Information for healthcare professionals

- CABLIVI is indicated for treatment of acquired thrombotic thrombocytopenic purpura in conjunction with plasma exchange and immunosuppression.
- CABLIVI inhibits the interaction of von Willebrand Factor (vWF) with platelets.
- CABLIVI may increase the risk of bleeding, including major bleeding.
- Cases of major bleeding, including potentially life-threatening and fatal bleeding, have been reported, mainly in patients using concomitant anti-platelet agents or anticoagulants.
- Caplacizumab should be used with caution in patients with underlying conditions associated with a bleeding risk.
- In case of significant bleeding requiring treatment, vWF/FVIII concentrate may be used to correct hemostasis.
- CABLIVI treatment should be stopped 7 days before elective surgery.
- Please refer to the local label for full information.

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Information for patients

- Always keep this card with you while on CABLIVI treatment and for one week after your last dose.
- Taking CABLIVI may increase your risk of bleeding (including potentially life-threatening and fatal bleeding).
- Please contact your doctor immediately if you develop excessive bruising, bleeding or experience any unusual symptoms, such as headache, shortness of breath, tiredness, dizziness, lightheadedness or fainting during treatment.
- Present this card to your healthcare professional (e.g. physician, dentist or surgeon) before any medical treatment or intervention.
- Please read the CABLIVI Package Leaflet carefully.

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Cablivi® caplacizumab

In case of any drug related adverse events, please contact:
The National Pharmacovigilance Center (NPC)
Call Center: 19999, Email:npc.drug@sfda.gov.sa, Website: https://ade.sfda.gov.sa/
And SANOFI Pharmacovigilance:
Phone: +966-544-284-797, Email: ksa_pharmacovigilance@sanofi.com
For Medical Information, Please contact:+966126893318 Email:
ksa.medicalinformation@sanofi.com
Website: www.sanofi.com.sa

PATIENT ALERT CARD

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This document has been reviewed and approved by The Saudi Food and Drug Authority (SFDA).

Cablivi® caplacizumab

Patient information

Name:

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name:

Phone number:

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Prescriber information

FOR MORE INFORMATION OR IN CASE OF EMERGENCY SITUATIONS, PLEASE CONTACT MY DOCTOR:

Name:

Phone number:

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Treatment information

(To be completed by your physician)

On [date] _____ **this patient started taking CABLIVI (caplacizumab) for acquired Thrombotic Thrombocytopenic Purpura (aTTP).**

(To be completed by your physician or yourself if you self inject CABLIVI)

Actual date of end of treatment: [date] _____

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