

HIGHLIGHTS OF PRESCRIBING INFORMATION

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

NEXPLANON® (etonogestrel implant)

Radiopaque

Subdermal Use Only

Initial U.S. Approval: 2001

INDICATIONS AND USAGE

NEXPLANON is a progestin indicated for use by women to prevent pregnancy. (1)

DOSAGE AND ADMINISTRATION

Insert one NEXPLANON subdermally just under the skin at the inner side of the non-dominant upper arm. NEXPLANON must be removed no later than by the end of the third year. (2)

DOSAGE FORMS AND STRENGTHS

NEXPLANON consists of a single, radiopaque, rod-shaped implant, containing 68 mg etonogestrel, pre-loaded in the needle of a disposable applicator. (3)

CONTRAINDICATIONS

- Known or suspected pregnancy. (4)
- Current or past history of thrombosis or thromboembolic disorders. (4, 5.4)
- Liver tumors, benign or malignant, or active liver disease. (4, 5.7)
- Undiagnosed abnormal genital bleeding. (4, 5.2)
- Known or suspected breast cancer, personal history of breast cancer, or other progestin-sensitive cancer, now or in the past. (4, 5.6)
- Allergic reaction to any of the components of NEXPLANON. (4, 6)

WARNINGS AND PRECAUTIONS

- Insertion and removal complications: Pain, paresthesias, bleeding, hematoma, scarring or infection may occur. (5.1)

- Menstrual bleeding pattern: Counsel women regarding changes in bleeding frequency, intensity, or duration. (5.2)
- Ectopic pregnancies: Be alert to the possibility of an ectopic pregnancy in women using NEXPLANON who become pregnant or complain of lower abdominal pain. (5.3)
- Thrombotic and other vascular events: The NEXPLANON implant should be removed in the event of a thrombosis. (5.4)
- Liver disease: Remove the NEXPLANON implant if jaundice occurs. (5.7)
- Elevated blood pressure: The NEXPLANON implant should be removed if blood pressure rises significantly and becomes uncontrolled. (5.9)
- Carbohydrate and lipid metabolic effects: Monitor prediabetic and diabetic women using NEXPLANON. (5.11)

ADVERSE REACTIONS

Most common ($\geq 10\%$) adverse reactions reported in clinical trials were change in menstrual bleeding pattern, headache, vaginitis, weight increase, acne, breast pain, abdominal pain, and pharyngitis. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Schering Corporation, a subsidiary of Merck & Co., Inc., at 1-800-526-4099 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

Drugs or herbal products that induce certain enzymes, such as CYP3A4, may decrease the effectiveness of progestin hormonal contraceptives or increase breakthrough bleeding. (7.1)

USE IN SPECIFIC POPULATIONS

- Pregnant women: NEXPLANON should be removed if maintaining a pregnancy. (8.1)
- Overweight women: NEXPLANON may become less effective in overweight women over time, especially in the presence of other factors that decrease etonogestrel concentrations, such as concomitant use of hepatic enzyme inducers. (8.8)

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

Revised: 05/2011

FULL PRESCRIBING INFORMATION: CONTENTS*

1 INDICATIONS AND USAGE

2 DOSAGE AND ADMINISTRATION

- 2.1 Initiating Contraception with NEXPLANON
- 2.2 Insertion of NEXPLANON
- 2.3 Removal of NEXPLANON
- 2.4 Replacing NEXPLANON

3 DOSAGE FORMS AND STRENGTHS

4 CONTRAINDICATIONS

5 WARNINGS AND PRECAUTIONS

- 5.1 Complications of Insertion and Removal
- 5.2 Changes in Menstrual Bleeding Patterns
- 5.3 Ectopic Pregnancies
- 5.4 Thrombotic and Other Vascular Events
- 5.5 Ovarian Cysts
- 5.6 Carcinoma of the Breast and Reproductive Organs
- 5.7 Liver Disease
- 5.8 Weight Gain
- 5.9 Elevated Blood Pressure
- 5.10 Gallbladder Disease
- 5.11 Carbohydrate and Lipid Metabolic Effects
- 5.12 Depressed Mood
- 5.13 Return to Ovulation
- 5.14 Fluid Retention
- 5.15 Contact Lenses
- 5.16 Monitoring
- 5.17 Drug-Laboratory Test Interactions

6 ADVERSE REACTIONS

- 6.1 Clinical Trials Experience
- 6.2 Postmarketing Experience

7 DRUG INTERACTIONS

- 7.1 Changes in Contraceptive Effectiveness Associated with Coadministration of Other Products

7.2 Increase in Plasma Concentrations of Etonogestrel Associated with Coadministered Drugs

7.3 Changes in Plasma Concentrations of Coadministered Drugs

8 USE IN SPECIFIC POPULATIONS

- 8.1 Pregnancy
- 8.3 Nursing Mothers
- 8.4 Pediatric Use
- 8.5 Geriatric Use
- 8.6 Hepatic Impairment
- 8.7 Renal Impairment
- 8.8 Overweight Women

10 OVERDOSAGE

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY

- 12.1 Mechanism of Action
- 12.2 Pharmacodynamics
- 12.3 Pharmacokinetics

13 NONCLINICAL TOXICOLOGY

- 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

14 CLINICAL STUDIES

- 14.1 Pregnancy
- 14.2 Return to Ovulation
- 14.3 Implant Insertion and Removal Characteristics

16 HOW SUPPLIED/STORAGE AND HANDLING

- 16.1 How Supplied
- 16.2 Storage and Handling

17 PATIENT COUNSELING INFORMATION

*Sections or subsections omitted from the full prescribing information are not listed.

FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

NEXPLANON® is indicated for use by women to prevent pregnancy.

2 DOSAGE AND ADMINISTRATION

The efficacy of NEXPLANON does not depend on daily, weekly or monthly administration.

All healthcare providers should receive instruction and training prior to performing insertion and/or removal of NEXPLANON.

A single NEXPLANON implant is inserted subdermally in the upper arm. To reduce the risk of neural or vascular injury, the implant should be inserted at the inner side of the non-dominant upper arm about 8-10 cm (3-4 inches) above the medial epicondyle of the humerus. The implant should be inserted subdermally just under the skin to avoid the large blood vessels and nerves that lie deeper in the subcutaneous tissues in the sulcus between the triceps and biceps muscles. NEXPLANON must be inserted by the expiration date stated on the packaging. NEXPLANON is a long-acting (up to 3 years), reversible, hormonal contraceptive method. The implant must be removed by the end of the third year and may be replaced by a new implant at the time of removal, if continued contraceptive protection is desired.

2.1 Initiating Contraception with NEXPLANON

IMPORTANT: Rule out pregnancy before inserting the implant.

Timing of insertion depends on the woman's recent contraceptive history, as follows:

- No preceding hormonal contraceptive use in the past month

NEXPLANON should be inserted between Day 1 (first day of menstrual bleeding) and Day 5 of the menstrual cycle, even if the woman is still bleeding.

If inserted as recommended, back-up contraception is not necessary. If deviating from the recommended timing of insertion, the woman should be advised to use a barrier method until 7 days after insertion. If intercourse has already occurred, pregnancy should be excluded.

