

INFANRIX® hexa

Combined Diphtheria-Tetanus-acellular Pertussis (DTPa), Hepatitis B, Poliovirus and *Haemophilus influenzae* type b vaccine

NAME OF THE MEDICINE

INFANRIX hexa

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DESCRIPTION

Powder and suspension for suspension for injection.

1 dose (0.5 ml) contains:

Diphtheria toxoid ¹	not less than 30 International units
Tetanus toxoid ¹	not less than 40 International units
<i>Bordetella pertussis</i> antigens	
Pertussis toxoid (PT) ¹	25 micrograms
Filamentous Haemagglutinin (FHA) ¹	25 micrograms
Pertactin (PRN) ¹	8 micrograms
Hepatitis B surface antigen (HBs) ^{2,3}	10 micrograms
Poliovirus (inactivated) (IPV)	
type 1 (Mahoney strain) ⁴	40 D-antigen unit
type 2 (MEF-1 strain) ⁴	8 D-antigen unit
type 3 (Saukett strain) ⁴	32 D-antigen unit
<i>Haemophilus influenzae</i> type b polysaccharide (polyribosylribitol phosphate, PRP) ³	10 micrograms
conjugated to tetanus toxoid as carrier protein	20 - 40 micrograms

¹adsorbed on aluminium hydroxide, hydrated (Al(OH)₃) 0.5 milligrams Al³⁺

²produced in yeast cells (*Saccharomyces cerevisiae*) by recombinant DNA technology

³adsorbed on aluminium phosphate (AlPO₄) 0.32 milligrams Al³⁺

⁴propagated in VERO cells

The DTPa-HBV-IPV component is presented as a turbid white suspension. Upon storage, a white deposit and clear supernatant can be observed.

The Hib component is presented as a white pellet.

The final vaccine also contains the excipients lactose, medium 199 (as stabiliser containing amino acids, mineral salts, vitamins and other substances), sodium chloride, aluminium hydroxide, aluminium phosphate and water for injections. The vaccine also contains the following residues: potassium chloride, polysorbate 20 and 80, formaldehyde, glycine, sodium phosphate dibasic dihydrate, potassium phosphate monobasic, neomycin sulfate and polymyxin B sulfate.

CLINICAL PHARMACOLOGY

Clinical Trials

Immunogenicity

The immunogenicity of *INFANRIX hexa* has been evaluated in clinical studies from 6 weeks of age. The vaccine was assessed in 2-dose and 3-dose priming schedules and as a booster dose. The results of these clinical studies are summarised in the tables below:

After a 3-dose primary vaccination schedule, at least 95.7% of infants had developed seroprotective or seropositive antibody levels against each of the vaccine antigens. After booster vaccination (post-dose 4), at least 98.4% of children had developed seroprotective or seropositive antibody levels against each of the vaccine antigens.

Percentage of subjects with antibody titres \geq assay cut-off one month after 3-dose primary and booster vaccination with Infanrix hexa

Antibody (cut-off)	Post-dose 3				Post-dose 4 (Booster vaccination during the second year of life following a 3-dose primary course)
	2-3-4 months N= 196 (2 studies)	2-4-6 months N= 1693 (6 studies)	3-4-5 months N= 1055 (6 studies)	6-10-14 weeks N= 265 (1 study)	N=2009 (12 studies)
	%	%	%	%	%
Anti-diphtheria (0.1 IU/ml) †	100.0	99.8	99.7	99.2	99.9
Anti-tetanus (0.1 IU/ml) †	100.0	100.0	100.0	99.6	99.9
Anti-PT (5 EL.U/ml)	100.0	100.0	99.8	99.6	99.9
Anti-FHA (5 EL.U/ml)	100.0	100.0	100.0	100.0	99.9
Anti-PRN (5 EL.U/ml)	100.0	100.0	99.7	98.9	99.5

Anti-HBs (10 mIU/ml) †	99.5	98.9	98.0	98.5*	98.4
Anti-Polio type 1 (1/8 dilution) †	100.0	99.9	99.7	99.6	99.9
Anti-Polio type 2 (1/8 dilution) †	97.8	99.3	98.9	95.7	99.9
Anti-Polio type 3 (1/8 dilution) †	100.0	99.7	99.7	99.6	99.9
Anti-PRP (0.15 µg/ml) †	96.4	96.6	96.8	97.4	99.7

N = number of subjects

* in a subgroup of infants not administered hepatitis B vaccine at birth, 77.7% of subjects had anti-HBs titres \geq 10 mIU/ml

† cut-off accepted as indicative of protection

After a complete vaccination according to a 2-dose primary and booster schedule with *INFANRIX hexa*, at least 97.9% of the subjects had developed seroprotective or seropositive antibody levels against each of the vaccine antigens.

