

# ETYQA - estradiol and norethindrone acetate tablet, film coated

## Aurobindo Pharma Limited

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### HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use ETYQA safely and effectively. See full prescribing information for ETYQA.

ETYQA (estradiol and norethindrone acetate) tablets, for oral use

Initial U.S. Approval: 1998

#### **WARNING: CARDIOVASCULAR DISORDERS, PROBABLE DEMENTIA, BREAST CANCER, and ENDOMETRIAL CANCER**

*See full prescribing information for complete boxed warning*

##### **Estrogen Plus Progestin Therapy**

- The Women's Health Initiative (WHI) estrogen plus progestin substudy reported increased risks of deep vein thrombosis (DVT), pulmonary embolism (PE), stroke and myocardial infarction (MI) (5.1)
- The WHI estrogen plus progestin substudy reported increased risks of invasive breast cancer (5.2)
- The WHI Memory Study (WHIMS) estrogen plus progestin ancillary study of WHI reported an increased risk of probable dementia in postmenopausal women 65 years of age and older (5.3)
- Do not use estrogen plus progestin therapy for the prevention of cardiovascular disease or dementia (5.1, 5.3)

##### **Estrogen-Alone Therapy**

- There is an increased risk of endometrial cancer in a woman with a uterus who use unopposed estrogens (5.2)
- The WHI estrogen-alone substudy reported increased risks of stroke and DVT (5.1)
- The WHIMS estrogen-alone ancillary study of WHI reported an increased risk of probable dementia in postmenopausal women 65 years of age and older (5.3)
- Do not use estrogen-alone therapy for the prevention of cardiovascular disease or dementia (5.2, 5.3)

#### **RECENT MAJOR CHANGES**

Warnings and Precautions, Malignant Neoplasms (5.2) 11/2023

#### **INDICATIONS AND USAGE**

Etyqa is an estrogen and progestin combination indicated in a woman with a uterus for:

- Treatment of Moderate to Severe Vasomotor Symptoms due to Menopause (1.1)
- Treatment of Moderate to Severe Symptoms of Vulvar and Vaginal Atrophy due to Menopause (1.2)

##### **Limitations of Use:**

When prescribing solely for the treatment of moderate to severe symptoms of vulvar and vaginal atrophy due to menopause, first consider the use of topical vaginal products.

- Prevention of Postmenopausal Osteoporosis (1.3)

##### **Limitations of Use:**

When prescribing solely for the prevention of postmenopausal osteoporosis, first consider the use of non-estrogen medications. Consider estrogen therapy only for women at significant risk of osteoporosis.

#### **DOSAGE AND ADMINISTRATION**

- Take a single Etyqa 1 mg/0.5 mg or 0.5 mg/0.1 mg tablet orally once daily for the Treatment of Moderate to severe Vasomotor Symptoms due to Menopause and for the Prevention of Postmenopausal Osteoporosis (2.1, 2.3)
- Etyqa 1 mg/0.5 mg tablets are taken orally once daily for the Treatment of Moderate to Severe Symptoms of Vulvar and Vaginal Atrophy due to Menopause (2.2)

## DOSAGE FORMS AND STRENGTHS

- Etyqa (estradiol and norethindrone acetate) 1 mg/0.5 mg tablet (3)
- Etyqa (estradiol and norethindrone acetate) 0.5 mg/0.1 mg tablet (3)

## CONTRAINDICATIONS

- Undiagnosed abnormal genital bleeding (4)
- Breast cancer or a history of breast cancer (4, 5.2)
- Estrogen-dependent neoplasia (4, 5.2)
- Active DVT, PE, or history of these conditions (4, 5.1)
- Active arterial thromboembolic disease (for example, stroke and MI), or a history of these conditions (4, 5.1)
- Known anaphylactic reaction, angioedema, or hypersensitivity to Etyqa (4)
- Hepatic impairment or disease (4, 5.10)
- Protein C, protein S, or antithrombin deficiency, or other known thrombophilic disorders (4)

## WARNINGS AND PRECAUTIONS

- Estrogens increase the risk of gall bladder disease (5.4)
- Discontinue estrogen if severe hypercalcemia, loss of vision, severe hypertriglyceridemia or cholestatic jaundice occurs (5.5, 5.6, 5.9, 5.10)
- Monitor thyroid function in women on thyroid replacement therapy (5.11, 5.18)

## ADVERSE REACTIONS

The most common adverse reactions (incidence  $\geq$  5 percent) with Etyqa are: back pain, headache, pain in the extremity, nausea, diarrhea, gastroenteritis, insomnia, emotional lability, upper respiratory tract infection, sinusitis, nasopharyngitis, weight increase, breast pain, post-menopausal bleeding, uterine fibroid vaginal hemorrhage, ovarian cyst, endometrial thickening, viral infection, moniliasis genital, and accidental injury. (6.1)

**To report SUSPECTED ADVERSE REACTIONS, contact Aurobindo Pharma USA, Inc. at 1-866-850-2876 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

## DRUG INTERACTIONS

- Inducers and/or inhibitors of CYP3A4 may affect estrogen drug metabolism and decrease or increase the estrogen plasma concentration. (7)

**See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.**

**Revised: 3/2024**

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## **FULL PRESCRIBING INFORMATION**

**WARNING: CARDIOVASCULAR DISORDERS, PROBABLE DEMENTIA,  
BREAST CANCER, and ENDOMETRIAL CANCER**

**Estrogen Plus Progestin Therapy**

**Cardiovascular Disorders and Probable Dementia**

The Women's Health Initiative (WHI) estrogen plus progestin substudy reported increased risks of deep vein thrombosis (DVT), pulmonary embolism (PE), stroke and myocardial infarction (MI) in postmenopausal women (50 to 79 years of age) during 5.6 years of treatment with daily oral conjugated estrogen (CE) [0.625 mg] combined with medroxyprogesterone acetate (MPA) [2.5 mg], relative to placebo [see *Warnings and Precautions (5.1)*, and *Clinical Studies (14.5)*].

The WHI Memory Study (WHIMS) estrogen plus progestin ancillary study of the WHI reported an increased risk of developing probable dementia in postmenopausal women 65 years of age and older during 4 years of treatment with daily CE (0.625 mg) combined with MPA (2.5 mg), relative to placebo. It is unknown whether this finding applies to younger postmenopausal women [see *Warnings and Precautions (5.3)*, *Use in Specific Populations (8.5)*, and *Clinical Studies (14.6)*].

Do not use estrogen plus progestogen therapy for the prevention of cardiovascular disease or dementia [see *Warnings and Precautions (5.1, 5.3)*, and *Clinical Studies (14.5, 14.6)*].

**Breast Cancer**

The WHI estrogen plus progestin substudy also demonstrated an increased risk of invasive breast cancer [see *Warnings and Precautions (5.2)*, and *Clinical Studies (14.5)*].

Only daily oral 0.625 mg CE and 2.5 mg MPA were studied in the estrogen plus progestin substudy of the WHI. Therefore, the relevance of the WHI findings regarding adverse cardiovascular events, dementia and breast cancer to lower CE plus other MPA doses, other routes of administration, or other estrogen plus progestogen products is not known. Without such data, it is not possible to definitively exclude these risks or determine the extent of these risks for other products. Discuss with your patient the benefits and risks of estrogen plus progestogen therapy, taking into account her individual risk profile.

Prescribe estrogens with or without progestogens at the lowest effective doses and for the shortest duration consistent with treatment goals and risks for the individual woman.

**Estrogen-Alone Therapy**

**Endometrial Cancer**

There is an increased risk of endometrial cancer in a woman with a uterus who uses unopposed estrogens. Adding a progestogen to estrogen therapy has been shown to reduce the risk of endometrial hyperplasia, which may be a precursor to endometrial cancer. Adequate

diagnostic measures, including directed or random endometrial sampling when indicated, should be undertaken to rule out malignancy in postmenopausal women with undiagnosed persistent or recurring abnormal genital bleeding [*see Warnings and Precautions (5.2)*].

#### **Cardiovascular Disorders and Probable Dementia**

The WHI estrogen-alone substudy reported increased risks of stroke and DVT in postmenopausal women (50 to 79 years of age) during 7.1 years of treatment with daily oral CE (0.625 mg)-alone, relative to placebo [*see Warnings and Precautions (5.1), and Clinical Studies (14.5)*].

The WHIMS estrogen-alone ancillary study of the WHI reported an increased risk of developing probable dementia in postmenopausal women 65 years of age and older during 5.2 years of treatment with daily CE (0.625 mg)-alone, relative to placebo. It is unknown whether this finding applies to younger postmenopausal women [*see Warnings and Precautions (5.3), Use in Specific Populations (8.5), and Clinical Studies (14.6)*].

**Do not use estrogen-alone therapy for the prevention of cardiovascular disease or dementia [*see Warnings and Precautions (5.1, 5.3), and Clinical Studies (14.5, 14.6)*].**

Only daily oral 0.625 mg CE was studied in the estrogen-alone substudy of the WHI. Therefore, the relevance of the WHI findings regarding adverse cardiovascular events and dementia to lower CE doses, other routes of administration, or other estrogen-alone products is not known. Without such data, it is not possible to definitively exclude these risks or determine the extent of these risks for other products. Discuss with your patient the benefits and risks of estrogen-alone therapy, taking into account her individual risk profile.

**Prescribe estrogens with or without progestogens at the lowest effective doses and for the shortest duration consistent with treatment goals and risks for the individual woman.**

## **1 INDICATIONS AND USAGE**

**Etyqa is indicated for:**

### **1.1 Treatment of Moderate to Severe Vasomotor Symptoms due to Menopause**

### **1.2 Treatment of Moderate to Severe Symptoms of Vulvar and Vaginal Atrophy due to Menopause**

#### **Limitation of Use**

When prescribing solely for the treatment of moderate to severe symptoms of vulvar

and vaginal atrophy due to menopause, first consider the use of topical vaginal products.

### **1.3 Prevention of Postmenopausal Osteoporosis**

#### **Limitation of Use**

When prescribing solely for the prevention of postmenopausal osteoporosis, first consider the use of non-estrogen medications. Consider estrogen therapy only for women at significant risk of osteoporosis.

## **2 DOSAGE AND ADMINISTRATION**

Use estrogen-alone, or in combination with a progestogen, at the lowest effective dose and the shortest duration consistent with treatment goals and risks for the individual woman. Reevaluate postmenopausal women periodically as clinically appropriate to determine whether treatment is still necessary.

### **2.1 Treatment of Moderate to Severe Vasomotor Symptoms due to Menopause**

Take a single Etyqa tablet orally once daily for the treatment of moderate to severe vasomotor symptoms due to menopause.

- Etyqa 1 mg/0.5 mg
- Etyqa 0.5 mg/0.1 mg

### **2.2 Treatment of Moderate to Severe Symptoms of Vulvar and Vaginal Atrophy due to Menopause**

Take a single Etyqa tablet orally once daily for the treatment of moderate to severe symptoms of vulvar and vaginal atrophy due to menopause.

- Etyqa 1 mg/0.5 mg

### **2.3 Prevention of Postmenopausal Osteoporosis**

Take a single Etyqa tablet orally once daily for the prevention of postmenopausal osteoporosis.

- Etyqa 1 mg/0.5 mg
- Etyqa 0.5 mg/0.1 mg

## **3 DOSAGE FORMS AND STRENGTHS**

Etyqa (estradiol and norethindrone acetate tablets, USP) are available in two strengths:

- Etyqa 1 mg/0.5 mg contains 1 mg of estradiol USP and 0.5 mg of norethindrone acetate USP. The tablets are white to off-white, round, biconvex, film-coated tablets debossed with “EN” on one side and “1” on the other side.
- Etyqa 0.5 mg/0.1 mg contains 0.5 mg of estradiol USP and 0.1 mg of norethindrone acetate USP. The tablets are white to off-white, round, biconvex, film-coated tablets debossed with “EN” on one side and “2” on the other side.

## 4 CONTRAINDICATIONS

Etyqa is contraindicated in women with any of the following conditions:

- Undiagnosed abnormal genital bleeding [see *Warnings and Precautions (5.2)*]
- Breast cancer or history of breast cancer [see *Warnings and Precautions (5.2)*]
- Estrogen-dependent neoplasia [see *Warnings and Precautions (5.2)*]
- Active DVT, PE, or history of these conditions [see *Warnings and Precautions (5.1)*]
- Active arterial thromboembolic disease (for example, stroke and MI), or a history of these conditions [see *Warnings and Precautions (5.1)*]
- Known anaphylactic reaction, angioedema, or hypersensitivity to Etyqa
- Hepatic impairment or disease
- Protein C, protein S, or antithrombin deficiency, or other known thrombophilic disorders

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Cardiovascular Disorders

Increased risks of PE, DVT, stroke and MI are reported with estrogen plus progestin therapy. Increased risks of stroke and DVT are reported with estrogen-alone therapy. Immediately discontinue estrogen with or without progestogen therapy if any of these occur or is suspected.

Manage appropriately any risk factors for arterial vascular disease (for example, hypertension, diabetes mellitus, tobacco use, hypercholesterolemia, and obesity) and/or venous thromboembolism (VTE) (for example, personal history or family history of VTE, obesity, and systemic lupus erythematosus).

#### Stroke

The WHI estrogen plus progestin substudy reported a statistically significant increased risk of stroke in women 50 to 79 years of age receiving daily CE (0.625 mg) plus MPA (2.5 mg) compared to women in the same age group receiving placebo (33 versus 25 strokes per 10,000 women-years) [see *Clinical Studies (14.5)*]. The increase in risk was demonstrated after the first year and persisted.<sup>1</sup> Immediately discontinue estrogen with or without progestogen therapy if a stroke occurs or is suspected.

The WHI estrogen-alone substudy reported a statistically significant increased risk of stroke in women 50 to 79 years of age receiving daily CE (0.625 mg)-alone compared to women in the same age group receiving placebo (45 versus 33 strokes per 10,000 women-years, respectively). The increase in risk was demonstrated in year 1 and persisted [see *Clinical Studies (14.5)*]. Immediately discontinue estrogen-alone therapy if a stroke occurs or is suspected.

Subgroup analyses of women 50 to 59 years of age suggest no increased risk of stroke for those women receiving CE (0.625 mg)-alone versus those receiving placebo (18 versus 21 per 10,000 women-years).<sup>1</sup>



## Coronary Heart Disease

The WHI estrogen plus progestin substudy reported an increased risk (not statistically significant) of coronary heart disease (CHD) events (defined as nonfatal MI, silent MI, or CHD death) in those women receiving daily CE (0.625 mg) plus MPA (2.5 mg) compared to women receiving placebo (41 versus 34 per 10,000 women-years).<sup>1</sup> An increase in relative risk was demonstrated in year 1, and a trend toward decreasing relative risk was reported in years 2 through 5 [see *Clinical Studies (14.5)*].

The WHI estrogen-alone substudy reported no overall effect on CHD events in women receiving estrogen-alone compared to placebo<sup>2</sup> [see *Clinical Studies (14.5)*].

Subgroup analyses of women 50 to 59 years of age, who were less than 10 years since menopause, suggest a reduction (not statistically significant) in CHD events in those women receiving daily CE (0.625 mg)-alone compared to placebo (8 versus 16 per 10,000 women-years).<sup>1</sup>

In postmenopausal women with documented heart disease (n=2,763), average 66.7 years of age, in a controlled clinical trial of secondary prevention of cardiovascular disease (Heart and Estrogen/Progestin Replacement Study; HERS), treatment with daily CE (0.625 mg plus MPA (2.5 mg) demonstrated no cardiovascular benefit. During an average follow-up of 4.1 years, treatment with CE plus MPA did not reduce the overall rate of CHD events in postmenopausal women with established CHD. There were more CHD events in the CE plus MPA-treated group than in the placebo group in year 1, but not during the subsequent years. Two thousand three hundred twenty-one (2,321) women from the original HERS trial agreed to participate in an open label extension of HERS, HERS II. Average follow-up in HERS II was an additional 2.7 years, for a total of 6.8 years overall. Rates of CHD events were comparable among women in the CE plus MPA group and the placebo group in HERS, HERS II, and overall.

## Venous Thromboembolism

The WHI estrogen plus progestin substudy reported a statistically significant 2-fold greater rate of VTE (DVT and PE) in women receiving daily CE (0.625 mg) plus MPA (2.5 mg) compared to women receiving placebo (35 versus 17 per 10,000 women-years). Statistically significant increases in risk for both DVT (26 versus 13 per 10,000 women-years) and PE (18 versus 8 per 10,000 women-years) were also demonstrated. The increase in VTE risk was demonstrated during the first year and persisted<sup>3</sup> [see *Clinical Studies (14.5)*]. Immediately discontinue estrogen plus progestogen therapy if a VTE occurs or is suspected.

