

# NEW ZEALAND DATA SHEET

## 1. PRODUCT NAME

TWINRIX: inactivated hepatitis A vaccine 720 EU/mL and recombinant DNA hepatitis B surface antigen, 20 µg/mL, suspension for injection

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

TWINRIX is a combined vaccine formulated by pooling bulk preparations of the purified, inactivated hepatitis A (HA) virus and purified hepatitis B surface antigen (HBsAg), separately adsorbed onto aluminium hydroxide and aluminium phosphate. The HA virus is propagated in MRC5 human diploid cells. HBsAg is produced by culture, in a selective medium, of genetically engineered yeast cells.

A 1.0 mL dose of TWINRIX contains not less than 720 ELISA units of inactivated HA virus, and 20 µg of recombinant HBsAg protein.

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

## 3. PHARMACEUTICAL FORM

Suspension for injection.

When re-suspended, the vaccine will have a uniform hazy white appearance. Upon storage, a fine white deposit with a clear colourless layer above may be observed.

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

TWINRIX is indicated for active immunisation against hepatitis A and hepatitis B virus infection in adults.

TWINRIX is indicated in, but not limited to, the following groups of susceptible subjects at risk of acquiring hepatitis A and hepatitis B virus infection:

- Healthcare personnel
- Patients frequently receiving blood products
- Personnel and residents of institutions
- Persons at increased risk due to their sexual behaviour
- Illicit users of addictive injectable drugs
- Travellers to areas of high HAV and HBV endemicity

- Persons originating from areas of high HAV and HBV endemicity
- Organ transplant candidates
- Armed forces personnel
- Persons who may be exposed to HAV and HBV through their work or lifestyle
- Household contacts of any persons in the above groups, or of patients with acute or chronic HBV infection

As hepatitis D (caused by the delta agent) does not occur in the absence of hepatitis B infection, it can be expected that hepatitis D will also be prevented by vaccination with TWINRIX. The vaccine will not protect against infection caused by hepatitis C or hepatitis E viruses, or other pathogens known to infect the liver.

#### **4.2 Dose and method of administration**

The vaccine should be re-suspended before use. When re-suspended, the vaccine will have a uniform hazy white appearance.

Upon storage, a fine white deposit with a clear colourless layer above may be observed.

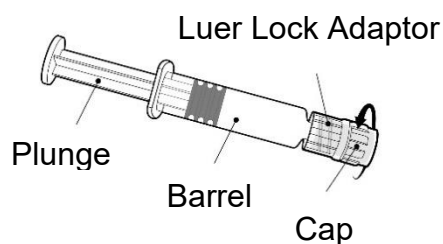
#### **Re-suspension of the vaccine to obtain a uniform hazy white suspension**

The vaccine can be re-suspended following the steps below:

1. Hold the syringe upright in a closed hand.
2. Shake the syringe by tipping it upside down and back again.
3. Repeat this action vigorously for at least 15 seconds.
4. Inspect the vaccine again:
  - a. If the vaccine appears as a uniform hazy white suspension, it is ready to use – the appearance should not be clear.
  - b. If the vaccine still does not appear as a uniform hazy white suspension - tip upside down and back again for at least another 15 seconds - then inspect again.

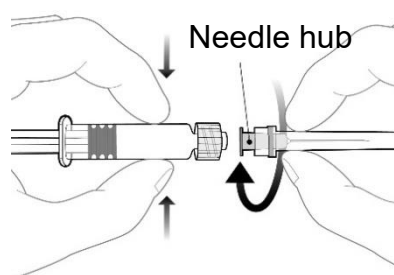
The vaccine should be inspected visually for any foreign particulate matter and/or abnormal physical appearance prior to administration. In the event of either being observed, do not administer the vaccine.

## Instructions for the pre-filled syringe



Hold the syringe by the barrel, not by the plunger.

Unscrew the syringe cap by twisting it anticlockwise.



To attach the needle, connect the hub to the Luer Lock Adaptor and rotate a quarter turn clockwise until you feel it lock.

Do not pull the syringe plunger out of the barrel. If it happens, do not administer the vaccine.

