

Premarin®
Intravenous
(conjugated estrogens, USP) for injection

Specially prepared for Intravenous & Intramuscular use

Rx only

WARNING: ENDOMETRIAL CANCER, CARDIOVASCULAR DISORDERS, BREAST CANCER and PROBABLE DEMENTIA

Estrogen-Alone Therapy

Endometrial Cancer

There is an increased risk of endometrial cancer in a woman with a uterus who uses unopposed estrogens. Adding a progestin to estrogen therapy has been shown to reduce the risk of endometrial hyperplasia, which may be a precursor to endometrial cancer. Adequate diagnostic measures, including directed or random endometrial sampling when indicated, should be undertaken to rule out malignancy in postmenopausal women with undiagnosed persistent or recurring abnormal genital bleeding. (See **WARNINGS, Malignant Neoplasms, Endometrial cancer.**)

Cardiovascular Disorders and Probable Dementia

Estrogen-alone therapy should not be used for the prevention of cardiovascular disease or dementia. (See **CLINICAL STUDIES** and **WARNINGS, Cardiovascular Disorders and Probable Dementia.**)

The Women's Health Initiative (WHI) estrogen-alone substudy reported increased risks of stroke and deep vein thrombosis (DVT) in postmenopausal women (50 to 79 years of age) during 7.1 years of treatment with daily oral conjugated estrogens (CE) [0.625 mg]-alone, relative to placebo. (See **CLINICAL STUDIES** and **WARNINGS, Cardiovascular disorders.**)

The WHI Memory Study (WHIMS) estrogen-alone ancillary study of the WHI reported an increased risk of developing probable dementia in postmenopausal women 65 years of age or older during 5.2 years of treatment with daily CE (0.625 mg)-alone, relative to placebo. It is unknown whether this finding applies to younger postmenopausal women. (See **CLINICAL STUDIES** and **WARNINGS, Probable Dementia** and **PRECAUTIONS, Geriatric Use.**)

In the absence of comparable data, these risks should be assumed to be similar for other doses of CE and other dosage forms of estrogens.

Estrogens with or without progestins should be prescribed at the lowest effective doses and for the shortest duration consistent with treatment goals and risks for the individual woman.

Estrogen Plus Progestin Therapy

Cardiovascular Disorders and Probable Dementia

Estrogen plus progestin therapy should not be used for the prevention of cardiovascular disease or dementia. (See [CLINICAL STUDIES](#) and [WARNINGS, Cardiovascular disorders](#) and [Probable Dementia](#).)

The WHI estrogen plus progestin substudy reported increased risks of DVT, pulmonary embolism (PE), stroke and myocardial infarction (MI) in postmenopausal women (50 to 79 years of age) during 5.6 years of treatment with daily oral CE (0.625 mg) combined with medroxyprogesterone acetate (MPA) [2.5 mg], relative to placebo. (See [CLINICAL STUDIES](#) and [WARNINGS, Cardiovascular disorders](#).)

The WHIMS estrogen plus progestin ancillary study of the WHI reported an increased risk of developing probable dementia in postmenopausal women 65 years of age or older during 4 years of treatment with daily CE (0.625 mg) combined with MPA (2.5 mg), relative to placebo. It is unknown whether this finding applies to younger postmenopausal women. (See [CLINICAL STUDIES](#) and [WARNINGS, Probable Dementia](#) and [PRECAUTIONS, Geriatric Use](#).)

Breast Cancer

The WHI estrogen plus progestin substudy also demonstrated an increased risk of invasive breast cancer. (See [CLINICAL STUDIES](#) and [WARNINGS, Malignant Neoplasms, Breast cancer](#).)

In the absence of comparable data, these risks should be assumed to be similar for other doses of CE and MPA, and other combinations and dosage forms of estrogens and progestins.

Estrogens with or without progestins should be prescribed at the lowest effective doses and for the shortest duration consistent with treatment goals and risks for the individual woman.

DESCRIPTION

Premarin Intravenous (conjugated estrogens, USP) for injection contains a mixture of conjugated estrogens obtained exclusively from natural sources, occurring as the sodium salts of water-soluble estrogen sulfates blended to represent the average composition of materials derived from pregnant mares' urine. It is a mixture of sodium estrone sulfate and sodium equilin sulfate. It contains as concomitant components, as sodium sulfate conjugates, 17 α -dihydroequilin, 17 α -estradiol, and 17 β -dihydroequilin.

Each Secule vial contains 25 mg of conjugated estrogens, USP, in a sterile lyophilized cake which also contains lactose 200 mg, sodium citrate 12.2 mg, and simethicone 0.2 mg. The pH is adjusted with sodium hydroxide or hydrochloric acid. The reconstituted solution is suitable for intravenous or intramuscular injection.

CLINICAL PHARMACOLOGY

Endogenous estrogens are largely responsible for the development and maintenance of the female reproductive system and secondary sexual characteristics. Although circulating estrogens exist in a dynamic equilibrium of metabolic interconversions, estradiol is the principal intracellular human estrogen and is substantially more potent than its metabolites, estrone and estriol, at the receptor level. The primary source of estrogen in normally cycling adult women is the ovarian follicle, which secretes 70 to 500 mcg of estradiol daily, depending on the phase of the menstrual cycle. After menopause, most endogenous estrogen is produced by conversion of androstenedione, secreted by the adrenal cortex, to estrone in the peripheral tissues. Thus, estrone and the sulfate-conjugated form, estrone sulfate, are the most abundant circulating estrogen in postmenopausal women.

Estrogens act through binding to nuclear receptors in estrogen-responsive tissues. To date, two estrogen receptors have been identified. These vary in proportion from tissue to tissue.

Circulating estrogens modulate the pituitary secretion of the gonadotropins, luteinizing hormone (LH) and follicle stimulating hormone (FSH), through a negative feedback mechanism. Estrogens act to reduce the elevated levels of these gonadotropins seen in postmenopausal women.

Pharmacokinetics

A. Absorption

Conjugated estrogens are water-soluble and are well-absorbed through the skin, mucous membranes, and gastrointestinal tract after release from the drug formulation.