In the WHI estrogen-alone substudy, the risk of VTE was increased for women receiving daily CE (0.625 mg)-alone compared to placebo (30 versus 22 per 10,000 women-years), although only the increased risk of DVT reached statistical significance (23 versus 15 per 10,000 women-years). The increase in VTE risk was demonstrated during the first 2 years<sup>4</sup> [see *Clinical Studies (14.5)*]. Immediately discontinue estrogen-alone therapy if a VTE occurs or is suspected.

If feasible, discontinue estrogens at least 4 to 6 weeks before surgery of the type

associated with an increased risk of thromboembolism, or during periods of prolonged immobilization.

## 5.2 Malignant Neoplasms

### Breast Cancer

After a mean follow-up of 5.6 years, the WHI substudy of daily CE (0.625 mg) plus MPA (2.5 mg) reported an increased risk of invasive breast cancer in women who took daily CE plus MPA compared to placebo.

In this substudy, prior use of estrogen-alone or estrogen plus progestin therapy was reported by 26 percent of the women. The relative risk of invasive breast cancer was 1.24, and the absolute risk was 41 versus 33 cases per 10,000 women-years, for CE plus MPA compared with placebo. Among women who reported prior use of hormone therapy, the relative risk of invasive breast cancer was 1.86, and the absolute risk was 46 versus 25 cases per 10,000 women-years, for CE plus MPA compared with placebo. Among women who reported no prior use of hormone therapy, the relative risk of invasive breast cancer was 1.09, and the absolute risk was 40 versus 36 cases per 10,000 women-years, for CE plus MPA compared with placebo. In the same substudy, invasive breast cancers were larger, were more likely to be node positive, and were diagnosed at a more advanced stage in the CE (0.625 mg) plus MPA (2.5 mg) group compared with the placebo group. Metastatic disease was rare, with no apparent difference between the two groups. Other prognostic factors, such as histologic subtype, grade and hormone receptor status did not differ between the groups <sup>5</sup> [see *Clinical Studies (14.5)*].

The WHI substudy of daily CE (0.625 mg)-alone provided information about breast cancer in estrogen-alone users. In the WHI estrogen-alone substudy, after an average follow-up of 7.1 years, daily CE-alone was not associated with an increased risk of invasive breast cancer [*relative risk (RR) 0.80*] compared to placebo <sup>6</sup> [see *Clinical Studies (14.5)*].

Consistent with the WHI clinical trials, observational studies have also reported an increased risk of breast cancer with estrogen plus progestin therapy, and a smaller increase in the risk for breast cancer with estrogen-alone therapy, after several years of use. One large meta-analysis of prospective cohort studies reported increased risks that were dependent upon duration of use and could last up to >10 years after discontinuation of estrogen plus progestin therapy and estrogen-alone therapy. Extension of the WHI Trials also demonstrated increased breast cancer risk associated with estrogen plus progestin therapy. Observational studies also suggest that the risk of breast cancer was greater, and became apparent earlier, with estrogen plus progestin therapy as compared to estrogen-alone therapy. These studies have not generally found significant variation in the risk of breast cancer among different estrogen plus progestin combinations, doses, or routes of administration.

The use of estrogen-alone and estrogen plus progestin therapy has been reported to result in an increase in abnormal mammograms requiring further evaluation.

In a one-year trial among 1,176 women who received either unopposed 1 mg estradiol or a combination of 1 mg estradiol plus one of three different doses of NETA (0.1, 0.25, 0.5 mg), seven new cases of breast cancer were diagnosed, two of which occurred among the group of 295 women treated with Etyqa 1 mg/0.5 mg and two of which occurred among the group of 294 women treated with 1 mg estradiol/0.1 mg NETA.

All women should receive yearly breast examinations by a healthcare provider and perform monthly breast self-examinations. In addition, mammography examinations should be scheduled based on patient age, risk factors, and prior mammogram results.

### Endometrial Cancer

An increased risk of endometrial cancer has been reported with the use of unopposed estrogen therapy in a woman with a uterus. The reported endometrial cancer risk among unopposed estrogen users is about 2- to 12- fold greater than in nonusers, and appears dependent on duration of treatment and on estrogen dose. Most studies show no significant increased risk associated with use of estrogens for less than 1 year. The greatest risk appears to be associated with prolonged use, with increased risks of 15- to 24-fold for 5 to 10 years or more. This risk has been shown to persist for at least 8 to 15 years after estrogen therapy is discontinued.

Clinical surveillance of all women using estrogen-alone or estrogen plus progestogen therapy is important. Perform adequate diagnostic measures, including directed or random endometrial sampling when indicated, to rule out malignancy in postmenopausal women with undiagnosed persistent or recurring abnormal genital bleeding with unknown etiology.

There is no evidence that the use of natural estrogens results in a different endometrial risk profile than synthetic estrogens of equivalent estrogen dose. Adding a progestogen to estrogen therapy in postmenopausal women has been shown to reduce the risk of endometrial hyperplasia, which may be a precursor to endometrial cancer.

Endometrial hyperplasia occurred at a rate of approximately 1 percent or less with Etyqa in a clinical trial.

### Ovarian Cancer

The CE plus MPA substudy of WHI reported that estrogen plus progestin increased the risk of ovarian cancer. After an average follow-up of 5.6 years, the relative risk for ovarian cancer for CE plus MPA versus placebo was 1.58 (95 percent confidence interval [CI], 0.77 to 3.24), but it was not statistically significant. The absolute risk for CE plus MPA versus placebo was 4 versus 3 cases per 10,000 women-years.<sup>7</sup>

A meta-analysis of 17 prospective and 35 retrospective epidemiology studies found that women who used hormonal therapy for menopausal symptoms had an increased risk for ovarian cancer. The primary analysis, using case-control comparisons, included 12,110 cancer cases from the 17 prospective studies. The relative risks associated with

current use of hormonal therapy was 1.41 (95% CI 1.32 to 1.50); there was no difference in the risk estimates by duration of the exposure (less than 5 years [median of 3 years] vs. greater than 5 years [median of 10 years] of use before the cancer diagnosis). The relative risk associated with combined current and recent use (discontinued use within 5 years before cancer diagnosis) was 1.37 (95% CI 1.27 to 1.48), and the elevated risk was significant for both estrogen-alone and estrogen plus progestin products. The exact duration of hormone therapy use associated with an increased risk of ovarian cancer, however, is unknown.

### **5.3 Probable Dementia**

In the WHI Memory Study (WHIMS) estrogen plus progestin ancillary study, a population of 4,532 postmenopausal women 65 to 79 years of age was randomized to daily CE (0.625 mg) plus MPA (2.5 mg) or placebo.

After an average follow-up of 4 years, 40 women in the CE plus MPA group and 21 women in the placebo group were diagnosed with probable dementia. The relative risk of probable dementia for the CE plus MPA versus placebo was 2.05 (95 percent CI, 1.21 to 3.48). The absolute risk of probable dementia for CE plus MPA versus placebo was 45 versus 22 cases per 10,000 women-years<sup>8</sup> [see *Use in Specific Populations (8.5)*, and *Clinical Studies (14.6)*].

In the WHIMS estrogen-alone ancillary study, a population of 2,947 hysterectomized women 65 to 79 years of age was randomized to daily CE (0.625 mg)-alone or placebo. After an average follow-up of 5.2 years, 28 women in the estrogen-alone group and 19 women in the placebo group were diagnosed with probable dementia. The relative risk of probable dementia for CE-alone versus placebo was 1.49 (95 percent CI, 0.83 to 2.66). The absolute risk of probable dementia for CE-alone versus placebo was 37 versus 25 cases per 10,000 women-years<sup>8</sup> [see *Use in Specific Populations (8.5)*, and *Clinical Studies (14.6)*].

When data from the two populations in the WHIMS estrogen-alone and estrogen plus progestin ancillary studies were pooled as planned in the WHIMS protocol, the reported overall relative risk of probable dementia was 1.76 (95 percent CI, 1.19 to 2.60). Since both ancillary studies were conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women<sup>8</sup> [see *Use in Specific Populations (8.5)*, and *Clinical Studies (14.6)*].

### **5.4 Gallbladder Disease**

A 2- to 4-fold increase in the risk of gallbladder disease requiring surgery in postmenopausal women receiving estrogens has been reported.

### **5.5 Hypercalcemia**

Estrogen administration may lead to severe hypercalcemia in women with breast cancer and bone metastases. Discontinue estrogens, including Etyqa if hypercalcemia occurs, and take appropriate measures to reduce the serum calcium level.

### **5.6 Vision Abnormalities**

Retinal vascular thrombosis has been reported in women receiving estrogens.

Discontinue Etyqa pending examination if there is a sudden partial or complete loss of vision, or a sudden onset of proptosis, diplopia, or migraine. Permanently discontinue estrogens, including Etyqa, if examination reveals papilledema or retinal vascular lesions.

### **5.7 Addition of a Progestogen When a Woman Has Not Had a Hysterectomy**

Studies of the addition of a progestogen for 10 or more days of a cycle of estrogen administration, or daily with estrogen in a continuous regimen, have reported a lowered incidence of endometrial hyperplasia than would be induced by estrogen treatment alone. Endometrial hyperplasia may be a precursor to endometrial cancer. There are, however, possible risks that may be associated with the use of progestogens with estrogens compared to estrogen-alone regimens. These include an increased risk of breast cancer.

### **5.8 Elevated Blood Pressure**

In a small number of case reports, substantial increases in blood pressure have been attributed to idiosyncratic reactions to estrogens. In a large, randomized, placebo-controlled clinical trial, a generalized effect of estrogen therapy on blood pressure was not seen.

### **5.9 Exacerbation of Hypertriglyceridemia**

In women with pre-existing hypertriglyceridemia, estrogen therapy may be associated with elevations of plasma triglycerides leading to pancreatitis. Discontinue Etyqa if pancreatitis occurs.

### **5.10 Hepatic Impairment and/or Past History of Cholestatic Jaundice**

Estrogens may be poorly metabolized in women with hepatic impairment. Exercise caution in any woman with a history of cholestatic jaundice associated with past estrogen use or with pregnancy. In the case of recurrence of cholestatic jaundice, discontinue Etyqa.

### **5.11 Exacerbation of Hypothyroidism**

Estrogen administration leads to increased thyroid-binding globulin (TBG) levels. Women with normal thyroid function can compensate for the increased TBG by making more thyroid hormone, thus maintaining free T<sub>4</sub> and T<sub>3</sub> serum concentrations in the normal range. Women dependent on thyroid hormone replacement therapy who are also receiving estrogen may require increased doses of their thyroid replacement therapy. Monitor thyroid function in these women during treatment with Etyqa to maintain their free thyroid hormone levels in an acceptable range.

### **5.12 Fluid Retention**

Estrogens plus progestogens may cause some degree of fluid retention. Monitor any woman with a condition(s) that might predispose her to fluid retention, such as a cardiac or renal impairment. Discontinue estrogen plus progestogen therapy, including Etyqa, with evidence of medically concerning fluid retention.

### **5.13 Hypocalcemia**

Estrogen-induced hypocalcemia may occur in women with hypoparathyroidism. Consider whether the benefits of estrogen therapy, including Etyqa, outweigh the risks in such women.

#### **5.14 Exacerbation of Endometriosis**

A few cases of malignant transformation of residual endometrial implants have been reported in women treated post-hysterectomy with estrogen-alone therapy.

#### **5.15 Hereditary Angioedema**

Exogenous estrogens may exacerbate symptoms of angioedema in women with hereditary angioedema. Consider whether the benefits of estrogen therapy, including Etyqa, outweigh the risks in such women.

#### **5.16 Exacerbation of Other Conditions**

Estrogen therapy, including Etyqa, may cause an exacerbation of asthma, diabetes mellitus, epilepsy, migraine, porphyria, systemic lupus erythematosus, and hepatic hemangiomas. Consider whether the benefits of estrogen therapy outweigh the risks in such women.

#### **5.17 Laboratory Tests**

Serum follicle stimulating hormone (FSH) and estradiol levels have not been shown to be useful in the management of moderate to severe vasomotor symptoms and moderate to severe symptoms of vulvar and vaginal atrophy.

#### **5.18 Drug-Laboratory Test Interactions**

- Accelerated prothrombin time, partial thromboplastin time, and platelet aggregation time; increased platelet count; increased factors II, VII antigen, VIII coagulant activity, IX, X, XII, VII-X complex, and beta-thromboglobulin; decreased levels of anti-factor Xa and antithrombin III, decreased antithrombin III activity, increased levels of fibrinogen and fibrinogen activity; increased plasminogen antigen and activity.
- Increased thyroid-binding globulin (TBG) levels leading to increased circulating total thyroid hormone levels as measured by protein-bound iodine (PBI), T<sub>4</sub> levels (by column or by radioimmunoassay), or T<sub>3</sub> levels by radioimmunoassay. T<sub>3</sub> resin uptake is decreased, reflecting the elevated TBG. Free T<sub>4</sub> and free T<sub>3</sub> concentrations are unaltered. Women on thyroid replacement therapy may require higher doses of thyroid hormone.
- Other binding proteins may be elevated in serum, for example, corticosteroid binding globulin (CBG), sex hormone-binding globulin (SHBG), leading to increased total circulating corticosteroids and sex steroids, respectively. Free hormone concentrations, such as testosterone and estradiol, may be decreased. Other plasma proteins may be increased (angiotensinogen/rennin substrate, alpha-1 antitrypsin, ceruloplasmin).
- Increased plasma high-density lipoprotein (HDL) and HDL<sub>2</sub> cholesterol subfraction concentration, reduced low-density lipoprotein (LDL) cholesterol concentration, increased triglyceride levels.
- Impaired glucose tolerance.

## 6 ADVERSE REACTIONS

The following serious adverse reactions are discussed elsewhere in the labeling:

- Cardiovascular Disorders [see Boxed Warning, Warnings and Precautions (5.1)]
- Malignant Neoplasms [see Boxed Warning, Warnings and Precautions (5.2)]

### 6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Adverse reactions reported with Etyqa 1 mg/0.5 mg by investigators during clinical trials regardless of causality assessment are shown in Table 1.

**TABLE 1 ALL TREATMENT-EMERGENT ADVERSE REACTIONS REGARDLESS OF RELATIONSHIP REPORTED AT A FREQUENCY OF  $\geq$  5 PERCENT WITH ETYQA 1 MG/0.5 MG**

	Endometrial Hyperplasia Study (12-Months)		Vasomotor Symptoms Study (3-Months)		Osteoporosis Study (2-Years)	
	Etyqa 1 mg/0.5 mg (n=295)	1 mg E <sub>2</sub> (n=296)	Etyqa 1 mg/0.5 mg (n=29)	Placebo (n=34)	Etyqa 1 mg/0.5 mg (n=47)	Placebo (n=48)
<b>Body as a Whole</b>						
Back Pain	6%	5%	3%	3%	6%	4%
Headache	16%	16%	17%	18%	11%	6%
<b>Digestive System</b>						
Nausea	3%	5%	10%	0%	11%	0%
Gastroenteritis	2%	2%	0%	0%	6%	4%
<b>Nervous System</b>						
Insomnia	6%	4%	3%	3%	0%	8%
Emotional Lability	1%	1%	0%	0%	6%	0%
<b>Respiratory System</b>						
Upper Respiratory Tract Infection	18%	15%	10%	6%	15%	19%
Sinusitis	7%	11%	7%	0%	15%	10%
<b>Metabolic and Nutritional</b>						
Weight Increase	0%	0%	0%	0%	9%	6%
<b>Urogenital System</b>						
Breast Pain	24%	10%	21%	0%	17%	8%
Post-						

Menopausal Bleeding	5%	15%	10%	3%	11%	0%
Uterine Fibroid	5%	4%	0%	0%	4%	8%
Ovarian Cyst	3%	2%	7%	0%	0%	8%
<b>Resistance Mechanism</b>						
Infection Viral	4%	6%	0%	3%	6%	6%
Moniliasis Genital	4%	7%	0%	0%	6%	0%
<b>Secondary Terms</b>						
Injury Accidental	4%	3%	3%	0%	17%*	4%*
Other Events	2%	3%	3%	0%	6%	4%
* including one upper extremity fracture in each group						

Adverse reactions reported with Etyqa 0.5 mg/0.1 mg by investigators during clinical trials regardless of causality assessment are shown in Table 2.

