**SUPPLEMENTAL DATA**

**Table e-1. Extended summary of studies reporting measurement of monoclonal antibody (mAb) therapies in breastmilk in women with chronic conditions treated during pregnancy and breastfeeding, including a review breastfeeding status and longitudinal infant outcomes.**

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| **mAb, abbreviation (Target)** | **Neuro-logical Use (if applicable)** | **Study Types** | **Conditions Studied** | **No. of Pregnancies** | **Treatment/Dosage** | **Pregnancy Outcomes** | **Breastfeeding Details** | **Longitudinal Infant Outcomes** | **Detectable mAb in Cord Blood/at delivery?** | **Detectable mAb in Breastmilk?** | **Maximum Concentration (Cmax) in Breastmilk (range) μg/mL** | **Cmax Time Post Treatment in breastmilk (range)** | **Infant Dose from BM (Calculated or Measured)** |
| **Adalimumab, ADA (TNF-α)** | n/a | Case Report1 | CD | 1 | -40mg q2w until 16w GA.  -ADA was resumed 24d postpartum. | Healthy infant delivered at 37.5w. | Infant was BF exclusively for 4 months post maternal ADA treatment. | Followed up to 7 months with normal development & no serious infections. | Detected in cord blood at delivery (150ng/mL). | NR | NR | NR | Not detectable in infant serum 3 months postpartum. |
| Case Report2 | CD | 1 | -40mg (frequency n/a) until 30w GA.  -40mg (frequency n/a) ADA was resumed 4w postpartum. | Healthy infant delivered at 38w. | BF was stopped at 4w postpartum when ADA was resumed. | NR | NR | -Detected in all BM samples 1d to 8d post-treatment.  -BM concentration was 1/100 of the level in maternal serum. | 0.031 (n/a) | 6 days | NR |
| Prospective Registry3 | IBD | 136 | 136 mothers treated postpartum, dosage not specified. | NR | 99 infants were BF post maternal ADA treatment. | Infant outcomes at 12 months included several mAb, including ADA & found infection risk, 39% (P=.9992), & development milestone scores (P>.99) did not differ between infants BF post maternal mAb exposure & non-BF infants. | NR | -21 mothers provided BM samples.  -7/21 mothers provided serial samples up to 7d post treatment with no detectable ADA in all samples.  -Only 2 mothers providing a single sample between 12-24h post treatment had detectable ADA. | 0.71 (0.45-0.71) | 12-24 hours | NR |
| Prospective Registry4 | IBD | 2 | 40mg q2w initiated postpartum at 14w & 7w2d, respectively; 1 mother received ADA until 3.5w before delivery. | Healthy infants delivered at term. | 2 infants were BF post maternal ADA treatment. | -Followed up to 14.5 and 18 months, respectively with no severe infections.  -1 infant developed spasmodic laryngitis at 10 months (common in young infants). | NR | ADA was detectable in 1 sample each provided by 2 mothers at 7d & 9d post treatment (BM concentration was <1/1000 compared to maternal serum). | 0.00488 (0.00483-0.00488) (only collected at 1 timepoint each) | NR (Only 1 sample collected from each mother) | ADA detected 1d postpartum only in infant exposed during gestation, 8.4 μg/mL; not detectable in serum 9d post maternal treatment in 1 BF infant. |
| **Bevacizumab, BVZ (VEGF-A)** | Glioblastoma | Case Report5 | CNV | 5 (4 mothers) | Mothers treated with a mean of 2.6+2.3 intravitreal injections (range 1 to 6) during pregnancy, with 1 treated while BF. | All healthy infants delivered at term with no complications during pregnancy. | 2 mothers treated with BVZ postpartum; only 1 elected to continue breastfeeding (received 5 intravitreal injections). | Followed for range of 3 to 23 months with normal development & no serious infections. | NR | NR | NR | NR | NR |
| Case Report6 | CNV | 1 | Intravitreal injection given 12w postpartum. | NR | BF continued post maternal BVZ treatment. | NR | NR | -9 BM samples collected within 0d to 42d post-injection had no detectable BVZ.  -19 BM samples collected within 0d to 98d post BVZ (ranibizumab given at 56 & 98d) were analyzed for VEGF-A concentration. | Not detectable. (Noted 35% reduction in VEGF-A in BM by 2w post-treatment) | n/a | NR |
