

# New Zealand Datasheet

## 1 PRODUCT NAME

TRISEQUENS®

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

17 $\beta$ -oestradiol and Norethisterone acetate tablets.

## 3 PHARMACEUTICAL FORM

Trisequens calendar dial pack contains 28 tablets as described below:

12 blue, round, film coated tablets with diameter 6mm and stamped "Novo 280" on one side. The other side is plain. Each tablet contains 2mg of 17 $\beta$ -oestradiol and weighs about 80mg.

10 white, round, film coated tablets with diameter 6mm and stamped "Novo 281" on one side. The other side is plain. Each tablet contains 2mg of 17 $\beta$ -oestradiol and 1mg of norethisterone acetate and weighs about 80mg.

6 red, film coated tablets with diameter 6mm and stamped "Novo 282" on one side. The other side is plain. Each tablet contains 1mg of 17 $\beta$ -oestradiol and weighs about 80mg.

Excipient with known effect: lactose monohydrate. For the full list of excipients, see section 6.1.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Trisequens is indicated for the treatment of oestrogen deficiency syndrome, including prevention of bone mineral content loss in postmenopausal women at increased risk of developing fractures who are intolerant of, or contraindicated for, other medicinal products approved for the prevention of osteoporosis (see section 4.4).

The experience of treating women older than 65 years is limited.

### 4.2 Dose and method of administration

Trisequens is a continuous sequential HRT product for women with an intact uterus. The oestrogen is dosed continuously. The progestagen is added for 10 days of every 28 day cycle, in a sequential manner.

One tablet should be taken orally once a day without interruption, preferably at the same time of the day starting with oestrogen therapy (blue film-coated tablet) over 12 days, followed by 10 days' of oestrogen/progestagen therapy (white film-coated tablet) and 6 days' of oestrogen therapy (red film-coated tablet). A regular shedding of the endometrium is usually induced during the red tablet phase. After intake of the last red tablet, treatment is continued with the first blue tablet of a new pack on the next day.

In women who are not taking HRT or women in transition from a continuous combined HRT product, treatment with Trisequens may be started on any convenient day. In women in transition from another sequential HRT regimen treatment should begin the day following completion of the preceding regimen.

For initiation and continuation of treatment of postmenopausal symptoms, the lowest effective dose for the shortest duration (see section 4.4) should be used.

If the patient has forgotten to take a tablet, the tablet should be taken as soon as possible within the next 12 hours. If more than 12 hours have passed, the tablet should be discarded. Forgetting a dose may increase the likelihood of breakthrough bleeding and spotting.

### 4.3 Contraindications

- Known hypersensitivity to the active substances or to any of the excipients
- Known, past or suspected breast cancer
- Known, past or suspected oestrogen dependent malignant tumours e.g. endometrial cancer
- Porphyria
- Undiagnosed genital bleeding
- Untreated endometrial hyperplasia
- Previous or current venous thromboembolism (deep venous thrombosis, pulmonary embolism)
- Known thrombophilic disorders (e.g. protein C, protein S, or antithrombin deficiency (see section 4.4))
- Active or previous arterial thromboembolic diseases (e.g. angina, myocardial infarction)
- Acute liver disease, or a history of liver disease as long as liver function tests have failed to return to normal.

### 4.4 Special warnings and precautions for use

For the treatment of postmenopausal symptoms, HRT should only be initiated for symptoms that adversely affect quality of life. The benefits and risks of HRT must always be carefully weighed, including consideration of the emergence of risks as therapy continues. All prospective and current users should be informed of these risks and benefits. The need for treatment with HRT should be reviewed on a yearly basis and include a physical and gynaecological examination. HRT should be used only in women with menopausal symptoms and ordinarily not for the long term maintenance of general health as the risks of long term treatment with HRT in most circumstances outweigh the benefits. HRT should be prescribed at the lowest effective doses and for the shortest duration (generally not longer than 3-4 years), consistent with the treatment goals and risks for the individual women.

Evidence regarding the risks associated with HRT in the treatment of premature menopause is limited. Due to the low level of absolute risk in younger women, however, the balance of benefits and risks for these women may be more favourable than in older women.