**TABLE 2 ALL TREATMENT-EMERGENT ADVERSE REACTIONS REGARDLESS OF RELATIONSHIP REPORTED AT A FREQUENCY OF  $\geq$  5 PERCENT WITH ETYQA 0.5 MG/0.1 MG**

	Etyqa 0.5 mg/0.1 mg (n=194)	Placebo (n=200)
<b>Body as a Whole</b>		
Back Pain	10%	4%
Headache	22%	19%
Pain in extremity	5%	4%
<b>Digestive System</b>		
Nausea	5%	4%
Diarrhea	6%	6%
<b>Respiratory System</b>		
Nasopharyngitis	21%	18%
<b>Urogenital System</b>		
Endometrial thickening	10%	4%
Vaginal hemorrhage	26%	12%

## 6.2 Postmarketing Experience

The following adverse reactions have been identified during post-approval use of Etyqa. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

### *Genitourinary System*

Changes in vaginal bleeding pattern and abnormal withdrawal bleeding or flow;



breakthrough bleeding; spotting; dysmenorrhea, increase in size of uterine leiomyomata; vaginitis, including vaginal candidiasis; change in amount of cervical secretion; changes in cervical ectropion; pre-menstrual-like syndrome; cystitis-like syndrome; ovarian cancer; endometrial hyperplasia; endometrial cancer.

### *Breast*

Tenderness, enlargement, pain, nipple discharge, galactorrhea; fibrocystic breast changes; breast cancer.

### *Cardiovascular*

Deep and superficial venous thrombosis; pulmonary embolism; thrombophlebitis; myocardial infarction, stroke; increase in blood pressure.

### *Gastrointestinal*

Nausea, vomiting; changes in appetite; cholestatic jaundice; abdominal pain/cramps, flatulence, bloating; increased incidence of gallbladder disease and pancreatitis.

### *Skin*

Chloasma or melasma that may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; seborrhea; hirsutism; itching; skin rash; pruritus.

### *Eyes*

Retinal vascular thrombosis, intolerance to contact lenses.

### *Central Nervous System*

Headache; migraine; dizziness; mental depression; chorea; insomnia; nervousness; mood disturbances; irritability; exacerbation of epilepsy; dementia.

### *Miscellaneous*

Increase or decrease in weight; edema; leg cramps; changes in libido; fatigue; exacerbation of asthma; increased triglycerides; hypersensitivity; anaphylactoid/anaphylactic reactions.

## **7 DRUG INTERACTIONS**

Co-administration of estradiol with norethindrone acetate did not elicit any apparent influence on the pharmacokinetics of norethindrone acetate. Similarly, no relevant interaction of norethindrone acetate on the pharmacokinetics of estradiol was found within the NETA dose range investigated in a single dose study.

### **Estradiol**

*In-vitro* and *in-vivo* studies have shown that estrogens are metabolized partially by cytochrome P450 3A4 (CYP3A4). Therefore, inducers or inhibitors of CYP3A4 may affect estrogen drug metabolism. Inducers of CYP3A4 such as St. John's wort (*Hypericum perforatum*) preparations, phenobarbital, carbamazepine, and rifampin may reduce plasma concentrations of estrogens, possibly resulting in a decrease in therapeutic effects and/or changes in the uterine bleeding profile. Inhibitors of CYP3A4 such as erythromycin, clarithromycin, ketoconazole, itraconazole, ritonavir and grapefruit juice may increase plasma concentrations of estrogens and result in adverse reactions.

## **Norethindrone Acetate**

Drugs or herbal products that induce or inhibit cytochrome P-450 enzymes, including CYP3A4, may decrease or increase the serum concentrations of norethindrone.

## **8 USE IN SPECIFIC POPULATIONS**

### **8.1 Pregnancy**

#### Risk Summary

Etyqa is not indicated for use in pregnancy. There are no data with the use of Etyqa in pregnant women; however, epidemiologic studies and meta-analyses have not found an increased risk of genital or nongenital birth defects (including cardiac anomalies and limb-reduction defects) following exposure to combined hormonal contraceptives (estrogen and progestins) before conception or during early pregnancy.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

### **8.2 Lactation**

#### Risk Summary

Estrogens plus progestogens are present in human milk and can reduce milk production in breast-feeding women. This reduction can occur at any time but is less likely to occur once breast-feeding is well established. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Etyqa and any potential adverse effects on the breastfed child from Etyqa or from the underlying maternal condition.

### **8.4 Pediatric Use**

Etyqa is not indicated for use in pediatric patients. Clinical studies have not been conducted in the pediatric population.

### **8.5 Geriatric Use**

There have not been sufficient numbers of geriatric women involved in clinical studies utilizing Etyqa to determine whether those over 65 years of age differ from younger subjects in their response to Etyqa.

### *The Women's Health Initiative Studies*

In the WHI estrogen plus progestin substudy (daily CE [0.625 mg] plus MPA [2.5 mg] versus placebo), there was a higher relative risk of nonfatal stroke and invasive breast cancer in women greater than 65 years of age [see *Clinical Studies (14.5)*].

In the WHI estrogen-alone substudy (daily CE [0.625 mg]-alone versus placebo), there was a higher relative risk of stroke in women greater than 65 years of age [see *Clinical Studies (14.5)*].

### *The Women's Health Initiative Memory Study*

In the WHIMS ancillary studies of postmenopausal women 65 to 79 years of age, there was an increased risk of developing probable dementia in women receiving estrogen plus progestin or estrogen-alone when compared to placebo. It is unknown whether this finding applies to younger postmenopausal women [see *Warnings and Precautions (5.3)*, and *Clinical Studies (14.6)*].

Since both ancillary studies were conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women<sup>8</sup> [see *Warnings and Precautions (5.3)*, and *Clinical Studies (14.6)*].

## **10 OVERDOSAGE**

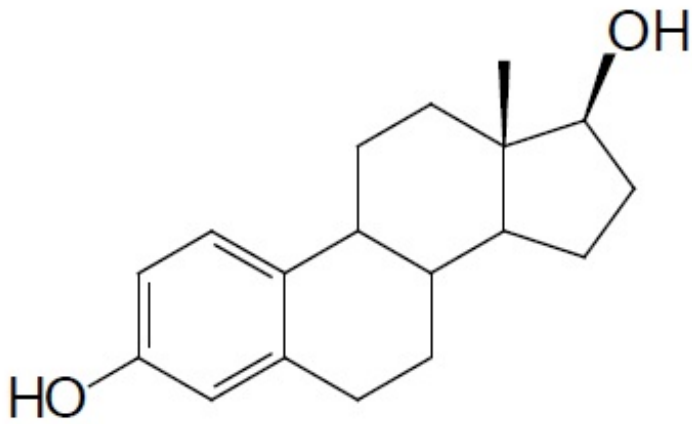
Overdosage of estrogen plus progestogen may cause nausea, vomiting, breast tenderness, abdominal pain, drowsiness and fatigue, and withdrawal bleeding may occur in women. Treatment of overdose consists of discontinuation of Etyqa therapy with institution of appropriate symptomatic care.

## **11 DESCRIPTION**

Etyqa (estradiol and norethindrone acetate tablets, USP) 1 mg/0.5 mg is a single tablet for oral administration containing 1 mg of estradiol USP and 0.5 mg of norethindrone acetate USP and the following excipients: corn starch, hydroxyl propyl cellulose, hypromellose, lactose monohydrate, magnesium stearate, talc and triacetin.

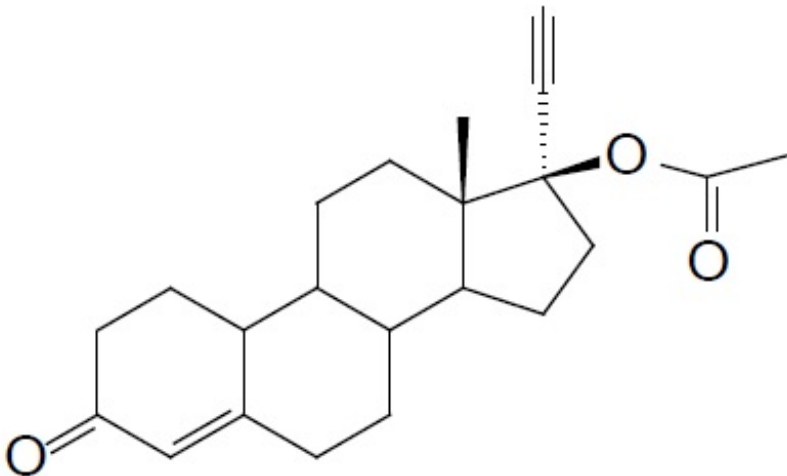
Etyqa (estradiol and norethindrone acetate tablets, USP) 0.5 mg/0.1 mg is a single tablet for oral administration containing 0.5 mg of estradiol USP and 0.1 mg of norethindrone acetate USP and the following excipients: corn starch, hydroxyl propyl cellulose, hypromellose, lactose monohydrate, magnesium stearate, talc and triacetin.

Estradiol is a white or creamy white, small crystals or crystalline powder. Its chemical name is estra-1, 3, 5 (10)-triene-3, 17 $\beta$ -diol hemihydrate with the empirical formula of C<sub>18</sub>H<sub>24</sub>O<sub>2</sub>, ½ H<sub>2</sub>O and a molecular weight of 281.4. The structural formula of E<sub>2</sub> is as follows:



## Estradiol

Norethindrone acetate (NETA) is a white to creamy white, odorless, crystalline powder. Its chemical name is  $17\beta$ -acetoxy-19-nor-17 $\alpha$ -pregn-4-en-20-yn-3-one with the empirical formula of  $C_{22}H_{28}O_3$  and molecular weight of 340.5. The structural formula of NETA is as follows:



## Norethindrone Acetate

## 12.1 Mechanism of Action

Endogenous estrogens are largely responsible for the development and maintenance of the female reproductive system and secondary sexual characteristics. Although circulating estrogens exist in a dynamic equilibrium of metabolic interconversions, estradiol is the principal intracellular human estrogen and is substantially more potent than its metabolites, estrone and estriol, at the receptor level.

The primary source of estrogen in normally cycling adult women is the ovarian follicle, which secretes 70 to 500 mcg of estradiol daily, depending on the phase of the menstrual cycle. After menopause, most endogenous estrogen is produced by conversion of androstenedione, secreted by the adrenal cortex, to estrone in the peripheral tissues. Thus, estrone and the sulfate-conjugated form, estrone sulfate, are the most abundant circulating estrogens in postmenopausal women.

Estrogens act through binding to nuclear receptors in estrogen-responsive tissues. To date, two estrogen receptors have been identified. These vary in proportion from tissue to tissue.

Circulating estrogens modulate the pituitary secretion of the gonadotropins, luteinizing hormone (LH), and FSH through a negative feedback mechanism. Estrogens act to reduce the elevated levels of these hormones seen in postmenopausal women.

Progestin compounds enhance cellular differentiation and generally oppose the actions of estrogens by decreasing estrogen receptor levels, increasing local metabolism of estrogens to less active metabolites, or inducing gene products that blunt cellular responses to estrogen. Progestins exert their effects in target cells by binding to specific progesterone receptors that interact with progesterone response elements in target genes. Progesterone receptors have been identified in the female reproductive tract, breast, pituitary, hypothalamus, and central nervous system.

## 12.2 Pharmacodynamics

Generally, a serum estrogen concentration does not predict an individual woman's therapeutic response to Etyqa nor her risk for adverse outcomes. Likewise, exposure comparisons across different estrogen products to infer efficacy or safety for the individual woman may not be valid.

## 12.3 Pharmacokinetics

### Absorption

#### **Estradiol**

Estradiol is absorbed through the gastrointestinal tract. Following oral administration of Etyqa tablets, peak plasma estradiol concentrations are reached within 5 to 8 hours. The oral bioavailability of estradiol following administration of Etyqa 1 mg/0.5 mg when compared to a combination oral solution is 53%. Administration of Etyqa 1 mg/0.5 mg

with food did not modify the bioavailability of estradiol.

### Norethindrone Acetate

After oral administration, norethindrone acetate is absorbed and transformed to norethindrone. Norethindrone reaches a peak plasma concentration within 0.5 to 1.5 hours after the administration of Etyqa tablets. The oral bioavailability of norethindrone following administration of Etyqa 1 mg/0.5 mg when compared to a combination oral solution is 100%. Administration of Etyqa 1 mg/0.5 mg with food increases norethindrone AUC<sub>0-72</sub> by 19% and decreases C<sub>max</sub> by 36%.

The pharmacokinetic parameters of estradiol (E<sub>2</sub>), estrone (E<sub>1</sub>), and norethindrone (NET) following oral administration of 1 Etyqa 1 mg/0.5 mg or 2 Etyqa 0.5 mg/0.1 mg tablet(s) to healthy postmenopausal women are summarized in Table 3.

**TABLE 3**

#### PHARMACOKINETIC PARAMETERS AFTER ADMINISTRATION OF 1 TABLET OF ETYQA 1 MG/0.5 MG OR 2 TABLETS OF ETYQA 0.5 MG/0.1 MG TO HEALTHY POSTMENOPAUSAL WOMEN

	1 x Etyqa 1 mg/0.5 mg (n=24) Mean <sup>a</sup> (%CV) <sup>b</sup>	2 x Etyqa 0.5 mg/0.1 mg (n=24) Mean <sup>a</sup> (%CV) <sup>b</sup>
<b>Estradiol<sup>c</sup> (E<sub>2</sub>)</b>		
AUC <sub>0-t</sub> (pg/mL*h)	766.5 (48)	697.3 (53)
C <sub>max</sub> (pg/mL)	26.8 (36)	26.5 (37)
t <sub>max</sub> (h): median (range)	6.0 (0.5 to 16.0)	6.5 (0.5 to 16.0)
t <sub>1/2</sub> (h) <sup>d</sup>	14.0 <sup>e</sup> (29)	14.5 <sup>f</sup> (27)
<b>Estrone<sup>c</sup> (E<sub>1</sub>)</b>		
AUC <sub>0-t</sub> (pg/mL*h)	4469.1 (48)	4506.4 (44)
C <sub>max</sub> (pg/mL)	195.5 (37)	199.5 (30)
t <sub>max</sub> (h): median (range)	6.0 (1.0 to 9.0)	6.0 (2.0 to 9.0)
t <sub>1/2</sub> (h) <sup>d</sup>	10.7 (44) <sup>g</sup>	11.8 (25) <sup>g</sup>
<b>Norethindrone (NET)</b>		
AUC <sub>0-t</sub> (pg/mL*h)	21043 (41)	8407.2 (43)
C <sub>max</sub> (pg/mL)	5249.5 (47)	2375.4 (41)
t <sub>max</sub> (h) : median (range)	0.7 (0.7 to 1.25)	0.8 (0.7 to 1.3)
t <sub>1/2</sub> (h)	9.8 (32) <sup>h</sup>	11.4 (36) <sup>i</sup>

AUC = area under the curve, 0 - last quantifiable sample

C<sub>max</sub> = maximum plasma concentration,

t<sub>max</sub> = time at maximum plasma concentration,

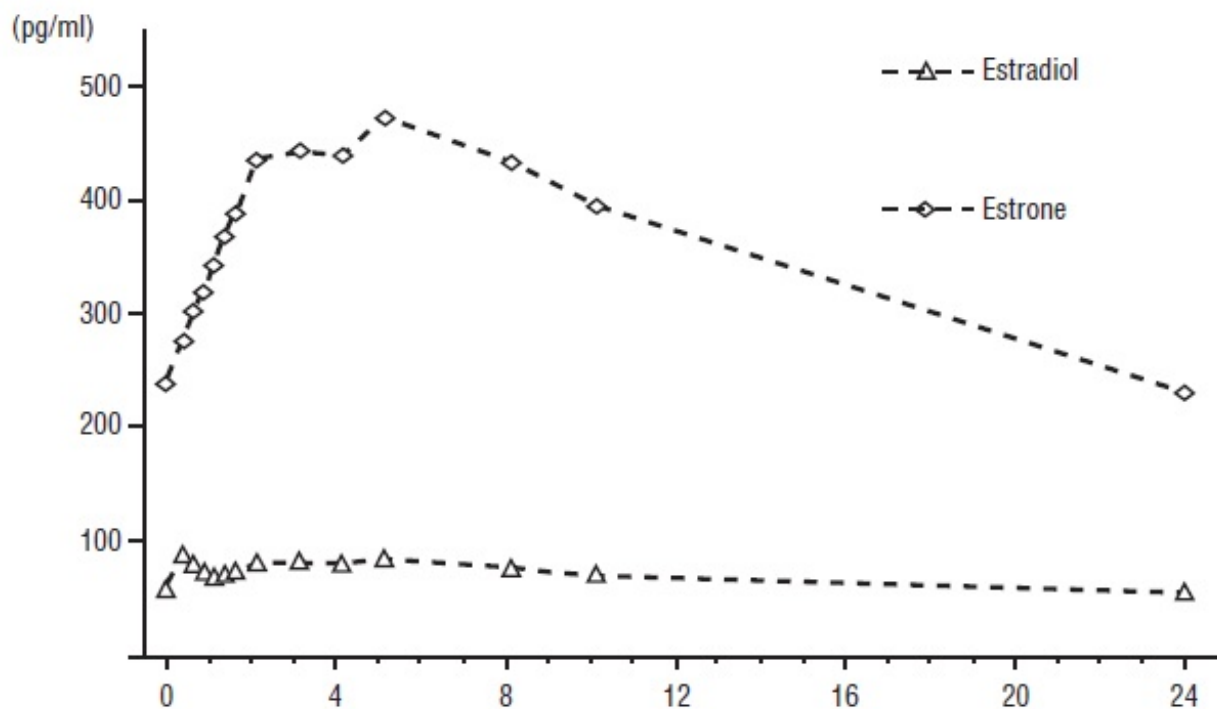
t<sub>1/2</sub> = half-life,

<sup>a</sup> geometric mean; <sup>b</sup> geometric % coefficient of variation; <sup>c</sup> baseline unadjusted data; <sup>d</sup> baseline unadjusted data; <sup>e</sup> n=18; <sup>f</sup> n=16; <sup>g</sup> n=13; <sup>h</sup> n=22; <sup>i</sup> n=21