Percentage of subjects with antibody titres \geq assay cut-off one month after 2-dose primary and booster vaccination with *Infanrix hexa*

Antibody (cut-off)	Post-dose 3 (Vaccination at 2-4-12 months of age) N=196 (1 study)	Post-dose 3 (Vaccination at 3-5-11 months of age) N=532 (3 studies)
	%	%
Anti-diphtheria (0.1 IU/ml) †	100.0	100.0
Anti-tetanus (0.1 IU/ml) †	100.0	100.0
Anti-PT (5 EL.U/ml)	99.5	100.0
Anti-FHA (5 EL.U/ml)	100.0	100.0
Anti-PRN (5 EL.U/ml)	100.0	99.2
Anti-HBs (10 mIU/ml) †	99.8	98.9
Anti-Polio type 1 (1/8 dilution) †	98.4	99.8
Anti-Polio type 2 (1/8 dilution) †	98.4	99.4
Anti-Polio type 3 (1/8 dilution) †	97.9	99.2
Anti-PRP (0.15 µg/ml) †	100.0	99.6

N = number of subjects

† cut-off accepted as indicative of protection

Serological correlates of protection have been established for diphtheria, tetanus, polio, Hepatitis B and Hib. For pertussis there is no serological correlate of protection. However, as the immune response to pertussis antigens following *INFANRIX hexa* administration is equivalent to that of *INFANRIX*, the protective efficacy of the two vaccines is expected to be equivalent.

Protective efficacy against pertussis

The protective efficacy of the pertussis component of *INFANRIX* (DTPa) against WHO-defined typical pertussis (≥ 21 days of paroxysmal cough with laboratory confirmation) was demonstrated after 3-dose primary immunisation in the studies tabulated below:

Study	Country	Schedule	Vaccine efficacy	Considerations
Household contact study (prospective blinded)	Germany	3,4,5 months	88.7%	Based on data collected from secondary contacts in households where there was an index case with typical pertussis
Efficacy study (NIH sponsored)	Italy	2,4,6 months	84%	In a follow-up of the same cohort, the efficacy was confirmed up to 60 months after completion of primary vaccination without administration of a booster dose of pertussis.

Immunogenicity in preterm infants

The immunogenicity of *INFANRIX hexa* was evaluated across three studies including approximately 300 preterm infants (born after a gestation period of 24 to 36 weeks) following a 3-dose primary vaccination course at 2, 4 and 6 months of age. The immunogenicity of a booster dose at 18 to 24 months of age was evaluated in approximately 200 preterm infants.

One month after primary vaccination at least 98.7% of subjects were seroprotected against diphtheria, tetanus and poliovirus types 1 and 2; at least 90.9% had seroprotective antibody levels against the hepatitis B, PRP and poliovirus type 3 antigens; and all subjects were seropositive for antibodies against FHA and PRN while 94.9% were seropositive for anti-PT antibodies.

One month after the booster dose at least 98.4% of subjects had seroprotective or seropositive antibody levels against each of the antigens except against PT (at least 96.8%) and hepatitis B (at least 88.7%). The response to the booster dose in terms

of fold increases in antibody concentrations (15- to 235-fold), indicate that preterm infants were adequately primed for all the antigens of *INFANRIX hexa*.

In a follow-up study, approximately 2.5 to 3 years after the booster dose, 85.3% of the children were still seroprotected against hepatitis B and at least 95.7% were seroprotected against the three poliovirus types and PRP.

Persistence of the immune response

The persistence of the immune response to a 3-dose primary and booster schedule with *INFANRIX hexa* was evaluated in children 4-8 years of age. Protective immunity against the three poliovirus types and PRP was observed in at least 91.0% of children and against diphtheria and tetanus in at least 64.7% of children. At least 25.4% (anti-PT), 97.5% (anti-FHA) and 87.0% (anti-PRN) of children were seropositive against the pertussis components.

With regards to hepatitis B, protective immunity following a 3-dose primary and booster schedule with *Infanrix hexa* has been shown to persist in $\geq 85\%$ of subjects 4-5 years of age and in $\geq 72\%$ of subjects 7-8 years of age. Additionally, following a 2-dose primary and booster schedule, protective immunity against hepatitis B persisted in $\geq 48\%$ of subjects 11-12 years of age.

