SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Tibolone 2.5 mg tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 2.5 mg of tibolone.

Excipient(s) with known effect:

Each tablet contains approximately 84.32 mg lactose

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Tablet.

White to off white, circular with flat face beveled edge, uncoated tablet debossed with ‘TO above 2’ on one side and plain on other side. Approximate Diameter 6.00±0.20 mm

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

• Treatment of oestrogen deficiency symptoms in postmenopausal women, more than one year after menopause.

• Prevention of osteoporosis in postmenopausal women at high risk of future fractures who are intolerant of, or contraindicated for, other medicinal products approved for the prevention of osteoporosis. (See also section 5.1.)

For all women the decision to prescribe Tibolone should be based on an assessment of the individual patient's overall risks and, particularly in the over 60s, should include consideration of the risk of stroke (see sections 4.4 and 4.8).

4.2 Posology and method of administration

Posology

The dosage is one tablet per day.

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

A separate progestogen should not be added with Tibolone treatment.

Starting Tibolone

Women experiencing a natural menopause should commence treatment with at least 12 months after their last natural bleed. In case of a surgical menopause, treatment with Tibolone may commence immediately.

Any irregular/unscheduled vaginal bleeding, either on or off HRT, should be investigated to exclude malignancy before starting Tibolone (see section 4.3).

Switching from a sequential or continuous combined HRT preparation

If changing from a sequential HRT preparation, treatment with Tibolone should start the day following completion of the prior regimen. If changing from a continuous-combined HRT preparation, treatment can start at any time.

Missed dose

A missed dose should be taken as soon as remembered, unless it is more than 12 hours overdue. In the latter case, the missed dose should be skipped and the next dose should be taken at the normal time. Missing a dose may increase the likelihood of breakthrough bleeding and spotting.

Elderly

No dose adjustment is necessary for the elderly.

Paediatric population

There is no relevant use of Tibolone in the paediatric population.

Method of administration

Oral use. The tablets should be swallowed with some water or other drink, preferably at the same time every day.

4.3 Contraindications

• Pregnancy and lactation

• Known, past or suspected breast cancer – Tibolone increased the risk of breast cancer recurrence in a placebo controlled trial

• Known or suspected oestrogen-dependent malignant tumours (e.g. endometrial cancer)

• Undiagnosed genital bleeding

• Untreated endometrial hyperplasia

• Previous or current venous thromboembolism (deep venous thrombosis, pulmonary embolism)

• Known thrombophilic disorders (e.g. protein C, protein S, or antithrombin deficiency, see section 4.4)

• Any history of arterial thromboembolic disease (e.g. angina, myocardial infarction, stroke or TIA)

• Acute liver disease, or a history of liver disease as long as liver function tests have failed to return to normal

• Hypersensitivity to the active substance(s) or to any of the excipients listed in section 6.1.

• Porphyria

4.4 Special warnings and precautions for use

For the treatment of postmenopausal symptoms, Tibolone should only be initiated for symptoms that adversely affect quality of life. In all cases, a careful appraisal of the risks and benefits should be undertaken at least annually and Tibolone should only be continued as long as the benefit outweighs the risk.

The risks of stroke, breast cancer and, in women with an intact uterus, endometrial cancer (see below and section 4.8) for each woman should be carefully assessed, in the light of her individual risk factors and bearing in mind the frequency and characteristics of both cancers and stroke, in terms of their response to treatment, morbidity and mortality.

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

Medical examination/follow-up

Before initiating or reinstituting HRT or tibolone, a complete personal and family medical history should be taken. Physical (including pelvic and breast) examination should be guided by this and by the contraindications and warnings for use.

• During treatment, periodic check-ups are recommended of a frequency and nature adapted to the individual woman. Women should be advised what changes in their breasts should be reported to their doctor or nurse (see 'Breast cancer' below). Investigations, including appropriate imaging tools, e.g. mammography, should be carried out in accordance with currently accepted screening practices, modified to the clinical needs of the individual.