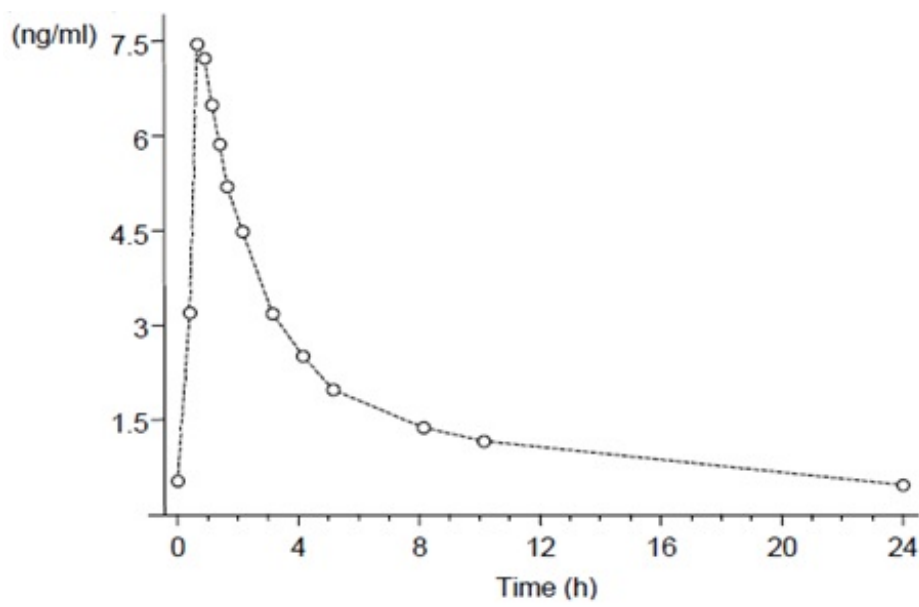
Following continuous dosing with once-daily administration of Etyqa 1 mg/0.5 mg, serum concentrations of estradiol, estrone, and norethindrone reached steady-state within two weeks with an accumulation of 33 to 47% above concentrations following single dose

administration. Unadjusted circulating concentrations of E<sub>2</sub>, E<sub>1</sub>, and NET during Etyqa 1 mg/0.5 mg treatment at steady-state (dosing at time 0) are provided in Figures 1a and 1b.

**Figure 1a: Mean Baseline-Uncorrected Estradiol and Estrone Serum Concentration-Time Profiles Following Multiple Doses of Etyqa 1 mg/0.5 mg (N=24)**



**Figure 1b: Mean Baseline-Uncorrected Norethindrone Serum Concentration-Time Profile Following Multiple Doses of Etyqa 1 mg/0.5 mg (N=24)**



Distribution

**Estradiol**

The distribution of exogenous estrogens is similar to that of endogenous estrogens. Estrogens are widely distributed in the body and are generally found in higher concentrations in the sex hormone target organs. Estradiol circulates in the blood bound to SHBG (37%) and to albumin (61%), while only approximately 1 to 2% is unbound.

### **Norethindrone Acetate**

Norethindrone also binds to a similar extent to SHBG (36%) and to albumin (61%).

### Metabolism

#### **Estradiol**

Exogenous estrogens are metabolized in the same manner as endogenous estrogens. Circulating estrogens exist in a dynamic equilibrium of metabolic interconversions. These transformations take place mainly in the liver. Estradiol is converted reversibly to estrone, and both can be converted to estriol, which is a major urinary metabolite. Estrogens also undergo enterohepatic recirculation via sulfate and glucuronide conjugation in the liver, biliary secretion of conjugates into the intestine, and hydrolysis in the intestine followed by reabsorption. In postmenopausal women, a significant proportion of the circulating estrogens exist as sulfate conjugates, especially estrone sulfate, which serves as a circulating reservoir for the formation of more active estrogens.

### **Norethindrone Acetate**

The most important metabolites of norethindrone are isomers of 5 $\alpha$ -dihydro-norethindrone and tetrahydro-norethindrone, which are excreted mainly in the urine as sulfate or glucuronide conjugates.

### Excretion

#### **Estradiol**

Estradiol, estrone, and estriol are excreted in the urine along with glucuronide and sulfate conjugates. The half-life of estradiol following single dose administration of Etyqa 1 mg/0.5 mg is 12 to 14 hours.

### **Norethindrone Acetate**

The terminal half-life of norethindrone is about 8 to 11 hours.

## **13 NONCLINICAL TOXICOLOGY**

### **13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility**

Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, uterus, cervix, vagina, testis, and liver.

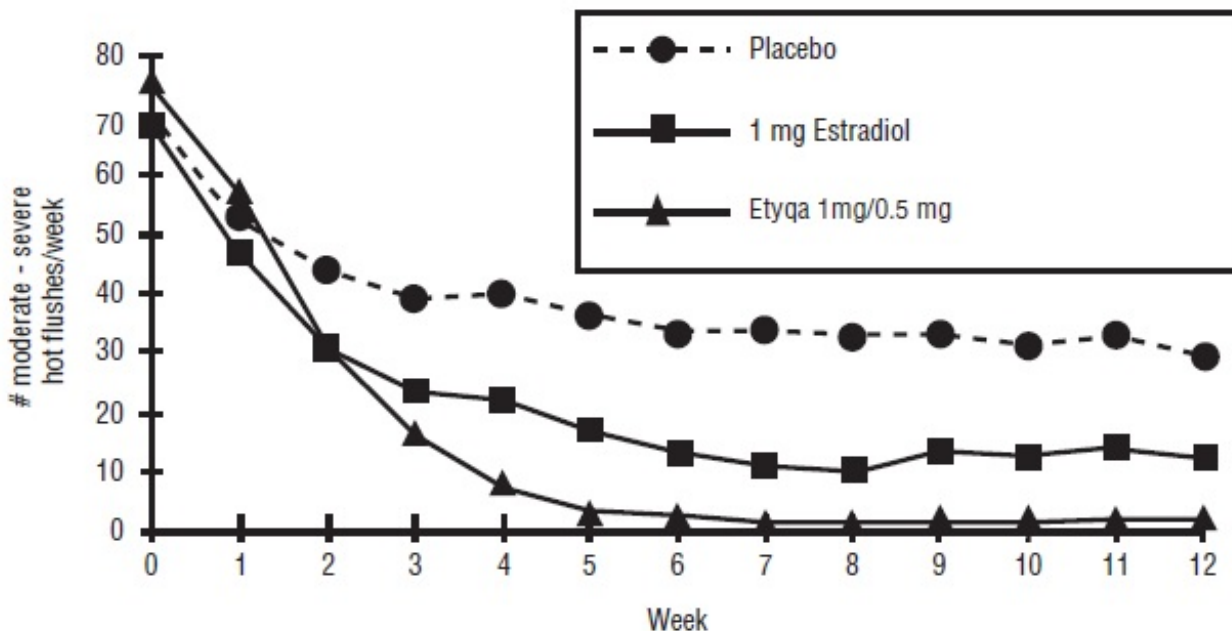


## 14 CLINICAL STUDIES

### 14.1 Effects on Vasomotor Symptoms in Postmenopausal Women

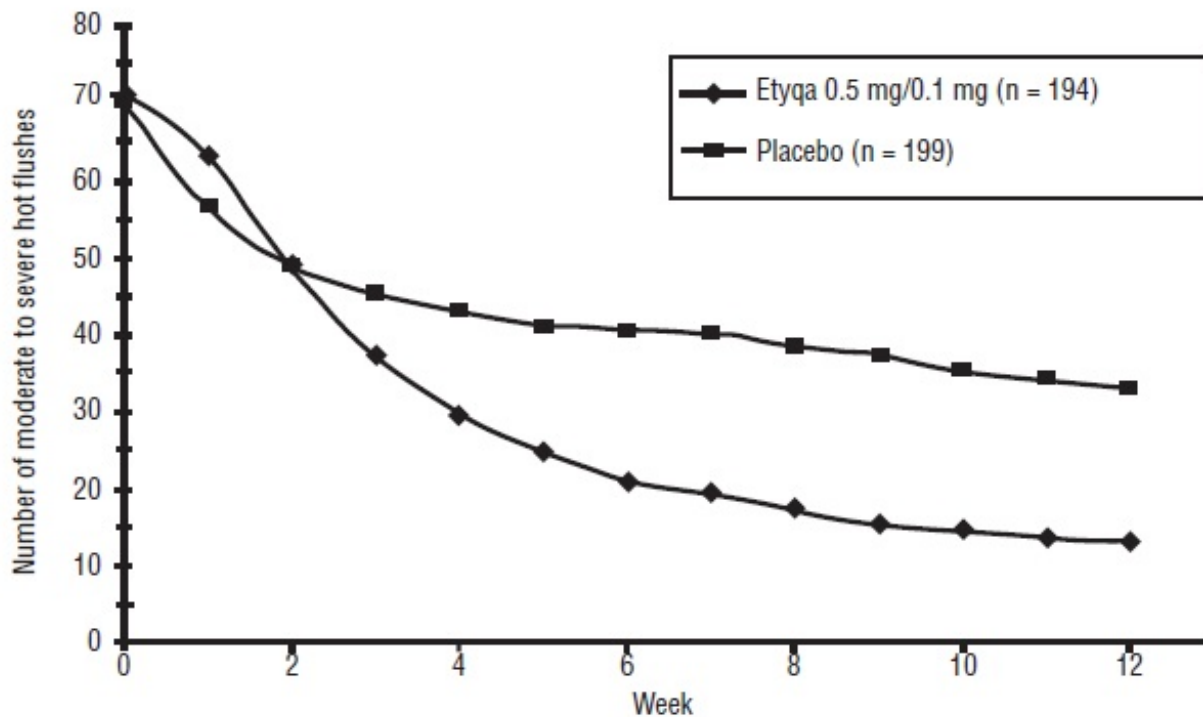
In a 12-week randomized clinical trial involving 92 subjects, Etyqa 1 mg/0.5 mg was compared to 1 mg of estradiol and to placebo. The mean number and intensity of hot flushes were significantly reduced from baseline to week 4 and 12 in both the Etyqa 1 mg/0.5 mg and the 1 mg estradiol group compared to placebo (see Figure 2).

**Figure 2**  
**Mean Weekly Number of Moderate and Severe Hot Flushes in a 12-Week Study**



In a study conducted in Europe a total of 577 postmenopausal women were randomly assigned to either Etyqa 0.5 mg/0.1 mg, 0.5 mg E<sub>2</sub>/0.25 mg NETA, or placebo for 24 weeks of treatment. The mean number and severity of hot flushes were significantly reduced at week 4 and week 12 in the Etyqa 0.5 mg/0.1 mg (see Figure 3) and 0.5 mg E<sub>2</sub>/0.25 mg NETA groups compared to placebo.

**Figure 3**  
**Mean Number of Moderate to Severe Hot Flushes for Weeks 0 Through 12**



#### 14.2 Effects on the Endometrium in Postmenopausal Women

Etyqa 1 mg/0.5 mg reduced the incidence of estrogen-induced endometrial hyperplasia at 1 year in a randomized, controlled clinical trial. This trial enrolled 1,176 postmenopausal women who were randomized to one of 4 arms: 1 mg estradiol unopposed (n=296), 1 mg E<sub>2</sub> + 0.1 mg NETA (n=294), 1 mg E<sub>2</sub> + 0.25 mg NETA (n=291), and Etyqa 1 mg/0.5 mg (n=295). At the end of the study, endometrial biopsy results were available for 988 women. The results of the 1 mg estradiol unopposed arm compared to Etyqa 1 mg/0.5 mg are shown in Table 4.

**TABLE 4**

#### INCIDENCE OF ENDOMETRIAL HYPERPLASIA WITH UNOPPOSED ESTRADIOL AND ETYQA 1 MG/0.5 MG IN A 12-MONTH STUDY

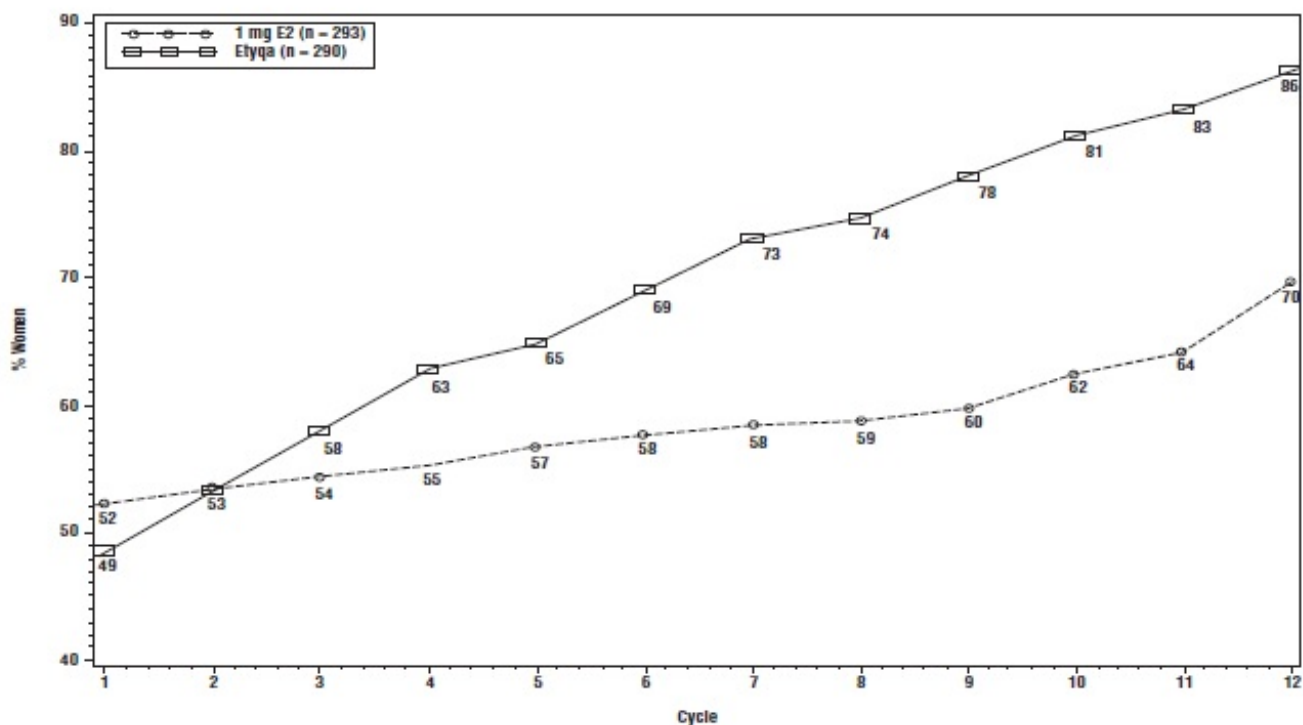
	1 mg E <sub>2</sub> (n=296)	Etyqa 1 mg E <sub>2</sub> /0.5 mg NETA (n=295)	1 mg E <sub>2</sub> /0.25 mg NETA (n=291 )	1 mg E <sub>2</sub> /0.1 mg NETA (n=294 )
No. of subjects with histological evaluation at the end of the study	247	241	251	249
No. (%) of subjects with endometrial hyperplasia at the end of the study	36 (14.6%)	1 (0.4%)	1 (0.4%)	2 (0.8%)

### 14.3 Effects on Uterine Bleeding or Spotting in Postmenopausal Women

During the initial months of therapy, irregular bleeding or spotting occurred with Etyqa 1 mg/0.5 mg treatment. However, bleeding tended to decrease over time, and after 12 months of treatment with Etyqa 1 mg/0.5 mg, about 86 percent of women were amenorrheic (see Figure 4).

