpi Ulnaris</td>
<td>1</td>
<td>50</td>
</tr>
<tr>
<td>Finger</td>
<td>Flexor Digitorum Profundus</td>
<td>1</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Flexor Digitorum Sublimis</td>
<td>1</td>
<td>50</td>
</tr>
<tr>
<td>Thumb Adductor Pollicis</td>
<td>0.4</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>Thumb Flexor Pollicis Longus</td>
<td>0.4</td>
<td>20</td>
<td>1</td>
</tr>
</tbody>
</table>

* injected only if spasticity is present in this muscle

The primary efficacy variable was wrist flexors muscle tone at week 6, as measured by the Ashworth score. The Ashworth Scale is a clinical measure of the force required to move an extremity around a joint, with a reduction in score clinically representing a reduction in the force needed to move a joint (i.e., improvement in spasticity).

Possible scores range from 0 to 4:

0 = No increase in muscle tone (none)
1 = Slight increase in muscle tone, giving a ‘catch’ when the limb was moved in flexion or extension (mild)
2 = More marked increase in muscle tone but affected limb is easily flexed (moderate)
3 = Considerable increase in muscle tone - passive movement difficult (severe)
4 = Limb rigid in flexion or extension (very severe).

Key secondary endpoints included Physician Global Assessment, finger flexors muscle tone, and thumb flexors tone at Week 6. The Physician Global Assessment evaluated the response to treatment in terms of how the patient was doing in his/her life using a scale from -4 = very marked worsening to +4 = very marked improvement. Study 1 results on the primary endpoint and the key secondary endpoints are shown in Table 15.

**Table 15: Primary and Key Secondary Endpoints by Muscle Group at Week 6 in Study 1**

<table>
<thead>
<tr>
<th>Median Change from Baseline in Wrist Flexor Muscle Tone on the Ashworth Scale††</th>
<th><em>BOTOX</em> (N=64)</th>
<th>Placebo (N=62)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-2.0*</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Change from Baseline in Finger Flexor Muscle Tone on the Ashworth Scale‡‡</td>
<td>-1.0*</td>
<td>0.0</td>
</tr>
<tr>
<td>Median Change from Baseline in Thumb Flexor Muscle Tone on the Ashworth Scale‡‡</td>
<td>-1.0</td>
<td>-1.0</td>
</tr>
<tr>
<td>Median Physician Global Assessment of Response to Treatment§§</td>
<td>2.0*</td>
<td>0.0</td>
</tr>
</tbody>
</table>

† Primary endpoint at Week 6
‡‡ Secondary endpoints at Week 6
* Significantly different from placebo (p≤0.05)
* _BOTOX_ injected into both the flexor carpi radialis and ulnaris muscles
* _BOTOX_ injected into the flexor digitorum profundus and flexor digitorum sublimis muscles
* _BOTOX_ injected into the adductor pollicis and flexor pollicis longus muscles
** Study 2 compared 3 doses of _BOTOX_ with placebo and included 91 patients (BOTOX 360 Units (N=21), BOTOX 180 Units (N=23), BOTOX 90 Units (N=21), and placebo (N=26)) with upper limb spasticity (expanded Ashworth score of at least 2 for elbow flexor tone and at least 3 for wrist flexor tone) who were at least 6 weeks post-stroke. _BOTOX_ and placebo were injected with EMG guidance into the flexor digitorum profundus, flexor digitorum sublimis, flexor carpi radialis, flexor carpi ulnaris, and biceps brachii (see Table 16).
The primary efficacy variable in Study 2 was the wrist flexor tone at Week 6 as measured by the expanded Ashworth Scale. The expanded Ashworth Scale uses the same scoring system as the Ashworth Scale, but allows for half-point increments.

Key secondary endpoints in Study 2 included Physician Global Assessment, finger flexors muscle tone, and elbow flexors muscle tone at Week 6. Study 2 results on the primary endpoint and the key secondary endpoints at Week 6 are shown in Table 17.

