NEW ZEALAND DATA SHEET

1. PRODUCT NAME

AREXVY Recombinant Respiratory Syncytial Virus pre-fusion F protein 120 micrograms powder and suspension for suspension for injection.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

After reconstitution, 1 dose (0.5 mL) contains 120 micrograms of RSVPreF3[1] antigen adjuvanted with $AS01_E$[2].

[1] Respiratory syncytial virus (RSV) glycoprotein F stabilised in the pre-fusion conformation (RSVPreF3) produced by recombinant DNA technology in Chinese Hamster Ovary (CHO) cells.

[2] The GlaxoSmithKline proprietary $AS01_E$ Adjuvant System is composed of the plant extract *Quillaja saponaria* Molina, fraction 21 (QS-21) (25 micrograms) and 3-O-desacyl-4'-monophosphoryl lipid A (MPL) from *Salmonella minnesota* (25 micrograms).

For the full list of excipients, see section 6.1 List of excipients.

3. PHARMACEUTICAL FORM

Powder and suspension for suspension for injection.

The powder is white.

The suspension is an opalescent, colourless to pale brownish liquid.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

AREXVY is indicated for active immunisation for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus RSV-A and RSV-B subtypes in:

- adults 60 years of age and older;
- adults 50 through 59 years of age who are at increased risk for RSV disease.

Consideration should be given to official vaccine recommendations on the appropriate use.

4.2 Dose and method of administration

Dose

Consideration should be given to official vaccine recommendations for immunisation schedules.

AREXVY is administered as a single dose of 0.5 mL.

Method of administration

AREXVY is for intramuscular injection only, preferably in the deltoid muscle.

The powder and suspension should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not reconstitute the vaccine.

For instructions on reconstitution of the medicinal product before administration, see section 6.6 Special precautions for disposal and other handling.

4.3 Contraindications

Hypersensitivity to the active substances or to any component of the vaccine (see section 6.1 List of excipients).

4.4 Special warnings and precautions for use

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

As with other vaccines, vaccination with AREXVY should be postponed in individuals suffering from an acute severe febrile illness. The presence of a minor infection, such as a cold, should not result in the deferral of vaccination.

As with any vaccine, a protective immune response may not be elicited in all vaccinees.

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

Precautions for use

Do not administer the vaccine intravascularly or intradermally. No data are available on subcutaneous administration of AREXVY.

As with other vaccines administered intramuscularly, AREXVY should be given with caution to individuals with thrombocytopenia or any coagulation disorder since bleeding may occur following an intramuscular administration to these individuals.

Systemic immunosuppressive medications and immunodeficiency

Safety and immunogenicity data on AREXVY are not available for immunocompromised individuals. Patients receiving immunosuppressive treatment or patients with immunodeficiency may have a reduced immune response to AREXVY.

Guillain-Barré Syndrome

Guillain-Barré syndrome has been reported very rarely following vaccination with AREXVY in individuals ≥60 years (see section 4.8 Undesirable effects).

Healthcare professionals should closely monitor signs and symptoms of Guillain-Barré syndrome in all AREXVY recipients to ensure correct diagnosis and to rule out

other causes. If Guillain-Barré syndrome is diagnosed, prompt management with adequate supportive care and treatment is recommended.

4.5 Interaction with other medicines and other forms of interaction

Use with other vaccines

AREXVY can be given concomitantly with an inactivated seasonal influenza vaccine (standard dose unadjuvanted, high dose unadjuvanted, or standard dose adjuvanted) or with herpes zoster vaccine (recombinant, adjuvanted), pneumococcal conjugate vaccine, or COVID-19 mRNA vaccine.

Upon concomitant administration of AREXVY with seasonal influenza vaccines, numerically lower RSV A and B neutralising titres and numerically lower influenza A and B haemagglutination inhibition titres were observed as compared to the separate administration. This was not observed consistently across studies. The clinical relevance of these findings is unknown.

The safety profile of AREXVY co-administration with either inactivated seasonal influenza vaccines, herpes zoster vaccine, or a pneumococcal conjugate vaccine, or COVID-19 mRNA vaccine was comparable to when AREXVY was administered in sequence at least 30 days apart with each of these vaccines.