#### Medical examination/follow-up

Before initiating or reinstating HRT, a complete personal and family medical history should be taken. Physical (including pelvic and breast) examination should be guided by this and by the contraindications and warnings for use. During treatment, periodic check-ups are recommended of a frequency and nature adapted to the individual woman. Women should be advised what changes in their breasts should be reported to their doctor or nurse (see Breast cancer below). Investigations, including appropriate imaging tools, e.g. mammography, should be carried out in accordance with currently accepted screening practices and modified to the clinical needs of the individual.

#### Conditions which need supervision

If any of the following conditions are present, have occurred previously, and/or have been aggravated during pregnancy or previous hormone treatment, the patient should be closely supervised. It should be taken into account that these conditions may recur or be aggravated during treatment with Trisequens, in particular:

- Leiomyoma (uterine fibroids) or endometriosis

- Risk factors for, thromboembolic disorders (see below)
- Risk factors for oestrogen-dependent tumours, e.g. 1st degree heredity for breast cancer
- Hypertension
- Liver disorders (e.g. liver adenoma)
- Diabetes mellitus with or without vascular involvement
- Cholelithiasis
- Migraine or (severe) headache
- Systemic lupus erythematosus
- A history of endometrial hyperplasia (see below)
- Epilepsy
- Asthma
- Otosclerosis

#### Reasons for immediate withdrawal of therapy

Therapy should be discontinued in case a contra-indication is discovered and in the following situations:

- Jaundice or deterioration in liver function
- Significant increase in blood pressure
- New onset of migraine-type headache
- Pregnancy

#### Endometrial hyperplasia and carcinoma

In women with an intact uterus the risk of endometrial hyperplasia and carcinoma is increased when oestrogens are administered alone for prolonged periods. The reported increase in endometrial cancer risk among oestrogen-only users varies from 2 to 12-fold compared with non-users, depending on the duration of treatment and oestrogen dose (see section 4.8). After stopping treatment, the risk may remain elevated for at least 10 years.

The addition of a progestagen cyclically for at least 10 days per month/28 day cycle or continuous combined oestrogen-progestagen therapy in non-hysterectomised women prevents the excess risk associated with oestrogen-only HRT.

Close clinical surveillance of all women taking oestrogens is important. Adequate diagnostic measures, including endometrial sampling when indicated, should be undertaken to rule out malignancy in all cases of undiagnosed persistent or recurring abnormal vaginal bleeding. There is no evidence that the use of "natural" oestrogens results in a different endometrial risk profile than synthetic oestrogens of equivalent oestrogen dose.

Breakthrough bleeding and spotting may occur during the first months of treatment. If breakthrough bleeding or spotting continues after the first months of treatment, appears after some time during therapy, or continues after treatment has been discontinued, the reason should be investigated, which may include endometrial biopsy to exclude endometrial malignancy.

#### Breast cancer

The overall evidence shows an increased risk of breast cancer in women taking combined oestrogen-progestagen or oestrogen-only HRT that is dependent on the duration of taking HRT.

The randomised placebo-controlled trial, the Women's Health Initiative study (WHI), and a meta-analysis of prospective epidemiological studies are consistent in finding an increased risk of breast cancer in women taking combined oestrogen-progestagen HRT that becomes apparent after about 3 (1-4) years (see section 4.8). Results from a large meta-analysis showed that after stopping treatment the excess risk will decrease with time and the time

needed to return to baseline depends on the duration of prior HRT use. When HRT was taken for more than 5 years, the risk may persist for 10 years or more.

HRT, especially oestrogen-progestagen combined treatment, increases the density of mammographic images which may adversely affect the radiological detection of breast cancer.

#### Ovarian cancer

Ovarian cancer is much rarer than breast cancer.

Epidemiological evidence from a large meta-analysis suggests a slightly increased risk in women taking oestrogen-only or combined oestrogen-progestagen HRT, which becomes apparent within 5 years of use and diminishes over time after stopping.

Some other studies, including the WHI trial, suggest that use of combined HRTs may be associated with a similar or slightly smaller risk (see section 4.8).