Hepatitis B immunological memory was confirmed in children 4 to 12 years of age. These children had received *INFANRIX hexa* as primary and booster vaccination in infancy, and when an additional dose of monovalent HBV vaccine was administered, protective immunity was induced in at least 96.8% of subjects.

Post Marketing Experience

Results of long term follow-up in Sweden demonstrate that acellular pertussis vaccines are efficacious in infants when administered according to the 3 and 5 months primary vaccination schedule, with a booster dose administered at approximately 12 months. However, data indicate that protection against pertussis may be waning at 7-8 years of age. This suggests that a second booster dose of pertussis vaccine is warranted in children aged 5-7 years who have previously been vaccinated following this schedule.

The effectiveness of the Hib component of *INFANRIX hexa* was investigated via an extensive post-marketing surveillance study conducted in Germany. The recommended schedule in Germany for all DTaP/Hib conjugate vaccines is a 3 dose primary series at the age of 2, 3 and 4 months with a booster at 11 to 14 months of age. Over a 7 year follow-up period, the effectiveness of the Hib

components of two hexavalent vaccines, of which one was *INFANRIX hexa*, was 89.6% for a full primary series and 100% for a full primary series plus booster dose (irrespective of the Hib vaccine used for priming).

INFANRIX hexa has been the principal Hib-containing vaccine available in Italy since 2006. The vaccine is administered at 3, 5 and 11 months of age and coverage has exceeded 95%. Hib disease has continued to be well controlled, with no more than three confirmed Hib cases reported annually between 2006 and 2011 in Italian children aged less than 5 years.

INDICATIONS

INFANRIX hexa is indicated for primary immunisation of infants from the age of 6 weeks against diphtheria, tetanus, pertussis, hepatitis B, poliomyelitis, and *Haemophilus influenzae* type b.

INFANRIX hexa is also indicated for use as booster dose if boosting with hepatitis B, poliomyelitis, and *Haemophilus influenzae* type b, as well as diphtheria, tetanus and pertussis is required.

Refer to DOSAGE AND ADMINISTRATION for further information

CONTRAINDICATIONS

INFANRIX hexa should not be administered to subjects with known hypersensitivity to the active substances or to any of the excipients or residues (see DESCRIPTION).

INFANRIX hexa should not be administered to subjects having shown signs of hypersensitivity after previous administration of diphtheria, tetanus, pertussis, hepatitis B, polio or Hib vaccines.

INFANRIX hexa is contraindicated if the child has experienced encephalopathy of unknown aetiology, occurring within 7 days following previous vaccination with pertussis containing vaccine. In these circumstances pertussis vaccination should be discontinued and the vaccination should be continued with diphtheria-tetanus, hepatitis B, inactivated polio and Hib vaccines.

PRECAUTIONS

Do not administer *INFANRIX hexa* intravascularly or intradermally.

As with other vaccines, the administration of *INFANRIX hexa* should be postponed in subjects suffering from acute severe febrile illness (with fever $>38.5^{\circ}\text{C}$). The presence of a minor infection, however, is not a contraindication.

It is good clinical practice that immunisation should be preceded by a review of the medical history (especially with regard to previous immunisation and possible occurrence of undesirable events) and a clinical examination.

A protective immune response may not be elicited in all vaccinees (see Clinical Trials).

INFANRIX hexa will not prevent disease caused by pathogens other than *Corynebacterium diphtheriae*, *Clostridium tetani*, *Bordetella pertussis*, hepatitis B virus, poliovirus or *Haemophilus influenzae* type b. However, it can be expected that hepatitis D will be prevented by immunisation as hepatitis D (caused by the delta agent) does not occur in the absence of hepatitis B infection. The vaccine will not prevent infection caused by other agents such as hepatitis A, hepatitis C and hepatitis E and other pathogens known to infect the liver.

If any of the following events are known to have occurred in temporal relation to receipt of whole cell or acellular pertussis-containing vaccine, the decision to give further doses of vaccine containing the pertussis component should be carefully considered:

- Temperature of $\geq 40.0^{\circ}\text{C}$ within 48 hours, not due to another identifiable cause.
- Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours of vaccination.
- Persistent, inconsolable crying lasting ≥ 3 hours, occurring within 48 hours of vaccination.
- Convulsions with or without fever, occurring within 3 days of vaccination.