| Case Series7 | CNV | 3 (2 mothers) | Intravitreal injections prior to conception with retreatment at 7w GA in 1 pregnancy, 36w & 12w postpartum in the other 2 pregnancies. | Delivered 3 healthy infants. | NR | NR | NR | -All BM samples collected 1d before & 1w after each BVZ injection (1d post & additional samples collected when possible) had no detectable BVZ.  -Mothers provided 6 & 28 samples (across 2 pregnancies), respectively. | Not detectable (0.003μg/mL detection limit). | n/a | NR |
| **Certolizumab, CZP (TNF-α)** | n/a | Case Report8 | RA | 1 | CZP initiated at 28w GA during pregnancy and continued postpartum (dosage not specified). | Healthy infant delivered at 40w. | BF was continued post maternal treatment. | NR | Not detected in cord blood at delivery. | Not detectable in 5 BM samples collected before then at 2h, 48h, & 14d post treatment. | Not detectable (<1μg/mL detection limit). | n/a | Not detectable in infant serum collected at 3d postpartum (<1μg/mL detection limit). |
| Case Series9 | RA, SpA | 13 | -200mg q2w initiated before 3 pregnancies (continued throughout gestation) & after conception in 10 pregnancies (8 treated with different mAb pre-conception).  -All 13 were treated with CZP postpartum. | -3/13 mothers developed an infection during pregnancy.  -12 full-term & 1 low-weight, pre-term delivery.  -1 case of clubfeet and Hirschsprung’s disease (noted in 1st trimester) in pregnancy where CZP had been initiated at 23w GA. | 6 infants were BF post maternal treatment. | NR | 3/11 pregnancies that provided cord blood samples had <1μg/mL of detectable CZP; all others were below the detection limit. | 2 women provided BM within 1h and 4h post treatment with no detectable CZP. | Not detectable. (<0.6μg/mL detection limit) | n/a | NR |
| Cohort Study10 | RA, CD, axSpA, PsA | 17 | -Lactating mothers > 6w postpartum, received either 200mg q2w (N=16) or q4w (N=1).  -Only women who delivered at term were included. | -5 AEs in 4 mothers were considered related to CZP use: 2 URTI, 1 herpes zoster, 1 CD flare, 1 pneumonia. | An unspecified subset of women continued BF post CZP treatment. | No adverse events in BF infants followed 5 weeks post maternal CZP treatment. | NR | -17 mothers provided 137 BM samples before and every 2d of dosing period (14d or 28d) after >3 doses.  -60/137 samples had detectable CZP (13/17 mothers). | 0.076 (0.032-0.076) with median Cmax 0.043 | 2.8-11.9 days with median tmax5.051 | 0.15% (0.04-0.30) (RID (range)); Median avg infant daily dose 0.0035 mg/kg/d (0-0.010) |
| Prospective Registry3 | IBD | 72 | 72 mothers treated postpartum (dosage not specified). | NR | 54 infants BF post maternal treatment. | Infant outcomes at 12 months included several mAb, including CZP & found infection risk, 39% (P=.9992), and development milestone scores (P>.99) did not differ between infants BF post maternal mAb exposure & non-BF infants. | NR | 3/13 mothers who provided serial samples between 1h to 7d post treatment had detectable CZP. | 0.29 (0.27-0.29) | 12-48 hours | NR |
| **Eculizumab (Complement protein C5)**  **NB: IgG2/G4 subclass hybrid** **11** | MG, NMOSD | Prospective Registry12 | PNH | 75 (61 mothers) | -600mg q1w for 4w then 900mg q2w (dose and frequency adjusted at discretion of clinician).  -45/46 mothers treated prior to conception continued treatment throughout gestation and postpartum.  -29 initiated eculizumab in the 2nd or 3rd trimester of pregnancy and continued postpartum. | -69 live births, 6 SABs & 3 still births.  -29% of births were premature, similar to other studies of PNH.  -1 infant with toxic megacolon.  -Acceptable pregnancy outcomes for PNH. | 25 infants BF post maternal eculizumab treatment. | -Formal follow up at 12 months (N=64) with no concerns & normal development in 62 infants.  -1 case of asymptomatic neutropenia & 1 case of delayed speech. | -7/20 cord-blood samples had detectable eculizumab levels at 11.8-21.2 μg/mL. | 10 mothers provided a single sample of BM post treatment with no detectable eculizumab. | Not detectable (<5μg/mL detection limit). | n/a | NR |
