CERVARIX

SCHEDULING STATUS:

S2

1. NAME OF THE MEDICINE:

CERVARIX

Human Papillomavirus vaccine Types 16 and 18 (Recombinant AS04 adjuvanted). Suspensions for injection.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION:

1 dose (0,5 mL) contains:

Human Papillomavirus type 16 L1 protein[1]	20 µg
Human Papillomavirus type 18 L1 protein[1]	20 µg
3-*O*-desacyl-4'- monophosphoryl lipid A (MPL)[2]	50 µg
Aluminium hydroxide, hydrated[2]	0,5 mg Al^{3+}

[1] L1 protein in the form of non-infectious virus-like particles (VLPs) produced by recombinant DNA technology using a Baculovirus expression system

[2] The GlaxoSmithKline proprietary $AS0_4$ adjuvant system is composed of aluminium hydroxide and 3-*O*-desacyl-4'- monophosphoryl lipid A (MPL) (see section 5.1)

Sugar-free

For full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM:

Suspensions for injection.

CERVARIX is presented as a turbid white suspension. Upon storage, a fine white deposit with a clear colourless supernatant can be observed.

4. CLINICAL PARTICULARS:

4.1 Therapeutic indications:

CERVARIX is indicated from the age of 9 years for the prevention of persistent infection, premalignant anogenital lesions (cervical, vulvar, vaginal and anal) and cervical, vulvar, vaginal and anal cancers (squamous-cell carcinoma and adenocarcinoma) caused by oncogenic Human Papillomaviruses (HPV) (see section 5.1 and section 4.3).

4.2 Posology and method of administration:

Posology:

The vaccination schedule depends on the age of the subjects.

Age at the time of the first injection	Immunization and schedule
9 to and including 14 years*	Two doses each of 0,5 mL. The second dose given between 5 and 13 months after the first dose
From 15 years and above	Three doses each of 0,5 mL at 0, 1, 6 months**

* If the second vaccine dose is administered before the 5th month after the first dose, a third dose should always be administered.

**If flexibility in the vaccination schedule is necessary, the second dose can be administered between 1 month and 2,5 months after the first dose and the third dose between 5 and 12 months after the first dose.

Although the necessity for a booster dose has not been established, an anamnestic response has been observed after the administration of a challenge dose (see section 5.1).

Paediatric population (children < 9 years of age):

CERVARIX is not recommended for use in children below 9 years of age due to limited data on safety and immunogenicity in this age group.

Method of administration:

CERVARIX is for intramuscular injection in the deltoid region (see section 4.3).

4.3 Contraindications:

CERVARIX should not be administered to subjects with known hypersensitivity to any component of the vaccine (see section 2 and section 6.1).

4.4. Special warnings and precautions for use:

Syncope (fainting) can occur following, or even before, any vaccination as a psychogenic response to the needle injection. It is important that procedures are in place to avoid injury from faints.

As with other vaccines, the administration of CERVARIX should be postponed in subjects suffering from acute severe febrile illness. However, the presence of a minor infection, such as a cold, should not result in the deferral of vaccination.

CERVARIX should under no circumstances be administered intravascularly or intradermally. No data are available on subcutaneous administration of CERVARIX.

As for other vaccines administered intramuscularly, CERVARIX should be given with caution to individuals with thrombocytopenia or any coagulation disorder since bleeding may occur following an intramuscular administration to these subjects.

As with any vaccine, a protective immune responses may not be elicited in all vaccinees.

CERVARIX is a prophylactic vaccine. It is not intended to prevent progression of HPV-related lesions present at the time of vaccination.

Vaccination is primary prevention and is not a substitute for regular cervical screening (secondary prevention) or for precautions against exposure to HPV and sexually transmitted diseases.

Except for asymptomatic human immunodeficiency virus (HIV) infected subjects for whom data are available (see section 5.1), there are no data on the use of CERVARIX in subjects with

impaired immune responsiveness such as patients receiving immunosuppressive treatment. For these individuals an adequate immune response may not be elicited.

Duration of protection has not fully been established. Sustained protective efficacy has been observed for up to 9,4 years after the first dose. Long-term studies are ongoing to establish the duration of protection (see section 5.1).

It is good clinical practice to precede vaccination by a review of the medical history (especially with regard to previous vaccination and possible occurrence of undesirable events) and a clinical examination.

As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of a rare anaphylactic event following the administration of the vaccine.

HPV-16 and HPV-18 are not responsible for all cervical cancers (see section 5.1). Other oncogenic HPV types can also cause cervical cancer. HPV infections and related clinical outcomes due to these other types may not be prevented by vaccination. CERVARIX does not provide protection against all oncogenic HPV types (see section 5.1).

CERVARIX contains less than 1 mmol sodium (23 mg) per dose, that is to say essentially 'sodium-free'.

4.5. Interactions with other medicines and other forms of interaction:

Use with other vaccines:

CERVARIX can be given concomitantly with any of the following vaccines: reduced antigen diphtheria-tetanus-acellular pertussis vaccine (dTpa), inactivated poliovirus vaccine (IPV) and the combined dTpa-IPV vaccine; meningococcal serogroups A, C, W-135, Y tetanus toxoid conjugate vaccine (MenACWY-TT); hepatitis A (inactivated) vaccine (HepA), hepatitis B (rDNA) vaccine (HepB) and the combined HepA-HepB vaccine.

Administration of CERVARIX at the same time as Twinrix (combined HepA-HepB vaccine) has shown no clinically relevant interference in the antibody response to the HPV and hepatitis A antigens. Anti-HBs geometric mean antibody titers were lower on co-administration, but the

clinical significance of this observation is not known since the seroprotection rates remain unaffected. The proportion of subjects reaching anti-HBs ≥ 10 mIU/ml was 98,3 % for concomitant vaccination and 100 % for Twinrix alone.

If CERVARIX is to be given at the same time as another injectable vaccine, the vaccines should always be administered at different injection sites.

Use with hormonal contraceptive:

In clinical efficacy studies, approximately 60 % of women who received CERVARIX used hormonal contraceptives. There is no evidence that the use of hormonal contraceptives has an impact on the efficacy of CERVARIX.

As with other vaccines it may be expected that, in patients receiving immunosuppressive treatment, an adequate response may not be elicited.

4.6 Fertility, pregnancy and lactation:

Pregnancy: The effect of CERVARIX on embryo-foetal, peri-natal and post-natal survival and development has been assessed in rats. Such animal studies do not indicate direct or indirect harmful effects with respect to fertility, pregnancy, embryonal/foetal development, parturition or post-natal development.

Data in pregnant women collected as part of clinical trials, pregnancy registries and epidemiological studies do not suggest that vaccination with CERVARIX alters the risk of abnormal outcomes in neonates including birth defects. Data are insufficient to conclude whether or not vaccination with CERVARIX affects the risk of spontaneous abortion.