No data currently exist on use of *INFANRIX hexa* in these children. There may be circumstances, such as a high incidence of pertussis, when the potential benefits outweigh possible risks, particularly since these events are not associated with permanent sequelae.

In children with progressive neurological disorders, including infantile spasms, uncontrolled epilepsy or progressive encephalopathy, it is better to defer pertussis (Pa or Pw) immunisation until the condition is corrected or stable. However, the

decision to give pertussis vaccine must be made on an individual basis after careful consideration of the risks and benefits.

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

INFANRIX hexa should be administered with caution to subjects with thrombocytopenia or a bleeding disorder since bleeding may occur following an intramuscular injection in these subjects.

A history of febrile convulsions, a family history of convulsions, or Sudden Infant Death Syndrome (SIDS) do not constitute contra-indications for the use of *INFANRIX hexa*. Vaccinees with a history of febrile convulsions should be closely followed up as such adverse events may occur within 2 to 3 days post vaccination.

Data from clinical studies indicate that, when *INFANRIX hexa* is co-administered with pneumococcal conjugate vaccine, the rate of febrile reactions is higher compared to that occurring following the administration of *INFANRIX hexa* alone.

Increased reporting rates of convulsions (with or without fever) and hypotonic hyporesponsive episode (HHE) were observed with concomitant administration of *INFANRIX hexa* and Prevenar 13 (see ADVERSE REACTIONS).

Antipyretic treatment should be initiated according to local treatment guidelines.

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

INFANRIX hexa should not be administered at birth. Infants born of HBsAg positive mothers should receive hepatitis B immune globulin and hepatitis B vaccine at birth.

The Hib component of the vaccine does not protect against diseases due to other strains of *Haemophilus influenzae* or against meningitis caused by other organisms.

Special Populations

Human Immunodeficiency Virus (HIV) infection is not considered as a contra-indication. However in patients with immunodeficiency or in patients receiving

immunosuppressive therapy, the expected immunologic response may not be achieved. No data currently exist on use of *INFANRIX hexa* in these patients.

Preterm Infants

Clinical data indicate that *INFANRIX hexa* can be given to preterm infants, however, as expected in this population, a lower immune response has been observed for some antigens (see ADVERSE REACTIONS and Clinical Trials).

The potential risk of apnoea and the need for respiratory monitoring for 48-72h should be considered when administering the primary immunisation series to very preterm infants (born \leq 28 weeks of gestation) and particularly for those with a previous history of respiratory immaturity. As the benefit of vaccination is high in these infants, vaccination should not be withheld or delayed.

Native populations (native Alaskans, native American Indians) with a high incidence of *Haemophilus influenzae* type b disease have shown a reduced antibody response to *Haemophilus influenzae* type b conjugate vaccines. The immunogenicity of *INFANRIX hexa* has not been studied in the Australian indigenous population and the possibility of a lower antibody response to the Hib component, than that seen in clinical studies, should be borne in mind.

Interference With Laboratory Testing

Since the Hib capsular polysaccharide antigen is excreted in the urine a positive urine test can be observed within 2 weeks following vaccination. Other tests should be performed in order to confirm Hib infection during this period.

Use In Pregnancy (Category B2)

As *INFANRIX hexa* is not intended for use in adults, adequate human data on use during pregnancy and adequate animal reproduction studies are not available.

Use In Lactation

As *INFANRIX hexa* is not intended for use in adults, adequate human data on use during lactation are not available.

INTERACTIONS WITH OTHER MEDICINES

INFANRIX hexa should not be mixed with other vaccines in the same syringe.

INFANRIX hexa can be given concomitantly with pneumococcal conjugate, MenC conjugate, MenACWY conjugate, rotavirus, measles, mumps, rubella and varicella vaccines. Data have shown no clinically relevant interference in the antibody response to each of the individual antigens

Data from clinical studies indicate that, when *INFANRIX hexa* is co-administered with pneumococcal conjugate vaccine, the rate of febrile reactions is higher compared to that occurring following the administration of *INFANRIX hexa* alone. (see PRECAUTIONS).

ADVERSE REACTIONS

Clinical trial experience

The safety profile presented below is based on data from more than 16,000 subjects.

As has been observed for DTPa and DTPa-containing combinations, an increase in local reactogenicity and fever was reported after booster vaccination with *Infanrix hexa* with respect to the primary course. The below table contains data from subjects receiving booster vaccinations and those receiving primary doses.