| **Golimumab, GOL (TNF-α)** | n/a | Prospective Registry3 | IBD | 1 | 1 mother treated postpartum (dosage not specified). | NR | Elected not to BF. | Infant outcomes at 12 months included several mAb, including GOL & found infection risk, 39% (P=.9992), and development milestone scores (P>.99) did not differ between infants BF post maternal mAb exposure & non-BF infants. | NR | Serial BM samples from 1 mother post GOL in the range of 1h to 7 days post treatment with no detectable GOL. | Not detectable. | n/a | NR |
| **Ipilimumab, IPI (CTLA-4)** | n/a | Case Report13 | Metastatic Melanoma | 1 | Postpartum treatment of metastatic melanoma with 4 infusions of IPI at 3mg/kg every 3 weeks. | Healthy, female infant delivered at 37w prior to any maternal IPI treatments. | BF was postponed until 3w after final IPI infusion. | NR | NR | -IPI detectable in all BM serially sampled up to 25d post first treatment (repeat infusion at 18d).  -Concern for cumulative toxicity with BF and increasing concentration with repeat infusion. | 0.147 (n/a) | 4 days post infusion 2 (21d post-treatment initiation) | Estimated 24 hour infant dose 53.481μg/day (based on Cavg in BM) |
| **Infliximab IFX (TNF-α)** | Neuro-Sarcoidosis | Case Report14 | CD | 1 | -10mg/kg IFX with 6 infusions (4w intervals) during pregnancy & resumed postpartum.  -Mesalamine also given until 37w gestation & resumed postpartum. | Healthy, male infant delivered by cesarean section at 39w. | Infant was BF post maternal IFX treatment. | -Followed to 27 months with normal development. | NR | Serial samples daily up to 30d post IFX with no detectable IFX. | Not detectable. | n/a | NR |
| Case Report15 | CD | 1 | 10mg/kg IFX with 5 infusions (6-8w intervals) during pregnancy (last at 39w) & resumed 2w postpartum. | Healthy, female infant delivered at 41w. | Infant was BF post maternal IFX treatment (stopped transiently for 3w at 6w postpartum & resumed as infant serum IFX levels continued to decrease). | -Followed to 12 months with normal development & routine vaccinations.  -Formal immune evaluation at 6 months showed normal lymphocyte subsets, IgG, IgM, IgA & immune response to vaccines. | NR | -BM sample collected postpartum at 6w, 10w & 13w postpartum (treatment occurred at 2w and 10w) with no detectable IFX.  -Corresponding maternal serum samples were also analyzed. | Not detectable. | n/a | 39.5μg/mL (Cmax in infant serum 6w postpartum; mother stopped BF & resumed after repeat infusion at 10w).  -IFX in infant serum was not attributed to BF as infant serum level decreased despite continued BF & maternal retreatment. |
| Case Report/Review16 | Psoriasis | 1 | -5mg/kg infusions initiated during pregnancy at 4w GA given q8w until 29w GA.  -IFX q8w resumed postpartum. | -Maternal UTI at 33w GA.  -Healthy, female infant delivered at 39w. | Infant was BF for 1 month post maternal IFX treatment. | -Noted normal development at follow-up (timing n/a). | NR | NR | NR | NR | NR |
| Case Series17 | IBD (CD & UC) | 3 | -IFX treatment before, during & after pregnancy (dosage not specified) in 2 women.  -IFX was initiated postpartum in 1 woman. | NR | 3 infants were BF post maternal IFX treatment. | At follow-up (timing n/a), all children were healthy with no adverse events. | NR | -3 mothers with detectable IFX in serially collected BM from time of infusion to 130h post treatment.  -2/3 mothers had detectable IFX within first 5d post 1st treatment & all subsequent samples; 1/3 with detectable IFX in samples 4 & 6d post 1st treatment & all samples post maintenance infusion. | 0.300 (0.130-0.300) | Approximately 80 hours | Absolute infant dose 0.15mg/kg/day (based on Cmax in BM & taking variation in recovery rate into account). |
| Case Series18 | CD | 3 | -5mg/kg given at 0, 2, 6w then q8w maintenance infusions.  -IFX was initiated prior to conception in 2 pregnancies & during the 2nd trimester of 1 pregnancy.  -The last dose of IFX was given in the 3rd trimester of all 3 pregnancies and resumed postpartum. | -3 healthy infants (2 full-term, 1 at 36w).  - In pregnancy carried to 36w, the mother was untreated for 6 years & had CD flare in 1st trimester treated with steroids & IFX initiation at 19, 21 & 25w. | 3 infants were BF post maternal IFX treatment. | At approximately 12 months, follow-up with all 3 infants showed normal development, no serious infections & routine vaccinations. | NR | 3 mothers with no detectable IFX in BM 7 to 43d post infusion. | Not detectable (<0.10 μg/mL detection limit). | n/a | Not detectable (2 infants with serum 10 to 57d postpartum) |