Women who are pregnant or trying to become pregnant, are advised to postpone vaccination until completion of pregnancy.

Lactation: The effect on breastfed infants of the administration of CERVARIX to their mothers has not been evaluated in clinical studies.

CERVARIX should only be used during breastfeeding when the possible advantages outweigh the possible risks.

Serological data suggest a transfer of anti-HPV16 and anti-HPV18 antibodies via the milk during the lactation period in rats. However, it is unknown whether vaccine-induced antibodies are excreted in human breast milk.

4.7 Effect on ability to drive and use machines:

No studies on the effects on the ability to drive or use machines have been performed.

4.8 Undesirable effects:

Summary of the safety profile:

In clinical studies a total of approximately 45 000 doses of CERVARIX were administered to approximately 16 000 female subjects aged 9-72 years and approximately 7 800 doses were administered to approximately 2 600 male subjects aged 10-18 years. These subjects were followed to assess the safety of the vaccine.

The most common reaction observed after vaccine administration was injection site pain which occurred after 78 % of all doses. The majority of these reactions were of mild to moderate severity and were not long lasting.

Adverse reactions considered as being at least possibly related to vaccination have been categorised by frequency.

Tabulated list of adverse events:

Clinical trials:

Frequencies are reported as:

Very common (≥ 1/10)

Common (≥ 1/100 to < 1/10)

Uncommon (≥ 1/1 000 to < 1/100)

Rare (≥ 1/10_000, < 1/1_000).

Table 1 Adverse events reported in clinical trials:

System Organ Class	Frequency	Adverse reaction
Infections and infestations	Uncommon	upper respiratory tract infection
Blood and lymphatic system disorders	Uncommon	Lymphadenopathy
Nervous system disorders	Very common Uncommon	Headache Dizziness
Gastrointestinal disorders	Common	Gastrointestinal symptoms including nausea, vomiting, diarrhoea and abdominal pain
Skin and subcutaneous tissue disorders	Common	Itching/pruritus, rash, urticaria
Musculoskeletal and connective tissue and bone disorders	Very common Common	Myalgia Arthralgia
General disorders and administration site conditions	Very common	Injection site reactions including pain, redness, swelling; fatigue
	Common	Fever (≥ 38 °C)
	Uncommon	Other injection site reactions such as induration, local paraesthesia

Post-marketing Data:

As the following events were reported spontaneously, it is not possible to reliably estimate their frequency.

Immune system disorders:

Unknown: allergic reactions (including anaphylactic and anaphylactoid reactions), angioedema

Nervous system disorders:

Unknown: syncope or vasovagal responses to injection, sometimes accompanied by tonic-clonic movements.

Reporting of suspected adverse events:

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Health care providers are asked to report any suspected adverse reactions to SAHPRA via the "6.04 Adverse Drug Reactions Reporting Form", found online under SAHPRA's publications: https://www.sahpra.org.za/Publications/Index/8.

4.9 Overdose:

Insufficient data are available.

5. PHARMACOLOGICAL PROPERTIES:

A 30.2 Antigens

5.1 Pharmacodynamic Properties:

Mechanism of Action:

Persistent infection with oncogenic HPV types has been demonstrated to be responsible for virtually all cases of cervical cancer worldwide.

CERVARIX is a non-infectious recombinant vaccine prepared from the highly purified viruslike particles (VLPs) of the major capsid L1 protein of oncogenic HPV types 16 and 18. Since the VLPs contain no viral DNA, they cannot infect cells, reproduce or cause disease. Animal

studies have shown that the efficacy of L1 VLP vaccines is largely mediated by the development of a humoral immune response and cell-mediated immune memory.

CERVARIX is adjuvanted with AS04 which has been shown in clinical trials to induce a higher and long lasting immune response compared to the same antigens adjuvanted with aluminium salt [$Al(OH)_3$] alone.

Invasive cervical cancer includes squamous cervical carcinoma (84 %) and adenocarcinoma (16 %, up to 20 % in developed countries with screening programs).

HPV-16 and HPV-18 are responsible for approximately 70 % of cervical cancers, 80 % of valvar and vaginal cancers, 90 % of anal cancers, 70 % of HPV related high-grade vulvar (VIN 2/3) and vaginal intra-epithelial neoplasma (VaIN 2/3) and 78 % of HPV related high-grade anal (AIN 2/3) intraepithelial neoplasma across all regions worldwide. Other oncogenic HPV types (HPV-31, -33, -35, -39, -45, -51, -52, -56, -58, -59, -66, -68) can also cause ano-genital cancers. HPV-16, -18, -45 and -31 are the 4 most common types identified in squamous cervical carcinoma (approximately 76 %) and adenocarcinoma (approximately 91 %).

Evidence of Anamnestic (Immune Memory) Response:

The administration of a challenge dose after a mean of 6,8 years following the first vaccination elicited an anamnestic immune response to HPV-16 and HPV-18 (by ELISA and pseudovirion-based neutralizing assay) at day 7. One month after the challenge dose, GMTs exceeded those observed one month after the primary vaccination course.

An anamnestic response was also observed for the related types HPV-31 and HPV-45 by ELISA.

Prophylactic Vaccine Efficacy:

Clinical efficacy in women aged 15-25 years:

The efficacy of CERVARIX was assessed in 2 controlled, double-blind, randomised clinical studies (HPV-001/007 and HPV-008) that included a total of 19 778 women aged 15 to 25 years at enrollment.

The clinical trial HPV-001/007 was conducted in North America and Latin America. Study HPV-023 followed-up subjects from the Brazilian cohort of study 001/007. Study entry criteria were: negative for oncogenic HPV DNA (HPV-16, -18, -31, -33, -35, -39, -45, -51, -52, -56, -58, -59, -66 and -68) in cervical samples, seronegative for HPV-16 and HPV-18 antibodies and normal cytology.

These characteristics are representative of a population presumed naïve to oncogenic HPV types prior to vaccination.

The clinical trial HPV-008 was conducted in North America, Latin America, Europe, Asia Pacific and Australia. Pre-vaccination samples were collected for oncogenic HPV DNA (HPV-16, -18, -31, -33, -35, -39, -45, -51, -52, -56, -58, -59, -66 and -68) testing and serum testing for HPV-16 and HPV-18 antibodies. Women were vaccinated regardless of baseline cytology and HPV serological and DNA status. These characteristics are representative of a population which includes women with evidence of past and/or current HPV infection.

As in any prophylactic efficacy trial, subjects initially infected with a particular HPV type were not eligible for the efficacy assessment of that type.