**Figure 4**

**Patients Treated with Etyqa 1 mg/0.5 mg with Cumulative Amenorrhea over Time Percentage of Women with no Bleeding or Spotting at any Cycle Through Cycle 13 Intent to Treat Population, LOCF**

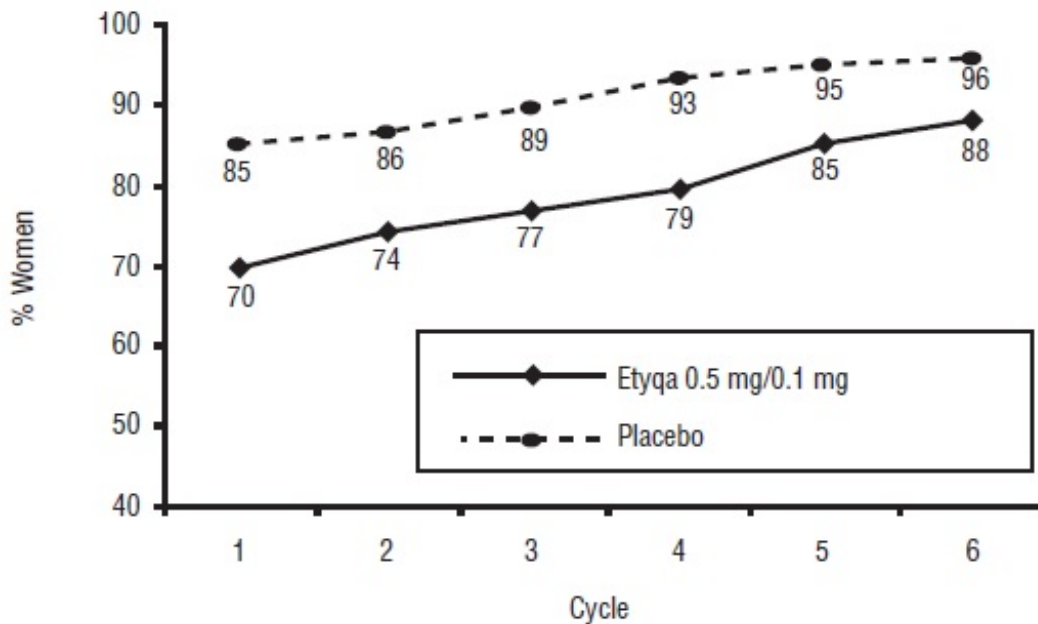


Note: the percentage of patients who were amenorrheic in a given cycle and through cycle 13 is shown. If data were missing, the bleeding value from the last reported day was carried forward (LOCF).

In the clinical trial with Etyqa 0.5 mg/0.1 mg, 88 percent of women were amenorrheic after 6 months of treatment (See Figure 5).

**Figure 5**

**Patients Treated with Etyqa 0.5 mg/0.1 mg with Cumulative Amenorrhea over Time Percentage of Women with no Bleeding or Spotting at any Cycle Through Cycle 6, Intent to Treat Population, LOCF**



#### 14.4 Effects on Bone Mineral Density in Postmenopausal Women

The results of two randomized, multicenter, calcium-supplemented (500 to 1,000 mg per day), placebo-controlled, 2 year clinical trials have shown that Etyqa 1 mg/0.5 mg and estradiol 0.5 mg are effective in preventing bone loss in postmenopausal women. A total of 462 postmenopausal women with intact uteri and baseline BMD values for lumbar spine within 2 standard deviations of the mean in healthy young women (T-score > -2.0) were enrolled. In a US trial, 327 postmenopausal women (mean time from menopause 2.5 to 3.1 years) with a mean age of 53 years were randomized to 7 groups (0.25 mg, 0.5 mg, and 1 mg of estradiol alone, 1 mg estradiol with 0.25 mg norethindrone acetate, 1 mg estradiol with 0.5 mg norethindrone acetate, and 2 mg estradiol with 1 mg norethindrone acetate, and placebo). In a European trial (EU trial), 135 postmenopausal women (mean time from menopause 8.4 to 9.3 years) with a mean age of 58 years were randomized to 1 mg estradiol with 0.25 mg norethindrone acetate, 1 mg estradiol with 0.5 mg norethindrone acetate, and placebo. Approximately 58 percent and 67 percent of the randomized subjects in the two clinical trials, respectively, completed the two clinical trials. BMD was measured using dual-energy x-ray absorptiometry (DXA).

A summary of the results comparing Etyqa 1 mg/0.5 mg and estradiol 0.5 mg to placebo from the two prevention trials is shown in Table 5.

**TABLE 5**

**PERCENTAGE CHANGE (MEAN ± SD) IN BONE MINERAL DENSITY (BMD) FOR ETYQA 1 MG/0.5 MG AND 0.5 MG E<sub>2</sub><sup>†</sup> (Intent to Treat Analysis, Last Observation Carried Forward)**

	US Trial			EU Trial	
	Placebo (n=37)	0.5 mg E <sub>2</sub> <sup>†</sup> (n=31)	Etyqa 1 mg/0.5 mg (n=37)	Placebo (n=40)	Etyqa 1 mg/0.5 mg (n=38)
Lumbar spine	-2.1 ± 2.9	2.3 ± 2.8 *	3.8 ± 3.0 *	-0.9 ± 4.0	5.4 ± 4.8 *

Femoral neck	-2.3 ± 3.4	0.3 ± 2.9 **	1.8 ± 4.1 *	-1.0 ± 4.6	0.7 ± 6.1
Femoral trochanter	-2.0 ± 4.3	1.7 ± 4.1***	3.7 ± 4.3 *	0.8 ± 6.9	6.3 ± 7.6 *

US= United States, EU = European

† While Etyqa 0.5 mg/0.1 mg was not directly studied in these trials, the US trial showed that addition of NETA to estradiol enhances the effect on BMD; therefore the BMD changes expected from treatment with Etyqa 0.5 mg/0.1 mg should be at least as great as observed with estradiol 0.5 mg.

\* Significantly (p<0.001) different from placebo

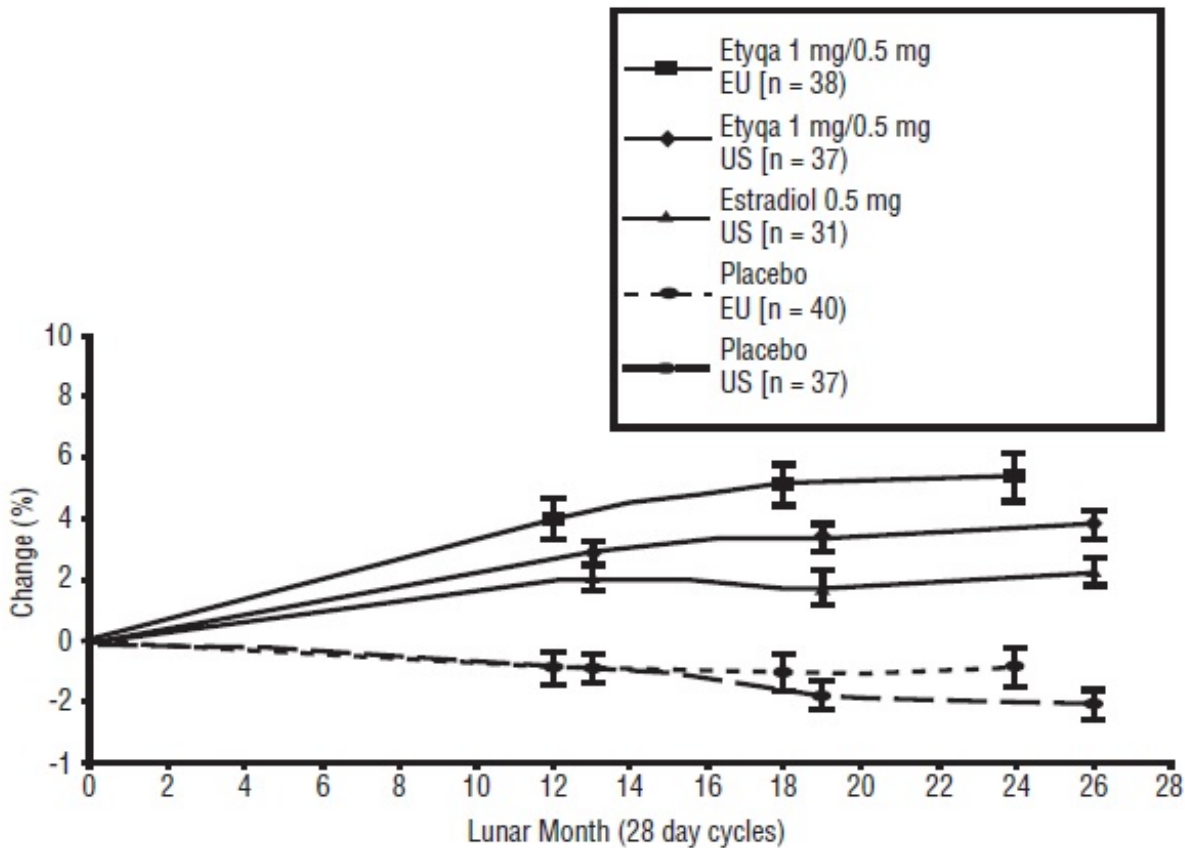
\*\* Significantly (p<0.007) different from placebo

\*\*\*Significantly (p<0.002) different from placebo

The overall difference in mean percentage change in BMD at the lumbar spine in the US trial (1000 mg per day calcium) between Etyqa 1 mg/0.5 mg and placebo was 5.9 percent and between estradiol 0.5 mg and placebo was 4.4 percent. In the European trial (500 mg per day calcium), the overall difference in mean percentage change in BMD at the lumbar spine was 6.3 percent. Etyqa 1 mg/0.5 mg and estradiol 0.5 mg also increased BMD at the femoral neck and femoral trochanter compared to placebo. The increase in lumbar spine BMD in the US and European clinical trials for Etyqa 1 mg/0.5 mg and estradiol 0.5 mg is displayed in Figure 6.

## Figure 6

**Percentage Change in Bone Mineral Density (BMD) ± SEM of the Lumbar Spine (L1-L4) for Etyqa 1 mg/0.5 mg and Estradiol 0.5 mg (Intent to Treat Analysis with Last Observation Carried Forward)**



## 14.5 Women's Health Initiative Studies

The WHI enrolled approximately 27,000 predominantly healthy postmenopausal women in two substudies to assess the risks and benefits of daily oral CE (0.625 mg)-alone or in combination with MPA (2.5 mg) compared to placebo in the prevention of certain chronic diseases. The primary endpoint was the incidence of CHD (defined as nonfatal MI, silent MI and CHD death), with invasive breast cancer as the primary adverse outcome. A "global index" included the earliest occurrence of CHD, invasive breast cancer, stroke, PE, endometrial cancer (only in the CE plus MPA substudy), colorectal cancer, hip fracture, or death due to other cause. These substudies did not evaluate the effects of CE plus MPA or CE-alone on menopausal symptoms.

### *WHI Estrogen Plus Progestin Substudy*

The WHI estrogen plus progestin substudy was stopped early. According to the predefined stopping rule, after an average follow-up of 5.6 years of treatment, the increased risk of invasive breast cancer and cardiovascular events exceeded the specified benefits included in the "global index." The absolute excess risk of events included in the "global index" was 19 per 10,000 women-years.

For those outcomes included in the WHI "global index," that reached statistical significance after 5.6 years of follow-up, the absolute excess risks per 10,000 women-years in the group treated with CE plus MPA were 7 more CHD events, 8 more strokes, 10 more PEs, and 8 more invasive breast cancers, while the absolute risk reductions per

10,000 women-years were 6 fewer colorectal cancers and 5 fewer hip fractures.

Results of the CE plus MPA substudy, which included 16,608 women (average 63 years of age, range 50 to 79; 83.9 percent White, 6.8 percent Black, 5.4 percent Hispanic, 3.9 percent Other) are presented in Table 6. These results reflect centrally adjudicated data after an average follow-up of 5.6 years.

**Table 6**

**Relative and Absolute Risk Seen in the Estrogen Plus Progestin Substudy of WHI at an Average of 5.6 Years<sup>a,b</sup>**

Event	Relative Risk CE/MPA versus Placebo (95% nCI <sup>c</sup> )	CE/MPA n = 8,506	Placebo n = 8,102
		Absolute Risk per 10,000 Women- Years	
CHD events	1.23 (0.99 to 1.53)	41	34
<i>Non-fatal MI</i>	1.28 (1.00 to 1.63)	31	25
<i>CHD death</i>	1.10 (0.70 to 1.75)	8	8
All strokes	1.31 (1.03 to 1.68)	33	25
<i>Ischemic stroke</i>	1.44 (1.09 to 1.90)	26	18
Deep vein thrombosis <sup>d</sup>	1.95 (1.43 to 2.67)	26	13
Pulmonary embolism	2.13 (1.45 to 3.11)	18	8
Invasive breast cancer <sup>e</sup>	1.24 (1.01 to 1.54)	41	33
Colorectal cancer	0.61 (0.42 to 0.87)	10	16
Endometrial cancer <sup>d</sup>	0.81 (0.48 to 1.36)	6	7
Cervical cancer <sup>d</sup>	1.44 (0.47 to 4.42)	2	1
Hip fracture	0.67 (0.47 to 0.96)	11	16
Vertebral fractures <sup>d</sup>	0.65 (0.46 to 0.92)	11	17
Lower arm/wrist fractures <sup>d</sup>	0.71 (0.59 to 0.85)	44	62
Total fractures <sup>d</sup>	0.76 (0.69 to 0.83)	152	199
Overall Mortality <sup>f</sup>	1.00 (0.83 to 1.19)	52	52
Global Index <sup>g</sup>	1.13 (1.02 to 1.25)	184	165

<sup>a</sup>Adapted from numerous WHI publications. WHI publications can be viewed at [www.nhlbi.nih.gov/whi](http://www.nhlbi.nih.gov/whi).

<sup>b</sup>Results are based on centrally adjudicated data.

<sup>c</sup>Nominal confidence intervals unadjusted for multiple looks and multiple comparisons.

<sup>d</sup>Not included in “global index”.

<sup>e</sup> Includes metastatic and non-metastatic breast cancer, with the exception of *in situ* breast cancer.

<sup>f</sup>All deaths, except from breast or colorectal cancer, definite or probable CHD, PE or cerebrovascular disease.

<sup>g</sup>A subset of the events was combined in a “global index” defined as the earliest occurrence of CHD events, invasive breast cancer, stroke, pulmonary embolism,

colorectal cancer, hip fracture, or death due to other causes.

Timing of the initiation of estrogen plus progestin therapy relative to the start of menopause may affect the overall risk benefit profile. The WHI estrogen plus progestin substudy, stratified by age, showed in women 50 to 59 years of age a non-significant trend toward reduced risk for overall mortality [*hazard ratio (HR) 0.69 (95 percent CI, 0.44 to 1.07)*].

#### *WHI Estrogen-Alone Substudy*

The WHI estrogen-alone substudy was stopped early because an increased risk of stroke was observed, and it was deemed that no further information would be obtained regarding the risks and benefits of estrogen-alone in predetermined primary endpoints.

Results of the estrogen-alone substudy, which included 10,739 women (average 63 years of age, range 50 to 79; 75.3 percent White, 15.1 percent Black, 6.1 percent Hispanic, 3.6 percent Other), after an average follow-up of 7.1 years, are presented in Table 7.