### Table 17: Primary and Key Secondary Endpoints by Muscle Group and BOTOX Dose at Week 6 in Study 2

<table>
<thead>
<tr>
<th>Muscles Injected</th>
<th>BOTOX low dose (90 Units) (N=21)</th>
<th>BOTOX mid dose (180 Units) (N=23)</th>
<th>BOTOX high dose (360 Units) (N=21)</th>
<th>Placebo (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medial Change from Baseline in Wrist Flexor Muscle Tone on the Ashworth Scale*</td>
<td>-1.5*</td>
<td>-1.0*</td>
<td>-1.5*</td>
<td>-1.0</td>
</tr>
<tr>
<td>Medial Change from Baseline in Finger Flexor Muscle Tone on the Ashworth Scale</td>
<td>-0.5</td>
<td>-0.5</td>
<td>1.0</td>
<td>-0.5</td>
</tr>
<tr>
<td>Medial Change from Baseline in Elbow Flexor Muscle Tone on the Ashworth Scale</td>
<td>-0.5</td>
<td>1.0</td>
<td>-0.5</td>
<td>-0.5</td>
</tr>
<tr>
<td>Medial Physiologist Global Assessment of Response to Treatment</td>
<td>1.0*</td>
<td>1.0*</td>
<td>1.0*</td>
<td>0.0</td>
</tr>
</tbody>
</table>

1 Primary endpoint at Week 6
2 Secondary endpoints at Week 6
3 Significantly different from placebo (p≤0.05)
4 p=0.053
5 Total dose of BOTOX injected into both the flexor carpi radialis and ulnaris muscles
6 Total dose of BOTOX injected into the flexor digitorum profundus and flexor digitorum sublimis muscles
7 Dose of BOTOX injected into biceps brachii muscle

Study 3 compared 3 doses of BOTOX with placebo and enrolled 88 patients [BOTOX 360 Units (N=23), BOTOX 180 Units (N=23), BOTOX 90 Units (N=23), and placebo (N=19)] with upper limb spasticity (expanded Ashworth score of at least 2 for elbow flexor tone and at least 3 for wrist flexor tone and/or finger flexor tone) who were at least 6 weeks post-stroke. BOTOX and placebo were injected with EMG guidance into the flexor digitorum profundus, flexor digitorum sublimis, flexor carpi radialis, flexor carpi ulnaris, and biceps brachii (see Table 16).

The primary efficacy variable in Study 3 was wrist and elbow flexor tone as measured by the expanded Ashworth score. A key secondary endpoint was assessment of finger flexors muscle tone. Study 3 results on the primary endpoint at Week 4 are shown in Table 18.
The percentage of responders based on at least a 2-grade decrease from baseline in HDSS or based on a >50% decrease from baseline in axillary sweat production was greater in both BOTOX groups than in the placebo group (p<0.001), but was not significantly different between the two BOTOX doses (see Table 21).

Duration of response was calculated as the number of days between injection and the date of the first visit at which patients returned to 3 or 4 on the HDSS scale. The median duration of response following the first treatment with BOTOX treatment of patients with either dose was 201 days. Among those who received a second BOTOX injection, the median duration of response was similar to that observed after the first treatment.

In study 2, 320 adults with bilateral axillary primary hyperhidrosis were randomized to receive either 50 Units of BOTOX (n=242) or placebo (n=78). Treatment responders were defined as subjects showing at least a 50% reduction from baseline in axillary sweating measured by gravimetric measurement at 4 weeks. At week 4 post-injection, the percentages of responders were 91% (219/242) in the BOTOX group and 36% (88/247) in the placebo group, p<0.001. The difference in percentage of responders between BOTOX and placebo was 55% (95% CI=43.3, 65.9).

Table 21: Study 1 - Study Outcomes

<table>
<thead>
<tr>
<th>Treatment Response</th>
<th>BOTOX 50 Units (N=104)</th>
<th>BOTOX 75 Units (N=110)</th>
<th>Placebo (N=108)</th>
<th>BOTOX 50-placebo CI</th>
<th>BOTOX 75-placebo CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDSS Score change ≥2(n)</td>
<td>55% (57)</td>
<td>49% (54)</td>
<td>6% (6)</td>
<td>49.3% (38, 59.7)</td>
<td>43% (33.2, 53.8)</td>
</tr>
<tr>
<td>&gt;50% decrease in axillary sweat production % (n)</td>
<td>81% (84)</td>
<td>86% (94)</td>
<td>41% (44)</td>
<td>40% (28.1, 52.0)</td>
<td>45% (33.3, 56.1)</td>
</tr>
</tbody>
</table>

* Patients who showed at least a 2-grade improvement from baseline value on the HDSS 4 weeks after both of the first two treatment sessions or had a sustained response after their first treatment session and did not receive re-treatment during the study.