In both studies the following endpoints were evaluated:

- CIN2+ (cervical intra-epithelial neoplasia grade 2 and higher-grade lesions)
- CIN1+ (cervical intra-epithelial neoplasia grade 1 and higher-grade lesions)
- cytological abnormalities including atypical squamous cells of undetermined significance (ASC-US), low grade squamous intra-epithelial lesions (LSIL), high grade squamous intraepithelial lesions (HSIL) and ASC-US of suspected high grade (ASCH)
- 6 month persistent infection is defined as at least 2 positive samples with the same HPV type over a minimum interval of 5 months
- 12 month persistent infection is defined as at least 2 positive samples with the same HPV type over a minimum interval of 10 months.

In study HPV-008, the following endpoints were also evaluated:

- CIN3+ (cervical intra-epithelial neoplasia grade 3 and higher-grade lesions)
- VIN1+ (vulvar intra-epithelial neoplasia grade 1 and higher-grade lesions)

- VaIN1+ (vaginal intra-epithelial neoplasia grade 1 and higher-grade lesions).

Cervical intra-epithelial neoplasia (CIN) grade 2 and 3 (CIN2+) was used in the clinical trials as a surrogate marker for cervical cancer. Persistent infection that lasts for at least 6 months has also been shown to be a relevant surrogate marker for cervical cancer. Although CIN1 is not a surrogate marker for cervical cancer, these lesions require medical follow-up.

1. **Vaccine efficacy against HPV-16/18 in women naïve to oncogenic HPV types (studies HPV-001/007/023)**

   Efficacy results for histological endpoints associated with HPV-16 and/or HPV-18 (HPV-16/18) observed in study HPV-001/007 (Total Cohort i.e. women who received at least one vaccine dose) are presented in Table 1 below.

   Table 1: Vaccine efficacy against CIN2+ and CIN1+ associated with HPV-16/18

HPV-16/18 endpoint	CERVARIX N = 481	Control (Aluminium salt) N = 470	% Efficacy (95% CI)
	Number of cases		
CIN2+	0	9	100 % (51,3; 100)
CIN1+	0	15	100 % (73,4; 100)

   Efficacy against HPV-16/18 cytological abnormalities was 96,7 % (95 % CI: 87,3; 99,6).

   Efficacy against HPV-16/18 persistent infection was 98,2 % (95 % CI: 89,5; 100) and 96,9 % (95 % CI: 81,4; 99,9) when using a 6-month and a 12-month definition, respectively.

   In study HPV-023, subjects (N = 437) were followed-up to 9,4 years (approximately 113 months) after dose one. There were no new cases of infection or histopathological lesions associated with HPV-16/18 in the vaccine group. In the placebo group, there were 4 cases of 6-month persistent infection, 1 case of 12-month persistent infection and 1 case of CIN1+ associated with HPV-16/18.

   In the descriptive combined analysis of studies HPV-001/007/023, efficacy against HPV-16/18 incident and 6-month persistent infection was 91,0 % (95 % CI: 80,2; 96,5) and 96,8 % (95 % CI: 80,4; 99,9), respectively.

Despite evidence of continuous exposure to HPV infections as observed in the control group, there is no evidence of waning protection in vaccinated women.

2. Vaccine efficacy in woman with evidence of past and/or current HPV infection (study HPV-008):

In study HPV-008, the primary analyses of efficacy were performed on the 'According to Protocol cohort' (ATP cohort: including women who received 3 vaccine doses and were naïve to the relevant HPV type at month 0 and month 6) and the 'Total Vaccinated Cohort-1' (TVC-1 cohort: including women who received at least one vaccine dose and were naïve to the relevant HPV type at month 0). Both cohorts included women with normal or low-grade cytology at baseline and excluded only women with high-grade cytology (0,5 %).

In addition, analyses of efficacy were performed on the broader 'Total Vaccinated Cohort' (TVC*:* including all vaccinated women) and TVC-naïve (including all vaccinated subjects (who received at least one dose of vaccine) who had normal cytology, were HPV DNA negative for 14 oncogenic HPV types and seronegative for HPV-16 and HPV-18 at baseline).

2.1 Summary of efficacy results:

In study HPV-008, statistically significant vaccine efficacy against HPV-16/18 was demonstrated in the ATP cohort and the TVC-1 cohort for the following endpoints (see section 2.2.1 for detailed efficacy results):

- Histological endpoints:
  - CIN2+ and CIN1+ (Tables 2 and 3)

  In addition, statistically significant vaccine efficacy against CIN2+ was demonstrated for HPV-16 and HPV-18 individually
- Virological and cytological endpoints
  - 6-month and 12-month persistent infection (Table 4)
  - cytological abnormalities (≥ ASCUS) (Table 4)

- Vulvar and vaginal endpoints
  - VIN1+ or VaIN1+.

In addition to vaccine efficacy against HPV-16 and HPV-18, the following was demonstrated in study HPV-008:

- Vaccine efficacy against CIN3+, CIN2+ and CIN1+ irrespective of HPV DNA type in the lesion and regardless of initial serostatus was demonstrated in the TVC and TVC-naïve cohorts. TVC-1 and the broader TVC cohort. In the same cohorts, CERVARIX was also efficacious in reduction of local cervical therapy (see section 2.2.2 for detailed efficacy results).
- Vaccine efficacy against other non-vaccine oncogenic HPV types was demonstrated in the ATP cohort and the TVC-1 cohort (see section 2.2.3 for detailed efficacy results).

2.2 Detailed efficacy results:

2.2.1 Prophylactic efficacy against HPV-16/18 in women with current or prior oncogenic HPV infection:

In study HPV-008, approximately 26 % of women had evidence of current and/or prior HPV 16/18 infection and less than 1 % of women were HPV DNA positive for both HPV-16 and HPV-18 types at baseline.

The final analysis of study HPV-008 was event-triggered, i.e. was performed when at least 36 CIN2+ cases associated with HPV-16/18 were accrued in the ATP cohort. The mean follow-up was approximately 39 months - post dose one.

End of study analysis was performed at the end of the 4-year follow-up period (i.e. 48 months post dose one) and included all subjects from the Total Vaccinated Cohort (TVC).