Conditions which need supervision

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

- Leiomyoma (uterine fibroids) or endometriosis

- Risk factors for thromboembolic disorders (see below)

- Risk factors for oestrogen dependent tumours, e.g. 1st degree heredity for breast cancer

- Hypertension

- Liver disorders (e.g. liver adenoma)

- Diabetes mellitus with or without vascular involvement

- Cholelithiasis

- Migraine or (severe) headache

- Systemic lupus erythematosus

- A history of endometrial hyperplasia (see below)

- Epilepsy

- Asthma

- Otosclerosis

Reasons for immediate withdrawal of therapy:

Therapy should be discontinued in case a contraindication is discovered and in the following situations:

- Jaundice or deterioration in liver function
- Significant increase in blood pressure

- New onset of migraine-type headache
- Pregnancy

Endometrial hyperplasia and carcinoma

• The available data from randomised controlled trials are conflicting; however, observational studies have consistently shown that women who are prescribed Tibolone in normal clinical practice are at an increased risk of having endometrial cancer diagnosed (see also section 4.8). In these studies, risk increased with increasing duration of use. Tibolone increases endometrial wall thickness, as measured by transvaginal ultrasound.

• Break-through bleeding and spotting may occur during the first months of treatment (see section 5.1). Women should be advised to report any break-through bleeding or spotting if it is still present after 6 months of treatment, if it starts beyond that time or if it continues after treatment has been discontinued. The woman should be referred for gynaecological investigation, which is likely to include endometrial biopsy to exclude endometrial malignancy.

Breast cancer

• Evidence with respect to breast cancer risk in association with tibolone is inconclusive. The Million Women Study (MWS) has identified a significant increase in the risk of breast cancer in association with use of the 2.5 mg dose. This risk became apparent within a few years of use and increased with duration of intake, returning to baseline within a few (at most five) years after stopping treatment, see section 4.8. These results could not be confirmed in a study using the General Practice Research Database (GPRD).

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

Ovarian cancer

Ovarian cancer is much rarer than breast cancer.

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

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

In the Million Women Study it was shown that the relative risk for ovarian cancer with use of tibolone was similar to the risk associated with use of other types of HRT.

Venous thromboembolism

• Oestrogen or oestrogen-progestogen HRT is associated with a 1.3-3 fold risk of developing venous thromboembolism (VTE), i.e. deep vein thrombosis or pulmonary embolism. The occurrence of such an event is more likely in the first year of HRT than later (see section 4.8). In an epidemiological study using a UK database, the risk of VTE in association with tibolone was lower than the risk associated with conventional HRT, but only a small proportion of women were current users of tibolone and a small increase in risk compared with non-use cannot be excluded.

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

• Generally recognised risk factors for VTE include use of oestrogens, older age, major surgery, prolonged immobilisation, obesity (BMI > 30 kg/m2), pregnancy/postpartum period, systemic lupus erythematosus (SLE), and cancer. There is no consensus about the possible role of varicose veins in VTE. As in all postoperative patients, prophylactic measures need to be considered to prevent VTE following surgery. If prolonged immobilisation is to follow elective surgery temporarily stopping HRT or tibolone 4 to 6 weeks earlier is recommended, if possible. Treatment should not be restarted until the woman is completely mobilised.

• In women with no personal history of VTE but with a first degree relative with a history of thrombosis at young age, screening may be offered after careful counselling regarding its limitations (only a proportion of thrombophilic defects are identified by screening). If a thrombophilic defect is identified which segregates with thrombosis in family members or if the defect is 'severe' (e.g, antithrombin, protein S, or protein C deficiencies or a combination of defects) HRT or tibolone is contraindicated.

• Women already on anticoagulant treatment require careful consideration of the benefit-risk of use of HRT or tibolone.

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

Coronary artery disease (CAD)

There is no evidence from randomised controlled trials of protection against myocardial infarction in women with or without existing CAD who received combined oestrogen-progestogen or oestrogen-only HRT. In an epidemiological study using the GPRD no evidence was found of protection against myocardial infarction in postmenopausal women who received tibolone.

Ischaemic stroke

• Tibolone increases the risk of ischaemic stroke from the first year of treatment (see section 4.8). The baseline risk of stroke is strongly age-dependent and so the effect of tibolone is greater with older age.

Other conditions

• Patients with rare hereditary problems of galactose intolerance, the total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

• Tibolone is not intended for contraceptive use.

• Treatment with Tibolone results in a marked dose-dependent decrease in HDL cholesterol (from -16.7% with a 1.25 mg dose to -21.8% for the 2.5 mg dose after 2 years). Total triglycerides and lipoprotein(a) levels were also reduced. The decrease in total cholesterol and VLDL-C levels was not dose-dependent. Levels of LDL-C were unchanged. The clinical implication of these findings is not yet known.

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

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

• Treatment with Tibolone results in a very minor decrease of thyroid binding globulin (TBG) and total T4. Levels of total T3 are unaltered. Tibolone decreases the level of sex-hormone-binding globulin (SHBG), whereas the levels of corticoid binding globulin (CBG) and circulating cortisol are unaffected.