For immunogenicity data, see section 5.1 Pharmacodynamic properties.

Data are currently not available for concomitant administration with other vaccines.

If AREXVY is to be given at the same time as another injectable vaccine, the vaccines should always be administered at different injection sites.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are no data from the use of AREXVY in pregnant women. AREXVY is not recommended during pregnancy.

After administration of an investigational unadjuvanted RSVPreF3 vaccine to 3,557 pregnant women in a single clinical trial, an increase in preterm births was observed compared to placebo.

Results from animal studies do not indicate direct or indirect harmful effects with respect to developmental and reproductive toxicity.

Breast-feeding

There are no data on the excretion of AREXVY in human or animal milk. AREXVY is not recommended in breast-feeding/lactating women.

Fertility

There are no data on the effects of AREXVY on human fertility.

Animal studies do not indicate direct or indirect harmful effects with respect to fertility in females.

4.7 Effects on ability to drive and use machines

No studies on the effects of AREXVY on the ability to drive and use machines have been performed.

4.8 Undesirable effects

Summary of the safety profile

The safety profile presented below is based on a placebo-controlled Phase III clinical study (conducted in Europe, North America, Asia and Southern hemisphere) in adults ≥ 60 years of age in which 12,467 adults received one dose of AREXVY and 12,499 received placebo with a follow-up period of approximately 12 months.

Adverse drug reactions (ADRs) are listed below by MedDRA system organ class and by frequency.

Very common	≥1/10
Common	≥1/100 to <1/10
Uncommon	≥1/1,000 to <1/100
Rare	≥1/10,000 to <1/1,000
Very rare	<1/10,000

Tabulated list of adverse reactions

System Organ Class	Frequency	Adverse reactions
Blood and lymphatic system disorders	Uncommon	lymphadenopathy
Immune system disorders	Uncommon	hypersensitivity reactions (such as rash)
Nervous system disorders	Very common	headache
Respiratory, thoracic, and mediastinal disorders	Common	rhinorrhoea
Gastrointestinal disorders	Uncommon	nausea, abdominal pain
Musculoskeletal and connective tissue disorders	Very common	myalgia, arthralgia
General disorders and administration site conditions	Very common	injection site pain, fatigue
	Common	injection site erythema, injection site swelling, fever, chills
	Uncommon	injection site pruritus
		pain, malaise

Additionally, in a placebo-controlled Phase III clinical study, 769 participants 50 through 59 years of age (including 386 participants with pre-defined, stable, chronic medical conditions leading to an increased risk for RSV disease) and 381 participants 60 years of age and older received one dose of AREXVY. The reported adverse reactions were consistent with those presented in the table above. There was a higher incidence of injection site pain, arthralgia, fatigue, myalgia, and headache in participants 50 through 59 years of age compared with those 60 years of age and older in the study. However, the duration and severity of these events were comparable across age groups in the study.

Post-marketing experience

System Organ Class	Frequency	Adverse reactions
Nervous system disorders	Very rare	Guillain-Barré Syndrome*

* See section 4.4 Special warnings and precautions for use.

Description of selected adverse events

Guillain-Barré Syndrome

The results of a post-marketing observational study over 1 RSV season in patients 65 years or older suggest an increased risk of Guillain-Barré Syndrome (estimated 7 excess cases per million doses administered) during the 42 days following vaccination with AREXVY (see section 4.4 Special warnings and precautions for use). However, available evidence is insufficient to establish a causal relationship.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions via: http://pophealth.my.site.com/carmreportnz/s.

4.9 Overdose

Insufficient data are available.

For risk assessment and advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Vaccines, other viral vaccines; ATC code: J07BX05.

Mechanism of action

The risk of developing RSV-associated LRTD increases with age and with presence of underlying comorbidities. AREXVY induces the functional humoral immune responses against the RSV-A and RSV-B subtypes and the antigen-specific cellular immune responses which contribute to protect against RSV-associated LRTD (see *Immunogenicity of AREXVY*).

In a Phase I/II clinical trial, formulation adjuvanted with AS01$_E$ showed the ability to restore RSVPreF3-specific CD4+ T cells in adults 60 to 80 years of age to levels similar to those observed in young adults, despite lower baseline levels in the older adults.