#### Venous thromboembolism

HRT is associated with a 1.3 to 3 fold risk of developing venous thromboembolism (VTE), i.e. deep vein thrombosis or pulmonary embolism. The occurrence of such an event is more likely in the first year of HRT than later (see section 4.8)

Patients with known thrombophilic states have an increased risk of VTE and HRT may add to this risk. HRT is therefore contraindicated in these patients (see section 4.3).

Generally recognised risk factors for VTE include use of oestrogens, older age, major surgery, prolonged immobilisation, obesity (BMI > 30 kg/m<sup>2</sup>) pregnancy/postpartum period, systemic lupus erythematosus (SLE) and cancer. There is no consensus about the possible role of varicose veins in VTE.

As in all postoperative patients, prophylactic measures need to be considered to prevent VTE following surgery. If prolonged immobilisation is to follow elective surgery temporarily stopping HRT 4 to 6 weeks earlier is recommended. Treatment should not be restarted until the woman is completely mobilised.

In women with no personal history of VTE but with a first degree relative with a history of VTE at a young age, screening may be offered after careful counselling regarding its limitations (only a proportion of thrombophilic defects are identified by screening).

If a thrombophilic defect is identified which segregates with VTE in family members or if the defect is 'severe' (e.g. antithrombin, protein S, or protein C deficiencies or a combination of defects), HRT is contraindicated. Women already on chronic anticoagulant treatment require careful consideration of the benefit-risk of use of HRT.

If VTE develops after initiating therapy, the drug should be discontinued. Patients should be told to contact their doctors immediately when they are aware of a potential thromboembolic symptom (e.g. painful swelling of a leg, sudden pain in the chest, dyspnoea).

#### Coronary artery disease (CAD)

There is no evidence from randomised controlled trials of protection against myocardial infarction in women with or without existing CAD who received combined oestrogen progestagen or oestrogen only HRT.

The relative risk of CAD during use of combined oestrogen-progestagen HRT is slightly increased. As the baseline absolute risk of CAD is strongly dependent on age, the number of

extra cases of CAD due to oestrogen-progestagen use is very low in healthy women close to menopause but will rise with more advanced age.

For the WHI study, a global index summarising the balance of risks and benefits included an analysis of the 2 primary outcomes, invasive breast cancer and CHD, and the following secondary outcomes: stroke, pulmonary embolism (PE), endometrial cancer, colorectal cancer, hip fracture, and death due to other causes. The women enrolled in the study had a mean age at entry of 63.3 years. On average they were overweight (mean body mass index [BMI] = 28.5) and one-third were obese (BMI $\geq$  30), 50% were previous or current smokers, one-third had received treatment for high blood pressure and over 10% had raised cholesterol levels requiring medication.

The oestrogen plus progestagen arm of the WHI study was prematurely stopped after an average follow-up of 5.2 years, based on the finding of increased breast cancer risk. The study also found increases in coronary heart disease, stroke, and pulmonary embolism in study participants on oestrogen plus progestin compared to women taking placebo pills. There were noteworthy benefits of oestrogen plus progestagen, including fewer cases of hip fractures and colon cancer, but on balance the harm was greater than the benefit (NHLBI press release July 9 2002)

**Table 1:** Increased Risks

	Relative Risk (RR)	Placebo arm: Cases/10000	CEE + MPA arm: Cases/10000	Increased Absolute Risk per 10000 women / year
Breast Cancer	1.26	30	38	8
Stroke	1.41	21	29	8
CHD	1.29	30	37	7
Thromboembolic Events (blood clots in legs and lungs)	2.11	16	34	18

**Table 2:** Decreased Risks

	Relative Risk (RR)	Placebo arm: Cases/10000	CEE + MPA arm: Cases/10000	Decreased Absolute Risk per 10000 women / year
Colorectal Cancer	0.63	16	10	6
Hip Fractures	0.66	15	10	5
Total Fractures	0.76	191	147	44

#### Ischaemic stroke

Combined oestrogen-progestagen and oestrogen-only therapy are associated with an up to 1.5-fold increase in risk of ischaemic stroke. The relative risk does not change with age or time since menopause. However, as the baseline risk of stroke is strongly age-dependent, the overall risk of stroke in women who use HRT will increase with age (see section 4.8).

