

DATA SHEET

Name of Medicine

Ovidrel®250 microgram Solution for Injection

Ovidrel contains recombinant human chorionic gonadotrophin hormone (choriogonadotropin alfa, (rch)).

CAS number 177073-44-8

Alfa subunit-(CAS-56832-30-5)

Beta subunit-(CAS-56832-34-9)

Presentation

Ovidrel is presented as a sterile liquid, single dose pre-filled syringe containing 250 µg r-hCG in 0.5 mL.

Ovidrel is supplied in boxes of 1 pre-filled syringe, each syringe containing 250 µg of choriogonadotropin alfa in 0.5 mL.

Each pre-filled syringe contains 250 µg of choriogonadotropin alfa, 27.3 mg mannitol, 0.49 mg phosphoric acid, 0.1 mg methionine, 0.05 mg poloxamer, sodium hydroxide (for pH adjustment) and water for injections to 0.5 mL.

Uses

Actions

Pharmacotherapeutic group: gonadotropins, ATC code: GO3G A01

Ovidrel is a preparation of chorionic gonadotrophin hormone produced by genetically engineered Chinese hamster ovary (CHO) cells. The physicochemical, immunological and biological activities of recombinant hCG are comparable to those of placental and human pregnancy urine-derived hCG. Choriogonadotropin alfa stimulates late follicular maturation and resumption of oocytes meiosis and initiates rupture of the pre-ovulatory ovarian follicle.

Choriogonadotropin alfa, the active component of Ovidrel, is an analogue of LH and binds to the LH/hCG receptor of the granulosa and the theca cells of the ovary to effect these changes in the absence of an endogenous LH surge. In pregnancy, hCG, secreted by the placenta, maintains the corpus luteum after LH secretion decreases and supports continued secretion of oestrogen and progesterone necessary to support the first trimester of pregnancy. Ovidrel is

administered when monitoring of the patient indicates that sufficient follicular development has occurred in response to FSH treatment for ovulation induction.

Pharmacokinetics

Following intravenous administration, choriogonadotropin alfa is distributed to the extra cellular fluid space within a few hours of its injection. There are no indications that choriogonadotropin alfa is metabolised and excreted differently than endogenous hCG. The terminal half-life is slightly longer after subcutaneous injection as compared to intravenous results.

Absorption

Following subcutaneous administration of Ovidrel 250 µg, maximum serum concentration (121 ± 44 IU/L) is reached after approximately 12 to 24 hours. The mean absolute bioavailability of Ovidrel after subcutaneous injection to healthy female volunteers is about 40%.

Distribution

Following intravenous administration of Ovidrel 250 µg to healthy down-regulated female volunteers, the serum profile of hCG is described by a two-compartment model with an initial half-life of 4.5 ± 0.5 hours. The volume of the central compartment is 3.0 ± 0.5 L and the steady state volume of distribution is 5.9 ± 1.0 L.

Metabolism/Excretion

After intravenous administration of Ovidrel 250 µg to healthy down-regulated females, the mean terminal half-life is 26.5 ± 2.5 hours and the total body clearance is 0.29 ± 0.04 L/h. One-tenth of the dose is excreted in the urine. Following subcutaneous administration of Ovidrel, hCG is eliminated from the body with a mean terminal half-life of about 38 hours (37.9 ± 3.6 hours for the freeze-dried preparation and 38.2 ± 5.0 for the liquid formulation).

Bioequivalence of Formulations

Ovidrel liquid has been determined to be bioequivalent to Ovidrel freeze-dried formulation based on the statistical evaluation of AUC and C_{max}. A summary of the Ovidrel freeze-dried and liquid pharmacokinetic parameters is presented in Table 1, and a summary of treatment ratios (test/reference) and 90% confidence intervals calculated from the ANOVA is presented in Table 2.

Table 1. Summary of Ovidrel Freeze-Dried and Liquid Pharmacokinetic Parameters

Parameter	Cmax (mIU/mL)	AUC _{last} (mIU.h/mL)	AUC (mIU.h/mL)	AUC extrapolated (%)	tmax (h)
Reference r-hCG Freeze-dried formulation (n=22) Mean (Min-Max)	129 (66.0 - 279)	10210 (5627 - 20070)	10480 (5751 - 20460)	2.67 (1.13 - 6.31)	24.0 (9.00 - 48.0)
Test r-hCG Liquid formulation (n=23) Mean (Min-Max)	125 (68.0 - 294)	10050 (5646 - 14850)	10350 (5800 - 15100)	2.85 (1.08 - 6.27)	20.0 (9.00 - 48.0)

Table 2. Summary of Treatment Ratios (Test/Reference) and 90% Confidence Intervals Calculated from the ANOVA

N=22	Estimated Ratio T/R	Intrasubject CV (%)	90% CI (0.8 - 1.25)
Cmax	0.9820	27.48	0.8529 - 1.1305
AUC _{last}	0.9811	15.18	0.9067 - 1.0615
AUC	0.9814	14.85	0.9085 - 1.0600

Indications

OVIDREL is indicated in the treatment of

- (i) *Women undergoing superovulation prior to assisted reproductive techniques such as in vitro fertilisation (IVF):* OVIDREL is administered to trigger final follicular maturation and luteinisation after stimulation of follicular growth.
- (ii) *Anovulatory or oligo-ovulatory women:* OVIDREL is administered to trigger ovulation and luteinisation in anovulatory or oligo-ovulatory patients after stimulation of follicular growth.