Table 2: Vaccine efficacy against CIN3+, CIN2+ and CIN1+ associated with HPV-16/18 - Protocol-specified analysis (ATP and TVC-1)

	Final study analysis			End of study analysis		
HPV 16/18 endpoint	CERVARIX	Control		CERVARIX	Control	

		N	n	N	n	% Efficacy (96,1% CI)	N	n	N	n	% Efficacy (95 % CI)
CIN3+	**ATP**[1]	7,344	2	7,312	10	80,0 % (0,3; 98,1)	7,338	2	7,305	24	91,7 % (66,6; 99,1)
	TVC-1[2]	8,040	2	8,080	22	90,9 % (60,8; 99,1)	8,068	2	8,103	40	95,0 % (80,7;99,4)
CIN2+	**ATP**[1]	7,344	4	7,312	56	92,9 % (79,9; 98,3)	7,338	5	7,305	97	94,9 % (87,7; 98,4)
	TVC-1[2]	8,040	5	8,080	91	94,5 % (86,2; 98,4)	8,068	6	8,103	135	95,6 % (90,1; 98,4)
CIN1+	**ATP**[1]	7,344	8	7,312	96	91,7 % (82,4; 96,7)	7,338	12	7,305	165	92,8 % (87,1; 96,4)
	TVC-1[2]	8,040	11	8,080	135	91,8 % (84,5; 96,2)	8,068	15	8,103	210	92,9 % (88,0; 96,1)

N = number of subjects included in each group
n = number of cases
(1) 3 doses of vaccine, DNA negative and seronegative at month 0 and DNA negative at month 6 to the relevant HPV type (HPV-16 or HPV-18)
(2) at least one dose of vaccine, DNA negative and seronegative at month 0 to the relevant HPV type (HPV-16 or HPV-18)

In addition, at the time of final study analysis, statistically significant vaccine efficacy against CIN2+ associated with HPV-16 and HPV-18 individually was demonstrated for both cohorts in the protocol-specified analysis.

Further investigation identified that several CIN3+, CIN2+ and CIN1+ cases had multiple oncogenic HPV types in the lesion. In order to distinguish between the HPV type(s) most likely to be responsible for a lesion, from the HPV type(s) only temporally associated, an HPV type assignment was applied (exploratory analysis). The HPV type assignment considered the HPV types detected by Polymerase Chain Reaction (PCR) in at least one of the two preceding cytologic samples, in addition to types detected in the lesion. Based on this HPV type assignment, the analysis excluded CIN1+ and CIN2+ cases (in the vaccine group and in the control group) which were not considered to be causally associated with HPV-16 or HPV-18 infections acquired during the trial (see Table below).

Table 3: Vaccine efficacy against CIN3+, CIN2+ and CIN1+ associated with HPV-16/18 - HPV type assignment (ATP and TVC-1)

HPV 16/18 endpoint		Final study analysis					End of study analysis				
		CERVARIX		Control		% Efficacy (96,1 % CI)	CERVARIX		Control		% Efficacy (95 % CI)
		N	n	N	n		N	n	N	n	
CIN3+	**ATP**[1]	7,344	0	7,312	8	100 % (36,4; 100)	7,338	0	7,305	22	100 % (81,8; 100)
	TVC-1[2]	8,040	0	8,080	20	100 % (78,1; 100)	8,068	0	8,103	38	100 % (89,8; 100)
CIN2+	**ATP**[1]	7,344	1	7,312	53	98,1 % (88,4; 100)	7,338	1	7,305	92	98,9 % (93,8; 100)

	TVC-1[2]	8,040	2	8,080	87	97,7 % (91,0; 99,8)	8,068	2	8,103	128	98,4 % (94,3; 99,8)
CIN1+	**ATP**[1]	7344	2	7312	90	97,8 % (91,4; 99,8)	7338	3	7305	154	98,1 % (94,3; 99,6)
	TVC-1[2]	8040	5	8080	128	96,1 % (90,3; 98,8)	8068	6	8103	196	97,0 % (93,3; 98,9)

N = number of subjects included in each group
n = number of cases
(1) 3 doses of vaccine, DNA negative and seronegative at month 0 and DNA negative at month 6 to the relevant HPV type (HPV-16 or HPV-18)
(2) at least one dose of vaccine, DNA negative and seronegative at month 0 to the relevant HPV type (HPV-16 or HPV-18)

In addition, *at the time of final study analysis,* statistically significant vaccine efficacy against CIN2+ associated with HPV-16 and HPV-18 individually was demonstrated for both cohorts in the HPV type assignment.

Table 4: Vaccine efficacy against virological and cytological endpoints associated with HPV-16/18 (ATP and TVC-1)

HPV 16/18 endpoint		**Final study analysis**					**End of study analysis**				
		CERVARIX		**Control**		**% Efficacy**	**CERVARIX**		**Control**		**% Efficacy**
		N	**n**	**N**	**n**	**(96,1 % CI)**	**N**	**n**	**N**	**n**	**(95% CI)**
Virological endpoints											
6 month persistent infection	**ATP**[1]	7,177	29	7,122	488	94,3 % (91,5; 96,3)	7,182	35	7,137	588	94,3 % (92,0; 96,1)
	TVC-1[2]	7,941	67	7,964	661	90,2 % (87,3; 92,6)	7,976	73	7,999	770	91,0 % (88,5; 93,0)
12-month persistent infection	**ATP**[1]	7,035	20	6,984	227	91,4 % (86,1; 95,0)	7,082	26	7,038	354	92,9 % (89,4; 95,4)
	TVC-1[2]	7,812	51	7,823	340	85,3 % (79,9; 89,4)	7,864	58	7,880	478	88,2 % (84,5; 91,2)
Cytological endpoint											
Cytological abnormalities (≥ASCUS)	**ATP**[1]	7,340	48	7,312	427	89,0 % (84,9; 92,7)	7,334	55	7,305	575	90,7 % (87,8; 93,1)
	TVC-1[2]	8,040	75	8,080	553	86,7 % (82,8; 89,8)	8,068	84	8,103	714	88,6 % (85,6; 91,0)

N = number of subjects included in each group
n = number of cases
(1) 3 doses of vaccine, DNA negative and seronegative at month 0 and DNA negative at month 6 to the relevant HPV type (HPV-16 or HPV-18)
(2) at least one dose of vaccine, DNA negative and seronegative at month 0 to the relevant HPV type (HPV-16 or HPV-18)

At the time of the final study analysis, statistically significant vaccine efficacy against VIN1+ or VaIN1+ associated with HPV-16/18 was observed in both cohorts: 80,0 % (96,1 % CI: 0,3; 98,1) in the ATP cohort and 83,2 % (96,1 % CI: 20,2; 98,4) in the TVC-1 cohort. At the end of study analysis, vaccine efficacy against VIN1+ or VaIN1+ associated with HPV-16/18 was 75,1 % (95 % CI: 22,9; 94,0) in ATP cohort and 77,7 % (95 % CI: 32,4; 94,5) in TVC-1 cohort. There were 2 cases of VIN2+ or VaIN2+ associated with HPV-16 or HPV-18 in the vaccine group and 7 cases in the control group

in the ATP cohort. The study was not powered to demonstrate a difference between the vaccine and the control group for these endpoints.

There was no evidence of protection from disease caused by the HPV types for which subjects were HPV DNA positive at study entry. However, individuals already infected with one of the vaccine-related HPV types prior to vaccination were protected from clinical disease caused by the other vaccine HPV type.