| Cohort Study19 | CD | 3 | -5mg/kg IFX prior to pregnancy & during pregnancy (frequency n/a) up until 28 and 30w GA in 2 pregnancies.  -IFX was initiated postpartum in all 3 mothers at 1w, 4 months & 6 months, respectively. | NR | BF was discontinued for all infants when IFX was resumed postpartum. | NR | NR | -IFX detectable in all serial BM samples collected to 8d post treatment from 2 mothers & in 1 sample provided 2d post from 1 mother. | 0.105 (0.02-0.105) | 2-3 days | NR |
| Prospective Registry3 | IBD | 228 | 228 mothers treated postpartum (dosage not specified). | NR | 168 infants were breastfed post maternal IFX treatment. | Infant outcomes at 12 months included several mAb, including IFX & found infection risk, 39% (P=.9992), and development milestone scores (P>.99) did not differ between infants BF post maternal mAb exposure & non-BF infants. | NR | -Serial BM samples in 29 mothers from 1h to 7d post infusion.  -19 had detectable IFX in BM & 17 detectable at 48h.  -5/8 mothers with serial samples had detectable IFX 48h to 7d post infusion. | 0.74 (0.15-0.74) | 24-48 hours | NR |
| Prospective Registry4 | IBD | 2 | 300mg administered postpartum at 2 frequencies (q4w & q8w) in 2 mothers. | Healthy infants delivered at term with one low birth weight (but reached 75th percentile by 11 months). | 2 infants were partially BF post maternal IFX treatment; 1 woman discontinued BF 5d post infusion 2 when IFX was detected in infant serum. | Followed up to 18 & 22 months with no serious infections. | NR | -IFX was detectable in all BM samples provided by 1 mother at 3w post IFX (BM:maternal serum 1:20) & 1 mother serially at 1d, 4d, & 4w (5d post repeat infusion) post treatment. | 0.2 (0.120-0.2) | NR (Only 1-2 samples were collected from each woman). | -IFX not detectable in 1 infant at 3w post maternal treatment  -IFX detected at 1.7μg/mL in a partially BF infant 5d post maternal follow-up infusion leading to stop BF. |
| **Natalizumab, NAT (α-4 Integrin)**  **NB: IgG4 Subclass** | MS | Case Report20 | MS | 1 | 300mg q4w initiated 11.5 months postpartum. | NR | Continued BF 3 times a day post maternal treatment. | NR | NR | -Serial BM samples from 1d to 50d post infusion 1 (repeat infusion at 29d).  -No detectable NAT 1-10d post-infusion 1.  -Detectable in all samples 14-50d post infusion. | 2.83 (n/a)  (Steady rise in concentration from repeat infusion on) | 21 days post infusion 2 (50 days post treatment initiation), but may continue to rise  (accumulation over time with repeat infusions) | - RID 1.74% (using Cavg.)  -RID 5.30% (using Cmax) |
| Cohort Study21 | MS | 11 (pregnancy) + 4 (BF) | -300mg q4w  -2 pregnancies continued NAT throughout; 1 discontinued in the 1st trimester but resumed later in pregnancy; 8 discontinued between 2 to 6 months before delivery.  -4 mothers received NAT in pregnancy & BF. | -3 women with MS flares during pregnancy (2 had discontinued NAT).  -All pregnancies resulted in live births. | 4 infants were BF post maternal NAT treatment. | -6/11 infants had hematological abnormalities at birth: anemia (N=5) & thrombocytopenia (N=3).  -Abnormalities were detected when mothers received NAT in the 3rd trimester. | Concentration of NAT 0.069-19.7μg/mL in infant serum collected at delivery | -NAT was detected in all BM samples provided by 4 mothers serially post 2-5 infusions up to 25w post treatment initiation. | 0.412 (0.02-0.412) | 46-170 days (post maternal infusion 1, maintenance infusion q4w) | NR |