Dosage and Administration

Ovidrel is intended for subcutaneous administration.

Treatment with Ovidrel should be performed under the supervision of a physician experienced in the treatment of fertility problems.

In comparative clinical trials, administration of a dose of 250 µg of Ovidrel was as effective as 5000 IU or 10,000 IU of urinary-derived hCG for the Assisted Reproductive Technique (ART) endpoint of number of oocytes retrieved per patient treated. In an Ovulation Induction (OI) study, 250 µg of Ovidrel was as effective as 5000 IU of urinary hCG in inducing final follicular maturation and ovulation. Consequently, the following dosing regimen should be applied:

(i) *Women undergoing superovulation prior to assisted reproductive techniques such as in vitro fertilisation (IVF):*

Initially one pre-filled syringe of Ovidrel (250 µg in 0.5 mL) should be administered 24 to 48 hours after the last administration of an FSH- or hMG preparation, i.e. optimal stimulation of follicular growth is achieved.

(ii) *Anovulatory or oligo-ovulatory women:*

Initially one pre-filled syringe of Ovidrel (250 µg in 0.5 mL) should be administered 24 to 48 hours after optimal stimulation of follicular growth is achieved. The patient is recommended to have intercourse on the day of and the day after, Ovidrel injection.

Ovidrel 250 µg is equivalent to approximately 6500IU of Profasi and adjustment to dosage should be in accord with clinical and biochemical monitoring.

Ovidrel is given as an injection under the skin (subcutaneously), usually near your stomach. Ovidrel is intended to be injected by the patient or their partner.

The patient should be instructed and assisted in learning the procedure and technique of self-injection. Prescribers and Dispensers should ensure the patient or their partner have a good understanding of the principles of sterile techniques and have been assessed in their adequacy of injection technique prior to use.

Prescribers and Dispensers should take the patient and their partner through the directions on 'How to Administer' found in the Consumer Medicine Information.

Contraindications

Ovidrel is contraindicated in women who exhibit:

- Prior hypersensitivity to hCG preparations or one of their excipients
- Primary ovarian failure
- Uncontrolled thyroid or adrenal dysfunction
- Uncontrolled tumours of the hypothalamus and pituitary gland
- Ovarian enlargement or cyst due to reasons other than polycystic ovarian disease
- Sex hormone dependent tumours of the reproductive tract and accessory organs

- Fibroid tumours of the uterus incompatible with pregnancy
- Postmenopausal women
- Ovarian, uterine or mammary carcinoma
- Extrauterine pregnancy in the previous 3 months
- Active thrombo-embolic disorders
- Gynaecological haemorrhages of unknown aetiology.

Warnings and Precautions

To date, there is no clinical experience with Ovidrel in other indications commonly treated with urine derived human chorionic gonadotrophin.

Gonadotrophins, including Ovidrel, should only be used by physicians who are thoroughly familiar with infertility problems and their management.

Before starting treatment, the couple's infertility should be assessed as appropriate and putative contraindications for pregnancy evaluated. In particular, patients should be evaluated for hypothyroidism, adrenocortical deficiency, hyperprolactinaemia and pituitary or hypothalamic tumours and appropriate specific treatment given.

Special precautions should be taken before administering Ovidrel to patients with clinically significant systemic disease where pregnancy could lead to a worsening of the condition.

Like other hCG products, Ovidrel is a potent gonadotrophic substance capable of causing Ovarian Hyperstimulation Syndrome (OHSS) in women with or without pulmonary or vascular complications. Gonadotrophin therapy requires a certain time commitment by physicians and supportive health professionals and requires the availability of appropriate monitoring facilities (See Precautions/Laboratory tests).

To minimise the risk of OHSS and of multiple pregnancy, ultrasound scans, as well as oestradiol measurements, are recommended prior to and during stimulation therapy for all patients. In anovulation, the risk of OHSS is increased by a serum oestradiol level > 1500 pg/mL (5400 pmol/L) and more than 3 follicles of 14 mm or more in diameter. In ART, there is an increased risk of OHSS with a serum oestradiol > 3000 pg/mL (11000 pmol/L) and 20 or more follicles of 12 mm or more in diameter. When the oestradiol level is > 5500 pg/mL (20000 pmol/L), and when there are 40 or more follicles in total, it may be necessary to withhold hCG administration.