Non-clinical data show that $AS01_E$ induces a local and transient activation of the innate immune system through specific molecular pathways. The adjuvant effect of $AS01_E$ is the result of interactions between MPL and QS-21 formulated in liposomes. This facilitates the recruitment and activation of antigen presenting cells carrying vaccine-derived antigens in the draining lymph node, which in turn leads to the generation of RSVPreF3-specific CD4+ T cells and induction of RSV-A and RSV-B neutralising titres. In addition, RSVPreF3 formulated with $AS01_E$ can elicit specific binding antibodies directed to site Ø, a highly neutralising sensitive epitope, exposed only on the pre-fusion conformation of the F protein.

Clinical efficacy and safety

Efficacy of AREXVY

Efficacy of AREXVY against RSV-associated LRTD in adults 60 years and older was evaluated for up to 3 RSV seasons in RSV OA=ADJ-006, a Phase III, randomised, placebo-controlled, observer-blind clinical study conducted in 17 countries from Northern and Southern Hemispheres.

The primary population for efficacy analysis (referred to as the modified Exposed Set), included adults 60 years of age and older receiving 1 dose of AREXVY or placebo and who did not report an RSV-confirmed acute respiratory illness (ARI) prior to Day 15 after vaccination.

The primary efficacy analysis set over the first RSV season included 24,960 participants who received 1 dose of AREXVY (N = 12,466) or placebo (N = 12,494).

Pre-Season 2, participants who received AREXVY were re-randomised to receive placebo (n = 4,991) or a second dose of AREXVY (n = 4,966). Participants who received placebo before Season 1 received a second dose of placebo before Season 2. The participants were followed up to the end of the third RSV season (median follow-up time 30.6 months).

The median age of participants was 69 years (range: 59 to 102 years), with approximately 74% over 65 years of age, approximately 44% over 70 years of age and approximately 8% over 80 years of age. Approximately 52% were female. At baseline, 39.3% of participants had at least one comorbidity of interest; 19.7% of participants had an underlying cardiorespiratory condition (COPD, asthma, any chronic respiratory/pulmonary disease, or chronic heart failure) and 25.8% of participants had endocrinometabolic conditions (diabetes, advanced liver or renal disease). Among participants in the modified Exposed Set for the analysis of efficacy over 2 and over 3 RSV seasons, demographic and baseline characteristics were similar to those in the modified Exposed Set for the analysis of the efficacy over the first RSV season.

Using the Gait speed test, 38.3% of participants were ranked as pre-frail (0.4-0.99m/s walking speed) and 1.5% as frail (<0.4 m/s walking speed or who were not able to perform the test).

Confirmed RSV cases were determined by quantitative Reverse Transcription Polymerase Chain Reaction (qRT-PCR) on nasopharyngeal swab during all ARI episodes. ARI was defined by the presence of at least 2 respiratory symptoms/signs for at least 24 hours (nasal congestion, sore throat, lower respiratory symptoms/signs, as described below), or at least 1 respiratory symptom/sign + 1

systemic symptom/sign (fever or feverishness, fatigue, body aches, headache, decreased appetite) for at least 24 hours.

LRTD was defined based on the following criteria: the participant must have experienced at least 2 lower respiratory symptoms/signs including at least 1 lower respiratory sign for at least 24 hours, or experienced at least 3 lower respiratory symptoms for at least 24 hours. Lower respiratory symptoms included: new or increased sputum, new or increased cough, new or increased dyspnoea (shortness of breath). Lower respiratory signs included: new or increased wheezing, crackles/rhonchi, respiratory rate ≥ 20 respirations/min, low or decreased oxygen saturation (O_2 saturation <95% or ≤90 % if baseline is <95%) or need for oxygen supplementation.

Severe RSV-associated LRTD was defined as qRT-PCR confirmed RSV-associated LRTD with at least 2 lower respiratory signs, or preventing normal, everyday activities or requiring supportive therapy.

Efficacy against RSV-associated LRTD over the first RSV season

The primary objective was to demonstrate the efficacy of AREXVY in the prevention of a first episode of confirmed RSV-A and/or B associated LRTD during the first season.