2.2.2 Overall impact of the vaccine on HPV disease burden:

The overall vaccine efficacy irrespective of HPV DNA type in the lesion and stratified by baseline HPV DNA and serostatus was evaluated in study HPV-008.

In the TVC and TVC-naïve cohorts which included all vaccinated women, vaccine efficacy against CIN3+, CIN2+ and CIN1+ was demonstrated (Table 5). The impact of CERVARIX on reduction of local cervical therapy (Loop Electro-Excision Procedure, Cone, Knife or Laser) was also demonstrated in the same cohorts (Table 5).

The TVC-naïve is a subset of the TVC that includes women with normal cytology, and who were HPV DNA negative for 14 oncogenic HPV types (HPV-16, -18, -31, -33, -35, -39, -45, -51, -52, -56, -58, -59, -66, -68) and seronegative for HPV-16 and HPV-18 at baseline.

Editorial change

Table 5: Vaccine efficacy irrespective of HPV DNA type in the lesion, regardless of initial serostatus

		Final study analysis					End of study analysis				
		CERVARIX		Control		% Efficacy (96,1 % CI)	CERVARIX		Control		% Efficacy (95 % CI)
		N	n	N	n		N	n	N	n	
CIN3+	TVC naïve [1]	5,449	3	5,436	23	87,0 % (54,9; 97,7)	5,466	3	5,452	44	93,2 % (78,9; 98,7)
	TVC [2]	8,667	77	8,682	116	33,4 % (9,1; 51,5)	8,694	86	8,708	158	45,6 % (28,8; 58,7)
CIN2+	TVC naïve [1]	5,449	33	5,436	110	70,2 % (54,7; 80,9)	5,466	61	5,452	172	64,9 % (52,7; 74,2)
	TVC [2]	8,667	224	8,682	322	30,4 % (16,4; 42,1)	8,694	287	8,708	428	33,1 % (22,2; 42,6)
CIN1+	TVC naïve [1]	5,449	106	5,436	211	50,1 % (35,9; 61,4)	5,466	174	5,452	346	50,3 % (40,2; 58,8)
	TVC [2]	8,667	451	8,682	577	21,7 % (10,7; 31,4)	8,694	579	8,708	798	27,7 % (19,5; 35,2)

Local cervical therapy	**TVC naïve** (1)	5,449	26	5,436	83	68,8 % (50,0; 81,2)	5,466	43	5,452	143	70,2 % (57,8; 79,3)
	TVC (2)	8,667	180	8,682	240	24,7 % (7,4; 38,9)	8,694	230	8,708	344	33,2 % (20,8; 43,7)

N = number of subjects included in each group
n = number of cases
(1) TVC naïve: includes all vaccinated subjects (who received at least one dose of vaccine) who had normal cytology, were HPV DNA negative for 14 oncogenic HPV types and seronegative for HPV-16 and HPV-18 at baseline.
(2) TVC: includes all vaccinated subjects (who received at least one dose of vaccine).

2.2.3 Prophylactic efficacy against infection by oncogenic HPV types other than HPV-16 and HPV-18

In study HPV-008, vaccine efficacy against 12 non-vaccine oncogenic HPV types (HPV-31, -33, -35, -39, -45, -51, -52, -56, -58, -59, -66, -68) was evaluated in the ATP and the TVC-1 cohorts.

Vaccine efficacy against 6-month persistent infection and CIN2+ associated with individual non-vaccine oncogenic HPV types observed in the ATP cohort is presented in Table 6.

Table 6: Vaccine efficacy against non-vaccine oncogenic HPV types for 6-month persistent infection and CIN2+ (ATP cohort)

ATP cohort(1)						
6 month persistent infection						
HPV type	**Final study analysis**			**End of study analysis**		
	CERVARIX	**Control**	**% Efficacy (96,1 % CI)**	**CERVARIX**	**Control**	**% Efficacy (95 % CI)**
	n	**n**		**n**	**n**	
HPV-16 related types(2)						
HPV-31	45	199	77,5 % (68,3; 84,4)	58	247	76,8 % (69,0; 82,9)
HPV-33	55	100	45,1 % (21,7; 61,9)	65	117	44,8 % (24,6; 59.9)
HPV-35	55	43	-28,4 % (-100,3; 17,2)	67	56	-19,8 % (-74,1; 17.2)
HPV-52	293	315	7,4 % (-9,9; 22,0)	346	374	8,3 % (-6,5; 21,0)
HPV-58	111	101	-10,3 % (-48,0; 17,7)	144	122	-18,3 % (-51,8; 7,7)
HPV-18 related types(2)						
HPV-39	147	149	1,0 % (-26,7; 22,7)	175	184	4,8 % (-17,7; 23,1)
HPV-45	19	79	76,1 % (59,1; 86,7)	24	90	73,6 % (58,1; 83,9)
HPV-59	56	59	4,8 % (-42,4; 36,4)	73	68	-7,5 % (-51,8; 23,8)
HPV-68	138	134	-3,1 % (-33,4; 20,3)	165	169	2,6 % (-21,5; 21,9)
Other types(2)						

HPV-51	304	354	14,5 % (-0,8; 27,4)	349	416	16,6 % (3,6; 27,9)
HPV-56	182	174	-5,0 % (-31,5; 16,1)	226	215	-5,3 % (-27,5; 13,1)
HPV-66	168	178	5,7 % (-18,4; 24,9)	211	215	2,3 % (-18,7; 19,6)
CIN2+						
HPV type	**Final study analysis**			**End of study analysis**		
	CERVARIX	**Control**	**% Efficacy (96,1 % CI)**	**CERVARIX**	**Control**	**% Efficacy at end of study (95 % CI)**
	n	**n**		**n**	**n**	
HPV-16 related types[2]						
HPV-31	2	25	92,0 % (66,0; 99,2)	5	40	87,5 % (68,3; 96,1)
HPV-33	12	25	51,9 % (-2,9; 78,9)	13	41	68,3 % (39,7; 84,4)
HPV-35	1	6	83,3 % (-49,1; 99,7)	3	8	62,5 % (-56,5; 93,6)
HPV-52	12	14	14,3 % (-108,1; 65,4)	24	33	27,6 % (-26,3; 59,1)
HPV-58	6	17	64,5 % (1,5; 89,2)	15	21	28,5 % (-45,5; 65,7)
HPV-18 related types[2]						
HPV-39	3	10	69,8 % (-24,2; 95,2)	4	16	74,9 % (22,3; 93,9)
HPV-45[3]	0	4	100 % (-67,8; 100)	2	11	81,9 % (17,0; 98,1)
HPV-59	1	4	74,9 % (-178,6; 99,6)	1	5	80,0 % (-79,1; 99,6)
HPV-68	5	11	54,4 % (-49,8; 88,4)	11	15	26,8 % (-70,7; 69,6)
Other types[2]						
HPV-51	10	27	62,9 % (18,0; 84,7)	21	46	54,4 % (22,0; 74,2)
HPV-56	4	10	59,9 % (-47,1; 91,5)	7	13	46,1 % (-45,2; 81,8)
HPV-66	4	10	60,0 % (-46,7; 91,6)	7	16	56,4 % (-12,1; 84,8)

n = number of cases

[1] 3 doses of vaccine, DNA negative for the corresponding HPV type in the analysis at month 0 and month 6

[2] types are listed in numerical order and not according to epidemiological data

[3] the number of CIN2+ cases associated with HPV-45 on which the estimate of vaccine efficacy was based was limited.