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

4.5 Interaction with other medicinal products and other forms of interaction

Since Tibolone may increase blood fibrinolytic activity, it may enhance the effect of anticoagulants. This effect has been demonstrated with warfarin. Caution should therefore be exercised during the simultaneous use of Tibolone and anticoagulants, especially when starting or stopping concurrent Tibolone treatment. If necessary, the dose of warfarin should be adjusted.

There is limited information regarding pharmacokinetic interactions with tibolone. An in vivo study showed that simultaneous treatment of tibolone affects pharmacokinetics of the cytochrome P450 3A4 substrate midazolam to a moderate extent. Based on this, drug interactions with other CYP3A4 substrates might be expected.

Compounds that induce CYP3A4 activity such as barbiturates, carbamazepine, hydantoins and rifampicin may enhance the metabolism of tibolone and thus affect its therapeutic effect.

Herbal preparations containing St.John's wort (Hypericum Perforatum) may induce the metabolism of oestrogens and progestogens via CYP3A4. Clinically, an increased metabolism of oestrogens and progestogens may lead to decreased effect and changes in the uterine bleeding profile.

4.6 Fertility, Pregnancy and lactation

Pregnancy

Tibolone is contraindicated during pregnancy (see section 4.3). If pregnancy occurs during medication with Tibolone treatment should be withdrawn immediately. For Tibolone no clinical data on exposed pregnancies are available.

Studies in animals have shown reproductive toxicity (see section 5.3). The potential risk for humans is unknown.

Breast-feeding

Tibolone is contraindicated during breast-feeding (see section 4.3).

Fertility

In animal studies, Tibolone had anti-fertility activities by virtue of its hormonal properties.

4.7 Effects on ability to drive and use machines

Tibolone is not known to have any effects on alertness and concentration

4.8 Undesirable effects

This section describes undesirable effects, which were registered in 21 placebo-controlled studies (including the LIFT study), with 4,079 women receiving therapeutic doses (1.25 or 2.5 mg) of Tibolone and 3,476 women receiving placebo. The duration of treatment in these studies ranged from 2 months to 4.5 years. Table 1 shows the undesirable effects that occurred statistically significantly more frequently during treatment with Tibolone than with placebo.

Table 1 Undesirable effects of Tibolone

System organ class	**Common >1%,<10%**	**Uncommon >0.1%,<1%**	**Rare >0.01%,<0.1%**
Metabolism and nutrition disorders		Oedema**	
Gastrointestinal disorders	Lower abdominal pain	Abdominal discomfort**	
Skin and subcutaneous tissue disorders	Abnormal hair growth	Acne	Pruritus**
Reproductive system and breast disorders	Vaginal discharge Endometrial wall thickening Postmenopausal haemorrhage Breast tenderness Genital pruritus Vaginal candidiasis Vaginal haemorrhage Pelvic pain Cervical dysplasia Genital discharge Vulvovaginitis	Breast discomfort Fungal infection Vaginal mycosis Nipple pain	
Investigations	Weight increase Abnormal cervical smear*		

* The majority consisted of benign changes. Cervix pathology (cervical carcinoma) was not increased with Tibolone compared to placebo.

** These adverse reactions were identified through post-marketing surveillance. The frequency category was estimated based on relevant clinical trials.

In market use, other undesirable effects that have been observed include:

dizziness, rash, seborrheic dermatosis, headache, migraine, visual disturbances (including blurred vision), depression, effects on the musculoskeletal system such as arthralgia or myalgia and changes in liver function parameters.

Breast cancer

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

Any increased risk in users of oestrogen-only and tibolone therapy is substantially lower than seen in users of oestrogen-progestogen combinations

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

• Results of the largest epidemiological study (MWS) are presented.

Table 2 Million Women study – Estimated additional risk of breast cancer after 5 years' use

Age range (years)	Additional cases per 1,000 never-users of HRT over a 5 year period*2	Risk ratio & 95%CI#	Additional cases per 1,000 HRT users over 5 years (95%CI)
Estrogen only HRT			
50-65	9-12	1.2	1-2 (0-3)
Combined estrogen-progestagen			
50-65	9-12	1.7	6 (5-7)
Tibolone			
50-65	9-12	1.3	3 (0-6)
#Overall risk ratio. The risk ratio is not constant but will increase with increasing duration of use.			