Compared with placebo, AREXVY significantly reduced the risk of developing RSV-associated LRTD by 82.6% (96.95% CI: [57.9, 94.1]) in participants 60 years of age and older, which met the pre-specified success criterion for the primary study objective (Table 1). High vaccine efficacy against RSV-LRTD is observed through the median follow-up period of 6.7 months.

The vaccine efficacy against RSV A-associated LRTD and RSV B-associated LRTD was 84.6% (95% CI [32.1, 98.3]) and 80.9% (95% CI [49.4, 94.3]), respectively.

Table 1. Efficacy Analysis over the first RSV season: First RSV-associated LRTD Overall, by Age and co-morbidity subgroups in RSV OA=ADJ-006 (modified Exposed Set)

Subgroup	AREXVY			Placebo			% Efficacy (CI)[a]
	N	n	Incidence Rate per 1,000 Person-Years	N	n	Incidence Rate per 1,000 Person-Years	
Overall (≥ 60 years)[b]	12466	7	1.0	12494	40	5.8	82.6 (57.9, 94.1)
60-69 years	6963	4	1.0	6979	21	5.5	81.0 (43.6, 95.3)
70-79 years	4487	1	0.4	4487	16	6.5	93.8 (60.2, 99.9)
≥80 years	1016	2	3.6	1028	3	5.4	Cannot be reliably estimated[c]
Participants with at least 1 comorbidity of interest	4937	1	0.4	4861	18	6.6	94.6 (65.9, 99.9)

[a]CI = Confidence Interval (96.95% for the overall (≥ 60 years) and 95% for all subgroup analyses). Two-sided exact CI for vaccine efficacy is derived based on Poisson model adjusted by age categories and regions.

[b]Primary confirmatory objective with pre-specified success criterion of lower limit of the 2-sided CI for vaccine efficacy above 20%

[c]Due to the low number of cases accrued in this age group.

N = Number of participants included in each group

n = Number of participants having first occurrence of RSV-confirmed LRTD occurring from Day 15 post vaccination

Compared with placebo, AREXVY significantly reduced the risk of developing RSV-associated LRTD by 84.4% (95% CI: [46.9, 97.0]) in participants 70 years of age and older.

Compared with placebo, AREXVY significantly reduced the risk of developing RSV-associated LRTD in pre-frail participants by 92.9% (95% CI [53.4, 99.8]). The vaccine efficacy in the frail subgroup (189 participants in AREXVY vs 177 participants in placebo) cannot be reliably estimated due to the low number of total cases accrued (2 cases).

Efficacy Against Severe RSV-associated LRTD and RSV-associated ARI over the first RSV season

Compared with placebo, AREXVY significantly reduced the risk of developing severe RSV-associated LRTD by 94.1% (95% CI [62.4, 99.9]) in participants 60 years of age and older. One case of severe RSV-associated LRTD in the AREXVY group and

17 cases in the placebo group were reported, amongst which 2 cases required supportive therapy (oxygen supplementation).

AREXVY significantly reduced the risk of developing confirmed RSV-associated ARI in adults ≥ 60 years of age by 71.7% (95% CI [56.2, 82.3]).

Patient Reported Outcome over the first RSV season

AREXVY was assessed vs. placebo in the RSV OA=ADJ-006 study to quantify the reduction in intensity of respiratory symptoms using a patient reported outcome measure, the FLU-PRO questionnaire. In participants with an RSV-confirmed ARI episode who completed the FLU-PRO questionnaire, AREXVY significantly reduced the intensity of lower respiratory tract symptoms of RSV by a clinically meaningful difference vs. placebo as assessed by the maximum FLU-PRO Chest score (scale range 0-4) over the first 7 days of the episode (Mean [standard deviation] of 1.32 [1.02] in the AREXVY group vs 1.90 [0.93] in the placebo group).

Efficacy against RSV-associated LRTD over 2 RSV seasons and over 3 RSV seasons

Participants 60 years of age and older who received 1 dose of AREXVY or placebo were followed over 3 RSV seasons (up to the end of the second and third seasons in the Northern Hemisphere), with a median follow-up time of 17.8 months over 2 RSV seasons and 30.6 months over 3 RSV seasons. The vaccine efficacy against RSV-associated LRTD over 2 RSV seasons was 67.2% (97.5% CI [48.2, 80.0]) and over 3 RSV seasons was 62.9% (97.5% CI [46.7, 74.8]).