At the time of the final study analysis, statistically significant vaccine efficacy against 6-month persistent infection has been observed for HPV types 31, 33 and 45 in the ATP cohort and for HPV types 31, 33, 45 and 51 in the TVC-1 cohort. Statistically significant vaccine efficacy against CIN2+ has been observed for HPV types 31, 51 and 58 in the ATP cohort and for HPV types 31, 33, 35 and 51 in the TVC-1 cohort.

At the end of study analysis, more cases were accrued and a lower limit of the 95 % CI above zero has been observed for HPV types 31, 33, 45 and 51 for both 6 month

persistent infection and CIN2+in the ATP and TVC-1 cohorts. For CIN2+, a lower limit of the 95 % CI above zero has also been observed for HPV type 39 in the ATP cohort and HPV type 66 in the TVC-1 cohort.

At the time of the final study analysis, *s*tatistically significant vaccine efficacy against CIN2+ for all HPV types combined (HPV-31, -33, -35, -39, -45, -51, -52, -56, -58, -59, -66, -68) excluding HPV types 16 and 18 was demonstrated with 54,0 % (96,1 % CI: 34,0; 68,4) in the ATP cohort and 46,0 % (96,1 % CI: 27,0; 60,3) in the TVC-1 cohort.

At the end of study analysis, vaccine efficacy against CIN2+ for all HPV types combined excluding HPV types 16 and 18 was 46,8 % (95 % CI: 30,7; 59,4) in the ATP cohort and 40,8 % (95 % CI: 25,5; 53,1) in the TVC-1 cohort.

Clinical efficacy in women aged 26 years and older:

The efficacy of CERVARIX was assessed in a double-blind, randomised Phase III clinical trial (HPV-015) that included a total of 5 778 women aged 26-72 (median: 37,0 years) years. The study was conducted in North America, Latin America, Asia Pacific and Europe. Final analysis was performed at study conclusion, 7 years after the first CERVARIX dose.

The primary endpoint was a combination of a virological and a histopathological endpoint: HPV-16/18 related 6-month persistent infection and/or CIN1+. The primary analyses of efficacy were performed on the ATP cohort for efficacy and the TVC which included a subset of up to 15 % of women with a history of HPV-associated infection or disease.

Vaccine efficacy at study conclusion is summarised in the following table.

Table 7 - Vaccine efficacy at study conclusion in study HPV-015

Endpoint	ATP(1)			TVC(2)		
	Cervarix n/N	Control n/N	% Efficacy (96,2 % CI)	Cervarix n/N	Control n/N	% Efficacy (96,2 % CI)
HPV-16/18						
6M PI and/or CIN1+	7/1852	71/1818	90,5 % (78,6; 96.5)	93/2768	209/2778	56,8 % (43,8; 67,0)
6M PI	6/1815	67/1786	91,4 % (79,4; 97,1)	74/2762	180/2775	60,0 % (46,4; 70,4)
ASC-US+	3/1852	47/1818	93,8 % (79,9; 98,9)	38/2727	114/2732	67,3 % (51,4; 78,5)
Cross protective efficacy						

HPV-31 6M PI	10/2073	29/2090	65,8 % (24,9; 85,8)	51/2762	71/2775	29,0 % (<0; 52,5)
HPV-45 6M PI	9/2106	30/2088	70,7 % (34,2; 88,4)	22/2762	60/2775	63,9 % (38,6; 79,6)
HPV-31 ASC-US+	5/2117	23/2127	78,4 % (39,1; 94,1)	34/2727	55/2732	38,7 % (2,0; 62,3)
HPV-45 ASC-US+	5/2150	23/2125	78,7 % (40,1; 94,1)	13/2727	38/2732	66,1% (32,7; 84,1)

N = number of subjects in each group
n = number of subjects reporting at least one event in each group
6M PI = 6-month persistent infection
CI = Confidence Interval
ASC-US = Atypical Cells of Undetermined Significance (abnormal cytology)
(1) 3 doses of vaccine, DNA negative and seronegative at month 0 (unless specified) and DNA negative at month 6 for the relevant HPV type (HPV-16 and/or HPV-18)
(2) at least one dose of vaccine, irrespective of HPV DNA and serostatus (unless specified) at month 0. Includes 15 % of subjects with previous history of HPV disease/infection

Clinical efficacy against anal prevalent infection in women aged 18-25 years:

Study HPV-009 evaluated vaccine efficacy against anal prevalent infection at the 4-year study visit. Vaccine efficacy against HPV-16/18 and against non-vaccine types HPV-31/33/45 is presented in Table 8. Cervical infection in the same women at the same visit was assessed for comparison purpose.

Table 8: Efficacy against anal and cervical prevalent infection associated with HPV-16/18 and HPV-31/33/45 in study HPV-009

		Number of women	***Number of HPV-16/18 infections***	***HPV 16/18 vaccine efficacy (95 % CI)***		***Number of women***	***Number of HPV-31/33/45 infection***	***HPV-31/33/45 vaccine efficacy (95 % CI)***
Full cohort*	***Anus***							
	HPV group	2 ,103	47	*62,0 % (47,1; 73,1)*	HPV group	2, 103	55	*49,4 % (30,3; 63,6)*
	Control group	2, 107	124		Control group	2 ,107	109	
	Cervix							
	HPV group	2, 103	40	76,4 % (67,0; 83,5)	HPV group	2 ,103	76	45,2 % (27,7; 58,7)
	Control group	2,107	170		Control group	2 ,107	139	
Restricted cohort	***Anus***							
	HPV group	1, 003	8	83,6 % (66,7; 92,8)	HPV group	1 ,629	31	61,8 % (42,8; 75,0)
	Control group	986	48		Control group	1, 684	84	
	Cervix							
	HPV group	*1, 003*	*10*	87,9 % (77,4; 94,0)	HPV group	1, 629	49	51,3 % (31,9; 65,5)
	Control group	*986*	*81*		Control group	1,684	104	

HPV group: treatment group vaccinated with CERVARIX vaccine
Control group: treatment group vaccinated with modified Havrix vaccine (Hepatitis A vaccine)

*Full cohort included all women with anal specimens available

** Restricted cohort for efficacy against HPV16/18 infection included subjects from the full cohort with no evidence of prevalent cervical HPV 16 and HPV 18 infection or HPV 16 and HPV 18 antibodies before vaccination, who received three doses of the HPV or control vaccines. Restricted cohort for efficacy against HPV-31/33/45 infection included women from the full cohort with no evidence of prevalent cervical HPV 31, 33, or 45 infections before vaccination, and who received three doses of the HPV or control vaccine.