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

## Dose

TWINRIX should be injected intramuscularly into the deltoid region of the upper arm in adults. The vaccine should not be administered intramuscularly in the gluteal region or subcutaneously/intradermally since administration by these routes may result in a less than optimal antibody response.

Exceptionally, the vaccine may be administered subcutaneously in patients with thrombocytopenia or bleeding disorders (e.g. haemophiliacs).

## **Vaccine schedule**

In those not previously exposed to the hepatitis A or hepatitis B viruses the course is as follows:

### TWINRIX, 1 mL (720/20)

Schedule (Course completed in)	Age	Total doses to complete course	Timing:
Standard (6 months)	1-15 years inclusive	2 doses	0, 6 to 12 months
Standard (6 months)	16 years and over	3 doses	0, 1 month, 6 months
Rapid (21 days + 12 months)	16 years and over	4 doses	0, 7 days, 21 days, 12 months

### *Rapid Schedule*

In adults, when travel is anticipated within one month or more after initiating the vaccination course, but where insufficient time is available to allow the standard 0, 1, 6 month schedule to be completed, a schedule of three intramuscular injections given at 0, 7, 21 days may be used. When this schedule is applied, a fourth dose is recommended 12 months after the first dose.

### *Booster dose*

Long term antibody persistence data following vaccination with TWINRIX are available up to 20 years after vaccination (see Section 5.1 Pharmacodynamic effects). The anti-HBs and anti-HAV antibody titres observed following a primary vaccination course with the combined vaccine are in the range of what is seen following vaccination with the monovalent vaccines. General guidelines for booster vaccination can therefore be drawn from experience with the monovalent vaccines.

## **Hepatitis B**

The need for a booster dose of hepatitis B vaccine in healthy individuals who have received a full primary course has not been established. Local recommendations should be followed. For some categories of individuals exposed to HBV (e.g. haemodialysis or immunocompromised patients) a precautionary attitude should be considered to ensure a protective antibody level  $\geq 10$  IU/L.

## **Hepatitis A**

It is not yet fully established whether immunocompetent individuals who have responded to hepatitis A vaccination will require booster doses as protection in the absence of detectable antibodies may be insured by immunological memory. Guidelines for boosting are based on the assumption that antibodies are required for protection.

In situations where a booster dose of both hepatitis A and Hepatitis B are desired, TWINRIX can be given. Alternatively, subjects primed with TWINRIX may be administered a booster dose of either of the monovalent vaccines.

### **4.3 Contraindications**

TWINRIX should not be administered to subjects with known hypersensitivity to any constituent of the vaccine, or to subjects having shown signs of hypersensitivity after previous administration of TWINRIX or the monovalent hepatitis A or hepatitis B vaccines.

### **4.4 Special warnings and precautions for use**

As with other vaccines, the administration of TWINRIX should be postponed in subjects suffering from acute severe febrile illness.

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.

It is possible that subjects may be in the incubation period of a hepatitis A or hepatitis B

infection at the time of vaccination. It is not known whether TWINRIX will prevent hepatitis A and hepatitis B in such cases.

The vaccine will not prevent infection caused by other agents such as hepatitis C and hepatitis E and other pathogens known to infect the liver.

TWINRIX is not recommended for post-exposure prophylaxis (e.g. needle stick injury).

The vaccine has not been tested in patients with impaired immunity. In haemodialysis patients and persons with an impaired immune system, adequate anti-HAV and anti-HBs antibody titres may not be obtained after the primary immunisation course and such patients may therefore require administration of additional doses of vaccine.

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

**TWINRIX should under no circumstances be administered intravenously.**

#### **4.5 Interaction with other medicines and other forms of interaction**

No data on concomitant administration of TWINRIX with specific hepatitis A immunoglobulin or hepatitis B immunoglobulin have been generated. However, when the monovalent hepatitis A and hepatitis B vaccines were administered concomitantly with specific immunoglobulins, no influence on seroconversion was observed although it may result in lower antibody titres.

Although the concomitant administration of TWINRIX and other vaccines has not specifically been studied, it is anticipated that, if different syringes and other injection sites are used, no interaction will be observed.

It may be expected that in patients receiving immunosuppressive treatment or patients with immunodeficiency, an adequate response may not be achieved.