**Table 7**

#### **Relative and Absolute Risk Seen in the Estrogen-Alone Substudy of WHI<sup>a</sup>**

Event	Relative Risk CE versus Placebo (95% nCI <sup>b</sup> )	CE n = 5,310 Absolute Risk per 10,000	Placebo n = 5,429 Women-Years
CHD events <sup>c</sup>	0.95 (0.78 to 1.16)	54	57
<i>Non-fatal MI<sup>c</sup></i>	<i>0.91 (0.73 to 1.14)</i>	40	43
<i>CHD death<sup>c</sup></i>	<i>1.01(0.71 to 1.43)</i>	16	16
All strokes <sup>c</sup>	1.33 (1.05 to 1.68)	45	33
<i>Ischemic stroke<sup>b</sup></i>	<i>1.55 (1.19 to 2.01)</i>	38	25
Deep vein thrombosis <sup>c,d</sup>	1.47 (1.06 to 2.06)	23	15
Pulmonary embolism <sup>c</sup>	1.37 (0.90 to 2.07)	14	10
Invasive breast cancer <sup>c</sup>	0.80 (0.62 to 1.04)	28	34
Colorectal cancer <sup>e</sup>	1.08 (0.75 to 1.55)	17	16
Hip fracture <sup>c</sup>	0.65 (0.45 to 0.94)	12	19
Vertebral fractures <sup>c,d</sup>	0.64 (0.44 to 0.93)	11	18
Lower arm/wrist fractures <sup>c,d</sup>	0.58 (0.47 to 0.72)	35	59
Total fractures <sup>c,d</sup>	0.71 (0.64 to 0.80)	144	197
Death due to other causes <sup>e,f</sup>	1.08 (0.88 to 1.32)	53	50
Overall mortality <sup>c,d</sup>	1.04 (0.88 to 1.22)	79	75
Global Index <sup>g</sup>	1.02 (0.92 to 1.13)	206	201

<sup>a</sup> Adapted from numerous WHI publications. WHI publications can be viewed at [www.nhlbi.nih.gov/whi](http://www.nhlbi.nih.gov/whi).

<sup>b</sup> Nominal confidence intervals unadjusted for multiple looks and multiple comparisons.



Results are based on centrally adjudicated data for an average follow-up of 7.1 years.

Not included in “global index”.

Results are based on an average follow-up of 6.8 years.

All deaths, except from breast or colorectal cancer, definite or probable CHD, PE or cerebrovascular disease.

A subset of the events was combined in a “global index,” defined as the earliest occurrence of CHD events, invasive breast cancer, stroke, pulmonary embolism, colorectal cancer, hip fracture, or death due to other causes.

For those outcomes included in the WHI “global index” that reached statistical significance, the absolute excess risk per 10,000 women-years in the group treated with CE-alone was 12 more strokes, while the absolute risk reduction per 10,000 women-years was 7 fewer hip fractures.<sup>9</sup> The absolute excess risk of events included in the “global index” was a non-significant 5 events per 10,000 women-years. There was no difference between the groups in terms of all-cause mortality.

No overall difference for primary CHD events (nonfatal MI, silent MI and CHD death) and invasive breast cancer incidence in women receiving CE-alone compared with placebo was reported in final centrally adjudicated results from the estrogen-alone substudy, after an average follow up of 7.1 years.

Centrally adjudicated results for stroke events from the estrogen-alone substudy, after an average follow-up of 7.1 years, reported no significant difference in distribution of stroke subtype or severity, including fatal strokes, in women receiving CE-alone compared to placebo. Estrogen-alone increased the risk for ischemic stroke, and this excess risk was present in all subgroups of women examined.<sup>10</sup>

Timing of the initiation of estrogen-alone therapy relative to the start of menopause may affect the overall risk benefit profile. The WHI estrogen-alone substudy, stratified by age, showed in women 50 to 59 years of age a non-significant trend toward reduced risk for CHD [*HR 0.63 (95 percent CI, 0.36 to 1.09)*] and overall mortality [*HR 0.71 (95 percent CI, 0.46 to 1.11)*].

## **14.6 Women’s Health Initiative Memory Study**

The WHIMS estrogen plus progestin ancillary study of WHI enrolled 4,532 predominantly healthy postmenopausal women 65 years of age and older (47 percent were 65 to 69 years of age, 35 percent were 70 to 74 years of age, 18 percent were 75 years of age and older) to evaluate the effects of daily CE (0.625 mg) plus MPA (2.5 mg) on the incidence of probable dementia (primary outcome) compared to placebo.

After an average follow-up of 4 years, the relative risk of probable dementia for CE plus MPA versus placebo was 2.05 (95 percent CI, 1.21 to 3.48). The absolute risk of probable dementia for CE plus MPA versus placebo was 45 versus 22 cases per 10,000 women-years. Probable dementia as defined in this study included Alzheimer’s disease (AD), vascular dementia (VaD) and mixed types (having features of both AD and VaD). The most common classification of probable dementia in the treatment group and the placebo group was AD. Since the ancillary study was conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal

women [see *Warnings and Precautions (5.3)*, and *Use in Specific Populations (8.5)*].

The WHIMS estrogen-alone ancillary study of WHI study enrolled 2,947 predominantly healthy hysterectomized postmenopausal women 65 to 79 years of age (45 percent were 65 to 69 years of age, 36 percent were 70 to 74 years of age, 19 percent were 75 years of age and older) to evaluate the effects of daily CE (0.625 mg)-alone on the incidence of probable dementia (primary outcome) compared to placebo.

After an average follow-up of 5.2 years, the relative risk of probable dementia for CE-alone versus placebo was 1.49 (95 percent CI, 0.83 to 2.66). The absolute risk of probable dementia for CE-alone versus placebo was 37 versus 25 cases per 10,000 women-years. Probable dementia as defined in this study included AD, VaD and mixed types (having features of both AD and VaD). The most common classification of probable dementia in the treatment group and the placebo group was AD. Since the ancillary study was conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women [see *Warnings and Precautions (5.3)*, and *Use in Specific Populations (8.5)*].

When data from the two populations were pooled as planned in the WHIMS protocol, the reported overall relative risk for probable dementia was 1.76 (95 percent CI, 1.19 to 2.60). Differences between groups became apparent in the first year of treatment. It is unknown whether these findings apply to younger postmenopausal women [see *Warnings and Precautions (5.3)*, and *Use in Specific Populations (8.5)*].

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10. Hendrix SL, et al. Effects of Conjugated Equine Estrogen on Stroke in the Women's

## 16 HOW SUPPLIED/STORAGE AND HANDLING

### 16.1 How Supplied

**Etyqa (estradiol and norethindrone acetate tablets, USP) 1 mg/0.5 mg** is a white to off-white, round, biconvex, film-coated tablets debossed with "EN" on one side and "1" on the other side. It is supplied as 28 tablets in a blister pack.

The blister packs are available in the following packages:

- The blister pack is packed in pouch and the pouch is packaged in carton

Carton of 1 Pouch    NDC 59651-424-87

- The blister pack is packed in carton

Carton of 1 blister pack                                      NDC 59651-424-28

**Etyqa (estradiol and norethindrone acetate tablets, USP) 0.5 mg/0.1 mg** is a white to off-white, round, biconvex, film-coated tablets debossed with "EN" on one side and "2" on the other side. It is supplied as 28 tablets in a blister pack.

The blister packs are available in the following packages:

- The blister pack is packed in pouch and the pouch is packaged in carton

Carton of 1 Pouch    NDC 59651-425-87

- The blister pack is packed in carton

Carton of 1 blister pack                                      NDC 59651-425-28

### 16.2 Storage and Handling

Store in a dry place protected from light. **Store at** 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature].

## 17 PATIENT COUNSELING INFORMATION

Advise women to read the FDA-approved patient labeling (Patient Information)

### Vaginal Bleeding

Inform postmenopausal women to report any vaginal bleeding to their healthcare provider as soon as possible [see *Warnings and Precautions* (5.2)].

### Possible Serious Adverse Reactions with Estrogen Plus Progestogen Therapy

Inform postmenopausal women of possible serious adverse reactions of estrogen plus progestogen therapy including Cardiovascular Disorders, Malignant Neoplasms, and Probable Dementia [see *Warnings and Precautions (5.1, 5.2, 5.3)*].

### **Possible Common Adverse Reactions with Estrogen Plus Progestogen Therapy**

Inform postmenopausal women of possible less serious but common adverse reactions of estrogen plus progestogen therapy such as headache, breast pain and tenderness, nausea and vomiting.

Distributed by:

**Aurobindo Pharma USA, Inc.**  
279 Princeton-Hightstown Road  
East Windsor, NJ 08520

Manufactured by:

**Aurobindo Pharma Limited**  
Hyderabad-500 032, India

Revised: 03/2024

### **Patient Information**

#### **Etyqa (ee-tee-ka) (estradiol and norethindrone acetate tablets, USP)**

#### **for oral use**

Read this Patient Information before you start using Etyqa and each time you get a refill. There may be new information. This information does not take the place of talking to your healthcare provider about your menopausal symptoms or your treatment.

#### **What is the most important information I should know about Etyqa (a combination of estrogen and progestogen)?**

- Do not use estrogens with or without progestogens to prevent heart disease, heart attacks, strokes, or dementia (decline of brain function).
- Using estrogens with progestogens may increase your chances of getting heart attacks, strokes, breast cancer, or blood clots.
- Using estrogens with progestogens may increase your chance of getting dementia, based on a study of women 65 years of age and older.
- Using estrogen-alone may increase your chance of getting cancer of the uterus (womb).
- Do not use estrogen-alone to prevent heart disease, heart attacks, strokes, or dementia (decline in brain function).
- Using estrogen-alone may increase your chances of getting strokes or blood clots.
- Using estrogen-alone may increase your chance of getting dementia, based

on a study of women 65 years of age and older.

- Only one estrogen with progestogen product and dose have been shown to increase your chances of getting heart attacks, strokes, breast cancer, blood clots, and dementia. Only one estrogen-alone product and dose have been shown to increase your chances of getting strokes, blood clots, and dementia.

Because other products and doses have not been studied in the same way, it is not known how the use of Etyqa will affect your chances of these conditions. You and your healthcare provider should talk regularly about whether you still need treatment with Etyqa.

## **What is Etyqa?**

Etyqa is a prescription medicine that contains two kinds of hormones, an estrogen and a progestogen.

## **What is Etyqa used for?**

Etyqa is used after menopause to:

- **Reduce moderate to severe hot flashes**

Estrogens are hormones made by a woman's ovaries. The ovaries normally stop making estrogens when a woman is between 45 and 55 yrs old. This drop in body estrogen levels causes the "change of life" or menopause, the end of monthly menstrual periods. Sometimes both ovaries are removed during an operation before natural menopause takes place. The sudden drop in estrogen levels causes "surgical menopause."

When estrogen levels begin dropping, some women get very uncomfortable symptoms, such as feelings of warmth in the face, neck, and chest, or sudden, intense feelings of heat and sweating ("hot flashes" or "hot flushes"). In some women, the symptoms are mild, and they will not need to use estrogens. In other women, symptoms can be more severe.

- **Treat moderate to severe menopausal changes in and around the vagina**

You and your healthcare provider should talk regularly about whether you still need treatment with Etyqa 1 mg/0.5 mg to treat these problems. If you use Etyqa 1 mg/0.5 mg only to treat your menopausal changes in and around your vagina, talk with your healthcare provider about whether a topical vaginal product would be better for you.

- **Help reduce your chances of getting osteoporosis (thin weak bones)**

Osteoporosis from menopause is a thinning of the bones that makes them weaker and easier to break. If you use Etyqa to prevent osteoporosis due to menopause, talk with your healthcare provider about whether a different treatment or medicine without estrogens might be better for you.

You and your healthcare provider should talk regularly about whether you still need treatment with Etyqa.

### **Who should not use Etyqa?**

#### **Do not use Etyqa if you have had your uterus (womb) removed (hysterectomy).**

Etyqa contains a progestogen to decrease the chance of getting cancer of the uterus. If you do not have a uterus, you do not need a progestogen and you should not use Etyqa.

#### **Do not start using Etyqa if you:**

- **have unusual vaginal bleeding**

Vaginal bleeding after menopause may be a warning sign of cancer of the uterus (womb). Your healthcare provider should check any unusual vaginal bleeding to find out the cause.

- **have been diagnosed with a bleeding disorder**
- **currently have or have had certain cancers**

Estrogens may increase the chance of getting certain types of cancers, including cancer of the breast or uterus (womb). If you have or have had cancer, talk with your healthcare provider about whether you should use Etyqa.

- **had a stroke or heart attack**
- **currently have or have had blood clots**
- **currently have or have had liver problems**
- **are allergic to Etyqa or any of the ingredients in it.**

See the list of ingredients in Etyqa at the end of this leaflet.

#### **Before you use Etyqa, tell your healthcare provider about all of your medical conditions, including if you:**

- **have any unusual vaginal bleeding**

Vaginal bleeding after menopause may be a warning sign of cancer of the uterus (womb). Your healthcare provider should check any unusual vaginal bleeding to find out the cause.

- **have any other medical conditions that may become worse while you are using Etyqa.**

Your healthcare provider may need to check you more carefully if you have certain conditions, such as asthma (wheezing), epilepsy (seizures), diabetes, migraine, endometriosis, lupus, angioedema (swelling of face and tongue), problems with your

heart, liver, thyroid, kidneys, or have high calcium levels in your blood.

- **are going to have surgery or will be on bed rest**

Your healthcare provider will let you know if you need to stop using Etyqa.

- **are pregnant or think you may be pregnant.**

Etyqa is not for pregnant women.

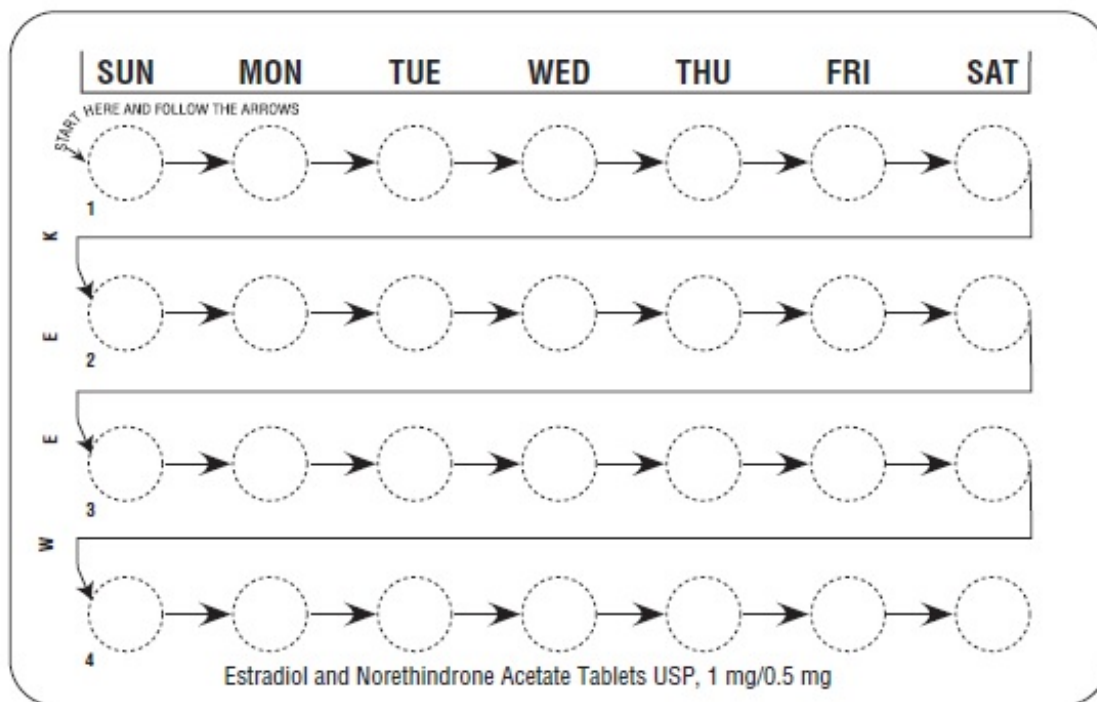
- **are breast feeding**

The hormones in Etyqa can pass into your breast milk.

**Tell your healthcare provider about all the medicines you take**, including prescription and over-the-counter medicines, vitamins, and herbal supplements. Some medicines may affect how Etyqa works. Etyqa may also affect how your other medicines work. Keep a list of your medicines and show it to your healthcare provider and pharmacist when you get new medicine.

### How should I use Etyqa?

- Use Etyqa exactly as your healthcare provider tells you to use it.
- Take 1 tablet at the same time each day.
- You and your healthcare provider should talk regularly (every 3 to 6 months) about your dose and whether you still need treatment with Etyqa.



### What are the possible side effects of Etyqa?

**Side effects are grouped by how serious they are and how often they happen when you are treated.**

**Serious, but less common side effects include:**

- heart attack

- stroke
- blood clots
- breast cancer
- cancer of the lining of the uterus (womb)
- cancer of the ovary
- dementia
- high or low blood calcium levels
- gallbladder disease
- visual abnormalities
- high blood pressure
- high levels of fat (triglycerides) in your blood
- liver problems
- changes in your thyroid hormone levels
- fluid retention
- cancer changes of endometriosis
- enlargement of benign tumors of the uterus (“fibroids”)
- worsening swelling of face and tongue (angioedema) in women who have a history of angioedema
- changes in laboratory tests results such as bleeding times and high blood sugar levels

**Call your healthcare provider right away if you get any of the following warning signs or any other unusual symptoms that concern you:**

- new breast lumps
- unusual vaginal bleeding
- changes in vision or speech
- sudden new severe headaches
- severe pains in your chest or legs with or without shortness of breath, weakness and fatigue

**Common side effects of Etyqa include:**

- irregular vaginal bleeding or spotting
- nausea
- stomach or abdominal cramps, bloating
- headache
- vomiting
- back pain
- breast pain
- diarrhea
- fluid retention
- vaginal yeast infection

These are not all the possible side effects of Etyqa. For more information, ask your healthcare provider or pharmacist. Tell your healthcare provider if you have any side effects that bother you or do not go away.