| Prospective Registry3 | IBD | 12 | 12 mothers treated postpartum (dosage not specified). | NR | 8 infants BF post maternal treatment. | Infant outcomes at 12 months included several mAb, including NAT & found infection risk, 39% (P=.9992), & development milestone scores (P>.99) did not differ between infants BF post maternal mAb exposure & non-BF infants. | NR | -2 mothers provided BM samples in 1-48h post NAT.  -NAT detected in only 2 samples from 1 woman at 12 & 24h. | 0.46 (n/a) | 24 hours (only measured up to 48h) | NR |
| **Ranibizumab, RBZ (VEGF-A)** | Glioblastoma | Case Report6 | CNV | 1 | -Intravitreal BVZ with reduction of VEGF-A in BM post treatment.  -Retreated with intravitreal injections of RBZ 56d & 98d post BVZ. | NR | BF at time of treatment once with BVZ and twice with RBZ. | NR | NR | Serial BM up to 42d post RBZ.  BM was analyzed for VEGF-A concentration (not RBZ) with no observed reduction (unlike BVZ). | NR | NR | NR |
| **Rituximab, RTX (CD20)** | MS, NMOSD, MG, Autoimmune encephalitis | Case Report22 | GPA | 1 | -1000mg RTX twice 2 weeks apart 5 months before conception and within 4 months postpartum.  -Also received prednisone 5 mg daily in pregnancy. | Healthy, female infant delivered at term. | Exclusively BF post maternal RTX treatment. | Followed for 18 months with normal development and no serious infections. | NR | Detected in all BM sampled daily from 7-10d post RTX  (BM to maternal serum concentration ratio <1:240). | 0.6 (n/a) | 8 days (but measurements only began at day 7) | NR |
| Prospective Registry23 | MS | 9 | -4/9 mothers treated with RTX within 6 months prior to conception.  -All 9 mothers received either 1 or 2 (500mg or 1000mg) infusions between 1.5 to 11 months postpartum. | NR | 5 infants BF post maternal RTX treatment. | 4/5 infants followed between 8 to 12 months with normal development, routine vaccinations, and no serious infections. | NR | 9 mothers provided 30 BM samples (4 with serial samples) with detectable RTX from 8h to 90d post-infusion. | - Median Cmax 0.074 (0.061-0.12).  -Cmax in a single sample 11 days post RTX was 0.29 | 1-7 days | - Estimated 24h infant dose 9.4 μg/kg/d (based on Cavg).  -Median RID 0.08% (0.06-0.10%)  -RIDmax was 0.33% in a single sample 11d post infusion. |
| **Tocilizumab, TCZ (IL-6 Receptor)** | NMOSD | Case Report24 | AOSD | 1 | 400mg monthly TCZ continued during pregnancy & postpartum. | Healthy, female infant delivered at 40w5d. | Infant was BF post monthly maternal TCZ treatment. | Followed for 6 months with normal development, routine vaccinations & no serious infections. | Detected in infant serum at delivery & 5d life. Cmax infant serum at delivery 0.683μg/mL. | TCZ was detectable in all BM serial samples up to 32d post-infusion. | 0.215 (n/a) | 2.8 days | TCZ not detectable at 4w postpartum despite BF. |
| Case Series25 | RA | 2 | -400mg monthly prior to conception & continued until 5w & 9d GA, respectively.  -TCZ resumed at 5w & 9d after delivery. | -Healthy infants delivered 37w & 36w. | Both infants BF exclusively post maternal TCZ resumption for 9 & 11 months, respectively. | Followed for 9 & 13 months with normal development, routine vaccinations & no serious infections. | NR | TCZ was detectable in all BM serial samples up to 34d after 3 TCZ treatments in both mothers. (BM to maternal serum concentration ratio <1:500) | 0.148 (0.068-0.148) | 3 days | NR |
| Retrospective Registry26 | RA, SJIA, PJIA, MCD | 61 (53 mothers) | -TCZ discontinued prior to conception (N=10) or in 1st trimester (N=30).  -TCZ continued during pregnancy in 1 mother and resumed in 2. | -50 with delivery outcomes: 36 live births, 9 SABs, 5 induced abortions.  - 2 premature (24 unknown GA).  -No congenital abnormalities.  -5 had low birth weight and 1 died by neonatal asphyxia. | 2 continued BF post TCZ with no adverse events reported in infants. | NR | NR | NR | NR | NR | NR |
| Cohort Study27 | RA, AOSD | 4 | -400mg q4w before pregnancy; 3 discontinued TCZ after conception & 1 continued throughout pregnancy.  -All 4 resumed q4w TCZ postpartum. | -All 3 mothers discontinuing TCZ post conception had RA flare requiring steroids in pregnancy.  -All resulted in live births. | 4 infants were breastfed post maternal TCZ treatment. | NR | NR | -TCZ detectable in all BM serial samples from 4 mothers 11h to 24d post-infusion.  -Trough BM to serum ratio was calculated for 3 mothers with a range of 0.00082-0.0015. | (Median(range) maximum concentration): 0.113 (0.068-0.205) | 2.9-3.5 days | NR |