Adverse reactions reported are listed according to the following frequency:

Very common: $\geq 1/10$

Common: $\geq 1/100$ to $< 1/10$

Uncommon: $\geq 1/1000$ to $< 1/100$

Rare: $\geq 1/10000$ to $< 1/1000$

Very rare: $< 1/10000$

System Organ Class	Frequency	Adverse events
Infections and infestations	Common	upper respiratory tract infection
Immune disorders	Very rare	Allergic reactions and anaphylactoid reactions (including dermatitis and urticaria*)
Metabolism and nutrition disorders	Very common	appetite lost
Psychiatric disorders	Very common	irritability, crying abnormal, restlessness
	Common	nervousness
Nervous system disorders	Uncommon	somnolence
	Very rare	convulsions (with or without fever)***
Respiratory, thoracic and mediastinal disorders	Common	Bronchitis, rhinitis
	Uncommon Rare	bronchospasm, laryngitis, stridor, cough*

Gastrointestinal disorders	Common	vomiting, diarrhoea, enteritis, gastroenteritis
	Uncommon	abdominal pain, constipation
Skin and subcutaneous tissue disorders	Common	pruritus*
	Rare	rash
	Very rare	dermatitis, urticaria*
Vision	Uncommon	conjunctivitis
General disorders and administration site conditions	Very common	pain, redness, local swelling at the injection site (≤ 50 mm), fever $\geq 38^{\circ}\text{C}$, fatigue
	Common	local swelling at the injection site (> 50 mm)**, fever $>39.5^{\circ}\text{C}$, injection site reactions, including induration
	Uncommon	diffuse swelling of the injected limb, sometimes involving the adjacent joint**

* observed only with other GSK DTPa-containing vaccines

** Children primed with acellular pertussis vaccines are more likely to experience swelling reactions after booster administration in comparison with children primed with whole cell vaccines. These reactions resolve over an average of 4 days.

*** Analysis of postmarketing reporting rates suggests a potential increased risk of convulsions (with or without fever) and HHE when comparing groups which reported use of *INFANRIX hexa* with Prevenar 13 to those which reported use of *INFANRIX hexa* alone.

Post marketing experience

The following drug-related adverse reactions were reported during post-marketing surveillance:

System Organ Class	Frequency	Adverse events
Blood and lymphatic system disorders	Rare	lymphadenopathy, thrombocytopenia
Immune system disorders	Rare	allergic reactions (including anaphylactic and anaphylactoid reactions)
Nervous system disorders	Rare	convulsions (with or without fever), collapse or shock-like state (hypotonic hyporesponsive episode)***
Respiratory, thoracic and mediastinal disorders	Rare	apnoea*[see Warnings and Precautions for apnoea in very preterm infants (≤ 28 weeks of gestation)]
Skin and subcutaneous tissue disorders	Rare	angioneurotic oedema*
General disorders and administration site conditions	Rare	extensive swelling reactions, swelling of the entire injected limb**, vesicles at the injection site

* Observed only with other GSK DTPa-containing vaccines

** Children primed with acellular pertussis vaccines are more likely to experience swelling reactions after booster administration in comparison with children primed with whole cell vaccines. These reactions resolve over an average of 4 days.

***Analysis of postmarketing reporting rates suggests a potential increased risk of convulsions (with or without fever) and HHE when comparing groups which reported use of *INFANRIX hexa* with Prevenar 13 to those which reported use of *INFANRIX hexa* alone.

Safety in preterm infants:

INFANRIX hexa has been administered to more than 1000 preterm infants (born after a gestation period of 24 to 36 weeks) in primary vaccination studies and in more than 200 preterm infants as a booster dose in the second year of life. In comparative studies, similar rates of symptoms were observed in preterm and full-term infants.

Experience with hepatitis B vaccine which is the same antigen used in Infanrix hexa:

Meningitis, allergic reactions mimicking serum sickness, paralysis, encephalitis, encephalopathy, neuropathy, neuritis, hypotension, vasculitis, lichen planus, erythema multiforme, arthritis and muscular weakness, Guillain-Barré syndrome have been reported during post-marketing surveillance following GlaxoSmithKline Biologicals' hepatitis B vaccine in infants < 2 years old. The causal relationship to the vaccine has not been established.

DOSAGE AND ADMINISTRATION

INFANRIX hexa is for deep intramuscular injection.