B. Distribution

The distribution of exogenous estrogens is similar to that of endogenous estrogens. Estrogens are widely distributed in the body and are generally found in higher concentration in the sex hormone target organs. Estrogens circulate in the blood largely bound to sex hormone-binding globulin (SHBG) and albumin.

C. Metabolism

Exogenous estrogens are metabolized in the same manner as endogenous estrogens. Circulating estrogens exist in a dynamic equilibrium of metabolic interconversions. These transformations take place mainly in the liver. Estradiol is converted reversibly to estrone, and both can be converted to estriol, which is a major urinary metabolite. Estrogens also undergo enterohepatic recirculation via sulfate and glucuronide conjugation in the liver, biliary secretion of conjugates into the intestine, and hydrolysis in the intestine followed by reabsorption. In postmenopausal women a significant

proportion of the circulating estrogens exist as sulfate conjugates, especially estrone sulfate, which serves as a circulating reservoir for the formation of more active estrogens.

D. Excretion

Estradiol, estrone, and estriol are excreted in the urine along with glucuronide and sulfate conjugates.

E. Special Populations

No pharmacokinetic studies were conducted in special populations, including patients with renal or hepatic impairment.

F. Drug Interactions

Data from a single-dose drug-drug interaction study involving oral CE and MPA indicate that the pharmacokinetic dispositions of both drugs are not altered when the drugs are coadministered. No other clinical drug-drug interaction studies have been conducted with conjugated estrogens.

In vitro and in vivo studies have shown that estrogens are metabolized partially by cytochrome P450 3A4 (CYP3A4). Therefore, inducers or inhibitors of CYP3A4 may affect estrogen drug metabolism. Inducers of CYP3A4, such as St. John's wort (*Hypericum perforatum*) preparations, phenobarbital, carbamazepine, and rifampin, may reduce plasma concentrations of estrogens, possibly resulting in a decrease in therapeutic effects and/or changes in the uterine bleeding profile. Inhibitors of CYP3A4, such as erythromycin, clarithromycin, ketoconazole, itraconazole, ritonavir and grapefruit juice, may increase plasma concentrations of estrogens and may result in side effects.

CLINICAL STUDIES

Women's Health Initiative Studies

The Women's Health Initiative (WHI) enrolled approximately 27,000 predominantly healthy postmenopausal women in two substudies to assess the risks and benefits of daily oral CE (0.625 mg)-alone or in combination with MPA (2.5 mg) compared to placebo in the prevention of certain chronic diseases. The primary endpoint was the incidence of coronary heart disease [(CHD) defined as nonfatal MI, silent MI and CHD death], with invasive breast cancer as the primary adverse outcome. A "global index" included the earliest occurrence of CHD, invasive breast cancer, stroke, PE, endometrial cancer (only in CE plus MPA substudy), colorectal cancer, hip fracture, or death due to other causes. These studies did not evaluate the effects of CE-alone or CE plus MPA on menopausal symptoms.

WHI Estrogen-Alone Substudy

The WHI estrogen-alone substudy was stopped early because an increased risk of stroke was observed, and it was deemed that no further information would be obtained regarding the risks and benefits of estrogen-alone in predetermined primary endpoints.

Results of the estrogen-alone substudy, which included 10,739 women (average 63 years of age, range 50 to 79; 75.3 percent White, 15.1 percent Black, 6.1 percent Hispanic, 3.6 percent Other) after an average follow-up of 7.1 years, are presented in Table 1.

TABLE 1. RELATIVE AND ABSOLUTE RISK SEEN IN THE ESTROGEN-ALONE SUBSTUDY OF WHI^a

Event	Relative Risk CE vs. Placebo (95% nCI ^b)	CE n = 5,310 Absolute Risk per 10,000 Women-Years	Placebo n = 5,429
CHD events ^c	0.95 (0.78-1.16)	54	57
<i>Non-fatal MI</i> ^c	0.91 (0.73-1.14)	40	43
<i>CHD death</i> ^c	1.01 (0.71-1.43)	16	16
All Stroke ^c	1.33 (1.05-1.68)	45	33
<i>Ischemic stroke</i> ^c	1.55 (1.19-2.01)	38	25
Deep vein thrombosis ^{c,d}	1.47 (1.06-2.06)	23	15
Pulmonary embolism ^c	1.37 (0.90-2.07)	14	10
Invasive breast cancer ^c	0.80 (0.62-1.04)	28	34
Colorectal cancer ^c	1.08 (0.75-1.55)	17	16
Hip fracture ^c	0.65 (0.45-0.94)	12	19
Vertebral fractures ^{c,d}	0.64 (0.44-0.93)	11	18
Lower arm/wrist fractures ^{c,d}	0.58 (0.47-0.72)	35	59
Total fractures ^{c,d}	0.71 (0.64-0.80)	144	197
Death due to other causes ^{e,f}	1.08 (0.88-1.32)	53	50
Overall mortality ^{c,d}	1.04 (0.88-1.22)	79	75
Global Index ^g	1.02 (0.92-1.13)	206	201

^a Adapted from numerous WHI publications. WHI publications can be viewed at www.nhlbi.nih.gov/whi.

^b Nominal confidence intervals unadjusted for multiple looks and multiple comparisons.

^c Results are based on centrally adjudicated data for an average follow-up of 7.1 years.

^d Not included in Global Index.

^e Results are based on an average follow-up of 6.8 years.

^f All deaths, except from breast or colorectal cancer, definite or probable CHD, PE or cerebrovascular disease.

^g A subset of the events was combined in a “global index,” defined as the earliest occurrence of CHD events, invasive breast cancer, stroke, pulmonary embolism, colorectal cancer, hip fracture, or death due to other causes.

For those outcomes included in the WHI “global index” that reached statistical significance, the absolute excess risk per 10,000 women-years in the group treated with CE-alone were 12 more strokes, while the absolute risk reduction per 10,000 women-years was 7 fewer hip fractures. The absolute excess risk of events included in the “global index” was a nonsignificant 5 events per 10,000 women-years. There was no difference between the groups in terms of all-cause mortality.

No overall difference for primary CHD events (nonfatal MI, silent MI and CHD death) and invasive breast cancer incidence in women receiving CE-alone compared with

placebo was reported in final centrally adjudicated results from the estrogen-alone substudy, after an average follow-up of 7.1 years.