| **Ustekinumab, UST (IL-12 & IL-23)** | n/a | Case Report28 | Psoriasis | 2 (1 mother) | -Previously treated with ADA and switched to UST at 45mg/kg q12w before conception & discontinued in 1st trimester of both pregnancies.  -UST was resumed postpartum after both pregnancies. | Both pregnancies were delivered pre-term, with one low birth-weight. | Only 1 infant was BF post maternal UST treatment. | NR | NR | NR | NR | NR | NR |
| Case Report29 | CD | 1 | -390mg loading dose then 90mg q8w prior to conception & last dose during pregnancy at 30w GA.  -UST resumed at 7w postpartum with loading dose then q8w. | Healthy male infant delivered at 38w. | BF continued post maternal UST treatment. | Followed up to 12 months with normal development and health. | -Detected in cord blood (4.1μg/mL) at higher concentration than maternal serum. | -Detectable in BM at 1d, 3w & 4w post 3rd maintenance infusion & 16w after postpartum treatment initiation (after 2nd infusion)  -UST levels in BM decreased over time. | 3.2 (n/a) | 1 day post maintenance infusion (16 weeks after postpartum treatment initiation) | NR |
| Prospective Registry3 | IBD | 6 | 6 mothers treated postpartum, dosages not specified. | NR | 6 infants BF post maternal treatment. | Infant outcomes at 12 months included several mAb, including UST & found infection risk, 39% (P=.9992), and development milestone scores (P>.99) did not differ between infants BF post maternal mAb exposure & non-BF infants. | NR | -6 mothers provided serial samples from 1h to 7d post treatment.  -4 mothers had detectable UST in BM (only 3 with detectable concentrations beyond 48h). | 1.57 (0.72-1.57) | 12-72 hours | NR |
| **Vedolizumab, VDZ (α4β7)** | n/a | Cohort Study30 | IBD (CD & UC) | 8 | -8 mothers treated with 300mg VDZ at different frequencies (5 initiated treatment during pregnancy and 3 initiated postpartum). | NR | 8 infants were BF post maternal treatment. | Followed up to 10 months with normal development, no serious infections & routine vaccinations. | NR | -5 mothers provided serial BM samples 1d to 15d post infusion; all had detectable VDZ.  -BM concentration was >2 orders of magnitude less than maternal serum. | 0.478 (0.108-0.478) | 3-4 days | NR |
| Cohort Study31 | IBD | 5 | -VDZ initiated prior to the infusion of 300 mg after which breastmilk collection occurred. | NR | 5 infants were BF post maternal treatment. | Followed for 10 months with normal development & routine vaccinations. | NR | 5 mothers provided serial samples between 30 min to 14d post treatment; all had detectable VDZ.  -BM Cmax was 1/179th of that in maternal serum. | 0.318 (0.196-0.318) | 3-7 days | Max absolute dose to infant in 24h 0.048 mg/kg; VZD BM Cmax <1% of C in maternal serum |
| **KEY:** ADA=adalimumab, AOSD=adult onset Still’s disease, axSpA=axial spondyloarthritis, BF=breast feeding, BLQ=below the lower limit of quantification, BM=breastmilk, BVZ=bevacizumab, CD=Crohn’s Disease, CNV=choroidal neovascularization, CZP=certolizumab, GA=gestational age, GOL=golimumab, GPA=granulomatosis with polyangiitis, IBD= inflammatory bowel disease, IFX=infliximab, IPI=ipilimumab, mAb=monoclonal antibodies, MCD=multicentric Castleman’s disease, MG= myasthenia gravis, MS=multiple sclerosis, NAT=natalizumab, NMOSD= neuromyelitis optica spectrum disorder, NR=not reported or not performed, PJIA=polyarticular juvenile idiopathic arthritis, PNH=paroxysmal nocturnal hemoglobinuria, PsA=psoriatic arthritis, RA =rheumatoid arthritis, RBZ=ranibizumab, RID=relative infant dose, RTX=rituximab, SJIA=systemic juvenile idiopathic arthritis, SpA=spondyloarthritis, TCZ=tocilizumab, UC=ulcerative colitis, URTI= upper respiratory tract infection, UST=ustekinumab, UTI=urinary tract infection, VDZ=vedolizumab | | | | | | | | | | | | | |

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