Endometrial cancer risk

Postmenopausal women with a uterus

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

The randomised placebo controlled trial that included women who had not been screened for endometrial abnormalities at baseline, and therefore reflected clinical practice, identified the highest risk of endometrial cancer, (LIFT study, mean age 68 years). In this study, no cases of endometrial cancer were diagnosed in the placebo group (n=1,773) after 2.9 years compared with 4 cases of endometrial cancer in the Tibolone group (n=1,746). This corresponds to a diagnosis of 0.8 additional case of endometrial cancer in every 1,000 women who used Tibolone for one year in this study (see section 4.4).

Risk of ischaemic stroke

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

• A 2.9 year randomised controlled study has estimated a 2.2-fold increase in the risk of stroke in women (mean age 68 years) who used 1.25 mg Tibolone (28/2,249) compared with placebo (13/2,257). The majority (80%) of strokes were ischaemic.

• The baseline risk of stroke is strongly age-dependent. Thus, the baseline incidence over a 5 year period is estimated to be 3 per 1,000 women aged 50-59 years and 11 per 1,000 women aged 60-69 years.

• For women who use Tibolone for 5 years, the number of additional cases would be expected to be about 4 per 1000 users aged 50-59 years and 13 per 1,000 users aged 60-69 years.

Other adverse reactions have been reported in association with oestrogen and oestrogen-progestogen treatment:

- Ovarian cancer

Long-term use of estrogen-only or combined oestrogen-progestogen HRT has been associated with a slightly increased risk of having ovarian cancer diagnosed (see section 4.4). In the Million Women Study 5 years of HRT resulted in 1 extra case per 2500 users. This study showed that the relative risk for ovarian cancer with tibolone was similar to the risk with other types of HRT

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

In the Million Women Study, taking 5 years of tibolone resulted in 1 extra case per 2,500 users (see section 4.4).

Risk of venous thromboembolism

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

Age range (years)	Incidence per 1000 women in placebo arm over 5 years	Risk ratio and 95%CI	Additional cases per 1000 HRT users
Oral estrogen-only*4			
50-59	7	1.2 (0.6-2.4)	1 (-3-10)
Oral combined estrogen-progestogen			
50-59	4	2.3 (1.2–4.3)	5 (1-13)

Risk of coronary artery disease

- The risk of coronary artery disease is slightly increased in users of combined oestrogen-progestogen HRT over the age of 60 (see section 4.4). There is no evidence to suggest that the risk of myocardial infarction with tibolone is different to the risk with other HRT.

Risk of ischaemic stroke

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

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

- A 2.9 year randomised controlled study has estimated a 2.2-fold increase in the risk of stroke in women (mean age 68 years) who used 1.25 mg Tibolone (28/2249) compared with placebo (13/2257). The majority (80%) of strokes were ischaemic.

The baseline risk of stroke is strongly age-dependent. Thus, the baseline incidence over a 5 year period is estimated to be 3 per 1000 women aged 50-59 years and 11 per 1000 women aged 60-69 years.

- For women who use Tibolone for 5 years, the number of additional cases would be expected to be about 4 per 1000 users aged 50-59 years and 13 per 1000 users aged 60-69 years.

Table 4 WHI Studies combined - Additional risk of ischaemic stroke over 5 years' use

Age range (years)	Incidence per 1000 women in placebo arm over 5 years	Risk ratio and 95%CI	Additional cases per 1000 HRT users over 5 years
50-59	8	1.3 (1.1-1.6)	3 (1-5)

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

-Gall bladder disease

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

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

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via Yellow Card Scheme Website: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

The acute toxicity of tibolone in animals is very low. Therefore, toxic symptoms are not expected to occur, even when several tablets are taken simultaneously. In cases of acute overdose, nausea, vomiting and vaginal bleeding in females may occur. No specific antidote is known. Symptomatic treatment can be given if necessary.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: urogenital system (including sex hormones), ATC code: G03CX01

Mechanism of action and pharmacodynamic effects

Following oral administration, tibolone is rapidly metabolised into three compounds, which all contribute to the pharmacodynamic profile of Tibolone. Two of the metabolites (3α-OH-tibolone and 3β-OH-tibolone) have oestrogenic-like activities, whereas the third metabolite (Δ4-isomer of tibolone) has progestogenic and androgenic-like activities.

Tibolone substitutes for the loss of oestrogen production in postmenopausal women and alleviates menopausal symptoms. Tibolone prevents bone loss following menopause or ovariectomy.

Clinical efficacy and safety

•Relief of oestrogen-deficiency symptoms

-Relief of menopausal symptoms generally occurs during the first few weeks of treatment.

•Effects on the endometrium and bleeding patterns

-There have been reports of endometrial hyperplasia and endometrial cancer in patients treated with Tibolone (see section 4.4 and 4.8).