The vaccine efficacy against RSV A-associated LRTD and RSV B-associated LRTD over 3 RSV seasons was 69.8% (97.5% CI [42.2, 85.7]) and 58.6% (97.5% CI [35.9, 74.1]), respectively.

The vaccine efficacy analyses by age subgroup and for participants with at least one comorbidity of interest are presented in Table 2.

Table 2. Efficacy Analyses over two RSV seasons and over three RSV seasons: First RSV-associated LRTD Overall, by Age and co-morbidity subgroups in RSV OA=ADJ-006 (modified Exposed Set)

	AREXVY[a]			Placebo			
Subgroup	N[b]	n	Incidence Rate per 1,000 Person-Years	N[b]	n	Incidence Rate per 1,000 Person-Years	% Efficacy[c] (CI)[d]
Over 2 RSV seasons							
Overall (≥60 years)	12469	30	2.0	12498	139	8.0	67.2 (48.2, 80.0)
60 to 69 years	6963	17	2.1	6981	74	7.7	65.4 (40.4, 80.9)
70 to 79 years	4489	9	1.7	4489	55	8.8	74.9 (48.4, 89.2)
≥80 years	1017	4	3.5	1028	10	7.2	Cannot be reliably estimated[e]
Participants with at least 1 comorbidity of interest	4983	16	2.7	4919	72	10.6	66.7 (41.8, 82.0)
Over 3 RSV seasons							
Overall (≥60 years)	12468	48	2.4	12498	215	7.9	62.9 (46.7, 74.8)
60 to 69 years	6962	28	2.5	6981	117	7.6	60.3 (39.5, 74.8)
70 to 79 years	4489	15	2.1	4489	85	8.6	70.6 (48.4, 84.3)
≥80 years	1017	5	3.3	1028	13	6.0	Cannot be reliably estimated[e]
Participants with at least 1 comorbidity of interest	5014	25	3.2	4951	116	10.8	64.7 (45.1, 78.1)

[a]Participants who received a second dose of AREXVY did not contribute to these efficacy analyses after receipt of Dose 2.

[b]Several analyses were performed resulting in a different number of participants included in each analysis due to new or updated information obtained for some participants.

[c]VE(%) Poisson method – adjusted by age, region, and season for overall (≥60 years) and participants with at least 1 comorbidity of interest and adjusted by region and season for analysis by age category.

[d]CI = Confidence Interval (97.5% for the overall ≥60 years and 95% for all subgroup analyses).

[e]Due to the low number of cases accrued in this age group.

Two-sided exact CI for vaccine efficacy is derived based on Poisson model adjusted by age categories, regions and season.

N = Number of participants included in each group.

n = Number of participants having first occurrence of RSV-confirmed LRTD occurring from Day 15 post-vaccination.

Subgroup analyses of RSV-associated LRTD vaccine efficacy over 2 RSV seasons and 3 RSV seasons showed similar efficacy point estimates. In participants 70 years of age and older, over 2 RSV seasons and over 3 RSV seasons, the vaccine efficacy against RSV-associated LRTD was 69.3% (95% CI [43.4, 84.6]) and 66.0% (95% CI [44.3, 80.2]), respectively.

The vaccine efficacy against severe RSV-associated LRTD over 2 RSV seasons was 78.8% (95% CI [52.6, 92.0]) in participants 60 years of age and older (7 cases in the AREXVY group and 48 cases in the placebo group, amongst which 1 case in the AREXVY group and 5 cases in the placebo group required supportive therapy [oxygen supplementation and positive airway pressure]). The vaccine efficacy against severe RSV-associated LRTD over 3 RSV seasons was 67.4% (95% CI [42.4, 82.7]) in participants 60 years of age and older (15 cases in the AREXVY group and 75 cases in the placebo group, amongst which 2 cases in the AREXVY group and 5 cases in the placebo group required supportive therapy [oxygen supplementation and positive airway pressure]).