Centrally adjudicated results for stroke events from the estrogen-alone substudy, after an average follow-up of 7.1 years, reported no significant difference in distribution of stroke subtype or severity, including fatal strokes, in women receiving CE-alone compared to placebo. Estrogen alone increased the risk of ischemic stroke, and this excess was present in all subgroups of women examined.

Timing of the initiation of estrogen-alone therapy relative to the start of menopause may affect the overall risk benefit profile. The WHI estrogen-alone substudy stratified by age showed in women 50 to 59 years of age, a non-significant trend toward reduced risk for CHD [hazard ratio (HR) 0.63 (95 percent CI, 0.36-1.09)] and overall mortality [HR 0.71 (95 percent CI, 0.46-1.11)].

WHI Estrogen Plus Progestin Substudy

The WHI estrogen plus progestin substudy was stopped early. According to the predefined stopping rule, after an average follow-up of 5.6 years of treatment, the increased risk of invasive breast cancer and cardiovascular events exceeded the specified benefits included in the “global index.” The absolute excess risk of events included in the “global index” was 19 per 10,000 women-years.

For those outcomes included in the WHI “global index” that reached statistical significance after 5.6 years of follow-up, the absolute excess risks per 10,000 women years in the group treated with CE plus MPA were 7 more CHD events, 8 more strokes, 10 more PEs, and 8 more invasive breast cancers, while the absolute risk reductions per 10,000 women-years were 6 fewer colorectal cancers and 5 fewer hip fractures. Results of the estrogen plus progestin substudy, which included 16,608 women (average 63 years of age, range 50 to 79; 83.9 percent White, 6.8 percent Black, 5.4 percent Hispanic, 3.9 percent Other) are presented in Table 2. These results reflect centrally adjudicated data after an average follow-up of 5.6 years.

TABLE 2. RELATIVE AND ABSOLUTE RISK SEEN IN THE ESTROGEN PLUS PROGESTIN SUBSTUDY OF WHI AT AN AVERAGE OF 5.6 YEARS^{a,b}

Event	Relative Risk CE/MPA vs. Placebo (95% nCI ^c)	CE/MPA n = 8,506 Absolute Risk per 10,000 Women-Years	Placebo n = 8,102
CHD events	1.23 (0.99-1.53)	41	34
<i>Non-fatal MI</i>	<i>1.28 (1.00-1.63)</i>	<i>31</i>	<i>25</i>
<i>CHD death</i>	<i>1.10 (0.70-1.75)</i>	<i>8</i>	<i>8</i>
All Strokes	1.31 (1.03-1.68)	33	25
<i>Ischemic Stroke</i>	<i>1.44 (1.09-1.90)</i>	<i>26</i>	<i>18</i>
Deep vein thrombosis ^d	1.95 (1.43-2.67)	26	13
Pulmonary embolism	2.13 (1.45-3.11)	18	8
Invasive breast cancer ^e	1.24 (1.01-1.54)	41	33
Colorectal cancer	0.61 (0.42-0.87)	10	16
Endometrial cancer ^d	0.81 (0.48-1.36)	6	7
Cervical cancer ^d	1.44 (0.47-4.42)	2	1
Hip fracture	0.67 (0.47-0.96)	11	16
Vertebral fractures ^d	0.65 (0.46-0.92)	11	17
Lower arm/wrist fractures ^d	0.71 (0.59-0.85)	44	62
Total fractures ^d	0.76 (0.69-0.83)	152	199
Overall mortality ^f	1.00 (0.83-1.19)	52	52
Global Index ^g	1.13 (1.02-1.25)	184	165

^a Adapted from numerous WHI publications. WHI publications can be viewed at www.nhlbi.nih.gov/whi.

^b Results are based on centrally adjudicated data.

^c Nominal confidence intervals unadjusted for multiple looks and multiple comparisons.

^d Not included in “global index”.

^e Includes metastatic and non-metastatic breast cancer, with the exception of in situ breast cancer.

^f All deaths, except from breast or colorectal cancer, definite or probable CHD, PE or cerebrovascular disease.

^g A subset of the events was combined in a “global index,” defined as the earliest occurrence of CHD events, invasive breast cancer, stroke, pulmonary embolism, colorectal cancer, hip fracture, or death due to other causes.

Timing of the initiation of estrogen plus progestin therapy relative to the start of menopause may affect the overall risk benefit profile. The WHI estrogen plus progestin substudy stratified by age showed in women 50 to 59 years of age a non-significant trend toward reduced risk for overall mortality [HR 0.69 (95 percent CI, 0.44-1.07)].

Women's Health Initiative Memory Study

The WHIMS estrogen-alone ancillary study of WHI enrolled 2,947 predominantly healthy postmenopausal women 65 to 79 years of age and older (45 percent were 65 to 69 years of age; 36 percent were 70 to 74 years of age; 19 percent were 75 years of age and older) to evaluate the effects of daily CE (0.625 mg)-alone on the incidence of probable dementia (primary outcome) compared to placebo.

After an average follow-up of 5.2 years, the relative risk of probable dementia for CE-alone versus placebo was 1.49 (95 percent CI, 0.83–2.66). The absolute risk of probable dementia for CE-alone versus placebo was 37 versus 25 cases per 10,000 women-years. Probable dementia as defined in this study included Alzheimer disease (AD), vascular dementia (VaD) and mixed type (having features of both AD and VaD). The most common classification of probable dementia in the treatment group and the placebo group was AD. Since the ancillary study was conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women. (See **WARNINGS, Probable Dementia** and **PRECAUTIONS, Geriatric Use**.)

The WHIMS estrogen plus progestin ancillary study enrolled 4,532 predominantly healthy postmenopausal women 65 years of age and older (47 percent were 65 to 69 years of age; 35 percent were 70 to 74 years of age; 18 percent were 75 years of age and older) to evaluate the effects of daily CE (0.625 mg) plus MPA (2.5 mg) on the incidence of probable dementia (primary outcome) compared to placebo.