14.6 Blepharospasm
Botulinum toxin has been investigated for use in patients with blepharospasm in several studies. In an open label, historically controlled study, 27 patients with essential blepharospasm were injected with 2 Units of BOTOX at each of six sites on each side. Twenty-five of the 27 patients treated with botulinum toxin reported improvement within 48 hours. One patient was controlled with a higher dosage at 13 weeks post initial injection and one patient reported mild improvement but remained functionally impaired.

In another study, 12 patients with blepharospasm were evaluated in a double-blind, placebo-controlled study. Patients receiving botulinum toxin (n=8) improved compared with the placebo group (n=4). The effects of the treatment lasted a mean of 12 weeks.

One thousand six hundred eighty-four patients with blepharospasm who were evaluated in an open label trial showed clinical improvement as evaluated by measured eyelid force and clinically observed intensity of lid spasm, lasting an average of 12 weeks prior to the need for re-treatment.

14.7 Strabismus
Six hundred seventy-seven patients with strabismus treated with one or more injections of BOTOX were evaluated in an open label trial. Fifty-five percent of these patients improved to an alignment of 10 prism dipters or less when evaluated six months or more following injection.

16 HOW SUPPLIED/STORAGE AND HANDLING
BOTOX is supplied in a single-use vial in the following sizes: 100 Units NDC 0023-1145-01 200 Units NDC 0023-3921-02

Vials of BOTOX have a holographic film on the vial label that contains the name “Allergan” within horizontal lines of rainbow color. In order to see the hologram, rotate the vial back and forth between your fingers under a desk lamp or fluorescent light source. (Note: the holographic film on the label is absent in the date/lot area.) If you do not see the lines of rainbow color or the name “Allergan,” do not use the product and contact Allergan for additional information at 1-800-890-4345 from 7:00 AM to 3:00 PM Pacific Time.

Storage
Unopened vials of BOTOX should be stored in a refrigerator (2° to 8°C) for up to 36 months for the 100 Units vial or up to 24 months for the 200 Units vial. Do not use after the expiration date on the vial. Administer BOTOX within 24 hours of reconstitution; during this period reconstituted BOTOX should be stored in a refrigerator (2° to 8°C). Reconstituted BOTOX should be clear, colorless, and free of particulate matter.

17 PATIENT COUNSELING INFORMATION
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Provide a copy of the Medication Guide and review the contents with the patient.

The mid-range of dose is calculated as the 25th to 75th percentiles. There were several randomized studies conducted prior to the double-blind, placebo-controlled study, which were supportive but not adequately designed to assess or quantitatively estimate the efficacy of BOTOX.

14.5 Primary Axillary Hyperhidrosis
The efficacy and safety of BOTOX for the treatment of primary axillary hyperhidrosis were evaluated in two randomized, multi-center, double-blind, placebo-controlled studies. Study 1 included adult patients with persistent primary axillary hyperhidrosis who scored 3 or 4 on a Hyperhidrosis Disease Severity Scale (HDSS) and who produced at least 50 mg of sweat in each axilla at rest over a period of 5 minutes. HDSS is a 4-point scale with 1 = “underarm sweating is never noticeable and never interferes with my daily activities”; to 4 = “underarm sweating is intolerable and always interferes with my daily activities.” A total of 322 patients were randomized in a 1:1:1 ratio to treatment in both axillae with either 50 Units of BOTOX, 75 Units of BOTOX, or placebo. Patients were evaluated at 4-week intervals. Patients who responded to the first injection were re-injected when they reported a mean increase in HDSS score to 3 or 4 and produced at least 50 mg sweat in each axilla by gravimetric measurement, but no sooner than 8 weeks after the initial injection.

Study responders were defined as patients who showed at least a 2-grade improvement from baseline value on the HDSS 4 weeks after both of the first two treatment sessions or had a sustained response after their first treatment session and did not receive re-treatment during the study. Spontaneous resting axillary sweat production was assessed by weighing a filter paper held in the axilla for a period of 5 minutes (gravimetric measurement). Sweat production responders were those patients who demonstrated a reduction in axillary sweating from baseline at least 50% at week 4.

In the three study groups the percentage of patients with baseline HDSS score of 3 ranged from 50% to 54% and from 46% to 50% for a score of 4. The median amount of sweat production (averaged for each axilla) was 102 mg, 123 mg, and 114 mg for the placebo, 50 Units and 75 Units groups respectively.