- Switching contraceptive method to NEXPLANON

Combination hormonal contraceptives:

NEXPLANON should preferably be inserted on the day after the last active tablet of the previous combined oral contraceptive or on the day of removal of the vaginal ring or transdermal patch. At the latest, NEXPLANON should be inserted on the day following the usual tablet-free, ring-free, patch-free or placebo tablet interval of the previous combined hormonal contraceptive.

If inserted as recommended, back-up contraception is not necessary. If deviating from the recommended timing of insertion, the woman should be advised to use a barrier method until 7 days after insertion. If intercourse has already occurred, pregnancy should be excluded.

Progestin-only contraceptives:

There are several types of progestin-only methods. NEXPLANON should be inserted as follows:

- **Injectable Contraceptives:** Insert NEXPLANON on the day the next injection is due.
- **Minipill:** A woman may switch to NEXPLANON on any day of the month. NEXPLANON should be inserted within 24 hours after taking the last tablet.
- **Contraceptive implant or intrauterine system (IUS):** Insert NEXPLANON on the same day the previous contraceptive implant or IUS is removed.

If inserted as recommended, back-up contraception is not necessary. If deviating from the recommended timing of insertion, the woman should be advised to use a barrier method until 7 days after insertion. If intercourse has already occurred, pregnancy should be excluded.

- Following abortion or miscarriage

- **First Trimester:** NEXPLANON should be inserted within 5 days following a first trimester abortion or miscarriage.
- **Second Trimester:** Insert NEXPLANON between 21 to 28 days following second trimester abortion or miscarriage.

If inserted as recommended, back-up contraception is not necessary. If deviating from the recommended timing of insertion, the woman should be advised to use a barrier method until 7 days after insertion. If intercourse has already occurred, pregnancy should be excluded.

- Postpartum

- Not Breastfeeding: NEXPLANON should be inserted between 21 to 28 days postpartum. If inserted as recommended, back-up contraception is not necessary. If deviating from the recommended timing of insertion, the woman should be advised to use a barrier method until 7 days after insertion. If intercourse has already occurred, pregnancy should be excluded.
- Breastfeeding: NEXPLANON should be inserted after the fourth postpartum week [see *Use in Specific Populations (8.3)*]. The woman should be advised to use a barrier method until 7 days after insertion. If intercourse has already occurred, pregnancy should be excluded.

2.2 Insertion of NEXPLANON

The basis for successful use and subsequent removal of NEXPLANON is a correct and carefully performed subdermal insertion of the single, rod-shaped implant in accordance with the instructions. Both the healthcare provider and the woman should be able to feel the implant under the skin after placement.

All healthcare providers performing insertions and/or removals of NEXPLANON should receive instructions and training prior to inserting or removing the implant. Information concerning the insertion and removal of NEXPLANON will be sent upon request free of charge [1-877-467-5266].

Preparation

Prior to inserting NEXPLANON carefully read the instructions for insertion as well as the full prescribing information.

Before insertion of NEXPLANON, the healthcare provider should confirm that:

- The woman is not pregnant nor has any other contraindication for the use of NEXPLANON [see *Contraindications (4)*].
- The woman has had a medical history and physical examination, including a gynecologic examination, performed.
- The woman understands the benefits and risks of NEXPLANON.
- The woman has received a copy of the Patient Labeling included in packaging.
- The woman has reviewed and completed a consent form to be maintained with the woman's chart.
- The woman does not have allergies to the antiseptic and anesthetic to be used during insertion.

Insert NEXPLANON under aseptic conditions.

The following equipment is needed for the implant insertion:

- An examination table for the woman to lie on
- Sterile surgical drapes, sterile gloves, antiseptic solution, sterile marker (optional)
- Local anesthetic, needles, and syringe
- Sterile gauze, adhesive bandage, pressure bandage

Insertion Procedure

Step 1. Have the woman lie on her back on the examination table with her non-dominant arm flexed at the elbow and externally rotated so that her wrist is parallel to her ear or her hand is positioned next to her head (Figure 1).

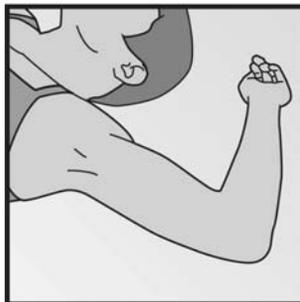


Figure 1

Step 2. Identify the insertion site, which is at the inner side of the non-dominant upper arm about 8-10 cm (3-4 inches) above the medial epicondyle of the humerus (Figure 2). **The implant should be inserted subdermally just under the skin to avoid the large blood vessels and nerves that lie deeper in the subcutaneous tissue in the sulcus between the triceps and biceps muscles** [see *Warnings and Precautions (5.1)*].

Step 3. Make two marks with a sterile marker: first, mark the spot where the etonogestrel implant will be inserted, and second, mark a spot a few centimeters proximal to the first mark (Figure 2). This second mark will later serve as a direction guide during insertion.

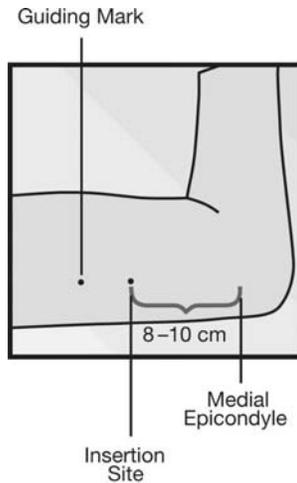


Figure 2

- Step 4. Clean the insertion site with an antiseptic solution.
- Step 5. Anesthetize the insertion area (for example, with anesthetic spray or by injecting 2 mL of 1% lidocaine just under the skin along the planned insertion tunnel).
- Step 6. Remove the sterile preloaded disposable NEXPLANON applicator carrying the implant from its blister. The applicator should not be used if sterility is in question.
- Step 7. Hold the applicator just above the needle at the textured surface area. Remove the transparent protection cap by sliding it horizontally in the direction of the arrow away from the needle (Figure 3). If the cap does not come off easily, the applicator should not be used. You can see the white colored implant by looking into the tip of the needle. **Do not touch the purple slider until you have fully inserted the needle subdermally, as it will retract the needle and prematurely release the implant from the applicator.**

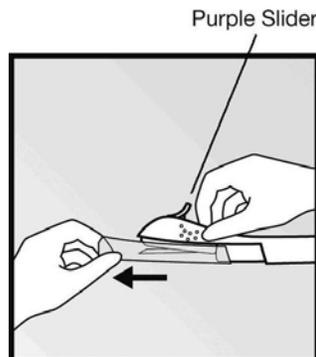


Figure 3

- Step 8. With your free hand, stretch the skin around the insertion site with thumb and index finger (Figure 4).

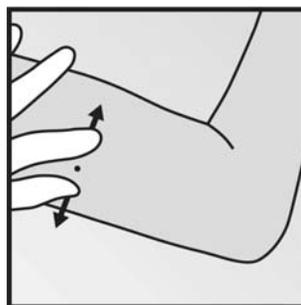


Figure 4

- Step 9. Puncture the skin with the tip of the needle angled about 30° (Figure 5).