After an average follow-up of 4 years, the relative risk of probable dementia for CE plus MPA was 2.05 (95 percent CI, 1.21–3.48). The absolute risk of probable dementia for CE plus MPA versus placebo was 45 versus 22 per 10,000 women-years. Probable dementia as defined in this study included AD, VaD and mixed type (having features of both AD and VaD). The most common classification of probable dementia in the treatment group and the placebo group was AD. Since the ancillary study was conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women. (See **WARNINGS, Probable Dementia** and **PRECAUTIONS, Geriatric Use**.)

When data from the two populations were pooled as planned in the WHIMS protocol, the reported overall relative risk for probable dementia was 1.76 (95 percent CI, 1.19-2.60). Differences between groups became apparent in the first year of treatment. It is unknown whether these findings apply to younger postmenopausal women. (See **WARNINGS, Probable Dementia** and **PRECAUTIONS, Geriatric Use**.)

INDICATIONS AND USAGE

Premarin Intravenous (conjugated estrogens, USP) for injection is indicated in the treatment of abnormal uterine bleeding due to hormonal imbalance in the absence of organic pathology.

Premarin Intravenous is indicated for short-term use only, to provide a rapid and temporary increase in estrogen levels.

CONTRAINDICATIONS

Premarin Intravenous therapy should not be used in individuals with any of the following conditions:

1. Undiagnosed abnormal genital bleeding.
2. Known, suspected, or history of breast cancer.
3. Known or suspected estrogen-dependent neoplasia.
4. Active DVT, PE or a history of these conditions.
5. Active arterial thromboembolic disease (for example, stroke and MI) or a history of these conditions.
6. Known anaphylactic reaction and angioedema to Premarin Intravenous therapy.
7. Known liver dysfunction or disease.
8. Known protein C, protein S, or antithrombin deficiency or other known thrombophilic disorders.
9. Known or suspected pregnancy.

WARNINGS

See **BOXED WARNINGS**.

Premarin Intravenous for injection is indicated for short-term use. However, warnings, precautions and adverse reactions associated with oral Premarin treatment should be taken into account.

1. Cardiovascular Disorders

An increased risk of stroke and DVT has been reported with estrogen-alone therapy.

An increased risk of PE, DVT, stroke, and MI has been reported with estrogen plus progestin therapy.

Should any of these events occur or be suspected, estrogen with or without progestin therapy should be discontinued immediately.

Risk factors for arterial vascular disease (for example, hypertension, diabetes mellitus, tobacco use, hypercholesterolemia, and obesity) and/or venous thromboembolism (VTE) (for example, personal history or family history of VTE, obesity, and systemic lupus erythematosus) should be managed appropriately.

a. Stroke

In the WHI estrogen-alone substudy, a statistically significant increased risk of stroke was reported in women 50 to 79 years of age receiving daily CE (0.625 mg)-alone compared to women in the same age group receiving placebo (45 versus 33 per 10,000

women-years). (See **CLINICAL STUDIES**.) The increase in risk was demonstrated in year 1 and persisted. Should a stroke occur or be suspected, estrogen-alone therapy should be discontinued immediately.

Subgroup analyses of women 50 to 59 years of age suggest no increased risk of stroke for those women receiving CE (0.625 mg)-alone versus those receiving placebo (18 versus 21 per 10,000 women-years).

In the WHI estrogen plus progestin substudy, a statistically significant increased risk of stroke was reported in women 50 to 79 years of age receiving daily CE (0.625 mg) plus MPA (2.5 mg) compared to women in the same age group receiving placebo (33 versus 25 per 10,000 women-years). (See **CLINICAL STUDIES**.) The increase in risk was demonstrated after the first year and persisted. Should a stroke occur or be suspected, estrogen plus progestin therapy should be discontinued immediately.

b. Coronary heart disease

In the WHI estrogen-alone substudy, no overall effect on CHD events (defined as nonfatal MI, silent MI, or CHD death) was reported in women receiving estrogen-alone compared to placebo. (See **CLINICAL STUDIES**.)

In the WHI estrogen plus progestin substudy, there was a non-statistically significant increased risk of CHD events reported in women receiving daily CE (0.625 mg) plus MPA (2.5 mg) compared to women receiving placebo (41 versus 34 per 10,000 women-years). An increase in relative risk was demonstrated in year 1, and a trend toward decreasing relative risk was reported in years 2 through 5.

In postmenopausal women with documented heart disease (n = 2,763, average 66.7 years of age), in a controlled clinical trial of secondary prevention of cardiovascular disease (Heart and Estrogen/Progestin Replacement Study; HERS), treatment with daily CE 0.625 mg/MPA 2.5 mg demonstrated no cardiovascular benefit. During an average follow-up of 4.1 years, treatment with CE plus MPA did not reduce the overall rate of CHD events in postmenopausal women with established coronary heart disease. There were more CHD events in the CE plus MPA-treated group than in the placebo group in year one, but not during the subsequent years. Two thousand three hundred and twenty-one (2,321) women from the original HERS trial agreed to participate in an open-label extension of HERS, HERS II. Average follow-up in HERS II was an additional 2.7 years, for a total of 6.8 years overall. Rates of CHD events were comparable among women in the CE plus MPA group and the placebo group in the HERS, the HERS II, and overall.

c. Venous thromboembolism

In the WHI estrogen-alone substudy, the risk of VTE (DVT and PE), was increased for women receiving daily CE (0.625 mg)-alone compared to placebo (30 versus 22 per 10,000 women-years), although only the increased risk of DVT reached statistical significance (23 versus 15 per 10,000 women-years). The increase in VTE risk was demonstrated during the first 2 years. (See **CLINICAL STUDIES**.) Should a VTE occur or be suspected, estrogen-alone therapy should be discontinued immediately.

In the WHI estrogen plus progestin substudy, a statistically significant 2-fold greater rate of VTE was reported in women receiving daily CE (0.625 mg) plus MPA (2.5 mg) compared to women receiving placebo (35 versus 17 per 10,000 women-years). Statistically significant increases in risk for both DVT (26 versus 13 per 10,000 women-years) and PE (18 versus 8 per 10,000 women-years) were also demonstrated. The increase in VTE risk was demonstrated during the first year and persisted. (See **CLINICAL STUDIES**.) Should a VTE occur or be suspected, estrogen plus progestin therapy should be discontinued immediately.