Vaccine-Induced Immunogenicity:

The antibody response to HPV-16 and HPV-18 was measured using a type specific ELISA which was shown to strongly correlate with 21neutralization assays (including pseudovirion-based neutralizing assay developed by the US National Cancer Institute). Transudation of antibodies from serum to the cervical mucosa has been demonstrated in clinical trials.

The immunogenicity induced by three doses of CERVARIX has been evaluated in 5 303 female subjects from 9 to 55 years of age and over 800 male patients aged 10 to 18 years.

In clinical trials, more than 99 % of initially seronegative subjects had seroconverted to both HPV type 16 and 18 one month after the third dose. Vaccine-induced IgG Geometric Mean Titres (GMT) were well above titres observed in women previously infected but who cleared HPV infection (natural infection). Initially seropositive and seronegative subjects reached similar titres after vaccination.

Immunogenicity in women aged 15 to 25 years:

The immune response against HPV-16 and HPV-18 was evaluated up to 76 months (after first vaccination in study HPV-001/007) in women 15 to 25 years old at the time of vaccination. In study HPV-023, this immune response continued to be evaluated up to 9,4 years (113 months) after first vaccination in a subset of the population from study HPV-001/007.

In study HPV-023, 100 % of women were seropositive for both HPV-16 and HPV-18 by ELISA or by pseudovirion-based neutralizing assay (PBNA) up to 9,4 years after first vaccination.

Vaccine-induced IgG Geometric Mean Titres (GMT) for both HPV-16 and HPV-18 peaked at month 7 and then declined to reach a plateau from month 18, with no substantial decline up to the end of the follow-up period (month 113). At month 113 GMTs for both HPV-16 and HPV-18, were still at least 11-fold higher than titres observed in women previously infected but who

cleared HPV infection (natural infection) and 100 % of the women were seropositive for both antigens.

In study HPV-008, immunogenicity up to month 48 was similar to the response observed in study HPV-001/007. A similar kinetic profile was observed with the neutralising antibodies.

Bridging the efficacy of CERVARIX demonstrated in 15 to 25 year olds to other age groups:

In a pooled analysis, 99,7 % and 100 % of females aged 9 years seroconverted to HPV types 16 and 18, respectively after the third dose (at month 7) with GMTs at least 1,4-fold and 2,4-fold higher as compared to females aged 10-14 years and 15 to 25 years, respectively.

In two clinical trials performed in girls aged 10 to 14 years, all subjects seroconverted to both HPV type 16 and 18 after the third dose (at month 7) with GMTs at least 2-fold higher as compared to women aged 15 to 25 years.

In an ongoing clinical trial (HPV-070) performed in girls aged 9 to 14 years receiving a 2-dose schedule (0, 6 months or 0, 12 months), all subjects seroconverted to both HPV types 16 and 18, one month after the second dose. The immune response after 2 doses in females aged 9 to 14 years was demonstrated to be non-inferior to the immune response after 3 doses in women aged 15 to 25 years.

The efficacy of CERVARIX is inferred on the basis of immunogenicity data observed in girls vaccinated from age 9 to 14 years.

Duration of the immune response in women aged 26 years and older:

In the Phase III study (HPV-015) in women 26 years and older *all subjects seroconverted one month after the third dose*. At the 84-month time point, i.e. 78 months after completion of the full vaccination course, 99,3 % and 95,9 % of initially seronegative women remained seropositive for anti-HPV-16 and anti-HPV-18 antibodies, respectively. Antibody titers peaked at month 7 then gradually declined up to month 18 and stabilized to reach a plateau up to month 84.

In another clinical study (HPV-014) performed in women aged 15 to 55 years (*229 aged 15-25 years, 226 aged 26-45 years and 211 aged 46-55 years*), all *women* were seropositive to both HPV type 16 and 18 after the third dose (at month 7). The GMTs were*, however,* lower in *the 26-55 years old* population compared to women aged 15 to 25 years. *Subjects (142 aged 15-25 years, 172 aged 26-45 years and 156 aged 46-55 years) who completed study HPV-014 and received the 3 dose schedule were followed-up for up to 10 years in the extension study HPV-060. Ten years after administration of the first dose, 100 % of subjects in the 15-25 years group, 99,2 %*

in the 26-45 years group and 96,3 % in the 46-55 years group were still seropositive for HPV-16, and 99,2 %, 93,7 % and 83,8 % for HPV-18, respectively. In all age groups, GMTs remained 5- to 32-fold for HPV-16 and 3- to 14-fold for HPV-18 above those elicited in women who cleared a natural infection.

Comparison of immunogenicity of CERVARIX and Gardasil:

In girls aged 9 to 14 years:

In a comparison trial with Gardasil in girls aged 9-14 years, superiority of the immune response elicited by CERVARIX administered according to the 2-dose schedule 0, 6 months compared to that of Gardasil administered according to the 2-dose 0, 6 months and the standard 3-dose 0, 2, 6 months schedules was demonstrated for both HPV-16 and HPV-18 by ELISA.

In women aged 18 to 45 years:

In a non-inferiority comparative trial with Gardasil (study HPV-010) in women aged 18-45 years, non-inferiority of the immune response elicited by CERVARIX was demonstrated for both HPV-16 and HPV-18 neutralizing antibodies in all age cohorts up to 5 years after first vaccination.

Immunogenicity in HIV infected women:

Two clinical studies assessed safety and immunogenicity of CERVARIX:

1. A study performed in 120 asymptomatic HIV-infected females aged 18 to 25 years (61 subjects received CERVARIX) in South Africa (HPV-020)~~,~~
2. A comparative study of CERVARIX and Gardasil performed in 257 asymptomatic HIV-infected females aged 15-25 years (129 subjects received Cervarix) in Brazil, Estonia, India and Thailand (HPV-019).

In both studies, seroconversion at Month 7 in HIV-infected subjects receiving Cervarix was 100 % for both antigens. In HPV-019, seropositivity rate at Month 24 after Cervarix vaccination was 100 % for HPV-16 antibodies and >96 % for HPV-18 antibodies with a Geometric Mean Concentration (GMC) level more than 12 times higher than the response to natural HPV infection. In both studies the antibody GMCs observed in HIV-infected subjects appeared lower than in HIV negative subjects. The Clinical relevance of this observation is unknown.