Efficacy against RSV-associated LRTD over the second RSV season and over the third RSV season

The vaccine efficacy against RSV-associated LRTD over the second RSV season with median follow-up of 6.3 months was 56.1% (95% CI [28.2, 74.4]) in participants 60 years of age and older (20 cases in the AREXVY group and 91 cases in placebo group).

The vaccine efficacy against RSV-associated LRTD over the third RSV season with median follow-up of 7.0 months was 48.0% (95% CI [8.7, 72.0]) in participants 60 years of age and older (16 cases in the AREXVY group and 61 cases in the placebo group).

Immunogenicity of AREXVY

An immunological correlate of protection has not been established, therefore, the level of immune response that provides protection against RSV-associated LRTD is unknown.

Adults 60 years and older

The immune responses to AREXVY were evaluated in a Phase III immunogenicity and safety study RSV OA=ADJ-004 in adults 60 years and older. Functional humoral immune responses post-vaccination compared to pre-vaccination were evaluated with results from 940 participants for RSV-A and 941 participants for RSV-B for month 1 vs. pre-vaccination, and 928 participants for RSV-A and 929 participants for RSV-B at month 6 vs. pre-vaccination. The cell-mediated immune responses were evaluated with results from 471 participants at pre-vaccination, 410 at month 1 and 440 at month 6.

AREXVY elicited RSV-specific humoral and cellular immune responses. The geometric mean increase of the RSV-A and RSV-B neutralising titres compared to pre-vaccination were 10.5-fold (95% CI [9.9, 11.2]) and 7.8-fold (95% CI [7.4, 8.3]) at 1-month post-vaccination, respectively, and 4.4-fold (95% CI [4.2, 4.6]) and 3.5-fold (95% CI [3.4, 3.7]) at 6-months post-vaccination, respectively. The median frequency (percentile [25^{th}, 75^{th}]) of the RSVPreF3-specific CD4+ T-cells (per million of CD4+ T cells) was 1339.0 (829.0, 2136.0) 1-month post-vaccination and 666.0 (428.0, 1049.5) 6-months post-vaccination as compared to 191.0 (71.0, 365.0) pre-vaccination.

Adults 50 through 59 years of age at increased risk for RSV disease

The non-inferiority of the immune response to AREXVY in adults 50 through 59 years of age compared to adults 60 years of age and older, where vaccine efficacy against RSV-associated LRTD was demonstrated, was evaluated in a Phase III, observer-blind, randomised, placebo-controlled study (RSV OA=ADJ-018).

Cohort 1 consisted of participants 50 through 59 years of age separated in 2 sub-cohorts according to their medical history. Sub-cohort 1 consisted of participants with pre-defined, stable, chronic medical conditions leading to an increased risk for RSV disease (AREXVY, N=386; placebo, N=191) such as chronic pulmonary disease, chronic cardiovascular disease, diabetes, chronic kidney or liver disease. Sub-cohort 2 consisted of participants without pre-defined, stable, chronic medical conditions (AREXVY, N=383; placebo, N=192). Cohort 2 consisted of participants 60 years of age and older (AREXVY, N=381).

The primary immunogenicity objective was to demonstrate non-inferiority of the humoral immune response (in terms of RSV-A and RSV-B neutralising titres) following the administration of AREXVY at 1-month post-vaccination in participants 50-59 years of age with pre-defined, stable, chronic medical conditions leading to an increased risk for RSV disease, compared to participants 60 years of age and older.

The prespecified criteria for non-inferiority of the immune responses were defined as the 2-sided (95%) CI upper limits (UL) on the group geometric mean titre (GMT) ratios ≤ 1.50 and the UL of the 2-sided (95%) CIs on the Seroresponse Rate (SRR) difference ≤ 10% for the RSV-A and RSV-B neutralising titres in participants 60 years of age and older relative to participants 50 through 59 years of age with pre-defined, stable, chronic medical conditions leading to an increased risk for RSV disease.