Before use of the vaccine, the *INFANRIX hexa* suspension should be well shaken in order to obtain a homogeneous turbid white suspension. The *DTPa-HBV-IPV* suspension and the Hib pellet should be inspected visually for any foreign particulate matter and/or any variation of physical aspect. In the event of either being observed, discard the vaccine.

INFANRIX hexa must be reconstituted by adding the entire contents of the pre-filled syringe containing the liquid component to the vial containing the Hib pellet.

After the addition of the liquid component to the pellet, the mixture should be well shaken until the pellet is completely dissolved in the suspension.

It is good clinical practice to only inject a vaccine when it has reached room temperature. In addition, a vial at room temperature ensures sufficient elasticity of the rubber closure to minimise any coring of rubber particles. To achieve this, the

vial should be kept at room temperature (25 ± 3 °C) for at least five minutes before connecting the pre-filled syringe and reconstituting the vaccine.

The reconstituted vaccine presents as a slightly more cloudy suspension than the liquid component alone. This is a normal observation.

The reconstituted vaccine should be inspected visually for any foreign particulate matter and/or abnormal physical appearance. In the event of either being observed, discard the vaccine.

After reconstitution, the vaccine should be injected immediately. However, the vaccine may be kept for up to 8 hours at room temperature.

Withdraw the entire contents of the vial.

Dosage

After reconstitution, each dose consists of a 0.5 ml ready to use sterile suspension.

Administration

INFANRIX hexa is administered by deep intramuscular injection. THE VACCINE SHOULD NEVER BE ADMINISTERED INTRAVENOUSLY.

INFANRIX hexa should be injected intramuscularly in the anterolateral aspect of the thigh or the deltoid region of the arm. The recommended dose (0.5 ml) of vaccine must be administered.

The primary immunisation course of *INFANRIX hexa* consists of two or three doses (of 0.5 ml) (see CLINICAL PHARMACOLOGY section for schedules evaluated in clinical trials).

Primary vaccination	Booster vaccination	General considerations
Full-term infants		
3-dose	A booster dose may be given.*	<ul style="list-style-type: none">• There should be an interval of at least 1 month between primary doses.• When giving a booster dose, this should be at least 6 months after the last priming dose and at or before 18 months of age.
2-dose	A booster dose must be given.*	<ul style="list-style-type: none">• There should be an interval of at least 1 month between primary doses.• When giving a booster dose, this should be at

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		least 6 months after the last priming dose and preferably between 11 and 13 months of age.
Preterm infants born after at least 24 weeks of gestational age		
3-dose	A booster dose must be given.*	<ul style="list-style-type: none"> • There should be an interval of at least 1 month between primary doses. • When giving a booster dose, this should be at least 6 months after the last priming dose and at or before 18 months of age.

* *INFANRIX hexa* may be considered for the booster if the antigen composition is in accordance with the Australian Immunisation Handbook

Where a dose of hepatitis B vaccine is given at birth, *INFANRIX hexa* can be used as a replacement for supplementary doses of hepatitis B vaccine from the age of 6 weeks. If a second dose of hepatitis B vaccine is required before this age, monovalent hepatitis B vaccine should be used.

Locally established immunoprophylactic measures against hepatitis B should be maintained.

Further guidance regarding the use of vaccines can be found in the Australian Immunisation Handbook (see CLINICAL PHARMACOLOGY section for schedules evaluated in clinical trials)

PRESENTATION AND STORAGE CONDITIONS

Presentations

INFANRIX hexa is presented as a turbid white suspension in a pre-filled syringe. Upon storage, a white deposit and clear supernatant can be observed. This is a normal observation.

The lyophilised Hib vaccine is presented as a white pellet in a glass vial.

The vials and pre-filled syringes are made of neutral glass type I, which conforms to European Pharmacopoeia Requirements.

This combination pack is supplied in packs of 1's or packs of 10's.

Storage

INFANRIX hexa should be stored at +2°C to +8°C.

The DTPa-HBV-IPV suspension and the reconstituted vaccine must not be frozen. Discard if it has been frozen.

Protect from light.

During transport, recommended conditions of storage must be respected.

Stability data indicate that the vaccine components are stable at temperatures up to 25°C for 72 hours. These data are intended to guide healthcare professionals in case of temporary temperature excursion only.

The expiry date of the vaccine is indicated on the label and packaging.

NAME AND ADDRESS OF THE SPONSOR

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Abbotsford, Victoria, 3067

Manufacturer:

GlaxoSmithKline Biologicals
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POISON SCHEDULE OF THE MEDICINE:

Schedule 4

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