<table>
<thead>
<tr>
<th>Muscle</th>
<th>Number of Patients Treated in this Muscle (N=88)</th>
<th>Mean % Dose per Muscle</th>
<th>Mid-Range of % Dose per Muscle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Splenius capitis/cervicis</td>
<td>83</td>
<td>38</td>
<td>25-50</td>
</tr>
<tr>
<td>Sternocleidomastoid</td>
<td>77</td>
<td>25</td>
<td>17-31</td>
</tr>
<tr>
<td>Levator scapulae</td>
<td>52</td>
<td>20</td>
<td>16-25</td>
</tr>
<tr>
<td>Trapezius</td>
<td>49</td>
<td>29</td>
<td>18-33</td>
</tr>
<tr>
<td>Semispinalis</td>
<td>16</td>
<td>21</td>
<td>13-25</td>
</tr>
<tr>
<td>Sclene</td>
<td>15</td>
<td>15</td>
<td>6-21</td>
</tr>
<tr>
<td>Longissimus</td>
<td>8</td>
<td>29</td>
<td>17-41</td>
</tr>
</tbody>
</table>

*Patients who showed at least a 2-grade improvement from baseline value on the HDSS 4 weeks after both of the first two treatment sessions or had a sustained response after their first treatment session and did not receive re-treatment during the study.

14.6 Blepharospasm
Botulinum toxin has been investigated for use in patients with blepharospasm in several studies. In an open label, historically controlled study, 27 patients with essential blepharospasm were injected with 2 Units of BOTOX at each of six sites on each side. Twenty-five of the 27 patients treated with botulinum toxin reported improvement within 48 hours. One patient was controlled with a higher dosage at 13 weeks post initial injection and one patient reported mild improvement but remained functionally impaired.

In another study, 12 patients with blepharospasm were evaluated in a double-blind, placebo-controlled study. Patients receiving botulinum toxin (n=8) improved compared with the placebo group (n=4). The effects of the treatment lasted a mean of 12 weeks.

One thousand six hundred eighty-four patients with blepharospasm who were evaluated in an open label trial showed clinical improvement as evaluated by measured eyelid force and clinically observed intensity of lid spasm, lasting an average of 12 weeks prior to the need for re-treatment.

14.7 Strabismus
Six hundred seventy-seven patients with strabismus treated with one or more injections of BOTOX were evaluated in an open label trial. Fifty-five percent of these patients improved to an alignment of 10 prism dipters or less when evaluated six months or more following injection.

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17 PATIENT COUNSELING INFORMATION
“See FDA-approved patient labeling (Medication Guide)”
Provide a copy of the Medication Guide and review the contents with the patient.
17.1 Swallowing, Speaking or Breathing Difficulties, or Other Unusual Symptoms

Patients should be advised to inform their doctor or pharmacist if they develop any unusual symptoms (including difficulty with swallowing, speaking, or breathing), or if any existing symptom worsens [see Boxed Warning and Warnings and Precautions (5.2, 5.5)].

17.2 Ability to Operate Machinery or Vehicles

Patients should be counseled that if loss of strength, muscle weakness, blurred vision, or drooping eyelids occur, they should avoid driving a car or engaging in other potentially hazardous activities.

17.3 Voiding Difficulties after Bladder Injections

After bladder injections for urinary incontinence, patients should be instructed to contact their physician if they experience difficulties in voiding.

Manufactured by: Allergan Pharmaceuticals Ireland

A subsidiary of: Allergan, Inc.

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Irvine, CA 92612

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U.S. Patents 5,437,291; 5,714,468; 6,667,041; 6,683,049; 6,896,886; 6,974,578; 7,001,602; 7,429,387; and 7,449,192

ALLERGAN

Based on 72309US11C and 72312US11C

MEDICATION GUIDE

BOTOX®

BOTOX® Cosmetic

(Boe-tox)

(onabotulinumtoxinA)

for Injection

Read the Medication Guide that comes with BOTOX or BOTOX Cosmetic before you start using it and each time it is given to you. There may be new information. This information does not take the place of talking with your doctor about your medical condition or your treatment. You should share this information with your family members and caregivers.

What is the most important information I should know about BOTOX and BOTOX Cosmetic?

BOTOX and BOTOX Cosmetic may cause serious side effects that can be life threatening, including:

• Problems breathing or swallowing

• Spread of toxin effects

These problems can happen hours, days, to weeks after an injection of BOTOX or BOTOX Cosmetic. Call your doctor or get medical help right away if you have any of these problems after treatment with BOTOX or BOTOX Cosmetic:

1. Problems swallowing, speaking, or breathing. These problems can happen hours, days, to weeks after an injection of BOTOX or BOTOX Cosmetic usually because the muscles that you use to breathe and swallow can become weak after the injection. Death can happen as a complication if you have severe problems with swallowing or breathing after treatment with BOTOX or BOTOX Cosmetic.