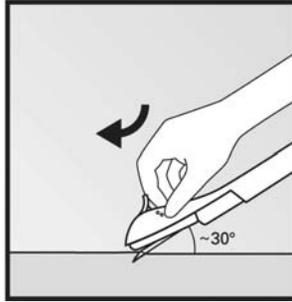


Figure 5

Step 10. Lower the applicator to a horizontal position. While lifting the skin with the tip of the needle (Figure 6), slide the needle to its full length. You may feel slight resistance but do not exert excessive force. **If the needle is not inserted to its full length, the implant will not be inserted properly.**

You can best see movement of the needle if you are seated and are looking at the applicator from the side and NOT from above. In this position, you can clearly see the insertion site and the movement of the needle just under the skin.

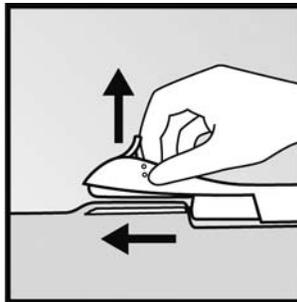


Figure 6

Step 11. Keep the applicator in the same position with the needle inserted to its full length. If needed, you may use your free hand to keep the applicator in the same position during the following procedure. Unlock the purple slider by pushing it slightly down. Move the slider fully back until it stops (Figure 7). The implant is now in its final subdermal position, and the needle is locked inside the body of the applicator. The applicator can now be removed. **If the applicator is not kept in the same position during this procedure or if the purple slider is not completely moved to the back, the implant will not be inserted properly.**

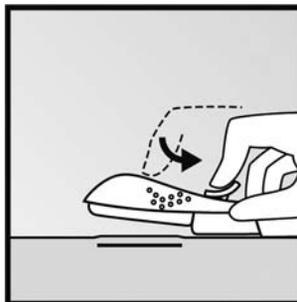


Figure 7

Step 12. **Always verify the presence of the implant in the woman's arm immediately after insertion by palpation.** By palpating both ends of the implant, you should be able to confirm the presence of the 4 cm rod (Figure 8).

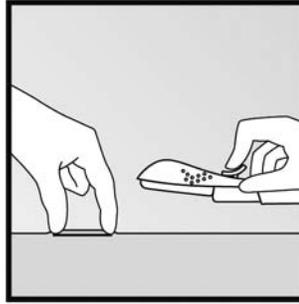


Figure 8

If you cannot feel the implant or are in doubt of its presence,

- Check the applicator. The needle should be fully retracted and only the purple tip of the obturator should be visible.
- Use other methods to confirm the presence of the implant. Suitable methods are: two-dimensional X-ray, X-ray computerized tomography (CT scan), ultrasound scanning (USS) with a high-frequency linear array transducer (10 MHz or greater) or magnetic resonance imaging (MRI). If these methods fail, call 1-877-467-5266 for information on the procedure for measuring etonogestrel blood levels.

Until the presence of the implant has been verified, the woman should be advised to use a non-hormonal contraceptive method, such as condoms.

Step 13. Place a small adhesive bandage over the insertion site. Request that the woman palpate the implant.

Step 14. Apply a pressure bandage with sterile gauze to minimize bruising. The woman may remove the pressure bandage in 24 hours and the small bandage over the insertion site after 3 to 5 days.

Step 15. Complete the USER CARD and give it to the woman to keep. Also, complete the PATIENT CHART LABEL and affix it to the woman's medical record.

Step 16. The applicator is for single use only and should be disposed in accordance with the Center for Disease Control and Prevention guidelines for handling of hazardous waste.

2.3 Removal of NEXPLANON

Preparation

Before initiating the removal procedure, the healthcare provider should carefully read the instructions for removal and consult the USER CARD and/or the PATIENT CHART LABEL for the location of the implant. The exact location of the implant in the arm should be verified by palpation. If the implant is not palpable, two-dimensional X-ray can be performed to verify its presence.

A non-palpable implant should always be first located prior to removal. Suitable methods for localization include: two-dimensional X-ray, X-ray computer tomography (CT), ultrasound scanning (USS) with a high-frequency linear array transducer (10 MHz or greater) or magnetic resonance imaging (MRI). If these imaging methods fail to locate the implant, etonogestrel blood level determination can be used for verification of the presence of the implant. For details on etonogestrel blood level determination, call 1-877-467-5266 for further instructions.

After localization of a non-palpable implant, consider conducting removal with ultrasound guidance.

There have been occasional reports of migration of the implant; usually this involves minor movement relative to the original position. This may complicate localization of the implant by palpation, CT, USS and/or MRI, and removal may require a larger incision and more time.

Exploratory surgery without knowledge of the exact location of the implant is strongly discouraged. Removal of deeply inserted implants should be conducted with caution in order to prevent injury to deeper neural or vascular structures in the arm and be performed by healthcare providers familiar with the anatomy of the arm.

Before removal of the implant, the healthcare provider should confirm that:

- The woman does not have allergies to the antiseptic or anesthetic to be used.

Remove the implant under aseptic conditions.

The following equipment is needed for removal of the implant:

- An examination table for the woman to lie on
- Sterile surgical drapes, sterile gloves, antiseptic solution, sterile marker (optional)
- Local anesthetic, needles, and syringe
- Sterile scalpel, forceps (straight and curved mosquito)
- Skin closure, sterile gauze, adhesive bandage and pressure bandages

Removal Procedure

Step 1. Clean the site where the incision will be made and apply an antiseptic. Locate the implant by palpation and mark the distal end (end closest to the elbow), for example, with a sterile marker (Figure 9).

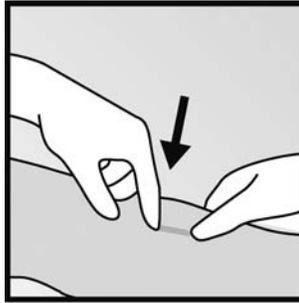


Figure 9

Step 2. Anesthetize the arm, for example, with 0.5 to 1 mL 1% lidocaine at the marked site where the incision will be made (Figure 10). Be sure to inject the local anesthetic under the implant to keep it close to the skin surface.

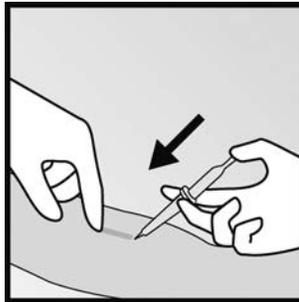


Figure 10

Step 3. Push down the proximal end of the implant (Figure 11) to stabilize it; a bulge may appear indicating the distal end of the implant. Starting at the distal tip of the implant, make a longitudinal incision of 2 mm towards the elbow.

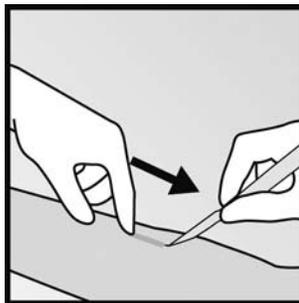


Figure 11

Step 4. Gently push the implant towards the incision until the tip is visible. Grasp the implant with forceps (preferably curved mosquito forceps) and gently remove the implant (Figure 12).