Table 3. Summary of Geometric Mean Titre ratios and Seroresponse Rate difference in terms of RSV-A and RSV-B neutralising titres (ED60) in adults 50 through 59 years of age with pre-defined, stable, chronic medical conditions[a] leading to an increased risk for RSV disease compared to adults 60 years of age and older – Per Protocol Set

	GMT ratio	SRR difference
RSV-A neutralising titres (ED60)	0.8 (95% CI [0.7, 1.0])	-6.5 (95% CI [-12.1, -0.9])
RSV-B neutralising titres (ED60)	0.8 (95% CI [0.7, 0.9])	-7.2 (95% CI [-13.3, -0.9])

[a]Pre-defined, stable, chronic medical conditions such as chronic pulmonary disease, chronic cardiovascular disease, diabetes, chronic kidney or liver disease.
ED60: Estimated Dilution 60; CI = Confidence interval; GMT = Geometric mean titre; SRR = Seroresponse rate

The non-inferiority criteria of the immune responses for the RSV-A and RSV-B neutralising titres were met. The efficacy of AREXVY, in adults 50 through 59 years of age at increased risk for RSV disease, can be inferred following comparison of the immune response in adults 50 through 59 years of age with the immune response in adults 60 years of age and older in which vaccine efficacy was demonstrated.

Immunogenicity following concomitant vaccination

Concomitant administration with influenza vaccines

In three open-label Phase III clinical studies, participants were randomised to receive 1 dose of AREXVY administered either concomitantly at Day 1 or separately (1 month apart) with inactivated seasonal quadrivalent influenza vaccine (standard dose unadjuvanted, adults ≥60 years of age, N=885; high dose unadjuvanted, adults ≥65 years of age, N=1,029; or standard dose adjuvanted, adults ≥65 years of age, N=1,045). The prespecified criteria for non-inferiority of the immune responses were defined as the 2-sided 95% confidence interval upper limits (UL) on the group geometric mean titre (GMT) ratios ≤ 1.50 for the RSV-A neutralising titres and haemagglutinin inhibition titres against each of the influenza strains, in the separate administration versus co-administration groups.

There was no evidence of interference in the immune response to RSV-A or any of the four influenza antigens when AREXVY was co-administered with standard dose unadjuvanted or high dose unadjuvanted seasonal influenza vaccines.

Upon coadministration of AREXVY with standard dose adjuvanted seasonal influenza vaccine, there was no evidence of clinically relevant interference in the immune response to RSV-A or any of the four influenza antigens. The UL of the GMT ratio was ≤ 1.50 for RSV A and three out of four influenza strains. For influenza A/H3N2, the UL of the GMT ratio was 1.53.

Concomitant administration with herpes zoster vaccine (recombinant, adjuvanted)

In an open-label Phase III clinical study, participants 50 years of age and older were randomised into two groups. In the first group (N = 265), on Day 1, participants received a dose of herpes zoster vaccine and a dose of AREXVY, followed by a second dose of herpes zoster vaccine on Day 61. In the second group (N = 265), participants received a dose of herpes zoster vaccine on Day 1 and on Day 61, and a dose of AREXVY on Day 31. The prespecified criteria for non-inferiority of the immune responses were defined as the UL of the 2-sided 95% CI of the GMT ratios of the separate versus co-administration groups ≤ 1.50 for the RSV-A and RSV-B neutralising titres, and a geometric mean concentration (GMC) ratio ≤ 1.50 for anti-gE antibody concentrations.

The non-inferiority criteria of the immune responses were met when the two vaccines were administered concomitantly.

Concomitant administration with 20-valent pneumococcal conjugate vaccine (adsorbed) (PCV20)

In an open-label Phase III clinical study, participants 60 years of age and older were randomised into two groups. In the first group (N = 553), participants received a dose of PCV20 and a dose of AREXVY on Day 1. In the second group (N = 557), participants received a dose of PCV20 on Day 1 and a dose of AREXVY on Day 31. The prespecified criteria for non-inferiority of the immune responses were defined as the UL of the 2-sided 95% CI of the GMT ratios of the separate versus co-administration groups ≤ 1.5 for the RSV-A and RSV-B neutralising titres, and a GMT ratio ≤ 2 for opsonophagocytic titres for each pneumococcal conjugate serotype contained in PCV20.

The non-inferiority criteria of the immune responses were met when the two vaccines were administered concomitantly.