2. Malignant Neoplasms

a. Endometrial cancer

An increased risk of endometrial cancer has been reported with the use of unopposed estrogen therapy in women with a uterus. The reported endometrial cancer risk among unopposed estrogen users is about 2 to 12 times greater than in non-users, and appears dependent on duration of treatment and on estrogen dose. Most studies show no significant increased risk associated with use of estrogens for less than 1 year. The greatest risk appears associated with prolonged use, with increased risks of 15- to 24-fold for 5 to 10 years or more and this risk has been shown to persist for at least 8 to 15 years after estrogen therapy is discontinued.

b. Breast cancer

The most important randomized clinical trial providing information about breast cancer in estrogen-alone users is the WHI substudy of daily CE (0.625 mg)-alone. In the WHI estrogen-alone substudy, after an average follow-up of 7.1 years, daily CE (0.625 mg)-alone was not associated with an increased risk of invasive breast cancer (relative risk [RR] 0.80). (See **CLINICAL STUDIES**.)

The most important randomized clinical trial providing information about breast cancer in estrogen plus progestin users is the WHI substudy of daily CE (0.625 mg) plus MPA (2.5 mg). After a mean follow-up of 5.6 years, the estrogen plus progestin substudy reported an increased risk of invasive breast cancer in women who took daily CE plus MPA. In this substudy, prior use of estrogen-alone or estrogen plus progestin therapy was reported by 26 percent of the women. The relative risk of invasive breast cancer was 1.24, and the absolute risk was 41 versus 33 cases per 10,000 women-years, for CE plus MPA compared with placebo, respectively. Among women who reported prior use of hormone therapy, the relative risk of invasive breast cancer was 1.86, and the absolute risk was 46 versus 25 cases per 10,000 women-years, for CE plus MPA compared with placebo. Among women who reported no prior use of hormone therapy, the relative risk of invasive breast cancer was 1.09, and the absolute risk was 40 versus 36 cases per 10,000 women-years for CE plus MPA compared with placebo. In the same substudy, invasive breast cancers were larger, were more likely to be node positive, and were diagnosed at a more advanced stage in the CE (0.625 mg) plus MPA (2.5 mg) group compared with the placebo group. Metastatic disease was rare, with no apparent difference between the two groups. Other prognostic factors, such as histologic subtype, grade and hormone receptor status did not differ between the groups. (See **CLINICAL STUDIES**.)

Consistent with the WHI clinical trial, observational studies have also reported an increased risk of breast cancer for estrogen plus progestin therapy, and a smaller increased risk for estrogen-alone therapy, after several years of use. The risk increased with duration of use, and appeared to return to baseline over about 5 years after stopping treatment (only the observational studies have substantial data on risk after stopping). Observational studies also suggest that the risk of breast cancer was greater, and became apparent earlier, with estrogen plus progestin therapy as compared to estrogen-alone therapy. However, these studies have not found significant variation in the risk of breast cancer among different estrogen plus progestin combinations, doses, or routes of administration.

The use of estrogen-alone and estrogen plus progestin has been reported to result in an increase in abnormal mammograms requiring further evaluation.

All women should receive yearly breast examinations by a healthcare provider and perform monthly breast self-examinations. In addition, mammography examinations should be scheduled based on patient age, risk factors, and prior mammogram results.

c. Ovarian cancer

The WHI estrogen plus progestin substudy reported a statistically non-significant increased risk of ovarian cancer. After an average follow-up of 5.6 years, the relative risk for ovarian cancer for CE plus MPA versus placebo was 1.58 (95 percent CI, 0.77 – 3.24). The absolute risk for CE plus MPA versus placebo was 4 versus 3 cases per 10,000 women-years.

A meta-analysis of 17 prospective and 35 retrospective epidemiology studies found that women who used hormonal therapy for menopausal symptoms had an increased risk for ovarian cancer. The primary analysis, using case-control comparisons, included 12,110 cancer cases from the 17 prospective studies. The relative risks associated with current use of hormonal therapy was 1.41 (95% confidence interval [CI] 1.32 to 1.50); there was no difference in the risk estimates by duration of the exposure (less than 5 years [median of 3 years] vs. greater than 5 years [median of 10 years] of use before the cancer diagnosis). The relative risk associated with combined current and recent use (discontinued use within 5 years before cancer diagnosis) was 1.37 (95% CI 1.27-1.48), and the elevated risk was significant for both estrogen-alone and estrogen plus progestin products. The exact duration of hormone therapy use associated with an increased risk of ovarian cancer, however, is unknown.

3. Probable Dementia

In the WHIMS estrogen-alone ancillary study of WHI, a population of 2,947 hysterectomized women 65 to 79 years of age was randomized to daily CE (0.625 mg)-alone or placebo.

After an average follow-up of 5.2 years, 28 women in the estrogen-alone group and 19 women in the placebo group were diagnosed with probable dementia. The relative risk of probable dementia for CE-alone versus placebo was 1.49 (95 percent CI, 0.83-2.66). The absolute risk of probable dementia for CE-alone versus placebo was 37 versus 25 cases

per 10,000 women-years. (See **CLINICAL STUDIES** and **PRECAUTIONS, Geriatric Use.**)

In the WHIMS estrogen plus progestin ancillary study of WHI, a population of 4,532 postmenopausal women 65 to 79 years of age was randomized to daily CE (0.625 mg) plus MPA (2.5 mg) or placebo.

After an average follow-up of 4 years, 40 women in the CE plus MPA group and 21 women in the placebo group were diagnosed with probable dementia. The relative risk of probable dementia for CE plus MPA versus placebo was 2.05 (95 percent CI 1.21-3.48). The absolute risk of probable dementia for CE plus MPA versus placebo was 45 versus 22 cases per 10,000 women-years. (See **CLINICAL STUDIES** and **PRECAUTIONS, Geriatric Use.**)

When data from the two populations in the WHIMS estrogen-alone and estrogen plus progestin ancillary studies were pooled as planned in the WHIMS protocol, the reported overall relative risk for probable dementia was 1.76 (95 percent CI, 1.19-2.60). Since both substudies were conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women. (See **PRECAUTIONS, Geriatric Use.**)

4. Gallbladder Disease

A 2- to 4-fold increase in the risk of gallbladder disease requiring surgery in postmenopausal women receiving postmenopausal estrogens has been reported.