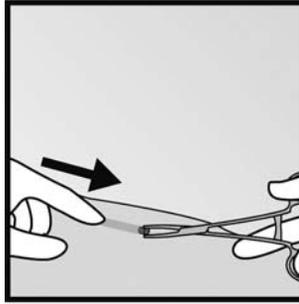


Figure 12

Step 5. If the implant is encapsulated, make an incision into the tissue sheath and then remove the implant with the forceps (Figures 13 and 14).

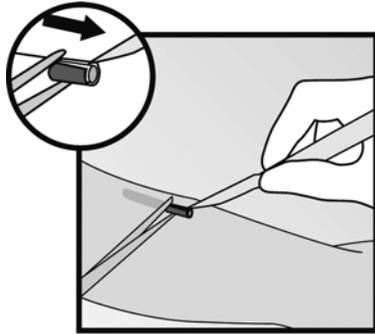


Figure 13

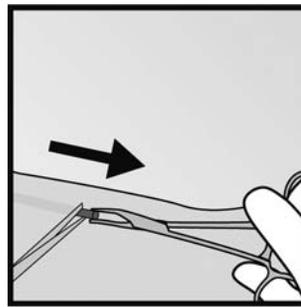


Figure 14

Step 6. If the tip of the implant does not become visible in the incision, gently insert a forceps into the incision (Figure 15). Flip the forceps over into your other hand (Figure 16).

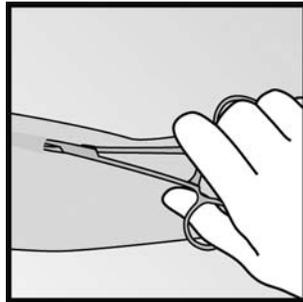


Figure 15

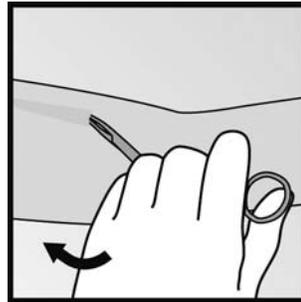


Figure 16

Step 7. With a second pair of forceps carefully dissect the tissue around the implant and grasp the implant (Figure 17). The implant can then be removed.

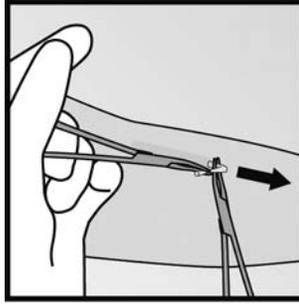


Figure 17

Step 8. Confirm that the entire implant, which is 4 cm long, has been removed by measuring its length. If a partial implant (less than 4 cm) is removed, the remaining piece should be removed by following the instructions in section 2.3. [See *Dosage and Administration (2.3)*.] If the woman would like to continue using NEXPLANON, a new implant may be inserted immediately after the old implant is removed using the same incision [see *Dosage and Administration (2.4)*].

Step 9. After removing the implant, close the incision with a steri-strip and apply an adhesive bandage.

Step 10. Apply a pressure bandage with sterile gauze to minimize bruising. The woman may remove the pressure bandage in 24 hours and the small bandage in 3 to 5 days.

2.4 Replacing NEXPLANON

Immediate replacement can be done after removal of the previous implant and is similar to the insertion procedure described in section 2.2 Insertion of NEXPLANON.

The new implant may be inserted in the same arm, and through the same incision from which the previous implant was removed. If the same incision is being used to insert a new implant, anesthetize the insertion site [for example, 2 mL lidocaine (1%)] applying it just under the skin along the 'insertion canal.'

Follow the subsequent steps in the insertion instructions [see *Dosage and Administration (2.2)*].

3 DOSAGE FORMS AND STRENGTHS

Single, white/off-white, soft, radiopaque, flexible, ethylene vinylacetate (EVA) implant, 4 cm in length and 2 mm in diameter containing 68 mg etonogestrel and 15 mg of barium sulfate.

4 CONTRAINDICATIONS

NEXPLANON should not be used in women who have

- Known or suspected pregnancy
- Current or past history of thrombosis or thromboembolic disorders
- Liver tumors, benign or malignant, or active liver disease
- Undiagnosed abnormal genital bleeding
- Known or suspected breast cancer, personal history of breast cancer, or other progestin-sensitive cancer, now or in the past
- Allergic reaction to any of the components of NEXPLANON [see *Adverse Reactions (6)*]

5 WARNINGS AND PRECAUTIONS

The following information is based on experience with either the non-radiopaque etonogestrel implant (IMPLANON), other progestin-only contraceptives, or experience with combination (estrogen plus progestin) oral contraceptives.

5.1 Complications of Insertion and Removal

NEXPLANON should be inserted subdermally so that it will be palpable after insertion, and this should be confirmed by palpation immediately after insertion. Failure to insert NEXPLANON properly may go unnoticed unless it is palpated immediately after insertion. Undetected failure to insert the implant may lead to an unintended pregnancy. Complications related to insertion and removal procedures, such as pain, paresthesias, bleeding, hematoma, scarring or infection, may occur.

If NEXPLANON is inserted too deeply (intramuscular or in the fascia), neural or vascular injury may occur. To reduce the risk of neural or vascular injury, NEXPLANON should be inserted at the inner side of the non-dominant upper arm about 8-10 cm (3-4 inches) above the medial epicondyle of the humerus. NEXPLANON should be inserted subdermally just under the skin to avoid the large blood vessels and nerves that lie deeper in the subcutaneous tissues in the sulcus between the triceps and biceps muscles. Deep insertions of the non-radiopaque etonogestrel implant (IMPLANON) have been associated with paraesthesia (due to neural injury) and migration of the implant (due to intramuscular or fascial insertion), and in a very few cases with intravascular insertion. If infection develops at the insertion site, start suitable treatment. If the infection persists, the implant should be removed. Incomplete insertions or infections may lead to expulsion.

Implant removal may be difficult or impossible if the implant is not inserted correctly, is inserted too deeply, not palpable, encased in fibrous tissue, or has migrated. Deep insertions may lead to difficult localization of the implant and may also result in the need for a surgical procedure in an operating room in order to remove the implant. Exploratory surgery without knowledge of the exact location of the implant is strongly discouraged. Removal of deeply inserted implants should be conducted with caution in order

to prevent injury to deeper neural or vascular structures in the arm and be performed by healthcare providers familiar with the anatomy of the arm. Failure to remove the implant may result in continued effects of etonogestrel, such as compromised fertility, ectopic pregnancy, or persistence or occurrence of a drug-related adverse event.