#### Other conditions

Oestrogens may cause fluid retention, and therefore patients with cardiac or renal dysfunction should be carefully observed.

Women with pre-existing hypertriglyceridemia should be followed closely during oestrogen replacement or hormone replacement therapy, since rare cases of large increases of plasma triglycerides leading to pancreatitis have been reported with oestrogen therapy in this

condition.

Oestrogens increase thyroid binding globulin (TBG), leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 levels (by column or by radio-immunoassay) or T3 levels (by radio-immunoassay). T3 resin uptake is decreased, reflecting the elevated TBG. Free T4 and free T3 concentrations are unaltered. Other binding proteins may be elevated in serum, i.e. corticoid binding globulin (CBG), sex-hormone-binding globulin (SHBG) leading to increased circulating corticosteroids and sex steroids, respectively. Free or biological active hormone concentrations are unchanged. Other plasma proteins may be increased (angiotensinogen/renin substrate, alpha-1-antitrypsin and ceruloplasmin).

HRT use does not improve cognitive function. There is some evidence of increased risk of probable dementia in women who start using continuous combined or oestrogen-only HRT after the age of 65.

Trisequens tablets contain lactose monohydrate. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

#### 4.5 Interaction with other medicines and other forms of interaction

The metabolism of oestrogens and progestagens may be increased by concomitant use of substances known to induce drug-metabolising enzymes, specifically cytochrome P450 enzymes, such as anticonvulsants (e.g. phenobarbital, phenytoin, carbamazepin) and anti-infectives (e.g. rifampicin, rifabutin, nevirapine, efavirenz).

Ritonavir, telaprevir and nelfinavir, although known as strong inhibitors, by contrast exhibit inducing properties when used concomitantly with steroid hormones. Herbal preparations containing St John's Wort (*Hypericum perforatum*) may induce the metabolism of oestrogens and progestagens.

Clinically, an increased metabolism of oestrogens and progestagens may lead to decreased effect and changes in the uterine bleeding profile.

Drugs that inhibit the activity of hepatic microsomal drug metabolising enzymes e.g. ketoconazole, may increase circulating levels of the active substances in Trisequens.

Concomitant administration of cyclosporine may cause increased blood levels of cyclosporine, creatinine and transaminases due to decreased metabolism of cyclosporine in the liver.

#### 4.6 Fertility, pregnancy and lactation

##### **Effects on Fertility**

Not applicable

##### **Use in Pregnancy**

Known or suspected pregnancy is a contraindication of Trisequens therapy. If pregnancy occurs during medication with Trisequens, treatment should be withdrawn immediately.

Clinically data on a limited number of exposed pregnancies indicate adverse effects of norethisterone on the foetus. At doses higher than those normally used in OC and HRT formulations masculinisation of female foetuses was observed.

The results of most epidemiological studies to date relevant to inadvertent foetal exposure to

combinations of oestrogens and progestagens indicate no teratogenic or foetotoxic effect.

### Use in Lactation

Trisequens is not indicated during lactation.

### 4.7 Effects on ability to drive and use machines

Trisequens has no known effect on the ability to drive or use machines.

### 4.8 Undesirable effects

Clinical experience:

The most frequently reported adverse events in the clinical trials with Trisequens were vaginal bleeding and breast pain/tenderness, reported in approximately 10% to 20% of patients. Vaginal bleeding usually occurred in the first months of treatment. Breast pain usually disappeared after a few months of therapy. All adverse events observed in the randomised clinical trials with a higher frequency in patients treated with Trisequens or similar HRT products as compared to placebo and which on an overall judgement are possibly related to treatment are presented in the table below:

<b>System organ class</b>	<b>Very common ≥1/10</b>	<b>Common ≥1/100; &lt;1/10</b>	<b>Uncommon ≥1/1,000; &lt;1/100</b>	<b>Rare ≥1/10,000; &lt;1/1,000</b>
<b>Infections and infestations</b>		Genital candidiasis or vaginitis, see also Reproductive system and breast disorders		
<b>Immune system disorders</b>			Hypersensitivity, see also Skin and subcutaneous tissue disorders	
<b>Metabolism and nutrition disorders</b>		Fluid retention, see also General disorders and administration site conditions		
<b>Psychiatric disorders</b>		Depression or depression aggravated	Nervousness	
<b>Nervous system disorders</b>		Headache, migraine or migraine aggravated		
<b>Vascular disorders</b>			Thrombo-phlebitis superficial	Pulmonary embolism Thrombo-phlebitis deep
<b>Gastrointestinal disorders</b>		Nausea Abdominal pain, abdominal distension or abdominal discomfort	Flatulence or bloating	
<b>Skin and subcutaneous tissue disorders</b>			Alopecia, hirsutism or acne Pruritus or	

System organ class	Very common ≥1/10	Common ≥1/100; <1/10	Uncommon ≥1/1,000; <1/100	Rare ≥1/10,000; <1/1,000
			Urticaria	
<b>Musculoskeletal, connective tissue and bone disorders</b>		Back pain Leg cramps		
<b>Reproductive system and breast disorders</b>	Breast pain or breast tenderness  Menstruation irregular or menorrhagia	Breast oedema or breast enlargement Uterine fibroids aggravated or uterine fibroids re-occurrence or uterine fibroids	Endometrial hyperplasia Dysmenorrhoea See also back pain under Musculoskeletal, connective tissue and bone disorders and abdominal pain under Gastrointestinal disorders.	
<b>General disorders and administration site conditions</b>		Oedema peripheral	Drug ineffective	
<b>Investigations</b>		Weight increased		

#### Post-marketing experience

In addition to the above mentioned adverse drug reactions, those presented below have been spontaneously reported, and are by an overall judgment considered possibly related to Trisequens treatment. The reporting rate of these spontaneous adverse drug reactions is very rare (< 1/10,000, not known (cannot be estimated from the available data)). Post-marketing experience is subject to underreporting especially with regard to trivial and well known adverse drug reactions. The presented frequencies should be interpreted in that light:

- Neoplasms benign and malignant (including cysts and polyps): Endometrial cancer
- Immune system disorders: Generalised hypersensitivity reactions (e.g. anaphylactic reaction/shock)
- Psychiatric disorders: Insomnia, anxiety, libido decreased, libido increased
- Nervous system disorders: Dizziness, stroke
- Eye disorders: Visual disturbances
- Cardiac disorders: Myocardial infarction
- Vascular disorders: Hypertension aggravated
- Gastrointestinal disorders: Dyspepsia, vomiting
- Hepatobiliary disorders: Gall bladder disease, cholelithiasis, cholelithiasis aggravated, cholelithiasis recurrence
- Skin and subcutaneous tissue disorders: Seborrhoea, rash, angioneurotic oedema
- Reproductive system and breast disorders: Endometrial hyperplasia, vulvovaginal pruritus
- Investigations: Weight decreased, blood pressure increased

Other adverse reactions have been reported in association with oestrogen/progestagen treatment:

- Skin and subcutaneous disorders: Alopecia, chloasma, erythema multiforme, erythema nodosum, vascular purpura



- Probable dementia over the age of 65 (see section 4.4)

### Breast cancer risk

An up to 2-fold increased risk of having breast cancer diagnosed is reported in women taking combined oestrogen-progestagen therapy for more than 5 years.

The increased risk in users of oestrogen-only therapy is lower than that seen in users of oestrogen-progestagen combinations.

The level of risk is dependent on the duration of use (see section 4.4).

Absolute risk estimations based on results of the largest randomised placebo-controlled trial (WHI study) and largest meta-analysis of prospective epidemiological studies are presented below.

### **Largest meta-analysis of prospective Epidemiological Studies – Estimated additional risk of breast cancer after 5 years' use in women with BMI 27 (kg/m<sup>2</sup>)**

Age at start HRT (years)	Incidence per 1,000 never-users of HRT over 5 years period (50-54 years)*	Risk ratio	Additional cases per 1,000 HRT users after 5 years
<b>Oestrogen-only HRT</b>			
50	13.3	1.2	2.7
<b>Combined oestrogen-progestagen</b>			
50	13.3	1.6	8.0
* Taken from baseline incidence rates in England in 2015 in women with BMI 27 (kg/m <sup>2</sup> ). Note: Since the background incidence of breast cancer differs by EU country, the number of additional cases of breast cancer will also change proportionately.			