Ovidrel has not been tested in women considered to be at risk of OHSS, who were withdrawn from the clinical studies prior to hCG administration. Because of this and because 250 µg Ovidrel may correspond to a dose greater than 5000 IU

urinary hCG, Ovidrel should be used with particular caution in women with higher order follicle numbers.

Adherence to recommended Ovidrel dosage, regimen of administration and careful monitoring of therapy will minimise the incidence of OHSS and multiple pregnancies.

Overstimulation of the ovary following hCG therapy

Ovarian Enlargement:

Mild to moderate uncomplicated ovarian enlargement which may be accompanied by abdominal distension and/or abdominal pain may occur in patients treated with FSH and hCG, and generally regresses without treatment within two or three weeks. Careful monitoring of the ovarian response can minimise the risk of overstimulation.

If the ovaries are abnormally enlarged on the last day of FSH therapy, choriogonadotropin alfa should not be administered in this course of therapy. This will reduce the risk of development of OHSS.

Ovarian Hyperstimulation Syndrome (OHSS):

OHSS is a medical event distinct from an uncomplicated ovarian enlargement. Severe OHSS may progress rapidly (within 24 hours to several days) to become a serious medical event. It is characterised by an apparent dramatic increase in vascular permeability, which can result in a rapid accumulation of fluid in the peritoneal cavity, thorax and potentially, the pericardium. The early warning signs of development of OHSS are severe pelvic pain, nausea, vomiting and weight gain. The following symptomatology has been seen with cases of OHSS: abdominal pain, abdominal distension, gastrointestinal symptoms including nausea, vomiting, diarrhoea, severe ovarian enlargement, weight gain, dyspnoea and oliguria. Clinical evaluation may reveal hypovolaemia, haemoconcentration, electrolyte imbalances, ascites, haemoperitoneum, pleural effusions, hydrothorax, acute pulmonary distress and thromboembolic events (see Pulmonary and Vascular complications). Transient liver function test abnormalities suggestive of hepatic dysfunction, which may be accompanied by morphologic changes on liver biopsy, have been reported in association with OHSS.

OHSS occurred in 4 of 236 (1.7%) patients treated with Ovidrel 250 µg during clinical trials of ART and 3 of 99 (3.0%) patients in the OI trial. OHSS occurred in 8 of 89 (9.0%) patients who received Ovidrel 500 µg. Two patients treated with Ovidrel 500 µg developed severe OHSS.

OHSS may be more severe and more protracted if pregnancy occurs. OHSS develops rapidly; therefore, patients should be followed up for at least two weeks after hCG administration. Most often, OHSS occurs after treatment has been discontinued and reaches its maximum at about seven to ten days following

treatment. Usually, OHSS resolves spontaneously with the onset of menses. If there is evidence that OHSS may be developing prior to hCG administration (see Precautions/Laboratory tests), the hCG must be withheld.

Embryo transfer should be deferred and embryos cryopreserved for later transfer if possible, if OHSS is developing.

If severe OHSS occurs, treatment with gonadotrophins must be stopped and the patient should be hospitalised.

Multiple Births:

As with other hCG products, reports of multiple births have been associated with Ovidrel treatment. In Assisted Reproductive Technologies (ART), the risk of multiple births is related to the number of embryos transferred. In patients undergoing Ovulation Induction (OI), the incidence of multiple pregnancies and births (mostly twins) is increased compared with natural conception. The patient should be advised of the potential risk of multiple births before starting treatment.

If the size and number of follicles suggest a substantial risk of multiple pregnancy with triplets or more, hCG should be withheld and contraception advised.

Miscarriage

The rate of miscarriage, in both anovulatory patients and women undergoing ART, is higher than that found in the normal population but comparable with the rates observed in women with other fertility problems.

Congenital Malformation

The prevalence of congenital malformations after ART may be slightly higher than after spontaneous conceptions. This could be due to parental factors (e.g. maternal age, genetics), ART procedures and multiple pregnancies.

Pulmonary and Vascular Complications

As with other hCG products, a potential for the occurrence of arterial thromboembolism exists.

Thromboembolic Events

In women with generally recognised risk factors for thromboembolic events, such as personal or family history, treatment with gonadotrophins may further increase the risk. In these women, the benefits of gonadotrophin administration need to be weighed against the risks. It should be noted however, that pregnancy itself as well as OHSS also carry an increased risk of thromboembolic events.

Precautions

General: Careful attention should be given to the diagnosis of infertility in candidates for hCG therapy.

Prior to therapy with hCG, patients should be informed of the duration of treatment and monitoring of their condition that will be required. The risks of OHSS and multiple births in women and other possible adverse reactions (see Adverse Effects) should also be discussed.

Use in Pregnancy

Category B3.

No reproduction studies with recombinant human choriogonadotropin alfa in animals have been performed. No clinical data on exposed pregnancies are available. The potential risk for humans is unknown. Ovidrel should not be used during pregnancy.

Use in Lactation

The potential effects of choriogonadotropin alfa in lactating animals have not been studied. There are no data on the excretion of choriogonadotropin alfa in breast milk. Because many drugs are excreted in human milk, Ovidrel should not be administered to breast feeding women.