5.2 Changes in Menstrual Bleeding Patterns

After starting NEXPLANON, women are likely to have a change from their normal menstrual bleeding pattern. These may include changes in bleeding frequency (absent, less, more frequent or continuous), intensity (reduced or increased) or duration. In clinical trials of the non-radiopaque etonogestrel implant (IMPLANON), bleeding patterns ranged from amenorrhea (1 in 5 women) to frequent and/or prolonged bleeding (1 in 5 women). The bleeding pattern experienced during the first three months of NEXPLANON use is broadly predictive of the future bleeding pattern for many women. Women should be counseled regarding the bleeding pattern changes they may experience so that they know what to expect. Abnormal bleeding should be evaluated as needed to exclude pathologic conditions or pregnancy.

In clinical studies of the non-radiopaque etonogestrel implant, reports of changes in bleeding pattern were the most common reason for stopping treatment (11.1%). Irregular bleeding (10.8%) was the single most common reason women stopped treatment, while amenorrhea (0.3%) was cited less frequently. In these studies, women had an average of 17.7 days of bleeding or spotting every 90 days (based on 3,315 intervals of 90 days recorded by 780 patients). The percentages of patients having 0, 1-7, 8-21, or >21 days of spotting or bleeding over a 90-day interval while using the non-radiopaque etonogestrel implant are shown in Table 1.

Table 1: Percentages of Patients with 0, 1-7, 8-21, or >21 Days of Spotting or Bleeding over a 90-Day Interval while using the Non-Radiopaque Etonogestrel Implant (IMPLANON)

Total Days of Spotting or Bleeding	Percentage of Patients		
	Treatment Days 91-180 (N = 745)	Treatment Days 271-360 (N = 657)	Treatment Days 631-720 (N = 547)
0 Days	19%	24%	17%
1-7 Days	15%	13%	12%
8-21 Days	30%	30%	37%
>21 Days	35%	33%	35%

Bleeding patterns observed with use of the non-radiopaque etonogestrel implant for up to 2 years, and the proportion of 90-day intervals with these bleeding patterns, are summarized in Table 2.

Table 2: Bleeding Patterns Using the Non-Radiopaque Etonogestrel Implant (IMPLANON) during the First 2 Years of Use^A

BLEEDING PATTERNS	DEFINITIONS	% ^B
Infrequent	Less than three bleeding and/or spotting episodes in 90 days (excluding amenorrhea)	33.6
Amenorrhea	No bleeding and/or spotting in 90 days	22.2
Prolonged	Any bleeding and/or spotting episode lasting more than 14 days in 90 days	17.7
Frequent	More than 5 bleeding and/or spotting episodes in 90 days	6.7

^A Based on 3,315 recording periods of 90 days duration in 780 women, excluding the first 90 days after implant insertion

^B % = Percentage of 90-day intervals with this pattern

In case of undiagnosed, persistent, or recurrent abnormal vaginal bleeding, appropriate measures should be conducted to rule out malignancy.

5.3 Ectopic Pregnancies

As with all progestin-only contraceptive products, be alert to the possibility of an ectopic pregnancy among women using NEXPLANON who become pregnant or complain of lower abdominal pain. Although ectopic pregnancies are uncommon among women using NEXPLANON, a pregnancy that occurs in a woman using NEXPLANON may be more likely to be ectopic than a pregnancy occurring in a woman using no contraception.

5.4 Thrombotic and Other Vascular Events

The use of combination hormonal contraceptives (progestin plus estrogen) increases the risk of vascular events, including arterial events (strokes and myocardial infarctions) or deep venous thrombotic events (venous thromboembolism, deep venous thrombosis, retinal vein thrombosis, and pulmonary embolism). NEXPLANON is a progestin-only contraceptive. It is unknown whether this increased risk is applicable to etonogestrel alone. It is recommended, however, that women with risk factors known to increase the risk of venous and arterial thromboembolism be carefully assessed.

There have been postmarketing reports of serious arterial and venous thromboembolic events, including cases of pulmonary emboli (some fatal), deep vein thrombosis, myocardial infarction, and strokes, in women using the non-radiopaque etonogestrel implant. NEXPLANON should be removed in the event of a thrombosis.

Due to the risk of thromboembolism associated with pregnancy and immediately following delivery, NEXPLANON should not be used prior to 21 days postpartum. Women with a history of thromboembolic disorders should be made aware of the possibility of a recurrence.

Evaluate for retinal vein thrombosis immediately if there is unexplained loss of vision, proptosis, diplopia, papilledema, or retinal vascular lesions.

Consider removal of the NEXPLANON implant in case of long-term immobilization due to surgery or illness.

5.5 Ovarian Cysts

If follicular development occurs, atresia of the follicle is sometimes delayed, and the follicle may continue to grow beyond the size it would attain in a normal cycle. Generally, these enlarged follicles disappear spontaneously. On rare occasion, surgery may be required.

5.6 Carcinoma of the Breast and Reproductive Organs

Women who currently have or have had breast cancer should not use hormonal contraception because breast cancer may be hormonally sensitive [see *Contraindications (4)*]. Some studies suggest that the use of combination hormonal contraceptives might increase the incidence of breast cancer; however, other studies have not confirmed such findings.

Some studies suggest that the use of combination hormonal contraceptives is associated with an increase in the risk of cervical cancer or intraepithelial neoplasia. However, there is controversy about the extent to which these findings are due to differences in sexual behavior and other factors.

Women with a family history of breast cancer or who develop breast nodules should be carefully monitored.

5.7 Liver Disease

Disturbances of liver function may necessitate the discontinuation of hormonal contraceptive use until markers of liver function return to normal. Remove NEXPLANON if jaundice develops.

Hepatic adenomas are associated with combination hormonal contraceptives use. An estimate of the attributable risk is 3.3 cases per 100,000 for combination hormonal contraceptives users. It is not known whether a similar risk exists with progestin-only methods like NEXPLANON.

The progestin in NEXPLANON may be poorly metabolized in women with liver impairment. Use of NEXPLANON in women with active liver disease or liver cancer is contraindicated [see *Contraindications (4)*].

5.8 Weight Gain

In clinical studies, mean weight gain in U.S. non-radiopaque etonogestrel implant (IMPLANON) users was 2.8 pounds after one year and 3.7 pounds after two years. How much of the weight gain was related to the non-radiopaque etonogestrel implant is unknown. In studies, 2.3% of the users reported weight gain as the reason for having the non-radiopaque etonogestrel implant removed.

5.9 Elevated Blood Pressure

Women with a history of hypertension-related diseases or renal disease should be discouraged from using hormonal contraception. For women with well-controlled hypertension, use of NEXPLANON can be considered. Women with hypertension using NEXPLANON should be closely monitored. If sustained hypertension develops during the use of NEXPLANON, or if a significant increase in blood pressure does not respond adequately to antihypertensive therapy, NEXPLANON should be removed.

5.10 Gallbladder Disease

Studies suggest a small increased relative risk of developing gallbladder disease among combination hormonal contraceptive users. It is not known whether a similar risk exists with progestin-only methods like NEXPLANON.

5.11 Carbohydrate and Lipid Metabolic Effects

Use of NEXPLANON may induce mild insulin resistance and small changes in glucose concentrations of unknown clinical significance. Carefully monitor prediabetic and diabetic women using NEXPLANON.

Women who are being treated for hyperlipidemia should be followed closely if they elect to use NEXPLANON. Some progestins may elevate LDL levels and may render the control of hyperlipidemia more difficult.