#### **4.6 Fertility, pregnancy and lactation**

##### Pregnancy

TWINRIX should be used during pregnancy only when clearly needed, and when the possible advantages outweigh the possible risks for the foetus.

The effect of TWINRIX on embryo-foetal, peri-natal and post-natal survival and development has not been prospectively evaluated in clinical trials.

The effect of TWINRIX on embryo-foetal, peri-natal and post-natal survival and development has been assessed in rats. Such animal studies do not indicate direct or indirect harmful effects with respect to fertility, pregnancy, embryonal/foetal development, parturition or post-natal development.

##### Breast-feeding

Adequate human data on use during lactation and adequate animal reproduction studies are not available. TWINRIX should therefore be used with caution in breastfeeding women.

#### Fertility

No data available.

#### **4.7 Effects on ability to drive and use machines**

The vaccines are unlikely to produce an effect on the ability to drive and use machines.

#### **4.8 Undesirable effects**

The safety profile presented below with TWINRIX is based on data from more than 6,000 subjects who received either the standard 0, 1, 6 month schedule or the accelerated 0, 7, 21 days schedule.

In a comparative study, it was noted that the frequency of solicited adverse events following the administration of TWINRIX is not different from the frequency of solicited adverse events following the administration of the monovalent vaccines.

Frequencies per dose are defined as follows:

Very common:  $\geq 1/10$

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

Uncommon:  $\geq 1/1,000$  to  $< 1/100$

Rare:  $\geq 1/10,000$  to  $< 1/1,000$

Very rare:  $< 1/10,000$

#### Infections and infestations

*Uncommon:* upper respiratory tract infection

#### Blood and lymphatic system disorders

*Rare:* lymphadenopathy

#### Metabolism and nutrition disorders

*Rare:* decreased appetite

#### Nervous system disorders

*Very common:* headache

*Uncommon:* dizziness

*Rare:* hypoaesthesia, paraesthesia

#### Vascular disorders

*Rare:* hypotension

#### Gastrointestinal disorders

*Common:* gastrointestinal symptoms (such as diarrhoea, nausea, vomiting)

#### Skin and subcutaneous tissue disorders

*Rare:* rash, pruritus

*Very rare:* urticaria

### Musculoskeletal and connective tissue disorders

*Uncommon:* myalgia

*Rare:* arthralgia

### General disorders and administration site conditions

*Very common:* pain and redness at the injection site, fatigue

*Common:* swelling at the injection site, injection site reaction, malaise

*Uncommon:* fever ( $\geq 37.5^{\circ}\text{C}$ )

*Rare:* influenza like illness, chills

In a clinical trial where TWINRIX was administered at 0, 7, 21 days, solicited general symptoms were reported with the same categories of frequency as defined above. After a fourth dose given at month 12, the incidence of systemic adverse reactions was comparable to that seen after vaccination at 0, 7, 21 days.

During post-marketing surveillance, the following adverse reactions have been reported with TWINRIX or with monovalent hepatitis A or B vaccines:

Infections and infestations: meningitis

Blood and lymphatic system disorders: thrombocytopenia, thrombocytopenic purpura

Immune system disorders: anaphylaxis, allergic reactions including anaphylactoid reactions and mimicking serum sickness

Nervous system disorders: encephalitis, encephalopathy, neuritis, neuropathy, paralysis, convulsions

Vascular disorders: vasculitis

Skin and subcutaneous tissue disorders: angioneurotic oedema, lichen planus, erythema multiforme

Musculoskeletal and connective tissue disorders: arthritis, muscular weakness

General disorders and administration site conditions: immediate injection site pain, stinging and burning sensation

### 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:

<https://pophealth.my.site.com/carmreportnz/s/>.

## **4.9 Overdose**

Cases of overdose have been reported during post-marketing surveillance. Adverse events reported following overdosage were similar to those reported with normal vaccine administration. For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmaco-therapeutic group: Hepatitis vaccines, ATC code J07BC20.

#### Mechanism of action

TWINRIX confers immunity against HAV and HBV infection by inducing specific anti-HAV and anti-HBs antibodies.