• People with certain breathing problems may need to use muscles in their neck to help them breathe. These people may be at greater risk for serious breathing problems with BOTOX or BOTOX Cosmetic.

• Swallowing problems may last for several months. People who cannot swallow well may need a feeding tube to receive food and water. If swallowing problems are severe, food or liquids may go into your lungs. People who already have swallowing or breathing problems before receiving BOTOX or BOTOX Cosmetic have the highest risk of getting these problems.

2. Spread of toxin effects. In some cases, the effect of botulinum toxin may affect areas of the body away from the injection site and cause symptoms of a serious condition called botulism. The symptoms of botulism include:

• loss of strength and muscle weakness all over the body

• double vision

• blurred vision and drooping eyelids

• hoarseness or change or loss of voice (dysphonia)

• trouble saying words clearly (dysarthria)

• loss of bladder control

• trouble breathing

• trouble swallowing

These symptoms can happen hours, days, to weeks after you receive an injection of BOTOX or BOTOX Cosmetic.

These problems could make it unsafe for you to drive a car or do other dangerous activities. See “What should I avoid while receiving BOTOX or BOTOX Cosmetic?”

There has not been a confirmed serious case of spread of toxin effect away from the injection site when BOTOX has been used at the recommended dose to treat chronic migraine, severe underarm sweating, blepharospasm, or strabismus, or when BOTOX Cosmetic has been used at the recommended dose to treat frown lines.

What are BOTOX and BOTOX Cosmetic?

BOTOX is a prescription medicine that is injected into muscles and used:

• to treat leakage of urine (incontinence) in adults with overactive bladder due to neurologic disease.

• to prevent headaches in adults with chronic migraine who have 15 or more days each month with headache lasting 4 or more hours each day.

• to treat increased muscle stiffness in elbow, wrist, and finger muscles in adults with upper limb spasticity.

• to treat the abnormal head position and neck pain that happens with cervical dystonia (CD) in adults.

• to treat certain types of eye muscle problems (strabismus) or abnormal spasm of the eyelids (blepharospasm) in people 12 years and older.

BOTOX is also injected into the skin to treat the symptoms of severe underarm sweating (severe primary axillary hyperhidrosis) when medicines used on the skin (topical) do not work well enough.

BOTOX Cosmetic is a prescription medicine that is injected into muscles and used to improve the look of moderate to severe frown lines between the eyebrows (glabellar lines) in adults younger than 65 years of age for a short period of time (temporary).

It is not known whether BOTOX is safe or effective in people younger than:

• 18 years of age for treatment of urinary incontinence

• 18 years of age for treatment of chronic migraine

• 18 years of age for treatment of spas ticity
• 16 years of age for treatment of cervical dystonia
• 18 years of age for treatment of hyperhidrosis
• 12 years of age for treatment of strabismus or blepharospasm

**BOTOX Cosmetic** is not recommended for use in children younger than 18 years of age.

It is not known whether **BOTOX** and **BOTOX Cosmetic** are safe or effective to prevent headaches in people with migraine who have 14 or fewer headache days each month (episodic migraine).

It is not known whether **BOTOX** and **BOTOX Cosmetic** are safe or effective for other types of muscle spasms or for severe sweating anywhere other than your armpits.

**Who should not take BOTOX or BOTOX Cosmetic?**

Do not take **BOTOX** or **BOTOX Cosmetic** if you:
• are allergic to any of the ingredients in **BOTOX** or **BOTOX Cosmetic**. See the end of this Medication Guide for a list of ingredients in **BOTOX** and **BOTOX Cosmetic**.
• had an allergic reaction to any other botulinum toxin product such as Myobloc®, Dysport®, or Xeomin®
• have a skin infection at the planned injection site
• are being treated for urinary incontinence and have a urinary tract infection (UTI)
• are being treated for urinary incontinence and find that you cannot empty your bladder on your own (only applies to people who are not routinely catheterizing)