### **Estimated additional risk of breast cancer after 10 years' use in women with BMI 27 (kg/m<sup>2</sup>)**

Age at start HRT (years)	Incidence per 1,000 never-users of HRT over a 10-year period (50-54 years) *	Risk ratio	Additional cases per 1,000 HRT users after 10 years
<b>Oestrogen-only HRT</b>			
50	26.6	1.3	7.1
<b>Combined oestrogen-progestagen</b>			
50	26.6	1.8	20.8
* Taken from baseline incidence rates in England in 2015 in women with BMI 27 (kg/m <sup>2</sup> ). Note: Since the background incidence of breast cancer differs by EU country, the number of additional cases of breast cancer will also change proportionately.			

### **US WHI Studies – Additional risk of breast cancer after 5 years' use**

Age range (years)	Incidence per 1,000 women in placebo arm over 5 years	Risk ratio and 95% CI	Additional cases per 1,000 HRT users over 5 years' use (95% CI)
<b>CEE oestrogen-only</b>			
50-79	21	0.8 (0.7-1.0)	-4 (-6-0)*

<b>CEE+MPA oestrogen-progestagen**</b>			
50-79	17	1.2 (1.0-1.5)	4 (0-9)
* WHI study in women with no uterus which did not show an increase in risk of breast cancer. ** When the analysis was restricted to women who had not used HRT prior to the study, there was no increased risk apparent during the first 5 years of treatment. After 5 years the risk was higher than in non-users.			

### Endometrial cancer risk

The endometrial cancer risk is about 5 in every 1,000 women with a uterus not using HRT.

In women with a uterus, use of oestrogen-only HRT is not recommended because it increases the risk of endometrial cancer (see section 4.4).

Depending on the duration of oestrogen-only use and oestrogen dose, the increase in risk of endometrial cancer in epidemiological studies varied from between 5 and 55 extra cases diagnosed in every 1,000 women between the ages of 50 and 65.

Adding a progestagen to oestrogen-only therapy for at least 12 days per cycle can prevent this increased risk. In the Million Women Study the use of 5 years of combined (sequential or continuous) HRT did not increase the risk of endometrial cancer (RR of 1.0 (0.8-1.2)).

### Ovarian cancer risk

Use of oestrogen-only or combined oestrogen-progestagen HRT has been associated with a slightly increased risk of having ovarian cancer diagnosed (see section 4.4).

A meta-analysis from 52 epidemiological studies reported an increased risk of ovarian cancer in women currently using HRT compared to women who have never used HRT (RR 1.43, 95% CI 1.31-1.56). For women aged 50 to 54 years taking 5 years of HRT, results in about 1 extra case per 2,000 users. In women aged 50 to 54 who are not taking HRT, about 2 women in 2,000 will be diagnosed with ovarian cancer over a 5-year period.

### Risk of venous thromboembolism

HRT is associated with a 1.3 to 3-fold increased relative risk of developing venous thromboembolism (VTE), i.e. deep vein thrombosis or pulmonary embolism. The occurrence of such an event is more likely in the first year of using HRT (see section 4.4). Results of the WHI studies are presented below.

### **WHI Studies – Additional risk of VTE over 5 years' use**

<b>Age range (years)</b>	<b>Incidence per 1,000 women in placebo arm over 5 years</b>	<b>Risk ratio and 95% CI</b>	<b>Additional cases per 1,000 HRT users over 5 years use (95% CI)</b>
<b>Oral oestrogen-only*</b>			
50-59	7	1.2 (0.6-2.4)	1 (-3-10)
<b>Oral combined oestrogen-progestagen</b>			
50-59	4	2.3 (1.2-4.3)	5 (1-13)
* Study in women with no uterus			

### Risk of coronary artery disease

The risk of coronary artery disease is slightly increased in users of combined oestrogen progestagen HRT over the age of 60 (see section 4.4).

### Risk of ischaemic stroke

The use of oestrogen-only and oestrogen-progestagen therapy is associated with an up to 1.5 fold increased relative risk of ischaemic stroke. The risk of haemorrhagic stroke is not increased during use of HRT.