Carcinogenicity and Mutagenicity

Long-term studies in animals have not been performed to evaluate the carcinogenic potential of Ovidrel. Gene mutation assays (bacteria and mammalian cells *in vitro*) and chromosomal aberration studies (human lymphocytes *in vitro* and mouse bone marrow erythrocytes *in vivo*) showed no evidence of genotoxic effects.

Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been reported.

Adverse Effects

Ovidrel is used to trigger final follicular maturation and early luteinisation after use of ovulation induction drugs. In this context, it is difficult to attribute undesirable effects to any one of the medications used.

In comparative trials with different doses of Ovidrel, the most common side effect was application site disorder, occurring in 14.6% of patients receiving Ovidrel 250 µg subcutaneously, compared to 28% of patients receiving u-hCG subcutaneously.

All adverse events reported with an incidence of 2% or greater are included for studies 9073, 7927, 7648 and 8209 and all adverse events for study 23286 in the following tables.

Table 3. Adverse Events for Study 9073

System class	250 µg r-hCG (Ovidrel) (n = 44)		5000 IU (Profasi) (n = 40)	
	Number of Patients	Percent Patients (%)	Number of Patients	Percent Patients (%)
Body as a whole	9	20.5	17	42.5
Injection site inflammation	0	0	2	5
Injection site pain	7	15.9	13	32.5
Injection site reaction	2	4.6	4	10.0
Hemic and lymphatic systems				
Ecchymosis	3	6.8	2	5.0
Nervous system	0	0	2	5.0
Hyperesthesia	0	0	1	2.5
Twitching	0	0	1	2.5

Table 4. Adverse Events for Study GF 7927

Body System	hCG-treated Patients					
	250 µg r-hCG (n=95)		500 µg r-hCG (n=89)		Profasi (n=96)	
	Patients	Events	Patients	Events	Patients	Events
Gastro-intestinal system disorders	17(17.9%)	30(32.3%)	19(21.3%)	34(33.7%)	16(16.7%)	27(37.5%)
Nausea	8(8.4%)	8(8.6%)	13(14.6%)	15(14.9%)	8(8.3%)	8(11.1%)
Abdominal Pain	8(8.4%)	12(12.9%)	10(11.2%)	11(10.9%)	8(8.3%)	8(11.1%)
Vomiting	5(5.3%)	5(5.4%)	7(7.9%)	8(7.9%)	5(5.2%)	5(6.9%)
Reproductive disorders, female	11(11.6%)	13(14%)	17(19.1%)	18(17.8%)	11(11.5%)	12(16.7%)
Ovarian Hyperstimulation	3(3.2%)	4(4.3%)	8(9.0%)	8(7.9%)	3(3.1%)	3(4.2%)
Intermenstrual bleeding	2(2.1%)	2(2.2%)	4(4.5%)	4(4.0%)	4(4.2%)	4(5.6%)
Secondary Terms Post-operative pain	11(11.6%)	11(11.8%)	14(15.7%)	14(13.9%)	9(9.4%)	9(12.5%)
Body as a whole-general disorders	7(7.4%)	9(9.7%)	6(6.7%)	7(6.9%)	9(9.4%)	9(12.4%)
Pain	4(4.2%)	4(4.3%)	2(2.2%)	2(2.0%)	4(4.2%)	4(5.60%)
Central and Peripheral Nervous	6(6.3%)	6(6.5%)	5(5.6%)	5(5.0%)	4(4.2%)	4(5.6%)

System disorders						
Headache	3(3.2%)	3(3.2%)	3(3.4%)	3(3.0%)	1(1.0%)	1(1.4%)
Skin and Appendage disorders	3(3.2%)	3(3.2%)	2(2.2%)	2(2.0%)	4(4.2%)	4(5.6%)
Rash	3(3.2%)	3(3.2%)	1(1.1%)	1(1.0%)	1(1.0%)	1(1.4%)

Table 5. Adverse Events for Study 7648

System class	250 µg r-hCG (Ovidrel) (n = 97)	5000 IU (Profasi) (n = 93)
	# AEs (#Patients - % Patients)	# AEs (#Patients - % Patients)
Application disorders		
Injection site bruising	7 (7 – 7.2%)	7 (7 – 7.5%)
Injection site inflammation	4 (3 – 3.1%)	19 (19 – 20.4%)
Injection site pain	7 (7 – 7.2%)	26 (22 – 23.7%)

