

1. NAME OF THE MEDICINAL PRODUCT

Novofem®

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

One red film-coated tablet contains:
Estradiol 1 mg (as estradiol hemihydrate).

One white film-coated tablet contains:
Estradiol 1 mg (as estradiol hemihydrate) and norethisterone acetate 1 mg.

Excipient with known effect: lactose monohydrate:
Each red film-coated tablet contains lactose monohydrate 37.3 mg
Each white film-coated tablet contains lactose monohydrate 36.8 mg

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablets.

Red film-coated, biconvex tablets engraved with NOVO 282. Diameter: 6 mm.

White film-coated, biconvex tablets engraved with NOVO 283. Diameter: 6 mm.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Hormone Replacement Therapy (HRT) for oestrogen deficiency symptoms in postmenopausal women with an intact uterus.

Prevention of osteoporosis in postmenopausal women at a high risk of future fractures, who are tolerant of, or contraindicated for, other medicinal products approved for the prevention of osteoporosis.

The experience treating women older than 65 years is limited.

4.2 Posology and method of administration

Novofem is a continuous sequential HRT product for oral use. The oestrogen is dosed continuously. The progestagen is added for 12 days of every 28 day cycle, in a sequential manner.

One tablet is taken daily in the following order: oestrogen therapy (red film-coated tablet) over 16 days, followed by 12 days of oestrogen/progestagen therapy (white film-coated tablet).

After intake of the last white tablet, treatment is continued with the first red tablet of a new pack on the next day. A menstruation-like bleeding usually occurs at the beginning of a new treatment cycle.

In women who are not taking HRT or women in transition from a continuous combined HRT product, treatment with Novofem 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 also section 4.4) should be used.

A switch to a higher dose combination product could be indicated if the response after 3 months is insufficient for symptom relief.

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, past or suspected breast cancer
- Known, past or suspected oestrogen-dependent malignant tumours (e.g. endometrial cancer)
- 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 disease (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
- Hypersensitivity to the active substances or to any of the excipients listed in section 6.1
- Porphyria

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. In all cases, a careful appraisal of the risks and benefits should be undertaken at least annually and HRT should only be continued as long as the benefit outweighs the risk.

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 reinstituting 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 Novofem 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 contraindication 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 greater 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 12 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.

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/m²), 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 venous thromboembolism 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 venous thromboembolism 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).

Smoking

This product should not be prescribed to a woman who is a smoker, especially if she is older than 35, without careful medical evaluation.

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.

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).

Hypothyroidism

Patients who require thyroid hormone replacement therapy should have their thyroid function monitored regularly while on HRT to ensure that thyroid hormone levels remain in an acceptable range.

Angioedema

Oestrogens may induce or exacerbate symptoms of angioedema, in particular in women with hereditary angioedema.

Other conditions

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

Women with pre-existing hypertriglyceridaemia 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 radioimmunoassay) or T3 levels (by radioimmunoassay). 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-I-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.

Novofem 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 medicinal products 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.

Some laboratory tests may be influenced by oestrogen therapy, such as tests for glucose tolerance or thyroid function.

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

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

Pregnancy

Novofem is not indicated during pregnancy.

If pregnancy occurs during medication with Novofem, 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.

Lactation

Novofem is not indicated during lactation.

4.7 Effects on ability to drive and use machines

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

4.8 Undesirable effects

Clinical experience

The most frequently reported adverse events during treatment in clinical trials conducted with an HRT product similar to Novofem were breast tenderness and headache (reported in $\geq 10\%$ of patients).

The adverse events listed below may occur during oestrogen-progestagen treatment.

The frequencies are derived from clinical trials conducted with an HRT product similar to Novofem and from a Post-marketing Surveillance study on Novofem.

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
Infections and infestations		Vaginal candidiasis		
Immune system disorders				Allergic reaction
Psychiatric disorders				Nervousness
Nervous system disorders	Headache	Dizziness	Migraine	Vertigo
		Insomnia	Libido disorder NOS (not otherwise specified)	
		Depression		
Vascular disorders		Increased blood pressure Aggravated hypertension	Peripheral embolism and thrombosis	
Gastrointestinal disorders		Dyspepsia	Vomiting	Diarrhoea
		Abdominal pain		Bloating
		Flatulence		
		Nausea		
Hepatobiliary disorders			Gall bladder disease	
			Gallstones	
Skin and subcutaneous tissue disorders		Rash	Alopecia	Acne
		Pruritus		
Musculoskeletal and connective tissue disorders			Muscle cramps	
Reproductive system and breast disorders	Breast tenderness	Vaginal haemorrhage		Uterine fibroid
		Uterine fibroids aggravated		
General disorders and administration site conditions		Oedema		
Investigations		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 judgement considered possibly related to Novofem treatment. Frequences of these adverse events cannot be estimated from the available data:

- Neoplasms benign and malignant (including cysts and polyps): Endometrial cancer
- Immune system disorders: Generalised hypersensitivity reactions (e.g. anaphylactic reaction/shock)
- Psychiatric disorders: Anxiety
- Nervous system disorders: Stroke
- Eye disorders: Visual disturbances
- Cardiac disorders: Myocardial infarction
- Vascular disorders: Hypertension aggravated
- Hepatobiliary disorders: Cholelithiasis aggravated, cholelithiasis recurrence

- Skin and subcutaneous tissue disorders: Seborrhoea, angioneurotic oedema, hirsutism
- Reproductive system and breast disorders: Endometrial hyperplasia, vulvovaginal pruritus
- Investigations: Weight decreased.