This relative risk is not dependent on age or on duration of use, but the baseline risk is strongly age-dependent. The overall risk of stroke in women who use HRT will increase with age (see section 4.4).

#### WHI Studies Combined – Additional risk of ischaemic stroke\* over 5 years' use

Age range (years)	Incidence per 1,000 women in placebo arm over 5 years	Risk ratio and 95% CI	Additional cases per 1,000 HRT users over 5 years' use (95% CI)
50-59	8	1.3 (1.1-1.6)	3 (1-5)

\* No differentiation was made between ischaemic and haemorrhagic stroke.

#### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions at <https://nzphvc.otago.ac.nz/reporting>.

## 4.9 Overdose

### Symptoms

Nausea and vomiting.

### Treatment

There is no specific antidote and treatment should be symptomatic. For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Progestagens and oestrogens, sequential preparations, ATC code G03FB05

Oestrogen and progestagen for continuous sequential hormone replacement therapy (HRT).

Oestradiol: The active ingredient, synthetic 17 $\beta$ -oestradiol, is chemically and biologically identical to endogenous human estradiol. It substitutes for the loss of oestrogen production in menopausal women, and alleviates menopausal symptoms.

Oestrogens prevent bone loss following menopause or ovariectomy.

Norethisterone acetate: Synthetic progestagen with actions similar to those of progesterone, a natural female sex hormone. As oestrogens promote the growth of the endometrium, unopposed oestrogens increase the risk of endometrial hyperplasia and cancer. The addition of a progestagen reduces the oestrogen-induced risk of endometrial hyperplasia in non-hysterectomised women.

Relief of menopausal symptoms is achieved during the first few weeks of treatment.

Regular withdrawal bleeding occurred in 93% of the women with a mean duration of 3-4 days.

Oestrogen deficiency at menopause is associated with an increased bone turnover and decline in bone mass. The effect of oestrogens on the bone mineral density is dose-dependent. Protection appears to be effective for as long as treatment is continued. After discontinuation of HRT, bone mass is lost at a rate similar to that in untreated women.

Evidence from the WHI trial and meta-analysis of trials show that current use of HRT, oestrogen alone or in combination with a progestagen – given to predominantly healthy women – reduces the risk of hip, vertebral and other osteoporotic fractures. HRT may also prevent fractures in women with low bone density and/or established osteoporosis, but the evidence for that is limited.

Studies based on measurement of bone mineral content have shown that Trisequens is effective in the prevention of osteoporosis in postmenopausal women. After 2 years of treatment, bone mineral density in the spine had increased by 5.14% and in the hip by 3.21%.

## 5.2 Pharmacokinetic properties

Following oral administration of 17 $\beta$ -oestradiol in micronised form, rapid absorption from the gastrointestinal tract occurs. It undergoes extensive first-pass metabolism in the liver and other enteric organs, and reaches a peak plasma concentration of approximately 44 pg/ml (range 30-53 pg/ml) within 6 hours after intake of 2 mg. The half-life of 17 $\beta$ -oestradiol is about 18 hours. It circulates bound to SHBG (37%) and to albumin (61%), while only approximately 1-2% is unbound. Metabolism of 17 $\beta$ -estradiol occurs mainly in the liver and the gut but also in target organs, and involves the formation of less active or inactive metabolites, including oestrone, catecholestrogens and several oestrogen sulfates and glucuronides. Oestrogens are excreted by the bile, hydrolysed and reabsorbed (enterohepatic circulation), and mainly eliminated in urine in biologically inactive form.

After oral administration norethisterone acetate is rapidly absorbed and transformed to norethisterone (NET). It undergoes first-pass metabolism in the liver and other enteric organs, and reaches a peak plasma concentration of approximately 9 ng/ml (range 6-11 ng/ml) within 1 hour after intake of 1 mg. The terminal half-life of NET is about 10 hours. NET binds to SHBG (36%) and to albumin (61%). The most important metabolites are isomers of 5 $\alpha$ -dihydro-NET and of tetrahydro-NET, which are excreted mainly in the urine as sulfate or glucuronide conjugates.

The pharmacokinetics of oestradiol is not influenced by norethisterone acetate.