Table 6. Adverse Events for Study 8209

System class	250 µg r-hCG (Ovidrel) (n = 99)	5000 IU (Profasi) (n = 99)
	# AEs (#Patients - % Patients)	# AEs (#Patients - % Patients)
Application disorders		
Injection site bruising	4 (3 – 7.3%)	7 (7 – 14%)
Injection site inflammation	2 (2 – 4.9%)	15 (15 – 30.0%)
Injection site pain	9 (8 – 19.5%)	20 (17 – 34%)
Injection site reaction	3 (3 – 7.3%)	8 (7 – 14%)
Gastrointestinal disorders		
Abdominal pain	2 (2 – 4.9%)	3 (3 - 3.6%)
Abdominal pain lower	-	3 (3 – 6%)
Reproductive disorders - female		
Ovarian cyst	3 (3 – 7.3%)	4 (4 – 8.0%)
OHSS	3 (3 – 7.3%)	-

Table 7. Adverse Events for Study 23286

Body System	250 µg r-hCG freeze-dried (n=22)	250 µg r-hCG liquid (n=23)
Gastro-intestinal system disorders	4 (18%)	4 (17%)
Mouth Ulceration	1 (5%)	1 (4%)
Nausea	3 (14%)	3 (13%)
General disorders and administration site conditions	1 (5%)	3 (13%)
Injection site bruising	0 (0%)	1 (4%)
Pyrexia	0 (0%)	1 (4%)
Rigors	0 (0%)	1 (4%)
Vessel puncture site haemorrhage	1 (5%)	1 (4%)
Infections and infestations	0 (0%)	2 (9%)
Pyelonephritis nos	0 (0%)	1 (4%)
Upper respiratory tract infections nos	0 (0%)	1 (4%)
Musculoskeletal and connective tissue disorders	1 (5%)	1 (4%)
Groin Pain	0 (0%)	1 (4%)
Peripheral Swelling	1 (5%)	0 (0%)
Nervous system disorders	4 (18%)	3 (13%)
Headache nos	4 (18%)	3 (13%)
Psychiatric disorders	1 (5%)	1 (4%)
Emotional disturbance nos	1 (5%)	1 (4%)
Renal and Urinary disorders	1 (5%)	1 (4%)
Loin pain	1 (5%)	1 (4%)
Reproductive system and breast disorders	0 (0%)	2 (9%)
Dysmenorrhoea	0 (0%)	2 (9%)
Respiratory, thoracic and mediastinal disorders	2 (9%)	0 (0%)
Pharyngolaryngeal pain	1 (5%)	0 (0%)
Rhinorrhoea	1 (5%)	0 (0%)

The following complications have been reported after treatment with FSH/choriogonadotropin alfa: ectopic pregnancy, spontaneous abortion, missed abortion, placenta previa, premature birth, ovarian torsion and congenital anomalies including Down's syndrome with atrial septal defect, chromosomal abnormality (47, XXX) and cranial malformation. These complications have previously been reported in patients undergoing infertility treatment with gonadotrophins. Ovarian Hyperstimulation Syndrome (OHSS) was observed in approximately 4% of patients treated with Ovidrel. Severe OHSS was reported in less than 0.5% of patients. Severe OHSS could be complicated in rare cases by haemoperitoneum, acute pulmonary distress, ovarian torsion and thromboembolism.

The following complications have also been reported to occur after treatment with menotropins/hCG: pulmonary and vascular complications (e.g.

Thromboembolism), adnexal torsion as a complication of ovarian enlargement, mild to moderate ovarian enlargement and haematoperitoneum. Although these adverse events were not observed, there is the possibility that they may also occur with menotropins/r-hCG.

Post Marketing Data

Isolated cases of mild systemic allergic reactions have been reported as post marketing data.

Skin and subcutaneous disorders: mild reversible skin reactions manifesting as rash.

Vascular disorders: very rare (1/10,000) thromboembolism, usually associated with moderate to severe OHSS.

Interactions

Interactions with Other Medicines

No clinically significant drug interactions have been reported during hCG therapy. Following administration, Ovidrel may interfere with the immunological determination of serum / urinary hCG for up to ten days, leading to a false positive pregnancy test.

During Ovidrel therapy, minor thyroid stimulation is possible, of which the clinical relevance is unknown.

Effects on Laboratory Tests

In most instances, treatment of women with FSH results only in follicular recruitment and development. In the absence of an endogenous LH surge, hCG is given when monitoring of the patient indicates that sufficient follicular development has occurred. This may be estimated by ultrasound alone or in combination with measurement of serum oestradiol levels. The combination of both ultrasound and serum oestradiol measurement are useful for monitoring the development of follicles, for timing of the ovulatory trigger, as well as for detecting ovarian enlargement and minimising the risk of the OHSS and multiple gestation. It is recommended that the number of growing follicles be confirmed using ultrasonography because serum estrogens do not give an indication of the size or number of follicles.

Human chorionic gonadotrophins can cross react in the radioimmunoassay of gonadotrophins, especially luteinising hormone. Each individual laboratory should establish the degree of cross reactivity with their gonadotrophin assay. Physicians should make the laboratory aware of patients on hCG if gonadotrophin levels are requested.