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

- Skin and subcutaneous disorders: Chloasma, erythema multiforme, erythema nodosum, haemorrhagic eruption, vascular purpura
- Probable dementia over the age of 65 (see section 4.4)
- Dry eyes
- Tear film composition changes.

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 the 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/m²)

Age at start HRT (years)	Incidence per 1,000 never-users of HRT over a 5 year period (50-54 years)*	Risk ratio	Additional cases per 1,000 HRT users after 5 years
Oestrogen-only HRT			
50	13.3	1.2	2.7
Combined oestrogen-progestagen			
50	13.3	1.6	8.0

* Taken from baseline incidence rates in England in 2015 in women with BMI 27 (kg/m²).

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/m²)

Age at start HRT (years)	Incidence per 1,000 never-users of HRT over a 10 year period (50-59 years)*	Risk ratio	Additional cases per 1,000 HRT users after 10 years
Oestrogen-only HRT			
50	26.6	1.3	7.1
Combined oestrogen-progestagen			
50	26.6	1.8	20.8

* Taken from baseline incidence rates in England in 2015 in women with BMI 27 (kg/m²).

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)
CEE oestrogen-only			
50-79	21	0.8 (0.7-1.0)	-4 (-6-0)*
CEE+MPA oestrogen-progestagen**			
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, this 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

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)
Oral oestrogen-only*			
50-59	7	1.2 (0.6-2.4)	1 (-3-10)
Oral combined oestrogen-progestagen			
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.

Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form: <https://sideeffects.health.gov.il>

4.9 Overdose

Symptoms of over dosage with oral oestrogens are breast tenderness, nausea, vomiting and/or metrorrhagia. Overdosage of progestagens may lead to a depressive mood, fatigue, acne and hirsutism. Treatment should be symptomatic.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

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

Estradiol: The active ingredient, synthetic 17 β -estradiol, is chemically and biologically identical to endogenous human estradiol. It substitutes for the loss of oestrogen production in postmenopausal women and alleviates menopausal symptoms.

Oestrogens prevent bone loss following menopause or ovariectomy.

Norethisterone acetate: Synthetic progestagen. 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 postmenopausal symptoms is achieved during the first few weeks of treatment.

In a post-marketing study regular withdrawal bleeding with a mean duration of 3-4 days occurred in 91% of women who took Novofem over 6 months. Withdrawal bleeding usually started a few days after the last tablet of the progestagen phase.

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.

Randomised, double-blind, placebo-controlled studies showed that 1 mg estradiol prevents the postmenopausal loss of bone minerals and increases the bone mineral density. The responses in the spine, femoral neck and trochanter were 2.8%, 1.6% and 2.5%, respectively, over 2 years with 1 mg 17 β -estradiol unopposed.

5.2 Pharmacokinetic properties

Following oral administration of 17 β -estradiol in micronised form, rapid absorption from the gastrointestinal tract occurs. It undergoes extensive first-pass metabolism in the liver and other enteric organs, and a peak plasma concentration of approximately 27 pg/ml (range 13-40 pg/ml) occurs within 6 hours after intake of 1 mg. The area under the curve ($AUC_{(0-t_z)}$) = 629 h x pg/ml. The half-life of 17 β -estradiol is about 25 hours. It circulates bound to SHBG (37%) and to albumin (61%), while only approximately 1-2% is unbound. Metabolism of 17 β -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 with 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 area under the curve ($AUC_{(0-t_z)}$) = 29 h x pg/ml. 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 α -dihydro-NET and of tetrahydro-NET, which are excreted mainly in the urine as sulfate or glucuronide conjugates.

The pharmacokinetics of estradiol is not influenced by norethisterone acetate.

The pharmacokinetic properties in the elderly have not been studied.

5.3 Preclinical safety data

Animal studies with estradiol and norethisterone acetate have shown oestrogenic and progestagenic effects as expected. Both compounds induced adverse effects in preclinical reproductive toxicity studies, in particular embryotoxic effects and anomalies in urogenital tract development. Concerning other preclinical effects, the toxicity profiles of estradiol and norethisterone acetate are well-known and reveal no particular human risks beyond those discussed in other sections of the Summary of Product Characteristics and which generally apply to hormone substitution therapy.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Both the white and the red tablets contain:

Lactose monohydrate
Maize starch
Hydroxypropylcellulose
Talc
Magnesium stearate

Film-coating

White film-coated tablet:
Hypromellose, triacetin and talc.

Red film-coated tablet:
Hypromellose, talc, titanium dioxide (E 171), propylene glycol and red iron oxide (E 172).

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

The expiry date of the product is indicated on the packaging materials.

6.4 Special precautions for storage

Store below 25°C. Do not refrigerate. Keep the container in the outer carton in order to protect it from light.

6.5 Nature and contents of container

1 x 28 tablets in calendar dial pack.

The calendar dial pack with 28 tablets consists of the following 3 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.

6.6 Special precautions for disposal and other handling

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

7. Registration Holder:

Novo Nordisk Ltd.
1 Atir Yeda St.,
Kfar-Saba, 4464301

8. Manufacturer:

Novo Nordisk A/S
Novo Allé
DK-2880 Bagsværd
Denmark

9. Registration number:

127-11-30604

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