The pharmacokinetic properties in the elderly have not been studied.

## 5.3 Preclinical safety data

The toxicity profiles of estradiol and norethisterone acetate are well known. There are no preclinical data of relevance to the prescriber which are additional to that already included in other sections of the datasheet.

# 6 PHARMACEUTICAL PARTICULARS

## 6.1 List of excipients

The tablet cores of the blue, white and red tablets contain:

Lactose monohydrate

Maize starch

Hydroxypropylcellulose  
Talc  
Magnesium Stearate

Film-coating:

Blue tablets: Hypromellose  
Talc  
Indigo carmine E 132  
Titanium dioxide E 171  
Macrogol 400

White tablets: Hypromellose  
Talc  
Triacetin

Red tablets: Hypromellose  
Talc  
Red Iron Oxide E172  
Titanium dioxide E171  
Propylene glycol

## 6.2 Incompatibilities

Not applicable.

## 6.3 Shelf life

The shelf-life for Trisequens tablets is 48 months.

## 6.4 Special precautions for storage

Store below 25°C

Do not refrigerate

Store in a dry place

Keep the container in the outer carton in order to protect it from light

Keep out of the sight and reach of children.

## 6.5 Nature and contents of container

Trisequens is supplied in a calendar dial pack containing 28 tablets.

### **Nature of the container**

The calendar dial pack with 28 tablets consists of the following three parts:

- The base made of coloured non-transparent polypropylene
- The ring-shaped lid made of transparent polystyrene
- The centre-dial made of coloured non-transparent polystyrene.

### **User Instructions**

#### **How to use the calendar pack**

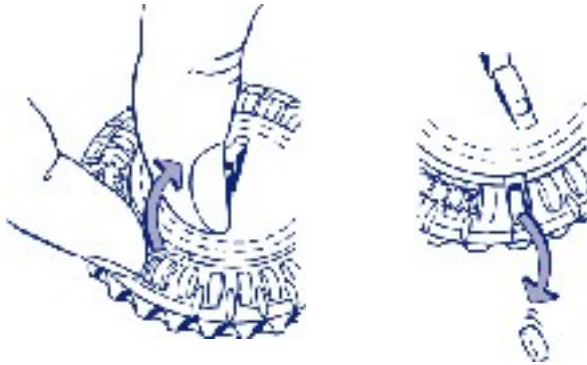
##### **1. Set the day reminder**

Turn the inner disc to set the day of the week opposite the little plastic tab.



## 2. Take the first day's tablet

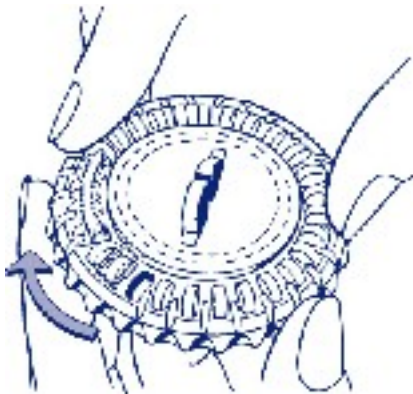
Break the plastic tab and tip out the first tablet.



## 3. Move the dial every day

On the next day simply move the transparent dial clockwise 1 space as indicated by the arrow. Tip out the next tablet. Remember to take only 1 tablet once a day.

**You can only turn the transparent dial after the tablet in the opening has been removed.**



## 6.6 Special precautions for disposal

Any unused product or waste material should be disposed of in accordance with local requirements.

## 7 MEDICINE SCHEDULE

Prescription Medicine.

## 8 SPONSOR

Novo Nordisk Pharmaceuticals Ltd

PO Box 51-268  
Pakuranga  
Auckland

Tel: (09) 916 5590  
Fax: (09) 916 5595

## **9 DATE OF FIRST APPROVAL**

6 December 1990

## **10 DATE OF REVISION OF THE TEXT**

6 October 2020  
CCDS v.18

Trisequens is a trade name owned by Novo Nordisk Health Care AG

## SUMMARY TABLE OF CHANGES

Section changed	Summary of new information
4.5	Updated data on breast cancer added
4.8	Updated data on breast cancer added