Concomitant administration with COVID-19 mRNA vaccine

In an open-label Phase III clinical study, participants 50 years of age and older were randomised into two groups. In the first group (N = 417), participants received a dose of COVID-19 mRNA vaccine and a dose of AREXVY on Day 1. In the second group (N = 416), participants received a dose of COVID-19 mRNA vaccine on Day 1 and a dose of AREXVY on Day 31. The prespecified criteria for non-inferiority of the immune responses were defined as the UL of the 2-sided 95% CI of the GMT ratios of the separate versus co-administration groups ≤ 1.5 for RSV-A, RSV-B and SARS-CoV-2 neutralising titres.

Upon concomitant administration of AREXVY with COVID-19 mRNA vaccine, immune responses to RSV-A and RSV-B were non-inferior to those after separate administration (UL of the GMT ratio was ≤ 1.5). For SARS-CoV-2 Omicron XBB.1.5, the UL of the GMT ratio was 1.51. The data do not suggest clinically relevant interference when AREXVY was co-administered with COVID-19 mRNA vaccine.

5.2 Pharmacokinetic properties

Evaluation of pharmacokinetic properties is not required for vaccines.

5.3 Preclinical safety data

Genotoxicity

AREXVY was not tested for genotoxicity.

Carcinogenicity

AREXVY was not tested for carcinogenicity.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Powder (RSVPreF3 antigen):

Trehalose dihydrate

Polysorbate 80

Monobasic potassium phosphate

Dibasic potassium phosphate

Suspension ($AS01_E$ Adjuvant System):

Dioleoyl phosphatidylcholine

Cholesterol

Sodium chloride

Dibasic sodium phosphate

Monobasic potassium phosphate

Water for injections

6.2 Incompatibilities

This medicinal product must not be mixed with other medicinal products.

6.3 Shelf life

36 Months

6.4 Special precautions for storage

Store in a refrigerator (2 °C – 8 °C).

Do not freeze. Discard if the vial has been frozen.

Store in the original package in order to protect from light.

After reconstitution, the vaccine should be used promptly; if not possible, the vaccine should be stored in the refrigerator (2°C – 8°C) or at room temperature up to 25°C. If not used within 4 hours it should be discarded.

6.5 Nature and contents of container

Powder for 1 dose in a vial (type I glass) with stopper (butyl rubber).

Suspension for 1 dose in a vial (type I glass) with a stopper (butyl rubber).

AREXVY is available in a pack size of 1 vial of powder plus 1 vial of suspension or in a pack size of 10 vials of powder plus 10 vials of suspension.

Not all pack sizes may be distributed in New Zealand.

6.6 Special precautions for disposal and other handling

The powder and suspension should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not reconstitute the vaccine.

How to prepare AREXVY:

AREXVY must be reconstituted prior to administration.

1. Withdraw the entire contents of the vial containing the suspension into a syringe with a suitable needle (21G to 25G).
2. Add the entire contents of the syringe into the vial containing the powder.
3. Gently swirl until the powder is completely dissolved.

The reconstituted vaccine is an opalescent, colourless to pale brownish liquid.

The reconstituted vaccine should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not administer the vaccine.

Before administration:

1. Withdraw 0.5 mL of the reconstituted vaccine into the syringe.
2. Change the needle so that you are using a new needle.
3. Administer the vaccine intramuscularly.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MEDICINE SCHEDULE

Prescription Medicine

8. SPONSOR

GlaxoSmithKline NZ Limited
Private Bag 106600
Downtown
Auckland
New Zealand

Phone: (09) 367 2900
Facsimile: (09) 367 2910

9. DATE OF FIRST APPROVAL

Date of publication in the New Zealand Gazette of consent to distribute the medicine: 04 April 2024.

10. DATE OF REVISION OF THE TEXT

19 November 2025

Summary table of changes:

Section changed	Summary of new information
4.5	Addition of concomitant administration of AREXVY with pneumococcal conjugate vaccine and COVID-19 mRNA vaccine
5.1	Addition of clinical data for concomitant administration of AREXVY with pneumococcal conjugate vaccine and COVID-19 mRNA vaccine

Version 6.0