5.12 Depressed Mood

Women with a history of depressed mood should be carefully observed. Consideration should be given to removing NEXPLANON in patients who become significantly depressed.

5.13 Return to Ovulation

In clinical trials with the non-radiopaque etonogestrel implant (IMPLANON), the etonogestrel levels in blood decreased below sensitivity of the assay by one week after removal of the implant. In addition, pregnancies were observed to occur as early as 7 to 14 days after removal. Therefore, a woman should re-start contraception immediately after removal of the implant if continued contraceptive protection is desired.

5.14 Fluid Retention

Hormonal contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention. It is unknown if NEXPLANON causes fluid retention.

5.15 Contact Lenses

Contact lens wearers who develop visual changes or changes in lens tolerance should be assessed by an ophthalmologist.

5.16 Monitoring

A woman who is using NEXPLANON should have a yearly visit with her healthcare provider for a blood pressure check and for other indicated health care.

5.17 Drug-Laboratory Test Interactions

Sex hormone-binding globulin concentrations may be decreased for the first six months after NEXPLANON insertion followed by gradual recovery. Thyroxine concentrations may initially be slightly decreased followed by gradual recovery to baseline.

6 ADVERSE REACTIONS

The following adverse reactions reported with the use of hormonal contraception are discussed elsewhere in the labeling:

- Changes in Menstrual Bleeding Patterns [see *Warnings and Precautions* (5.2)]
- Ectopic Pregnancies [see *Warnings and Precautions* (5.3)]
- Thrombotic and Other Vascular Events [see *Warnings and Precautions* (5.4)]
- Liver Disease [see *Warnings and Precautions* (5.7)]

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.

In clinical trials involving 942 women who were evaluated for safety, change in menstrual bleeding patterns (irregular menses) was the most common adverse reaction causing discontinuation of use of the non-radiopaque etonogestrel implant (IMPLANON) (11.1% of women).

Adverse reactions that resulted in a rate of discontinuation of $\geq 1\%$ are shown in Table 3.

Table 3: Adverse Reactions Leading to Discontinuation of Treatment in 1% or More of Subjects in Clinical Trials of the Non-Radiopaque Etonogestrel Implant (IMPLANON)

Adverse Reactions	All Studies N = 942
Bleeding Irregularities*	11.1%
Emotional Lability†	2.3%
Weight Increase	2.3%
Headache	1.6%
Acne	1.3%
Depression‡	1.0%

* Includes "frequent", "heavy", "prolonged", "spotting", and other patterns of bleeding irregularity.

† Among US subjects (N=330), 6.1% experienced emotional lability that led to discontinuation.

‡ Among US subjects (N=330), 2.4% experienced depression that led to discontinuation.

Other adverse reactions that were reported by at least 5% of subjects in the non-radiopaque etonogestrel implant clinical trials are listed in Table 4.

Table 4: Common Adverse Reactions Reported by ≥5% of Subjects in Clinical Trials with the Non-Radiopaque Etonogestrel Implant (IMPLANON)

Adverse Reactions	All Studies N = 942
Headache	24.9%
Vaginitis	14.5%
Weight increase	13.7%
Acne	13.5%
Breast pain	12.8%
Abdominal pain	10.9%
Pharyngitis	10.5%
Leukorrhea	9.6%
Influenza-like symptoms	7.6%
Dizziness	7.2%
Dysmenorrhea	7.2%
Back pain	6.8%
Emotional lability	6.5%
Nausea	6.4%
Pain	5.6%
Nervousness	5.6%
Depression	5.5%
Hypersensitivity	5.4%
Insertion site pain	5.2%

In a clinical trial of NEXPLANON, in which investigators were asked to examine the implant site after insertion, implant site reactions were reported in 8.6% of women. Erythema was the most frequent implant site complication, reported during and/or shortly after insertion, occurring in 3.3% of subjects. Additionally, hematoma (3.0%), bruising (2.0%), pain (1.0%), and swelling (0.7%) were reported.

6.2 Postmarketing Experience

The following additional adverse reactions have been identified during post-approval use of the non-radiopaque etonogestrel implant (IMPLANON). Because these reactions are reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Gastrointestinal disorders: constipation, diarrhea, flatulence, vomiting.

General disorders and administration site conditions: edema, fatigue, implant site reaction, pyrexia.

Infections and infestations: rhinitis, urinary tract infection.

Investigations: clinically relevant rise in blood pressure, weight decreased.

Metabolism and nutrition disorders: increased appetite.

Musculoskeletal and connective tissue disorders: arthralgia, musculoskeletal pain, myalgia.

Nervous system disorders: convulsions, migraine, somnolence.

Pregnancy, puerperium and perinatal conditions: ectopic pregnancy.

Psychiatric disorders: anxiety, insomnia, libido decreased.

Renal and urinary disorders: dysuria.

Reproductive system and breast disorders: breast discharge, breast enlargement, ovarian cyst, pruritus genital, vulvovaginal discomfort.

Skin and subcutaneous tissue disorders: (aggravation of) angioedema and/or aggravation of hereditary angioedema, alopecia, chloasma, hypertrichosis, pruritus, rash, seborrhea, urticaria.

Vascular disorders: hot flush.

Complications related to insertion or removal of the non-radiopaque etonogestrel implant reported include: bruising, slight local irritation, pain or itching, fibrosis at the implant site, paresthesia or paresthesia-like events, scarring and abscess.

7 DRUG INTERACTIONS

7.1 Changes in Contraceptive Effectiveness Associated with Coadministration of Other Products

Drugs or herbal products that induce enzymes, including CYP3A4, that metabolize progestins may decrease the plasma concentrations of progestins, and may decrease the effectiveness of NEXPLANON. In women on long-term treatment with hepatic enzyme inducing drugs, it is recommended to remove the implant and to advise a contraceptive method that is unaffected by the interacting drug.

Some of these drugs or herbal products that induce enzymes, including CYP3A4, include:

- barbiturates

- bosentan
- carbamazepine
- felbamate
- griseofulvin
- oxcarbazepine
- phenytoin
- rifampin
- St. John's wort
- topiramate

HIV Antiretrovirals

Significant changes (increase or decrease) in the plasma levels of progestin have been noted in some cases of co-administration with HIV protease inhibitors or with non-nucleoside reverse transcriptase inhibitors. Consult the labeling of all concurrently-used drugs to obtain further information about interactions with hormonal contraceptives or the potential for enzyme alterations.

7.2 Increase in Plasma Concentrations of Etonogestrel Associated with Coadministered Drugs

CYP3A4 inhibitors such as itraconazole or ketoconazole may increase plasma concentrations of etonogestrel.

7.3 Changes in Plasma Concentrations of Coadministered Drugs

Hormonal contraceptives may affect the metabolism of other drugs. Consequently, plasma concentrations may either increase (for example, cyclosporin) or decrease (for example, lamotrigine). Consult the labeling of all concurrently-used drugs to obtain further information about interactions with hormonal contraceptives or the potential for enzyme alterations.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

NEXPLANON is not indicated for use during pregnancy [*see Contraindications (4)*].