**What should I tell my doctor before taking BOTOX or BOTOX Cosmetic?**

Tell your doctor about all your medical conditions, including if you:
• have a disease that affects your muscles and nerves (such as amyotrophic lateral sclerosis [ALS or Lou Gehrig’s disease], myasthenia gravis or Lambert-Eaton syndrome). See “What is the most important information I should know about **BOTOX** and **BOTOX Cosmetic**?”
• have allergies to any botulinum toxin product
• had any side effect from any botulinum toxin product in the past
• have or have had a breathing problem, such as asthma or emphysema
• have or have had swallowing problems
• have or have had bleeding problems
• have plans to have surgery
• had surgery on your face
• have weakness of your forehead muscles, such as trouble raising your eyebrows
• have drooping eyelids
• have any other change in the way your face normally looks
• have symptoms of a urinary tract infection (UTI) and are being treated for urinary incontinence. Symptoms of a urinary tract infection may include pain or burning with urination, frequent urination, or fever.
• have problems emptying your bladder on your own and are being treated for urinary incontinence
• are pregnant or plan to become pregnant. It is not known if **BOTOX** or **BOTOX Cosmetic** can harm your unborn baby.
• are breast-feeding or plan to breastfeed. It is not known if **BOTOX** or **BOTOX Cosmetic** passes into breast milk.

Tell your doctor about all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal products. Using **BOTOX** or **BOTOX Cosmetic** with certain other medicines may cause serious side effects. Do not start any new medicines until you have told your doctor that you have received **BOTOX** or **BOTOX Cosmetic** in the past.

Especially tell your doctor if you:
• have received any other botulinum toxin product in the last four months
• have received injections of botulinum toxin, such as Myobloc® (rimabotulinumtoxinB), Dysport® (abobotulinumtoxinA), or Xeomin® (incobotulinumtoxinA) in the past. Be sure your doctor knows exactly which product you received.
• have recently received an antibiotic by injection
• take muscle relaxants
• take an allergy or cold medicine
• take a sleep medicine
• take anti-platelets (aspirin-like products) and/or anti-coagulants (blood thinners)

Ask your doctor if you are not sure if your medicine is one that is listed above.

Know the medicines you take. Keep a list of your medicines with you to show your doctor and pharmacist each time you get a new medicine.

**How should I take BOTOX or BOTOX Cosmetic?**

• **BOTOX** or **BOTOX Cosmetic** is an injection that your doctor will give you.
• **BOTOX** is injected into your affected muscles, skin, or bladder.
• **BOTOX Cosmetic** is injected into your affected muscles.
• Your doctor may change your dose of **BOTOX** or **BOTOX Cosmetic**, until you and your doctor find the best dose for you.
• Your doctor will tell you how often you will receive your dose of **BOTOX** or **BOTOX Cosmetic** injections.

**What should I avoid while taking BOTOX or BOTOX Cosmetic?**

**BOTOX** and **BOTOX Cosmetic** may cause loss of strength or general muscle weakness, or vision problems within hours to weeks of taking **BOTOX** or **BOTOX Cosmetic**. If this happens, do not drive a car, operate machinery, or do other dangerous activities. See “What is the most important information I should know about **BOTOX** and **BOTOX Cosmetic**?”
What are the possible side effects of BOTOX and BOTOX Cosmetic?

BOTOX and BOTOX Cosmetic can cause serious side effects. See “What is the most important information I should know about BOTOX and BOTOX Cosmetic?”

Other side effects of BOTOX and BOTOX Cosmetic include:

- dry mouth
- discomfort or pain at the injection site
- tiredness
- headache
- neck pain
- eye problems: double vision, blurred vision, decreased eyesight, drooping eyelids, swelling of your eyelids, and dry eyes.
- urinary tract infection in people being treated for urinary incontinence
- inability to empty your bladder on your own and are being treated for urinary incontinence.
- allergic reactions. Symptoms of an allergic reaction to BOTOX or BOTOX Cosmetic may include: itching, rash, red itchy welts, wheezing, asthma symptoms, or dizziness or feeling faint. Tell your doctor or get medical help right away if you are wheezing or have asthma symptoms, or if you become dizzy or faint.

Tell your doctor if you have any side effect that bothers you or that does not go away.

These are not all the possible side effects of BOTOX and BOTOX Cosmetic. For more information, ask your doctor or pharmacist.

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

General information about BOTOX and BOTOX Cosmetic:

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide.

This Medication Guide summarizes the most important information about BOTOX and BOTOX Cosmetic. If you would like more information, talk with your doctor. You can ask your doctor or pharmacist for information about BOTOX and BOTOX Cosmetic that is written for healthcare professionals. For more information about BOTOX and BOTOX Cosmetic call Allergan at 1-800-433-8871 or go to www.BOTOX.com.

What are the ingredients in BOTOX and BOTOX Cosmetic?

Active ingredient: botulinum toxin type A
Inactive ingredients: human albumin and sodium chloride