The clinical confirmation of ovulation, with the exception of pregnancy, is obtained by direct and indirect indices of progesterone production. The indices most generally used are as follows:

1. A rise in basal body temperature
2. Increase in serum progesterone
3. Menstruation following a shift in basal body temperature

When used in conjunction with the indices of progesterone production, sonographic visualisation of the ovaries will assist in determining if ovulation has occurred. Sonographic evidence of ovulation may include the following:

1. Fluid in the cul-de-sac
2. Ovarian stigmata
3. Collapsed follicle
4. Secretory endometrium

Overdosage

No case of overdosage has been reported. Nevertheless, there is a possibility that Ovarian Hyperstimulation Syndrome (OHSS) may result from an overdosage of OVIDREL (see Warnings).

Advise your patients to immediately contact their doctor or the Poisons Information Centre (in Australia telephone 131 126, in New Zealand telephone 0800 764 766) if they are concerned that they have given themselves too much OVIDREL.

Pharmaceutical Precautions

Shelf-life:

24 months

Product is for single use in one patient only. Contains no antimicrobial preservative. Discard any residue.

Special Precaution for Storage:

Ovidrel should be stored at 2°C to 8°C (Refrigerate. Do not freeze) in its original container. Protect from light. Ovidrel can also be stored for up to 30 days below 25°C in its original container and protected from light. Discard any residue.

Medicine Classification

Prescription Medicine

Package Quantities

Ovidrel is supplied in boxes of 1 pre-filled syringe, each syringe containing 250 µg of choriogonadotropin alfa in 0.5 mL.

Further Information

Clinical Trials

The safety and efficacy of Ovidrel have been evaluated in four well-controlled clinical studies in women; three studies for Assisted Reproductive Technologies (ART) and one study for Ovulation Induction (OI).

Assisted Reproductive Technologies (ART)

Study 9073

The safety and efficacy of Ovidrel 250µg administered subcutaneously and 5000 IU of an approved urinary-derived hCG product administered intramuscularly were assessed in a randomised, controlled, double-blind, double-dummy, phase III study in infertile women undergoing in vitro fertilisation and embryo transfer. Randomisation occurred at the time of hCG administration.

The primary efficacy parameter in this study was the number of oocytes retrieved per patient. 90 patients entered the study, of whom 44 were randomised to receive Ovidrel 250µg. The number of oocytes retrieved was similar in all treatment groups. The efficacy of Ovidrel 250 µg was found to be clinically and statistically equivalent to the urinary derived hCG product for the primary endpoint of the study. The efficacy results (both primary and secondary) for the patients who received Ovidrel 250 µg are summarised below in Table 8:

Table 8. Efficacy Outcomes of r-hCG and u-hCG in ART (Study 9073)

Parameter	Ovidrel 250 µg (n=43)	u-hCG 5000 IU (n=38)
Mean number of oocytes retrieved per patient	10.86	10.45
Mean number of mature oocytes retrieved per patient*	9.0	8.27

* Secondary efficacy outcome

The outcomes of the pregnancies are presented below in Table 9.

Table 9: Pregnancy Outcomes of r-hCG and u-hCG in ART (Study 9073)

Parameter	Ovidrel 250 µg (n=39)	u-hCG 5000 IU (n=36)
Clinical pregnancies not reaching full term	0 (0%)	3 (42.9%)
*Live births	6 (100%)	4 (57.1%)
<i>Singletons</i>	5 (83.33%)	7 (100%)
<i>Multiple births</i>	1 (16.66%)	1 (14.3%)

* Secondary efficacy outcome

12 of the 44 patients who received hCG reported 13 adverse events after hCG administration. Of the 84 patients, 44 had received 250 µg of r-hCG and 40 received u-hCG. There was no report of OHSS in this study. Overall, the pattern of adverse events was similar between treatment groups and was consistent with the profile of events reported in this indication. Local tolerance to study drug was also similar and no patient developed antibodies to hCG.

Study 7927

The safety and efficacy of Ovidrel 250 µg and Ovidrel 500 µg administered subcutaneously and 10,000 USP Units of an approved urinary-derived hCG product administered intramuscularly were assessed in a randomised, open label, multicentre study in infertile women undergoing in vitro fertilisation and embryo transfer. Randomisation occurred at the time of hCG administration.

The primary efficacy parameter in this single cycle study was the number of oocytes retrieved per patient. 297 patients entered the study, of whom 94 were randomised to receive Ovidrel 250 µg. The number of oocytes retrieved was similar in all treatment groups. The efficacy of Ovidrel 250 µg and 500 µg were both found to be clinically and statistically equivalent to the urinary derived hCG product and to each other for the primary endpoint of the study. The efficacy results (both primary and secondary) for the patients who received Ovidrel 250 µg are summarised below in Table 10:

Table 10. Efficacy Outcomes of r-hCG and u-hCG in ART (Study 7927)

Parameter	Ovidrel 250 µg (n=94)	u-hCG 10000 IU (n=92)
Mean number of oocytes retrieved per patient	13.60	14.64
*Mean number of mature oocytes retrieved per patient	7.6	9.4

* Secondary efficacy outcome

The outcomes of the pregnancies are presented below in Table 11.