#### Pharmacodynamic effects

##### *Adults*

Protection against hepatitis A and hepatitis B develops within 2-4 weeks. In the clinical studies, specific humoral antibodies against hepatitis A were observed in approximately 94% of the adults one month after the first dose and in 100% one month after the third dose (i.e. month 7). Specific humoral antibodies against hepatitis B were observed in 70% of the adults after the first dose and approximately 99% after the third dose.

For use in adults, the 0, 7, 21 day primary schedule plus a fourth dose at month 12 results in 82% and 85% of vaccinees having seroprotective levels of anti-HBV antibodies at 1 and 5 weeks respectively, following the third dose. One month after the fourth dose, all vaccinees demonstrated seroprotective levels of antibody. Seropositivity rates for anti-HAV antibodies were 100% and 99.5% at 1 and 5 weeks respectively following the third dose, and reached 100% one month after the fourth dose.

In a clinical study conducted in subjects over 40 years of age, the seropositivity rate for anti-HAV antibodies and seroprotection rate against hepatitis B following TWINRIX on a 0, 1, 6 month schedule were compared with the seropositivity and seroprotection rates of monovalent hepatitis A and B vaccines when administered separately.

The seroprotection rates against hepatitis B after the administration of TWINRIX were 92% and 57% at 7 and 48 months following the first dose respectively, versus 80% and 40% after the GlaxoSmithKline Biologicals monovalent 20 µg hepatitis B vaccine, and 71% and 27% after another licensed monovalent 10 µg hepatitis B vaccine. In all groups, anti-HBs antibody concentrations decreased as age and body mass index increased; concentrations were also lower in males compared with females.

The seropositivity rates for anti-HAV antibodies after TWINRIX were 97% at both 7 and 48 months following the first dose versus 99% and 94% after the GlaxoSmithKline Biologicals monovalent hepatitis A vaccine and 99% and 96% after another licensed monovalent hepatitis A vaccine.

Subjects received an additional dose of TWINRIX to assess the immune memory 48 months after the first dose of the primary vaccination course with the same vaccine. One month after this dose, 95% of subjects elicited anti-HBV antibody concentration  $\geq 10$  mIU/ml and Geometric Mean Concentrations (GMC) increased by 179-fold (GMC of 7233.7 mIU/ml) indicative of an immune memory response.

##### *Antibody Persistence*

In two long term clinical studies conducted in adults, 20 years after the primary vaccination with TWINRIX the anti-HAV seropositivity rates were 100% and 96% respectively and the anti-HBs seroprotection rates were 94% and 92%, respectively (n=43).

## **5.2 Pharmacokinetic properties**

Evaluation of pharmacokinetic properties is not required for vaccines.

## **5.3 Preclinical safety data**

Non-clinical data reveal no special hazard for humans based on general safety studies (see Section 4.6 Fertility, pregnancy and lactation).

# **6. PHARMACEUTICAL PARTICULARS**

## **6.1 List of excipients**

TWINRIX contains aluminium phosphate, aluminium hydroxide, sodium chloride and water for injection.

### Residues

TWINRIX contains amino acids, dibasic sodium phosphate, formaldehyde, monobasic sodium phosphate, neomycin sulphate, polysorbate 20 and trometamol as residues.

## **6.2 Incompatibilities**

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

## **6.3 Shelf life**

The expiry date of the vaccine is indicated on the label and packaging. The shelf life of TWINRIX is 36 months from the date of manufacture at a temperature of +2°C to +8°C.

## **6.4 Special precautions for storage**

TWINRIX must be stored between +2 °C to +8 °C. DO NOT FREEZE; freezing destroys the potency of the product. Discard the vaccine if it has been frozen.

## **6.5 Nature and contents of container**

TWINRIX

1 mL of suspension in a pre-filled syringe (type I glass) with a plunger stopper (butyl rubber) and with a rubber tip cap.

The tip cap and rubber plunger stopper of the pre-filled syringe are not made with natural rubber latex.

Prefilled syringes in packs of 1.

Not all strengths may be distributed in New Zealand.

## 6.6 Special precautions for disposal

Any unused medicine 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:  
15/10/1998

## 10. DATE OF REVISION OF THE TEXT

10 March 2026

### Summary table of changes

Section changed	Summary of new information
1.0, 2.0, 4.0, 5.0, 6.0	Updates to remove Twinrix junior throughout

Version 9.0

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