5. Hypercalcemia

Estrogen administration may lead to severe hypercalcemia in patients with breast cancer and bone metastases. If hypercalcemia occurs, use of the drug should be stopped and appropriate measures taken to reduce the serum calcium level.

6. Visual Abnormalities

Retinal vascular thrombosis has been reported in patients receiving estrogens. Discontinue medication pending examination if there is sudden partial or complete loss of vision, or a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, estrogens should be permanently discontinued.

7. Anaphylactic Reaction and Angioedema

Cases of anaphylaxis, which developed within minutes to hours after using PREMARIN Intravenous and require emergency medical management, have been reported in the postmarketing setting. Skin (hives, pruritis, swollen lips-tongue-face) and either respiratory tract (respiratory compromise) or gastrointestinal tract (abdominal pain, vomiting) involvement has been noted.

Angioedema involving the tongue, larynx, face, hands, and feet requiring medical intervention has occurred postmarketing in patients using PREMARIN Intravenous. If angioedema involves the tongue, glottis, or larynx, airway obstruction may occur. Patients who develop an anaphylactic reaction with or without angioedema after

treatment with PREMARIN Intravenous should not receive PREMARIN Intravenous again.

8. Hereditary Angioedema

Exogenous estrogens may induce or exacerbate symptoms of angioedema, particularly in women with hereditary angioedema.

PRECAUTIONS

A. General

Premarin Intravenous for injection is indicated for short-term use. However, warnings, precautions and adverse reactions associated with oral Premarin treatment should be taken into account.

1. Addition of a progestin when a woman has not had a hysterectomy
Studies of the addition of a progestin for 10 or more days of a cycle of estrogen administration or daily with estrogen in a continuous regimen have reported a lowered incidence of endometrial hyperplasia than would be induced by estrogen treatment alone. Endometrial hyperplasia may be a precursor to endometrial cancer.

There are, however, possible risks which may be associated with the use of progestins with estrogens compared to estrogen-alone regimens. These include an increased risk of breast cancer.

2. Elevated blood pressure

In a small number of case reports, substantial increases in blood pressure have been attributed to idiosyncratic reactions to estrogens. In a large, randomized, placebo-controlled clinical trial, a generalized effect of estrogen therapy on blood pressure was not seen.

3. Hypertriglyceridemia

In women with pre-existing hypertriglyceridemia, estrogen therapy may be associated with elevations of plasma triglycerides leading to pancreatitis. Consider discontinuation of treatment if pancreatitis occurs.

4. Hepatic impairment and/or past history of cholestatic jaundice

Estrogens may be poorly metabolized in women with impaired liver function. For women with a history of cholestatic jaundice associated with past estrogen use or with pregnancy, caution should be exercised, and in the case of recurrence, medication should be discontinued.

5. Hypothyroidism

Estrogen administration leads to increased thyroid-binding globulin (TBG) levels. Women with normal thyroid function can compensate for the increased TBG by making more thyroid hormone, thus maintaining free T₄ and T₃ serum concentrations in the normal range. Women dependent on thyroid hormone replacement therapy who are also receiving estrogens may require increased doses of their thyroid replacement therapy. These women should have their thyroid function monitored in order to maintain their free thyroid hormone levels in an acceptable range.

6. Fluid retention

Estrogens may cause some degree of fluid retention. Women with conditions that might be influenced by this factor, such as a cardiac or renal dysfunction, warrant careful observation when estrogens are prescribed.

7. Hypocalcemia

Estrogen therapy should be used with caution in individuals with hypoparathyroidism as estrogen-induced hypocalcemia may occur.

8. Exacerbation of endometriosis

A few cases of malignant transformation of residual endometrial implants have been reported in women treated post-hysterectomy with estrogen-alone therapy. For women known to have residual endometriosis post-hysterectomy, the addition of progestin should be considered.

9. Exacerbation of other conditions

Estrogen therapy may cause an exacerbation of asthma, diabetes mellitus, epilepsy, migraine, porphyria, systemic lupus erythematosus, and hepatic hemangiomas and should be used with caution in women with these conditions.

B. Patient Information

Physicians are advised to discuss the contents of the **PATIENT INFORMATION** leaflet with patients who are being treated with Premarin Intravenous.

C. Laboratory Tests

Estrogen administration should be guided by clinical response at the lowest dose, rather than laboratory monitoring.

D. Drug-Laboratory Test Interactions

1. Accelerated prothrombin time, partial thromboplastin time, and platelet aggregation time; increased platelet count; increased factors II, VII antigen, VIII antigen, VIII coagulant activity, IX, X, XII, VII-X complex, II-VII-X complex, and beta-thromboglobulin; decreased levels of anti-factor Xa and antithrombin III, decreased antithrombin III activity; increased levels of fibrinogen and fibrinogen activity; increased plasminogen antigen and activity.

2. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T₄ levels (by column or by radioimmunoassay) or T₃ levels by radioimmunoassay. T₃ resin uptake is decreased, reflecting the elevated TBG. Free T₄ and free T₃ concentrations are unaltered. Patients on thyroid replacement therapy may require higher doses of thyroid hormone.

3. Other binding proteins may be elevated in serum, i.e., corticosteroid binding globulin (CBG), SHBG, leading to increased total circulating corticosteroids and sex steroids respectively. Free hormone concentrations, such as testosterone and estradiol, may be decreased. Other plasma proteins may be increased (angiotensinogen/renin substrate, alpha-1-antitrypsin, ceruloplasmin).

4. Increased plasma high-density lipoprotein (HDL) and HDL₂ subfraction concentrations, reduced low-density lipoprotein (LDL) cholesterol concentration, increased triglyceride levels.

5. Impaired glucose tolerance.

E. Carcinogenesis, Mutagenesis, and Impairment of Fertility

(See **BOXED WARNINGS**, **WARNINGS**, and **PRECAUTIONS**.)

Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, uterus, cervix, vagina, testis, and liver.