You may report side effects to Aurobindo Pharma USA, Inc. at 1-866-850-2876 or to FDA at 1-800-FDA-1088.

### **What can I do to lower my chances of a serious side effect with Etyqa?**

- Talk with your healthcare provider regularly about whether you should continue using Etyqa.
- If you have a uterus, talk with your healthcare provider about whether Etyqa is right for you.
- In general, the addition of a progestogen is generally recommended for a woman with a uterus to reduce the chance of getting cancer of the uterus (womb).
- See your healthcare provider right away if you get vaginal bleeding while using Etyqa.
- Have a pelvic exam, breast exam and mammogram (breast X-ray) every year unless your healthcare provider tells you something else.
- If members of your family have had breast cancer or if you have ever had breast lumps or an abnormal mammogram (breast x-ray), you may need to have breast exams more often.
- If you have high blood pressure, high cholesterol (fat in the blood), diabetes, are overweight, or if you use tobacco, you may have higher chances for getting heart disease.
- Ask your healthcare provider for ways to lower your chances for getting heart disease.

### **How should I store Etyqa?**

- Store Etyqa at room temperature between 68° to 77°F (20° to 25°C).
- Store Etyqa in a dry place protected from light.

### **Keep Etyqa and all medicines out of the reach of children.**

### **General information about the safe and effective use of Etyqa.**

Medicines are sometimes prescribed for purposes other than those listed in patient information leaflets. Do not use Etyqa for conditions for which it was not prescribed. Do not give Etyqa to other people, even if they have the same symptoms you have. It may harm them.

You can ask your healthcare provider or pharmacist for information about Etyqa that is written for health professionals.

For more information call Aurobindo Pharma USA, Inc. at 1-866-850-2876

### **What are the ingredients in Etyqa?**

**Active ingredients:** estradiol and norethindrone acetate

**Inactive Ingredients:** corn starch, hydroxyl propyl cellulose, hypromellose, lactose

monohydrate, magnesium stearate, talc and triacetin.

This Patient Information has been approved by the U.S. Food and Drug Administration.

Distributed by:

**Aurobindo Pharma USA, Inc.**  
279 Princeton-Hightstown Road  
East Windsor, NJ 08520

Manufactured by:

**Aurobindo Pharma Limited**  
Hyderabad-500 032, India

Revised: 03/2024

**PACKAGE LABEL-PRINCIPAL DISPLAY PANEL - 0.5 mg/0.1 mg Pouch Label**  
**NDC 59651-425-87**

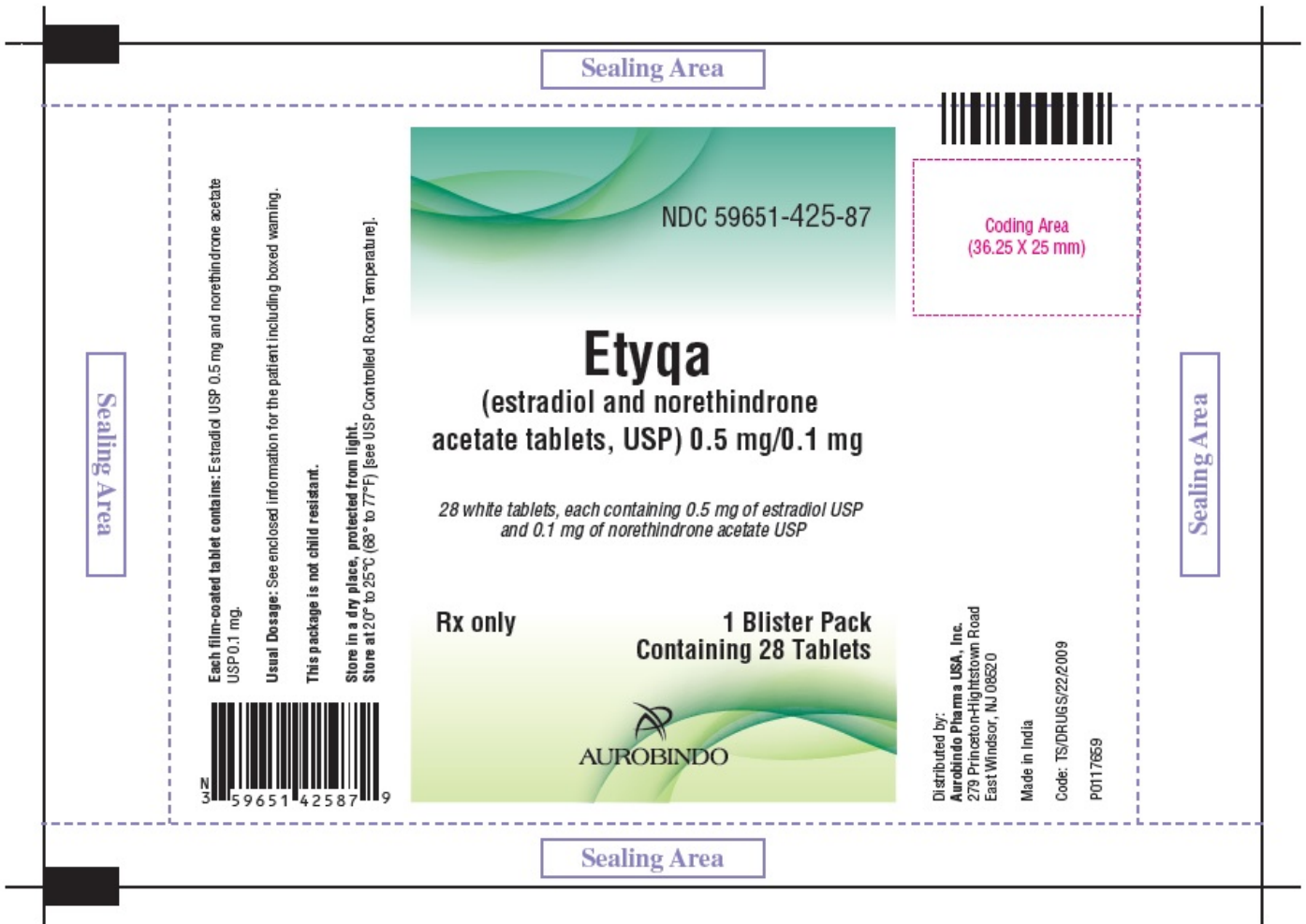
**Etyqa**  
**(estradiol and norethindrone**  
**acetate tablets, USP) 0.5 mg/0.1 mg**

*28 white tablets, each containing 0.5 mg of estradiol USP  
and 0.1 mg of norethindrone acetate USP*

**Rx only**

**1 Blister Pack**  
**Containing 28 Tablets**

**AUROBINDO**



**PACKAGE LABEL-PRINCIPAL DISPLAY PANEL - 0.5 mg/0.1 mg Pouch Carton  
NDC 59651-425-87**

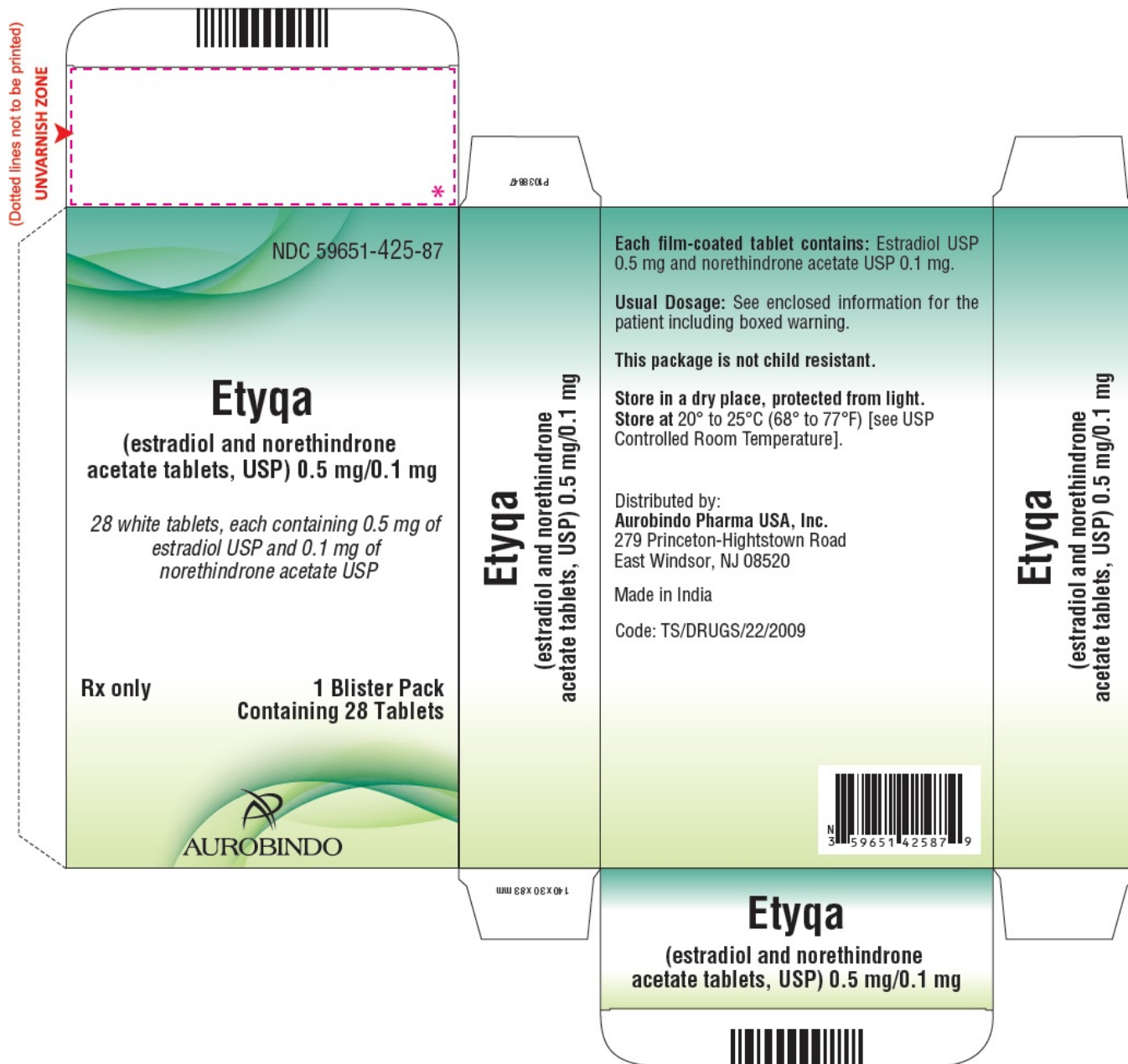
**Etyqa  
(estradiol and norethindrone  
acetate tablets, USP) 0.5 mg/0.1 mg**

*28 white tablets, each containing 0.5 mg of  
estradiol USP and 0.1 mg of  
norethindrone acetate USP*

**Rx only**

**1 Blister Pack  
Containing 28 Tablets**

**AUROBINDO**



**PACKAGE LABEL-PRINCIPAL DISPLAY PANEL - 0.5 mg/0.1 mg Blister Carton  
NDC 59651-425-28**

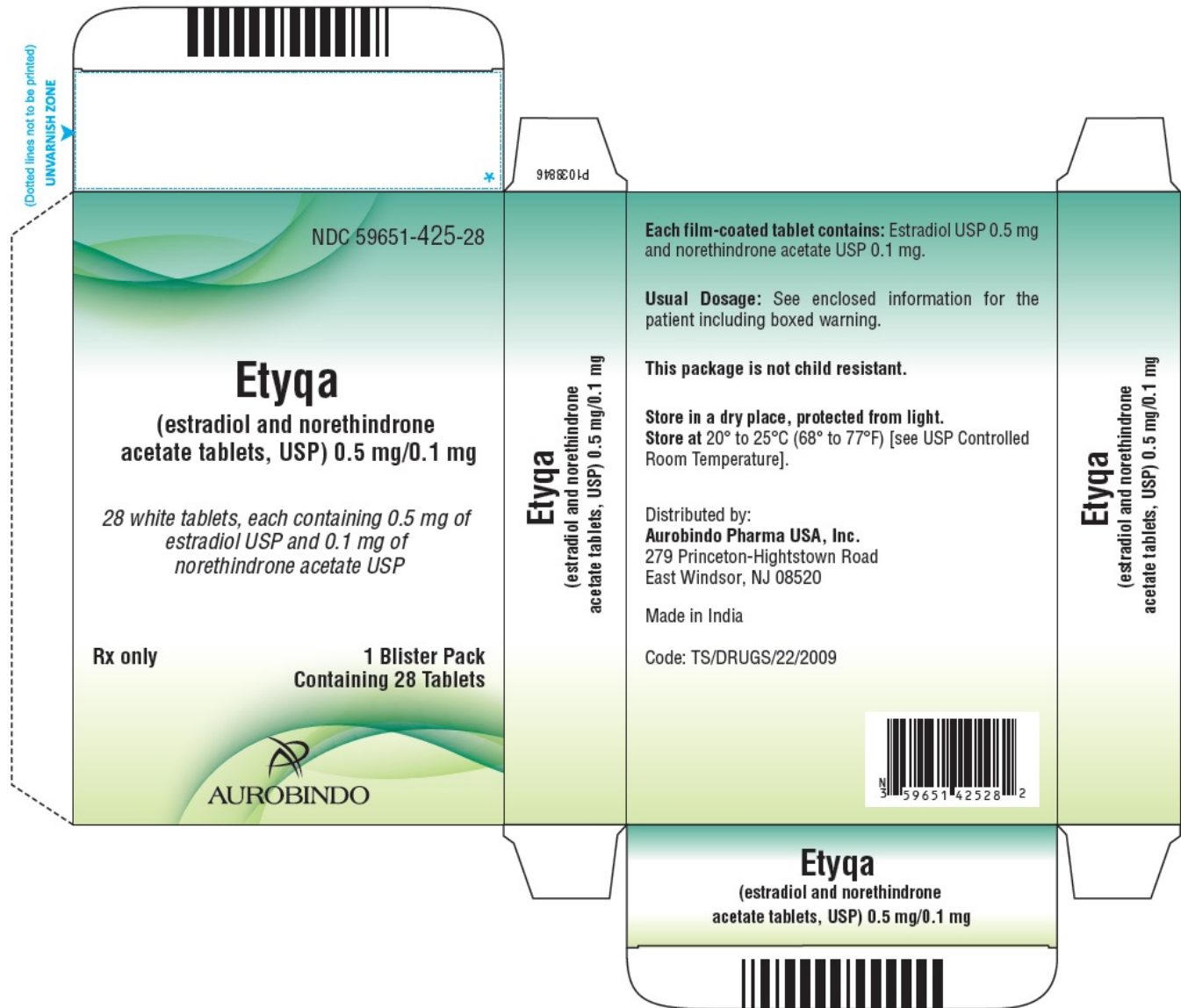
**Etyqa**  
**(estradiol and norethindrone acetate tablets, USP) 0.5 mg/0.1 mg**

*28 white tablets, each containing 0.5 mg of estradiol USP and 0.1 mg of norethindrone acetate USP*