Teratology studies have been performed in rats and rabbits using oral administration up to 390 and 790 times the human etonogestrel dose (based upon body surface), respectively, and revealed no evidence of fetal harm due to etonogestrel exposure.

Studies have revealed no increased risk of birth defects in women who have used combination oral contraceptives before pregnancy or during early pregnancy. There is no evidence that the risk associated with etonogestrel is different from that of combination oral contraceptives.

NEXPLANON should be removed if maintaining a pregnancy.

8.3 Nursing Mothers

Based on limited clinical data, NEXPLANON may be used during breastfeeding after the fourth postpartum week. Use of NEXPLANON before the fourth postpartum week has not been studied. Small amounts of etonogestrel are excreted in breast milk. During the first months after insertion of NEXPLANON, when maternal blood levels of etonogestrel are highest, about 100 ng of etonogestrel may be ingested by the child per day based on an average daily milk ingestion of 658 mL. Based on daily milk ingestion of 150 mL/kg, the mean daily infant etonogestrel dose one month after insertion of the non-radiopaque etonogestrel implant (IMPLANON) is about 2.2% of the weight-adjusted maternal daily dose, or about 0.2% of the estimated absolute maternal daily dose. The health of breast-fed infants whose mothers began using the non-radiopaque etonogestrel implant during the fourth to eighth week postpartum (n=38) was evaluated in a comparative study with infants of mothers using a non-hormonal IUD (n=33). They were breast-fed for a mean duration of 14 months and followed up to 36 months of age. No significant effects and no differences between the groups were observed on the physical and psychomotor development of these infants. No differences between groups in the production or quality of breast milk were detected.

Healthcare providers should discuss both hormonal and non-hormonal contraceptive options, as steroids may not be the initial choice for these patients.

8.4 Pediatric Use

Safety and efficacy of NEXPLANON have been established in women of reproductive age. Safety and efficacy of NEXPLANON are expected to be the same for postpubertal adolescents. However, no clinical studies have been conducted in women less than 18 years of age. Use of this product before menarche is not indicated.

8.5 Geriatric Use

This product has not been studied in women over 65 years of age and is not indicated in this population.

8.6 Hepatic Impairment

No studies were conducted to evaluate the effect of hepatic disease on the disposition of NEXPLANON. The use of NEXPLANON in women with active liver disease is contraindicated [*see Contraindications (4)*].

8.7 Renal Impairment

No studies were conducted to evaluate the effect of renal disease on the disposition of NEXPLANON.

8.8 Overweight Women

The effectiveness of the etonogestrel implant in women who weighed more than 130% of their ideal body weight has not been defined because such women were not studied in clinical trials. Serum concentrations of etonogestrel are inversely related to body weight and decrease with time after implant insertion. It is therefore possible that NEXPLANON may be less effective in overweight women, especially in the presence of other factors that decrease serum etonogestrel concentrations such as concomitant use of hepatic enzyme inducers.

10 OVERDOSAGE

Overdosage may result if more than one implant is inserted. In case of suspected overdose, the implant should be removed.

11 DESCRIPTION

NEXPLANON is a radiopaque, progestin-only, soft, flexible implant preloaded in a sterile, disposable applicator for subdermal use. The implant is white/off-white, non-biodegradable and 4 cm in length with a diameter of 2 mm (see Figure 18). Each implant consists of an ethylene vinylacetate (EVA) copolymer core, containing 68 mg of the synthetic progestin etonogestrel and barium sulfate (radiopaque ingredient), surrounded by an EVA copolymer skin. Once inserted subdermally, the release rate is 60-70 mcg/day in week 5-6 and decreases to approximately 35-45 mcg/day at the end of the first year, to approximately 30-40 mcg/day at the end of the second year, and then to approximately 25-30 mcg/day at the end of the third year. NEXPLANON is a progestin-only contraceptive and does not contain estrogen. NEXPLANON does not contain latex.



Figure 18 (Not to scale)

Etonogestrel [13-Ethyl-17-hydroxy-11-methylene-18,19-dinor-17 α -pregn-4-en-20-yn-3-one], structurally derived from 19-nortestosterone, is the synthetic biologically active metabolite of the synthetic progestin desogestrel. It has a molecular weight of 324.46 and the following structural formula (Figure 19).

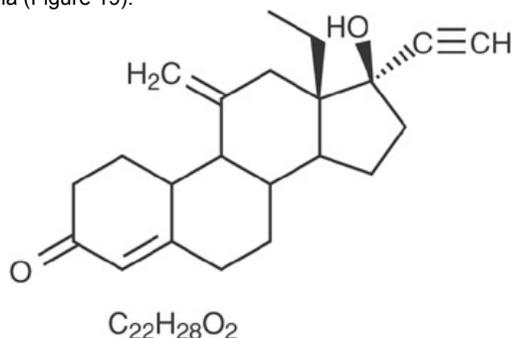


Figure 19

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

The contraceptive effect of NEXPLANON is achieved by suppression of ovulation, increased viscosity of the cervical mucus, and alterations in the endometrium.

12.2 Pharmacodynamics

Exposure-response relationships of NEXPLANON are unknown.

12.3 Pharmacokinetics

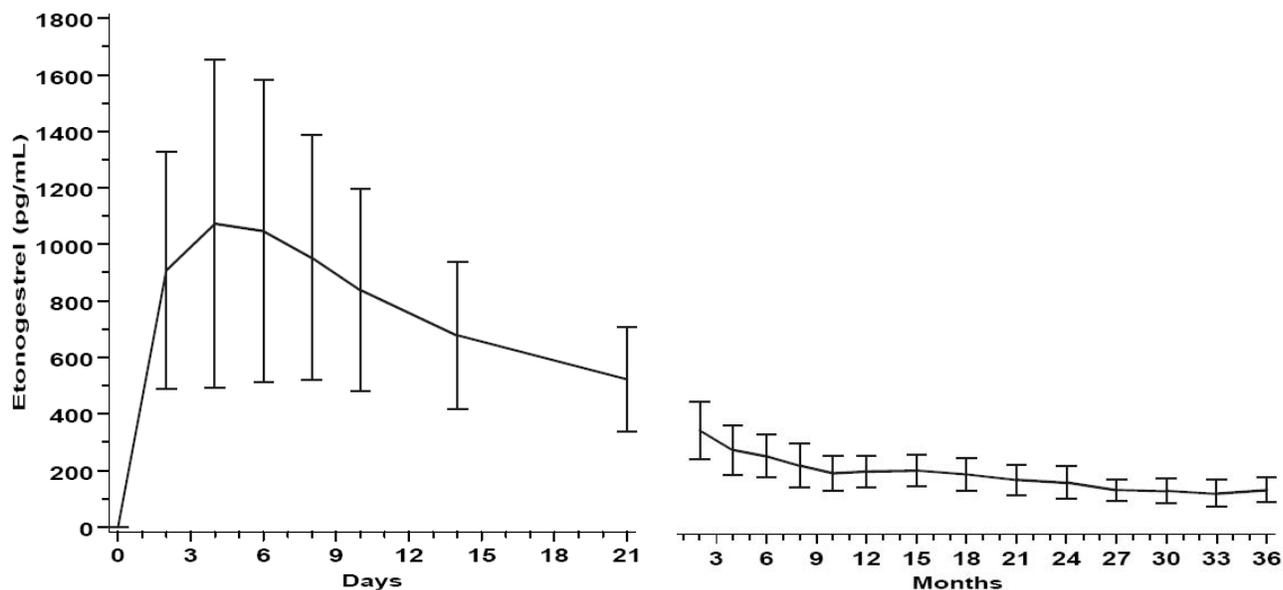
Absorption

After subdermal insertion of the etonogestrel implant, etonogestrel is released into the circulation and is approximately 100% bioavailable.