In HPV-019, superiority of immune responses (neutralizing antibodies) to both HPV-16 (GMT ratio = 2,74 [95 % CI 1,83; 4,11]) and HPV-18 (GMT ratio = 7,44 [95 % CI 4,79; 11,54]) antigens was demonstrated with CERVARIX compared to Gardasil, at Month 7 in HIV-infected subjects.

The observed reactogenicity and safety profile of CERVARIX in HIV-infected women was in line with the known safety profile in healthy subjects (see section 4.8). The vaccine did not affect the CD4+ cell count, the HIV viral load and the HIV clinical stage.

Immunogenicity in males aged 10 to 18 years:

Immunogenicity in males was assessed in 2 clinical trials. The data showed comparable immunogenicity in males and females. In study HPV-011, all subjects seroconverted to both HPV-16 and -18 and GMT levels were non inferior to those observed in females aged 15 to 25 years in study HPV-012.

5.2 Pharmacokinetic properties:

Evaluation of pharmacokinetic properties is not required for vaccines.

5.3 Preclinical safety data:

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, acute and repeated dose toxicity, local tolerance, fertility, embryo-foetal and postnatal toxicity (up to the end of the lactation period).

6. PHARMACEUTICAL PARTICULARS:

6.1 List of Excipients:

Sodium chloride, sodium dihydrogen phosphate dihydrate, water for injections.

6.2 Incompatibilities:

In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products.

6.3 Shelf life:

60 months

6.4 Special Precautions for Storage:

Store in a refrigerator (+2 °C to +8 °C).

DO NOT FREEZE. DISCARD IF THE VACCINE HAS BEEN FROZEN.

Store in the original package in order to protect from light. A fine white deposit with a clear colourless supernatant may be observed upon storage of the syringe/vial. The content of the syringe/vial should be inspected visually both before and after shaking for any foreign particulate matter and/or abnormal physical appearance prior to administration. In the event of either being observed, discard the vaccine.

CERVARIX should be administered as soon as possible after being removed from the refrigerator. However, stability data generated indicate that CERVARIX presented in monodose containers remains stable and can be administered in case it has been stored

outside the refrigerator up to three days at temperatures between 8 °C and 25 °C or up to one day at temperatures between 25 °C and 37 °C.

After first opening of the multidose vial, immediate use is recommended. If not used immediately, the vaccine should be stored in a refrigerator (2 °C – 8 °C). If not used within 6 hours it should be discarded.

Keep out of reach of children.

For state packs only: The Vaccine Vial Monitor (VVM) is part of the label used for all Cervarix batches supplied by GlaxoSmithKline Biologicals. The colour dot that appears on the label of the vial is a VVM. This is a time-temperature sensitive dot that provides an indication of the cumulative heat to which the vial has been exposed. It warns the end user when exposure to heat is likely to have degraded the vaccine beyond an acceptable level.

The interpretation of the VVM is simple. Focus on the central square. Its colour will change progressively. As long as the colour of this square is lighter than the colour of the ring, then the vaccine can be used. As soon as the colour of the central square is the same colour as the ring or of a darker colour than the ring, then the glass container should be discarded.

It is absolutely critical to ensure that the storage conditions specified above (in particular the cold chain) are complied with. GlaxoSmithKline Biologicals will assume no liability in the event CERVARIX has not been stored in compliance with the storage instructions.

Furthermore, GlaxoSmithKline Biologicals assumes no responsibility in case a VVM is defective for any reason.

Inner square lighter than outer circle. **If the expiry date has not been passed, USE the vaccine.**

At a later time, inner square still lighter than outer circle. **If the expiry date has not been passed, USE the vaccine.**

Discard point: Inner square matches colour of outer circle. **DO NOT use the vaccine**.

Beyond the discard point: Inner square darker than outer ring. **DO NOT use the vaccine**.

6.5 Nature of contents and container:

0,5 mL of suspension in a pre-filled syringe (type I glass) with a plunger stopper (butyl rubber) with or without needles.

0,5 mL of suspension in a vial (type I glass) with a stopper (butyl rubber).

1 mL of suspension in a vial (type I glass) with a stopper (rubber butyl) for 2 doses.

6.6 Special precaution for disposal and other handling:

A fine white deposit with a clear colourless supernatant may be observed upon storage of the syringe/vial. This does not constitute a sign of deterioration.

The content of the syringe/vial should be inspected visually both before and after shaking for any foreign particulate matter and/or abnormal physical appearance prior to administration.

In the event of either being observed, discard the vaccine.

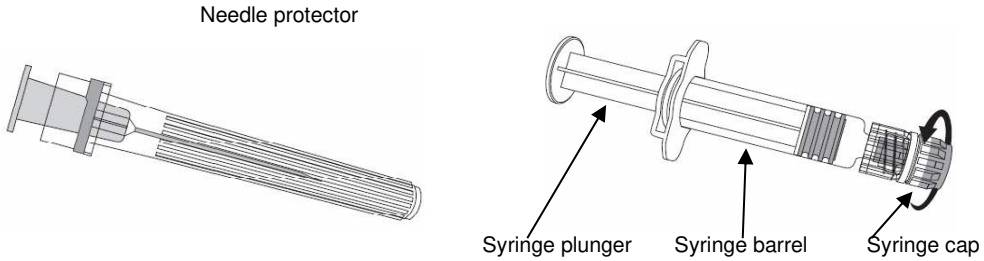
The vaccine should be well shaken before use.

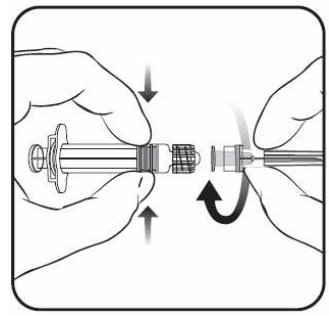
When using a multidose vial, each 0,5 mL dose should be withdrawn using a sterile needle and syringe; precautions should be taken to avoid contamination of the contents.

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

Instructions for administration of the vaccine presented in pre-filled syringe:

Needle Syringe





1. Holding the syringe barrel in one hand (avoid holding the syringe plunger), unscrew the syringe cap by twisting it anticlockwise.
2. To attach the needle to the syringe, twist the needle clockwise into the syringe until you feel it lock (see picture).
3. Remove the needle protector, which on occasion can be a little stiff.
4. Administer the vaccine.

7. HOLDER OF CERTIFICATE OF REGISTRATION:

GlaxoSmithKline South Africa (Pty) Ltd

39 Hawkins Avenue

Epping Industria 1, 7460

8. REGISTRATION NUMBER:

41/30.1/0366

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION:

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10. DATE OF REVISION OF TEXT:

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