Table 11. Pregnancy Outcomes of r-hCG and u-hCG in ART (Study 7927)

Parameter	Ovidrel 250 µg (n=33)	u-hCG 10000 IU (n=34)
Clinical pregnancies not reaching full term	4 (12.1%)	5 (15.2%)
*Live births	29 (87.9%)	28 (84.8%)
<i>Singletons</i>	20 (69.0%)	14 (50.0%)
<i>Multiple births</i>	9 (31.0%)	14 (50%)

* Secondary efficacy outcome

132 of the 280 patients who received hCG reported 266 adverse events after hCG administration, including 27 serious adverse events. Of the 132 patients, 44 had received 250 µg of r-hCG, 51 received 500 µg of r-hCG and 37 had received u-hCG. 12 of the serious events occurring after hCG occurred before study completion and 12 occurred during pregnancy resulting from treatment. Overall, the pattern of adverse events was similar between treatment groups and was consistent with the profile of events reported in this indication. Local tolerance to study drug was also similar and no patient developed antibodies to hCG.

Study 7648

The safety and efficacy of Ovidrel 250 µg administered subcutaneously versus 5000 IU of an approved urinary derived hCG product administered subcutaneously were assessed in a second, double blind, randomised, multicentre study in infertile women undergoing in vitro fertilisation and embryo transfer.

The primary efficacy parameter in this single-cycle study was the number of oocytes retrieved per patient. 205 patients entered the study, of whom 97 received Ovidrel 250 µg. The efficacy of Ovidrel was found to be clinically and statistically equivalent to that of the approved urinary derived hCG. The efficacy results (both primary and secondary) for the 97 patients who received Ovidrel 250 µg are summarised below in Table 12.

Table 12. Efficacy Outcomes of r-hCG and u-hCG in ART (Study 7648)

Parameter	Ovidrel 250 µg (n=97)	u-hCG 5000 IU (n=93)
Mean number of oocytes retrieved per patient	11.4	10.7
*Mean number of mature oocytes retrieved per patient	9.8	7.8

* Secondary efficacy outcome

The outcomes of the pregnancies are presented below in Table 13.

Table 13. Pregnancy Outcomes of r-hCG and u-hCG in ART (Study 7648)

Parameter	Ovidrel 250 µg (n=32)	u-hCG 5000 IU (n=23)
Clinical pregnancies not reaching term	6 (18.8%)	2 (8.7%)
*Live births	26 (81.2%)	21 (91.3%)
<i>Singletons</i>	18 (69.2%)	13 (61.9%)
<i>Multiple births</i>	8 (30.8%)	8 (38.1%)

* Secondary efficacy outcome

64 of the 190 patients who received hCG reported 97 adverse events after hCG administration, 32 (33%) in the r-hCG group and 65 (67%) in the u-hCG group. There were 11 serious adverse events reported following hCG administration, 5 up to study completion and 6 during pregnancy resulting from treatment. Overall, the pattern of adverse events was similar between treatment groups and was consistent with the profile of events reported in this indication. Local tolerance to study drug was statistically different between treatment groups (p = 0.0001) in favour of the r-hCG treatment group, and no patient developed antibodies to hCG.

Ovulation Induction (OI)

Study 8209

The safety and efficacy of Ovidrel 250 µg administered subcutaneously versus 5000 IU of an approved urinary derived hCG administered subcutaneously were assessed in a double blind, randomised, multicentre study in anovulatory infertile women.

The primary efficacy endpoint in this single cycle study was the patient ovulation rate. 242 patients entered the study, of whom 99 received Ovidrel 250 µg. The efficacy of Ovidrel 250 µg was found to be clinically and statistically equivalent to the approved urinary derived hCG. The efficacy results (both primary and secondary) of those patients who received Ovidrel are summarised below in Table 14.

Table 14. Efficacy Outcomes of r-hCG and u-hCG in OI (Study 8209)

Parameter	Ovidrel 250 µg (n=99)	u-hCG 5000IU (n=99)
Ovulation rate	91 (91.9%)	85(85.9%)
*Clinical pregnancy rate ¹	22 (22.2%)	29(29.3%)

* Secondary efficacy outcome

¹ Clinical pregnancy was defined as a pregnancy during which a fetal sac (with or without heartbeat activity) was detected by ultrasound on day 35-42 after HCG administration

The outcomes of the pregnancies are presented below in Table 15.