In a three year clinical trial, NEXPLANON and the non-radiopaque etonogestrel implant (IMPLANON) yielded comparable systemic exposure to etonogestrel. For NEXPLANON, the mean (\pm SD) maximum serum etonogestrel concentrations were 1200 (\pm 604) pg/mL and were reached within the first two weeks after insertion (n=50). The mean (\pm SD) serum etonogestrel concentration decreased gradually over time, declining to 202 (\pm 55) pg/mL at 12 months (n=41), 164 (\pm 58) pg/mL at 24 months (n=37), and 138 (\pm 43) pg/mL at 36 months (n=32). For the non-radiopaque etonogestrel implant (IMPLANON), the mean (\pm SD) maximum serum etonogestrel concentrations were 1145 (\pm 577) pg/mL and were reached within the first two weeks after insertion (n=53). The mean (\pm SD) serum etonogestrel concentration decreased gradually over time, declining to 223 (\pm 73) pg/mL at 12 months (n=40), 172 (\pm 77) pg/mL at 24 months (n=32), and 153 (\pm 52) pg/mL at 36 months (n=30).

The pharmacokinetic profile of NEXPLANON is shown in Figure 20.

Figure 20: Mean (\pm SD) serum concentration-time profile of etonogestrel after insertion of NEXPLANON during 3 years of use



Distribution

The apparent volume of distribution averages about 201 L. Etonogestrel is approximately 32% bound to sex hormone binding globulin (SHBG) and 66% bound to albumin in blood.

Metabolism

In vitro data shows that etonogestrel is metabolized in liver microsomes by the cytochrome P450 3A4 isoenzyme. The biological activity of etonogestrel metabolites is unknown.

Excretion

The elimination half-life of etonogestrel is approximately 25 hours. Excretion of etonogestrel and its metabolites, either as free steroid or as conjugates, is mainly in urine and to a lesser extent in feces. After removal of the implant, etonogestrel concentrations decreased below sensitivity of the assay by one week.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

In a 24-month carcinogenicity study in rats with subdermal implants releasing 10 and 20 mcg etonogestrel per day (equal to approximately 1.8-3.6 times the systemic steady state exposure in women using NEXPLANON), no drug-related carcinogenic potential was observed. Etonogestrel was not genotoxic in the *in vitro* Ames/Salmonella reverse mutation assay, the chromosomal aberration assay in Chinese hamster ovary cells or in the *in vivo* mouse micronucleus test. Fertility returned after withdrawal from treatment.

14 CLINICAL STUDIES

14.1 Pregnancy

In clinical trials of up to 3 years duration that involved 923 subjects, 18-40 years of age at entry, and 1,756 women-years of use with the non-radiopaque etonogestrel implant (IMPLANON), the total exposures expressed as 28-day cycle equivalents by study year were:

- Year 1: 10,866 cycles
- Year 2: 8,581 cycles
- Year 3: 3,442 cycles

The clinical trials excluded women who:

- Weighed more than 130% of their ideal body weight

- Were chronically taking medications that induce liver enzymes

In the subgroup of women, 18-35 years of age at entry, 6 pregnancies during 20,648 cycles of use were reported. Two pregnancies occurred in each of Years 1, 2, and 3. Each conception was likely to have occurred shortly before or within 2 weeks after removal of the non-radiopaque etonogestrel implant. With these 6 pregnancies, the cumulative Pearl Index was 0.38 pregnancies per 100 women-years of use.

14.2 Return to Ovulation

In clinical trials with the non-radiopaque etonogestrel implant (IMPLANON), the etonogestrel levels in blood decreased below sensitivity of the assay by one week after removal of the implant. In addition, pregnancies were observed to occur as early as 7 to 14 days after removal. Therefore, a woman should re-start contraception immediately after removal of the implant if continued contraceptive protection is desired.

14.3 Implant Insertion and Removal Characteristics

Out of 301 insertions of the NEXPLANON implant in a clinical trial, the mean insertion time (from the removal of the protection cap of the applicator until retraction of the needle from the arm) was 27.9 ± 29.3 seconds. After insertion, 300 out of 301 (99.7%) NEXPLANON implants were palpable. The single, non-palpable implant was not inserted according to the instructions.

For 112 out of 114 (98.2%) subjects in 2 clinical trials for whom insertion and removal data were available, NEXPLANON implants were clearly visible with use of two-dimensional x-ray after insertion. The two implants that were not clearly visible after insertion were clearly visible with two-dimensional x-ray before removal.

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

One NEXPLANON package consists of a single implant containing 68 mg etonogestrel that is 4 cm in length and 2 mm in diameter, which is pre-loaded in the needle of a disposable applicator. The sterile applicator containing the implant is packed in a blister pack.

NDC 0052-0274-01

16.2 Storage and Handling

Store NEXPLANON (etonogestrel implant) Radiopaque at 25°C (77°F); excursions permitted to 15°-30°C (59°-86°F) [see USP Controlled Room Temperature]. Avoid storing NEXPLANON at temperatures above 30°C (86°F).

17 PATIENT COUNSELING INFORMATION

See *FDA-Approved Patient Labeling*.

Information for Patients

- Counsel women about the insertion and removal procedure of the NEXPLANON implant. Provide the woman with a copy of the Patient Labeling and ensure that she understands the information in the Patient Labeling before insertion and removal. A USER CARD and consent form are included in the packaging. Have the woman complete a consent form and retain it in your records. The USER CARD should be filled out and given to the woman after insertion of the NEXPLANON implant so that she will have a record of the location of the implant in the upper arm and when it should be removed.
- Counsel women that NEXPLANON does not protect against HIV infection (AIDS) or other sexually transmitted diseases.
- Counsel women that the use of NEXPLANON may be associated with changes in their normal menstrual bleeding patterns so that they know what to expect.

FDA-Approved Patient Labeling

See the full patient product information for NEXPLANON.

Manufactured by: N.V. Organon, Oss,
The Netherlands, a subsidiary of

 **MERCK & CO., INC.**, Whitehouse Station, NJ 08889, USA

Distributed by: Schering Corporation, a subsidiary of

 **MERCK & CO., INC.**, Whitehouse Station, NJ 08889, USA

Copyright © 2011 N.V. Organon, a subsidiary of Merck & Co., Inc.
All rights reserved.

Issued: May 2011

37847