F. Pregnancy

Premarin Intravenous should not be used during pregnancy. (See **CONTRAINDICATIONS**.)

G. Nursing Mothers

Premarin Intravenous should not be used during lactation. Estrogen administration to nursing women has been shown to decrease the quantity and quality of the breast milk. Detectable amounts of estrogens have been identified in the breast milk of women receiving estrogens. Caution should be exercised when Premarin Intravenous is administered to a nursing woman.

H. Pediatric Use

Estrogen therapy has been used for the induction of puberty in adolescents with some forms of pubertal delay. Safety and effectiveness in pediatric patients have not otherwise been established.

Large and repeated doses of estrogen over an extended time period have been shown to accelerate epiphyseal closure, which could result in short adult stature if treatment is initiated before the completion of physiologic puberty in normally developing children. If estrogen is administered to patients whose bone growth is not complete, periodic monitoring of bone maturation and effects on epiphyseal centers is recommended during estrogen administration.

Estrogen treatment of prepubertal girls also induces premature breast development and vaginal cornification, and may induce vaginal bleeding. In boys, estrogen treatment may modify the normal pubertal process and induce gynecomastia.

I. Geriatric Use

There have not been sufficient numbers of geriatric patients involved in studies utilizing Premarin to determine whether those over 65 years of age differ from younger subjects in their response to Premarin.

The Women's Health Initiative Studies

In the WHI estrogen-alone substudy (daily CE [0.625 mg]-alone versus placebo), there was a higher relative risk of stroke in women greater than 65 years of age. (See **CLINICAL STUDIES**.)

In the WHI estrogen plus progestin substudy (daily CE [0.625 mg] plus MPA [2.5 mg] versus placebo), there was a higher relative risk of nonfatal stroke and invasive breast cancer in women greater than 65 years of age. (See **CLINICAL STUDIES**.)

The Women's Health Initiative Memory Study

In the WHIMS ancillary studies of postmenopausal women 65 to 79 years of age, there was an increased risk of developing probable dementia in women receiving estrogen-alone or estrogen plus progestin when compared to placebo. (See **CLINICAL STUDIES** and **WARNINGS, Probable Dementia**.)

Since both ancillary studies were conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women. (See **CLINICAL STUDIES** and **WARNINGS, Probable Dementia**.)

ADVERSE REACTIONS

See **BOXED WARNINGS, WARNINGS, and PRECAUTIONS**.

Premarin Intravenous for injection is indicated for short-term use. However, the warnings, precautions and adverse reactions associated with oral Premarin treatment should be taken into account.

The following adverse reactions have been identified during post-approval use of oral or intravenous Premarin. 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.

Genitourinary system

- Abnormal uterine bleeding/spotting.
- Dysmenorrhea or pelvic pain.
- Increase in size of uterine leiomyomata.
- Vaginitis, including vaginal candidiasis.
- Change in amount of cervical secretion.
- Change in cervical ectropion.
- Ovarian cancer.
- Endometrial hyperplasia.
- Endometrial cancer.

Breasts

- Tenderness, enlargement, pain, discharge, galactorrhea.
- Fibrocystic breast changes.
- Breast cancer.

Cardiovascular

Deep and superficial venous thrombosis.
Pulmonary embolism.
Thrombophlebitis.
Myocardial infarction.
Stroke.
Increase in blood pressure.

Gastrointestinal

Nausea, vomiting.
Abdominal cramps, bloating.
Cholestatic jaundice.
Increased incidence of gallbladder disease.
Pancreatitis.
Enlargement of hepatic hemangiomas.
Ischemic colitis.

Skin

Chloasma or melasma that may persist when drug is discontinued.
Erythema multiforme.
Erythema nodosum.
Hemorrhagic eruption.
Loss of scalp hair.
Hirsutism.
Pruritis.
Rash.

Eyes

Retinal vascular thrombosis.
Intolerance to contact lenses.

Central Nervous System

Headache.
Migraine.
Dizziness.
Mental depression.
Exacerbation of chorea.
Nervousness.
Exacerbation of epilepsy.
Dementia.
Possible growth potentiation of benign meningioma.

Miscellaneous

Increase or decrease in weight.
Glucose intolerance.
Aggravation of porphyria.
Edema.
Arthralgia.

Leg cramps.
Changes in libido.
Urticaria.
Hypocalcemia (preexisting condition).
Injection site pain.
Injection site edema.
Phlebitis (injection site).
Exacerbation of asthma.
Increased triglycerides.

OVERDOSAGE

Overdosage of estrogen may cause nausea, vomiting, breast tenderness, abdominal pain, drowsiness and fatigue, and withdrawal bleeding may occur in women. Treatment of overdose consists of discontinuation of Premarin therapy with institution of appropriate symptomatic care.

DOSAGE AND ADMINISTRATION

For treatment of abnormal uterine bleeding due to hormonal imbalance in the absence of organic pathology:

One 25 mg injection, intravenously or intramuscularly. Intravenous use is preferred since more rapid response can be expected from this mode of administration. Repeat in 6 to 12 hours if necessary. The use of Premarin Intravenous for injection does not preclude the advisability of other appropriate measures.

One should adhere to the usual precautionary measures governing intravenous administration. Injection should be made SLOWLY to obviate the occurrence of flushes.

Infusion of Premarin Intravenous for injection with other agents is not generally recommended. In emergencies, however, when an infusion has already been started it may be expedient to make the injection into the tubing just distal to the infusion needle. If so used, compatibility of solutions must be considered.

COMPATIBILITY OF SOLUTIONS: Premarin Intravenous is compatible with normal saline, dextrose, and invert sugar solutions. **It is not compatible with protein hydrolysate, ascorbic acid, or any solution with an acid pH.**

DIRECTIONS FOR STORAGE AND RECONSTITUTION

STORAGE BEFORE RECONSTITUTION: Store package in refrigerator, 2° to 8°C (36° to 46°F).

TO RECONSTITUTE: Reconstitute Premarin Intravenous with 5 mL of Sterile Water for Injection, USP. Introduce the sterile diluent slowly against the side of SECULE vial and agitate gently. **Do not shake violently. Use immediately after reconstitution.**

HOW SUPPLIED

NDC 0046-0749-05—Each package provides one SECULE vial containing 25 mg of conjugated estrogens, USP, for injection (also lactose 200 mg, sodium citrate 12.2 mg,

and simethicone 0.2 mg). The pH is adjusted with sodium hydroxide or hydrochloric acid.