-Amenorrhea has been reported in 88% of women using Tibolone 2.5 mg after 12 months of treatment. Breakthrough bleeding and/or spotting has been reported in 32.6% of women during the first 3 months of treatment, and in 11.6% of women after 11-12 months of use.

•Prevention of osteoporosis

-Oestrogen deficiency at menopause is associated with an increasing bone turnover and decline in bone mass. Protection appears to be effective for as long as treatment is continued. After discontinuation of HRT, bone mass is lost at a rate similar to that in untreated women.

−In the LIFT study, Tibolone reduced the number of women (mean age 68 years) with new vertebral fractures compared to placebo during the 3 years of treatment (ITT: Tibolone to placebo odds ratio 0.57; 95% CI [0.42, 0.78]).

−After 2 years of treatment with Tibolone (2.5 mg), the increase in lumbar spine bone mineral density (BMD) was 2.6 ± 3.8%. The percentage of women who maintained or gained BMD in lumbar zone during treatment was 76%. A second study confirmed these results.

− Tibolone (2.5 mg) also had an effect on hip BMD. In one study, the increase after 2 years was 0.7 ± 3.9% at the femoral neck and 1.7 ± 3.0% at the total hip. The percentage of women who maintained or gained BMD in the hip region during treatment was 72.5%. A second study showed that the increase after 2 years was 1.3 ± 5.1% at the femoral neck and 2.9 ± 3.4% at the total hip. The percentage of women who maintained or gained BMD in the hip region during treatment was 84.7%.

• Effects on the breast

− In clinical studies mammographic density is not increased in women treated with Tibolone compared to placebo.

5.2 Pharmacokinetic properties

Absorption and biotransformation

Following oral administration, tibolone is rapidly and extensively absorbed. The consumption of foods has no significant effects on the extent of absorption.

Due to rapid metabolism, the plasma levels of tibolone are very low. The plasma levels of the Δ4-isomer of tibolone are also very low. Therefore, some of the pharmacokinetic parameters could not be determined. Peak plasma levels of the 3α-OH and the 3β-OH metabolites are higher but accumulation does not occur.

Table 5 Pharmacokinetic parameters of Tibolone (2.5 mg)

	tibolone		**3α-OH metabolite**		**3β-OH metabolite**		**Δ4-isomer**	
	SD	MD	SD	MD	SD	MD	SD	MD
C_{max} (ng/ml)	1.37	1.72	14.23	14.15	3.43	3.75	0.47	0.43
$C_{average}$	--	--	--	1.88	--	--	--	--
T_{max} (h)	1.08	1.19	1.21	1.15	1.37	1.35	1.64	1.65
$T_{1/2}$ (h)	--	--	5.78	7.71	5.87	--	--	--
C_{min} (ng/ml)	--	--	--	0.23	--	--	--	--
AUC_{0-24} (ng/ml.h)	--	--	53.23	44.73	16.23	9.20	--	--

SD = single dose; MD = multiple dose

Elimination

Excretion of tibolone is mainly in the form of conjugated (mostly sulfated) metabolites. Part of the administered compound is excreted in the urine, but most is eliminated via the faeces.

Other special populations

The pharmacokinetic parameters for tibolone and its metabolites were found to be independent of renal function.

5.3 Preclinical safety data

In animal studies, tibolone had anti-fertility and embryotoxic activities by virtue of its hormonal properties. Tibolone was not teratogenic in mice and rats. It displayed teratogenic potential in the rabbit at near-abortive dosages (see section 4.6). Tibolone is not genotoxic under in vivo conditions. Although a carcinogenic effect was seen in certain strains of rat (hepatic tumours) and mouse (bladder tumours), the clinical relevance of this is uncertain.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

potato starch,

lactose monohydrate,

magnesium stearate,

ascorbyl palmitate

anhydrous lactose

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years.

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions

6.5 Nature and contents of container

Tibolone tablets are packaged in blisters consisting of a transparent polyvinyl chloride film and an aluminium blister foil. The following packages are available: Carton packs containing 1, 3 blisters of 28 tablets and Carton packs containing 2,3 blisters of 10 tablets.

6.6 Special precautions for disposal

Not applicable.

7 MARKETING AUTHORISATION HOLDER

STRIDES PHARMA UK LTD
Unit 4 The Metro Centre,
Dwight Road,
Watford,
WD18 9SS

8 MARKETING AUTHORISATION NUMBER(S)

PL 13606/0249

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

21/02/2018

10 DATE OF REVISION OF THE TEXT

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