Table 15. Pregnancy Outcomes of r-hCG and u-hCG in OI (Study 8209)

Parameter	Ovidrel 250 ug (n=22)	u-hCG 5000 IU (n=29)
Clinical pregnancies not reaching term	7 (31.8%)	5 (17.2%)
*Live births	15 (68.2%)	20 (68.9%)
<i>Singletons</i>	13 (86.7%)	17 (85%)
<i>Multiple births</i>	2 (13.3%)	3 (15%)

* Secondary efficacy outcome

65 of the 198 patients who received hCG reported 100 adverse events after hCG administration. Of the 100 events, 34 (34%) occurred in 26 patients who had received 250 µg of r-hCG and 66 (66%) occurred in 39 patients who had received u-hCG. 9 serious adverse events occurred in 7 patients after study completion during pregnancy resulting from treatment. Overall, the pattern of adverse events was similar between treatment groups and was consistent with the profile of events reported in this indication. Local tolerance to study drug was statistically different between treatment groups (p = 0.0015) in favour of the r-hCG treatment group.

Primary Outcomes

Primary Efficacy endpoints of ART studies are shown in Table 16 below.

Table 16. Studies GF 7648, GF 7927, and GF 9073: Number of oocytes retrieved per patient, by study and hCG treatment group.

Statistics	Study GF 7648 ^(a)		Study GF 7927 ^(b)			Study GF 9073	
	hCG Treatment Group		hCG Treatment Group			hCG Treatment Group	
	250 µg r-hCG	5000 IU u-hCG	250 µg r-hCG	500 µg r-hCG	10000 IU u-hCG	250 µg r-hCG	5000 IU u-hCG
n	97	93	94	89	92	43	38
Mean(SEM)	11.6 (0.533)	10.6 (0.558)	13.60 (0.75)	14.64 (0.77)	13.66 (0.77)	10.86 (0.603)	10.4 (0.642)
Median	11.0	10.0	12.5	14.0	13.5	10.0	10.0
Range	(0, 27)	(0, 35)	(3, 37)	(4, 38)	(3, 29)	(1, 24)	(3, 26)
	Treatment Equivalence		Treatment Equivalence			Treatment Equivalence	
	250 µg r-hCG vs. u-hCG		500 µg r-hCG vs. u-hCG	500 µg r-hCG vs. 250µg r-hCG		250 µg r-hCG vs. u-hCG	
Mean Difference (SEM)	-0.01 (0.72)		0.98 (1.06)	1.04 (1.06)		0.95 (1.90)	
90% CI for the Mean Difference	(-1.206, 1.183)		(-0.775, 2.729)	(-0.706, 2.781)		(-0.517, 2.424)	

(a) A two-way ANCOVA model with treatment and centre effects and number of follicles > 10mm as the covariate was used for all estimates.

(b) A two-way ANCOVA model with treatment and centre effects was used for all estimates.

The studies clearly demonstrate equivalence between 250 µg r-hCG and 5000 IU u-hCG (studies GF 7648 and GF 9073), and between 250 µg r-hCG, 500 µg r-hCG, and 10000 IU u-hCG (study GF 7927) with respect to this end-point.

Primary efficacy end-point of Ovulation Induction study (GF 8209) are shown in Tables 17a and 17b below.

Table 17a. Summary statistics for ovulation: Per Protocol data set

250 µg r-hCG			5000 IU u-hCG			All			$\pi_r - \pi_u$ %
Success (%)	Failure (%)	n	Success (%)	Failure (%)	n	Success (%)	Failure (%)	n	
81 (95.3)	4 (4.7)	85	81 (88.0)	11 (12.0)	92	162 (91.5)	15 (8.5)	177	73
Lower limit of one-sided 95% CI									-1.9

Table 17b. Summary statistics for ovulation: All Patients Data set

250 µg r-hCG			5000 IU u-hCG			All			$\pi_r - \pi_u$ %
Success (%)	Failure (%)	n	Success (%)	Failure (%)	n	Success (%)	Failure (%)	n	
91 (91.9)	8 (8.1)	99	85 (85.9)	14 (14.1)	99	176 (88.9)	22 (11.1)	198	6.1
Lower limit of one-sided 95% CI									-3.7

Chemical structure

Choriogonadotropin alfa is a water soluble glycoprotein consisting of two non-covalently linked subunits – designated alfa (α) and beta (β) consisting of 92 and 145 amino acids residues, respectively, with carbohydrate moieties linked to ASN-52 and ASN-78 (on alfa subunits) and ASN-13, ASN-30, SER-121, SER-127, SER-132 and SER-138 (on beta subunit). The chemical structure of the proteins are $C_{437}H_{682}N_{122}O_{134}S_{13}$ [alfa subunit] and $C_{668}H_{1090}N_{196}O_{203}S_{13}$ [beta subunit]. Mw is 70kDa.

The primary structure of the α -subunit of the recombinant human chorionic gonadotrophin (r-hCG) is identical to that of the α -subunit of the human chorionic gonadotrophin (hCG), follicle stimulating hormone (FSH) and luteinising hormone (LH). The glycoform pattern of the α subunit of r-hCG is closely comparable to the urinary derived hCG (u-hCG), the differences mainly being due to the branching and sialylation extent of oligosaccharides.

The β -subunit has both O- and N-glycosylation sites and its structure and glycosylation pattern are also very similar to that of u-hCG.

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Date of Preparation

26 November 2009

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