**Rx only**

**1 Blister Pack  
Containing 28 Tablets**

# AUROBINDO



## PACKAGE LABEL-PRINCIPAL DISPLAY PANEL - 1 mg/0.5 mg Pouch Label

NDC 59651-424-87

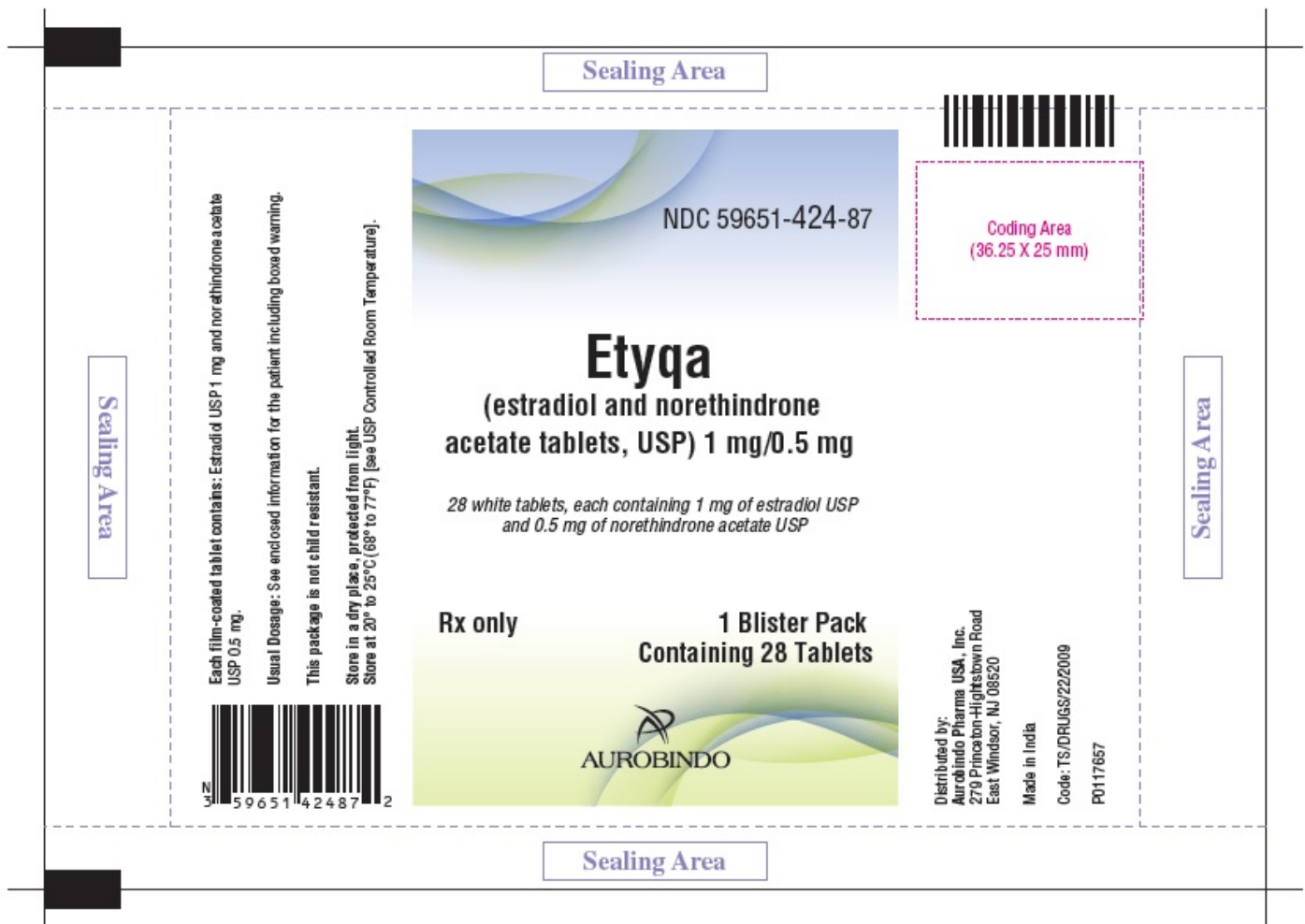
### **Etyqa** **(estradiol and norethindrone** **acetate tablets, USP) 1 mg/0.5 mg**

*28 white tablets, each containing 1 mg of estradiol USP  
and 0.5 mg of norethindrone acetate USP*

**Rx only**

**1 Blister Pack**  
**Containing 28 Tablets**

# AUROBINDO



## PACKAGE LABEL-PRINCIPAL DISPLAY PANEL - 1 mg/0.5 mg Pouch Carton NDC 59651-424-87

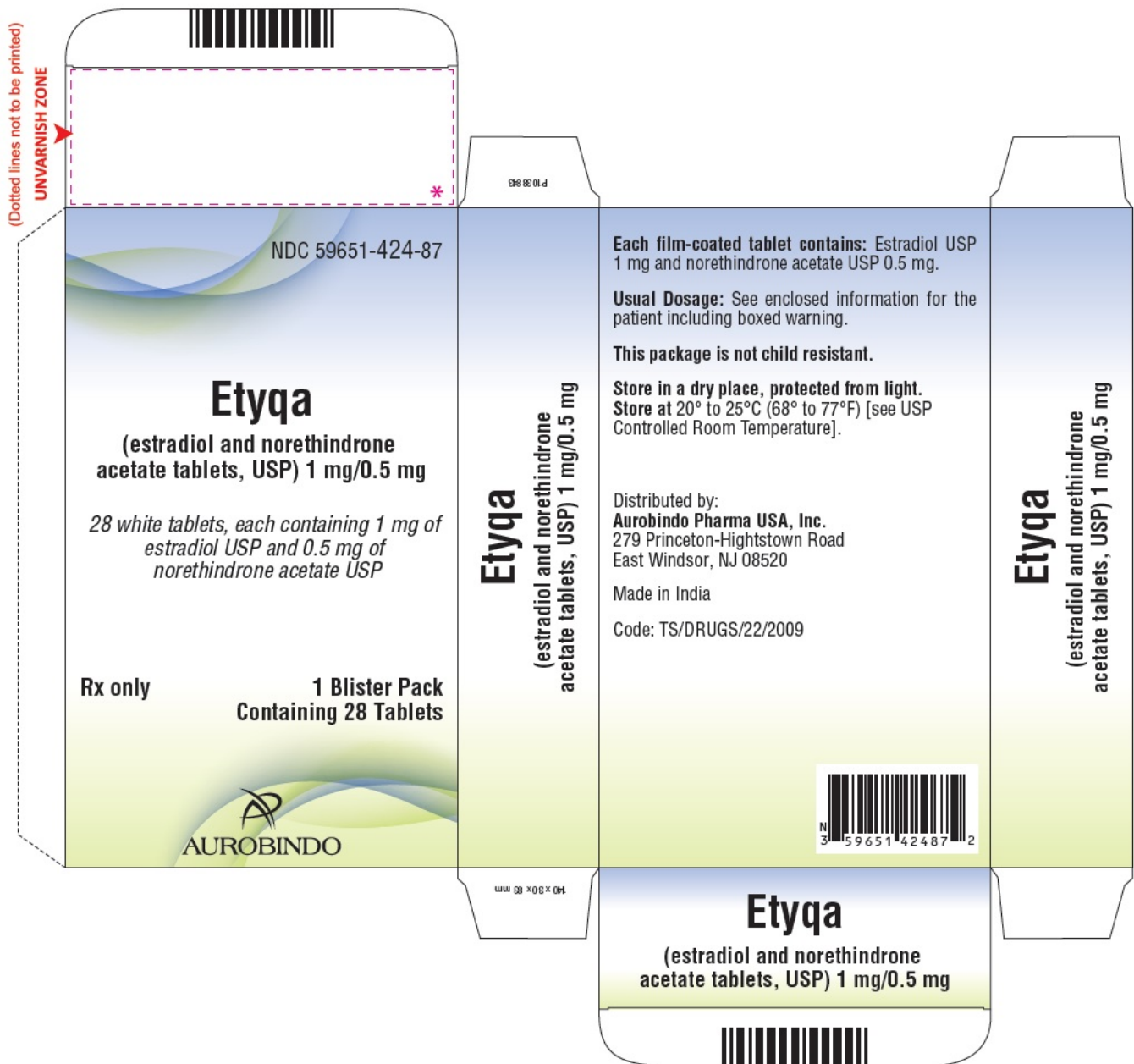
### **Etyqa** **(estradiol and norethindrone** **acetate tablets, USP) 1 mg/0.5 mg**

*28 white tablets, each containing 1 mg of estradiol USP and 0.5 mg of norethindrone acetate USP*

**Rx only**

**1 Blister Pack**  
**Containing 28 Tablets**

# AUROBINDO



## PACKAGE LABEL-PRINCIPAL DISPLAY PANEL - 1 mg/0.5 mg Blister Carton NDC 59651-424-28

### **Etyqa** (estradiol and norethindrone acetate tablets, USP) 1 mg/0.5 mg

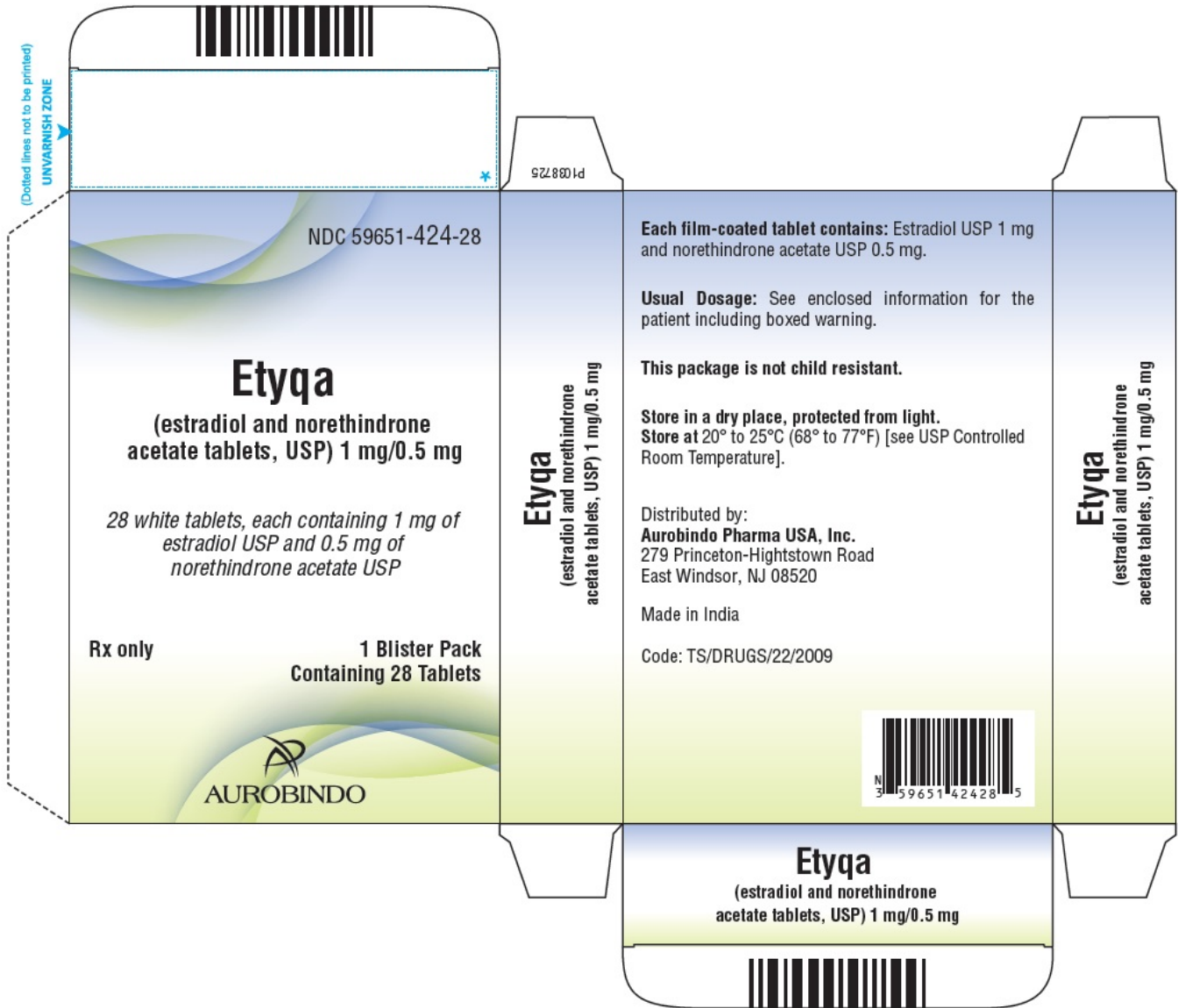
*28 white tablets, each containing 1 mg of estradiol USP and 0.5 mg of norethindrone acetate USP*



Rx only

**1 Blister Pack  
Containing 28 Tablets**

**AUROBINDO**



**ETYQA**

estradiol and norethindrone acetate tablet, film coated

**Product Information**

<b>Product Type</b>	HUMAN PRESCRIPTION DRUG	<b>Item Code (Source)</b>	NDC:59651-425
<b>Route of Administration</b>	ORAL		



## Active Ingredient/Active Moiety

Ingredient Name	Basis of Strength	Strength
<b>ESTRADIOL</b> (UNII: 4TI98Z838E) (ESTRADIOL - UNII:4TI98Z838E)	ESTRADIOL	0.5 mg
<b>NORETHINDRONE ACETATE</b> (UNII: 9S44LIC7OJ) (NORETHINDRONE - UNII:T18F433X4S)	NORETHINDRONE ACETATE	0.1 mg

## Inactive Ingredients

Ingredient Name	Strength
<b>STARCH, CORN</b> (UNII: O8232NY3SJ)	
<b>HYDROXYPROPYL CELLULOSE (110000 WAMW)</b> (UNII: 5Y0974F5PW)	
<b>HYPROMELLOSE 2910 (6 MPA.S)</b> (UNII: 0WZ8WG20P6)	
<b>LACTOSE MONOHYDRATE</b> (UNII: EWQ57Q8I5X)	
<b>MAGNESIUM STEARATE</b> (UNII: 70097M6I30)	
<b>TALC</b> (UNII: 7SEV7J4R1U)	
<b>TRIACETIN</b> (UNII: XHX3C3X673)	

## Product Characteristics

<b>Color</b>	WHITE (white to off-white)	<b>Score</b>	no score
<b>Shape</b>	ROUND (biconvex)	<b>Size</b>	6mm
<b>Flavor</b>		<b>Imprint Code</b>	EN;2
<b>Contains</b>			

## Packaging

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:59651-425-87	1 in 1 CARTON	06/30/2023	
1		1 in 1 POUCH		
1		28 in 1 BLISTER PACK; Type 0: Not a Combination Product		
2	NDC:59651-425-28	1 in 1 CARTON	06/30/2023	
2		28 in 1 BLISTER PACK; Type 0: Not a Combination Product		

## Marketing Information

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA214729	06/30/2023	

## ETYQA

estradiol and norethindrone acetate tablet, film coated

## Product Information

<b>Product Type</b>	HUMAN PRESCRIPTION DRUG	<b>Item Code (Source)</b>	NDC:59651-424
<b>Route of Administration</b>	ORAL		

## Active Ingredient/Active Moiety

<b>Ingredient Name</b>	<b>Basis of Strength</b>	<b>Strength</b>
<b>ESTRADIOL</b> (UNII: 4TI98Z838E) (ESTRADIOL - UNII:4TI98Z838E)	ESTRADIOL	1 mg
<b>NORETHINDRONE ACETATE</b> (UNII: 9S44LIC7OJ) (NORETHINDRONE - UNII:T18F433X4S)	NORETHINDRONE ACETATE	0.5 mg

## Inactive Ingredients

<b>Ingredient Name</b>	<b>Strength</b>
<b>STARCH, CORN</b> (UNII: O8232NY3SJ)	
<b>HYDROXYPROPYL CELLULOSE (110000 WAMW)</b> (UNII: 5Y0974F5PW)	
<b>HYPROMELLOSE 2910 (6 MPA.S)</b> (UNII: 0WZ8WG20P6)	
<b>LACTOSE MONOHYDRATE</b> (UNII: EWQ57Q8I5X)	
<b>MAGNESIUM STEARATE</b> (UNII: 70097M6I30)	
<b>TALC</b> (UNII: 7SEV7J4R1U)	
<b>TRIACETIN</b> (UNII: XHX3C3X673)	

## Product Characteristics

<b>Color</b>	WHITE (white to off-white)	<b>Score</b>	no score
<b>Shape</b>	ROUND (biconvex)	<b>Size</b>	6mm
<b>Flavor</b>		<b>Imprint Code</b>	EN;1
<b>Contains</b>			

## Packaging

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:59651-424-87	1 in 1 CARTON	06/30/2023	
1		1 in 1 POUCH		
1		28 in 1 BLISTER PACK; Type 0: Not a Combination Product		
2	NDC:59651-424-28	1 in 1 CARTON	06/30/2023	
2		28 in 1 BLISTER PACK; Type 0: Not a Combination Product		

## Marketing Information

<b>Marketing Category</b>	<b>Application Number or Monograph Citation</b>	<b>Marketing Start Date</b>	<b>Marketing End Date</b>
ANDA	ANDA214729	06/30/2023	

**Labeler** - Aurobindo Pharma Limited (650082092)

**Establishment**

Name	Address	ID/FEI	Business Operations
Aurobindo Pharma Limited		650381903	ANALYSIS(59651-424, 59651-425) , MANUFACTURE(59651-424, 59651-425)

Revised: 3/2024

Aurobindo Pharma Limited