Premarin Intravenous (conjugated estrogens, USP) for injection is prepared by cryodesiccation.

SECULE-Registered trademark to designate a vial containing an injectable preparation in dry form.

PATIENT INFORMATION

Premarin Intravenous (conjugated estrogens, USP) for injection

Read this PATIENT INFORMATION which describes the benefit and major risks of your treatment, as well as how and when treatment should be used. This information does not take the place of talking to your healthcare provider about your medical condition or your treatment.

What is the most important information I should know about Premarin Intravenous (an estrogen mixture)?

- Using estrogen-alone increases your chance of getting cancer of the uterus (womb)

Report any unusual vaginal bleeding right away. Vaginal bleeding after menopause may be a warning sign of cancer of the uterus (womb). Your healthcare provider should check any unusual vaginal bleeding to find out the cause.
- Do not use estrogen-alone to prevent heart disease, heart attacks, strokes, or dementia (decline in brain function)
- Using estrogen-alone may increase your chances of getting stroke or blood clots
- Using estrogen-alone may increase your chance of getting dementia, based on a study of women 65 years of age or older
- Do not use estrogens with progestins to prevent heart disease, heart attacks, strokes or dementia
- Using estrogens with progestins may increase your chances of getting heart attacks, strokes, breast cancer, or blood clots
- Using estrogens with progestins may increase your chance of getting dementia, based on a study of women 65 years of age or older
- You and your healthcare provider should talk regularly about whether you still need treatment with estrogens

What is Premarin Intravenous?

Premarin Intravenous is a medicine that contains a mixture of estrogen hormones.

Premarin Intravenous is used to:

- Treat certain types of abnormal uterine bleeding due to hormonal imbalance when your doctor has found no other cause of bleeding

Who should not use Premarin Intravenous?

Premarin Intravenous should not be used if you:

- **Have unusual vaginal bleeding that has not been evaluated by your healthcare provider**
- **Currently have or have had certain cancers**
Estrogens may increase the chance of getting certain types of cancers, including cancer of the breast or uterus. If you have or have had cancer, talk with your healthcare provider about whether you should use Premarin Intravenous.
- **Had a stroke or heart attack**
- **Currently have or have had blood clots**
- **Currently have or have had liver problems**
- **Have been diagnosed with a bleeding disorder**
- **Are allergic to Premarin Intravenous or any of its ingredients**
See the list of ingredients in Premarin Intravenous at the end of this leaflet.
- **Think you may be pregnant**

Tell your healthcare provider:

- **If you are breast feeding**
The hormones in Premarin Intravenous can pass into your breast milk.
- **About all of your medical problems**
Your healthcare provider may need to check you more carefully if you have certain conditions, such as asthma (wheezing), epilepsy (seizures), diabetes, migraine, endometriosis, lupus, problems with your heart, liver, thyroid, kidneys, or have high calcium levels in your blood.
- **About all the medicines you take**
This includes prescription and nonprescription medicines, vitamins, and herbal supplements. Some medicines may affect how Premarin Intravenous works.

What are the possible side effects of Premarin Intravenous?

Premarin Intravenous is for short-term use only. However, the risks associated with oral Premarin treatment should be taken into account.

Side effects are grouped by how serious they are and how often they happen when you are treated.

Serious, but less common side effects include:

- Heart attack
- Stroke

- Blood clots
- Dementia
- Breast cancer
- Cancer of the lining of the uterus (womb)
- Cancer of the ovary
- High blood pressure
- High blood sugar
- Gallbladder disease
- Liver problems
- Enlargement of benign tumors of the uterus (“fibroids”)
- Severe allergic reactions

Call your healthcare provider right away if you get any of the following warning signs or any other unusual symptoms that concern you:

- New breast lumps
- Unusual vaginal bleeding
- Changes in vision or speech
- Sudden new severe headaches
- Severe pains in your chest or legs with or without shortness of breath, weakness and fatigue
- Swollen lips, tongue and face

Less serious, but common side effects include:

- Headache
- Breast pain
- Irregular vaginal bleeding or spotting
- Stomach or abdominal cramps, bloating
- Nausea and vomiting
- Hair loss
- Fluid retention
- Vaginal yeast infection

These are not all the possible side effects of Premarin. For more information, ask your healthcare provider or pharmacist for advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

What can I do to lower my chances of getting a serious side effect with Premarin Intravenous?

- If you have high blood pressure, high cholesterol (fat in the blood), diabetes, are overweight, or if you use tobacco, you may have higher chances for getting heart disease

Ask your healthcare provider for ways to lower your chances for getting heart disease.

General information about the safe and effective use of Premarin Intravenous

Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets. Do not use Premarin Intravenous for conditions for which it was not prescribed. Do not give Premarin Intravenous to other people, even if they have the same symptoms you have. It may harm them. **Keep Premarin Intravenous out of the reach of children.**

This leaflet provides a summary of the most important information about Premarin Intravenous. If you would like more information, talk with your healthcare provider or pharmacist. You can ask for information about Premarin Intravenous that is written for health professionals. To report SUSPECTED ADVERSE REACTIONS, contact Pfizer at 1-800-438-1985 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

What are the ingredients in Premarin IV?

Premarin Intravenous for injection contains a mixture of conjugated estrogens, which are a mixture of sodium estrone sulfate and sodium equilin sulfate and other components including sodium sulfate conjugates: 17 α -dihydroequilin, 17 α -estradiol, and 17 β -dihydroequilin. Premarin Intravenous for injection also contains lactose, sodium citrate, simethicone, and sodium hydroxide or hydrochloric acid in dry form. The reconstituted solution is suitable for intravenous or intramuscular injection.

Each Premarin Intravenous (conjugated estrogens, USP) for injection package provides 25 mg of conjugated estrogens, USP, in dry form for intravenous or intramuscular use.

This product's label may have been updated. For current full prescribing information, please visit www.pfizer.com.



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Rx only

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